

REVIEW ARTICLE

Female Genital Mutilation: A Literature Review of the Current Status of Legislation and Policies in 27 African Countries and Yemen

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Abstract

This article discusses the results of a literature review that has assessed the impact of Female Genital Mutilation (FGM) legislation in 28 countries (27 in Africa and Yemen) where FGM is concentrated. Evidence on the impact of FGM legislation was available on prevalence of FGM; changes in societal attitudes and perceptions of FGM; knowledge and awareness of FGM legislation and consequences, and the impact on medicalization. While the majority of countries have adopted legal frameworks prohibiting FGM, these measures have been ineffective in preventing and/or in accelerating the abandonment of the practice. Anti-FGM laws have had an impact on prevalence in only two countries where strict enforcement of legal measures has been complemented by robust monitoring, coupled with robust advocacy efforts in communities. Owing to poor enforcement and lax penalties, legal measures have had a limited impact on medicalization. Similarly, legal frameworks have had a limited impact on societal attitudes and perceptions of FGM, with evidence suggesting rigid enforcement of FGM laws has in some instances been counterproductive. Although evidence suggests legislation has not influenced the decline in FGM in the majority of countries, legal frameworks are nevertheless key components of a comprehensive response to the elimination and abandonment of the practice, and need to be complemented by measures that address the underlying socio-cultural causes that are the root of this practice. (*Afr J Reprod Health* 2015; 19[3]: 32-40).

Keywords: FGM/C, legislation, national plans of action, health policies and Africa

Résumé

Cet article étudie les résultats d'un examen de la documentation sur l'évaluation de l'impact de la législation sur la mutilation génitale féminine (MGF) dans 28 pays (27 en Afrique et au Yémen) où la MGF s'est concentrée. Les preuves de l'impact de la législation de la MGF étaient disponibles sur la prévalence de la MGF, les modifications dans les attitudes et les perceptions de la société à l'égard de la MGF, la connaissance et la sensibilisation par rapport à la législation et à des conséquences des MGF, et l'impact sur la médicalisation. Alors que la majorité des pays ont adopté des cadres juridiques interdisant la MGF, ces mesures ont été inefficaces dans la prévention et / ou dans l'accélération de l'abandon de la pratique. Les lois anti-MGF ont eu un impact sur la prévalence dans seulement deux pays où l'application stricte des mesures juridiques a été complétée par un suivi rigoureux, ajouté à de solides efforts de la sensibilisation dans les communautés. En raison de la mauvaise application et des sanctions laxistes, des mesures juridiques ont eu un impact limité sur la médicalisation. De même, les cadres juridiques ont eu un impact limité sur les attitudes et les perceptions de la société envers la MGF, avec des preuves qui suggèrent que l'application rigide des lois de la MGF a été, dans certains cas, contre-productive. Bien que la preuve suggère que la législation n'a pas influencé la baisse de la MGF dans la majorité des pays, les cadres juridiques sont néanmoins des éléments clés d'une réponse globale à l'élimination et à l'abandon de la pratique, et doivent être complétées par des mesures qui se préoccupent des causes socioculturelles sous-jacentes qui sont à la racine de cette pratique. (*Afr J Reprod Health* 2015; 19[3]: 32-40).

Mots-clés: l'E / MGF, la législation, plans d'action nationaux, les politiques de santé et de l'Afrique

Introduction

Female Genital Mutilation (FGM) is defined by the World Health Organization (WHO) as all procedures that are involved in the partial or total

removal of the external female genitalia or other injury to the female genital organs for non-medical reasons, and is classified into four categories¹. FGM is concentrated in 28 countries - 27 in Africa² and Yemen, (see table 1) and also occurs

in the diaspora in Australia, New Zealand, North-America and Europe, and in some countries in the Middle East and Asia. While FGM is in decline in some parts of the world, current estimates show that approximately 125 million women and girls living worldwide have undergone the practice and many more are at risk³.

The adoption of recommendations on violence against women in 1992 by the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW), and reinforced by the World Conference on Human Rights, the global movement against violence against women catalyzed international action on FGM⁴. Subsequently, FGM became recognized as a violation of the human rights of women and girls by several international rights treaties that affirm the rights of physical integrity and freedom from all forms of torture, inhumane, degrading treatment and discrimination⁵.

The Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa – the Maputo Protocol (2003) to which the majority of the 27 African countries are signatories, recognizes FGM as a violation of women's rights and a form of gender-based discrimination, as does the Convention on the Rights of the Child (CRC), which has provisions to protect children from harmful traditional practices. The adoption of UN resolution A/RES/67/146 - *Intensifying global efforts for the elimination of female genital mutilation* in December 2012 by all 194 members of the General Assembly, including the 28 countries that are the focus of this article, is an indication of the commitment at the global level to eliminate FGM and accelerate its abandonment. States that are signatories to or have ratified international treaties against FGM have a responsibility to not only ensure the protection of these rights, but also to refrain from violating them. In order to effectively implement these treaties at the domestic level, it is necessary for States to take legislative, administrative and policy actions that will ensure the treaties' rights are guaranteed. In the case of FGM, enacting national legislation criminalizing

FGM is one of the actions that States can take to protect and ensure girls' and women's rights.

FGM is a public health issue that was first identified by the WHO as a serious threat to women's health in 1979 and a violation of a person's right to the highest attainment of health as it damages healthy genital tissue and can lead to severe consequences for girls' and women's physical health⁶. Health implications of FGM can range from structural complications of the genitourinary system, post-procedural complications, obstetrical complications and even death in certain cases⁷. Moreover, the WHO condemned medicalization or the practice of FGM by health professionals in 1979, and in its interagency statement on the elimination of FGM⁸. A comprehensive review of FGM legislation in Africa was undertaken in 2000⁹. Several recent accounts have examined the effectiveness of FGM legislation in Egypt, Ghana, Senegal and Uganda, and the impact of Egypt's FGM ban on women's attitudes towards the practice has been explored¹⁰. Since 2000, much has changed in the 28 countries where FGM is concentrated, with several countries enacting laws criminalizing the practice, and in some cases, developing national plans of action aimed at implementing the law, and integrating FGM into their health policies.

In view of these developments, this article conducted a review of published articles and grey literature on legislation and policies prohibiting FGM in 27 African countries where the practice is concentrated and Yemen, with an aim of assessing the extent to which legislation, national plans of action and the integration of FGM in health frameworks have been effective in fostering the prevention of FGM and/or in accelerating its abandonment in these countries.

Methods

Standard database searches were undertaken in August 2013. Articles published in English on FGM/C laws and/or legislation in Africa and Yemen, national plans of action and health policies were obtained from PubMed, Popline,

CABI Direct, Social Sciences Abstracts and African Index Medicus. To supplement the database search, reports published by international organizations undertaking work on FGM - (UNICEF and UNFPA) were reviewed. In addition, interviews were conducted with a small sample of researchers, and UNFPA and UNICEF country program staff.

Analysis FGM

Legislation in 28 Countries

Most African countries where the practice is concentrated have passed national legislation outlawing FGM. With the exception of Tanzania, Somalia and Sudan, 14 countries in Africa have ratified CEDAW and 10 countries and Yemen have acceded to CEDAW, legally binding them to terms of the Convention. With the exception of Egypt and Eritrea, 25 countries in Africa where FGM is concentrated have ratified the Maputo Protocol, which prohibits all forms of the practice¹². Despite this, FGM remains pervasive in many countries that have ratified the Maputo Protocol, suggesting that the Protocol's standards have not been met.

Of the 28 countries that are the focus of this article, 18 have enacted national laws banning FGM (See Table 1). While Sudan lacks national legislation outlawing FGM, several states in Sudan, including South Kordofan, Blue Nile and Gadaref have enacted legislation outlawing FGM. In addition, South Kordofan and Gadaref State ratified the Children's Act in 2008 and 2009, respectively, while Kassala State adopted a recommendation prohibiting FGM but lacks specific legislation against the practice. Although Nigeria passed its federal law outlawing FGM in May 2015, prior to the enactment of the legislation, only eleven states - Bayelsa, Delta, Cross River, Ebonyi, Edo, Ekiti, Kwara, Ogun, Ondo, Osun and Rivers States had laws against FGM, while Lagos and Imo states had legislation on violence against persons that could be applied to FGM.

While Gambia, Mali, Mauritania, Liberia, Sierra Leone and Yemen have no national laws

banning FGM, both Gambia and Mauritania have submitted draft legislation criminalizing the practice to their respective legislatures. Mali's Personal and Family Code (2011) has provisions that can be applied to FGM.

Table 1: Percentage of Girls and Women aged 15-49 who have undergone FGM

Country and Year when national FGM Legislation was Enacted	% of girls and women aged 15-49 who have undergone FGM*
Benin (2003)	13
Burkina Faso (1996)	76
Cameroon	1
Central African Republic (1966)	24
Chad	44
Cote D'Ivoire (1998)	38
Djibouti (1995)	93
Egypt (2008)	91
Eritrea (2007)	89
Ethiopia (2004)	74
Gambia	76
Ghana (1994 amended 2007)	4
Guinea (2000)	96
Guinea-Bissau (2011)	50
Kenya (2011)	27
Liberia	66
Mali	89
Mauritania	69
Niger (2003)	2
Nigeria (2015)	27
Senegal (1999)	26
Sierra Leone	88
Somalia (2012)	98
Sudan	88

Tanzania	15
Togo (1998)	4
Uganda (2010)	1
Yemen	23

*Source: UNICEF (2013)

Legal regulation of FGM varies widely. Benin (2003) and Tanzania (1998) have provisions in their laws on FGM that protect minors from the practice, while Kenya enacted the Children's Act in 2001 outlawing FGM among children. Mauritania, which lacks national FGM legislation, has provisions against harmful practices in its Children's Act (2005) and the Women's Act (2010) that can be applied to FGM¹³. Similarly, Mali's Family Health Act (2003) and Sierra Leone's Children's Right Act (2007) have provisions that protect children from harmful practices.

Penalties for performing FGM vary considerably across countries and range from a few months to a couple of years' imprisonment. Fines for performing FGM vary widely and range from about US \$40 to \$400 in Niger, \$47 in Ethiopia, and \$140 - \$780 in Egypt to about \$208 to up to \$4,000 in Benin, Central African Republic and Togo. Djibouti has among the highest fines at \$2,080. Benin, Eritrea, Ethiopia, Kenya and Senegal have penalties for aiding and abetting FGM, which range from 1 month to 6 years imprisonment. Benin, Burkina Faso, Cote D'Ivoire, Eritrea, Ethiopia, Guinea, Kenya, Niger, Senegal, Togo and Uganda also have penalties for death resulting from FGM. Kenya has provisions for extraterritoriality - taking an individual to another country or bringing an individual into the country to undergo FGM.

Burkina Faso, Cote D'Ivoire, Egypt, Eritrea, Kenya, Mauritania, Mali, Niger, Senegal and Yemen prohibit medicalization, with penalties varying considerably across countries. In Eritrea and Kenya, penalties for medicalization include the revocation of medical professionals' licenses (up to 2 years in Eritrea), while in Burkina Faso and Cote D'Ivoire, medical professionals can be suspended for up to 5 years for performing FGM.

Mauritania and Yemen, which lack national FGM legislation, have decrees against medicalization. Benin, Burkina Faso, Cote D'Ivoire, Eritrea and Togo also have provisions on failing to report FGM to competent authorities.

Health Policies and National Action Plans

Several countries including Burkina Faso, Djibouti, Egypt, Ethiopia, Gambia, Guinea, Guinea-Bissau, Kenya, Mauritania, Nigeria, Senegal and Sudan have developed national plans aimed at preventing FGM or accelerating its abandonment. Across countries, national bodies or committees have adopted varying mandates related to FGM prevention and the acceleration of its abandonment. For instance, in 1990, Burkina Faso established the National Committee for the Campaign to Fight the Practice of Excision (CNLPE) with provincial committees to oversee the prevention of the practice at the local level, and in 1997, a Secretariat was created to oversee FGM abandonment. Similarly, Cote D'Ivoire established a National Anti-Female Circumcision Commission to conduct research and advocate for the prevention of FGM, while Djibouti established the National Committee to Combat Female Genital Excision in 1992. Ethiopia's national coordinating body within the Ministry of Justice is implementing its action plan on violence against women and children, which includes FGM¹⁴. Kenya's Anti-FGM Board which coordinates public awareness programs against FGM and advises the government on FGM-related matters, also implements abandonment programmes.

Eritrea's Anti-FGM Committees, which operate at the local level, raise awareness of the law among families and monitor its violation within communities, while Guinea-Bissau's National Committee to Fight Harmful Traditional Practices (CNAPN) was instrumental in advocating for the law on FGM.

In addition, FGM prevention and care has been integrated in several countries' health policies and programmes. Burkina Faso, Eritrea, Ethiopia, Gambia, Guinea, Kenya, Mali (in its Action Plan for the prevention and care of FGM), Mauritania, Senegal and Sudan have integrated

FGM into their sexual and reproductive strategies and other health frameworks¹⁵, while Kenya has integrated FGM in its reproductive health policy (2007). Although Djibouti and Guinea-Bissau have not integrated FGM in their health care policies, FGM is included in their health care training programmes. In addition, Sudan has integrated FGM into its sectoral plans of action and incorporated FGM in the work of other line ministries besides health, such as the Ministry of Religious Guidance and Endowment.

FGM has been integrated into several countries' public health systems. In Eritrea, for instance, health care professionals are trained to identify and treat women and girls with FGM-related complications and provide clinical assessments for girls under 5 years¹⁶. In Burkina Faso, Egypt, Gambia, Guinea, Kenya, Mauritania, Mali and Sudan, FGM is included as part of health professionals' training, while Djibouti offers a module on FGM to all health professionals¹⁷. Elsewhere, frameworks have been established within the health policies to address specific issues related to FGM. For instance, Somalia has an anti-medicalization strategy, while Sudan's reproductive health policy explicitly prohibits medicalization¹⁸.

Implementation of Legislation on FGM and Enforcement Practices

Evidence suggests that FGM legislation has had some effect in preventing FGM or in accelerating its abandonment in a few countries such as Burkina Faso where strict enforcement of the law has led to a decline in the practice in some parts of the country¹⁹. In 2011, 5 circumcisers and 57 accomplices were sentenced to prison for periods ranging from three months to three years for cutting 88 girls - nearly three times the 23 cases brought against offenders in 2010²⁰. Moreover, enforcement of the law has been reinforced by reporting of FGM incidents through the hotline operated by the CNLPE, which oversees the prevention of FGM nationwide. In 2011, 10 FGM cases were reported to the authorities through the anti-FGM hotline²¹. Evidence shows that

awareness of FGM laws and policies among criminal justice personnel can have a positive effect in reinforcing laws²². In addition, political support for anti-FGM efforts in Burkina Faso, which dates back to 1983 when the political establishment and Terres des Hommes held discussions on FGM²³, and support for the CNLPE's establishment, may have played a catalytic role in changing norms related to FGM, and in providing the impetus for FGM decline in some parts of Burkina Faso.

In Eritrea, robust monitoring of the violation of the FGM law and the establishment of an enforcement mechanism at the community level has ensured its compliance²⁴. Moreover, the establishment of local anti-FGM committees in each community in Eritrea which engage local law enforcement officials in raising awareness of FGM among families, and in monitoring against the law's violation and in reporting to law enforcement officials when FGM occurs have been effective in preventing FGM, with these efforts resulting in charges and convictions against 54 circumcisers and parents in 2011 and in 2012, convictions and fines of 155 perpetrators in Eritrea^{25,26,27}. While there are indications that a decrease in prevalence rates has been observed among girls under 5 and under 15, with an estimated rate of 12.9% and 33%, respectively, FGM prevalence has increased in the Southern Red Sea Region²⁸.

Elsewhere in Africa, the enforcement of FGM laws has been sporadic and rare, and can be attributed to several factors. In Ghana, lack of enforcement of the law is partly linked to lack of political will to follow up legislation with practical action²⁹. As evidence from countries where enforcement of FGM legislation has been rare suggests, there may be a link between lack of enforcement and high prevalence rates. No prosecutions were made against FGM perpetrators in Djibouti, Egypt, and Somalia in 2012, all of which have high prevalence rates³⁰. Similarly, evidence from countries where the enforcement of FGM legislation is lax suggests it has had limited effect on prevalence. In 2012, Guinea Bissau and Kenya, less than five arrests were made in each

country³¹. In Kenya, prosecution against parents whose daughter underwent FGM stalled due to lack of witnesses³².

Laws prohibiting FGM have had little effect in changing societal attitudes towards the practice. Despite the ban on FGM in Egypt, prevalence rates in some parts of Egypt are still high³³. Five years after the complete ban of the practice in Egypt, attitudes on FGM among educated families in Upper Egypt were largely unchanged and FGM prevalence rates remained high³⁴. Lax penalties and low fines fail to deter perpetrators from practicing or abetting and aiding FGM. In Kenya, fines (50,000 Shillings or about \$600) have not discouraged affluent Kenyans from having the practice performed or from discouraging the Somali diaspora from taking girls to Kenya to undergo FGM³⁵.

Medicalization or the practice of FGM by professionals, which is outlawed in several countries and is a violation of their code of ethics, is on the rise in Egypt, Guinea, Kenya, Nigeria, Sudan and Yemen. Despite enacting a decree in 2007 that banned health providers from performing FGM, Egypt has the highest prevalence of medicalization, with an estimated 77% of health care professionals performing the practice³⁶, which is widely accepted by Egyptian health care providers³⁷. Penalties for health professionals who perform FGM may be too low, possibly encouraging the practice to thrive. In Eritrea, for instance, the fine for health care providers that perform FGM in Eritrea is about \$95, which may be too low to deter providers. Where action has been taken against health care professionals for performing FGM, it has been protracted, and there is little evidence that it has had a deterrent effect on their behavior. For example, 12 criminal cases brought against parents and/or doctors implicated in carrying out FGM in Egypt lingered in courts for a long time³⁸.

Knowledge of laws on FGM and the consequences for performing the practice is not only limited, but also varies widely within countries throughout Africa. In Uganda, for instance, evidence suggests that there is greater awareness of the law on FGM in the eastern part

of the country where much of the advocacy work on the law against FGM has been undertaken and less so in other areas³⁹. While local police and community monitors in Uganda routinely travel to villages in the summer to raise awareness of the law outlawing FGM⁴⁰, in other parts of Africa, efforts to raise awareness on FGM laws have largely been limited to urban areas.

Inconsistencies in FGM laws may undermine efforts to eliminate the practice. Since the late 1950s, Egypt's policies on FGM have been characterized by inconsistencies. In 1959, Egypt's Ministry of Health, which issued a decree (No.7) prohibiting FGM from being performed in public health facilities, reversed its position in 1994 when the Ministry issued a decree permitting doctors in government hospitals to perform FGM. After a reversal in 1995 that banned hospitals from performing FGM, a ministerial decree issued in 1996 allowed both public and private hospitals to perform FGM if approved by a doctor⁴¹. Following the death of two girls in 2007, Egypt's Ministry of Health issued another decree (No.271) that banned FGM in clinics as well as in public and private hospitals, overruling the 1996 decree. Similarly, in Sudan, article 13 of the Children's Act, which had a provision against performing FGM on children was repealed in 2009, making the practice permissible among children once again. Moreover, Sudan's 1946 law on FGM, which outlawed infibulation (a crime punishable by imprisonment and a fine), made other less severe forms of FGM permissible in Sudan.

Discussion

Laws against FGM vary considerably across the 28 countries where the practice is concentrated. While legislation outlawing FGM is a vital element in its prevention and in providing the impetus for accelerating its abandonment, with the exception of Burkina Faso and Eritrea, both of which have systematically enforced FGM laws and monitored their violation, despite the existence of FGM legislation in almost all major practicing countries, evidence that legislation has had a deterrent effect in preventing FGM and/or in

accelerating its abandonment is limited. In the majority of countries, sporadic enforcement of FGM laws, along with a lax attitude towards the practice, may be contributing to FGM's persistence.

The enactment of legislation that is not accompanied by robust monitoring and supported by adequate mechanisms and institutions to enforce the legislation, and backed by community-based supports underlying socio-cultural norms that perpetuate FGM is unlikely to be effective in eliminating FGM or accelerating its abandonment. Advocates for legal reform argue that laws against harmful practices can strengthen the stance of those favoring abandonment and can complement other reform strategies by creating an "enabling environment" for advocacy work and for those who wish to abandon FGM⁴².

There is an indication that rigid enforcement of FGM laws can be counterproductive to efforts to prevent the practice. Evidence from cross-national comparisons, suggests that stricter laws or more rigorous enforcement may not necessarily result in a decrease in the practice⁴³. Results of a survey undertaken in Burkina Faso suggest that rigid enforcement of the law may have unwanted consequences and could inadvertently push the practice underground, making reporting of FGM occurrences less likely⁴⁴. Similar tendencies have been observed in Senegal where a number of high profile arrests and convictions took place⁴⁵. As some observers have noted, when legal norms run counter to social norms, there is a risk of both reactance and increased disrespect of laws in general⁴⁶. In addition, enforcement of laws without sufficient emphasis on raising awareness of the law may be problematic. Strict enforcement can also have unwanted consequences for the victims that the laws are meant to protect, i.e. the girls who may be traumatized by seeing their parents punished and left in a vulnerable situation if their caregivers are imprisoned⁴⁷.

As is illustrated above, provisions against medicalization are limited to a few countries. Lack of provisions on medicalization in Chad, Djibouti, Ethiopia, Guinea, Guinea Bissau, Mali, Nigeria, Somalia, Sierra Leone, Sudan, Tanzania and Togo

creates loopholes that could potentially encourage health care professionals to perform the practice. As with the enforcement of FGM legislation, insufficient budget allocations, lack of robust institutions and inadequate capacity-building efforts hinder FGM prevention and the acceleration of its abandonment.

Conclusion

The enactment of FGM legislation and the implementation of health policies designed to prevent FGM and accelerate its abandonment in the 28 countries where the practice is concentrated has had a limited impact in the majority of these countries to a large degree because of sporadic enforcement of the laws, lack of comprehensive legislation, lack of robust institutions to enforce the law and programmes aimed at addressing the underlying social norms that perpetuate the practice.

For FGM legislation to be effective, enforcement of the law needs to be complemented by capacity-building efforts among enforcement authorities, with robust monitoring at the local level as evidenced in Eritrea, and to some degree in Uganda. Legislation has been ineffective partly because criminalizing FGM does not address root causes of the practice. Consequently, interventions aimed at changing societal perceptions towards FGM need to address underlying social norms that are at the root of the practice. Legislation needs to be comprehensive, with provisions and stiff penalties for medicalization as well as for individuals that abet and aid FGM in order to address legal loopholes that may inadvertently encourage individuals to practice FGM. Legislation should also conform to the Convention on the Rights of the Child (CRC), which has provisions that prohibit FGM on children.

While much of the evidence on the enforcement of legislation has been largely limited to the 15 countries that participated in the initial phase of UNFPA-UNICEF Joint Programme, additional evidence on the status of enforcement of FGM legislation in the other 13 countries may shed light on the extent to which legal frameworks

have been effective. Further research on the process and type of legislative reform that can contribute to changing harmful traditional practices like FGM in different settings is needed, as is additional evidence on the implementation of national plans of action and their effectiveness in accelerating the abandonment of FGM in the 28 countries.

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