



Dynamics of decision-making and change in the practice of female genital mutilation in the Gambia and Senegal

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## Introduction

Decades of programming efforts aimed at eliminating female genital mutilation (FGM) have yielded varied and, in general, limited results. Reviews point to limits in the understanding of the process of decision making and change in the practice of FGM, and call for theoretical models to understand better how and why interventions cause change.

This WHO-supported study was developed to improve the understanding of the dynamics of decision-making, and to assess the correspondence of these dynamics to theories of behaviour change. Improved theoretical, methodological and empirical insights can assist in the design, implementation, and evaluation of increasingly effective programmes aimed at ending FGM.

## Methods

The study was conducted in the Gambia and Senegal in communities purposely selected to allow comparisons across a range of factors including age, sex, ethnicity, urban versus rural residence, differing interventions, and among contiguous communities bisected by a national border. The study was not designed to be nationally representative, but rather to capture decision making processes and the dynamics of change.

Data were collected using a set of mixed qualitative and quantitative methods in a closely integrated fashion over a three-year period beginning in 2004.

Qualitative research techniques included participant observation, interviews with 300 adult women and men, and 28 focus group discussions.

Survey data were collected from 1220 women between the ages of 18 and 40 who had given birth to at least one daughter, and 96 husbands of the mothers interviewed, and others involved in decision-making.

## Results

Decisions about FGM are usually made by multiple family members, including most often mothers, fathers, grandparents and aunts. These decisions occur in a context marked by extensive social pressure and strong expectations to comply with the practice of FGM.

Differences of opinion, also within decision-making groups, are often extensive. Fathers were generally less supportive of the continuation of FGM than mothers, and were often involved in decisions where daughters remained uncut.



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This research finds empirical support for social convention theory, a model that highlights the fact that actions of individuals are interdependent on those of others, and that behaviour change must be coordinated among interconnected individuals. While the original formulation of social convention theory describes FGM as a practice locked in place by interdependent expectations regarding marriagability, this research finds that in the Gambia and Senegal FGM is not strongly linked to concerns about marriage.

In the study areas, the prime motivating factor for the continuation of FGM was an intergenerational peer convention and peer pressure among women. FGM serves as a signal to other women that a girl or woman has been trained to be obedient, respects the authority of her cut elders and is worthy of inclusion in their network for social support. In this manner, FGM facilitates access to social capital by younger women and an accumulation of power and prestige by elder women.

The multiple decision makers and broad social pressure to conform renders individuals less able to act upon intentions to abandon FGM. In the Gambia 65% of the mothers agreed with the statement, “Whether or when female circumcision is practiced depends mostly on what the other decision-makers want, not what I want.”

To grasp the interplay between individual and social factors, the study developed a model of readiness to change that involves two dimensions: **preference** and **actual behaviour** (Table 1). Five categories of readiness to change were identified.

1. Supporters of FGM – those who want to and will continue the practice.
2. Reluctant practitioners – those who practice FGM despite opposing its continuation.
3. Contemplators – those who continue the practice but consider abandonment.

Table 1. Model of readiness to change practice of female genital mutilation

BEHAVIOUR	PREFERENCE		
	Supports FGM	Ambivalent	Opposes FGM
Practitioner	Willing practitioner (noncontemplative)		Reluctant practitioner
Undecided		Contemplative	
Abandoner	Reluctant abandoner		Willing abandoner

4. Willing abandoners – those who want to and are able to abandon.

5. Reluctant abandoners – those who gave up practicing FGM against their will (e.g. due to peer pressure).

Motivation to change is influenced by the balance between perceived benefits and perceived risks. A motivational balance measure was created, and shown to affect readiness to change.

Information on obstetric health risk from FGM was less readily accepted than information of the risk of HIV. This because the former did not align with women’s understanding of reasons for birth complications, and because it was seen as a negative judgement of their foremothers. By contrast, due to the newness of the threat of HIV/AIDS, this message was seen as less threatening to the value of tradition and the wisdom of elders.

Concern over the risk of transmitting of HIV through cutting not only encouraged the abandonment of FGM, but also led to an increased quest for medicalized ways of performing FGM that could reduce the risk.

The legal ban on FGM in Senegal provoked fear of prosecution and increased motivation to abandon FGM in some. It did not, however, lead to actual change until a community-based program coordinated abandonment.

Other responses to the law included driving the practice underground, resentment at interference with cultural tradition, and less often, blatant defiance of the ban. It was also reported that a number of local circumcisers stopped performing FGM for fear of prosecution; this, in turn, led people to travelling circumcisers who were considered less qualified and trustworthy.

Internalization of the health risks, closeness to a leader who spoke out against the practice and fear of the law were the strongest motivations supporting abandonment and wish for abandonment of FGM. Pressure to conform, peer pressure and religion were the strongest motivations for continuing the practice.

The way in which FGM is carried out has changed over the past generation. Ritual training and celebration is reduced, the practice more often being done individually and in the homes, rather than in groups in the “bush”. Additionally, the age at FGM is declining.

The type of cutting shows no significant change when comparing mother and daughter, although many informants voiced support for reducing the degree of cutting.

## Policy implications

Interventions need to coordinate change among interconnected members of social networks, which are intergenerational and include both men and women. Engagement of leaders in interventions is important.

Measuring readiness to change in ways that grasp differences between preference and actual behaviour, capturing the significance of a wider decision-making group as well as the significance of social pressure, can be a useful tool for identifying change short of total abandonment. This provides potentially useful metrics for monitoring and evaluation.

Identification of individuals who adhere to the practice but favour abandonment may point to groups potentially prepared for change.

Health information should be formulated in ways that resonate with local perceptions and experiences. 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 FGM, rather than using one blade per girl.

Rapid assessment of motivation and motivational balance (perceived advantages and disadvantages) might be a useful tool for preparation prior to intervention, as well as monitoring of change and final evaluation.

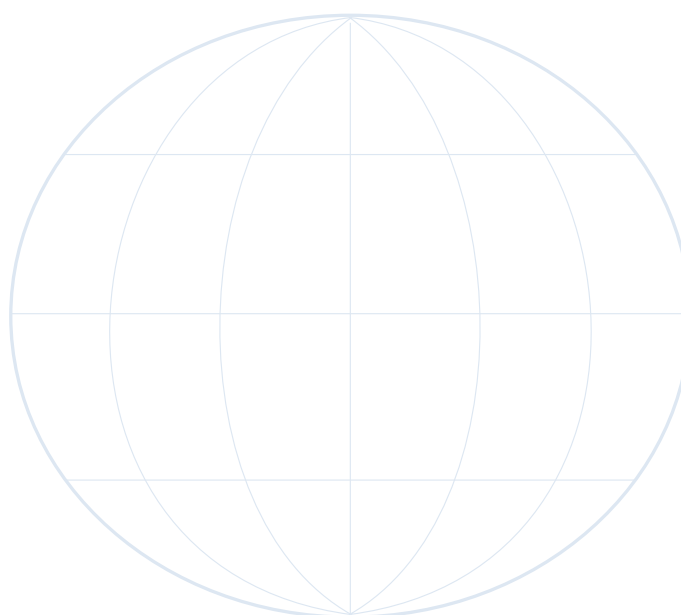
Legislation can serve as a deterrent of FGM, but can also create an “enabling environment”, providing support for those who have or wish to abandon FGM. Legislation should not be implemented as a stand-alone strategy. Instead it should be implemented alongside multisectoral integrated community interventions.

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A full copy of the report is available at: <http://csde.washington.edu/bsd>





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