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Decriminalizing Protection: The Drivers of the Push to Repeal Anti-FGMC Legislation in The Gambia and Their Implications for Human Rights Law

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Abstract

In 2024, the Gambian National Assembly became the first legislature in the world to vote to repeal a national prohibition on female genital mutilation/cutting (FGM/C), a bill ultimately unsuccessful but now before the Supreme Court. This paper examines the three structural drivers of this unprecedented decriminalisation push: the social legitimacy deficit of the Women's (Amendment) Act 2015, enacted without meaningful community consultation under the authoritarian government of Yahya Jammeh; the active contestation of the medical evidence on which the law's public health justification rests, compounded by the emergence of medicalisation as a credible policy alternative; and the deployment of a postcolonial critique of Western double standards that gives decriminalisation advocates an internationally legible human rights counter-argument. Drawing on analysis of DHS 2019–20 individual-level data, doctrinal legal analysis of domestic and international instruments, and engagement with postcolonial scholarship including Mutua, Shahvisi, and Shweder, the paper argues that the decriminalisation push is not reducible to cultural conservatism but reflects genuine structural failures in the prohibitionist framework. It concludes with recommendations for a graduated, consultative legal reform that maintains child protection while engaging adult autonomy, and proposes medicalisation as a sunset strategy for long-term abandonment.

Keywords: Female genital mutilation/cutting; decriminalisation; social legitimacy; postcolonial human rights; The Gambia; medicalisation; cultural imperialism

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1. Introduction

Female genital mutilation/cutting (FGM/C) is recognised internationally as a harmful traditional practice that subjects girls and women to sexual and gender-based human rights violations. More than 230 million women and girls are currently living with its consequences, predominantly in Africa and Asia(Women's (Amendment) Act, 2015; 28 Too Many, 2018b, 2018a; GBoS, 2020; WHO, 2025). The international human rights framework — spanning the UDHR, ICCPR, ICESCR, CEDAW, CRC, the Banjul Charter, and the Maputo Protocol — imposes binding obligations on states to prohibit and eliminate the practice. In The Gambia, approximately 73% of women and girls have undergone FGM/C, and the Women's (Amendment) Act 2015 criminalised the practice with penalties of up to three years imprisonment(Women's (Amendment) Act, 2015; 28 Too Many, 2018a; GBoS, 2020).

In 2024, the Gambian National Assembly voted to repeal this prohibition, the first time in the world that a national legislature attempted to decriminalise an anti-FGM/C law after its enactment(The Guardian, 2025). The bill failed to pass, but the movement that drove it has since taken the matter to the Supreme Court(The Point, 2025; United Nations, 2026). The 2023 landmark conviction of three women under the Act, the first-ever prosecution under the law, triggered public outcry and the organised formation of a decriminalisation movement led by religious leaders and a National Assembly member(UNFPA The Gambia, 2023; BBC, 2025; United Nations, 2026).

This paper asks: what are the structural drivers of this unprecedented push for decriminalisation? It argues that the answer is not reducible to cultural conservatism or religious opposition to reform. The decriminalisation push has found sufficient political traction to reach the floor of a national parliament because it draws energy from three genuine structural failures in the prohibitionist framework. These are, a legitimacy deficit rooted in the

conditions of the law's enactment; an evidentiary contestation rooted in the methodological weaknesses of the medical literature; and a postcolonial critique rooted in the selective application of universal human rights norms. Understanding these drivers is essential not only for The Gambia but for the broader human rights project, because any successful decriminalisation in The Gambia could set a global precedent for the rollback of anti-FGM/C legislation.

2. The Legal Framework: International Obligations and Domestic Law

2.1 International Human Rights Instruments

The international legal framework addressing FGM/C is extensive and multi-layered. The Universal Declaration of Human Rights (1948) provides foundational protections — the right to life, liberty and security (Article 3), freedom from torture, cruel and inhuman or degrading treatment (Article 5), and the right to health and wellbeing (Article 25) — all of which have been invoked against FGM/C. However, the UDHR is a soft law and faced significant limitation in its application. The ICCPR and ICESCR, that followed, gave binding legal force to these protections, with Article 7 (ICCPR) prohibiting torture and degrading treatment, and Article 12 (ICESCR) establishing the right to the highest attainable standard of health(United Nations, 1948, 1966b, 1966a).

The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW, 1979) provided the most direct early mandate for action on FGM/C. Article 5 obliged states to modify social and cultural patterns based on ideas of sex inferiority or superiority, and the CEDAW Committee's General Recommendation No. 19 specifically classified FGM/C as a form of gender-based violence. The Convention on the Rights of the Child (1989) reinforced this through Articles 6 and 19(United Nations, 1979, 1980).

At the regional level, the Maputo Protocol (2003) represents the most significant milestone, specifically naming FGM/C as a harmful practice and placing binding commitment on states to prohibit, condemn, and take all necessary legislative measures to eliminate it (Article 5)(African Union, 2003; Nabaneh and Muula, 2019). Ratified by 45 AU member states including The Gambia, the Maputo Protocol closes the cultural relativism loophole in Article 29 of the Banjul Charter(African Union, 1981) by explicitly naming the practice.

2.2 The Women's (Amendment) Act 2015

The Gambia's Women's (Amendment) Act 2015 amended sections 32A and 32B of the Women's Act 2010 to criminalise FGM/C. Section 32A prohibits FGM/C and provides for imprisonment of up to three years, a fine of 50,000 Dalasi, or both; and life imprisonment if the circumcision causes death. Section 32B targets accomplices: those who request, incite, or promote FGM/C, or who fail to report knowledge of imminent or past practice(Women’s Act, 2010; Women’s (Amendment) Act, 2015; Durojaye and Nabaneh, 2021).

The law was enacted following a sudden executive directive by former President Yahya Jammeh, announced at a political rally on 24 November 2015 and passed by the National Assembly within four weeks, without a formal public consultation process and without engagement with the cultural and religious communities most directly affected(BBC News, 2015; The Guardian, 2015). This legislative process has proven consequential. It is the procedural deficit that decriminalisation advocates have most effectively exploited.

3. The Drivers of the Push to Repeal Anti-FGM/C Legislation: Study Findings

There are factors that are likely to continue driving a push to decriminalise FGM/C in The Gambia. These factors are cross-cutting and hard to ignore. From the perception of people towards the law, to the social implication surrounding its implementation, and the growing contestation of anti-FGM/C laws and policies at the global stage, this study found that the attempt to repeal the ban on the practice is slowly moving away from being symbolic to posing real threat to derailing or undoing progress made towards eliminating the practice. Haply, while this is occurring and concerning one country, The Gambia, any success in achieving the set goals of the FGM/C advocates and practitioners could set a global precedence. In The Gambia, these drivers may be recognised as set below.

3.1 The Social Legitimacy Deficit

The term 'social legitimacy deficit' in this case describes the absence of acceptance, trust, or respect for a law

among the people it affects. It could also be described as a failure of moral obligation sufficient to generate compliance without external enforcement. Laws face this deficit where they are experienced as foreign to the culture and beliefs of the society they govern, where key stakeholders were excluded from the legislative process, or where there is a lack of trust in the motive behind the law. All three conditions apply to the 2015 Act.

Female genital mutilation or cutting is a deeply important part of the cultural life of the majority of the Gambian population. There is little to no evidence that relevant communities were involved in the legislative process. The duration between Jammeh's announcement and the law's enactment was four weeks which is far shorter than any normal multi-year legislative drafting cycle involving formal national consultation. No formal, government-sanctioned national consultation with religious and cultural entities was conducted in 2015.

The impact of this procedural failure has been substantial. Communities have not taken ownership of the law and have felt no moral obligation to observe it. Analysis of DHS 2019–20 individual-level data comparing four-year pre-ban and post-ban periods reveals 899 cases in the four years before the ban and 684 in the four years after, a 23.9% reduction that is real but far from elimination, confirming the law did not generate the behavioural change a prohibition with genuine social legitimacy would produce. These data are presented in Table 1 and Figure 1 below.

Table 1. Number of FGM/C Cases Reported in The Gambia, 2012–2019: Pre-Ban and Post-Ban Comparison

Year	**Legislative Period**	**Pre-Ban (2012–2015)**	**Post-Ban (2016–2019)**	**Annual Total**
2012	Pre-Ban	211	—	211
2013	Pre-Ban	232	—	232
2014	Pre-Ban	236	—	236
2015	Pre-Ban	220	—	220
2016	Post-Ban	—	199	199
2017	Post-Ban	—	159	159
2018	Post-Ban	—	186	186
2019	Post-Ban	—	140	140
Total	**2012–2019**	**899**	**684**	**1,583**

Note. *Data represent the number of FGM/C cases reported across the study period. The Women's (Amendment) Act 2015 criminalizing FGM/C came into force in 2015, with enforcement operative from 2016. (—) = not applicable. A reduction of 23.9% in reported cases is observed between the pre-ban (n = 899) and post-ban (n = 684) periods.*

Proponents of the 2024 decriminalisation bill explicitly cited the absence of community consultation in 2015 as justification for repeal. Their argument, that the law was imposed without respect for cultural and religious consensus, has resonated precisely because it is grounded in a real procedural failing. The DHS 2019–20 further shows that at least 46% of women believe the practice should continue, with that percentage likely higher when adjusted for ethnicity. The study conducted by Sanneh in 2022 on the perspective of victims (school girls) concluded that the opinion of female students on the practice of FGM/C has not changed, in that they support the practice(Sanneh, 2022). Thus, without the meaningful engagement, approval, and support of the communities the law claims to protect, its impact has been counter-productive, generating resistance rather than reform.

3.2 The Contestation of Medical Evidence and the Promise of Medicalisation

The second driver operates at the level of the evidentiary foundations on which the 2015 Act's public health justification rests. The prohibition was presented, for the most part, as a response to medical evidence demonstrating FGM/C's harms. This evidence was drawn primarily from the Kaplan and colleagues' 2011 and 2013 clinical studies conducted in The Gambia(Kaplan *et al.*, 2011; Kaplan, Forbes, *et al.*, 2013). These studies have significant methodological limitations that have been actively exploited in the decriminalisation debate.

The 2011 study, the first nationally representative clinical dataset, lacked a control group, performed no multivariate adjustment, and relied on a symptomatic healthcare-seeking population that almost certainly overestimated complication rates. The attribution of late-presenting infections and anaemia specifically to FGM/C across temporal gaps of years or decades, and without controlling for pregnancy, nutritional status, or ambient morbidity, rested more on assumption rather than evidence.

The 2013 study introduced a comparator group but failed to adjust for a major ethnic imbalance: the no-FGM/C group was 82.5% Wolof, while the FGM/C groups were dominated by Mandinka, Fula, Sarahole, and Jola women. No multivariate logistic regression was performed. The study's own data showed overlapping confidence intervals between no-FGM/C and Type I groups for dysmenorrhoea, recurrent UTI, vaginal discharge, and bleeding during or after intercourse, which means that for these outcomes, the difference was not statistically significant. Rather than addressing this non-significance, the authors aggregated Type I and Type II for odds ratio calculations, which made the stronger Type II signal to inflate the headline findings.

The WHO collaborative prospective study, enrolling 28,393 women across six countries with multivariate adjustment for nine confounders, found non-significant adjusted relative risks for Type I FGM/C across all major obstetric outcomes(Banks *et al.*, 2006). A similar observation was made a year earlier published study conducted in sudan, and a later 2022 study in The Gambia by Idoko et al., regarding fatal outcomes between no FGM/C and Type I groups(Almroth *et al.*, 2005; Idoko *et al.*, 2022). This convergence provides decriminalisation advocates with a credible argument that the evidence does not justify blanket prohibition of the dominant form practiced in The Gambia, the Type I. It is also important to note that different studies have reported different prevalence rate of the various types of FGM/C. A batch of studies claimed Type I is the most dominant, as in the case of the Kaplan studies, while another claimed Type II is the most dominant, as in the case of Idoko *et al.*, (2022).

Survey data from 156 Gambian medical professionals collected for the master dissertation show that 54.5% support medicalisation as an interim harm-reduction strategy and 82.1% agree that if FGM/C is going to occur regardless, performance by a trained health worker is preferable to a traditional practitioner. When health professionals whose clinical expertise is expected to anchor the evidence base for policy themselves generate a medically credentialed counter-narrative to prohibition, they inadvertently supply the decriminalisation movement with its most persuasive argument.

3.3 Western Double Standards and the Cultural Imperialism Critique

The third driver is the postcolonial critique of selective application of human rights norms, an argument that has gained significant traction precisely because it is not without foundation. Critics including Makau Mutua, Arianne Shahvisi, Richard Shweder, Fuambai Ahmadu, and Juliet Rogers have exposed the civilisational schema embedded in the international anti-FGM/C framework(Shweder, 2000, 2022; Ahmadu, 2001; Mutua, 2001; Ahmadu and Shweder, 2009; Shahvisi, 2023; Ahmadu *et al.*, 2025). Mutua has described as the 'Savage, Victims, and Saviors' narrative, in which African cultural practices are constructed as barbaric violations of universal norms, African women are cast as passive victims incapable of self-determination, and Western institutions are positioned as enlightened saviours(Mutua, 2001).

The double standards argument sharpens this critique. Labiaplasty, surgical reduction or reshaping of the labia minora, is performed on adult and adolescent women in Europe, North America, and Australia, frequently for aesthetic rather than medical reasons, and is legal in all of these jurisdictions. Infant male circumcision involves the non-consensual removal of the foreskin from a minor who cannot give informed consent, yet is not only legal but medically mainstreamed across the United States. As Shahvisi in 2023 has argued, Western women undergoing cosmetic genital procedures are perceived as rational agents making their own choices, while women of colour are seen as victims of their cultures and their menfolk(Shahvisi, 2023).

The inconsistency extends to children. Children in Western countries undergo gender-affirming and intersex surgeries without their informed consent, yet these are not framed as child rights violations to the degree comparable to FGM/C. The selective application of human rights language: 'mutilation' for one culture,

'procedure' for another; 'violation' for one child, 'affirmation' for another, exposes a framework in which the cultural origins of a practice, rather than its physical nature or consent implications, determine its moral and legal status.

In the Gambian context, the framing of FGM/C as patriarchal gender-based violence is contested by the reality that the practice is almost entirely women-dominated. Kaplan et al. studied the role of men in the practice in 2013 and found that only 8% of men in The Gambia took part in active decision-making on whether their daughters should undergo FGM/C, and in more than 75% of cases the procedure was the woman's choice, done without the father's knowledge(Kaplan, Cham, *et al.*, 2013).

It is important, however, to resist the implication that culture and religion speak with a homogeneous voice. Within The Gambia and across Muslim communities in West Africa, the practice is actively contested from the inside. The 2011 International Conference of Islamic Scholars of West Africa, Egypt and Sudan produced a resolution recognising FGM/C as a harmful practice inconsistent with Islamic teaching(ORCHID Project, 2011). The DHS 2019–20 shows that 54% of women and 58% of men believe the practice should not continue, and 34% of women and 31% of men believe it is not a religious requirement. A postcolonial defence of cultural autonomy that privileges the voices of those who continue the practice over those within the same communities who oppose it risks reproducing the same homogenising logic it identifies in Western universalism.

4. Implications: Why the Current Framework Is Failing

Taken together, the three drivers reveal a prohibitionist framework that is failing on its own terms. The 2015 Act was enacted without social legitimacy, defended with contested evidence, and justified by a rights discourse that has not been applied consistently. The result is a law that has produced a measurable but incomplete reduction in reported cases, driven some practice underground, generated organised political resistance sufficient to reach the National Assembly floor, and failed to build the broad social consensus necessary for genuine, durable abandonment.

This failure has a further dimension specific to the Gambian context in that it has made the protection of girls and women hostage to a political debate that could have been avoided had the original law been built on stronger procedural, evidentiary, and normative foundations. Every legislative cycle in which decriminalisation is a live possibility is a cycle in which the protection the law provides is uncertain, and it is girls and women who bear the cost of that uncertainty.

5. Recommendations

5.1 Consultative Review of the Legal Framework

The immediate priority is a formal, inclusive review of the Women's (Amendment) Act 2015, conducted through a more transparent and participatory process that meaningfully involves affected communities, religious leaders, women's organisations, health professionals, legal scholars, and civil society actors. This is not a concession to the decriminalisation movement; it is the repair of the procedural deficit that gave that movement its most powerful argument.

5.2 Consultative Review of the Legal Framework

The revised framework should maintain the criminal prohibition in full force for all FGM/C performed on girls under the age of 18 as a non-negotiable child protection floor grounded in the CRC, the Maputo Protocol, and the Gambia's constitutional commitments. For women aged 18 and above, the framework should create a regulated space for autonomous, informed decision-making through a rigorous informed consent protocol developed in collaboration with health professionals and women's rights organisations.

5.3 Medicalisation as a Sunset Strategy

The most novel recommendation concerns the strategic use of medicalisation as a pathway to long-term abandonment. This runs against the explicit positions of the WHO and the International Federation of Gynecology and Obstetrics, which oppose medicalisation on grounds that it legitimises the practice. The argument here does not rest on the claim that medicalised FGM/C is safe or ethically unproblematic. It rests on a

pragmatic assessment of where the practice currently sits and where it can realistically be moved over time.

Channelling the practice into regulated clinical settings would, in the short to medium term, reduce the infection and haemorrhage risks associated with unhygienic traditional practice. More strategically, it would concentrate the practice within a population of health professionals subject to regulation, ethical oversight, and professional accountability. Over two to three decades, as traditional circumcisers age out of practice and the transmission of the skill within communities is interrupted by the shift to clinical settings, the practice becomes institutionally dependent on the health system. At that point, when FGM/C is performed by a small, regulated, and accountable professional population rather than distributed across communities, a comprehensive professional ban becomes both administratively feasible and socially less disruptive.

This strategy must not be framed as an endpoint. It must be embedded within an explicit abandonment trajectory, with clear milestones, sunset clauses, and regular review so that it cannot be captured by those who would use it to normalise the practice permanently.

6. Conclusion

The decriminalisation push in The Gambia is not, at its core, a movement in favour of harm. It is a movement that has found political energy in the genuine failures of the prohibitionist approach: failures of process, failures of evidence, and failures of moral consistency. Addressing those failures honestly is not a betrayal of the women and girls the law seeks to protect. It is the necessary precondition for building a framework capable of actually protecting them.

The international human rights community must reckon with the fact that a selectively applied universalist rights framework will always be vulnerable to the postcolonial critique that gives decriminalisation advocates their most resonant arguments. It criminalises FGM/C while accommodating labiaplasty. It demands community consultation in theory while bypassing it in practice. It deploys contested evidence as if it were settled science. These are not invented grievances; they are real contradictions, and they have real political consequences.

The ultimate goal, a Gambia in which no girl undergoes FGM/C against her will, in which the practice has been voluntarily abandoned because communities have come to understand its harms and chosen differently, cannot be realised by a law that lacks legitimacy, rests on contested foundations, and has generated a backlash capable of threatening its own existence. It is realised through a graduated, consultative, evidence-based, and culturally engaged framework that meets communities where they are and builds, incrementally and patiently, toward the world the human rights framework promises but has not yet delivered.

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