Upper Tribunal
(Immigration and Asylum Chamber)

K and others (FGM) The Gambia CG [2013] UKUT 00062(IAC)

THE IMMIGRATION ACTS

Heard at Field House	**Determination promulgated**
on 20th - 22nd November 2012	
	……

Before

UPPER TRIBUNAL JUDGE MACLEMAN
UPPER TRIBUNAL JUDGE COKER

Between

K
J
MISS K

Appellants

and

THE SECRETARY OF STATE FOR THE HOME DEPARTMENT

Respondent

THE SECRETARY OF STATE FOR THE HOME DEPARTMENT

Appellant

and

AS

Respondent

1. *FGM has been practised upon about three quarters of the female population of The Gambia historically. The most recent scientific evidence, based on data from 2005, showed no significant change in its incidence. There are ongoing campaigns, principally by GAMCOTRAP (Gambia Committee on Traditional Practices Affecting the Health of Women and Children), aiming to reduce and eventually to eliminate FGM. There has been some increase in published opinion in the Gambia against FGM, and there have been local declarations of renunciation, but there has been no scientific evaluation of GAMCOTRAP's effectiveness in establishing a decline.*

2. *Incidence of FGM varies by ethnic group. Within the four main ethnic groups there are subgroups, within which the incidence may vary – see the table below. In no ethnic group is the practice universal; in some ethnic groups the practice is absent. Ethnic groups are thoroughly interspersed. The country is small and highly interconnected. (Where reference is made to ethnic group we include sub-groups save where specified)*

3. *The evidence as at November 2012 falls short of demonstrating that intact females in The Gambia are, as such, at real risk of FGM. The assessment of risk of FGM is a fact sensitive exercise, which is likely to involve ethnic group, (whether parental or marital), the attitudes of parents, husband and wider family and socio-economic milieu.*

4. *There are significant variables which affect the risk:*

(i) the practice of the kin group of birth: the ethnic background, taking into account high levels of intermarriage and of polygamy;
(ii) the education of the individual said to be at risk;
(iii) her age;
(iv) whether she lived in an urban or rural area before coming to the UK;
(v) the kin group into which she has married (if married); and
(vi) the practice of the kin group into which she has married (if married).

Also relevant is the prevalence of FGM amongst the extended family, as this may increase or reduce the relevant risk which may arise from the prevalence of the practice amongst members of the ethnic group in general.

5. *In assessing the risk facing an individual, the starting point is to consider the statistical information currently known about the prevalence of the practice within the ethnic group that is the relevant ethnic group in the individual's case, as follows:*

    a. *If the individual is unmarried and given that ethnicity is usually taken from the father in The Gambia, the relevant ethnic group is likely to be the ethnic group of the father.*
    b. *If the individual is married to a man from an ethnic group that is different from her father's ethnic group, then the relevant ethnic is the ethnic group of the husband.*

The statistics from which the prevalence of the practice of FGM within the ethnic groups in the Gambia is drawn, vary considerably given the lack of detailed research and analysis undertaken in The Gambia. From the material before the Upper Tribunal, those statistics indicate as follows:

Ethnic group	Prevalence of FGM/C
Mandinka	May be as high as 80-100%
Fula (Overall)	30%, although some estimates are as high as 84%
Hobobehs (sub group of Fula)	0%
Jama (sub group of Fula)	0%
Toranks, Peuls, Futas, Tukuleurs, Jawarinkas, Lorbehs, Ngalunkas and Daliankos (sub groups of Fula)	Practise but % unknown
Sarehule	May be as high as 100%
Serer (overall)	May be as high as 64%
Njefenjefe (within the Serer ethnic grouping)	0%
Niumikas (within the Serer ethnic grouping)	Practise but % unknown
Jola & Karonikas	90 to 100%
Jola Foni	Practise but % not known
Jola Casa	0%
Wolof (overall)	May be as high as 20%
Wolof – those who migrated from Senegal Oriental	0%
Wolof – those who migrated from Sine Saloum	Practise but % not known
Others	Variable

6. *The next step is to consider the various other factors mentioned in paragraph 4 above as some may increase the risk, whilst others may reduce the risk. Whist each case will turn on it own facts, the following are of general application:*

    a. *In the case of an unmarried woman, parental opposition reduces the risk. In the case of a married woman, opposition from the husband reduces the risk. If the husband has no other "wives", the risk may be reduced further. However, it should be borne in mind that parental/spousal opposition may be insufficient to prevent the girl or woman from being subjected to FGM where the extended family is one that practises it, although this will always be a question of fact.*
    b. *If the prevalence of the practice amongst the extended family is greater than the prevalence of the practice in the ethnic group in question, this will increase the risk. Conversely, if the prevalence of the practice amongst the extended family is less than the prevalence of the practice in the ethnic group in question, this will reduce the risk.*
    c. *If the woman is educated (whether she is single or married), the risk will reduce.*
    d. *If the individual lived in an urban area prior to coming to the United Kingdom, this will reduce the risk. Conversely, if the individual lived in a rural area prior to coming to the United Kingdom, this will increase the risk.*
    e. *The age of a woman does not affect the risk measurably; it is an issue upon marriage. Amongst the Fula, FGM has been carried out on babies as young as one week old. The average age at which FGM is carried out appears to be reducing and this may be*

due to concerns about the international pressure to stop the practice. Although there are statistics about the average age at which FGM is carried out on girls and women for particular ethnic groups, the evidence does not show that,in general, being above or below the relevant average age has a material effect on risk. It would therefore be unhelpful in most cases to focus on the age of the girl or woman and the average age at which FGM is carried out for the ethnic group of her father (if unmarried) or that of her husband (if married).

7. *Thus, it is possible to arrive at a conclusion that the risk faced by an individual is less than, or more than, the rate of incidence of FGM in the ethnic group of the individual's father (if unmarried) or her husband (if married). The rate of incidence of FGM in an ethnic group must therefore be distinguished from the degree of likelihood of infliction on an individual against her will or against the will of her parents. Some individuals from ethnic groups with a high incidence may not be at risk, while some individuals from ethnic groups with a low incidence may be at risk.*

8. *State protection: FGM is not specifically criminalised in The Gambia although it may be covered by the existing criminal law on assault or in The Gambia's Children's Act 2005. However, there are no known cases of prosecutions under the general criminal law or under the 2005 Act. There is no reliable evidence to suggest that a female who may be at real risk of FGM can avail herself of effective State protection or that her father or husband could invoke such protection on her behalf.*

9. *Internal flight: As a general matter, an individual at real risk of FGM in her home area is unlikely to be able to avail herself of internal relocation, although this is always a question of fact. Cogent reasons need to be given for a finding that the individual would be able to relocate safely, especially given the evidence that ethnic groups are thoroughly interspersed, the country is small and ethnic groups in different parts of the country are highly interconnected.*

Representation:

For K, J and Miss K: Ms S Harrison, of Halliday Reeves, Solicitors
For AS: Ms E Njenga, of Corbans, Solicitors.
For the Secretary of State: Mr Parkinson, Senior Presenting Officer

DETERMINATION AND REASONS

Introduction

1. This is the determination of the Tribunal, to which both members of the panel have contributed.

2. K, J and Miss K are husband, wife and child, citizens of The Gambia, born on 30th April 1979, 29th July 1981 and 8th March 2009 respectively. The first Claimant came to the UK as a student in July 2005. His wife joined him in June 2007. On 2nd November 2009, some time after K's application for further leave to remain as a student was rejected, he, his wife and his daughter applied for asylum. That application was refused and a decision to remove in accordance with section 10 of the Immigration and Asylum Act 1999 served. Their appeal against that decision came before Judge Fisher on 20th January 2010; he dismissed the appeal. They sought reconsideration which, under transitional provisions came to be treated as an application for permission to appeal. That was granted by Senior Immigration Judge Goldstein on 17th February 2010. This family are appellants in this appeal; for ease of reference we refer to them as claimants.

3. AS is a citizen of The Gambia aged 20. She first came to the UK as a visitor in December 2009. She overstayed and subsequently sought asylum. AS's application for asylum was refused on 10 June 2011 and a decision to remove her from the UK by way of directions made and served. She appealed and on 19 August 2011 her appeal against that decision was allowed by Judge Herbert. The Secretary of State was successful in obtaining permission to appeal. That grant of permission was specifically restricted to "limited grounds", namely "that it is properly arguable that the judge may have erred in relation to the question of internal relocation and in respect of his finding at para 44, where he appears to speculate". In response to this grant on limited grounds, the Secretary of State did not apply for the grant to be varied. AS is the respondent in this appeal but for ease of reference we shall refer to her as a claimant.

Error of law re K and family

4. Following a hearing on 7 September 2010, Upper Tribunal Judge Macleman held that the AIT decision erred in law, by failing to make unambiguous findings on whether Miss K is reasonably likely (if not immediately, then in the foreseeable future) to suffer the infliction of FGM against the will of her parents. The case turned on whether the background evidence discloses a real risk of that nature. The judge's findings of fact (including credibility) were the starting point in re-deciding the appeals.

Error of law re AS

5. On 6th January 2012 Upper Tribunal Judge Storey heard submissions with regard to whether there was an error of law in the determination of the First-tier Tribunal. He found that the First-tier Tribunal judge's findings on internal relocation were not legally sound, firstly because in assessing the viability of internal relocation it was incumbent on the First-tier Tribunal judge to explain why he considered the claimant's educational background would not place her in an advantageous position in relation to the employment sector in potential places of relocation such as Banjul, which, on the First-tier Tribunal judge's own findings, had a vibrant tourist industry. Secondly, so far as the First-tier Tribunal judge's finding at para 42 that the practice of female genital mutilation ("FGM") is "widespread and pervasive in the Gambia", that was a finding insufficiently supported by the

background material before him which, *inter alia*, noted significantly different rates of incidence of FGM in rural and urban areas and also between different tribal groups. Thirdly, insofar as the First-tier Tribunal judge appeared to rely on the evidence relating to the practice of FGM by the Mandinka (or Mandingo), he noted at para 37 that this ethnic group "are by and large traditional, whatever their status or education within society"; it was not clear that he took into account his acceptance of her evidence that she had a non-Mandinka mother.

Country Guidance

6. The appeals of K, J and Miss K were identified as possible country guidance on those identified as being at risk of FGM in The Gambia, including the prospect of internal relocation, and bearing in mind that the procedure potentially to be inflicted is upon the 3 year old child, not the mother, such risk amounting to persecution for a Convention reason.

7. The case of AS was identified as possible country guidance on internal relocation, and in particular on whether in The Gambia a woman from an educated family can relocate without a real risk of being tracked down by non-state actors from her home area (family members, or others acting at their behest), such risk amounting to persecution for a Convention reason.

Hearing

8. Mr Parkinson stated that he would seek to further cross-examine K and AS's uncle in relation to their situation and, in respect of AS, her education.

9. The determinations under appeal made findings on the education and personal situation of the claimants. The Secretary of State had made no previous challenge to those. The claimants did not seek to lead further evidence-in-chief other than from expert witnesses. We found that the case did not give scope for further oral evidence, other than from the experts.

10. An application was made on behalf of K, J and Miss K for an anonymity order. An anonymity order had already been made in the case of AS. The Secretary of State did not oppose the application. We decided that anonymity should apply to all four claimants.

11. Mr Parkinson confirmed that the Secretary of State had not objected to either expert, or to the instructions given to the experts, and had not submitted any questions to the experts, as provided for in directions made on 11th April 2011.

12. Mr Parkinson submitted two bundles of additional documents and his skeleton argument. He had already filed one very large bundle of documents but of that bundle he relied in submissions only upon one item: Female Genital Mutilation in the Gambia, a Desk Review, published in 2002 by the National Women's Bureau, Office of the Vice President, The Gambia. Neither expert was asked to comment specifically upon that document, either in advance or at the hearing.

13. The parties agreed that FGM, in any of forms 1-4 (see paragraph 23), is persecution for a Convention reason not only of a girl child but also of the parents of a minor child where they are opposed to the procedure and where there is a real risk of its infliction, and that FGM is prevalent in the Gambia. The parties also agreed that the live issues were -

    i. the significance of ethnic background and ethnic mixing in the prevalence of FGM;

    ii. the ability of parents to protect a minor girl child until the age of 18;

    iii. whether the risk ceases at age 18; and

    iv. the feasibility of internal relocation, which was in reality the question whether there is risk throughout the country; it was unlikely that anything turned on whether it would be unduly harsh to relocate.

14. We heard oral evidence from Professor Barnett and Professor Chant. We have attached a schedule of the documentary evidence before us – Annex B.

Retained Findings of Fact

15. K is a member of the Mandinka tribe. The Mandinka make up something in the region of 42% of Gambia's population. Prior to coming to the UK he had worked in the capital for some 11 years. His purpose on first coming to the UK was to study business management.

16. Mrs J is Fula, who constitute about 18% of the country's population (all estimates vary). J underwent FGM aged about 5.

17. The child claimant, Miss K, has two loving parents who are opposed to the FGM procedure. Judge Fisher found that she was likely to be subjected to FGM at some undetermined time in the future.

18. The father of AS is from the Mandinka ethnic group and her mother from the Wolof ethnic group. Her father is a part-time lecturer at the University of Gambia. Her mother conducts a small-scale business selling food. When she was 12 years old her father's family members went to her parents and informed them that she was required to undergo FGM. On 25 December 2009 AS travelled to the UK to visit an uncle. Whilst here she received a phone call to inform her that her status as an uncircumcised woman was becoming a big problem within the family and that her father had given his word that she would be subject to FGM on her return from the UK. Her mother confirmed this. Judge Herbert accepted the claimant's evidence as credible, and that she would be at real risk of being subjected to FGM on her return to her home area in Gambia, Dippakunde, which is part of Greater Banjul.

Background material

GAMCOTRAP

19. GAMCOTRAP (Gambia Committee on Traditional Practices Affecting the Health of Women and Children) has this mission statement - "To create awareness about traditional practices in the Gambia. We aim for the preservation of beneficial practices as well as the girl children's political, social, sexual, reproductive health and educational rights". It was formed in 1984, and was the first NGO to mount a sensitisation and information campaign aimed at eradicating harmful traditional practices. Their project Operations Rescue begun in 1997 was funded by UNICEF and is part of a long term education and communication strategy to eradicate FGM. That project is located in Central and Upper River Regions where the practice is most prevalent. In 1998, following a symposium organised by GAMCOTRAP for religious leaders and medical personnel, the Banjul declaration was signed. This stated that the practice of FGM has neither Christian nor Islamic origins nor religious justifications, and condemned its continued practice. Since 2007 there have been three 'Dropping the Knife" ceremonies (in 2008 in Upper River Region, 2009 Upper River Region, 2011 Lower River Region) following educative and training activities carried out by GAMCOTRAP.

20. The 2011 annual report, the Report of the Dropping of the Knife 2011 and the GAMCOTRAP profile of circumcisers from the Lower River Region set out the educational programmes undertaken culminating in public ceremonies where circumcisers pledge to cease their activities along with awareness raising campaigns amongst religious leaders, security officers, women leaders, youth, circumcisers, wards councillors and community leaders. There are a number of testimonies reported (in translation) of the effect that education and training have had on their perception of FGM and their future activities. We were particularly referred to the work done with and statements given by district chiefs, community leaders and security officers together with the capacity building undertaken to provide alternative livelihoods. Reference was made to specific testimonies supportive of changed views and attitudes to FGM with pledges not to have daughters circumcised, and by circumcisers to cease their activities. The Annual report refers to monitoring and evaluation at national and international level in the following terms:

> "Monitoring of activities is at different levels. GAMCOTRAP conducts its own monitoring of communities supported by its community based facilitators.
> The monitoring visits reiterated the importance of reaching out to the individual communities to gauge their understanding of the issue discussed during the training activities. It has created opportunity for GAMCOTRAP to know what the issues are and the need to reach out to many more people and help the communities to reach consensus. The monitoring boosts the morale of those who have been trained and shared information with their communities. It also emphasised the importance of the campaign to the communities and seriousness in which it is given. It gave opportunity to capture the views of both the trained and those who have not been trained and thus gives a fair indication of the situation on the ground."

21. The annual report goes on to set out the various monitoring visits that took place with the various organisations involved in the funding of the project. There is no

annual report for the years covering the previous Dropping of the Knife ceremonies or the nature or extent of evaluation conducted before us. The Report of the Dropping of the Knife 2011 describes the training activities undertaken including Alternative Employment Opportunities and health effects. This report refers to the two declarations in 2007 and 2009 and to "gradual but steady success", and says that -

> "…. through effective and efficient social mobilisation processes and a committed leadership, these communities have been consistently engaged in dialogue and consensus building through our sensitization and training programmes ….. success is associated with the fact that communities can understand what is contained in the very instruments signed on their behalf, the realities associated with HTPs/FGM [harmful traditional practices/Female Genital Mutilation] and their health and making an informed choice based on clear knowledge of the harmful practices."

The Gambia Multiple Indicator Cluster Survey 2005/2006 Report (MICS Report)

22. This survey was conducted as part of a third round of MIC surveys carried out around the world following the declaration and Plan of Action adopted at the World Summit for Children held in New York in 1990 which established a set of goals for the decade 1990 to 2000. Survey tools utilised were based on the models and standards developed by the Global MICS project (produced by UNICEF in collaboration with other UN agencies such as WHO, UNFPA and the US Public Health Services). The report sets out details of the sample and survey methodology, sample coverage and the characteristics of households and covers nutrition, child health, the environment, reproductive health, child development, child protection HIV/AIDS. Appendices include estimates of sampling errors and data quality tables. In its summary it states that there is 71.1% approval for female genital mutilation/cutting ("FGM/C"); 78.3% prevalence and 72.9% would like their daughters to undergo FGM/C. Table CP.7 (attached as Annex A) provides a detailed breakdown by local government area, residence, age, education, experience of FGM/C, wealth index and ethnic group head of household. The breakdown provides percentage distribution for women who believe the practice should continue, be discontinued and would like their daughter circumcised. The figures for those who responded that it depended upon the situation, or who did not know, were very small.

Female Genital Mutilation In The Gambia: A Desk Review

23. This report (first published in 2002) was initiated by the Women's Bureau in the Office of the Vice President and the Secretary of State for Women's Affairs to analyse the existing literature on FGM and future strategies and recommendations for action. It provides an overview of the breakdown of society by ethnic group and draws attention to the bonding of ethnic groups by virtue of religion and to extended family linkages through cross marriage. It says the "individual in society is an integral part of the community with his/her identity depending on his/her

role, status and relations within society. Traditional or historical determinants of status are age, kinship and, in some cases, caste."

24. The summary of the report states that FGM is "seen both officially and by the public as a cultural issue, and thus a problem, which is difficult to deal with, as it is deep-rooted and therefore politically sensitive." It refers to the lack of nationwide statistics on public attitudes to FGM and refers to limited sample size surveys carried out by some NGOs which indicate (in one survey) 69% of respondents want FGM maintained, while (in another nationwide survey) only 15.4% of males and 11.2% of females aged 14-24 were in favour of FGM. The report sets out the perceived prevalence of FGM in The Gambia from a community based survey on the "long term reproductive consequences of FGM in rural Gambia" and to what it describes as "other less representative surveys". Thus in the first survey "98% of Mandinkas, 32% of Fulas and 4% of Wollofs had signs of genital cutting" whereas in the latter surveys practice was estimated "among the Sarahules and Mandinkas at 100%, relatively diminishing among the Jola (96%), Fulas (84%), Sere(64%) and Wollofs (20%). Practice among the minor ethnic groups (Aku Marabout, Tilibonka ad Karonika) is also estimated at 100%."

25. The report considers emerging trends and refers to a GAMCOTRAP report (1999) which observes that some circumcisers who have participated in sensitisation workshops have continued in practice but have modified their practice "cutting the tip of the clitoris instead of the more customary deep cutting to remove the clitoris and part of the *labia minora*". There is reference to the younger age at which the procedure is carried out possibly indicating a trend in part a reaction against campaigns and in part because young girls are seen as less capable of fighting back. There were indications of fewer celebratory rituals, that for those circumcised against their will and those of their parents there was no celebration, and no celebration follows if the girls are considered 'too old'. There is also reference to instances where circumcisers agreed to stop the procedure but continued to perform it in secret.

26. The Desk Review provides some useful information about the societal reasons for the practice of FGM (for example see (vi) below) as well as factors that impact on the prevalence including:

i. Age:

> "…the studies that communities practice FGM as "religious obligation" perform it during infancy. In contrast, when the practice is explicitly referred to as an "initiation rite" for entrance into womanhood and preparation for marriage, it is performed later…This is however dependant on whether the community abides by community arrangements….The studies also indicate that Circumcisers will operate on all girls in a community during the prescribed period in order to clear a backlog of candidates for the operation if the last initiation rite, for example, took place seven years ago. In such cases, every child in the community between ages 0-7 years may be subjected to the operation, even if the baby were born on the very day the operation is planned to take place…. There are

some instances, though, when adolescents are taken. This is mainly applicable to girls who are living away from home and on return are subjected to the practice, the late age notwithstanding."

ii. Ethnic and Regional Affiliation:

"Ethnic origin is an important factor in the maintenance of the practice…..some Wollofs who practise FGM migrated to The Gambia from Senegal Oriental while those from Sine Saloum, also in Senegal do not practice FGM even though they are Muslims….not all categories of Fula practise FGM even though studies have shown that the ethnic group generally has about the second highest rate of practice of FGM in the country……[Hobobehs and Jama do not practice FGM]…. All other subgroups within the Fula category (Toranks, Peuls, Futas, Tukuleurs, Jawarinkas, Lorobehs, Ngalunkas and Daliankos) practise FGM.
Within the Serer ethnic groupings, the Njefenjefe do not practice FGM although the Niumikas from the same ethnic group do. ….the Jola Foni practise FGM the Jola Casa…do not…"

iii. Rural and Urban settings:

"[there are indications] that the practice of FGM is more prevalent in the rural areas than in urban settings to the extent that in some rural communities….the entire female population has undergone the practice or are potential candidates."

iv. Religion:

"The predominantly Muslim population…perceive FGM as a "religious obligation" in Islam. However not all Muslim groups in the country practice FGM."

v. Education:

"….educational background does not have a significant bearing on whether people practice FGM or not…"

vi. Chastity and avoiding shame, rite of passage, marriageability, social standing:

"FGM is believed to be associated with positive moral values…a means of protecting them against bringing shame upon the family by avoiding pre-marital sex or abstaining."

""…in some Gambian communities [FGM] is considered a "rite of passage to adult womanhood and represents a medium for the transmission of long held values, attitudes and norms of behaviour to the effective performance of the role of mother, wife, home manager"… with the reduction in the age at which the operation is carried out nowadays, some studies have concluded that FGM as a 'rite of passage' is becoming less important"

> "From anecdotal accounts it is only after undergoing FGM that a girl is rendered marriageable…in the communities that practice it FGM and virginity are strong requirements for marriage."
>
> "[FGM] has become a class phenomenon ….Those who have [undergone FGM] tend to regard themselves as superior in all respects to those who have not and there are "strict codes of conduct about whom they should mix with….""

vii. Identity Gender and sexuality:

> "…FGM is a woman's affair as women make the decisions themselves with little or no male involvement….. The concern that men's energies would be used up if they married uncircumcised women is particularly so in polygamous relationships. And although women do not see FGM as a means by which men control women's sexuality, to Gambian men it is an important consideration."

viii. Economic factors:

> "…economic reasons prevail in different facets of the practice…the conclusions reached in a number of these studies differ…for most Circumcisers, FGM is not the main source of livelihood although the financial benefits that accrue from it tempt them to continue the practice."

27. The report refers to programmes to "compensate the cutters" initiated by almost all the local organisations, but they have not all succeeded in reducing the prevalence. A feasibility study of an Alternative Employment Opportunities programme in 2001 conducted by GAMCOTRAP in 3 divisions found that the 12 circumcisers identified were willing to give up the practice if assisted with an alternative source of income. The report also states that "in general paying people to change their attitude does not work".

28. The report refers to a pro-FGM lobby including Muslim religious leaders who are respected within their communities and within the Muslim community generally and who hold influential positions in the country and have access to the media, using religious and traditional arguments to influence people. The report states -

> "As these are a primary source of information for most people, the pro FGM lobby has a wide edge over the anti FGM advocates and is therefore a force to be reckoned with."

29. Amongst its conclusions the report states that there is a need for "Government to clearly define an official position on harmful traditional practices including FGM". The report states that "current efforts by government and non-governmental organisations have had little or no significant impact on the magnitude of the practice of FGM in the country".

30. On page 4, Box 2, the Review states:

"* Despite being a party to international rights instruments calling on State Parties to eliminate harmful traditional practices, including FGM, The Gambian Government has not yet defined and declared a national policy on the practice.
* Official attitudes continue to be ambiguous and ambivalent.
* There is need to present key policy makers with the results of incountry research and documentation studies in order to convince and persuade them about the necessity of adopting and declaring an official policy on harmful traditional practices, including FGM."

Country of Information Report – The Gambia October 2011

31. The COI report refers to FGM in two sections. [21.18] states:

> "….. - Domestic violence, female genital mutilation (FGM) and forced marriages also happen and seem to be one of the commonest human rights abuses against women in The Gambia. Beyond the said constitutional provisions and sections 24 and 25 of the Children's Act that prohibit child marriage and betrothal, there is no legislation specifically criminalising domestic violence, FGM and forced marriage."

32. [22.14] states:

> A further extract from the Childs Rights Information Network (CRIN), United Nations compilation of National Reports submitted for Gambia's *Universal Periodic Review*, dated 10 February 2010, stated:
>
> "UNICEF [United Nations Children's Fund] noted that social and cultural norms hindered the execution of the 2005 Children's Act, as harmful practices such as corporal punishment, female genital mutilation/cutting, early or forced marriage, domestic violence, were still widely practiced. CRC recommended taking legislative measures to prohibit all forms of physical and mental violence, including corporal punishment as a penal sanction within the juvenile justice system, in schools and care institutions, as well as in families. It also recommended undertaking studies on domestic violence, ill-treatment and abuse, including sexual abuse within the family."

33. [22.20] of the COI report goes on to say:

> "The USSD Human Rights Report 2010 stated "The law does not prohibit female genital mutilation (FGM) and the practice remained widespread""

The Gambia Operational Guidance Note ("OGN") v4.0 29 August 2007

34. The OGN provides guidance on the handling of claims. [3.6.2] states:

> "3.6.2 ….The law does not prohibit Female Genital Mutilation (FGM). In 2006, the Government publicly supported efforts to eradicate FGM and discouraged it through health education; however the practice remained widespread and entrenched…."
>
> 3.6.10 …. in June 2004 the National Assembly passed a Children's bill aimed at curbing violence against children, that outlaws social and cultural practices that affect the welfare, dignity, normal growth and

development of the child and in particular, those customs and practices that are prejudicial to the health and life of the child ….

3.6.11 ….Although the authorities do not condone FGM and publicly support efforts to eradicate it through health and education programmes, the practice remains legal and is widespread throughout The Gambia. It is generally considered a cultural issue in which the authorities do not interfere and therefore individuals may not be able to access sufficiency of protection.

3.6.13 …Although the National Assembly passed the Children's Bill in 2004, aimed at curbing violence against children, which specifically outlaws the type of violence against children that is characteristic of FGM, the practice of FGM is not illegal….the Government's official stance is that FGM is a cultural issue that the Government cannot forbid or interfere with and therefore any protection that the authorities are able or willing to offer will be limited. However the Gambian authorities publicly supports efforts to eradicate FGM and discourages it through health and education programmes….."

The Children's Act of 2005

35. We were not provided with an actual extract of the Children's Act (effective since 2 August 2005) but it was agreed between the parties that there was provision in the Act to "prohibit social and cultural practices that affect the welfare, dignity, normal growth and development, and life and health of a child or are discriminatory to the child on the grounds of sex". A summary of the main provisions is set out in a document produced by the Child Protection Alliance which is funded by save the Children Sweden.

The Expert Evidence

36. Five expert reports were obtained in advance of the hearing of K, J and Miss K. No expert reports were produced on behalf of AS. Two medical reports have been submitted on behalf of J.

Professor Tony Barnett

37. We received reports from Professor Tony Barnett, dated 25 June 2011 and updated on 16 January 2012. Our references are to the later report.

38. Professor Barnett is Professorial Research Fellow in Health in the Department of Social Policy at the London School of Economics and Political Science and Honorary Professor in the Social Sciences of Infectious Diseases in the Department of Global Health and Development at the London School of Hygiene and Tropical Medicine. He has not, so far as he is aware, met K, J or the child, Miss K.

39. In his report he sets out the background to The Gambia in general and in relation to FGM in that country and the wider region. He describes the World Health Organisation's classification of FGM into four broad categories namely -

i. type 1 involving nicking of, or partial or total removal of the clitoris;

ii. type 2 involving partial or total removal of the clitoris together with partial or total excision of the labia minora;

iii. type 3 is partial or total removal of the external genitalia and stitching or narrowing of the vaginal opening;

iv. type 4 is relatively rare and refers to other forms of traditional genital mutilation such as pricking or stretching the clitoris and/or surrounding tissues.

40. He did not include pictorial illustrations in his report but provided a link through to a WHO publication, "Female Genital Mutilation: a Handbook for Frontline Workers Geneva World Health Organisation 2000 (WHO/FCH/WMH/00.5 Rev.1)".

41. The report includes a table which showed an overview of FGM in Africa from the Demographic and Health surveys. He describes the source of this as coming from one of the most rigorous sources available, but notes that The Gambia does not appear in that table. He comments that the Demographic and Health Surveys (DHS) are prepared by an -

> "excellent research organisation called ICF Macro… [an] organisation that is very rigorous in its methods and particularly careful to evaluate the data they publish in relation to how it has been collected and how carefully the data collection methods have been evaluated for their scientific rigour."

42. He states that the quality and availability of data on The Gambia is of some general importance because it is frequently compiled from "secondary and even tertiary sources". Data should in some cases be treated with some caution and there were few dependable data studies on the prevalence of FGM in The Gambia. As an example he refers to an extract from the Secretary of State's COI report on the Gambia dated 9 June 2011 which he describes as a "factoid" – "a piece of information frequently repeated and accepted as true when in reality it is merely an unsubstantiated assertion the source for which it may be very difficult to trace." The reference he makes is to the estimated prevalence of FGM in girls and women aged 15 to 29 as 78.3% in the 2005/6 Multiple Indicator Cluster Survey (MICS), a matter referred to in his report and in the MICS report. His reference to "factoids" appears to refer to the limited reliably sourced data, such that one must be wary of placing too much weight on information that is repeated without proper sourcing.

43. The publication by the WHO "Female genital mutilation: integrating the prevention and the management of the health complications into the curricula of nursing and midwifery; a student's manual 2001" refers to "fingernails have been used to pluck out the clitoris of babies in some areas in The Gambia". Professor Barnett states that the significance of that is firstly that it is from the WHO, secondly it concerns

The Gambia, and thirdly it indicates that the operation is performed on very young children including babies.

44. Professor Barnett refers also to an unpublished PhD thesis by Heidi Skramstad "Making and managing femaleness, fertility and motherhood within a Gambian urban area" 2008. Dr Skramstad carried out her research over a period of around twenty years. She speaks both Mandinka and Wolof and is married to a member of a very large extended family in the urban part of western Gambia within a few miles of Dippakunda. He considers this to be one of very few theses considering FGM in The Gambia and of particular importance because of the author's knowledge and experience. She states (page 59 of her thesis) -

> "All Gambian boys and almost all Mandinka girls as well as the majority of Foula, Jola and Serahule, undergo an initiation that includes genital cutting (see table in Appendix 4). Mandinka girls are usually initiated between the age of 4 and 10 but some girls are genitally cut while they are babies… in the rituals I observed the youngest was 1½ and the eldest was 10 years old".

45. She also says –

> "…the estimated prevalence of FGM in girls and women of 15 to 49 years was 78.3% in 2005-2006. FGM is widely practised all over the country and all FGM types are carried out at infancy, childhood or at adolescence."

46. Professor Barnett considers issues of relocation, ethnic identity and the differential risk of exposure to FGM in The Gambia.

47. Professor Barnett provides considerable information on issues of ethnic identity, which cannot -

> "be assumed to be internally homogenous with clear boundaries and perhaps consistent customs, structures and practices…".

The Mandinka as encountered in The Gambia are –

> "in fact the remnant of a very large Islamic patrimonial empire which spanned a very large area of this part of Sahelian and sub-Sahelian Africa."

The Fula are-

> "part of a very extensively originally nomadic confederacy which cross-cuts the remnant Mandinka empire east to west, reflecting the ancient migration."

In The Gambia today what is seen are –

> "nationalities and national boundaries which have been superimposed upon a complex sub-structure of these two forms of ethnicity along with many others living in the same geographical region".

The region is -

> "multi-ethnic and so is the Gambia. While people may see themselves as a Serahule, Jola, Wolof, Foula or Mandinka at a genetic and cultural level, they are very mixed and inter-marriage is and has been common. The domestic and personal practices adopted by people entering into these 'mixed' marriages reflect a mixture of what is demanded by public acknowledgment of the patriarchal principle moderated by the particular conjugal bargain which is struck within each marriage."

He further states that -

> "notions of 'pure', 'tribes', of consistent ethnicity should be questioned in relation to this entire region and in relation to the Gambia specifically."

Professor Barnett confirmed in his oral evidence what he says in his report: individuals generally trace their ethnicity through their paternal lineage, although their mother's group may have an influence.

48. In drawing up his conclusions Professor Barnett relies upon what he describes as the more dependable sources, including: The long term Reproductive Health Consequences of Female Genital Cutting in Rural Gambia (2001); Tropical Medicine and Reproductive Health (2010); Contingency and Change in the practice of Female Genital Cutting: Dynamics of Decision Making in Senegambia: Summary Report (1999), Listening to the voices of the people: A situation Analysis of Female Genital Mutilation in the Gambia (1999). He concludes that from the limited number of sources available -

    a. there are variations in prevalence of FGM as between sections of The Gambian female population by urban versus rural, by age of respondent, by education and by ethnic identity;

    b. it is likely that the mean prevalence of the practice in the total living female population may be around 80%;

    c. among those who claim Mandinka identity this may rise to more than 90% and it may fall to around 30% among the Foula;

    d. in some groups the prevalence may approach 0.

49. So far as relocation is concerned, Professor Barnett referred to the size of the country (10,500 square kilometres) and to a population of 1.75 million people, about a third of whom live below the international poverty line of US$1.25 per day, with about 55% of the total population in the metropolitan areas of Banjul, Kanifing and

Brikama. Banjul is the centre for government, has trade, education and relatively good healthcare services by local standards. Outside of the heavily populated area:

> "…employment is extremely scarce and any kind of professional employment would be limited and any available in government services or major utilities would be within the urbanised area, communications are extremely good and personal networks efficient at transmitting information because they are dense and people have multiple links to each other."

50. His oral evidence amplified the extent to which employment opportunities depend upon personal and familial contacts, including where individuals are reasonably well qualified, such as K. The formal sector is mainly within the Greater Banjul area and consists of government and government associated organisations including the tourism industry. It would be "highly unlikely" for someone to find a job in the formal sector without contacts. Outside this formal sector, for example in agriculture as a labourer away from the Greater Banjul area, he would have to explain who he was, where he came from, what he was doing, who his spouse was, how many children he had and so on. His family links would readily be identified.

51. He confirmed that internal migration to the Greater Banjul Area was relatively recent and predominantly to take advantage of economic opportunities.

52. In oral evidence Professor Barnett described the nature of housing and accommodation in Gambia: people live in what in the UK are called 'compounds', a large series of interconnecting sets of residences with shared space, meals, child care etc. The number of people in such living arrangements can be very large, sometimes as many as 170 people all related in terms of the elder man having his wives, their children, their sons' wives and their children all occupying the space. In response to questioning on whether individuals or small families might have separate accommodation, he confirmed this was possible and referred to, for example, expatriates having housing along the tourist coast (depending on income) although such an individual would be readily identified because of the unusual nature of such an arrangement. He also described the extent to which questions of relationship are the basis of initial communication, with detailed questioning devoted to establishing the extent to which individuals fit within perceived kinship groups, whether there is any relationship, and where the grouping comes from or is based in The Gambia. He gave a personal example of how quickly he had been able to re-establish contact with someone he had last seen some 35 years previously.

53. Professor Barnett concludes -

> "The reported FGM prevalence rates among the Mandinka and/or Foula people together with the statements by her parents provide [him] with sufficient evidence to tell the Tribunal that there is a risk to Miss K… [he has] no doubt that the risk is likely to be considerable and that she faces it at her present age."

54. He goes on to say-

a. "if this family were to return to the Gambia they would be easily traced by their extended families – particularly as they would naturally want to make contact with their son who is currently in the care of their extended family;

b. it is entirely probable that Miss K's intact genitals would be noticed by neighbours and friends because (as in our own society) small children's nether regions are often exposed to public inspection through nappy changing, potty use, bathing etc and this even more so in a hot climate where people live at considerably greater density and with far less privacy than is generally the case in the UK."

55. In Professor Barnett's view, the relatives of Miss K would go to considerable lengths to ensure that she is cut. FGM is:

> "surrounded by profound systems of symbolism and cosmological and ontological meanings … concepts of the individual and attitudes regarding individual freedom of choice are constrained by a pronounced cultural perspective which sees (a) individuals as bearers of the faith and future of the lineage into which they have been born, and (b) women as bearing the future of the lineage in their reproductive capacities which are therefore of general interest to the entire lineage past, present and future. Thus, in such an environment abduction of a female child for purposes of FGM does not appear as a criminal or immoral act in the eyes of those who might do it. Rather, it appears as a deeply moral and correct act".

56. Professor Barnett refers to a UN funded news agency report in April 2010 which reports that the President of The Gambia backs a ban on Female genital mutilation/cutting ("FGM/C"), but is not ready to pass a law banning the practice.

57. Professor Barnett states that it would be illogical and incorrect to state that because a very large or small percentage of one ethnic group practise FGM, then it is necessarily the case that an individual will or will not be treated in that way. He describes this as a logical fallacy whereby the characteristics of a group are attributed to an individual member of that group; a reported prevalent characteristic of a group is not a probability statement of the likelihood of any individual member possessing that particular characteristic.

58. Professor Barnett was questioned extensively about the various GAMCOTRAP reports. He does not accept that the reports reflected a reduction in the prevalence of FGM. He accepts they are indicative of a movement to bring about change, and that there are a number of individual testimonies stating an intention to cease FGM by circumcisers, and statements by various leaders re-iterating that intention. He points out that there is no scientific evaluation or follow-up of those intentions, no indication what questions had been asked, by whom, or how, or over what timescale those intentions had been carried to fruition. One reference was to an intention to abolish FGM within a generation i.e. some 30 years. There was no indication of the level of educational achievement of those quoted or the extent of

the population base covered. The reports were written for a particular target audience – donors, government departments, official bodies. He does not accept that such reports provided the same scientific rigour as research reports. He does not accept that the GAMCOTRAP report is indicative of fundamental change in the prevalence of FGM. He prefers the MICS report of 2005/6, as a robust analysis of some 10,000 participants and subject to scientific critique. The lack of scientific analysis and evaluation of personal testimonials in GAMCOTRAP reports is such that little weight could be placed upon them as indicative of fundamental or sustainable change. He describes the 2011 annual report as a "public relations document", reporting to donors. Little scientific weight can be placed upon its content. He drew comparison with the MICS report which set out in detail its methodology, sampling technique and (comparatively large) number of participants.

59. Professor Barnett knew of no cases where a person had been prosecuted under The Gambian 2005 Children Act for serious assault or causing harm.

60. He confirmed that there is considerable inter-ethnic marriage, and that in general ethnic identity flows through the male line. There is considerable ethnic fluidity depending on education, economic status and personal affection. There are no specific ethnically identifiable areas within Gambia. The country is small and although there may be areas where one ethnic identity is prevalent, there are no exclusive areas.

Professor Sylvia Hamilton Chant

61. We received two written reports from Professor Chant, dated 20 June 2011 and updated on 22 January 2012. Our references are to the later report.

62. Professor Chant is Professor of Development Geography at the London School of Economics and Political Science, with research experience in The Gambia which dates back to 2003. Her research has covered women, gender, the family, youth poverty, female employment, sexuality (including FGM and reproductive rights) and migration. She has published widely including a recent chapter entitled "Women and Gender in the Gambia; Problems, Progress and Prospects" in "The Gambia: essays on contemporary issues and future direction 1965-2011". An updated version is due to be published as "Gender in the Gambia in retrospect and prospect".

63. Professor Chant also states that the individual risk of FGM in The Gambia is difficult to determine with precision since there is no official state source of information concerning the practice. She refers to Female Genital Mutilation in The Gambia: a Desk Review ("Desk Review") as indicative of the relegation of FGM to the personal and private sphere with no questions on FGM included in the National Census. She refers to data being "muddied" by the "culture of silence" around the practice which has "traditionally involved the passing on of 'female secrets' to initiates". Notwithstanding the lack of precise or official State sources of information she states that a prevalence rate of between 60% and 90% is commonly cited as the general range for The Gambia. She bases this on a wide range of sources

including primary and/or desk based research conducted by academics, NGOs and international agencies such as UNICEF published in 1999, 2002, 2005, 2007, and 2010. She also refers to the MICS report referred to by Professor Barnett. Her report quotes from rather more sources than Professor Barnett and refers to one of those sources proposing a proportion of less than 60% compared to some of the percentage figures quoted in rural areas in other studies. She surmises that this is possibly accounted for by "by the fact that non-practising Foula groups such as the Hobbobeh are found in the North Bank region".

64. Professor Chant states that there is evidence from the Medical Research Council and other studies that "the risk of FGM is reportedly particularly marked among the Mandinka, Foula, Jola and Serahule ethnic groups (four out of the five major ethnic groups in the Gambia, the remaining one being the Wolof)."

65. The most common form of FGM in The Gambia is type 2 (see paragraph 39 above).

66. She considers the work done by GAMCOTRAP and Tostan (another, smaller, NGO working for the elimination of FGM) and states that there is evidence of some decline in some parts of the country but that it is possible to "presume with a reasonable degree of confidence that around 3 in every 5 women have undergone genital cutting".

67. In paragraph 9 of her report Professor Chant states -

> "Ethnic group rather than geographic location… appears to be the strongest predictor of FGM in the country… this is due in part to inter-marriage between communities in rural areas and also on account of high levels of rural-urban migration in recent years which have been mainly directed towards the Greater Banjul area…".

68. She goes on to say that "in the wake of more than a doubling of the urban population in the last two decades, all ethnic groups can be found in greater or lesser number in The Gambia…where various surveys I have conducted have included migrants of different ethnic affiliation from different regions of the country."

69. At paragraph 10 she says that "in the light of the ethnic mixing… it is difficult to generalise about the geographically specific risks of FGM within the country even in relation to rural and urban areas." She refers to the contradictions in some reports which show a lower incidence of FGM in rural areas than urban areas whereas a more nationally representative figure from MICS data indicates the rural level is higher than the urban level. She comments that some of the discrepancies may be as a result of the rural and community-based approach of anti-FGM campaigns and that the focus on rural areas is "partly because it is reportedly easier to penetrate and work with more closely-knit rural communities on account of greater social cohesion group identity and receptivity to professional change agents".

70. In referring to internal migration she comments that relocation is theoretically possible but -

> "in a society in which 60% of people live below the poverty line and where norms of reciprocity and the maintenance of kinship ties including in the overseas diaspora are not only integral to the culture but often vital for social and economic support and survival, nationally resident persons tend to live on their family compounds or in the immediate environs."

71. She concludes that K and J are justified in their concern that if they return to The Gambia their daughter will be subjected to forcible FGM. She refers to a child being commonly classified as belonging to the father's ethnic group (K being Mandinka). The risk of FGM for the child of a Mandinka would "conceivably be between 80 and 100%". She comments that the views of the child's parents may be taken into account and the father's veto may hold some sway but -

> "there is usually a constellation of decision-makers involved in the process of determining whether or not a child should be circumcised… indeed, rather than being seen as the exclusive property of parents, children in the Gambia are customarily regarded as belonging to the husband's natal extended family or 'clan'."

72. She challenges the evidence cited by the UKBA that Mandinkas only practise FGM on girls aged 10 to 15 (paragraph 3.6.4 Gambia OGN v4.0 29 August 2007 refers to the average age being 12, with 50% of those undergoing the procedure being aged between 5 and 18) because, firstly, there appear to be no fixed age boundaries and, secondly, the general age at which girls can be or are circumcised is reportedly declining. She amplifies the flexibility of age boundaries, by way of example -

> "if a community level peer group circumcision takes place only every few years or so, then all girls in the community eligible for cutting, which could be from infancy into adolescence, may undergo the procedure".

73. She refers to the declining age of circumcision having been noted in several studies (including the Desk Review) and that Mandinka and Serahule girls in particular "may now be circumcised as early as 1 week old, at the time of the baby's naming ceremony". Foula are also reported as normally circumcising their daughters between the ages of 1 and 10.

74. Professor Chant states that information on the state of an uncircumcised girl would be readily discerned by relatives. A girl is likely to be repeatedly asked whether she has undergone the 'procedure' and may be subject to a physical examination if the response is unsatisfactory. She refers to pressure through a husband's female kin in later life after marriage.

75. Professor Chant also refers to a factor commonly cited "for the tendency towards declining age of FGM". This is the concern that it may be outlawed, as it has been

in many other countries, including neighbouring Senegal (1999). There is also international pressure on Gambia to comply with International Conventions such as the Convention on the Elimination of all Forms of Discrimination against Women 1979 ("CEDAW") and the Convention on the Rights of the Child 1990 ("CRC").

76. Professor Chant also considers the possibility of internal relocation within Gambia for a family of mixed Mandinka and Foula ethnicity. She gives five main reasons for that option not to be available:

    a. to return to The Gambia and not live with near kin for reasons other than employment would constitute a major personal and social slide; it would make it very difficult for K and his wife and daughter to earn respect in other social circles;

    b. it is difficult to envisage how the family could repatriate without the support of their families;

    c. obtaining employment depends far more on who you know than what you know, and K's comparatively advanced educational and professional work experience would probably restrict him to job searches in the greater Banjula area;

    d. in that context, he would be known to people beyond his family who would spread news of his return.

    e. the family son is being raised by the paternal grandparents and that would undoubtedly cause a major deterrent to remaining out of contact with kin since that would mean sacrificing reunion with their son.

77. Furthermore she refers to The Gambia being a small country geographically, that short physical differences are made shorter by the fact that news and gossip travel fast, and there is increasingly widespread access to mobile phones.

78. Professor Chant indicates that it is highly probable that the child would be subjected to a physical inspection. She refers to the inability of the parents being able to keep a vigil for 24 hours a day. She draws attention to FGM not being regarded as a criminal offence, but as a family matter beyond the purview of the police and the judiciary.

79. Professor Chant refers to inter-ethnic marriage being not uncommon and that there is also a rising trend in the marriage of Gambians to non-Gambians but she states "unless an inter-ethnic union is accompanied by the promise of significant economic resource flows or an opportunity to obtain overseas residency, generally speaking people aim to marry within their ethnic and religious group." She states that whether a woman is circumcised or not may not be taken into account and may not be discussed but it is -

> "likely to become an issue once a woman is taken into her husband's family and needs social acceptance from her female in-laws… rather than marrying an individual, women marry into the whole family group… women from non-circumcising groups who marry into circumcising families may find they have no choice but to have their daughters circumcised and/or to undergo the practice themselves."

80. If a child was able to avoid FGM through childhood, Professor Chant states that the issue would arise on or after marriage. Around 40% of marital unions are polygamous and FGM is considered a tribal right with the agreement of the family; there is pressure from co-wives as well as the husband's female kin. The lack of circumcision keeps the woman out of the social group because she is unclean. She is seen as "wearing her husband out with insatiable sexual desires". Professor Chant described these cumulative pressures as tantamount to force.

81. Although not questioned about the Desk Review, Professor Chant refers to this in her report. She refers to the dispersal of all ethnic groups throughout The Gambia although some areas have a predominance of particular groups. She draws attention to the Mandinka (who make up 42% of the total population) being found in especially large numbers in the Lower River and North Bank Regions) and the Fula (who make up 19% of the overall population) being mostly settled in the Central River and Upper River regions. She confirmed this in oral evidence. She refers to the Desk Review supporting a 2010 report stating that the level of FGM is higher in rural communities (in contrast to one 2010 report which notes a lower incidence in rural areas) which claims that it is especially marked in areas where there is a high degree of ethnic homogeneity "as among the Mandinka communities in the Lower River Region and North Bank Region".

82. She states that intra rural discrepancies may reflect the rural and community based approach of anti FGM campaigns where the campaigns are focussed on particular settlements. She refers to the number of villages who have pledged to discontinue the practice (over 500) but notes that this is less than a third of all villages and a "pledge does not necessarily mean follow–through or universal observance nor permanent conformity with the decision".

83. Although there is provision in The Gambia 2005 Children Act for prosecution for harmful social and customary procedures, Professor Chant states that FGM is not seen as a criminal offence but as a family matter. She refers to an interview with the head of the Female Lawyers Association of the Gambia who says that there has yet to be a case before the courts on FGM practised against the parents' wishes. Where forced FGM takes place the authorities are not asked to intervene, even where a child dies: the child is buried with no investigation by the authorities. In oral evidence she said that the practice was a secretive women's practice shrouded in silence; sometimes men are not aware what genital cutting is. She was asked whether if undertaken in the face of the opposition of the parents this would not result in intense anger. She responded that extreme secrecy is practised, that it is 'not done' to drag family through the courts, and that there is very little recourse for parents to protest, particularly because there is no specific law against the procedure.

84. Professor Chant knows of no organisation able to provide individual personal protection. The various NGOs work on strategic issues of public concern only.

85. On being asked whether a young intact educated woman, aware of the implications, might reasonably bring up the issue before marriage, Professor Chant said this would not necessarily be so: men and women do not talk about sex; and the question presupposes that a woman has an alternative livelihood. For many women, it is essential to marry.

86. Professor Chant was questioned extensively about the GAMCOTRAP reports. She said that GAMCOTRAP was a laudable organisation which had done and was doing good work in raising awareness and education about FGM. She spoke of the serious and important mission they are undertaking and that they have worked wonders in being able to get some Islamic scholars behind them on the point that FGM is not fundamental to Islam. But she also referred to the claims in the reports as self-proclaimed and not independently verified. Some of the material produced by GAMCOTRAP gives rise to a statement that FGM has been nearly eliminated, but that is very far from the case. The process was that GAMCOTRAP would provide education and a one-off grant to provide alternative livelihood strategies, roughly equivalent to three months income. She would want to see evaluation over a period of time to ascertain the extent to which any short term reduction was sustainable. She gave the example of Senegal which had previously had an FGM level of around 30-40%. The majority population in Senegal is Wolof, with a lower rate of FGM. FGM became illegal in Senegal in 1999. There had been intensive activity in Senegal by Toscan (an anti-FGM NGO) along with legislative activity since then, and there has been a reduction in the overall rate to about 13%. She referred to disturbing evidence that those who wished their daughters circumcised were taking them to Gambia; this indicated that despite all the rhetoric it is extremely difficult to eradicate a practice that has been embedded for centuries. Even if there had been a reduction in FGM in some regions of The Gambia since the "Dropping of the Knife" ceremonies and there was thus some support for those who did not wish their daughters to undergo the procedure, there would remain many opportunities for those within the extended kin group to perform it. On being referred to specific testimonials in the reports, she reiterated that such statements were evidence of a will by those individuals at that time, but not necessarily of the community as a whole. Reference to large meetings did not mean that all those attending agreed or abided by the professed statements. There had been no evaluation of the long term significance of the three ceremonies. Drawing upon the experience of Senegal, the process of abandonment was lengthy and difficult, given the continuing demand.

87. Professor Chant accepts that the higher up the social spectrum, the greater the exposure to education, and that education is likely to turn people against the practice. She refers to about 60% living below the poverty line, and the majority of the population supporting the practice. She refers both in her written report and in oral evidence to the numerous studies since the 2005/6 MICS report quoting similar figures as in the MICS report. The Gambia was shown as the only country where the 15-19 year old group in favour was as high as 35 year olds; this did not indicate

a declining trend, whereas for other countries there is evidence of a declining trend. She acknowledged that the GAMCOTRAP report appears to indicate a political will to change at that time by those people, but whether that had or would translate into change was another matter.

88. There has been some media support for the elimination of FGM campaign. Professor Chant referred also to statements by some Islamic scholars that they were opposed to Female Genital *Mutilation*, but that they described what is practised in Gambia as Female Genital *Circumcision,* which was acceptable.

89. Professor Chant agreed in oral evidence that migration to Greater Banjul is primarily for economic purposes. Although initial migration is usually of young males, because of the importance of propinquity to family, once single males have established themselves the tendency is for other relatives to join them over time.

Comfort Momoh

90. Ms Momoh is an FGM and Public Health Specialist at Guys and St. Thomas Foundation Trust and runs the African Well Woman's Clinic associated with those hospitals. She has published widely on FGM, has won numerous awards as a nurse/midwife and was awarded an Honorary Doctorate by Middlesex University. Her report summarises the practice and dangers of FGM. She refers to FGM being widely practised in Gambia -

> "particularly away from the urban areas and up river. The estimated prevalence of FGM in Gambia is 80% affecting women and girls, statistics show that it is performed one or two years before their teens, however can be performed as a baby or child. FGM is also practised by an estimated 7 out of 9 ethnic groups in Gambia."

91. She confirms that there is no law in The Gambia prohibiting FGM as of 2007. (She makes no reference to the current situation, but there was no other evidence before us which indicated that FGM was now specifically unlawful.) She states that she was not aware of any cases where women or girls had sought protection from the practice.

<u>Submissions for the Secretary of State</u>

92. Mr Parkinson relied upon his skeleton argument, and made further oral submissions, as follows.

93. The risk to the third claimant arose only from an expressed family intention. It did not realistically reach the level of likely pursuit into other parts of the country. In respect of the fourth claimant, internal relocation might have disadvantages, but it would not be unduly harsh. There was no evidence of adult females being at risk of FGM except in cases of marriage into families which carried out that practice.

94. It was acknowledged that much of Professor Chant's evidence should be treated as uncontentious. Paragraph 8 of her report supported the proposition that there has been some decline in the incidence of FGM. In the context of the availability of internal relocation, the evidence from Professor Chant and other sources showed extensive internal migration to the greater Banjul area, where around one million or 58% of the population now lives. Both experts said that The Gambia is a small and interconnected country, but the evidence did not support the possibility that the return of any of the claimants would become known to their relatives, in such a highly and densely populated urban area.

95. Professor Chant had accepted that there were no reported incidents of a child being forcibly abducted for purposes of FGM. GAMCOTRAP and other NGO's were active in the field. He submitted that if there were such incidents, even infrequently, they would be highlighted in such reports.

96. There has been a significant change in relation to FGM in The Gambia since GAMCOTRAP began its activities in 2007. There have been 3 "Dropping the Knife" ceremonies at which circumcisers renounced their activities. The President has made statements against FGM. Local political leaders have spoken out. Significantly, even religious leaders, Imams, have publicised their changed views. GAMCOTRAP's activities have already covered about one quarter of the village communities of rural Gambia. The campaigns have clearly had positive results. There was no evidence on the other hand of publicity in favour of FGM, or describing a return to the practice of FGM.

97. There was some evidence that the age at which FGM is inflicted is declining, but that is another sign of change. It could be inferred that this reflects the fear of parents that the practice will be stamped out, as in Senegal.

98. Professor Barnett's report at page 4, paragraph 10, criticises the sources used in compiling the respondent's COI report, but in fact the statistics in the COI report are based on scientific study. The Professor says that the COI report uses figures not specific to The Gambia, but the extracts are from the MICS report which was based on The Gambia. The making of such an error called into question the rigour of Professor Barnett's approach.

99. Professor Barnett was also wrong in saying that there was no prohibition in the law in The Gambia against FGM, because The Gambia 2005 Children Act was clearly intended to make FGM punishable, even if it was not specifically mentioned. Mr Parkinson said that he could not point to any reported prosecutions, but that might be attributable to the sea change in attitudes which has taken place.

100. Mr Parkinson made a point based on the report by Comfort Momoh. FGM represents a significant health risk both at the time of its infliction and through its long term consequences. The risks of childbirth double for those who have suffered FGM. Figures in reports such as MICS showing a higher incidence of FGM in the younger generation might have another explanation. Women who have undergone FGM are more likely to have died at an earlier age. Higher non-FGM rates in

older age groups might not reflect an increase in the practice. It might show that women who had not suffered FGM are more likely to have survived into old age.

101. GAMCOTRAP reports should not lightly be dismissed as designed to reflect their successes and to paint the best possible picture. Professor Barnett went too far in describing these as public relations documents. GAMCOTRAP was a long term operation which would not continue to gain foreign support if it was not achieving results. Neither expert report had taken proper account of all the evidence from GAMCOTRAP about its activities. There was no indication that GAMCOTRAP have not succeeded; GAMCOTRAP projects are not based upon coercive change following the implementation of specific legislation, but are based upon education and consensus over a number of years. There was no adequate evidence to show that what was reported by GAMCOTRAP as happening was not happening.

102. Given that there have been public declarations by the President, by community and religious leaders and by circumcisers themselves, it is highly unlikely that in those areas where FGM has been renounced there has been a reversion.

103. The Desk Review, undertaken in 2002, was indicative of reducing levels of FGM and thus added credence to the GAMCOTRAP report. Although the MICS report post-dated the Desk Review, the Desk Review assessed a very wide range of sources. The evidence in that report of a significant decline in support for FGM amongst younger age groups could be relied upon. The MICS report should not be taken as the only indicator, when there are other indicators which show that the younger generation do not appear to be in favour of FGM.

104. The inference to be drawn from all the evidence was that there are in The Gambia areas safe against the risk of FGM.

Submissions for the claimants

105. We heard from the claimants' representatives briefly, further to their skeleton arguments. All the salient points made (with which we broadly agree) are dealt with in our discussion and conclusions.

Discussion

106. We do not agree that reliance on Professor Barnett's report should be limited because his comments about sourcing in the COI report called into question the rigour of his approach. Professor Barnett is correct to point out that reliance on some information can masquerade as fact whereas it is simply repetitive retelling. We do not accept that Professor Barnett was seeking to undermine the COI report, which is a collation of background material. He was merely clarifying the extent to which differential weight should be placed upon different elements of evidence, particularly given the paucity of rigorous scientific research on the issue of FGM in The Gambia. To the extent that he may have had a wrong impression about the source of one particular statement, that does not diminish the value of his evidence as a whole.

107. We were impressed by the evidence from both Professor Barnett and Professor Chant. They did not seek to exaggerate their knowledge, and were careful in their evaluation. They readily agreed with points put by Mr Parkinson where those were supported by evidence, but were also careful to identify exhortation, reportage and information without proper scientifically backed research. Both experts gave considerable credit to GAMCOTRAP for the very difficult work they are doing in attempting to change embedded practices.

108. The Desk Review is a literature review the purpose of which was to attempt to identify the "most viable and effective way forward in the campaign to accelerate the elimination of female genital mutilation in The Gambia". It provides a summary of the situation as understood at that time in the light of the limited research undertaken. Its overriding conclusion is that there are major difficulties in changing attitudes to a practice that is deeply embedded and entrenched. It is correct that there is reference to a significant reduction in support for FGM amongst the younger generation, as submitted by Mr Parkinson. It is a review of existing material which, as was made clear by the experts, is significantly less reliable than the MICS report some five years later. The research and reports referred to in the Desk Review are based on small sample sizes and limited research. We are satisfied that the reliance by Mr Parkinson on one figure as support for his contention that the prevalence of FGM was going down, and that the Dropping of the Knife statements ought to be taken entirely at face value, was not borne out when the whole of the content of the Desk Review is considered.

109. As a major conclusion the Desk Review states that current efforts by government and NGOs "have had little or no significant impact on the magnitude of the practice of FGM in the country". The Desk Review does not conclude that the evidence they have seen indicates that there is a propensity for major positive change in the future, but rather draws attention to the possibility of lack of change without very considerable further work being undertaken. When comparing the summary of the situation with the more up to date information provided through the MICS report and the experts there are some discrepancies, for example the impact of education on attitude although the information upon which the Desk review conclusions was based was particularly circumscribed. Given the more recent provenance of the MICS report information and the extensive research undertaken by them, we have accepted the information in the MICS report that increasing levels of education reduces the risk.

110. GAMCOTRAP reports are written largely to inform sponsors. We are confident that they are honest and well-intentioned but they are geared to a particular audience and a particular purpose. As the expert witnesses explained, the reports have to be read carefully. They do not purport to investigate and analyse the long-term practical consequences of the statements and testimonials recorded. Although the organisation refers to 'monitoring', under that heading the reports deal with the benefits of continued support and education, and enhanced awareness of participants, not with fieldwork on the extent to which FGM continues.

111. The evidence from Senegal, where approximately 40% of the population is Mandinka, is instructive. The level of FGM in 1999 was some 40%. After the passing of specific legislation, followed by intense NGO and government activity, there has been a fall over more than a decade to about 13%. This is laudable and encouraging, but also indicates that the extent of such entrenched practices in the cultural make-up of society means that very considerable work has to be undertaken to reduce their prevalence. Assertion and exhortation are not a sufficient basis upon which to found a conclusion that significant change has occurred. That conclusion can come only once there has been rigorous analysis of the extent to which stated new attitudes and intentions have been carried through into practice.

112. Mr Parkinson stressed to us the absence of evidence of any instances of abduction for purposes of enforced FGM. While that is a point he was entitled to make, the absence of such reports has to be considered against the reality of a kin-based society and in the context of cumulative social pressure and the difficulty of making and carrying through an official complaint. We also have to take account of the equal lack of evidence of any official action over what must be a significant ongoing level of injuries and even fatalities. To look for a report of an individual kidnapping may be missing the point.

113. Some of the background materials state that there is no legislation against FGM in The Gambia. We are inclined to doubt if that was ever strictly correct. It is more likely that in legal theory FGM involved offences of assault. More recently, The Gambia Children's Act 2005 contains provisions which could be used to prosecute in cases of FGM. The more important point is that there has been effectively no will to prosecute, and no will to bring in a specific legal prohibition.

114. Ms Njenga drew our attention to the Secretary of State's OGN of May 2012, which refers at 3.6.5 to "two FGM court cases recently" (sourced in 2006) "one of which was thrown out due to the lack of any law protecting those who do not want to circumcise their children". There is a lack of detail about these cases, and we have seen no other meaningful references to court proceedings.

115. Mr Parkinson stressed to us statements by the President of The Gambia against FGM. We note that in the same statements he has said that the time for legislation is not yet. We also note at 3.6.7 of the OGN, Presidential statements which are disturbingly to the contrary, including a veiled threat to campaigners reported in February 2010.

116. We cannot but conclude that FGM continues to be widely practised; that it results in serious injuries and even fatalities; that although legislation exists which could be used, it is rarely if ever prosecuted; and that there is such a lack of effective official intervention as to amount to absence of legal protection.

117. Although we of course accept that there are villages where there have been pronouncements of an intention to cease the practice of FGM and there have been pronouncements by circumcisers that they have ceased that work, we are unable to accept that this amounts, at this stage, to more than a beginning. Whilst we accept

there is an increasing awareness of the health problems and the need for change – as predicated by the Desk Review – we do not accept that the situation in The Gambia has improved as markedly as the Secretary of State would have us conclude.

118. At the same time we think it clear that the evidence falls well short of demonstrating that young females in The Gambia in general are at real risk of FGM. There are significant variables which affect the risk: the practice of the kin group of birth; the ethnic background, taking into account high levels of intermarriage and of polygamy; the educational and rural/urban spectrums; and the kin group into which a woman marries. Risk, as Professor Barnett reminded us, cannot be shown by general statistics, but always depends on a careful evaluation of the circumstances of the individual.

119. The interconnected nature of Gambian society and the small size of the country, despite the existence of a major conurbation, is such that if the risk is real, there is in general no safe internal relocation option.

General conclusions

120. FGM has been practised upon about three quarters of the female population of The Gambia historically. The most recent scientific evidence, based on data from 2005, showed no significant change in its incidence. There are ongoing campaigns, principally by GAMCOTRAP, aiming to reduce and eventually to eliminate FGM. There has been some movement in published opinion against FGM, and there have been local declarations of renunciation, but there has been no scientific evaluation of GAMCOTRAP's effectiveness in establishing a decline.

121. Incidence of FGM varies by ethnic group. Within the five main ethnic groups there are subgroups, within which the incidence may vary – see the table below. In no ethnic group is the practice universal; in some ethnic groups the practice is absent. Ethnic groups are thoroughly interspersed. The country is small and highly interconnected. (Where reference is made to ethnic group we include sub-groups save where specified)

122. The evidence as at November 2012 falls short of demonstrating that intact females in The Gambia are, as such, at real risk of FGM. The assessment of risk of FGM is a fact sensitive exercise, which is likely to involve ethnic group, (whether parental or marital), the attitudes of parents, husband and wider family and socio-economic milieu.

123. There are significant variables which affect the risk: the practice of the kin group of birth: the ethnic background, taking into account high levels of intermarriage and of polygamy; the education of the individual said to be at risk; her age; whether she lived in an urban or rural area before coming to the UK; the kin group into which she has married (if married); and the practice of the kin group into which she has married (if married). Also relevant is the prevalence of FGM amongst the extended family, as this may increase or reduce the relevant risk which may arise from the prevalence of the practice amongst members of the ethnic group in general.

124. In assessing the risk facing an individual, the starting point is to consider the statistical information currently known about the prevalence of the practice within the ethnic group that is the relevant ethnic group in the individual's case, as follows:

    a. If the individual is unmarried and given that ethnicity is usually taken from the father in The Gambia, the relevant ethnic group is likely to be the ethnic group of the father.
    b. If the individual is married to a man from an ethnic group that is different from her father's ethnic group, then the relevant ethnic is the ethnic group of the husband.

The statistics from which the prevalence of the practice of FGM within the ethnic groups in the Gambia are drawn, vary considerably given the lack of detailed research and analysis undertaken in The Gambia. From the material before the Upper Tribunal at this time those statistics (although these do not include all sub groups) indicate as follows:

Ethnic group	Prevalence of FGM/C
Mandinka	May be as high as 80-100%
Fula (Overall)	30%, although some estimates are as high as 84%
Hobobehs (sub group of Fula)	0%
Jama (sub group of Fula)	0%
Toranks, Peuls, Futas, Tukuleurs, Jawarinkas, Lorbehs, Ngalunkas and Daliankos (sub groups of Fula)	Practise but % unknown
Sarehule	May be as high as 100%
Serer (overall)	May be as high as 64%
Njefenjefe (within the Serer ethnic grouping)	0%
Niumikas (within the Serer ethnic grouping)	Practise but % unknown
Jola & Karonikas	90 to 100%
Jola Foni	Practise but % not known
Jola Casa	0%
Wolof (overall)	May be as high as 20%
Wolof – those who migrated from Senegal Oriental	0%
Wolof – those who migrated from Sine Saloum	Practise but % not known
Others	Variable

125. The next step is to consider the various other factors mentioned in paragraph 123 above as some may increase the risk, whilst others may reduce the risk. Whilst each case will turn on it own facts, the following are of general application:

    a. In the case of an unmarried woman, parental opposition reduces the risk. In the case of a married woman, opposition from the husband reduces the risk. If the husband has no other "wives", the risk may be reduced further. However, it should be borne in mind that parental/spousal opposition may be insufficient to prevent the girl or woman from being subjected to FGM where the extended family is one that practises it, although this will always be a question of fact.
    b. If the prevalence of the practice amongst the extended family is greater than the prevalence of the practice in the ethnic group in question, this will increase the risk. Conversely, if the prevalence of the practice amongst the extended family is less than the prevalence of the practice in the ethnic group in question, this will reduce the risk.
    c. If the woman is educated (whether she is single or married), the risk will reduce.
    d. If the individual lived in an urban area prior to coming to the United Kingdom, this will reduce the risk. Conversely, if the individual lived in a rural area prior to coming to the United Kingdom, this will increase the risk.
    e. The age of a woman does not affect the risk measurably; it is an issue upon marriage. Amongst the Fula, FGM has been carried out on babies as young as one week old. The average age at which FGM is carried out appears to be reducing and this may be due to concerns about the international pressure to stop the practice. Although there are statistics about the average age at which FGM is carried out on girls and women for particular ethnic groups, the evidence does not show that, in general, being above or below the relevant average age has a material effect on risk. It would therefore be unhelpful in most cases to focus on the age of the girl or woman and the average age at which FGM is carried out for the ethnic group of her father (if unmarried) or that of her husband (if married).

126. Thus, it is possible to arrive at a conclusion that the risk faced by an individual is less than, or more than, the rate of incidence of FGM in the ethnic group of the individual's father (if unmarried) or her husband (if married). The rate of incidence of FGM in an ethnic group must therefore be distinguished from the degree of likelihood of infliction on an individual against her will or against the will of her parents. Some individuals from ethnic groups with a high incidence may not be at risk, while some individuals from ethnic groups with a low incidence may be at risk.

127. State protection: FGM is not specifically criminalised in The Gambia although it may be covered by the existing criminal law on assault or in The Gambia's Children's Act 2005. However, there are no known cases of prosecutions under the general criminal law or under the 2005 Act. There is no reliable evidence to suggest that a female who may be at real risk of FGM can avail herself of effective State protection or that her father or husband could invoke such protection on her behalf.

128. Internal flight: As a general matter, an individual at real risk of FGM in her home area is unlikely to be able to avail herself of internal relocation, although this is always a question of fact. Cogent reasons need to be given for a finding that the individual would be able to relocate safely, especially given the evidence that ethnic groups are thoroughly interspersed, the country is small and ethnic groups in different parts of the country are highly interconnected.

Conclusions on the present appeals

129. We now apply our general conclusions to the cases before us.

K, J and Miss K

130. The AIT dismissed the three connected appeals because the risk of FGM for the third claimant was remote in time, and could be avoided through relocation. There is error of law in that decision, such that it has been set aside and is to be re-made. The practice of FGM can be carried out from an early age, and there is evidence that the age is declining. The risk to Miss K exists in the reasonably foreseeable future – the next few years. The AIT's primary finding of fact, which was not criticised by the Secretary of State, is that there is a risk of FGM to Miss K from non-state agents. We find that there is no effective state protection, and that in this case the risk cannot be avoided by relocating. We re-make the decision in the three linked appeals by allowing them on asylum grounds.

AS

131. The First-tier Tribunal found AS to be at risk in her home area, a finding that has not been challenged by the Secretary of State and one by which we are bound. We apply our country guidance to these undisputed facts. This includes our conclusion that, if an individual is at real risk of FGM in her home area, she is unlikely to be able to relocate safely. Our attention has not been drawn to any considerations that reduce the risk of FGM to her on relocation. Judge Herbert found AS credible. He accepted her evidence that her father's family members had informed her parents that she would be required to undergo FGM, that her father had given his word that she would be subject to FGM on her return to The Gambia and her mother had confirmed this. On these accepted facts and given our guidance in relation to relocation, we are satisfied that for this particular individual the risks cannot be avoided by internal relocation.

132. We do not intend to convey by this finding that all single Mandinka women of marriageable age are at risk of FGM. Each appeal is fact sensitive and will have to be determined on the basis of those facts.

Conclusion

K, J and Miss K: The making of the decision of the First-tier Tribunal involved the making of an error on a point of law.
We set aside the decision.
We re-make the decision in the appeals by allowing the appeals on asylum grounds.

AS: The making of the decision of the First-tier Tribunal involved the making of an error on a point of law.
We set aside the decision.
We re-make the decision in the appeal by allowing the appeal on asylum grounds.

Signed Date 28th

Upper Tribunal Judge Coker

Appendix A

1	Rites of Passage Report, BAFROW 1999	1999
2	A Handbook for frontline Workers 2000	2000
3	Female Genital Mutilation A Student's Manual 2001	2001
4	Long term health consequences December 2001	2001
5	Female Genital Mutilation In The Gambia: A Desk Review 2002	2002
6	DHS Comparative Report No 7 September 2004	September 2004
7	Child Protection Alliance, summary of provisions of The Children's Act 2005 of the Gambia	2005
8	The Gambia Multiple Indicator Cluster Survey report 2005/2006	2005
9	Contingency Context and Change	22 June 2007
10	HJT Research, 'Seventy-five percent of women subjected to FGM in Gambia'	27 March 2008
11	Making and Managing femaleness, fertility and motherhood Skramstad	March 2008
12	AFROL News Report	6 June 2008
13	United Nations paper	21 May 2009
14	IRIN News Report	18 June 2009
15	UNICEF Report	23 June 2009
16	All Africa.Com Report	30 September 2009
17	Female Genital Cutting Education and Networking Project	12 November 2009
18	GAMCOTRAP Annual Report 2009	2009
19	Dynamics of decision making in Senegambia summary report	3 January 2010
20	Anonomised Report by Prof Barnett	9 March 2010
21	Article in The Point by the President Female Lawyers Association 11.06.10 on Women's Act 2010	11 June 2010
22	Minority Rights Group International	1 July 2010
23	Women Living Under Muslim Laws (UK), 'Urgent: Gambia: Women's rights defenders Isatou Touray & Amie Bojang-Sissoho arrested and detained'	13 October 2010
24	Equality Now (USA), 'Call on the Government of The Gambia to release immediately on bail women's rights activists, Dr Isatou Touray and Amie Bojang-Sissoho'	19 October 2010
25	Population Reference Bureau	7 February 2011
26	OHCHR, Report of the Special Rapporteur on the situation of human rights defenders: Summary of cases transmitted to Governments and replies received (Gambia excerpt)	28 February 2011
27	US Department of State report	8 April 2011
28	US Department of State Report	22 April 2011
29	COI report, The Gambia	9 June 2011
30	Prof. Sylvia Hamilton Chant Report	20 June 2011
31	Prof. Tony Barnett Report	25 June 2011
32	GAMCOTRAP press Release	4 July 2011
33	CIA World Fact Book extract	30 August 2011
34	BBC New report	5 September 2011
35	IRIN	5 September 2011

36	United Nations paper	5 September 2011
37	Frontline (Ireland), The Gambia: Continuing judicial harassment of Isatou Touray & Amie Bojang-Sissoho	2 November 2011
38	COI responses in respect of FGM in the Gambia	4 November 2011
39	Assisted Return and Reintegration Programme December 2011	December 2011
40	Dr Comfort Momoh MBE Report, 2011	2011
41	Freedom House Document extract 2011	2011
42	GAMCOTRAP Annual Report 2011	2011
43	GAMCOTRAP Dropping of the Knife Report 2011	2011
44	How the Gambia is fighting female Genital Cutting 2011	2011
45	US State Department 2011 Human Rights Reports: The Gambia	2011
46	Report on FGM in The Gambia, Prof. Tony Barnett	16 January 2012
47	Report on Gambia & Female Genital Mutilation, Prof. Sylvia H Chant	22 January 2012
48	GAMCOTRAP Zero Tolerance Speech	February 2012
49	BMJ, 344:1-50 No 7848 General Practice	17 March 2012
50	The Gambia OGN v5.0	May 2012
51	GAMCOTRAP Training Workshop for Kombos religious leaders	July 2012
52	GAMCOTRAP Central River Region AEO support August 2012	August 2012
53	COI responses in respect of FGM in the Gambia	27 September 2012
54	GAMCOTRAP Profile of circumcisers from the Lower River Region	September 2012
55	Save the Children Sweden UN supported training workshops Kombo	October 2012
56	Refworld report on The Gambia	12 November 2012
57	GAMCOTRAP Officials theft and fraud case: court decision	13 November 2012
58	Wikipedia extract accessed 19.11.12	19 November 2012
59	Amnesty International Report 2012: Gambia	2012
60	GAMCOTRAP Central River region training programme 2012	2012
61	GAMCOTRAP Executive Committee 2012	2012
62	Clinical Review: Female genital mutilation: the role of health professionals in prevention, assessment, and management, Jane Simpson, Kerry Robinson, Sarah M Creighton, Deborah Hodes	Undated
63	FGM a Teachers Guide	Undated
64	FGM Gambia – Access Gambia	Undated
65	FGM Legislation & Other National Provisions – www.ipu.org	Undated
66	FORWARD UK	Undated
67	Gambia Information Site partial extract	Undated
68	IRIN	Undated
69	Maps of The Gambia and the Greater Banjul Area	Undated
70	PATH female genital Mutilation – The Facts	Undated
71	The Gambia tourist industry information	Undated