AFRICA HEALTH ORGANISATION

Strategy and Plan of Action on Ending Female Genital Mutilation (FGM)

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Contents:

Introduction

As an international health agency, one of the key areas of concern for Africa Health Organisation (AHO) is "promoting equity in health" across Africa.[1] Fundamental to achieving this aim is a thorough understanding of the ways in which gender affects health. Beyond recognising the biologically unique healthcare requirements of women in relation to pregnancy, menstruation and other key issues, we must understand how some of the cultural traditions practiced by African communities jeopardise the standard of health and quality of life experienced by women living within these communities. Female genital mutilation/cutting (FGM/C) – as a widespread practice which violates numerous human rights including "the right to non-discrimination on the grounds of sex" and "the right to freedom from torture or cruel, inhuman or degrading treatment or punishment"[2] – poses a particularly significant threat to the health of African women.

Classification

FGM/C refers to "all procedures that involve the partial or total removal of external genitalia or other injury to the female genital organs for non-medical reasons".[3] The World Health Organization (WHO) has classified FGM/C into four broadly-accepted categories. These categories are outlined in Figure 1 (below), using the WHO definitions as they appear on the AHO website.[4]

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[1] Africa Health organisation (AHO) (2020b) About AHO [online]. Africa Health organisation. Available from: https://aho.org/about/ [Accessed 14th July 2020].

[2] World Health Organization (WHO) (2010). *Global strategy to stop health-care providers from performing female genital mutilation*. [online] *World Health Organization*, Geneva: World Health Organization, pp.1–17. Available at: https://apps.who.int/iris/bitstream/handle/10665/70264/WHO_RHR_10.9_eng.pdf;jsessionid=B07BC0FE5C0269369FF29A8432B654F6?sequence=1 [Accessed 25 Jul. 2010], p. 6.

[3] Williams-Breault, B. D. (2018) 'Female Genital Mutilation/Cutting: Human Rights-Based Approaches of Legislation, Education, and Community Empowerment', *Health and Human Rights,* 20(2), p. 223.

[4] Africa Health Organisation (AHO) (2020a) Female Genital Mutilation (FGM) [online]. Africa Health Organisation. Available from: https://aho.org/health-topics/female-genital-mutilation-fgm/ [Accessed 15th July 2020].

	Definition	Subcategory A	Subcategory B	Subcategory C
Type I	Partial or total removal of the clitoris and/or the prepuce (clitoridectomy).	Removal of the clitoral hood or prepuce only.	Removal of the clitoris with the prepuce.	
Type II	Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision).	Removal of the labia minora only.	Partial or total removal of the clitoris and the labia minora.	Partial or total removal of the clitoris, the labia minora and the labia majora.
Type III	Narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation).	Removal and apposition of the labia minora.	Removal and apposition of the labia majora.	
Type IV	All other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, piercing, incising, scraping and cauterization.			

Figure 1 - WHO Definition and Classification of FGM Types I-IV.[5]

Background

FGM/C is prevalent in 30 African countries,[6] with an estimated 92 million women and girls aged 10 years and older having endured some form of the practice.[7] Each year, a further 3 million girls are at risk of undergoing FGM/C [8] [9] – usually before the age of 15 [10] – with a high concentration of cases in 'hotspot' countries such as Ethiopia, Nigeria, Sudan, Somalia, and Mali.[11]

Although FGM/C was discussed by the United Nations (UN) Commission on Human Rights as early as 1952, the WHO initially declined to adopt an active position on the matter, understanding FGM/C as a cultural and social phenomenon – rather than an issue of health – and therefore one outside of its jurisdiction.[12] From the 1990s onwards, however, the international effort to bring an end to FGM/C has become far more structured and ambitious. Following the African Parliamentary Conference's resolution "calling on states to enact laws to ban FGM" in 2005[13], a consortium statement was made in 2008 by the WHO, UNICEF and UNFPA declaring the international commitment to eliminating FGM/C.[14] Indeed, the 5th goal of the UN Sustainable Development Goals (SDGs) includes the elimination of violence against women and harmful practices – notably FGM/C – by the year 2030.[15]

This international mobilisation against FGM/C has brought about considerable progress; many African countries have legislated against the practice, and across the 31 countries with nationally

[5] AHO (2020a).
[6] Williams-Breault (2018), p. 224.
[7] Nabaneh, S. and Muula, A. S. (2019) 'Female genital mutilation/cutting in Africa: A complex legal and ethical landscape', *International Journal of Gynecology & Obstetrics,* 145(2), p. 253.
[8] WHO (2010), p. 3.
[9] World Health Organisation (2020) Female genital mutilation (FGM) [online]. Available from: https://www.who.int/reproductivehealth/topics/fgm/prevalence/en/ [Accessed 25th August 2020].
[10] Ibid.
[11] Awolola, O. O. and Ilupeju, N. A. (2019) 'Female genital mutilation; culture, religion, and medicalization, where do we direct our searches for it eradication: Nigeria as a case study', *Tzu Chi Medical Journal,* 31(1), p. 1.
[12] Andro, A. and Lesclingand, M. (2016) 'Female Genital Mutilation. Overview and Current Knowledge', *Population,* 71(2), p. 221.
[13] Ibid, p. 225.
[14] Ibid, p. 224.
[15] Nabaneh and Muula (2019), p. 254.

representative prevalence data, the proportion of girls between the ages of 15 and 19 who have undergone FGM/C has fallen from roughly one in two to one in three over the last 30 years.[16] Yet there remains a great deal left to be achieved, particularly in regards to the increased trend of medicalised FGM/C. FGM/C is increasingly being carried out 'safely' by medical professionals – in up to 80% of cases, in some African countries.[17] Figure 2 (below) demonstrates this recent trend using data from 2017 across African and Middle-Eastern countries, displaying a consistently higher level of medicalised FGM/C amongst daughters in comparison to their mothers.[18]

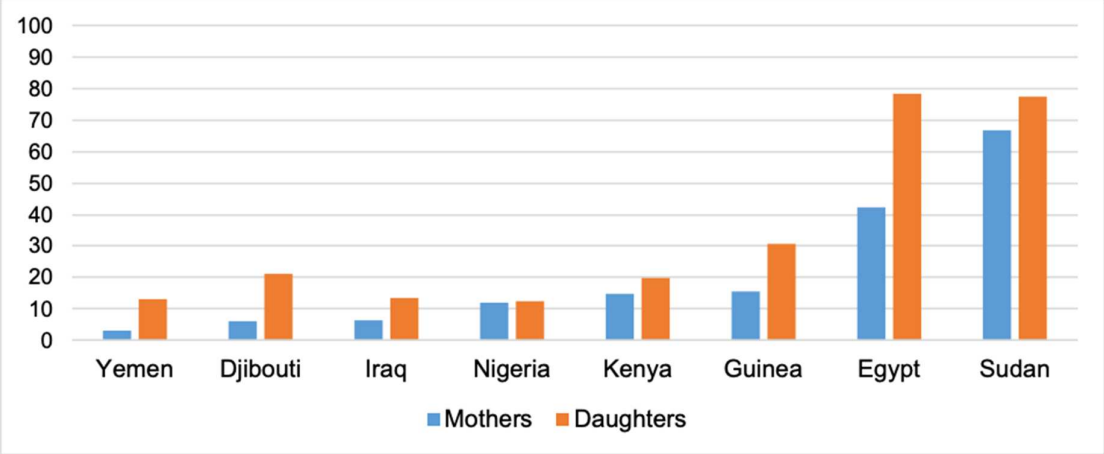

Figure 2 – Comparing percentage rates of FGM/C medicalisation amongst mothers and daughters.[19]

Yet whilst the medicalisation of FGM/C lessens some of the associated health risks, it constitutes a break in medical professionalism and a breach of the ethical responsibility of health care workers.[20] Given that the practice remains in violation of so many fundamental human rights,[21] the medicalisation of FGM/C in fact "serves to legitimize a harmful practice",[22] and so must not be accepted as an adequate modification of the practice in lieu of its extermination.

Proposal Strategy

World Vision has rightly emphasised that any further effort to eradicate FGM/C in Africa must be carried out with a focus on education and empowerment, and not merely on legislation.[23] AHO's Strategy and Plan of Action on Ending Female Genital Mutilation is no exception to this rule; whilst AHO recognises the crucial importance of continued legislative action against FGM/C, it remains acutely aware of the fact that little more progress can be made without addressing the "individual attitudes and normative expectations" of the African communities in which the practice maintains its status as an important social custom.[24] That is to say that campaigns to end FGM/C must work *with*

[16] UNICEF (2020) Female genital mutilation (FGM) [online]. Available from: https://data.unicef.org/topic/child-protection/female-genital-mutilation/ [Accessed 1st September 2020].
[17] Andro and Lesclingand (2016), p. 266.
[18] Shell-Duncan, B., Njue, C. and Moore, Z. (2018). *Trends in Medicalisation of Female Genital Mutilation/Cutting: What do the Data Reveal?* [online] New York: The Population Council, pp.1–19. Available at: https://www.popcouncil.org/uploads/pdfs/2018RH_MedicalizationFGMC_update.pdf [Accessed 15 Sep. 2020], p. 7.
[19] Ibid.
[20] WHO (2010), p. 8.
[21] Ibid, p. 10.
[22] World Vision (2020) From The Field: 6 facts about female genital mutilation (FGM) [online]. World Vision. Available from: https://www.worldvision.org/child-protection-news-stories/female-genital-mutilation-fgm-facts [Accessed 1st September 2020].
[23] Ibid.
[24] Grose, R. G., Hayford, S. R., Cheong, Y. F., Garver, S., Kandala, N. and Yount, K. M. (2019) 'Community Influences on Female Genital Mutilation/Cutting in Kenya: Norms, Opportunities, and Ethnic Diversity', *Journal of Health and Social behaviour,* 60(1), p. 97.

local African communities, helping them to understand the dangers and implications of the practice, rather than seeking to unilaterally impose new customs upon them. Ultimately, "methods of prevention must be holistic".[25] In line with this view, AHO has outlined 7 specific goals as part of its Strategy and Plan of Action on Ending Female Genital Mutilation.

Goals

Goal 1 – Challenge the discriminatory reasons FGM/C is practised.

The justifications offered for the continued practice of FGM/C by its advocates are myriad; "the preservation of ethnic and gender identity, femininity, female "purity", and family hono[u]r", "the maintenance of cleanliness and health" and the "assurance of women's marriageability" are all cited as rationalisations for the procedure.[26] Throughout African communities, the clitoris is frequently understood to be a dangerous and/or impure organ.[27] [28] In some cases, women who have not undergone FGM/C are even perceived as harbouring a "curse", supposedly responsible for causing poor health, divorce and crop failure.[29]

Many of these discriminatory justifications for FGM/C are rooted in a "perceived need to control female sexuality".[30] Working with communities to change this damaging perception of female sexuality and genitalia must form a central part of any strategy against FGM/C. Ultimately, the patriarchal justifications for FGM/C – centred around purifying and de-sensitizing women for the sake of male pleasure and dominance[31] – are unacceptable, and must be overtly and vigorously challenged.

Goal 2 – Change traditions – with the support of mothers and older generations.

Despite the increased medicalisation of FGM/C, the practice is still predominantly performed by traditional practitioners (almost always female community leaders and/or mothers),[32] as can be seen in Figure 3 (below).[33] The result of this is "the erasure of male responsibility", with women participating "in the destruction of their own kind".[34] It is of paramount importance, however, that these women are not criticised or villainised for perpetuating FGM/C. Rather, we must work with these women, uplifting them and preserving their status as important community figures, whilst encouraging a departure from traditional cutting ceremonies. One promising method for achieving this is that of creating new ceremonies which bear "the semblance of the [traditional FGM/C] ritual without the actual cutting".[35] This strategy has already been implemented with some success in Kenya, Senegal and Tanzania.[36] AHO is committed to reviving and maintaining the special relationships which used to exist between girls and their mothers and grandmothers, whilst simultaneously redesigning the traditional 'coming-of-age' ceremonies led by these female family leaders, to eradicate FGM/C.[37]

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[25] Odukogbe, A. A., Afolabi, B. B., Bello, O. O. and Adeyanhu, A. S. (2017) 'Female genital mutilation/cutting in Africa', *Translational Andrology and Urology*, 6(2), p. 144.
[26] Williams-Breault (2018), p. 227.
[27] Ibid.
[28] Daly, M. (2017) 'African Genital Mutilation: The Unspeakable Atrocities' in Rycenga, J. and Barufaldi, L. (eds.), The Mary Daly Reader. NYU Press: New York City, p. 173.
[29] Brown, E., Mwangi-Powell, F., Jerotich, M. and le May, V. (2016) 'Female Genital Mutilation in Kenya', *Reproductive Health Matters,* 24(47), p. 120.
[30] AHO (2020a).
[31] Daly (2017), p. 173.
[32] Nabaneh and Muula (2019), p. 255.
[33] Shell-Duncan et al. (2018), p. 7.
[34] Daly (2017), p. 177.
[35] Nabaneh and Muula (2019), p. 255.
[36] Ibid.
[37] AHO (2020a).

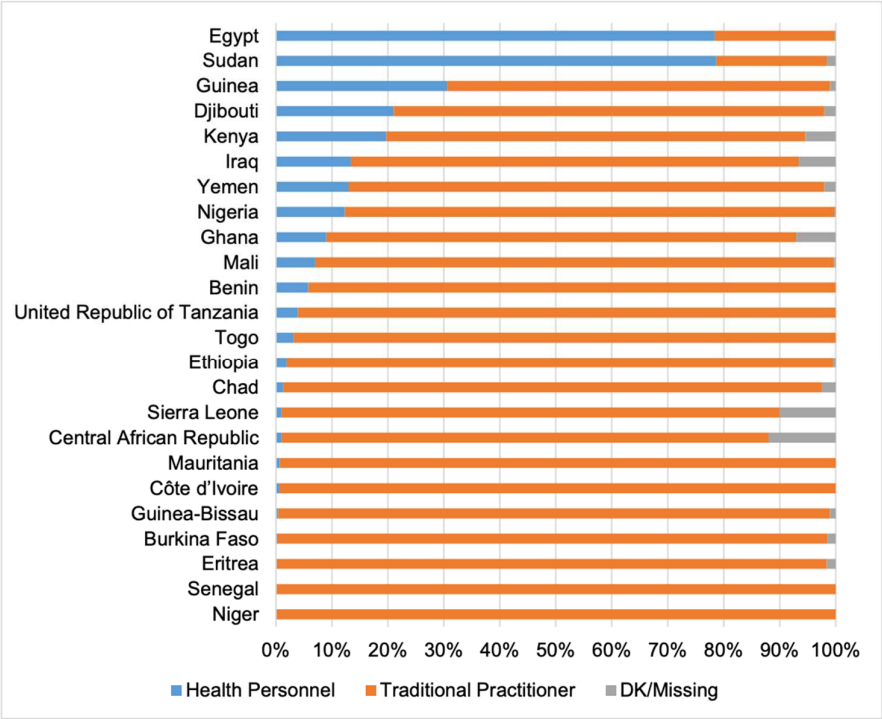

Figure 3 – Rates of medicalised FGM/C (performed by 'Health personnel') vs. non-medicalised FGM/C (performed by 'Traditional Practitioner[s]').[38]

Goal 3 – Educate girls on their right to decide what happens to their body, and educate boys to respect them.

With persistent "social shaming and ostracisation of women who [have] not undergone FGM" still widespread amongst African communities,[39] we must focus on educating girls in regards to their fundamental rights to bodily autonomy. This education must be provided from a young age wherever possible, in terms of both institutionalised learning, and more informal lessons passed down from senior family members and peers as they themselves become more aware of the dangers of FGM/C. Evidence suggests that education efforts of this sort have already proved successful in encouraging women to consider their rights to bodily autonomy; in a number of African countries, including Togo, Kenya, Ghana and Burkina Faso, over 90% of females between the ages of 15 and 49 who are aware of FGM/C believe it should be eradicated.[40] In some countries, however, such as Somalia and Mali, this percentage remains far lower, indicating a great deal of progress yet to be made.[41] The full extent to which this figure differs between countries is represented below, in Figure 4.[42]

[38] Shell-Duncan et al. (2018), p. 7.
[39] Brown et al. (2016), p. 120.
[40] UNICEF (2020).
[41] Ibid.
[42] Ibid.

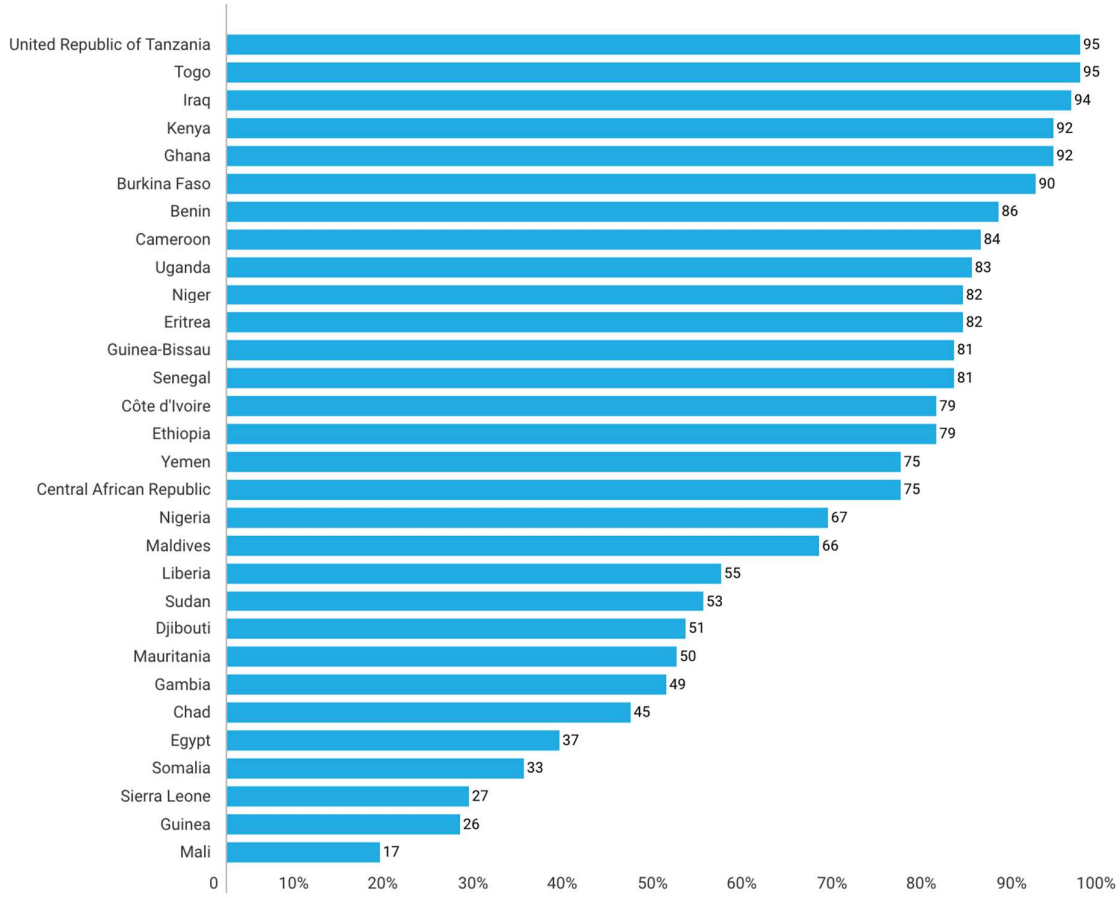

Figure 4 – Percentage of women and girls aged 15-49 who are aware of FGM/C and believe the practice should end (using 2020 UNICEF global databases).[43]

Crucially, comprehensive education about the rights of women must also be provided to young boys. Although evidence shows that some young African men view themselves as "valuable allies in ending FGM/C",[44] a great many remain "concerned about women's rising social status and education", or – in some cases – are still overt advocates of FGM/C.[45] Whilst male support for ending FGM/C varies across countries and communities, it is imperative that young boys are educated in regards to gender equality and the detrimental effects of FGM/C upon the physical and psychological health of its victims. In some areas, youth-led discussion groups have proved themselves to be a powerful first step in initiating such education.[46]

Goal 4 – Speak out about the risks and realities of FGM/C.

As part of the educational programmes discussed above – and education initiatives targeting adult communities more broadly – the horrific physical and psychological consequences of FGM/C must be acknowledged and openly discussed. It has been documented that some survivors of FGM/C live their entire lives "preoccupied by pain".[47] Excessive bleeding, swelling, haemorrhage, infertility, ovarian

[43] UNICEF (2020).
[44] Brown et al. (2016), p. 118.
[45] Ibid.
[46] Brown et al. (2016), p. 122.
[47] Daly (2017), p. 170.

cysts, bacterial infections and death are but some of the physical dangers commonly associated with FGM/C, both during the practice itself and throughout a woman's entire life thereafter.[48] Furthermore, a great many psychological effects have been identified as a direct result of FGM/C, including posttraumatic stress disorder (PTSD), depression, and anxiety disorders.[49] Only by explicitly acknowledging and raising awareness of these appalling risks and realities of FGM/C can we hope to fully eradicate its practice.

Goal 5 – Spread understanding that religion does not demand FGM/C.

Although perpetrators of FGM/C often call upon religion as a justification for the practice, it must be recognised that records of FGM/C predate the introduction of most major religions, including both Christianity and Islam.[50] Whilst it is true that "the line between religious requirement and encouraged practice may be blurred",[51] the fact remains that religion does not explicitly demand FGM/C. Some advocates of FGM/C believe that they are "satisfying religious obligations" by upholding the tradition.[52] These beliefs, however, are a product of mis-interpretation and/or ill-intent on the part of the perpetrators, rather than a product of religious text in itself. In fact, religious leaders can – and often do – play an instrumental role in helping to abolish the practice; in Ethiopia, for example, religious leaders wilfully engaged with efforts to eradicate FGM/C.[53] It has also been noted that, by obscuring the discussion surrounding FGM/C with a disproportionate focus on religion, attention is deflected from the underlying, patriarchal power structures which are truly at the root of the practice.[54] "Patriarchal ideology within religion, and not religion itself, is the cause of gendered violence among religious adherents."[55] AHO recognises this and encourages further cooperation with local religious leaders in order to maximise the effectiveness of anti-FGM/C campaigns.

Goal 6 – Tackle the secrecy that allows cutting to continue, especially by mothers.

As FGM/C has become increasingly controversial, the secrecy surrounding the practice has intensified; as a direct result of this, "[a]ccurate statistics are impossible to obtain".[56] Although the educative programmes outlined above ought to naturally reduce this secrecy, as victims are empowered and encouraged to speak out more openly, an active effort must still be made to combat the secret nature of FGM/C rituals. The harsh medical realities of FGM/C must be documented in full – as they have been here – in order to avoid sentimentalising the practice or concealing its true dangers. Beyond raising awareness of these medical realities, AHO seeks to tackle the "strong sociocultural influences which ensure that it [FGM/C] is secretly done and underreported".[57]

Goal 7 – Keep pushing for legislation for FGM to be banned.

In conjunction with all of these normative goals, AHO strives to continue pushing for further legislative progress against FGM/C. Although the continuation of FGM/C in some regions in spite of legislative measures taken against it "raises the question of whether change can be legislated",[58] an official and complete legal ban on FGM/C across the whole of Africa must be understood as nothing

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[48] Williams-Breault (2018), p. 226.
[49] Odukogbe et al. (2017), p. 143.
[50] Koski, A. and Heymann, J. (2019) 'Changes in support for the continuation of female genital mutilation/cutting and religious views on the practice in 19 countries', *Global Public Health,* 14(5), p. 697.
[51] Ibid.
[52] Awolola and Ilupeju (2019), p. 2.
[53] Ibid, p. 706.
[54] Kelleher, R. (2019) 'The Cut in Conflict: Female Genital Mutilation and the Concept of Religious Violence in the Western World', *Journal of the Council for Research on Religion,* 1(1), p. 466.
[55] Ibid, p. 65.
[56] Daly (2017), p. 174.
[57] Odukogbe et al. (2017), p. 139.
[58] Nabaneh and Muula (2019), p. 253.

less than a fundamental prerequisite in bringing about an end to the practice. Where legislation has already been enacted, as in Kenya and The Gambia, further efforts must be made to increase the severity with which these laws are imposed and upheld.[59] In the few African countries where anti-FGM/C legislation is yet to be enacted, the prevalence of FGM/C remains especially high, as demonstrated by Figure 5 (below).[60]

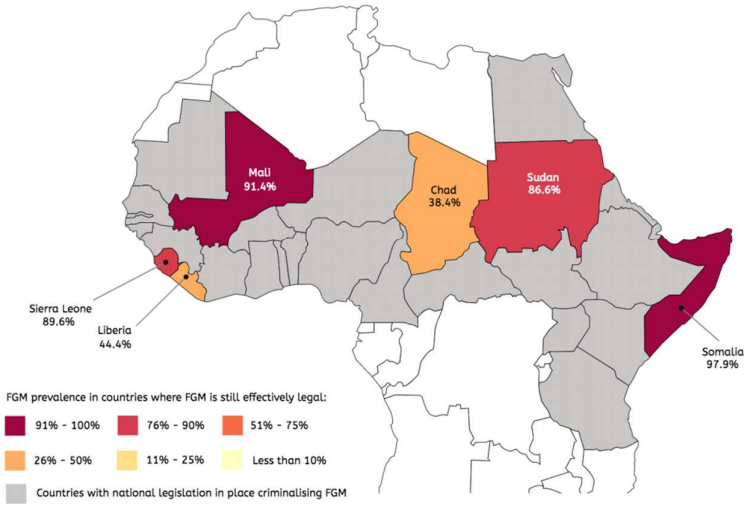

Figure 5 – Prevalence of FGM/C in African countries which have yet to criminalise the practice, as of 2018.[61]

Ultimately, the criminalisation of FGM/C "creates an enabling environment to facilitate the overall strategy of African governments in [the] eradication of the practice".[62] Continued legislative action against FGM/C is a necessary (though by no means sufficient) condition in achieving the complete elimination of the practice.

Projected Time Frame

It is difficult to establish a concrete time-frame for the implementation of the 7 goals listed above, due to the current lack of accurate statistics surrounding FGM/C in some regions of Africa and the normative nature of many of these goals. Kenya can be called upon as a rough indication of the rate of change where anti-FGM/C campaigns have been adopted; the rates of FGM/C "dropped by almost half between the 1998 Kenya Demographic and Health Survey (KDHS) and the 2014 KDHS".[63] This suggests that a reduction by roughly half in the prevalence of FGM/C can be expected in roughly a 15-year period, calling into question whether the 5th SDG – to have FGM/C completely eradicated by 2030 – is achievable. However, recent proliferation of meaningful discussion surrounding FGM/C, as well as significant improvement in the universal understanding of effective methods to bring about its eradication, suggests that the rate of change may, in fact, occur faster than it did in Kenya from 1998-2014. Ultimately, AHO is aligned with the UN's SDGs in aiming to see a complete elimination of FGM/C – and thereby the fulfilment of AHO's 7 goals – by the year 2030.

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[59] Nabaneh and Muula (2019), p. 256.
[60] 28 Too Many (2018). *The Law and FGM: An Overview of 28 African Countries*. [online] London: Thomson Reuters Foundation, pp.1–79. Available at: https://www.28toomany.org/static/media/uploads/Law%20Reports/the_law_and_fgm_v1_(september_2018).pdf [Accessed 23 Sep. 2020].
[61] Ibid.
[62] Nabaneh and Muula (2019), p. 253.
[63] Grose et al. (2019), p. 85.

Resources

Achieving AHO's 7 goals will require a great many resources – predominantly financial. Funding must be made available by national governments, and – where possible – by international organisations, non-governmental organisations (NGOs), and grassroots campaigns. These monetary resources will be essential in facilitating the necessary lobbying and campaigning of government officials across Africa, and even more so in developing and entrenching the educational and social community programmes outlined in AHO's 7 goals. With the UN observing an encouraging budget increase of 600% from 2006 to 2016 for campaigns against FGM/C,[64] it would seem that the international community is both aware of the urgent need for financial resources, and willing to provide them.

Summary

Significant progress has been made over recent decades in tackling FGM/C globally. Since the international community began actively fighting against FGM/C in the 1990s, a great deal of legislative progress has been made across Africa. Yet the lack of legislation in some countries, along with frequent under-enforcement of anti-FGM/C laws,[65] suggests that the legislative campaign is far from over. Moreover, with a significant proportion of the necessary legislative groundwork having now been completed, the focus must shift onto a more holistic approach to eradicating FGM/C. AHO advocates working with local African communities, religious leaders, and community leaders, aiming to provide education and support in helping these communities to permanently bring an end to FGM/C.

[64] United Nations (2016) Sustainable Development Goals: UN event mobilizes action toward ending female genital mutilation [online]. Available from: https://www.un.org/sustainabledevelopment/blog/2016/02/un-event-mobilizes-action-toward-ending-female-genital-mutilation/ [Accessed 10th August 2020].
[65] Nabaneh and Muula (2019), p. 256.