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Contingency and Change in the Practice of Female Genital Cutting: Dynamics of Decision Making in Senegambia

Summary Report

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Executive Summary

After decades of programming efforts yielding, in many instances, limited results, many observers and participants in the global campaign to end female genital cutting (FGC) have echoed a question posed by a World Health Organization review: *What works and what doesn't?* In addressing this question, a lack of understanding of the process of decision making and change in the practice of FGC becomes glaringly apparent. The objective of this research was to develop an improved understanding of the dynamics of decision making, and to assess the correspondence of these dynamics to theories of behavior change. It is our hope that improved theoretical and empirical insights on the dynamics of change will assist in the design, implementation, and evaluation of increasingly effective programs aimed at ending FGC.

The main questions guiding this research were: Are there stages of readiness to change the practice of FGC? Who are the decision makers, and what stake do they hold in the practice? What motivates individuals to change, and how do broader social factors or contingencies influence the change process? Do theories on behavior change correspond with observed dynamics of change, and provide insights for designing programs to end the practice of FGC? What are the effects of legislation banning FGC?

This mixed-method study was conducted in Senegal and The Gambia in communities purposely selected to allowed comparisons across a range of factors including age, gender, ethnicity, urban versus rural residence, differing interventions and among contiguous rural communities bisected by a national border. Data collection was conducted in three phases: 1) qualitative research involving in depth interviews and focus group discussions, 2) developing and pretesting an ethnographically grounded survey instrument, and 3) survey data collection.

Key findings from this study are as follows:

- Across generations, the way that FGC is being practiced is changing in key ways. Ritual training and celebration are less common, and increasingly it is being performed individually and at home, rather than in groups in the bush. Additionally, the age at circumcision is declining. Although many informants voiced support for reducing the degree of cutting, comparisons of mothers and daughters show there are no significant changes in the severity of cutting.
- Decision making is often done by multiple family members, and despite being described as "women's business," fathers were often involved; in comparison to other decision makers, more fathers were involved in conversations regarding girls who remained uncircumcised, and 50% fewer Senegalese fathers, as compared to mothers, were supporters of FGC. This suggests that men can play an important role in ending the practice.
- Because there are often multiple decision makers and broader social sanctions for not conforming with the practice of FGC, individuals are often not able to act upon their intentions. Consequently, the concept of readiness to change is a complex construct that involves two dimensions: preference and actual behavior. We identify five categories of readiness to change: 1) supporters of FGC, 2) reluctant practitioners (those who practice FGC despite opposing its continuation), 3) contemplators (adherents of FGC considering abandonment), 4) willing abandoners, and 5) reluctant abandoners. We demonstrate that it is possible to identify change short of total abandonment, providing potentially useful metrics for monitoring and evaluation.
- Motivation to change is influenced by weighing the advantages of the practice of FGC against the perceived risks. We had hypothesized that knowledge of health risks does not influence motivation to change since campaigns have delivered health risk messages for decades without causing widespread abandonment. Surprisingly, we find that the health risk message resonates strongly among willing abandoners, in large part because of a shift away from a primary focus on obstetrical risk, and instead focusing new messaging on HIV/AIDS risk. The newness of the threat of HIV/AIDS

makes this message less threatening to the value of tradition and wisdom of elders. Internalization of the health message is associated not only with abandonment of FGC, but also medicalization of the practice. Thus, in order to avoid promotion of medicalization, campaigns should emphasize that the safest way to avert HIV infection is to entirely abandon the practice of FGC, rather than using one blade per girl.

- Social convention theory, a game-theoretic approach to understanding decision making regarding FGC, has advantages over rational choice approaches that weigh costs against benefits because it considers the interdependent nature of decision making and the need to coordinate change. According to social convention theory, FGC emerged under highly stratified social conditions as a means of securing better marriage opportunities for daughters, and spread to become a prerequisite for marriage for all women. The practice became "locked in place" by parents' expectation that their daughters' peers will all be circumcised and prospective husbands' expectation that their wives will be circumcised. Social convention theory predicts that change in FGC will result from coordinated agreement within an intramarrying group to abandon the practice and create a marriage market for uncircumcised girls. While we do find evidence for a convention operating to maintain FGC in Senegambia, it does not appear to be driven primarily by concerns regarding marriagability. In our study sites, interethnic and FGC-discordant marriages are far from anomalous, and many men, from both circumcising and non-circumcising families, are willing to marry uncircumcised women. Instead, FGC in the Senegambia seems to be best described as a peer convention: we propose that being circumcised serves as a signal to other circumcised women that a girl or woman has been trained to be obedient, respects the authority of her circumcised elders and is worthy of inclusion in their network for social support. In this manner, FGC facilitates the accumulation of social capital by younger women and of power and prestige by elder women. Based on this new evidence and reinterpretation of social convention theory, we suggest that interventions need to coordinate change among interconnected members of social networks which are intergenerational, and include both men and women.
- We identify contingencies – proximate social experiences and actors – affecting an individual's shifting opinion about FGC over time: health risk messages, migration, pressure to conform, marriagability, acceptability of interethnic marriage, female social pressure, influential leaders, difficulty finding qualified circumcisers and religion. Multivariate analyses indicate that the factors that are most strongly associated with abandonment of FGC are peer pressure and pressure to conform. This lends additional support to our finding that FGC is maintained by an intergenerational peer convention.
- In order to assess the impact of legislation as a means of reducing the practice of FGC, we present our findings from Senegal, where FGC was outlawed in 1999. Supporters of legislative reform argue that legal prohibition of FGC has a general deterrent effect, while other argue legislation, as a top-down approach, can be perceived as coercive, and derail local efforts to end the practice. We find that in our study communities, mass enforcement of the law is not required to provide a deterrent effect on FGC. However, while fear of prosecution increased motivation to abandon FGC for some, it did not, in most instances, lead to actual change until the Tostan program coordinated abandonment. Moreover, legislation generated multiple responses, not just within a single region or village, but even in some instances within extended families. These include driving the practice underground, inciting resentment for criminalizing culture, and driving away circumcisers considered to be qualified and trustworthy. At the same time, some individuals who had or wished to abandon FGC welcomed the passage of the law. This demonstrates that a legislative approach can work in a complementary fashion with an integrated community intervention approach by creating what UNICEF refers to as "an enabling environment."

Résumé

Après des décennies d'efforts pour mettre en oeuvre des programmes n'ayant donné, dans la plupart des cas que des résultats limités, plusieurs observateurs et participants à la campagne globale pour que cessent les mutilations génitales féminines (MGF) se sont fait l'écho des questions posées par une publication de l'Organisation mondiale de la santé : *Qu'est-ce qui marche et qu'est-ce qui ne marche pas?* En tentant de répondre à celles-ci, il devient évident, que l'on ne comprends pas le processus de prise de décision ni les changements apparus dans la pratique des MGF. L'objectif de cette recherche était de concevoir une meilleure compréhension de la dynamique de prise de décision et de comparer ces mécanismes aux théories de changement de comportement. Nous espérons que les approches théoriques et empiriques améliorées de ces dynamiques de changement puissent contribuer à une meilleure conception, mise en oeuvre et évaluation de programmes dont les résultats sont devenus meilleurs ayant pour objectif l'élimination des MGF.

Les questions essentielles formant la base pour cette recherche étaient: Observe-t-on des phases dans le volonté de changement dans la pratique des MGF? Qui sont les décisionnaires et quel est leur part dans cette pratique? Qu'est-ce qui motive les individus à changer et comment les déterminants sociaux plus étendus ou autres éventualités influenceraient-elles le processus de changement? Les théories de changement de comportement correspondent-ils aux changement de dynamiques observés et offrent-elles des pistes pour concevoir des programmes pour que cessent les MGF? Quels sont les effets de la législation interdisant les MGF?

Cette étude à méthode mixte a été conduite au Sénégal et en Gambie parmi des communautés sélectionnées précisément pour permettre la comparaison d'un éventail de facteurs dont l'âge, le sexe, l'éthnicité, différence de résidence - urbaine ou rurale, différences d'interventions et parmi communautés rurales contigues mais séparées par une frontière. La collection de données était conduite en trois phases: 1) recherche qualitative comprenant des entretiens approfondies et se concentrant sur des discussions en groupe, 2) Développer et pré-tester un outil de sondage basé sur l'éthnographie, 3) collecte de données de l'enquête.

Les principales découvertes de cette étude sont :

- A travers les générations, la façon de pratiquer les MGF a changé de manières importantes. Les initiations rituelles et cérémonies sont moins habituels et de façon croissante, elles sont pratiquées individuellement et dans les foyers, plutôt qu'en groupe et dans la nature. En outre, l'âge de l'excision est en baisse. Même si plusieurs sources manifestaient leur soutien pour la réduction du degré des mutilations, la comparaison entre les mères et leurs filles démontre qu'il n'y a pas de changement les types de mutilations.
- La prise de décision est souvent effectuée par plusieurs membres de la famille, et malgré le fait qu'elle soit décrite comme étant une "affaire de femmes", les pères étaient souvent impliqués; en comparaison avec d'autres décisionnaires, plus de pères étaient présents lors de discussions se rapportant aux filles qui demeuraient non mutilées, et la moitié moins de pères sénégalais, comparée au nombre de mères, étaient en faveur des MGF. Ceci suggère, que les hommes pourraient jouer un rôle important dans la cessation de cette pratique.
- Comme il y a souvent des décisionnaires multiples et à cause des sanctions sociales plus importants si on ne se conforme pas à la pratique des MGF, les individus ne sont souvent pas à même de s'en tenir à leur intentions. Par conséquent, le concept de la volonté de changer est un édifice complexe qui comprend deux dimensions : la préférence et le comportement effectif. Le fait d'être prêt pour un changement nous apparaît sous cinq catégories: 1) les "supporters," 2) les "praticiens réticents" (ceux qui continuent à pratiquer les MGF malgré leur opposition à leur maintien, 3) les "contemplateurs" (ceux qui adhèrent à la pratique des MGF bien que pensant l'abandonner), 4) les "abandonneurs" volontaires, 5) les "abandonneurs" réticents. Nous démontrons qu'il est possible

d'identifier le changement, proche de l'abandon total, en fournissant un système de mesure potentiellement utile.

- La motivation pour le changement est influencée par la comparaison des avantages de la pratique des MGF aux risques perçus. Nous avions émis l'hypothèse, selon laquelle la connaissance des risques pour la santé n'influençait pas la motivation pour le changement parce que des campagnes de sensibilisation aux risques pour la santé avaient conduites durant des décennies n'ont pas eu pour autant comme résultat l'arrêt répandue de cette pratique. Etonnamment, nous avons découvert, que les messages montrant les risques sanitaires résonnaient fortement parmi les "abandonneurs volontaires", en grande partie à cause d'un transfert de la première préoccupation sur les risques obstétriques à un nouvelle concentration d'efforts sur une communication liée aux risques liés au VIH/SIDA. La nouveauté que représente la menace du VIH/SIDA a moins d'effet sur les valeurs traditionnelles et la sagesse des anciens. L'internationalisation du message sanitaire est non seulement associée à l'abandon de la pratique des MGF, mais aussi à la médicalisation de cette pratique. Ainsi, afin d'éviter la promotion de la médicalisation, les campagnes devraient insister sur le fait que l'abandon total de la pratique des MGF est la façon la plus sure pour éviter l'infection du VIH/SIDA plutôt que n'utiliser qu'une lame par fille.
- La théorie de conventions sociales, une approche "game theory" pour comprendre la prise de décision concernant les MGF, a ses avantages par rapport au choix rationnel qui compare les avantages et inconvénients car il considère la nature interdépendante de la prise de décision et le besoin pour coordonner le changement. Selon la théorie des conventions sociales, les MGF sont apparus sous une structure sociale extrêmement hiérarchisée comme moyen pour assurer de meilleures opportunités de mariage pour les filles, et s'est étendue pour devenir une condition préalable au mariage pour l'ensemble des femmes. La pratique devenait comme ancrée pour les parents dont l'attente était qu'en plus de leurs propres filles, les autres filles seraient toutes excisées et que les maris potentiels s'attendaient à ce que leurs femmes fussent toutes excisées. La théorie des conventions sociales prédit que les changements concernant les MGF résulteraient en un accord coordonné à l'intérieur d'un groupe de personnes se mariant entre elles afin d'abandonner la pratique des MGF et créer une opportunité de mariage pour les filles n'ayant pas subi les MGF. Alors que nous avons des preuves d'une convention visant à maintenir les MGF en Sénégambie, il ne semble pas qu'elle soit guidée principalement par des préoccupations liées à l'éligibilité au mariage. A l'intérieur de nos sites-cibles, les mariages interethniques et à opinions sur les MGF opposées sont loin d'être exceptionnels, and plusieurs hommes, issues aussi bien de familles pratiquant l'excision et de familles ne la pratiquant pas, sont prêts à épouser des femmes non excisées. Au lieu de ceci, les MGF en Sénégambie semblent être le mieux définies comme des conventions de pairs : nous suggérons que le fait d'être excisée est une indication pour les autres femmes excisées qu'une femme ou une jeune fille a été formée pour être obéissante, qu'elle respecte l'autorité des ses ainées elles aussi excisées et mérite sa place parmi les cercles sociaux bénéficiant ainsi de leur soutien. Ainsi, l'excision facilite l'accumulation d'un capital social pour les jeunes femmes et de pouvoir et prestige parmi les ainées. Selon ces nouvelles découvertes et la réinterprétation de la théorie de la convention sociale, nous suggérons que les interventions doivent coordonner le changement parmi les membres interconnectés des réseaux sociaux qui sont intergénérationnels et qui comprennent aussi bien des hommes que des femmes.
- Nous avons identifié des contingents - actions sociales de proximité et acteurs - affectant l'opinion d'un individu sur les MGF changeante avec le temps : les messages comprenant la mention du risque sanitaire, les migrations, les pressions pour se conformer, l'éligibilité au mariage, l'acceptation d'un mariage interethnique, pression sociale féminine, dirigeants influents, la difficulté à trouver des exciseuses qualifiées dans la région. Les analyses à variables multiples indiquent que les facteurs les plus fortement associés à l'abandon de la pratique des MGF sont la pression des pairs et la pression

pour se conformer aux traditions. Ceci soutien d'avantage encore notre découverte selon laquelle le maintien des MGF repose sur une convention intergénérationnelle de pairs.

- Afin d'évaluer l'impact de la législation en tant que moyen visant à réduire la pratique des MGF, nous présentons nos découvertes au Sénégal, où les MGF furent interdits par la loi en 1999. Les supporters de la réforme législative soutiennent que l'interdiction légale des MGF a un effet général dissuasif, tandis que d'autres considèrent la législation comme étant à approche du haut vers le bas, pouvant être perçue comme contraignante et entraver les efforts sur le plan local pour en finir avec cette pratique. Nous avons trouvé dans nos communautés étudiées, imposer fortement la loi n'était pas nécessaire pour obtenir un effet dissuasif sur les MGF. Cependant, tandis que la peur d'être poursuivi augmentait la motivation pour abandonner les MGF pour certains, il n'a pas encouragé le changement, dans la plupart des cas, avant que le programme Tostan coordonnait l'abandon. Du reste, la législation a généré des réponses multiples, non seulement à l'intérieur d'une seule région ou d'un seul village, mais même dans certains cas parmi des familles étendues. Celle-ci comprend le fait de rendre la pratique clandestine incitant à une aversion envers la criminalisation d'une tradition, et éloignant les exciseuses considérées comme qualifiées et dignes de confiance. Au même moment, les individus ayant abandonné ou ayant souhaité l'abandon des MGF accueillaient avec plaisir la nouvelle loi. Ceci démontre qu'une approche législative peut avoir un effet complémentaire à une intervention communautaire en créant ce qu'UNICEF appelle un "environnement habilitant".

I. Introduction to the Study

Summary

After decades of programming efforts yielding, in many instances, limited results, many observers and participants in the global campaign to end female genital cutting (FGC) have echoed a question posed by a World Health Organization review: *What works and what doesn't?* In addressing this question, a lack of understanding of the process of decision making and behavior change regarding FGC becomes glaringly apparent. Theoretical models of behavior change are needed to better understand behavior change.

The broad long-term objective of this research was to develop an improved understanding of the dynamics of decision making, and to assess the correspondence of these dynamics to theories of behavior change. It is our hope that improved theoretical and empirical insights on the dynamics of change will assist in the design, implementation, and evaluation of increasingly effective programs aimed at ending FGC.

The specific aims of this research were:

1. To investigate the decision making process regarding change or abandonment of the practice of FGC, and to assess whether stages or categories of readiness to change could be identified.
2. To identify and quantify interdependent social factors which represented contingencies for changing the practice of FGC.
3. To identify and measure constructs associated with the perceived advantages and disadvantages of FGC and sources of influence on motivation to proceed with change.
4. To identify factors that influence the ability to maintain the decision to abandon FGC.
5. To identify the constellation of decision makers involved in the decision of whether and how to proceed with FGC.
6. Among decision makers, to assess the readiness to change with respect to the practice of FGC.
7. To assess responses to legislation banning FGC, and its ability to deter FGC.
8. To empirically test predictions from theories of behavior change in order to gain insights on the dynamics of change.

This mixed-method study was conducted in three sites in Senegambia: 1) peri-urban communities surrounding Banjul, 2) rural communities in the North Bank border region in The Gambia, and 3) communities on the opposite side of the border in Senegal, some of whom have participated in the Tostan program. Data collection was conducted in three phases: 1) qualitative research involving in depth interviews and focus group discussions, 2) developing and pretesting an ethnographically grounded survey instrument, and 3) survey data collection. Our research methods are described in this chapter.

Introduction

Female genital cutting (FGC), also known as female genital mutilation (FGM) or female "circumcision," refers to a set of practices involving the partial or complete removal of the external female genitalia. These practices can be found in a wide variety of contexts throughout much of Africa and the African diaspora, as well as parts of the Middle East and Asia. Although opposition to the practice can be traced back to early 20th century colonial governments and Christian missionaries, a more recent resurgence in opposition and subsequent intervention was sparked by a series of conferences starting in the 1970s, in which FGM became framed as an assault on women's health and

well-being (Shell-Duncan and Hernlund 2000). In the last two decades the international community, national and local institutions, and the governments of numerous countries have openly taken a stance against FGM, which is increasingly being considered a human rights violation (Hernlund and Shell-Duncan 2007; Shell-Duncan 2008). Political action and advocacy have fueled numerous campaigns aimed at eliminating FGM, utilizing a variety of approaches.

Most common have been educational campaigns highlighting the adverse health outcomes, assuming that as people become aware of the risks, they will be motivated to abandon the practice. This approach has failed to recognize the broader social factors motivating the practice, and there is little evidence that it has resulted in significant behavior change. Recently, however, there have been reported cases of community abandonment, in, for example, Egypt (Hadi 1998) and Ethiopia (Dagne 2009; UNICEF 2010). Perhaps better known are the developments in Senegal, where the NGO Tostan has, as part of a broader program of education and empowerment, initiated a movement of public collective anti-FGM pledges (Mackie 2000). The various forms of Tostan interventions, which have now been successfully implemented in other West African countries including Guinea and The Gambia, are arguably the most successful anti-FGM program completed thus far (see the long-term evaluation on the Tostan program by UNICEF 2008). However, efforts to replicate the results in other countries have not been uniformly successful (Melching, personal communication), raising the question of what is required to scale up or transfer this approach to different cultural settings. Other approaches that have been used to end FGC include intergenerational dialogues, compensate-the-cutter programs, various forms of alternative rituals, and the passage of legislation specifically banning FGC.

After decades of programming efforts yielding, in many instances, limited results, many observers and participants in the global campaign to end FGC have echoed a question posed by a World Health Organization (WHO 1999) review: *What works and what doesn't?* In addressing this question, a lack of understanding of the process of decision making and behavior change regarding FGM becomes glaringly apparent. One review of intervention efforts (Frontiers in Reproductive Health/Population Council 2002; henceforth Frontiers 2002) emphasizes that intervention research needs to be informed by theory on behavior change. The report notes that, for the most part, "interventions have been implemented with little attempt to…elucidate their impact on knowledge, beliefs, attitudes and behaviors" (Frontiers 2002:1), and proceeds to argue that theoretical models of behavior change are needed to understand why and how interventions cause change.

A significant body of academic research has, indeed, focused on the development of theoretical models of behavior change. These models fall broadly under two main paradigms: 1) decision-theoretic models, and 2) game-theoretic models. Decision-theoretic models employ a rational choice approach for weighing costs and benefits of behavioral options for independent actors. For example, community-based health education programs, which were widely employed in the first two decades of the global campaign to end FGC (and still are used, though now often alongside other approaches), were framed by a health-belief model that employs a rational choice approach. These programs centered on delivering messages about the adverse health risks of FGC, assuming that improved knowledge of medical risks would alter the cost-benefit calculus of proceeding with FGC, and promote behavior change. For a variety of reasons, community-based health education programs alone have failed to motivate large-scale abandonment of FGC, and in some cases may have yielded unintended consequences, such as medicalization of the practice (Shell-Duncan 2001; Shell-Duncan 2008).

Modernization theory is another example of a decision-theoretic model. The central tenet of modernization theory is that improvements in socioeconomic status and education, particularly for women, will have far reaching social effects, including a decline in the demand for FGC (Kennedy 1970; Hayes 1975; van der Kwaak 1992). Empirical evidence for modernization theory is, however, unconvincing. While some studies find support for modernization theory (Kennedy 1970; Assaad 1980; Caldwell, Orubuloye et al. 1997), they fail to document a causal relationship between socioeconomic

status and changes in the practice of FGC. Other studies report a lack of change in FGC with modernization and development (Shell-Duncan, Obiero et al. 2000), or a higher prevalence of genital cutting in association with urban residence, increased wealth, and higher levels of education (El Dareer 1982; Lightfoot-Klein 1989; Gallo and Viviani 1992; Mackie 1996; Carr 1997; Balk 2000).

Each of these decision-theoretic models, as well as others, rest on the assumption that costs and benefits are weighed by individuals who are capable of acting upon their own intention. As an alternative to the rational choice models, Mackie (1996; 2000) has proposed a game-theoretic model, convention theory, which delineates the means by which actions of individuals are interdependent, necessitating coordinated change among interconnected actors. Drawing analogies with foot binding, which ended rapidly after being practiced in China for over 1,000 years, Mackie (2000) argues that FGC and foot binding are conventions maintained by interdependent expectations in the marriage market. Once it is practiced at high frequencies, the practice becomes locked in place because those who fail to comply also risk failure to marry and reproduce. Abandonment of FGC is predicted to occur as a result of a convention shift, whereby a critical mass of people is educated about the adverse consequences of FGC, pledges to abandon the practice, and eliminates FGC as a prerequisite for marriage. Mackie finds strong correspondence between convention theory and the Senegalese Tostan project of public declarations in Senegal to abandon FGC (see Mackie 1996; Mackie 2000).

Yet in assessing theoretical models of behavior change and designing intervention programs to end the practice of FGC, empirical evidence about the dynamics of decision making are needed. Yoder (2004) stresses the importance of empirical research on how female circumcision is being conducted so that program specialists can design effective interventions. He notes that FGC occurs most often in one of two social contexts: 1) within families that are part of clans or ethnic groups that practice it routinely; or 2) in mixed contexts (usually urban, occasionally rural) where some families or groups practice FGC and others do not. He urges that "a better understanding of how circumcision occurs in both of these contexts can provide valuable information for programs seeking to abolish FGC" (Yoder 2004:14).

The broad long-term objective of this research was to develop an improved understanding of the dynamics of decision making, and to assess the correspondence of these dynamics to theories of behavior change. It is our hope that the points of correspondence and departure with current theories of behavior change will lead to refinement and advances in theory. And more importantly, it is our hope that improved theoretical and empirical insights on the dynamics of change will assist in the design and implementation of increasingly effective programs aimed at ending FGC.

The specific aims of this research were:

1. To investigate the decision making process regarding change or abandonment of the practice of FGC, and to assess whether stages or categories of readiness to change could be identified.
2. To identify and quantify interdependent social factors which represented contingencies for changing the practice of FGC.
3. To identify and measure constructs associated with the perceived advantages and disadvantages of FGC and sources of influence on motivation to proceed with change.
4. To identify factors that influence the ability to maintain the decision to abandon FGC.
5. To identify the constellation of decision makers involved in the decision of whether and how to proceed with FGC.
6. Among decision makers, to assess the readiness to change with respect to the practice of FGC.
7. To assess responses to legislation banning FGC, and its ability to deter FGC.
8. To empirically test predictions from theories of behavior change in order to gain insights on the dynamics of change.

Study Population

This research project was conducted at sites located in the West African nations of Senegal and The Gambia. Often these nations are referred to collectively as Senegambia, owing to the fact that they share much in common in terms of language, dominant religion (over 90% Muslim in both), subsistence activities, cultural practices, landscape, and climate. Geographically, Senegal is the western-most country on the African continent, extending to the western edge of the Sahel, with an area of just under 200,000 square kilometers, and a population estimated in 2008 at 12.2 million (The World Bank, 2009). The tiny nation of The Gambia (only 11, 295 square kilometers, with a population of 1.6 million) is a long thin strip of land that extends from the Atlantic coast inward 300 kilometers along the banks of the Gambia River (The World Bank, 2009). It is an enclave, bordered on three sides by Senegal, which nearly bisects the nation of Senegal. The national borders are a vestige of colonial rule: Senegal was formerly ruled by France, while the British controlled the Gambia River. Post-independence, each nation has remained an autonomous state, despite sharing a common historical and cultural heritage.

As the practice of FGC is most closely tied to ethnic affiliation, the overall prevalence rates for The Gambia and Senegal vary. For example, the Wolof, who largely do not practice FGC, are the ethnic majority in Senegal, yet make up only 16% of the Gambian population; the Mandinka, who almost universally practice FGC, constitute 42% of the population in The Gambia, and a much smaller proportion in Senegal (according to the U.S. State Department, 19% of the Senegalese population is made up of Mandinka/Mandingue, Jola/Diola and "others"). Hence, the prevalence of FGC at the national level differs dramatically: 80% in The Gambia (Daffeh, Dumbuya et al. 1999), and 28% in Senegal (Diop 2006). It is important to note, however, that inter-ethnic marriage is not uncommon (Sylla 1990; Hernlund 2000). As a consequence of ethnic mixture, the conceptualization of ethnic identity is complex and often situational and contested, particularly in relation to issues such as FGC. In Senegal the prevalence of FGC varies dramatically by subregion. The regions in which our study was conducted, Fatick and Kaolack, have estimated prevalences of 6 % and 11%, respectively.

Age at cutting is not fixed and ranges from infancy to adulthood, and also varies from one ethnic group to another. For example, in Senegal, most operations among the Tukulor are on girls aged between one week and three years, while among the Mandingue the average age is four (Sylla 1990) . Type I (clitoridectomy) is the most common form of FGC practiced in both countries, but Type II (excision of the clitoris and labia minora), and to a lesser extent Type III (sealing, which differs from infibulation in that it involves no stitching) are also found (Daffeh, Dumbuya et al. 1999; Diop 2006). In some cases, the operation is carried out in "the bush," and in other instances it is conducted at the home of the traditional circumciser or of the girl. Accompanying ceremony also varies tremendously, including the possibility of none at all.

Anti-circumcision campaigns have been ongoing in The Gambia and Senegal for several decades. However, the two countries have experienced very different trajectories regarding strategies to eliminate FGC. Senegal is the original site of the massive Tostan grassroots project, which has reportedly led to abandonment of the practice in over 3,700 villages, with continued rapid spread (www.tostan.org, accessed September 1, 2009). The Tostan program began work in The Gambia in the Upper River Region during our study, and in June, 2009, 24 communities participated in public declarations to end FGC (http://www.tostan.org/web/module/events/pressID/111/interior.asp). At the time of our study, however, Gambian participants were unaware of these activities, although many were familiar with some of the other campaigns that have been ongoing in The Gambia. In our study sites in The Gambia, there were no cases of large scale, community-wide abandonment of FGC, although cases of abandonment by individuals or families, particularly in urban areas, can be found. The purpose of this research study is *not* to evaluate the effectiveness of the Tostan campaign, but to assess the dynamics

of change, whether they arise through communal decision making to abandon FGC directed by an intervention or individual decisions to abandon FGM.

In another divergence between the two countries, in 1999 Senegal passed legislation criminalizing FGC within the country, whereas the Gambian government has not done so. Thus, the research methodology has been carefully designed to assure that no respondent is made to feel policed or urged to confess to planning an illegal act. It is important to note, for one thing, that the Senegalese legislation does not include penalties for genital cutting performed abroad. Therefore, if a Senegalese respondent should assert an intention to circumcise a daughter, it should not be assumed that this plan involves illegal activity, but instead travel to relatives living in communities across the border in The Gambia, where the practice remains legal.[1]

Research Sites

Research was conducted in three distinct regions: 1) peri-urban communities surrounding the Gambian capital, Banjul; 2) The Gambian North Bank Division border area known as Baddibu, and 3) the Senegalese region directly across the border from Baddibu, falling in Kaolack Division.

Senegalese Border Region

Research was conducted in the border frontier region of Kaolack Division in the following villages: Némanding, Taïba, Némaba, Toubacouta, Missina, Darsilami Serer, Sokone, Jagleh, Joofen, Chamen Biran, Quatene Barbara, Passi, Sandicoley, Kular Soce, Sukoto, Bambugar, Karang Posto, Drammeh Ndimbu and Kerr Foday. This region contains several villages covered in the Tostan program. We contacted Tostan to assure that our research activities did not interfere with their program activities, and they welcomed us to conduct research in this region. Originally, we envisioned selecting two separate sub-locations in Kaolack Division: a location containing a block of villages covered by the Tostan program and one containing villages not yet targeted by the program. However, on our initial visit to this region we discovered that there are not distinct contiguous geographic areas that have either been targeted by Tostan or not. Instead, it is possible to find one village that has participated in the program located next to another village that has not participated. This is due in part to the fact that there is a great deal of ethnic mixture, and villages dominated by non-circumcising groups would not be targeted. However, it was also not the case that all neighboring villages comprised of ethnic groups who formerly practiced FGC participated in Tostan. Instead, the recruitment of villages to participate in the intervention program was based more on family ties than on geographic proximity. Therefore, in this border region, the picture that emerges is more one of a patchwork of villages that did or did not traditionally practice FGC, and that did or did not participate in the Tostan program.

Movement across the border is very fluid, and communities on either side share very similar characteristics. It is not, in fact, uncommon for extended families to live divided on different sides of the political boundary, and some villages are literally bisected by the border. Therefore, this setting is ideal for examining the effects of differing national programs and policies addressing FGC.

Gambian Border Region

In the second site of Baddibu in the North Bank Division, research has been conducted in the following communities: Njawara, Panneh Bah, Samba Mussa, Amdullai, Fass, Kerr Sangang, Kerr Ardoo, and Kerr Patteh. This region was selected because of its relatively high level of interaction with communities across the border to Senegal where, as previously discussed, a different set of circumstances around FGC prevail. A few years ago Tostan-sponsored meetings were held in Amdullai,

[1] Discussions regarding drafting legislation are underway in The Gambia, but as of the finalization of this report in February 2010, legislation banning FGC has not been introduced into Parliament.

and delegations of officials from the two nations have held follow-up meetings there. Thus, this border area provides a unique research site for examining the diffusion (or lack thereof) of anti-FGM messages.

Gambian Urban Communities

Research has been conducted in the following peri-urban communities: Talinding, Bundung, Ebou Town, Fajikunda, Serrekunda, London Corner, and Dippakunda**.** In particular in the urban areas, individual or family decision making is centered within a broader local debate over FGC and national identity and ideas of "culture" (Hernlund 2000). The way that female "circumcision" is talked about is changing rapidly and dramatically. Prior to the 1980's, the topic was seldom publicly addressed, but was considered secret. Recent years, however, have seen intense media coverage of "FGM," in newspapers, on the radio and, in the last few years, on television. Gambians are not only consumers of international media that often have treated "FGM" in a sensationalist manner, but have also repeatedly become the subjects of such reports, and there is widespread awareness that this "local practice" has become part of a global debate. In the last fifteen years, an increasingly intense dialogue has emerged between those Gambians who perceive a need to "eradicate female genital mutilation" and those who seek to preserve "female circumcision" as an integral part of culture. Conflicting views are commonly found not only within communities, but also within families and compounds. Moreover, a person's opinion may alter over time in response to lived experience and shifting social needs and realities. Consequently, the continually shifting cultural menu—that is, options as to whether, when, or how to perform FGC—is large (Hernlund 2003). Therefore, the communities surrounding Banjul were selected because they provide an ideal setting to examine the process of change and dynamics surrounding the decision making process.

Within these settings it is possible to examine variability in stages of change in the practice of FGC, differences in the dynamics of decision making when based on individual or family-level decision making processes, urban/rural comparisons, and the effect of a national border.

Methods

Data collection was initiated in 2004, and involved mixed methods integrated over three phases across a three year period. Data collection was completed in July 2007, and consequently this report does not reflect more recent developments.

Phase 1

The first phase of the research involved qualitative research in each subsection of the study region. Data were collected by six Gambian fieldworkers supervised by a Gambian field manager, all of whom grew up in families where FGC is practiced. They received training in qualitative research methods from Ylva Hernlund. One male and one female fieldworker were assigned to each of the three study sites and, for fieldworkers in the border region, lodging was obtained so that they could become temporary residents in their study sites. Their activities were coordinated by the field manager, who negotiated entry to the study communities, reviewed transcripts, and clarified questions that arose from transcripts. Gaining access to the study sites was facilitated by the fact that members of our research team often had family connections in the study sites. Consequently, the fieldworkers were quickly able to become accepted in the study communities, and residents were in most cases willing to participate in interviews and focus group discussions.

Research techniques consisted of observation while living in the study communities (fieldworkers wrote field journals containing information on the village setting and activities in general) and interviews to obtain case histories of decision making regarding the nature and practice of FGC. In depth interviews with men, women, community and religious leaders, health professionals and former circumcisers were conducted following interview guidelines, and later transcribed and translated into English. In the process of transcribing the interviews, fieldworkers were also able to add explanatory

comments regarding issues that would possibly not be clear for the investigators. At the University of Washington, the transcripts were then typed and coded in a qualitative data analysis program, Atlas ti® by the senior investigators and a team of three research assistants. An initial list of codes was created by the senior investigators, and expanded while coding initial interviews. A subsample of interviews was coded separately by Bettina Shell-Duncan and each research assistant, and comparison of coding revealed high consistency. The investigators and research assistants met weekly to discuss key findings and emerging themes.

Focus group discussions were also conducted in order to identify perceptions regarding social norms, advantages and disadvantages of FGC, and recent changes in the practice. They were divided by gender, age (elder vs. younger men or women), circumcising tradition (whether FGC was a tradition in the participants' families or not), and (in Senegal) whether participants came from a village that had or had not participated in the Tostan program. Focus group data were analyzed following methods described by Knodel (1993). For each focus group, themes and the degree of consensus or division were recorded, and analyzed across focus groups by constructing an overview grid organizing the focus group findings along break characteristics. Overall, the qualitative data collection yielded over three hundred interviews, and twenty-eight focus groups that contain tremendously rich information on decision making and the broader contexts of factors influencing whether and how the practice of FGC is changing.

Phase II

The second phase of this research involved developing and pre-testing an ethnographically grounded survey questionnaire. Constructs and categories relevant to decision making regarding FGC were identified through analysis of the in depth interviews and focus group data. To operationalize these constructs in a survey instrument, we developed items drawing on text segments in our transcripts. For several items, alternate forms of questions were created. These questions were reviewed and edited by our research team at the University of Washington, and transcripts were re-examined to assess content validity.

A developmental pre-test of the survey was carried out in March and April of 2006. Steps in this pre-test were designed by Bettina Shell-Duncan, and implemented in the field by Ylva Hernlund working in close collaboration with our field manager, Alhagy Bah, and our lead field worker, Naisatou Konteh, as well as with field workers trained to be enumerators of the survey. The linguistic and cultural competence of these Gambian collaborators was invaluable in developing the final survey draft, as was the deep understanding of the research project previously gained while working for six months on the qualitative first phase of the project, conducting numerous interviews and focus groups discussions, and immersing themselves in the study communities. Data generated in the pretest were sent to Bettina Shell-Duncan, and analysis was conducted at the University of Washington.

The initial portion of the pre-test was a participating pretest, which involved working in a transparent manner with volunteer consultants, who were told in detail about our task at hand and were invited and encouraged to offer their feedback and insights in order to assist us in gradually developing an effective and culturally appropriate survey. All ethics procedures were followed as in a "real" survey, and consent forms (available in English, Mandinka, and Wolof) were signed or thumb-printed by all respondents, while the filled-in surveys were coded to ensure confidentiality. Great care was taken to ensure that privacy was maintained during all interviews. No respondent was paid money to participate, but refreshments were provided.

The developmental pretest first involved a conceptual review of entire questionnaire with the lead fieldworker. Next, sections of questionnaire were administered and followed up with in depth interviews on meaning. In cases where the survey started out with alternate forms of a question, it began to become apparent which questions worked the best, and wording continued to be fine-tuned

and probes added. We assessed the influence of order of questions by administering particular sections to 30 people , returning two days later to re-interview the same individual with the same questions but in a different order. Reliability was assessed using a test/re-test process, returning to re-interview the same subject two days later. In the literature, there is debate regarding appropriate interval for repeat testing to assess reliability (Converse and Presser 1986). An interval too short can lead to overestimation of reliability since respondent may remember their earlier answers. An interval that is too long can lead to underestimation of reliability since the situation and opinions of respondents may have changed in the interim period. Because of the time constraints on our pretest period, and because people can be difficult to locate after a long interval, we opted for a shorter interval. Finally, for scales created using responses to several questions, internal consistency was assessed by calculating Cronbach's α, and followed Nunnally's (1967) recommendation that, in initial stages of research, reliabilities of .5-.6 suffice. We assessed scales used to measure the preference dimension of readiness to change (support, oppose, ambivalent), two different concepts regarding pressure to conform (outside pressure to continue, outside pressure to stop circumcision), a general measure of "traditionalism," and three contingencies (internalized health message, marriagability, peer pressure).

The entire questionnaire was then translated into Mandinka and Wolof by one translator, and back-translated into English by a different translator. The research team compared the versions and discussed any discrepancies. The translated questionnaires were then used to conduct an undeclared pretest among 15 respondents in both of our Gambian fieldsites, and in Senegal. The final English and translated surveys were then submitted to the human subjects review division at the University of Washington for final approval. Investigator Ylva Hernlund's funding and participation ended at the end of this phase of the project; she has served in an advisory capacity in reviewing this report. Ahmadu Moreau was brought in as a project manager in the next phase, and continues currently as a research collaborator.

Phase III

The third phase of our research involved administering the survey questionnaire, entering the data, and quantitative analysis. A complete list of all communities in which qualitative work had been completed in Phase I of this study was compiled. Referring back to the community profiles written by fieldworkers during Phase I, the following information was recorded for each site: population size, approximate number of compounds, whether it has residents who currently or (in the case of Senegal) formerly practiced FGC, whether it had participated in the Tostan education program, and whether it had participated in a public declaration to stop FGC. Study sites in which the practice of FGC is not found were excluded for consideration. Also removed was one site in which only two interviews had been conducted, and one site in which people had refused to participate in interviews about FGC.

Sites in which participants were recruited for the survey questionnaire were selected though cluster sampling. Villages were stratified based on whether they had participated in the Tostan program or not, and if they were large or small. One main site, Koular, and its surrounding communities were excluded due to the fact that they had participated in the Tostan education program, but were never invited to participate in a public declaration.

Table 1.1

Tostan villages	**Size**	**Non-Tostan villages**	**Size**
Némanding	Small	Sokone	Large
Taïba	Small	Jagleh	Small
Toubacouta	Large	Joofen Malang	Small
Némaba	Large	Quatene Bambara	Small
		Passi	Small

From the list of Tostan villages, we randomly chose one large and one small site. The chosen sites were Toubacouta and Taïba. From the list of non-Tostan villages, we chose Sokone because it was the only large location. We randomly selected from the small villages, selecting Joofen Malang. Our study sites in Senegal were: Toubacouta, Taiba, Sokone and Joofen Malang. In Senegal, survey questionnaires were completed by 347 subjects. Of these, 265 were administered to women between the ages of 18 and 40 who had given birth to at least one girl. Eighty-two were administered to randomly selected participating women's husbands. In Senegal, community maps were created, assigning numbers to each compound, while in The Gambia maps were available from the Gambian Bureau of Statistics. The number of compounds sampled from each site was proportional to the total number of compounds. A random number generator was used to select compounds to be approached for recruitment. Residents were asked to list all women residing there who were between the ages of 18 and 40 who have given birth to at least one girl. From the list of eligible women, one was selected using a random number table. The chosen woman was asked for consent to be interviewed. If the selected woman was not available, the interviewer was instructed to return to the compound up to two more times. If the woman was not reached after three tries, a different woman meeting the eligibility criteria was selected from that compound. Women were asked if they have a husband, and if he is alive. If they responded positively, a random number table was used to select 1 out of every five husbands to be invited to be interviewed.

In The Gambia, cluster sampling was also used to select the study sites. In the urban area, eligible sites were: Talinding, Bundung, Ebou Town, Fajikunda, Serrekunda, and Dippakunda. Using a random number generator, two sites were randomly selected: Dippakunda and Bundung. In the rural area, all the eligible sites were sampled because they were all small. These were: Kerr Pateh, Njawara, Fass, Kerr Sangang, and Samba Mussou. Sampling of compounds in the urban area was proportional to size, while all compounds in the rural area were eligible for recruiting subjects. A total of 256 and 636 women were interviewed in the rural and urban Gambian sites, respectively.

In The Gambia, if a woman reported a recently (in the last 3 years) circumcised daughter or foster daughter, or if she had a daughter or foster daughter who was currently being considered for circumcision, or recently had been considered, she was asked to list all people participating in the decision making process. These people were invited to participate in an abbreviated version of the Gambian survey questionnaire that captured readiness to change, contingencies, and social network.

Records were kept regarding non-response due to unavailability and refusal to participate. The overall response rate was 82.5%.

The survey team held one week of training session, under the supervision of Amadou Moreau. The interviewers were trained on the purpose and scope of the survey questionnaire, and on techniques for collecting high quality survey data. Specifically, the training session with the interviewers focused on:

1. An overview of the objectives of the study;
2. Methods used for sampling;
3. Procedures for selection of compounds and respondent women within the compounds;
4. Procedures for replacement of target in case of need;
5. Verification techniques for a greater reliability of information;
6. Review of the translated versions of the different survey tools (Wolof, and Mandinka);
7. Set-up of feedback sessions and breaks during the data collection process.

At the end of the training session, a practice session for administering the questionnaire was held in the locality of Latrikunda, The Gambia. That locality has been selected because of the similarities in terms of population size with the other survey sites in urban Gambia. This session was used to assess interviewers' understanding of the selection criteria of women within compounds, ability to properly

respond to non-availability or refusal to participate, techniques for obtaining consent, level of understanding of the survey, difficulties administering any questions, and pace in administering the questionnaire. This dry run was followed by individual and group sessions to discuss any problems observed.

Survey questionnaires were reviewed for completeness by the field manager, and delivered to the project office in Bakau, where data entry took place. All data entry, checks for internal consistency and data cleaning were performed by the data entry staff and Amadou Moreau. The data were analyzed at the University of Washington by Bettina Shell-Duncan, Katherine Wander, and Corinne Mar using several statistical packages: SPSS, Stata and SAS. Details of the analyses are presented in each chapter.

Summary Report: Content and Purpose

The integrated qualitative and quantitative data collected in this study allow us to examine in detail the ways in which FGC is being practiced, and the dynamics of behavior change in Senegambia. Beyond empirically describing the process of change, we further aim to compare our findings to predictions derived from theories of behavior change. Throughout the design, implementation and completion of this project we benefited from active input from an advisory committee in The Gambia. Membership of our advisory committee included representatives from The Women's Bureau, The Gambian Bureau of Statistics, Worldview The Gambia, Gambia College-Brikama Campus, TANGO (an association of non-governmental organizations), UNDP, UNICEF, and The Gambia WHO. In Senegal we received advice and input from numerous representatives from The Population Council, Tostan and the Senegal WHO office. A preliminary draft of this report was shared with our advisory committee in The Gambia, and with our informal advisors in Senegal, and the findings were discussed in Validation Seminars held in November 2009. This report now incorporates feedback and suggestions from our advisors and their designees.

II. Female Genital Cutting in Senegambia: A Practice in Flux

Summary

The purpose of this research was to examine the ways in which female genital cutting is practiced across a range of contexts in parts of Senegal and The Gambia. We purposely selected communities that allowed comparisons across a range of factors including age, gender, ethnicity, urban versus rural residence, differing interventions and among contiguous rural communities bisected by a national border. In this chapter we provide descriptive statistics on our study population, and the way that FGC is practiced in these regions. Key findings include:

- 58% of women report coming from families that traditionally practiced FGC, and 56% report being circumcised (notably, 12% are sealed);
- Interethnic marriage is common (34%), and 12% of women report being in FGC-incongruent marriages (such that the woman's husband's tradition does not match her circumcision status);
- Seclusion in the bush and celebration at the time of circumcision are becoming less common;
- The age at circumcision is declining, while there is no change in the degree or type of circumcision performed across generations;
- Decision making is often done by multiple family members, and despite being described as "women's business," fathers were often involved;
- In comparison to other decision makers, more fathers were involved in conversations regarding girls who remained uncircumcised, suggesting that men can play an important role in ending the practice.

Introduction

The purpose of this research was to examine the ways in which female genital cutting is practiced across a range of contexts in parts of Senegal and The Gambia. We purposely selected communities that allowed comparisons across a range of factors including age, gender, ethnicity, urban versus rural residence, differing interventions and among contiguous rural communities bisected by a national border. As such, communities were not randomly selected across the entirety of Senegal and The Gambia, but were instead intentionally selected to optimize comparative analyses. Consequently, the prevalence and characteristics of FGC are not intended to be nationally representative; such figures are already available for Senegal from the Demographic and Health Survey. We provide here an overview of the practice of FGC within our study communities by describing the nature and timing of FGC, identifying the range of individuals who participate in the decision making process, and examining how the practice has been changing across generations. We take our lead from Stanley Yoder, who argues that:

> In contexts where FGC is routine, the research strategy should focus on the process of deciding when and how FGC should be carried out, and who participates in the action, so that the most effective ways to create discussion on the subject can be identified. In contexts where individuals and families interact with both those who practice FGC and those who do not, the research should focus on the interactions through which the decision to circumcise or not is negotiated within the families or lineages, so that ways to support the decision not to practice FGC can be identified. (Yoder 2004: 14).

This research is not intended to provide in depth ethnographic information on the cultural meanings of the practice of FGC; it does, however, draw from the rich ethnography by Ylva Hernlund (Hernlund 2003) entitled *Winnowing Culture: Negotiating Female "Circumcision" in the Gambia*. We

also draw from Fuambai Ahmadu's (2005) ethnography, *Cutting the Anthill: The Symbolic Foundations of Female and Male Circumcision Rituals among the Mandinka of Brikama, The Gambia*. Our focus in this study is to examine the nature and context of the practice of FGC, to provide further insight into the process of decision making, and to assess the dynamics with respect to theoretical models of the process of change.

Female Genital Cutting in Senegambia: Ethnographic Background

The data that we analyze here are from a three-year mixed-method study of dynamics of decision making regarding female genital cutting in Senegambia. Communities that lie on one side or the other of the Senegambia border share a tremendous amount in common in terms of culture, ethnicity, religion, pre-colonial history, landscape and climate. The practice of FGC is found in both places as well. While a few lineages have a long-standing tradition of practicing FGC at young ages, for most people interviewed in our study, female circumcision took place in the context of the initiation of adolescent girls. Often, this took place in three stages. First, prepubescent girls in a village were gathered into a group and taken to "the bush." As similarly described by Ahmadu (2005) in the Gambian town of Brikama, this location was typically a site adjacent to rice fields at the outskirts of town where women worked while girls recovered. There, girls underwent clitoridectomy, or less often excision, in the course of a series of adolescent initiation rites. Afterwards, girls remained secluded (some informants used the word "camped") while they were nursed by and received training from elder women. At the conclusion of the seclusion period, there was often a coming out ceremony in which girls danced back into the village and participated in a community-wide celebration that included feasting, music, dance, and masquerades.

When discussing the significance of female circumcision, our informants provided a multitude of reasons for the practice that touched on themes related to identity, religion, proper childrearing, and upholding tradition. While much of the existing literature describes FGC as running predominantly along ethnic lines, we found considerable variability in some ethnic groups. Instead, FGC appears to vary according to clan or lineage, being passed down from elders to the younger generations by serving as an obligation for acceptance and social integration. Daffeh and colleagues (1999: 4) state that FGC "ensures identification with the clan. The only way an outsider gets full recognition is by undergoing the operation."

Beyond demarking group membership, the practice can also serves as a form of initiation that marks the transition from childhood to adulthood. An important element in the transformation into womanhood involves training that was traditionally performed in seclusion, but now is said to continue across the following years. Girls who are cut are often viewed by practitioners of FGC as being morally superior, often described as having come to "know the eye." This term refers to having become indoctrinated into the social hierarchy along lines that include age and gender, and being able to display signs indicating acknowledgement of their place in the social hierarchy. Hernlund argues that it is women who have the biggest stake in this hierarchy and who thus actively perpetuate female circumcision. She notes that "[i]n a marriage system involving the young wife moving to her husband's family's home, and becoming subservient to the mother-in-law, there is a 'revolving hierarchy,' i.e. young women endure oppression on their way to becoming matriarchs who have the privilege of oppressing another younger generation of women" (2003: 160). Girls who "know the eye" are able to communicate their respect to elders though non-verbal signs, and are said to be able to behave in a fashion that is socially refined in comparison to uncut women. Hernlund explains that "those who are not 'circumcised' – as well as those who 'act like they are not' – are contemptuously insulted as *solema*. This extremely powerful invective means not only 'uncircumcised' but rude, ignorant, immature, uncivilized, unclean - 'someone who does not know herself'" (2000: 239). An important element of displaying respect is also to not question the wisdom of elders, and hence, not challenge traditions. As

Hernlund (2000, 2003) notes, informants express this commonly using the phrase "we found it from our grandmothers."

In addition to training, elements of the physical cutting are also viewed as essential to the development of womanhood. Cutting involves removal of "male" tissue (the clitoris, which can grow into a penis) and produces pain that can serve a transformative purpose (Ahmadu 2005). The pain is viewed by some as a lesson in learning how to suffer, and demonstrating strength and maturity to withstand future adversity.

In some instances FGC is associated with Islam, which is perhaps unsurprising given Islam's compulsory male circumcision. Despite the fact that the Qu'ran does not require FGC and that not all Mulims practice FGC, the practice is for many associated with cleanliness and purification required for religious participation and prayer (see also Michelle Johnson 2000 on religious identity among the Mandinga in Guinea Bissau). Despite the lack of texual dictates, powerful religious leaders debate whether FGC is a religious mandate, resulting in what Daffeh and colleagues describe as "an absence of a clear Islamic position on FGM" (1999: 35). Hernlund emphasizes that despite the range of reasons given for the practice of FGC, no single narrative exists, and at least partially in response to campaigns, a number of divergent views on meaning of the practice are found among both practitioners and non-practitioners of FGC.Despite the paramount importance placed on training, the seclusion phase is one of several aspects of circumcision practices that have changed dramatically in recent years. A phenomenon described in our study communities, and reported elsewhere throughout Senegal, The Gambia, and other West African countries, is that increasingly FGC is being performed in the absence of the formerly common large-scale celebration. While some point to the costliness of elaborate ritual celebrations, others attribute this change to the tendency to perform FGC among individual girls or small groups of girls privately in the family home or that of the circumciser. Another change in the practice is a decline in the age at cutting. While girls previously underwent FGC and seclusion as pre-adolescents, typically between the ages of 9 and 13, it is increasingly common for FGC to be performed on younger girls, in some instances during infancy[2]. Respondents provided several reasons for this change: young girls are said to heal more quickly; the lower age at circumcision leads to a reduced risk of a girl becoming pregnant before being circumcised; and circumcision of young girls can be performed more discretely, beyond the view of opponents of the practice. Hernlund (2000) suggests that one of the main unintended effects of the last several decades of anti-circumcision campaigns has been to drive down the age of cutting and promote "cutting without ritual."

Like neighboring Gambia, Senegal has as well been the site of a number of initiatives aimed at ending the practice of FGC. Of particular significance is that Senegal is the original site of Tostan, a non-governmental organization which has reportedly made significant progress in eliminating FGC. Tostan, which means "breakthrough" in Wolof, articulates the goal of enhancing active participation of village residents in the social, economic, political, and cultural development of their communities (Tostan 1999). This concept, known as participatory development, rests on delivering a basic education program divided into four modules: hygiene, problem solving, women's health, and human rights (Diop, Faye et al. 2003). Beginning in 1997, the basic education program resulted in the organization of public declarations to end FGC. Those participating in declarations include members of villages which had received the basic education program, as well as some individuals from villages contacted in "outreach" and recruited to join the declaration. To date, over 3,700 villages in Senegal have participated in such declarations (www.tostan.org). A 2003 evaluation of the Tostan program (Diop, Faye et al. 2003: 41) concluded that in villages receiving the education program the public declaration to end FGC provided "social support needed to enable individual families to undertake the change." A more recent long-term evaluation reported that in a decade after the Tostan program and declarations, the prevalence of FGC

[2] There are, however, a few ethnic groups who have traditionally performed FGC on infants.

in the 0-9 year old group was lower both in villages that participated in both the program and declaration (15%), as well as the declaration only (8%), as compared to "control" villages (47%) (UNICEF 2008).

In our Senegalese study site, communities varied as to whether they had or had not participated in the Tostan education program, or in a public declaration. Prior to commencing work in this region, we had envisioned that there would be large sections of the country that had either been targeted or not by Tostan or other anti-FGM interventions, but this is not the case. Along the border region, it is often the case that one community that has participated in the program neighbors others that have not. This is partly attributable to ethnic variation. One village dominated by Mandinka residents who traditionally practice FGC may be located less than a mile from another village comprised of largely non-practicing Wolof. Moreover, it is not the case that all practicing villages in one area participated in the intervention program, as "outreach" was often directed at villages with family relations, rather than nearest neighbors (Diop, Faye et al. 2003) found this in the Kolda region of Senegal as well). Therefore, the picture that emerges is a patchwork of villages where FGC is or is not found, or that have or have not participated in the intervention program or public declaration.

It is important to note that the ground was laid for human-rights based programming such as that employed by Tostan by Senegalese activists who took a prominent role in the international human rights movement in general (Welche Jr. 1995; Shell-Duncan 2008), and specifically in the international campaign to end FGC. In February, 1984, Senegal hosted a UN-sponsored conference that aimed to discuss anti-FGC policies. With delegates from 20 African nations in attendance, a pivotal outcome of this seminar was the formation of the Inter African Committee on Traditional Practices Affecting the Health of Women and Children (IAC). One of the primary mandates of the IAC was to coordinate national and international efforts to abolish FGM, and to call for government backing of these efforts. Specifically, the IAC urged the use of existing national legislation banning FGM, and implementation of legislation specifically banning the practice. In 1999 Senegal adopted a criminal law that prohibits the violation of "the integrity of the genital organs of a female person by total or partial ablation of one or several of the organ's parts, by infibulation, by desensitization or by any other means." The law is applicable to anyone "who violates or attempts to violate" the prohibition; anyone who through "gifts, promises, influences, threats, intimidation, or abuse of authority or of power, provokes these sexual mutilations or gives instructions for their commission." The penalty includes prison for 6 months to 5 years, with the maximum penalty for medical personnel convicted of violating the law. Where cutting results in death, the penalty is hard labor for life.

In the first year following the passage of the law, there were two arrests, but no convictions. In July, 1999, the public prosecutor in Tambacounda ordered the arrest of a grandmother and a mother of a five year old girl following the complaint filed by the girl's father alleging the two women had ordered FGC performed on his daughter. The circumciser was also charged. Following an emotional public outcry in that region, however, the cases were not pursued and no convictions resulted.

The Practice of Female Genital Cutting

Our survey data provide descriptive information on the study respondents, and the varied ways that FGC is practiced by people in our study sites. Survey data were collected from mothers between the ages of 18 and 40 who had given birth to at least one girl. Survey data were also collected from a subsample of husbands in Senegal, and from a small convenience sample of identified decision makers in The Gambia. Table 2.1 summarizes the demographic characteristics of the 1220 Senegambian mothers surveyed. Nearly all respondents were Muslim, and generally had low levels of formal education: more than half (59%) reported no school attendance or Arabic schooling only.

All three study areas (rural Senegal, rural Gambia, and urban Gambia) included women from multiple ethnic groups, and women from who reported that their family did or did not come from a

"circumcising tradition." Overall, 58% of women reported that they came from families that traditionally practiced FGC.

Women were asked to report their own ethnicity, as well as that of their husband, mother and father. They were also asked to report their circumcising tradition ("Is/was female circumcision a tradition in your family?") and that of their husband's family. This allowed us to assess congruity for both ethnicity and circumcising tradition: while interethnic marriages can be FGC-incongruent, FGC-incongruent marriages can also occur within an ethnicity-congruent marriage. 28% of women reported being in an inter-ethnic marriage, an increase from 11% in parents of respondents. 12% of women were in FGC-incongruent marriages (wherein the respondent's FGC status did not match the circumcising tradition of her husband's family; uncircumcised women married to men from circumcising families or circumcised women married to men from non-circumcising families). Table 2.2 shows a cross-tabulation of inter-ethnic and FGC-incongruent marriages among Senegambian women. As is unsurprising, ethnicity-congruent, FGC-congruent marriages are the most common, at 68.7% of marriages described. Ethnicity-incongruent, FGC-congruent marriages are also quite common (19.7% of marriages described). Interethnic marriage often seems to result in FGC-incongruent marriage: 8.4% of marriages described are congruent for neither ethnicity nor FGC.

Table 2.1 Characteristics of Senegambian Mothers

Number of respondents	
Rural Senegal	265
Rural Gambia	319
Urban Gambia	636
Total	1220
Age range	18-40 years
Muslim	97%
School attendance (%)	
None	28
Arabic school only	31
Primary school	21
Secondary school	18
College	2
Ethnicity (%)	
Fula	19
Mandinka	26
Serer	14
Wolof	22
Other	29
Marital Status (%)	
Never married	5.6
Currently married	86.2
Widowed	2.1
Divorced	5.7
Separated	.4
% from families that traditionally practice FGC	
Fula	72
Mandinka	97
Serer	25
Wolof	4
Overall	58
% in inter-ethnic marriage	28
% in FGC-incongruent marriage*	12

*Husband's circumcision tradition does not match respondent's circumcision status

Because FGC is not universally present or absent within ethnic groups, we explore how closely FGC incongruence is associated with interethnic marriage in Table 2.2. We find that that 72% of the cases of FGC incongruence appear in interethnic marriages, whereas 28% arise in marriages between partners in the same ethnic group.

Table 2.2 Interethnic and FGC-incongruent marriages among Senegambian women

Interethnic	FGC-incongruent marriage		
marriage	Yes	No	Total
Yes	90	212	302
No	35	738	773
Total	125	950	1,075

Decision makers

In Senegal, because FGC is illegal, we did not inquire about recent or upcoming circumcisions of daughters, or participation in these recent or on going decisions regarding FGC. Instead, we solicited survey data from every 5th husband, providing data from 82 men (see Table 2.3). These respondents ranged in age from 22 to 73 years, and 98% were Muslim. As expected, levels of formal education were slightly higher among men than among women. Only 35% of men had never been to school or had attended Arabic school only. The majority had received either a primary, secondary or college education. The ethnicity of Senegalese husbands/fathers sampled in this study was mixed, with 33% self-reported as Mandinka, 23% Serer, 17% Wolof, and 16% Fula. 57% were from families that had traditionally practiced FGC, and 20% were in an FGC-incongruent marriage. This parallels the high levels of inter-ethnic marriage, reported by 32% of male respondents. We report later on the degree of concordance in readiness to change the practice of FGC among husbands and wives.

Table 2.3 Characteristics of Senegalese Fathers

Number of respondents	82
Age Range	22-73 years
Muslim	98%
School attendance (%)	
None	9
Arabic school only	26
Primary school	23
Secondary school	26
College	17
Ethnicity (%)	
Fula	16
Mandinka	33
Serer	23
Wolof	17
Other	11
% from families that traditionally practice FGC	
Fula	54
Mandinka	100
Serer	32
Wolof	0
Overall	57
% in inter-ethnic marriage	32
% in FGC-incongruent marriage*	20

*Respondents' tradition does not match wife/wives' reported circumcision status

In The Gambia, where female circumcision is legal, survey data for decision makers were collected for a subset of participants. In cases where girls had recently been circumcised (within the last 3 years), or where circumcision was actively being discussed for one or more uncut girls, participating mothers were asked to identify people who took part in the decision making process. Survey data were collected from a small convenience sample of decision makers; while we originally planned to complete questionnaires with all decision makers, this was not logistically possible. Participating decision makers ranged in age from 27 to 90 years, were predominantly female, and were all Muslim. Only a minority (12%) had any

level of formal education. 44% of decision makers were Mandinka, 11% were Fula, and 6% were Wolof; all Mandinka and Fula decision makers, and one third of Wolof decision makers, were from a circumcising tradition. Concordance in readiness to change between survey respondents and the decision makers they referred are reported in Chapter III.

Table 2.4 Characteristics of Gambian Decision makers

Number of respondents	54
Age Range	27-90 years
Sex	26% male
Muslim	100%
School attendance (%)	
None	44
Arabic school only	18
Primary school	6
Secondary school	6
College	0
Ethnicity (%)	
Fula	11
Mandinka	44
Serer	0
Wolof	6
Other	39
% from families that traditionally practice FGC	
Fula	100
Mandinka	100
Wolof	33
Overall	96
% in inter-ethnic marriage	21

Circumcision characteristics

When asked about their own circumcision status, 56% of Senegambian women reported being circumcised. Although some studies have highlighted the questionable quality of self-reported circumcision status, in a study in the Farafenni region of Gambia, Morison and colleagues (2001) (Morison, Scherf et al. 2001) found 97% concordance between a respondent's self-reported status as circumcised or not circumcised and verification based on gynecological examination.

The prevalence of FGC varied substantially between our study sites, being least common in the rural Gambian sites (33%) and most common in the urban Gambian sites (71%). Nearly all women reported having been circumcised by a local circumciser (known as a *ngangsingba*). While male circumcision has since the 1950's become increasingly medicalized, and is now most often performed by nurses in hospitals or clinics, female circumcision has not undergone similar clinicalization. Historically, FGC was performed as part of coming-of-age rituals, which involved extended seclusion "in the bush" and elaborate training by women elders. Less than half of our respondents, however, report being circumcised in the bush. Instead, many were circumcised in their own home or that of the circumciser or a relative, and only 53% were secluded for healing and training. These figures support the emergence of what Hernlund (2000) describes as "cutting without ritual"—a purely physical procedure that is not accompanied by training or celebration.

Despite the sensitivity of the topic, we attempted to collect self-reported data on type of circumcision. This was one of the most challenging aspects of our pre-test. Most surveys do not attempt to differentiate clitoridectomy (WHO Type I) from excision (WHO Type II) as one grades into the other, making self reporting difficult and unreliable. Instead, most surveys differentiate infibulations from non-infibulating forms of FGC. In our developmental pretest, great effort was devoted to investigating the most accurate and culturally acceptable means of inquiring about type of FGC. Our lead fieldworker cautioned that questions about circumcision type would not make any sense to people and that these questions would be perceived as too personal, intrusive, and rude. Her initial suggestion was to pose two questions: "You have had just regular circumcision (sunna)?" and "Have you had sealing?" An additional solution later arose spontaneously during the Mandinka language pre-test in Senegal. There, women answered "No" both to "Have you had just the regular kind (sunna)?" *and* to "Have you been sealed?" They then volunteered the information that it is excision that has been practiced there, using words meaning "all has been removed." The final version of the survey used two questions, one on type of circumcision, with response choices of sunna, all removed, or don't know, followed by a question on sealing.

Table 2.5 Characteristics of Senegambian Women's Circumcisions

	Senegal*	Rural Gambia	Urban Gambia	Total Senegambia women
Circumcised	49%	33%	71%	56%
Who performed circumcision				
Local circumciser	88	93	91	91
Other circumciser	5	5	1	2
Nurse	0	0	4	2
Other	7	2	4	4
Location of circumcision				
Circumciser's compound	25	19	36	31
Own compound	17	19	19	19
Bush	45	52	37	41
Other	12	10	9	10
Don't know	1	0	0	0
Celebration at time of circumcision	48	56	54	53
Seclusion at time of circumcision	52	64	50	53
Dismissal ceremony after circumcision		73	65	67
Type of circumcision**				
Sunna	64	46	37	44
All removed	21	39	45	40
Don't know	15	14	18	17
Sealing	19	17	14	15
Circumcised daughters (any)***	18			35

*Senegalese women only

**We use terminology on type used by our informants. "Sunna" refers to clitoridectomy or WHO Type I FGM, "all removed" refers to excision or WHO Type II FGM.

***Before the law, for Senegalese women

Arenas of Decision making

When we originally conceptualized this research project, we anticipated that a main arena of decision making would be among parents or family members regarding whether, when, or how to circumcise a young daughter. We find that this is indeed the case. However, two additional arenas of decision making have been identified, initially in Hernlund's previous work (2003) and confirmed by findings of the current study. Interviews have revealed that the question of whether FGC should be performed may arise after marriage, particularly in instances of inter-ethnic marriage (which is neither rare nor problematic in any of our study sites) between members of circumcising and non-circumcising groups. In several instances, co-wives and/or female relatives of the husband arranged for the circumcision of the new wife. Uncircumcised women who live with circumcised co-wives or in-laws often report being contemptuously insulted as *solema*. The fear of being labeled as solema acts as an extremely strong motivation for a woman to "join" herself or her daughter with those who are circumcised. Additionally, women who are not circumcised are not able to participate in the initiation of their own daughters, and some women were motivated to agree to being circumcised in order to be allowed such inclusion. Consequently, in a small but notable number of instances, FGC is being performed on adult women after they move to reside with their husband's family.

> Q: Can you tell me if you remember the time you went?
> A: Yes, I was a grown-up. I came here when I got married, I had one child.
> Q: At that time, how old were you?
> A: Thirty years. But I did not know, I just found myself in it.
> —Jola woman in her 50s, urban Gambia

> Q: Can you remember when you went to circumcision?
> A: Yes, I can remember…At that time I had five children.
> Q: You had five children!
> A: Yes, when I went.
> Q: Can you tell me if you knew what was going to happen before you went?
> A: I knew I was going, but I could not understand what was going to happen.
> Q: You did not know what they were going to do to you?
> A: My mind was already made up that I was going to tear my body. Yes, "I am going to tear my body." I felt it a lot, going up to this stage, then "cut off my body and throw it."
> Q: Now can you tell me who made you do this?
> A: The person who made me do this is my husband's brother's wife because I was hearing insults. They were telling me "jankadingo" [bastard, illegitimate child]. I used to feel bad about it. If you are living with them, you must be insulted if you have not gone, and I was living with my co-wives. When I told my husband that I was going he did not agree. He did not want me to go. He said to me, "I don't have anything in that," but I went.
> —Young Wolof woman who married into a Serer family, urban Gambia

This phenomenon does not appear to be new, as it can be traced back at least one generation. One elderly Gambian Wolof woman from a rural area recalled from her childhood:

> [E]ven if you are in the midst of circumcised women, you are isolated at times. For example, there was an uncircumcised woman who got married in the home I was brought up in; anytime she cooked, we did not eat and when we cooked we let her eat alone. And sometimes we always called her "Solema," meaning someone who knows

nothing. As a result, she one day went to the [circumciser] and asked her to circumcise her.

A third arena of decision making involves girls from non-circumcising families who spontaneously join their friends for circumcision (see also Hernlund 2003: 45). This explains, for example, how FGC is found among a small percentage of Wolof women (4% in our sample), who are generally said to not practice. During in depth interviews, many respondents suggested that this phenomenon of spontaneously "joining" circumcision has become less common in recent years, partly in response to anti-circumcision campaigns. While FGC was previously performed on young girls in groups and accompanied by public celebration, more recently there is a tendency to perform it at younger ages (even on infants) privately in the home. This has diminished the opportunity for "joining." However, for adult women who joined their friends at a young age, the decision as to whether their daughters will be circumcised is influenced by the fact that FGC "is not their tradition."

Constellation of Decision makers

While all individuals have to decide how they feel about the practice, the decision to circumcise a girl (or not) is complicated and often based on the opinion of multiple persons. Decision making regarding FGC can happen simultaneously on multiple levels. Interview and focus group discussion participants describe decision making by the community, the family, and the individual.

The community

Traditionally, in many communities, circumcision for all girls was basically assumed. The decision to be made was not whether to circumcise, but when and how. Often, elders would designate a time for a large circumcision when enough girls of age to be circumcised had accumulated in the community. The community-wide decision to hold a group circumcision would then instigate decision making at family and individual levels; for example, whether to participate in the group circumcision or to postpone until the next opportunity, or whether to travel or send a girl to a neighboring community to participate in circumcision there.

The family

Decision making discussions within the family can be precipitated by the scheduling of a community-wide group circumcision or a circumcision at a relative's home or can be initiated by one of the decision makers. Our qualitative data reveal that mothers, fathers, and grandmothers are consistent participants in this decision; where there is conflict, these individuals have different degrees of power (to either prevent circumcision or make circumcision happen). Especially regarding fathers, the extent of their "veto power" seems to vary a great deal from family to family.

The individual

As large group circumcisions have become less common, decision making regarding when and how to circumcise has shifted to the family, also providing more opportunity to revisit the question of *whether* (rather than *when*) a girl will be circumcised. Some individuals act as the sole decision maker regarding whether they (or a child) are going to be circumcised. Often, this is by circumcising a girl in secret, circumventing debate that might otherwise occur and subverting other would-be decision makers. In other cases, the decision lies with a particularly powerful or overbearing decision maker. It is rare that the decision is deliberately left to a girl herself; however, girls and adult women can take the decision into their own hands by "joining" the circumcision of one or more of their friends. Girls from non-circumcising familes who are circumcised occasionally report that they made the decision on their own.

Survey results

In the survey questionnaire, we asked mothers whether circumcision had been recently discussed (in the past 3 years) regarding any currently uncircumcised girls in their family. Additionally, we inquired about participants in decision making for girls circumcised within the last three years. We did not ask these questions among Senegalese respondents because FGC has been illegal since 1999, and it was unclear how this might affect their responses. All of the girls who were asked about here are at some risk of circumcision: mothers reported that they either have circumcised daughters, or that they or their family might decide at some point to circumcise a daughter.

A total of 332 uncircumcised girls were identified, and mothers were asked an open ended question about why the girl has remained uncircumcised. Responses fell into the categories listed in Table 2.6. The most common response was that it is not yet time to circumcise the girl (meaning often that the girl was not yet old enough, that not enough money had been saved, or that key participants were away). The next four reasons involved various forms of lack of consensus between decision makers; this suggests a growing level of ambivalence about a practice that was once assumed to occur.

Table 2.6 Reason Girls Have Remained Uncircumcised

	Frequency	Percent
It is not time to circumcise her yet	137	40.48
Consensus between decision makers hasn't been reached	76	22.36
Circumcision is not her or her family's tradition	38	12.39
Her mother/decision makers remain undecided or haven't discussed	34	9.97
Her mother opposes the practice	35	9.97
Unknown/other reason	16	4.83

For girls for whom circumcision had been recently discussed or performed, information was solicited regarding participants in the decision making process. Follow-up interviews reveal that mothers' participation was under-reported since their involvement was assumed. In most cases mothers were not sole decision makers. The survey results support the qualitative findings that extended family members often participate in the decision making process. In The Gambia, as well as other parts of Africa, FGC is often described as "women's business." These findings (Table 2.7) show, however, that fathers are frequently involved in the decision making process. It is particularly important to note that more fathers were involved in the conversations regarding girls who remain uncircumcised.

Table 2.7 Decision making participants reported by Senegambian women for daughters' FGC

For uncircumcised girls recently discussed			For recently circumcised girls		
Relationship	Frequency	Percent	Relationship	Frequency	Percent
Mother	10	13.33	Mother	34	20.99
Father	29	38.67	Father	28	17.28
Paternal grandmother	12	16.00	Paternal grandmother	32	19.75
Maternal grandmother	12	16.00	Maternal grandmother	35	21.60
Paternal aunt	9	12.00	Paternal aunt	19	11.73
Maternal aunt	2	2.67	Maternal aunt	7	4.32
Other	1	1.33	Other	7	4.32

Survey respondents were asked to report the preferences of decision makers in recent discussions or decisions regarding the circumcision of a girl in their immediate family (Table 2.8). These preferences reveal that when fathers were included in decision making, a much lower percentage of them favored

FGC than any other group of decision maker: 25% of fathers were reported to have opposed FGC, as compared to 7% of mothers.

Table 2.8 Opinions of Decision makers Regarding FGC

Relationship	Advocate Circumcision		Oppose Circumcision		Unknown/Undecided		Total
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency
Mother	40	90.91	3	6.82	1	2.27	44
Father	41	73.21	14	25.00	1	1.79	56
Paternal grandmother	41	93.18	3	6.82	0	0.00	44
Maternal grandmother	46	97.87	1	2.13	0	0.00	47
Paternal aunt	27	96.43	1	3.57	0	0.00	28
Maternal aunt	8	88.89	0	0.00	1	11.11	9
Other	7	87.50	1	12.50	0	0.00	8
Total	210	88.98	23	9.75	3	1.27	236

At the outset, we anticipated finding some differences in the constellation of decision makers in urban versus rural settings. Daffeh and colleagues point out that the "communal way of life in the rural areas prevents any radical departures from community values and norms," and adds that it "would be easier for an anti-FGM protagonist to survive in the peri-urban and urban areas than in the agrarian rural communities" (Daffeh, Dumbuya et al. 1999: 35). It might thus be expected that in the urban setting the decision regarding FGC would more commonly rest within a nuclear family. We find, however (as did Hernlund 2003), that in both rural and urban settings the decision is most often shared with extended family members. In both rural and urban areas, non-family members can also be important factors in the family's decision making: peer pressure on parents and grandparents regarding what is considered "proper parenting," including ensuring that their daughters are circumcised, can be substantial. Social pressure is an important factor not just among young girls, but across generations.

Decision making in some instances results from achieving consensus among decision makers. In other cases, individuals can act against the will of other decision makers and have a girl cut despite the opposition of other family members. In particular, when there is a lack of agreement among decision makers, those who do not want a girl to be circumcised are often on constant vigil to prevent the girl from being "taken." A female participant in a focus group discussion in rural Gambia explained:

> I once encountered difficulties. My younger sisters went to circumcision, and one girl followed them. This girl came from a family that did not practice FGC, and even believed that going through the process would result in death, because it is against their culture. So, when this girl followed my sisters, we took her to circumcision, and when her mother heard the news, she came attacking me, and even wanted to take me to the police. I asked her [the mother] to take me anywhere her legs could carry her. It was her daughter who followed us to where we were and, of course, we should and must circumcise her, so we did. Whether it was their taboo or not, this was not our business. It is our traditional duty that we were exercising, and any uncircumcised female that met us there will surely be circumcised. The mother of this girl did say all sorts of things, but the bottom line is that any uncircumcised girl who comes to our place, where our newly circumcised girls are kept, must experience the process by herself. As for us, we do not compromise this issue.
>
> -Middle aged rural Mandinka woman, rural Gambia

It is important to note, as well, that the constellation of decision makers is not static, but rather changes over time, as, for instance, relatives migrate into or away from the compound, and as girls shift to reside with different relatives or transfer from their natal to marital home. Additionally, the power of persuasion is not equal among all decision makers, and varies as group composition changes. In the survey questionnaire, Gambian mothers were asked two questions about self-efficacy (Table 2.9). Seventy percent of Gambian mothers reported that they felt unable to change the minds of other decision makers, and 65% agreed that the decision rests in the hands of other decision makers, and not themselves.

Table 2.9 Self-efficacy among Gambian Mothers

Statement	Agree	Disagree	Don't know
If the other decision makers do not agree with me about whether to circumcise a girl or not, there is nothing I can do to change their minds.	70%	5%	25%
Whether or when female circumcision is practiced depends mostly on what the other decision makers want, not what I want.	65%	6%	29%

Change in FGC across generations: Comparing mothers' and daughters' circumcision

During semi-structured interviews and focus group discussions, respondents reported that many changes have occurred in female circumcision over the years. Most commonly cited is a shift from circumcision performed in the bush, usually drawing girls from the whole community or beyond, to circumcision of small numbers of girls performed in the home. This shift away from "bush" circumcisions is reportedly often accompanied by a reduction in the amount of training and celebration performed at the time of circumcision.

> Before, it used to be a big celebration in which many surrounding villages came together. And relatives came also to grace the ceremony—that is, on the first and last days. People spent a lot of money, and killed a lot of animals, such as goats, sheep, and the rich ones would even offer cows. In addition, one knife could be used for a good number of people, being washed in the same pan of water. People would stay in the bush with all practices that are a risk to one's health. But, then, as I used to say, it was only Allah that guided us, but now things are changing.
> —Middle-aged Mandinka woman, rural Gambia

> You know, initially, it used to be done in the bush, where you would stay for about one month, but now, as I said earlier, it is done at home. Before, men did not see circumcised girls until the day they came out, because this was seen as a taboo, even the uncircumcised women were not allowed to see them, but now, this is no more the case. You see newly circumcised girls mingling with uncircumcised girls and even with men. This is why there is no more secret about the whole issue, even male circumcision, too, is made known to the women.
> —Middle-aged Jola woman, rural Gambia

The other major change reported in female circumcision is the use of "one blade per girl." Health messages regarding the risk of disease transmission (specifically, transmission of the HIV virus) when multiple girls are circumcised sequentially with the same instrument seem to have resonated deeply with many who are planning to circumcise their daughters. Most participants who continue to practice female circumcision report that they take care to provide each girl with her own blade for

circumcision. Less frequently reported changes in the practice include a reduction in the prevalence of female circumcision, a reduction in the age at which most girls are circumcised, and a tendency for circumcisers to remove less during circumcision.

We used survey data to detect changes in circumcision over time by comparing characteristics of respondents' circumcisions to those they reported for their daughters' circumcisions. First, we compared rates of characteristics between generations (e.g., the percent of respondents who reported being circumcised "in the bush" compared to the percent of their daughters who were circumcised "in the bush"); second, we examined mother daughter pairs for concordance (e.g., a respondent reported that both she and her daughter were circumcised "in the bush"). Concordance was calculated as the percentage of mother/daughter pairs with the same circumcision characteristic. The kappa statistic (κ) was calculated as the extent to which observed concordance exceeded that expected solely by chance:

	Mother		
Daughter	Category 1	Category 2	Total
Category 1	a	b	m
Category 2	c	d	n
Total	o	p	t

Observed concordance = (a + d)/t

Expected concordance = [(m/t)*(o/t)] + [(n/t)*(p/t)]

κ = (Observed concordance – expected concordance)/(1 – expected concordance)

Equations were expanded to accommodate more than two categories when necessary (e.g., circumcision location).

Survey data bear out reports from the qualitative data: changes in circumcision location, the degree of celebration, and age at circumcision are striking, while no change in the type or degree of cutting are apparent (Table 2.10). Similar rates of "sunna" circumcision in mothers' and daughters' generations, and high concordance between mother/daughter pairs, suggests no important secular trend in circumcision type; similarly, no change across generations is apparent for sealing, or for the type of circumciser employed. The much lower percentage of daughters circumcised in the bush and the low concordance for circumcision location between mother/daughter pairs, on the other hand, suggests a trend away from bush circumcisions. Similarly, the higher percentage of daughters who experienced no celebration associated with circumcision and the low concordance between mother/daughter pairs for celebration suggest a trend away from circumcision celebrations.

Table 2.10 Concordance and Kappa Statistics for Characteristics of Gambian Mothers' and Daughters' Circumcisions

Characteristic	Mothers' generation	Daughters' generation	Concordance (κ)*
Type of circumcision			
Sunna	38.59%	44.82%	91.96% (83.98%)
All removed	43.84	38.98	
Unknown	17.57	16.20	
Sealing			
Sealed	14.74	11.75	91.36 (60.15)
Not sealed	85.35	88.25	
Unknown	.18	---	
Location			
Circumciser's compound	34.95	49.85	47.95 (26.62)
Own compound	20.19	34.41	
Bush	42.52	13.09	
Other	2.33	2.65	
Circumciser			
Local circumciser	94.19	90.00	87.54 (11.69)
Other circumciser	1.87	7.62	
Nurse	3.00	1.62	
Other	.94	1.03	
Celebration			
Celebration	82.46	52.87	65.65 (28.72)
None	17.54	47.13	

* Pairs in which either mother or daughter's circumcision type was reported to be "Unknown" were eliminated from the calculation of concordance/kappa statistics.

Differences in age at circumcision were assessed in two ways. First, for mothers with at least one circumcised daughter, the mother's age at circumcision was compared to that of her most recently circumcised daughter (Table 2.11) or her youngest daughter (Table 2.12). For those mother/daughter pairs from whom both mother's and daughter's age at circumcision was reported (excluding "Unknown/Missing"), whether comparing mothers to their most recently circumcised daughter or their youngest circumcised daughter, in a substantial majority (≥ 75%) of pairs, the mother was circumcised at an older age than the daughter.

Table 2.11 Mother's Age at Circumcision Compared to Most Recently Circumcised Daughter's Age at Circumcision

Mother was…	Frequency	Percent	Frequency*	Percent*
Older	188	56.29	188	77.37
Same age	28	8.38	28	11.52
Younger	27	8.08	27	11.11
Unknown/Missing	91	27.25		
Total	334	100.00	243	100.00

*Without "Unknown/Missing"

Table 2.12 Mother's Age at Circumcision Compared to Youngest Daughter's Age at Circumcision

Mother was…	Frequency	Percent	Frequency*	Percent*
Older	168	37.17	168	75.00
Same age	23	5.09	23	10.27
Younger	33	7.30	33	14.73
Unknown/Missing	228	50.44		
Total	452	100.00	224	100.00

*Without "Unknown/Missing"

Second, we used Kaplan-Meier methods to assess generation (mothers vs. daughters) as a risk factor for circumcision to quantify the difference between generations in age at circumcision. Mothers and their daughters were included in this analysis if: 1) mothers were circumcised, reported that any of their daughters were circumcised, or reported that their family might decide to circumcise any of their daughters, and 2) information about mothers' and daughters' circumcision status and age at circumcision were complete (all mothers and daughters were excluded or included individually for incomplete information: if a mother's information was incomplete but her daughter's was complete, the mother was excluded and the daughter included; if only one of a respondent's daughter's information was incomplete, only that daughter was excluded). 396 mothers (372 circumcised) and 818 daughters (543 circumcised) were included in this analysis. The result is shown in Figure 2.1.

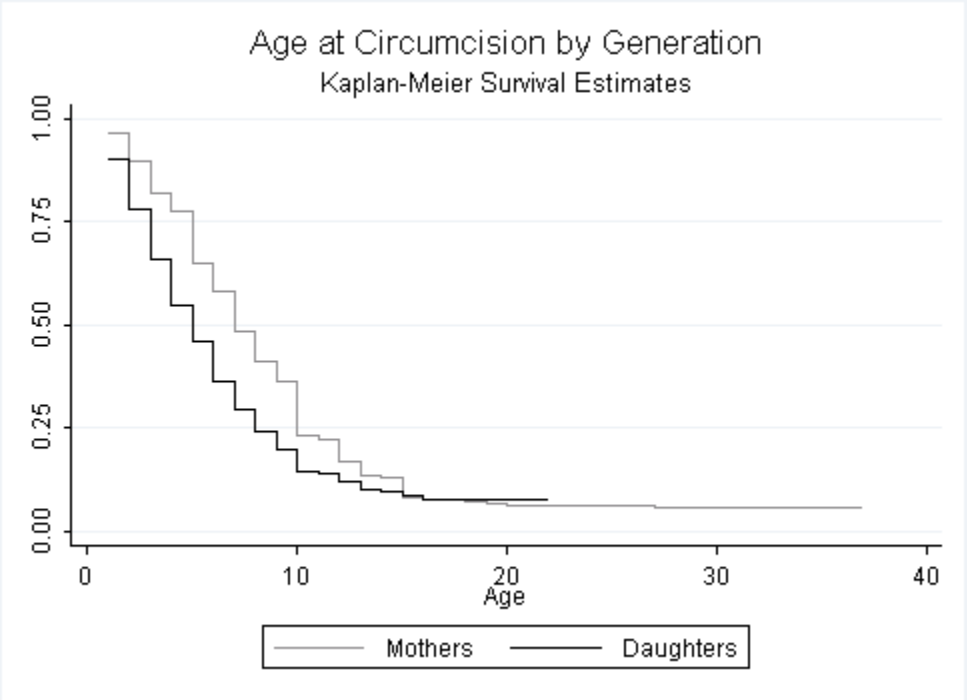

Figure 2.1 Survival curve for remaining uncut. Mothers (grey; survey questionnaire respondents) from circumcising families and their daughters (black) for whom age at circumcision was available (either a provided age or not yet circumcised) were included in survival analysis. Members of the daughters' generation were, on average, circumcised at a significantly younger age; log-rank test for equality of survivor functions: $\chi^2 = 36.58$; $p < .0001$.

This analysis shows that being from the daughters' generation is a risk factor for early circumcision: age at circumcision appears to be decreasing among those who practice female circumcision.

Consistent with reports from qualitative interviews, questionnaire data document a dramatic decrease in the prevalence of circumcision performed "in the bush" (and concomitant increase in circumcisions performed in compounds), a decrease in the ceremony or celebration surrounding circumcision (including celebration or ceremony going into or coming out of circumcision, as well as ceremony during any seclusion time associated with circumcision), and a trend toward younger age at circumcision among the daughters of survey respondents.

The similarity between mothers' and daughters' generations in the prevalence of circumcision types (sunna versus "all removed") and in the prevalence of sealing, as well as the high concordance between mother/daughter pairs in circumcision type and sealing, suggest that no significant change in actual cutting has occurred in the practice of female circumcision (although the high percentage of "unknown" circumcision type should be noted). Similarly, when asked directly, very few women (5.08%) perceive any difference between their circumcision and their daughters'. Of those who reported a difference, a majority reported that their daughter had experienced *more* cutting.

Thus, while we find important changes in the practices surrounding female circumcision (circumcision location, celebration, and age at circumcision), we do not find changes in the physical cutting itself. These changes may be best interpreted as changes made to ameliorate problems associated with female circumcision while preserving its essential features. When decision makers acknowledge disadvantages associated with circumcision, like the expense of traditional celebrations, risk of infection, including HIV, or excessive pain and bleeding, they may make changes in how they circumcise their girls to minimize these risks, rather than abandoning the practice. Shifts from the bush to household circumcisions, abandonment of celebrations surrounding circumcision, the employment of "one blade per girl" and medical interventions such as tetanus vaccination, and circumcising girls at a younger age may be some of these changes. In this way, decision makers can address objections to the practice without compromising their ability to realize its perceived advantages for their daughters and their family.

III. Readiness to Change the Practice of Female Genital Cutting[3]

Summary

In recent years there has been growing interest in developing theoretical models for understanding behavior change with respect to the practice of female genital cutting (FGC). Drawing on extensive qualitative data collected in Senegal and The Gambia, the research reported here explores whether and how theoretical models of stages of behavior change can be applied to FGC. Our findings suggest that individual readiness to change the practice of FGC is most clearly seen as operating along a continuum, and that broad stages of change characterize regions or segments of this continuum. Stages identified by previous researchers for other "problem behaviors," such as smoking, inadequately describe readiness to change FGC, since this decision is often a collective rather than individual one. The data reveal that the concept of stage of change is a complex construct that simultaneously captures behavior, motivation, and features of the environment in which the decision is being made. Consequently, stages identified in this research reflect two dimensions of readiness to change the practice of FGC: preference and actual behavior. We identified five categories of readiness to change: 1) supporters of FGC, 2) reluctant practitioners, 3) contemplators (practitioners considering abandonment), 4) willing abandoners, and 5) reluctant abandoners.

Respondents were categorized by two means: self categorization, and through an algorithm based on responses to a series of survey items. There was 65% concordance in categorization, and the pretest suggested construct validity in self-categorization. Among Senegambian women from circumcising families, 52% were supporters, <1% reluctant practitioners, 26% contemplators, 13% willing abandoners, and 8% reluctant abandoners. Serer ethnicity, interethnic marriage, and FGC-incongruent marriage were positively associated with being an abandoner.

Readiness to change was also assessed in a subsample of husbands in Senegal. Almost half of the couples were in different categories of readiness to change, and 50% fewer husbands were supporters of the practice. In a convenience sample of decision makers in The Gambia, referred by survey respondents (mothers of girls who are or may be circumcised), 20% were at different categories of readiness to change than the mother of the girl in question, again revealing profound disagreement regarding FGC. This is consistent with our qualitative findings that not uncommonly families experience heated conflict over the decision of whether or not to circumcise a girl.

Readiness to change as measured in this study may be of use in survey research or monitoring and evaluation by providing an important metric of change short of abandonment. Additionally, our findings regarding gender-based differences in readiness to change further supports the importance of including men in campaigns to end the practice of FGC.

Introduction

Across the social and health sciences, a number of cognitive models have been developed to analyze the process of behavior change for a wide variety of "problem behaviors." These models employ the concept of "readiness to change" (RTC), which refers to the degree to which an individual is motivated to change a problem behavior such as smoking or substance abuse (Carey, Purnine et al. 1999). RTC can be conceptualized as an index of the willingness or behavioral readiness to initiate behavior change (Carey, Purnine et al. 1999). In recent decades, as the construct of RTC has become increasingly popular, cognitive models have proliferated. These include the Health Belief Model (Janz

[3] Portions of this chapter have already appeared in publication: Shell-Duncan, B. and Y. Hernlund (2006). "Are there 'stages of change' in the practice of female genital cutting?: Qualitative research findings from Senegal and The Gambia." African Journal of Reproductive Health 10(2): 57-71. They are reprinted here with permission of the editor.

and Becker 1984), the Theory of Planned Behavior (Ajzen and Madden 1986), and the Theory of Reasoned Action (Fishbein and Ajzen 1975). Two recent reports (Izett and Toubia 1999; WHO 1999) have raised the issue of potentially employing cognitive models to analyze the outcome of FGC interventions, although, to our knowledge, research extending these models to FGC has not been conducted. Discussions have centered on two distinct, but interrelated, models for describing the adoption of behavior change: diffusion theory, and the trans-theoretical model.

Diffusion theory analyzes the "process by which an innovation is communicated through certain channels over time among members of a social system" (Rogers 1995: 10). One particular area of focus of diffusion theory is the decision to adopt a novel or innovative behavior. Rogers (1995: 162) notes that diffusion scholars have long recognized that an individual or decision making group passes through a sequence, and that a "decision about innovation is not an instantaneous act. Rather it is a *process* that occurs over time." This decision making process, observed over a wide range of behaviors, has been described as a potential progression along a series of five stages. The first stage, *knowledge*, occurs when an individual or decision making unit is made aware of the existence of the innovative behavior and gains some understanding of how it functions. In the next stage, *persuasion*, decision makers form a favorable or unfavorable opinion of the novel behavior. The third stage, *decision*, occurs when an individual or decision making unit chooses to adopt or reject the innovation. Next, *implementation* involves putting the innovation into use; and, finally, *confirmation* occurs when decision makers seek reinforcement of an innovation decision, or reject the innovation if exposed to conflicting messages or dissatisfaction with the innovation.

A second, closely related model, developed in the field of public health, is known as the trans-theoretical model of behavior change or "stage of change" model. This model was developed by Prochaska and DiClemente (1982; 1992) as a means of integrating different behavior change theories used in psychology, with particular reference to smoking cessation. It was noted that all smokers identified a common sequence of stage of change in their efforts to quit smoking. The model proposes five distinct stages of behavior change: 1) *pre-contemplation*–not intending to make behavior changes in the foreseeable future; 2) *contemplation*–considering behavior change but not yet making a firm commitment to change; 3) *preparation*–commitment to behavior change in the next thirty days but not yet changing behavior (those in preparation may have also made unsuccessful attempts in the past, but have made small changes); 4) *action*–successfully changing behavior; and 5) *maintenance*–behavior change sustained over six months. More recently, a sixth stage–*termination*–has been proposed to reflect behavior change with little chance of relapse (Prochaska, Norcross et al. 1994). The model proposes that individuals in different stages will be influenced by different types of intervention, and that the best intervention will be one that is matched to the person's current stage of change (Brown-Peterside, Redding et al. 2000; but for a counter example which illustrates a case in which matching the stage to intervention did not appear to help, see Quinlan and McCaul 2000).

The introduction of the trans-theoretical model to the field of health psychology has sparked enormous research interest, extending this approach to other behaviors such as substance abuse, dietary change, exercise promotion, and safe sex (Prochaska, Velicer et al. 1994). While some studies have modified the stages (preparation was added after the initial conceptualization of the stage of change model), a progression through an identifiable sequence of stages has been hypothesized for all behaviors studied (Prochaska and DiClemente 1982; Prochaska, Velicer et al. 1994). Some investigators assess only a subset of stages or subdivide stages for a particular research question (Carey, Purnine et al. 1999), yet the suitability of transferring stages developed with respect to smoking behavior to other behaviors is often not critically evaluated. Notably, definitions or conceptualizations of stages are not demonstrated to be grounded in qualitative data reflecting the experiences, behaviors, and articulated perspectives of members of the study population.

FGC researchers have begun adopting the concepts and terminologies of diffusion theory and the trans-theoretical model (see, for example, Diop, Faye et al. 2003; Toubia and Sharief 2003), despite the fact that there have been no rigorous investigations of whether or how these models are applicable to the case of FGC. This shift is not merely to a new "problem behavior," but to an extremely different cultural context in comparison to that in which conceptualization of stages of change was originally formulated, and to a decision that is often a collective rather an individual one. Using both qualitative data, in the form of ethnographic interviews and focus group discussions (FGD), and survey data, we explore whether and how theoretical models of stages of behavior change can be applied to the case of FGC in the Senegambia.

Lessons Learned from HIV Research

Cognitive models of behavior change have been extended to the study of behavior change for a wide variety of behaviors, ranging from smoking cessation to the adoption of new computer technologies, from weight control to condom use, and from the acceptance of novel agricultural techniques to using clean needles when injecting drugs. With extended applications, several models have been extensively revised and refined. Yet, particularly within the last decade, a number of scholars have leveled criticisms, most prolifically and thoughtfully with respect to HIV prevention (e.g. Airhihenbuwa et al., 1999, cited in Davies and SIGMA 1992; Ingham, Woodcock et al. 1992; Yoder 1997; Melkote, Muppidi et al. 2000; Yoder 2001; Parker 2004). Behavioral interventions to control the transmission of HIV have largely centered on risk reduction through abstinence, being faithful, or condom use (the so-called ABC's of HIV prevention). Several scholars have argued that cognitive theories and models of health behavior do not provide an adequate framework for promoting the adoption of safe sex; and we suggest that issues problematized in this literature may have several important parallels to the case of FGC.

Yoder (2001) highlights two key assumptions common to cognitive models of behavior change: 1) the capacity for behavior change is viewed as being in control of the individual, and it is assumed that if individuals are educated about health risks they will be motivated to change their behavior; and 2) individuals act rationally in assessing information and risk, and are empowered to take action to protect themselves. Unlike smoking cessation or the adoption of preventive medical care, safe sex (except for the case of abstinence) is not something that individuals engage in alone. Airhihenbuwa and colleagues (1999, cited in Parker 2004) argue that the assumption that individuals can or will exercise total control over their behavior has led to a focus on the individual rather than on the social context in which the individual functions. This viewpoint has been dubbed the "individualist fallacy" by Davies (Davies and SIGMA 1992), who also points out that the interpersonal activity is preceded by a "complex social negotiation, which we understand poorly."

He further suggests that "it is more fruitful to seek the causes of a particular sexual behavior in the interaction between individuals," rather than in characteristics of the individual (Davies and SIGMA 1992: 135). This suggests that the unit of analysis is more appropriately the interaction in a sexual session, as opposed to specific cognitive characteristics of an individual (Yoder 2001). Emphasis on the negotiating aspects of sexual encounters draws attention to the dynamics of interpersonal power, and raises the issue of self efficacy, the extent to which individuals have control over the course of events (Ingham, Woodcock et al. 1992). Yoder (1997: 134) emphasizes that, in cognitive models, "most social behavior is assumed to be based on volition, and very closely linked to intention to perform that behavior." Yet for sexual encounters, this may not be the case. As Parker (2004: 2) notes, "Sexual interactions take place in a wide range of contexts and along a continuum of consent that extends from willed or conscious engagement in sexual activity through to unwilled non-consensual sex, that include the use of coercion and possibly physical violence." With respect to consensual sex, Davies (Davies and SIGMA 1992) notes that sexual negotiation is not necessarily between *equals.* Instead, there exist

situations in which one individual becomes more able to decide the course of events than the other, and the decision making power is not fixed over time, but continuously renegotiated, even between the same two individuals. As Yoder (2001) points out, however, most cognitive models "assume individuals make a once-and-for-all decision to have safe sex … (and) minimize the negotiating aspects of sexual acts." Similarly, Parker (2004: 2) argues that behavior change cannot be assumed to be consistently maintained, and emphasizes that the "complexity of sexual relationships and interactions over a lifetime…are influenced by diverse changing contexts—for example changing partnerships, changing relative empowerment/disempowerment." Consequently, individual intention is mediated by this shifting power dynamic, influenced by interpersonal actors, as well as fluctuating social and political realities.

The second broad assumption of cognitive behavior change models—that individuals educated about risks will act rationally—has also been called into question. Ingham and colleagues (1992: 164) point out the narrow use of the concept of rationality in behavior change theory: "Campaigns and interventions rest on the assumption that 'correcting' false beliefs and misconceptions will enable any 'rational' person to alter their behavior in the 'desired' direction." Missing from this formulation of rationality is the fact that individuals may have valid reasons for not complying with the advice, or may have other factors constraining or motivating their behavior. Ingham and colleagues (1992: 168) thus describe "varied rationalities" that may be "at odds with and counteract the 'received rationality' of official biomedical wisdom." This, again, points to the fact that decisions are made in the context of broader social and political realities that also influence decision making. While some models have been extended to attempt to address this by adding sociodemographic variables, Yoder (1997: 136) concludes that "factors of social relations and ecological context are given short shrift."

Along with Davies (Davies and SIGMA 1992), Yoder (1997; 2001) emphasizes the utility of focusing on social interaction for understanding behavior change, and elucidating contexts in which specific actions are negotiated or imposed. He concludes that focused ethnographic methods are essential to understanding behavior in its social contexts and requires the development of a commonsense understanding of the world that may differ from our own.

From HIV to FGC: What Can We Learn?

Issues of individualism, self-efficacy, negotiation and power pertain to the application of decision making models to FGC. Several commentators (e.g. Izett and Toubia 1999; WHO 1999; Shell-Duncan 2002) note, quite importantly, that behavior change in the case of FGC is fundamentally different from that for individually based behaviors such as smoking or alcohol cessation, since decisions are often made by a larger group. Clearly, any analysis of decision making regarding FGC must consider readiness for change among multiple stakeholders in the decision to abandon FGC.

We argue that a focus on the individual may not be entirely inappropriate with respect to FGC, but instead it is simply not the final point of analysis. Individuals bring to the negotiation process their own perspectives and opinions, which have been shaped by a unique repertoire of experiences and sources of influence, as well as greater or lesser skills in communication, powers of persuasion, and varying degrees of power and authority in decision making. The questions, then, are: How do individual attributes and opinions influence social interactions and the dynamics of negotiation? Who make up the constellation of decision makers, and how does this change over time? How can we best describe an individual's readiness for change?

Identification of the readiness to change of individuals may be useful for making aggregate descriptions of a community—is it one that is largely receptive to change, or are many residents resistant to change? This may provide useful information regarding the immediate social environment in which decision makers are operating.

Identifying Stages of Change

Although scholars have suggested that behavior change with respect to FGC may be conceptualized in terms of stages of change, no previous research has investigated whether and what identifiable stages can be defined. It has also been questioned whether assessment of stage of change for an individual is meaningful given that the decision to continue or abandon FGC is often not in the hand of individuals, but rather a group of decision makers. We do, however, find the concept of stage of change to be potentially useful for describing the position of individuals who comprise the decision making group, and we believe that understanding the degree of concordance, as well as the degree of leverage in the final decision, is potentially useful for comprehending the dynamics of decision making. Our findings reveal that behavior change with respect to FGC is operating in two directions: 1) some people from families that have traditionally practiced FGC are abandoning the custom, and 2) some people from families that have not previously practiced FGC are newly adopting the practice. For the sake of scope, here we consider only the former.

Our data reveal that the process of behavior change for individuals is best seen as falling on a continuum, although individuals do not necessarily progress through this continuum in a regular or linear fashion. Instead, readiness to change appears to be a complex construct that is influenced by numerous social interactions and experiences (see also Hernlund 2003). Stages of change can, however, be used to describe segments or regions of this continuum. The stages defined for trans-theoretical or stage of change models for behaviors such as smoking or substance abuse do not adequately describe the process of behavior change for FGC. Carey and colleagues (1999) point out that stages of change defined for such behaviors are complex in that they combine information on 1) an individual's actual behavior change and 2) an individual's self-reported intentions. Since the decision regarding FGC is often made by a decision making group, we find it necessary to define stages that reflect an individual's opinion vis-à-vis the group decision, in addition to her or his own behavior and intention. Our interpretation of the data suggests the following stages of change as applicable to decision making around FGC in the Senegambia area:

- Non-contemplator or supporter (willing practitioner)
- Contemplator
- Reluctant practitioner
- Reluctant abandoner
- Willing abandoner

Non-contemplator/Supporter

These are individuals who are supporters of the continuation of FGC. The term "pre-contemplation" was originally proposed by Prochaska and DiClemente (1982) to describe individuals who are not considering attempting to quit smoking. We prefer the term "non-contemplation" to "pre-contemplation" since the latter seems to imply that individuals will necessarily eventually become contemplative. Alternatively, we employ the term willing practitioner. In our study sites, people are well aware of local and international efforts to end the practice of FGC. Hernlund (2000: 240) writes that in urban areas, "few individuals are unaware of local campaigns to convince people of the need to eradicate 'female genital mutilation.' In rural areas, as well, many communities have been contacted by fieldworkers from groups trying to abolish FGC." Daffeh and colleagues report, however, that a staggering 93% of their respondents claimed to be unaffected by the campaigns (1999: 22). Consequently, those who support the practice do so not because they are unaware of alternatives or efforts to change the practice. Instead, they have been exposed to, but were unpersuaded by, arguments for ending the practice. Within this category we see a range of responses to anti-circumcision messages, ranging from simple rejection of arguments for ending the practice, to strong reactance to what are perceived as attacks on culture and, sometimes, religion:

Non-contemplation:
Even if the majority of Gambians campaign against it, I and my family will not stop it because this is our tradition and we will make sure that we do what our tradition says.
—Elderly Jola man, urban Gambia

Strong reactance:
These campaigners are in the habit of spreading money into the villages, so that the people will forget their culture. Some of the people have been brainwashed, and they are already in for the eradication. For me, as a typical Mandinka, I can't abandon my culture. And if this process is harmful, the majority of my parents should have been dying like mosquitoes.
—Elderly Mandinka woman, village leader, rural Gambia

Contemplator

This stage describes individuals who are practitioners of FGC, but are experiencing ambivalence, and questioning aspects of the practice:

If they campaign against it, it is good, and if they don't campaign against it, it is also good for me. In these modern days, it is not safe to circumcise many people with one blade. There are several infections that can be transmitted during circumcision. To my understanding, if there are more disadvantages than advantages in the practice, a law can be implemented. People's health is a government concern.
—Middle-aged Wolof man, rural Gambia

Reluctant practitioner

This category does not fit with typical stages in models for individually-based behaviors, but instead reflects the fact that the decision is often not solely in the hand of an individual. An individual's opinion can be overruled by the other decision makers. Additionally, people may be in favor of abandoning the practice, but be reluctant to do so because of factors such as peer and/or family pressure. Consequently, there can be people who oppose the continuation of the practice but continue it anyway:

The men don't even take it very seriously, because there are some men who don't even want their daughter to be circumcised. You will see, the mother will be the one to force the child to be circumcised and will say "because I am circumcised, she will also be circumcised."
—Young Manjago/Jola woman urban Gambia

The person [who decides not to practice] will not be comfortable in the community in which she is living because whenever she goes out, people will start pointing fingers at her: "that is that woman who decided not to circumcise her daughters, while she [herself] is circumcised." Some will even encourage her daughters to be circumcised; they will tell them, "you are sitting here, your mother or parents don't want you to be circumcised, while they themselves are circumcised, and if they happen to pass away, you will be at a big loss, because you will know nothing in your tradition," and that can cause the daughters to be circumcised, which may bring problems between children and

parents, because the parents will say their children don't respect them, that's why they didn't obey what they said to them.
—Young, Manjago/Jola woman, urban Gambia

Reluctant abandoner

People may abandon the practice of FGC even if they personally favor the continuation of the practice if other decision makers or other social pressures force them to stop the practice. Cases of people who reluctantly abandon the practice include those in Senegal who still strongly value the practice and wish for its continuation, but abandon the practice because of fear of prosecution for breaking the law:

No, it should not be stopped. But there is a law that says we should not practice it. And I myself do not support the law against it. It is just that we should not argue with the law because it is more powerful than us…. Even if I had another daughter I would not take her to circumcision because people are not doing it in our village now. And that is because of the law.
—Elderly, Serer man, rural Senegal

However, in addition to stages of change, another important concept is the level of tolerance of the behaviors of others. While some informants expressed strong opinions regarding whether members of their community should practice or abandon FGC, others expressed more tolerance:

Q: We understand that there are people who are trying to do campaigning against female circumcision. Can you tell me how you feel about that?
A: You know, they are saying what they want to say and people are doing what they have to do, so really I don't worry myself about them. It's a free country.
Q: Do you think that female circumcision should stop?
A: I think people who do not want to do it can stay without it and those who want to do it should be able to do it.
—Young Tillibonka man, urban Gambia

Willing abandoner

This describes individuals who are motivated to end the practice of FGC, and are able to act upon their intention:

I felt happy because the people of this community have agreed to stop it, so therefore I am also ready to stop it. It should be stopped because it has bad effects, like difficult births, and tetanus, which may result in death. I have seen that here, a girl was circumcised and through that she died.
—Middle-aged, Serer woman, rural Senegal

The concept of readiness for change in terms of "stages" may seem to imply that the stages represent a sequence through which individuals progress in a linear fashion (Weinstein, Rothman et al. 1998). We find that for the case of FGC in our study sites, this is not necessarily true. For instance, it is possible for people who decided to abandon the practice to later become ambivalent about the decision. Additionally, individuals who are non-contemplative may remain so, and not necessarily ever become contemplative. Moreover, for people who have shifted their opinion, it is not necessarily the case that they have moved in a linear fashion from one stage to the next. In Senegal, for example,

people whom we describe as "reluctant abandoners" have not necessarily experienced ambivalence. Consequently, viewing stages as a progressive sequence is an oversimplification of scenarios in which change (or lack of change) occurs. In addition, our current research findings, which include a number of instances of previously non-practicing women undergoing circumcision after marriage–even after the birth of several children–calls into question previous assumptions about a "cut-off" age after which it can be assumed that a woman will not undergo the practice.

Operationalizing Readiness to Change in Survey Research

Carey and colleagues (1999) have extensively reviewed instruments used to measure readiness to change (RTC) with respect to substance abuse; similar instruments have been developed for other behaviors such as smoking, exercise and condom use. Instruments are classified as: 1) staging algorithms, 2) self-administered questionnaires, or 3) clinician-administered questionnaires. Staging algorithms are a short series (4-5) of questions that correspond to discrete stages of change in the transtheoretical model (Prochaska and DiClemente 1982). An example of the staging algorithm for people identified as current or former smokers is described by Prochaska and colleagues (1985). Across studies, the basic algorithm varies, for example, as stages are omitted or added. A number of longer instruments, either self-administered or clinician-administered, have also been developed to measure RTC, although they vary as to whether they were derived from a theory of behavior change. Examples of scales that refer specifically to stages in the Transtheoretical Model include the University of Rhode Island Change Assessment (URICA) Scale (McConnaughy, DiClemente et al. 1989), the Readiness to Change Questionnaire (RTCQ) (Rollnick, Heather et al. 1992), and the Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES) (Miller and Tonigan 1996). These scales are structured as multi-item questionnaires ranging from 12 to 32 items, with segments corresponding to a specific stage of change. In some cases, the interpretation of scores for each stage has been problematic (Carey, Purnine et al. 1999). In the URICA questionnaire, for example, there has reportedly been a high positive correlation between contemplation, action and maintenance scales. The RTCQ, which also derives scales from multiple items for discrete stages of change, specifies that stage assignment is based on the scale with the highest score, and in the case of ties, the more advanced stage is assigned (Carey, Purnine et al. 1999).

While we considered creating scales derived from multiple items representing our identified categories of change, we realized the complexity of crafting questions that simultaneously address different dimension of readiness to change. We have defined our categories of readiness to change along two dimensions: individual preference and actual or intended behavior (Figure 3.1).

		Preference	
Behavior	Supports FGC	Ambivalent	Opposes FGC
Practitioner	Non-Contemplative (Willing Practitioner)		Reluctant Practitioner
Undecided		Contemplative	
Abandoner	Reluctant Abandoner		Willing Abandoner

Figure 3.1 Dimensions of Readiness to Change Female Genital Cutting. Individual preference for female genital cutting (FGC) and actual behavior regarding FGC combine to form five stages of change for FGC: non-contemplative/willing practitioner, contemplative, reluctant practitioner, willing abandoner, and reluctant abandoner (Source: Shell-Duncan and Hernlund 2006).

To simultaneously capture both preference and behavior, we needed to create compound questions. For example, to identify a reluctant abandoner, we would anticipate a response of agreement to the following item:

> *I do not want to see female circumcision continue, but my friends and family do not agree.*

Clearly, it is possible for a respondent to agree with the first part of the statement, and not the second (or *vice versa*), making it difficult to provide a clear and unambiguous response. To avoid such ambiguity, we constructed questions to discern *preference* separate from those to identify actual *behavior* (Table 3.1) to categorize readiness to change (as shown in Figure 3.1).

Table 3.1 Questionnaire items corresponding to two dimensions of readiness to change

Preference	
Supports FGC	*I see no problem with continuing the practice of FGC.* *The way I see it, it is not acceptable to stop circumcising our girls.* *It is better if our girls are circumcised.*
Ambivalent	*I think we need to consider ways of solving problems that do arise from female circumcision.* *Things have changed from the past, and I think it is OK for us to think about making changes in the practice of female circumcision too.* *People say different things about female circumcision, and it is hard to know who is correct.*
Opposes FGC	*I would like to see female circumcision stop in my family.* *I believe there are serious problems with female circumcision.* *The way I see it, female circumcision has no use.*
Behavior	
	Will the uncircumcised girls in your immediate family be circumcised?
Will circumcise	*Yes*
Undecided	*Not sure*
Will not circumcise	*No*

Phrases in these questions (e.g., “female circumcision has no use”) were drawn from interview and focus group transcripts to ensure they were meaningful and culturally appropriate. Questions were pre-tested for clarity and meaning among six informants and found to be easily understood and to correspond well with subjects’ expressed preferences regarding FGC.

As a means of further assessing the validity of the hypothesized stages of change, we discussed the identified RTC categories with pre-test participants. The categories of readiness for change were explained conceptually to respondents, and they were asked to select the category or categories that describe themselves. Even though they were offered the opportunity to choose more than one

category, all pretest respondents chose only one category, and self-categorization was not observed to be difficult or problematic. In general, RTC categories "rang true" with pretest participants: they recognized and understood the proposed categories and could readily identify their own and others' stage. Because participants seemed to understand the RTC stages we identified so well, we chose to assess both self-described and assigned stages of change (SOC) in the full survey.

Survey Results

Assigned stage of change

Individual preference regarding FGC was evaluated based on the nine survey items described in Table 3.1. Respondents were asked whether they agreed, disagreed, or were unsure of their agreement with each statement. Scores based on their agreement with these nine statements were then calculated: a respondent's support (or opposition or ambivalence) score was given three points for each "Agree" response to a supportive (or opposed or ambivalent) statement; two points for each "Not Sure" response; one point for each "Disagree" response. Support, opposition, and ambivalence scores ranged from 3 to 9. These scores were used to create a categorical variable, preference. Respondents were categorized as *supportive* if, of their three scores (support, opposition, and ambivalence), the support score was highest. Respondents were categorized as *opposed* if their opposition score was highest, or if their opposition score and ambivalence scores were equal and higher than their support score. Respondents were categorized as *ambivalent* if their ambivalence score was highest, or if their support and opposition scores were equal and higher than their ambivalence score, or if their support and ambivalence scores were equal and higher than their opposition score. Table 3.2 shows individual preference among all Senegambian women.

Table 3.2 Preference for FGC among Senegambian women

Preference	Frequency	Percent
Supportive	365	44.51
Opposed	202	24.63
Ambivalent	253	30.85
Total	820	100.00

Behavior regarding FGC was evaluated with a single survey item: "I would like to ask you about girls in your immediate family who are not yet circumcised. Will the uncircumcised girls in your immediate family be circumcised?" Those who responded "Yes" were considered practitioners, those who responded "No" were considered abandoners, and those who responded "Not sure" were considered undecided. Based on these two dimensions of stage of change, preference and behavior, assigned stages of change were defined as described in Table 3.3.

Table 3.3 Algorithm for assigning stage of change among Senegambian respondents

Behavior	Preference: Supportive	Preference: Ambivalent	Preference: Opposed
Practitioner	Supporters	Contemplators	Reluctant Practitioners
Undecided			Willing Abandoners
Abandoner	Reluctant Abandoners		

Assigned stage of change in the sample (all Senegambian women and only those from circumcising families) is described in Table 3.4. Among Senegambian women from circumcising families, the majority were assigned to the supporter (willing practitioner) stage (52.21%); many (26.03%) fell into the contemplator stage; reluctant practitioner was the rarest assigned stage (only one respondent); willing and reluctant abandoners were also fairly common (13.38% and 8.24%, respectively).

Table 3.4 Distribution of Assigned Stage of Change among Senegambian Women

Among all Senegambian women			Among Senegambian women from circumcising families		
Assigned Stage	Frequency	Percent	Assigned Stage	Frequency	Percent
Supporter	357	43.54	Supporter	355	52.21
Contemplator	182	22.20	Contemplator	177	26.03
Reluctant Practitioner	3	.37	Reluctant Practitioner	1	.15
Reluctant Abandoner	79	9.63	Reluctant Abandoner	56	8.24.
Willing Abandoner	199	24.27	Willing Abandoner	91	13.38
Total	820	100.00	Total	680	100.00

Self-described stage of change

The identified stages of change were described to respondents, and they were asked which stage best described them (Table 3.5). These self-described stages included all of the hypothesized stages (supporter, contemplator, reluctant practitioner, willing abandoner, reluctant abandoner) as well as the option “none of these”. Those who selected “none” were asked to described their position on female circumcision in their own words; when this response clearly fit into one of the described stages, the respondent was assigned to the described stage (9 cases), otherwise, they remained in the “none” category for self-described stage of change.

Table 3.5 Distribution of Self-Described Stage of Change among Senegambian Women

Among all Senegambian women			Among Senegambian women from circumcising families		
Self-described Stage	Frequency	Percent	Self-described Stage	Frequency	Percent
Supporter	476	57.98	Supporter	472	69.31
Contemplator	32	3.90	Contemplator	30	4.41
Reluctant Practitioner	23	2.80	Reluctant Practitioner	21	3.08
Reluctant Abandoner	35	15.47	Reluctant Abandoner	33112	4.85
Willing Abandoner	127	4.26	Willing Abandoner	112	16.45
None	128	15.59	None	13	1.91
Total	821	100.00	Total	681	100.00

Concordance between assigned and self-described stage of change

Assigned and self-described stage of change were compared for all women for whom both characterizations were available. Among all Senegambian women and those from circumcising families, concordance was approximately 65% (Tables 3.6 and 3.7).

Table 3.6 Self-Described and Assigned Stage of Change among All Senegambian Women

Self-described stage	Assigned Stage					Total
	Supporter	Contemplator	Reluctant Practitioner	Reluctant Abandoner	Willing Abandoner	
Supporter	327	138	0	2	8	475
Contemplator	9	19	0	3	1	32
Reluctant Practitioner	16	6	0	1	0	23
Reluctant Abandoner	2	6	0	18	9	35
Willing Abandoner	0	20	1	29	87	127
None of these	3	3	2	97	23	128
Total	357	182	3	199	79	820

Concordance (excluding self-described stage "None") = 65.17%

Table 3.7 Self-Described and Assigned Stage of Change among Senegambian Women from Circumcising Families

Self-described stage	Assigned Stage					Total
	Supporter	Contemplator	Reluctant Practitioner	Reluctant Abandoner	Willing Abandoner	
Supporter	325	137	0	8	1	471
Contemplator	9	19	0	0	2	30
Reluctant Practitioner	16	4	0	0	1	21
Reluctant Abandoner	2	6	0	18	7	33
Willing Abandoner	0	10	1	27	74	112
None of these	3	1	0	3	6	13
Total	355	177	1	56	91	680

Concordance (excluding self-described stage "None") = 65.37%

The staging algorithm identified many more contemplators than did subjects themselves, and the bulk of discrepancies between self-described and assigned stage of change involved this stage. Among women from circumcising families, the majority (77.40%) of those who were assigned to the contemplator stage described themselves as supporters, while many (30.00%) of those who described themselves as contemplators were assigned to the supporter stage.

This overall degree of concordance between assigned and self-described stage is high enough to support the validity of the hypothesized stages of change. However, since neither represents a "gold

standard," we contrasted the strengths and weaknesses of each categorization method. Because these stages of change so clearly resonated with pretest participants, providing confidence in construct validity, we elected to use self-described stage, rather than assigned stage, as the primary outcome of additional analyses.

Demographics and Stage of Change

We chose to look at three binary comparisons in assessing demographic variation in self-described stage of change: all practitioners (including supporters, contemplators, and reluctant practitioners) compared to all abandoners (willing abandoners and reluctant abandoners); supporters compared to willing abandoners; and supporters compared to contemplators. The demographic variables we considered were: age, education, socioeconomic status (assessed with one survey item, "When you plan your budget for the month, does it sometimes happen that you have to turn to others for help with food at the end of the month?"), ethnic group, marital status, polygyny, interethnic marriage, and FGC-incongruent marriage. FGC-incongruent marriages were identified by comparing respondent's circumcision status or circumcising tradition to her husband's reported tradition (is/was FGC a tradition in your/your husband's family?).

Associations between stage of change and demographic characteristics were assessed with univariate and multiple logistic regression. First, univariate associations were assessed. Second, associations were assessed with all demographic variables included in the model to eliminate potential confounding between demographic variables; however, colinearity between interethnic marriage and circumcision-incongruent marriage variables was very high, so no more than one of these three variables was included in a multiple logistic regression model.

Table 3.8 Univariate Associations between Demographics and Stage of Change, Comparing Abandoners (Willing and Reluctant) to Practitioners (Supporters, Contemplators, and Reluctant Practitioners)

Variable	OR	95% CI	P-value
Age			
Continuous (each additional year)	1.003	0.971, 1.034	0.887
Education Level			
None	1.000	Reference	
Arabic School Only	1.062	0.667, 1.689	0.801
Primary School	1.017	0.592, 1.744	0.953
Secondary School	1.106	0.642, 1.904	0.717
Socioeconomic status			
Lower SES (occasional reported budget shortfalls)	1.000	Reference	
Higher SES (no reported budget shortfalls)	1.051	0.724, 1.526	0.792
Ethnic group*			
Wolof	0.712	0.084, 6.036	0.756
Fula	1.085	0.667, 1.765	0.742
Mandinka	1.000	Reference	
Serahule	0.610	0.247, 1.508	0.285
Jola	1.084	0.590, 1.991	0.795
Aku Marabout	2.136	0.190, 23.985	0.538
Serer	7.559	3.604, 15.856	0.000
Other	1.282	0.576, 2.855	0.543
Marital status			
Never married	1.344	0.553, 3.268	0.514
Currently married	1.000	Reference	
Widowed	0.663	0.145, 3.030	0.596
Divorced	1.122	0.496, 2.539	0.781
Polygyny			
One wife	1.000	Reference	
Two wives	0.713	0.457, 1.113	0.136
Three wives	0.577	0.234, 1.422	0.232
Interethnic marriage			
No	1.000	Reference	
Yes	1.857	1.240, 2.781	0.003
FGC-incongruent marriage (comparing respondent's status to husband's tradition)			
No	1.00	Reference	
Yes	3.722	2.264, 6.117	0.000

*Because they contained few individuals and little variation in stage of change, Manjago, Mankange, and Balanta ethnicities were dropped.

Univariate logistic regression models reveal that Serer ethnicity, interethnic marriage, and FGC-incongruent marriage are all significantly positively associated with being an abandoner (Table 3.8). Control for other demographic variables with multiple logistic regression did not substantially alter these associations. Serer women are 7.6 times more likely to be abandoners, women in inter-ethnic marriages are nearly twice as likely to be abandoners, and women in FGC-incongruent marriages are nearly four times more likely to be abandoners.

Table 3.9 Univariate Associations between Demographics and Self-Described Stage of Change, Comparing Willing Abandoners to Supporters

Variable	OR	95% CI	P-value
Age			
Continuous (each additional year)	1.054	0.990, 1.122	0.100
Education Level			
None	1.000	Reference	
Arabic School Only	0.917	0.392, 2.142	0.841
Primary School	1.205	0.474, 3.066	0.696
Secondary School	0.294	0.064, 1.345	0.115
Socioeconomic status			
Lower SES (occasional reported budget shortfalls)	1.000	Reference	
Higher SES (no reported budget shortfalls)	1.603	0.760, 3.381	0.215
Ethnic group*			
Fula	0.730	0.278, 1.917	0.523
Mandinka	1.000	Reference	
Jola	0.225	0.029, 1.731	0.152
Serer	12.150	4.321, 34.164	0.000
Other	0.466	0.060, 3.642	0.466
Marital status**			
Currently married	1.000	Reference	
Divorced	1.243	0.279, 5.532	0.775
Polygyny			
One wife	1.000	Reference	
Two wives	0.860	0.381, 1.941	0.716
Three wives	0.832	0.186, 3.732	0.810
Interethnic marriage			
No	1.000	Reference	
Yes	1.494	0.694, 3.212	0.305
FGC-incongruent marriage (comparing respondent's status to husband's tradition)			
No	1.000	Reference	
Yes	4.610	1.986, 10.701	0.000

* Because they contained few individuals and little variation in stage of change, Wolof, Serahule, Aku Marabout, Manjago, Mankange, and Balanta ethnic groups were dropped.

** Because they contained few individuals and little variation in stage of change, never married and widowed marital status groups were dropped.

Univariate logistic regression models reveal that Serer ethnicity and FGC-incongruent marriage are significantly positively associated with being a willing abandoner (Table 3.9). Control for other demographic variables with multiple logistic regression did not substantially alter these associations.

Table 3.10 Univariate Associations between Demographics and Self-Described Stage of Change, Comparing Contemplators to Supporters

Variable	OR	95% CI	P-value
Age			
Continuous (each additional year)	0.958	0.898, 1.023	0.200
Education Level			
None	1.000	Reference	
Arabic School Only	1.250	0.480, 3.254	0.648
Primary School	1.807	0.654, 4.992	0.254
Secondary School	0.882	0.258, 3.017	0.842
Socioeconomic status			
Lower SES (occasional reported budget shortfalls)	1.000	Reference	
Higher SES (no reported budget shortfalls)	0.916	0.437, 1.920	0.816
Ethnic group*			
Wolof	15.429	2.410, 98.791	0.004
Fula	3.892	1.527, 9.921	0.004
Mandinka	1.000	Reference	
Serahule	1.624	0.325, 8.115	0.555
Jola	1.543	0.387, 6.148	0.539
Serer	6.171	1.134, 33.598	0.035
Marital status**			
Currently married	1.000	Reference	
Divorced	2.141	0.603, 7.606	0.239
Polygyny			
One wife	1.000	Reference	
Two wives	0.704	0.289, 1.717	0.440
Three wives	0.438	0.057, 3.386	0.429
Interethnic marriage			
No	1.000	Reference	
Yes	0.617	0.228, 1.668	0.341
FGC discordant marriage (comparing respondent's status to husband's tradition)			
No	1.000	Reference	
Yes	1.891	0.624, 5.734	0.260

* Because they contained few individuals and little variation in stage of change, Aku Marabout, Manjago, Mankange, Balanta and Other ethnic groups were dropped.
** Because they contained few individuals and little variation in stage of change, never married and widowed marital status groups were dropped.

Univariate logistic regression models reveal that Wolof, Fula, and Serer ethnicity were significantly positively associated with the contemplator (vs. supporter) stage (Table 3.10). Control for

other demographic variables with multiple logistic regression did not substantially alter these associations.

Thus, we conclude that ethnicity is an important factor in stage of change: women from the Serer ethnic group, and those in interethnic marriages, were more likely to be abandoners, and women from the Wolof, Fula, and Serer ethnic groups were more likely to be contemplators. Stage of change was not perceivably associated with other demographic characteristics, including age, education level, poverty, marital status, and polygyny.

Concordance between Decision makers in Stage of Change

Senegalese husbands and wives

Surveys were completed by 82 men in Senegal; of these, complete information about husband and wife was available for 75. While the majority of their wives described themselves as supporters, the majority of husbands described themselves as being in the willing abandoner stage of change (Table 3.11).

Table 3.11 Senegalese husbands' self-described stage of change*

Self-described stage	Frequency	Percent
Supporter	9	18.75
Contemplator	3	6.25
Reluctant Practitioner	1	2.08
Willing Abandoner	14	29.17
Reluctant Abandoner	12	25.00
None	9	18.75
Total	48	100.00

*Restricted to husbands of women for whom FGC was a tradition before the law banning FGC.

Table 3.12 Concordance between husbands' and wives' stage of change among Senegalese respondents*

Wife's stage of change	Husband's stage of change						
	Supporter	Contemplator	Reluctant Practitioner	Reluctant Abandoner	Willing Abandoner	None	Total
Supporter	8	1	1	3	2	3	18
Contemplator	0	1	0	1	0	0	2
Reluctant Practitioner	0	0	0	1	0	0	1
Reluctant Abandoner	1	1	0	4	5	4	15
Willing Abandoner	0	0	0	2	7	0	9
None	0	0	0	1	0	2	3
Total	9	3	1	12	14	9	48

*Restricted to those couples for whom FGC was a tradition in the wife's family before the law banning FGC.

Concordance within Senegalese married couples was 52.63% (Table 3.12). This demonstrates substantial potential discord within couples: almost half of husbands were in a different stage of change than their wife.

Gambian decision makers

Surveys were completed by a convenience sample of 54 individuals referred by Gambian respondents as participants in recent discussions about the circumcision of a girl in the respondent's family. Of these, complete information was available for 47. Thirty-six decision makers were female; of these, 35 (97.22%) were circumcised, and one was uncircumcised (2.78%). Forty-five (95.74%) decision makers were from circumcising families. Like the Gambian mothers referring them, the majority of these decision makers described themselves as being in the supporter stage of change (Table 3.13).

Table 3.13 Decision makers' (N = 47) self-described stage of change

Self-described stage	Frequency	Percent
Supporter	37	78.72
Contemplator	1	2.13
Reluctant Practitioner	2	4.26
Reluctant Abandoner	1	2.13
Willing Abandoner	4	8.51
None	2	4.26
Total	47	100.00

Table 3.14 Concordance between respondents' (Gambian mothers') and decision makers' stage of change

Gambian mother's stage of change	Decision maker's stage of change						
	Supporter	Contemplator	Reluctant Practitioner	Willing Abandoner	Reluctant Abandoner	None	Total
Supporter	35	1	1	3	0	1	41
Contemplator	0	0	1	0	0	0	1
Willing Practitioner	0	0	0	1	1	0	2
Reluctant Abandoner	1	0	0	0	0	0	1
None	1	0	0	0	0	1	2
Total	37	1	2	4	1	2	47

Concordance between decision makers was 81.82% (Table 3.14). Even with this small convenience sample, we observed substantial discordance in stage of change between decision makers. Using self-described stage, just under 20% of decision makers are in a different stage of change than the Gambian mother who referred them; in three cases (6%), this discordance is between a supporter and a willing abandoner, suggesting profound disagreement regarding FGC.

Discussion

In recent years, a proliferation of studies has employed the construct of readiness for change through "stage of change" or related measures for a broad array of "problem behaviors." Despite the popularity of this approach, a number of commentators have raised serious questions about methods of assessment and theoretical underpinnings as applied to an increasingly wide range of behaviors and settings (Weinstein, Rothman et al. 1998; Carey, Purnine et al. 1999; Yoder 2001). With growing interest in understanding factors influencing behavior change regarding FGC, it has been proposed that theoretical models of behavior change may offer useful insights (WHO 1999; Frontiers 2002). This study takes a first step in analyzing the applicability and utility of a stage of change approach for describing the process of behavior change regarding FGC in Senegal and The Gambia.

Our findings, based on analysis of extensive qualitative data, suggest that readiness to change for individuals is most clearly seen as operating along a continuum and that broad stages of change characterize regions or segments of this continuum. The concept of stage of change as applied to FGC is a complex construct that rests not only on an individual's internal motivation to proceed with change, but also with her or his willingness and ability to do so. This construct simultaneously captures behavior, motivation, and features of the environment in which the decision is being made. One important aspect of this environment is the decision making group in which an individual is situated. Additionally, it is important to note that decision making is also situated within and influenced by a broader social and political context. Consequently, the stages identified in this research reflect the multidimensional nature of readiness to change for FGC.

We note limitations of applying the concept of stage of change to FGC. First, a description of stages of change of an individual or a group of individuals provides a cross-sectional snapshot of readiness to change. It does not capture the fluidity of the composition of the decision making group, nor the fact that an individual's opinion regarding FGC can shift as he or she moves between social actors and contexts. Such shifts can, however, be detected through long-term qualitative research following the same individuals over years at they negotiate their way through shifting realities (see Hernlund 2003). Second, because decision making often occurs among a group, there are important aspects of the decision making process that are not addressed by a stage of change model. Specifically, whether and how a decision is negotiated, differentials in power between decision makers, and how power dynamics shift over time are not captured by stage of change or other models of readiness to change. Consequently, critiques leveled at the use of RTC models for HIV prevention pertain in large part to the practice of FGC as well. Alternative methods are required to examine the dynamic and fluid dimensions of the decision making process.

Despite these shortcomings, categories of readiness to change are useful for describing individuals, concordance between decision makers, or at an aggregate level, patterns of readiness for change in the community. Such descriptors are useful for identifying factors that motivate readiness for change, and may be useful for creating intervention strategies matched to the predominating stage of change. Additionally, the measurement of stages of change may be of use in community survey research and in program monitoring and evaluation by creating metrics of change short of complete abandonment of FGC. In the field of health psychology, a number of survey instrument have been developed for categorizing individuals, and quantifying RTC in a particular study population (see Carey, Purnine et al. 1999 for a comprehensive review of instruments for measuring RTC regarding substance abuse). Due to differences in the proposed stages of change, however, staging algorithms developed for other individually based behaviors are not applicable to the case of FGC.

In The Gambia and neighboring areas of Senegal, we identified stages of change that are specific to the practice of FGC: supporter, contemplator, reluctant practitioner, willing abandoner, and reluctant abandoner. These stages seem to comprehensively describe variation in readiness to change in this population: our description of stages of change resonated with study participants, most could easily

describe their present position regarding FGC with only one of the offered stages, and these self-described stages agreed well with those assigned by our staging algorithm.

Consistent with other descriptions of FGC in this area of the Senegambia, we found that the majority of women participating in the survey were supporters of the practice of FGC, and that only a small percentage of women from a circumcising background had willingly abandoned the practice. We found a small percentage of women in the contemplator stage; our staging algorithm identified a much higher number of contemplators than women themselves did, potentially suggesting that many supporters feel more ambiguity toward the practice than they themselves recognize. A small percentage of women were also found in the reluctant practitioner and reluctant abandoner stages.

We found that, among Senegambian women from families in which FGC is a tradition, stage of change did not vary systematically with most demographic characteristics, except those related to ethnicity. Women from some ethnic groups (Serer, Wolof, or Fula) were more likely to be contemplators or willing abandoners than women from Mandinka or other ethnic groups; and women in interethnic or FGC-incongruent marriages were more likely to be abandoners than other women. Other demographic characteristics, such as age, education, or marital status, were unrelated to stage of change.

We detected ample opportunity for conflict between decision makers regarding FGC, with 20% of decision making pairs in different stages of change, and 6% of pairs containing a self-described supporter and a self-described willing abandoner. This is consistent with qualitative and survey results indicating that families occasionally experience heated conflict over whether or not to circumcise a girl. Discordance in stage of change may contribute to some of this conflict over circumcising girls.

Having documented that the concept of stages of change is informative in describing readiness to change the practice of FGC in the Senegambia, and identified pertinent stages of change, we now turn to the question of variation in stage of change. What sets abandoners apart from practitioners of FGC? What are the important determinants of stage of change?

IV. Motivation to Change the Practice of FGC in Senegambia

Summary

In this chapter we assess factors influencing motivation to change the practice of FGC. Motivation was assessed by developing a decisional balance inventory that weighs advantages of FGC against disadvantages. A list of pros and cons of circumcision for girls and others was drawn from focus group transcripts. Survey data showed that the advantage statements formed a single scale, while disadvantage statements separated into health risks and non-health disadvantages.

Studying motivational balance across categories of readiness to change provides insight about how people weigh pros and cons and about factors that tip this balance. As predicted, we find that individuals in different categories of readiness to change have different valuations of the advantages and disadvantages of FGC. Supporters of FGC have the highest mean advantage scores, willing abandoners have the lowest, and contemplators have scores that fall between those of the other two groups. We find, as well, that as people shift from supporting to opposing the practice of FGC, the valuation of disadvantages changes. We had hypothesized that health-related disadvantages do not influence motivation to change since campaigns have delivered health risk messages for decades without causing widespread abandonment. Surprisingly, we find that health-related disadvantages resonate strongly among willing abandoners. Our interview data suggest that this may be attributable in part to recent changes in the health risk message, shifting away from a focus on obstetrical risks, which have not, for the most part, been deemed credible. By contrast, new messaging focused on HIV/AIDS risk resonates strongly among a growing number of Senegambian men and women. Despite the very low prevalence of HIV in Senegal and The Gambia, the risk of contracting HIV is deemed to be a significant threat. Moreover, despite the limited epidemiological evidence linking FGC to HIV, this message has been deemed credible, and is associated not only with abandonment of FGC, but also medicalization of the practice.

These results suggest that health education campaigns that include messaging about HIV/AIDS can contribute to motivation to change the practice of FGC, including both abandonment and medicalization. Thus, in order to avoid promotion of medicalization, campaigns should emphasize that the safest way to avert HIV infection is to entirely abandon the practice of FGC, rather than using one blade per girl.

Introduction

In 1979 the World Health Organization convened in Sudan the first international conference on female circumcision, a forum at which attendees adopted a platform that called for the total elimination of the practice (Boyle 2002; Toubia and Sharief 2003). This landmark event signaled strong consensus regarding the legitimacy of international action, and sparked a proliferation of programs aimed at ending FGC. A wide range of approaches have been employed, including information and education campaigns (IEC), compensate-the-cutter programs, alternative rituals, legislation, and integrated social development programs that address FGC within the context of broader programs focused on issues such as health, literacy and economic development. As noted by Toubia and Sharief (2003: 252), “By 1999, 20 years after the WHO conference in Sudan, questions on whether there is progress made in the field were raised by donors, technical agencies and program managers alike.” An overview of Demographic and Health Survey data revealed that overall declines in FGC had been small and slow, and that the practice was still favored among large segments of the African population (Carr 1997). A number of reviews of programs were commissioned (e.g. WHO 1999; Frontiers 2002) along with guidelines for monitoring and evaluation of programs (e.g. Izett and Toubia 1999). Among suggestions put forth was the recommendation of adapting models of readiness to change used in the fields of psychology, health education, and communication, such as the “stage of change,” or trans-theoretical, model.

In the previous chapter we outlined our research findings regarding the identification of categories of readiness to change. Our research suggests that individuals' readiness to change the practice FGC can be described as falling broadly into one of five categories: supporters of the continuation of FGC, those contemplating abandonment, reluctant practitioners of FGC, willing abandoners, and those who have reluctantly abandoned. These categories reflect two dimensions of readiness to change FGC, one on preference, and the other on actual behavior. This arises due to the fact that behavior change is more complex than individuals acting upon their own intent. Constraints from other decision makers, expectations of others' behavior, and powerful social sanctions can preclude an individual or group from acting upon their own preferences (this is discussed in greater detail in the next chapter). Nonetheless, large scale behavior change and maintenance of abandonment of FGC requires that a critical portion of the population favor abandonment. Importantly, Toubia and Izett (1998) note that "the most neglected area is that of applied or operations research on how to design interventions that would convince individuals and communities to stop the practice." Our aim in this chapter is to advance methodology for assessing factors influencing motivation to change. We address several key questions: What factors contribute to motivation to change or abandon the practice of FGC? How can we measure motivational balance? Does motivation vary across categories of readiness to change in predicted ways? While our specific findings may be unique to our study communities in Senegambia, our methodology of examining motivation to proceed with change may be easily replicated in other settings.

In our Senegambian study communities, respondents often mentioned a number of factors that promote the practice, including cleanliness, protection of virginity, control of female sexuality, and greater ease in childbirth. We find, however, that FGC is linked first and foremost to the concept of tradition. Numerous informants describe the practice as inherited from time immemorial, and often repeated the phrase, "We found it from our grandmothers." Being from a "circumcising culture" features centrally in the formation of cultural identity, and girls who have been circumcised are, according to many practitioners, thought to have been properly raised to show respect and value "tradition."

Although strong emphasis is placed on preserving culture and upholding tradition, certain aspects of circumcision and initiation practices have changed dramatically in recent years (described in detail in Chapter II). As is common in many parts of Africa, there is a tendency for circumcision to be performed at younger and younger ages. In The Gambia, as in other regions, the reduced age at cutting is, in part, explained as a reaction to campaigns aimed at eliminating the practice, such that girls, and in some cases infants, are circumcised before it becomes "too late." Other recent changes include the fact that circumcision is often now done individually rather than in large groups, and with little or no teaching or celebration. More commonly, now, girls are not taken to circumcision camps in the bush, but instead are circumcised in their own home or in the home of the ngangsingba. And in number of instances individuals, families or large segments of communities have opted to abandon the practice of FGC.

The question we address here is whether these changes may be motivated by reappraisal of other costs and benefits of the practice, and to determine which factors most influence motivational balance. We predict that motivation to change varies across different categories of readiness to change. Specifically, willing abandoners should show higher motivation to change than supporters of FGC. Contemplators should display motivation levels that fall between those of supporters and willing abandoners. We note that motivation to change may be driven by a decrease in the perceived disincentives or an increase in the incentives to change. Since education campaigns regarding the health risks have been ongoing in Senegambia for decades, but resulted in negligible abandonment, we predict that knowledge of health risks contribute little to differences in motivational balance across different

categories of readiness to change. Instead, we hypothesize that motivation to abandon FGC is driven by devaluation of the benefits conferred by the physical act of cutting and attendant training.

FGC in Senegambia: Developing a Decisional Balance Inventory

In the field of health psychology, a variety of instruments have been developed to assess "decisional balance," a schema that measures motivation to proceed with change (Prochaska, Norcross et al. 1994). The "Decisional Balance Sheet of Incentives" was first developed by Janis and Mann (1977) to measure motivation to quit smoking, and was later employed as a predictor of smoking status six months later (Velicer, DiClemente et al. 1985). Since that time, decisional balance inventories have been found to provide information that complements readiness to change instruments, and have been used to study a range of health-related behaviors as varied as quitting cocaine, weight control, diet modification, safer sex, adolescent delinquent behaviors, and sunscreen use. In an effort to gain an improved understanding of factors influencing change in the practice of FGC, we analyze data from our focus group discussions, and develop and test an ethnographically grounded inventory of advantages and disadvantages of continuing or abandoning FGC.

The focus group data have provided rich and detailed information on the perceived advantages and disadvantages of continuing or abandoning FGC from the perspective of numerous individuals: girls themselves, mothers, elders, husbands, and fathers. From the analysis of the focus group data, we identified a number of themes with respect to perceived advantages and disadvantages of FGC-related behavior change. For example, some of the stated advantages of continuing the practice include receiving training in how to show respect for elders, being considered a proper woman in one's community**,** and gaining control of sexual urges so as to protect virginity before marriage and fidelity after marriage (see Chapter II for a fuller explanation). Some of the stated advantages of stopping FGC include averting health risks, and avoiding the expense of food and clothes that are purchased for the training period and celebration.

To develop a decisional balance inventory, we compiled a list of statements regarding pros and cons of circumcision that appeared in focus group discussions. We incorporated language from our transcripts, providing an ethnographically grounded series of statements. We originally considered following methods for creation of a decisional balance inventory that were developed by Janis and Mann (1977) and validated by Velicer, DiClemente et al. (1985). They assigned constructs to at least one of four categories: 1) gains and/or losses for self; 2) gains and/or losses for others; 3) self-approval or self-disapproval; and 4) approval or disapproval from others. However, we instead chose to employ categories revealed in our analysis of the focus group data: 1) advantages to a) the girl, and b) others, 2) lack of disadvantages of female circumcision, 3) disadvantages of female circumcision, and 4) disadvantages of not performing FGC. Our review of the focus group data was used to generate of list of 69 statements that fell under one of the above categories. Items were grouped by theme and assessed in a two-part pretest.

The initial portion of the pretest involved working in a transparent manner with volunteer consultants, who were told in detail about our task at hand and were invited and encouraged to offer their feedback and insights in order to assist us in gradually developing an effective and culturally appropriate survey. Following a conceptual review of the decisional balance inventory by our lead fieldworker, Naisatou Konteh, questions were administered in English to six people and followed by in depth interviews on meaning. These first interviews provided clarity which questions were easier or more difficult for people to understand, and provided insight for making further adjustments. The list of survey items was reduced to 14 statements with a response of agree, disagree, or unsure, translated into Mandinka and Wolof, and administered to 40 individuals. In a factor analysis items clustered as simply advantages (both to the girl and others) and disadvantages (again, both to the girl and others). The following statements were retained after the pretest for clarity and meaning:

Table 4.1 Survey instrument items relating to the advantages and disadvantages of FGC

Advantages
Circumcision shows respect to our grandmothers.
Female circumcision makes a girl be clean.
Female circumcision helps a girl stay a virgin until she marries.
A benefit of female circumcision is that it teaches girls to obey and respect their elders.
A benefit of female circumcision is that a girl will know the eye.
Female circumcision does not cause any problems.
Circumcision is a very important tradition.
Disadvantages
Non-Health Disadvantages
A bad part of the practice is that it is very painful.
Men enjoy sex more with uncircumcised women.
Girls can be trained even without being circumcised.
When you circumcise your daughters, you have to spend too many resources.
Health Disadvantages
Female circumcision can cause serious problems with childbirth.
Female circumcision can spread HIV/AIDS.
Female circumcision can cause a person to bleed too much.
Female circumcision can cause tetanus.

Participants were asked to give one response of *Agree*, *Unsure*, or *Disagree* to each of the above items.

Full Survey Results

In the full survey, the decisional balance inventory was administered to 820 women between the ages of 18 and 40 years who had given birth to at least one girl. Responses regarding the advantages of FGC are shown in Table 4.2. Compared to Gambian women, there was slightly less support for all advantage statements among Senegalese women, although there was still overall strong support for most advantage statements.

Table 4.2 Responses to questions regarding circumcision's advantages among Senegambian women

	Senegalese Women			Gambian Women		
	Agree	Unsure	Disagree	Agree	Unsure	Disagree
Circumcision shows respect to our grandmothers	80%	8%	12%	88%	3%	8%
Female circumcision makes a girl be clean	71	12	18	82	8	10
Female circumcision helps a girl stay a virgin until she marries	42	18	40	52	20	27
A benefit of female circumcision is that it teaches girls to obey and respect their elders	76	8	16	77	8	15
A benefit of female circumcision is that a girl will know the eye	76	7	17	80	6	15
Female circumcision does not cause any problems	53	12	35	74	13	13
Female circumcision is an important tradition	88	7	6	93	3	4

	Senegambia Women n=820		
	Agree	Unsure	Disagree
Circumcision shows respect to our grandmothers	87%	4%	9%
Female circumcision makes a girl be clean	81	8	11
Female circumcision helps a girl stay a virgin until she marries	51	20	30
A benefit of female circumcision is that it teaches girls to obey and respect their elders	77	8	15
A benefit of female circumcision is that a girl will know the eye	80	6	14
Female circumcision does not cause any problems	71	12	17
Female circumcision is an important tradition	93	3	6

Because the data are ordinal, and not continuous, we examined the correlation between advantage statements using Spearman's nonparametric correlation (Spearman's rho, results not shown). All advantage statements were positively and significantly correlated, and Cronbach's alpha of 0.899 indicates very high internal consistency.

In contrast to the statements on advantages, there was much more variability in agreement with disadvantage statements (Table 4.3). Statements that received strong agreement were those expressing the disadvantages of FGC in terms of pain and training of girls. There was strong disagreement with the statement regarding FGC causing risk during childbirth.

Table 4.3 Responses to questions regarding circumcision's disadvantages among Senegambian women

	Senegalese Women			Gambian Women		
	Agree	Unsure	Disagree	Agree	Unsure	Disagree
A bad part of the practice of female circumcision is that it is very painful	81%	8%	11%	87%	4%	10%
Men enjoy sex more with uncircumcised women	12	49	39	12	56	32
Girls can be trained even without being circumcised	83	4	39	77	9	14
When you are circumcising your daughter, you have to spend too many resources	64	12	34	43	12	45
Female circumcision can cause serious problems with childbirth	27	26	47	10	16	73
Female circumcision can spread HIV/AIDS	34	34	32	17	37	46
Female circumcision can cause a person to bleed too much	53	18	29	47	17	36
Female circumcision can cause tetanus				47	17	36

	Senegambian Women n=820		
	Agree	Unsure	Disagree
A bad part of the practice of female circumcision is that it is very painful	86%	4%	10%
Men enjoy sex more with uncircumcised women	13	54	33
Girls can be trained even without being circumcised	78	8	14
When you are circumcising your daughter, you have to spend too many resources	47	12	41
Female circumcision can cause serious problems with childbirth	13	18	70
Female circumcision can spread HIV/AIDS	20	36	44
Female circumcision can cause a person to bleed too much	48	18	5
Female circumcision can cause tetanus	27	32	41

Spearman's nonparametric correlation statistics reveal that not all statements are significantly and positively correlated with one another (Table 4.4). Nonetheless, the Cronbach's alfa of 0.747 reveals reasonably high internal consistency.

Table 4.4 Spearman's nonparametric correlation between disadvantage statements among Senegambian women (N = 820)

	Painful	Men enjoy sex	Train w/out FC[1]	Costs too much	Childbirth	HIV	Bleed	Tetanus
Painful	1							
Men enjoy sex	.015	1						
Train w/out FC[1]	.005	.131**	1					
Costs too much	.168**	.159**	.065	1				
Childbirth	-.023	.267**	.248**	.208**	1			
HIV	.070*	.238**	.250**	.174**	.609**	1		
Bleed	.118*	.245**	.205**	.215**	.422*	.498**	1	
Tetanus	.147**	.229**	.240**	.190**	.582**	.711**	.544**	1

[1]FC = Female circumcision

* p<.05

**p<.01

All advantage statements and disadvantage statements were analyzed collectively in a factor analysis for ordinal data to see if they separate into two factors that could be used to construct an advantage scale and a disadvantage scale. A two factor solution suggested that 5 advantage statements (know the eye, obey and respect elders, cleanliness, respect grandmothers, and protects virginity until marriage) cluster together (coefficients >.5). Additionally, the four disadvantage statements regarding health (problems in childbirth, bleed too much, spread HIV/AIDS and cause tetanus) also cluster together. A numerical advantage or disadvantage scale was created by combining values for each statement: agree=3, not sure=2 and disagree=1. The sum was then scaled by dividing by the total number of items. We created one 5-item advantage scale, and three different disadvantage scales: all combined disadvantage statements, health-related disadvantage statements, and non-health disadvantage statements. All scales were distributed approximately normally.

Motivational Balance and Stage of Change

We expected that advantages scores would be highest among supporters, lower among contemplators and still lower among willing abandoners; disadvantages scores would be highest among willing abandoners, lower among contemplators, and still lower among supporters. First, we evaluated these expectations across stage of change groups. Specifically, we were interested in disaggregating patterns in these two scores, i.e., whether differences in advantages or disadvantages scores are more pronounced across readiness to change groups (Table 4.5). Second, as a clue to the impact of health messages, a major thrust of anti-FGM campaigns in recent years, we were interested in separating health disadvantages from other disadvantages, which have not been so strongly emphasized by campaigns (Figure 4.1).

Table 4.5 Advantages and Disadvantages Scores among Senegambian women from circumcising families

Self-Described Stage of Change	Mean Advantages Score	SD* Advantages Score	Mean Combined Disadvantages Score	SD* Combined Disadvantages Score
Supporter	2.81	0.297	1.89	.357
Contemplator	2.44	0.483	2.28	.382
Reluctant Practitioner	2.82	0.24	2.13	.359
Willing Abandoner	2.02	0.561	2.52	.362
Reluctant Abandoner	2.38	0.592	2.44	.342
None	2.25	0.724	2.37	.407

*SD = Standard deviation

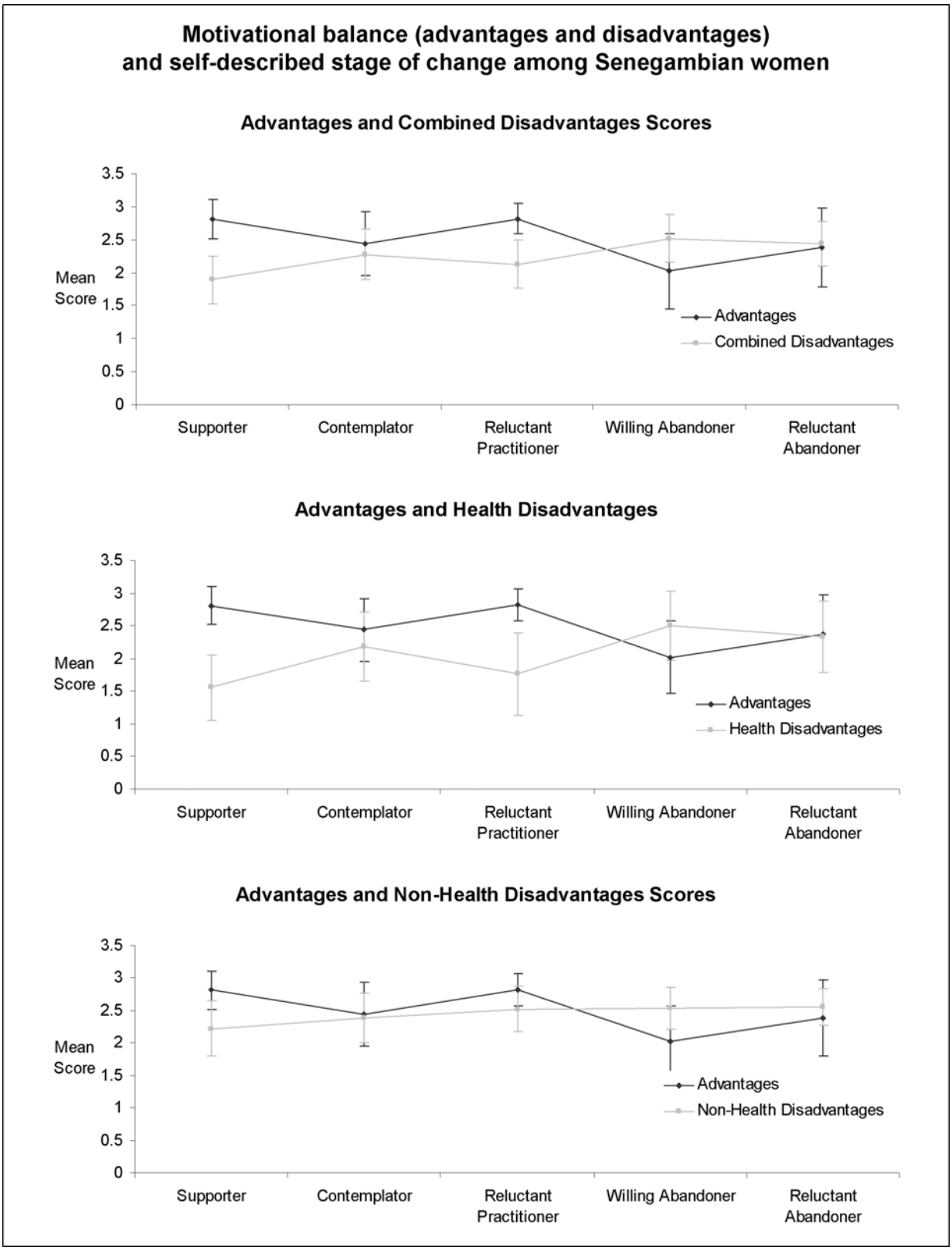

Figure 4.1 Motivational balance and self-described stage of change among Senegambian women. Among all Senegambian women from circumcising families, mean advantages and disadvantages (health and non-health) broken down by self-described stage of change show dramatic variation in advantages

and health-related disadvantages ascribed to FGC, but little variation in non-health disadvantages ascribed to FGC.

The expected patterns are apparent: Supporters (and reluctant practitioners) have the highest advantages scores and lowest disadvantages scores; willing abandoners have the lowest advantages scores and the highest disadvantages scores; contemplators' advantages and disadvantages scores fall between these two groups.

When health specific disadvantages are excluded (leaving the disadvantages *female circumcision is very painful*; *men enjoy sex more with uncircumcised women*; *girls can be trained without being circumcised*; and *circumcising daughters costs too many resources*), the pattern of disadvantages across readiness to change groups is attenuated. Supporters still have the lowest, contemplators moderate, and willing abandoners the highest disadvantages scores (except for self-described reluctant abandoners). However, the difference between these groups is much less dramatic than when health disadvantages are included in the disadvantages score.

When only health-specific disadvantages are included (*childbirth complications*; *HIV/AIDS*; *excessive bleeding*; and *tetanus*), the pattern of disadvantages scores across readiness to change groups is exaggerated. Supporters have the lowest, contemplators moderate, and willing abandoners the highest disadvantages scores. This difference is more pronounced for supporters (mean non-health disadvantages score, 2.22; mean health disadvantages score, 1.56; difference 29%) than contemplators (mean non-health disadvantages score, 2.38; mean health disadvantages score, 2.18; difference 8.4%) or willing abandoners (mean non-health disadvantages score, 2.54; mean health disadvantages score, 2.50; difference 1.6%).

Surveys were completed by 82 men in Senegal (see Chapter II). Complete information to pair these men with their wives (a randomly selected subsample of Senegalese women respondents) and to characterize their stage of change and motivational balance inventory was available for 75 men. When restricted to men married to women from a circumcising tradition, information on 48 married couples is available. There was significant correlation between husbands and wives for all motivational balance scores (Table 4.6).

Table 4.6 Pairwise correlation coefficients and p-values for motivational balance scores

Score	Correlation	P-value
Advantages Score	.377	.0082
Non-Health Disadvantages Score	.419	.0031
Health Disadvantages Score	.471	.0007

Surveys were also completed by a convenience sample of 48 individuals referred by Gambian respondents as participants in recent discussions about the circumcision of girl in the respondent's family (see Chapter II). There was significant correlation between decision makers and referring Gambian mothers for two motivational balance scores: advantages scores and health disadvantages scores (Table 4.7); there was no significant correlation in non-health disadvantages scores.

Table 4.7 Pairwise correlation coefficients and p-values for motivational balance scores

Score	Correlation	P-value
Advantages Score	.418	.0035
Non-Health Disadvantages Score	.097	.5172
Health Disadvantages Score	.478	.0007

These analyses suggest that as people shift from supporting to opposing the practice of FGC, both the valuation of advantages and disadvantages change. As people lose support for the practice of

FGC, they increasingly internalize the message about adverse health risks. We had hypothesized that the health message may not motivate behavior change due to the fact that health risk messaging that has until recently been centered on obstetrical risk has often lack credibility among women who practice FGC (Hernlund 2003). We find, however, that now with the addition of information of HIV risk due to FGC, the entire health message, including that of obstetrical risk, resonates strongly among informants who have abandoned the practice. It appears that this message might be used by people to bolster the decision to abandon FGC – that is, add it to an arsenal of reasons for maintaining their decision. Another possibility is that the changes in content of the health message now make it increasingly credible, and contributes more strongly to motivation to change. This latter interpretation is supported by findings from our qualitative data. These data show that, apart from motivating abandonment of FGC, the health message may also motivate changes in the way FGC is performed, including medicalization of the practice.

"One blade per girl": Responses to changes in health education campaigns

Conducting in depth interviews on decision making around FGC in Senegambia, we were struck by the degree to which respondents report having internalized recent health educational messages about HIV/AIDS prevention. Although HIV rates remain relatively low in this region of sub-Saharan Africa, this approach appears to resonate more profoundly than earlier anti-FGM campaigns stressing obstetrical health. Ironically, however, those who remain in favor of FGC are using these messages to call for moderate medicalization of FGC. Consequently, it is important to assess responses to changes in health education campaigns, including HIV-related medicalization of the practice, and consider the broader implications of the new phenomenon.

Hernlund, based on earlier research conducted throughout the 1990's in The Gambia, reported that "Each of the Gambian activist groups seeks to educate the public about the harmful effects of genital cutting and this message is circulated widely…in open village workshops, in symposia for healthcare professionals, in articles in the daily Observer newspaper, and in assemblies for high school students" (Hernlund 2003: 197). At that time, the content of these messages were drawn from activist literature that divided the health risks into the oft-repeated categories of short-term, long-term, and obstetrical consequences, failing to differentiate risks most often associated with infibulation. In The Gambia, where the majority of women have undergone clitoridectomy, the obstetrical messages, in particular, resulted in what Hernlund (2003) describes as a "credibility gap" – a disjunction between the subjective experiences of Gambian women and the purported health risks described in the campaign messages. Hernlund's interviews with women and girls who attended workshops revealed a consistent skepticism regarding the obstetrical health risk messages that was also shared by healthcare professionals and trained midwives, some of whom were adamantly opposed to FGC. She writes, "Again and again I received similar answers: no one disputed the short term consequences of genital cutting gone wrong, and everyone had seen patients suffering from shock, excessive bleeding, infections and tetanus; but no one attributed obstetrical difficulties to FGC" (Hernlund 2003: 201). Our findings are consistent with those of Hernlund's in that most women were well aware of the risks associated with childbirth, but attribute this to other factors. Moreover, many practitioners of FGC believe that clitoridectomy actually facilitates an *easier* delivery. And importantly, many participants insist that if circumcision were truly dangerous, their ancestors would not have practiced it. For many circumcised women, abandonment of the practice is viewed as an egregious act of disrespect for elders by questioning the traditions they handed down. Women are reluctant to insult previous generations of their family or to cast doubt on the judgment of their mothers and grandmothers, and thus value the preservation of FGC as their inherited tradition.

In the late 1990's health risk messages began to change in a context of speculation regarding the potential risk of HIV transmission associated with FGC. Despite lack of epidemiological evidence that

female circumcision constitutes a risk factor for HIV infection, anti-FGC campaigns have increasingly incorporated HIV prevention into arguments for abandonment. The degree to which this message has resonated with women in The Gambia—from practicing and non-practicing groups alike—is striking. Moreover, those who have become convinced that FGC poses a risk HIV transmission are increasingly likely to accept other aspects of the health risk campaign message, including the previously oft-rejected claims regarding obstetrical risk.

There are a variety of mechanisms by which FGC could increase risk of HIV transmission. These include direct transmission of the virus by the cutting instrument when multiple girls are circumcised in succession with the same instrument. Brewer and colleagues (2007) indirectly estimate the effect of circumcision on HIV risk using DHS data from Kenya. To isolate non-sexual routes of HIV transmission, they examine HIV rates among adolescent girls who are self-reported virgins. Their analysis suggests that circumcised female virgins were substantially more likely to be HIV positive than uncircumcised virgins (3.2% vs. 1.4%, odds ratio 2.38). Critics, however, point to the unreliability of self-reported data on sexual activity and effects on statistical bias (Adams, Trinitapoli et al. 2007), and suggest that girls from families that practice FGC may be more likely to underreport sexual experience (Westreich, Rennie et al. 2007). Kun and colleagues (1997) consider the indirect effects of circumcision on HIV risk, postulating that FGC may increase the probability of sexual transmission throughout life; scarring from circumcision may make injury or inflammation during sex more likely, facilitating transmission of the virus. Further, if circumcision causes women to experience pain during vaginal sex, circumcised women might be more willing to participate in anal sex, which is associated with a greater risk of HIV transmission (ibid.). Finally, if vaginal scarring associated with circumcision increases women's risk of obstructed labor, she could be at increased risk of HIV transmission through blood transfusion (ibid.). Morison and colleagues (2001) suggest that FGC may increase susceptibility to sexually transmitted infections that are known cofactors for HIV transmission. They found that among rural Gambian women, those who had been circumcised had a higher risk of infection with bacterial vaginosis and herpes simplex virus 2, both of which have been shown elsewhere to be positively associated with HIV infection (Morison, Scherf et al. 2001). Yount and Abraham (2007) also find support for indirect ways that FGC is associated with HIV risk. Using Kenyan DHS data, they find that in comparison to uncut women, circumcised women have a higher chance of having older male sexual partners, sexual debut before age 20, and at least one extra-union partner, all factors known to be associated with an increased risk of contracting HIV.

Perceptions among Senegambians of the HIV/AIDS risk associated with FGC are limited to direct transmission during circumcision through shared instruments. Interestingly, the message that FGC might increase the risk of sexual transmission later in life does not appear to have been internalized at all; in fact, some study participants argue that FGC decreases sexual promiscuity and is therefore important in protecting women and communities from sexual transmission of HIV (see also Yount and Abraham 2007 for a discussion of hypothetical means by which FGC might lower risk of HIV transmission).

What is particularly striking is the fact that the HIV/AIDS risk message resonates strongly despite the fact that in comparison to other African nations, Senegal and The Gambia have been fortunate to experience low HIV rates; according to the 2008 UNAIDS report, the prevalence of HIV in Senegal remains steady at 1%, and is slightly lower in The Gambia (.9%). Senegal, along with Uganda, has been successful in thwarting the spread of HIV through behavior change campaigns, as well as good STD surveillance, including among female sex workers. And The Gambia has benefitted from being geographically buffered by Senegal. Protective cultural factors have also been promoted, such as strong social and religious mores regarding premarital and extramarital sex (UNAIDS 2008).

One important reason that the HIV message appears to resonate is that the newness of the threat of HIV/AIDS makes the message less threatening to the value of tradition. A large number of participants, when discussing HIV transmission and circumcision, emphasized that the threat of HIV is

new to the current generation, and consequently the recognition of this risk does not imply that their ancestors were wrong to promote this tradition. Moreover, departures from tradition as a means of coping with this new threat are not seen as constituting an insult to elders or ancestors, and allow for the consideration of alterations that would have otherwise been unthinkable. One Mandinka woman explained:

> As a traditional woman, this is part of my culture to practice female circumcision. During the time of our mothers, there was nothing like this transferring of infections. The *ngangsingba* could circumcise many people with one blade and you would see no infections transferred. We are living in a generation where transmitted diseases are rampant. So, to get rid of these infections, is to use one blade per person.
> —Middle-aged Mandinka woman, rural Gambia

While the risks of child bearing are well understood, the risk of contracting AIDS–a disease that will strike many years after infection–is unknown, yet plausibly linked to sharing instruments or supplies, not only for circumcision, but other purposes, such as shaving, as well. In fact, for strong proponents, the risk of contracting HIV was often the *only* disadvantage cited to be associated with the practice.

> I see only one disadvantage in it: The instrument that the circumciser uses to circumcise may cause infection by circumcising more than one person with one blade.
> —Middle-aged Konyaginka man, rural Gambia

> I say people should be left in their own cultural practice in that one should be free to carry out his/her own traditional practices since these are practices that have been going on since memorial times, but then care must be taken to avoid spread of disease during the practice.
> —Elder Serer man and community leader (*alkalo*), rural Gambia

While most participants from non-circumcising families argued that HIV risks are one of the reasons the practice should be abandoned, participants from circumcising families perceived it as a threat that needed to be mitigated by implementing a change in the practice—namely, eliminating the risk of direct transmission by using "one blade per girl":

> We make sure that each time a girl is circumcised, a new razor blade is used, and a new sponge and soap are used, and even the bathing pan is a new one. No item is used for two people during circumcision.
> —Middle-aged Tilibonka woman, rural Gambia

> It is the same thing: use one blade, a washing pan, a sponge and a soap only for one person, because this generation is different from the olden days, now you have a lot of diseases.
> —Elder Wolof woman, raised in a Mandinka household, rural Gambia

In addition, a few also reported that that they intend to seek out other biomedical medical care prior to or during circumcision, including obtaining dispensary supplies, tetanus inoculations, and antibiotics. Thus it appears that the HIV/AIDS health message has not only contributed to increased motivation to abandon FGC, but has also resulted in the inadvertent medicalization of the practice.

Senegambia is one of the few settings in Africa in which the practice of FGC has not become rapidly medicalized (Daffeh, Dumbuya et al. 1999; Diop 2006).[4] In other regions of Africa, the medicalization of FGC has often followed the lead of medicalization of male circumcision. While the international community sees male and female circumcision as distinct practices, in many African communities, including our study communities, the practices are seen as complementary, and often referred to by the same term (for further discussion, see Chapter V). Consequently, the application of procedures adopted for male circumcision to female circumcision is often seen as a logical extension. In the 1990's among the Rendille in northern Kenya, for example, local healthcare workers helped promote medicalization of male circumcision. At male initiations in the bush, male circumcision had been performed by traditional specialists, who moved from one hut to the next in the initiation *menyatta* (circular compound of huts) to circumcised initiates. This was replaced by a male nurse, who set up a table in the center of the menyatta, and one by one circumcised initiates using provisions such as local anesthesia and topical antibiotics. Similarly, for subsequent female circumcisions, there was an increased demand for antibiotics and anti-tetanus injections (Shell-Duncan, Obiero et al. 2000).

In The Gambia, male initiation, as well, traditionally took place in the context of male circumcision and training in the bush, often lasting as long as three months. Today, however, male circumcision is most often performed in a clinic by a male nurse or dispenser. According to a senior lecturer at a nursing college, the clinicalization of male circumcision can be traced back to the mid 1950's, and today it is the predominant forum for the practice. Female circumcision has not, however, followed suit. While the Gambia Medical Association, as well as groups campaigning against the practice, strongly condemn medicalization of FGC, the key source of resistance has been the practitioners themselves. The majority of male and female informants from circumcising groups voice opposition to having FGC performed in a clinic by a nurse or a dispenser. The central authoritative role of the ngangsingba in performing FGC was clear. While a few informants expressed a desire for women to benefit from safer clinic-based circumcisions similar to men, the unacceptability of this option was readily apparent to nearly everyone. One aberrant case drew strong condemnation. One informant, when asked if he had ever heard of a nurse or dispenser performing FGC, replied:

> Well, once. And I have protested against it. . . There is a female dispenser who actually circumcised girls and I went there and told them "Look, this is a customary practice." We don't mind a male dispenser circumcising males, but when it comes to female circumcision it should be secretive. It is exclusively the area of the *ngangsingbas*. Nobody can do it here, except the *ngangsingba.*
> —Elder Mandinka man, urban Gambia

While "one blade per girl" was by far the most consistent medicalization theme among participants, it seems to be one of many permissible changes in circumcision to avoid infectious disease risk. Shared cutting instruments are avoided to reduce the risk of HIV transmission; vaccinations for tetanus before circumcision and antibiotics after circumcision are also used to avoid infection. Bush circumcisions are avoided because they are associated with unsanitary conditions such as no bathing; and group circumcisions are avoided to avoid exposure to contagious individuals (see also Ahmadu 2005).

[4] The term "medicalization" refers to a wide array of modifications, ranging from "clinicalization," where the practice is performed by biomedical health professionals in clinics or hospitals, to the adoption of prophylactic and hygienic measures, such as the use of anti-tetanus injections, antibiotics and sterile razors.

Discussion

Along with Prochaska and colleagues (1994) we find that it is useful to simultaneously examine readiness to change alongside a decision making model of pros and cons. Studying motivational balance across categories of readiness to change provides insight about how people weigh pros and cons and about factors that tip this balance. However, rather than focusing on the predictive power of decisional balance, as has been done for behaviors such as smoking cessation, we suggest the value of this approach lies in the ability to identify factors that resonate among individuals at different levels of readiness to change, and support desired behavior change.

As predicted, we find that individuals in different categories of readiness to change have different valuations of the advantages of FGC. Supporters of FGC have the highest mean advantage scores, willing abandoners have the lowest, and contemplators have scores that fall between those of the other two groups. Contrary to expectations, we find that as people shift from supporting to opposing the practice of FGC, the valuation of disadvantages changes. We had hypothesized that health-related disadvantages do not influence motivation to change since campaigns have delivered health risk messages for decades without causing widespread abandonment. Surprisingly, we find that health-related disadvantages resonate strongly among willing abandoners. Our interview data suggest that this may be attributable in part to recent changes in the health risk message, shifting away from a focus on obstetrical risks, which have not, for the most part, been deemed credible. By contrast, new messaging focused on HIV/AIDS risk resonates strongly among a growing number of Senegambian men and women. Despite the very low prevalence of HIV in Senegal and The Gambia, the risk of contracting HIV is deemed to be a significant threat. Moreover, despite the lack of epidemiological evidence linking FGC to HIV, this message has been deemed credible, and is associated not only with abandonment of FGC, but also medicalization of the practice.

These results suggest that health education campaigns that include messaging about HIV/AIDS can contribute to motivation to change the practice of FGC, including both abandonment and medicalization. Thus, in order to avoid promotion of medicalization, it may be prudent to develop a harm reduction approach, emphasizing that the safest way to avert HIV infection is to entirely abandon the practice of FGC.

V. Dynamics of Change in the Practice of FGC: Testing Predictions of Social Convention Theory

Summary

Social convention theory, a game-theoretic approach to understanding decision making regarding FGC, has advantages over decision-theoretic approaches because it considers individual decision makers in their social context and recognizes decision making as contingent on actions of others. According to social convention theory, FGC, like footbinding, emerged under highly stratified social conditions as a means of securing better marriage opportunities for daughters, and spread to become a prerequisite for marriage for all women, "locked in place" by parents' expectation that their daughters' peers will all be circumcised and prospective husbands' expectation that their wives will be circumcised. Social convention theory predicts that change in FGC will result from coordinated agreement within an intramarrying group to abandon the practice and create a marriage market for uncircumcised girls.

However, both qualitative and quantitative data show that FGC is most often not directly related to marriagability in the Senegambia. Interethnic and FGC-discordant marriages are far from anomalous, and many men, from both circumcising and non-circumcising families, are willing to marry uncircumcised women. We find mixed support for an indirect relationship between FGC and marriagability by helping to preserve virginity until marriage. While marriagability does not appear to be a widespread primary consideration in the decision to circumcise a girl, decision makers' expectations of others' behavior (i.e., that other girls will be circumcised and others will expect the girl in question to be circumcised) does. Thus, we find little support for a marriage convention *per se*, but do find broader support for a convention operating to maintain FGC in the Senegambia.

Instead, FGC in the Senegambia seems to be best described as a peer convention: we propose that being circumcised serves as a signal to other circumcised women that a girl or woman has been trained to be obedient and to respect the authority of her circumcised elders and is worthy of inclusion in their social network. In this manner, FGC facilitates the accumulation of social capital by younger women and of power and prestige by elder women.

Many of the cited "benefits" of FGC, such as proper behavior, cleanliness, easing childbirth, and preventing prostitution, can be seen as justifications circumcised women use for excluding uncircumcised women from their social networks. Further support for FGC as a peer convention comes from our observation that circumcised women in the Senegambia often go to seemingly extraordinary lengths to exclude uncircumcised women from their activities, households, and acquaintance.

Based on this new evidence and reinterpretation of social convention theory, we suggest that interventions aimed at eliminating FGC should target women's social networks which are intergenerational, and include both men and women. Our findings support Mackie's assertion that because expectations regarding FGC are interdependent, change must be coordinated among interconnected members of social networks.

Introduction

A recent review of intervention efforts (Frontiers 2002) argues that FGC interventions should be informed by theory on behavior change; that theoretical models of behavior change are needed to understand why and how interventions cause change. Models of behavior change fall broadly under two main paradigms: 1) decision-theoretic models, and 2) game-theoretic models. Decision-theoretic models rest on the assumption that costs and benefits are weighed by individuals who are capable of acting upon their own intention. However, as we have described in earlier chapters, our data show that several significant constraints restrict individuals from being able to easily act upon their intentions. First, while decisions regarding FGC can be made by an individual, they are very frequently made collectively by a group. Our survey data showed that for 45% of Gambian girls circumcised in the past

three years, between two and four decision makers were involved. Moreover, our qualitative findings documented that the size and composition of the decision making group often changes over time, as does the power of persuasion of different group members. Further complexity is added by the fact that sole decision makers who oppose FGC often also reported that in all likelihood their daughters will be circumcised in the future. This seemingly perplexing finding is better understood when we consider that the concept of intent or personal opinion fails to capture the powerful influence of social expectations and social sanctions, a point which we will explore further below. And finally, we find that the issue of intent is quite complex; we use the concept of "contingencies" to describe the multiple sources of influence that cause people's opinions about the practice of FGC to shift as they navigate various social and physical settings, and create different experiential histories and viewpoints (Hernlund and Shell-Duncan 2007; see also chapter VII). Our finding resonate with Johnsdotter who, writing about Somali immigrants in Sweden, urges people to not look at FGC simply as "culture" – something that is inherited and expected to be upheld – but rather as a strategy for optimizing a daughter's future. She understands FGC as a *strategy*, emphasizing that it involves reconciling greater or lesser degrees of ambivalence, weighing both positive and negative feelings toward the practice (Johnsdotter 2007: 114).

Game-theoretic models of behavior change capture the concepts of strategy and collective action. Social convention theory, a game-theoretic model of FGC proposed by Mackie (1996; 2000), delineates the means by which actions of individuals are interdependent, necessitating coordinated change among interconnected actors. Mackie (2000) argues that FGC is a convention maintained by interdependent expectations in the marriage market. Once it becomes widely expected of potential brides, the practice is locked in place: those who fail to comply also fail to marry and reproduce. A convention shift, whereby a critical mass of people abandons the practice and allows their children to marry only uncircumcised women, is necessary to sustain abandonment of FGC. The success of community-based programs that seek to coordinate change within a community, such as the Senegalese Tostan project, which organizes public declarations of abandonment of FGC, provide strong initial support for social convention theory (Tostan 1999; Mackie 2000). This correspondence has drawn considerable attention from individuals designing, implementing and evaluating programs, as well as donors, policy makers and academics. UNICEF, in particular, has been instrumental in organizing a series of academic consultations to explore the theoretical dimensions of behavior change, and insights from correspondences or divergences with empirical program experiences.

The purpose of this research is to add to a growing body of empirical research that explores the dynamics of decision making, explicitly testing predictions from theory against integrated in depth qualitative and quantitative data. We compare qualitative and quantitative findings against predictions derived from Mackie's formulation of social convention theory, namely that marriagability is a central theme in decision making around FGC and that marriage patterns differ by FGC status.

Mackie's Social Convention Theory: Original Formulation

In its original formulation, Mackie (1996; 2000) outlined a game-theoretic model, social convention theory, which delineates the means by which actions of individuals are interdependent, necessitating coordinated change among interconnected actors. Mackie proposed that FGC arose under conditions of imperial polygyny and extreme resource inequality, with a powerful elite at the apex controlling crucial resources. He suggests that within this context, FGC may have originated as a means of signaling fidelity control to highly polygynous male elites who control great economic resources.

> Men…are more or less uncertain that a child is their own.... When resource inequality reaches a certain extreme, a woman is more likely to raise her children successfully as the second wife of a high-ranking man than as the first wife of a low-ranking man…. The higher the male's rank, the greater the resource support he offers, the greater number

> of consorts he attracts, the greater his costs of controlling the fidelity of his consorts, and thus the greater competition among families to guarantee the fidelity of their daughters (Mackie 2000: 262).

Furthermore, Mackie suggests that once FGC was adopted and improved chances of marriage to higher social strata, it spread by hypergenous diffusion; the practice became exaggerated and diffused through lower strata of society as parents attempted to improve the chances of their daughters marrying into higher social strata. The cascading effect is that FGC became associated with improved chances of good marriages throughout society. Mackie explains:

> However the custom originated, as soon as women believed that men would not marry an unmutilated woman, and men believed that an unmutilated woman would not be a faithful partner in marriage, the convention was locked in place. A woman would not choose nonmarriage and not to have her own children; a man would not choose an unfaithful partner and not to have his own children (Mackie 2000: 264).

To explain how FGC became a convention locked in place, Mackie (1996) outlines the practice in terms of a game theory matrix, describing the practice of FGC with respect to "self" and "others".

	Self cut	Self uncut
Others cut	(+, -) 3	(--, +) 4
Others uncut	(++, -) 2	(+ , +) 1

Figure 5.1 Payoff matrix for the marriage convention hypothesis of female genital cutting. Columns represent a woman's ("self") choices; rows represent the choices made by other women in the community. Symbols represent the payoff for a woman ("self") of being circumcised or not on in terms of (marriagability, health/sexuality). Cells are ranked from 1 (most desirable) to 4 (least desirable) from the perspective of the woman ("self").

The situation in which a woman is uncut while others are cut is rated lowest (4) since she foregoes marriage, legitimate reproduction and higher social status (- -). Both self and others being cut is third best (3), and is described as a stable equilibrium, since marriagability is retained (+), but health risks are posed (-). Having self cut and other uncut ranks second (2) since it bears the advantages of improving marriagability (+ +), but confers health risks (-) (this option is as well an unstable equilibrium). And finally, all uncut ranks highest at 1 since everyone retains marriagability (+), and avoids the risks of cutting (+). The implication of this is that in order to avert the unstable equilibrium scenarios, and because of the interdependency of decision making, behavior change must be coordinated to shift from all cutting to no cutting. It is not necessary that the entire population ends the practice at once, but that change is coordinated amongst a critical mass of individuals to assure the existence of a marriage market for uncut girls.

Mackie illustrates the concept of coordinated change with a metaphor:

> [I]magine that there is a group that has a convention whereby audiences (at the cinema, at plays, at recitals) stand up rather than sit down…. Standing is both universal and persistent. An outsider comes along and explains that elsewhere audiences sit…. [S]ome

> people begin to think that sitting might be better, but it would be better only if enough other people sit at the same time. If only one person sits, she doesn't get to see anything on the stage. If only one family abandons FGC, its daughter doesn't get married.... However, if a critical mass of people in the audience can be organized to sit, even just one column of people who are less than a majority, they realize that they can attain both the ease of sitting and a clear enough view of the stage…. Similarly, if a critical mass of people in an intramarrying group pledge to refrain from FGC, then the knowledge that they are a critical mass makes it immediately in their best interest to keep their pledges and persuade other to join in (Mackie 2000: 255).

Mackie (2000) asserts that even though marriagability is the "main engine of continuation" of FGC, within various cultural groups it can become associated with other factors such as female initiation or religion; indeed he explains that the theory does not require that "marriagability be the most important factor associated with FGC." It does, however, impose the requirement that change be coordinated within intermarrying groups to reach a new stable equilibrium. Hence, in Mackie's original formulation of social convention theory, marriagability is the source for the origins, spread, and maintenance of FGC. Mackie did, however, also identify a second possible source for the maintenance of FGC: peer pressure. We first, however, look for empirical support for the specification of Mackie's theory as outlined thus far.

Social Convention Theory: Empirical Insights from Senegambia

Qualitative data analysis

According to the marriage convention scenario, FGC should have the following features:

1. It should be necessary for marriage or an avenue to better marriage prospects.
2. It should be self-enforcing: the expectation that other girls will be circumcised should be sufficient reason to favor circumcising a girl.
3. While other justifications may be imposed on it (accompanying training, health, cleanliness), it is the physical signal (cutting) itself that is conserved; accompanying ritual, celebration, or training should be abandoned more readily than the actual physical modification.
4. It should be prone to exaggeration, as women compete to send a stronger signal and gain the best husbands.

What follows are summaries of qualitative findings that speak to whether or how the practice of female circumcision in Senegambia fits predictions from the marriage convention hypothesis. The quotes come from focus group discussions and open ended individual interviews.

1. Circumcision is a prerequisite for marriage or related to marrying well.

Marriages between men from ethnic groups and families that practice female circumcision and uncircumcised women are far from unheard of. Most everyone interviewed agreed that circumcision was not necessary for marriage, and none asserted that it was an avenue to get a richer or better husband.

> No, there are husband who don't mind whether you are circumcised or not.
> —Middle-aged Wolof woman, urban Gambia

> Finding a husband depends on God. Some have a husband and they are circumcised, some have a husband and they are not circumcised. Finding a husband is God's decision.
> —Young Mandinka woman, urban Gambia

No, that has nothing to do with it, whether you have gone or not you will have a husband.
—Middle-aged Mandinka woman, urban Gambia

Q: Do you think men feel that it is important for their wives to be circumcised?
Maybe, but for me, all my three are circumcised.
Q: How do you know?
I hear them say it is good for a woman to be circumcised; from there I know they have gone.
Q: Do people discuss this when arranging to be married?
I don't think that it is important to discuss about.
Q: Is there a difference between circumcised and uncircumcised women?
No, they are all women and all of them are fit to be wives.
—Elder Jola man, urban Gambia

Where respondents did assert that circumcision was important or necessary for a good marriage, it was most often not because men refused to marry uncircumcised women, but because an uncircumcised woman marrying into a circumcising family would face difficult relationships with other women in her marital home.

If you have two wives—one who is circumcised and the other one who is uncircumcised—the one who is circumcised always calls the uncircumcised one Solima, meaning uncircumcised woman full of odors. I have seen many cases pertaining to circumcised and uncircumcised women here in this village.
—Middle-aged Jahanka man, rural Gambia

Q: What are the problems that daughters will face if they are not circumcised?
If they happen to marry into a compound where it is practiced, they will not be comfortable because, anytime, they call them "solema." Even if they have children in that compound and they want to circumcise them, you the mother will not have a right to be present because you are not circumcised, and that is an insult to you the mother.
—Middle-aged Wolof woman, urban Gambia

2. Circumcision is self-enforcing.

Expectations regarding whether other girls in the community will be cut (or whether potential marriage partners will prefer circumcised wives) were not listed among the major considerations in the decision making process regarding FGC. While the marriage convention hypothesis predicts that such expectations alone will be sufficient to perpetuate FGC (just as driving on the right or left side of the road requires little enforcement beyond an expectation that other drives will do so), we found that FGC is actively promoted, or enforced, among those who practice it. We identified three primary ways that female circumcision is enforced: 1) Those who choose not to circumcise a daughter face direct pressure from family and community members.

The person will not be comfortable in the community in which she is living because whenever she goes out, people will start pointing fingers at her: "that is that woman who decided not to circumcise her daughters, while she [herself] is circumcised." Some will even encourage her daughters to be circumcised, they will tell them, "you are sitting here, your mother or parents don't want you to be circumcised, while they themselves

are circumcised, and if they happen to pass away, you will be at a big loss, because you will know nothing in your tradition," and that can cause the daughters to be circumcised, which may bring problems between children and parents, because the parents will say their children don't respect them, that's why they didn't obey what they said to them.
—Young Fula woman, urban Gambia

2) Uncircumcised girls and women face substantial harassment from circumcised women of all ages.

Q: Is there a difference in the way that circumcised and uncircumcised women are treated?
Yes, because in the areas were those people are circumcised their tradition allows them to be circumcised. When you are not circumcised, sitting between them, once they discover that you are not circumcised they will start talking, that you are smelling, you are doing this, you are doing that, and all sort of talking to just encourage you to be circumcised.
—Middle-aged Manjago woman, urban Gambia

Because, at times if you are within the family system, if you don't do it, at times, they sabotage you and you can be outcast one day or the other.
—Middle-aged Wolof man, rural Gambia

3) Uncircumcised women are excluded from participating in, or even being present for, some activities (most commonly listed is circumcision itself, e.g. an uncircumcised woman would not be allowed to attend the circumcision of her daughters, uncircumcised women are also reportedly sometimes excluded from aspects of wedding ceremonies). Some also assert that uncircumcised women are excluded from collective (family or community) decision making.

If a Wolof woman comes here for a marriage, if her daughters happen to be circumcised, she will never see them until they get dismissed.
—Elder Tukulor woman, rural Senegal

Some people say if you are circumcised, you will be taught many things, like how to respect elders, how to behave with your husband. And if you happen to get married, I heard that when there is a wedding, it is only the circumcised women who are allowed to enter the in the married husband's house with the woman married, and for two or three days before the woman is given to her husband she will stay with the old circumcised women, who will teach her some of the things they were taught during circumcision [she is referring to a Serer custom].
—Young Manjago woman, urban Gambia

Q: If you decided to stop female genital cutting, what are the problems your daughters would face?
They will not be respected in the society because anywhere they go that they happen to meet with circumcised women, if they are making their decisions, especially the traditional decisions they will not be allowed to take part because they are not circumcised.

—Elder Wolof man, urban Gambia

3. The physical modification is more valued than the accompanying training or ritual (circumcision without training is more acceptable than training without circumcision).

This prediction is supported by findings from both the qualitative and quantitative data. Many respondents describe the training that accompanies circumcision; training seems to be the primary purpose women give for taking their girls to circumcision. According to Mackie, the accompanying training is likely a justification that was imposed on the practice, rather than a genuine explanation of its persistence. Consistent with this, we found that increasingly, the physical cutting of FGC is becoming divorced from the training and ritual that traditionally accompany circumcision. In comparisons of circumstances surrounding circumcision for mothers and daughters, we found that the frequency of FGC being performed without any accompanying training or celebration rose from 18% to 47% across generations (see Chapter II). Most participants found performing circumcision on girls at younger ages and shifting from circumcisions in the bush to the family compound acceptable, or even advocated these changes.

Q: So which part of these traditions do you think are important to keep?
The tradition of circumcising. The tradition of circumcision itself, it should not be left.
Q: Do you mean to circumcise girls and leave the other things?
That depends on the parents, if they feel they cannot do it (spend resources) then it is not a force on them. One thing I know, it [circumcision] should not stop.
—Elder Tilibunka woman, urban Gambia

Q: Within the tradition of circumcision, which traditions do you think are the most important to keep?
Well, only one thing. The way they say it is a sunna, if that is true then maybe they should just do it (circumcision) and stop taking the children to the bush. The bush is not for human beings to stay.
—Middle-aged Mandinka woman, urban Gambia

Changes in the practice are vital. For example, girls should be taken at a very early stage and not in groups, neither stay in the bush as was the case during our time. We stayed for almost two months in the bush but came home every evening after sunset and went back before sunrise, in very unhealthy conditions. As such, since the boys are now taken to the clinics by doctors why should not also the girls be taken to trained medical personnel?
—Middle-aged Mandinka woman, rural Gambia

As Hernlund (2000: 239) explains, those who are not circumcised are contemptuously insulted by being labeled *solema*, meaning not only uncircumcised, but also rude, ignorant, immature, uncivilized and unclean. While *solema* are told they "know nothing," and are harassed and excluded by women for not knowing how to behave properly, what truly makes a girl/woman no longer *solema* is not her behavior, but her circumcision; the proof that a woman is not *solema* is her circumcised genitals (Ahmadu 2005). A few respondents describe circumstances under which they have physically examined women to verify their circumcised status (e.g., women suspected of being uncircumcised who attempt to enter the circumcision camp).

I have witnessed two such incidents within these surrounding villages…. Two ladies were

> quarreling and it happened that the uncircumcised lady called the circumcised one solema. The uncircumcised lady was led to the bush to testify whether she had seen her opponent's "solema" [uncircumcised genitals].
> —Young Mandinka woman, rural Gambia

> You know, it is just now that some of the things done are being abandoned. If not, then when a woman enters a bush *jujuwo* [where circumcision is being held], the older women confirm first to see if that woman is circumcised. To do this, the older women would undress the woman naked to see with their own eyes if the women present are all circumcised.
> —Elder Mandinka woman, rural Gambia

4. Competition for the wealthiest husbands promotes a greater degree of cutting.

This prediction is not borne out in the qualitative data. Most participants are willing to accept (or advocate) reducing the degree of cutting.

> People should stop removing/cutting all, but remove just a little. And care should be taken not to use one instrument or material for more than one person. And also go singly, rather than in groups.
> —Middle-aged Mandinka woman, rural Gambia

This voiced support is, however, not accompanied by any significant change in the severity of cutting. Comparisons of FGC among mothers and daughters show that there is no secular trend in circumcision type, neither increasing nor decreasing in severity (see Chapter II).

Quantitative data analysis

Our survey data can address predictions 1) *circumcision should be necessary for marriage or an avenue to better marriage prospects;* and 2) *accompanying ritual, celebration, or training should be abandoned more readily than the actual physical modification.*

We tested prediction one in two ways. First, the survey contained two items directly related to the importance of FGC for marriagability. Second, women responding to the survey provided information about their circumcision status, tradition, ethnicity, and (for those who are or were married) the circumcision tradition and ethnicity of their husbands, allowing us to examine actual marriage pairings and concordance within marriages for FGC status and tradition. We tested prediction two by examining changes in the practice. As discussed in Chapter II, women responding to the survey provided information about the circumstances of their own and their daughters' circumcision. By comparing mothers to daughters, we identified changes that have occurred between the two generations, and evaluated whether change was evident in the ritual and training associated with circumcision, or in the cutting itself.

1. Circumcision should be necessary for marriage or an avenue to better marriage prospects.

Most Senegambian women do not see a connection between circumcision and marriagability. The majority of respondents did not agree with the statement, "If a girl is circumcised, she has a better chance of finding a good husband" (Table 5.1), nor with the statement, "A girl who is not circumcised will have difficulty finding a husband" (Table 5.2). We find mixed support for an indirect link between FGC and marriagability via its usefulness for protecting virginity until marriage. In the Chapter III we showed that 51% of respondents agreed with the statement, "Female circumcision helps a girl remain a virgin until she marries."

Table 5.1 Responses to the survey item, *"If a girl is circumcised, she has a better chance of finding a good husband"* among Senegambian women.

Among all Senegambian women responding (those with a daughter who is or might be circumcised)			Among all Senegambian women from a circumcising background		
Response	Frequency	Percent	Response	Frequency	Percent
Agree	163	19.88	Agree	163	23.97
Unsure	115	14.02	Unsure	100	14.71
Disagree	542	66.10	Disagree	417	61.32
Total	820	100.00	Total	680	100.00

Table 5.2 Responses to the survey item, *"A girl who is not circumcised will have difficulty finding a husband."* among Senegambian women.

Among all Senegambian women responding (those with a daughter who is or might be circumcised)			Among all Senegambian women from a circumcising background		
Response	Frequency	Percent	Response	Frequency	Percent
Agree	76	9.27	Agree	76	11.18
Unsure	150	18.29	Unsure	141	20.74
Disagree	594	72.44	Disagree	463	68.09
Total	820	100.00	Total	680	100.00

Among women in the Senegambia, circumcising tradition and ethnicity are two separate questions. Ethnicity was evaluated with the question, "What is your ethnic group?" Circumcising tradition was evaluated with the questions, "Is female circumcision a tradition in your family?" in The Gambia, and "Was female circumcision a tradition in your family before the law?" in Senegal. Some of the most common ethnic groups are close to uniform in their circumcising tradition (97% of Mandinka women participating in the survey reported that FGC is/was a tradition in their family; 96% of Wolof women reported that it is/was not). For others, this is not the case: among Fula women, 72% reported that FGC is/was a tradition in their family; among Jola women, 85%; and among the Serer, 25% (Table 5.3 and 5.4).

Table 5.3 Circumcising tradition *(Is/was female circumcision a tradition in your family?)* by ethnic group among all Senegambian women

Ethnic group	From a circumcising tradition		
	Yes	No	Total
Wolof	12 (4.43%)	259 (95.57%)	271
Fula	162 (72.00)	63 (28.00)	225
Mandinka	301 (96.78)	10 (3.22)	311
Serahule	48 (96.00)	2 (4.00)	50
Jola	88 (85.44)	15 (14.56)	103
Aku Marabout	4 (57.14)	3 (42.86)	7
Serer	42 (25.00)	126 (75.00)	168
Manjago	1 (3.85)	25 (96.15)	26
Mankange	0 (0.00)	3 (100.00)	3
Balanta	3 (60.00)	2 (40.00)	5
Other	41 (85.42)	7 (14.58)	48
Total	702 (57.68)	515 (42.32)	1217

Table 5.4 Circumcision status by ethnic group among all Senegambian women

Ethnic group	Circumcised		
	Yes	No	Total
Wolof	12 (4.43%)	259 (95.57%)	271
Fula	157 (69.78)	6 (30.22)	225
Mandinka	297 (95.50)	14 (4.50)	311
Serahule	48 (96.00)	2 (4.00)	50
Jola	85 (82.52)	18 (17.48)	103
Aku Marabout	3 (42.86)	4 (57.14)	7
Serer	40 (23.81)	128 (76.19)	168
Manjago	1 (3.85)	25 (96.15)	26
Mankange	0 (0.00)	3 (100.00)	3
Balanta	3 (60.00)	2 (40.00)	5
Other	38 (79.17)	10 (20.83)	48
Total	684 (56.20)	533 (43.80)	1217

While marriage partners often have ethnicity and circumcising tradition in common, this is far from universally true. We examined concordance for ethnicity and circumcision separately, and then attempted to disentangle the effects of these two factors. Concordance within marriages for FGC and ethnicity was calculated as the percentage of pairs with the same characteristic. The kappa statistic (κ) was calculated as the extent to which observed concordance exceeded that expected solely by chance:

Respondent (wife)	Husband		
	Category 1	Category 2	Total
Category 1	A	b	M
Category 2	C	d	N
Total	o	p	T

Observed concordance = (a + d)/t

Expected concordance = [(m/t)*(o/t)] + [(n/t)*(p/t)]

κ = (Observed concordance – expected concordance)/(1 – expected concordance)

Equations were expanded to accommodate more than two categories when necessary (e.g., for ethnicity).

Concordance between survey respondents' FGC status and their husbands' tradition (restricted to women who are or have been married) is described in Table 5.5 and 5.6.

Table 5.5 Concordance between husband's tradition and circumcision status among all Senegambian women*

Female circumcision is a tradition in husband's family	Circumcised		
	Yes	No	Total
Yes	576	54	630
No	80	436	516
Unsure	2	0	2
Total	658	490	1148

*Restricted to ever married women.

Table 5.6 FGC-incongruent marriages (comparing respondent's status to husband's tradition) among Senegambian women*

Among all Senegambian women			Among Senegambian women from circumcising families		
Concordance between husband's tradition and wife's circumcision	Frequency	Percent	Concordance between husband's tradition and wife's circumcision	Frequency	Percent
Yes	1,012	88.31	Yes	586	87.07
No	134	11.69	No	87	12.93
Total	1,146	100.00	Total	673	100.00

*Restricted to ever married women.

Concordance between respondents' circumcision status and husbands' family's circumcising tradition (ignoring "unsure" responses) was .8806. Expected concordance was .5058; kappa was .7584, indicating greater concordance than expected by chance. Similarly, concordance between respondents' and husbands' family's circumcising traditions (ignoring "unsure" responses) was .8822. Expected concordance was .5070; kappa was .7611, again, indicating greater concordance than expected by chance. However, the observed high concordance for FGC in respondents' marriages could be attributable entirely to high concordance for ethnicity, described in Tables 5.7 and 5.8.

Table 5.7 Own and spouse's ethnicity among all Senegambian women

Respondent's Ethnicity	Spouse's Ethnicity											
	Wolof	Fula	Mandinka	Serahule	Jola	Aku Marabout	Serer	Manjago	Mankange	Balanta	Other	Total
Wolof	186 (81.22)	5	14	1	3	1	11	1	0	0	7	229
Fula	12	151 (74.02)	9	6	5	5	8	0	0	0	8	204
Mandinka	21	11	201 (69.55)	11	8	1	25	2	0	0	9	289
Serahule	0	2	2	38 (82.61)	0	0	3	0	0	0	1	46
Jola	7	8	12	2	46 (54.12)	2	5	0	1	0	2	85
Aku Marabout	0	2	0	0	1	2 (40.00)	0	0	0	0	0	5
Serer	15	7	15	1	4	1	108 (71.05)	0	0	0	1	152
Manjago	4	0	1	0	0	1	1	13 (65.00)	0	0	0	20
Balanta	1	1	0	0	0	0	1	0	0	2 (40.00)	0	5
Other	5	3	2	1	1	1	2	0	0	0	30* (66.67)	45
Total	251	190	256	60	68	14	164	16	1	2	58	1080

Table 5.8* Own and spouse's ethnicity among concordant "other" marriages

Own	Spouse's Ethnicity								
Ethnicity	Bamabara	Jahanka	Koniadji	Laobe	Maure	Nar	Teubonka	Turka	Total
Bambara	11	0	0	0	0	0	0	0	11
Jahanka	0	2	0	0	0	0	0	0	2
Koniadji	0	0	2	0	0	0	0	0	2
Laobe	0	0	0	3	0	0	0	0	3
Maure	0	0	0	0	3	0	0	0	3
Nar	0	0	0	0	0	1	0	0	1
Tilibonka	0	1	0	0	0	0	0	0	1
Teubonka	0	0	0	0	0	0	2	0	2
Turka	0	0	0	0	0	0	0	5	5
Total	11	3	2	3	3	1	2	5	30

Of 1,080 Senegambian women's marriages for which complete information were available, 776 (71.85%) were concordant for ethnicity and 304 (28.15%) were interethnic (the respondent's and husband's reported ethnic groups were not the same). If "other" is treated as a single ethnic group (which is justified; 97% of "other" concordant marriages are actually concordant), chance predicts a concordance of .1772. The observed concordance (.7185) is much higher than this, giving a kappa value of .6579. This indicates a greater concordance for ethnicity than chance explains, despite the substantial number of interethnic marriages reported.

High concordance for ethnicity could explain much of the concordance for FGC that we observed. To control for ethnic group, we examined FGC concordance only among marriages concordant for ethnicity, and focused on groups with moderate prevalence of FGC (Fula[5], 70% of surveyed women circumcised; Jola, 83% of surveyed women circumcised; Serer, 24% of surveyed women circumcised) to evaluate whether circumcised women are more likely married to men from circumcising traditions.

[5] According to Daffeh and colleagues (1999), FGC among Fulas varies among sub-groups, with the practice being either near-universal or absent within sub-groups.

Table 5.9 Concordance between husband's circumcision tradition and circumcision status by ethnic group among Senegambian women from circumcising families in ethnically concordant marriages

Ethnic group	FGC is a tradition in husband's family	Circumcised	Uncircumcised	Concordance	Kappa
Wolof	Yes	2	0	.9946	.7974
	No	1	183		
Fula	Yes	105	5	.9133	.7730
	No	8	32		
Mandinka	Yes	191	3	.9600	.1820
	No	4	1		
Serahule	Yes	37	0	1.000	1.000
	No	0	1		
Jola	Yes	38	2	.9111	.5500
	No	2	3		
Aku Marabout	Yes	1	0	1.000	1.000
	No	0	1		
Serer	Yes	16	2	.9259	.7551
	No	6	84		
Manjago	Yes	0	0		
	No	0	13		
Balanta	Yes	1	0	1.000	1.000
	No	0	1		
Other	Yes	23	2	.9333	.7931
	No	0	5		

If FGC is maintained by a marriage convention, we should expect to observe men from circumcising traditions married only (or close to only) to circumcised women, while men not from circumcising traditions should be married to circumcised and uncircumcised women at more equal rates (or rather, in proportion to their representation in men's ethnic group). It appears assortative pairing is at work for men from both backgrounds: among the Fula, Jola, and Serer (three ethnic groups with moderate prevalence of FGC and large numbers participating in the survey), it seems that circumcised women are more likely to be married to men from circumcising backgrounds and uncircumcised women are more likely to be married to men not from circumcising backgrounds.

While the observed concordance in marriages for ethnicity and FGC is higher than expected by chance, it is far from perfect: 28% of respondents reported being in ethnicity-discordant marriages, and 11-12% reported being in FGC-discordant marriages (depending on how this discordance was defined).

These results suggest that the marriage prospects for uncircumcised women are far from dismal, as marriage across both ethnic and FGC tradition lines are possibilities. We also find assortative marriages for FGC within ethnic groups; the marriage convention hypothesis finds some support in this result, as it predicts the preference of men from circumcising families for circumcised women, but does not predict any preference for uncircumcised women among men from non-circumcising families (and instead predicts that the preference for circumcised wives will be rather contagious).

2. Accompanying ritual, celebration, or training should be abandoned more readily than the actual physical modification.

As discussed in Chapter II, we found significant changes between mothers' and daughters' generations in circumcision location, the degree of celebration, and age at circumcision, but no change in the type or degree of cutting (Tables 2.10 and 2.11). We observed similar rates of "sunna" circumcision and sealing in mothers' and daughters' generations, and high concordance between mother/daughter pairs. The much lower percentage of daughters circumcised in the bush and the low concordance for circumcision location between mother/daughter pairs, on the other hand, suggests a trend away from bush circumcisions; similarly, the higher percentage of daughters who experienced no celebration associated with circumcision and the low concordance between mother/daughter pairs for celebration suggest a trend away from circumcision celebrations. Consistent with predictions from the marriage convention hypothesis, the ritual, celebration, and training surrounding FGC seem to be have been abandoned by many practitioners of FGC, who retain the cutting itself; this phenomenon has been previously described by Hernlund (2000: 235) as "cutting without ritual."

Thus, in the Senegambia, neither qualitative nor quantitative analyses strongly support the marriage convention hypothesis. From this, we conclude that FGC in our study communities in Senegambia is not maintained primarily by a marriage convention, although it is possible that marriagability contributed to the origin and spread of FGC in the past. Michelle Johnson, writing on FGC among the Mandinga in Guinea-Bissau, similarly reported that FGC, which takes place well before puberty, currently bears no direct relationship to marriage, although ethnographic reports from the 1940's suggest this was not always the case (Johnson 2000: 219). Further, we conclude that, while a woman's marriage prospects are not tied to her circumcision status, FGC may still be interpretable as a convention, in as much as it represents a *strategy* that girls or women can use to facilitate social interaction to their benefit. Rather than a marriage convention, FGC in the Senegambia may be perpetuated by a peer convention, a scenario similar to marriage convention in many ways.

Beyond Marriage Convention

The peer convention hypothesis has important benefits over the marriage convention hypothesis for explaining FGC in the Senegambia. First, it potentially explains both female *and male* circumcision. Male circumcision is not addressed by Mackie (1996; 2000) or in other treatments of social convention theory. However, our interview data reveal that male and female circumcision are clearly considered complementary practices within Senegambian groups in which both males and females are traditionally circumcised. This finding is consistent with Ahmadu (2005), who finds that female excision and male circumcision are viewed by both Mandinka men and women as parallel processes and institutions. Ahmadu's analysis elaborates that rituals for both female and male initiation are effectively symbolic reenactments of dual-sex roles in myths of the creation of the universe and sociocultural order. She argues that excision and circumcision "refer to the creation and transformation of the world from androgynous nature to sexually differentiated culture marked by cross-sex relations of power," and consequently concludes that female and male initiation assert interdependence and complementarity of both "matriarchy" and "patriarchy" (Ahmadu 2005: 2). While the physical aspects of male and female circumcision differ (the clitoris is not the physiological equivalent of the foreskin, and the male

equivalent of excision or sealing is unheard of), the training that traditionally accompanies each is similar in certain respects, and both training and physical transformation are reported to play a similarly significant role in a person's life in the Senegambia. According to our qualitative data, they also share recent trends toward younger ages at circumcision and a decoupling of this training from circumcision itself.

Second, the peer convention hypothesis can better accommodate a situation like that in Senegambia, where a significant proportion of the female population remains uncircumcised. If female circumcision persists because it is a marriage convention, originally providing an avenue for young women to "marry up" and eventually becoming a prerequisite for marriage in all social strata, we should expect it to have been adopted more widely in ethnic groups interacting with circumcising groups. The marriage convention hypothesis seems to necessitate that the convention be prone to spreading; that ethnic groups such as the Mandinka and the Wolof, with a long history of interaction and only individual examples of adoption, could persist with different practices regarding a marriage convention is unlikely. Such a tendency to spread, however, is not necessarily a prediction of the peer convention explanation of FGC.

FGC as a strategy for accessing social capital

We suggest that a peer convention operates to maintain circumcision in our study communities by facilitating entry into a social network and conferring access to social support and resources. *Social capital* refers to resources embedded in a person's social network that may be accessed by virtue of membership in the network or by calling on particular connections. Resources accessed through such networks and connections can take the form of social norms (e.g., norms against theft; Coleman 1988), information and opportunities (e.g., job openings; Sprengers et al., 1988), or material resources (e.g., assistance in launching a small business; Lin et al., 1981). Individuals benefit from social capital in myriad ways. Higher social capital (in the form of higher status network connections or more network connections) is positively associated with greater social status attainment (Lin 1986; Angelusz 1991; Burt 1997), success in the job market (Sprengers et al., 1988), and earlier promotion (Burt 1997). Higher social capital (in the form of denser, more interconnected networks) is also associated with better psychological health (Barbieri 2003), and access to entrepreneurial opportunities (Lin et al., 1981; Light 1984).

In the socioeconomic conditions of the Senegambia, where poverty is common, crises frequent, and opportunities scarce, adults rely heavily on social networks to access resources and opportunities in many arenas. N'Dione (1992 cited in Zaoual 1997: 35), writing on Senegal, asserts that "the upkeep and maintenance of social networks is the surest strategy to protect oneself from life's uncertainties," and points to a Senegalese proverb that expresses this belief: Man is the remedy for man. According to Zaoual (1997: 32), across many African societies, "local milieux work… on the principle of social links," and contribute to the strong cultural value placed on relationships, sharing, and solidarity. What emerges is a system of reciprocity that improves the security of a group's members by reducing hazards and risks. Such a system relies on social networks and social cohesion, resulting in a group that is bound through mutual obligations (see also Cobbah 1987; Carney and Watts 1991; Schroeder 1999; Ahmadu 2005). Both men and women in the Senegambia rely on extensive networks of friend, acquaintance, and family contacts in a variety of ways: for example, contacts may be used to access job and business opportunities, family may be relied on for childcare or helping to cover expenses, and both family and social contacts relied on for public and social support (e.g. in a dispute with another member of the community). If having circumcision in common enhances the likelihood that two individuals will form a social connection (the currency of social capital), then circumcision represents a viable strategy to access social capital. As Moore writes regarding the Marakwet of Kenya, "the bond which is established between women during initiation provides them with their own networks of support and obligation,

which are separate from those of men" (Moore 1988: 193). These "ready-made" connections may be particularly useful to young women, who, upon marriage, face the prospect of leaving the majority of their social connections behind in their natal home, to build their social capital anew in their marital home. As Ahmadu (2005: 58) explains, "on one hand the pain and hardship that girls undergo was said to harden and prepare them to be strong and self-assertive in their marital homes. On the other hand, female elders also stressed that through initiation young girls are taught the art of subordination to their husbands, their husband's brothers and, importantly, to their future mothers in-law."

As insiders, circumcised women cement their belonging in their social network and maximize their social capital by excluding uncircumcised women through harassment and ostracization (as described above). Further, many of the benefits of female circumcision that supporters of the practice cite, including cleanliness, preventing promiscuity, preventing disease, and even easing childbirth, can be understood as justifications for excluding uncircumcised women.

> In my Mandinka tradition, if a woman is not circumcised, she will be in the habit of requesting sex always. If the husband is tired of that, he may divorce her. After divorce, she will be lonely and that will lead to prostitution.
> —Elder Mandinka woman, rural Gambia

> If you are circumcised, you control yourself from running from man to man. If you are circumcised, you give respect to your husband. It also eradicates teenage pregnancy, for example in some countries in Africa, they always have teenage pregnancy, because they banned female genital mutilation and remain uncircumcised. The more you are not circumcised, the more you are addicted to sex. That being the case, HIV/AIDS may be introduced in your system. That's why HIV/AIDS is getting rampant in Africa.
> —Middle-aged Konyaginka man, rural Gambia

> You see, when a circumcised woman is in labor, one can be outside without knowledge of what is going on, but when these people [the Wolofs], the uncircumcised, are giving birth they shout so much that even a passerby would hear. This is because of the severe pain they're undergoing. The clitoris would first of all split in two to give way to the child's head.
> —Middle-aged Mandinka woman, rural Gambia

These "benefits" of circumcision all emphasize a shortcoming of uncircumcised women, a reason to exclude them.

Thus, we interpret much of the teasing and exclusion that uncircumcised girls and women experience as part of circumcised girls and women using their circumcised status to make social connections and accrue social capital. Emphasizing what circumcised women have in common and how uncircumcised women are lacking may help facilitate the forming of connections between circumcised women, allowing them to make the most of their circumcised status.

Intergenerational aspects to women's peer networks

Female circumcision and female networks seem to have an important intergenerational component. As Ahmadu (2005) explains, female circumcision is closely tied to notions of women's power among Mande groups throughout West Africa; "far from being oppressed by excision rituals, women are the organizers, the champions, and staunch defenders of these practices and, importantly they strategically manipulate and exploit gender ideologies as well as gender asymmetries." She argues

that women's investment in perpetuating the practice of FGC goes far beyond concerns for marriage and future reproduction. FGC, she asserts, is also about ideology and the exercise of power and authority by some women over other women and men; it serves to perpetuate the structural position and influence of female elders (see also Thomas 2000 on excision and women's power and social hierarchy among the Meru of Kenya). It is within this hierarchy of power that younger women undergo FGC.

Elder women, established in the community and often wealthier, are at an advantage in forming networks, and, at the same time, are less likely than younger women (in new marriages, with fewer connections, and with young children) to need to rely on their connections for social or material support. In including a younger woman in her network, an older woman is more likely to be called upon by the new connection for support than she is to be the recipient of support. Some of our qualitative data suggest that, in order to gain entry into women's networks, young women/girls offer their deference or obedience to older women in the network, enhancing the elder's power and standing in the community. Female circumcision may serve as a signal by these girls (or their family, on the girls' behalf) that they will be well-mannered and obedient subordinate members of the network.

Sudarkasa (1980:50) organizes rights and duties in African societies around four underlying principles: respect, restraint, responsibility, and reciprocity. Although African society is communal, it is hierarchical, with respect governing behavior of family members to elders. Sudarkasa describes restraint as the principle that makes communalism in the family possible, but reduces the autonomy of individuals since they are embedded in relationships to one another (see also Zaoual, 1997). Responsibility offers the network of security, but also imposes the burden of obligation. And finally, the principle of reciprocity, as discussed above, extends not only between individuals, but also across generations. This intergenerational peer convention seems to be the most consistent with what women describe. For younger girls, the benefit of being circumcised is that they learn to have respect, they can "stay anywhere" (form new connections and amass social capital in a new compound or community):

> Yes, [if you are circumcised,] you will have respect, you will know the eye. And it will make you be independent, because of the teachings you undergo during circumcision you will be able to stay anywhere.
> —Middle-aged (circumcised) Wolof woman, urban Gambia

> *Q: Are there some other benefits that you can tell me?* Yes, because wherever you meet people doing it, you can go there freely.
> —Elder Balanta woman, urban Gambia

> Speaker 1: Yes, wherever she goes, she will be able to stay there. You, the parent, also, you will have your peace of mind because you will know that [your daughter] whatever you ask her to do, that is what she will do. She will not spoil your hopes.
> —Middle-aged Jola woman, urban Gambia

For older women, the benefit of being circumcised is that they have power to make decisions or be a leader in their community:

> Another benefit is that if you are circumcised, you have high regard in the community. When it also comes to decision making, people listen to you.
> —Middle-aged Mandinka woman, rural Gambia

> In the Konyaginka tribe, if you are circumcised, you have all the rights of the community.

> If you are not circumcised and you stand for leadership, no one will listen to you. If you are not circumcised, you cannot make decisions for younger ones, unlike if you are circumcised. If you are not circumcised as a Muslim, you are not entitled to cook for people in the community in which you live. But, if you are circumcised, you are free.
> —Middle-aged (circumcised) Wolof woman, rural Gambia

> If you are circumcised, it would be easy for you to settle disputes in the community where you live. If you are not circumcised in my tribe, no one will be listening to you in terms of settling disputes between the compounds.
> —Middle-aged Konyaginka woman, rural Gambia

Social Convention Theory Extended

In the original formulation of social convention theory as applied to FGC, Mackie presented peer pressure as a potential independent source for maintaining FGC, secondary to marriagability (2000: 264). In a recent extension of this theory, Mackie and LeJeune (2009) examine recent advances in scholarship that specifically define different types of social norms, and differentiate norms from social conventions. They argue that although the initial application of the theory has been useful in practice, and often matches observations well, it has not paid enough attention to the role of social, legal, religious and moral norms in the continuation and abandonment of the practice. In the process of outlining a coordinated strategy for ending FGC, UNICEF has also emphasized the need to assess broader normative factors associated with FGC: "Although marriagability is the underlying explanatory factor for the universality and persistence of FGM/C within most practicing groups, in certain ethnic groups and cultures, FGM/C has become inextricably linked with other social practices and norms. Identifying these associations is necessary for effective programming" (UNICEF 2006: 30).

For social conventions, one family's choice is dependent on other families' choices; they are self-enforcing. As Biccieri (2005: 35) explains, "when a convention is in place, expectations of compliance are *mutual*. An actor expects others to follow the convention, and she also believes she is expected to follow it by the other participants in the conventional practice…. [F]ailure to coordinate and communicate comes with a personal cost." Social norms, by contrast, are social practices that are actively enforced by informal positive and/or negative sanctions, such as acceptance, esteem, and approval, or avoidance, ostracism, and disapproval. Unlike a convention, the decision to follow a social norm does not need to be coordinated, and it is the individual, and in some instances their family, who accrues the cost or benefit of sanctions. By this distinction, Mackie and LeJeune suggest that enforcement of FGC, like that we observed in the Senegambia, and that Hernlund described earlier elsewhere in The Gambia (Hernlund 2003), represents a social norm that is enforced both by positive and negative sanctions. Positive features include the fact that girls are trained to show respect, have cleanliness and self control, and are honored in some cases in a ritual celebration for having been initiated. Negative sanctions for not being cut include taunting by being called "solema," and being excluded from ceremonial events and decision making.

In addition to social conventions and social norms, Mackie and LeJeune (2009) distinguish three additional norms: moral, legal and religious norms[6]. Moral norms, like social norms, are widely accepted by individuals and generate social regularities. They do not, however, do so through external sanctions, but rather through internalized values of right and wrong which result in compliance even if it is not observed or enforced by others (McAdams 1997). Scholars have emphasized that while exogenous social sanctions can play a role in enforcing norms, much conformity appears to be

[6] Mackie and LeJeune draw upon the typologies developed by Bicchieri 2006, Elster 2007, Nichols 2004, McAdams 1997.

endogenously motivated by emotions, most notably shame (Boyd and Richerdson 1992, Fessler 2004). Legal norms, like social norms, impose external sections, in this case through formally stated laws and punishments for violation of the law (we examine the role of legal sanctions in greater detail in Chapter VI). And finally, religious norms are defined as, "those believed to be commanded by God, and are obeyed by believers out of love and fear of the deity" (Mackie and LeJeune 2009: 20).

Mackie and LeJeune (2009) argue that social customs may be maintained simultaneously by social conventions and social, moral, religious and legal norms. Specifically addressing the issue of FGC, they suggest that the practice may be held in place by a marriagability convention and other norms, and that even when a marriage convention no longer exists, as we found in our study, these norms may continue to hold the practice in place. Biccieri (2005: 38-39) notes that the neat boundaries between conventions and norms are often in reality blurred, and that social practices can shift between being conventions, conventions and norms, or norms only. Our results document dramatic active enforcement of FGC, consistent with a social peer norm as described by Mackie and LeJeune (2009). However, we suggest that considering the intergenerational nature of peer pressure, and the role of FGC in maintaining a female hierarchy of power, it appears that there exists a great deal of mutual interest among younger and older women in maintaining FGC. For elders, interest in organizing the circumcision of younger women extends beyond moral norms of good parenting. It is a key avenue for demarcating and building social networks, and maintaining intergenerational power structures. For younger women, the benefits of FGC, beyond the positive sanctions described above, also include gaining access to a network of social support and social capital. Consequently, this may be an instance where a social norm has shifted to a social peer convention.

We argue that this powerful intergenerational peer convention also rests upon religious and moral norms. A number of informants linked FGC and Islam, arguing that the practice provides the cleanliness and purification required for religious participation and prayer. Even stronger concensus centers on the moral imperative of having come to "know the eye" (as described at greater length in Chapter II). This term refers to having been indoctrinated into the social hierarchy along lines that include age and gender, and being able to show deference to those in a higher position in the social hierarchy. Fessler (2004) argues that in highly hierarchical societies, subordination is associated with a culturally-shaped emotion of shame. He describes shame as a rank-related aversive emotion that internally motivates conformity. This description resonates with our findings, as great emphasis is placed on displaying respect to elders. Uncircumcised women living among people who practice FGC experience not only negative sanctions through exclusion, but also experience the aversive emotion of shame. This powerful emotion helps explain why some women in our study reported having individually opted to become circumcised, in some cases long after marriage. Consequently, the intergenerational peer convention also plays an important role in generating a moral norm that motivates conformity with the practice of FGC.

Discussion

Both ethnographic and survey data suggest that FGC is associated with marriagability in many regions of Africa. In our study sites, however, we do not find strong support for a marriage convention. Instead, it appears that intergenerational peer convention better explains the perpetuation of circumcision in our study sites in Senegambia than does a marriage convention model. We propose that limited, variable resources render individuals reliant on extensive networks for support (e.g., in disputes, in child-rearing, for emergency resources, or for employment opportunities). To gain entry to a women's peer network, girls and younger women give elders their obedience, giving them more power in the community. This allows young women to expand their social capital, and, as they age, they benefit from younger women's deference or obedience, which gives them power in the community. To gain entry to a network, young women (and, potentially, young men) use circumcision to signal a willingness to

participate in the hierarchy of power. Just as Mackie (1996, 2000) describes for a marriage convention, this could then become a prerequisite for participation in any network among practicing groups, leaving uncircumcised individuals little option for accruing social capital. This intergenerational peer convention is supported, as well, by religious and moral norms. Where circumcision is near universal, or where it might be expected of a particular family, circumcising children (and training to display respect to circumcised elders) may be the best choice for parents or families to make, as a strategy for facilitating their entry to women's networks and maximizing their social capital. Our interview and focus group discussion data from the Senegambia reveal that approval of appropriate behavior is one major perceived benefit of circumcision ("knowing the eye" and being able to "stay anywhere"). We interpret this to mean circumcised women can behave appropriately, and offer their elders appropriate deference, and thus can fit in and find social support anywhere they find other circumcised women.

Additional support comes from our finding, discussed above, that the major deterrent to marriage between men from circumcising families and uncircumcised women, and the major perceived problem with such marriages when they occur, is not men's refusal or distrust of uncircumcised women, but the hostility and discrimination an uncircumcised woman faces among circumcised women. It is likely that both circumcised and uncircumcised women prefer to marry into families, compounds, and communities in which they can form connections and accumulate the most social capital; for circumcised women, this means marrying into circumcising families, and for uncircumcised women, this means marrying into non-circumcising families. This may explain the pattern of assortative mating we observed among survey respondents.

Interpreting female circumcision as a peer convention, rather than as a marriage convention or a social norm, suggests some specific recommendations for intervention. As Mackie and LeJeune (2009: 27) note, "the process for abandoning a social norm is identical for abandoning a social convention": a large enough proportion of the relevant community must resolve to shift from a social norm and associated sanctions for performing FGC to a norm and associated sanctions for not performing FGC. The practice will be readily abandoned when a critical mass of families in a community pledge to abandon the practice and follow through on this commitment. Our interpretation of FGC in Senegambia as maintained though an intergenerational peer convention has implications for the design of interventions, in particular, for who might best be targeted for inclusion in an initial critical mass for abandonment. While the marriagability convention suggests targeting intermarrying groups, an intergenerational peer convention points to the need to direct efforts across generations, and to aim to include as comprehensively as possible members of a women's social network, and their families. In reality, this is probably already achieved though efforts to include intermarrying groups. Indeed, Mackie and LeJeune note that, "Since FGM/C is maintained as a mariagability convention, a social norm, or both, the process for reversing a social norm can be identical to reversing a social convention" (Mackie and LeJeune 2009: 30). However, because a marriagability convention and/or a range of social norms may coexist, and the specific constellation may differ across settings, it is essential that program designs reflect the local and potentially shifting contexts in which FGC is practiced.

VI. Legislating Change?: Community Responses to the Law Banning FGC in Senegal

Summary

Since the early 1990's the practice of female genital cutting (FGC) has become framed as a human rights violation, leading the international community to favor legal instruments as important tools in campaigns to end the practice. To date nineteen African nations have passed legislation that specifically bans FGC, and other nations are under pressure to do so as well, despite the fact that there exist divergent views on the potential effects of legislative action. Supporters argue that legal prohibition of FGC has a general deterrent effect, while other argue legislation, as a top-down approach, can be perceived as coercive, and derail local efforts to end the practice. In this paper we examine the range of responses that have been observed as legal measures are introduced and potentially enforced in Africa. In particular we present research findings from Senegal, where FGC was outlawed in 1999, and analyze response in relation to two leading theories on social regulation, the law and economics paradigm and the law and society paradigm. We find that in our study communities, mass enforcement of the law is not required to provide a deterrent effect on FGC. However, while fear of prosecution has, in some instances, reportedly led people to abandon FGC, it has generated multiple responses. For those who defy the ban on FGC, the practice has often been driven underground. Reactance in our study communities has not resulted in visible public protests, but rather simmered just below the surface, and boiled over easily when the topic was raised. It is important to note as well that there exist some individuals who expressed serious reservations about the prospect of circumcising their daughter, and welcomed the arrival of both the law and a local anti-circumcision intervention program. Surprisingly, these multiple responses were found to co-exist not just within a single region or village, but even within an extended family. We argue that the legislative approach to abandonment of FGC is most effective when complemented by an integrated community intervention approach. We find that legislation can create what UNICEF describes as an "enabling environment," providing support for those who have or wish to abandon FGC. And as is the case with other strategies aimed at eliminating FGC, it must be recognized that no single approach is likely to be broadly applicable across diverse African contexts.

Introduction

At the United Nations Fourth World Conference on Women held in Beijing in 1995, then U.S. First Lady Hilary Rodham Clinton declared in a keynote address that "it is a violation of human rights when girls are brutalized by the painful and degrading practice of female genital mutilation" (*San Francisco Examiner*, September 11, 1995). Mrs. Clinton repeated her stance before several international bodies,[7] and in April 1998 she traveled to Senegal to praise men and women who "come together to stand against and speak out against a key ancient custom" (quoted in Hecht 1999a). Ten months later, in the wake of active debate among Senegal's parliamentarians, legal scholars, religious leaders, as well as some local anti-FGM activists and program leaders, parliament enacted legislation that makes it a crime to carry out "female genital mutilation" or to encourage anybody else to do so. [8] International media drew attention to the fact that this law was passed just one month before the release of the American State Department's Annual Report on Human Rights (*Economist* 1999; Hecht 1999a), arguing that this report is used as a guide for Congress and U.S. agencies as to how to allocate foreign financial assistance. The passage of the Senegalese anti-FGM law was, thus, portrayed as an imposition of Western values on an African nation, overlooking the long history of debate on FGC among Senegalese

[7] See for example, the text of her 1998 speech at the World Health Assembly, May 14, 1998, www.usembassy-israael.org.il/publish/press/whouse/archive/1998/may/wh6515htm

[8] Article 299A of Senegal's penal code, punishable by a prison term of six months to five years.

intellectuals and the leadership of Senegalese in the international human rights movement.[9] An article in the *Economist*, for instance, argued that Senegal's government, which receives substantial aid from the U.S., implemented the law "only to please American sensitivities" (*Economist* 1999). American organizations were not, however, the only foreign actors implicated. Media reports also disclosed that UNICEF reportedly financed a study that created the original draft of the law (without noting that this is a widespread and common practice), and that copies were vetted not only by representatives of USAID, but also of French and U.N. development organizations in Dakar before being passed by the Senegalese parliament (Hecht 1999a).

Although media reports failed to highlight the internal debates in Senegalese society, they captured the centerpiece of these debates by posing the question, "Is it a crime or is it culture?" (*Economist* 1999). The enactment of the law did, in fact, create a formal legal system for regulating the practice of FGC that was at odds with the local culture and social sanctions systems in a minority of Senegalese communities with a long-standing history of practicing female circumcision.

In the background of these events lies an unanswered question: Is legislation an effective tool for ending the practice of FGC? Divergent views have been forwarded. On one hand, some commentators and activists believe that legal prohibition will accelerate abolition of the practice, while others argue that such a top-down approach can be perceived as coercive and may derail local efforts to end the practice. Rahman and Toubia, however, suggest that the debate over whether legislation should be used as a tool to combat FGC is moot, arguing that "the fact that many Africans and Western cultures have recently enacted laws prohibiting the practice creates a *de facto* role for legislation, the effects of which should be closely observed and documented in the coming years" (2000: xiv). In 1994 Ghana was the first African nation to pass legislation specifically banning FGC. Currently[10], nineteen other African nations have followed suit (Senegal, as well as Benin, Burkina Faso, the Central African Republic, Chad, Côte d'Ivoire, Djibouti, Egypt, Eritrea, Ethiopia, Ghana, Guinea, Kenya, Mauritania, Niger, some Nigerian states, South Africa, Tanzania, Togo, and most recently Uganda). The varied effects of enacting specific anti-FGM legislation in the African context are, however, poorly understood.

In this chapter we examine range of responses that have been observed as legal measures are introduced and potentially enforced in Africa. In particular, we analyze responses to the Senegalese law, and illustrate the complexity of interrelated responses. This research serves an important case study examining how anti-circumcision legislation, when superimposed on communities in which the practice is already being contested and targeted for elimination, potentially alters an ongoing process of change in both expected and unanticipated ways. More broadly, this case study sheds light on broader theoretical debates on the nature of social regulation and the influence of formal legal mechanisms, focusing on two competing paradigms: law and economics and law and society. With differing perspectives on the influence of local norms and sanctions and national rules of law, each theoretical position suggests divergent perspectives on local responses to anti-FGM legislation. We test these predictions using in depth ethnographic data from Senegal, as well as findings from an ethnographically grounded survey. In this context, we can examine a number of key questions: How widespread is knowledge of the law banning FGC? What effect, if any, do test cases have on perceptions of enforceability? Does legislation have an effect on responses to anti-circumcision efforts? How does legislation interact with ongoing processes of change in the practice of FGC? Answers to such questions provide us with both practical insights on the utility of law as a tool to reduce or eliminate the practice

[9] Since the early 1990's, Senegalese leaders have held prominent positions in international human rights work, including the Chair of the United Nations Commission on Human Rights (Kéba Mbaye), President of the Geneva-based Commission of Jurists (Adama Dieng), Head of the United Nations Center for Human Rights (Ibrahim Fall), and head of Amnesty International (Pierre Sané) (Welche Jr. 1995).

[10] Current as of February 2010.

of FGC, and theoretical insights regarding the relationship between culturally mediated norms and sanctions and formal law.

Legal Theories on Social Regulation

Legal theories of social control are often described as falling predominantly into one of two schools of thought, law and economics and law and society, each of which examines, to some extent, the interplay between informal local social control and the formal legal system regulating human behavior. Although most scholars recognize that both law and norms[11] shape and constrain people's perception of acceptable or even preferable courses of action, extreme positions within each paradigm differ with respect to the primacy given to each.

The law and economics movement rests on the assumption that social control is achieved primarily by the state through the legal system, and that governments are the chief source of rules and enforcement mechanisms. The law and economics perspective underlies what is known as deterrence theory. According to the deterrence theory of justice, the specification of punishment serves to prevent behavior that has been classified as criminal or deviant (Levinson 2002). General deterrence focuses on creating a social climate that reduces the likelihood of intentional transgression by creating a fear of detection and punitive consequences. This is often accomplished by making the punishment of individuals public in order to create the perception that apprehension and punishment will be "swift, severe and certain" (Siegel 1992).

The concept of deterrence focuses on an analysis of individual personal choice of actions, drawing on the concept of rational choice theory (Levinson 2002). The central point of this concept is that individuals, in pursuit of their goals, will rationally calculate the costs and benefits of behavioral outcomes, including criminal or deviant behaviors. Given the opportunity to commit a criminal act, the person presumably weighs the costs and rewards of doing so in comparison to other behavioral options, and chooses the option with the greatest gains. Choices can, however, be constrained by conveying the understanding that there exists a punishment that elevates the cost of the criminalized behavior. One question that has been raised is: Does a general theory of deterrence work as intended? This has been investigated with numerous deviant behaviors, and answers seem to vary as one analyzes, for instance, the effect of fines on reducing speeding, versus the effect of capital punishment on refraining from murder.

Several scholars note that while there are numerous examples of deterrence-based strategies, there also exist instances in which compliance or non-compliance is not easily explained using a law and economics rationale. Tyler (1990), for example, claims that there are instances in which people have been found to break the law in cases involving substantial risk, as well as to obey the law when the risk of punishment is quite small. Tyler (1990) illustrates the latter case with the example of paying income tax, noting that even though the probability of being punished for tax evasion is low, the majority of people comply with reporting income. Conversely, substantial risk of penalty has also been found to have limited power to deter behavior under certain circumstances, such as when laws are poorly understood, difficult to follow, or antithetical to the norms of a social group. To illustrate the latter,

[11] The writings of legal scholars focused on the issue of social regulation of human behavior center largely around the concept of norms. Ellickson, for instance, defines social control as rules of normatively appropriate human behavior enforced through sanctions (1991). He points out that the word "norm" is often used in two ways: descriptive, defining behavior that is normal; and proscriptive, designating behavior that people should mimic to avoid punishment. Recent scholarly advances have defined more nuanced taxonomies of norms (see, for example, Biccieri, 2005). Here we focus on differentiating social norms or conventions held in place by informal sanctions for legal norms enforced through formal sanctions.

Ellickson (1991) offers the example of academic photocopying and copywrite law. Current federal law places severe restrictions on an instructor's photoduplication of copyrighted material for inclusion in class readings. Ellickson reports that there is abundant evidence university professors engage in rampant unconsented photocopying when preparing class materials. And this is done despite the daunting legal backdrop: infringement of the Copyright Act authorizes a judge to award a copyright owner a civil penalty of up to $100,000 plus legal fees (Ellickson 1991: 259), and there have been a small number of high profile cases that have publicized this penalty. Ellickson argues that "professor's substantive norms seem to permit unconsented copying for class use, year after year, of articles and minor portions of books. Professors apparently allow this informal rule to trump copyright law" (Ellickson 1991: 260).

Many law and society scholars contend that formal law has often been overrated as an instrument of social change, and point to a growing body of evidence that suggests that segments of social life are located and shaped beyond the reach of the law. It is argued that beyond the threat of sanctions, other important factors influence compliance, including opinions of peers, personal morality, and perceptions of legitimacy of the law and legal authorities (Tyler, 1990).

Beyond these two polar extremes there exist a range of intermediate positions which reflect the fact that the power of law to shape society depends not only upon punishment alone, but upon becoming embedded within the social customs that shape everyday practices and decisions. In the last chapter we described in detail the role of intergenerational peer networks as a means of accruing social capital, and the role of FGC in signaling inclusion within networks and access to resources and social support. It is in the context of this powerful peer convention that the law banning FGC was implemented. How do legal norms, bearing formal sanctions, weigh against social norms or conventions with strong informal sanctions? We explore this by testing predictions derived from the law and economics and law and society perspectives with respect to several key questions:

- Is there widespread knowledge of the existence of a law banning FGC in Senegal?
- For those with knowledge of the legal provision, does this alter or influence their behavior, or do local norms regarding FGC override legal restrictions?
- Is the law viewed as enforceable?
- What are the indirect or unintended consequences of enacting anti-FGM legislation?

Is there widespread knowledge of the law banning FGC in Senegal?

The law and economics paradigm rests on the assumption that people are aware of the law, and that this knowledge factors into their calculation of risks and benefits of a particular course of action. The law must, therefore, be effectively communicated and relevant to local actors (Ellickson 1991). Alternatively, the law and society perspective holds that often people are often unaware or only vaguely familiar with the content of legal provisions. Instead, the role of local norms is paramount, evidenced in the force of weight given to local sanctions such as ostracism. Ellickson, for instance, contents that "ordinary people have little knowledge of…law applicable to decisions in everyday life" (1991:144). In his study of closed range ordinances regarding cattle ranching in California, Ellickson (1991) demonstrated that people often settle disputes in total ignorance of their legal rights, and that scant knowledge of the content of legal measures makes it improbable that fear of noncompliance meaningfully regulates behavior. In assessing responses to the law banning FGC in Senegal in our study communities, one crucial question, then, is what is the awareness level regarding the anti-FGM law?

In depth interviews revealed that knowledge of the existence of a law banning FGC is widespread. Many informants reported hearing radio broadcasts informing the general public about the anti-circumcision law, and others learned of the ban in *bantabas* (outdoor public meetings) organized by the elders, or through word of mouth. Very few people, however, knew details about the content of the legal provision, including potential targets of prosecution, the penalty for violation, or whether the statute contains an extra-territoriality clause banning FGC outside of Senegal's national borders. One

respondent, however, contended that the details regarding extra-territoriality are unimportant since it would be difficult to prove that a Senegalese girl was not circumcised in her home community: "A girl is taken for circumcision in The Gambia… this can happen. But how can someone here know [what has happened]? The law has been passed, and we cannot escape it."

For those with knowledge of the legal provision, does this alter or influence their behavior, or do local norms regarding FGC override legal restrictions?

Does scant knowledge of the specific details of the anti-FGM law erode its effect in promoting abandonment FGC? According to Ellickson, even when there is a greater or lesser degree of knowledge of legal regulations, substantive norms may supplement, or even preempt, formal law. Eric Posner (2000: 4), as well, maintains that "the law is always imposed against a background stream of nonlegal regulations – enforced by gossip, disapproval, ostracism and violence." Citing examples such as fair business practices and traffic regulations, Ellickson (1991) illustrates that rules enforced at local levels often differ from formal law, but adhere to widely shared understandings of appropriate behavior and practices. This perspective, more widely represented in the law and society movement, holds that both law and social norms influence behavior, but often substantive norms supplement, and even preempt, formal laws.

Tyler also notes that people are reluctant to commit acts – either legal or illegal – for which family and friends would sanction them (1990: 24). Indeed, legal scholars are increasingly recognizing the influence of peer pressure related to law breaking. Peoples' judgments about the rewards and sanctions their behaviors elicit from members of their social group strongly influence decisions on courses of action.

In the previous chapter we outlined the broader social factors that contribute to the continuation of the practice of FGC. Beyond internalized moral norms regarding proper parenting, we suggest that the practice is held in place through a powerful intergenerational peer network. We propose that limited and variable resources render individuals reliant on extensive social networks for support. To gain entry into a women's peer network, girls and younger women communicate their obedience through FGC, and uphold a female hierarchy of power. Positive sanctions include approval for having received training and displaying respect, having cleanliness and self-control, and gaining access to women's social networks. Negative sanctions for failing to be circumcised include shaming, such as being called solema, being excluded from certain ceremonial events and decision making, and lacking access to the social network of circumcised women. This supports the view of Tyler, who contends that the influence of the social groups can be instrumental since "social groups punish and reward their members by withholding or conferring signs of status and respect or by changing material resources toward or away from particular members" (1990: 23). The law and society paradigm, therefore, predicts that other important factors influence compliance with law, including social relations (opinions of friends, family and peers) and normative values. We find support for the prediction that rewards and sanctions from the social group should exert considerable influence on individual actions regarding FGC, above and often beyond externally imposed rewards or punishments.

According to the law and economics rationale, people ought to look to the law to determine the appropriate course of action. Ellickson (1991: 52) posits that people would "regard those substantive rules as beyond their social influence (as "exogenous," to use economists' adjective)." We find in our ethnographic data support for this claim as well.

A number of respondents in our study communities in Senegal report abandoning FGC following media broadcasts informing the general public about the anti-circumcision law, though responses to these announcements were mixed. Many individuals reported being sad about being forced to leave a valued cultural practice, and viewed themselves as powerless against the force of the law:

> In my opinion, I feel sad about the law because it is more powerful than us and we can not disagree with the law. The law forced us to stop it, but it should not be stopped because it is our tradition that we found our grandmothers practicing.
> —Young Mandinka woman

> I personally did not feel happy about the law banning female circumcision because it is our tradition that makes a girl to have respect, to have a polite way of talking to the elders. But they make us stop practicing it and that is not our interest. That is not how we want it to be. You know the law is more powerful than us and whatever it says is what we should do.
> —Serer Male Elder

Researchers have noted that the prospect of punishment is not the only factor that bears on a decision to commit a crime. Siegel (1992:131) suggests that "law-violating behavior should be viewed as an event that occurs when an offender decides to risk violating the law after considering his or her own personal situation (need for money, personal values, learning experiences) and situational factors (how…efficient the local police happen to be)." Specifically with respect to FGC, Obiora contends that "prohibition may prove impotent to deter persons who consider the practice fundamental to their culture and who are fervently committed to it." (1997: 354-355). She adds that "the penalty of a fine is equally problematic. The practitioners' allegiance to the custom may far outweigh the pecuniary loss" (Obiora 1997: 353). One female Mandinka elder responded to the threat of legal sanctions defiantly:

> Q: What is your opinion about the law banning FGM?
> A: I'm not saying that I'm not against it, but when I take my granddaughter if they want to jail me I'm not going to run. Then I will know that I was jailed for practicing what parents and grandparents used to practice.

Some scholars argue that the deterrent effect of legislation must be analyzed in the context of the social environment upon which is it superimposed. Obiora (1997: 358), for instance, argues that "law alone seldom changes behavior…. It is instead a mechanism that is integral to, and contingent on, a broader societal scheme. Against this backdrop, it is reasonable to infer that law can wield considerable influence over actions and attitudes where it is accepted as a legitimate authority." In one Senegalese community some informants suggested that while the law generated fear of prosecution, it did not on its own motivate all community members to end FGC. Instead, FGC continued, but caused practitioners deep anxiety about the prospect of potential punitive action by the government. When the Tostan intervention was introduced in the village, however, their anti-FGM program was welcomed as a means of ending the ongoing fear of punishment. As one Serer woman commented: "The campaign was after the law. But after the law people were doing it. The campaign made the law stronger and many people have agreed that they have stopped." As predicted by law and economics, the fear of prosecution did contribute to a perception of increased "costs" of FGC, and for some, contributed to a preference to end the practice. However, as we showed in Chapter V, because the practice is maintained by a powerful intergenerational peer convention that influences social acceptance and access to social capital, abandonment needed to be coordinated, in this case by Tostan. This lends support to the assertion of Rahman and Toubia (2000:13) that "law can be a useful tool for change, giving NGOs and individuals greater leverage in persuading communities to abandon the practice."

At the same time, we found that those who abandon the practice in response to the law, intervention, or other factors sometimes express concern over the social repercussions of not having

circumcised their daughters, and often experience deep ambivalence about their decision. One Senegalese informant, for instance, reported sleeplessness from worrying about the fate of her two daughters who have fallen in the "law trap." She explained: "the law was passed seven years ago and my daughters were seven and five years old at the time. Now the eldest is fourteen years old. If I look at them I get scared."

Is the law viewed as enforceable?

It has been argued that in certain contexts, the passage of legislation is not intended to be enforced, but is instead symbolic in nature (Boyle and Preves 2000). According to Hecht (1999a) some Senegalese government representatives claimed that the law was "mostly for Western consumption." Senegalese President Abdou Diof was quoted as saying that the law would be applied "intelligently," a statement that, according to Hecht, was "widely understood to mean that it won't be applied at all" (Hecht 1999b). Senegalese parliamentarian Momar Lo, who introduced the bill in the parliament, was quoted shortly after the passage of the law claiming that "no one is really going to go to jail…. The government will ensure the courts don't apply the law" (Hecht 1999a). There were no provisions in place, however, to ensure the purely symbolic nature of the law. Since being enacted in 1999, the Senegalese law has, in fact, led to the prosecution of several cases (U.S. Department of State 2005).

Mackie argues that "criminal laws work because thieves and murderers are a minority of the population" (Mackie 2000: 278). By contrast, he views laws against FGC, which is often near-universal within circumcising groups, as unenforceable: "It is not possible to criminalize the entirety of a population or the entirety of a discrete and insular minority of the population without methods of mass terror" (Mackie 2000: 278). If Senegal's penal code were fully applied, it is estimated that more than a million people would go to jail (Hecht 1999b). Rather than striving for large-scale enforcement, deterrence theory rests on a *psychological process* in a rational choice model whereby individuals are dissuaded from committing a crime if they perceive legal sanctions as certain, swift, and/or severe (Williams and Hawkins 1986). Obiora (1997:354) asserts that by highly publicizing a few cases of prosecution, "some percentage of the populace may be disinclined to participate in a practice such as circumcision." Williams and Hawkins, however, draw a distinction between *perceived* legal sanctions and *objective* legal sanctions (the actual likelihood of arrest). Importantly, they note that objective measures of legal sanctions do not in all instances equate with perceived legal sanctions (Williams and Hawkins 1986). This appears to be true in our study communities in Senegal, since most informants, when asked, were unaware of any cases of enforcement in their own community, or elsewhere in Senegal.[12] One informant, did, however, recount a case of enforcement abroad:

> If I could remember, last year I heard over the radio that a Jola woman had circumcised her daughter in France. And after circumcising her, some people reported her and the law has taken place and she should be jailed. If we also stick to our law it will stop finally.
> —Serer Male Elder

Despite the fact that most informants could not recite a single specific case of enforcement of Senegal's anti-circumcision law, most strongly viewed the law as potentially enforceable. Mere rumors or imaginings of enforceability engender fear of prosecution. This finding was supported by the survey questionnaire data, as well. In response to the question, "I believe the law banning female circumcision

[12] This may have changed in the time since our data collection was completed. In May 2009 a court in Matem sentenced two women to six months in jail. The sentence was given to a traditional circumciser and a 16 month old girl's grandmother, while the parents were given suspended sentences since they did not organize the circumcision. This story was covered widely by the media (AFP, 2009).

can be easily enforced in this community," 79% of respondents agreed, while only 6% disagreed. Additionally, 80% of respondents agreed with the following statement: "Someone who openly breaks the law needs to worry about being punished." The question raised is whether people seek punishment through the formal legal process, or by invoking local sanction systems. The law and economics approach suggests that when disputes arise, formal legal rules and processes are invoked to seek resolution, whereas the law and society paradigm suggests that local rules trump formal legal systems.

In some communities targeted by Tostan, enforcement committees, instituted to assure that people comply with the pledge to end FGC, threatened the use of legal sanctions, but invoked the informal dispute resolution system involving the village leader and council of elders. One former member of an enforcement committee explained:

> Q: How did people feel when they first heard about the law banning female circumcision?
> A: The reaction was bad. Elderly people said that the government was trying to get rid of our culture. And then we agreed to go secretly. But Tostan taught us how to identify people who do it in secret. That is why nobody does it in secret. If they do, it would be reported to me…. Once the committee identified someone who circumcised their daughter across the border. And we went to the Alkalo (village leader), and in front of the whole village we said, "We will fine you, and you pay, or we will report you to the authority." This family paid the fine. They were used as an example, and now people are afraid to take girls across the border.
> Q: It is my understanding that it is not illegal to take girls to circumcision in The Gambia. Would the authorities still get involved?
> A: Yes, they could. We have agreed [to stop circumcision] and where the girl was taken is not something we can know.
> -Mandinka Female Elder

What are the indirect or unintended consequences of enacting anti-FGM legislation?

Reactance : Reviews of strategies for eliminating FGC (e.g. Mackie 2000; Shell-Duncan and Hernlund 2000; Toubia and Sharief 2003) have often concluded that legislation is a poor tool for evoking behavior change. This view is supported by several well-known examples of responses to laws enacted under colonial rule that provide evidence that legislation can be ineffective or counterproductive, failing to act as a deterrent, and instead sparking reactance. For example, Lynn Thomas's compelling account of responses to the 1956 ban on excision in Meru, Kenya, reveals that girls defied the ban by circumcising one another (Thomas 1997; 2000). Other reports document public protests and backlash reactions so strong that they actually resulted in an increase in the practice, at least temporarily. Janice Boddy's account of Sudan on the eve of legislation being enacted banning infibulation reveals that scores of parents rushed to have their daughters infibulated (Boddy 1991:16). Gunning has suggested that the failure of early legislative efforts "lies partly in their colonial origins. Such a history has led African people to view outside interests in the surgeries as just another form of imperialism" (Gunning 1991-92:228). She further predicted that "the problem is likely to plague even attempts at legislation in a contemporary climate filled with far more African feminists and indigenous activists" (ibid).

Not surprisingly, some Senegalese people viewed the law banning FGC as a form of cultural imperialism. One Mandinka woman remarked, "If they [the people who passed the law] did not leave their tradition, we will not leave ours. They want us to be like them." According to Hecht (1999a), most practitioners of FGC were not consulted in drafting the Senegalese law, and most were not at all aware that the government planned to formally criminalize the practice. Senegalese parliamentarian Jean Paul Diaz, who opposed passage of the law, argued that "the law has not only undermined local efforts to

stop female circumcision, it has undermined our democratic process," noting the irony of individual's rights being dictated by outsiders rather than presented to the public for debate (Hecht 1999a).

Initial responses to the law provide reason to question the effectiveness of legislative approaches to curbing FGC. Backlash from the law resulted in Tostan having to temporarily suspend activities in ten villages that were about to participate in public declarations to end the practice of FGC. Hecht (1999a) reported that "since the passing of the new law, some villagers say they may no longer be able to abide by the declaration, because it is the 'spark' that has turned relatives and friends in neighboring villages into criminals." Molly Melching, director of Tostan, was quoted immediately after the passage of the law as saying that "when you have something imposed on you, all of a sudden you have more resistance to listening to the dangers and the reasons why you would want to stop" (Hecht 1999a). Religious leaders in Senegal also initially spoke out against the practice, and one "rebellious village" reportedly circumcised 120 girls en masse (Hecht 1999b). This reactance, however, was temporary, and never reached the scale that occurred elsewhere in Africa during colonial rule.

In some of our study communities, reactance simmered below the surface, and it took little to incite fervent vocal opposition to the law. In particular, in one conservative community that has not been targeted by Tostan, people were at first very reluctant to participate in our research because they suspected that we were interested in challenging the practice of FGC. Following one tense focus group discussion, participants stood and chanted phases such as, "We will not let our culture be destroyed!" This serves to confirm Boyle and Preve's (2000: 705) assertion that "although nation-states are immersed in an international culture, the appropriateness of national action is often contested at some level." Yet the fact that recent laws in African nations have been enacted without inciting the level of backlash seen during colonial rule is testament to the care with which compromise solutions have been crafted.

Traveling Circumcisers: Williams and Hawkins (1986) distinguish between the direct (i.e. fear) and indirect (e.g. stigma of arrest) consequences of legal sanctions that promote deterrence. With respect to FGC it is important, as well, to examine direct and indirect consequences of criminalizing the practice. The Senegalese law, for instance, is aimed at deterring not only parents of young girls, but also circumcisers. Interviews with some former circumcisers revealed that they had stopped practicing following the passage of the law. Additionally, while the skills of circumcisers were previously passed down from one generation to the next, most claimed that they did not train an apprentice before "putting down the knife." As Obiora (1997) argues, deterrence aimed at circumcisers may have unintended effects because it does not reduce the demand for circumcision (see also Gosselin 2000; Mackie 2000). She notes that "without an acceptable alternative, the prospects of inexperienced parents and women when taking it upon themselves to perform circumcision are not inconsequential" (Obiora 1997: 355). Informants in our study communities sometimes noted that in the absence of trusted and experienced local circumcisers, the demand has been met by "traveling circumcisers," who reportedly circulate throughout communities in The Gambia, Guinea Bissau, and elsewhere. Many informants were suspicious of the training and qualifications of these circumcisers, and suspected that they are motivated by economic gain:

> Q: What is your opinion about the law banning FGM?
> A: My opinion towards it is that when I heard of law banning FGM, I felt happy about it because in the past, our ancestors did it accordingly and correctly, but now everybody wants to be a circumciser because of money and will not be qualified.
> —Elderly Serer woman

> Q: What is your opinion about the law banning FGM?

A: I like the law against female circumcision because it is the only way it can be controlled. In the past, it was not a problem because circumcisers with qualifications did it correctly, but now it is done just for the sake of doing it without the skill.
—Middle-aged Serer woman

One indirect effect, then, of deterrence of circumcisers is that those favoring continuation of the practice must weight the risks of employing a traveling circumciser with questionable skills. Not uncommonly, people report this as a reason to favor legal bans on FGC.

Beyond the Shadow of the Law

Several scholars note that while there are numerous examples of deterrence-based strategies, there also exist instances in which compliance or non-compliance is not easily explained using a law and economics rationale. Law and society scholars point to a growing body of evidence that suggests that segments of social life are located and shaped beyond the shadow of the law (e.g. Tyler, 1990).

Extensive reviews have documented difficulties in establishing clear and unambiguous evidence of the deterrent effect of legal sanctions (e.g. Williams and Hawkins 1986). With respect to anti-circumcision laws, this will almost certainly be true as well, due partly to the fact that the climate of intolerance and threat of legal sanctions serves, in some instances, to drive the practice underground, making detection and monitoring difficult. As Gunning notes, "if people support the practice, then the law will not actually prevent the surgeries from being performed: people will just hide the fact that they are doing it" (Gunning 1991-92: 229). Consequently, in a fashion parallel to the case of abortion, health risks of underground procedures may be exacerbated by worsening sanitary conditions, questionable qualifications of circumcisers, reduced preventive medical support, and barriers to seeking professional emergency medical care. Although a WHO survey of eighty-eight agencies with anti-FGM programs found that two-thirds of respondents felt that national anti-circumcision legislation would have a positive impact on their programs, most respondents also expressed concern that a law would drive the practice underground (WHO 1999).

Obiora (1997: 357) notes that, "even with the most conducive legal culture and structure, the prohibition of female circumcision presents peculiar monitoring problems because it deals with intimate part of the body whose scrutiny is further frustrated by cultural reticence." In European settings, controversy has arisen around enforcement mechanisms, and in particular proposals to conduct physical exams on immigrant girls to detect any genital cutting. Mason (2001) reports that some states in Australia, courts allow for periodic genital examinations to ensure that FGC has not taken place . Essén and Johnsdotter (2004) report that genital screening of all children starting school is taking place in some cities in Denmark, and Elise Johansen relates that such screenings are being performed in France and are contemplated in Norway (personal communication). We are unaware, however, of any proposals for physical examinations in the African context (Hernlund and Shell-Duncan, 2007).

Senegalese parliamentarian Diaz predicted that following implementation of the law, "there would be backroom circumcisions in unhygienic conditions" (quoted in Hecht 1999a). For ethical reasons we did not in our study ask people if, following the ban, they had continued the practice of FGC, either openly or in a clandestine fashion. Nonetheless informants often offered general comments.

Q: What changes have you seen in the practice over the years?
A: People are not practicing it as how it was in the past. Even if they are doing it, then it is done secretly but not openly done. And that is a change I have noticed in our community here.
—Middle-aged Serer woman

Secrecy, some informants explained, was achieved partially by eliminating the public celebration that had formerly accompanied the practice. Additionally, it was considered more difficult to detect that FGC has occurred when being performed on infants, as opposed to older girls. The recovery of young infants, who are swaddled in their mother's arms, is less apparent than that of older children. Additionally, as one informant explained, older girls may be less likely to keep the practice secret:

> It (FGC) happens – in secret. Some went to Gambia, but we had a way to identify who is or who is not circumcised. Even if the mother or the grandmother is quiet, girls talk. They tell their friends, and we find out.
> —Middle-aged Mandinka woman

Consequently, some of the unintended effects of passing legislation have been, in some instances, to drive the practice underground, as well as to contribute to diminishing the training and celebration and further reducing the age at which FGC is performed.

Discussion

We have analyzed our findings on responses to the law in relation to two leading theories on social regulation, the laws and economics paradigm and the law and society paradigm. The law and economics paradigm adopts a rational choice perspective, presuming that given the opportunity to commit a criminal act, the person weighs the costs and rewards of doing so in comparison to other courses of action, and chooses the option with the greatest gains. The prospect of criminal sanctions raises the cost of performing FGC. By contrast, the law and society perspective suggest that local social norms, enforced through informal sanctions, trump legal norms in influencing decision making. Our research indicates that within our study communities in Senegambia, FGC is perpetuated by a powerful intergenerational peer convention. Consequently, there is strong pressure to conform to local social norms, as predicted by the law and society perspective. In our survey, 70% of respondents agreed with two key statements: "Nobody in my family wants to be the first to stop female circumcision," and "If we did not circumcise our girls, then we would be pressured by friends and family." This suggests that the deterrence effect of imposing criminal sanctions is weighed against the punitive effect of defying local norms, and consequently a range of local responses are found.

Key findings of our research include the fact that mass enforcement of a law is not required to provide a deterrent effect on FGC. However, fear of prosecution, while contributing to motivation to abandon FGC for some individuals, results in multiple responses. While some people view the ban as a reason to reluctantly abandon FGC, others may defy the ban and continue the practice in a clandestine fashion. Reactance in our study communities has not sparked visible public protests, although in some communities deep resentment of the "criminalization of culture" simmers just below the surface and boils over readily when the topic is raised. It is important to note, as well, that there exist some individuals, not only in elite urban echelons of Senegalese society, but in a relatively poor, rural context as well, who expressed having serious reservations about the prospects of circumcising their daughters and who welcomed the passage of the law or intervention. Surprisingly, these multiple responses can co-exist not just within a single region or village, but even within an extended family.

Lewis and Gunning (1998: 133) predicted that "top-down eradication campaigns will only result in backlash if they are conducted in isolation from the promotion of related rights to gender equality, health care, education, economic access and political participation." While reactance to announcements of the passage of the Senegalese anti-circumcision law did initially impede the progress made by Tostan, this setback was temporary. Some residents in villages that had participated in public declarations to stop FGC reportedly questioned their ability to abide by the collective agreement, and plans to conduct

further declarations were delayed (Hecht 1999a). Eventually, however, Tostan was able to successfully resume their basic education program, including the portions focused on FGC. In some communities in our study, the law reportedly served to force the practice underground, and some respondents expressed deep anxiety and fear of being caught by the authorities. Consequently, for these individuals, the Tostan intervention was positively viewed as a means of promoting compliance with the anti-circumcision law, and other Tostan programs, such as literacy, preventive healthcare and sanitation, were welcomed as well. Our findings support the view expressed by UNICEF (2005: 29), who describe the role of legislation in terms of "creating an enabling environment"; they emphasize that, beyond serving as a deterrent, legal bans provide a support mechanism for those who have or wish to abandon FGC. Consequently, as Lewis and Gunning (1998) anticipated, a legislative approach can work in a complementary fashion with an integrated community intervention approach when addressing FGC.

At the same time it is prudent to heed Obiora's warning against a "naively idealized confidence in the law" (Obiora 1997: 352). We suggest that proponents of criminal prohibition of FGC often overlook the complexities of the realities of enforcement and, along with Isabelle Gunning (1991-92), we express concern over the hardships borne to both girls and their families as they are cast into the roles of "victim" and "criminal," "complainant" and "defendant." Moreover, it is important to recognize that legislative measures are prohibiting a behavior that is not universally recognized as "deviant," forcing some individuals to choose between complying with the dictates of law or culture. As Obiora (1997: 358) notes, "legislation has had some success in reducing or eradicating some cultural practices such as foot-binding and *sati* that, analogous to female circumcision, defied simplistic analysis. The outcome has been born of a series of complex and interactive processes and events, as opposed to being solely determined by prohibitive superimposition." By the same token, responses to legislation against FGC must be understood within the social, cultural, political, and historical context onto which legal measures are superimposed. And as is the case with other strategies aimed at eliminating FGC, it must be recognized that no single approach is likely to be broadly applicable across diverse African cultural contexts.

VII. Contingency, Context, and Change: Negotiating Female Genital Cutting in The Gambia and Senegal[13]

Summary

Despite the vast and growing body of literature aimed at deepening our understanding of the practice of female genital cutting (FGC), the issue of behavior change remains poorly understood. In this chapter we argue that, both within and beyond the context of formal intervention, the decision of whether, when, and how to perform FGC results from a constant process of negotiation about how to position oneself in light of shifting social relationships, contexts, and experiences, representing what Caroline Bledsoe refers to as *contingencies* – proximate social experiences and actors – affecting decision making. We find that a number of proximate experiences and persons influence, in an ongoing and sometimes conflicting fashion, the way in which individuals construct their "opinions" about the practice of FGC. Consequently, we argue that the decision making process is more fluid than two diametrically opposed camps of supporters and opponents, and that dichotomizing those who reject or retain the practice oversimplifies the complexity of contemplation and decision making.

Through analysis of in depth interviews and focus group discussions, we have identified and examined various contingencies that bear upon the decisions Senegalese and Gambians make regarding FGC. Results from our ethnographically grounded survey allow us to describe, as well, how these differ in magnitude between individuals at different categories of readiness to change. Through analysis of in depth interviews and focus group discussions, we identified a number of themes that are consistent with our notion of contingencies; that is experiences, persons and situations that help shape an individual's opinion over time. The study of contingencies is best understood though long-term detailed and focused ethnographic study of individuals, examining the contexts in which opinions are shaped and decisions negotiated. In this study, however, we attempted to operationalize the concept of contingencies in an ethnographically grounded survey, examining, in particular, the following:

- Internalization of the health risk message
- Migration
- Pressure to conform
- Marriagability
- Marriage across ethnic lines
- Female social pressure
- Proximity to influential people
- Difficulty finding a good circumciser
- Religion

Cross-sectional survey research does not allow us to examine the ongoing process of shifting and negotiating; it provides instead a snapshot at one point in time of factors identified as contingencies. As a first step in understanding the magnitude of the effects of contingencies, we examine how they vary across categories of readiness to change. Logistic regression reveals that health messages and conformity are universally important contingencies for stage of change: those who have more thoroughly internalized messages regarding the negative health impact of FGC are more likely to be abandoners than practitioners, and more likely to be either willing abandoners or contemplators (compared to those who have not internalized health messages to the same degree); those who have a greater aversion to breaking convention are less likely to be abandoners, and less likely to be either

[13] Portions of this chapter have appeared in publication: Hernlund, Y. and B. Shell-Duncan (2007) "Contingency, context and change: Negotiating female genital cutting in The Gambia and Senegal." Africa Today 54(4): 43-57. Segments are reprinted here with permission of the editor.

willing abandoners or contemplators (compared to those who perceive less pressure to conform regarding FGC). Peer pressure and conformity were highly correlated, and therefore could not be included in the models at the same time. Peer pressure was also significant, but the magnitude was smaller than models with the broader concept of conformity. This supports our findings in the last chapter suggesting that beyond a peer pressure norm, an intergenerational peer network convention holds the practice of FGC in place.

We found that religion was a significant factor in stage of change. In particular, the belief that FGC is not only a tradition, but a practice encouraged or mandated by Islam, was much more common among practitioners compared to abandoners and among supporters compared to willing abandoners. Beliefs about religion and FGC did not set contemplators apart from supporters, however. We also found that having community leaders who "speak out" against FGC and knowing firsthand of an instance of a serious health complication arising from FGC influenced participants' stage of change. These effects were only apparent when comparing all abandoners to all practitioners.

We propose that, in order to obtain an improved understanding of the dynamics of decision making with respect to FGC, it will be essential to integrate the concept of contingency into theoretical models of behavior change.

Introduction

In recent years, practices of female genital cutting (FGC), also referred to as female "circumcision" or "female genital mutilation" (FGM), have become increasingly publicized locally and internationally, and singled out for insistent intervention efforts. In some areas, backlash has arisen in reaction to anti-"FGM" campaigns (Shell-Duncan and Hernlund 2000: 23). Anthropologists have suggested that the FGC debate is a case in which Africans ought to be allowed to "argue this one out for themselves" (Gruenbaum 1996; Scheper-Hughes 1991). In many parts of Africa and its diasporas, this is precisely what people are engaged in doing: in village meetings, among small gatherings of friends, on TV, in newspapers, at NGO workshops, and on the Internet, individuals and organizations are passionately discussing their positions on the practice of FGC and attempts at its elimination.

Our data from the West African countries of The Gambia and Senegal, however, point to something much more fluid than two diametrically opposed camps of unequivocal "supporters" and "opponents." As anthropologist Caroline Bledsoe found in her research on Gambian women's reproductive decisions, reality is usually far more complex than the image of a large sea of "unpersuaded" traditionalists surrounding a tiny island of enlightened "acceptors" of the desired innovation or behavior change, in the case of her study of Western contraception (Bledsoe 2002: 94). Instead, Bledsoe argues that individuals actively reinterpret social norms about childbearing and attempt to manipulate events to meet their own fertility goals (Bledsoe, Banja et al. 1998; Bledsoe 2002). Similarly, in the case of FGC, dichotomizing those who retain and those who abandon the practice oversimplifies the complexity of contemplation and decision making (Hernlund 2003).

Instead, we argue, Gambian and Senegalese individuals, families, and even entire communities are engaged in a constant process of negotiation on how to position themselves vis-à-vis, on the one hand, a "traditional" practice which many have come to question and, on the other, interventions which are often perceived as imperialistic assaults on "cultural rights." Within communities, families, and compounds co-exist widely different accounts of what female circumcision is and what it means and what, if anything, needs to be done about it. Even within one single individual, seemingly oppositional views may compete and to some extent co-exist over time, attuned to shifting relationships, contexts, and experiences (see Hernlund 2003).

In her earlier work, Ylva Hernlund (2000, 2003) found an astounding variety in the reported encounters that individuals in The Gambia have with both the practice of female circumcision itself and with campaigns against it. Therefore, we argue, the construction of a person's "opinion" about this

controversial practice is more correctly an ongoing positioning vis-à-vis fluctuating needs and realities, representing contingencies affecting decision making. As suggested by Bledsoe, the "organizing idea of contingency is that of proximity or contiguity, usually both physical and social. The fact that one person is proximate to another implies that the acts of one will likely have repercussions for the other" (Bledsoe 2002: 20). Thus, a person's perspective is influenced by experiences accumulated over her or his lifetime. Anthropologist Ulf Hannerz has suggested:

> It is…perhaps more than ever before possible for individuals to become constructed in unique ways, through particular sets of involvements and experiences. As she changes jobs, moves between places, and makes her choices in cultural consumption, one human being may turn out to construct a cultural repertoire which in its entirety is like nobody else's. It may be that each of its varied components (is) shared with different sets of other people, yet to the extent that the repertoire is integrated – to the degree that it becomes a perspective, a self – it becomes an individual matter (Hannerz 1993: 105, cited in Lambek and Boddy 1997: 12).

Rather than simply seeking to attach decisions about FGC to a constellation of characteristics (such as ethnic group, education, or socioeconomic status), this study aims to identify the contingencies that lead individuals, families, and communities in The Gambia and Senegal to make the decisions they do. It is these contingencies that guide selection from the options currently available – the ever-shifting cultural "menus" from which people construct their cultural repertoires regarding FGC.

This region provides an exceptionally interesting site for studying decision making in flux. Although the two nation states, at times collectively referred to as Senegambia, share much in terms of culture, religion (more than 90% Muslim in both), ethnicity, climate, livelihood, and linguistics, The Gambia and Senegal have nonetheless experienced different pasts under British and French colonial rule respectively. In addition, in recent years the two countries have taken radically different trajectories when it comes to the practice of FGC and attempts at its abandonment.

Prevalence rates have differed from the outset, as different ethnic groups predominate in the two nations: in The Gambia a strong majority of the population, 80% or more, practice FGC (Daffeh, Dumbuya et al. 1999), whereas in Senegal, it is practiced by an estimated minority of 28% (Diop 2006). Anti-"FGM" campaigns have been ongoing in both countries since the early 1980s (Hernlund 2003), but in recent years the nature of intervention efforts in each has sharply diverged. While Senegal elected to pass a law in 1999, the Gambian government has not yet done so (we discussed in greater depth the dilemmas surrounding legislating against FGC and the effects of such policies in the previous chapter). In addition, Senegal has witnessed the notable rise of the grass-roots organization Tostan, which began as a basic education and empowerment program but rapidly became well-known internationally for its program of community-wide declarations against FGC and early marriage for women, now having involved over 3,700 villages in an apparent "convention shift" (Mackie 2000, www.tostan.org). In The Gambia, at the time of our data collection, educational campaigns were ongoing, as were projects to replace circumcision with "alternative" non-cutting initiation rituals (Hernlund 2000, 2003). Tostan's activities had not diffused across the otherwise porous and heavily trafficked border from Senegal. In the summer of 2006, Tostan, in partnership with UNICEF The Gambia, began to implement its program activities in a select number of villages in the Upper River Division. Gambian participants in our study, however, had no knowledge of the Tostan program.

We believe that there is a broad range of realities inhabited by those who participate in FGC in this region – from strong support to strong opposition, but with potential movement over time by an individual or even community from one category to another (and potentially back again). While it has been pointed out in much of the FGC literature that ethnicity is a better predictor than nationality of

whether a person or community is likely to practice FGC, we find that in the Senegambia area, because of these divergent developments, the national boundary does indeed make a difference; and people with otherwise similar characteristics who find themselves on the Gambian versus Senegalese sides of the border are faced with a different set of realities, in which different contingencies weigh more or less heavily.

In The Gambia, an overwhelming majority practices FGC although, as discussed above, not necessarily in the exact same ways that they have done before (see also Ahmadu 2005; Hernlund 2000, 2003). We propose, however, that a comparatively small number of them (especially secret society members and ritual specialists) are actively engaged with the "deep" reasons for practicing (see Ahmadu 2005); that a significant proportion of people, like people everywhere, are "going along" with accepted praxis, following what is perceived as "tradition" without reflecting extensively on the "real" reasons; that many are primarily submitting to social convention, fearful of the consequences of deviating from community norms, including exclusion from inter-generational peer networks of social support (as discussed in Chapter V).

It is thus likely that the reasons contemporary Gambians see for circumcising their daughters (as did Senegalese until very recently) range from multi-layered complexity to unquestioning acceptance of "tradition" (Hernlund 2003). A report by Daffeh et al. in fact reports that 15% of respondents gave *all* the offered variables as the reason for the practice (Daffeh, Dumbuya et al. 1999:13): religion, health, cleanliness, tradition, and control of female sexuality. Fuambai Ahmadu has cautioned that although each of the "explanations" for practicing FGC are discussed distinctly, they are in fact "interconnected and mutually reinforcing and, taken together, form overwhelming unconscious and conscious motivations" for its continuation (Ahmadu 2000: 295). At the same time, few Gambians remain unaware of anti-"FGM" initiatives, although a staggering 93% claimed to be unaffected by their messages (Daffeh, Dumbuya et al. 1999: 22). On the Senegalese side of the border, a different set of realities dominate as the Tostan campaign spreads, the majority population expresses disdain for FGC, and there is widespread and tangible concern for the consequences of breaking the law.

Identifying Contingencies

Through analysis of in depth interviews and focus group discussions, we have identified and examined various contingencies that bear upon the decisions Senegalese and Gambians make regarding FGC. Results from our ethnographically grounded survey allow us to describe, as well, how these differ in magnitude between individuals at different categories of readiness to change. Through analysis of in depth interviews and focus group discussions, we identified a number of themes that are consistent with our notion of contingencies; that is experiences, persons and situations that help shape an individual's opinion over time. The study of contingencies is best understood though long-term detailed and focused ethnographic study of individuals, examining the contexts in which opinions are shaped and decisions negotiated (see Hernlund 2003). In this study, however, we attempted to operationalize the concept of contingencies in an ethnographically grounded survey. Cross-sectional survey research does not allow us to examine the ongoing process of shifting and negotiating; it provides instead a snapshot at one point in time of factors identified as contingencies. As a first step in understanding the magnitude of the effects of contingencies, we examine how they vary across categories of readiness to change. While several of these are discussed below, this should not be seen as an exhaustive or static list. We begin with the condition particular to Senegal:

Fear of Prosecution

While scholars have argued that legislation against FGC is a poor tool for effecting behavior change, positing that it is, at best, ineffective, because "it is not possible to criminalize the entirety of a population or the entirety of a discrete and insular minority of the population without methods of mass

terror" (egg. Mackie 2000: 278), our current research in Senegal reveals that large-scale enforcement is not needed in order to generate a widespread fear of prosecution. Deterrence theory suggests that awareness of a few highly publicized cases of prosecution can also create fear of prosecution, and discourage illegal behavior. In our study sites we were surprised to find that no one had knowledge of the few cases of arrest and prosecution in Senegal. Nonetheless, rumors and imaginings of enforceability engender fear of prosecution. In the previous chapter we show that a range of reactions to the law can coexist within communities, and even within families. The responses include fear of prosecution, resignation to the power of the law, satisfaction with support from the law to stop FGC, and reactance and defiance of the law.

The survey results show that the majority of respondents in our Senegalese study sites believe that the law can easily be enforced (79%), and consider this to be a reason for changing the practice. The strain of living with fear of prosecution is one important reason that several informants reported for abandoning the practice, and in certain instances, for welcoming the Tostan intervention into their community.

Exposure to or participation in an intervention program

Community-based programs and media messages aimed at discouraging the practice of FGC have been ongoing in Senegal and The Gambia for decades. Our survey results reveal that only a small portion of the female respondents had directly participated in workshops or classes, although many believed that their community leaders had done so. The majority of women had, however, been exposed to media messages. The influence of these messages in altering opinions about the practice of FGC differed in Senegalese and Gambian study sites; the majority of Senegalese women exposed to the media messages claimed that they did influence their opinion about the practice, while the majority of Gambian women claimed they did not.

Table 7.1 Responses to survey items regarding exposure to media messages/campaigns among Senegambian women from circumcising families

	Senegal (N = 137)		Rural Gambia (N = 101)		Urban Gambia (N = 443)		Total Senegambia (N = 681)	
	Yes	No	Yes	No	Yes	No	Yes	No
Have you heard any information about female circumcision on the radio or television?	72%	28%	59%	41%	69%	31%	68%	32%
Of those who said yes: Has this information influenced your opinion about female circumcision?	58	42	25	72	24	74	31	67
Have you attended bantabas, workshops, or classes where people talked against female circumcision?	9	91	14	86	6	94	8	92

In Senegalese communities that have been targeted by the Tostan intervention program, several informants remarked that they had wished to leave the practice of FGC after learning about the law, but could not do so because of pressures from others to circumcise their daughters.[i] Under the direction of the Tostan program, a significant number of people in the community agreed to abandon the practice of FGC. This, as a result, lifted the pressure formerly placed on people who wished to comply with the law and abandon the practice. One elderly male respondent explained, "Before Tostan came here, the Senegalese government came first to talk about female circumcision and obviously we did not have any fear the time Tostan came here because already we knew that they were going to talk about this."

In The Gambia, reactions to educational campaigns (which vary significantly in their approaches) include support, rejection, and ambivalence. A male nurse in a rural Gambian community explained, "Well, in my perspective, we the doctors, nurses, and health officers are definitely against the practice. We always invite them […], telling them about the infections of the practice. At the meeting they will accept. But when they return home, they change their minds. I cannot say that it will be eradicated. It is not an easy task." Another rural Gambian man expressed the frustration of others: "I see no reasons to eradicate it. These European people want to destroy our country. They give huge amounts of money to the sensitizations to brainwash the local people. For example, you meet a poor farmer in the village and you give him some money […] whatever you say, that is what the farmer is going to do."

As we describe in Chapter IV, the content of educational campaigns have changed over time, shifting from a health risk message centered on obstetrical complications, to one that now focuses risk of contracting HIV. Significantly, this shift appears to be responsible for changes in acceptance of a health risk message.

Knowledge of cases of death or adverse health outcomes after circumcision

This is, as expected, a very sensitive topic, although some respondents were willing to discuss cases of severe circumcision-related ill health effects and/or deaths with which they themselves were familiar. The survey results show that, overall, 7% of women had direct knowledge of a death or serious health problem believed to arise from female circumcision.

Table 7.2 Responses to survey items regarding knowledge of adverse experience attributable to FGC among Senegambian women from circumcising families (percents)

	Senegal (N = 137)		Rural Gambia (N = 101)		Urban Gambia (N = 443)		Total Senegambia (N = 681)	
	Yes	No	Yes	No	Yes	No	Yes	No
Do you know of any girl or woman in your family or community who has had a serious health problem after being circumcised?	12%	88%	3%	97%	6%	94%	6%	94%
Do you know of any time a girl died after being circumcised?	4	96	3	97	8	92	7	93

Although many ascribe other causes to such cases (in particular, witchcraft, or that it was God's will that the girl die at that time in her life), qualitative data suggest that witnessing death or trauma is

often a key pivotal event in the decisional balance of already ambivalent decision makers. A rural Gambian man, of Wolof ethnicity but married to a woman from a practicing group, related:

> It brings problems. My wife's younger sister was sealed after being circumcised. This is because they wanted her to maintain her virginity at marriage. On the day she got married, the husband couldn't penetrate. As such, a *ngangsingba* [circumciser] was called to perform some operation, and later she was given to her husband. The young one suffered a lot of serious pain, so that she was rushed to the hospital. Just imagine what troubles they had caused her! Though for a girl to keep her virginity till marriage is a good thing, but it has to be achieved through discipline by parents, and not through this maltreatment of human beings.

Another respondent, an elderly Mandinka woman living in an urban area in The Gambia, argued that: "If it is done in the wrong way, the person can bleed to death [….] I once had a granddaughter who, because of this, she died."

Internalized health messages

A number of NGOs have engaged in informational campaigns primarily centered on health messages. Initially, health-based interventions succeeded in breaking the culture of silence surrounding the practice of FGC across Africa, but they had not resulted in large-scale behavior change at the time of this study. In some instances, people in circumcising communities were found to be already aware of many or most potential health risks, and weighed these risks against the perceived social benefits. Alternatively, in communities that practice milder forms of FGC, health messages drawn from extreme case studies of infibulation have, in some instances, not resonated with the experience of local women, and have undermined the credibility of such campaigns.

Table 7.3 Responses to survey items regarding internalization of health messages among Senegambian women from circumcising families

	Senegal (N = 137)			Rural Gambia (N = 101)			Urban Gambia (N = 443)			Total Senegambia (N = 681)		
	Agree	Unsure	Disagree	Agree	Unsure	Disagree	Agree	Unsure	Disagree	Agree	Unsure	Disagree
Female circumcision can cause serious problems with childbirth	27%	26%	47%	8%	8%	84%	9%	18%	72%	13%	18%	69%
Female circumcision can spread HIV/AIDS	34	34	32	18	25	57	16	40	44	20	36	44
Female circumcision can cause a person to bleed too much	53	18	28	42	14	45	47	18	35	48	17	35
Female circumcision can cause tetanus	43	27	30	22	27	51	23	35	42	27	32	41

While we continue to encounter many respondents who deny that there are any negative health effects associated with, in particular, milder forms of genital cutting, we have been struck by the extent to which the health message is now beginning to resonate. As we showed in Chapter IV, a key factor has been a shift away from a message centered largely on obstetrical risks to one that now emphasizes the risk of contracting HIV/AIDS. As we discussed earlier, the obstetric risk message was viewed as an attack on tradition, and a challenge of the knowledge and authority of elders. The HIV risk message, by contrast, is perceived as a new risk, and consequently is not an insult or challenge of the wisdom of elders. And despite the fact that the prevalence of HIV is low (1%), the message of health risks resonate overall more strongly with the addition of the HIV message content. For those who oppose FGC, the fact that the practice can spread HIV/AIDS (although there is little or no documentation backing up this assertion) is often stated as a primary reason for that opposition. At the same time, many others prefer to continue practicing FGC, but using "one blade per girl," resulting in the inadvertent medicalization of the practice.

Migration

A significant portion of families in this region (54% among our survey respondents) have at least one member living abroad, and there is frequent traffic of people coming and going from far-flung diasporas.

Table 7.4 Responses to survey items regarding the influence of international migration on opinions about FGC among Senegambian women from circumcising families

	Senegal (N = 137)		Rural Gambia (N = 101)		Urban Gambia (N = 437)		Total Senegambia (N = 681)	
	Yes	No	Yes	No	Yes	No	Yes	No
Have you or anyone in your family lived abroad?	48%	52%	41%	59%	58%	42%	53%	47%
If yes, has this influenced your opinion about the practice?	17	83	10	90	11	89	12	88

Although a minority of those with transnational contact claim that this has influenced their opinion about the practice of FGC, qualitative data reveal striking examples of individuals influenced by the shifting realities of migration of self or others: "There was a time, I was in Europe, you see, my elder sister and brother's children, none of them went [to circumcision]. Because if you take your child to the antenatal clinic [in Europe], they check her to see if you have taken her to circumcision, they know it from there and if they know it from there, if God does not help you, you will go to court" (middle-aged Fula woman, urban Gambia). Another Gambian respondent added: "Yes, even some Mandinkas want to see it removed [see FGC end]. All that depends on education, awareness, and exposure. You know, if you are educated and you travel outside your country, you see a lot of things." (middle-aged Serer woman, urban Gambia).

Convention/pressure to conform

Mackie has argued that when the abandonment of FGC comes, it will not be gradual but very rapid, as entire inter-marrying communities engage in convention shifts expressed in public declarations. In our survey, we operationalized questions regarding convention effects in terms of outside pressure to conform. Although fewer women agree with questions on outside pressure to

conform in Senegal than in The Gambia, overall the majority of women agree with these statements. This suggests that there is a need to coordinate abandonment regardless of whether marriagability or other factors contribute to holding the practice of FGC in place.

Table 7.5 Responses to survey items relating to pressure to conform in FGC among Senegambian women from circumcising families

	Senegal (N = 137)			Rural Gambia (N = 101)			Urban Gambia (N = 443)			Total Senegambia (N = 681)		
	Agree	Unsure	Disagree	Agree	Unsure	Disagree	Agree	Unsure	Disagree	Agree	Unsure	Disagree
If we did not circumcise our girls, then we would be pressured by friends and family.	55%	4%	41%	74%	7%	19%	74%	12%	14%	70%	10%	20%
Nobody in my family wants to be the first to stop female circumcision.	52	15	33	74	11	15	75	11	14	70	12	18

Marriagability

The issue of marriagability is central to the convention model as first proposed by Mackie (1996, 2000) and this concern certainly seems to be driving the practice in many other parts of Africa. As Hernlund concluded from previous research in primarily urban areas of The Gambia, however, the assumption that FGC is necessary in order for a woman to "find a husband" is simply not borne out in this region (Hernlund 2003; see also Ahmadu 2005).

Table 7.6 Responses to survey items regarding marriagability of circumcised and uncircumcised women among Senegambian women from circumcising families

	Senegal (N = 137)			Rural Gambia (N = 101)			Urban Gambia (N = 443)			Total Senegambia (N = 681)		
	Agree	Unsure	Disagree	Agree	Unsure	Disagree	Agree	Unsure	Disagree	Agree	Unsure	Disagree
If a girl is circumcised, she has a better chance of finding a good husband.	16%	11%	73%	30%	14%	56%	25%	16%	59%	24%	15%	61%
A girl who is not circumcised will have difficulty finding a husband.	11	16	73	12	24	64	11	21	67	11	21	68

We find this lack of concern with marriagability to generally be true, as well, in the current rural Gambian and Senegalese study sites. In all three study sites the majority of respondents claim that circumcision does not improve a girl's chance of becoming married, nor her chance of finding a "good husband." Circumcision status is not customarily discussed when arranging marriages, and males do not commonly state that their potential wives must be circumcised. There were exceptions, as a handful of respondents, especially from small communities with little ethnic diversity, referred to a requirement that men from circumcising groups marry circumcised women, but almost all claimed that this only had applied in the past. The vast majority of respondents (in both Senegal and The Gambia, males as well as females, of older and younger generations, and regardless of their general views on FGC) stated unequivocally that "circumcision has nothing to do with a woman finding a husband." Therefore, contrary to what has often assumed to be the case, marriagability does not appear to be a contingency in this study setting. This does not mean, however, that circumcision has nothing at all to do with marriage, as a woman's uncircumcised status often becomes an issue after she marries into a circumcising group and attempts to gain entry into a female network of social support.

Marriage across ethnic lines

The survey data confirm that interethnic marriage is common across our study sites. Overall, 28% of women report being in an interethnic marriage, with the lower levels found in the rural Gambian communities (20%) than in urban Gambian (30%) or Senegalese (34%). Women were also asked about the ethnicity of their parents. We find that 10% of the parents of respondents were of mixed ethnicity, suggesting that inter-ethnic marriage has recently become more common. We also examined how often inter-ethnic marriage results in mixed traditions, that is, having discordance regarding each partner coming from a family that traditionally practices or practiced (in Senegal) FGC.

Table 7.7 Responses to survey item regarding the acceptability of inter-ethnic marriage among Senegambian women from circumcising families

	Senegal (N = 137)			Rural Gambia (N = 101)			Urban Gambia (N = 442)			Total Senegambia (N = 680)		
	Agree	Unsure	Disagree	Agree	Unsure	Disagree	Agree	Unsure	Disagree	Agree	Unsure	Disagree
I think it is better for people to marry within their own ethnic group.	9%	4%	88%	16%	2%	82%	10%	2%	88%	11%	3%	87%

Table 7.8 Percent of women in FGC-discordant marriages among Senegambian women from circumcising families

	Senegal	Rural Gambia	Urban Gambia	Total Senegambia
Discordance between husband's tradition and respondent's circumcision status	20%	24%	8%	13%
Discordance between husband's tradition and respondent's tradition	21	24	8	13

As we expected, inter-ethnic marriage has complex effects on the practice of FGC. On the one hand, some women from practicing ethnic groups report having married into non-practicing (mostly Wolof) families, and therefore might not have to address the issue of the circumcision of their daughters if they oppose it. More commonly, however, women from non-circumcising groups who marry into circumcising families find that they have no choice but to have their daughters circumcised and/or to undergo the practice themselves.

Again, it is not typically the case that FGC is a prerequisite for marriage, as has been reported to be the case in other parts of Africa. Instead, we do find ample evidence that circumcision status can become a major source of tension and intra-family conflict *after* an uncircumcised woman has married into a circumcising family. Uncircumcised women generally have little opportunity to oppose the circumcision of their own daughters and they are not allowed to attend the ceremonies or even to visit their daughters in seclusion. As we showed in Chapter V, in many instances these women also remain marginalized in their new compounds, are excluded from general household decision making and serious discussions among mature women, and are unable to draw from the social support network of circumcised women. Many are insulted as *solema*, especially by circumcised co-wives, branding the "one who has not gone" as ignorant, uncivilized, sexually loose, and incapable of showing proper respect (Hernlund 2000, 2003; Ahmadu 2005). This day-to-day pressure can lead to adult women undergoing the practice (even after having borne several children) or, occasionally, being forcefully circumcised. A woman from a non-practicing family related:

> Here, not every person practices it, but a good number do. […] Though a Wolof, I've been circumcised, because I was interested in knowing what actually FGM was. So when I got married to my husband, newly, as a second wife, my co-wife – that is the first wife of my husband – had a big female circumcision in her hometown; and her children were to be circumcised. When I wanted to attend the celebration the day of the circumcision, my co-wife told me it was not done – unless I was circumcised, I could not enter. So, I couldn't go. Then another circumcision took place, and I did not go. Then, it became a burden to me. I then decided that I was going. When I discussed the issue with my co-wife, she was really very much glad, and the next day she took me to the [circumciser] for circumcision.
> Q: Then, how old were you?
> A: Anyway, I already had my first child.
> Q: Did you encounter any problems?
> A: No, just for a few days I was getting better. And moreover, since I was sick and tired of the isolation and insults that the Mandinka women gave us, it was like I did not notice the pain much. And just after the event, my co-wife congratulated me for being so brave and also presented me with some gifts of gold earrings and a ring.
> -Elder Wolof woman, rural Gambia

During the qualitative research, we were surprised to find a number of respondents who report these instances and at the advanced ages at circumcision reported by some of the women (even into their mid-30s). This supports the contention that in the case of The Gambia, as well as in Senegal before the passage of the law banning FGC, the driving factor behind the persistence of FGC has been a powerful inter-generational peer convention, rather than a concern with marriagability (see also Ahmadu 2005).

Female social pressure

Such female social pressure manifests itself not only in the context of inter-ethnic marriage, but also in mixed-ethnicity peer groups of girls and young women. Sometimes Wolof girls, for example, "join" their friends when they are going to circumcision, even against the will of their own parents (Hernlund 2003). From the present data we are seeing some evidence, however, that such cases are becoming slightly less common, at least in the urban areas of The Gambia. There, girls are increasingly circumcised alone or with one other girl, and with little accompanying ritual or training. In these cases, there is less of a group dynamic in which uncircumcised girls could get swept up. The qualitative data reveal that peer pressure continues among older women involved in decision making regarding the circumcision of girls in their family; they face judgments about whether they are properly rearing a girl to show respect for elders and to value tradition.

There were a few notable interviews in which informants described exceptions regarding peer pressure on women. It was reported that women from non-practicing families who "joined" their friends for circumcision in some instanced experienced reduced social pressure to continue the practice among their daughters. This reveals that while a woman may have been circumcised and initiated in some manner, she may not garner full "insider" status; whether one is from a family that holds the tradition of FGC seems, at least for some, to be a potentially important influence on social expectations and pressure.

In a focus group discussion in a rural Gambian community, however, the middle-aged women participants were unanimous in their insistence that every woman in their community must undergo the practice, regardless of her ethnic background:

> In this area, female circumcision is by force. Even the children insult their mates who are not circumcised as "solema." It is common to hear children calling their fellow children: "You solemas, you will not follow us." At times, you will see those children crying bitterly because their mates have isolated them and they are being called solema. They will cry bitterly and sometimes run home to their mothers, crying. They will not stop complaining to their mothers that their mates insult them as solema, and as such they are always isolated from their mates who have been circumcised. In this way, the mother will end up taking the daughter to circumcision. If not, neither the mother nor the child will be at ease or comfortable.

The survey data as well support the fact that female peer pressure regarding FGC has declined only slightly in Senegal, as compared to The Gambia, despite the fact that some of the Senegalese communities have participated in public declarations to end FGC and despite the law banning the practice.

Table 7.9 Responses to survey items regarding female peer pressure to perform FGC among Senegambian women from circumcising families

	Senegal (N = 137)			Rural Gambia (N = 101)			Urban Gambia (N = 443)			Total Senegambia (N = 681)		
	Agree	Unsure	Disagree	Agree	Unsure	Disagree	Agree	Unsure	Disagree	Agree	Unsure	Disagree
If a girl in my immediate family is not circumcised, she will suffer from insults from her friends	61%	4%	35%	68%	5%	27%	72%	10%	18%	70%	8%	22%
If a grown woman in my immediate family is not circumcised, she will suffer from insults from her relatives and friends	59	9	32	71	4	25	72	11	16	69	10	21
Women in my immediate family who are not circumcised are excluded in some ways	45	12	43	58	10	32	49	21	30	50	17	33

Proximity to influential people

Mackie has pointed out that when a convention shift occurs, it is important to win over influential individuals who hold genuine authority, such as the religious leader who facilitated the very first Tostan declaration in 1998 (Mackie 2000). Our data, as well, show that being close to or under the influence of such central actors – village leaders, religious authorities, powerful patrons – can indeed constitute another powerful contingency. In one rural Gambian study site, informants explained that although chiefs do not have the power to stop people from circumcising in the community, they can exert authority over the conditions under which it is practiced. One chief elaborated:

> Each time the ngangsingba wants to circumcise children/females, she informs me first, and also gives me some kola nuts. […] But each time she comes here to inform me about such arrangements, I only give her this piece of advice: not to circumcise anyone without the consent of either a parent or guardian or even a relative. She should circumcise a person upon the request of someone but not to circumcise a child on her own wishes and willingness. If she circumcised any child without anyone asking her to do so, should there be any problems, she must be accountable for it.

In one of the Senegalese sites supportive of the Tostan project, an influential village member actively involved in the project, whose mother used to be the traditional circumciser, related how his mother stopped her practice because:

> When Tostan came here, they came straight to my compound and they know me very well because I do go with them to many places. So when that happened I told my mother to stop it. It would not be fair for the people in this community to stop while my mother is doing it, but it will be good and fair for my mother to stop first because she is the leader of the thing which is circumcision. If I stop her it will be easy for the community to stop. She was the only circumciser in this community.

Thus is evident a shift, as a "new" influential leader associated with a powerful social movement rather suddenly gains comparative authority over a traditionally significant actor.

The survey data, however, did not bear out the importance of influential leaders. Most respondents reported that leaders or influential people were not, for the most part, speaking out about FGC. And only a small fraction, even in Senegal, claimed that leaders caused them to rethink their opinion about FGC. It may be the case that the emergence of "new" influential leaders occurs so spontaneously that it is not captured adequately in a survey instrument.

Table 7.10 Responses to survey items regarding the influence of influential leaders on opinions about FGC among Senegambian women from circumcising families

	Senegal (N = 137)		Rural Gambia (N = 101)		Urban Gambia (N = 443)		Total Senegambia (N = 681)	
	Yes	No	Yes	No	Yes	No	Yes	No
Are there any leaders or important people in this community who speak out about female circumcision?	8%	81%	2%	96%	2%	96%	3%	93%
Is there a leader or important person who caused you to seriously rethink your opinion about female circumcision?	7	89	1	98	1	99	2	97

Difficulty finding a good circumciser

As noted in the previous chapter, one of the consequences of the Senegalese law banning FGC has been to cause local traditional circumcisers to stop performing FGC. And while the skills of circumcisers were previously passed down from one generation to the next, most claimed that they did not train an apprentice before "dropping the knives." As Obiora (1997) argues, deterrence aimed at circumcisers may have unintended effects because it does not reduce the demand for circumcision (see also Gosselin, 2000; Mackie, 2000). She notes (1997: 355) that "without an acceptable alternative, the prospects of inexperienced parents and women then taking it upon themselves to perform circumcision are not inconsequential." Informants in our study communities sometimes noted that in the absence of trusted and experienced local circumcisers, the demand has been met by "traveling circumcisers," who reportedly circulate throughout communities in The Gambia, Guinea Bissau, and elsewhere. Many informants were suspicious of the training and qualifications of these circumcisers, and suspected that they are motivated by economic gain:

> Q: What is your opinion about the law banning FGM?
> A: My opinion towards it is that when I heard of law banning FGM, I felt happy about it because in the past, our ancestors did it accordingly and correctly, but now everybody wants to be a circumciser because of money and will not be qualified.
> —Elderly Serer woman

> Q: What is your opinion about the law banning FGM?
> A: I like the law against female circumcision because it is the only way it can be controlled. In the past, it was not a problem because circumcisers with qualifications did it correctly, but now it is done just for the sake of doing it without the skill.
> —Middle-aged Serer woman

Consequently, concerns about the qualification of available circumcisers may be motivating people to favor abandonment of the practice.

The survey results show that respondent frequently report having difficulty finding a "good circumciser" not only in Senegal, but even more so in our study sites in rural Gambia. The border is very fluid, and it may be the case that rural Gambian women had, in the past, employed circumcisers from

neighboring communities in Senegal. Many rural Gambian and Senegalese respondents agreed that availability of “good circumcisers” does indeed influence their opinion about whether the practice should be continued.

Table 7.11 Responses to survey items regarding limited circumciser availability among Senegambian women from circumcising families

	Senegal (N = 137)			Rural Gambia (N = 101)			Urban Gambia (N = 443)			Total Senegambia		
	Yes	No	Unsure	Yes	No	Unsure	Yes	No	Unsure	Yes	No	Unsure
Is it a problem for people in your community to find a good circumciser?	34%	47%	20%	51%	44%	5%	12%	67%	21%	22%	59%	18%
Does this influence your opinion about whether female circumcision should be continued?	65	35	0	27	60	13	15	73	13	34	57	9

Religion

FGC is widely seen as a practice that predates Islam in the Senegambia. Accordingly, most respondents distinguished FGC as a question of *tradition*, rather than religion. However, this intersection of tradition and religion seems to be an opportunity for an individual's support for the practice to either be strengthened, as they find a way to incorporate the practice inherited from their ancestors with deeply held religious beliefs, or to wane, in favor of traditions associated more directly or explicitly with Islam.

There is a great deal of ambiguity and debate about Islam's stance on FGC, among our respondents and globally. Consistent with this ambiguity, few respondents believe that Islam either demands or absolutely forbids circumcision for females. Most see a middle ground, arguing that Islam tolerates, permits, or supports the practice. The often repeated sentiment among interview respondents regarding FGC and Islam is that "… whoever wants to do it, can do it."

Many respondents argue that the Prophet Muhammed was aware of FGC (and perhaps that his wife was circumcised) and did not forbid it, interpreting this as tolerance or tacit support for the practice.

> The practice is a religious act because, for us Muslims, anything the prophet…did not go against becomes part of Islam. Our mother Fatoumatta had gone through it and it is a sign of cleanliness. Therefore, where Mother Fatoumatta, the prophet's wife had done it, it is due for every Muslim woman.
> —Middle-aged Mandinka woman, rural Gambia

> We found female circumcision and it is not rejected by Islam. That is why I support it.
> —Middle-aged Jola man, urban Gambia

Many respondents refer to a hadith sanctioning FGC, and see it as a *sunna*. Again, for some, this merely allows the practice, while for others, it more strongly advocates it.

> We had one Islamic teacher…who told us that there was a "hadith" revealed by the Prophet Muhammed. He once asked his people why are they taking their children, especially the girls, for the circumcision. And they said that they were practicing it and the Prophet looked onto it and he saw that it was a good practice. He told them, anyway you can continue practicing this, but any time you see there is more disadvantage than advantages, please, you can stop it. So, from there people continued it as a "Sunna." Because people believe that the sunnas are sayings and doings of the Prophet. So, as far as he went on to accept that thing as part of them, so they say that it is sunna. As a Muslim you have to practice it.
> —Middle-aged Fula man, rural Gambia

> …some Islamic scholars are saying it is just a sunna, not obligatory, (you can do it or you can stay out of it, it is not a problem). Some cultures believe that Islam says that you have to do it. Some even go to the extent of believing that if you don't do it, you are not clean.
> —Middle-aged Wollof man, rural Gambia

Survey data confirm that, among Senegambians, FGC is more widely seen as a *sunna,* and rarely seen as the more compulsory *farata*: 18% of women from circumcising families agreed with the statement that FGC is a *farata,* whereas 76% agreed with the statement that FGC is a *sunna*.

Table 7.12 Responses to survey items regarding limited circumciser availability among Senegambian women from circumcising families

	Senegal (N = 137)			Rural Gambia (N = 101)			Urban Gambia (N = 443)			Total Senegambia		
	Yes	No	Unsure	Yes	No	Unsure	Yes	No	Unsure	Yes	No	Unsure
According to Islam, female circumcision is a farata (obligation).	20%	20%	61%	20%	21%	59%	17%	27%	56%	18%	25%	57%
According to Islam, female circumcision is a sunna (duty).	68	15	16	80	9	11	77	13	10	76	13	11

For some, Islam may be more closely tied with FGC through the training girls traditionally receive "in the bush" at the time of their circumcision. This training includes lessons on how to show respect to elders and behave properly as a woman; in some cases, religious training has been incorporated in this "bush" training. Some women report that they learned to pray or to perform ritual cleaning (*jahnab*) "in the bush".

> I was taught so many things, especially things pertaining to Islam, like how to perform ablution, how to perform your daily prayers, how to fast during Ramadan, how to respect people, how to share things, how to approach elderly people in terms of exchanging ideas, how to respect your father and mother and also your friends.
> —Middle-aged Wollof woman, rural Gambia

Many circumcised women see Islam's emphasis on ritual washing and cleanliness as indirectly requiring FGC, as uncircumcised women are "unclean" (and an unclean woman's prayers "won't be accepted by Allah").

> It makes a girl clean in the religion.
> —Middle-aged Serer woman, rural Senegal

> Furthermore, our religion, Islam, calls for cleanliness, part of which is achieved through circumcision.
> —Middle-aged Mandinka woman, rural Gambia

Finally, FGC may be a way for women to demonstrate their piety. Piety seems to be an important avenue to gain respectability and prominence in our study communities. For this reason, even though women don't believe FGC, as a *sunna*, is strictly required by Islam, they may see it as a way to show that they do *more* than the Quran's minimum requirements, and are thus *more* pious.

> If you are circumcised, that means you are clean and respected in the community where Islam is strong and tradition.
> —Middle-aged Wollof woman, rural Gambia

Multivariate Analysis of Contingencies

We chose to look at three binary comparisons in assessing the effect of contingencies on self-described stage of change: all practitioners (including supporters, contemplators, and reluctant practitioners) compared to all abandoners (willing abandoners and reluctant abandoners); supporters compared to willing abandoners; and supporters compared to contemplators.

Each contingency (described above) was described with a single variable. Some contingencies were captured entirely with one survey question; others are relevant to multiple questions. When more than one survey question was used to assess a contingency, a score was generated which included the agree/unsure/disagree responses to all questions: "agree" or "yes" responses were given three points, "unsure" two points, and "disagree" or "no" responses one point. The number of points was then averaged across all pertinent questions to generate the score for each contingency. Contingency variables are described in Table 7.12.

Table 7.13 Description of contingency variables

Contingency	Variable name	Variable type	Survey items
Fear of prosecution (Senegal only)	Law score	Continuous	*I believe that the law banning female circumcision can be easily enforced in this community.* *The law banning female circumcision is more powerful than we are, so we must change the practice.* *Someone who openly breaks the law banning female circumcision needs to worry about being punished.*
Exposure to or participation in an intervention program	Anti-FGM campaigns	Binary (yes/no)	*Have you heard any information about female circumcision on the radio or television?*
Knowledge of cases of death or adverse health outcomes after circumcision	Adverse experience	Binary (yes/no)	*Do you know of any girl or woman in your family or community who has had a serious health problem after being circumcised?*
Internalized health messages	Health disadvantages score	Continuous	*Female circumcision can cause serious problems with childbirth.* *Female circumcision can spread HIV/AIDS.* *Female circumcision can cause a person to bleed too much.* *Female circumcision can cause tetanus.*
Migration	Migration	Binary (yes/no)	*Have you or has anyone in your family lived abroad?*
Convention/pressure to conform	Conformity score	Continuous	*If we did not circumcise our girls, then we would be pressured by friends and family.* *Nobody in my family wants to be the first to stop female circumcision.*
Marriagability	Marriagability score	Continuous	*If a girl is circumcised, she has a better chance of finding a good husband.* *A girl who is not circumcised will have difficulty finding a husband.*
Marriage across ethnic lines*	Interethnic marriage	Binary (yes/no)	*I think it is better for people to marry within their own ethnic group, such as Mandinkas marrying Mandinkas and Wolofs marrying Wolofs.*
Female social pressure	Peer pressure score	Continuous	*If a girl in my immediate family is not circumcised, she will suffer from insults from her friends.* *If a grown woman in my immediate family is not circumcised, she will suffer from insults from her relatives and friends.* *Women in my immediate family who are not circumcised are excluded in some ways.*

Table 7.12 (continued) Description of contingency variables

Contingency	Variable name	Variable type	Survey items
Proximity to influential people	Leadership score	Continuous	*Are there any leaders or important people in this community who speak out about female circumcision?* *Is there a leader or important person in this community who caused you to seriously rethink your opinion about female circumcision?*
Difficulty finding a good circumciser	Circumciser availability	Binary (yes/no)	*Is it a problem for people in your community to find a good circumciser?*
Religion	Religion score	Continuous	*According to Islam, female circumcision is a farata (obligation).* *According to Islam, female circumcision is a sunna (duty).*

*The relationship between interethnic marriage *per se* and stage of change is described in Chapter III.

We used logistic regression to assess the effect of contingencies on stage of change outcomes (abandoners vs. practitioners; willing abandoners vs. supporters; contemplators vs. supporters) among survey respondents from circumcising families. Associations between stage of change and law scores were assessed only among Senegalese respondents; the effect of all other contingencies on stage of change outcomes was assessed among all Senegambian women, by including all these contingencies in a single logistic regression model for each stage of change comparison. However, we observed a high correlation between peer pressure and conformity scores ($\rho = .6234$; $p < .0001$), precluding their use in the same model. Thus, each multiple logistic regression model was evaluated twice, once including the conformity score and once including the peer pressure score. These regressions gave similar results: both peer pressure and conformity scores were similarly associated with stage of change outcomes. However, associations between conformity score and stage of change outcomes were consistently of larger magnitude and significance. For this reason, we chose to use conformity scores for the results presented here.

We present results of logistic regressions as both odds ratios (OR) and predicted probabilities to characterize the effect of contingencies on SOC. Odds ratios can be interpreted as the change in the odds of the outcome (e.g., being an abandoner of FGC) associated with a one-unit change in the predictor (e.g., health disadvantages score), holding all other variables in the model constant. Because odds ratios tend to overstate associations for outcomes that are not rare (e.g., > 5% prevalence; Davies et al., 1998), we also calculated probabilities (rather than odds, upon which odds ratios are based) from logistic regression results. Predicted probabilities were calculated by calculating values for logit X (where X is the binary stage of change outcome) across the observed range of a variable (e.g. health disadvantages score) holding all other values in the regression formula constant at either the observed mean (for continuous variables) or mode (for discrete or categorical variables) value (among Senegambian women from circumcising families); the probability $\pi(X)$ was then calculated as $\exp(\text{logit } X)/[1 + \exp(\text{logit } X)]$. Graphed probabilities show the change in the outcome (e.g., being an abandoner of FGC) associated with change in the predictor (e.g., health disadvantages score) across the range of observed values and holding all other variables in the model constant.

The effect of fear of prosecution on stage of change could only be assessed in Senegal and thus was analyzed separately. Tables 7.14-7.16 describe the results of logistic regression for fear of prosecution and stage of change, controlling for age: in Table 7.14, all abandoners (willing and unwilling) are compared to all practitioners (supporters, contemplators, and reluctant practitioners); in

Table 7.15, willing abandoners are compared to supporters; in Table 7.16, contemplators are compared to supporters. These results are represented graphically in Figure 7.1; and show that fear of prosecution (stronger agreement with assertions that the law banning FGC is powerful and readily enforced) was significantly positively associated with abandonment (compared to practicing FGC), and with being a willing abandoner or contemplator (compared to supporter).

Table 7.14 Association between law scores and odds of being an abandoner (of any kind) versus being a practitioner (of any kind) among Senegalese respondents by logistic regression (N = 169)

Variable	Coefficient	OR	95% CI	P-value
Age	.024	1.023	-.033, .081	.417
Law score	4.118	61.450	2.830, 5.407	.000

Table 7.15 Association between law scores and odds of being a willing abandoner versus being a supporter among Senegalese respondents by logistic regression (N = 99)

Variable	Coefficient	OR	95% CI	P-value
Age	.074	1.077	-.007, .155	.075
Law score	3.612	37.029	2.056, 5.168	.000

Table 7.16 Association between law scores and odds of being a contemplator versus being a supporter among Senegalese respondents by logistic regression (N = 68)

Variable	Coefficient	OR	95% CI	P-value
Age	.046	1.047	-.125, .216	.600
Law score	2.524	12.480	.518, 4.530	.014

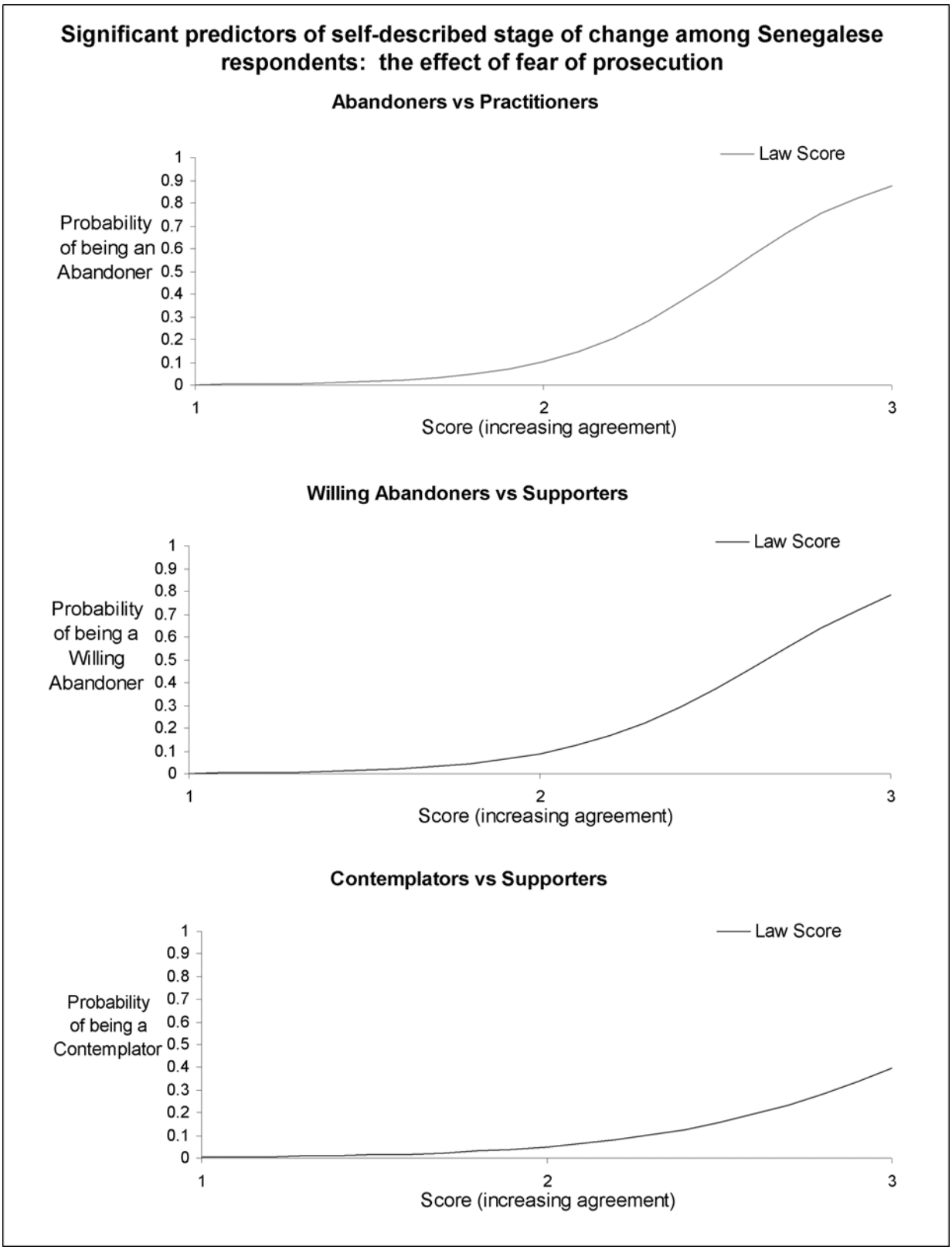

Figure 7.1 Effect of fear of prosecution on stage of change among Senegalese respondents. Significant associations between increasing law score (reflecting agreement with statements about the enforceability of laws banning FGC) and the predicted probability (calculated from results of logistic

regression) of being an abandoner (compared to a practitioner; N = 169; above), a willing abandoner (compared to supporter; N = 99; middle), or a contemplator (compared to supporter; N = 68; below), controlling for respondents' age.

We then turn to the contingencies that could be analyzed among both Senegalese and Gambian women. Table 7.17 described the results of logistic regression for these contingencies comparing all abandoners (willing and reluctant) to practitioners (supporters, contemplators, and reluctant practitioners). Associations between significant predictors from the regression in Table 7.17 (adverse experience, health score, conformity score, leadership score, and religion score,) and probability of being an abandoner are represented graphically in Figure 7.2. These results demonstrate that knowledge of an adverse outcome of FGC (a case in which a girl died or experienced serious complications from FGC), increasing agreement with assertions about the negative health consequences of FGC, and influential anti-FGC community leadership were all positively associated with abandonment, while conformity (reluctance to be first in the community to abandon and perceived pressure to conform) and the view of FGC as a religious obligation were negatively associated with abandonment.

Table 7.17 Association between contingencies and odds of being an abandoner (of any kind) versus being a practitioner (of any kind) among Senegambian women by logistic regression (N = 642)

Variable	Coefficient	OR	95% CI	P-value
Age	0.003	1.003	-0.049, 0.055	0.903
Anti-FGM campaigns	0.138	1.148	-0.511, 0.787	0.676
Adverse experience	1.306	3.692	0.268, 2.344	0.014
Health score	2.260	9.585	1.630, 2.890	<0.001
Migration	-0.083	0.920	-0.692, 0.525	0.789
Conformity score	-1.873	0.154	-2.307, -1.438	<0.001
Marriagability score	-0.330	0.719	-0.898, 0.239	0.256
Interethnic marriage	-0.297	0.743	-0.998, 0.404	0.406
Leadership score	1.332	3.789	0.345, 2.320	0.008
Circumciser availability	0.293	1.341	-0.064, 0.651	0.107
Religion score	-1.000	0.368	-1.645, -0.356	0.002

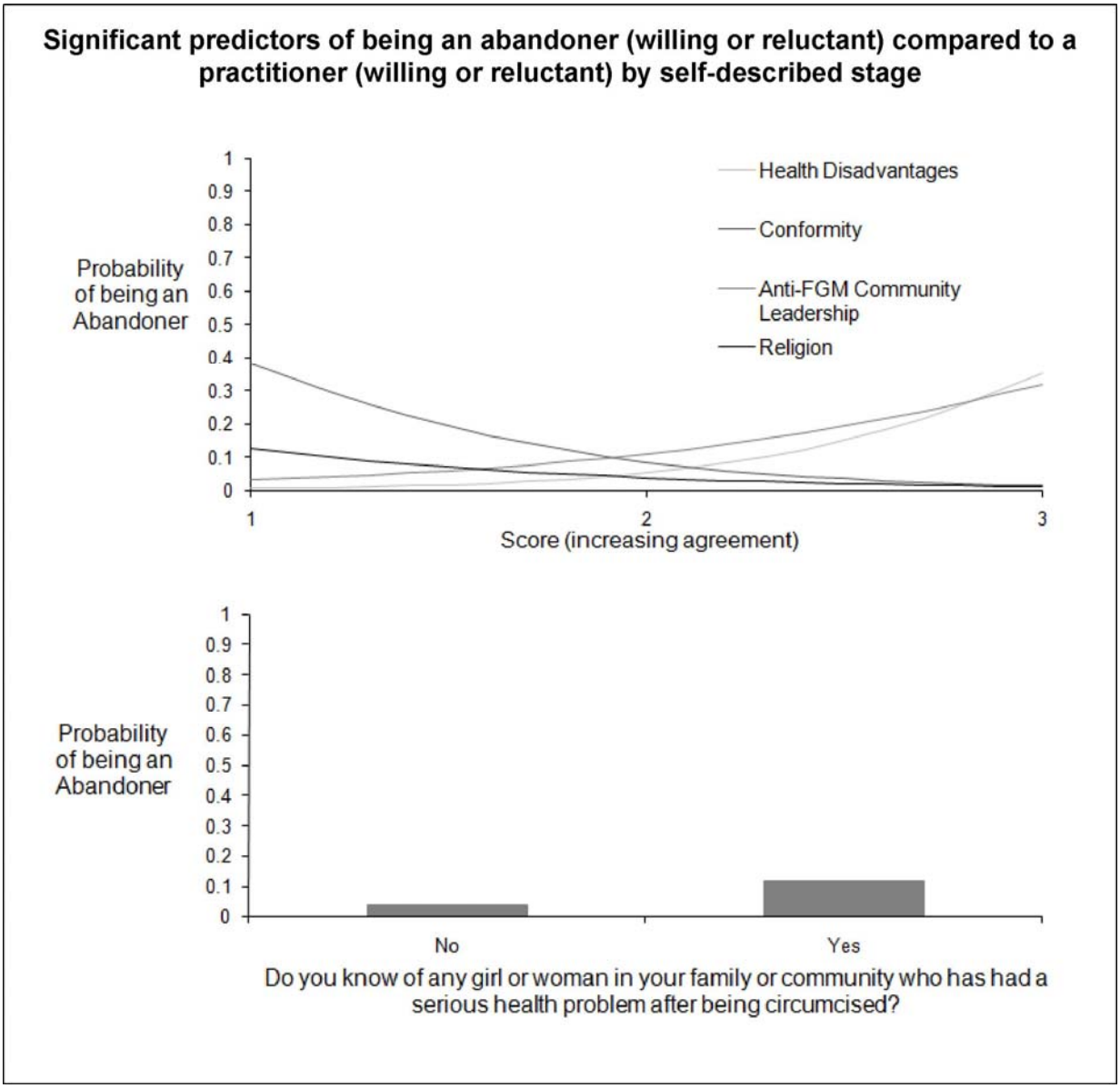

Figure 7.2 Effect of contingencies on stage of change (comparing abandoners to practitioners). Significant ($p < .05$) associations between contingencies and the predicted probability (calculated from results of logistic regression) of being an abandoner (compared to a practitioner; N = 642): increasing health score (reflecting agreement with statements about health risks associated with FGC; above), conformity score (reflecting agreement with statements about pressure to conform in FGC; above), community leader score (reflecting interaction with and influence of community leadership vocal about FGC; above), religion score (reflecting increasing agreement with statements about the importance of FGC to Islam), and knowledge of an adverse outcome after FGC (below).

Table 7.18 describes the results of logistic regression for contingencies comparing willing abandoners to supporters. These results demonstrate that increasing agreement with assertions about

the negative health consequences of FGC was positively associated with being a willing abandoner, while conformity (reluctance to be first in the community to abandon and perceived pressure to conform) and increasing agreement with assertions about FGC as a religious obligation were negatively associated with being a willing abandoner. Table 7.19 describes the results of logistic regression for contingencies comparing contemplators to supporters. Similar to the regression in Table 7.18, these results demonstrate that increasing agreement with assertions about the negative health consequences of FGC was positively associated with being a contemplator, while conformity (reluctance to be first in the community to abandon and perceived pressure to conform) was negatively associated with being a contemplator. These results are represented graphically in Figure 7.3.

Table 7.18 Association between contingencies and odds of being a willing abandoner versus being a supporter among Senegambian women by logistic regression (N = 485)

Variable	Coefficient	OR	95% CI	P-value
Age	0.092	1.096	-0.001, 0.185	0.053
Anti-FGM campaigns	0.145	1.156	-0.966, 1.256	0.798
Adverse experience	-0.512	0.599	-2.443, 1.419	0.603
Health score	3.082	21.802	1.801, 4.363	<0.001
Migration	-0.393	0.675	-1.425, 0.639	0.455
Conformity score	-1.536	0.215	-2.312, -0.760	<0.001
Marriagability score	-0.717	0.488	-1.770, 0.337	0.182
Interethnic marriage	0.184	1.202	-0.726, 1.093	0.692
Leadership score	1.293	3.642	-0.144, 2.729	0.078
Circumciser availability	0.501	1.651	-0.075, 1.078	0.088
Religion score	-1.286	0.276	-2.451, -0.121	0.030

Table 7.19 Association between contingencies and odds of being a contemplator versus being a supporter among Senegambian women by logistic regression (N = 487)

Variable	Coefficient	OR	95% CI	P-value
Age	-0.027	0.974	-0.103, 0.050	0.492
Anti-FGM campaigns	0.027	1.027	-0.869, 0.923	0.953
Adverse experience	0.140	1.150	-1.716, 1.995	0.883
Health score	2.019	7.529	1.103, 2.933	<0.001
Migration	0.223	1.250	-0.624, 1.070	0.606
Conformity score	-1.304	0.271	-1.955, -0.654	<0.001
Marriagability score	-0.570	0.566	-1.364, 0.224	0.160
Interethnic marriage	-0.245	0.783	-1.164, 0.675	0.602
Leadership score	-0.864	0.422	-3.295, 1.568	0.486
Circumciser availability	0.248	1.282	-0.258, 0.754	0.336
Religion score	-0.529	0.589	-1.445, 0.387	0.258

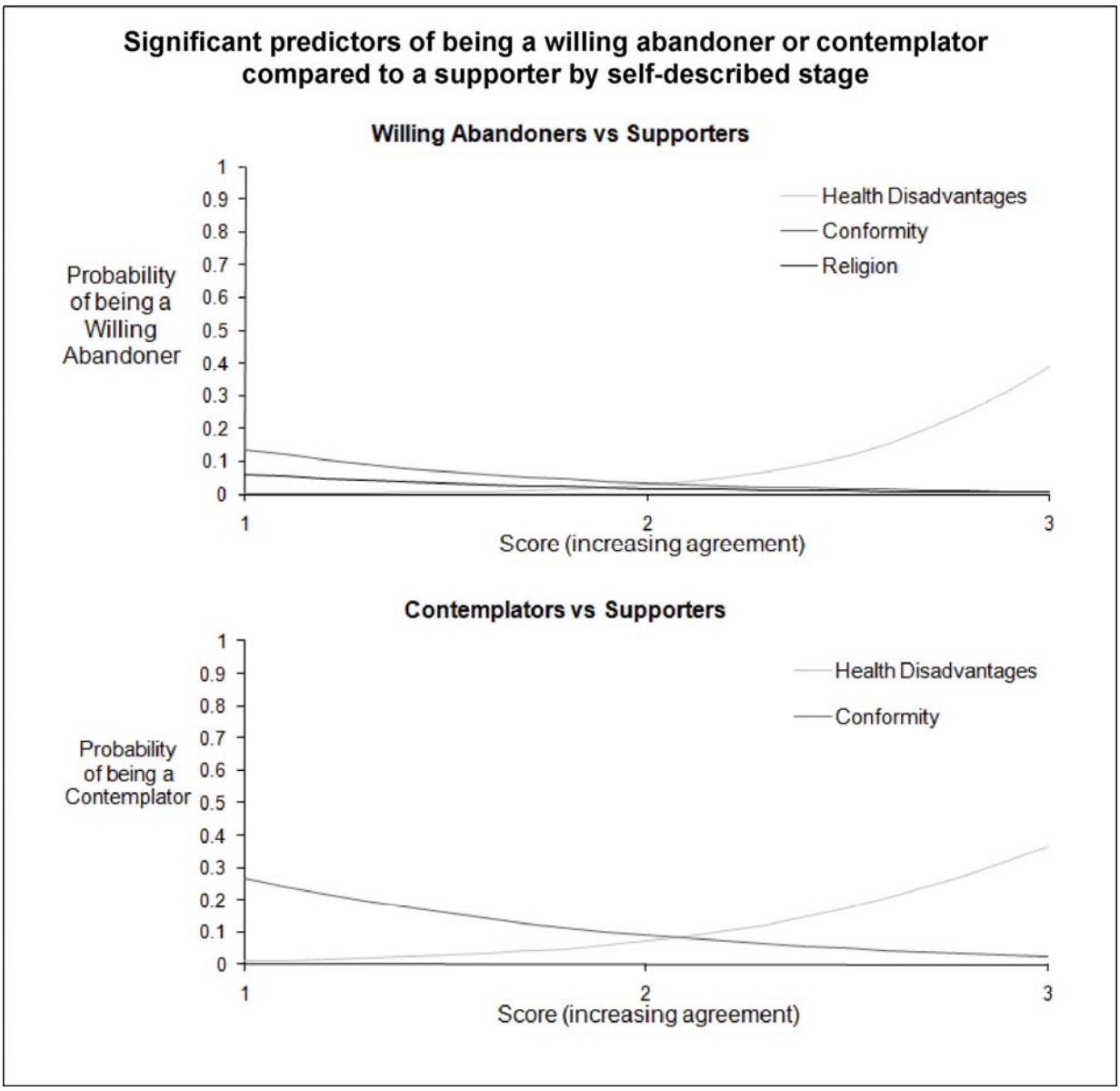

Figure 7.3 Effect of contingencies on stage of change (comparing willing abandoners to supporter, above, and contemplators to supporters, below). Significant ($p < .05$) associations between increasing health score (reflecting agreement with statements about health risks associated with FGC), religion score (reflecting agreement with statements about FGC as a religious obligation in Islam), and conformity score (reflecting agreement with statements about pressure to conform in FGC) and the predicted probability (calculated from results of logistic regression) of being a willing abandoner (compared to a supporter; N = 485; above) or being a contemplator (compared to a supporter; N = 487; below).

Conclusions

Despite the vast and growing body of literature aimed at deepening our understanding of the practice of female genital cutting, the issue of behavior change remains poorly understood. The practice is often portrayed as static when, in reality, even in the absence of intervention efforts, its meaning is continuously contested and reexamined in light of changing social circumstances. Whether and how the practice is performed is repeatedly modified in order to address fluid and often interdependent social

needs. Thus, the manner in which behavior change occurs and the factors that alter or deter readiness to change must be examined within the social context in which individuals are operating.

In a setting in which people are acutely aware that their tradition has come under attack, debates surrounding the practice of FGC have intensified. Varied responses to such assaults – ranging from reactance to ambivalence to abandonment of the practice – have served to expand the available cultural "menu." Mackie's convention theory posits that when people abandon FGC, they will do so quickly (Mackie 2000). This portrayal, however, does not unpack the complex, varied, and shifting responses that individuals may have over time. Our data suggest that such shifts in people's intent do not occur in a simple linear fashion nor in the manner of an on/off switch.

Instead, we have found in the case of FGC in Senegal and The Gambia that the data point to something much more fluid than two diametrically opposed camps of "supporters" and "opponents," and we thus caution that falsely dichotomizing those who retain and those who abandon the practice oversimplifies the complexity of contemplation and decision making (Hernlund 2003). We find the concept of contingency particularly useful in developing an understanding of the contexts and factors shaping shifting opinions and behaviors.

Ideally, the effects of contingencies are best studied through focused prospective ethnographic research, as this concept is about fluidity in opinions. Our survey data, however, allow us to examine the magnitude of effects at one point in time, and provide insights that are consistent with our findings from earlier chapters. Logistic regression reveals that health messages and conformity are universally important contingencies for stage of change: those who have more thoroughly internalized messages regarding the negative health impact of FGC are more likely to be abandoners than practitioners, and more likely to be either willing abandoners or contemplators (compared to those who have not internalized health messages to the same degree); those who have a greater aversion to breaking convention are less likely to be abandoners, and less likely to be either willing abandoners or contemplators (compared to those who perceive less pressure to conform regarding FGC).

Internalized health messages: Most participants reported that the anti-FGM campaigns they had been exposed to had not influenced their opinion of FGC, and we find no significant effect of exposure to campaign messages on stage of change; yet, the health messages that have been central to many of these campaigns do seem to have had an impact. Those who have come to believe that FGC poses potential health risks are less likely to be practitioners and supporters of the practice.

Convention/peer pressure: We found little evidence supporting the marriage convention hypothesis put forward by Mackie (1996; 2000) and Mackie and LeJeune (2009): concern for marriagability was not a significant factor in stage of change. As we discuss in Chapter V, marriage across lines of ethnicity and circumcising tradition are common and circumcision in most instances is not a prerequisite for marriage in this setting. However, we do find that concern with others' decisions regarding FGC (not wanting to be the first to abandon) and pressure to conform are important factors in stage of change, more generally supporting FGC as a social convention. As we discuss in Chapter V, whether FGC is viewed as a social norm, enforced by active sanctioning, or a social convention, enforced merely by expectations of other community members' actions, concern for social networks and relationships is paramount in the practice of FGC in the Senegambia.

Religion: While not as strong or universal in its effect as those listed above, religion nonetheless emerges as a significant and important contingency among survey respondents. Our results indicate that those women who are able to incorporate FGC into their religious practice, and come to believe that FGC is supported (as a *sunna*) or required (as a *farata*) by Islam, are less likely to abandon the practice, and are less likely to be willing abandoners (compared to supporters).

We also found that having community leaders who "speak out" against FGC and knowing first-hand of an instance of a serious health complication arising from FGC influenced participants' stage of change. These effects were only apparent when comparing all abandoners to all practitioners.

VIII. Implications for Programs Aimed at Ending FGC

In this research we bring together analyses of the interplay of ongoing cultural change, responses to anti-circumcision programs, and national policy that shape people's shifting opinions about the practice, and influences whether and how FGC is performed. Improved understandings of the social science theories on the dynamics of change provide some useful insights for the design and evaluation of intervention program.

At a very basic level, the categories of readiness to change identified in this study provide us with a more specific vocabulary for describing the change process. We point to the fact that decision making is often conducted by groups of individuals, and is relational – what one person chooses to do is dependent on the decisions of others. As a consequence, individuals cannot always act upon their desire to abandon FGC. Our categories capture two dimensions of readiness to change: actual behavior, and preference. They can be measured in survey questionnaires that pose two questions: 1) Have you or will you circumcise your daughter, and 2) Do you support continuation or discontinuation of the practice of FGC?

Actual Behavior	Preference: Supports FGC	Preference: Ambivalent	Preference: Opposes FGC
Has or will cut	Non-Contemplative (Willing Practitioner)		Reluctant Practitioner
Undecided		Contemplator	
Will not cut	Reluctant Abandoner		Willing Abandoner

The identification of individuals who adhere to the practice but favor abandonment (reluctant practitioners) may provide important metrics of change short of abandonment, and points to groups potentially prepared for change.

Insights from theory show that the practice of FGC can be held in place by a variety of social conventions and norms that certainly vary across time and locales. A commonality, however, is that individuals suffer shame and exclusion for failing to conform with social expectations regarding proper behavior. Consequently, individuals who come to support abandonment of FGC often cannot act upon this preference unless members of their family and their extended social community agree. Programs that focus on individuals without also reaching out to their social networks will not be effective in mitigating social sanctions and stigma from failing to conform. Our findings in Senegambia support previous recommendations that interventions should be multisectoral, targeting both women and men across generations (UNICEF 2005). We find evidence supporting the claim that greater change occurs when abandonment is coordinated among members of extended networks. Importantly, our study reveals that despite the fact that the practice of FGC is commonly described as "women's business," men play an important role in the abandonment decision. This finding seems to be robust; Demographic and Health Survey data collected from both men and women in numerous African countries find that fewer men than women support continuation of the practice (Yoder 2004). Campaign messages must take into account local cultural values, practices and experiences in order to be deemed credible, and be situated within an understanding of how advantages are weighted against disadvantages. As there exist a wide range of scenarios regarding the valuation of FGC practices, methods that we have employed for assessing motivational balance may be of use. Guidelines for rapid assessment methodology are in preparation by the authors.

Finally, our results from Senegal demonstrate the legislation elicits multiple responses. It can provide a supportive environment for those who have abandoned FGC, and it can create fear of prosecution and help motivate change. But legal bans can also incite reactance and drive the practice of FGC underground. Our findings suggest that legislation does not appear to coordinate change, and therefore has limited utility as a stand alone measure. Legislation can, however, bolster the effectiveness of integrated community intervention efforts.

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