Female Genital Mutilation in Africa

POLITICS OF CRIMINALISATION

Edited by
Satang Nabaneh

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Female genital mutilation in Africa: Politics of criminalisation

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FOREWORD

*Fareda Banda**

Professor of Law, SOAS, University of London

There is a song by Billie Holiday, 'Good morning heartache.' It starts:

'*Good morning heartache*
You old gloomy sight
Good morning heartache
Thought we said goodbye last night
I turned and tossed until it seemed you had gone
But here you are with the dawn
Wish I'd forget you, but you're here to stay.'[1]

•••

Reading this collection about the practice of Female Genital Mutilation (FGM), reminded me of that song. There are times when it has seemed that the message had penetrated; this is a harmful practice whose negative effects last a lifetime and can even lead to death. In short it constitutes a violation of myriad human rights. This knowledge has not always led to substantive change. Resistance has been resolute. *Is the FGM induced heartache here to stay?* In the words of Holiday, it seems we 'Can't shake you, no how.'

UNICEF statistics issued to mark International Women's Day in 2024 showed that while some communities had stopped cutting their children 'more than 230 million women and girls around the world have undergone female genital cutting … an increase of 30 million

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1 B Holiday 'Good morning heartache' (Decca, 1946). Songwriters: Irene Higginbotham, Ervin M Drake, Dan Fisher.

since the organization's last global estimate in 2016.'[2] UNICEF also noted; 'laws and campaigns against it have had no impact.'[3]

So how did we get here?

This new edited collection engages that question. It is the latest intervention on FGM augmenting the vast literature on how to tackle the practice. We are witnessing the seemingly intractable conflict between human rights demands and promises, the *de jure* and what is going on in real life (IRL), the *de facto*. Attempts to outlaw the practice using criminal law has so often met with resistance. Changing the law really is easier than changing society. The book asks whether criminal law is an *adequate* and indeed *appropriate* response to FGM. It also adds to the growing literature challenging the carceral approach to issues pertaining to women's lives.

In her introductory chapter, Satang Nabaneh proves to be an excellent guide in navigating the twists and turns that have brought us to this juncture. She sets out the history of colonial imposition of laws banning the practice and the resulting nationalist inflected resistance mounted by those who did not think their practices deserved this contempt. Nabaneh's narrative shows us that in post-colonial states the resistance has mutated in unexpected ways. An example includes the case brought by a female doctor who challenged the banning of the practice in Kenya arguing that it violated the autonomy rights of adult women.[4] This provokes one of the questions addressed in the collection: 'whether there is a legitimate reason to criminalise consent based or voluntary FGM by adult women and whether such criminalisation violates their human rights.'[5]

2 UNICEF 'Over 230 million girls and women alive today have been subjected to female genital mutilation' (8 March 2024) https://www.unicef.org/romania/press-releases/over-230-million-girls-and-women-alive-today-have-been-subjected-female-genital.

3 As above.

4 *Kamau v Attorney General & 2 others; Equality Now & 9 others (Interested Parties)* [2021] KEHC 450 (KLR). See S Nabaneh, chapter 1 and E Kinama, chapter 6 of this volume. These intra-group disagreements are not new. In the early 2000s diasporic African women were incensed by Alice Walker's *Possessing the secret of joy* (1992) charging her with reinforcing stereotypes about Africa and questioning her right to speak on the issue. Walker had company, for Germaine Greer was also criticised. See also F Banda *Women, law and human rights in Africa* (2005) 214-217.

5 S Nabaneh, chapter 1, in this volume, 11.

Nabaneh also shows how resistance has also come from religious leaders. In The Gambia they very nearly succeeded in overturning the 2015 law banning the practice. Significantly, those arguing for the continuation of the practice framed their demands in human rights terms invoking rights to culture and religion. The collection challenges us to engage with these counter-narratives.[6] It advocates a decolonial perspective rooted in African feminism(s).

I was reminded me of the work of Rao who asks; *who speaks for culture, who is involved in the construction of cultural norms and what is culture after all*.[7] Rao's questions help to explain the necessity of including article 17 of the Maputo Protocol on women's right, 'to participate at all levels in the determination of cultural policies.'[8]

The collection skilfully brings together national case studies on legal reform; considers the controversy over the medicalisation of the practice and offers the reader a first person account from one who has undergone FGM. Through these nuanced interventions, we come to understand the limits of law. Vertical transmission of norm change -from state to citizen using punitive means is unlikely to bring about the necessary change in behaviour. Some states recognise this and so engage in half-hearted law reform. An example of this is Nigeria's Violence Against the Persons (Prohibition) Act 2015, which does not apply in many of the states where FGM is prevalent.[9]

Other states eschew law. The table of national legislation presented in the introduction shows that the states with the highest incidence of FGM do not have any laws addressing the practice (Niger, Somalia and Somaliland).[10] These are also the countries with high rates of child marriage and therefore high birth rates showing the interconnectedness of rights violations.[11]

It is gratifying to see a new generation of scholars carrying on the work that was started by giants such as Efua Dorkenoo whose book *Cutting the rose* and work at the World Health Organization (WHO)

6 See A An-Naim *Decolonising Human Rights* (2021) 9, 81-101,102-124.
7 A Rao 'The politics of gender and culture in international human rights discourse' in J Peters & A Wolper (eds) *Women's rights, human rights: International feminist perspectives* (1995) 167.
8 African Union 'Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa' (11 July 2003).
9 See FR Adegbite, chapter 2 and MA Abdulraheem-Mustapha, chapter 11 in this volume.
10 S Nabaneh, chapter 1, in this volume, 9-10.
11 See also UNICEF (n 2).

led to the practice being more widely known.[12] We do not walk this journey alone and so we recall the impactful advocacy of Sudanese gynaecologist Nahid Toubia.[13] Civil society has remained central to the fight, lobbying states to legislate to ban the practice.[14] It has always been understood that it was in working with communities that transformative change would come.[15] TOSTAN, the NGO headquartered in Senegal has long been a proponent of transformative engagement. This new work stands on their shoulders and builds on that rich legacy.

Mukoma Professor Charles Ngwena left us a precious gift in his prescient book *What is Africanness?*[16] He gave us the intellectual and strategic tools and methodology with which to engage. His book also helps us to operationalise article 17 of the Maputo Protocol on women's right to live in a positive cultural context and to participate in the formulation of positive cultural policies.

This excellent collection is the spur that we need to honour those who have laboured before and those who left too soon – *Mukoma Professor Charles Ngwena*. It reminds us that we must not give up but continue to fight for the rights of women and girls to be free from FGM, however blue and despondent we may sometimes feel.

12 E Dorkenoo *Cutting the rose* (1994).
13 P Shetty 'Nahid Toubia' (2007) 369 (9564) *The Lancet* 819.
14 A Rahman & N Toubia *Female genital mutilation: A guide to laws and practices worldwide* (2000).
15 A An Na-im 'State responsibility under international human rights law to change religious and customary laws' in R Cook (ed) *Human rights of women: National and international perspectives* (1994) 167.
16 C Ngwena *What is Africanness? Contesting nativism in race, culture and sexualities* (2018).

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PREFACE

> 'Our ethical responsibility to Africanness is not to deny agency but instead to keep the door open for social reflexibility and ever-transforming Africanness.'
>
> Charles Ngwena, *What is Africanness? Contesting nativism in race, culture and sexualities* (2018)

Professor Charles Ngwena makes a poignant statement, which remains profoundly relevant and true. In the years since, several crucial developments have underscored the importance of his insight. First, as Charles himself emphasises, we must ground our analysis in the lived realities of African people, acknowledging the diversity and complexity of their experiences. Second, his call for social reflexivity and recognition of the ever-transforming nature of Africanness requires us to continuously challenge static notions and engage with the dynamic evolution of African identities and practices

I owe an immeasurable debt to Charles, my guru and intellectual mentor throughout this project. When we conceived the 2022 Colloquium on FGM, his challenge resonated deeply: 'How much do you want to push the needle, Satang?' He suggested I loosen the grip on traditional human rights discourse and foreground the complexities of criminalisation and its intersection with sexual and reproductive health rights. He envisioned a Colloquium that transcended the typical human rights event, one that ignited a genuine dialogue about the unintended consequences of prevailing approaches to FGM and its criminalisation and explored innovative alternative strategies. This counsel resulted in a remarkably engaging and thought-provoking Colloquium, one that engaged critically with established paradigms and generated new avenues of research. He also challenged me to shepherd a further inquiry into the politics of FGM criminalisation, culminating in this Book. This intellectual journey, however, is not merely academic. It is deeply rooted in my personal experiences, upbringing and background.

I consistently grapple with the disparity between theoretical frameworks and my own embodied reality. Growing up in The Gambia, I became acutely aware of the stark gender disparities that permeated my world. Like so many African women, I navigate spaces where I constantly confront gender-based challenges, stereotypes, prejudices, and discrimination. The deeply ingrained traditional beliefs, such as 'a woman's place is the home' and 'women cannot be leaders,' were a

constant presence, shaping my environment and fueling my resistance. But the realities of the statements remain the same for women in Africa today. Though women hold 'half the sky' of the continent, systemic inequalities and unjust discrimination continue to erode the fundamental rights promised by international human rights law, and enshrined in most constitutions, including addressing harmful social and traditional practices.

This erosion is not abstract. As my sister sister Musu Bakoto Sawo powerfully articulates in this Book, her own lived experience, scarred by both FGM and the forced loss of childhood through child marriage, underscores the urgent need to center survivors' voices. She reminds us that FGM survivors have the right to reclaim their narratives, to share their stories with dignity, to be listened to with respect and to define their own terms of healing.

Driven by the persistent erosion of rights, the mounting criticisms of a carceral approach to women's lives, and the necessity for critical inquiry, I examined the prevailing legal strategies for eradicating FGM. As detailed in our International Journal of Gynecology and Obstetrics article, 'Female Genital Mutilation/Cutting in Africa: A Complex Legal and Ethical Landscape,' the gross violation of girls' and women's human rights is comprehensively recognised across numerous international legal instruments. Consequently, African governments have predominantly employed legal sanctions in their intensified eradication efforts. This emphasis on legal measures is reflected in the growing trend towards criminalisation, evident over the past three decades in various laws, including penal codes, specific anti-FGM laws, Women's Acts, Children's Acts and Domestic Violence Acts.

Globally, a significant legal shift has occurred, with over 60 countries, including more than 25 in Africa, enacting laws criminalising FGM. This legislative trend commenced in the early 1990s and continued through the 2000s, with Sudan being a recent addition in 2020. Several African nations have adopted specific national anti-FGM laws, including Benin, Eritrea, Guinea-Bissau, Kenya, and Uganda. In other countries, while not having stand-alone FGM legislation, the practice is specifically mentioned or covered within broader legal frameworks. These nations include Burkina Faso, Cameroon, Central African Republic, Chad, Côte D'Ivoire, Djibouti, Egypt, Ethiopia, The Gambia, Ghana, Guinea, Mauritania, Niger, Nigeria, Senegal, Tanzania, and Togo.

Conversely, some countries with high prevalence rates of FGM have not yet enacted specific laws or explicitly covered the practice within existing legislation. These include Mali (88.6% prevalence), Liberia (31.8% prevalence), and Sierra Leone (83% prevalence). Somalia, with an exceptionally high prevalence of 99.2%, presents a unique case; while its Constitution expressly prohibits the 'circumcision of girls,' there is no national legislation explicitly implementing this provision, and no known instances of FGM offences being prosecuted under general criminal laws.

The stark reality is that despite increasing legal prohibitions against FGM across Africa, the harmful practice persists, affecting over 230 million girls and women globally, with an estimated 92 million in Africa aged 10 and above. This significant gap between law and practice forms the central focus of Female Genital Mutilation (FGM) in Africa: Politics of Criminalisation, which critically examines this paradox by posing crucial questions: Why, despite the lack of proven efficacy, has the criminalisation of FGM become such a dominant global trend, particularly in Africa? And how do we explain the discourses that have led to its seemingly superficial acceptance by African governments? Given the stark contrast between intensified global efforts to criminalise FGM and the continued resistance from practicing communities, a critical analysis of dominant discourses surrounding criminalisation is imperative. This resistance, alongside the complex interplay of global and local forces, has resulted in notable 'mutations' in the legal landscape surrounding FGM, demonstrating that the process is not a straightforward imposition of Western values but rather a dynamic negotiation. As evidenced by the Kenyan Anti-FGM Act 2011, while international power hierarchies undeniably influence the discourse, local agency and context significantly shape legal outcomes. This nuanced understanding is further reinforced by the Gambian case, where the threat in 2024 to repeal the Women's (Amendment) Act (2015), which criminalises FGM, clearly illustrates how post-colonial resistance and evolving socio-political-religious dynamics can lead to significant and potentially regressive shifts in legal frameworks.

This book fills a critical gap in the legal discourse on FGM in Africa, stimulating a vibrant line of discussions. It seeks to provoke deeper reflection on universal human rights norms and their influence on national laws, essential for understanding FGM's multifaceted

nature. To achieve these goals, this Book distinguishes itself through decolonial and African feminist perspectives, challenging dominant Western narratives and prioritising African voices for a nuanced understanding. Its interdisciplinary approach synthesises diverse fields, offering holistic analysis crucial for effective solutions. Context-specific analyses from diverse African regions enhance its practical relevance. While critically assessing criminalisation, it acknowledges the potential of legal frameworks to enable broader eradication strategies.

This work, as Professor Ngwena reminds us, is not about 'throwing out the baby with the bath water,' but a call for nuanced, context-specific approaches that complement legal frameworks with community engagement, education, and social change initiatives.

Satang Nabaneh
University of Pretoria
February 2025

ENDORSEMENTS

'This collection is a significant and timely contribution to the field, offering a rigorous examination of the complex legal landscape surrounding FGM in Africa. Through its critical analysis of legal frameworks, diverse perspectives, and nuanced exploration of the legal and policy approaches to prohibition, it serves as an invaluable resource for policymakers and advocates striving to develop effective legal strategies. The resurgence of debates around 'decriminalisation' in some African countries underscores the urgent need for sustained vigilance and robust legal protections to safeguard the rights of women and girls.'

Janet Ramatoulie Sallah-Njie
Vice Chairperson & Special Rapporteur on the Rights of Women in Africa, African Commission on Human and Peoples' Rights

'This compelling book offers a vital examination of law's role in combatting Female Genital Mutilation (FGM). It compels us to ask: why and how do we legislate? As the chapters powerfully demonstrate, our aim must be to protect victims, not merely abolish a harmful practice. We should also endeavour to have a participatory approach that takes onboard the user's view. This is critical for the implementation if we want to make the law an instrument of change. This is essential reading for policymakers, legal experts, and activists striving to end FGM and uphold human rights. It provides a powerful, insightful lens on this critical issue.'

Kembo Takam Gatsing Hermine
Member of the African Committee on the Rights and Welfare of the Child & Special Rapporteur on Child Marriage and other Harmful Practice

'Many African countries have outlawed the practice of FGM through enactment of laws with different levels of punishment to the practitioners of FGM. Unfortunately, hardly anyone is punished because of the secrecy under which they practice and the consideration of the impact of the jail terms on the children left behind after the parents are punished. Those who aid or abet together with the practitioners need to be punished according to the law of the country so as to protect the children. This book is a good opportunity to educate the law makers, the judiciary and sociologist and all advocates against this heinous crime against humanity and specifically against the girl child. More similar work should be done and disseminated widely.'

Guyo W Jaldesa
Researcher, advocate of women reproductive health rights and professor of obstetrics and Gynaecology

'Female Genital Mutilation in Africa: Politics of Criminalisation explores the role of law, legislation, and criminalisation in efforts to eradicate FGM across the continent and beyond. FGM is a silent tragedy and a harmful practice, still prevalent in many African countries where it is deeply rooted in culture, tradition, religion and identity. Although evidence suggests legislation has not influenced the decline in FGM in most 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 norms that are the root of this practice. This book is a wake up call for many regions of the world and underlines that the struggle against FGM must be a combined effort of law enforcement, targeted information- and sensibilisation campaigns, education and training activities for various target groups, aiming at eradicating this harmful practice.'

Marleen Temmerman
Professor OB/GYN, Aga Khan University & AKU-UNESCO Chair Youth Leaders Science, Health, Gender Education

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Finally, I extend our deepest gratitude to SOAS Professor of Law, Fareda Banda. Her powerful reminder, 'You have to be kind to yourself. Look after YOU to be able to look after the struggle,' resonates deeply. I am immensely thankful for her unwavering support and for the inspiring example she sets for us as African feminists.

Hybrid Colloquium, 25-26 July 2022 at the University of Pretoria

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Nabaneh, Satang is an award-winning legal scholar, educator, researcher, and human rights practitioner. She is the Director of Programs and Assistant Professor of Practice at the Human Rights

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LIST OF ACRONYMNS AND ABBREVIATIONS

ACHPR	African Commission on Human and Peoples' Rights
African Charter	African Charter on Human and Peoples' Rights
African Court	African Court on Human and Peoples' Rights
ACERWC	African Committee of Experts on the Rights and Welfare of the Child
AU	African Union
AUC	African Union Commission
BPA	Beijing Platform of Action
CEDAW	Convention on the Elimination of All forms of Discrimination Against Women
CESCR	Committee on Economic, Social and Cultural Rights
CRC	Convention on the Rights of the Child
DHS	Demographic Health Survey
FC	Female Circumcision
FGC/m	Female Genital Cutting/Mutilation
GC	General Comment
HRC	Human Rights Council
ICESCR.	International Covenant on Economic, Social and Cultural Rights
ICCPR	International Covenant on Civil and Political Rights
ICPD	International Conference on Population and Development
Maputo Protocol	Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa
MICS	Multiple Indicator Cluster Surveys
NGOs	Non-Governmental Organisations
SDGs	Sustainable Development Goals
SRHR	Sexual and Reproductive Health & Rights
UDHR	Universal Declaration on Human Rights
UN	United Nations
UNFPA	United Nations Population Fund
WB	World Bank
WHO	World Health Organization

DEDICATION

Thank you *Prof Charles Ngwena*,
for being the ultimate feminist
(1957-2025)

Equality Now 'The time is now: End female genital mutilation/cutting, an urgent need for global response 2025' (2025)

1

BEYOND LEGISLATION: EXAMINING THE EFFICACY OF CRIMINALISATION OF FEMALE GENITAL MUTILATION IN AFRICA

*Satang Nabaneh**

1 Introduction

Rights-based advocacy and organised international mobilisation against female genital mutilation (FGM) have emerged in the past 30 years, including at the 1994 International Conference on Population and Development (ICPD).[1] During the 1995 Beijing Conference, African feminists led efforts for the explicit condemnation of FGM in the Beijing Declaration and Platform for Action (POA). This resulted in the POA's call for governments to '[e]nact and enforce legislation against the perpetrators of practices and acts of violence against women, such as female genital mutilation'.[2] However, this framing is not universal. African feminists have decried the Western framing of FGM premised on colonial and neo-colonial underpinnings.[3] In this book the term 'FGM' is used to highlight its human rights implications, especially in respect of sexual and reproductive health. However, it is acknowledged

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1 UN 'International Conference on Population and Development Programme of Action' (1994) para 7.

2 1995 Beijing Declaration and Platform for Action.

3 See A Thiam *Speak out, black sisters: Black women and oppression in black Africa* trans DS Blair (1995); O Nnaemeka *Sisterhood, feminism and power: From Africa to the diaspora* (1998); O Nnaemeka 'Theorising, practicing, and pruning Africa's way' (2004) 29 *Signs: Journal of Women in Culture and Society* 357-385.

that FGM as a practice, including its naming as 'FGM', is contested on various grounds.[4]

FGM was initially opposed by colonial regimes in the early twentieth century.[5] Historically, FGM and post-colonial struggles and nationhood are intertwined in Africa.[6] FGM was regarded by colonisers as contrary to morality and a barrier to civilisation. Attempts were made, for instance, by the British, to ban FGM.[7] The Kikuyu people in Kenya rose up against the attempt by the colonial state and Christian missionaries to ban the practice.[8] The Kikuyu resistance against the ban demonstrated the assertion of indigenous communities in the face of Western imperialism. It became a symbol for the struggle for national independence.[9] At the same time, while serving to contextualise imperialism, the resistance also rendered FGM an entry point for patriarchal nationalism premised on controlling women's bodies as 'symbols' of the nation.[10]

FGM comprises all procedures that involve the partial or total removal of the external female genitalia or other injuries to the female genital organs for non-medical reasons.[11] According to the World Health Organisation (WHO), there are four types of FGM.[12] Type I (clitoridectomy) is the partial or total removal of the clitoris (a small, sensitive and erectile part of the female genitals) and, in very rare cases, only the prepuce (the fold of skin surrounding the clitoris). Type II

4 See, eg, H Lewis 'Between *irua* and "female genital mutilation": Feminist human rights discourse and the cultural divide' (1995) 8 *Harvard Human Rights Law Journal* 1; IR Gunning 'Arrogant perception, world-travelling and multicultural feminism: The case of female genital surgeries' (1992) 23 *Columbia Human Rights Law Review* 189.

5 M Berer 'The history and role of the criminal law in anti-FGM campaigns: Is the criminal law what is needed, at least in countries like Great Britain?' (2015) 23 *Reproductive Health Matters* 145-157.

6 J Snively *Female bodies. Male politics: Women and the female circumcision controversy in Kenyan colonial discourse* (1994).

7 See NW Njambi '*Irua ria atumia* and anti-colonial struggles among the Gikuyu of Kenya: A counter-narrative on "female genital mutilation"' (2007) 33 *Critical Sociology* 689-708.

8 As above.

9 J Kenyatta *Facing Mount Kenya (1962).*

10 See BF Frederiksen 'Jomo Kenyatta, Marie Bonaparte and Bronislaw Malinowski on clitoridectomy and female sexuality' (2008) 65 *History Workshop Journal* 23-48; VT le Vine 'African patrimonial regimes in comparative perspective' (1980) 18 *Journal of Modern African Studies* 657-673.

11 WHO 'FGM fact sheet' (2024) https://www.who.int/en/news-room/fact-sheets/detail/female-genital-mutilation (accessed 24 February 2024).

12 As above.

(excision) is the partial or total removal of the clitoris and the labia minora (the inner folds of the vulva), with or without excision of the labia majora (the outer folds of skin of the vulva). Type III (infibulation) is the narrowing of the vaginal opening by creating a covering seal. The seal is formed by cutting and repositioning the labia minora, or labia majora, sometimes through stitching, with or without removal of the clitoris (clitoridectomy). Type IV includes all other harmful procedures to the female genitalia for non-medical purposes, for example, pricking, piercing, incising, scraping and cauterising of the genital area.

2 International human rights norms and standards

FGM is well recognised as a gross violation of the human rights of girls and women in numerous international conventions, declarations and treaties, consensus documents and policies, which impacts on the enjoyment of sexual and reproductive health and rights of women.[13] The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (African Women's Protocol) is the only human rights instrument that explicitly refers to FGM.[14] Article 5(b) obligates states to take all necessary measures, including 'prohibition, through legislative measures backed by sanctions, of all forms of female genital mutilation, scarification, medicalisation and para-medicalisation of female genital mutilation and all other practices in order to eradicate them'. The African Commission on Human and Peoples' Rights (African Commission) has called on states to institute harsher penalties for all persons involved, including parents and family members.[15]

13 See E Durojaye & S Nabaneh 'Addressing female genital cutting/mutilation (FGC/M) in The Gambia: Beyond criminalisation' in E Durojaye, G Mirugi-Mukundi & C Ngwena (eds) *Advancing sexual and reproductive health and rights in Africa: Constraints and opportunities* (2021) 115.

14 For a comprehensive assessment of the drafting history and obligations arising from the provision, see S Nabaneh 'Article 5: Elimination of harmful practices' in A Rudman, CN Musembi & TM Makunya (eds) *The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa: A commentary* (2023) 117-134.

15 See Concluding Observations and Recommendations on the Combined 3rd and 4th Periodic Report of Burkina Faso on the Implementation of the African Charter on Human and Peoples' Rights 2011-2013, African Commission on Human and Peoples' Rights adopted at 21st extraordinary session 23 February-4 March 2017, Banjul, The Gambia.

In addition, article 21(1) of the African Charter on the Rights and Welfare of the Child (African Children's Charter) prohibits harmful social and cultural practices that are prejudicial to the health or life of the child.

The African Commission adopted a resolution in 2007 urging African states to outlaw FGM.[16] In their first ever joint General Comment, the African Commission and the African Committee of Experts on the Rights and Welfare of the Child (African Children's Committee) addressed the human rights violations in the context of child marriage and other harmful cultural practices.[17]

The African Children's Committee and the African Commission have recently adopted a joint General Comment on FGM, clarifying state obligations relating to article 5(b) of the African Women's Protocol and article 21(1) of the African Children's Charter.[18] This General Comment offers extensive guidance on the steps that states must take to eliminate FGM, taking into account various factors such as cultural, religious, economic and patriarchal influences that contribute to its persistence in Africa.

A significant aspect of this joint General Comment is its emphasis on the careful framing of anti-FGM laws. It highlights the need for laws to be crafted meticulously to protect victims from unjust prosecution, ensuring that they are not wrongfully perceived as complicit in criminal activities. This approach signifies a crucial shift in the discourse surrounding FGM, demonstrating a nuanced understanding of legal complexities and human rights imperatives. This is particularly relevant as in certain African countries such as Nigeria and Kenya, victims of FGM have sometimes been arrested, prosecuted, and even convicted of crimes.[19] The African Commission has called on states to not only sensitise, but also closely

16 Resolution on the Health and Reproductive Rights of Women in Africa ACHPR/Res.110(XXXXI)07.

17 Joint General Comment of the African Commission on Human and Peoples' Rights and the African Committee of Experts on the Rights and Welfare of the Child on ending child marriage adopted by the African Commission on Human and Peoples' Rights and the African Committee of Experts on the Rights and Welfare of the Child 2017.

18 Joint General Comment of the African Commission on Human and Peoples' Rights and the African Committee of Experts on the Rights and Welfare of the Child (2023).

19 See American Bar Association & Clooney Foundation for Justice 'Monitoring Prosecutions under the Prohibition of FGM ACT In Kenya' (2024).

collaborate with religious, traditional and political leaders in efforts to eliminate harmful practices.[20] The ACERWC has also recommended that the state take necessary measures to create awareness about the adverse effect of FGM among all relevant stakeholders to eliminate the practice.[21]

Moreover, the General Comment provides guidance on safeguarding women from FGM, even in cases where consent is claimed. It stresses the importance of offering comprehensive medical, psychosocial and other forms of support essential for the rehabilitation and well-being of FGM survivors. For instance, the African Children's Committee recommended Eritrea to provide financial, medical and psychological assistance to victims of FGM.[22]

The joint General Comment also addresses the issue of cross-border FGM, outlining preventive measures and mechanisms for accountability. It also underscores the measures that should be taken to protect asylum seekers who flee their countries due to the threat of FGM, as well as those who are internally displaced for the same reason. This comprehensive approach marks a significant milestone in the global effort to eradicate FGM and protect the rights and well-being of women and girls affected by this harmful practice.

The African Commission also adopted the Guidelines on Combating Sexual Violence and its Consequences in Africa (Niamey Guidelines) in 2017.[23] The goal of the Niamey Guidelines is to guide and support the member states of the African Union (AU) in effectively implementing their commitments and obligations to combat sexual violence and its consequences.[24] In the Guidelines the Commission recognises FGM as a

20 See for example General Comments on Article 14(1)(d) and (e) of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa paras 23 & 46.

21 ACERWC 'Concluding Recommendations on the initial report of Sierra Leone' (2017).

22 Concluding Recommendations on the initial report of Eritrea, African Committee of Experts on the Rights and Welfare of the Child, adopted at the 28th session (21 October-1 November 2016).

23 African Commission 'Guidelines on Combatting Sexual Violence and its Consequences in Africa' (2017) (Niamey Guidelines).

24 See S Nabaneh 'Sexual harassment in the workplace in The Gambia: An analysis of recent developments from a feminist perspective' in E Durojaye, S Nabaneh & T Adebanjo (eds) *Sexual harassment, law and human rights in Africa* (2023) 279; A Johnson & S Nabaneh 'The invisible woman: Limits to achieving criminal accountability for violence against women with disabilities' in A Budoo-Scholtz

form of sexual violence that can constitute torture or cruel, inhuman and degrading treatment.[25]

The African Children's Committee has also adopted Agenda 2040, which provides the prohibition of FGM by all African states as a goal under Aspiration 7.[26] Agenda 2063 of the AU also condemns all forms of violence and discrimination against women and girls, including FGM.[27] A continental campaign to end FGM was launched by the AU in 2019.[28] The campaign, also known as the Saleema Initiative, was launched to save more than 50 million girls in Africa under the age of 15 years who are at risk of FGM by 2030 if urgent action is not taken.[29] The Initiative calls for regular reporting by member states to AU statutory bodies and requests the AU Commission (AUC) to develop the AU Accountability Framework on Eliminating Harmful Practices.

At the global level, while early human rights instruments, such as the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), make no specific reference to FGM, it explicitly prohibits traditional practices that discriminate against women and harm children under articles 2 and 5. The Convention on the Rights of the Child (CRC) also obligates states under article 24(3) to abolish traditional practices harmful to children. UN treaty-monitoring bodies have also addressed the practice of FGM as a human rights violation.[30] The CEDAW Committee under General Recommendation 24 specifically recommended governments to devise health policies that take into account the needs of girls and adolescents who may be vulnerable to

& EC Lubaale (eds) *Violence against women and criminal justice in Africa: Volume II, Sustainable Development Goals Series* (2022) 281-282.

25 Niamey Guidelines (n 18) 15.

26 African Children's Committee 'Africa's agenda for children 2040' (2016), https://www.acerwc.africa/wp-content/uploads/2018/06/Agenda_2040_for_Children_Rights_in_Africa_15x24.pdf (accessed 18 June 2023).

27 AU 'Agenda 2063: The Africa we want' (2013), https://au.int/sites/default/files/pages/3657-file-agenda2063_popular_version_en.pdf (accessed 18 June 2023).

28 AU Assembly Decision 737/2019.

29 'The African Union launches a continental initiative to end female genital mutilation and save 50 million girls at risk' (11 February 2019), https://au.int/fr/node/35892 (accessed 18 June 2023).

30 See Human Rights Committee General Comment 28: Article 3 (The equality of rights between men and women), 29 March 2000, (CCPR/C/21/Rev.1/Add.10). See Committee Against Torture (CAT) General Comment 2: Implementation of Article 2 by States Parties, 24 January 2008, CAT/C/GC/2; Human Rights Committee (HRC).

traditional practices such as FGM.[31] Joint General Recommendation/ General Comment 31 of the CEDAW Committee and 18 of the African Children's Committee provides for various legislative to eliminate the practice of FGM.[32]

While international and regional norms have made significant strides in addressing FGM, the effectiveness of these measures remains mixed. The treaty bodies' observations underscore the need for robust enforcement. For example, the CEDAW Committee has also raised concerns during the state reporting process about the obligations of African countries in addressing the practice. The Committee acknowledged Tanzania's law and policies addressing FGM, it remains concerned about the persistent practice.[33] The Committee also highlighted the weak enforcement of the law, the lack of official attention to the recent trend of FGM on newborns in private homes, and the continued legality of FGM for women over 18, who are often pressured or forced into it. The Committee noted that the continued practice of FGM is a serious violation of women's and girls' human rights and a breach of Tanzania's obligations under the Convention.[34] While FGM is not so common in Zanzibar, it persists in Mainland Tanzania, with an overall prevalence rate of 10 percent.[35] Similarly in 2023, it raised concerns about the continued occurrence of this harmful practice in Mauritania and the widespread impunity enjoyed by perpetrators.[36]

In essence, to fulfil their obligation to address FGM, states must take comprehensive legal, administrative, judicial, and budgetary measures. This includes implementing legal reforms and allocating resources for the enforcement of laws and policies.

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31 CEDAW Committee 'General Recommendation No 14 (9th session, 1990), http://www.un.org/womenwatch/daw/cedaw/recommendations/recomm.htm. (accessed 5 May 2023).

32 Joint general recommendation/General Comment 31 of the Committee on the Elimination of Discrimination against Women and 18 of the Committee on the Rights of the Child on harmful practices (14 November 2014), CEDAW/C/GC/31/CRC/C/GC/1.

33 CEDAW Committee 'Concluding observations of the Committee on the Elimination of Discrimination against Women: United Republic of Tanzania' (16 July 2008) CEDAW/C/TZA/CO/6.

34 As above, paras 121-122.

35 World Bank 'Tanzania Gender Assessment' (2022).

36 CEDAW Committee 'Concluding observations of the Committee on the Elimination of Discrimination against Women: Mauritania' (2 March 2023) CEDAW/C/MRT/CO/4, para 20.

3 Legal and jurisprudential trends around FGM

Globally, more than 60 countries have adopted laws that criminalise FGM, including more than 25 African countries.[37] During the past decade, the trend towards criminalisation is increasingly found in various laws, including penal codes, specific anti-FGM laws, Women's Acts and Domestic Violence Acts. Between 2007 and 2018 countries such as Zimbabwe, Uganda, South Sudan, Kenya, Guinea Bissau, Mozambique, The Gambia and Cameroon adopted laws that punish the practice of FGM. The primary rationale for this trend includes several factors: aligning with international treaties and commitments, protecting human rights, deterring and holding perpetrators accountable, ensuring public health and safety, and promoting gender equality. Subsequently, new laws have been introduced or existing laws amended. The rationale behind amending existing laws is based on the premise that it is easier to amend laws than to draft entirely new ones, especially when relevant laws already exist that can be strengthened. For instance, whereas The Gambia amended its Women's Act 2015, Nigeria adopted the Violence Against Persons (Prohibition) Act in 2015 with article 6 prohibiting FGM, although it is only directly applicable in the federal capital territory, Abuja, and not in all 36 states. In Mauritania, article 12 of the Children's Code of 2015 prohibited FGM. Guinea also adopted a similar provision in its Children's Code, 2008. Guinea-Bissau adopted a separate and specific FGM law in 2011.[38]

Despite an increasing uptake of criminalisation by African states, FGM has persisted. More than 200 million girls and women alive today have been cut throughout countries in Africa, the Middle East and Asia, and increasingly among immigrant populations in Europe, Australia and North America.[39] The WHO estimates that 100 to 140 million girls and

37 See World Bank *Compendium of international and national legal frameworks on female genital mutilation* (2018).

38 S Nabaneh & A Muula 'Female genital mutilation/cutting: A complex legal and ethical landscape' (2019) 145 *International Journal of Gynecology and Obstetrics* 253-257.

39 UNICEF 'Female genital mutilation/cutting: A global concern' (2016) https://data.unicef.org/resources/female-genital-mutilationcutting-global-concern/ (accessed 5 May 2023). See D Gollaher *Circumcision: A history of the world's controversial surgery* (2000).

women worldwide are currently living with the consequences of FGM.[40] In Africa, an estimated 92 million girls from the age of 10 years and above have undergone FGM.[41] The treatment of FGM-related complications costs billions of dollars every year in high-prevalence countries, with this cost expected to rise to US $2,3 billion by 2047.[42]

Table 1: Summary of how FGM is incorporated into national legislative frameworks

Country	Specific national anti-FGM laws in place	Prohibits FGM within another domestic law	Type of law	Year law was enacted
Benin	✖	✖	Child/VAW	2003
Burkina Faso	✖	✖	Penal Code	1996
Cameroon	—	✖	Penal Code	2016
CAR	—	✖	VAW/Penal Code	1966
Chad	—	—	—	N/A
Côte d'Ivoire	✖	✖	VAW	1998
DRC	✖	✖	Penal Code	2009 (criminalised)
Djibouti	✖	✖	Penal Code	2008
Egypt	✖	✖	Penal Code	2007
Eritrea	✖	—	—	2004
Ethiopia	✖	✖	Criminal Code	1994
The Gambia	✖	✖	Women's Act	1965
Ghana	✖	✖	Criminal Code	2011
Guinea	✖	✖	Child/Criminal Code	2001
Guinea Bissau	✖	✖	—	2011
Kenya	✖	✖	Child/Domestic Violence	2001
Liberia	—	—	—	N/A
Malawi	—	—	—	N/A
Mali	—	—	—	N/A

40 WHO 'FGM fact sheet' (2020), https://www.who.int/en/news-room/fact-sheets/detail/female-genital-mutilation (accessed 5 May 2023).
41 As above.
42 As above.

Mauritania	—	✖	Child	2005
Mozambique	—	—	—	N/A
Niger	—	✖	Violence Against Persons	2003
Nigeria	✖	✖	Penal Code	2015
Senegal	✖	✖	Penal Code	1999
Sierra Leone	—	—	—	N/A
Somalia	—	—	—	N/A
Somaliland	—	—	—	N/A
South Sudan	—	✖	Penal Code/Child	2008
Sudan	✖	✖	—	2020
Tanzania	✖	✖	Sexual Offences/ Penal Code	1998
Togo	✖	✖	Penal Code	1998
Uganda	✖	✖	Child	2010
Zambia	✖	✖	Penal Code	2005
Zimbabwe	✖	✖	Domestic Violence	2006

While an increasing number of African countries have adopted specific legislation prohibiting FGM, as illustrated, it predominantly follows a crime and punishment model. For instance, the laws do not impose state duties to educate and raise awareness about the harmful effects of the practice. This also provides insights into the problems embedded in the global travel of legal frameworks responding to violence against women, including FGM. As a socio-cultural and religious phenomenon, the continued practice of FGM in many African countries is illustrative of the challenges related to the enforcement of anti-FGM laws. Power relations, culture and religion continue to be the drivers and determinants of the practice and impact public discourse that shapes policy. Thus, the trend towards criminalising FGM also comes on the heel of the push that legislation should be a supportive tool that serves as a catalyst of social change and fosters an enabling environment for the abandonment of the practice.

There also is emerging constitutional jurisprudence on FGM practice in the region through national courts. For instance, in 2010, on the issue of whether the custom and practice of FGM was unconstitutional, the Ugandan Constitutional Court held that FGM violated the rights of women, including the right to equality and freedom from discrimination,

the right to protection of life, the right to privacy, dignity, and integrity, as well as women's rights. The Court highlighted that FGM poses a direct threat to the lives of girls and women, often leading to fatal consequences. The Court held that FGM must be prohibited in the jurisdiction for being inconsistent with the Constitution. The impact of this case is further discussed in this book.

Recently, in Kenya, a medical professional, Dr Tatu Kamau, challenged the constitutionality of the Prohibition of Female Genital Mutilation Act.[43] She argued that sections of the Act contravened the Kenyan Constitution by prohibiting an adult woman from freely electing to undergo FGM under a trained and licensed medical practitioner, thereby denying women access to the right to health care. She claimed to speak on behalf of communities that practise female circumcision and the women who have been imprisoned for carrying out the rite. On 17 March 2021 the High Court of Kenya ruled that the practice of FGM violates a woman's right to health, human dignity and the right to life when it results in death, and that the practice also undermines international human rights standards. The Court rejected the argument that individuals, including adult women, could choose to undergo a harmful practice like FGM. It held that the fact that someone is an adult does not change the unconstitutionality of FGM. This case is further discussed in one of the chapters.

The emerging jurisprudence not only provides opportunities for holding African governments accountable but also raises important questions on issues of morality, culture and law. For example, how does the jurisprudence speak to African women's intersectional and complex experiences that do not reify the universalisation of women's bodies and culture? Another question that arises is whether there is a legitimate reason to criminalise consent based or voluntary FGM by adult women and whether any such criminalisation violates their human rights.

Overall, while there have been significant efforts to eradicate FGM through criminalisation and enhanced law enforcement, practising communities have reacted with changed tactics resulting in emerging trends such as cross-border cutting, reduced age of practice and medicalisation. In addition, due to COVID-19 disruptions, it has been

43 *Dr Tatu Kamau v Attorney General & Others* Constitutional Petition 244 of 2019, High Court of Kenya.

reported that a one-third reduction in the progress towards ending FGM by 2030 is anticipated.[44] For instance, the President of Kenya in 2020 ordered an investigation into rising reports of violence against women and girls – including rape, domestic violence, FGM and child marriage – as a result of COVID-19 restrictions.[45]

Recent evidence of politicisation of FGM criminalisation is illustrated in the Gambian case, wherein, it became the first country in the world to potentially repeal the anti-FGM law. In 2023, three women were convicted for their involvement in performing and abetting FGM from Niani Bakadaji, Central River Region (CRR), for circumcising eight children between the ages of four months and one year, a direct violation of the provisions outlined in Section 32(a) and (b) of the amended Women's Act of 2015.[46] According to newspaper reports, there seems to be substantial pressure on the Magistrate to prosecute the suspect. However, the sentence imposed is widely perceived as inadequate given the harm caused. They were fined only 15,000 Gambian Dalasis (approximately USD 220) or in default to serve one year imprisonment, a sentence that is not consistent with the prescribed punishment of three years imprisonment or a fine of 50,000 Gambian Dalasi (approximately USD 750) or to both under the law.[47]

Interestingly, on the day that they were fined, Imam Abdoulie Fatty, a religious advisor known for his radical views and associated with former dictator Yahya Jammeh and part of the Supreme Islamic Council paid it, defying the Court's decision to emphasise that this is an integral part

44 UNFPA-UNICEF 'COVID-19 disrupting SDG 5.3: Eliminating female genital mutilation: Technical note' (2020), https://www.unfpa.org/sites/default/files/resource-pdf/COVID19_Disrupting_SDG.3_Eliminating_Female_Genital_Mutilation.pdf (accessed 5 May 2023). See also UN Women and UNFPA 'Impact of COVID-19 on gender equality and women's empowerment in East and Southern Africa' (2021).

45 UN Women & UNDP 'COVID-19 global gender response tracker. Factsheet: sub-Saharan Africa' (2020), https://data.undp.org/gendertracker/ (accessed 5 May 2023).

46 T Bojang '3 Women Sentenced for FGM in CRR' *The Standard* (28 August 2023) https://standard.gm/3-women-sentenced-for-fgm-in-crr/ (accessed 1 September 2023).

47 S Nabaneh and MB Sawo 'Threats to #EndFGM Law in The Gambia' AfricLaw (22 March 2024) https://africlaw.com/2024/03/22/threats-to-endfgm-law-in-the-gambia/#more-3155 (accessed 10 May 2024). See also S Nabaneh & MB Sawo 'En Gambie, l'interdiction des mutilations génitales menacée' AfriqueXXI (4 April 2024) https://afriquexxi.info/En-Gambie-l-interdiction-des-mutilations-genitales-menacee (accessed 10 May 2024).

of their culture. He argued that if everyone openly supported it, the government would not be able to imprison an entire town, let alone an entire country.[48] This led to intense and regressive debates in the National Assembly, eventually garnering overwhelming support for the repeal of FGM, indicating that the practice should be discontinued.[49] On 4 March 2024, Hon. Almameh Gibba introduced a Private Member's Bill in the National Assembly, the Women's (Amendment) Bill 2024 , which seeks to delete Sections 32A and 32B of the Women's (Amendment) Act 2015. The objects and purpose states that:

> This Bill seeks to lift the ban on female circumcision in The Gambia, a practice deeply rooted in the ethnic, traditional, cultural, and religious beliefs of the majority of the Gambian people. It seeks to uphold religious purity and safeguard cultural norms and values. The current ban on female circumcision is a direct violation of citizens' rights to practice their culture and religion as guaranteed by the Constitution. Given The Gambia's predominantly Muslim population, any law that is inconsistent with the aspirations of the majority of the people should be reconsidered. Female circumcision is a culturally significant practice supported by Islam, with clear proves of the teachings from our Prophet (S.A.W). It is to be noted that the use of laws to restrict religious or cultural practices, whether intentional or otherwise, can lead to conflict and friction. Interestingly, the continued existence of the ban on female circumcision and penalising practitioners has directly contradicted the broader principles of the United Nations, which encourages, through its agencies, the preservation and practice of cultural and historical heritages ...

Adding to the complexity of the situation, the Supreme Islamic Council on 25 September 2023, issued an unprecedented *Fatwa* supporting the decriminalisation of FGM.[50] In Islamic jurisprudence, this *Fatwa* serves as an equivalent to the Attorney General's legal opinion in the absence of a Supreme Court interpretation. The essence of the Supreme Islamic Council's *Fatwa* is to suggest that FGM is sanctioned by Islam, and it is a part of Gambian culture that should not be abandoned. This declaration

48 A Jadama 'Imam Fatty calls for social, economic boycott of FGM campaigners' *The Standard* (11 September 2023) https://standard.gm/imam-fatty-calls-for-social-economic-boycott-of-fgm-campaigners/ (accessed 15 September 2023).

49 S Nabaneh & MB Sawo 'La Gambie pourrait autoriser à nouveau les mutilations génitales féminines : un nouveau signe d'une tendance mondiale à l'érosion des droits des femmes' Seneweb (30 March 2024). https://www.seneweb.com/news/Afrique/la-gambie-pourrait-autoriser-a-nouveau-l_n_437108.html (accessed 10 May 2024).

50 B Bah 'Islamic Council issues fatwa in defence of female circumcision' *The Standard* (29 September 2023) https://standard.gm/islamic-council-issues-fatwa-in-defence-of-female-circumcision/ (accessed 5 October 2023).

further complicates efforts to eradicate the practice, particularly in a majority Muslim society.

On 18 March 2024, after its First Reading and debate, the lawmakers voted to send the bill to a committee for further review and public consultation. Public consultations have occurred over a three month period with direct engagements with 143 witnesses and subject matter experts. On 8th July, the Parliamentary Joint Committee of Health and Gender presented its report on the Bill, highlighting the negative health effects of FGM on women and girls and emphasising that FGM is not a religious obligation. The Joint Committee's report made several key recommendations. Firstly, it suggested that the Women's (Amendment) Act 2015 should be maintained to prohibit FGM in all its forms in The Gambia. It also recommended that legal support and protection be provided to women and girls at risk of FGM, as well as those who have undergone the procedure. Additionally, the government should enforce the law and issue clear policy directives prohibiting FGM. Lastly, the report advised that the government should unequivocally ban any attempts to medicalise the practice of FGM.

Thus, the National Assembly adopted the report, recommending that the law remain unchanged. A week later, following sustained efforts by civil society, including feminist activists and women's rights advocates, the Assembly voted to reject the bill. Subsequently, the parliamentarian and seven others have filed a case before the Supreme Court seeking to decriminalise the practice.[51] The case is ongoing. This potential reversal has thrust the country into the global spotlight as the latest example of the backlash against gender equality.[52]

The criminalisation of FGM, has become a global trend, especially on the African continent, even though its efficacy by no means has

51 'Almameh Gibba, Others Ask Supreme to Decriminalize Female Circumcision in The Gambia' *Foroyaa*, 31 July 2024.

52 S Nabaneh 'The Gambia may allow female genital mutilation again – another sign of a global trend eroding women's rights' *The Conversation* (28 March 2024) https://theconversation.com/the-gambia-may-allow-female-genital-mutilation-again-another-sign-of-a-global-trend-eroding-womens-rights-226632 (accessed 10 May 2024). See also, S Nabaneh 'La Gambie pourrait autoriser à nouveau les mutilations génitales féminines : un nouveau signe d'une tendance mondiale à l'érosion des droits des femmes' The Conversation (5 April 2023) https://theconversation.com/la-gambie-pourrait-autoriser-a-nouveau-les-mutilations-genitales-feminines-un-nouveau-signe-dune-tendance-mondiale-a-lerosion-des-droits-des-femmes-227003 (accessed 10 May 2024).

been proven. This evolution, which is illustrative of the influence of international culture and norms on national laws, deserves to be interrogated. For instance, why have African countries adopted anti-FGM laws? How do we explain the discourses that created its seemingly cosmetic acceptance by African governments? Given the increased global effort to criminalise FGM, on the one hand, and continued defiance by practising communities around the continent, on the other, there is a need to critique dominant discourses surrounding criminalisation.

This book seeks to provide a more nuanced and analytical exploration of the practice, going beyond the traditional frameworks of crime and punishment, as well as the human rights lens. Doing so allows one to engage in a more holistic critical discourse on 'universalising' human rights norms and their influences on national laws, which is necessary to understand the complexity of the practice. The continued justifications for the practice are a good portrayal of the anti-neo-colonial discourse, as the practice has often been viewed as morally unacceptable, primitive and barbaric.[53]

4 Objectives

The main objective of the book is to challenge hegemonic epistemologies and expand critical discourses and facilitate learning across disciplinary, national, ethnic and religious boundaries on the use of the law and criminalisation to eradicate FGM on the continent and beyond. It aims to highlight the effectiveness of laws and policies to eradicate FGM in Africa. Other objectives are

- to interrogate universalising human rights norms and standards in creating national laws on FGM;
- to contribute to new scholarship that develops theoretical approaches in gaining an understanding of the limited effectiveness of legislation/criminalisation against FGM;
- to engage in a critical discourse on the impact of culture, religion and social beliefs that drive the practice of FGM; and
- to identify and critically discuss the effects of criminalisation, including emerging issues such as medicalisation of FGM, consent and cross-border cutting.

53 See S Tamale 'Researching and theorising sexualities in Africa' in S Tamale (ed) *African sexualities: A reader* (2011) 19-20.

5 Structure

The book is divided into four parts, each offering unique insights into the complex issue of FGM in Africa, with contributions from a diverse range of experts, including academics, human rights activists, and members of regional and national human rights bodies. Cross-cutting themes pervade many chapters.

5.1 Female genital mutilation: Unpacking the cultural context

In part I the book explores the intricate cultural context of FGM in Africa, critically examining the limitations of previous approaches aimed at eradicating this practice and advocating more inclusive, community-specific strategies tailored to the unique needs of each region.

In chapter 2 ('Developing home-grown approaches to eradicating FGM across communities in Africa') Adegbite argues that previous approaches to eradicating FGM have been too top-down and have not taken into account the specific needs and beliefs of different communities. Adegbite concludes by advocating a home-grown approach that is developed and implemented by community members themselves.

Building on this foundation, chapter 3 ('The disabled genitalia: Countering dominant narratives to ending female genital mutilation in Africa') by Johnson pushes for re-evaluation of the intervention strategies related to FGM in Africa. Johnson emphasises the importance of adopting an intersectional and feminist decolonial perspective that considers disability and sex/gender as interconnected and dynamic, rather than treating them as separate, fixed, uniform, colonial, or essentialist identity categories.

In chapter 4 ('Research and FGM prevention: Evidence from Africa') Dawson continues the discussion by highlighting the crucial role of research in addressing FGM. Dawson argues that research can help one to understand the root causes of FGM, develop effective prevention strategies, and measure the impact of our interventions. She also highlights the need for research, capacity building and ethical research practices.

5.2 Ethics, law and criminalisation

Part II explores the ethical and legal dimensions of FGM, delving into the challenges and opportunities associated with the criminalisation of FGM, and shedding light on the complex landscape of laws and regulations surrounding this practice.

In chapter 5 ('Medicalisation of FGM/Cutting: Ethical Dimensions'), Kimani discusses the ethical dilemmas posed by the medicalisation of FGM. Kimani argues that while medicalisation aims to reduce the immediate complications of FGM, it fails to address long-term effects and human rights violations. This chapter explores a dual approach, integrating health and human rights perspectives to combat the medicalisation of FGM, and underscores the need for professional dialogue and engagement to effectively tackle these challenges.

Chapter 6 ('Understanding Women's Rights, Culture, and the Need to Criminalise FGM in Kenya*: Kamau v Attorney General & Others')* by Kinama examines a significant legal case in Kenya involving the Prohibition of Female Genital Mutilation Act. Kinama analyses the key aspects of the judgment, focusing on whether adult women can be restricted from choosing to undergo FGM within their cultural context. The chapter highlights the importance of considering women's rights and state obligations, both domestically and internationally, in addressing violence against women.

Complementing the discussion, chapter 7 ('Eradicating undesirable cultural or religious practices through criminalisation: The need for equity in the case of body modification surgeries') by Tangwa explores the challenges of eradicating deeply rooted cultural and religious practices. Tangwa argues that while criminalisation can be an effective tool for eradicating FGM, it must be implemented carefully and equitably, especially considering the impact on marginalised groups.

5.3 Survivor narratives and feminist perspectives

Part III shifts the focus to survivor narratives and feminist perspectives, emphasising the significance of understanding the experiences of FGM survivors and the pivotal role of feminism in challenging and addressing this issue

In chapter 8 ('Re-telling the experiences of african women with FGM through an African feminist lens'), Meroka-Mutua employs an

African feminist perspective to examine the experiences of African women who have undergone FGM. Meroka-Mutua argues that African feminism offers a unique lens for understanding the complex and often contradictory ways in which African women respond to FGM. This chapter provides a nuanced examination of FGM in Africa, considering cultural, social, and gender dynamics

Continuing this exploration, chapter 9 ('Female genital mutilation: A survivor's narrative') by Sawo shares her personal experiences of FGM and discusses the long-term and short-term physical and psychological trauma that she and other survivors have endured. Sawo emphasises the adverse impact of FGM on survivors' quality of life, sexual and reproductive health, well-being, and relationships. She also examines the factors contributing to the high prevalence of FGM in The Gambia and discusses efforts by organisations and survivors to end this practice. Her narrative sheds light on the challenges and the importance of addressing FGM from a survivor's perspective.

5.4 Legal cases and societal responses

Chapters in part IV examine the complex relationship between criminalisation, state obligations, grassroots communities, and cultural and religious demands in the fight against FGM. It also explores the challenges and opportunities presented by legal and societal responses to eradicate the practice, offering a comprehensive and multifaceted exploration of FGM in Africa.

In chapter 10 ('The curse of beyond reasonable doubt'), Mbaabu examines the complex relationship between criminalisation, state obligations, and grassroots communities in the fight against FGM. Highlighting the importance of considering all three perspectives, Mbaabu uses Kenya as a case study to argue that states have a responsibility to protect women and girls from FGM and to prosecute those who perpetrate this crime. However, he also discusses the challenges in prosecuting the practice due to the high burden of proof required and the lack of resources available to law enforcement and the judiciary.

Chapter 11 ('Should female genital mutilation be decriminalised in Nigeria?') by Abdulraheem-Mustapha explores the practice of FGM in Nigeria, its cultural and religious roots, and its impact on the sexual and reproductive health rights of women. Despite its criminalisation in Nigerian laws, FGM remains prevalent. The chapter explores the

need for a balanced approach that addresses both cultural and religious demands and constitutional and criminal requirements. Abdulraheem-Mustapha advocates for a socio-legal approach that examines the role of legal, social, and political forces in enforcing FGM laws, deploying strategies such as advocacy, political will, educational initiatives, and engaging gatekeepers to amend existing laws to effectively combat FGM.

Following this, chapter 12 ('A case commentary on law and advocacy for women in *Uganda v Attorney General')* by Nyirinkindi provides a comprehensive analysis of the legal efforts in Uganda to combat FGM. The chapter explores Uganda's commitment to international human rights conventions, forming the basis for the country's legal provisions on gender equality and women's rights. Nyirinkindi delves into the Constitutional Court's role as a crucial platform for addressing human rights violations, including those related to FGM. The chapter assesses the implementation of the Prohibition of Female Genital Mutilation Act 2010 and its accompanying regulations, examining their effectiveness in deterring the practice and safeguarding potential victims.

Lastly, chapter 13 ('Female genital mutilation/cutting and the global politics of cultural relativism') by Milde examines the contentious issue of FGM within the framework of cultural relativism. Milde critically examines the concept of cultural relativism and its application as an ethical principle, highlighting the challenges posed by FGM to cultural relativism, especially concerning its impact on the autonomy and well-being of affected communities, particularly women. This analysis sheds light on the complex dynamics between cultural relativism and universalism, and the global discourse surrounding FGM.

6 Conclusion

The criminalisation of FGM has become a global trend, particularly across the African continent, though its effectiveness remains uncertain. This development, influenced by international culture and norms, requires critical examination. There has been a lack of assessment of how the use of criminal law and human rights are deeply interconnected. Debates regarding the use of criminal law in advancing women's rights continue to be a global issue in both the Global South and the Global North.

It appears criminalisation has contested efficacy. Why did it become an option? What kind of discourses created its cosmetic

acceptance by African governments? By examining the contestations and contradictions in criminalising the practice, this book aims to shed light on the complexities of the issue. Given the increased global efforts to criminalise FGM and the ongoing resistance from practicing communities across the continent, it is essential to critique the dominant narratives surrounding criminalisation. This book offers an entrée into such conversations and debates.

The enforcement of laws against FGM varies significantly across African countries where the practice is prevalent. Although legislation outlawing FGM is crucial for its prevention and for promoting its abandonment, in most countries where FGM is practiced, legislation exists, but evidence of its effectiveness in deterring FGM and accelerating its abandonment is limited. The application of criminal law also has material effects, and its potential impact should be part of the policy reform conversation. If criminal law is the last resort, how do we center prevention measures?

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PART I: Female genital mutilation: Unpacking the cultural context

2

DEVELOPING HOME-GROWN APPROACHES IN ERADICATING FEMALE GENITAL MUTILATION ACROSS COMMUNITIES IN AFRICA

*Folashade Rose Adegbite**

Abstract

As the world became more enlightened, it became clearer that female genital mutilation is a practice that should be done away with globally. In contemporary society, the practice of FGM not only violates the sexual and reproductive rights of women, but it also creates health-related complications. This age-long practice has been widely condemned as uncivilised both at national and international levels. Globally, there have been several attempts deployed at tackling FGM using human right instruments. Unfortunately, despite global governance and the most recent efforts at criminalising the practice, it has persisted. While the lingering practice underscores the relevance and impact of culture on crime, it is equally indicative that whatever a society regards as criminal is an act that not only threatens it but also presents the possibility of harming its fabrics and social existence, causing that society to declare such act a menace, as well as an injury to its organised well-being. In examining the perspective, prevalence and origin of FGM and its criminalisation, this chapter argues that it is insufficient for states and governments to declare an act of cultural origin such as FGM criminal since criminal law is embedded in its socio-cultural and religious acceptability. A single universal method

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possibly will be inefficient in eradicating FGM simply because the purpose of FGM differs for each clime, community, and culture. Until local mechanisms peculiar to each society and culture are fashioned into a bottom-up approach aimed at the eradication of FGM, and promote positive social change, the practice, which has remained malignant, may be with us for a very long time.

1 Introduction

Female Genital Mutilation (FGM), also known by other names such as Female Genital Cutting or female circumcision, is an ongoing practice in many countries around the world, particularly across parts of Africa, the Middle East and South Asia. Many girls and women living today have been victims of one or other form of FGM/C, and millions more are annually being affected. FGM is an issue that has been on the front burner of discussion in the international scene for a long time, a frightening portrait that is not only uncalled for and insensitive, but also an invasion of women's dignity.

The need to dimension this concept and put it in the right perspective, the various angles and arguments regarding it, therefore, cannot be discountenanced. While, despite several combative efforts, FGM remains a vibrant practice across the several jurisdictions that still actively engage in it, the dimension of human rights, and the criminalisation of the act, therefore, present us with an edge-of-the-seat discussion. Undeniably, criminalisation has presented several challenges that made its effectiveness low.

This chapter therefore examines the underlining issues militating against the effectiveness of previous approaches. It begins by presenting the various perspectives of FGM, its prevalence and the spread of the practice. It further discusses some of the various approaches that have been engaged globally in times past and proceeds with the discussion on the reasons some of the previous approaches remain ineffective, and the dynamics serving as constrains to the effectiveness of previous approaches. The chapter concludes by discussing and recommending the use of the home-grown bottom-up approach whereby a specifically designed approach is derived from within each community to meet the needs of such community.

2 Perspectives on FGM

FGM is a procedure where there is the total or partial removal of the external female genitalia or other forms of injuries to the female genital organs for non-medical reasons.[1] The use of the word 'mutilation' in describing or defining this procedure is rather contestable and will be addressed later in the chapter. Traditionally, the procedure is mostly carried out by traditional practitioners. However, there are modern trends in which healthcare givers are now performing FGM, since it is erroneously believed that medicalising the procedure will make the procedure safer.

While the precise origin of this practice is unclear, there have been several suggestions by scholars, based on the discovery of some circumcised mummies from the fifth century, that it originated from ancient Egypt (that is, the present-day Sudan and Egypt). Others scholars hold that FGM spread across the routes where slave trade was trending, cutting across the geographies of the Western shore of the Red Sea across the Southern and West African regions, and Middle Africa through the Arab traders.[2] In ancient Rome, slaves were also genitally cut to deter them from any form of sexual relations that can result in pregnancy.[3] There is yet another theory to the fact that the practice originated from multiple sources.[4]

The World Health Organization (WHO) classified FGM into four categories. The first type is the partial or total removal of the clitoris and/or the prepuce; the second is the partial or total removal of the labia minora; the third is the narrowing of the vaginal orifice; while the fourth includes all other harmful procedures carried out on female genitalia for non-medical purposes.[5] In interrogating the classification, the question arises as to whether there should be any reason for the alteration of the female reproductive organ aside from medical reasons. The answer is to

1 World Health Organisation 'Female genital mutilation', https://www.who.int/health-topics/female-genital-mutilation#tab=tab_1 (accessed 19 May 2022).
2 A Andro & M Lesclingand 'Female genital mutilation: Overview and current knowledge' (2016) 71 *Population* 217. See also CT Ross and others 'The origins and maintenance of female genital modification across Africa' (2016) 27 *Human Nature* 173.
3 Andro & Lesclingand (n 2).
4 Ross and others (n 2).
5 World Health Organisation (n 1).

be found in looking at the purpose for which FGM is carried out. The purposes and function for which FGM is done vary: The first identified purpose for which the practice is carried out is for the reduction of the predisposition of women to pre-marital sexual behaviour and exposure, that is, it protects the concept of 'virginity', 'purity' and 'sexual restraint' which is a prized virtue in the cultural society.[6] A second perceived purpose or function is for 'cultural identity' and transition to adulthood.

In some societies the practice of FGM is a rite of passage that ushers in an individual from girlhood into womanhood.[7] Most parents will be fearful that their families or daughters would be ostracised from society if they fail to perform FGM,[8] for example, the Maasai communities in Magadi and Oloitkitok sub-counties in Kenya.[9] Similarly, in Kenya some communities believe that circumcision is a rebirth and a community of women who have undergone FGM are named *Kipsigis when translated means 'we the circumcised'*.[10]

Additionally, it is also held that FGM serves to protect the health of girls and women and their unborn children. Some believe that FGM improves women's hygiene and increases her likelihood of falling pregnant.[11] In fact, some hold the belief that the baby's head touching the clitoris of his or her mother during childbirth may lead to the death of such baby. Another reason adduced is to ensure that the woman remains chaste after marriage, as well as to prevent rape and enhance aesthetic appeal and providing a source of income for circumcisers.[12]

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6 J Llamas 'Female circumcision: The history, the current prevalence and the approach to a patient' (2017) 1-7, https://med.virginia.edu/family-medicine/wp-content/uploads/sites/285/2017/01/Llamas-Paper.pdf (accessed 19 May 2022).

7 As above.

8 NM Nour 'Female genital cutting: A persisting practice' (2008) 3 *Reviews in Obstetrics and Gynecology* 135-139.

9 S Muhula and others 'The impact of community led alternative rite of passage on eradication of female genital mutilation/cutting in Kajiado county, Kenya: A quasi-experimental study' (2021), https://doi.org/10.1371/journal.pone.0249662 (accessed 19 May 2022).

10 Llamas (n 6) 2.

11 As above.

12 J Abdulcadir & M Rodriguez 'A systematic review of the evidence on clitoral reconstruction after female genital mutilation/cutting' (2015) 129 *International Journal of Gynecology and Obstetrics* 93-97; B Vissandjée and others 'Female genital cutting (FGC) and the ethics of care: Community engagement and cultural sensitivity at the interface of migration experiences' (2014) 14 *BMC International Health and Human Rights*. See also BD Williams-Breault 'Eradicating female genital mutilation/cutting: Human rights-based approaches of legislation,

On aggregate, there is substantial cultural justification for FGM as the practice is immensely rooted in culture and its continuation is also reinforced and deep-rooted in tradition. Culturally FGM is considered part of the essentials of raising a girl child and preparing her for marriage, adulthood and childbirth. The result of research carried out by Berg and Denison, using three stakeholder groups of persons exiled from communities where FGM is being practised, healthcare workers and government officials, indicates that six factors are largely responsible for the continuation of the practice. These include cultural tradition; the interconnected factors; sexual morals and marriageability; religion; health benefits; and male sexual enjoyment.[13]

According to them, there is an intricate web of cultural socio-religious and medical pretext for the continual existence of FGM. The practice of FGM as carried out across jurisdictions in Africa aligns with the classification according to the WHO which essentially sums up the entire practice as alteration either through remodelling and or cutting the female genitals.

It is interesting to note that in the Western culture in the late nineteenth century, the reasons why FGM was carried out was to regulate certain sexual practices, especially female masturbation hysteria, lesbianism, and clitoral enlargement.[14] According to Rodriguez, the practice of FGM in the West was basically to control female sexuality.[15]

With the advancement in knowledge and modern medicine, however, several beliefs on the purpose for carrying out FGM have been ousted due to increased human rights awareness and advocacy. Internationally, FGM has been described as an affront on the human rights of girls and women, violating girls' and women's sexual and reproductive rights, their rights to dignity, to choose, against discrimination, and their rights to be free from torture, cruel, inhuman and degrading treatment. It mirrors a

education, and community empowerment' (2018) 20 *Health and Human Rights* 223-233.

13 RC Berg, E Denison & A Fretheim 'Factors promoting and hindering the practice of female genital mutilation/cutting (FGM/C)' (2010) Oslo, Norway: Knowledge Centre for the Health Services at the Norwegian Institute of Public Health (NIPH) Report from Norwegian Knowledge Centre.

14 Nour (n 8); see also Andro & Lesclingand (n 2).

15 SW Rodriguez 'Rethinking the history of female circumcision and clitoridectomy: American medicine and female sexuality in the late nineteenth century' (2008) 63 *Journal of the History of Medicine and Allied Sciences* 323-347.

deep-seated sex inequality. Should death ensue from FGM, it obviously violates girls' and women's rights to life.

Modern medicine and science have revealed that FGM has no derivable health benefits. Rather, it only leads to health risks, either in the immediate or the remote future, as complications can always arise in the immediate and/or long term. These consequences and risks range from haemorrhage; acute anaemia; infections (such as tetanus); repetitive low urinary tract infections; infections of urethral mucus and/or cystitis; septicaemia; vulvovaginitis with or without leucorrhoea; abnormal scarring (such as fibrosis, cheloids, synechia, tissue rotation); and organic dyspareunia which is a gynecological complication characterised by pains during sexual intercourse due to the cutting or mutilation of the genitals.[16]

The perspectives and attitudes of women and girls equally have changed over time, but there is still a pool of women who perceive no evil in the practice and think that FGM should continue. According to a report of the United Nations Children's Fund (UNICEF), the highjest degree of support can be found in countries such as Mali, The Gambia, Sierra Leone, Guinea, Egypt and Somalia. In these countries, over half of the female population are of the opinion that FGM should continue.[17] However, there has been progress in some other countries in Africa and the Middle East where the majority of females are of the opinion that the practice should be discontinued.[18]

3 Prevalence and spread of female genital mutilation

It is estimated that over 200 million women and girls have been victims of FGM across the globe, especially in countries where FGM is concerted.[19] From data available, FGM spread across many countries around the globe. There is a high concentration of the practice in 'a swath of countries from

16 A Kaplan and others 'Health consequences of female genital mutilation/cutting in The Gambia: Evidence into action' (2011) 8 *Reproductive Health* https://doi.org/10.1186/1742-4755-8-26 (accessed 20 May 2022).
17 UNICEF 'Female genital mutilation' (2022) https://data.unicef.org/topic/child-protection/female-genital-mutilation/ (accessed 20 May 2022).
18 As above.
19 As above.

the Atlantic coast to the Horn of Africa, in areas of the Middle East'.[20] It appears encouraging that over the last decades, there has been a decline in the practice of FGM in several jurisdictions owing to modern medicine, legislation, health policies, science and human rights advocacy. However, not all countries have achieved this progress, coupled with the fact that the rate of the decline is uneven and the progression is not sufficient to keep up with the growth in population. Hence, if the current trend continues, the number of females who would have suffered FGM will be significantly high over the next 15 years.[21] The majority of the victims were cut before the age of puberty, that is, between the ages of six and 12 years. In some areas, the victims are cut at birth, or at menarche or just before marriage.[22] The procedure is usually carried out by traditional practitioners.[23]

FGM is still prevalent in approximately 29 countries, spanning across parts of Africa, the Middle East and Southeast Asia.[24] The various types of cutting is practised across various countries and cultures. For instance, the first type is common in Ethiopia, Kenya and Eritrea; the second type is found mostly in Western African nations such as Benin, The Gambia, Guinea and Sierra Leone; the third type is found in Northern Sudan, Somalia, Eastern Chad, Southern Egypt, Djibouti (in fact, 80 per cent of the most severe type of this third form is found in Somalia); while the fourth type is found mainly in Northern Nigeria.[25]

From available data,[26] there has been a decline in the percentage of occurrences across various jurisdictions. FGM/C is most prevalent in The Gambia among girls between the ages of 0 to 14 years (46 per cent) while it is most prevalent in Somalia among women and girls between ages 15 and 49 years (99 per cent). In The Gambia, 55 per cent of

20 UNICEF 'Female genital mutilation/cutting: A global concern', https://data.unicef.org/wp-content/uploads/2016/04/FGM/CC-2016-brochure_250.pdf (accessed 20 May 2022).
21 As above.
22 Nour (n 8).
23 World Health Organisation 'Female genital mutilation', https://www.who.int/news-room/fact-sheets/detail/female-genital-mutilation (accessed 29 January 2023).
24 Andro & Lesclingand (n 2).
25 E Gruenbaum *The female circumcision controversy: An anthropological perspective* (2001); see also Nour (n 8).
26 E Durojaiye & S Nabaneh *Addressing female genital cutting/mutilation in The Gambia: Beyond criminalisation* (2021).

women reported being circumcised before the age of five; 28 per cent were circumcised between five and nine years of age; 7 per cent between 10 and 14 years of age.[27] In Somalia, types one, two, three and four are prevalent.[28]

4 Approaches at eradicating female genital mutilation/cutting: The human rights-based approach

Human rights are rights inherent to all human being irrespective of their race, nationality, sex, religion, language, ethnicity, or any other status.[29] FGM is a practice that violates several forms of rights of girls and women who are culturally compelled to undergo the procedure. Women's rights are human rights. Therefore, the human rights principle of equality and non-discrimination based on sex, the right to freedom from torture, cruel, inhuman and or degrading treatment or punishment, the right to life (particularly when it results in the death of the victim), and the rights of the child are all violated. FGM also violates the sexual and reproductive rights of women, that is, the rights of women to enjoy complete physical, mental, and social well-being in all matters relating to the reproductive system and to have a satisfying as well as safe sex life,[30] the right to dignity and autonomy.[31]

Attention to correcting this issue was on the forefront during the United Nations (UN) Women's Decade of 1975-1985. There have been several conferences and gatherings calling attention to this human rights violation. In 1995 at the UN Fourth World Conference on Women in Beijing, the wife of the former US President, Hillary Clinton, opined

27 As above.

28 Directorate of National Statistics, Federal Government of Somalia (2020) The Somali Health and Demographic Survey (2020) DNS: Mogadishu, https://www.unicef.org/esa/media/8936/file/Somalia-Case-Study-FGM/C-2021.pdf (accessed 23 May 2022).

29 United Nations 'Human rights', https://www.un.org/en/global-issues/human-rights (accessed 5 September 2022).

30 S Nabaneh & A Muula 'Female genital mutilation/cutting: A complex legal and ethical landscape' (2019) 145 *International Journal of Gynecology and Obstetrics* 253-257; see also E Durojaye & P Sonne 'A holistic approach to addressing female genital cutting (FGC) in Africa: The relevance of the Protocol to the African Charter on the Rights of Women' (2011) *Akungba Law Review* 240.

31 *Schloendorff v Society* of *New York Hospital* 133 NYS 1143 (1912).

that 'it is a violation of human rights when young girls are brutalised by the painful and degrading practice of female genital mutilation'.[32]

There are several international and regional human rights instruments that have been deployed over the years to speak against the practice of FGM either directly or indirectly, by guaranteeing the various rights the practice violates. There is the Universal Declaration of Human Rights (Universal Declaration); the International Covenant on Economic, Social and Cultural Rights (ICESCR); the International Covenant on Civil and Political Rights (ICCPR); the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW); and the Convention of the Right of the Child (CRC).

In a 2008 interagency statement the UN defines FGM as a violation of human rights and a form of discrimination, based not only on gender and violence against girls, but also because it violates a number of rights guaranteed under the Universal Declaration, CEDAW and CRC. CEDAW is an instrument intended to change the human rights narratives concerning women globally, even though some countries have refused to embrace this instrument.[33]

Sustainable Development Goal (SDG) 5 also addresses this menace, aiming to achieve gender equality and empowerment of all women and girls. Goal 5.3 provides for the elimination of all harmful practices, such as early and forced marriage of children and FGM.

In the same vein, CRC is an instrument aimed at protecting the child as well as enhancing their ability to make decisions that directly affect them, particularly life-changing ones. A major guiding principle of this Convention is the 'the best interests of the child', by which the parents' decision to subject their daughters to this life-changing procedure while believing in its benefits cannot justify the decision as being in the best interests of the child since the procedure is non-reversible. Moreover, CRC specifically guarantees the right of a child against harmful traditional practices such as FGM.

At African regional level, instruments aimed at combating FGM date as far back as the African Charter on the Rights and Welfare of the Child (African Children's Charter) which was adopted by the then

32 M Antonazzo 'Problems with criminalising female genital cutting' (2003) 15 *Peace Review* 471-477.

33 Countries such as Somalia that refuse to sign or ratify this Convention.

Organisation of African Unity (OAU), now the African Union (AU), in 1990. Further, in 2003 the AU also adopted the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa[34] (African Women's Protocol). Article 5 of this Protocol specifically states:

> States Parties shall prohibit and condemn all forms of harmful practices which negatively affect the human rights of women, and which are contrary to recognised international standards. States Parties shall take all necessary legislative and other measures to eliminate such practices, including:
>
> ...
>
> prohibition, through legislative measures backed by sanctions, of all forms of female genital mutilation, scarification, medicalisation and para-medicalisation of female genital mutilation and all other practices in order to eradicate them;
>
> ...
>
> (c) provision of necessary support to victims of harmful practices through basic services such as health services, legal and judicial support, emotional and psychological counselling as well as vocational training to make them self-supporting;
>
> (d) protection of women who are at risk of being subjected to harmful practices or all other forms of violence, abuse, and intolerance.

The AU also declared the decade 2010 to 2020 the African Women's Decade to assist in promoting gender equality and the eradication of FGM and all other forms of violence against women and girls.[35]

Measures are taken at the sub-regional level to arrest the trends of cross-border FGM/C, wilfully done to avoid prosecution under local domestic laws. In 2016, the East Africa Legislative Assembly comprising Kenya, South Sudan, Tanzania and Uganda enacted the East African Community Prohibition of Female Genital Mutilation Act (EAC Act) to promote cooperation in the prosecution of perpetrators of FGM.[36]

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34 Adopted on 11 July 2003 (African Women's Protocol).

35 African Union, UN Office of the High Commissioner for Human Rights, UN Women (2017) 'Women's Rights in Africa'.

36 DCK Byamuka 'The EAC Prohibition of Female Genital Mutilation Bill' (2016), http://www.eala.org/documents/view/the-eac-prohibition-of-female-genital-mutilation-bill2016; see a similar discussion by the Economic Community of West African States (ECOWAS); Economic Community of West African States 'First ladies move to eliminate obstetric fistula and protect child rights in West Africa' (2017), http://www.ecowas.int/first-ladies-move-to-eliminate-obstetric-fistula-and-protect-child-rights-in-west-africa/ (accessed 5 September 2022).

Some countries have not signed CEDAW and the African Women's Protocol based on their reservations as Islamic nations. This is because some provisions of CEDAW and the Women's Protocol are not in line with Shari'a law. These nations, members of the Organisation of Islamic Co-operation, in 2003 adopted the Cairo Declaration on the Elimination of FGM (CDEFGM). They did so following the Afro-Arab Expert Consultation on Legal Tools for the Prevention of Female Genital Mutilation held in Cairo.[37]

Seventeen recommendations are suggested for governments to follow CDEFGM with the aim of preventing and prohibiting FGM. Encouragingly, CDEFGM was adopted by Benin, Burkina Faso, Cameroon, Central African Republic, Chad, Côte d'Ivoire, Djibouti, Egypt, Eritrea, Ethiopia, The Gambia, Liberia, Mali, Mauritania, Niger, Nigeria, Senegal, Sierra Leone, Sudan, Tanzania, Togo and Uganda.

The human rights-based approach, which has several benefits, entails the development of suitable action plans and strategies that often require measures beyond legal procedures for adequate implementation. It also requires human rights education and gender sensitisation at all levels of society. The summation at the international level that FGM is a human rights abuse has shaped decisions, laws and attitude of regions and countries and has equally provided remedies for women who have been victims. Further, the human rights-based approach has helped in engaging states in a way that other approaches have not. Most importantly, this approach creates entitlement for rights holders (girls and women) while creating duties for the state.

However, one basic drawback of this approach is its fulfilment. This is because FGM is often performed outside the area of effective enforcement of the law, such as within the family where the perpetrators are private non-state actors or individuals, making human rights implementation difficult or impossible. For effectiveness of the human rights-based approach, there should be massive, intense, consistent and continuing education, which education should be available, accessible, acceptable and adaptable.[38]

37 The National Council for Childhood and Motherhood 'Afro-Arab expert consultation legal tools for the prevention of female genital mutilation: Cairo Declaration for the Elimination of FGM/C' (2003).

38 Adopted by the Committee on Economic, Social and Cultural Rights in General Comment 13 (E/C.12/1999/10). For more information, see www.right-to-

4.1 Criminalisation and legislation

Another approach that has been adopted over time is the use of laws and criminal sanctions as a form of deterrence for the continuance of the practice of FGM. Several countries have imposed sanctions in the form of terms of imprisonment and/or fines for perpetrators of FGM. This approach is premised on the theory of deterrence, that is, the use of penalty as a threat to deter people from wrongdoings. Deterrence proposes that individuals act based on their calculations on the gains and consequences that such action will incur from the law. Hence, the costs that will be incurred by the perpetrators will be a form of deterrence for him or her from engaging in the particular action.[39]

Perpetrators of FGM may be deterred from such practice based on the certainty of the penalty that will attend such actions. The deterrence theory can be traced back to early philosophers such as Thomas Hobbes (1588-1678), Cesare Beccaria (1738-1794) and Jeremy Bentham (1748-1832).

According to Hobbes, deterrence can be general or specific.[40] People within society give up their personal self-interest and enter into a social contract with the government while the government deploys its apparatus to enforce the social contract for the benefit and advancement of society.[41] Hobbes further states that, irrespective of this social contract entered into by the people and the government, crimes may still occur and, as such, punishment for crime must therefore be greater than the benefits derived from committing crime.

Deterrence, therefore, is the reason why offenders are punished for violating the tenets of social contract so as to maintain the agreement between the state and its citizens.[42] In building on Hobbes's idea on deterrence, Beccaria states that since people are rationally self-interested, they will not commit crimes if the cost of committing such crime prevails over the benefits.[43] He states further that the swiftness and certainty

education.org (accessed 5 September 2022).

39 MM Mello & TA Brennan 'Deterrence of medical error: Theory and evidence for malpractice reform' (2002) 80 *Texas Law Review* 1603.

40 F Schmalleger *Criminal justice: Brief introduction* (2003) 406.

41 WG Pogson *Smith Hobbes's Leviathan reprinted from the ed 1651* (1929).

42 As above.

43 C Beccaria *Crimes and punishments* trans H Paolucci (1963) 107 Library of Liberal arts Macmillan library of arts 8.

of punishment are the best means of both preventing and controlling crimes.[44] Bentham, a contemporary of Beccaria, posits that 'nature has placed mankind under the governance of two sovereign masters, pain and pleasure'.[45] He holds that the duty of the state is to promote the happiness of society, both by punishing and rewarding.[46]

Essentially, criminalising FGM is founded on the theory of deterrence which posits that persons are likely to be deterred from doing a wrongful act when there are sanction grids attending the wrongdoings, and the more serious the punishment, the more rational-minded persons will abstain from committing the crime.

According to a study carried out by the Thomas Reuters Foundation, 22 countries have national laws in place penalising the performance of FGM, and the penalties comprise fines and other forms of punishment, including imprisonment. Various countries set out a range of minimum and maximum sanction grids, except for Cameroon, Ghana, Guinea Bissau, Senegal and Uganda. Twenty-two countries with anti-FGM laws apply prison sentences ranging between two months to a maximum of 20 years; the amount paid as fines ranges between US $5,5 and US $3,08. The countries that have the highest amount in fines are Benin, Cote d'Ivoire and Kenya, while the countries imposing the longest maximum number of prison terms are Cameroon (20 years) and Tanzania (15 years). Penalties vary between countries; the countries with the lowest penalties are Ethiopia, Niger, Sudan and Guinea. Separate penalties are set out against aiding and abetting FGM and/or a failure to report the practice, in which case the penalties are usually lower. In instances where the performance of FGM results in the death of the victim, sanctions are increased, and imprisonment may be for life. A good example is Kenya. Some jurisdictions specially profile who the perpetrator is, and the degree of harm caused, of which Uganda is an example.

Enacting laws that criminalise FGM is important as 'it can challenge the traditional *status quo by providing legitimacy to new behaviours*'.[47] Deterrence also helps in restraining perpetrators generally from participating in FGMC, and in instances where there has been a

44 As above.
45 J Bentham with an introduction in W Harrison (ed) *An introduction to the principles of morals and legislation* (1948) 125.
46 Bentham (n 45) 189.
47 Williams-Breault (n 12) 223-233.

commission by a perpetrator, the individual is further incapacitated when they are punished by being removed from society and being kept incarcerated.

However, the criminalisation approach, which is anchored on the theory of deterrence, has several criticisms and skepticisms. Deterrence makes some assumptions that are rebuttable, such as that every member of the society knows what the penalties are for a crime; individuals have good control over some of their actions, particularly those committed under reflex; and, third, that persons think things through and make choices about their conduct based on logic and not passion. Another assumption is that crime rates can be reduced by decreasing benefits of crime or increasing the severity of the sanction.[48]

Relating the above to the issue of FGM, criminalisation may not be achieving its goal or, at least, not as quickly as would have been expected. First, in a few countries where FGM has been criminalised, the number of prosecutions has been low or non-existing and sentences have been lenient and unpublished. When other prospective perpetrators are unaware of the sanctions befalling already sanctioned perpetrators, the weight of deterrence and essence of criminalisation is lost.

Added to this are issues of record keeping and availability of data, enforcement,[49] administration of criminal justice procedures where there may be unwilling witnesses, and so forth. Further, inflation rates have caught up with the monetary sanctions imposed in several jurisdictions making the fines pitiably low and there is a lack of administrative mechanisms to periodically review prescribed fines, increasing these in line with inflation.[50]

The question therefore is whether the criminalisation of FGM indeed has had any positive impact in abating and eradicating the crime of FGM/C, and to what extent. Laws criminalising FGM appear ineffective in most countries where it has been criminalised, basically because the communities where FGM is prevalent are neither sensitised nor informed on the ills and dangers of the practice, more so that the practice has been proscribed by law. Moreover, legal sanctions alone are

48 EA Fattah 'Critique of deterrence research with particular reference to the economic approach' (1983) 25 *Canadian Journal of Criminology* 79.

49 '28 too many: The law and FGM/C: An overview of 28 African countries' (2018), https://www.28toomany.org/Law (accessed 10 August 2022).

50 As above.

not sufficient to change the attitudes and dispositions of people since legal sanctions fail to address the underlying socio-cultural drivers of FGM. Hence, unless criminalisation is complemented by other measures designed at influencing cultural expectations, it tends to be futile.[51]

African countries where FGM is concentrated that have enacted decrees or legislations related to FGM are Benin, Burkina Faso, Central African Republic, Chad, Côte d'Ivoire, Djibouti, Egypt, Eritrea, Ethiopia, Ghana, Guinea, Guinea-Bissau, Kenya, Mauritania, Niger, Nigeria (some states), Senegal, Somalia, Sudan (some states), Togo, Uganda and Tanzania.[52]

The argument on the efficacy of using legislation to ban FGM has been reached by the increasing mutual consensus that law ought to be one of the sets of approaches and interventions to tackle FGM.

4.2 Education and enlightenment

Education is a powerful change agent essential to the success of every crusade, especially in the eradication of FGM/C. Education is a vital and important mechanism that can be used in communicating the increased danger and menace of FGM to society. The education-based approach, therefore, offers communities, girls and women the opportunity to learn, unlearn and relearn. As the world rallies at finding effective means of eradicating FGM, education plays a crucial role in achieving this. The inclusion of gender education and gender-based issues, such as violence against women, gender equality and FGM, in learning curricula has not only become imperative but also expedient.

Education as an approach has two dimensions: The first is educating girls and women who are prospective victims; the second is educating the entire society so that everyone will have knowledge of what FGM is and

51 K Brown and others 'The applicability of behaviour change in intervention programmes targeted at ending female genital mutilation in the EU: Integrating social cognitive and community level approaches' (2013) *Obstetrics and Gynecology International* 1155.

52 UNICEF 'Female genital mutilation/cutting: A statistical overview and exploration of the dynamics of change', https://data.unicef.org/wp-content/uploads/2019/04/UNICEF_FGM/C_report_July_2013.pdf (accessed 10 August 2022). Bans outlawing FGM/C/C were passed in some African countries, including Kenya and Sudan, during colonial rule. This table includes only legislation that was adopted by independent African nations and does not reflect earlier rulings.

an understanding of the dangers inherent in it; this is a community-based educational initiative. When an educated girl or woman is empowered to stand up and make her decisions, plans and aspirations, she is less likely to be a victim of FGM. The two approaches discussed above find a meeting point in the education-based approach because with education, all the participants, that is, the prospective victims, the perpetrators and the communities will have the understanding that FGM is against the rights of the victims and that it has been proscribed by law.

However, a major shortfall of this approach is the fact that parents often subject their girls to FGM/C early in life before they are aware of anti-FGM messages in their school curricula. Consequently, education may not be sufficiently preventive, but there is a positive potential that in the near future educated women are less likely to support or continue FGM. Moreover, girls and women are powerful agents of positive social change in society, particularly when they are educated and enlightened and are able to channel their energy and thoughts in the right direction. Similarly, while this approach is often favoured over the other approaches as it is seen as less repressive,[53] however, this intervention can sometimes be seen by the community members as 'an unsolicited top-down approach'.[54] It therefore is good that communities should be sensitised and worked with, prior to its implementation to guarantee community acceptance.[55] Higher education is another main factor that has shown to support the discontinuance of FGM.[56] The more education a society imbibes, the more liberated it becomes.

4.3 Involvement of men approach

Most societies in Africa are patrilineal in nature where men hold sway in decision making and influence societal outlook. There is an obvious imbalanced power relation where women are the underdogs. Whereas

53 S Waigwa and others 'Effectiveness of health education as an intervention designed to prevent female genital mutilation/cutting (FGM/C/C): A systematic review' (2018) 15 *Reproductive Health* 1-14.

54 Williams-Breault (n 12) 223.

55 S Babalola and others 'Impact of a communication programme on female genital cutting in Eastern Nigeria' (2006) 11 *Tropical Medicine and International Health* 1594-1603.

56 K Dalal and others 'Adolescent girls' attitudes toward female genital mutilation: A study in seven African countries' (2018) *F1000 Research* 7.

it appears that women are in the forefront of the practice of FGM, it is important that men as husbands, fathers, religious leaders and community heads lead initiatives in impelling a change. It therefore is pivotal to secure the buy-in of men in campaigns aimed at attitudinal change, such as the eradication of FGM. The perceptions of men vary from country to country, although most are similar.

In a study carried out in Egypt on men, it revealed that men believed that uncircumcised women are promiscuous.[57] Men regard FGM as important for a good marriage and sexual objective and to ensure that women remain faithful in marriage. However, according to findings of a study carried out in a rural community in Egypt, men opine that women likewise have an equal right to enjoy sex.[58] For men in Guinea, FGM help girls to reduce the possibility of premarital sex.[59] For men in Somalia there is a division on whether FGM prevents premarital sex, preserves girls' dignity, and maintain marital fidelity.[60] In Northern Sudan men appear not to accurately understand FGM because it is until they are married that they appreciate the impact of FGM on their wives.[61]

Several factors influence the support of men for the continuation of FGM, the major one being social obligation.[62] The strong sense of social obligation perhaps is stronger than other considerations such as religion or their sense of rightness or wrongness of the practice of FGM.[63] Another is the level of education of men in addition to their location, whether they live in urban or rural areas.[64] Younger men who have a better

57 A Abdelshahid & C Campbell 'Should I circumcise my daughter?' Exploring diversity and ambivalence in Egyptian parents' social representations of female circumcision (2015) 25 *Journal of Community and Applied Social Psychology* 49.

58 F Fahmy and others 'Female genital mutilation/cutting and issues of sexuality in Egypt (2010) 18 *Reproductive Health Matters* 181.

59 AJ Gage & R van Rossem 'Attitudes toward the discontinuation of female genital cutting among men and women in Guinea' (2006) 92 *International Journal of Gynecology and Obstetrics* 92-96.

60 AA Gele, BP Bø & J Sundby 'Have we made progress in Somalia after 30 years of interventions? Attitudes toward female circumcision among people in the Hargeisa district' (2013) 6 *BMC Research Notes* 1-9.

61 V Berggren and others 'Being victims or beneficiaries? Perspectives on female genital cutting and reinfibulation in Sudan' (2006) 10 *African Journal of Reproductive Health* 24.

62 N Varol 'The role of men in abandonment of female genital mutilation: A systematic review' (2015) *BMC Public Health*, https://doi.org/10.1186/s12889-015-2373-2 (accessed 10 August 2022).

63 Abdelshahid & Campbell (n 57).

64 Varol (n 62).

understanding of the negative health and psychosexual implications of FGM on girls are less supportive of the practice.[65] All these factors act as barriers as to why this approach has not been very effective.

Nevertheless, involving men in this campaign is very beneficial for its eradiation since men play a significant role in society as fathers, brothers, uncles, husbands and religious and community leaders.[66] Their voices are louder, more emphatic, and often final in deciding the social ideology and direction. Also, being the gatekeepers of customs and tradition, men are in a better position to bring dynamics and a paradigm shift to the established social order that has been considered inimical to the social well-being of certain members of society. Through advocacy and men ensemble, our social existence could rapidly be re-directed toward the side of anti-FGM. In communities where there is a high prevalence of FGM, it is important to involve influential men who could lead programmes and advocacy.[67] However, the involvement of men in advocacy at eradicating FGM should be complemented with the rights-based approach, as well as the education and female empowerment approaches.[68]

5 Discussion: Dynamics against the seeming inadequacy of the different approaches

Various approaches have been adopted in fighting FGM/C globally, ranging from the rights-based advocacy, to the education-based approach, the involvement of men, and criminalisation. Despite the sustained efforts at enforcing compliance, the practice subsists in many countries. The question then is, what are we getting right or, rather, what are we doing wrong? It is estimated that between 100 and 140 million girls and women globally are presently living with the consequences of FGM/C, while about 92 million girls, whose ages range from 10 years and above, have been victims of FGM/C.[69] There clearly are perceived hitches and flashpoints in the current approaches requiring attention.

65 A Kaplan 'Female genital mutilation/cutting: The secret world of women as seen by men' (2013) *Obstetrics and Gynecology International* 1.
66 Varol (n 62).
67 As above.
68 As above.
69 WHO 'FGM/C fact sheet' (2020), https://www.who.int/en/news-room/fact-sheets/detail/female-genitalmutilation (accessed 10 May 2022).

It therefore is necessary to reconsider these methods, interrogate their strong points and inherent weaknesses. Consequently, this part of the chapter discusses the various dynamics interfering with achieving success at the eradication of FGM/C, and the identified causes of the inadequacy of the current approaches. There are a few considerations and mitigating factors that should be put in perspective that will enable us to fashion out best-fit-approach that will help at eradicating or reducing FGM/C. These are discussed below.

The strong influence of culture and customary law on people: Culture is a vital concept to the sociological perspective.[70] Culture basically affects the behaviour, beliefs and value systems of any person or society, and it differentiates and impacts the identity of any given society. Culture or cultural practices and perceptions are intricately connected to people's world view and their social existence and interactions are shaped by culture. Over the years, culture has been used to validate practices of each locality or social geography. Persons' orientation, ideologies and perspectives are all embedded in their cultural orientations, and until the orientation itself is rightly addressed from the source, it may become nearly impossible to filter out cultural perceptions and beliefs, since culture is intrinsic. There are questions emerging from cultural perspectives that need to be answered appropriately and satisfactorily, to secure the support of cultural change: Is FGM/C bad? What makes it bad?

The practice of FGM/C is entrenched in cultural perspectives, which have been described as viewing a situation, concept, or practice through the eyes of a person's native environmental and social influence.[71] While there is a tendency to underestimate the impact of culture on the 'owners' of the culture and cultural practices, the truth remains, namely, that individuals are unlikely to do any act contrary to the dictates of his or her culture. Thus, 'FGM/C is still central to the status of women and the normative meaning of being a woman in the cultures that practice it'.[72]

70 https://2012books.lardbucket.org/books/sociology-brief-edition-v1.1/s05-01-culture-and-the-sociological-p.html (accessed 10 June 2022).

71 CulturalPerspective,https://www.alleydog.com/glossary/definition-cit.php?term=Cultural+Perspective (accessed 30 May 2022).

72 M Berer 'The history and role of the criminal law in anti-FGM/C campaigns: Is the criminal law what is needed, at least in countries like Great Britain?' (2015) 23 *Reproductive Health Matters* 145.

Therefore, it is imperative that the cultural stronghold on FGM/C should be tackled right from the source, to get the culture of FGM/C outlawed or changed by the custodians of culture and tradition in each society. There is a need to get the buy-in of the gatekeepers of culture to understand and appreciate the hazards of FGM/C, and these are the set of people who will bring about the desired change and dynamism expected in culture. Eradicating the practice will be difficult if members of the local society fail to identify the practice as unpleasant and dangerous.

There is a need to demystify the cultural purpose of the practice, that is, to keep chastity, family honour, the protection of virginity, the prevention of promiscuity, purification, transition rites, enhancing fertility, and increasing matrimonial opportunities.[73] A failure to change the cultural perspective of society and the cultural gatekeepers to see the dangers inherent in FGM will elongate the bland inability to eradicate the practice. The procedure of cutting girls and women will keep mutating with newer dimensions of existential challenges. This is seen in the situation in Kenya, where there is the medicalisation of the process to remove the threat of hygiene or loss of life associated with the practice when done locally by untrained hands.[74]

It also is essential to develop a process that will make each society understand that FGM/C should not be perceived as a cultural right nor an expression of social identity in a way unique to them but should rather be seen as a practice that undermines the right and health of women and girls in society. Until the cultural values are changed to accommodate the facts that FGM/C is detrimental to the overall good of any girl or woman, the wilful misconduct will continue while the ignorant victims will joyfully and willingly be partakers.

Added to the above equally is the impact of customary law and the inability of the national laws to influence or change the existing customary laws. Several African countries have mixed legal systems referred to as legal pluralism, a situation whereby there are many legal systems

73 TC Okeke and others 'An overview of female genital mutilation in Nigeria' (2012) 2 *Annals of Medical and Health Sciences Research* 70-73.

74 S Kimani & B Shell-Duncan 'Medicalised female genital mutilation/cutting: Contentious practices and persistent debates' (2018) 10 *Current Sexual Health Reports* 25.

operating simultaneously in the same geographical area.[75] This is mainly due to the colonial past of most African countries. There undeniably are several laws and policies outlawing the practice of FGM/C in many African countries, but these laws and policies have had very little impact on the existing customary laws that prescribe and support FGM/C. Using Nigeria and Kenya as examples: In Nigeria, although the 1999 Constitution does not specifically make provision prohibiting FGM/C, there are provisions that protect the rights of citizens against violations.[76]

There is also the Child Rights Act; the Violence Against Persons Prohibition Act 2015; the National Gender Policy 2006; the National Policy on the Health and Development of Adolescent and Young People in Nigeria 2007; the National Gender Policy Strategic Framework (Implementation Plane) 2008-2013; the National Policy and Plan of Action for the Elimination of Female Genital Mutilation in Nigeria 2013-2017; among others. A number of states equally have state laws and policies prohibiting FGM/C.[77]

In Kenya there is the Kenya Constitution 2010;[78] the Prohibition of FGM Act 2011; the Children's Act of 2001; the Penal Code Cap 63; the Protection Against Domestic Violence Act 2015; the National Policy for the Eradication of Female Genital Mutilation 2019; the National Adolescent Sexual and Reproductive; the Health Policy 2015; the National Plan of Action for the Elimination of FGM in Kenya 1999-2019; and the Reference Manual for Health Care Providers on Management of Complications from FGM/C (2007). The Penal Code of Kenya 2012 also contains provisions that when interpreted can be used to charge circumcisers. Both countries equally are signatories to several international human rights instruments that outlaw, condemn and criminalise FGM/C.

75 FR Adegbite 'Legal pluralism and marriage in Nigeria: A structure for denying rights to women' (2020-2021) 31 *University of Ghana Law Journal* 110.

76 Secs 15(2), 17(2) & 34(1).

77 Examples are the Bayelsa State: FGM (Prohibition) Law (224); Cross River: The Girl-Child Marriages and Female Circumcision (Prohibition) Law (2000); Ebonyi State: Law Abolishing Harmful Traditional Practices Against Women and Children (2001); Edo State: Prohibition of Female Genital Mutilating Law (1999); Enugu State: FGM (Prohibition) Law (2004); Rivers State: Child Right Act (2009).

78 Arts 29(c) & (f), 44(3), 53(d).

However, despite these national and state laws, the impact and operation of the customary law remains strong on the indigenous people to the detriment of the national and state laws. For many reasons, members of the local community can relate better with the customary laws than other laws. They often are more aware of customary laws than of the national laws that are unknown and obscure to them; they find identity through the customary laws, which remain more accessible and acceptable than other forms of laws operating in the area.

5.1 The limitation of criminalisation of FGM/C as a means of eradication

The UN in December 2012 adopted the first ever resolution to ban FGM/C/C globally.[79] Several countries have enacted legislation criminalising FGM/C. Several countries have put in place penalties such as prison terms and/or the payment of a fine. The question that arises is how effective criminal law is to curb FGM/C. In jurisdictions that have adopted the criminalisation of FGM/C, has this helped in the reduction or eradication? Do the custodians of culture, women and girls who participate in FGM/C believe the procedure to be criminal? Do they believe that the practice is a violation of a woman's sexual and reproductive rights? Do they see it as violating their rights to choose, rights against discrimination, rights to be free from torture, cruel, inhuman, and degrading treatment?

One major limitation of criminalisation is that since the procedure is mostly not done in public, identification is very challenging, limiting the process for punishing perpetrators. If the victims or the participants fail to report, how then can the government set in motion the apprehension, prosecution, enforcement, and punishment mechanisms, particularly when the girls and women involved give consent to the procedure based on their cultural perspective and values?

Moreover, in instances when arrests are made, the procedure would have been carried out, suggesting that criminalisation not often is preventive, rather, it only gives remedy and succour to any unwilling victim. There have been growing debates on the efficacy of criminalisation as an approach, and it appears that the consensus is that criminal law is only

79 UNFPA. Demographic perspectives on FGM/C/C (2015) New York: UNFPA.

one of the many approaches to the eradication of FGM/C. There should be other sets of combative approaches to accompany criminalisation, approaches that influence cultural values and perspectives.

However, it is conceded that legislations banning the practice is a firm government commitment and standpoint on the practice of FGM/C. Criminalisation challenges the existing traditional position by providing a new acceptable model which is inevitable. The success of criminal law, therefore, lies in its tolerance and open-mindedness to socio-cultural and religious acceptability, and its implications. While criminalisation may not be the best or absolute method for eradicating FGM/C, it is equally necessary to create the enabling environment to expedite the overall strategy in its eradication.[80] As such, legislation should be complemented with other measures.

5.2 Straightening out some misconceptions

There are some misconceptions that need to be straightened out to enable us effectively to address FGM/C. The need to straighten these out is apt and necessary to identify the underlining causes and roots of FGM/C. The first is the misconception that FGM/C is forced on women by men. The society that carries out FGM/C comprises men and women and the persons who do the actual cutting are both men and women. While there is a substantial role that men play or should play in its eradication, the level of knowledge and understanding of the nature and implication of FGM/C goes a long way in the effectiveness of any method to be used in its eradication. There is a need to attend to the belief system and perception held by men of uncut women. The focus, therefore, should be placed on how these perspectives can be positively redirected. In fact, it has been revealed that some men accurately do not understand FGM/C and its negative impacts on the health of a woman and marital sexual relationships.[81]

Another issue is tied to the terminology attached to this procedure, that is, 'mutilation'. Mutilation appears derogatory, condescending and connotes destruction, whereas, FGM/C to the communities are 'value-adding procedures' and not damaging. The perpetrators, victims and

80 Nabaneh (n 30).
81 Varol (n 62).

the entire community do not regard it as destructive, but as a process of creating social order that is sexually and morally sane. Research has shown that in some African cultures, it is believed that bodies are androgynous where all male and female bodies have male and female parts.[82] Therefore, the man's foreskin is a female part and the female's clitoris covering is a male part, and both should be cut away so as to be wholly male or female.[83] The use of the word 'mutilation' sounds offensive to the sensibility of society and should be entirely changed to 'modification' and 'cutting' rather than 'mutilation'.

5.4 Medicalisation of FGM/C (the mutation of domestic responses)

There is an increase in the use of medical facility to perpetrate FGM/C across many countries. It is estimated that 26 per cent of females in the age range of 15 to 49 have been reported to have been cut by health professionals, and the rates are rising.[84] Five countries with the highest rate of this include Sudan (67 per cent); Egypt (38 per cent); Guinea (15 per cent); Kenya (15 per cent); and Nigeria (13 per cent).[85] The medicalisation of FGM/C occurs when FGM/C is carried out by any category of health professional, whether in a public or private health facility and at any point in a female's life, either as a minor or an adult,[86] particularly, when the female involved is giving informed consent, that is, exercising her right to determine what should be done to her body. Based on this, can a female adult with capacity and competency request FGM/C? Can this be seen as part of an adult woman's right to do what she desires with her body? Is it bad only when it is perpetrated on a minor? Is it ethical for medical practitioners to participate in FGM/C?

82 O Khazan 'Why some women choose to get circumcised', https://www.theatlantic.com/international/archive/2015/04/female-genital-mutilation-cutting-anthropologist/389640/ (accessed 27 May 2022). An anthropologist discusses some common misconceptions about female genital cutting, including the idea that men force women to undergo the procedure.

83 Khazan (n 82).

84 B Shell-Duncan, C Njue & J Muteshi 'Medicalisation of female genital mutilation/cutting: What do the data reveal?' (2017) *Reproductive Health*.

85 As above.

86 E Leye and others 'Debating medicalisation of female genital mutilation/cutting (FGM/C/C): Learning from (policy) experiences across countries' (2019) 16 *Reproductive Health* 158.

Has medicalisation reduced the harm and pains being inflicted on the perceived victims?

There have been a number of researches debating the medicalisation of FGM/C. The prevailing argument is that medicalisation cannot be right or acceptability based on the ethical principles that predate the era of rights; largely anchored on the principles of (a) beneficence, that is, doing what is the best for the patient; (b) non-maleficence, that is, do no harm justice, that is, all persons will be treated fairly and equitably, equal respects for all persons.[87] It is glaring that, based on these ethical medical principles, the healthcare professional will be doing wrong by engaging in FGM/C. This chapter aligns with the conclusion that the medicalisation of FGM/C is a human rights abuse with lifelong consequences, irrespective of who performed it.[88] Moreover, the fact that the healthcare professionals are making financial gains from sustaining and supporting cultural norms that have been outlawed and regarded as being wrong and against human rights presents a scorecard of profit objectives.

5.5 Socio-cultural and religious distrust of Western interventions

There exists a type of distrust by developing countries on ideologies and interventions emanating from developed countries. This perhaps is one of the reasons why there is much hesitancy and many agitations whenever there is an evolvement of any intervention ideas or programmes from the developed countries and, conceivably, this may not be unfounded. Some time in 1996, Pfizer, an American multinational pharmaceutical and biotechnology corporation, had an 'illegal trial of an unregistered drug', trovafloxacin (Trovan) in the northern part of Nigeria during an epidemic of meningococcal meningitis which led to several deaths and disabilities of the participants.[89] This singular incident closed the minds of the indigenous northerners to Western drugs and medical interventions. Similarly, the COVID-19 vaccine was greeted with doubt

87 JP Olejarczyk & M Young 'Patient rights and ethics' (2021) StatPearls Treasure Island (FL), https://www.ncbi.nlm.nih.gov/books/NBK538279/ (accessed 30 May 2022).

88 Shell-Duncan and others (n 84).

89 J Lenzer 'Secret report surfaces showing that Pfizer was at fault in Nigerian drug tests' (2006) 332 *BMJ Clinical Research ed* 1233.

when it was first produced and projected as a potent prevention for the ravaging pandemic. Another is the issue of rights. The Western world has been able to achieve an admirable compliance with human rights, but unfortunately some of these rights have found no resting place in the value systems of many African countries. Examples are abortion rights, same-sex unions, and marriages. These practices that are seen as immutable human rights by developed nations are still abhorred in many developing countries. Based on this, most ideologies and interventions from the developed nations are seen as an imposition of Western ideologies and value systems on developing countries. This misplaced perception is also based on the level of education, information, and enlightenment among the populace. To pierce through this mistrust, attention should be given to trust-enhancing triggers while strategic communication approaches should be used to burst the trust bubbles.[90]

6 The home-grown approaches: Bottom-up method

FGM/C is a menace affecting girls and women globally and there have been many approaches employed by each country for its eradication. However, FGM/C appears to still be thriving in our various communities. The question then arises as to what else can be done to achieve better, faster and more accurate success at its eradiation. Over the years, there has been a shift from medical arguments to human right arguments as regards the wrongness of FGM/C. Also, the inability of the human rights-based approach at eradicating the practice brought about its criminalisation in order for women to be able to turn to the state for protection.

Granted, FGM/C is an international concern that has elicited various discussions and researches. Accordingly, it is apposite to have a global perspective of the issue so as to develop a universal vision, comprised of what has been done, what has not been done and what ought to be done to attain success. However, if a speedy and precise success is to be attained, adopting the locally home-grown method is best suited. The home-grown approach is a call on indigenous people to become active participants and no longer passive subjects of what is being done to

90 J Amo-Adjei and others 'Trust and willingness towards COVID-19 vaccine uptake: A mixed-method study in Ghana (2021) 80 *Archives of Public Health* 64.

them. This model entails the use of the bottom-up approach wherein the process of decision making and implementation originates from the lower level or the community and proceeds upwards. With this approach, persons who are direct participants of FGM/C, that is, victims, customs gatekeepers, and community leaders are also included in the ideation of the innovative means of eradicating it and this is done per community.

Having identified the foremost factors that promote FGM/C in their community, each community is empowered through discussion and negotiation to ascertain and make use of the appropriate form of interventions that will be appropriate for a quicker and more accurate response. For instance, in a community where FGM/C is a rite of passage based on the dictate of culture, such community may require an eradication approach different from one wherein the justification for FGM/C is the prevention of promiscuity. The implication of this is that there will be a spread of diverse approaches across communities in each region or county and this will originate from within the community itself. There should be a painstaking engagement with the members of each community and, jointly, justification for FGM/C will be identified, and a concession will be reached as to the most effective form of approach to be utilised in such community. A strong team is formed with the members of the community who will invent a home-grown approach from within.

It is imperative to involve the customs gatekeepers, to identify the custodians of customs in each locality and do a micro-education and enlightenment, not a one-cap-fits-all. It may be necessary to align with the idiosyncrasy of each locality and culture. Each country should embark on a campaign project to hear out the local women before handing down a law or policy. There should be focused group discussions by these women on why they still support FGM/C, buy them over and make them the anti-FGM/C ambassadors.

Let the collaborative campaign evolve from within the society and not from the outsiders (international) or Western campaigners. In providing solutions, it is important that the government does not alienate the people it intends to help. Until FGM/C is regarded as wrong by the custodians of culture, the practice may not be eradicated. The custodians must speak out and say that it is bad. It is also worthy to generate discussions that will set the agenda by the indigenous people and the local communities. This will enable them to participate in positive decision-making processes

aimed at eradicating FGM/C. There is also a need to engage victims (and their spouses) with proof of backlash and side effects on health status of victims of FGM/C.

There are a number of benefits in engaging this form of approach, ranging from increased collaboration, improved team motivation and morale, better alignment of every participant, faster innovation, increase of trust among stakeholders as more informed decisions are made while the lower part of the team leverage the knowledge.[91] Also, using the home-grown bottom-up approach, better mileage and traction can be gained in the fight at eradicating FGM/C, since the benefits of this approach appear vast. In solving problems and creating solutions, the people one intends to help should not be alienated. The approach must not appear condescending as one must first appreciate the cultural imports of the procedure, deploy persuasive communication to stem the tide rather than outrightly degrade the practice.

Essentially, the domestic solution through the bottom-up model entails that the specific method of eradication should be identified and applied to specific locations, irrespective of the geographical proximity of each location. This, therefore, requires that a particular approach that predominantly and effectively works in a particular location and culture may not work in another. This may be based on different reasons, ranging from the level of enlightenment of each community, to the environmental situation, socio-cultural experience and other factors that may affect the reception and ability to change by each community.

There should be a multiplicity of methods engaged across board, requiring further inquiries and research to understand the predominant cause in each locality, so that the government of each country can have multiple strategies in place to end FGM/C. Multiple strategies comprising of laws, education and other integrated approaches that will enhance its success in their respective localities. As mentioned earlier, there is also a need for government to identify the root causes per locality and deploy customised models that can solve the problem per locality. The proximity of geographical areas does not mean that the solutions that worked in area A will work effectively in area B.

91 A Arrizza '6 benefits of using a bottom-up management approach', https://voila.app/en/blog/6-benefits-of-using-a-bottom-up-management-approach/ (accessed 1 June 2022).

An example of the use of home-grown alternative methods and interventions can be seen in some communities in Kajiado county in Kenya, the implementation mode of which has left a positive experience.[92] A community-led alternative rite of passage (CLARP) was initiated and implemented as an alternative to the traditional rite of passage in which the female genital was cut as an indication of transition to adulthood. It was created with the intention of curtailing the prevalence of FGM/C within that community. CLARP is an alternative rite of passage designed for girls to celebrate their initiation into womanhood in adherence with the cultural practice of the community but without undergoing the cut.[93] The aim of this initiative is to help maintain the cultural requirement of a rite to transit girls into womanhood without them undergoing the cutting of their genitals.

CLARP sought to change the existing social norms and reverse the rate of FGM/C in Kajiado, and this is achieved by involving the stakeholders in the community, such as the cultural leaders referred to as *Morans, religious leaders and other community leaders. The initiative was not a swift and instant process because several steps were taken while executing the CLARP which had a duration of six to 48 months.*[94] Some of the significant outcomes of the CLARP intervention in the community was the creation of 'a community movement that takes action to transform social and gender norms that perpetuate FGM/C'.

The initiative helped in initiating community-led discussions around FGM/C and equally empowered girls and women, community leaders and policy makers to develop policies and laws on FGM/C and its detriments within the community.[95] Similar alternative rites of passage (ARP) have been successfully executed in other communities such as Meru, Kisii, Kuria and Narok which were practising FGM/C as a large celebration in the community.[96]

92 https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0249662; https://data.unicef.org/topic/child-protection/female-genital-mutilation/ (accessed 7 June 2022).

93 L Hughes 'Alternative rites of passage: Faith, rights, and performance in FGM/C abandonment campaigns in Kenya' (2018) 77 *African Studies* 274.

94 S Muhula and others 'The impact of community led alternative rite of passage on eradication of female genital mutilation/cutting in Kajiado county, Kenya: A quasi-experimental study' (2021) 16 PLoS ONE. DOI 10.1371/journal.pone.0249662.

95 As above.

96 As above.

The findings of a study carried out by Muhula and others suggest that the successful implementation of CLARP led to a 24.2 per cent decline in FGM/C in that community and has contributed to the drop in the prevalence of FGM/C.[97] The study was also able to demonstrate that CLARP has been positively received by the Maasai community, and it has played a huge role in reducing the FGM/C practice in Kajiado. Although CLARP as an alternate rite of passage came with its several barriers; there is resistance to cultural change, particularly by some *Morans and elderly who believe that FGM/C is central to the sacredness of the cultural practice.*[98]

Therefore, some people within the community still stigmatise girls who partook in CLARP instead of the existing traditional rite of passage wherein girls are cut. Further, there is the peer pressure, particularly from young men who are still resistant to marrying girls who are uncut.[99] Nevertheless, the study has demonstrated that this community home-grown initiative has been able to significantly reduce not only FGM/C but other vices such as teenage pregnancy, early and forced marriage rates of children and that there is a slow and gradual embrace of it by the community.

Contrast the above scenario to the situation in Dawe district, Afar region in Ethiopia where, in spite of its criminalisation, the practice remains prevalent. Ethiopia has a high prevalence of FGM/C and the Afar region is one of the regions with a prevalence rate above 80 per cent.[100] The severity of FGM/C in Afar region is high compared with other highland areas of Ethiopia and the practice is deep-rooted in socio-cultural beliefs of the people.[101]

A study was carried out to interrogate why, in spite of the several local and international interventions on FGM/C in the region, there has been very little reduction and despite the legislative interventions that criminalise the practice the rate remains high.[102] One of the findings is

97 As above.
98 As above.
99 As above.
100 UNICEF 'Female genital mutilation/cutting: A statistical over-view and exploration of the dynamics of change' (2013) New York: United Nations Children's Fund, UNICEF.
101 As above.
102 YA Masresha 'The difficulties of ending female genital mutilation (FGM): Case of Afar Pastoralist communities in Ethiopia' MA dissertation, International Institute

that a major factor contributing to the slow reduction in FGM/C is the 'lack of proper linkage between the main actors within the society and the factors that directly affect the process of eradication'. The failure at eradicating FGM/C is a cause of the unfriendly top-down intervention approaches. Interventions at eradicating it need the active involvement of major groups and stakeholders in the community to bring about attitudinal changes entrenched in customs and culture. The findings of the research further stated that the 'unfitted approached to the socio-cultural conditions of the society plays a great role for the failure in achieving goals'.[103]

It therefore is pertinent to localise solutions for this global issue by identifying the causes peculiar to each locality and the use of model or combined models that can address that specific locality. The implication of this is that, in a single country, there will be varying models and the emphasis will be placed on the model suitable for each locality. The government should assist locals to come to the verdict that FGM/C is harmful and should be done away with, rather than the international community and the government at the top echelon imposing the verdicts on the people. The decision to stop should evolve from within.

Further, attention should be given to trust enhancers and influencers between the international community and the local communities while strategic communication approaches be used to remove the mistrust triggers. The campaign should be louder and should build a bigger and better structure for surveillance that involves the local people, community leaders and influencers, not only the official surveillance structure.

Likewise, incentivisation can be used in curbing FGM/C; using the system of rewards and incentivising community where it can work, particularly in communities where there is acute poverty, when locals gets financial and material rewards. Perhaps this can strengthen people's will to embrace the eradication of FGM/C. There could be incentives such as the partial exemption of fathers from tax payments for some time and/or making the parents of uncut girls enjoy some advantages above those that have subjected their girls to FGM/C, such as subsidised or free education for uncircumcised girls.

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of Social Studies, Ethiopia.

103 As above.

Incentives can also be extended to whistle blowers who make reports that will facilitate the arrest of participants and victims, in order for criminalisation to be effective. The use of incentives will help in strengthening the link between the activity and the objective of the activity, which is the eradication of FGM. Equally, the use of incentives often helps in a change of behaviour towards the proposed outcome.

7 Conclusion

This chapter identified FGM/C and its various types. It also examined the origin, perspectives, prevalence and spread of the practice. It discussed the numerous approaches in which the various government have engaged previously, aimed at reducing and/or eradicating FGM/C, but discovered that the battle is far from being won. There is a need for the deployment of a multi-faceted approach.

While governments should identify the root cause or the predisposing basis for its continuation, knowledge of the initial practice in each locality becomes compelling to assist in tackling the menace. It should be noted that the fact that a community is geographically close to another does not suggest that the reasons for the practice of FGM/C are the same. When the reasons are identified, then the tailor-made homegrown approach that is fit for that locality should be engaged.

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3

THE DISABLED GENITALIA: COUNTERING DOMINANT NARRATIVES TO ENDING FEMALE GENITAL MUTILATION IN AFRICA

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Abstract

Disability is an essential identity in the female genital mutilation discourse in two ways. First, a genitally-mutilated woman potentially is a disabled woman. For instance, because of the invasive nature of the FGM procedures, genitally-mutilated women in Africa could become 'disabled'. Indeed, 'mutilation' makes an incomplete body. Second, women with disabilities are subjected to the same harmful practices, such as FGM, that women without disabilities encounter daily. For instance, compared to women without disabilities, women with disabilities are increasingly susceptible to violent, harmful and forced practices and are more likely to be genitally mutilated in Africa. FGM, therefore, is not only gendered but also ableist and disabling. Yet, the disabled woman's experience is mainly unacknowledged, silenced and invisible in the legal and human rights responses to ending FGM in Africa. Centring the disabled woman's experience shows that FGM is both gendered, ableist and disabling, simultaneously confirming the interactions and intersections between the identity categories of sex/gender and disability. Against this background, this chapter uses the disabled woman's experience to argue for a reconceptualisation of the FGM's response in Africa. Effective responses and interventions must be attentive to how gender and disability as identity categories are mutually constitutive, intersecting and impact the FGM experience.

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Consequently, this chapter calls for an intersectional and feminist decolonial understanding where FGM is not viewed as if disability and sex/gender are entirely separate, stable, monolithic, colonial and essentialist identity categories.

1 Introduction

Approximately 140 million African women and girls have undergone female genital mutilation (FGM).[1] Furthermore, millions more women and girls are threatened and are likely to experience the practice globally and in Africa if the procedure is not entirely abandoned.[2] These staggering figures confirm FGM as one of the most severe and widespread human rights infringements committed against women and girls in Africa and worldwide, sparking renewed calls for an end to the harmful practice.

Disability is an essential identity in the FGM discourse for two reasons. On the one hand, there is FGM's potential to disable women, given the invasive nature of the FGM procedure. Unsurprisingly, 'mutilation' has been found to have the 'nuance of making a body incomplete'.[3] Indeed, the link between FGM and disability has been well established.[4] If this link is accurate, a genitally-mutilated woman in Africa potentially is either a 'disabled' or a dead woman.[5] What this

1 United Nations Children's Fund (UNICEF) 'Towards ending harmful practices in Africa: A statistical overview of child marriage and female genital mutilation' (2022), https://data.unicef.org/resources/harmful-practices-in-africa/ (accessed 27 September 2022). See also United Nations 'Ending female genital mutilation by 2030', https://www.un.org/en/observances/female-genital-mutilation-day (accessed 27 September 2022).

2 World Health Organisation 'Female genital mutilation factsheet' (2022), https://www.who.int/news-room/fact-sheets/detail/female-genital-mutilation (accessed 27 September 2022).

3 Y Iguchi & A Rashid 'Female genital mutilation and the politics of discourse: Questioning the self-evidence of the modern medical scientific gaze' (author's translation) (2019) 7 *Annual Review of Cultural Typhoon* 2.

4 In my DPhil thesis, I argued that FGM does not only cause disabilities (impairments and disabilities used interchangeably in this chapter) but it is also a form of sexual disability. See: A Johnson 'The voiceless woman: Countering dominant narratives concerning disabled women in Nigeria' (2019) Faculty of Law, University of Pretoria 36. Another author that makes this argument is M Owojuyigbe and others 'Female genital mutilation as sexual disability: Perceptions of women and their spouses in Akure, Ondo State, Nigeria' (2017) 25 *Reproductive Health Matters* 80 81.

5 CEDAW Committee General Recommendation 24: Article 12 of CEDAW (Women and health) UN Doc A/54/38/Rev.1 ch 1 (5 February 1999) para 12b.

could mean, although scary, is that if the FGM practice is not entirely abandoned, more women and girls are likely to die or become disabled as a consequence of undergoing the FGM procedure.

On the other hand, and which is rarely acknowledged, women with disabilities are subjected to the same harmful practices committed against women without disabilities, including FGM.[6] Indeed, compared to women without disabilities, women with disabilities are increasingly susceptible to encountering violent, dangerous and forced treatments, which includes FGM, in Africa.[7] This increased susceptibility to undergo FGM could lead to more severe disabilities.[8]

Yet, the disabled woman's experience is unacknowledged, silenced and invisible in the legal and human rights responses aimed at ending FGM in Africa. Few studies have investigated how disabled women undergo FGM simply because of their intersectional positioning and on the grounds of their gender and disability in Africa. Indeed, it is telling that although disabled women are more likely to undergo FGM, the number of disabled women or women with disabilities that have experienced FGM is unknown in Africa.[9]

Against this background, this chapter uses the disabled woman's FGM experience to argue for a change of approach to FGM's response in Africa. This is bearing in mind that effective responses and interventions must be attentive to how gender and disability as identity categories are mutually constitutive, intersecting and impact the FGM experience. Centring the disabled woman's experience exposes FGM as gendered, ableist and disabling, simultaneously confirming the interactions and intersections between the identity categories of sex/gender and disability.

The chapter uncovers how law's dominant interventionist narrative, which views identity categories such as sex/gender and disability as biological realities rather than mutually constitutive, socially constructed signifiers of FGM oppression, needs to be countered. In other words, to interpret FGM in terms of its gendered implications alone risks overlooking its potentially more significant ableist and disabling

6 Committee on the Rights of People with Disabilities (CRPD Committee) General Comment 3: Women and girls with disabilities (2016) CRPD/C/GC/3 para 37.
7 As above.
8 As above.
9 As above.

consequences. Similarly, efforts to end the FGM practice without considering disability reinforce disabling stereotypes around the practice.

Consequently, a change of approach in FGM's response in Africa involves a combined intersectional and feminist decolonial lens where FGM is not viewed as if disability and sex/gender are entirely separate, stable, monolithic and essentialist identity categories.

The chapter proceeds in six parts. Part 1 is the introduction. Part 2 discusses the reality of the FGM practice in Africa. This part exposes the prevalence of the FGM practice in Africa in three ways: as gendered; as disabling; and as both sexist/gendered and ableist, simultaneously manifesting in an intersectional 'disabled female' dilemma. This exposure lays a good foundation for part 3, which explores the legal and human rights responses to ending FGM in Africa.

Subsequently, in advocating a reconceptualisation of the FGM response, part 4 proposes an intersectional understanding in efforts to end FGM. Next, part 5 discusses how, for an intersectional lens to work in efforts to end FGM in Africa, it must apply a feminist 'decolonial' perspective. Finally, part 6 offers conclusive arguments that advocate legal and human rights responses that apply a feminist decolonial intersectionality lens in its efforts to abolish FGM in Africa.

2 Reality of the female genital mutilation practice in Africa

The global prevalence of FGM has been well documented.[10] However, despite its prevalence, some African countries have reported an uneven decline in FGM.[11] Furthermore, the advent of the Coronavirus (COVID-19) pandemic in 2019 and its disproportionate negative impacts on women have led to severe warnings about the pandemic's potential to overturn any decline in the FGM practice in Africa and

10 World Health Organisation (n 2); United Nations Children's Fund 'Female genital mutilation/cutting: A global concern' (2016), https://www.unicef.org/media/files/FGMC_2016_brochure_ final_UNICEF_SPREAD.pdf (accessed 27 September 2022); BM Gbadebo and others 'Cohort analysis of the state of female genital cutting in Nigeria: Prevalence, daughter circumcision and attitude towards its discontinuation' (2021) 21 *BMC Women's Health* 2.

11 UNICEF 'The decline of female genital mutilation in Ethiopia and Kenya' (2021), https://www.unicef.org/esa/media/8891/file/The-Decline-of-FGM-Ethiopia-Kenya-2021.pdf (accessed 27 September 2022). See also Gbadebo and others (n 10) 184.

globally.[12] Indeed, these warnings cite recent rises in FGM rates among young women in some African countries.[13] Thus, if the FGM practice is not abandoned, staggering numbers of African women and girls in Africa and globally remain at risk, making its abandonment crucial.

Extensive scholarly debates have been drawn around FGM. For instance, there have been conceptual debates on what FGM signifies. For example, disagreements are rife about whether the genitalia of females are cut, circumcised[14] or mutilated,[15] with implications for each scenario. These implications include the question of the practice's prevalence despite a plethora of eradication efforts and the effectiveness of these efforts and interventions, primarily legal and criminal sanctions, employed to end the practice in Africa.[16]

Despite these contentions, FGM's stark reality, severity and global prevalence have earned significant attention amidst urgent calls for its

12 UNICEF 'COVID-19 disrupting SDG 5.3: Eliminating female genital mutilation' (2020), https://www.unicef.org/media/68786/file/External-Tehnical-Note-on-COVID-19-and-FGM.pdf (accessed 27 September 2022). See also: A Johnson and A Budoo-Scholtz 'COVID-19 and women's intersectionalities in Africa' in A Johnson and A Budoo-Scholtz (eds) *COVID-19 and women's intersectionalities in Africa'* (2023) 13.

13 UNICEF 'UNICEF warns FGM on the rise among young Nigerian girls: Organisation launches community-led initiative to end harmful practice on International Day of Zero Tolerance for FGM' (2022) https://www.unicef.org/nigeria/press-releases/unicef-warns-fgm-rise-among-young-nigerian-girls#:~:text=Abuja%2C%2006%20February%202022%20%E2%80%93%20UNICEF,FGM)%20remains%20widespread%20in%20Nigeria (accessed 27 September 2022).

14 WN Njambi 'Dualisms and female bodies in representations of African female circumcision: A feminist critique' (2004) 3 *Feminist Theory* 283-285. See also WN Njambi 'Irua ria atumia and anti-colonial struggles among the gı̃kuy̆u̇̃ of Kenya: A counter narrative on female genital mutilation' (2007) 33 *Critical Sociology* 690; WN Njambi 'Irua ria atumia and anticolonial struggles among the Gĩkũyũ of Kenya: A counternarrative on "female genital mutilation"' in O Oyěwùmí (ed) *Gender epistemologies in Africa* (2011) 179-197.

15 WHO 'Eliminating female genital mutilation: An interagency statement OHCHR, UNAIDS, UNDP, UNECA, UNESCO, UNFPA, UNHCR, UNICEF, UNIFEM, WHO' (2008) 22, https://www.who.int/publications/i/item/9789241596442 (accessed 27 September 2022). See also UNFPA 'Implementation of the international and regional human rights framework for the elimination of female genital mutilation' (2014) 12, https://www.unfpa.org/sites/default/files/pub-pdf/FGMC-humanrights.pdf (accessed 27 September 2022).

16 R Khosla and others 'Gender equality and human rights approaches to female genital mutilation: A review of international human rights norms and standards' (2017) 14 *Reproductive Health* 2.

elimination globally.[17] I discuss three manifestations of FGM in Africa below.

2.1 Female genital mutilation as gendered in Africa

FGM is a gendered act in Africa. It is commonly regarded as a private cultural and religious practice targeted explicitly at African women and girls.[18] In other words, African women and girls have their genitalia mutilated simply because of their gender. For instance, the FGM practice is done to retain the female marriageability of women and girls by ensuring that they maintain their virginity until marriage when their husbands have sexual intercourse with them.[19] Findings from Nigeria confirm how FGM is practised so that women's and girls' virginity is retained.[20] Consequently, FGM is exposed as a gendered act because it is a by-product of patriarchal and sexist tendencies and descriptions that reinforce men's sexual superiority over women in Africa.[21]

FGM is also recognised globally as a form of gender-based violence.[22] Gender-based violence refers to the 'violence directed against a woman because she is a woman or that affects women disproportionately'[23] and, as such, infringes on their human rights.

Multiple reasons advanced for the FGM practice further expose it as a gendered act. For instance, several accounts document how in African societies where FGM is practised, it is considered a cultural rite of passage to womanhood in Africa.[24] The FGM practice is so profoundly entrenched culturally that women in practising communities view FGM

17 United Nations General Assembly Resolution 75/160 'Intensifying global efforts for the elimination of female genital mutilation' (2020) (A/75/471).

18 A Idowu 'Effects of forced genital cutting on human rights of women and female children: The Nigerian situation' (2008) 12 *Law, Democracy and Development* 116.

19 O Omigbodun and others 'Perceptions of the psychological experiences surrounding female genital mutilation/cutting (FGM/C) among the Izzi in Southeast Nigeria' (2019) 57 *Transcultural Psychiatry* 213.

20 As above.

21 Omigbodun and others (n 19) 116. See also CEDAW Committee General Recommendation 19 Violence against women para 11; AO El-Tom 'Female circumcision and ethnic identification in Sudan with special reference to the Beti of Darfur' (1998) 46 *GeoJournal* 164 166.

22 Declaration on the Elimination of Violence against Women (Declaration) art 2.

23 As above.

24 L Muzima 'Towards a sensitive approach to ending female genital mutilation/cutting in Africa' (2016) 3 *SOAS Law Journal* 81.

as essential to their cultural identity as African women.[25] Additionally, FGM is still considered a prestigious and honourable custom.[26] For instance, despite strict laws in 19 of the 36 states and the federal capital territory (FCT) in Nigeria prohibiting FGM, varying sanctions and sometimes culture is used to legitimise the practice.[27] Moreover, in other African societies, the lack of laws or weak enforcement of laws on FGM is linked to its powerful cultural force.[28]

This cultural rite of passage argument thrives in several African societies because of representations of women's bodies as unruly and in dire need of sexual control.[29] This sexual control manifests by stifling or reducing women's sexual desires to guard against deviant and immoral sexual behaviour.[30] Thus, without the sexual control that FGM ostensibly proffers, true womanhood is believed to be unattainable.

Similarly, the FGM prevalence thrives on genital cleansing and sexual purity arguments.[31] In practising African communities, women who do not undergo FGM are considered unclean, dirty and corrupt.[32] As argued previously, it is held that the practice is done to retain the female marriageability of women and girls by ensuring that they maintain their virginity until marriage when their husbands have sexual intercourse with them.[33] As a rite of passage to womanhood in Nigeria, women who refuse to undergo FGM are viewed as promiscuous or unmarriageable.[34] Even when married, studies find that FGM is practised to ensure marital fidelity since the practice limits women's sexual desires due to painful

25 As above.
26 Muzima (n 24) 73.
27 CC Nnanatu and others 'Evaluating changes in the prevalence of female genital mutilation/cutting among 0-14 years old girls in Nigeria using data from multiple surveys: A novel Bayesian hierarchical spatio-temporal model' (2021) 16 *PLoS ONE* 1; see also Idowu (n 18) 116.
28 CEDAW Committee and CRC Committee Joint general recommendation 31 of the Committee on the Elimination of Discrimination against Women/General Comment 18 of the Committee on the Rights of the Child (2014) on harmful practices para 19. See also CRPD Committee Concluding Observations on the initial report of Uganda 12 May 2016 CRPD/C/UGA/CO/1 para 34.
29 AA Odukogbe and others 'Female genital mutilation/cutting in Africa' (2017) 6 *Translational Andrology and Urology* 139.
30 Omigbodun and others (n 19) 213.
31 As above 213.
32 Omigbodun and others (n 19) 223.
33 Omigbodun and others (n 19) 213.
34 Johnson (n 4) 62.

sexual intercourse, thereby reducing the potential for promiscuity and extramarital sex.[35]

Not surprisingly, when a woman fails to undergo this practice, she is stigmatised and ostracised in many African countries.[36] The outcome is that women and girls 'voluntarily' submit themselves to FGM to attain womanhood and achieve societal approval, recognition and acceptance despite proof that many women who undergo FGM are unwilling to do so.[37]

Besides, FGM is also performed to prepare women and young girls for motherhood, guard reproductive potential, increase fertility, and aid childbirth.[38] This assertion is bolstered by a widely-held belief among practising communities that women who do not undergo FGM are more susceptible to stillbirths. According to the myth, if the baby's head touches an unmutilated clitoris, death will occur.[39] Yet, paradoxically, evidence demonstrates otherwise, showing how it is women who have their genitals mutilated that are at risk of infertility.[40]

Nevertheless, some practising African communities object to the idea that FGM 'mutilates' but insist that it is part of a beautification process of women's genitalia that makes women more attractive physically and socially.[41] The FGM practice is also linked to religion. However, substantial evidence for a possible link between FGM and Christianity or Islam is unsubstantiated.[42]

2.2 FGM is disabling in Africa

As discussed above, FGM is gendered because it specifically targets women and girls in Africa. However, the truth is that exposing FGM as a gendered practice reveals its disabling oppressive nature in Africa. The

35 Gbadebo and others (n 10) 2.
36 Johnson (n 4) 62.
37 ZE Harivandi 'Invisible and involuntary: Female genital mutilation as a basis for asylum' (2010) 95 *Cornell Law Review* 600.
38 Omigbodun and others (n 19) 213.
39 PO Anuforo and others 'Comparative study of meanings, beliefs, and practices of female circumcision among three Nigerian tribes in the United States and Nigeria' (2004) 15 *Journal of Transcultural Nursing* 105.
40 C Onyemelukwe 'Intersections of violence against women and health: Implications for health law and policy in Nigeria (2016) 22 *William and Mary Journal of Women and the Law* 619.
41 Omigbodun and others (n 19) 213.
42 Omigbodun and others (n 19) 213-214.

severe health complications and consequences of violence against women in Africa are well documented.[43] For instance, research finds that forms of violence against women, including harmful practices such as FGM, are a more prominent reason for women's ill-health than traffic accidents and malaria combined' and is 'as serious a cause of death as cancer'.[44] Consequently, objections to the FGM practice have not only relied on the argument that it is a violent, sexist act targeted at women but mostly stresses its disabling medical and public health consequences.[45]

Indeed, women who have undergone FGM are susceptible to extensively documented public health challenges and are more likely to contract medically severe diseases. For instance, specific mental health outcomes, including post-traumatic stress disorders, low self-esteem, anxiety, depression, sexual dysfunction, and obsessive-compulsive disorders, have been attributed to FGM.[46] Further, women who undergo FGM will likely experience adverse reproductive health consequences, including pain and difficulties enjoying sexual relations, painful menstruation, vesicovaginal fistula, rectovaginal fistula, pelvic inflammatory disease, and obstructed labour.'[47]

Additionally, FGM may result in bleeding and infections since it is primarily done in unsanitary conditions. Studies have attributed the extent of health complications arising from FGM to the procedures used.[48] For instance, literature has shown that 'unsterilised equipment can potentially cause primary infections like urinary tract infections, staphylococcus, haemorrhaging, and excessive and uncontrollable pains'.[49] Moreover, other severe infections such as HIV, clostridium tetani, HSV 2, chlamydia trachomatis, and others have been associated with type 3 mutilation.[50]

Similarly, literature draws a correlation between FGM and disability.[51] For example, a United Nations (UN) thematic study links FGM to

43 CEDAW Committee and CRC Committee (n 28) paras 15 & 19.
44 Onyemelukwe (n 40) 616.
45 Onyemelukwe (n 40) 619.
46 As above.
47 As above.
48 GO Shakirat and others 'An overview of female genital mutilation in Africa: Are the women beneficiaries or victims' (2020) 12 *Cureus* 3 8.
49 As above.
50 As above.
51 Human Rights Council 'Thematic study on the issue of violence against women and girls and disability Report of the Office of the United Nations High

various physical and psychological impairments.[52] Research suggests that women who had no prior disabilities and impairments could potentially develop disabilities that manifest in distinct forms, for example, sexual, psychosocial and intellectual disabilities, once they have undergone this practice.[53] Apart from the health consequences of FGM, it is held that FGM type 3 (infibulation) is considered a disability perpetrated after birth in African countries.[54] Moreover, disabilities could occur due to short-term health complications of FGM exacerbated by the limited healthcare services available in African countries to deal with such difficulties.[55]

Thus, as demonstrated above, a mutilated woman is potentially a disabled woman. However, this argument does not negate scholarship that insists that while it is crucial to recognise the impact of FGM on mental health, there is a need to avoid pathologising women who have experienced violence, including FGM, given its implications.[56]

Yet, in extreme cases, FGM can also result in maternal morbidities.[57] The manifestation of short-term complications resulting from FGM could lead to avoidable deaths. As earlier indicated, this situation is exacerbated by the limited healthcare services available in Africa to deal with such difficulties.[58] Several examples in African countries have garnered prominent attention. For instance, in 2021, a 21-year-old Sierra-Leonean woman died from acute bleeding and shock after being subjected to FGM.[59] A few days later, in a different region in Sierra Leone,

Commissioner for Human Rights' 30 March 2012 (A/HRC/20/5) para 27.

52 As above.

53 Owojuyigbe and others (n 4) 80 81.

54 UNFPA 'Implementation of the international and regional human rights framework for the elimination of female genital mutilation' (2014) para 4.7, https://www.unfpa.org/sites/default/files/pub-pdf/FGMC-humanrights.pdf (accessed 27 September 2022).

55 Onyemelukwe (n 40) 627.

56 Onyemelukwe (n 40) 631.

57 Onyemelukwe (n 40) 612. See also CEDAW Committee 'Concluding Observations of the Committee on the Elimination of Discrimination against Women Djibouti' 28 July 2011CEDAW/C/DJI/CO/1-3 para 18.

58 Onyemelukwe (n 40) 627.

59 Equality Now 'Sierra Leone urged to ban FGM following death of 21 year-old woman' (2021), https://www.equalitynow.org/news_and_insights/sierra-leone-urged-to-ban-fgm-following-death-of-21-year-old-woman/ (accessed 27 September 2022).

a 15-year-old girl was admitted to the hospital for urgent treatment after suffering severe complications due to FGM.[60]

Scenarios such as these encourage the focus on FGM's adverse health consequences in a bid to end the practice. However, the focus on FGM's negative health consequences has unintentionally fuelled the medicalisation of the procedure.[61] Some states have permitted health practitioners to perform FGM ostensibly to reduce the associated harms.[62] These efforts are based on the false premise that this shift would decrease serious health complications. However, although well-intentioned, the involvement of healthcare practitioners in performing FGM behoves a false sense of legitimacy on the practice giving the impression that the procedure is beneficial for medical reasons or at least is harmless.[63]

Yet, medicalisation as a reduction strategy is unacceptable.[64] The argument is that medicalisation does not represent a holistic and human rights approach to abandoning FGM.[65] The World Health Organisation (WHO) corroborates this point by describing medicalisation as an infringement of medical ethics based on its potential to cause harm.[66]

2.3 The disabled female: FGM as an intersectional dilemma

From the above sketch, it is clear that FGM is performed on women and potentially disables them. However, women with disabilities are also targeted for FGM in Africa. A disabled woman is more likely to be genitally mutilated and, compared to women without disabilities, is twice and sometimes thrice as likely to be violated and face distinct forms of violence and forced treatments, including FGM in Africa.[67]

60 As above.
61 E Leye and others 'Debating medicalisation of female genital mutilation/cutting (FGM/C): Learning from (policy) experiences across countries' (2019) 16 *Reproductive Health* 2.
62 As above.
63 Khosla and others (n 16) 6.
64 WHO 'Eliminating female genital mutilation: An interagency statement OHCHR, UNAIDS, UNDP, UNECA, UNESCO, UNFPA, UNHCR, UNICEF, UNIFEM, WHO' (2008) 12, https://www.who.int/publications/i/item/9789241596442 12 (accessed 27 September 2022).
As above.
65 Leye and others (n 61) 2.
66 WHO (n 64) 12.
67 Human Rights Council (n 51) paras 12-27.

In the African patriarchal context, where women are often viewed as subordinate to men, women and girls with disabilities struggle to attain the feminine norms of women without disabilities, thus giving rise to increased susceptibility to different forms of discrimination and violence.[68] Literature finds that the increased exposure of women with disabilities to sexual violence often results from their intersecting identities of gender and disability.[69] FGM is no exception. Although her womanhood and identity as a woman is questioned and doubted based on her disability, a disabled woman is simultaneously female and disabled. Therefore, women and girls with disabilities are not only predisposed to FGM based on their gender but also on the severity of their disability.

Thus, women with disabilities are more likely to experience distinct forms of sexual violence, including FGM. The Committee on the Rights of Persons with Disabilities (CRPD Committee), in its Concluding Observations to Gabon, Kenya, Ethiopia and Uganda, confirm the prevalence of FGM affecting girls and women with disabilities in African countries.[70] Research reinforces how children with disabilities in rural areas in Kenya are more likely to undergo the FGM practice.[71] The Special Rapporteur on the Rights of Persons with Disabilities described how a girl or young woman with disabilities becomes vulnerable to gender-based violence, including harmful practices such as FGM, while being treated or when overmedicated.[72] The reality shows that perpetrators of FGM often are family members and caregivers who usually justify FGM under the guise of best interests.[73]

68 United Nations General Assembly 'Report of the Special Rapporteur on the Rights of Persons with Disabilities: Sexual and reproductive health and rights of girls and young women with disabilities' (2017) A/72/133 paras 33-34.

69 As above para 34.

70 UNGA (n 68) paras 33-34. See also CRPD Committee Concluding Observations on the initial report of Gabon 2 October 2015 CRPD/C/GAB/CO/1, paras 40-41. See also CRPD Committee Concluding Observations in relation to the initial report of Kenya 4 September 2015 CRPD/C/KEN/CO/1 paras 33-34. See also CRPD Committee 'Concluding Observations on the initial report of Ethiopia 4 November 2016 CRPD/C/ETH/CO/1, paras 39-40. See also CRPD Committee Concluding observations on the initial report of Uganda 12 May 2016 CRPD/C/UGA/CO/1 paras 34-35.

71 I Inguanzo 'The situation of indigenous children with disabilities' (2017) Policy Department, Directorate-General for External Policies, European Union, http://www.europarl.europa.eu/RegData/etudes/STUD/2017/603837/EXPO_STU(2017)603837_EN.pdf (accessed 27 September 2022).

72 UNGA (n 68) para 34.

73 As above.

Research has focused chiefly on FGM performed on women without disabilities, with limited information regarding the number of women and girls with disabilities that undergo FGM.[74] Besides, studies tend to focus on the forced sterilisation of women with disabilities in Africa, and lose sight, in a critical and political sense, of 'less restrictive alternatives to sterilisation, particularly FGM and menstrual suppressant drugs'.[75] Yet, like the forced sterilisation of women and girls with disabilities in African countries,[76] FGM is also a violent form of sexual control. In addition, the practice impacts bodily integrity and autonomy significantly, involving mostly non-consensual surgical mutilation, and is similarly perpetuated based on misconceptions about disability, gender, and even menstruation in Africa.

Contradictory misconceptions of asexuality, hyper-sexuality or deviant, immoral sexual behaviour of women with disabilities are used as a double-edged sword to perpetuate FGM: first, to create doubts about whether women with disabilities undergo FGM; and, second, to rationalise why women with disabilities are often forced to undergo FGM in Africa. These misconceptions surrounding the sexuality of the disabled female have meant that the genital mutilation of the disabled female has received less legal and political scrutiny. For instance, if, as shown, FGM is considered a rite of passage to marriage and motherhood in Africa,[77] women with disabilities who are often considered not human or lesser 'women' in Africa fuel the misconception that they do not undergo FGM.[78] Women with disabilities are often viewed as mentally and physically unable or incapable of meeting gendered norms that disqualify them from marriage and motherhood in Africa.[79] As such, because of this perception of women with disabilities as unable to meet

74 CRPD Committee (n 6) para 37.
75 L Steele & B Goldblatt 'The human rights of women and girls with disabilities: Sterilisation and other coercive responses to menstruation' (2020) 78.
76 AI Ofuani 'Protecting adolescent girls with intellectual disabilities from involuntary sterilisation in Nigeria: Lessons from the Convention on the Rights of Persons with Disabilities' (2017) 17 *African Human Rights Law Journal* 552.
77 Omigbodun and others (n 19) 213.
78 CJ Eleweke & J Ebenso 'Barriers to accessing services by people with disabilities in Nigeria: Insights from a qualitative study' (2016) 6 *Journal of Educational and Social Research* 118.
79 GI Grobbelaar-Du Plessis 'African women with disabilities: The victims of multilayered discrimination' (2007) 22 *South African Public Law* 406.

gendered standards of motherhood and marriage, it is erroneously believed that they are exempt from FGM.

However, this argument has been debunked. Scholarships confirm that women and girls with disabilities do get married and become mothers.[80] Examples abound about how girls with disabilities are likely to be married in regions and communities where child marriage occurs.[81] Indeed, families in African countries are more prone to force girls with disabilities into marriage because they see it as a way to ensure long-term security and protection.[82] If this is accurate, the susceptibility of women and girls with disabilities to the FGM practice becomes more apparent.

Moreover, in African cultures such as the Ethiopian culture, women with disabilities undergo FGM to avoid what sometimes is regarded as deviant sexual behaviour since a woman who does not undergo FGM is generally considered unclean.[83] This increases the likelihood of FGM for women with disabilities since they are usually assumed to be unable to control their sexuality and manage their fertility. These misconceptions could manifest in two ways.

On the one hand, the prevalence of FGM has been attributed to the need for sexual control and reduced sexual desires reinforcing the asexuality label usually imposed on 'disabled' women.[84] On the other hand, FGM also stems from the view that women with disabilities cannot control their fertility leading to the assumption that they are hypersexual or exhibiting deviant and immoral sexual behaviour.[85] In these cases, FGM is viewed as a procedure that alleviates the perceived burdens that might result from uncontrolled sexuality. In all these scenarios, FGM or, in extreme cases, forced sterilisation is practised under the guise of their best interests.

Additionally, despite the misconceived assumption of asexuality, research has documented the increased vulnerability of women with

80 J Morris *Feminism, gender and disability* (1998) 8.
81 AS Kanter & C Villarreal Lopez 'A call for an end to violence against women and girls with disabilities under international and regional human rights law' (2018) 10 *Northeastern University Law Review* 592.
82 As above.
83 DIA Hirpa 'Sexual violence and motherhood among women with disabilities in Ambo Town, Ethiopia' (2022) *Disability and Society* 5.
84 A Johnson 'The voiceless woman: Protecting the intersectional identity under Section 42 of the Nigerian Constitution' (2021) 9 *African Disability Rights Yearbook* 90-91.
85 As above 91.

disabilities to sexual violence, including FGM, for multiple reasons. For instance, on account of misconceptions about their gender and disability, women with disabilities are often denied the ability to make informed decisions on their reproductive choices, especially on their sexuality and whether or not they consent to FGM.[86] Indeed, restricting or removing legal capacity can trigger forced medical interventions.[87] Thus, FGM exemplifies an infringement of rights that many women and adolescent girls with disabilities suffer without consent or fully understanding its intentions.

Women with disabilities are often denied the opportunity to make free and informed choices or decisions on their own accord.[88] Such denial is predicated on the false assumptions that girls and young women with intellectual disabilities cannot grasp sexuality and their bodies.[89] This situation is exacerbated by family members who are scared of being held liable for allowing such sexual escapades,[90] making girls and young women susceptible to FGM as a form of monitoring sexual control.

The assumption that forced medical procedures and interventions such as FGM are essential hinges on the medical understanding of disability.[91] This understanding portrays the disabled woman as a victim of a flawed body or mind. Based on this understanding, women with disabilities are denied the ability to make reproductive choices. Their wishes are considered irrelevant and overridden if the intervention is deemed medically beneficial.[92] Yet research has shown how FGM as a non-consensual medical care intervention ostensibly done in the best interests of women with disabilities, in reality, are 'violent acts directed towards imposing a specific normative order reinforcing hierarchies.

Moreover, forced sterilisation, a representation of eugenic and holocaust tendencies, exemplifies how a harmful practice has been redefined and enforced in many African societies as necessary for medical

86 UNGA (n 68) para 28.
87 As above.
88 CRPD Committee (n 6) para 37.
89 UNGA (n 68) para 22.
90 As above.
91 BA Areheart 'Disability trouble' (2011) 29 *Yale Law and Policy Review* 348.
92 B Ribet 'Emergent disability and the limits of equality: A critical reading of the UN Convention on the Rights of Persons with Disabilities' (2011) 14 *Yale Human Rights and Development Law Journal* 164.

or therapeutic reasons.[93] Notably, attempts have been made to analogise FGM to forced sterilisation.[94] Concerning the latter, while the rationale can be said to be a purely medical procedure, the former is usually rationalised for mainly cultural reasons.[95] However, the correlation between the two practices is obvious: FGM and forced sterilisation have similar types of physical and emotional harm and similar long-term effects.[96] Moreover, women who are genitally mutilated against their will and individuals who are forcibly sterilised suffer a grievous violation of bodily autonomy.[97]

Indeed, many African governments have continued to support measures that enable forced sterilisation and other coercive interventions, including FGM targeting the sexuality of women and girls with disabilities.[98] This support is given despite clear and documented evidence that these practices infringe on the human rights of women and girls with disabilities.[99] Furthermore, perpetrators are seldom held accountable, and women and girls with disabilities who have experienced this egregious form of violence can rarely obtain any form of redress or justice. Additionally, physical and communication vulnerabilities such as the inability to defend themselves, shout for help or express their displeasure or lack of consent make women with disabilities vulnerable to sexual violence, including FGM.[100] Other challenges, such as the inability to testify in court as credible witnesses or being less likely to be aware of sexual violence as harmful or report it makes women with disabilities easy prey to sexual violence, including FGM.[101]

Additionally, research has found that men in most African societies are often willing to have sexual relationships with women with disabilities privately but are often unwilling to be publicly associated with them.[102]

93 Kanter and Villarreal Lopez (n 81) 594.
94 Harivandi (n 37) 600.
95 Harivandi (n 37) 619.
96 As above.
97 Harivandi (n 37) 621.
98 CRPD Committee (n 6) para 37.
99 As above.
100 T Meer & H Combrinck 'Invisible intersections: Understanding the complex stigmatisation of women with intellectual disabilities in their vulnerability to gender-based violence' (2015) *Agenda: Empowering Women for Gender Equity* 1.
101 As above.
102 S Dessie and others 'Sexual violence against girls and young women with disabilities in Ethiopia. Including a capability perspective' (2019) 15 *Journal of Global Ethics* 327.

FGM, therefore, is performed as a means of protection and prevention from pregnancies as it tends to cause painful sexual intercourse.[103] Women with disabilities' vulnerability to rape and sexual harassment that could result in unwanted and unplanned pregnancies would therefore encourage FGM as a means of protection and prevention from pregnancies.[104] Furthermore, girls and young women with disabilities, especially those with albinism, are more likely to experience sexual violence due to the virgin-cure practice.[105] Rape from this practice and its tendency to lead to unwanted and unplanned pregnancies make girls and young women with disabilities susceptible to undergoing FGM.

Paradoxically, the erroneous belief that women with intellectual disabilities cannot express pleasure or pain or shout for help might encourage sexual violence, including invasive procedures, including FGM.[106] Additionally, because women and girls with disabilities are prone to social isolation and dependence, they are more likely to undergo FGM, even in African countries where such practices are prohibited.[107]

Likewise, having children out of wedlock is considered taboo and fuels stigma, discrimination and exclusion in most African cultures. This belief is worsened for women with disabilities. It is held that women with disabilities who become pregnant outside of wedlock face heightened discrimination and stigma because they are not only disabled, but they now have children before marriage.[108]

Consequently, FGM is essential since, according to research, the double discrimination of being disabled and having a child before marriage could lead to increased social isolation and exclusion.[109] Therefore, women with disabilities must undergo the FGM practice to protect them from such situations.

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103 Hirpa (n 83) 5.
104 As above.
105 The 'virgin-cure' practice is when young women and girls with disabilities, especially albinism, who because of their disabilities are often believed to be virgins and sexually chaste are raped because of the misconception that having such sexual relations would cure HIV/AIDS. See generally United Nations General Assembly Enjoyment of human rights by persons with albinism: Report of the Independent Expert on the enjoyment of human rights by persons with albinism: A preliminary survey on the root causes of attacks and discrimination against persons with albinism 29 July 2016 A/71/255, para 17.
106 Meer & Combrinck (n 101) 1.
107 Human Rights Council (n 51) para. 24.
108 Hirpa (n 83) 5.
109 As above.

3 Legal and human rights responses to ending female genital mutilation in Africa

Global efforts to end FGM have grown significantly over the last decade. For instance, in July 2020, the UN Human Rights Council adopted Resolution 44/16 on eliminating FGM.[110] This call echoes Goal 5.3's mandate fundamental to the '2030 Agenda for Sustainable Development' adopted by all UN member states in 2015 to end FGM.[111] A similar obligation underpins Aspiration 6 and Goal 17 of the African Union (AU) Agenda 2063, emphasising the achievement of gender equality.[112] This mandate is reinforced by the AU Continental Initiative on Eliminating FGM (Saleema Initiative) and protects an estimated 50 million girls in Africa under 15 years at risk of FGM by 2030.

Moreover, the African Commission on Human and Peoples' Rights (African Commission) adopted a resolution on Women's Health and Reproductive Rights in Africa that urges member states to ban FGM to protect African women's reproductive rights.[113] More recently, in 2019, the AU adopted the Ouagadougou Call to Action on Eliminating Female Genital Mutilation, which aimed at fuelling enough political action by AU member states to end FGM by 2030.[114] In 2021 the African Commission adopted Resolution 493 on the Development of a General Comment prohibiting Female Genital Mutilation in Africa.[115] Efforts are underway to draft this joint General Comment by the African Commission and the African Charter on the Rights and Welfare of the Child (African Children's Charter).

110 Human Rights Council 'Resolution 44/16. Elimination of female genital mutilation' A/HRC/RES/44/16 (24 July 2020) A/HRC/RES/44/16.

111 United Nations Department of Economic and Social Affairs 'Transforming our world: The 2030 agenda for sustainable development', https://sdgs.un.org/2030agenda (accessed 27 September 2022).

112 African Union (AU) 'Our aspirations for the Africa we want', https://au.int/agenda2063/aspirations (accessed 27 September 2022).

113 African Commission Resolution 110 on the Health and Reproductive Rights of Women in Africa' ACHPR/Res.110 (XXXXI)07, https://www.achpr.org/sessions/resolutions?id=162 (accessed 27 September 2022).

114 African Union 'Ouagadougou call to action on eliminating female genital mutilation' (2019).

115 African Commission Resolution 493 on the Development of a General Comment on the prohibition of Female Genital Mutilation in Africa – ACHPR/Res. 493 (LXIX) (2021), https://www.achpr.org/sessions/resolutions?id=525 (accessed 27 September 2022).

With less than a decade to go to 2030, the elimination of FGM has been enshrined in several international, regional and national human rights instruments. When women, including those with disabilities, are genitally mutilated, many of their rights are infringed.[116] For instance, FGM violates the right to be free from discrimination and violence, the right to health, the right to bodily autonomy and rights related to marriage and family and the right to education and information. FGM is also viewed as torture and cruel, inhuman and degrading treatment.

For a long time, the law failed to recognise FGM as a form of violence against women as it was often done privately and for cultural reasons. However, for the first time, article 2 of the Declaration on the Elimination of Violence against Women (Declaration) expanded the definition of violence against women to include but is not limited to, FGM and other traditional practices harmful to women.[117] The Declaration also recognised FGM as a form of violence against women and reinforced efforts to understand gender-based violence as an infringement of human rights.

From an African women's perspective, the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)- the International Bill of Rights for Women has received near universal ratification in Africa.[118] However, despite the massive CEDAW ratification, FGM remains a prevalent cultural rite of passage to womanhood in many African countries.[119]

Like disability, FGM is not explicitly mentioned in CEDAW's text. However, FGM as discriminatory can be read into article 1 of CEDAW.[120] For example, the Committee on the Elimination of All Forms of Discrimination against Women (CEDAW Committee) recognises all forms of violence against women, including forced medical procedures

116 UNFPA 'Implementation of the international and regional human rights framework for the elimination of female genital mutilation' (2014) 12, https://www.unfpa.org/sites/default/files/pub-pdf/FGMC-humanrights.pdf (accessed 27 September 2022).

117 Declaration on the Elimination of Violence against Women (Declaration) art 2.

118 Somalia and Sudan are the only African states that have not ratified CEDAW. For the CEDAW ratification table, see https://indicators.ohchr.org/ (accessed 27 September 2022).

119 Idowu (n 18) 116.

120 CEDAW art 1.

such as forced sterilisation and FGM, as a discriminatory practice under the CEDAW and, therefore, an infringement of women's rights.[121]

Additionally, FGM is recognised under articles 2 and 5 of CEDAW as a globally harmful traditional practice. Member states of CEDAW are therefore mandated under these provisions to 'take necessary steps, including legislation, to change or abolish existing laws, regulations, customs and practices which constitute discrimination against women'.[122]

Some scholars insist that CEDAW adopts a single-issue perspective that sees women as if there is only one way to be a woman, although there are a few exemptions.[123] If this argument is accurate, it is problematic for disabled women who undergo FGM in two ways. First, because of the misconceptions around the disabled female's sexuality, the disabled female, especially in Africa, contends with the need to end the culturally-dominant models of femininity while simultaneously aspiring to achieve such femininity.[124] FGM considered a rite of passage to womanhood in many African countries, could erroneously be viewed as a way to attain such femininity. Second, the intersecting disability and gender identities that disabled women embody have meant that their experiences of FGM are not just gendered, disabling, or ableist but can be simultaneous and, thus, silenced by the law.

Other scholars argue that adopting general recommendations has addressed perceived gaps in the CEDAW text.[125] Using this reasoning to rectify its failure to name and tackle FGM, in 1990 explicitly, the CEDAW Committee adopted General Recommendation 14 on female circumcision.[126] This General Recommendation mandates state parties to protect women against violence, including FGM, which is 'harmful to the health of women and girls'. State parties are directed to take

121 CEDAW General Recommendation 35 on gender-based violence against women, updating General Recommendation 19 26 July 2017 CEDAW/C/GC/35.

122 CEDAW arts 2(2) & 5.

123 JE Bond 'International intersectionality: A theoretical and pragmatic exploration of women's international human rights violations' (2003) 52 *Emory Law Journal* 96.

124 M Lloyd 'The politics of disability and feminism, discord or synthesis' (2001) 35 *Sociology* 716 718.

125 M Campbell 'CEDAW and women's intersecting identities: A pioneering new approach to intersectional discrimination' (2015) 11 *DIREITO GV Law Review* 486.

126 CEDAW General Recommendation 14 on female circumcision (9th session, 1990), UN Doc. A/45/38 para 80.

appropriate, effective measures to end the practice. Again, consistent with General Recommendation 18, although CEDAW does not explicitly mention disabled women but mentions women, it implicitly would cover disabled women.[127]

As a form of violence against women, FGM violates women's bodily autonomy. As such, General Recommendations 19 and 35 on violence against women address FGM. Although not explicitly named in General Recommendation 35, FGM may be read into the General Recommendation. For example, the CEDAW Committee recognises violations of women's sexual and reproductive health, such as forced sterilisation.[128] It acknowledges how these violations could amount to torture and degrading treatment.[129] It mentions how intersecting factors such as disability can increase the experience of these violations and violence against women.[130] It mandates state parties to abolish all customary, religious and local laws that are discriminatory against women and tolerate any form of gender-based violence,[131] including provisions that permit medical procedures to be performed on women with disabilities without their informed consent. It urges states to develop and disseminate accessible information through diverse and accessible media and community dialogue aimed at women, particularly those affected by intersecting forms of discrimination, such as those with disabilities.[132]

Furthermore, from the Concluding Observations issued to several African countries, the CEDAW Committee recognises FGM as harmful to the health of women and children that 'carries a high risk of death and disability'.[133] In its Concluding Observations, it is common to see the concern shown on the persistence of harmful cultural practices, including FGM, that are detrimental and discriminatory to women's rights in African countries. For example, in these Concluding Observations to

127 A Bruce and others 'Gender and disability: The Convention on the Elimination of All Forms of Discrimination against Women' in A Bruce and others *Human rights and disability: The current use and future potential of United Nations human rights instruments in the context of disability* (2002) 165.
128 CEDAW General Recommendation 35 (n 122) para 18.
129 CEDAW General Recommendation 35 (n 122) paras 15 & 16.
130 As above.
131 CEDAW General Recommendation 35 (n 122) para 29(c)(i).
132 CEDAW General Recommendation 35 (n 122) para 31(d).
133 CEDAW Committee General Recommendation 24 (n 5) para 12b.

African states, the CEDAW Committee has expressed how negative stereotypes about women contribute to the prevalence of FGM.

In the Concluding Observations issued to Djibouti, for instance, the CEDAW Committee acknowledged the Djibouti government's efforts to end harmful practices but expressed concern that the FGM prevalence in the rural part of the country remained high.[134] The CEDAW Committee found that the increased prevalence was mostly because FGM cases generally were not reported, prosecuted and punished.[135] As such, the CEDAW Committee found that the state party's efforts were not enough, sustainable and systematic.[136] Consequently, the CEDAW Committee emphasised the need to prioritise sanctions against the perpetrators of FGM 'and ensure the investigation of cases, as well as ensure perpetrators are punished and prosecuted in Djibouti.'[137]

Generally, the FGM performed on women with disabilities in Africa is rarely explicitly mentioned in CEDAW's Concluding Observations. A common trend in most concluding remarks issued by the CEDAW Committee to African countries is usually the concern about the scarcity of data on the situation of women, such as those with disabilities who experience multiple and intersecting forms of discrimination.[138]

Unlike CEDAW, article 5 of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (African Women's Protocol) explicitly mentions FGM as a harmful practice.[139] Similarly, under article 4(2)(h), State parties are mandated to end all medical and scientific experiments conducted on women without their informed consent. Therefore, the 44 signatories to the treaty must eliminate all forms of FGM through legislative sanctions and other measures.[140] Article 23 of the African Women's Protocol also mentions the right of women with disabilities to special protection, including freedom from violence.

134 CEDAW Concluding Observations of the Committee on the Elimination of Discrimination against Women: Djibouti (2011) CEDAW/C/DJI/CO/1-3 para 16.
135 CEDAW Concluding Observations (n 133) para 18.
136 CEDAW Concluding Observations of the Committee on the Elimination of Discrimination against Women: Chad (2011) CEDAW/C/TCD/CO/1-4 para 22.
137 As above.
138 CEDAW Concluding Observations (n 135) para 34.
139 African Women's Protocol art 5(b).
140 As above. Art 5(b); art4(2)(h).

From the African children's perspective, the Convention on the Rights of the Child (CRC) holds a similar stance to CEDAW on harmful practices such as FGM.[141] FGM infringes on the 'best interests standard' as it violates children's rights and bodily autonomy as guaranteed under article 3 of CRC. Furthermore, article 23 of the treaty is dedicated to the rights of children with disabilities with the adoption of General Comment 9 to clarify that all provisions in CRC apply to children with disabilities.

Article 24(3) of the CRC urges state parties to eliminate 'traditional practices such as FGM that are prejudicial to children's health'. Like the CEDAW Committee, the CRC Committee has made numerous observations recognising FGM and other harmful practices as harmful to the health of women and children that 'carries a high risk of death and disability'.[142] The CRC and CEDAW Committees jointly describe how 'socially-constructed gender roles and systems of patriarchal power relations and negative perceptions or discriminatory beliefs regarding certain disadvantaged groups of women and children, including individuals with disabilities or albinism, reinforce harmful practices such as FGM.'[143] The CRC Committee has expressed several concerns about the prevalence of FGM in several African countries. This concern, for example, has ranged from a lack of recent information on preventive and eradication measures to a lack of knowledge about anti-FGM laws.[144]

The *RHM* case is insightful.[145] The case involved a Somali woman who was five months pregnant when she applied for asylum in Denmark. This application was unsuccessful. The woman had applied for asylum because her newborn daughter, YAM, would be compelled to undergo FGM in Somalia if they were deported. The Danish authorities disagreed and argued that since FGM is banned in Somalia, mothers can prevent their daughters from being subjected to FGM. After having exhausted domestic remedies and given birth to her daughter, she submitted a

141 CEDAW Committee and CRC Committee (n 28) para 9.
142 CEDAW Committee General Recommendation 24 (n 5) para 12(b).
143 CEDAW Committee and CRC Committee (n 28) para 9.
144 CEDAW Committee and CRC Committee (n 28) paras 15-19.
145 Committee on the Rights of the Child 'Views adopted by the Committee on the Rights of the Child under the Optional Protocol to the Convention on the Rights of the Child on a communications procedure in respect of Communcation No 3/2016' (2018) CRC/C/77/D/3/2016 advanced unedited version paras 2.1-2.4, 3.1-3.5.

complaint to the CRC Committee on behalf of her daughter that their deportation would violate articles 3 and 19 of CRC. The CRC Committee decided that Denmark would violate its obligations under articles 3 and 19 of CRC if the young girl facing the practice of FGM in her country of origin were forced to return. According to article 3 of CRC, the child's best interests should be a primary consideration in all actions concerning children. According to article 19 of CRC, states should take all appropriate measures to protect the child from physical and mental violence.

Similarly, article 21(1) of the African Children's Charter prohibits harmful social and cultural practices affecting the child's welfare, dignity, normal growth and development. Furthermore, it mandates states to end customs and traditions prejudicial to the health or life of the child as well as those that are discriminatory to the child on the grounds of sex or other status. Article 13 clarifies that all rights, including the freedom from harmful practices, apply to children with disabilities. Notably, Aspiration 7 of Agenda 2040 of the African Committee of Experts on the Rights and Welfare of the Child (African Children's Committee) mentions the need to ensure that every child is protected against violence, exploitation, neglect and abuse and calls for the elimination of FGM by all African states by 2020.

As the first legal treaty to ensure the human rights of persons with disabilities, the Convention on the Rights of Persons with Disabilities (CRPD)[146] recognises under article 6 that women and girls with disabilities are subject to multiple and intersecting discrimination, although FGM is not explicitly mentioned.[147] Nonetheless, FGM is a form of violence, and article 16 of CRPD guarantees protection from violence against every person with a disability, including protecting women with disabilities. The provision mandates state parties to eliminate acts of exploitation, abuse and violence committed by third parties. Moreover, FGM is recognised as torture or cruel, inhuman or degrading treatment or punishment prohibited under article 15. FGM as a form of forced treatment is prohibited under articles 12, 17 and 25.

146 Adopted by the UN General Assembly on 13 December 2006 and entered into force on 3 May 2008.

147 Committee on the Rights of Persons with Disabilities General Comment 3: Women and girls with disabilities (2016).

The CRPD Committee explicitly acknowledges that women with disabilities are subjected to the same harmful practices committed against women without disabilities, such as FGM.[148] It underscores how restricting legal capacity can encourage forced interventions such as FGM.[149] It recognises FGM as a form of intersectional discrimination against women with disabilities on account of their gender, disability and other factors that are inadequately tackled in legislation.[150] FGM is usually done against the will of women with disabilities.[151] Furthermore, in its Concluding Observations, the Committee has expressed concern about 'the persistence of violence against women and girls with disabilities, including sexual violence and abuse; female genital mutilation; and sexual and economic exploitation'.[152] From its Concluding Observations to Gabon, Kenya, Ethiopia and Uganda and other African countries, the CRPD Committee draws attention to the often unacknowledged FGM experiences that violate the rights of women and girls with disabilities in these African countries.[153] In 2019 the Committee expressed concern with the 'lack of specific legislation, policies and programmes' to protect women with disabilities from violence, abuse and economic exploitation.[154]

As in the case of CRPD, the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Persons with Disabilities (African Disability Protocol) does not explicitly mention FGM. However, the treaty explicitly protects women with disabilities and prohibits harmful practices.[155]

148 CRPD Committee (n 148) para 37.
149 CRPD Committee (n 148) para 44.
150 CRPD Committee (n 148) para 10.
151 CRPD Committee (n 148) para 32.
152 CRPD Committee (n 148) para 10.
153 CRPD Committee (n 148) paras 33-34. See also CRPD Committee Concluding Observations on the initial report of Gabon 2 October 2015 CRPD/C/GAB/CO/1 paras 40-41. See also CRPD Committee Concluding Observations in relation to the initial report of Kenya 4 September 2015 CRPD/C/KEN/CO/1 paras. 33-34. See also CRPD Committee 'Concluding Observations on the initial report of Ethiopia 4 November 2016 CRPD/C/ETH/CO/1, paras 39-40. See also CRPD Committee Concluding Observations on the initial report of Uganda 12 May 2016 CRPD/C/UGA/CO/1 paras 34-35.
154 Concluding Observations on the initial report of Senegal, CRPD/C/SEN/CO/1 (2019) para 29(a).
155 African Disability Protocol art 11, art 27.

The Preamble to the African Disability Protocol specifically mentions concern for the multiple violations women and girls with disabilities encounter.[156] It cites a grave concern for human rights violations, including the harmful practices that persons with disabilities face.[157] Harmful practices are practices 'based on tradition, culture, religion, superstition or any other reasons violating human rights or fuels discrimination'.[158] Moreover, article 11 is dedicated explicitly to harmful practices. It specifically urges state Parties to take the necessary steps, including offering support and assistance to victims of harmful practices.[159] The African Disability Protocol takes a multifaceted approach to ending harmful practices by requiring not only the enactment of legal sanctions but also education and advocacy.[160]

Similarly, article 10 provides freedom from torture or cruel, inhuman or degrading treatment or punishment. Persons, including women with disabilities, have the right to dignity and freedom from torture, cruel, inhuman or degrading treatment or punishment, which could be read to include FGM.[161] State parties are obligated to take necessary steps to ensure that persons with disabilities on an equal basis with others are not 'subjected to torture cruel, inhuman or degrading treatment or punishment'.[162] The Protocol expands the obligation by explicitly prohibiting subjection to sterilisation or any invasive procedure without their free, prior and informed consent.[163] It upholds the right of persons with disabilities by mandating that no scientific or medical intervention can be done without free, prior and informed consent.[164] Such medical interventions include sterilisation or any other invasive procedure, which could include FGM.[165] It reiterates the need for persons with disabilities to be protected from violence, abuse and exploitation.[166] However, where

156 Preamble to the African Disability Protocol para 20.
157 African Disability Protocol paras 17-18.
158 African Disability Protocol art 1.
159 African Disability Protocol art 11(1).
160 As above.
161 African Disability Protocol art 10(1).
162 African Disability Protocol art 10(2)(a).
163 African Disability Protocol art 10(2)(c).
164 African Disability Protocol art 10(2)(b).
165 African Disability Protocol art 10(2)(c).
166 African Disability art 10(2)(d).

these abuses occur, state parties must prosecute perpetrators of these acts and offer remedies to victims.[167]

Article 27 provides for the rights of women and girls with disabilities. This article outlines the rights of women with disabilities to be free from disability-based discrimination.[168] It protects them from sexual and gender-based violence with access to rehabilitation and psychosocial support.[169] It guarantees their sexual and reproductive health rights, including the right to retain and control their fertility and not be sterilised without consent.[170] Furthermore, article 28, which guarantees the rights of children with disabilities, also applies to the protection from FGM. For example, the article is against any form of trafficking or sexual exploitation, violence, abuse and sterilisation in the family, institutions or any setting.[171] It explicitly demands that children with disabilities should not be sterilised under any circumstances.[172] By giving this mandate, the Protocol drafters are alive to the lived realities of children, particularly girls with disabilities who are sterilised daily in Africa.[173] Again, although these provisions could be read to include FGM, they confirm the earlier assertion about the emphasis on forced sterilisation compared to FGM,

However, at the time of writing, the Protocol has not entered into force as it has yet to be ratified by at least 15 member states.[174] As a result, the ability for the Protocol to be used is limited until such time as it comes into force.

Despite strict laws banning FGM internationally, regionally and domestically, countries that continue to support measures that enable forced sterilisation and other coercive interventions that could include FGM targeting the sexuality of women and girls with disabilities[175] provide a leeway for the practice to continue. The unspoken legal message seems to be that FGM is outlawed, mainly to prevent disabilities, but

167 African Disability Protocol art 10(3).
168 African Disability Protocol art 27(d).
169 African Disability Protocol art 27(j).
170 African Disability Protocol art 27(k).
171 African Disability Protocol arts 28(e), (f), (k) & (l).
172 African Disability Protocol art 28(l).
173 Ofuani (n 76)552.
174 The Protocol can only enter into force once it is ratified by 15 of the 55 AU member states that have accepted to be bound by the African Charter.
175 CRPD Committee (n 6) para 37.

silent when women who already have disabilities are subjected to the practice disregarding its potential to cause even more severe disabilities.

4 Applying an intersectional understanding to the FGM intervention agenda in Africa

Crenshaw coined the term 'intersectionality' to highlight the fault in the way the antidiscrimination legal framework in the United States (US) defined discrimination as a single issue.[176] She used the employment experiences of African American women to explain how the discrimination these women encountered interacted with the multiple intersecting identities of gender and race that they embodied.[177] She argued that these discriminatory experiences are not mutually exclusive and are more than an additive equation expressed as sexism on top of racism but rather are synergistic.[178] Crenshaw's point is that although discrimination is usually presented in America and most antidiscrimination legislation, including in African countries, as separate and mutually exclusive, African American women's discriminatory employment experiences demonstrate a different intersectional reality.[179] Crenshaw focused on two identity categories, namely, race and gender. However, other categories of identities, such as sexuality, disability, ethnicity and class, also shape women's discrimination experiences.[180]

From Crenshaw's insight, understanding FGM as a form of intersectional discrimination invokes the idea that gender is not the sole reason women are genitally mutilated in Africa. Although FGM is gendered, it is also evident that other intersecting identities, such as race, disability and class, impact the FGM experience. In other words, when a woman or girl is genitally mutilated, it is most likely not only because of her gender alone but could also be because of her race as a black African. The scholarship identifying FGM as an African cultural practice and

176 K Crenshaw 'Demarginalising the intersection of race and sex: A black feminist critique of anti-discrimination doctrine, feminist theory and antiracist politics' (1989) *University of Chicago Legal Forum* 139.
177 Crenshaw (n 177) 149.
178 As above.
179 As above.
180 K Crenshaw 'Mapping the margin: Intersectionality identity politics and violence against women of colour' (1991) 43 *Stanford Law review* 1241.

statistics showing African women's increased vulnerabilities confirm this point.[181]

Indeed, this chapter underscores how when a disabled woman or girl is genitally mutilated, it is most likely not only because of her gender. It could also be because of her race as a black African and because she has a disability. Therefore, using Crenshaw's reasoning, the exclusion of disabled women from the FGM response cannot be simply solved by including disabled women's FGM experiences. Still, the intersectional lens urges an interrogation and a rethink of the legal and human rights framework through which the disabled woman's FGM discrimination experience is recognised and redressed.[182]

Employing an intersectional lens to the FGM response, I propose three ways to rethink Africa's legal and human rights frameworks. First, an intersectional lens challenges the tendency of antidiscrimination law to treat FGM discrimination as a single issue. This is the tendency to present FGM responses that focus on gender and ableist tendencies as single issues in attempting to end the practice in Africa. For instance, efforts to end FGM in most African states have emphasised ableist biases, focusing on how the performance of FGM can lead to disability, with little attention paid to the severity of disabilities resulting from the FGM performed on women with disabilities in Africa.

An intersectional perspective pays attention to how women and girls with disabilities are disproportionally affected by FGM mainly because of the intersecting identities such as gender, age, race, ethnicity and severity of the disability they embody. In other words, antidiscrimination law must recognise the complexity of the FGM experience, namely that when gender intersects with disability, it impacts the experience.

Understanding FGM as intersectional discrimination involves refusing to view FGM as discrimination from a single-issue perspective; for example, as a discrimination or distinct form of violence that affects only women without disabilities, but recognising its multiple and intersecting nature. The inattention to the synergistic nature of intersectional discrimination could explain why FGM statistics are mostly not disaggregated by disability in Africa. It could also explain, as argued above, why the number of women with disabilities that

181 UNICEF (n 1).
182 Crenshaw (n 181) 1241.

undergo FGM, especially in Africa, remains unknown. Yet, as shown above, disabled women in Africa, precisely because of their intersecting identities of gender and disability, are more likely to suffer FGM in more complex ways. Therefore, the intersectional lens renders visible and adequately remedies the wrongs of women, such as disabled women in Africa who are multiply disadvantaged by FGM.

Second, the intersectionality lens confronts the idea of the universal woman's experience of FGM. This experience presupposes a binary, essentialist view of gender difference which silences the multiplicity of identities and the intersectionality of FGM discrimination. The idea that FGM experiences, even among African women, are the same is false and invalid since intersectional experiences of FGM interlock with experiences of racism, class and ableist oppression. Therefore, an intersectional lens rejects the liberal approach to antidiscrimination law adopted by most African countries that pretend there is a universal, disembodied, 'woman of reason' experience of FGM.

Third, the intersectionality lens removes the narrow focus on identities to unequal power relationships. Ribet's example of the unequal power relationship that exists, for instance, between the disabled female patient and the medical practitioner, is apt.[183] When medical practitioners assume that a woman, based on her disability, is unfit to make decisions concerning her reproductive health and, on that basis, is genitally mutilated, it exposes the unequal power relationships

5 Applying a feminist decolonial understanding to the FGM's intervention agenda in Africa

As argued above, human rights responses to end FGM must be intersectional and think intersectionally. However, these responses must also involve feminist decolonial thinking.

Decolonial thinking is a subject that has recently started to receive significant scholarly attention. Decolonial thinking suggests a rethinking or resistance to coloniality or colonial tendencies.[184] Decolonial feminists have tried to unpack what decolonial thinking could mean. Despite the messiness that might characterise the feminist decolonial understanding,

183 I make similar arguments in my DPhil thesis. See: Ribet (n 92) 164.
184 S Tamale *Decolonisation and Afro-feminism* (2020) 18.

it allows for alternative thinking, including interrogation of unequal power dynamics and relationships.

Decolonial feminism, as understood by Lugones, is inspired by intersectionality and the coloniality of power perspective and focuses on the 'modern/colonial gender system'.[185] For her, intersectionality exposes what is hidden when categories such as gender and race – or, in this case, disability are viewed as separate.[186] She draws attention to the experiences and voices of the Global South's silenced, marginalised, and 'othered' women.[187] Lugones also introduces the coloniality of gender to highlight an essentialist concept of sex and argues that gender is socially constructed and grounded in colonial processes.[188] Her insight emphasises the experiences of silenced voices of women from the Global South, especially African women, to become agents in producing knowledge.[189] Tamale's insight on decolonial thinking is also valuable for drawing attention to the need for internalised racism, sexism and, in this case, ableism to be dismantled by decolonising the mind.[190]

Consequently, in efforts to interrogate and rethink the legal and human rights framework for ending FGM, it might be helpful to deploy a feminist decolonial lens. Applying these decolonial feminist insights to the FGM is grounded in African women's lived experiences and challenges dominant narratives about the FGM response in Africa in three ways.[191] First, it allows a rethink of the agency of African women. In so doing, we can rethink the interventions to end FGM from a dominant Western-gendered system. These decolonial contributions, for instance, foster and allow African women the agency to think of culturally sensitive rite of passage alternatives without involving mutilation or cutting applied in countries such as Kenya.[192] These arguments object to colonial responses

185 M Lugones 'The coloniality of gender' (2008) *Worlds and Knowledges Otherwise* 4. See also M Lugones 'Toward a decolonial feminism (2010) 25 *Hypatia* 743-745.

186 M Lugones 'Heterosexualism and the colonial/modern gender system (2007) 22 *Hypatia* 192.

187 Lugones (n 186) 3 4.

188 As above.

189 As above.

190 Tamale (n 185) 18, 39, 235.

191 Borrowing from the reasoning put forward by J Manning 'Decolonial feminist theory: Embracing the gendered colonial difference in management and organisation studies' 1204, 1205.

192 L Hughes 'Alternative rites of passage: Faith, rights, and performance in FGM/C abandonment campaigns in Kenya (2018) 77 *African Studies* 276.

that attempt to regulate perceived deviance and eradicate what is often viewed as barbaric cultural practices.

Second, decolonial feminist theory offers an alternative way of thinking from the perspective of 'otherness', where FGM interventions benefit from insight from different experiences and perspectives. This argument objects to the essentialist view that there is a universal woman experience and common discriminatory FGM women experience as disingenuous and false.

FGM is a controversial and 'othered' practice. This controversy manifests in the Global North and Global South contestations that characterise the practice. For example, from a human rights perspective, generally, the dominant Global North argument for ending the procedure relies on universal human rights and essentialist ideas that tend to suggest that all culture is negative.[193] Such arguments portray FGM as a vile and grotesque disfigurement of the African female body.[194] This disabling representation is underlined by patriarchal and misogynistic tendencies that FGM is a harmful practice rationalised by culture and religion that infringes on women's rights.[195] Thus, it portrays the African women and their culture that legitimises FGM as uncivilised and needing urgent Western intervention and salvation – a stark reminder of the 'colonial civilising mission.'[196] The perception of African women as victims of FGM has been rejected because it is often used to belittle African cultures. It allows for dominant colonial narratives that position the Global North feminists as the saviours.[197] Consequently, decolonial feminist thinking helps in putting up a resistance to the hostile Western gaze that seeks to control the African woman's body to make it conform to the Global North's dominant narrative of embodiment, health, and sexuality.[198]

193 TE Higgins 'Anti-essentialism, relativism, and human rights (1996) 19 *Harvard Women's Law Journal* 101-104.

194 C Mohanty 'Under Western eyes: Feminist scholarship and colonial discourses' (1984) 12 *Duke University Press* 337.

195 Muzima (n 24) 73.

196 Mohanty (n 195) 335-337.

197 As above.

198 M Lugones (n 186)743-745. See also Mohanty (n 195) 335-337.See also B Deirdre 'Decolonial African feminism for white allies' (2020) 21 *Journal of International Women's Studies* 38.

From the Global South perspective and Africa in general, the FGM practice is cultural and often relies on cultural relativism arguments to support the practice.[199] This contention is evident in *Kamau v Attorney General,*[200] where a medical doctor questioned the constitutionality of FGM prohibition in Kenya. The petitioner claimed that the 2011 Anti-FGM Act in Kenya is an 'imperialist imposition from another culture with different beliefs or norms'. Furthermore, she questioned the unfair application of the law, which prohibits FGM but still allows some harmful contemporary practices such as the consumption of alcohol and smoking. The petition confirms that FGM is still considered a cultural rite of passage perceived by its advocates and those who practise it 'as a right and an obligation in some African societies'.[201] Thus, failing to undergo this cultural practice could lead to a loss of prestige and stripping of the woman's cultural identity.[202]

Scholarship describes the outright banning of FGM as the result of Western influences and a possible misreading of these cultural practices.[203] The argument is that FGM's representation and intervention agenda attempts to impose dominant Global North and Eurocentric colonial views on what constitutes female bodily autonomy.[204] Similarly, the politics of naming the FGM practice is also worth mentioning. There are Global North and South debates on the naming of the practice. Scholarships have questioned why genital modifications are viewed as legitimate, desirable, and empowering when done in the Global North.

An example could be transsexual genital modifications that are upheld to reinforce sex-gender integrity for the subject.[205] Yet, when genital

199 Muzima (n 24) 73.

200 *Kamau v Attorney General;* Equality Now (Interested Parties); Katiba Institute (*Amicus Curiae*) (2021).

201 R Murray *'Articles 27–29: Individual duties' in R Murray The African Charter on Human and Peoples' Rights: A commentary* (2019) 594.

202 Idowu (n 18) 117.

203 J Geng 'The Maputo Protocol and the reconciliation of gender and culture in Africa' in S Harris-Rimmer & K Ogg (eds) *Research handbook on feminist engagement with international law* (2019) 12.

204 F Ahmadu 'Rights and wrongs: An insider/outsider reflects on power and excision' in B Shell-Duncan & Y Hernlund (eds) *Female 'circumcision' in Africa: Culture, controversy and change* (2000) 283-312. See also IR Gunning 'Arrogant perception, world-travelling and multicultural feminism: The case of female genital surgeries' (1992) 23 *Columbia Human Rights Law Review* 191.

205 N Sullivan 'The role of medicine in the (trans)formation of wrong bodies' (2008)14 *Body and Society* 107.

modifications are performed in the Global South, especially among African women, they are read as culturally objectionable and, as such, in need of global surveillance and interventions.[206] Again, literature echoes how similar indulgent humanist logic is denied to non-Western subjects and their culturally heterogeneous practices of genital modification.

Indeed, while African feminists agree that FGM is harmful, they have objected to the intervention agenda that frames FGM as a cultural problem.[207] Such objections to this representation from the Global South scholarship have led to the rejection of gender and cultural essentialism and arguments about the outsider/insider connotations, but, importantly, they have inspired feminist decolonial thinking.

Third, it emphasises an invocation of plural knowledge, ideas and experiences.[208] Feminist contestations about FGM have tended to ignore the violence of colonialism. Colonisation has been described as a form of gender and sexual violence.[209] Indeed, the African colonial conquest was characterised by mass rape and colonised women in Africa remained targets of the colonisers' sexuality with severe implications for colonised women.[210] This feminist decolonial thinking essentially questions cultural and colonial imperialism, including the coloniality of gender, the female body and sexuality.[211]

Centring disability analysis in the FGM intervention agenda encourages feminist decolonial thinking because it complicates and expands ideas about identity, demonstrating how a woman can embody multiple subject positions and be claimed by several identity categories. The disabled woman's experience of FGM gives African women and their multiple and intersecting identities a voice, agency or a defined perspective on their own FGM experiences. In other words, it allows thinking beyond FGM as gendered or disabling as separate issues but as intersectional.

Conclusively, the dominant narrative from the Global North about FGM demonstrated even in the interventions to end the practice is

206 Mohanty (n 195) 335-337.
207 Hughes (n 193) 276.
208 As above.
209 AAF Bernard 'Colonising black female bodies within patriarchal capitalism: Feminist and human rights perspectives' (2016) *Sexualization, Media and Society* 2.
210 As above.
211 Lugones (n 186) 743-745.

essentialist. It targets a specific type of ableist woman, evidenced by the limited scholarship on FGM when performed on disabled women. It is also culturally insensitive, usually borne out of dominant essentialist ideas of a harmful African culture that focuses narrowly on the negative aspects of FGM. Research has found that such interventions ignore the lived experiences, the multifaceted nature of the practice, and the meanings attached to the associated rituals.[212] The point is that although the FGM practice is unacceptable, African decolonial feminists reject the colonial imperialist, racist and dehumanising narratives that diminish African women's agency that mostly underpin the responses and interventions to end FGM.[213]

6 Conclusion

The above analysis has centred the disabled woman's experience of FGM, which has been mainly unacknowledged, silenced and invisible in the legal and human rights responses to ending FGM in Africa. Centring the disabled woman's experience has exposed FGM as: (a) sexist or gendered; (b) as disabling, and notably (c) as both gendered, disabling and ableist, that simultaneously manifest in an intersectional 'disabled female' dilemma. This dilemma confirms the mutually constitutive interactions and intersections between the identity categories of sex/gender and disability. This exposure necessitated exploring the legal and human rights responses to ending FGM in Africa.

In advocating a reconceptualisation of the FGM response, I have proposed that laws and human rights interventions to end FGM in African countries must be intersectional and think intersectionally. Laws and human rights interventions must avoid the single-issue approach to ending FGM and adopt an intersectional understanding. An intersectional lens rejects the liberal approach to antidiscrimination law adopted by most African countries that pretend that there is a universal, disembodied, 'woman of reason' experience of FGM. This is the tendency to present FGM interventionist agenda that focuses on gender and ableist tendencies as single issues when focusing on ending FGM in Africa.

212 S Tamale *African sexualities: A reader* (2011) 20.
213 As above. See also Deirdre (n 199) 38.

An intersectional analysis centres on the disabled woman's experience to demonstrate how a woman can embody multiple subject positions and how several different complex identities and unequal power structures intersect and impact the FGM experience in Africa. In other words, in striving to end FGM, it might be helpful to question, interrogate and unpack whose female genitalia are to be mutilated. This questioning is valid because it avoids the tendency to universalise and essentialise the female or her genitalia. It also allows the definition of the female in the FGM experience to be expanded as widely as possible.

Moreover, the chapter further suggests that it is insufficient for human rights interventions to end FGM to be intersectional and think intersectionally. Still, it must also involve feminist decolonial thinking. As shown above, feminist decolonial thinking is a subject that has recently started to receive significant scholarly attention. Decolonial thinking suggests a rethinking or resistance to colonial tendencies or coloniality. When applied to FGM, it could mean different things, including exploring alternative indigenous rites to womanhood that maintains positive African culture but rejects the cutting, mutilation and disabling of the female genitalia rooted in coloniality[214] and colonial tendencies.

Finally, for an intersectional lens to work in efforts to end FGM in Africa, it must apply a feminist 'decolonial' perspective. The insight reinforces the need for legal and human rights frameworks to use a feminist decolonial intersectionality lens and understanding in its efforts to abolish FGM in Africa. This decolonial intersectional perspective is crucial in legal and human rights responses to FGM in African countries, mainly if this procedure performed on African women, especially women with disabilities, is to be eliminated and not just remain an afterthought.

214 Coloniality is defined as an 'invisible power structure that sustains colonial relations of exploitation and domination long after the end of direct colonialism'. See, generally, Tamale (n 182) xiii.

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4

RESEARCH AND FEMALE GENITAL MUTILATION PREVENTION: EVIDENCE FROM AFRICA

*Angela J Dawson**

Abstract

Research must benefit society, including improving the health and well-being of women and girls and contributing to achieving Sustainable Development Goal target 5.3, which focuses on eliminating all harmful practices, including female genital mutilation. Research that aims to transform gender norms, particularly those related to the sensitive and deeply-entrenched cultural practice of FGM, requires careful consideration of epistemology or the theory of knowledge that will underpin the study question and define the researcher's relationship with the research. The aim of a research study will influence the selected paradigm, methodology and research design. These choices will direct the analysis and interpretation of the results and how the findings will be disseminated and applied to maintain or change policy and practice. This chapter will discuss what research evidence we have concerning interventions that have demonstrated a change in knowledge, attitudes, and behaviour resulting in FGM prevention in communities, across nations, and regionally in Africa. A public health prevention framework will be applied to understanding how these interventions have influenced the practice of FGM at primary, secondary and tertiary levels to prevent FGM and care for affected women and girls. The characteristics of FGM research, including the methodologies applied, will be outlined to reveal the theoretical underpinning of current research and the funding, institutions and countries involved. Current knowledge gaps and research questions

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will be identified, and the needs of researchers to build research capacity to generate the evidence required for policy and practice will be explored. The role of research as an instrument for change and ethical questions will be examined alongside the possible pathways for FGM prevention, including current research partnerships and knowledge exchange activities, translation efforts and insights into research in progress.

1 Introduction

Research aims to improve society by advancing knowledge through developing scientific theories, concepts and ideas. However, it no longer is enough to generate and disseminate this knowledge in scholarly journals. Researchers must also engage with stakeholders to select meaningful and relevant questions for study and contribute to applying this knowledge in the world. This includes work to ensure research evidence is used to benefit individuals and their communities and deliver real impact, including preventing female genital mutilation (FGM).

The Sustainable Development Goals (SDGs) contain a set of 17 measures to foster sustainable development across many areas, including target 5.3, which focuses on eliminating all harmful practices, including FGM. Research plays an essential role in delivering evidence on the contribution of interventions, including laws and policies to preventing FGM and how these can be best implemented. Research can evaluate how these interventions change attitudes and norms and track progress or trends over time to demonstrate a reduction in the prevalence of FGM. Research focusing on achieving the SDG5 targets related to gender equality, including eliminating FGM, varies according to the region.[1] A bibliometric analysis of FGM literature between 1930 and 2015 indicates that this is a growing area of research, with more than half of the 1 032 retrieved articles published between 2006 and 2015.[2] Well-resourced research to monitor progress on SDG target 5.3 should be a priority alongside funding to scale up evidence-based interventions.

1 AL Salvia and others 'Assessing research trends related to Sustainable Development Goals: Local and global issues' (2019) 208 *Journal of Cleaner Production* 841-849.

2 WM Sweileh 'Bibliometric analysis of literature on female genital mutilation: 1930-2015' (2016) 13 *Reproductive Health* 130.

There are challenges in undertaking research on FGM due to its sensitive nature. Researchers must carefully consider the risks and consequences associated with such research. This may affect research participants, affected communities and researchers themselves. It may be challenging if the researchers are undertaking work to identify routes to prevention in contexts where there is active support for FGM, or they are documenting FGM prevalence in contexts where it is illegal. The clandestine practice of FGM in many settings means that participants may be hard to reach and data difficult to elicit. There is the potential for research on FGM to cause harm, especially in situations where affected women and girls are interviewed. They may experience distress or anxiety about reawakening painful memories or disclosing sensitive information. Participants may be concerned about the researcher's credibility, power differentials or being stigmatised. Despite this, the experiences of vulnerable populations participating in research on sensitive topics have been largely positive.[3] The research process itself may also contribute to the elimination of FGM by identifying the issue and engaging people in conversations about FGM that may raise awareness, improve knowledge and result in the contemplation of behavioural change.

Achieving SDG 5.3 is a complex task that will require the transformation of embedded gendered social norms. Research activity that is part of this process will involve drawing upon multiple theories, methodologies, and tools to answer a range of research questions that requires the participation of women and girls and affected communities to achieve change.

1.1 Epistemological underpinnings of FGM research

Research that addresses a complex issue such as FGM prevention, where there is no single way forward, has led to researchers embracing multiple views on what constitutes knowledge. How knowledge is discovered and analysed in a systematic way is dictated by a subscribed theory or epistemology about how knowledge should be gathered. These epistemological understandings include objectivism, constructivism

3 S Alexander, R Pillay & B Smith 'A systematic review of the experiences of vulnerable people participating in research on sensitive topics' (2018) 88 *International Journal of Nursing Studies* 85.

and subjectivism.[4] FGM research aligned with objectivism focuses on using credible, objective tools to collect data and make measurements. Knowledge is generated through controlled observation and experimentation to confirm explanations. This draws on positivism or post-positivist theory associated with experimental or survey research. Examples of these quantitative studies include those based on a secondary analysis of the data on FGM that are derived from standard questions in the Demographic Health Survey (DHS) and Multiple Indicator Cluster Survey (MICS).[5] The DHS and MICS are nationally-representative household surveys in over 90 countries that provide programme data for a range of monitoring and impact evaluation indicators in population, health and nutrition.[6] These studies provide insight into trends in the prevalence of FGM,[7] enable researchers to analyse the associated demographic and health factors [8] and future project trends in practice.[9] Such research helps identify a baseline before and after to measure change over time and assess the current context to plan interventions, including the health system response to FGM.

Other FGM qualitative research is underpinned by a constructivist epistemology that posits knowledge depends on interpretation and focuses on the details of phenomena. Interpretative research that draws on constructivism seeks to understand 'how members of a social group, through their participation in social processes, enact their particular realities and endow them with meaning, and to show how these meanings, beliefs and intentions of the members help to constitute their

4 M Crotty *The foundations of social research: Meaning and perspective in the research process* (2020) 5.

5 N Kandala and others 'Secular trends in the prevalence of female genital mutilation/cutting among girls: A systematic analysis' (2018) 3 *BMJ Global Health* 1-7.

6 USAID 'DHS Overview Washington DC: US Agency for International Development or the US Government' 2022, https://www.dhsprogram.com/Methodology/Survey-Types/DHS.cfm (accessed 26 May 2022); UNICEF 'Multiple indicator cluster surveys (MICS)'; https://mics.unicef.org/ (accessed 26 May 2022).

7 Kandala and others (n 5) 1-7.

8 BO Ahinkorah and others 'Socio-economic and demographic determinants of female genital mutilation in sub-Saharan Africa: Analysis of data from demographic and health surveys' (2020) 17 *Reproductive Health* 162.

9 K Weny and others 'Towards the elimination of FGM by 2030: A statistical assessment' (2020) 15 *PLOS ONE* 1.

actions'.[10] One example of such research is by Doucet and others who undertook ethnographic work in villages in Conakry to explore how FGM is embedded in social and family dynamics.[11] Other constructivist research employs a critical paradigm acknowledging that knowledge is not neutral, is socially constructed and constantly influenced by power relations within society. This research seeks to generate theory from action or practice to help people address change in the interest of social justice. One example is a study with young men involved in FGM prevention in Somaliland that explores how they negotiate violence against women and gender norms.[12] Other studies have applied participatory approaches involving people from FGM-affected communities. These studies are underpinned by the notion that research should serve social goals such as emancipation, particularly of marginalised and vulnerable groups such as those with FGM.[13]

FGM research has also embraced subjectivism, which espouses that all knowledge is a matter of perspective. Auto-ethnography is one methodology associated with the post-modern theory that may involve intensely personal studies that challenge the victim mentality. While no such studies can be located in Africa, one example from the United Kingdom is arts-based research with Somali community members engaged in expressing their stories of changing social norms, captured in podcasts to use as education resources.[14]

While some research may be aligned with one epistemology, there is growing support for research that embraces all forms of knowledge. In these studies, knowledge is regarded as constantly renegotiated and debated in terms of its usefulness in different situations. Subjective

10 WJ Orlikowski & JJ Baroudi 'Studying information technology in organisations: Research approaches and assumptions' (1991) 2 *Information Systems Research* 1.

11 M Doucet and others 'Beyond the sociocultural rhetoric: Female genital mutilation, cultural values and the symbolic capital (honor) of women and their family in Conakry, Guinea – A focused ethnography among "positive deviants"' (2022) 26 *Sexuality and Culture* 1858.

12 M Väkiparta *Young men against female genital mutilation/cutting in Somaliland: Discursively negotiating violence, gender norms and gender order* (2019) 107-125.

13 K Greiner, A Singhal & S Hurlburt 'With an antenna we can stop the practice of female genital cutting: A participatory assessment of Ashreat Al Amal, an entertainment-education radio soap opera in Sudan' (2007) 15 *Investigación and Desarrollo* 226.

14 S Penny & P Kingwill 'Seeds of the future/Somali programme: A shared autoethnography on using creative arts therapies to work with Somali voices in female genital mutilation refusal in the UK' (2018) 15 *New Writing* 55.

interpretations and objective phenomena are considered helpful in providing knowledge through qualitative and quantitative research. This research focuses on solving problems or dealing with unique issues. Mixed-methods research is applied to accommodate this pragmatic worldview to answer one or more research questions from different perspectives. This methodology enables exploratory and confirmatory questions to be answered simultaneously, which allows theory to be verified and generated within one study. One example of mixed-methods research is the evaluation of the Tostan's Village Empowerment Programme in Mali. Data was collected using qualitative interviews, observational checklists and surveys that shed light on the empowerment process and how the programme changed attitudes and practices to various issues, including FGM.[15]

No research activity is theory or value-free. The epistemological orientation will determine the paradigm or theoretical perspective that is taken and the methodology employed. This will determine the position of the researcher and their work along a continuum. At one end is realism, where the researcher is distant and knowledge objectively discovered and generalised. At the other end of the continuum is relativism, where the researcher and participants are deeply embedded in the research process. While findings might be transferrable to different contexts, these are constantly changing. These positions and researchers' backgrounds mean that research is culturally and ethically loaded. While those undertaking experimental or survey research appear distant, their gender, ethnicity, culture, and socio-economic background will determine how the research is undertaken and influence the findings, their publication and uptake.

2 What research evidence do we have to prevent FGM?

The publication of research findings in peer-reviewed journals or reports is a critical step towards considering research findings as evidence and, therefore, useful to inform policy and practice. The peer review process ensures the rigour of research methods, the quality of the findings and

15 K Monkman, R Miles & P Easton 'The transformatory potential of a village empowerment program: The Tostan replication in Mali' (2007) 30 *Women's Studies International Forum* 451.

the credibility of their implications. However, not all published evidence is considered equal depending on the research discipline. In medicine, hierarchies of evidence dictate the relative strength of the evidence.[16] The Oxford Centre for Evidence-Based Medicine Levels of Evidence[17] begins with expert opinion, moving to individual studies or primary research, to systematic reviews of randomised controlled trial studies (RCTs). Quantitative systematic reviews constitute a meta-analysis of pooled statistical data from individual studies that have been filtered and reappraised to ensure included studies are of high quality. The Cochrane library and the Campbell Collection are repositories of this top-level systematic review evidence that focuses on the effectiveness of interventions. Another useful source of systematic reviews on child well-being in low and middle-income countries is the Mega-Map.[18]

However, in emerging research fields or areas where RCTs are difficult to conduct, including in FGM, individual studies are a useful indication of evidence or promising prevention policy or programmes. Different study types may be required to answer different questions. Table 1 outlines different clinical questions and the suggested experimental individual study types that may be required to answer these questions. The issue with adopting this approach to understanding research and its role in preventing FGM is that it would be restricted to post-positivist studies underpinned by objectivism. This would result in the continued dominance of a bio-medical approach to prevention and the classification of FGM as a 'disease-like state' that would discount other views of what constitutes evidence that may provide helpful insights into understanding and preventing FGM.

16 A DiCenso, L Bayley & RB Haynes 'Accessing pre-appraised evidence: Fine-tuning the 5S model into a 6S model' (2009) 151 *Annals of Internal Medicine* 99-101.

17 J Howick *The 2011 Oxford levels of evidence* (2011); https://www.cebm.ox.ac.uk/files/levels-of-evidence/cebm-levels-of-evidence-2-1.pdf (accessed 4 February 2023).

18 UNICEF 'Mega-map on child well-being interventions in LMIC's New York' UNICEF Innocenti Centre 2022, https://www.unicef-irc.org/megamap/ (accessed 2 June 2022).

Table 1: Question types and study types

Type of question	Description of research	Best study type
Prevalence/ risk	Seeks to determine the occurrence of a condition and the likelihood of exposure	Local and current random sample surveys
Aetiology/ Causation	Seeks to determine if a harmful factor is related to the development of an illness	Cohort study or case-controlled study Case report for a rare illness
Prognosis	Seeks to determine the likely course of a disease or condition	Longitudinal survey
Diagnosis/ Screening	Tests the validity of diagnostic or mass screening tests	Cross-sectional survey
Therapy/ Intervention	Tests the efficacy of drugs, surgical procedures, therapy, or service delivery	RCT
Prevention	Seeks to determine how to reduce the chance of disease by identifying and reducing risk factors, and to achieve early diagnosis by screening	RCT, cohort study or case-controlled study

A comprehensive understanding of prevention requires including evidence from science-based disciplines such as medicine alongside the humanities, arts and social sciences. This knowledge can be used to describe interventions and make observations about outcomes (observational studies) but also examine issues, contextual factors, artefacts or phenomena that may or may not contribute to the prevention of FGM. This research enables the exploration of power dynamics and ethical dilemmas and the embracement of various research questions, theoretical perspectives, methodologies and study designs, including qualitative research synthesis. Qualitative systematic reviews are not concerned with measuring effectiveness. These meta-syntheses explore phenomena such as health-care experiences, the meaning of health or well-being, as well as environmental, organisational, and individual factors that affect the implementation of a healthcare service, educational initiative, policy, law or clinical intervention.

A valuable way to understand how research can contribute to preventing FGM is using a public health approach that embraces the

knowledge of multiple disciplines. Prevention is categorised according to four stages: primordial, primary, secondary and tertiary prevention levels.[19] Primordial prevention focuses on reducing risk factors for health issues at the population level by improving social and environmental conditions. Improving the education and employment opportunities of girls and women from FGM-practising communities may be one approach at this level. Primary prevention consists of individual and population efforts to prevent FGM from occurring through laws or community education, for example. Secondary prevention emphasises early detection and could include antenatal screening for women affected by FGM and safeguarding activities. Tertiary level prevention focuses on the care and support for those affected by FGM.

2.1 The evidence for the primordial prevention of FGM

While no longitudinal intervention studies identify the social determinants that contribute to preventing FGM at the population levels, we have systematic reviews of observational studies that show associations with factors that place women and girls at risk or protect them from FGM. These factors are valuable considerations when planning large prevention programmes.

Studies of DHS and MISCs data provide insight into the relationship between FGM and socio-economic factors. Ahinkorah and others[20] undertook a study of pooled DHS data collected between 2010 and 2018 in 12 countries in sub-Saharan Africa (Côte d'Ivoire and The Gambia excluded). A binary logistic regression analysis on the influence of socio-demographic characteristics on FGM found that FGM among women and their daughters decreases according to wealth status, education and urban residence. A study by Batyra and others[21] provides a greater understanding of the situation within countries. Batyra and others examined relative changes in prevalence rates in 23 African countries from DHS and MSICs data collected between 2002 and 2016 and related socio-demographic characteristics in two cohorts of women born

19 L Kisling & J Das *Prevention strategies (2022),* https://www.ncbi.nlm.nih.gov/books/NBK537222/ (accessed 4 February 2023).

20 Ahinkorah and others (n 8) 162.

21 E Batyra and others 'The socio-economic dynamics of trends in female genital mutilation/cutting across Africa' (2020) 5 *BMJ Global Health* 1-9.

between 1965 and 1969 and 1990 and 1994. While there was a decline in FGM prevalence, except for The Gambia, considerable variation exists across countries over time. There is also cross-national variation in the magnitude of educational and urban-rural differences in FGM prevalence. For women born in the youngest cohort (1990-1994) those with no education have a much higher prevalence in Guinea-Bissau, Côte d'Ivoire, Eritrea, Sierra Leone and Kenya (differentials of >15 percentage points as compared with those who have any education). However, the opposite is the case in Sudan, where those with education have a higher prevalence. There is little difference between women with education and those without in Benin, Somalia, Togo and Ghana, where educational differentials have reduced over time and FGM prevalence is low. In most countries, women residing in urban areas had lower FGM prevalence than rural women. However, the difference is small or negligible in many cases. This study found that countries with the highest prevalence of FGM for women born 1965 to 1969 also had a much smaller relative change in prevalence than women born over the next 30 years.

Research has explored other social determinants worthy of consideration in planning prevention programmes at the population level. These include gender norms and values that may predict the practice and, therefore, present opportunities for strategies in prevention programmes. A qualitative systematic review of reviews by Yount and others[22] notes an association between FGM, later child marriage and forced first sexual encounter. Research conducted in Egypt, Mali, Côte d'Ivoire and Kenya reported a positive association between FGM and intimate partner violence (IPV).[23] Programmes designed to prevent FGM may also need to consider IPV, child marriage and rape.

22 KM Yount, KH Krause & SS Miedema 'Preventing gender-based violence victimisation in adolescent girls in lower-income countries: Systematic review of reviews' (2017) 192 *Social Science and Medicine* 1.

23 HM Salihu and others 'The association between female genital mutilation and intimate partner violence' (2012) 119 *BJOG An International Journal of Obstetrics and Gynaecology* 1597-1605; K Peltzer & S Pengpid 'Female genital mutilation and intimate partner violence in the Ivory Coast' (2014) 14 *BMC Women's Health* 13; A Refaat and others 'Female genital mutilation and domestic violence among Egyptian women' (2001) 27 *Journal of Sex and Marital Therapy* 593-598; Y Sano and others 'Physical intimate partner violence justification and female genital mutilation in Kenya: Evidence from the Demographic and Health Survey (2021) 30 *Journal of Aggression, Maltreatment and Trauma* 781-791.

Social-cultural determinants can also influence FGM and provide insights for prevention. A systematic review by Berg and Dennison[24] identified factors that were perceived to interrupt the continuation of FGM, including laws prohibiting FGM, information on adverse health outcomes, the belief that FGM is not a religious requirement, and community opposition to the practice. The picture is complex. Those involved in making decisions regarding FGM were found to differ according to region depending on the power and status they hold.[25] One ethnographic study examines decisions around FGM concerning gender, culture, ethnicity and place, including the ongoing effects of colonialism in Kenya.[26]

Maternal attitudes toward the practice of FGM and community-level characteristics were examined in research based on the DHS from Burkina Faso, Côte d'Ivoire, Guinea and Mali.[27] While considerable variation was found within each country, mothers' attitudes towards FGM were significantly associated with a lower threat of a daughter being cut in all four countries. Community opposition was also negatively associated with FGM, except in Guinea, with relatively low community support levels for the practice. The study also examined 'community extra-familial opportunity structures' defined as the proportion of married women in the community who had their first co-residential union under 18 years of age, the proportion of adult women not in a polygamous union at the time of the survey (unmarried or in a monogamous marriage) and the proportion of women who had completed primary school or above. These factors were found to lower a woman's reliance on marriage and kinship networks and were significantly and negatively associated with daughters' FGM in Burkina Faso and Côte d'Ivoire. The presence of high levels of community support was not necessarily related to the low

24 RC Berg & E Denison 'A tradition in transition: Factors perpetuating and hindering the continuance of female genital mutilation/cutting (FGM/C) summarised in a systematic review' (2013) 34 *Health Care for Women International* 837.

25 A Alradie-Mohamed, R Kabir & SMY Arafat 'Decision-making process in female genital mutilation: A systematic review' (2020) 17 *International Journal of Environmental Research and Public Health* 3362.

26 EP Graamans and others 'Lessons learned from implementing alternative rites in the fight against female genital mutilation/cutting' (2019) 32 *Pan-African Medical Journal* 1.

27 SR Hayford and others 'Community influences on female genital mutilation/cutting: A comparison of four Francophone West African countries' (2020) 51 *Studies in Family Planning* 3.

prevalence of FGM. Research has indicated the importance of involving men as allies in prevention.[28]

A meta-analysis by Berg and others[29] provides insight into the effectiveness of a village-level programme in Mali, Burkina Faso and Senegal that is concerned with addressing social determinants of health such as education in hygiene, problem solving, women's health and human rights.[30] The Empowerment through Education (TOSTAN programme) is not focused on FGM. Instead, it is included, as are many other issues under the broader goal of community development. Descriptive analysis showed how this programme fared on indicators related to FGM. Statistically significant findings ($p < 0.05$) post-intervention was only found in the studies from Senegal and Burkina Faso. Statistically significant findings were noted for women and men in both studies concerning improved recall for at least two consequences of FGM post-intervention.

This research clearly shows that any prevention programmes at the primordial level will need to address multiple social determinants of FGM based on a detailed understanding of the setting. However, these studies were conducted in relatively stable environments, not humanitarian contexts, where community attitudes towards FGM and their practice may change to cope with crises such as displacement due to conflict or epidemics. For example, a report noted that in a camp setting in Mali, a displaced minority group who did not traditionally practise FGM experienced social pressure from their host communities to take up FGM, among whom the practice was prevalent.[31] This observation indicates the need for population-level programmes to focus on multiple groups. One study reported that isolation measures put in place due to

28 E Brown and others 'Female genital mutilation in Kenya: Are young men allies in social change programmes?' (2016) 24 *Reproductive Health Matters* 118-125.

29 RC Berg & E Denison 'Effectiveness of interventions designed to prevent female genital mutilation/cutting: A systematic review' (2012) 43 *Studies in Family Planning* 135.

30 P Easton, R Miles & K Monkman 'Final report on the evaluation of the TOSTAN/IEP village empowerment program pilot project in the Republic of Mali Florida State University' (2002); N Diop and others 'The TOSTAN program: Evaluation of a community-based education program in Senegal' FRONTIERS Final Report Washington, DC Population Council (2004); D Ouoba and others 'Experience from a community-based education program in Burkina Faso: The Tostan program' FRONTIERS Final Report Washington, DC Population Council (2004).

31 M Ryan and others 'The impact of emergency situations on female genital mutilation 28 Too Many' Briefing Paper (2014).

the Ebola epidemic in Sierra Leone affected the ability of communities to come together to conduct FGM.[32] However, public health measures to reduce infectious disease rates may also interrupt prevention measures and increase the incidence of FGM. Modelling commissioned by the United Nations Children's Fund (UNICEF) based on data from 31 countries estimated that due to the COVID-19 pandemic, there would be a 30 per cent reduction in progress towards ending FGM by 2030, resulting in two million cases of FGM that would otherwise have been prevented.[33]

2.2 Primary prevention and FGM research

Primary prevention focuses on individual, community or population-level actions taken to prevent FGM from occurring. There are several systematic reviews of primary prevention programmes,[34] a scoping review[35] and a rapid review.[36] United Nations (UN) bodies have also conducted various reviews.[37] These reviews and individual studies provide

32 K Kostelny and others 'Worse than the war: An ethnographic study of the impact of the Ebola crisis on life, sex, teenage pregnancy, and a community-driven intervention in rural Sierra Leone' Save the Children (2016).

33 UNFPA 'Impact of the COVID-19 pandemic on family planning and ending gender-based violence, female genital mutilation and child marriage' Interim Technical Note (2020).

34 RC Berg & E Denison 'Interventions to reduce the prevalence of female genital mutilation/cutting in African countries' (2012) 8 *Campbell Systematic Reviews* 1; RC Berg & E Denison 'Effectiveness of interventions designed to prevent female genital mutilation/cutting: A systematic review' (2012) 43 *Studies in Family Planning* 135-146; RC Berg & E Denison 'A realist synthesis of controlled studies to determine the effectiveness of interventions to prevent genital cutting of girls' (2013) 33 *Paediatrics and International Child Health* 322; S Waigwa and others 'Effectiveness of health education as an intervention designed to prevent female genital mutilation/cutting (FGM/C): A systematic review' (2018) 15 *Reproductive Health* 62; C Njue and others 'Preventing female genital mutilation in high income countries: A systematic review of the evidence' (2019) 16 *Reproductive Health* 113; TM Abidogun and others 'Female genital mutilation and cutting in the Arab League and diaspora: A systematic review of preventive interventions' (2022) 27 *Tropical Medicine and International Health* 468.

35 H Baillot and others 'Addressing female genital mutilation in Europe: A scoping review of approaches to participation, prevention, protection, and provision of services' (2018) 17 *International Journal for Equity in Health* 21.

36 D Matanda and others 'Effectiveness of interventions designed to prevent or respond to female genital mutilation: A review of evidence Nairobi' UNFPA, UNICEF, WHO & Population Council Kenya (2021).

37 SS Piazza 'The dynamics of social change: Towards the abandonment of female genital mutilation/cutting in five African countries' United Nations Children's Fund Innocenti Research Centre (2010); WHO 'Female genital mutilation

insight into multidimensional community activities, school education, health worker training, laws, safeguarding and child protection efforts, and media communication and advocacy campaigns. Primary prevention initiatives are also often based on a theory of change. A review of reports of community-based FGM programme evaluations in West Africa published between 2000 and 2013 described various health promotion models underpinning interventions, including behaviour change, client-centred/empowerment, social change and health education.[38]

2.2.1 Research on community-level prevention interventions

There are no randomised control trials of community-level interventions to provide a clear view of the effect of activities on the practice of FGM. However, Berg and others undertook a meta-analysis of the effectiveness of interventions in controlled before-and-after studies outlining programmes in community settings in African countries. Three studies included community activities in a refugee camp in Kenya, villages in Ethiopia[39] and villages, local government and at the state level in Nigeria.[40] This featured education, advocacy via media and drama and measured FGM knowledge, beliefs, attitudes and intentions. The descriptive analysis found statistically significant positive findings concerning participant's FGM/C beliefs post-intervention. In Kenya and Ethiopia most participants changed their views to agree that FGM/C compromised women's human rights. Participants' knowledge of the harmful consequences of FGM significantly improved in the Ethiopian study, and changes were found in participants' intention not to perform FGM on their daughters. In the Nigerian study, significant results were noted from women participants who reported having encouraged someone not to perform FGM/C on their daughter since

programmes to date: What works and what doesn't' World Health Organisation (2011).

38 R Ekundayo & S Robinson 'An evaluation of community-based interventions used on the prevention of female genital mutilation in West African countries' (2019) 15 *European Scientific Journal.*

39 J Chege and others 'Testing the effectiveness of integrating community-based approaches for encouraging abandonment of female genital cutting into CARE's reproductive health programmes in Ethiopia and Kenya' FRONTIERS Final Report Population Council (2004) 12-32.

40 'Evaluation report of female circumcision eradication project in Nigeria' Annual meeting of the American Public Health Association (1996).

the programme had commenced and had changed their intention to perform FGM on their daughter. Significant findings were identified concerning the number of men who believed that FGM had no benefits since the programme commenced. More men thought that community members were more likely to favour discontinuation.

Systematic reviews have been conducted to provide insight into the mechanisms that contribute to the successful implementation of community-level FGM prevention interventions. Berg and Dennison's realist review suggests that disseminating information about FGM is critical to changing knowledge, attitudes and behaviours.[41] Some community-level FGM education initiatives were examined in Waigwa and others'[42] qualitative synthesis. Factors influencing programme outcomes were noted, including religious affiliations of either the participants or the facilitators of health education interventions in a refugee camp in Kenya and villages in Ethiopia.[43] It was recommended that facilitators and participants be of the same religion, but mixed results were noted with regard to including religious leaders, especially when they believed FGM was a religious requirement. Mounir and others[44] indicated that facilitators in their quasi-experimental study of an education programme for female students living in hostels in an Egyptian university dressed in a similar style of clothing to participants in an attempt to encourage shared identity and break down barriers. The outcomes of education sessions were found to be affected by attendance[45] and building rapport with communities prior to interventions was key. An FGM health education programme in rural villages in Nigeria noted the importance of including all members of the community including traditional practitioners, health professionals, community and religious

41 Berg & Denison (n 34) 322-333.
42 Waigwa and others (n 34) 62.
43 Chege and others (n 39) 12-32 .
44 GM Mounir, NH Mahdy & IM Fatohy 'Impact of health education programme about reproductive health on knowledge and attitude of female Alexandria University students' (2003) 78 *Journal of the Egyptian Public Health Association* 433.
45 S Babalola and others 'Impact of a communication programme on female genital cutting in Eastern Nigeria' (2006) 11 *Tropical Medicine and International Health* 1594-1603; N Diop & I Askew 'The effectiveness of a community-based education programme on abandoning female genital mutilation/cutting in Senegal (2009) 40 *Studies in Family Planning* 307.

leaders (male and female) as they are also responsible for change.[46] Another review appraised studies focusing on using religious and cultural leaders has described their critical role in supporting the abandonment of FGM,[47] but this varies according to the setting.[48]

Matanda and others'[49] rapid evidence assessment of the available literature on FGM interventions published from 2008 to 2020 provides a synthesis of community-level primary prevention activities categorised by community engagement, health education, media/social marketing/communication, public statement/declarations, rescue centres, use of religious/cultural leaders, conversion of traditional practitioners and alternative rituals.[50] While some pre- and post-intervention studies in this review show promising results, they are still focused on knowledge and attitude change.[51] Findings confirm the importance of contextual factors and positive framing.[52]

Alternative and non-harmful rites of passage have been trialled to replace the ceremonies in many countries with another event that does not include FGM or remove FGM from the original ceremonial activities. Ceremonies in Kenya and Tanzania have been described that involve the families, community members and leaders in the development of training activities for young girls that are held in seclusion, followed by a public

46 EO Asekun-Olarinmoye & OA Amusan 'The impact of health education on attitudes towards female genital mutilation (FGM) in a rural Nigerian community' (2008) 13 *The European Journal of Contraception and Reproductive Health Care* 289.

47 Matanda and others (n 36) 49-50.

48 G Mehari and others 'Exploring changes in female genital mutilation/cutting: Shifting norms and practices among communities in Fafan and West Arsi zones, Ethiopia. Evidence to end FGM/C: research to help girls and women thrive' Population Council (2020).

49 Matanda and others (n 36).

50 REB Johansen and others 'What works and what does not: A discussion of popular approaches for the abandonment of female genital mutilation' (2013) 2013 *Obstetrics and Gynecology International.*

51 O Ekwueme, H Ezegwui & U Ezeoke 'Dispelling the myths and beliefs toward female genital cutting of woman assessing general outpatient services at a tertiary health institution in Enugu State, Nigeria' (2010) 7 *East African Journal of Public Health* 66-69; M Galukande and others 'Eradicating female genital mutilation and cutting in Tanzania: An observational study' (2015) 15 *BMC Public Health* 1147; DM Abdulah, A Dawson & BM Sedo 'The impact of health education on attitudes of parents and religious leaders towards female genital mutilation' (2020) 46 *BMJ Sexual and Reproductive Health* 51.

52 A Winterbottom, J Koomen & G Burford 'Female genital cutting: Cultural rights and rites of defiance in Northern Tanzania' (2009) 52 *African Studies Review* 47.

celebration and awarding of certificates.[53] While these can be valuable efforts to change attitudes towards FGM, the risk of exclusion, perceived loss of cultural identity and negative stereotyping may limit the success of such programmes.[54] Programmes focused on interventions encouraging traditional practitioners to abandon FGM have not provided conclusive insights for prevention.[55]

2.2.2 Research on school-based prevention interventions

Some research has explored the outcomes of interventions designed to prevent FGM in school settings. A cross-sectional study in the Somali and the Harari regional states of Eastern Ethiopia found that among the 480 male and female school students surveys, school-based awareness campaigns and TV-based media communications were the main sources of information that influenced a high proportion of young people.[56] A mixed-methods observational study in Kenya examining a multifaceted educational campaign involving school clubs disseminating information about FGM was found to influence children's attitudes.[57] Mahgoub and others[58] undertook an observational study of school-based education sessions on FGM in Sudan. A pre-post intervention survey found significant changes in knowledge of FGM and attitudes towards the practice. A pre-post design was reported in a paper by Moustafa and Muhammad[59] described an increase in FGM knowledge among female school students following an educational programme on reproductive health in Egypt.

53 Johansen and others (n 50); D Matanda, AK Meroka-Mutua S & Kimani 'Lessons from a five-year research programme on FGM/C and their relevance for policy and programmes in Kenya' (2020).
54 Graamans and others (n 26) 1.
55 Matanda and others (n 36) 51; Johansen and others (n 50).
56 AD Abathun, J Sundby & AA Gele 'Pupil's perspectives on female genital cutting abandonment in Harari and Somali regions of Ethiopia' (2018) 18 *BMC Women's Health* 167.
57 Galukande and others (n 51) 1147.
58 E Mahgoub and others 'Effects of school-based health education on attitudes of female students towards female genital mutilation in Sudan' (2019) 25 *East Mediterranean Health Journal* 406-412.
59 N Moustafa & Y Muhammad 'Impact of educational programme on reproductive health knowledge of female preparatory school students in Alexandria Governorate' (2018) 48 *Journal of High Institute of Public Health* 24-29.

2.2.3 Research on the law and FGM prevention

Studies have examined the effect of the law on FGM knowledge, attitudes and behaviours in various African nations. Muthumbi and others[60] reviewed the current status of legislation and policies in 27 African countries. This literature review identified programme evaluations in Burkina Faso and Eritrea that suggest that strict enforcement may have some effect on preventing FGM. In addition, the authors suggest that awareness of FGM laws among criminal justice personnel can positively reinforce laws. National FGM legislation was enacted in Burkina Faso in 1996. While reports of prosecutions are noted in the literature in 2010, the socialisation of the law alongside national advocacy efforts and politics may have affected the prevalence of FGM over the ten years. However, there has been little reduction in FGM prevalence in Burkina Faso. There was a slight rise in FGM from 71.6 per cent in 1999 to 75.8 per cent in 2010.[61] FGM legislation was introduced in Eritrea in 2007, but prevalence has been falling since 1995 when the prevalence was 94.55 per cent, dropping to 83 per cent in 2010.[62]

Research has not been able to determine whether the introduction of laws in Egypt has had any impact. New FGM legislation was introduced in Egypt in 2008 through amendments to the Child Act (1996) and the Penal Code. In September 2016 Law 58 was further strengthened, and penalties were increased.[63] A study comparing a 2006 sample of 500 women with another sample of women in 2011 in the same location noted a decline in prevalence among the mothers who had indicated that at least one of their daughters had been circumcised (71.6 per cent versus 77.8 per cent, P=0.04).[64] However, this change cannot be attributed to

60 J Muthumbi and others 'Female genital mutilation: A literature review of the current status of legislation and policies in 27 African countries and Yemen' (2015) 19 *African Journal of Reproductive Health* 32-40.

61 World Bank 'Female genital mutilation prevalence (%) – Burkina Faso' 2022, https://data.worldbank.org/indicator/SH.STA.FGMS.ZS?locations=BF (accessed 3 November 2022).

62 World Bank 'Female genital mutilation prevalence (%) – Eritrea' 2022, https://data.worldbank.org/indicator/SH.STA.FGMS.ZS?locations=ER (accessed 3 November 2022).

63 World Bank *Compendium of international and national legal frameworks on female genital mutilation* (2021).

64 IMA Hassanin & OM Shaaban 'Impact of the complete ban on female genital cutting on the attitude of educated women from Upper Egypt toward the practice' (2013) 120 *International Journal of Gynecology and Obstetrics* 275-278.

the effect of the law alone, as female education and wealth had improved over this time. National prevalence has also fallen from 97 per cent in 1996 to 87 per cent in 2014.[65] Quasi-experimental and cross-sectional studies from Senegal, Mauritania and Mali have shown little effect of the law on FGM practice.[66]

Other scholars have explored the inadequacies of current FGM legislation that could affect prevention efforts. Yusuf and Fessha[67] discuss the limitations in the Tanzanian Penal Code. These include the lack of a specific definition of acts that constitute FGM; the inadequate scope of criminal liability; issues concerning punishment; and the failure to criminalise FGM performed on women above the age of 18 years. The authors also note contextual issues impacting the ability of laws to be enacted, such as community views that support FGM. The political will of key decision makers in shaping laws is analysed in a working paper examining FGM legislation in the Red Sea state in Sudan. al-Nagar and others[68] outline how conservative tribal groups such as the Beja tribe and its subgroups Hadendawa and Beni Amer played a key role in preventing the criminalisation of FGM in the Child Act of 2007. Although the Act was revised in 2011 to address FGM, it does so only weakly and does not prohibit the most severe types of FGM.

There are divergent views on the role of legislation and its effect on prevention. Some argue that legal prohibition of the practice has a deterrent effect. In contrast, others argue legislation can be coercive and disrupt local efforts to end FGM. Perceptions of the law and its influence on FGM practice were explored in a mixed-methods study in Senegal.[69] In-depth interviews with community people in three villages were

65 World Bank 'Female genital mutilation prevalence (%) – Egypt', https://data.worldbank.org/indicator/SH.STA.FGMS.ZS?locations=EG (accessed 3 November 2022).

66 G Camilotti 'Interventions to stop female genital cutting and the evolution of the custom: Evidence on age at cutting in Senegal (2016) 25 *Journal of African Economies* 133; V Cetorelli and others 'Female genital mutilation/cutting in Mali and Mauritania: Understanding trends and evaluating policies' (2020) 51 *Studies in Family Planning* 51.

67 C Yusuf & Y Fessha 'Female genital mutilation as a human rights issue: Examining the effectiveness of the law against female genital mutilation in Tanzania' (2013) 13 *African Human Rights Law Journal* 356.

68 S al-Nagar, L Tønnessen & S Bamkar 'Weak law forbidding female genital mutilation in Red Sea State, Sudan' Working Paper (2017).

69 B Shell-Duncan and others 'Legislating change? Responses to criminalising female genital cutting in Senegal' (2013) 47 *Law and Society Review* 803.

analysed and informed an ethnographically-grounded survey to examine readiness to change. The study found that participants' decisions to practise were influenced by their consideration of the threat of criminal sanctions against the effects of defying local norms. The study also found that law enforcement was not necessary to instil fear of persecution. In contexts where the practice is contested, a legal norm may predispose readiness to change and provide a platform for those who do not wish to practise enacting this. While some participants reported that the law had resulted in their decision to reluctantly not practise, others stated that they were defiantly practising covertly. A similar finding has been noted in qualitative interviews with community members in Ghana, where participants reported that legislation had driven the practice underground.[70]

Many researchers have examined contested issues concerned with FGM, traditional cultural practices, secular laws, women's rights, and Islamic ethico-legal standpoints. Sallah's doctoral thesis explores how the criminalisation of FGM in Ghana and the Western values underpinning this legislation are at odds with the social norms supporting the practice.[71] As a result, Sallah argues that the law has a limited effect. In 2009 in Mali, a new family code was proposed by the government. These changes included banning FGM; setting 18 years as the minimum age for marriage; changing inheritance rules for women that enabled them to remain in their homes after their husbands died; and changing the regulations for adoption and recognising children born out of marriage. However, the reform was not signed into law due to vehement opposition. The High Islamic Council of Mali repeatedly stated that this proposed law was a 'vision from another culture, another milieu' to describe the reform.[72] In Mali, a Muslim-majority country where the national FGM prevalence has declined, banning FGM was not regarded as consistent with Islamic law or Shari'a. However, internationally, there is no clear consensus among Muslim scholars regarding the need

70 M Aberese Ako & P Akweongo 'The limited effectiveness of legislation against female genital mutilation and the role of community beliefs in Upper East Region, Ghana' (2009) 17 *Reproductive Health Matters* 47-54.

71 AA Sallah 'International imposition vs domestic assimilation: The criminalisation of female genital cutting in Ghana' LLM thesis, University of Windsor, 2021.

72 M Diamoutani 'Position du HICM relative à l'adoption par l'Assemblée Nationale du code des personnes et de la famille. Bamako: Ligue Malienne des Imams et Erudits pour la Solidarité Islamique (2009).

to perform FGM, as there is no direct mention of this in the Qu'ran. Blaz analysed a historical case from Egypt and found that while the Court argued that there were no legitimising reasons to force FGM on women, they also held that circumcision was neither a duty (*fard) nor an obligation (wâjib) under Islamic law.*[73] Researchers have suggested a middle ground between secular law, human rights, zero tolerance and an Islamic ethico-legal standpoint as a harm-reduction strategy.[74] This constitutes medicalisation but has been opposed in many countries as it has been argued that this has undermined abandonment efforts.[75] If prevention is the goal, then secular law appears to play a role, but it may not require vigorous enforcement to be effective. Alongside advocacy, political will and bottom-up participatory community-development activities are required.

2.2.4 Research on advocacy and communication

Matanda and others[76] bring together studies that have examined outcomes related to media and communication interventions on the practice of FGM. A quasi-experimental study investigating the Saleema social marketing strategy effectively changed norms in Sudan.[77] This examined self-reported exposure to the awareness campaign, social dialogue, public declarations and role models and pro-FGM social norms using a household survey across a nationally-represented sample across 18 states in Sudan. An RCT study in Sudan examined the effect of film dramas where family members debate whether they should continue or abandon FGM on attitudes toward FGM.[78] The results show that emphasising local consensus in terms of both values and marriageability

73 K Bälz 'Human rights, the rule of law, and the construction of tradition. The Egyptian Supreme Administrative Court and female circumcision (Appeal 5257/43, 28 December 1997)' (1998) 34 *Egypte/Monde arabe* 141.

74 R Duivenbode & AI Padela 'The problem of female genital cutting: Bridging secular and Islamic bioethical perspectives' (2019) 62 *Perspectives in Biology and Medicine* 273.

75 S Kimani and others 'Female genital mutilation/cutting: Emerging factors sustaining medicalisation related changes in selected Kenyan communities' (2020) 15 *PLOS ONE.*

76 Matanda and others (n 36) 44-47.

77 WD Evans and others 'The Saleema Initiative in Sudan to abandon female genital mutilation: Outcomes and dose response effects' (2019) 14 *PLOS ONE.*

78 S Vogt and others 'Changing cultural attitudes towards female genital cutting' (2016) 538 *Nature* 506-509.

can change attitudes to favour the abandonment of cutting. Other observational studies show that communication interventions, including theatre and TV-based media in Nigeria and Ethiopia, can help to increase knowledge, stimulate conversations about the practice and change attitudes.[79]

2.3 Secondary prevention and FGM research

Secondary prevention aims to reduce the impact of FGM on the lives of girls and women who have already experienced the practice. Sensitive, multifaceted, collaborative approaches appear to be required.

2.3.1 Research on protection and safeguarding measures

Safeguarding measures are based on policies and laws aimed at protecting children or women at risk of FGM. Women at risk may be preparing to marry a partner whose family fully supports FGM while a child whose mother and sibling may be cut, is likely to be at risk. Matanda and others[80] identify several studies that evaluate the use of rescue centres or safe houses to provide protection and refuge for girls at risk of FGM during the cutting period in Africa. Limited resources and a lack of buy-in from the community affect the ability of these centres to keep girls safe in Tanzania and Kenya. Van Bavel's[81] ethnographic study documents the conflict the shelters cause between girls and their families in Kenya.

2.3.2 Research on interventions to support women with FGM

Deinfibulation (antenatal or intrapartum) is recommended for preventing and treating obstetric complications in women with type III FGM by the World Health Organisation (WHO).[82] A systematic

79 I Ugwu & A Ashaver 'TFD and community education on female genital mutilation in Igede Land of Benue State: Ugengen community experience' (2014) 8 *A Journal of Theatre and Media Studies* 74.
80 Matanda and others (n 36) 58-59.
81 H van Bavel 'At the intersection of place, gender, and ethnicity: Changes in female circumcision among Kenyan Maasai' (2020) 27 *Gender, Place and Culture* 1071.
82 WHO *Care of women and girls living with female genital mutilation. A clinical handbook* (2020).

review by Bello and others[83] could not locate any studies demonstrating evidence of the impact of counselling before deinfibulation on patient satisfaction, marital satisfaction, and rate of requests for reinfibulation among women living with type III FGM.

A systematic review and meta-analysis found that providing information to improve body image and care-seeking behaviour of women and girls living with FGM can be a helpful approach to preventing FGM continuations.[84] Women and girls who received the educational intervention were more willing to discuss FGM, and women demonstrated a change in their attitudes toward not recommending FGM for their daughters and were less likely to plan to cut their daughters than those who did not receive the intervention.

2.3.3 Research on supporting health professionals to provide secondary FGM prevention

Several studies have examined health professionals' experiences providing care for women and girls with FGM.[85] Socio-cultural challenges have been noted by professionals related to medicalisation that pressure them to provide FGM.[86] Some health professionals remain supportive as they regard their involvement as a harm reduction strategy despite knowledge of adverse effects and a low understanding of legal status.[87] Midwives in Sudan reported providing re-infibulation as a valuable service for women

83 S Bello and others 'Counselling for deinfibulation among women with type III female genital mutilation: A systematic review' (2017) 136 *International Journal of Gynecology and Obstetrics* 47-50.

84 E Esu and others 'Antepartum or intrapartum deinfibulation for childbirth in women with type III female genital mutilation: A systematic review and meta-analysis' (2017) 136 *International Journal of Gynecology and Obstetrics* 21-29.

85 M Reig-Alcaraz, J Siles-González & C Solano-Ruiz 'A mixed-method synthesis of knowledge, experiences and attitudes of health professionals to female genital mutilation' (2016) 72 *Journal of Advanced Nursing* 245-260.

86 E Isman and others 'Midwives' experiences in providing care and counselling to women with female genital mutilation (FGM) related problems (2013) 2013 *Obstetrics and Gynecology International* 3-6.

87 AAA Ali 'Knowledge and attitudes of female genital mutilation among midwives in Eastern Sudan' (2012) 9 *Reproductive Health* 2-3.

that supplied them with an income.[88] Providers in Guinea were found to largely oppose FGM and its medicalisation.[89]

Few studies are available on interventions to support providers in FGM abandon medicalisation. There are considerable gaps in the capacity of the health workforce and system limitations,[90] and there have been efforts to improve provider education.[91] A systematic review of interventions to improve healthcare provider skills[92] identified only one study. This controlled before-and-after study examined a training intervention in Mali that was found to improve 108 health professionals' knowledge, attitudes and practice on FGM.[93]

2.4 Evidence-based tertiary prevention for FGM

Tertiary prevention aims to assist women and girls in managing long-term, often-complex health problems and injuries associated with FGM to improve their ability to function and their quality of life. These are medically-indicated procedures and are carried out with consent. The WHO has developed research-informed clinical guidelines[94] and training to support health professionals to communicate effectively with women and girls (WHO 2022) effectively. Many countries have responded with their clinical practice guidelines with recommended approaches to management, such as Kenya and Ethiopia.[95]

88 V Berggren and others 'An explorative study of Sudanese midwives' motives, perceptions and experiences of re-infibulation after birth' (2004) 20 *Midwifery* 299.

89 MD Balde and others 'Attitudes of health care providers regarding female genital mutilation and its medicalisation in Guinea' (2021) 16 *PLOS ONE* 6-13.

90 S Kimani & C Okondo 'A diagnostic assessment of the health system's response to female genital mutilation/cutting management and prevention in Kenya' Population Council (2020).

91 S Kimani and others 'Female genital mutilation/cutting: Innovative training approach for nurse-midwives in high prevalent settings' (2018) 2018 *Obstetrics and Gynecology International* 3-9.

92 Berg & Denison (n 34) 135-146.

93 N Diop and others 'Study of the effectiveness of training Malian social and health agents in female genital cutting issues and in educating their clients' Bamako: Division of Family and Community Health' Population Council, Association for the Support and Development of Population Activities, Republic of Mali (1998).

94 WHO (n 82) 1-445.

95 'Management of complications, pregnancy, childbirth and the postpartum period in the presence of FGM/C' A Reference Manual for Health Service Providers' Ministry of Health Kenya; W Gudu, S Kumbi & M Abdulahi 'Guidelines for the

Systematic reviews on tertiary prevention interventions for women with FGM can be categorised according to those focused-on counselling and those related to surgical procedures. A qualitative evidence synthesis of psychological and counselling interventions for FGM[96] identified two African studies from The Gambia and Somaliland. However, no information concerning preferences or direct psychological outcomes from the interventions were reported. Women in these studies described personal coping mechanisms to deal with FGM-related trauma. They were often reluctant to seek help due to shame and poor health professional knowledge and attitudes. Midwives in Somaliland described friction between practising their culture and caring for women.

The types of surgical interventions available to manage FGM, women's motivation for seeking them, and their satisfaction with these procedures are examined in a qualitative systematic review by Berg and others[97] that included studies from eight African nations. Three types of surgical intervention were described: defibulation or separation of fused labia; excision of a cyst with or without some form of reconstruction; and clitoral or clitoral-labial reconstruction. Women sought surgery to remove cysts and reduce associated swelling, improve birth and sexual pleasure and the appearance of their genitalia, and recover their identity. Most women were satisfied with their surgery.

Three systematic reviews have examined the evidence for clitoral reconstructive surgery after FGM.[98] These note limitations with current studies and weak evidence for the procedure's effectiveness. Researchers have summarised that clitoral reconstructive surgery after FGM cannot be medically indicated on physical or anatomical grounds. There may be

management and prevention of female genital mutilation in Ethiopia' *Ministry of Health Ethiopia* (2016).

96 H Smith & K Stein 'Psychological and counselling interventions for female genital mutilation' (2017) 136 *International Journal of Gynecology and Obstetrics* 60-64.

97 RC Berg and others 'Reasons for and experiences with surgical interventions for female genital mutilation/cutting (FGM/C): A systematic review' (2017) 14 *Journal of Sexual Medicine* 977.

98 J Abdulcadir, MI Rodriguez & L Say 'A systematic review of the evidence on clitoral reconstruction after female genital mutilation/cutting' (2015) 129 *International Journal of Gynecology and Obstetrics* 93-97; RC Berg and others 'The effectiveness of defibulation and reconstructive surgery following female genital mutilation/cutting: A systematic review' (2017) 14 *Journal of Sexual Medicine;* e246; V Auricchio and others 'Clitoral reconstructive surgery after female genital mutilation: A systematic review' (2021) 29 *Sexual and Reproductive Healthcare.* 2-4.

exceptions in situations where women continue to experience pain or sexual dysfunction when they have not responded to other treatments.[99] Clinicians should be aware of the need for women to understand the risks versus the possible benefits of such a procedure and ensure that they make an informed decision. However, informed consent may be difficult if women are experiencing pressure from the media or their partner to undertake surgery to restore their vulva in the hope that they will achieve physical and sexual fulfilment. Clinicians must ensure that women are appropriately informed of the risks of such surgery, educated on genital anatomy and any myths dispelled. The ethical implications of clitoral reconstructive surgery after FGM have not been fully considered, including the medico-legal implications.[100]

3 Limitations of FGM prevention research and knowledge

This review of the research on the prevention of FGM in Africa on four levels summarises what is currently known, as well as the gaps in the research. This review also reveals the characteristics of FGM research, including the types of studies and the discipline areas involved. The evidence for prevention is diverse, embraces multiple paradigms and provides views across different cultural and socio-economic contexts at the individual, community and population levels.

There are considerable challenges with using the findings from these studies in policy and practice. No longitudinal studies or RCTs of interventions provide insight into the effectiveness of interventions to prevent FGM. While RCTs will give the most reliable evidence of the efficacy of interventions, ethical issues concerning the appropriateness of assigning women to intervention and control groups will also affect women's willingness to undergo randomisation. As a result, conducting RCT trials will be challenging. There is only one published study protocol outlining African research to establish the effectiveness of the

99 M Sharif and others 'Clitoral reconstruction after female genital mutilation/cutting: A review of surgical techniques and ethical debate' (2020) 17 *Journal of Sexual Medicine* 531-542.

100 As above.

implementation of an initiative targeting antenatal care providers to provide FGM and care services in Guinea, Kenya and Somalia.[101]

This means that the evidence is primarily based on quasi-experimental pre-test-post-test designs. Most of these studies do not include control groups. Such designs have weak internal validity and cannot establish a reliable cause-and-effect relationship between a treatment and an outcome. Issues affecting the reliability of the result can include selection bias, where those in the intervention group and those in the control are so different they are not comparable. The composition of the sample and the size may not be representative of the population and, therefore, results are not generalisable. In addition, individuals in a study may experience some event outside of the study that affects the measurements before and after exposure, so the change may not be attributable to the intervention. The measures taken in most of these before and after studies only assess increased knowledge and intention to change but not actual behavioural change. No follow-up studies of these interventions identify whether individuals abandoned FGM. As a result, we rely on the findings of DHS and MISCs studies that provide an understanding of changes in prevalence over time at the population level, not at the individual level. While these prevalence studies cannot map change to interventions, including legislation, they are also limited by the fact they are cross-sectional surveys based on self-report data or discursive explorations.

Much of the evidence cited in this review of current knowledge of prevention is based on evaluations conducted by various agencies concerned with assessing the merit of a project or a programme and producing information for decision making and reporting. These pragmatic studies are descriptive or quasi-experimental and focus on short-term outcomes and understanding the contextual factors that help to support their implementation. Many are in report format, not published in peer-reviewed journals, and have weak methodology sections. Matanda and others[102] note that many evaluation studies are of moderate to low quality. This review has also identified a diverse range of qualitative studies that explore factors that affect the implementation of

101 W Ahmed and others 'A hybrid, effectiveness-implementation research study protocol targeting antenatal care providers to provide female genital mutilation prevention and care services in Guinea, Kenya and Somalia' (2021) 1 *BMC Health Services Research* 109.

102 Matanda and others (n 36) 27.

interventions or those that should be considered in the development of prevention programmes. These studies explore individuals' FGM-related knowledge, what they understand, emotional drivers and the meaning ascribed to attitudes, beliefs and behaviours. Qualitative studies also research shared meanings, norms, and codes in relation to FGM and how these are shaped by culture. While these insights can be enlightening, they provide rich descriptions of FGM in unique contexts that are not generalisable and help to understand the acceptability and feasibility of interventions.

Numerous authors have raised issues concerning the methodological limitations of FGM research.[103] These methodological limitations highlight the complex nature of research in this field and the need for research that is designed with translation in mind from the beginning and underpinned by a theory of change.[104] Therefore, a systematic approach to planning, executing, and disseminating high-quality FGM prevention research is needed to coordinate efforts and effectively use resources to deliver a comprehensive picture of what works, how and why. This will enable evidence derived from different approaches to be connected to provide the best insights for change. Askew[105] outlines the need for quality research designs and using valid and feasible indicators to map behavioural change process, outcomes and impact. This will enable programme monitoring and evaluation objectives to be linked to research so that progress towards SDG 5.3 can be assessed.[106] FGM

103 I Askew 'Methodological issues in measuring the impact of interventions against female genital cutting' (2005) 7 *Culture, Health and Sexuality* 463; J Abdulcadir, MI Rodriguez & L Say 'Research gaps in the care of women with female genital mutilation: An analysis' (2015) 122 *BJOG: An International Journal of Obstetrics and Gynaecology* 294-303; T Esho, J Karumbi & C Njue 'Rapid evidence assessment: Quality of studies assessing interventions to support FGM/C abandonment' (2017); L Droy and others 'Alternative rites of passage in FGM/C abandonment campaigns in Africa: A research opportunity' *LIAS Working Paper Series* (2018).

104 K Brown, D Beecham & H Barrett 'The applicability of behaviour change in intervention programmes targeted at ending female genital mutilation in the EU: Integrating social cognitive and community level approaches' (2013) 2013 *Obstetrics and Gynecology International* 1-11; JM Strachan 'A commentary: using a theory-based approach to guide a global programme of FGM/C research: What have we learned about creating actionable research findings? Evaluation and programme planning' (2021).

105 Askew (n 103) 463-477.

106 D Matanda & E Lwanga-Walgwe 'A research agenda to strengthen evidence generation and utilisation to accelerate the elimination of female genital

prevention studies should examine effectiveness, acceptability, and feasibility and be underpinned by rigorous theory and models. Theory provides a way of structuring the prevention intervention and the research analysis. This can ensure that assumptions and hypotheses are empirically testable or logically connected. The theory of change approach is one such causal model that can explain the complexity of FGM-related change by revealing the conceptual framework that describes the causal relationships between prevention activities and the immediate, short term and long-term outcomes.[107] Coherent research questions are also required that strengthen the evidence and address knowledge gaps.

The Population Council has called for 'high-quality evidence as the basis of our responses' to FGM,[108] and various researchers have described research gaps.[109] Mpinga and others[110] identified a dearth of research on the socioeconomic impact of FGM. Abdulcadir and Say identified several gaps in the clinical evidence, including the obstetric outcomes of women with FGM, the impact of surgical interventions (defibulation and clitoral reconstruction) and the effect of skills and training of healthcare professionals involved in the prevention and management of FGM.[111] Evidence on how the law works to promote the abandonment of FGM has been found to be lacking.[112] Alternative rites of passage have been highlighted as an important area that has so far received inadequate attention.[113]

A Research Agenda to Strengthen Evidence Generation and Utilisation to Accelerate the Elimination of FGM was published by the Population Council in Kenya.[114] This document reports the top-

mutilation, Kenya' UNFPA, UNICEF, WHO & Population Council (2022).

107 I Vogel 'Review of the use of "Theory of Change" in international development' *Review Report: UK Department of International Development* (2012).

108 B Shell-Duncan and others 'Using research to understand and accelerate abandonment of FGM/C presentation at end-of-project dissemination meeting, Nairobi' Population Council (2020).

109 Matanda & Lwanga-Walgwe (n 106) 66-72.

110 EK Mpinga and others 'Female genital mutilation: A systematic review of research on its economic and social impacts across four decades' (2016) 9 Global *Health Action* 1-12.

111 Abdulcadir and others (n 103) 294-303.

112 Matanda & Lwanga-Walgwe (n 106) 32-37.

113 Droy (n 103) 1.

114 D Matanda & E Lwanga-Walgwe 'A research agenda to strengthen evidence generation and utilisation to accelerate the elimination of female genital mutilation' (2022).

ten ranked research questions discussed in a plenary session where experts reached a consensus. None of these questions relates to the criminalisation of FGM despite there being two lawyers and a child protection officer from UNICEF on the list of experts who participated in the consensus-building workshops. It is possible that research focusing on efforts to strengthen laws and enforce legislation is not considered a helpful focus. However, the role of legislation can be considered in some of these questions, particularly one, nine and ten, as they relate to medio-legal and child protection issues.

Table 2: Top ten prioritised research questions

1	How can healthcare providers and the health system be effectively utilised in the prevention of FGM and the provision of services to women and girls affected by FGM?
2	How can FGM intervention activities be more effectively integrated into educational, social and economic development programmes (e.g., programmes dealing with SRHR and gender-based violence (GBV), formal and informal education avenues for girls and boys as well as women empowerment programmes?
3	What are the valid measures of change in social and gender norms and practices that should be used in the evaluation of FGM interventions?
4	What intervention approaches are effective in preventing FGM across countries that border each other?
5	How can interventions integrate girl-centred approaches in bringing social change?
6	How can other health-related areas, including mental health, social work, sexology, and psychology, be incorporated to support response and prevention of FGM?
7	How do we strengthen partnerships and collaboration with governments, UN agencies, humanitarian partners, CSOs, and private partners in emergency settings to enhance prevention and support services as part of (prevention, protection, and recovery measures) routine package of care?
8	How can men and/or boys be effectively engaged as allies of gender equality and ending FGM?
9	What lessons on the effectiveness of interventions can interventions that seek to end FGM gain from other related fields such as GBV, SRHR and child marriage?
10	What context-specific factors (mechanisms) motivate communities or individuals to stop practising FGM?

4 Best practice high-quality FGM research

FGM research should not only strive to be of the highest quality but be conducted according to ethical principles, embrace diversity, and engage stakeholders throughout all aspects of the research process. Research support is needed to ensure that studies can provide a comprehensive picture of the merit of complex FGM prevention initiatives. This will require input from multiple disciplines, such as medicine, law, demography, epidemiology, health services, community development and the arts. Researchers will also need to consider important issues of power, trust, cultural competence, respectful and legitimate research practice and recognition of individual and communities' health assets in a decolonising research process.

4.1 Ethical research practice

Any researcher conducting research with human participants must ensure that their research is conducted in a way that provides honesty and sincerity and demonstrates the utmost respect for the dignity of participants. Informed consent is necessary so that participants knowingly and voluntarily consent to participate in research. Participants must have the right to withdraw at any study point without fear of penalty. Researchers have an ethical obligation to maximise possible benefits, minimise potential harm to the respondents, and ensure their anonymity and confidentiality. A statement declaration outlining ethical approval is required in primary research studies reported in papers in peer-reviewed journals. This is not always the case in evaluation reports. For example, several reports outlining the research undertaken in the community do not outline ethical procedures.[115] Ethical frameworks for FGM research must be decolonised so that those affected by FGM are represented on human research ethics panels so that the expertise and world views of community people inform decisions about the research at all stages. Ethical qualities of care should be applied (attentiveness, responsibility, competence, responsiveness, plurality, communication,

115 Diop and others (n 30) 4-7.

trust and respect) emphasising that research is relational and requires care.[116]

Any assessment of the quality of FGM prevention research must examine that these ethical principles are adhered to by checking that there is a statement describing human ethics research committee approval and demonstrating adherence in the procedures. This strengthens the foundations of research and accurate guideline development and promotes community trust. While quality assessment has been undertaken in many reviews of FGM research, an ethical check has not been included.[117]

4.2 Intersectionality and FGM research

Research conducted in contexts where FGM is practised must be cognisant of intersectionality, providing a framework for considering how aspects of an individual's social and political identities interact to create discrimination and privilege. Little is written on how FGM intersects with gender, sex, ethnicity, class, sexuality, religion and disability and how prevention efforts should respond to interconnecting and overlapping social identities. Intersectionality must be considered to ensure FGM interventions are effective and appropriate for various population segments.[118] An intersectional lens was applied to social network analysis undertaken in two regions in a low FGM/C prevalence, ethnically mixed region in Central Senegal, and a high FGM prevalence, ethnically homogeneous region in South Senegal.[119] This study identified differences in intersecting lines of power and influence over FGM decision making. The study recommended that prevention efforts should engage older women and men, especially fathers of young girls and their brothers. It also identified the need to reduce structural barriers to abandonment, such as negative responses to the law, gendered vulnerability to prosecution, reduced community cohesion and social

116 J Tronto *Caring democracy: Markets, equality and justice* (2013) 34-35.
117 Esho and others (n 103) 2-7.
118 RM Mestre i Mestre 'Exploring intersectionality: Female genital mutilation/cutting in the Istanbul Convention' in J Niemi, L Peroni & V Stoyanova (eds) *International law and violence against women* (2020) 157-172.
119 A Moreau & B Shell-Duncan 'Tracing change in female genital mutilation/cutting through social networks: An intersectional analysis of the influence of gender, generation, status, and structural inequality' Population Council (2020).

support, and factors preventing healthcare seeking. While studies of the intersectional factors that promote FGM abandonment or work to maintain it are essential in unique contexts, the findings of this lens need to be applied in practice and interventions evaluated to establish their usefulness.

4.3 Stakeholder engagement in research

Stakeholder engagement is central to all FGM research to ensure meaningful prevention strategies can be found and buy-in for implementation. Participatory methods have been applied across several studies and insights have been identified to guide future efforts. One study in Kenya used participatory ethnographic evaluation research to understand young men's perceptions of FGM, demand for FGM among future spouses, and perceptions of efforts to end FGM.[120] These men saw themselves as part of the solution. Greiner and others used drawing and photography exercises to examine how listeners of a radio soap opera entertainment-education initiative in Sudan understood the adverse effects of FGM. This research raised awareness and dialogue on the topic.[121] The Tostan project is an example of how community members can be involved in deciding the focus of a project on FGM as well as the evaluation of the programme.[122] While these studies engaged communities in generating the research data, there do not appear to be studies that engage stakeholders in the data analysis.

What is clear is that if research is to be part of a change in communities, then researchers will need to be part of those communities and initiatives directed by them. While we have seen that top-down legal strategies have little benefit, in contrast, bottom-up initiatives such as the Tostan project have value, including at scale.[123] While non-Africans may play a role in supporting FGM research endeavours on the continent, African

120 Brown and others (n 28) 118-125.
121 Greiner and others (n 13) 226-259.
122 Monkman and others (n 15) 451-464.
123 B Cislaghi and others 'Changing social norms: The importance of "organised diffusion" for scaling up community health promotion and women empowerment interventions' (2019) 20 *Prevention Science* 936-946; I Katz and others 'Cost and impact of scaling up female genital mutilation prevention and care programmes: Estimated resource requirements and impact on incidence and prevalence' (2021) 16 *PLOS ONE* 1-11.

researchers and communities must be empowered to develop their own research agenda and plans for intervention research. This involves a genuine decolonisation of knowledge production that must rest on indigenous knowledge and self-determination.

4.4 Building the capacity of researchers to prevent FGM

Supporting the capacity building of researchers from all research disciplines to undertake research and develop their careers is a key part of all efforts to produce quality evidence to prevent FGM. The African Coordinating Centre for abandonment of FGM at the University of Nairobi and the Population Council have been actively training researchers in national organisations and individuals to undertake research. Partnerships are vital to delivering impactful research, including south-south, north-south, or transnational collaborations.[124] Several international efforts have brought researchers together to share their work and network. The Universities of Geneva, Brussels, and Montreal (Le G3 de la Francophonie) organised three international experts' meetings to promote dialogue debate and build research relationships (2017-2019).[125] The Transnational Observatory of Research Applied to New Strategies for Preventing FGM, located in The Gambia and Spain at the Universitat Autònoma de Barcelona, also runs regular conferences for researchers.[126] Another group is the Community of Practice on Female Genital Mutilation (CoP FGM), an international, bilingual (French/English) network for professionals and activists.[127] An initiative

124 AK Marcusan 'Transnational observatory of applied research and knowledge transfer in cascade to key agents for the management and prevention of FGM/C' (2020) 42 *Journal of Obstetrics and Gynaecology Canada* e19.

125 J Abdulcadir and others 'Female genital mutilation/cutting: Sharing data and experiences to accelerate eradication and improve care' (2017) 14 *Reproductive Health* 96.

126 ENDFGM. Wassu Gambia Kafo and our member Wassu-UAB Foundation organised the V International Forum on Female Genital Mutilation (FGM) in The Gambia on 7 and 8 February, commemorating the International Day of Zero Tolerance for FGM. Brussels: ENDFGM European Network, 2022, https://www.endfgm.eu/news-en-events/news/wassu-foundation-international-forum-on-gender-based-violence-and-harmful-traditional-practices-in-the-gambia-and-west-africa / (accessed 17 June 2022).

127 G Belgium 'Community of practice on female genital mutilation (CoP FGM)' Brussels GAMS Belgium 2022, https://copfgm.org/ (accessed 17 June 2022).

led the key stakeholders from the African Centre for the Abandonment of FGM at the University of Nairobi and researchers at the University of Technology Sydney (UTS) brought together 37 researchers from sub-Saharan Africa and the middle eastern North African region to discuss research priorities and capacity-building needs. In response, a series of 14 workshops have been run for early career researchers, including PhD students and lecturers at institutions across the regions.[128]

4.5 Embracing complexity and scale

Achieving Sustainable Development Goal target 5.3 will require research to deliver high-quality evidence of the value of complex interventions to eliminate FGM. A systematic approach is needed to co-ordinate research efforts and use resources efficiently to provide a comprehensive picture of what works, how and why. Complex intervention research can incorporate questions about the effectiveness, appropriateness and feasibility of interventions and glean insights into the mechanisms that support successful implementation. This knowledge is critical to real world decision making that can inform how interventions can be scaled up in one context or transferred to others and what resources need to be dedicated.[129] A framework commissioned by the National Institute of Health Research and the Medical Research Council in the UK can be used to support FGM researcher's work with stakeholders to identify research questions for complex interventions and to design and conduct research with diverse perspectives and appropriate methods.[130] This framework considers complex intervention research as a series of phases: development or identification of an intervention; assessment of the feasibility of the intervention and evaluation design; evaluation of the intervention; and impactful implementation. At each phase, six questions are asked to complete the assessment before moving to the next stage:

- How does the intervention interact with its context?
- What is the underpinning programme theory?
- How can diverse stakeholder perspectives be included in the research?

128 A Dawson and others 'Addressing female genital mutilation in Africa and the Middle East: Ways forward for research' The University of Technology Sydney (2021).
129 Katz (n 123).
130 Berg and others (n 98).

- What are the key uncertainties?
- How can the intervention be refined?
- What are the comparative resources and outcome consequences of the intervention?

5 Conclusion

Research is essential to prevent FGM. Research provides intervention and descriptive studies to understand the distribution and determinants of FGM, why it is practised and associated risk factors in specified populations at community, provincial, national, regional and global levels. This knowledge is central to developing and tailoring tools, programmes, laws and policies to better care for affected women and girls and change behaviour to end FGM. Reviews of research on FGM prevention demonstrate the need for complex interventions where multiple approaches are employed to assess social norms and structural change within and alongside communities. Such interventions should be delivered and evaluated at individual and societal levels. We have found promising insights from research that show the need to incorporate prevention at the primordial,[131] primary,[132] secondary and tertiary levels.[133] This research provides qualitative and quantitative insights and embraces multiple paradigms and theories of change. While considerable limitations have been identified in the research to date, we note the need for ethical, participatory and inclusive multi-disciplinary approaches that incorporate capacity building for researchers and partnerships

131 Abidogun and others (n 34) 468-478.
132 Kostelny and others (n 32) 1-59.
133 Berg and others (n 98).

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PART II: Ethics, law and criminalisation

5

MEDICALISATION OF FEMALE GENITAL MUTILATION/CUTTING: ETHICAL DIMENSIONS

*Samuel Kimani**

Abstract

The global vision of a world without female genital mutilation/cutting, where women's and girls' sexual and reproductive health rights are fulfilled, cannot be achieved with persistent FGM/C and its medicalisation. The vision is articulated in the global development goals with specific member states domesticating the agenda and enacting international treaties that guarantee women's rights through FGM/C prevention, response and outlawing medicalisation. Medicalisation is FGM/C performed by health professionals perpetuated through harm reduction narrative used for countering the practice by highlighting its health complications. Although medicalisation lessens immediate FGM/C-related complications, it does not eliminate long-term effects, including psychological impacts. Medicalisation also does not address human rights violations, notably sexual and reproductive rights, but negates the 'Hippocratic oath' and 'do no harm' principles that guide the conduct of health professionals. A two-prong strategy involving health and human rights approaches has been used to address medicalisation. The health approach is anchored on harm reduction for mitigation of FGM/C-related complications using medical-surgical expertise and health awareness. The human rights approach

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adopts a zero tolerance stand agreed upon by the global community to guarantee human rights violated by FGM/C. Adopting either of the approaches presents a professional ethical dilemma in prevention and response to medicalisation between harm reduction and total adherence to the 'do no harm'. Conversely, while the human rights approach is critical in protecting women and girls, it compromises the right to bodily autonomy and freedom of choice. At the centre of these contestations are the economic benefits for health professionals as key driver for medicalisation. These dilemmas cannot be addressed through legislations, but rather through professional discourses, engagements and dialogues. This chapter presents a comprehensive narrative of medicalisation adduced through content analyses of the existing evidence. It showcases the magnitude of medicalisations of FGM/C and spotlights approaches for ending it as well as existing ethical considerations and dilemmas.

1 Introduction

Global attention towards female genital mutilation/cutting (FGM/C) has gained momentum because of its persistence and the impediment it poses to the attainment of sexual reproductive health and rights as well as full potential for women and girls. On a bigger scale, the practice of FGM/C is a threat to the achievement of the national development agenda and, notably, the attainment of the Sustainable Development Goals (SDGs). Indeed, SDG 5.3 of the United Nations (UN) spotlights the eradication of all harmful practices, including FGM/C, as a means of achieving sustainable development.[1] This is based on the evidence that FGM/C is implicated with negative social impacts, health complications, human rights violations, gender inequalities and the undermining of the realisation of full potential for women and girls.[2]

1 United Nations Statistical Division '5.3.2 Proportion of girls who have undergone female genital mutilation or cutting' Global SDG Indicator platform, https://sdg.tracking-progress.org/indicator/5-3-2-proportion-of-girls-who-have-undergone-fgmc/ (accessed 17 February 2023).

2 UNICEF 'Female genital mutilation/cutting: A global concern. UNICEF's data work on FGM/C support for data collection data analysis and dissemination' 2016, https://data.unicef.org/resources/female-genital-mutilationcutting-global-concern/ (accessed 17 February 2023).

The practice of FGM/C comprises all procedures that involve the partial or total removal of the female external genitalia and/or injury to the organs for non-therapeutic reasons.[3] The terms 'mutilation', 'cutting' and 'circumcision' are generally used interchangeably to signify the practice of FGM/C. However, mutilation denotes the extent and the extreme to which healthy tissues are severed as well as differentiates the practice of FGM/C from the medically beneficial circumcision performed on males (male circumcision). The term is also used to reinforce the notion that FGM/C is a violation of the human rights of girls and women.[4] Notwithstanding this, at community and individual levels the use of the term 'mutilation' can be problematic, offensive, and may appear judgmental, making terms such as 'cutting' or 'circumcision' more acceptable. Additionally, the correct naming of the practice based on context and environment is crucial because it can serve as a facilitator or barrier to buy-in and partnership building with practising communities for effective FGM/C abandonment strategies. This is based on the notion that the use of acceptable terms is interpreted as respect for the culture of the community and diffuses tension and the idea of foreigners 'undermining our culture'. Moreover, the utility of these terms is dictated by sensitivity with regard to FGM/C issues, the context, environment, the audience, as well as the need to be non-judgmental towards the practising individuals and communities.[5] In this narrative, female genital mutilation/cutting (FGM/C) will suffice.

The practice of FGM/C has been reported in 31 countries that have representative data about the practice. Among these countries are 28 African nations spanning from the West, through Central to East and the Horn of Africa (the so-called FGM/C belt) as well as countries in the Middle East, Latin America and Asia.[6] The practice has also been reported among the diaspora communities residing in Europe, North

3 World Health Organisation 'Guidelines on the management of health complications from female genital mutilation' 2016, http://www.who.int/reproductivehealth/topics/fgm/management-health-complications-fgm/en/ (accessed 17 February 2023).

4 GI Serour 'Medicalisation of female genital mutilation/cutting' (2013) 19 *African Journal of Urology* 145-149.

5 K Monahan 'Cultural beliefs, human rights violations, and female genital cutting: Complication at the crossroad of progress' (2007*) 5 Journal of Immigrant and Refugee Studies* 21.

6 UNICEF 'At least 200 million girls and women alive today living in 31 countries have undergone FGM' Global databases on FGM based on 2004-2021 DHS,

America, Australia and New Zealand, among them migrants and those seeking asylum due to economic reasons as well as socio-political conflicts/instabilities.[7] To date, more than 230 million girls and women are estimated to have undergone some form of FGM/C, with an additional more than 4.3 million girls at risk of being cut annually.[8]

The World Health Organisation (WHO) categorises FGM/C into four types, namely, clitoridectomy (type I); excision (type II); infibulation (type III); and other harmful procedures on female external genitalia (type IV) practised by ethnic groups across countries.[9] Clitoridectomy is the partial or total removal of the clitoris and/or the prepuce (where the glans and/or the body of the clitoris are cut);[10] excision or type II is the partial or total removal of the clitoris and/or the prepuce (where the glans and/or the body of the clitoris are cut) as well as the labia minora, with or without excision of the labia majora; infibulation or type III is the narrowing of the vaginal orifice and the creation of a covering seal by cutting and apposition or sewing together the labia minora and/or the labia majora, with or without excision of the clitoris; and type IV entails all other harmful procedures or injury to the female genitalia for non-medical reasons, which include pulling, pricking, piercing, incising, scraping and cauterisation.[11] The severity of the cut progressively increases from clitoridectomy to excision and infibulation respectively as more tissue is damaged as well as the attendant health complications. The type of FGM/C varies within and between communities and geographies. Furthermore, the practice of FGM/C has undergone considerable changes in form and context across practising communities. Some of these changes include shifting from traditionally performed FGM/C types (infibulation or excision) to less severe forms (type I or IV), the cutting of girls at a younger age and medicalisation of FGM/C.[12]

MICS and other national surveys, 2023, https://data.unicef.org/topic/child-protection/female-genital-mutilation/ (accessed 9 February 2023).

7 A Armelle & M Lesclingand 'Female genital mutilation around the world' (2017) 543 *Population and Societies* 1-4.

8 UNICEF Female genital mutilation statistics, 2024, https://data.unicef.org/topic/child-protection/female-genital-mutilation/ (accessed 15 March 2025).

9 WHO (n 3).

10 A Jasmine and others 'Care of women with female genital mutilation/cutting' (2011) 6 *Swiss Medical Weekly* w13137.

11 WHO (n 3).

12 S Kimani and others 'Female genital mutilation/cutting: Emerging factors sustaining medicalisation related changes in selected Kenyan communities' (2020)

2 Introduction to medicalisation of female genital mutilation/cutting

The WHO defines medicalisation as situations in which FGM/C is practised by any cadre of healthcare providers in a public or private clinic, at home, or elsewhere, at any point in a woman's life (including re-infibulation).[13] It represents a change where the healthcare professional (doctor, nurse, midwife, or other health allied professionals or their trainees) performs FGM/C either in a health facility, at home or a neutral place, often using surgical tools, anesthetics and antiseptics.[14] Medicalisation also includes the practice of re-infibulation which entails re-closing of the external genitalia of a woman who had been de-infibulated (opened) to allow for delivery, sexual intercourse to consummate marriage and/or other specific gynecologic procedures for non-medical reasons by health workers.[15]

The classification of medicalisation of FGM/C as per the WHO definition, which mainly considers the extent of damage to the genital tissue, is problematic.[16] Indeed, there has been no clear evidence of what medicalisation entails in terms of the tissues involved because of a lack of objective clinical examination data on the status of external genitalia. However, findings from interviews reveal that medicalisation is a less severe form of FGM/C, implying that it could be a clitoridectomy or type IV based on the extent of tissue and structures involved. That said, a number of FGM/C sub-types are consistent with the broad definition of less severe types of FGM/C carried out during medicalisation, including rubbing, scraping, stretching, pricking and piercing, incision, and excision. For example, evidence from Indonesia shows that there are FGM/C sub-types that would fit as type I and type IV based on

15 *PLoS ONE* e0228410. See also S Kimani & B Shell-Duncan 'Medicalised female genital mutilation/cutting: Contentious practices and persistent debates' (2018) 10 *Current Sexual Health Reports* 25-34.

13 WHO, UNFPA, UNHCR, UNICEF, UNIFEM, FIGO, ICN, MWIA, WCPA, WMA 'Global strategy to stop health-care providers from performing female genital mutilation' 2010, https://www.who.int/publications/i/item/WHO-RHR-10.9 (accessed 9 February 2023).

14 WHO and others (n 13) 14.

15 WHO and others (n 13) 14-15.

16 WHO and others (n 13).

the WHO typology.[17] However, there also exists a sub-type referred to as symbolic FGM/C that is allegedly less harmful and that does not explicitly fit into the WHO typology – the rubbing of the female genitalia using antiseptic as a way of cleaning.[18]

The definition and naming of medicalisation are problematic and have implications for end FGM/C programming. For example, whereas previous studies have depicted medicalisation to perpetuate less severe type of FGM/C, the opposite is also true. Evidence by Dewi and others[19] showed that 46 per cent of the health professionals cut more tissue by removing the clitoral hood compared to 23 per cent of the traditional cutters. The professionals performed 30 per cent type IV FGM/C compared to 35 per cent performed by the traditional cutters. These findings are consistent with evidence that midwives and other health professionals perform fewer (26 per cent) less invasive cuttings such as incision, compared to traditional cutters who carried out 41 per cent rubbing/scrapping and incision (50 per cent). This evidence refutes harm reduction as a justification for medicalisation and indicates that healthcare professionals may be performing equally or more severe forms of FGM/C.[20]

Although the definition of medicalisation is universally applied, its applicability may be problematic when attempting to address the practice, especially when targeting the performer. This is because it does not preclude non-clinically (skilled) trained practitioners such as messengers, cleaners, traditional cutters and traditional birth attendants who may perform FGM/C using hospital/clinic-based supplies such surgical antiseptics, pain killers and anesthesia. This is because such practitioners, although not categorised as healthcare professionals, may

17 MP Budiharsana, L Amaliah & B Utomo 'Female circumcision in Indonesia. Extent, implications and possible interventions to uphold women's health rights' 2003, https://knowledgecommons.popcouncil.org/cgi/viewcontent.cgi?article=1033&context=departments_sbsr-rh (accessed 18 February 2023). S Dewi and others 'Female-genital mutilation-cutting: Standing between the tradition and modernity' 2017 Centre for Population Studies, Universitas Gadjah Mada, https://cpps.ugm.ac.id/wp-content/uploads/sites/1070/2020/02/Female-Genital-Mutilation-Cutting_English.pdf (accessed 16 February 2023). WHO (n 3).

18 Dewi and others (n 17).

19 As above.

20 WHO and others (n 13). See also S Kimani, H Barrett & J Muteshi-Strachan 'Medicalisation of female genital mutilation is a dangerous development' (2023) 380 *BMJ* 302.

still access the aforementioned supplies from hospitals or pharmacies and use them in performing FGM/C in many countries with high prevalence of FGM/C. Furthermore, the clinically-trained professionals (doctors, nurses, midwives and medical assistants) may feel demeaned or demotivated for being grouped together with non-skilled professionals in committing a non-ethical practice such as the medicalisation of FGM/C.

Moreover, the skilled healthcare workers, including doctors, midwives, nurses and medical assistants, subscribe to vibrant associations and regulatory bodies enabling professional advancement, advocacy and quality control through self-regulation. These institutions are important in addressing ethical and professional actions involving acts of commission and omission, for example, the medicalisation of FGM/C. Their interventions for addressing medicalisation are enshrined in laws and regulatory policies that impose sanctions and disciplinary actions against professional who may perpetrate the practice. This makes the professionals an important facet for the advancement of human rights, fitting into advocacy roles as well as protection and care of the vulnerable and hard to reach girls at risk of FGM/C. These deterrent mechanisms may be difficult to find in non-skilled persons who participate in the performance of FGM/C. This calls for a specific and comprehensive definition of medicalisation of FGM/C for more targeted strategies towards the practice.[21] It also calls for multi-sectoral collaboration to facilitate reconciliation between professional regulatory policies and national laws that address FGM/C in tackling the medicalisation of FGM/C.

2.1 Magnitude of medicalisation of female genital mutilation/cutting

The phenomenon of medicalisation is of great interest because girls (0-14 years of age) are increasingly subjected to the practice. It also presents a new challenge in achieving the total abandonment of FGM/C. Data on magnitude and prevalence of FGM/C, including its medicalisation, is generated from representative data obtained using the FGM/C module incorporated in the Demographic Health Survey

21 Kimani and others (n 20).

(DHS) and Multiple Indicator Cluster Surveys (MICS) implemented across various countries.[22] Emerging evidence from these data sources has been critical for monitoring the prevalence, trends and patterns of FGM/C across countries, while qualitative studies suggest that families in certain communities are increasingly opting for medicalisation for their daughters. The practice has become popular because of its alleged potential to minimise FGM/C-related health risks, the willingness of the health professionals to carry out the procedure, financial incentivisation and social recognition for the performer who is purported to offer 'special services'.[23]

Significantly, the highest proportion of women (15 to 49 years of age) who have undergone medicalised FGM/C have been reported in Sudan where seven in ten (67 per cent) have been cut by healthcare professionals, followed by Egypt with four out of ten (38 per cent), Guinea with two out of ten (15 per cent), Kenya, two out of ten (15 per cent) and Nigeria has one out of ten (13 per cent).[24] Of interest is Nigeria where the prevalence appears small but huge in absolute numbers given the population size of the country. Furthermore, nuanced analyses of medicalisation data show that the risk of FGM/C is higher among daughters (0 to 14 years) compared to their mothers (15 to 49 years). Girls who have FGM/C performed by healthcare professionals amount to 82 per cent in Egypt, 78 per cent in Sudan, 20 per cent in Kenya and 12 per cent in Nigeria.[25] This is an indication that medicalisation is gaining momentum based on geography and ethnicity, a trend more likely to normalise FGM/C, encouraging its continuation rather than its abandonment.[26] This calls for more targeted strategies toward medicalisation, because there is realistic evidence that the practice may

22 UNICEF (n 6).

23 Kimani & Shell-Duncan (n 12) and WHO and others (n 13). B Shell-Duncan, Z Moore & C Njue 'The medicalisation of female genital mutilation/cutting: What do the data reveal?' 2017 Population Council New York, https://www.popcouncil.org/uploads/pdfs/2017RH_MedicalizationFGMC.pdf (accessed 17 February 2023).

24 Kimani & Shell-Duncan (n 12) and Shell-Duncan and others (n 23).

25 As above.

26 Kimani & Shell-Duncan (n 12) and HM Doucet, C Pallitto & D Groleau 'Understanding the motivations of health-care providers in performing female genital mutilation: An integrative review of the literature' (2017) 14 *Reproductive Health* 46.

continue to erode the gains achieved in addressing FGM/C for decades across the globe.

2.2 Reasons why families choose medicalisation of female genital mutilation

Evidence shows that the decision to adopt medicalisation of FGM/C is dependent on community as well as healthcare professional-related factors. These factors include conforming to communities' social norm systems, sustained through rewards and punishment aimed at enforcing adherence over generations. Medicalisation has also been perpetuated through the narrative that it allegedly minimised the risk of immediate complications, such as pain and bleeding, associated with FGM/C. This narrative is based on the notion that in the case of medicalisation there is less severe cutting, FGM/C is done by a healthcare professional, and the use of health facility supplies could help address the expected immediate complications.[27] The practitioners of medicalised FGM/C are known to benefit financially from payments done for the girl as well as the elevated social recognition status for offering 'special services' to the community. This status and consideration help to build trust among community members, promoting the uptake of other healthcare services offered by the professional guaranteeing income for the longest.[28]Of importance is the notion that community members and healthcare professionals from FGM/C-prevalent cultures believe that medicalisation is acceptable, promotes quick recovery and could help evade law enforcement because of a quick turnaround time of healing.[29] The healthcare professionals perform FGM/C to reduce harm as they consider performing it would prevent expected danger that would arise if the procedure was to be carried out by traditional practitioners.[30]

27 WHO and others (n 13).

28 C Njue & I Askew 'Medicalisation of female genital cutting among the Abagusii in Nyanza province' 2004 Population Council, https://knowledgecommons.popcouncil.org/departments_sbsr-rh/32/ (accessed 17 February 2023). AJ Pearce & S Bewley 'medicalisation of female genital mutilation. Harm reduction or unethical' (2014) 24 *Obstetrics, Gynaecology and Reproductive Medicine* 29-30. B Shell-Duncan 'The medicalisation of female "circumcision": Harm reduction or promotion of a dangerous practice?' (2001) 52 *Social Science and Medicine* 1013. Shell-Duncan (n 23).

29 Kimani & Shell-Duncan (n 12).

30 Shell-Duncan (n 23).

However, medicalisation has been condemned and challenged at global and national level as it neither has any medical benefit, nor does it prevent long-term medical, psychological or sexual complications associated with the practice, and it also perpetuates human rights violations.[31] On the contrary, medicalisation is believed to normalise and encourage the continuation of FGM/C among the practising communities. This is because healthcare professionals are respected members of society and are likely to be emulated when they subject their daughters to FGM/C or participate in the cutting of girls.[32] Although laws, policies and strategies for addressing the abandonment of FGM/C including medicalisation have been developed, their effectiveness have not been ascertained because of a paucity of real time data. However, fewer strategies exist for tackling increasing medicalisation, while their effectiveness is unclear. Among the countries that have banned the medicalisation of FGM/C, Burkina Faso is the best case scenario.[33]

3 How has medicalisation of FGM/C been addressed? A health approach

Generally, interventions for addressing FGM/C have largely adopted the health approach model. This approach highlights the negative health effects of FGM/C, including the immediate and long-term physical effects, birth, gynecological, psychosocial and sexual complications that compromise the right to health of women and girls.[34] However, the narrative involving health complications has been attributed to the rise of medicalisation as families figured how they could mitigate these effects. Indeed, persistent medicalisation is shown to have been promoted by heightened awareness about health complications associated with traditionally performed FGM/C. These interventions motivated families to seek FGM/C services from healthcare professionals who

31 WHO and others (n 13).
32 WHO and others (n 13).
33 UNFPA & UNICEF 'Joint evaluation of the UNFPA-UNICEF Joint Programme on the Elimination of Female Genital Mutilation: Accelerating change Phase III (2018-2021), https://www.unfpa.org/joint-evaluation-unfpa-unicef-joint-programme-elimination-female-genital-mutilation-accelerating (accessed 17 February 2023).
34 WHO study group on female genital mutilation and obstetric outcome 'Female genital mutilation and obstetric outcome: WHO collaborative prospective study in six African countries' (2006) 9525 *Lancet* 1835-1841.

were assumed to conduct the procedure safely and could cut less severely while the recovery period was shorter for medicalised girls.[35] The practice was aimed at countering the narrative of FGM/C-related health impacts linked to unhygienic conditions; the use of unclean or non-sterile equipment; alleged poor skills of traditional cutters; extensive cutting and the associated immediate health complications including pain, bleeding and infections associated with traditionally performed FGM/C.[36]

Notwithstanding this, the assertion that medicalisation is safe is not correct. This is because it does not address the long-term health complications such as keloids and psychological effects, for example, psycho-trauma linked to FGM/C.[37] Furthermore, the healthcare professionals lack the expertise for performing FGM/C as no formal training is offered during medical/health training programmes on how to conduct it. Therefore, the professionals may be utilising the general principles learnt in surgical and medical practice, bringing to question their competencies and skills in performing FGM/C procedures involving sensitive female external genitalia. In some cases, extremely young girls in their neonatal period (0 to 28 days) have been subjected to FGM/C. The practice of FGM/C with all its illegality and the extensive damage to healthy tissues is characterised by a lack of curriculum and standard protocols on how to perform it. This fact is quite different from male circumcision – a beneficial practice that is erroneously equated to FGM/C, despite the less severe tissues cut compared to FGM/C. In male circumcision the health professionals undergo specialised training; there is an approved curriculum as well as standard operating procedures on how the procedure should be performed across countries.[38]

35 N Bedri and others 'Shifts in FGM/C practice in Sudan: Communities' perspectives and drivers' (2019) 19 *BMC Women's Health* 168. S Modrek & M Sieverding 'Mother, daughter, doctor: Medical professionals and mothers' decision making about female genital cutting in Egypt' (2016) 42 *International Perspectives on Sexual and Reproductive Health* 81. Kimani & Shell-Duncan (n 12) and Shell-Duncan (n 23).

36 Kimani & Shell-Duncan (n 12), Pearce & Bewley (n 28) and Shell-Duncan (n 40). S Kimani, J Muteshi & C Njue 'Health impacts of female genital mutilation/cutting: A synthesis of the evidence' 2016 Population Council, http://www.popcouncil.org/EvidencetoEndFGM-C (accessed 17 February 2023).

37 Kimani and others (n 36).

38 WHO 'Manual for male circumcision under local anaesthesia and HIV prevention services for adolescent boys and men' Geneva, 2018, World Health Organisation,

The evidence on the lack of protocols for FGM/C is affirmed by interviews with medical professionals from Indonesia, a country with very high rates of medicalisation and where close to 60 million women have been subjected to FGM/C.[39] The findings revealed that no special training was offered to the medical professionals, traditional birth attendants and circumcisers on how to perform FGM/C as opposed to the structured training on male circumcision, performed regularly, and based on clear and standardised protocols.[40] Furthermore, the use of anesthesia which dampen the pain sensation and the fact that FGM/C is performed on very young girls are likely to harm more or extensively damage the external genital tissues because of a large body surface area compared to when the procedure is done on mature girls or adults.[41] For example, in the case of a seven days old girl, how much tissue can the fingers of the health care worker or traditional cutter hold for cutting during the FGM/C procedure. I theorise that there is more extensive cutting during FGM/C for infants than when a mature girl is involved.

Interestingly, the health approach has been used in addressing FGM/C by spotlighting the FGM/C-related health complications in the hope that communities will be motivated to abandon the practice. This is premised on the evidence that all forms of FGM/C have no known health/medical benefits but instead are harmful to girls and women.[42] Moreover, the practice of FGM/C interferes with the natural functioning of girls' and women's bodies, as it removes and/or damages healthy functional genital tissue.[43] This compelling messaging anchored through the health approach might have encouraged health professionals to comply with their clients' requests to perform FGM/C and justified this as a 'less harmful' alternative when compared to the traditionally

https://apps.who.int/iris/bitstream/handle/10665/272387/9789241513593-eng.pdf (accessed 17 February 2023).

39 UNICEF (n 7).

40 R Patel & K Roy 'Female genital cutting in Indonesia' 2016, Islamic Relief Canada, https://had-int.org/e-library/female-genital-cutting-in-indonesia/ (accessed 17 February 2023).

41 Kimani and others (n 20) and DF Huelke 'An overview of anatomical considerations of infants and children in the adult world of automobile safety design' (1998) 42 *Annual Proceedings/Association for the Advancement of Automotive Medicine* 93-113.

42 WHO (n 3).

43 WHO (n 38).

performed cutting.[44] This narrative is supported by regulatory policies issued by governments' ministries' of health in Egypt in the 1990s, and Indonesia in the 2000s, that issued decrees for FGM/C to be performed by a specific cadre of healthcare professionals in designated health facilities to minimise the negative health complications.[45] The policy decrees were criticised by human rights activists leading to their revocation with notable residual professionals and infrastructure that supplied and might have enjoyed financial lucrativeness of the medicalised FGM/C services. This was not difficult to sustain the supply-demand chain of medicalised FGM/C despite its outlawing as facilitative residual loopholes for the practice still existed.[46] No wonder, therefore, that the proportions of medicalisation are extremely high in these two countries partly because of the initial legal/policy decisions made around FGM/C.

Similar moves were observed in Europe and North America during the 1990s because of an influx of immigrants from FGM/C-prevalent countries. The proposals were to allow for pricking and consent for FGM/C instead of the severe cutting in older children as a way of balancing respect for cultural values, host countries laws, medical and ethical principles while minimising health risks. These proposals, however, remained as ideas because of pressure and backlash from human rights activists. From the aforementioned narrative, the health approach has had mixed outcomes with regard to the elimination of FGM/C. The unintended consequences of medicalisation of FGM/C are the most prominent outcomes.

Nevertheless, professional bodies associated with medical doctors, for example, the World Medical Association, the American College of Obstetricians and Gynecologists and the American Medical Association, have unequivocally condemned medicalisation. This is in addition to the global body for obstetricians and gynecologists, the International Federation of Gynecology and Obstetrics (FIGO), which also condemned medicalisation.[47] However, the American Association

44 WHO and others (n 13).
45 Kimani & Shell-Duncan (n 12). See also O El-Gibaly, M Aziz & SA Hussein 'Health care providers' and mothers' perceptions about the medicalisation of female genital mutilation or cutting in Egypt: A cross-sectional qualitative study' (2019) 19 *BMC International Health and Human Rights* 26.
46 Kimani & Shell-Duncan (n 12) and Dewi and others (n 17).
47 WHO and others (n 13).

of Pediatrics in 2010 took a position of supporting medicalisation by issuing a statement calling for permissibility of pediatricians to perform nicking/pricking.[48]

The pronouncement triggered stiff public outcry and condemnation prompting a swift recall of the statement.[49] The pronouncements and actions by the medical regulatory bodies resulted to a singular commitment by medical doctors in condemning the medicalisation of FGM/C globally. These positive actions beg the question of whether this could be part of the reason why the proportions of FGM/C cases performed by medical doctors are fewer compared to other healthcare cadres. Of course, with the exception of Egypt, a country where medicalised FGM/C is predominantly performed by medical doctors. Conversely, could the absence of other healthcare cadres in issuing pronouncements and statements condemning medicalisation be the missing link in addressing this practice globally? These critical questions should be interrogated because inclusivity and equity in policy making and programming can accelerate and scale up the pace of addressing FGM/C.[50] For example, most nurse-midwives and other healthcare allied workers interface with community members, including women and girls at risk of FGM/C within primary healthcare facilities (healthcare centres and dispensaries) presenting a special opportunity to address the practice.

Therefore, this special human resource for health should be targeted for a health approach to succeed in addressing FGM/C and its medicalisation. Recently, in a 2017 summit organised in Egypt, public statements against medicalisation were issued by professional medical associations from Djibouti, Egypt, Somalia, Sudan and Yemen.[51] There is a need for an evaluation to understand the impact of condemnation in regard to the prevalence of medicalisation in countries of which professionals were involved. It should be noted that the health approach tolerates some FGM/C provided harm is minimised. Indeed, the health model triggered debates on how to distinguish acceptable risk from

48 Serour (n 4).
49 Serour (n 4).
50 Government of Canada 'Best practices in equity, diversity and inclusion in research' 2021, https://www.sshrc-crsh.gc.ca/funding-financement/nfrf-fnfr/edi-eng.aspx (accessed 16 February 2023).
51 Kimani & Shell-Duncan (n 12).

intolerable harm, or who has the right to make such distinctions opening up interpretive issues, linked to legal, ethical, medical and human rights claims about the limits of individual autonomy and tolerance of multiculturalism.[52] Generally, interventions for addressing FGM/C through the health approach have permissibility to harm reduction model of addressing FGM/C which may be tolerable to interventions that prevent harms associated with the cutting conducted by traditional practitioners. This presents a dilemma and tension with the do no harm principle as well as zero tolerance stand by the right based model of addressing FGM/C. Clearly, to address medicalization of FGM, intervention should integrate both elements of health as well as rights-based model.

4 How has medicalisation of FGM/C been addressed? A human rights-based approach

The practice of FGM/C has also been addressed from the perspective of a human rights-based approach. The rights-based model is premised on the narrative that FGM/C is a violation of women's and girls' rights, interferes with bodily integrity, damages normal functional genital tissue, compromises the possibility of the highest standard of health and undermines the right to health.[53] The proponents of this model argue on the aforementioned facts encapsulated in the international legal-policy instruments and treaties that member states have ratified and whose accountability is required. The human rights approach in ending FGM/C is anchored on provisions contained in international standards and norms (mechanisms/treaties) that provide important frameworks for clarifying that the practice constitutes a violation of human rights.[54]

Importantly, the international treaties address the impact of FGM/C in hindering women's and girls' agency, their enjoyment of human rights and gender equality. The treaties stipulate governments' obligations to

52 Kimani & Shell-Duncan (n 12).
53 WHO and others (n 13) and R Khosla, S Lale & M Temmerman 'Sexual health, human rights, and law' (2015) 386 *The Lancet* 725-726.
54 R Khosla and others 'Gender equality and human rights approaches to female genital mutilation: A review of international human rights norms and standards' (2017) 14 *Reproductive Health* 322-325.

establish legislative and policy instruments, specify requirements and actions for duty bearers in advancing the actualisation of human rights.[55]

Several international human rights treaties explicitly and implicitly address states' obligations to eliminate FGM/C as explained below. The Universal Declaration of Human Rights (Universal Declaration) is cited to have provisions for ensuring that all people enjoy freedom, equality and dignity. With regard to ending FGM/C, it avers that no one shall be subjected to torture or cruel, inhuman or degrading treatment or punishment.[56] The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) requires states to take all appropriate measures, including legislation, to modify or abolish existing laws, regulations, customs and practices which constitute discrimination against women. It promotes the advancement of women.[57] The Convention on the Rights of the Child (CRC) underscores the importance of ensuing protection and care for children and recognises the responsibility of state parties in this regard. CRC established the 'best interests of the child' standard in addressing the rights of children, as well as autonomy related to their evolving capacity. The practice of FGM/C is recognised as a violation of the best interest standard and a violation of children's rights, and mandates state parties to abolish traditional practices prejudicial to the health of children.[58]

Moreover, the International Covenant on Civil and Political Rights (ICCPR) protects the rights to life, liberty, freedom from torture and slavery with specific end-FGM/C provisions stating that no one shall be subjected to torture or to cruel, inhuman or degrading treatment or

55 UN General Assembly 'Intensifying global efforts for the elimination of female genital mutilations' UNGA, A/C.3/67/L.21/Rev.1, 16 November 2012, https://digitallibrary.un.org/record/746164?ln=en (accessed 17 February 2023).

56 United Nations The Universal Declaration of Human Rights Proclaimed by the United Nations General Assembly in Paris on 10 December 1948 (General Assembly Resolution 217 A, during its 183rd plenary meeting), https://www.un.org/en/about-us/universal-declaration-of-human-rights (accessed 17 February 2023).

57 United Nations Convention on the Elimination of All Forms of Discrimination against Women General Assembly Resolution 34/180 of 18 December 1979, https://www.un.org/womenwatch/daw/cedaw/ (accessed 17 February 2023).

58 UNICEF Convention on the Rights of the Child General Assembly Resolution 44/25 of 20 November 1989, https://www.unicef.org/child-rights-convention/convention-text (accessed 17 February 2023).

punishment.[59] The International Covenant on Economic, Social and Cultural Rights (ICESCR) protects the right to economic, social and cultural rights. With regard to ending FGM/C, it mandates member states to ensure equal rights of men and women to the enjoyment of all economic, social and cultural rights set forth in ICESCR.[60]

Importantly, a number of regional human rights treaties explicitly and implicitly address the elimination of FGM/C as described in the following narrative. The African Charter on Human and Peoples' Rights (African Charter) contains provisions that guarantee fundamental and human rights for the African people. In regard to FGM/C, it prohibits all forms of degradation, particularly torture, cruel, inhuman or degrading punishment and treatment of humans.[61]

Similarly, the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (African Women's Protocol)[62] provides for the protection of the human rights of African women. It mandates state parties to combat all forms of discrimination against women through appropriate legislative, institutional and other measures (article 2).[63] The specific provisions addressing FGM/C include that every woman shall have the right to dignity through the recognition and protection of her human and legal rights (article 3); [64] that all forms of cruel, inhuman or degrading punishment and treatment shall be prohibited (article 4); [65] and that state parties have an obligation

59 United Nations International Covenant on Civil and Political Rights General Assembly Resolution 2200A (XXI) of 16 December 1966, https://treaties.un.org/doc/publication/unts/volume%20999/volume-999-i-14668-english.pdf (accessed 17 February 2023).

60 United Nations International Covenant on Economic, Social and Cultural Rights General Assembly Resolution 2200A (XXI) of 16 December 1966, https://treaties.un.org/doc/treaties/1976/01/19760103%2009-57%20pm/ch_iv_03.pdf (accessed 17 February 2023).

61 African Union African Charter on Human and Peoples' Rights. Decision 115 (XVI) of the Assembly of Heads of State and Government at its 16th ordinary session held in Monrovia, Liberia, 1979, https://au.int/sites/default/files/decisions/9526-assembly_en_17_20_july_1979_assembly_heads_state_government_sixteenth_ordinary_session.pdf (accessed 17 February 2023).

62 African Union Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, adopted by the 2nd ordinary session of the Assembly of the Union 2003, https://au.int/en/treaties/protocol-african-charter-human-and-peoples-rights-rights-women-africa (accessed 17 February 2023).

63 Arts 2(1) & (2) African Women's Protocol.

64 Arts 3(1) & (4) African Women's Protocol.

65 Arts 4(1) & (2) African Women's Protocol.

to prohibit and condemn all forms of harmful practices that negatively affect the human rights of women and that are contrary to recognised international standards (article 5).[66]

The African Charter on the Rights and Welfare of the Child (African Children's Charter) seeks to protect the human rights and welfare of the African child. The treaty contains provisions addressing FGM/C,[67] namely, any custom, tradition, cultural or religious practice that is inconsistent with the rights, duties and obligations for the protection of a child shall be discouraged (article 1);[68] all actions concerning the child undertaken by any person or authority shall be in the best interests of the child as the primary consideration (article 4);[69] state parties are mandated to take specific legislative, administrative, social and educational measures to protect the child from all forms of torture, inhuman or degrading treatment while in the care of a parent, legal guardian or school authority or any other person who has been assigned the care of the child; and state parties are obliged to take all appropriate measures to eliminate harmful social and cultural practices affecting the welfare, dignity, normal growth and development of the child (article 21).[70]

Moreover, the African Youth Charter contains provisions that protect human rights and freedom of the African youth.[71] In regard to addressing FGM/C, the Youth Charter has the following provisions: Every young person shall have the right to enjoy the best attainable state of physical, mental and spiritual health (article 16);[72] state parties shall eliminate all traditional practices that undermine the physical integrity and dignity of women (article 20);[73] state parties shall introduce legislative measures that eliminate all forms of discrimination against girls and

66 Arts 5(a)-(d) African Women's Protocol.
67 African Union African Charter on the Rights and Welfare of the Child (AHG/ST.4 Rev.l) adopted by the Assembly of Heads of State and Government of the Organisation of African Unity at its 16th ordinary session in Monrovia, Liberia, 1979, https://www.achpr.org/public/Document/file/English/achpr_instr_charterchild_eng.pdf (accessed 17th February 2023).
68 Art 1(3) African Children's Charter.
69 Art 4(1) the African Children's Charter.
70 Art 21(1) African Children's Charter.
71 African Union African Youth Charter Resolution of the Heads of State and Government during the 1999 Algiers Summit for the development of the Pan-African Charter, https://au.int/sites/default/files/treaties/7789-treaty-0033_-_african_youth_charter_e.pdf (accessed 17 February 2023).
72 Art 16(1) African Youth Charter.
73 Art 20(a) African Youth Charter.

young women and ensure their human rights and fundamental freedoms (article 23);[74] they shall enact and enforce legislation that protect girls and young women from all forms of violence and FGM/C (article 23);[75] the development of programmes of action that provide legal, physical and psychological support to girls and young women who have been subjected to violence and abuse such that they can fully be re-integrated into social and economic life (article 23);[76] and state parties shall take all appropriate steps to eliminate social and cultural practices that affect the welfare and dignity of youth (article 25).[77]

The adoption and ratification of these treaties reflect a consensus that FGM/C constitutes a violation of human rights, and member states should take actions to end the practice and its medicalisation. The state parties' interventions include taking necessary measures, such as enacting and enforcing legislation to prohibit FGM/C. The adoption of the legal-policy instruments stimulated the end of FGM/C interventions in the member states with over 40 countries having banned the practice of FGM/C through laws or constitutional decrees. Countries have also addressed medicalisation, with some having specific prohibitions on FGM/C laws or provisions in their penal codes that prescribe penalties (imprisonment and/or fine) for medical professionals who perform FGM/C, as well as additional punitive actions such as the suspension of practising licences of those who perform FGM/C.[78]

Importantly, the rights-based model is premised on a 'zero tolerance' approach of which the key principle is intolerance for all forms of FGM/C. The platform for action developed at the 1995 Fourth World Conference on Women laid a blueprint for framing FGM/C as a human rights violation.[79] Drawing on these principles, the UN advanced a zero tolerance approach opposing all forms of FGM/C, a position that reflected a break from the earlier health framework on how health risks

74 Art 23(1)(a) African Youth Charter.
75 Art 23(1l) African Youth Charter.
76 Art 23(1)(m) African Youth Charter.
77 Art 25 African Youth Charter.
78 B Shell-Duncan and others 'Legislating change? Responses to criminalising female genital cutting in Senegal' (2013) 47 *Law and Society Review* 803.
79 UNESCO 'Beijing Declaration and Platform for Action' 1995 Fourth World Conference on Women, https://www.un.org/womenwatch/daw/beijing/pdf/BDPfA%20E.pdf (accessed 17 February 2023).

might be minimised.[80] Strategies that promote and protect these rights have faced the challenge of simultaneously addressing competing rights claims, namely, how the rights of the child, women's rights to freedom from discrimination, freedom from torture, and the right to bodily integrity and health can be reconciled with a right to culture or religious freedom.[8182] The challenges have presented legal, ethical, medical and human rights dilemmas about FGM/C and interventions that need to be implemented, slowing the efforts against FGM/C, including its medicalisation.

The strictest application of the zero tolerance stance prohibits any non-therapeutic procedure involving the female genitalia. However, when prohibition is linked to the concept of harm, as is stipulated in certain penal codes,[83] questions arise as to whether restrictions also apply to nicking, pricking or scraping of the clitoris or clitoral hood (type IV procedures).[84]

The growing consensus on defining FGM/C as a human rights violation underscores that concerns are not limited to minimising health risks, but rather extend to broader concerns on child protection and well-being, consent, bodily integrity, and discrimination against women. Medical ethicists, legal experts and policy makers alike have been forced to confront competing rights claims, including the right to health, the right to bodily integrity, the rights of the child, the right to culture and the right to religious freedom. The lack of clear-cut, definitive answers regarding the priority of the competing claims has stimulated debates surrounding medicalisation, some of which have now become objects of scrutiny in courts of law around the world.[85]

Interestingly, there has been a very thin line between the health and rights-based approaches. While proponents of the right-based approach depict that FGM/C violates the rights of women and girls, those who advance the health-based model highlight pervasiveness of health impacts of FGM/C, an indication of convergence in the two

80 B Shell-Duncan 'From health to human rights: Female genital cutting and the politics of intervention' (2018) 110 *American Anthropologist* 225.
81 Kimani & Shell-Duncan (n 12).
82 Shell-Duncan (n 78).
83 Khosla & others (n 54).
84 WHO & others (n 13).
85 Kimani & Shell-Duncan (n 12).

models. This portends that combining the elements and components of the two models in responding to FGM/C prevention, protection and care has the potential for success as opposed to adopting a singular approach. The strength of a combined approach could be based on the principle of complementarity and synergy with weaknesses in one model being cancelled out by the strengths of the other. The successful implementation of the combined model requires capacity building through training of proponents of the two approaches to help reconcile the approaches for concerted efforts in addressing FGM/C. This could also address the issue of framing of the practice and consistency across actors in ending FGM/C. In sum, there has been a convergence and/or intersection between the health and human rights-based approaches in response to FGM/C, calling for a reconciliation of the two models.

5 Ethical dilemma in the context of medicalisation

The healthcare professionals face a dilemma in handling the medicalisation of FGM/C. This is partly because of the cultural nature of FGM/C, the negative impacts associated with the procedure, systemic and capacity challenges, the need for respect of clients' autonomy, as well as professional and ethical requirements. Some healthcare professionals belong to or identify with the culture of the FGM/C practising communities. However, these professionals are ethically required to adhere to the 'Hippocratic oath' and the 'do no harm principle', as well as the best practices prescribed in the WHO generated tools on FGM/C prevention and response. The emergence of and increasing request by families for the healthcare professionals to perform medicalisation on their daughters present some personal and community contestations that require reconciliation. These tensions can be resolved through professional training, dialogues as well as communication to help them apply professionalism when dealing with clients and communities.

The principle of 'do no harm' was first documented by a Hippocratic writer approximately 2 400 years ago, and has since been the basis and guide for ethical behaviour for the practice and training in medicine education.[86] Doctors have been observing this principle for centuries as

86 M Wallace 'From principle to practice: A user's guide to do no harm 2014 CDA Collaborative Learning Projects, https://cdacollaborative.org/wordpress /wp-

part of the Hippocratic oath upon which they uphold their practice.[87] The basis of this principle is that the well-being of the people being helped must be the focus of efforts or interventions to help them. In other words, the cure must not be worse than the disease and the intervention must not destroy (or harm) that which it is meant to help.[88] The implication of the 'do no harm' principle is the need to have a holistic perspective and focus on both harm and benefit in the actions taken. In other words, if there is the slightest possibility of harm, this should not warrant doing nothing at all because harm cannot be avoided by failing to act. This is because doing nothing when people are in need is clearly doing harm.[89]

Therefore, in the context of FGM/C, harm reduction has been proposed as a key justification for medicalisation and used to depict pacification of mostly the immediate complications compared to traditionally-performed cutting.[90] However, it is well understood that medicalisation address neither long-term complications nor human rights violations associated with the procedure. This is the contention between the context of the 'doing no harm' principle and harm reduction. These terms have been erroneously and interchangeably used to justify medicalisation. However, in no way would medicalisation be a marker of the 'do no harm' principle because of its associated health complications, human right violations, and negation of the Hippocratic oath to which healthcare professionals swore to adhere. Additionally, medicalisation is more delicate given that healthcare professionals are never trained to perform FGM/C and, therefore, their FGM/C skills level could be sub-optimal compared to the traditional cutters. This ethical dilemma and assertion could be reinforced by case studies from Egypt and Indonesia. These two countries have very high prevalence of FGM/C and its nascent medicalisation. In an effort to implement harm reduction, governments in these countries issued a policy directive allowing medicalisation.[91]

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content/uploads/2016/07/2015-CDA-From-Principle-to-Practice.pdf (accessed 17 February 2023). CM Smith 'Origin and uses of primum non nocere: Above all, do no harm!' (2005) 45 *Journal of Clinical Pharmacology* 371-377.

87 AD Giovanni 'A pebble in the shoe: Assessing international uses of do no harm' (2014) 15 *Völkerrechtsblog.*

88 Giovanni (n 87).

89 As above.

90 Shell-Duncan (n 23).

91 Kimani & Shell-Duncan (n 12) and Patel and others (n 40).

However, vehement outcries and protests from anti-FGM activists and the international community resulted in the revocation of the policy decrees. Such a policy directive had an immediate impact as well as residual effects to date, characterised by a high prevalence of medicalisation of FGM/C in these countries. This is because the infrastructure, human resource, demand and possibly professional culture had already been well established and could not be demolished with a policy revocation. The implication has been that medicalisation has gone underground and is mostly performed under the disguise of genital modification surgeries performed by healthcare professionals in their clinics.[92] This brings to the fore instances of violations of the 'do no harm' principle where girls obviously are the most impacted in terms of health and rights.

Conversely, there is the dilemma based on the conviction for harm reduction associated with the notion that if the health professional does not perform the FGM/C procedure, the girl or woman would be cut unprofessionally by a traditional cutter. This would expose the girl to danger because of unsafe equipment, unclean environment, risking the girl's life with resultant health complications and potentially death. Although this may present a compelling reason, it marks another dilemma around harm reduction making the professionals violate the 'do no harm' principle. This contestation is associated with the inadequate capacity of the health sector players to address dilemmas that may affect professional conduct among healthcare workers. This calls for capacity building through training of healthcare providers on the philosophy and principles of ethical conduct and human rights issues around FGM/C while implementing health interventions towards the practice.

The decision to continue with medicalisation is hinged on such benefits as acceptability, elevated status, economic gain and community trust accorded to the healthcare professionals. This has been linked to heightened uptake of non-FGM/C healthcare services offered by the professionals as the singular most important driver for medicalisation as it guarantees a perpetual income for the professionals. Although the income from performing FGM/C on a girl may not seem high,

92 Kimani & Shell-Duncan (n 13). T McCoy 'Female circumcision led to the death of this Egyptian girl. Today, her doctor stands trial in landmark case' *The Washington Post* 11 May 2014, https://www.washingtonpost.com/news/morning-mix/wp/2014/05/22/female-circumcision-led-to-the-death-of-this-egyptian-girl-today-her-doctor-stands-trial-in-landmark-case/ (accessed 17 February 2023).

the dividends lie in the large number of girls that seek services as well as long-term relationships with families as their choice for provision of comprehensive healthcare services. This presents an ethical dilemma based on economic benefits accrued from the practice. The economic reasons are similar to what is taunted to promote the emerging practice of female genital modifications. The genital modification surgeries are increasingly being performed on well-educated and well-to-do women, and such procedures are presumed to be fashionable and modern. Looking at the modifications, these are mostly performed on mature consenting women, while they mimic type IV FGM/C. However, when FGM/C is performed on a woman, it represents a dilemma of violation of self-determination (autonomy) in regard to who should have the liberty to make decisions on what to do with their body. With the debate on genital modifications, there is a need to adopt a zero tolerance attitude for all forms of FGM/C in Africa due to the high prevalence and the negative impacts associated with the practice. This will allow for a substantial decline of the practice until the proportions of girls at risk have drastically reduced, when perhaps the debates on genital modification can be canvassed. This will give FGM/C programmers seeking to eradicate the practice an opportunity to address the challenges of abandoning the practice, before debating on issues around bodily autonomy that are likely to throw FGM/C abandonment in Africa into disarray.

5.1 Issues of informed consent in the context of medicalisation of FGM/C

Ordinarily, surgical procedures such as FGM/C would require the practitioner to obtain informed consent from the client before performing it. However, FGM/C is mostly performed on girls between the ages of 0 to 14 years, under coercion and situations in which they cannot provide informed consent mainly because of being dependent and legally under age. The best practice dictates that children should be provided with information on the what, why and how of the surgical procedure so that they can give assent while their parents or guardians should give the informed consent. Surprisingly, even when FGM/C is performed on adult women, it is under coercion and immense pressure,

and the decision is made by the healthcare professional, female relatives and husband.[93]

The scenario of not consenting to a surgical procedure presents a professional dilemma that needs reconciliation with other professional best practices. Indeed, this undermines the principle of self-determination (autonomy) on the side of the woman that is affected by social and economic disparities, among other factors.[94] The dilemma is linked to powerlessness and a lack of agency for girls and women because the decision-making capability are usurped by the larger family, the husband/partner and healthcare professionals. The healthcare professional has a role to advocate for the patient's right to health instead of being the perpetrator of FGM/C. This is based on the principle of a fiduciary relationship between a healthcare professional and their patients, which requires them to do no harm and ensure the clients are treated with respect and dignity.[95] Of course, a key driver for FGM/C in whatever form, is the lack of women's rights and economic dependence on men which influences decision making for women's bodies, including medicalisation.[96] Furthermore, a woman may undergo FGM/C in situations of the worst state of helplessness incompatible with principles of consenting (self-determination). For example, a woman who has had FGM/C performed during labour or immediately after giving birth or under anesthesia is in an unsuitable condition and environment for informed consent. Under such circumstances, the woman is helpless, in pain, while her judgment may be blurred subjecting her to the mercy of the healthcare professional who may have a vested interest in the practice. Under such circumstances, what are the chances the woman would resist FGM/C? The informed consent around FGM/C and medicalisation are not tenable and should not be contemplated because the practice

93 GI Serour 'The issue of reinfibulationo' (2010) 109 *International Journal of Gynecology and Obstetrics* 93-96.

94 LM Henry 'An overview of sexual and reproductive health in the context of public health ethics' in AC Mastroianni, JP Kahn & NE Kass (eds) *The Oxford handbook of public health ethics* (2019) 370-377, https://academic.oup.com/edited-volume/28138/chapter-abstract/212903388?redirectedFrom=fulltext (accessed 17 February 2023).

95 BR Furrow 'Patient safety and the fiduciary hospital: Sharpening judicial remedies' (2009) 1 *Drexel Law Review* 439.

96 Serour (n 4).

is outlawed in most countries and is not permissible across healthcare professionals' ethical and professional practice.

5.2 Dilemmas amongst healthcare professionals based on economic gain from medicalisation of FGM/C

Evidence reveals that healthcare professionals perform FGM/C for financial gain. Medicalisation of FGM/C is purportedly performed to mitigate the health complications, notably, immediate health risks through cutting less severely and the use of hospital-related supplies to minimise such effects, for example, infections and bleeding through the harm reduction strategy. To the professionals, although they may be cognisant of these harms, the economic benefits is a key driver of medicalisation outweighing the anticipated harms. In addition, because the professionals seem 'committed' to the social norms of the community, accepting to offer medicalisation services guarantees an amplification of their status and trust among community members. This is both advantageous and economically enticing as the professionals are perceived to offer 'special services' that promote confidence among community members towards their professional services. This promotes the uptake of other healthcare services offered by the professionals, guaranteeing the long-term economic survival of their healthcare businesses.

This incentive presents a dilemma as it borders on a conflict of interest where the professionals put economic gain before service to humanity. Indeed, there is evidence related to the fear of loss of clients by professionals because of a refusal to perform medicalisation. Furthermore, through medicalisation of FGM/C the professionals deliberately or selectively refuse to advise women against FGM/C or re-infibulation despite the known risks associated with the practice. This would amount to doing harm in not sharing vital information with clients regarding the disadvantages of medicalisation. The professional's advice should be based on best medical practice and ethics but, instead, the professional performs FGM/C for personal financial gain.[97] This allegedly has been the reason to escalate the medicalisation of FGM/C in parts of Kenya.[98]

97 WHO & others (n 13).
98 Kimani & Shell-Duncan (n 12).

5.3 Respect for client choice of medicalised FGM/C

Healthcare professionals have had a long history of forging and maintaining relationships with patients based on mutual respect and trust allowing for informed choice with regard to matters of reproductive health. Indeed, a relationship could have existed between the professional and the family long before the parents seek FGM/C services for their daughter. The relationship is characterised by trusting environment where the patient is confident to discuss, negotiate and make decisions around sexual and reproductive health. For example, decisions on the number of children one would wish to have or the choice of family planning methods are some examples involving discussion with the healthcare professional. A similar principle ought to be applied on decision making regarding FGM/C services to allow women to discuss, negotiate and make choices around the procedure. However, because of the patriarchal nature of communities where FGM/C is practised, gender inequality and social norms, such opportunities are never available because the *modus operandi* is through coercion, peer pressure and the disempowerment of women, leaving them with no choice but to embrace and comply with the norms. The fact that the healthcare professionals are not trained and competent to perform FGM/C compounded with no medical benefit and illegal nature of the practice substantially compromises the consenting process.

However, there is growing interest in genital modification surgeries that almost mimic the procedure involved in the practice of FGM/C. Focusing on these surgeries, the emanating broader picture is that, some can go through as type IV FGM/C as per the WHO typology. These surgeries appear to seemingly perpetuate the medicalisation of FGM/C. A typical case study is Egypt and Indonesia, where most FGM/C procedures are performed by healthcare professionals some disguised as genital modification surgeries.[99] The notion of consenting in a women undergoing body piercing procedures and body modification surgeries is often used. However, in body piercing and cosmetic surgery the woman is counselled and gives her informed consent, which can be withdrawn at any time before the procedure as it is not absolute. The issue of decision making in relation to FGM/C among adult women has been of critical interest and gaining momentum. An example is the

99 Patel and others (n 40) and Kimani & Shell-Duncan (n 12).

Dr Tatu Kamau case in Kenya, where she argued that women should be accorded the opportunity to make decisions to undergo FGM/C based on the right to culture which is guaranteed in the Constitution. The case was adjudicated with the Court handing down a judgment that FGM/C remains illegal in Kenya. Additionally, the Court proposed amendments to the Prohibition of Female Genital Mutilation Act 32 of 2011 (Act) to address the gaps identified in the law, including how to address/regulate genital modifications as potential procedures that could be used to shift the way FGM/C is performed moving forward.[100]

6 Conclusion

There is a persistent twin challenge of FGM/C and its medicalisation in some countries with a high prevalence of the practice. These challenges imply continued negative long-term health effects and human rights violations of women and girls. Medicalisation and its associated impacts that are poorly understood present an ethical and moral dilemma amongst healthcare professionals as they offer healthcare services in response to communities' cultural needs. Interventions for addressing FGM/C have coalesced around health and human rights-based approaches. The health approach adopts a harm reduction strategy based on the evidence that the professionals could address the negative health complications. The approach is adopted in the hope that communities understand the severe effects of FGM/C, act to protect girls and women from the practice, abandon the practice in solidarity with a clarion call for promoting and protecting human rights. The approach, however, created unintended consequences where communities believed the complications could be resolved by healthcare professionals through medicalisation. This erroneous notion is compounded by the fact that healthcare professionals lacked skills and knowledge to resist medicalisation, while medicalisation itself is not safe from long-term complications and human rights violation. The human rights-based approach adopts a zero tolerance approach to any form of FGM/C based on the fact the practice interferes with the fundamental right to bodily integrity, the right to health, affects normal functional genital tissue and is a violation of the

100 High Court of Kenya 2019 'Republic of Kenya in the High Court of Kenya at Nairobi, Constitutional Petition No. 244 of 2019' (244): 1-81.

human rights of women and girls. Actors advocating either the health or human rights-based approach converge in principle on the need to end FGM/C. However, the stand-alone approach in which the two models have been implemented has not successfully eradicated the practice.

Indeed, the approach has resulted in tensions between the implementers of the health and rights-based approaches that require reconciliation at all levels. This chapter proposes an integrated model of the dual approaches to promote cohesion, speed and a scaling-up of the eradication of the medicalisation of FGM/C, as well as resolving the dilemmas of the unintended consequences. There is a need for policy makers, programmers and implementers to consider training dialogues and engagement to promote intersectionality of a health and human rights-based model in the eradication of medicalisation.

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6

UNDERSTANDING WOMEN'S RIGHTS TO CULTURE, CONSENT, AND THE NEED TO PROHIBIT FEMALE GENITAL MUTILATION IN KENYA: *KAMAU V ATTORNEY GENERAL & OTHERS*

*Emily Kinama**

Abstract

Kenya enacted the Prohibition of Female Genital Mutilation Act 32 of 2011 (the Act) which commenced on 4 October 2011. In 2017 a Kenyan medical doctor filed a petition at Machakos in the High Court of Kenya in the case of Dr Tatu Kamau v the Honourable Attorney General & Other*s seeking to declare specific provisions of the Act as well as the entire Act unconstitutional for, among other reasons, infringing on the rights of adult women to participate in their culture and religion, a lack of public participation when Parliament was enacting the Act and discriminatory to the extent of prohibiting female genital mutilation against women but allowing men to undergo circumcision. The Court delivered its judgment on 17 March 2021 where it upheld the constitutionality of the Act but made proposals to Parliament to amend section 19 of the Act to prohibit type IV FGM. This chapter analyses the judgment in relation to the constitutionality of the Prohibition on Female Genital Mutilation Act, specifically whether an adult woman can be prohibited from freely choosing to undergo*

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FGM in line with her culture. The author also makes the following contributions in relation to the judgment: that adult women cannot consent to harm being done on them; that state obligations both at the constitutional/domestic level, regional and international level demand that the state take all necessary measures to prevent and protect women from violence against women and the balancing of rights and limitation of rights is necessary in instances where women want to undergo FGM for other purposes.

1 Introduction

This chapter analyses the judgment delivered in the High Court of Kenya in *Dr Tatu Kamau v the AG & Others.*[1] The judgment arises from a petition filed by a medical doctor, Dr Tatu Kamau (Dr Kamau) who challenged the constitutionality of the Prohibition of Female Genital Mutilation Act (Act)[2] on the basis that it prohibits and criminalises female genital mutilation (FGM).[3] She argued that the Act violated the constitutional rights of adult women to equality and non-discrimination;[4] the freedom of conscience, religion, belief and opinion;[5] the right to the highest standard of attainable health;[6] and the right to participate in a cultural life of one's own choice.[7] In addition, Dr Kamau challenged the Anti-Female Genital Mutilation Board (Board) because the functions it is mandated to carry out infringe on the rights of women who want to practise FGM.

The judgment addressed different issues for determination, but this chapter will only provide an analysis of the judgment with respect to four issues. The first is the right to culture and the scope of harmful cultural practice; the second the issue of consent to undergo FGM; the third part will be on criminalisation of all types of FGM; and, finally, the fourth part will address the balancing of rights in relation to FGM.

1 Petition 244 of 2019 (*Kamau).*
2 Act 32 of 2011.
3 Dr Tatu Kamau did not use the term 'female genital mutilation' but instead insisted on it being called 'female circumcision'. The 10th interested party also referred to it as female circumcision.
4 Art 27 Constitution of Kenya, 2010 (Constitution).
5 Art 32 Constitution.
6 Art 43 Constitution.
7 Art 44 Constitution.

2 Background

The primary source of challenge for Dr Kamau in the petition was that provisions of the Act are unconstitutional. Dr Kamau filed the suit on behalf of communities that practise 'female circumcision' and for women who have been jailed for carrying out the rite.[8] The Constitution of Kenya, 2010 (Constitution) allows any person to institute court proceedings in their own interest as well as on behalf a group of persons, where they claim that a right or fundamental freedom has been denied, violated or infringed.[9] This petition could be classified as one filed in the public interest even though the prayers sought were challenged for being contrary to the public interest. A public interest litigation does not cease from being in the public interest because the arguments are not in line with the law. A case is public interest in nature once the petitioner pleads that they have filed the suit on behalf of members of the public. The Kenyan Constitution introduced public interest standing that previously was not accepted under the old Constitution. This means that a party does not need to provide proof that they are directly affected by violations for them to appear before the Court to pursue a case, and they can file a case in the public interest.

The respondents who were sued were the Attorney-General, the Anti-Female Genital Mutilation Board, and later the Director of Public Prosecution applied to be joined in the case as a respondent.[10] There were also ten interested parties and the roles that they played in the case as highlighted in the submissions. There were also two *amici curiae* who contributed to the case on different areas of the law.

In the amended petition Dr Kamau used the term 'female circumcision' and 'female surgery' and not 'female genital mutilation' (FGM) because she averred that the latter showed malice, yet it was part of national heritage.[11]

8 *Kamau* (n 1) para 5.
9 Arts 22 (1) & (2)(b) Constitution.
10 *Kamau* (n 1) para 2.
11 Amended Petition para 9 when she defines the procedures that are considered FGM under sec 2 of the Act and para 13 where Dr Kamau argued that mutilation cannot be used to cure physical or mental health as per the exception in sec 19(3) of the Act, which deals with exceptions where medical professions can carry out FGM. See also *Kamau* (n 1) para 12(a).

It is also worth noting that although the petition challenged the rights of adult women and categorically excluded issues on children, the Court allowed organisations on children's rights to join the case. The interested parties that joined the case on behalf of children averred that, although the case only argued for FGM for consenting adult women, children were at risk if the Act was to be amended as they are the ones on whom communities culturally conduct FGM. The Court recognised that from the evidence provided in court by women who underwent FGM, it was carried out when they were as young as nine years of age in some instances.[12]

3 Culture, consent, criminalisation and the balancing of rights

As already stated, the judgment analysed several issues for determination. This chapter will tackle the issues of culture; consent to undergo FGM for adult women; the criminalisation of FGM; and the balancing of rights of FGM. This is mainly because these four main issues set forth jurisprudential anchors not only for future cases on FGM but also in instances where people might seek to practise cultural practices that can cause harm. It is also the first case in Kenya that was not criminal in nature that addressed aspects of FGM.

3.1 The right to culture and the prevention of harmful cultural practices

3.1.1 Harmful cultural practices

In addressing issues related to the right to culture and prevention of harmful cultural practices, the judgment began by examining the different terms used to refer to FGM. These terms were female circumcision and female cutting, which the court stated all refer to procedures that deal with the partial or total removal of external genitalia or any injury or harmful procedure on the female genitalia.[13] The Court further added that this procedure must be for non-medical purposes.[14] The petitioner

12 *Kamau* (n 1) para 117.
13 *Kamau* (n 1) 124.
14 As above.

and 10th interested party were strongly against using the term 'female genital mutilation' and the Court then found that it was necessary to examine FGM, its causes and consequences in order to determine whether there was any harm occasioned by the procedure.[15]

The Court relied on the definition of harm from the Penal Code,[16] and Black's *Law dictionary.*[17] 'Harmful cultural practice' is not defined under article 260 of the Constitution, which is the definition clause. However, the Court correctly noted that the phrase 'harmful cultural practice' is found in other provisions of the Constitution.[18] The prohibition of harmful cultural practices is provided for in Part Three of the Bill of Rights of the Constitution titled 'Specific application of rights'. To be precise, the Constitution emphasises that the specific part of the Bill of Rights expounds on certain rights to 'ensure greater certainty of application of those rights and fundamental freedoms to certain groups of persons'.[19]

There also are no national legislations that have expressly defined 'harmful cultural practices',[20] but national legislation prohibits harmful cultural practices. The Children's Act prohibits 'harmful cultural rites' and lists female circumcision as one of the harmful cultural rites.[21]

Case law has defined instances where FGM is a harmful cultural practice, but this was in line with the classification as such under the Children Act because FGM was conducted on a 16 year-old child. This was in the case of *Katet Nchoe & Another v Republic,*[22] where the High Court dealt with a case where two accused persons were charged with manslaughter arising out of FGM where the second appellant approached the first appellant to perform FGM on her 16 year-old daughter. The

15 *Kamau* (n 1) para 129.
16 As above.
17 *Kamau* (n 1) para 130.
18 Art 53(1)(d) of the Constitution provides that every child has the right to be protected from harmful cultural practices. Art 55(d) of the Constitution commands the state to take measures to ensure that the youth are protected from harmful cultural practices.
19 Art 52(1) Constitution.
20 *Kamau* (n 1) ara 131.
21 Ch 141 of the Laws of Kenya, Act 8 of 2001, sec 14(1) reads: 'No person shall subject a child to female circumcision, early marriage or other cultural rites, customs or traditional practices that are likely to negatively affect the child's life, health, social welfare, dignity or physical or psychological development.'
22 Criminal Appeal 115 of 2010 as consolidated with Criminal Appeal 117 of 2010 (*Nchoe*).

High Court in this instance recognised the harmful nature of the FGM custom.[23]

Regionally, Kenya together with some other African countries ratified the African Charter on Human and Peoples' Rights (African Charter)[24] and the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa[25] (African Women's Protocol). These two treaties expressly distinguish between promoting positive cultural values and prohibiting harmful cultural practices. These regional instruments are applicable in Kenya under article 2(6) of the Constitution that states that international treaties that Kenya has ratified are part of Kenyan law.

Article 17 of the African Charter, which entered into force on 21 October 1986, and places a duty on the individual to 'preserve and *strengthen positive African values in his relations with other members of the community ... and, in general, to contribute to the moral well-being in the society*'.[26] This provision is more general and places a duty on individuals when they exercise their culture with others rather than a right to culture.[27] It also places a duty on the state to promote and protect traditional values recognised by the community. These provisions, however, are problematic considering that in most African patriarchal communities, the traditional values and cultures are often dictated by men who are the designated traditional elders.

Despite the African Charter coming into operation and other international instruments protecting women against discrimination, women in Africa continue to experience 'harmful practices', including FGM.[28]

However, on 25 November 2005 the African Women's Protocol entered into force and provides wider rights guaranteed to women in relation to culture. Article 17(1) enshrines the right of women to live in

23 *Nchoe* (n 22) 4. The learned judge held: 'In our case, female genital mutilation is certainly harmful to the physical and no doubt the psychological and sound well-being of the victim. It may lead to childbirth complications, in this case, it led to premature death of a teenager. That kind of custom could truly be well discarded and buried in the annuals of history, just as we no longer remove our two, four or six teeth from our lower jaws, or adorn our faces, cheeks with healed blisters.'

24 Kenya ratified the African Charter on 23 January 1992.

25 Kenya ratified the African Women's Protocol on 6 October 2010.

26 Art 29(7) African Charter.

27 Art 17(3) African Charter.

28 Preamble to African Women's Protocol.

a positive cultural context. Article 17(2) also places a duty on the state parties to 'take all appropriate measures to enhance the participation of women in the formulation of cultural policies at all levels'. This provision has been argued to be progressive to the extent of giving women agency to dialogue with members of the community who have the power to impact change to culture – that is, men who are often the elders in the community.[29] Therefore, the provision is a strategy for women to actively participate in the development of positive cultural contexts.[30] It also extensively prohibits harmful cultural practices on women and girls. Other international instruments on the rights of the child also list the criteria for recognising harmful cultural practices.[31]

The High Court relied on the definition of harmful cultural practices as provided in the African Women's Protocol.[32] The Women's Protocol mandates the state 'to enact and effectively implement appropriate legislation or regulatory measures including prohibiting harmful

29 J Geng 'The Maputo Protocol and the reconciliation of gender and culture in Africa' in SH Rimmer & K Ogg (eds) *Research handbook on feminist engagements with international law* (2019) 17.

30 As above.

31 The Joint General Recommendations 31 of the Committee on the Elimination of Discrimination against Women/General Comment 18 of the Committee on the Rights of the Child on Harmful Practices, dated 4 November 2014, lists the criteria of recognising harmful cultural practices. Para 16 provides as follows: 'For the purposes of the present joint general recommendation/General Comment, practices should meet the following criteria to be regarded as harmful: (a) They constitute a denial of the dignity and/or integrity of the individual and a violation of the human rights and fundamental freedoms enshrined in the two Conventions. (b) They constitute discrimination against women or children and are harmful insofar as they result in negative consequences for them as individuals or groups, including physical, psychological, economic and social harm and/or violence and limitations on their capacity to participate fully in society or develop and reach their full potential. (c) They are traditional, re-emerging or emerging practices that are prescribed and/or kept in place by social norms that perpetuate male dominance and inequality of women and children, on the basis of sex, gender, age and other intersecting factors. (d) They are imposed on women and children by family members, community members or society at large, regardless of whether the victim provides, or is able to provide, full, free and informed consent.'

32 Art 1(g) of the African Women's Protocol defines harmful cultural practices to mean '[a]ll behaviour, attitudes and/or practices which negatively affect the fundamental rights of women and girls, such as their right to life, health, dignity, education and physical integrity'.

practices that endanger the health and well-being of women'.[33] It also mandates state parties to prevent harmful cultural practices.[34]

The Court relied on article 5(b) of African Women's Protocol, which expressly condemns FGM and places an obligation on state parties to prohibit all forms of FGM that negatively affect the human rights of women through legislative measures backed by sanctions of all forms of FGM. Article 5(b) of the Women's Protocol expressly obligates the state to FGM through legislative measures backed by sanctions. Kenya ratified the treaty on 6 October 2010 and enacted the Prohibition of Female Genital Mutilation Act on 4 October 2011. Therefore, the Act needs to be in line with international standards that have placed a ban on all forms of FGM. This, therefore, is also in line with the Court's finding that the Act is faulted to the extent of omitting type IV FGM,[35] in the definition of the different types of FGM defined under section 2 of the Act.[36]

Indeed, the Constitution obligates the state to enact and implement legislation to fulfil its international obligations on human rights and fundamental freedoms.[37] Besides, article 19(3)(b) clarifies that the rights in the Bill of Rights do not exclude other rights and fundamental freedoms not in the Bill of Rights but recognised or conferred by law. Accordingly, women have a right under the African Women's Protocol to be free from FGM and other forms of harmful cultural practices that negatively affect the human rights of women.

Consequently, the Constitution obligates the state and every state organ to observe, respect, protect, promote and fulfil the right of every woman to be free from FGM.[38] Certainly, under article 21(3) all state

33 Art 2(1)(b) African Women's Protocol.

34 Art 2(2) African Women's Protocol. It reads: 'States Parties shall commit themselves to modify the social and cultural patterns of conduct of women and men through public education, information, education and communication strategies, with a view to achieving the elimination of harmful cultural and traditional practices and all other practices which are based on the idea of the inferiority or the superiority of either of the sexes, or on stereotyped roles for women and men.'

35 The World Health Organisation (WHO) defines Type IV Female Genital Mutilation as 'all other harmful procedures to the female genitalia for non-medical purposes, for example pricking, piercing, incising, scraping and cauterisation', https://www.who.int/teams/sexual-and-reproductive-health-and-research-(srh)/areas-of-work/female-genital-mutilation/types-of-female-genital-mutilation (accessed 2 January 2023).

36 *Kamau* (n 1) para 105.

37 Art 21(4) Constitution.

38 Art 21(1) Constitution.

organs and all public officers have the duty to address the needs of vulnerable groups within society, including women, older members of society, persons with disabilities, children, youth, members of minority or marginalised communities, and members of particular ethnic, religious or cultural communities.

In terms of policy, the Ministry of Health and Sanitation and the Population Reference Bureau published a policy brief titled 'Ending female genital mutilation: Laws are just the first step'[39] which recognises FGM as a harmful traditional practice.[40] Kenya further published the National Plan of Action for the Elimination of Female Genital Mutilation in Kenya 1999-2019, Nairobi, June 1999 in which it categorised FGM as a harmful traditional practice.

Several bodies of the United Nations (UN) have stated that FGM has no benefits.[41] They emphasise that there are no health benefits of FGM because 'the removal or damage to healthy, normal genital tissue interferes with the natural functioning of the body and causes several immediate and long-term health consequences'.[42] In addition, there are short and long-term health and psychological effects of FGM. For example, short term effects include infections, and long-term consequences include decreased sexual enjoyment, chronic pain and post-traumatic stress disorder. Children of mothers who have undergone FGM have higher death rates during and after birth, unlike those mothers who have not undergone FGM.[43]

In addition, Kenya, with other countries, has committed itself to the Sustainable Development Goals (SDGs), and among them is to achieve gender equality and empower all women and girls.[44] Among the targets is the elimination of all harmful practices, such as early and forced marriage

39 Republic of Kenya, Ministry of Health and Sanitation and the Population Reference Bureau published a policy brief titled 'Ending female genital mutilation: Laws are just the first step' Policy Brief 32 June 2013.

40 As above.

41 OHCHR, UNAIDS, UNDP, UNECA, UNESCO, UNFPA, UNHCR, UNICEF, UNIFEM & WHO 'Eliminating female genital mutilation: An interagency statement' 2008 1.

42 As above.

43 OHCHR and others (n 41) 11. See also PD Mitchum 'Slapping the hand of cultural relativism: Female genital mutilation, male dominance and health (2013) 19 *William and Mary Journal of Women and the Law* 585 592.

44 Goal 5 Sustainable Development Goals.

of children and female genital mutilation.[45] The relevant indicator is the percentage of girls and women aged 15 to 49 years who have undergone FGM/cutting.[46]

Based on the definitions of harmful cultural practices listed above, the testimony and affidavit evidence provided by medical experts and several witnesses who underwent FGM, the Court held that FGM is a harmful cultural practice.[47]

Further, the definition of youth under the Kenyan Constitution consists of persons who have attained 18 years of age but are not more than 35 years of age,[48] and the African Women's Protocol defines women as persons of the female gender, including girls. [49] This definition, read together with article 55 of the Constitution of Kenya, requires the state to ensure that women above the age of 18 years and between the ages of 18 and 35 years are protected from harmful cultural practices such as FGM. These laws show that the nature of the harm does not end the moment a girl turns 18 years, or a woman turns 36 years and is no longer a youth, because the impact of the harm remains the same.

Given the lack of definition or criteria of identifying harmful cultural practices that have not been expressly listed in legislation or the Constitution, the High Court could have taken the approach taken in *Satrose Ayuma & 11 Others v Registered Trustees of the Kenya Railways Staff Retirement Benefits Scheme & 3 Others (Satrose Ayuma),*[50] where the High Court recognised that there were no laws in Kenya to deal with the procedures of evictions. The High Court proceeded to adopt the procedures laid down in the UN Basic Principles and Guidelines on Development based Eviction and Displacement (2007) because Kenya had already ratified the UN International Covenant on Economic, Social and Cultural Rights (ICESCR). This judgment was also directed to Parliament to enact legislation on the procedure of evictions.[51] Only three years after the judgment was delivered, that is, 21 September

45 SDG target 5.3.
46 http://www.undp.org/content/undp/en/home/sustainable-development-goals/goal-5-gender equality/targets/ (accessed 11 March 2018).
47 *Kamau* (n 1) paras 137-138.
48 Art 260 Constitution.
49 Art 1(k) African Women's Protocol.
50 Petition 65 of 2013, judgment delivered on 30 August 2013, paras 79-88.
51 Petition 65 (n 50) para 109.

2016, the Land Laws Amendment Act[52] provided for the procedure of evictions that drew heavily from the UN Guidelines earlier relied on in the *Satrose Ayuma* case.

The High Court perhaps could have developed a working definition of the phrase 'harmful cultural practice' from the different international laws and instruments that have sought to categorise which practices are harmful cultural practices. This could be as follows: Harmful cultural or traditional practices include:

(a) a denial of the dignity and/or integrity of the individual and a violation of the human rights and fundamental freedoms enshrined in the Constitution and other laws;

(b) discrimination against women, men or children and are harmful insofar as they result in negative consequences for them as individuals or groups, including physical, psychological, economic and social harm and/or violence and limitations on their capacity to participate fully in society or develop and reach their full potential;

(c) traditional, re-emerging or emerging practices that are prescribed and/or kept in place by social norms that perpetuate male dominance and inequality of women and children, on the basis of sex, gender, age and other intersecting factors;

(d) they are imposed on women and children by family members, community members or society at large, regardless of whether the victim provides, or is able to provide, full, free and informed consent.

3.1.2 The right to participate a culture of one's own choice (article 44)

The Court analysed the right to culture under the Kenyan Constitution in relation to the right of women to undergo FGM as per their culture. This is because it was the central issue of the case. Dr Kamau contended that the right to participate in a cultural life of one's own choice has been violated because willing women from communities who once carried out the cultural practice of FGM can no longer do so. She further suggested that they have also lost their cultural claim of acceptance before their loved ones and elders. She averred that the offences under sections

52 Act 28 of 2016, sec 98.

19(6), 20 and 21 of the Act condemned and misrepresented an age-old tradition as violent and dangerous.[53]

Dr Kamau also argued that section 19(5) of the Act violates the right to participate in a cultural life of one's own choice under article 44 of the Constitution to the extent that it provides that a person's culture, religion, other custom or practice cannot be used to perform FGM and that it can only be performed on a person for a physical or mental health purpose.

Section 19 of the Act provides for the offence of FGM as follows:

(1) A person, including a person undergoing a course of training while under supervision by a medical practitioner or midwife with a view to becoming a medical practitioner or midwife, who performs female genital mutilation on another person commits an offence.

...

(3) No offence under subsection (1) is committed by an approved person who performs –

(a) a surgical operation on another person, which is necessary for that other person's physical or mental health.

...

(5) In determining, for purposes of subsection (3)(a), whether or not any surgical procedure is performed on any person for the benefit of that person's physical or mental health, a person's culture, religion or other custom or practice shall be of no effect.

(6) It is no defence to a charge under this section that the person on whom the act involving female genital mutilation was performed consented to that act, or that the person charged believed that such consent had been given.

Sections 20 and 21 of the Act read:

20 A person who aids, abets, counsels or procures –

(a) a person to commit an offence under section 19; or

(b) another person to perform female genital mutilation on that other person, commits an offence.

21 A person commits an offence if the person takes another person from Kenya to another country or arranges for another person to be brought into Kenya from another country, with the intention of having that other person subjected to female genital mutilation.

Based on the above provisions, in a nutshell the constitutional challenge from the amended petition on the provisions were that, first, the criminal

53 Amended Petition (n 11) para 16.

offences provided under sections 19(6), 20 and 21 of the Act violate the rights of women to participate in a cultural life of their own choice, which is FGM.

Second, the exception for approved persons (medical practitioners and midwives) performing FGM only for physical and mental health purposes, during labour and childbirth and not for cultural reasons, infringes on the right to participate in a cultural life of one's own choice.[54]

The Court further found that it was important to understand the content of the right to participate in a cultural life of one's own choice to determine whether the provisions of the Act have interfered with the right. In Kenya, culture, and the right to participate in a cultural life of one's own choice, are provided for under articles 11 and 44 of the Constitution. The right to participate in a cultural life of one's own choice is enshrined in article 44 of the Constitution. It guarantees every person the right to participate in the cultural life of the person's choice.[55] It also guarantees a person belonging to a cultural or linguistic community with the right together with other members of the community to enjoy their culture,[56] and not to be compelled by another person to undergo any cultural practice or rite.[57]

This right is also guaranteed in several international and regional instruments to which Kenya is a party. The Constitution stipulates that the general rules of international law and international treaties that Kenya has ratified form part of Kenyan law.[58] The African Charter protects the individual's right to participate in the cultural life of his or her community and recognises the duty of the state to promote and protect the moral and traditional values of a community.[59] ICESCR[60] obligates states to recognise the right of everyone to take part in cultural life.[61] The Convention on the Elimination of All Forms of Discrimination against

54 This was a challenge based on sec 19(5) of the Act.
55 Art 44(1) Constitution.
56 Art 44(2)(a) Constitution.
57 Art 44(2)(b) Constitution.
58 Arts 2(5) & 5 Constitution. See also the Court of Appeal judgments in *Seventh Day Adventist Church (East Africa) Limited v Minister for Education & 3 Others* Civil Appeal 172 of 2014; [2017] eKLR; *Karen Njeri Kandie v Alssane Ba & Another* Civil Appeal 20 of 2013; [2015] eKLR; *David Njoroge Macharia v Republic* Criminal Appeal 497 of 2007; [2011] eKLR.
59 Arts 17(1) & (2).
60 Kenya ratified ICESCR on 1 May 1972.
61 Art 15(1).

Women (CEDAW)[62] places a duty on state parties to take all appropriate measures to eliminate discrimination against women, including through ensuring that they participate in a cultural life.[63]

Although 'culture' or a 'cultural life' is not expressly defined in the Constitution, article 11 recognises culture as the foundation of the Kenyan people. The Universal Declaration on Cultural Diversity of the United Nations Educational, Scientific and Cultural Organisation (UNESCO), 2001, defines culture in its fifth preambular paragraph as 'the set of distinctive spiritual, material, intellectual and emotional features of a society or a social group, [which] encompasses, in addition to art and literature, lifestyles, ways of living together, value systems, traditions and beliefs'.[64]

The following therefore are the elements of the right to participate in a cultural life of one's own choice, namely, that (i) every person has the right to participate in a cultural life;[65] (ii) participation must be out of one's own choice; (iii) the right to enjoy culture within a community and with members of the community; and (iv) a person must refrain from forcing another person to practice and observe cultural practices.

Courts have dealt with the question of the right to participate in a cultural life of one's own choice. In the case of *JK (suing on behalf of CK) v Board of Directors of R School & Another*[66] the High Court dispensed with the issue of whether the petitioner's child should be allowed to wear dreadlocks in the respondent's school. According to the petitioner, her son had a right to exercise a culture of his own choice by wearing dreadlocks, as he was part of the Jamaican culture from where his father hailed. On the other hand, the respondent school argued that the

62 Kenya ratified CEDAW on 9 March 1984.

63 Art 13(1). See also art 22 of the Universal Declaration.

64 Art 2 of the Fribourg Declaration on Cultural Rights defines culture as 'those values, beliefs, convictions, languages, knowledge and the arts, traditions, institutions and ways of life through which a person or a group expresses their humanity and the meanings that they give to their existence and to other developments'.

65 Y Donders 'The enjoyment of cultural rights by women on an equal basis with men' in L Belder & H Porsdan (eds) *Negotiating cultural rights issues at stake, challenges and recommendations* (2017) 100-120. The author posits that 'personal cultural identities are made up of participation (or non-participation) in different (cultural) communities' (106).

66 High Court Petition 450 of 2014; [2014] eKLR (JK (suing on behalf of C, K) (*JK*).

petitioner neither provided evidence of the Jamaican culture exercised, nor did the child profess the Rastafarian religion.

The High Court held that it was the obligation of the petitioner to demonstrate to the Court the Jamaican culture that her child practised.[67] However, there was no evidence placed before the court by the petitioner to prove the child's 'Jamaican culture'. The Court further held:[68]

> While the wearing of dreadlocks for cultural or religious reasons is in my view entitled to protection under the Constitution and should be accorded reasonable accommodation, the sporting of dreadlocks for fashion or cosmetic purposes is not, and an institution such as the representative school is entitled to prohibit it in its grooming code.

In analysing whether the cultural right to practise FGM has been infringed, the Court examined the evidence that the petitioner produced to support their case as well as the Act. The title of the Act illustrates that its purpose is 'to prohibit the practice of female genital mutilation, to safeguard against violation of a person's mental or physical integrity through the practice of female genital mutilation and for connected purposes'.

Sections 19, 20 and 21 further place criminal sanctions on persons who perform FGM or aid and abet the practice of FGM. The only exceptions where an offence is not committed are contained in section 19, which provides that an approved person[69] can conduct FGM during a surgical operation that is (i) necessary for a person's physical or mental health; and (ii) conducted in any stage of labour or birth.

It is not in dispute that FGM is considered a cultural practice.[70] In effect, Dr Kamau argued that the Act restricted an individual from exercising the right to practise a culture of one's own choice. This is because it creates an offence in instances where FGM is carried out. In essence, the argument means that if a woman belongs to a culture that practises FGM, she cannot participate in it because the Act prohibits it, and she could face criminal sanctions for performing it.

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67 *JK* (n 66) para 48.
68 *JK* para 51.
69 According to sec 19(4) an 'approved person' is a medical practitioner in subsection (3)(a), and in (b) it includes a medical practitioner, midwife or anyone training to become a medical practitioner or a midwife.
70 Republic of Kenya (n 39) 3-4.

Article 44 is not the only provision in the Constitution dealing with the right to participate in a cultural life of one's own choice. The Constitution must be read as an integrated whole to verify if there are other instances where cultural practices are provided for in the Constitution that have a bearing or affect the practice of FGM. In the Ugandan case of the *Tinyefuza v the Attorney General*[71] the Court held that '[t]he entire Constitution has to be read as an integrated whole, and no one particular provision destroying the other but each sustaining the other'.[72]

Further, in the Supreme Court of Kenya decision in *In Re the Matter of the Kenya National Human Rights Commission*[73] the Court interpreted the holistic interpretation of the Constitution to mean reading a constitutional provision alongside other provision considering the history of the Constitution, the issues being disputed and the current circumstances.[74]

Based on the above, the Bill of Rights contains provisions that prohibit and direct the state from taking measures to ensure that 'harmful cultural practices' are barred. This means that the Constitution acknowledges that harmful cultural practices are prohibited. This type of analysis is critical because, based on article 2(4) of the Constitution, any law or act that violates the Constitution shall be declared unconstitutional to the extent of its unconstitutionality.

Dr Kamau also stated that the Act defines 'female circumcision' as 'mutilation', which connotes an intention to incapacitate and destroy, and that female circumcision *is part of the national heritage and history*.[75]

Although the Court did not delve into the issue of what the heritage of Kenya was in relation to FGM, it is critical to show that FGM was never a heritage of Kenya. The heritage of Kenya is mentioned in the Constitution. The first instance is in the Preamble, which provides that the people of Kenya are respectful of the 'environment which is our heritage and determined to sustain it for the benefit of future

71 Constitutional Petition 1 of 1996 [1997] UGCC 3.
72 Constitutional Petition (n 71) 18.
73 Reference 1 of 2012 [2012] eKLR.
74 *Kenya National Human Rights Commission* (n 73) para 26.
75 Amended Petition (n 11) para 10.

generations'. Second, article 11 of the Constitution recognises culture.[76] In a nutshell, article 11(1) of the Constitution recognises culture as the foundation of the nation; article 11(2)(a) obligates the state 'to promote all forms of natural and cultural expressions through ... traditional celebrations ... and other cultural heritage'; and article 11(3)(a) also commands Parliament to enact legislation 'to ensure communities receive compensation on royalties for the use of their cultures and cultural heritage'.[77] The Court, however, recognised legislation specific to cultural heritage, that is the Protection of Traditional Knowledge and Cultural Expressions Act,[78] which defines intangible cultural heritage to mean 'the practices, representations, expressions, knowledge and cultural spaces associated therewith that communities, groups and, in some cases, individuals recognised as part of their social cultural heritage'.

From the above reading of the Constitution, culture is recognised as the foundation and the cumulative civilisation of the Kenyan people and that the state has the duty to promote all forms of traditional celebration and cultural heritage. The Court should have noted that beyond the definitions of cultural heritage, cultural heritage *is not* national heritage. The cultural heritage of a group of people cannot be considered a national heritage. One reason is because the cultural heritage of a specific group of people is not necessarily adopted by other cultures to the extent that it becomes a national heritage. FGM, which is a cultural practice in few cultural communities in Kenya, cannot be classified as a national heritage. Further, considering that it is a harmful cultural practice, it cannot be deemed a national heritage that all Kenyan people recognise.

The case also unveiled issues related to cultural relativism, cultural diversity, and the universality of rights. Dr Kamau averred that each community has the liberty to practise any culture that is 'native' and relevant to that society without the imperialist imposition from another culture that holds a different set of beliefs and opinions.[79] She also opines

76 The relevant part of art 11(1) of the Constitution states: '(1) This Constitution recognises culture as the foundation of the nation and as the cumulative civilisation of the Kenyan people and nation. (2) The State shall –
(a) promote all forms of national and cultural expression through literature, the arts, traditional celebrations, science, communication, information, mass media, publications, libraries and other cultural heritage.'

77 *Kamau* (n 1) para 204.

78 33 of 2016.

79 Amended Petition (n 11) para 15.

that those moral principles are not apparent and widely acclaimed and, therefore, there is a need for tolerance of and respect for all cultures, and a misrepresentation of a cultural practice by external societies should not take precedence.[80]

The proponents of cultural relativism argue that all customs, traditions, practices and beliefs ought to be respected and cherished, with no moral codes, whereas those of universality state that rights belong to everyone wherever the individual may or may not be.[81] Tilley in his journal article titled 'Cultural telativism'[82] puts it simply that

> a judgment as to whether a culture is valid or not: is *universally valid* in case it is valid for everyone; that it is *locally valid* if it is valid for some but not all cultures; and it is culturally relative just in case it has features that ensure that it is best locally valid and never universally so.[83]

On the other hand, recent authors, such as Msuya, argue that cultural relativism has been criticised for ignoring the violation of women's rights and actually supporting perpetuating violations of human rights.[84] Tamale also raises the differences between African feminism and cultural relativism where African feminists' argument is that attention should be paid to gender whereas relativists argue that culture should be upheld.[85]

Based on the above definitions, when it comes to women's rights, cultural relativism will seek to promote culture at the expense of women's rights, especially where the custodians of the culture often are men in patriarchal societies. Whereas cultural diversity is respected under the Constitution, the universality of rights and limitation of some rights also exists.[86] This means that where cultures are harmful or discriminatory towards women or other marginalised groups, they cannot be upheld.

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80 Amended Petition (n 11) para 16.

81 S Aleksandra 'Amid cultural relativism and human rights universalism: The case of female genital mutilation/cutting: A cultural practice and a human rights violation' LLM dissertation, Tilburg University, 2017 3.

82 This was earlier published in *Human Rights Quarterly* (2000) 22 501, now published on https://philpapers.org/rec/TILCR (accessed 23 January 2018).

83 Tilley (n 82) 5.

84 NH Msuya 'The concept of cultural relativism and women's rights in sub-Saharan Africa' (2019) 54 *Journal of Asia and African Studies* 1150.

85 S Tamale 'The right to culture and the culture of rights: A critical perspective on women's sexual rights' 155, https://www.fahamu.org/mbbc/wp-content/uploads/2011/09/Tamale-2007-Right-to-Culture.pdf (accessed 2 January 2023).

86 See arts 19(2) & (3) of the Constitution supporting this and which reads: '(2) The purpose of recognising and protecting human rights and fundamental freedoms is to preserve the dignity of individuals and communities and to promote social

The Constitution of Kenya and international instruments promote cultural diversity and the universality of rights. This means that under the recognition of cultural diversity, Dr Kamau has the right to practise a culture of her own choice, different from others. However, a reading of articles 2(4) and 25 of the Constitution illustrates that the right to practise a culture of one's own choice is not an absolute right and, therefore, the right may be limited, or a cultural practice can be declared unconstitutional to the extent of its unconstitutionality. Article 2 states that the Constitution is supreme and any act or contravention, even cultural practices under the notion of cultural relativism, are invalid.

In relation to the right to culture the Court held that culture is dynamic,[87] and although the Constitution grants people the freedom to exercise their own culture, the freedom must be carried out in line with other constitutional provisions.[88] This means the freedom is subject to limitations. It is interesting that the Court, in an *obiter dictum, provided instances of limitations of freedoms where attempted suicide*[89] and abortion[90] constitute offences in the Penal Code.[91]

The Court also conducted an analysis under article 24 of the Constitution and found that, indeed, the right to culture can be limited in an open and democratic society. In this instance, the Court held that by the Act creating the offence of FGM, it was a justifiable limitation of the right to culture because of the duty of the state to protect persons against harmful cultural practices.[92]

3.2 Consent to female genital mutilation

The other question that arose was whether willing women should undergo the procedure, and its related question, namely, what the effect

justice and the realisation of the potential of all human beings. (3) The rights and fundamental freedoms in the Bill of Rights – (a) belong to each individual and are not granted by the state; (b) do not exclude other rights and fundamental freedoms not in the Bill of Rights, but recognised or conferred by law, except to the extent that they are inconsistent with this chapter; (c) are subject only to the limitations contemplated in this Constitution.'

87 *Kamau* (n 1) para 205.
88 *Kamau* (n 1) para 211.
89 Sec 226 Penal Code.
90 Secs 158-160 Penal Code.
91 *Kamau* (n 1) para 211.
92 *Kamau* (n 1) paras 201 & 210.

of allowing this would be. Dr Kamau argued that willing women and not children should be allowed to undergo the procedure, as per their culture. Article 53 as well as the Children's Act protect children from undergoing the procedure. Therefore, the law is clear that FGM should not be performed on children.

With respect to willing women, article 260 of the Constitution defines an adult as a person who has attained the age of 18 years. Section 2 of the Children's Act defines a child as 'any human being under the age of 18 years'. Article 55 of the Constitution also requires the state to put in place measures to prohibit harmful cultural practices against 'the youth'. According to article 260 of the Constitution, the term 'youth' means 'the collectivity of all individuals in the Republic who (a) have attained the age of eighteen years; but (b) have not attained the age of thirty-five years'.

Using a holistic reading and interpretation of the Constitution as to who should not undergo harmful cultural practices, we submit that the Court should consider interpreting articles 53 and 55(d) to mean that the Constitution mandates the state to protect girls (children) as well as women between the ages of 18 and 35 years from harmful cultural practices such as FGM. Therefore, based on this interpretation, the state has a duty to protect women between the ages of 18 and 35 years against FGM.

However, the next question for the Court to decide would be whether article 55(d) of the Constitution, which requires the state to put in place measures to prohibit harmful cultural practices, can limit a person's right to participate in a cultural life of one's own choice under article 44(1) of the Constitution. The answer to this is in the negative. This is because, first, an express provision of the Constitution must be implemented in its entirety unless a constitutional amendment as per article 255 is done. Second, article 19(3)(c) of the Constitution stipulates that '[t]he rights and fundamental freedoms in the Bill of Rights – (c) are subject only to the limitations contemplated in this Constitution'. The general limitation clause is enshrined in article 24 of the Constitution. Article 52(2) of the Constitution further provides that in interpreting the rights under Part Three, '[t]his Part shall not be construed as limiting or qualifying any right'. '

A reading of articles 19(3)(c), 24 and 52(2) of the Constitution means that although articles 53(1)(d) and 55(d) prohibit harmful

cultural practices, they cannot be seen to be limitations on the rights under article 44(1). However, we wish to reiterate that the Constitution proscribes harmful cultural practices in relation to persons below 18 years and between the ages of 18 and 35 years with no exception. The Court ought to have conducted an analysis that if the tate has the duty to protect the women in these age brackets, then women above the age of 35 years should also be protected from harmful cultural practices. The special protection for children and the youth, therefore, should be extended to women above the age of 35 years. Article 55 of the Constitution only sought to emphasise the protection of rights of the youth who were previously marginalised. Indeed, it could be interpreted that a harmful cultural practice does not become harmless the moment a woman reaches the age of 36 years. Women also fall in the category of persons who were previously marginalised.[93]

From the wording of article 44, the scope of the right is that the participation in a cultural life is a matter of choice. This is emphasised both article 44(1) by the reference to 'the right to ... participate in the cultural life, of the person's choice' and in clause (3): 'A person shall not compel another person to perform, observe or undergo any cultural practice or rite'. What this means is that there is no right to compel or force another person to undergo any cultural practice.

The case Dr Kamau raised was not related to compulsion, but to free choice. However, the questions the Court seemed to ask itself was how it happens that even young or old women choose to undergo such a procedure that is painful and causing harm. Do they do so because of pressure and persuasion? Is the choice of a woman who has no or little idea that other women do not undergo such a practice really a free choice?

The Court scrutinised the cultural reasons as to why the practice is done to arrive at a decision whether the decision of a woman to undergo FGM is her free choice. The Court indeed analysed the evidence of

93 Art 56 of the Constitution protects minority and marginalised groups and mandates the state to ensure that there are affirmative action measure to promote their culture, in this instance their positive culture. Art 260 of the Constitution defines marginalised group to mean a group of people who, because of laws or practices before, on, or after the effective date, were or are disadvantaged by discrimination on one or more of the grounds in art 27(4). Women in Kenya were previously marginalised based on their gender. See *In the Matter of the Principle of Gender Representation in the National Assembly and the Senate* [2012] eKLR, dissenting opinion of Mutunga CJ, as he then was, para 11.4.

three survivors who confirmed that misinformation, deception and societal pressure contributed to them undergoing the cut.[94] One witness who managed to escape the cut suffered beatings from family and was shunned by the community and future prospective suitors who could have married her in future because of her refusal to undergo FGM.[95]

Other evidence, although not mentioned in the judgment, which shows the causes of FGM is the National Plan of Action for the Elimination of Female Genital Mutilation in Kenya,[96] where it is noted that the rationale behind the practice of FGM in communities in Kenya include that it is a rite of passage for girls to womanhood; it protects girls and guarantees that they are accepted and respected in the community; it makes girls and women suitable for marriage; it promotes the birth of healthy children; it ensures cleanliness; ensures that the girls remain virgins; enhances male sexuality; and prevents promiscuity as well excessive clitoris growth.[97] Socially, girls or women who have not undergone the procedure are often stigmatised and not accepted in their communities.[98]

As the Court noted, the reasons for performing FGM are to be suitable for marriage and to suppress women's sexuality, and a failure to do so will result in not being accepted by the community. The Court also evaluated whether these reasons affected the choice of a woman to participate in a cultural practice such as FGM.[99]

The Court analysed the issue of choice using the case of *United Millers Limited & Another v John Mangoro Njogu,*[100] where Mativo J commented as follows:

> A man cannot be said to be truly willing unless he is in a position to choose freely, and freedom of choice predicates, not only full knowledge of the circumstances on which the exercise of choice is conditioned, so that he may be able to choose wisely, but the absence from his mind of any feeling of constraint so that nothing shall interfere with the freedom of his will.

94 *Kamau* (n 1) para 167.
95 As above.
96 Republic of Kenya National Plan of Action for the Elimination of Female Genital Mutilation in Kenya 1999-2019, Nairobi, June 1999.
97 Republic of Kenya (n 96) para 1.3.
98 As above.
99 *Kamau* (n 1) para 171.
100 High Court Nyeri Civil Appeal 118 of 2011; [2016] eKLR.

In addition, the European Court of Human Rights has examined choice in relation to a person conducting harm on themselves. In the case of *Laskey, Jaggard and Brown v the United Kingdom*[101] the issue of whether willing consenting adults who participate in sado-masochistic encounters in private should be criminally punished and whether the sanctioning of these encounters was in violation of the right to private life under article 8 of the European Convention of Human Rights. In that case the petitioners argued that they were willing consenting adults and that the sado-masochism encounters were a form of sexual expression and not violence because there were neither permanent injuries, infections to wounds nor was medical treatment required after the acts. They further argued that the state could not regulate private morality and that the Act that criminally sanctioned their acts violated their right to a private life under article 8 of the European Convention of Human Rights.

The European Court of Human Rights dealt with the issue of whether the state could regulate actions of willing consenting adults. It held that the state could regulate activities that caused harm and that, therefore, the state did not infringe the petitioners' right to a private life.[102]

From the above case, what is essential in the protection of rights is not whether a willing adult consents to participate in an activity due to one or another reason. The state has the responsibility in instances where the act consented to can cause harm to regulate such actions. This means that the state's duty to uphold, protect and to fulfil rights in the Bill of Rights does not diminish because an adult has consented to participate in harmful activities.

In the *Kamau* case the cultural reasons for performing FGM on girls and women can, therefore, be interpreted to mean that they decided to go undergo FGM, primarily because of heavy persuasion, amounting to coercion because of a fear of lack of acceptance in the community. It will

101 ECHR Application: 109/1995/615/703-705.

102 *Laskey, Jaggard and Brown* (n 101) paras 43-44. The Court held: '43. The Court considers that one of the roles which the state is unquestionably entitled to undertake is to seek to regulate, through the operation of the criminal law, activities which involve the infliction of physical harm. This is so whether the activities in question occur in the course of sexual conduct or otherwise. 44.The determination of the level of harm that should be tolerated by the law in situations where the victim consents are in the first instance a matter for the State concerned since what is at stake is related, on the one hand, to public health considerations and to the general deterrent effect of the criminal law, and, on the other, to the personal autonomy of the individual.'

not be an informed decision and choice to undergo the practice for their own benefit or enjoyment. If people routinely based on heavy persuasion and societal pressure, this amounts to coercion and is not a violation of any right to exercise one's culture, because the element of choice is absent. The girl or woman has not made a choice to participate in the culture.

The Court held that although FGM is a cultural practice, a person has no constitutional right to undergo a harmful cultural practice, and since the element of choice is absent, there is no violation of the right to culture as espoused in article 44(3) of the Constitution.[103]

4 Conclusion

In conclusion, the judgment of the Kenyan High Court clearly affirmed that every person has the constitutional right to practise a culture of their choice. However, this right may be limited by the state if the culture being practised is not positive but a harmful cultural practice. Kenya met its constitutional and international law obligations to ensure that girls and women are protected from any form of harmful cultural practices such as FGM through the enactment of the Act, which was a legislative measure used to eradicate this harm. FGM is a form of violence against women and, therefore, Kenya met its state due diligence obligation to protect women from undergoing FGM, and where they have undergone it, to ensure that the perpetrators are punished. The Court also noted that the Act fell short of creating an offence of all types of FGM through the exclusion of type IV FGM, and noted that a specific group of women could use the gap in the law to pay for procedures that would be categorised under type IV FGM, and it was necessary that such procedures be criminalised in line with the Constitution and the law. Therefore, although the Dr Tatu Kamau case was filed with the goal of decriminalising and medicalising FGM in Kenya, the Court affirmed the constitutional aspirations of the Kenyan people to ensure that this harmful cultural practice is completely eradicated, and that women are fully protected.

103 *Kamau* (n 1) para 215.

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7

ERADICATING UNDESIRABLE CULTURAL OR RELIGIOUS PRACTICES THROUGH CRIMINALISATION: THE NEED FOR EQUITY IN THE CASE OF BODY MODIFICATION SURGERIES

*Godfrey B Tangwa**

Abstract

Cultural and religious practices are particularly difficult to modify, let alone eradicate, as they are anchored in the beliefs, habits, routine practices and attitudes of specific groups of human beings. Attempting to eradicate any such practice is a Herculean though not impossible task. Modification or even eradication of any such practice is more feasible if initiated from within the practising group. In the case of what some have called female genital mutilation, attempting to eradicate it through criminalisation is particularly problematic for various non-exhaustive reasons. First, the call for criminalisation has generally been advocated and championed by people not belonging to the practising group. Second, FGM generally belongs in the same category of kind with similar practices that are not equally canvassed for criminalisation, resulting in treating equals unequally, a clear case of unjustifiable discrimination or exceptionalism. Third, criminalisation belongs in the domain of the law, typically used in every society by the governing classes to control the governed, and not necessarily in the domain of human reason, morality, or rights. Fourth, the practice of FGM has persisted in some jurisdictions where it has been criminalised, thereby calling into question the effectiveness and advisability of criminalisation as a strategy for eradication.

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1 Introduction

If it is right to pierce your upper lips, can it be wrong to pierce your lower lips?

Female genital mutilation (FGM)) evidently is an instance or a subset of a group of practices that may be designated as or subsumed under terms such as 'genital surgeries', or 'bodily modifications' including such others (randomly) as female circumcision; male circumcision; tattooing; breast reduction; breast enlargement; breast removal; penis elongation; foreskin replacement; body piercing; ear/lip/eyelid/chin; facial scarification; and so forth.[1] Any specifiable difference among the foregoing categories is a difference in degree, method or procedure, not a difference of kind. To gingerly pick out FGM from this long list of morally problematic practices and to particularly lambast it as a universal scandal requires both an explanation and a convincing justification. However, while there are explanations for the focal interest on, if not obsession with, FGM, none of these alone or even all of these together constitute a sufficiently convincing justification for such discriminatory particularistic focal interest. In this chapter I consider FGM within the company of its moral equals and I attempt to outline rational and morally imperative arguments or conditions under which any such practices may be deemed wrong, unacceptable, and justifiably legally possible to be criminalised.

1.1 Moral argument on body modification surgeries

In 2004 Tangwa made a moral argument covering all these ethically questionable cases indiscriminately.[2]

> [E]xcept for indisputably curative therapeutic reasons, circumcision (male and female), and other types of body modification ... surgeries, is clearly ethically wrong, if carried out without the explicit solicitation and fully mature and well-informed consent of the person on whom it is performed, because it violates bodily integrity, autonomy and self-determination. On no account, therefore, should any of these surgeries be carried out on an infant, child or other morally incompetent human being, for non-therapeutic reasons.

1 WHO 'Female genital mutilation' (2022), https://www.who.int/news-room/fact-sheets/detail/female-genital-mutilation (accessed 21 January 2022).

2 GB Tangwa 'Bioethics, biotechnology and culture: A voice from the margins' (2004) 4 *Developing World Bioethics* 125-138.

The above argument may not be as elegant as it could possibly be stated but, as far as the moral concern with the practices under discussion goes, we need no more than the above seminal argument that can be expanded or rephrased according to need. It is important to recognise that the argument prescribes the proscription of FGM and its moral equals under the clear conditions delimited. Ngwena, who has critiqued my chapter, leaves the impression that it is any of my argument that FGM should not be eradicated simply because its moral equals have not also been proposed for eradication. That is none of my argument.

However, every individual exclusively owns his or her own body and there are things any such individual, provided they possess full maturity, rationality, and moral competence, can legitimately freely choose to do to their body; that is what the fundamental moral principle of autonomy is all about. Of course, autonomy is not an absolute principle; it is constrained by human epistemological limitations, and sometimes it may be justifiable to refuse respecting the autonomy of some individual choices, a good example being any choice implying severe bodily harm and requiring the cooperation of a third party.

In the absence of the provisos outlined, modifying the body, especially in a permanent and irreversible manner, is conceivable only for indisputably medically curative reasons (enhancement may not pass the test) aimed at avoiding permanent harm or saving life. It thus is ethically problematic to carry out any permanent body modification on an immature/incompetent person because this can only depend on proxy consent. While proxy consent can validly be given by parents or other legal guardians on behalf of incompetent persons, this is not sufficient in the case of permanent body modifications on account of their drastic nature and irreversibility. A criminalisation law for any legal jurisdiction, therefore, can justifiably be crafted along the lines of the above moral reasoning.

1.2 Complexifiers of the problem

The discussion of FGM has been made more complex and complicated by cultural, religious, racial and political considerations. Furthermore, the advocacy or campaign approach by people whose activism on the issue evidently is not based solely on moral considerations or moral outrage; otherwise, they would not have ignored FGM's moral equals, and even more outrageous practices such as racism, alcoholism, tobacco

consumption and drug addiction. In many of these cases, including FGM and its moral companions, sanctions, if not carefully rationalised, may be targeting the victims rather than the real perpetrators of the problem or undesirable situation.

Within the broad culture that covers what is designated as the industrialised 'developed world' paradigmised by Europe, America, Canada, Australia and, to an emerging extent, South Africa, the discussion of FGM and the campaign for its eradication has been intense and persistent. It has successfully converted and proselytised many voices from within practising groups. Involving some of the best minds within the *cultural bracket, rigorous analyses of the problem have scarcely left out any significant considerations.*[3]

The questions of moral rightness or wrongness defy, and cannot be settled by intellectual discussion and rigorism alone. On moral matters, the common (wo)man on the street may sometimes get it right where intellectuals and university professors have failed. Correct moral judgment requires moral sensibility and sensitivity, altruistic empathy and absence of egoism. More importantly, moral right and wrong are not about supremacy, activism or democratic opinion polls. Activism may intimidate people into accepting as right what is wrong or accepting as wrong what is neutral between morally wrong and morally right.

The reason for the focal interest on, not to say obsession with, FGM may not be unconnected with the fact that Western industrialised culture seems both fascinated and repelled (*mysterium tremendum et fascinans)* by human sexuality but also that the topic under discussion is of a strange practice of 'other' cultures, not recognised as a value or an acceptable practice anywhere within 'own' culture. In this way, underlying unavowed racist beliefs and stereotypes may quietly be animating both the discussion and the activism.[4] That is one plausible reason that the equality or similarities between female circumcision, cutting, alteration (FGM) and male circumcision, cutting, alteration (MGM), let alone other types of body modification, has not been recognised in the eradication

3 H Burrage 'Preventing FGM: Beware a turf war between medicine and law' 7 March 2015, https://hilaryburrage.com/2015/03/07/preventing-fgm-beware-a-turf-war-between-medicine-and-law/ (accessed 21 January 2022).

4 M Fish and others 'A new Tuskegee? Unethical human experimentation and Western neo-colonialism in the mass circumcision of African men'(2021) 21 *Developing World Bioethics* 211.

campaigns and has been vigorously conceptually combated when this is pointed out.

2 Undesirable practices of identifiable human groups

Any identifiable human grouping, be it cultural, religious or political, may have undesirable practices, moral or otherwise; just like any individual human being. Such practices are easier and best eliminated if the impulse for such elimination comes from within the person concerned or the group itself. From without, the group or person can be provoked, encouraged, or persuaded to consider eliminating any such practice. Where the motivation to eliminate FGM is initiated by external forces outside of the person or group, the task is likely to be more difficult. The other option available is through the application of constraint or coercion rather than persuasion; in which case a relationship of colonisation, superior or inferior, master or slave or, in any case, of dominating power and control is necessary. Industrialised Western culture and the societies that share that culture is a globally-dominant culture. The dominating power structures of Western industrialised culture include without being limited to the World Bank, the International Monetary Fund (IMF), the World Health Organisation (WHO), the World Trade Organisation (WTO), and the World Economic Forum.

These powerful structures could conceivably be reformed, transformed, and adapted to serve the diverse human global communities with equity, fairness, and even-handedness. However, that is never ever likely to happen without a paradigm shift in the orientation, mindset, and attitudes of those who created, run and control these structures. For that to happen, an ubuntu orientation in leadership, bioscience, medicine and healthcare would be necessary.[5] [6] [7]

5 NS Munung and others 'Genomics governance: Advancing justice, fairness and equity through the lens of the African communitarian ethic of ubuntu' (2021) 24 *Medicine, Health Care and Philosophy* 377-386.

6 TI Nzimakwe 'Practising ubuntu and leadership for good governance: The South African and continental dialogue' (2014) 7 *African Journal of Public Affairs* 30-41.

7 GB Tangwa 'Bioethics and ubuntu: The transformative global potential of an African concept' in H Lauer & H Yitah (eds) *The tenacity of truthfulness: Philosophical essays in honour of Mogobe Bernard Ramose* (2019) 239-249.

2.1 Legal criminalisation as a solution

The legal criminalisation is an extreme coercive method. It would scarcely be contemplated from within a group some of whose practices require, even by their own admission, reform, change, or elimination. Its prescription, therefore, signifies the likelihood that those interested in the change are outsiders to the group or proselytised converts, which does not, of course, invalidate the prescription. In the case of so-called FGM, it is evident that the motivation and prescription of criminalisation can only be external to the group even if it may involve some members of the group who have been externally persuaded and proselytised into believing in criminalisation as a solution. Otherwise, had their conviction been genuinely independent, they would have first attempted internal methods for effecting change and that could hardly begin with legal criminalisation for a practice current within a group to which they themselves belong.

The first sign of the external drive for criminalisation in this case is in the choice of the very expression 'female genital mutilation' (FGM) rather than female circumcision, female genital cutting, female genital excision, or female genital alteration which come to mind as alternative expressions describing the same reality. The second sign is the choice of the concept of eradication (destroying and getting rid of) rather than elimination (removing or taking away), change (replacing with something more acceptable), or discouragement (making someone less enthusiastic and willing to do something) as a solution.

No parent worthy of his or her parenthood would set out to 'mutilate' or to harm the child knowingly and willingly in any way. It is a fact that within the practising groups, FGM is perceived as doing something good to the child no matter how erroneously. No one within the practising community could conceivably argue that 'we believe in mutilating our children because that is our culture, and our religion'. The term 'female genital mutilation' is a strongly pejorative term loaded and laden with negativity and condemn-ability, connoting unmitigated, unequivocal harm.

It is a description imposed from the outside by people with a superiority complex and a vested third party interest against the practice. It is an unfortunate choice of a linguistic expression (despite its endorsement by the WHO) to describe a practice of which the abolition for all non-

competent or non-consenting individuals is strongly justifiable and can easily be justified.

The inevitable taint that culture and social milieu imposes on our apprehension and appreciation of objective facts can only be adjusted by frank rational dialogue between those with differing views or perspectives, devoid of political motives, superiority complex, and campaign or winning stratagems. However, one of the hallmarks of a dominant and dominating culture is precisely insensitivity to difference and the need to listen with sympathetic attention to the point of view and perspective of the dominated counterpart.

3 Neutrality and fairness: Treating equals equally

One condition for making valid moral judgments and, in fact, judgments in general is objective neutrality before the facts from which the judgments are drawn. Without such neutrality, we are likely to judge equals unequally or the un-equals equally. It is conceptual neutrality and fairness that enables us to elaborate a rational argument on any issue as opposed to making a special pleading for it. An objective rational argument distinguishes philosophy from mere sophistry. Our critical sense of objectivity, neutrality, and fairness should put us on the alert when we are making judgments about what we have not experienced personally or at least vicariously as well as what we might have uncritically accepted or rejected based on religious or cultural dogmas.

3.1 Circumcision in Nso' culture

As elsewhere in Africa, circumcision among the people of Cameroon, particularly within the culture of the Nso' people of the grassy highlands of Bamenda, primarily is an initiation ritual, a *rite de passage* to adulthood. The Nso', like the Jews, are similar in one respect: They circumcise their male but not their female children. It is not quite clear why the Nso', unlike some other African groups, never thought of female circumcision, but they cherish female intactness at marriage and make fun of the very idea of circumcising a female child in the same way that they ridicule, say, the practice of bride price as 'selling out a daughter like a goat'. Unlike the Jews, however, the Nso' do not circumcise as a matter of any divine command nor even from any other religious reason, except in so far as the very idea of ritual might connote and evoke a certain religious

feeling. Nso' traditional religion, like African traditional religion (ATR) in general, is neither a doctrinaire nor a proselytising religion. Circumcision among the Nso' is a purely secular and profane ritual of initiation into adult manhood.

Rituals are very important in Nso' culture, like in nearly all other African sub-cultures, and the most important stages in life are always marked by appropriate rituals.[89] As a ritual, the term 'circumcision' may be considered a euphemism, and the Nso' have two further euphemisms for this euphemism. They call it *nangsin* which literally means to fix, repair or correct, but which also connotes prepare or arrange. They also call it, more obscurely, sang mbe which literally means to mark or scarify the shoulders, on which most heavy loads are carried, but which also connotes to toughen, fortify or strengthen. Circumcision, both male and female where it is practised in Africa, therefore is nothing extraordinary to be overly obsessed about beyond other practices of the same order or category.

3.2 Personal experience

Before 1996 I was not personally aware that the practice of circumcision raises serious medical and ethical problems. I had, of course, especially from 1994 onward, increasingly been aware of the great Western campaign against 'female sexual mutilations', a campaign that looked like an off-shoot of the feminist movement and which, perhaps because of my own peculiar cultural background, I considered quite appropriate and timely, even if somewhat exaggerated. I had heard stories about how, in the USA, some African women, in danger of being deported as illegal immigrants, had successfully used the 'female genital mutilation card' to avert the danger of deportation by claiming that they ran the risk of being forcibly circumcised if they returned to their motherland.

I had first become aware of the existence of the practice of female circumcision during my university student days (1974-1984) in Nigeria where the practice is common among some indigenous groups. I then considered it an extremely strange practice, not knowing at the time that it also existed in some parts of Cameroon; so great are the diversities in

8 GB Tangwa 'Bioethics: An African perspective' (1996) 10 *Bioethics* 183.
9 VW Turner 'Symbols in African ritual' (1973) 179 *Science* 1100.

the sub-cultures of Africa. When I tried to enquire as to why anyone would do such a 'senseless thing' as 'circumcising a female', I gathered that it was believed to reduce promiscuity among young women and to facilitate childbirth. Such reasoning by unlettered folk with insufficient awareness is quite understandable even if not completely convincing as a justification for the practice.

4 Rationalisations for circumcision

The pretext that FGM reduces promiscuity among young women while facilitating childbirth is a typical uncritical rationalisation of a cultural practice, and rationalisations of the type for various cultural practices as well as taboos that exist in all cultures. There were three main rationalisations in favour of male circumcision (in the absence of anything that could pass for female circumcision) in traditional Nso': To begin with, circumcision prepared the penis, putting it in a state of readiness for coitus and procreation, which was considered the main purpose and *raison d'être* of marriage. In addition, circumcision tested the courage and endurance ability of a boy at the threshold of adulthood, during which these qualities would be indispensable and frequently needed. Finally, circumcision tames, moderates and tempers the sexual instinct, thereby helping a man to act responsibly as an adult and especially as a parent. The traditional Nso' were very much aware that the pleasures of sex, like those of drink and food, are best enjoyed in moderation, even if that awareness was often recognised more in the breech than in the observance.

The above rationalisations for (male) circumcision, thanks to historical evolution and development of Nso' culture, to better critical awareness, and to the influence of ideas originating from outside the culture, would hardly be convincing today or, at any rate, would be considered insufficient to justify generalised routine circumcision. However, until recent times Nso' traditional society was a society greatly obsessed with procreation or parenthood and one in which great endurance and courage were called for, especially from men. Men's main occupations were warfare, internal security, hunting, housebuilding and long-distance perambulate trading, while women and children concentrated on home-keeping, farming and child care. Whenever any danger threatened the traditional Nso', the impulsive reaction was always quickly to move the women and children to a safe place, as men came

out and faced frontally whatever danger it was. In fact, once a danger alarm was heard, a man grabbed his machete (in a scabbard) and spears, gave quick instructions to his wife/wives and children, and dashed off in the direction of the alarm without any precise knowledge of what it might be all about. Against such an existential background, it is easy to imagine how the necessity for male circumcision would have arisen, been rationalised, and become an unquestioned cultural practice.

5 Female genital mutilation, feminism and patriarchy

The campaign against FGM in the Western world has been linked and closely connected with feminism and its severe critiques of patriarchy within the broader context of gender discourse. Although John Stuart Mill, a social critic and male feminist in his day and time, had made the strongest case for equality of the sexes when he expressed the opinion that

> the principle which regulates the existing social relations between the two sexes – the legal subordination of one sex to the other – is wrong in itself, and ... one of the chief hindrances to human improvement; and ... ought to be replaced by a principle of perfect equality, admitting no power or privilege on the one side, nor disability on the other[10]

it is the Western feminist movement that has carried out the most far-reaching reaction to gender – an advocacy of women's rights in the face of discrimination, oppression or marginalisation – on the ground of the equality of the sexes implied in the equality of human beings.

This has helped to complicate and to complexify the simple and straightforward moral case against FGM and similar practices of equal moral concern. Gender discourse arises from the relationships between the two almost equal halves of humanity – women and men. As a biological fact that we do not fully understand, human beings in their vast majority come into the world, from the point of view of sex alone, as either male or female, with a small minority of anomalous or ambiguous cases neither clearly male nor female.

10 JS Mill *The subjection of women* (1869) 1.

5.1 Sex and gender

The ratio between human beings who come into the world in this sense as females to those who come as males is roughly 50/50 in nature. However, this balance, like the erstwhile balance in the climate, has rudely been upset by reckless human interventions and manipulations. That is as far as biological sex goes, but maleness or femaleness considered not merely as a biological fact but with reference to socio-cultural functions/expectations, norms, attitudes, and deep personal feelings is what is meant by gender. Gender considerations tend considerably to increase the marginal anomalous cases between maleness and femaleness and reveal many problems underlying socio-cultural, religious, and legal organisation/categorisation in all societies of the world.

In this situation, those who continue to see the world as populated only by males and females, men and women, have been accused of binary thinking and a great campaign, anchored on human rights, has ensued defending non-gender, bisexual, and transgender human beings as different but equal with any other human beings. The campaign logically and naturally then defends the right as well to be of any sexual orientation – heterosexual, homosexual, lesbian, bisexual, pansexual. Acronyms such as LGBTQIA (lesbian, gay, bisexual, transgender, queer and/or questioning, intersex and asexual and/or ally) have surfaced and are dominating global discourses. This development is perfectly in line and harmony with what this chapter considers to be the first postulate of bioethics, namely, a human being is a human being simply by being a human being and not for any other reason. Unfortunately, the full logical implications and consequences of this postulate have not yet been drawn in the current state of global bioethics. The reason for this failure lies in beliefs and practices that have become unquestioningly accepted within the dominant culture of the world.

5.2 Morality and the law

The natural allies or road companions, to use a common metaphor, of ethics are law, human rights theory and practice, civics, religion, and the customs, taboos and traditions of communities or societies. All the above are necessarily mingled and interwoven with ethics; but ethics is separable from each and all of them. Ethics, moreover, is rationally more compelling than any of its road companions. For instance, no law, no

custom, cultural or religious practice, is justifiable if it is unethical if it can rightly be judged as morally wrong or bad because, in a sense, all these are meant to serve morality and morality is more important than all of them. On the other hand, it cannot be argued that any putative practice is ethical simply because it is the law, cultural custom or religious practice. As Cook and others have rightly pointed out with regard to the law:[11] [12]

> Law aims to serve the ethical principle of justice. Accordingly, it is not an ethical justification of a policy simply that it is legal. It is not even an ethical justification that a democratic government of a country had a popular mandate to introduce or support the particular law, and that it has been upheld by a country's most significant court according to the country's constitution. These features alone, while legally and politically significant, do not show that the law is ethical.

The most basic ethical injunction intuitively apparent to all rational beings can be stated as 'Do good (right) and avoid evil (harm).' Ethics is indispensable in all human activities and, for any activity, behaviour, act, or action we can consider that ethics holds up one of three possible cards – green for ethically okay and please go right ahead, yellow for ethically problematic and please pause to think carefully before proceeding, and red for ethically wrong and please stop and do not proceed. There are situations and circumstances in which it may not be possible completely to do good or right and to avoid harm or evil. In such situations we are in a moral dilemma and, no matter how we proceed, some evil or harm will result. In situations of dilemma, we proceed with that course of action that achieves better than harm or lesser than greater harm.

5.3 Between good and evil in human societies

Rationality and morality can be called the universals of cultures. They are of the very essence or definition of being human or having a culture and no human culture seems possible without them. Human rights for their part are a subset or derivative of ethics/morality, a powerful heuristic device or tool for canvassing ethical conduct and facilitating

11 RJ Cook and others *Reproductive health and human rights: Integrating medicine, ethics, and law* (2003) 554.

12 GB Tangwa 'Ethics in African education' in AB Nsamenang & TM Tchombé (eds) *Handbook of African educational theories and practices: A generative teacher education curriculum* (2012) 91.

behaviour-change in the modern world. Similarly, law is also a derivative or subset of ethics/morality with the notable advantage of being more robust and efficacious in its coercive and behaviour-changing effects, but with the limitation of being restricted to particular or specific politico-geographical areas of jurisdiction. The idea of 'international law' or of 'international human rights law' is today still basically a prescriptive ideal whose limitations are set by the idea or an obsession with 'national sovereignty'.

The WHO, as one of the powerful UN regulatory arms of Western industrialised culture has a zero-tolerance policy against FGM. According to the WHO and other UN agencies, female genital modification of any type is inherently patriarchal, reflecting deep-rooted inequality between the sexes and characterised by male dominance over the female gender which it considers as an extreme form of discrimination against women.[13] We should all be concerned about discrimination, let alone extreme discrimination, but there is no rational reason why our concern should be limited to women. Many societies around the globe do practise genital modifications, some as cultural rituals, and others not. Now, many societies that carry out genital modifications for men do not carry out any equivalent modifications for women, but nearly all societies that carry out genital modifications for women always also carry out equivalent modifications for men.[14] In other words, societies that practise FGM also practise male genital mutilation (MGM) whereas not all societies that practise MGM also practise FGM. To the extent, therefore, that genital modification is a problem, it is more prevalent for men than women. It therefore clearly is discriminatory to severely condemn it in the case of women but not in that of men. Such discrimination and double standards occur because the WHO is one of the powerful regulatory institutions of industrialised Western culture where male genital modification is an acceptable routine practice whereas female genital modification is unheard of and looked upon as one of those strange practices of other cultures. As a global institution, at least at the intentional level, the WHO needs to take non-Western

13 Turner '(n 9) 1100-1105; UNAIDS and others 'Eliminating female genital mutilation: An interagency statement (2008).

14 E Gruenbaum and others 'Reconsidering the role of patriarchy in upholding female genital modifications: Analysis of contemporary and pre-industrial societies' (2022) *International Journal of Impotence Research* 202–211.

cultures seriously into account and not consider them through the prism of the ever-abiding impulse of Western colonising power and control.

The idea of patriarchy is a legitimate and important problematic but it should not be brought into this discussion to complicate and obscure simple, clear, and persuasive arguments. Western societies are the paradigm of pure patriarchal societies whereas other cultures have a variety of other systems that challenge and constrain pure patriarchy. In Africa, for example, besides patriarchal societies, matriarchal societies exist, and other societies cannot easily be described as either patriarchal or matriarchal. It is hard to describe, say, my own natal culture as either patriarchal or matriarchal and I have attempted to describe it as patriarchy founded and grounded on matriarchy.[15] The Nso' kingdom was founded by a woman, Ngonnso', whose emblem was looted from the Nso' palace by colonising German soldiers in 1902 and Nso' culture is obsessed with the *Kitaryiy system* whereby everybody's well-being and life fortunes are considered to emanate from the mother's rather than the father's lineage. Anybody discussing patriarchy in Africa ought first to be familiar with the diversity and complexity of African cultural systems. It is not enough to adopt a superiority complex and to allege from a safe distance the existence of patriarchy and to attribute to it practices that in themselves have little or nothing to do with it.

6 Conclusion

Genital modification, whether male or female, including what some people prefer calling female genital mutilation (FGM) and male genital mutilation (MGM), raises important ethical problems. It is invasive and violates personal bodily integrity in ways that maybe irreversible. Such genital modification is envisage-able as ethically permissible if and only if it is carried out for curative therapeutic purposes or if it is carried out on the solicitation of a well-informed competent adult on him/herself. Outside of these two instances, any such modification is fraught with serious ethical problems. This argument is not only simple but valid and rationally persuasive. It has got nothing to do with patriarchy which could conceivably only come in as an explanation, not a justification. Whether your society is patriarchal, matriarchal, neither or both, the

15 GB Tangwa *Elements of African bioethics in a Western frame* (2010) 14-27.

argument remains valid and persuasive. The argument also has nothing to do with feminism. Even though we should all be feminists, as urged by Chimamanda Ngozi Adichie, neither feminism nor male chauvinism has anything of substance to add or subtract from this argument. Legislation, including criminalisation, is a good way to canvass compliance for ethically imperative issues but it must be employed judiciously after ensuring that it is not discriminatory between individuals or groups of individuals and is not supportive of double standards in any way.

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PART III: Survivor narratives and feminist perspectives

8

RE-TELLING THE EXPERIENCES OF AFRICAN WOMEN WITH FEMALE GENITAL MUTILATION THROUGH AN AFRICAN FEMINIST LENS

*Agnes Meroka-Mutua**

Abstract

Female genital mutilation/cutting (FGM/C) is a contested issue in Africa because, although there is overwhelming evidence to show how it is harmful to women and girls, there also has been resistance to efforts aimed at its abandonment, and especially its criminalisation. Some of this resistance has come from women in communities that practise FGM/C. As a theoretical paradigm that uses an African centered methodology, African feminism is grounded in the history and experiences of African women. To this extent, it provides tools that are useful in analysing the way in which African women have responded to efforts aimed at promoting their rights through the abandonment of FGM/C. This chapter analyses the experiences of African women with regard to FGM/C through an African feminist lens and looks specifically at the tensions that exist in the way in which African women have responded to anti-FGM interventions. It finds that at different points in time, African women have led and supported abandonment efforts and at other times, they have resisted abandonment efforts. Through the stories of African women, we see that both the cultural practice of FGM and the efforts aimed at its abandonment curtail women's autonomy over their bodies. In responding to both FGM and abandonment efforts, African women are primarily concerned with questions of autonomy and agency.

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1 Introduction

Female genital mutilation/cutting (FGM/C) refers to a set of practices that result in the total or partial removal of the external female genitalia. There are different types of FGM/C, which vary in terms of severity, and these are classified by World Health Organisation (WHO) as type one which entails clitoridectomy; type two which entails the total or partial removal of the labia; and type three which entails the removal and appositioning of the labia as a way of narrowing the vaginal canal.[1] WHO also lists type four, which includes all other procedures that result in the alteration of the external female genitalia and can include pulling, pricking, piercing or cauterisation, among other practices. It should be noted, however, that the term 'female genital mutilation' is contested, hence the practice is also sometimes referred to as female genital cutting (FGC). This is because the term 'mutilation' is seen as connoting malice and ill-intent.[2] However, in the African context, the women who subject their daughters, granddaughters and nieces to the practice do so out of love and positive motivations. The drivers of the practice include marriageability, hygiene, religion, and rites of passage into womanhood.[3] Thus, when women and girls are subjected to the practice, it is not motivated by ill-intent, but rather by the need to have the women and girls conform to a given culture, so that they are socially acceptable and marriageable. Nonetheless, the more commonly used terminology is female genital mutilation (FGM).

FGM is prevalent in 28 African countries.[4] Article 5 of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (African Women's Protocol) calls on state parties to pass legislative and other measures towards the elimination of harmful cultural practices. It therefore is generally accepted that FGM/C is a harmful cultural practice. Because FGM is classified as a harmful

1 World Health Organisation 'Female genital mutilation' www.who.int, 3 February 2020, https://www.who.int/news-room/fact-sheets/detail/female-genital-mutilation#:~:text=Female%20genital%20mutilation%20(FGM)%20involves,benefits%20for%20girls%20and%20women (accessed 16 June 2022).

2 MC Barbera *Multicentered feminism: Revisiting the "female genital mutilation" discourse* (2009).

3 As above.

4 28 Too Many 'The law and FGM: An overview of 28 African countries' (*28 Too Many* 2018).

cultural practice, and because much evidence exists to show that it has negative impacts on women's and girls' sexual and reproductive health, states where FGM is prevalent have put in place anti-FGM interventions. Such interventions include the use of law to prohibit and deter the practice and other related practices, such as early and forced marriage; the adoption of alternative rites of passage, which recognise the importance of the transition from childhood to adulthood, but encourage that this transition should happen without causing harm; the adoption of strategies other than community-based approaches, such as male engagement, community dialogues and training.[5] These anti-FGM interventions are primarily based on the need to protect, promote and guarantee the rights of women and girls.[6]

The aim of this chapter is to address the ways in which African feminist thought has responded to the question of FGM, given the challenges it poses for the rights of women and girls. The first part of the chapter is a general introduction of what FGM is. The next part discusses various approaches to anti-FGM interventions, and distinguishes between the African feminist approach to FGM, on the one hand, and the human rights approach to FGM, on the other. This part highlights the importance of distinguishing between these two approaches, given that the human rights approach to FGM is the most dominant one that has been used in providing definitions and explanations of FGM. The third part of the chapter discusses what African feminism is in the context of FGM, and highlights that it is both a theoretical paradigm and a collection of practical strategies that are indigenous to the continent, and based on the lived experiences of African women, and provides key highlights of how FGM fits into African feminist discourses. The fourth part of the chapter discusses the various perspectives of African feminism to FGM. It examines the way in which African women have understood, influenced and challenged interventions aimed at addressing FGM as a harmful cultural practice. The part also maps out the strategic efforts by African women to influence initiatives to end FGM, such as the inclusion

5 UNICEF 'A decade of action to achieve gender equality: The UNICEF approach to the elimination of female genital mutilation' (2020).

6 B Shell-Duncan 'Social and structural factors influencing women's agency regarding female genital mutilation/cutting: An intersectional analysis – a reply to "The prosecution of Dawoodi Bohra women" by Richard Shweder' (2022) 12 *Global Discourse* 167.

of FGM as a harmful cultural practice in article 5 of the African Women's Protocol, and the local application of this article by African states. The part also analyses the response of African feminism to key questions that form the contestations around FGM, which include the issue of choice and autonomy over one's body, the cultural imperatives for FGM/C, racism and FGM.

2 Key approaches to anti-FGM interventions

As we have already seen, FGM has implications for the rights of women and girls and, therefore, human rights approaches have been used to promote anti-FGM interventions in most countries where the practice is prevalent. Thus, the more dominant approach to FGM is the human rights approach. Within this approach, we can situate key human rights documents on the rights of women and girls, such as the Convention on Elimination of All Forms of Discrimination Against Women (CEDAW) and the African Women's Protocol. These human rights documents are the foundational basis upon which FGM is classified as a harmful cultural practice, and one that threatens several other fundamental rights that women and girls should enjoy.[7] Within the human rights approach, FGM is problematised and the specific ways in which it violates the rights of women and girls are highlighted. In addition, the human rights approach has informed most anti-FGM interventions, so that such interventions are guided by human rights standard and principles.[8]

This human rights approach can be distinguished from an African feminist approach. From an African feminist lens, the aim is not necessarily to highlight the ways in which FGM is a violation of the rights of African women and girls, but rather to describe, tell and re-tell the lived experiences of women with regard to FGM. This includes telling stories that might not necessarily be in consonance with the human rights approach. Thus, the African feminist perspective is one that allows for space to problematise the dominant human rights approach

African feminist thought on FGM is informed by the experiences of African women with FGM. This is because African feminism is a

7 AK Meroka and others 'When the law fails to regulate culture: The case of FGM in Kenya' (2016) 2 *Journal of Law and Ethics* 137.

8 A Meroka-Mutua and others 'Coercion versus facilitation: Context and the implementation of anti-FGM/C law' (2021) 55 *Law and Society Review* 1.

paradigm that is concerned with putting the experiences and concerns of African women at the center of analysis of any given issue. Informed by the specific ways in which African women have been at the margins of both gender analyses and also analyses on race, ethnicity, religion as well as other axes of identity, African feminism deliberately prioritises the African woman and uses her experiences to theorise about specific issues that are germane to the continent. Hellum and Stewart argue that while scant attention has been paid to the experiences of (African) women, hence the need for a grounded theory approach, which places African women at the center of analysis.[9] This is understood as the primary motivation for African feminist approaches. Consequently, African feminist thought on FGM is not necessarily informed by the human rights paradigm which seeks to protect, promote and guarantee the rights of women and girls. This distinction is important as it helps us understand that there can be divergent viewpoints between a human rights approach to FGM and African feminist thought on FGM.

3 Understanding African feminism in the context of female genital mutilation

To understand how African feminism addresses the question of FGM, it is first important to explain what African feminism is. This is because, unlike mainstream feminist thought which is comprised of a number of different strands that can clearly be pointed out and explained, African feminism requires a level of constructionism. Although multiple strands of African feminist thought exist that can be pointed out, such as motherism, Stewanism, femalism and nego-feminism, these are not exhaustive of African feminist thought. There is a large body of work developed by African thinkers on questions of women's rights, and although some of the scholars who have developed such works may not identify outrightly as African feminists, the fact that they write about the experiences and concerns of African women enables them to contribute to African feminist thought. The aim of the discussion on African feminism in this chapter is not necessarily to explain what different strands of African feminism say concerning FGM, but rather to highlight the key

9 A Hellum & J Stewart *Pursuing grounded theory in law: South-north experiences in developing women's law* (1998).

tenets of African feminist thought and rely on those tenets in describing and explaining African feminist perspectives of FGM. It should also be noted that African feminism is viewed here as a form of decolonial feminism, because it is necessarily concerned with colonialism and the how women's oppression is understood in the context of the continent's colonial legacy. Decolonial feminism, therefore, may be understood as a broad term, and African feminism as one of the forms and sites for decolonial feminism.

Mama[10] demonstrates that African feminism is primarily concerned with liberating Africa through the liberation of women. Thus, from an African feminist standpoint, women's liberation is an essential precondition for the attainment of justice, democracy, respect for human rights and rule of law in Africa. The struggle for Africa's liberation, therefore, is at the heart of African feminist thought. Thus, African feminist thought can be traced through the different time periods that have characterised the struggle for liberation on the continent. Indeed, we will see later in this chapter that FGM was used strategically by African women who fought against colonialism, and the liberation of their nations.

Methodologically, African feminism is concerned with the lived experiences of the African woman. As a response to mainstream feminist thought that did not place much emphasis on questions of intersectionality, and instead focused primarily on how gender constructions impacted the lived experiences of women, African feminism emphasises the importance of understanding the lived experiences of African women based on gender and other axes of identity, including race, ethnicity, religion, age, disability and economic status. Thus, in order to map out African feminist thought on FGM, it is important to situate the discussion within the different time periods relating to the struggle for liberation on the continent. Further, it is important to adopt an intersectional approach as a methodology aimed at understanding the experiences of African women, based on gender and other key aspects of their identity such as religion and ethnicity. This approach is also useful

10 A Mama 'African feminist thought' *Oxford research encyclopedia of African history* (2019), https://doi.org/10.1093/acrefore/9780190277734.013.504 (accessed 16 June 2022).

in understanding the way in which the drivers of FGM, including culture and religion, impact the decisions that women make concerning FGM.

Mama[11] also cautions against the perception that feminism in general is a Western idea and, thus, African feminists are building upon an originally Western idea. This is problematic to the extent that it presumes that Africans have never had ideas that challenge forms of gender exclusion and marginality. Indeed, this very notion is what has placed African women in the 'margins of marginality' because they have been viewed as a category that lacks the voice and agency to articulate their concerns on their own behalf and in their own words. The problematic assumption here is that African women must borrow a 'Western' vehicle and build up that vehicle for them to articulate their concerns. From this standpoint, what we see is that the way in which mainstream feminism treated the experiences of African women, black women and women of colour as peripheral, and instead purported to give a universal character to the experiences of white women is one of the reasons why feminism is accused of being a Western conception.

To echo Mama, Verges[12] makes the point that if Western feminism is responsible for the development and evolution of feminisms in the Global South, what she calls decolonial feminism, then it is because of the role Western feminism has played in the oppression of women in the Global South. Thus, decolonial feminism is a site through which Western feminism is challenged for its role in capitalist and racial oppression. Tamale[13] further emphasises that while white women were subordinated to white men, they (white men) were always empowered over indigenous men and women. Indeed, during the suffrage struggle, white women felt cheated that black men attained the right to vote before they (white women) did. There was an implicit racism here – with the expectation from white women that they were somehow more human than black men. More significantly, white women were never concerned with the suffering of black women. Thus, the suffrage struggle did not concern itself very much with the sexual objectification and rape of black women slaves. Tamale[14] argues that it is important to understand this history in

11 As above.
12 See F Verges *A decolonial feminism* (2021).
13 S Tamale *Decolonisation and Afro-feminism* (2020).
14 As above.

order to effectively engage in decolonial projects. Thus, gender and race are inextricably intertwined and the struggle for the liberation of black women cannot happen on a single axis of gender alone, yet for Western feminism, the singular analysis of women's inequality based on gender has been the norm.

The point here is that it should never be assumed that feminism in general always is concerned with liberation. This is because history has shown that in fact feminism and the concern for women's rights have been appropriated and used to promote capitalist ideals. For purposes of liberation, one must look to the feminisms that challenge dominant world orders, such as empire and capitalism. Decolonial feminism, which is concerned with women's rights in the context of broader struggles for liberation, is more likely to be emancipatory. However, Tamale[15] points out that a blind spot for decolonial scholarship is its lack of interaction with theorisation on gender. Thus, the task of decolonial feminism is to bring in theorisation on gender, feminism and women's rights into a field that is predominantly masculine.

Thus, there is a need to understand the various feminisms that exist and what their premise is, before concluding that those feminisms are sites for liberation. In this regard, African feminism could be considered a form of decolonial feminism, because it is concerned with understanding and exposing the experiences of African women in the context of the broad issues affecting the continent, including the north-south economic and political relationships. It is also concerned with feminising decolonial projects that which predominantly are masculine. A central tenet of African feminist scholarship is the re-telling of the stories of African women in order to destabilise long-held assumptions and beliefs about African women. For example, Win argues that in development ideology, the image of the African woman as poor, powerless and pregnant is one that sells and one that elicits response from development actors.[16] However, the African woman who does not fit into this image is often forgotten – she is not a priority as far as development ideology goes. From an African feminist perspective, there is a need to break such skewed

15 As above.

16 EJ Win 'Not so poor, powerless or pregnant: The African woman forgotten by development' (2004) 35 *IDS Bulletin,* https://doi.org/10.1111/j.1759-5436.2004.tb00156.x (accessed 16 June 2022).

perceptions of who African women are and what their experiences are by re-telling their stories.[17]

Thus, in this sense, African feminism is a response, and necessarily so to works that have depicted African women in ways that are inaccurate or in ways that silence the voices of African women. In addition, decolonial feminism is concerned with how colonialism altered the way in which men and women related on the continent and, specifically, how colonialism diminished African women and made them invisible. This is why for African feminism, the telling and re-telling of the experiences of African women is critical – it is a strategy for making African women visible and, therefore, decolonising knowledge.

In the context of FGM, this entails the telling of all kinds of narratives, not only those that are against FGM/C, but those that also support the practice. There is a growing body of work that seeks to do this, for example, the works of Njambi, who challenges dominant views about FGM and instead seeks to provide a different lens through which FGM may be viewed as being empowering to the African woman.[18]

Both Tamale[19] and Vegres[20] see that colonialism provided the historical roots for present-day capitalism in post-colonial societies. Thus, an important aspect of decoloniality is to understand the colonial roots of capitalism in order to effectively challenge capitalist dominance and oppression. Regarding FGM, the concern of decolonial feminism with capitalism is an important insight into understanding the commercialisation of FGM, especially in the context of medicalisation, where healthcare providers seek to benefit financially by preforming the 'cultural cut' in modern healthcare facilities. Decoloniality provides a lens through which the role of capitalism in sustaining or altering FGM trends might be examined.

While decolonial feminism is concerned with the experiences of women in the Global South, the actors include feminists in the Global

17 D Lewis 'African feminist studies, 1980-2002: A review essay for the African Gender Institute's Strengthening Gender and Women's Studies for Africa's Social Transformation' Project' (2003), http://www.gwsafrica.org/knowledge/ (accessed 16 June 2022).

18 WN Njambi 'Irua ria atumia and anti-colonial struggles among the Gikuyu of Kenya: A counter narrative on "female genital mutilation"' (2007) 33 *Critical Sociology* 689.

19 Tamale (n 14).

20 Verges (n 13).

North, who align themselves with the struggles of women in the Global South. Thus, here we see that decolonial feminism is a site whereby there is a coming together of women in the south with those in the north, united in the struggle against capitalist and racial oppression. Indeed, in the context of FGM, we will see that actors in the Global North have contributed immensely to the discourse on FGM. For example, the work of Dembour[21] in analysing the legal responses to FGM in the context of African immigrant communities in France is a site where scholarship in the context of the Global North resonates with the experiences of women in the Global South.

The point here is that the struggle by African women against oppression on the basis of sex and gender is not a Western imposition and, in fact, in some ways it is a reaction and a challenge to Western feminism. African women have faced and resisted sex oppression in their own right – they have not been instigated into doing so by mainstream feminism. However, there are also points of convergence between actors in the south and those in the north in the shared struggle against the oppression of women in the Global South. The failure to tell the stories of African women is what has led to an incorrect assumption that they do not challenge sex oppression or other forms of oppression. We will see that, in fact, African women have used FGM to challenge various forms of oppression, including colonialism as well as the oppression resulting from the unfulfilled human rights promises by current political regimes. Thus, African women have used the cultural practice of FGM to align themselves with their own nationalist movements and to resist colonial rule, albeit in the context of a gendered liberation struggle.[22] In contemporary African contexts, women have also used FGM as a means of protest against empty promises made by modern states. Thus, in Uganda, for example, we will see the story of Yeko, the Ugandan woman who underwent FGM as an act of protest against the Ugandan state which, on one hand, has failed to implement basic rights such as

21 MB Dembour 'Following the movement of a pendulum: Between universalism and relativism' in JK Cowan and others (eds) *Culture and rights: Anthropological perspectives* (2001) 56-79.

22 A Meroka-Mutua 'A history without women: The emergence and development of subaltern ideology on land in Kenya' (2021) *Feminist Legal Studies* DOI 10.1007/s10691-022-09488-4.

access to education and health but, on the other hand, uses human rights arguments to ban FGM.[23]

Mikell[24] argues that the main distinguishing factor between African feminism and mainstream feminism is that the former is concerned with the general challenges that the continent faces and is not pre-occupied with the issues that have traditionally been the focus of mainstream Western feminist thought. Mikell[25] suggests that African feminism is evolving and developing even as African women respond to the crises that the continent faces, and as they address the way in which such crises are understood through a gender lens. African feminism thus is emerging from the engagement of women with the issues that affect the continent such as the threats to the stability of states, given that many countries on the continent have experienced political crises such as *coups* and civil wars; there are also issues of power such as the widespread violations of human rights, a lack of respect for the rule of law, dictatorships and authoritarian regimes; economic crises and failing economies; and general threats to life such as food insecurity leading to starvation. African women are constantly engaging with these issues and in that engagement, there has emerged a distinctly African feminist thought, of which the starting point is not gender inequality or sex oppression but, rather, the political, economic, social, and cultural challenges that Africa faces. In the context of FGM, we see that African women have had instances where they approach the question of FGM not as an issue of gender inequality or discrimination, but from a broader perspective of equality between different ethnic and cultural groups.

Nnaemeka also supports the idea that African feminist thought is indigenous to the continent, and argues that for one to understand African feminism, she must not look to Western feminism, but rather, she must refer to the African environment. She further asserts that 'African feminism is not reactive but proactive'.[26] This seems to suggest that rather than Western feminism being the catalyst for the emergence

23 C Byaruhanga 'Uganda FGM ban: "Why I broke the law to be circumcised aged 26"' *BBC News* (Africa) 6 February 2019, https://www.bbc.com/news/world-africa-47133941 (accessed 6 June 2022).

24 G Mikell *African feminism: Towards a new politics of representation* (1995).

25 As above.

26 O Nnaemeka 'Nego-feminism: Theorising, practicing and pruning Africa's way' (2003) 29 *Signs* 357-376.

and development of African feminist thought, it is the circumstances in the continent that have given rise to African feminism. Nnaemeka[27] further emphasises that the emergence of theory in the African context happens in the space where academic work engages with lived realities – as has been espoused by Hellum and Stewart.[28]

The ideas of Mikell and Nnaemeka are evident in the case of the Maasai women in Kenya, who have aligned themselves with the broad questions of equality and non-discrimination of all groups in Kenya and used the argument of ethnic and cultural equality to protest against the prohibition of the practice, which they see as integral to their ethnic and cultural identities. Notably, the broader issues around the issues of equality for the Maasai revolve around historical injustices relating to land, and the impact of colonial and post-colonial land policies on the pastoralist way of life that is practised by the Maasai. Nationalisation approaches have tended to view the Maasai way of life as needing to change in order to allow for the community to become fully 'Kenyan'.[29] The Maasai have generally resisted these types of approaches and have agitated for the respect of diversity in Kenya.[30] We see that in protesting the prohibition of FGM, the Maasai women align themselves with the need to respect diversity and promote inclusivity of all communities in Kenya's economic and political spheres.

What we see, therefore, is that African feminism is a theoretical paradigm that has evolved out of the lived experiences of African women. In addition, African feminism is not simply a theoretical standpoint, but rather it is also a collection of strategies that African women have used in addressing the issues that are of concern to them. African feminist approaches emphasise the lived experiences of women as relevant and central in informing theory but, at the same time, the strategies that African women use to address their concerns are just as relevant as the theoretical positions.

Maathai demonstrates how the Green Belt Movement was both a vehicle for promoting environmental protection as much as addressing

27 As above.
28 Hellum & Stewart (n 10).
29 M Kituyi *Becoming Kenyans: The socio-economic transformation of pastoral Maasai* (1990).
30 P Kantai 'In the grip of the vampire state: Maasai land struggles in Kenyan politics' (2007) 1 *Journal of Eastern African Studies* 107.

gender inequality.[31] By working with women on a general issue such as environmental protection, this provided Maathai with a platform where she could also safely have dialogues with women on issues of gender inequality.[32] Similarly, Kabira demonstrates that strategy is just as important as theory, when she describes the specific ways in which women were able to achieve a number of wins, including the two-thirds gender rule during the making of Kenya's current Constitution.[33] Thus, by women making their voices heard and sharing their experiences with the Constitution of Kenya Review Commission, the few women who were part of the Commission could use the stories of these ordinary women (who later came to be known as Wanjiku) to push for a women's agenda and the inclusion of a raft of provisions promoting gender equality in the Constitution.[34] Hassim demonstrates how the women of South Africa's African National Congress (ANC) are not merely secondary political subjects, but an integral part of the Congress, and this, in turn, has allowed women to have a voice concerning matters that affect them as women, while at the same time agitating in a national liberation struggle that transcends gender concerns.[35] What we see, therefore, is that African women have used practical strategies that simultaneously enable them to address the general issues affecting the nations to which they belong and, at the same time, these strategies have enabled them to have a space in which they are able to address gender concerns.

We have seen so far that FGM could be understood both as experience and strategy. The way in which African women have experienced FGM – both those who view it as empowering and those who view it as disempowering – is important. Further, it is also evident that African women have used FGM strategically to achieve particular ends. We see, therefore, how these lived experiences and the use of FGM as a strategy against oppression have contributed to the development of African feminist thought.

31 W Maathai *Unbowed* (2008).
32 As above.
33 W Kabira *A time for harvest: Woman and constitution making in Kenya 1992-2010* (2012).
34 As above.
35 S Hassim 'Nationalism, feminism and autonomy: The ANC in exile and the question of women' (2004) 30 *Journal of South African Studies* 433.

Because African feminism is about praxis – the intersection of theory and practice – it is important to discuss who the actors are. Here, Lewis argues that unlike mainstream Western feminism, where the actors have been organised into feminist movements and organisations, with a clear synergy between the feminist academics and feminist movements and organisations, the same is not necessarily true for African feminists.[36] It is, however, not by deliberate choice that the actors of African feminism have not formed into feminist movements and organisations, but rather the circumstances on the continent, ranging from the difficulties faced in funding the cause, the general differences among African women in terms of their identities and priorities and the challenges this poses to the creation of a unified movement, have been some of the factors that have made the emergence and development of an African feminist movement difficult.[37]

Thus, the actors who theorise about African feminism and those who practise it are known by their stories and by their actions, rather than by how they organise. Kabira empahsises the stories of ordinary women in the making of Kenya's Constitution – as a collective, these women are African feminists, having been involved in such an important moment in the country's history, not simply because of the implications the Constitution would have on the rights of women, but because of the concern these women had about the country in general.[38] Likewise, the Mau Mau women who fought for liberation from colonial oppression are African feminists.[39] The ANC women who fought against apartheid are African feminists.[40] The women have planted trees as a way of protecting the environment for posterity – for their children and future generations are African feminists.[41] The Ugandan women who have stood up against a regime of dictatorship are African feminists.[42] The ordinary women, concerned about general issues affecting their communities and doing something about it, are African feminists.[43] The scholars in different academic fields who tell the stories of these women are African feminists.

36 Lewis (n 18).
37 As above.
38 Kabira (n 34).
39 T Kanogo *Squatters and the roots of Mau Mau 1905-1963* (1987).
40 Hassim (n 36).
41 Maathai (n 32).
42 S Nyanzi *No roses from my mouth* (2020).
43 Mikell (n 25).

The women in leadership who seek to influence policies and laws in response to the concerns raised by women at the grassroots are African feminists.[44] In the context of FGM, the survivors who tell their stories as a way of preventing other women and girls from also suffering the negative impacts of FGM are African feminists. Likewise, the women who support the practice of FGM as an important means for promoting cultural and ethnic inclusivity and equality are also African feminists. In the context of FGM, we see that there is space for opposing voices to all be viewed as African feminists based on the issues that they advocate. Thus, African feminists are known not because they name and identify themselves as such, but rather, they are known because of what they do.

4 African feminist perspectives on female genital mutilation

In the context of FGM, a practice that is prevalent in Africa, we are able to tell the stories of African women, and we can see the tensions that exist in these stories. While it is generally now accepted that FGM has serious and long-term negative effects on the reproductive health of women, on the other hand, African women value their cultural and religious identity, which is one of the key drivers of FGM. FGM raises key issues concerning specific human rights, including the right bodily autonomy and the right to culture (which also includes the right to practise one's religion). In the context of FGM, African women have navigated the tensions between sexual and reproductive health, culture and bodily autonomy in different ways. In this part we look at how African women have responded to these tensions, and what their lived experiences have been even as they have addressed challenges that FGM poses.

4.1 African feminist responses to female genital mutilation: Polemics of resistance and support

It is important to begin the discussion in this part by looking at the ways in which African feminism has historically evolved. Here, we will therefore see that there have been periods in history when African women have been opposed to the prohibition of FGM and periods when they have supported such prohibition. The imagery of a pendulum used by Marie

44 Lewis (n 18).

Benedict-Dembour in demonstrating how approaches to FGM swing between universalist and cultural relativist approaches is also useful in understanding how African feminist thought has responded to FGM.[45] It cautions us against taking one hardline position as being the one that is supported by African feminism. Thus, African feminist thought on FGM has moved between different positions at different points in time. During the colonial period, African women opposed attempts by colonial governments to prohibit FGM. African women stood in solidarity with their cultural and nationalist inclinations, having seen that the colonial interventions to prohibit FGM would have been of great benefit to the colonial governments by serving to weaken nationalist sentiments.[46] Therefore, Njambi argues that the narrative that FGM is a means of oppression of African women is a narrative that misrepresents the experiences of African women, and it overlooks the specific ways in which African women may find empowerment through the cultural practice of female circumcision.[47] It should, however, be noted that the struggle against colonialism was itself gendered and, although women participated in the struggle, their concerns were never central to the nationalist cause. In fact, during the post-independence period, women realised that while their communities might have been free from colonial rule, women themselves continued to experience oppression on the basis of their gender, and this was evident in a number of areas, for example, women could not hold land in their own names. Thus, while women used FGM strategically to oppose colonial rule, the end of colonialism did not result in equality between the sexes.

During the post-independence decade, as the harmful effects of FGM were brought to light, African women increasingly began to support the abandonment of FGM. Informed by factors such as the impact of FGM on the girl child, given that FGM meant that a girl was marriageable and, therefore, her education could be curtailed, and later by the onslaught of the HIV pandemic which meant that the traditional way in which girls were cut could expose them to the virus, African women began to support the prohibition of FGM, and the United Nations Children's Fund (UNICEF) reports that the number of women who are opposed

45 Dembour (n 22).
46 Njambi (n 19).
47 As above.

to FGM in high prevalent countries has been increasing since 2000.[48] In support of the abandonment of FGM, African women have used survivor narratives so as to lower support of the practice in communities where FGM is culturally entrenched.[49] In particular, survivors of FGM have used their own lived experiences to campaign against the practice. These survivors use their impact stories to highlight how FGM affected them with the aim of protecting other girls from undergoing the practice. Survivor testimonies have been used as a powerful tool in empowering girls and women in contexts where FGM is culturally entrenched. In such contexts, survivor testimonies provide an alternative narrative about FGM. Thus, as highlighted by Njambi, FGM may be understood as a site where women are empowered through the practice of their culture,[50] but the alternative narrative is that FGM also poses significant negative effects to a woman's sexual and reproductive health, and for girls, undergoing FGM may also mean that their education is curtailed, because they can then be married off having become marriageable after undergoing FGM. Through survivor testimonies, girls and women are provided information about the various aspects of FGM in order to enable them to make fully-informed choices and, from a human rights approach, survivors' testimonies are useful in promoting social change towards abandonment of the practice.

In some contexts, rather than the complete abandonment of FGM, women have responded to reports of the harmful effects of FGM by embracing medical interventions that make the practice safer by providing pain relief and reducing the risk of immediate complications such as bleeding and sepsis.[51] However, medicalised FGM has been problematised, because it is still performed for non-medical reasons and, further, research has shown that there are no health benefits of FGM.[52] What we see here is that while women are concerned about the harmful

48 UNICEF (n 6).

49 UN Women 'Survivors speak: Women leading the movement to end FGM' 4 February 2019, https://www.unwomen.org/en/news/stories/2019/2/compilation-women-leading-the-movement-to-end-female-genital-mutilation (accessed 16 June 2022).

50 WN Njambi 'Dualisms and female bodies in representations of African female circumcision: A feminist critique' (2004) 5 *Feminist Theory* 281.

51 E Leye and others 'Debating medicalisation of female genital mutilation/cutting (FGM/C): Learning from (policy) experiences across countries' (2019) 16 *Reproductive Health* 158.

52 As above.

effects of FGM, the total abandonment is also a concern for them, because the choice to abandon is perceived as a break from culture, yet culture is an important part of an African woman's identity.[53]

A particularly important moment in the development of African feminism is marked by the adoption of the African Women's Protocol. The Protocol specifically lists FGM as a harmful cultural practice and requires state parties to take measures against it. During the making of the Protocol, African women were involved supporting its adoption.[54] Presently, African women continue to call for the full implementation of the Protocol and, indeed, they view it as an important vehicle for the advancement of women's rights on the continent.[55]

Article 5 of the African Women's Protocol was the first normative provision under international law to specifically require state parties to take measures towards the elimination of harmful cultural practices. Although other instruments, such the Convention on the Rights of the Child (CRC) (article 24 requires state parties to take measures to abolish traditional practices that are prejudicial to the health of children) and the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) (which requires state parties to take measures to eliminate all forms of discrimination against women) contain implicit provisions that may be interpreted as prohibiting FGM, the African Women's Protocol contains an explicit and specific provision. Thus, article 5 of the Women's Protocol is one of the most important provisions under international law, which provides the impetus for the adoption of local legislation by African states that prohibit the practice.

Since the adoption of the African Women's Protocol, and the passing of legislation to prohibit FGM in most countries where FGM is prevalent, there have been instances where women have resisted the total prohibition of FGM, as has been witnessed by women from practising communities in Kenya. In 2014 Maasai women in Kenya held protest marches against Kenya's anti-FGM law, with local leaders having

53 Njambi (n 51).

54 F Viljoen 'An introduction to the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa' (2009) 16 *Washington and Lee Journal of Civil Rights and Social Justice* 11.

55 Equality Now 'The Maputo Protocol: Protecting African women's rights', https://www.equalitynow.org/promoting_african_womens_rights/#:~:text=The%20Maputo%20Protocol%20Advances%20African,Reproductive%20health%20and%20rights (accessed 16 June 2022).

supported these protests.[56] Indeed, in some practising communities in Kenya, local leaders publicly indicated that they would continue to support the practice, regardless of the fact the fact that the state had enacted a law prohibiting it, and no action was taken against the leaders.[57] Similarly, in Cameroon there has been resistance to the prohibition of FGM, which is motivated by economic factors – traditional cutters, who are women, earn a living from the practice and, thus, this has proved a challenge in getting communities to comply with prohibition.[58] Thus, there are multiple factors that inform the decisions women make to continue with the practice, ranging from their strong cultural and ethnic identity, as in the Kenyan case, to economic factors, as in the case of Cameroon.

There have also been instances where women have supported the prohibition and called for the enforcement of laws prohibiting FGM, prompted by various reasons. For instance, in Somalia women activists issued renewed demands for the prohibition of FGM when a girl bled to death as a result of the practice.[59] Similarly, in the context of COVID-19, when schools were closed for extended periods of time, thus exposing the girl child to various forms of violence, there was a push specifically by African women towards calling for the enforcement of already-existing anti-FGM laws, and the putting in place of measures to protect the girl child from further forms of violence.[60] Here, motherism, the strand of African feminism, which argues that for African women, motherhood is an important space, is instructive. African women are concerned about the well-being of their girls, and this has motivated them to oppose the practice and to call for its prohibition.

Given the ways in which African women have responded to FGM at different points in time, we see the image of the Dembour's[61] pendulum.

56 Meroka and others (n 8).
57 As above.
58 N Divine 'Cameroon encounters resistance to female circumcision ban' 12 June 2014, https://www.voanews.com/a/cameroon-encounters-resistance-to-female-circumcision-ban/1935833.html (accessed 16 June 2022).
59 N Bhalla 'Campaigners demand anti-FGM law as girl bleeds to death in Somalia' *Thomson Reuters Foundation* 18 September 2018, https://www.reuters.com/article/us-somalia-women-fgm-idUSKCN1LY1V5 (accessed 16 June 2022).
60 S Johnson 'On a rampage: The African women fighting to end FGM' 9 June 2021, https://www.theguardian.com/global-development/2021/jun/08/on-a-rampage-the-african-women-fighting-to-end-fgm (accessed 16 June 2022).
61 Dembour (n 21).

The responses of African women to FGM have varied, protesting against its prohibition to supporting the same. From the perspective of African feminism, it is important to tell both the story of resistance to anti-FGM interventions and the story of support for such interventions. To tell one side of the story, namely, that of African women supporting abandonment in line with the human rights approach, would be to fall into the danger of the single story.[62]

4.2 African feminism, female genital mutilation and bodily autonomy

Although the control of their bodies is not always in their hands, the bodies of African women tell many stories. Sometimes, African women are able to control the stories that their bodies tell or that are told by other people about their bodies and, sometimes, they cannot control these stories or how they are told. Simply defined, bodily autonomy refers to the ability of a woman to make free and informed decisions concerning her body – not only what should or should not happen to her body, but how and why it ought to happen. Bodily autonomy is an important aspect of equality and non-discrimination, particularly because there are different standards imposed on women and men what they can do with their bodies. For women, there have been greater limitations placed on the decisions they can make concerning their reproductive health. Often, this is rooted in gender and social norms that perceive the women as having the role of reproduction and caring.

Bodily autonomy is a problematic concept in the context of FGM, because there are two divergent positions on the issue of bodily autonomy. The first is that culture has historically impeded the extent to which women are able to exercise autonomy over their bodies, resulting in the subjugation of women, which has informed human rights approaches to FGM and other aspects of sexual and reproductive health rights such as early and forced marriage. The second is that well-meaning human rights approaches have themselves appropriated the ability of women to exercise autonomy over their bodies in a space where culture and human

62 CN Adichie 'The danger of a single story' (2009), https://www.ted.com/talks/chimamanda_ngozi_adichie_the_danger_of_a_single_story?language=en (accessed 16 June 2022).

rights have come into sharp conflict. In this part, we look at both these positions, and demonstrate the ways in which they both have a similar effect in curtailing women's bodily autonomy.

In the context of sexual and reproductive health rights, the concept of bodily autonomy has been understood as fundamental to the enjoyment of these rights. Autonomy, which may be defined as self-rule, and it is the expectation that every African man will have self-rule, is distinct from personhood.[63] Personhood may be defined as the ability of an individual who is endowed with certain rights as a result of which she is able to have a relationship with the state and other semi-autonomous fields such as the clan, kinship group an ethnic community, we see then that personhood really is speaking to questions of citizenship and belonging.[64]

Historically, personhood has not been a right that women have freely enjoyed, but while the gender dimensions of personhood to a large extent have been problematised, thus opening up the space for greater recognition of female personhood,[65] the same is not true for autonomy, so that there still is no expectation that they will enjoy respect for their autonomy or that they will have self-rule.[66] It should not be taken for granted that if women enjoy the rights relating to personhood then they also enjoy autonomy. This may be attributed to the fact that in post-colonial society, formal law, informed by the legal systems of the colonial masters, has generally stayed out of personal matters.[67] This has meant that matters that most affect the bodily autonomy of women, such as domestic and other forms of violence against women, have not been regulated. The public-private distinction apparent in law has meant that while women can indeed enjoy personhood, it is not always the case that they will also enjoy autonomy, and especially bodily autonomy.[68]

In the context of culture, one of the reasons why FGM is practised is the need to control female sexuality. Thus, FGM has been used to curtail

63 C Kithinji and others 'Between autonomy and solidarity: An African woman's autoethnography' (2021) 14 *International Journal of Feminist Approaches to Bioethics* 61.

64 PK Mbote *Contending norms in plural legal systems: The limits of formal law* (2020).

65 N Naffine 'The man of law' in N Naffine (ed) *Law and the sexes: Explorations in feminist jurisprudence* (1990).

66 Kithinji and others (n 64).

67 S Tamale 'The right to culture and the culture of rights: A critical perspective on women's sexual rights in Africa' (2008) 16 *Feminist Legal Studies* 47.

68 As above.

female sexual pleasure and, therefore, ensure that women remain faithful to their husbands, because by curtailing female pleasure, the idea is that women will be less inclined to seek sex outside of marriage, while only persevering it in marriage. The purpose of this was to ensure that the children born by a man's wife were actually his biological children. From very early on, we see that FGM has been used as a way of controlling women's bodies and taking away their ability to make certain choices about their sexuality.[69] There are women who resisted this attempt to control an integral part of who they are as their sexuality. Njoya illustrates how important such a quest for selfhood was for women who refused to undergo FGM, as his own mother did in 1925.[70]

Thus, the argument here is that bodily autonomy and integrity are core aspects of selfhood and, therefore, culture in itself was problematic in denying women the ability to make decisions about their bodies and their sexuality. The denial of that choice has ramifications that affect not only the woman, but her husband and any children that she bears. In this sense, bodily autonomy goes beyond the individual woman and her ability to make decisions concerning her own body, but it also involves the implications that those choices have for those around her. Bodily autonomy has implications for families and, by extension, communities. Indeed, Njoya does ponder upon what his own existence would have been like had his mother undergone FGM, and been dowrised, instead of continuing with her education and eventually marrying his father on her own terms.[71] In addition to the cultural entrenchment of FGM being viewed as a denial of women's bodily autonomy, it is also seen as a site for the profiteering of men because, while it is women who subjected girls to the cut, it is men who have profited by collecting dowry once the girls were cut and became marriageable.[72]

In the context of human rights approaches to sexual and reproductive health in post-colonial Africa, the decisions and choices concerning the bodies of women are not fully in the hands of women. In many African nations, there are abortion laws that determine whether or not some of the choices that women make with regard to pregnancy are legal or illegal.

69 T Njoya *Selfhood: The divinity of the clitoris* (2017).
70 As above.
71 As above.
72 As above.

In the context of marital rape, many African countries do not recognise the ability of a married woman to say no to sex with her husband, hence the failure to recognise marital rape as a crime. However, unlike questions of abortion and marital rape, where many African states have neither passed laws to liberalise abortion nor to criminalise marital rape, human rights approaches have been very successful in making a case for the prohibition of FGM and, thus, many of the countries where FGM is prevalent have passed laws that prohibit the practice. 28 Too Many highlights that out of 28 countries where FGM is prevalent, only six countries have not passed laws that specifically prohibit the practice. Out of these six countries without local laws that prohibit FGM, five have signed international human rights instruments that require them to take action to end FGM. Thus, it is only one country out of the 28 practising countries that has no laws in place for the prohibition of FGM.[73] While anti-FGM laws in various countries on the continent have different levels of severity, the basic principle is clear – FGM is considered a harmful cultural practice and it is prohibited. In 2019, the African Union (AU) Summit of Heads of States launched the AU Initiative in Elimination FGM (Saleema) with the aim of galvanising political action towards abandonment.[74]

The general prohibition of the practice under international and regional frameworks and legislative measures by individual African states that prohibit FGM shows that there is significant commitment towards abandonment by policy makers. While this is tremendous progress from the point of view of advancing the sexual and reproductive rights of women, it has also had the knock-on effect of limiting the extent to which African women can exercise bodily autonomy, because they are prohibited by law from making the choice to undergo FGM. Yet, there are adult women who would voluntarily make the choice to undergo FGM.

As already illustrated in the previous part, there have been instances where African women have protested the enactment of laws that prohibit FGM, with various factors, such as strong cultural identity and economic factors, driving such protests. There are also other examples of women who undergo FGM for different reasons. Take, for instance, the case of

73 As above.
74 https://au.int/fr/node/35892.

a Ugandan woman, Sylvia Yeko, who chose to undergo FGM at the age of 26, risking a jail term of up to five years.[75] Hers was an act of protest against a state which she sees as paying nothing more than lip service and making empty promises about promoting the rights of women and girls. Yeko argues that the ban on FGM in Uganda in 2010 was aimed at protecting the rights of girls, and one such right is the right to education. However, even after the ban on FGM, education remains prohibitively expensive for most girls, and the state has done little to address the situation.[76] By choosing to undergo FGM and allowing her story to be told in the media, Yeko's act of rebellion is one that resonates with the strategies that African women have used to make their voices heard. Tamale argues that aside from simply outlawing cultural practices that are seen as violating the rights of women, a culture of rights, one that is actually committed to attaining human rights standards and ideals ought also to be established.[77] Law does not operate in a cultural vacuum, thus if a cultural practice is prohibited due to its harmful effects, for such a law to be effective, then the harmful cultural practice ought to be replaced by another, which is more oriented towards the respect for human rights. The point here is that the prohibition of FGM, which necessarily has implications on women's bodily autonomy, must not be seen simply as an end in itself. It must be understood as meeting other broader human rights goals, otherwise it is no more than a right on paper. The effect of a community viewing a human rights law as nothing more than a right on paper might be resistance to the law.[78]

4.3 Anti-FGM laws, culture and African feminism: From demonised cultures to well-meaning laws

In prohibiting FGM, the law seeks to protect women from cultural practices that exploit the bodies of women for the sake of patriarchal interests. With specific regard to the use of legal sanctions to prohibit FGM, the practice is to encourage the passing of strong laws, which provide for stiff penalties for the practice of FGM, and the thinking here is that such strong laws are more likely to have a strong deterrent effect

75 Byaruhanga (n 24).
76 As above.
77 Tamale (n 68).
78 Meroka-Mutua and others (n 9).

and they will encourage greater obedience.[79] There also is an assumption that women will make choices about their bodies that are in line with human rights standards, because these standards seek to protect them from abusive cultural practices, hence it is not expected that the very women who are meant to be protected by such well-meaning laws would also be perpetrators of prohibited actions under the same laws. Thus, for FGM, it is assumed that in exercising bodily autonomy, women will make decisions that support the abandonment of the practice. In Kenya, this is illustrated by the *Tatu Kamau* case,[80] which was a constitutional petition challenging the constitutionality of a law that prohibits adult women from making the choice to undergo FGM. Before this case was filed in court, there had been protests against Kenya's anti-FGM law by women from practising communities, particularly the Maasai community.[81] By arguing in the petition that the total prohibition of FGM was a violation the constitutionally enshrined right to culture, Tatu Kamau was seen as speaking for the women in FGM-practising communities, who felt that they were being denied the right to freely practise their culture.

In that case, the Court held that adult women who consent to FGM actually are not acting out of their free will, but rather, they are pressured by prevailing social and cultural norms into making a decision that ultimately has negative impacts on their health. In this case, we see that the Court's position was that with regard to FGM, women cannot be said to be making free and informed decisions to undergo the practice. Hence, the reasoning is that with regard to a practice that is so culturally entrenched, it is not possible for women to exercise autonomy in choosing to conform with that practice. Tamale has argued that there is a perception of African cultures as being sites in which women's rights are violated.[82] African cultures have been demonised as being the basis for the forms of gender and sex oppression that women on the continent face. It therefore is not surprising that a court that sees itself as being progressive would make a determination to the extent that adult women from FGM-practising communities are not capable of making free and informed decisions to undergo FGM.

79 As above.
80 *Tatu Kamau v Attorney General & 14 Others* (2018) Kenya Law Reports.
81 Meroka and others (n 8).
82 As above.

This position that African cultures as inherently discriminatory of women has been problematised through an African feminist lens.[83] Amadiume, for example, has demonstrated that pre-colonial African cultures to a large extent were inclusionary of women and provided great space for women to participate in decision making, but this was changed by the gendered nature of colonial regimes, informed by Western notions of gender discriminatory nature of Victorian society, and this thinking was introduced in the way in which colonial regimes interacted with their subjects.[84] The arguments surrounding African's women's rights to culture may be extended by appreciating the fact, as highlighted by Shweder, that wherever there is FGM, there also is male circumcision, thus culturally, the practice is gender inclusive.[85] Generally, male circumcision is encouraged because of its apparent health benefits, and it has also been medicalised in some communities. This can be taken to mean that men have a greater right to their cultural identity and to engage in practices that promote that cultural identity, while women cannot enjoy a similar right, on the basis that it is likely to violate their fundamental rights.[86]

In addition to taking a rather paternalistic view of the ability by women to exercise autonomy in consenting to FGM, the Court in the *Tatu Kamau* case also failed to consider the question as to whether adult women who consent to FGM are victims or perpetrators of the practice. Hence, it did not provide direction as to whether such women should be charged with aiding and abetting the practice of FGM as is currently the practice or whether they should be viewed as victims of a pervasive culture. This has resulted in some level of incongruence where, on the one hand, the Court perceives women who consent to FGM as doing so under the yoke of cultural pressure but, on the other hand, the Court remained silent as to whether the continued arrest and prosecution of these women for the offence of aiding and abetting is in consonance with the idea that they are victims of such a pervasive culture. These women therefore are simultaneously victims and perpetrators. What the *Tatu Kamau* case demonstrates is that the experiences of women destabilise

83 I Amadiume *Male daughter, female husbands* (1987).
84 As above.
85 RA Shweder 'The prosecution of Dawoodi Bohra women: Some reasonable doubts' (2022) 12 *Global Discourse* 9.
86 As above.

the assumption that in exercising bodily autonomy, women will make decisions that support the abandonment of the practice.

There is tension between the well-meaning state interventions aimed at abandonment and the lived experiences of women. Practising communities have tended to find ways of circumventing strong laws that prohibit FGM, resulting in the practice going underground and, particularly, hidden from state intervention.[87]

Thus, rather than meet the specific objectives of deterrence, which leads to eventual abandonment of the practice, the response by communities has been to find ways of carrying on with the practice, while minimising the risk of being caught.[88] In a sense, we see women responding to the law that they perceive as unjust in ways that then thwart the objective of the law – which is to protect the rights of these very women, hence the law runs the risk of becoming counter-productive. The perception of the courts that the women who choose to carry on with cultural practice are simply acting under the yoke of patriarchy is rather misplaced, because it assumes that women cannot of their own right feel very strongly about their cultural identity, and that they can only do so if they are motivated by patriarchy. This is a view that, of course, denies female agency. It is likely that African women will rebel against such a position, as they have often done when they have asserted their agency, and challenged perceptions that have purported to minimise their ability to make decisions.[89]

In response to the question of how law ought to respond to women who choose to undergo FGM, Nnaemeka's work on nego-feminism is useful.[90] The premise of nego-feminism is that in African feminism, decisions are arrived at through negotiations. There must be a listening to the different views and a reaching of a compromise between these differing views. Indeed, this is the African way of life in general, as has been espoused by theories of African life and values such ubuntu or *utu*. Rather than take a paternalistic approach that assumes to know what is best for women, especially those women who are make seemingly bad choices such as choosing FGM, there ought to be a space for dialogue and for reaching a workable compromise, where the women feel that they

87 Shell-Duncan (n 7).
88 A Meroka-Mutua and others *Assessing when and how law is effective in reducing the practice of FGM/C in Kenya* (2020).
89 Lewis (n 18).
90 Nnaaemeka (n 26).

have been heard and where also the state feels that the harmful effects of FGM are understood. Wuoango and others demonstrate that in Burkina Faso, the anti-FGM law, which is more conciliatory in nature, seems to be having a better compliance response, thus demonstrating that a nego-feminist position that allows for dialogue may be useful in navigating the delicate space between culture and human rights.[91]

4.4 Double standards in the naming and categorisation of actions that lead to modification of female genitalia

The question here is with regard to the classification of procedures that are categorised specifically as mutilation. Indeed, the definition of FGM by WHO has raised the concern that the target of this definition is that which excludes Western practices. Consequently, the definition of FGM as a number of procedures that result in the total or partial removal of the external female genitalia for non-medical purposes seems to suggest that when it is done for cultural reasons, then it is mutilation. However, when similar procedures, which may generally be referred to as female genital cosmetic surgery, are done as medical procedures but for cosmetic reasons, then this is not mutilation, which suggests that there is an element of racism in the definition of what constitutes FGM.[92] It should, however, be noted that these cosmetic procedures are recognised and accepted within the medical fraternity as being of therapeutic value, unlike FGM, which is seen as not having any therapeutic value.

From a social , however, Boddy argues that traditional FGM and modern labiaplasty are both based on the same ideology – that the normal or natural look of the external female genitalia is deformed and ugly and, therefore, needs fixing.[93] However, while Female Genital Cosmetic Surgery (FGCS) is not prohibited and is considered essential for the mental health and well-being for the women and girls who seek the procedure, FGM is categorised as harmful.

Hehir further demonstrates that migrant communities in the global North have also been subjected to what may be perceived as racism, based

91 J Wouango and others *When and how does law effectively reduce the practice of female genital mutilation/cutting?* (2020).

92 J Boddy 'Re-thinking the zero tolerance approach to FGM/C: The debate around female genital cosmetic surgery' (2020) 12 *Current Sexual Health Reports* 302.

93 As above.

on the history of FGM in their countries of origin.[94] Consequently, as in the case of Kenya, there is an assumption in the United Kingdom that a girl (which also includes adult women) cannot exercise their autonomy and make the choice to undergo FGM. This may be contrasted with teenagers who wish to undergo a sex change or take puberty blockers, and under the law in the UK, such teenagers are viewed as having the autonomy to make such a decision. There generally is a perception about African women as being victims and also as being helpless in addressing the circumstances that lead to their victimhood. African women require protection, and this therefore means, in certain circumstances, limiting the extent to which they can make decisions concerning their bodies, because again the belief is that African women are so entrenched in a pervasive patriarchal culture that they are incapable of making good choices for themselves. The outcome is that among migrant communities in the UK, just as in Kenya, adult women cannot consent to FGM.

From an African feminist perspective, the narrative that African cultures are so oppressive that women who want to conform to those cultures are viewed as acting out of the compulsion and pressure of the same oppressive culture, is one that ought to be confronted. Indeed, patriarchy and the need to conform to patriarchal standards of beauty and pornography are some of the factors that cause women in the Global North to seek FGCS procedures.[95] However, these aspects of cultures in the Global North that cause women to make certain decisions do not seem to be problematic, but African cultures are.

This double standard transcends questions of gender and sex oppression. It goes to the very heart of racist ideology. However, anti-racist discourse itself has been problematised for ignoring the experiences of women. Crenshaw demonstrated that in the context of racism, race is the primary axis of analysis, and because masculinity is generally dominant, the experiences of men with regard to racism tend to take a universalising character, which ignores the experiences women have with regard to racism.[96] FGM is a uniquely feminine experience, and from an

94 B Hehir 'Why we should be concerned about UK female genital mutilation laws and associated monitoring and reporting systems: A reply to "The prosecution of Dawoodi Bohra women" by Richard Shweder' 2022 12 *Global Discourse* 131.

95 Boddy (n 94).

96 K Crenshaw 'Demarginalising the intersection of race and gender: A black feminist critique of antidiscrimination doctrine, feminist theory and antiracist

intersectional perspective, analysis of racism with regard to FGM may be limited on one extreme. On the other extreme, from a hardline cultural relativist standpoint, the treatment of FGM versus the treatment of FGCS in international guidelines, particularly the WHO guidelines, may result in a justification for FGM. This means that the treatment of only African cultures as patriarchal and retrogressive, when even cultures in the Global North are equally patriarchal with both resulting in more or less similar perceptions of the female genitalia, could create a space for arguing that the WHO guidelines on FGM ought to be ignored in the African context. This would be a dangerous position, which would threaten the gains that so far have been made in advancing the sexual and reproductive health rights of girls and women.

Recalling the analysis of Njoya on the dangers of FGM on selfhood, it is necessary to stress that, indeed, FGM is a problematic cultural practice, which also has negative impacts on the health and well-being of women.[97] From an African feminist perspective, the point is that while there is a clear double standard in the international treatment of FGM, on the one hand, and FGCS, on the other hand, this should be acknowledged and problematised, without necessarily undoing the gains that have so far been made in protecting women and girls from harmful cultural practices.

In achieving this, it would be important to adopt a position that looks for the possibilities in African cultures and works with those cultures to promote the rights of women. Nyamu-Musembi has demonstrated that African cultures have the possibility to be fences or pathways, that is, they can inhibit the enjoyment of human rights just as they can promote the enjoyment of those rights.[98] Hellum and Stewart also highlight that in plural legal systems, African women seek justice in multiple spaces, depending on the possibilities offered by those spaces.[99] Thus, there are instances where African women will look to culture and custom for justice, and this should not be ignored in favour of the narrative that demonises African cultures and instead privileges of international human

politics' (1989) 1 *University of Chicago Law Forum* 139.

97 Njoya (n 70).

98 C Nyamu-Musembi 'Are local norms and practices fences or pathways? The example of women's property rights' in A An-Naim (ed) *Cultural transformation and human rights in Africa* (2002) 126-150.

99 Hellum & Stewart (n 8).

rights and formal state interventions. Thus, a cultural transformation approach as espoused by An-Naim would be relevant in this context.[100] Such an approach begins from the premise that African cultures indeed are inherently good, and that the right to pursue one's culture is a fundamental right that ought to be respected. However, culture is not ossified and it is in a constant state of evolution. Thus, for cultural transformationists, the question is not whether African cultures indeed are capable of transforming so that they take on aspects of human rights, but rather, the question is how such transformation should occur. This is very much in line with African feminism, because it is at once aligned with and in support of African cultures but, on the other hand, it is concerned with the ways in which problematic gender aspects of such cultures may be addressed.

5 Conclusion

Through the experiences of African women, we see that there are various dimensions to the issue of FGM. At different points in time and for varied reasons, African women have supported anti-FGM interventions, and, at other times, they have protested against those interventions. The cultural entrenchment of FGM may be seen as curtailing women's autonomy over their bodies and, likewise, legal prohibitions of FGM informed by human rights standards may have the same outcome of limiting women's bodily autonomy. The way in which FGM is defined and categorised may also result in intersectional forms of marginalisation, occurring both on the basis of race and gender. Well-meaning anti-FGM interventions can have the outcome of being paternalistic and infantilising African women. Survivors of FGM who have told their stories have been empowered in the process and they have also empowered other women and girls to make fully informed choices about FGM. On the other hand, some women who have undergone FGM and who would choose to undergo FGM have found this to be an empowering experience for them to the extent that it allows women to express their cultural identities.

What we see, therefore, is that there are numerous different and often times conflicting stories about FGM. From an African feminist perspective, all these stories are important, and they must be told. This

100 A An-Naim *Cultural transformation and human rights in Africa* (2002).

chapter has not attempted to provide answers as to how some of the tensions that arise in how African women respond to FGM should be addressed. Such an objective indeed might not be achievable. Rather, the aim of this chapter was to simply tell the many different stories of women's experiences, to explain those stories and through that, to provide greater understanding of what African feminism is about. Thus, African feminism is not primarily a site through which particular positions are taken or particular issues are advanced. Rather, African feminism is about making African women and their concerns visible – because African women and that which concerns them matters.

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9

FEMALE GENITAL MUTILATION: A SURVIVOR'S NARRATIVE

*Musu Bakoto Sawo**

Abstract

Globally, over 200 million girls have undergone female genital mutilation). FGM is considered beneficial among practising communities and is often motivated by cultural and religious considerations, gender inequality, the desire to restrict women's sexuality, and economic benefits for those performing the mutilation. Long-term and short-term effects of the practice include extended physical and psychological trauma that can potentially reduce victims' and survivors' quality of life. Thus, the physical and psychological repercussions of FGM exceed the supposed benefits of the practice. In this chapter I describe my personal experience as a survivor of FGM and its impact on my daily life, particularly on my sexual and reproductive health and well-being, and sexual relationships. In addition, I also examine the factors that contribute to the high prevalence rate of FGM in The Gambia and discuss the current status quo of FGM in The Gambia, drawing on work that organisations and survivors have done to end the practice.

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1 Introduction

The Gambia is a highly patriarchal society where male dominance and superiority are the order of the day.[1] Women are often seen as second-class citizens, and their human rights often are not respected despite the fact that laws are in place to protect them.[2] The lack of implementation of laws, compounded by certain social and cultural dimensions, has resulted in women and girls being subjected to harmful traditional practices such as female genital mutilation (FGM).[3] FGM is the total or partial removal of the female genitalia for non-medical purposes.[4] It is a social norm that is deeply entrenched in the cultural and historical beliefs of various ethnic groups in The Gambia and has religious connotations. Although the practice remains a serious human rights violation, people have disguised it as a religious and customary obligation, and young girls, in particular, suffer the consequences either in the early or later parts of their lives. The consequences vary from physical and emotional to psychological.

2 Factors that contribute to the high prevalence rate of FGM in The Gambia

FGM is widely practised in The Gambia for a variety of reasons. The key to these is religion. The majority of the practising communities, including my community, who are largely Muslim, consider it obligatory for them. Despite the efforts of anti-FGM religious leaders and scholars to dispel the myth that FGM is associated with Islam, the practice persists. Others believe that subjecting their women and girls to this harmful traditional practice is socially acceptable. Due to stigmatisation, social marginalisation, and discrimination against uncut women who

1 MB Sawo 'Is the ban on FGM and child marriage in The Gambia the end of these practices?' https://www.thegirlgeneration.org/blog/ban-fgm-and-child-marriage-gambia-end-these-practices (accessed 20 June 2022).

2 'Human Rights Committee examines the state of civil and political rights in The Gambia in absence of report 2018, https://www.ohchr.org/en/press-releases/2018/07/human-rights-committee-examines-state-civil-and-political-rights-gambia (accessed 20 June 2022).

3 World Health Organisation 'Prevalence of female genital mutilation', https://www.who.int/teams/sexual-and-reproductive-health-and-research/key-areas-of-work/female-genital-mutilation/prevalence-of-female-genital-mutilation (accessed 24 May 2022).

4 World Health Organisation 'Female genital mutilation', https://www.who.int/news-room/fact-sheets/detail/female-genital-mutilation (accessed 20 June 2022).

are married into practising communities, many of these women are compelled to undergo FGM in order to fit into their practising spouses' communities.[5] This is exacerbated by the fact that women who have undergone FGM appear to enjoy social prestige and respect, fostering inferiority complexes among women who have not undergone FGM.

There is a general belief among many practising communities, such as the one I come from, that FGM increases the desirability of a woman for marriage, thus providing income for her family through the payment of dowry. Many are of the belief that the practice prepares girls for womanhood and for their lives ahead as wives, mothers and caregivers. This is also related to the fact that FGM is aimed at controlling and suppressing women's sexual desires in an attempt to preserve their chastity, which is considered a matter of family honour. Practising communities in The Gambia commonly believe that by mutilating girls, their sexual desire will diminish, hence encouraging chastity or preventing promiscuity. In societies where virginity testing is considered important, this, according to them, is done to protect the family name.

The practice also occurs as a result of misconceptions around the practice. For many practising communities, there is a belief that a failure to perform FGM will result in abnormal births. It is a common misconception that if the clitoris is not cut, it will grow longer and resemble the size of a penis. Consequently, during childbirth, once the clitoris touches the head of the baby, the baby will develop a mental and intellectual disability. In spite of the existence of legislation against FGM, these and a number of other social-cultural factors continue to motivate the practice. This is largely due to the lack of implementation of the law by the state and the failure of the state to put in place mechanisms that facilitate the implementation and enforcement of the Women's Amendment Act 2015.[6] Since its enactment in 2015, no single case has been prosecuted or prosecuted successfully. Even though cases have been reported, the conviction rate remains at zero.[7]

5 S Nabaneh & A Muula 'Female genital mutilation/cutting in Africa: A complex legal and ethical landscape' (2019) 145 *International Journal of Gynaecology and Obstetrics* 3.

6 E Durojaye & S Nabaneh 'Addressing female genital cutting/mutilation (FGC/M) in The Gambia: Beyond criminalisation' in E Durojaye, G Mirugi-Mukundi & C Ngwena (eds) *Advancing sexual and reproductive health and rights in Africa: Constraints and opportunities* (2021) 126.

7 Durojaye & Nabaneh (n 6) 125.

3 Impact of female genital mutilation on my life as a survivor

My memories of undergoing FGM are not as faded as I would wish them to be. I was about five or six years old when I went through it. I remember being told that I would be visiting my paternal grandmother, who is also my namesake. I was so excited that I would be taking my first trip to my village. Little did I know that even my father did not know his mother, as she passed away when he was a toddler. This journey to my village would haunt me almost two decades later. Even though I did not see my paternal grandmother, I returned from the village with so much pride because I had been mutilated. I remember walking around my neighbourhood and school with my *Jujus* around my neck, thinking that I was better than the other children. This was because I was told that undergoing FGM had cleansed and purified me.

Even as a child, I felt superior to other girls from non-practising communities and would even call them *Solima*, a Mandinka word meaning 'the uncut or unclean one'. This personal feeling of superiority and pride gives credence to scholarship that has linked the practice to prestige and social acceptance. For instance, in many practising communities, FGM is regarded as an integral component of the ethnic identity of girls and offers them a sense of pride, maturation and acceptance into their communities.[8] Although members of some practising communities in Africa are aware of the severe health implications of FGM, many of these communities continue to strive to preserve the practice because it represents prestige and cultural identification, which they feel obligated to protect.[9] Thus, women and girls are often mutilated because this practice confers a high social status and prestige on women and girls who have undergone FGM.

I first learnt about FGM as a human rights issue during an advocacy training on the rights of the child organised by the Child Protection Alliance (CPA) in The Gambia. As a member of the Voice of The Young, a child-led advocacy group under CPA, I had the opportunity to learn at an early age about human rights issues, including harmful traditional

8 M Refaei and others 'Socio-economic and reproductive health outcomes of female genital mutilation' (2016) 19 *Archives of Iranian Medicine* 807.

9 AK Halder and others 'Female genital mutilation: From the life story of girls in remote villages in Pokot county, Kenya' (2015) 3 *Journal of Child and Adolescent Behaviour* 3.

practices such as FGM. It was through several advocacy trainings that I realised that what I went through as a child not only violated my human rights but would also completely change my adult life and have a devastating impact on it.

Although I had theoretical knowledge of the harmful effects of FGM, my first real experience of the harmful effects of FGM was on the night my marriage was consummated. Married at the age of 14 and coming from a family where virginity testing is non-negotiable, my first sexual encounter was horrific and left me scarred for good. This was a result of the type of FGM I underwent. For three nights, my marriage could not be consummated. Every attempt made on each night caused nothing but excruciating pain, resulting in physical disfiguration. Not only was I scarred physically, but I was also left in a state of shock and pain.

The practice of FGM causes a variety of health problems, such as pain, repeated urinary and vaginal infections and difficulty during childbirth.[10] It is viewed as a form of exploitation and discrimination against women and girls and results in numerous sexual and reproductive health consequences, including sexual disability.[11] Consequently, the practice can lead to psychological issues, and destruction of women's ability to be intimate and perform sexually.[12] FGM has affected my desire for sex and left me with a great sense of loss and denial about the prospect of having pleasant sexual relations with a partner. For me, sexual interactions will always mean pain and suffering. In addition, the scarring of my genitalia as a result of the infibulation has also impacted my confidence and self-esteem and has exacerbated my lack of desire for intimacy. Although I encountered difficulty during the birth of my first child as a result of having undergone FGM, the physical trauma of FGM became a lifelong issue and has had an impact on my mental health and well-being.

The physical impact of FGM on my bodily integrity has also made it almost impossible for me to seek gynaecological care when necessary. As someone who suffers from recurrent chronic infections, I have always dreaded seeking medical assistance due to the reaction I sometimes receive

10 MIH Mahmoud 'Effect of female genital mutilation on female sexual function' (2016) 52 *Alexandria Journal of Medicine* 56.

11 M Owojuyigbe and others 'Female genital mutilation as sexual disability: Perceptions of women and their spouses in Akure, Ondo state, Nigeria' (2017) 25 *Reproductive Health Matters* 80.

12 Mahmoud (n 10).

from practitioners, especially those from non-practising communities or those who are unfamiliar with FGM. The questions from those who are not familiar with FGM leave me with little or no desire to return. These reactions, while not malicious, leave me feeling uncomfortable, ashamed, and judged by medical practitioners. As a result of my reluctance to seek medical assistance for these reactions, my medical issues are often exacerbated, and I am forced to rely on ineffective home remedies that sometimes are harmful to my reproductive health. Thus, the impact of FGM cannot be underestimated.

FGM robs women and girls of their right to be autonomous and in charge of their bodies as it prevents them from making informed decisions about a procedure that has lifelong implications on their lives.[13] The practice infringes on the right to bodily integrity, which covers a variety of wider human rights principles, including the fundamental right to dignity of the individual and the freedom to make autonomous choices regarding one's own person. FGM is an invasion of a person's right to this bodily autonomy as well as a violation of other fundamental rights.[14] This is because, in the majority of cases, the victims or survivors of FGM are not capable of exercising such autonomy and thus do not or cannot give their voluntary and well-informed consent to the practice.[15] My experience of FGM has resulted in a loss of self and the colonisation of mind and body. This is because the thought of undergoing FGM has resulted in lingering trauma and residual pain and, to a large extent, has made me feel like a prisoner in my own body, thus robbing me of my wholeness as a person. For the longest time, this inhibited my ability to think and also prevented me from thriving. For an extended period of time, I was neither able to internalise my trauma emanating from the consequences of FGM nor devise any useful strategy for dealing with it. I was silent about my struggles with my mental health and the physical

13 OHCHR and others 'Eliminating female genital mutilation: An interagency statement', https://www.un.org/womenwatch/daw/csw/csw52/statements_missions/Interagency_Statement_on_Eliminating_FGM.pdf (accessed 20 June 2022).

14 Centre for Reproductive Rights 'Female genital mutilation: A matter of human rights: An advocate's guide to action' (2006) 14, https://www.reproductiverights.org/sites/default/files/documents/FGM_final.pdf (accessed 20 June 2022).

15 GI Serour 'Medicalisation of female genital mutilation/cutting' (2013) 19 *African Journal of Urology* 147.

pain I have had to endure as a result of FGM and did not seek professional help to enable me to deal with my trauma.

The concealment of my trauma stemmed from a sense of shame toward myself and toward my family by others whom I believed would judge my family and me if I ever spoke about the traumatic experiences I was exposed and subjected to. This was exacerbated by the fear of losing my family should I tell my story. For the very first time that I shared my story and started using my experience to accelerate the campaign to end FGM in The Gambia, my fears came to light. I felt unwelcome in my family and was described as a person bringing shame to the family and tainting its good name. I had expected this rejection because anti-FGM campaigners quite often encounter a backlash from practising communities, particularly conservative communities, in their efforts to eradicate FGM.[16]

Notwithstanding this, anti-FGM advocates continue to take action to end FGM, despite the danger of being ostracised by their families and other members of their communities.[17] Thus, sharing my story provided me with a sense of escape and security, allowing me to work on resolving the pain and humiliation I have endured for more than a decade. While this may be my narrative for the rest of my life, I refuse to let it define me. Hence, my refusal to identify as a victim but rather as a survivor.

Studies have shown that the effects of FGM on women and girls are lifelong and include several physical health issues such as extended bleeding, urinal problems, cyst development, recurrent infections, pain during sexual intercourse, and complications during childbirth, among others.[18] FGM can also have severe psychological implications, with a high incidence of anxiety and depression-related concerns, along with post-traumatic stress disorder.[19] Sexual performance is often hampered, and women who have undergone FGM have significantly lower

16 Equality Now 'No time for inaction: Female genital mutilation is global, but so is the movement to end it' (2021), https://www.equalitynow.org/news_and_insights/ztd_2021/ (accessed 20 June 2022).

17 UNFPA '"I refused": Brave women and girls take a stand against FGM', https://www.unfpa.org/news/i-refused-brave-women-and-girls-take-stand-against-fgm (accessed 20 June 2022).

18 E Klein and others 'Female genital mutilation: Health consequences and complications – A short literature review' (2018) *Obstetrics and Gynecology International* 2.

19 J Rymer & N O'Flynn 'Female genital mutilation: Everyone's problem' (2013) 63 *British Journal of General Practice* 515.

reproductive and sexual performance scores than those who have not been mutilated.[20]

4 Current status quo of female genital mutilation in The Gambia

Globally, over 200 million girls have undergone female genital mutilation.[21] In the Gambia, prior to the enactment of the Women's Amendment Act 2015, which banned FGM, more than 75 per cent of women and girls in The Gambia had been mutilated.[22] While legal frameworks are without doubt important in the campaign to end FGM, it is important to note that laws alone cannot bring about the change we desire when it comes to ending FGM, especially in communities where the practice is mandatory.[23] It is imperative that legislative frameworks are complemented by other approaches and strategies to achieve social change.[24] Thus, the promotion of non-legislative, judicial and legal efforts to end FGM has gained prominence in recent years, as stakeholders recognise the necessity for supplementary approaches to statutory provisions prohibiting FGM.[25]

In The Gambia these efforts have taken multifaceted approaches such as awareness-raising initiatives that have served as a primary intervention to induce voluntary cessation of the practice based on improved awareness of its negative consequences. Other interventions include youth-led educational and advocacy campaigns involving men and boys, mentorship programmes for girls, among others. The use of these methods are based on the premise that FGM remains a social convention issue that will require training to transform these social norms and encourage practising communities to cease pressuring their

20 As above.
21 Nababeh & Muula (n 5) 1.
22 A Kaplan and others 'Female genital mutilation/cutting in The Gambia: Long-term health consequences and complications during delivery and for the newborn' (2013) 5 *International Journal of Women's Health* 323.
23 Durojaye & Nabaneh (n 6); see also B Shell-Duncan and others 'Legislating change? Responses to criminalising female genital cutting in Senegal' (2013) 47 *Law and Society Review* 39.
24 United Nations Population Fund 'Driving forces in outlawing the practice of female genital mutilation/cutting in Kenya, Uganda and Guinea-Bissau' (2013) 22, https://www.unfpa.org/sites/default/files/resource-pdf/Legislation%20and%20FGMC.pdf (accessed 20 June 2022).
25 UNFPA Regional Office for West and Central Africa 'Analysis of legal frameworks on female genital mutilation in selected countries in West Africa' (2018) 19.

girls to undergo the procedure.[26] It also emphasises on community participation in formulating and implementing homegrown solutions, since these education and awareness-raising programmes oftentimes necessitate active and voluntary involvement of community members and influencers.[27] The steps and approaches taken in The Gambia are consistent with Article 5 of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol), which outlines comprehensive and systematic approaches to eradicating harmful traditional practices such as FGM.

5 Steps taken to curb female genital mutilation in The Gambia

Over the past three decades, several steps have been taken to accelerate the abandonment of FGM. These, among others, include coordinated efforts of young people, civil society organisations (CSOs) and survivors of FGM. CSOs, international non-governmental organisations (INGOs), United Nations (UN) agencies, and survivors of FGM, such as myself, have exerted a substantial degree of effort for many years in an effort to end FGM, including advocacy that resulted in the promulgation of law that banned FGM. As a survivor, I use my voice and story to educate parents and guardians across The Gambia, including in communities where FGM is most prevalent, about the complex and lasting impacts FGM can have on women and girls. As the National Coordinator for Think Young Women (TYW), a young women-led, non-profit organisation in The Gambia, and a former programme officer for the Girl Generation, I was able to formulate and design impactful projects and programmes that are aimed at curbing FGM in The Gambia. My advocacy efforts, alongside those of many other survivors, CSOs and INGOs, led to the reduction in the prevalence of the practice of FGM in The Gambia. I am committed to ending the cycle of FGM in my family, country, and lifetime.

Understanding the need for a comprehensive and inclusive approach, together with my team I designed and coordinated various regional initiatives for young people across The Gambia, particularly those in

26 As above.

27 P Mwendwa and others 'Promote locally led initiatives to fight female genital mutilation/cutting (FGM/C): Lessons from anti-FGM/C advocates in rural Kenya' (2020) 17 *Reproductive Health* 2.

rural Gambia. The rationale behind these initiatives is to increase the number of youths involved in the campaign to end FGM and to give them the opportunity to meet and acquire vital knowledge, skills and tools necessary in the campaign to end FGM. The initiatives and engagements also enabled and supported the beneficiaries to create, lead and implement their own programmes and initiatives and enabled them to serve as change agents and ambassadors in their own communities. With an increasing number of young people pledging to never subject their daughters to FGM once they become parents, the desire to end FGM in one generation is not out of reach. Similarly, multiple organisations, including TYW, have embarked on community-led activities in our quest to curb FGM in The Gambia. It is my belief that the *status quo* surrounding FGM in The Gambia will only change with the full inclusion and participation of everyone at the community level. By applying social change communications techniques, the 'do no harm' principle, and using survivor and positive stories of change to reach communities, the narratives would change. TYW believes storytelling can enlighten, equip, engage, and communicate messages, including those concerning FGM. Storytelling may convey the bodily, cognitive and behavioural characteristics of a person within the framework of their present or previous experiences, allowing for a more complete comprehension of the person.[28] Studies have shown that narrative telling encourages self-reflection and personal growth and creates resilience, which is the drive to turn life's emotional pain into something positive and empowering.[29]

As part of its efforts to end FGM through the use of extra-legal strategies involving social action advocacy, TYW has carried out a variety of activities. The Girls' Mentorship Programme, which TYW has been running since 2011, is one of these initiatives. The Girls' Mentorship is a school-based programme designed to empower and inspire girls to be active participants in their communities, equip them with interpersonal and communication skills, and build their self-esteem. It also focuses on educating girls on sexual and reproductive health rights in an effort

28 M Drumm 'The role of personal storytelling in practice' (2013), https://www.iriss.org.uk/resources/insights/role-personal-storytelling-practice (accessed 20 June 2022).

29 As above.

to teach them about their bodies, promote dialogue, and foster a sense of sisterhood. Over 700 girls have completed and graduated from this programme and now serve as ambassadors in their various schools and communities. Many have taken up leadership positions in their schools and communities and have influenced critical changes within their homes, including preventing child marriages and FGM. The most impressive outcome of this programme is that some of the graduates have returned to volunteer as mentors in the subsequent classes, creating an opportunity to sustain the programme and transfer knowledge and skills across generations.

To achieve its vision of creating a new generation of enlightened and well-informed young women, TYW has replicated and extended its girls' mentorship programme in order to reach more girls at the grassroots level. It accomplished this by training regional mentees who would implement and sustain this programme in rural communities. Part of this expansion also includes targeting out-of-school girls so that no girl is left behind. Not only is the mentorship programme more accessible to girls at the grassroots level, but it has also increased the involvement of adolescent voices in addressing FGM and other harmful traditional practices in their communities.

In our quest to find more innovative ways of engaging communities through 'Artvocacy', TYW engaged Gambian artists and poets for an intensive training on FGM and child marriage. This provided an opportunity to raise their awareness of these issues while also emphasising the critical role they can play in ending these social challenges. Using this information and their creativity, young artists collaborated and produced a music album of seven songs with key messages on these issues and a music video for an enhanced visual experience to accompany the transmission of these messages. Following the production of these materials, national caravans across the country have been conducted to popularise the songs while raising awareness about FGM and other harmful traditional practices in various communities across the country. Similarly, several poster competitions for schoolchildren on FGM and other forms of gender-based violence have also been implemented under my leadership. The activity, themed 'Engaging Young People for Amplified Action to End FGM', targeted students from senior secondary schools. The training aimed to equip the students with accurate information about FGM and child marriage, which led to an arts competition among the

participating schools, depicting their views on the issues. The winning entries from these competitions have been developed into billboards and serve as advocacy materials in our campaign to end FGM.

Bearing in mind the patriarchal nature of Gambian society, through TYW and other CSOs, I created and supported programmes that targeted young men as a strategy to end FGM. In The Gambia, men as custodians of customary powers control the narratives around social norms and practices. While there is an acknowledgment that many of the rights of women that are suppressed are done so by men, a theoretical shift in understanding gender more holistically, backed by practice, has revealed the important role young men can play in ending harmful traditional practices, particularly FGM. The increasing recognition of the role of young men in violence prevention, the promotion of gender equality, and ending FGM and other traditional practices resulted in the promulgation of these initiatives. With conversations centred on raising awareness and debunking some of the myths and stereotypes about gender roles in our society, as well as influencing the creation of a generation of gender-sensitive young men, these initiatives left great impressions on the beneficiaries. Not only did they open up avenues for healthier conversations around gender issues and violence against women, including FGM in The Gambia, but they also reminded our male counterparts of the role they play in advancing the fundamental rights of women and girls.

In line with the objectives of The Gambia National Action Plan (NaPA) on FGM/C and in an effort to develop a more effective programme of intervention in the campaign to end FGM, TYW, with support from INGOs, has embarked on data collection and sensitisation on FGM. With very little data concerning why FGM is practised or its harmful effects on those who have undergone it, the research was set to identify the knowledge and attitudes of people around FGM, the factors that motivate the practice, and the impact on those who have undergone FGM, while at the same time raising awareness of FGM and its harmful effects, encouraging the use of dialogue in changing the mindsets of people concerning the issues, and documenting and sharing the voices of young people so as to influence policy makers into taking a more active role in ending FGM.

Recognising that access to health services, including psychosocial support services, is integral to the well-being of victims and survivors,

several CSOs and survivor-led initiatives have been providing such services to survivors of FGM who need such services. Consortiums such as the Network Against Gender-Based Violence (Network), of which I am the Chairperson of the executive board, have been providing psychosocial support services for people who have experienced or are experiencing trauma from FGM through its One Stop Centres. The Network also provides capacity-building services to other service providers such as the police, nurses, and social workers to ensure quality service delivery to victims and survivors.

Throughout its years of existence and under my direction, TYW has shown ingenuity and creativity in addressing issues affecting women and girls in The Gambia. TYW pioneered a much-needed transition in the way in which organisations communicate their work in order to expand their reach and increase partnership opportunities. This comparative advantage has been utilised by the organisation to contribute to national campaigns to end FGM and other harmful traditional practices. Representatives of the organisation have also been assisting other organisations with the development of their communication strategies in an effort to end FGM. Other initiatives that I have coordinated include mentorship programmes for girls; intergenerational dialogues, and engagement with traditional and religious leaders; 'artvocacy' through the use of musicians and poets; and training for law enforcement officers, members of the judiciary, and members of the legislature. Through the collective efforts and innovations of CSOs, survivors, and all other relevant stakeholders, despite limited resources to support the work of ending FGM, significant strides have been made.

6 Conclusion

The consequences of FGM on women and girls are irreparable. The impact of FGM on the physical and psychological well-being of women and girls who undergo it is devastating. Despite being prohibited by several international and regional human rights treaties and domestic legislation, its prevalence remains high. While survivors, CSOs and INGOs have taken meaningful steps to curb the practice, the need for states to redouble their efforts in fulfilling their obligations under international human rights law by protecting women and girls from harmful traditional practices such as FGM is paramount. These, among other things, include not only the enactment of laws but the development

of mechanisms and the allocation of monetary and human resources that will ensure the effective implementation and enforcement of the law, as well as provide services that will support the rehabilitation of survivors who have suffered from physical or mental health emanating from FGM.

The need for the development of holistic programmes that are youth and community-led and which allow communities to take ownership of such initiatives cannot be overemphasised. Engaging all relevant stakeholders such as survivors, women and girls, boys and men, traditional and religious leaders, community members, CSOs, INGOs, and the state can lead to the desired outcome. FGM should be a priority and should be everyone's problem.

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PART IV: Legal cases and societal responses

10

THE CURSE OF BEYOND REASONABLE DOUBT

*Kenneth K Mbaabu**

Abstract

Strategic legislation has played an important role in the criminalization of Female Genital Mutilation. The nature of strategic litigation is one that involves the community being both the foundation and the propellor in some instances. The aim of this chapter is to first investigate the criminalisation of FGM. This entails taking a deep look into the Prohibition of FGM Act that was enacted in 2011 which make FGM illegal. Not only does the Act state that FGM is illegal, but also introduces other various offences pertaining to FGM. The chapter also seeks to elaborate on the various responses to the criminalisation; those who are for the criminalisation and against. This will encapsulate the effect of criminalisation including the laws driving the act underground as well as public participation, or lack thereof, during the enactment of the Prohibition of FGM Act. A further examination of the role of the state to protect its citizens is also done taking int account reporting, investigation and prosecution of the cases. Barriers to prosecution are also discussed at length. The chapter also probes the issue of reasonable doubt in the legal cases and directly relates the doctrine to the offences listed in the Act in a bid to examine whether the doctrine of beyond reasonable doubt truly aids in convictions or acquittals. Lastly, an investigation into the role of grassroots communities in litigation from the ground level to the national courts highlighting both the negative and positive impact the community bears on criminalisation and the prosecution of cases and a list of recommendations are provided.

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1 Introduction

Kenya is one of the countries in Africa that continues to fight the war against female genital mutilation (FGM). According to the United Nations Population Fund (UNFPA), in 2022 it is reported that 21 per cent of women aged between the ages of 15 to 49 years have undergone the cut.[1] This was recorded as a decrease in the number from 27 per cent that had previously been recorded in 2009.[2]

Kenya has ratified several international laws and treaties that have abolished the cut, such as the Universal Declaration of Human Rights (Universal Declaration); the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW); the International Covenant on Economic, Social and Cultural Rights (ICESCR); not forgetting to mention the regional Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (African Women's Protocol). This is made possible by article 2(6) of the Kenyan Constitution that states that any treaty ratified by Kenya shall form part of the laws of Kenya.

The aim of this chapter is threefold: First, it seeks to investigate the criminalisation of FGM and how the local communities have responded to said criminalisation; second, as criminalisation culminates in the prosecution of the said crime, we will look at the state obligations to protect and subsequent prosecution of FGM and related crimes before the national courts; and, lastly, an investigation into the role of grassroots communities in litigation from the ground level to the national courts highlighting both the negative and positive impact the community bears on criminalisation and the prosecution of cases. We shall start with the criminalisation and the community response.

1 United Nations Population Fund (2022), https://www.unfpa.org/data/fgm/KE (accessed 6 June 2022).

2 According to the Kenya Demographic and Health Survey 2014, there is evidence of a trend to circumcise girls at younger ages. 46% of circumcised women age 5-19 were circumcised at age 5-9, as compared with 17% of circumcised women age 45-49. While there is overlap in these categories, Muslim women are much more likely to be circumcised at age 5-9 (65 per cent) than women from other religious groups, as are Somali women (73 per cent). Urban women are more likely to be circumcised at age 5-9 (34 per cent) than rural women (24 per cent). About 78 per cent of women in urban areas are circumcised by age 14, compared with 69 per cent of those in rural areas. Women in the coastal region were most likely to have been circumcised when they were less than age 5 (22 per cent).

2 Criminalisation of female genital mutilation

The process of enacting legislation is cemented under the Constitution of Kenya, 2010. The Kenyan Constitution states that the legislative powers vest in Parliament.[3] In theory, the first stage is referred to as the first reading where the Bill is introduced and a committee assigned to it. The next step is the second reading. At this stage the draft is read out loud and votes are taken as it regards to the outline of the said draft Bill. The committee then affects all passed amendments to the draft Bill. This is followed by the third reading where the draft Bill is scrutinised by legislators and, if satisfied, the legislators give it the final approval. The last stage is presidential assent where the head of the executive, the President, gives his assent and the Bill becomes law.[4]

The Prohibition of Female Genital Mutilation Act, 2011 (Act) was passed on 30 September 2011 and was consequently enforced on 4 October 2011. The Act criminalises FGM and other acts relating to FGM. According to the provisions of the Act, the elements of the offence with regard to FGM include:

2.1 Offence of female genital mutilation

Section 19 of the Act stipulates that it is an offence to perform FGM. It continues to list that if death occurs during the commission of FGM, the person upon conviction will be liable to imprisonment for life. Under subsection (6), it is clear that it is no defence to any charge under the section to state that the person on whom the act was performed consented to the act or that the person charged believed that such consent had been given.

2.2 Aiding and abetting female genital mutilation

Any person who aids, abets, counsels or procures a person to undergo FGM commits an offence.[5]

3 Art 109 Constitution of Kenya.

4 Kenya Law Reports; The Legislative Process, http://kenyalaw.org/kl/index.php?id=528 (accessed 6 June 2022).

5 Sec 20 of the Prohibition of Female Genital Mutilation Act states: 'Aiding and abetting female genital mutilation: A person who aids, abets, counsels or procures

2.3 Procuring a person to perform female genital mutilation in another country

It is an offence for any person to take a person from Kenya to another country or arranges for another person to be brought to Kenya from another country for the purpose of performing FGM.[6]

2.4 Use of premises to perform female genital mutilation

An offence is committed if a person knowingly allows any premises over which they have control or are responsible for to be used for purposes of performing FGM.[7]

2.5 Possession of tools and equipment

Any person found in possession of a tool or equipment for a purpose connected with the commission of FGM commits an offence.[8]

2.6 Failure to report commission of offence

It is considered an offence if a person is aware that FGM has occurred or is in the process of being performed or intends to be performed and does not report it to a law enforcement officer.[9]

(a) a person to commit an offence under section 19; or (b) another person to perform female genital mutilation on that other person, commits an offence.'

6 Sec 21 of the Prohibition of Female Genital Mutilation Act states: 'A person commits an offence if the person takes another person from Kenya to another country, or arranges for another person to be brought into Kenya from another country, with the intention of having that other person subjected to female genital mutilation.'

7 Sec 22 of the Prohibition of Female Genital Mutilation Act states: 'A person who knowingly allows any premises, for which that person is in control of, or responsible for, to be used for purposes of performing female genital mutilation commits an offence.'

8 Sec 23 of the Prohibition of Female Genital Mutilation Act states: 'A person who is found in possession of a tool or equipment for a purpose connected with the performance of female genital mutilation, commits an offence.'

9 Sec 24 of the Prohibition of Female Genital Mutilation Act states: 'A person commits an offence if the person, being aware that an offence of female genital mutilation has been, is in the process of being, or intends to be, committed, fails to report accordingly to a law enforcement officer.'

2.7 Use of derogatory or abusive language

Any person who uses derogatory or any abusive language intended to ridicule or embarrass a woman who has undergone FGM or a man marrying or otherwise supporting a woman who has undergone the cut commits an offence and upon conviction shall be liable to a term of not less than six months' imprisonment or a fine not less than 50 000 Kenyan shillings (approximately 385 USD).[10]

Having been edified on the various crimes punishable as under the Prohibition of FGM Act and the fact that every Kenyan citizen is bound to the same regardless of whether or not they practise the culture, it is necessary for one to look into the responses that the criminalisation has received in various communities.

3 Responses to the criminalisation of FGM

In our view, two contrasting responses arise from the criminalisation of FGM, namely, those who agree with the criminalisation and others who the criminalisation bears no impact and still continue with the practice. We focus on the latter.

In 1920, as per an amendment to the United States Constitution, the US government banned the manufacture, sale and transport of intoxicating liquor.[11] It was argued that the prohibition would reduce crime and corruption and lower the tax burden on prisons. Granted that alcohol consumption rapidly reduced, in a few years the consumption was at an all-time high. To make matters worse, the type of alcohol that was being consumed was of a higher potency level and there was an increase in alcohol-related deaths, which then led to the repeal of the

10 Sec 25 of the Prohibition of Female Genital Mutilation Act states: 'Any person who uses derogatory or abusive language that is intended to ridicule, embarrass or otherwise harm a woman for having not undergone female genital mutilation, or a man for marrying or otherwise supporting a woman who has not undergone female genital mutilation, commits an offence and shall be liable, upon conviction, to imprisonment for a term not less than six months, or to a fine of not less than fifty thousand shillings, or both.'

11 18th Amendment- United States Constitution, https://constitution.congress.gov/constitution/amendment-18/ (accessed 6 June 2022).

amendment banning the manufacture and sale of intoxicating liquor.[12] The prohibition of alcohol was not ineffective but was counterproductive.

It is our contention that demanding an instantaneously enforced law to end the cut does little to nothing to change the hearts and mind of communities. Further, vilifying those who practise it only pushes it further from the mainstream society and to far rural areas.[13] An empirical analysis of FGM data supports this assertion. The prevalence varies greatly depending on the region – the (former) province with the highest prevalence is North Eastern (97.5 per cent of women aged 15 to 49), and the province with the lowest is Western (0.8 per cent). The prevalence is more common among women who live in rural areas, at 25.9 per cent, than among women who live in urban areas, at 13.8 per cent.[14]

According to a survey done by the Population Council in 2017, it was suggested that the criminalisation of the cut led to the fear of prosecution which drove the practice underground. This then in turn influences the survey respondents as they are unwilling to be honest, with the result that inaccurate data was gathered.[15] The Kenya Demographic and Health Survey spanning across eight years, with a distinction on before and after the Prohibition of FGM Act, indicate that the prevalent areas are rural areas. Furthermore, as the majority of the people still practising FGM are grassroots communities, and given the rigidity of culture and traditions, the mere fact that the act is outlawed is not enough for them to stop the practice.

Another reason why the practice is still prevalent is the concept of participation in the legislative process. It is often argued that the law is largely unknown to those it is supposed to protect and those who

12 CJ Coyne & AR Hall *Four decades and counting: The continued failure of the war on drugs* (2017).

13 Reproductive Health Matters 'The history and role of the criminal law in anti-FGM campaigns: Is the criminal law what is needed, at least in countries like Great Britain?' https://www.tandfonline.com/doi/pdf/10.1016/j.rhm.2015.10.001?needAccess=true (accessed 6 June 2022).

14 28 Too Many 'FGM prevalence in Kenya', https://www.28toomany.org/country/kenya/ (accessed 6 June 2022).

15 Population Council 'Female genital mutilation/cutting in Kenya: is change taking place? Descriptive statistics from four waves of demographic and health surveys', https://knowledgecommons.popcouncil.org/cgi/viewcontent.cgi?article=1595&context=departments_sbsr-rh (accessed 2nd July 2023)

are supposed to apply it.[16] In the legislative process, once a committee is assigned to a draft Bill, the committee is mandated to ensure that they obtain public views on the said Bill and issues that surround it. Under article 1 of the Constitution of Kenya, 2010, it is indicated that all sovereign power belongs to the people of Kenya and, thus, the people have a right to take part in any law-making process as under the Constitution. The same Constitution states that Parliament has a mandatory duty to facilitate public participation and involvement in the legislative and other business of Parliament and its committees.[17] This public participation is done through inviting submissions, holding public hearings and consulting the relevant stakeholders.[18] The committee then takes into consideration the views expressed and makes amendments before returning the draft Bill to the floor of the house for discussion. However, no statute clearly indicates the length of public participation and further know-hows of the same.

There being no concrete laws on the parameters of public participation, we draw inferences from various court decisions in which the same has been elaborated. In the matter of *Mui Coal Basin* the Court held that public participation is not a formality and a programme of public participation needs to be developed by the state agency or legislative body.[19] Furthermore, there should be different mechanisms that will enable inclusivity of all people.

Another example of where public participation was a contentious issue is *Dr Tatu Kamau v Attorney General & Others* at the High Court of Kenya, where Dr Tatu Kamau, the petitioner, requested the Court to declare that the Prohibition of Female Genital Mutilation Act, 2011 was unconstitutional due to lack of public participation.[20] The three-bench judge ruled otherwise and held that according to Parliament Hansard, there were proceedings in the departmental committee and debates by representatives of the people as it pertained to the draft Bill. A thorough investigation into the holding of the Court concluded that the Court never specified who the said representatives were and if their presence during the public participation of the Act was sufficient.

16 https://copfgm.org/law%20and%20fgm (accessed 13 June 2022).
17 Art 118 Constitution of Kenya.
18 National Assembly's *Public participation in the legislative process.*
19 *In the Matter of the Mui Coal Basin Local Community* [2015] eKLR.
20 Constitutional Petition 244 of 2019.

Considering the importance of public participation and the holding of the Court in the *Dr Tatu* case, a practical analysis of the stand in grassroot communities as it pertains to the cut is contradictory. Public participation ought to be examined vis-à-vis the level of illiteracy in the different communities. A case study of the Samburu community concludes that the recorded illiteracy level is 83 per cent. This means that the majority of the people in the community cannot fathom any legislation that has been enacted or is in the process of being enacted despite the fact that they are the ones to feel the impact of the same first hand. This leads us to the question of how a community can participate in a written Bill that they cannot comprehend. Consequently, according to Kenya National Bureau of Statistics, the prevalence rate of FGM in Samburu County is 78 per cent.

Regardless of the illiteracy levels and other factors contributing to the responses from the communities, as per the Constitution of Kenya, it is the duty of the state to protect its citizens from and ensure the fulfilment of all their rights and freedoms as so clearly enshrined under the Bill of Rights. These duties of the state to protect are discussed below.

4 State obligation to protect

The Constitution of Kenya imposes a fundamental duty of the state and every state organ to observe, respect, protect, promote and fulfil the rights and fundamental freedoms of every citizen in Kenya.[21] It goes further to state that the state shall take legislative and policy measures to ensure the same.[22]

The obligations are also in line with international laws that have been fully ratified by Kenya that espouse the primary obligation of the state in protection and fulfilment of human rights.[23] In this regard, states are expected to take appropriate steps to prevent, investigate, punish and redress any abuses by having in place effective policy, legal and regulatory measures.

The Kenyan criminal justice system involves four steps. The first is reporting of the crime, which is closely followed by the investigation of

21 Art 21(1) Constitution of Kenya, 2010.
22 Art 21(2) Constitution of Kenya, 2010.
23 Convention on the Elimination of All Forms of Discrimination against Women.

said crime. The result of the investigation determines the prosecution and, lastly, judgment and sentencing. From the enforcement of the Prohibition of FGM Act, there have been numerous reports of the commission of FGM, but very few cases have resulted in conviction, implying a disconnect between the first two steps and the latter, as discussed below.

4.1 Reporting

The first step is filing of a complaint or reporting the incident. Upon the report, the complainant is given an occurrence book number which basically means that a complaint was recorded and, therefore, can be investigated by the police. If the police investigates and establishes that a crime has been committed, it is forwarded to the Director of Public Prosecutions and the process of litigation begins.

Some communities prefer not to report the cases where the cut is performed, as the cut has been done by their family and/or those who have high status in the community. Furthermore, those who report it risk stigmatisation and rejection by the community. According to CEDAW, it gives recommendations for states to ensure effective complaint mechanisms and a whole range of criminal and civil remedies serving the purpose of addressing the lack of accountability of perpetrators in a family set-up. However, the same remains just a recommendation as Kenya is yet to fully practise the same.[24]

After the reporting of a complaint or a crime being committed, the report is assigned to a police officer who begins the investigation.

4.2 Investigation

The ways of gathering evidence as per the conducting of the investigation are guided by various laws. The Constitution of Kenya protects human rights in the criminal justice system.[25] It further states the national values and principles of governance bind all state organs. The National Police

24 UN Committee on the Elimination of Discrimination Against Women (CEDAW Committee), CEDAW General Recommendation 19: Violence against women, 1992, https://www.refworld.org/docid/52d920c54.html (accessed 13 September 2022).

25 Art 50 Constitution of Kenya.

Service Act lays down the functions of investigators and ways of gathering evidence.[26] Investigations are also guided by the rules of evidence. The general rule is that the evidence must be in relation to the fact.[27] As for international law, the Universal Declaration and the International Covenant on Civil and Political Rights (ICCPR) are ratified by Kenya and therefore form part of the laws. [28]

Given the intimate nature of FGM, the investigation needs to be in line with the crime. The victims are taken to the police doctor for an examination and an official report called a P3 form. The P3 form is what is used during the prosecution of the offence before the national courts. Unfortunately, despite the fact that the form is clear unequivocal evidence of the offence being committed, that is not enough. The investigating officer needs to now investigate and arrest those responsible and gather additional witnesses in order to secure a conviction.

The police in charge of investigation also plays a major role in the continuance of the cut and the rare cases that procced to prosecution. The police in affected communities do not investigate the reports made as either they also believe in the practice or they are paid off. It is no secret that corruption is one of the major vices that Kenya is fighting, hence the alleged payment of police officers is not unheard of. Several officers have been the subject of investigations by the Independent Policing Oversight Authority due to corruption.[29] In Samburu, though unsubstantiated, allegations plague the community that the police officers do not conduct or further investigations as they have been paid by the families or even local leaders.

Reliance can also be placed on the Samburu Girls Foundation.[30] The Rescue Centre is home to more than one thousand girls who have been rescued but there is no statistics in regard to any matter proceeding to court despite the fact that the offences have been reported and an occurrence book number given. In Samburu County, according to studies

26 Sec 28 National Police Service Act, 2014.
27 Sec 55 Evidence Act.
28 Art 10 United Declaration of Human Rights; art 13 International Covenant on Civil and Political Rights.
29 https://www.ipoa.go.ke (accessed 2 July 2023).
30 Samburu Girls Foundation is a rescue centre where the pastoralist girl child receives education and protection from physical, mental and emotional harm for personal development through life skills in a community setting, info@samburugirls.foundation.

done by the United Nations Children's Fund (UNICEF), the county has the second highest rate of FGM of girls and women aged between 11 and 49 years.[31] The number of court cases is not representative of the prevalence of the practice. The reason for the lack of prosecution, in our opinion, is because of the laxity that exists in investigations.

The chances of the parties involved in the investigation coming from the same community are high. For example, in Samburu County, one might find that the perpetrator, police officer, doctor, victim and prosecutor, who all play different roles in the prosecution, are from the same practising community. Conflicts of interest can be seen as a hindrance as it serves as an interference with their ability to perform their professional roles. It can subconsciously compromise their judgment and decision-making skills in the matters.

The sanctions against the victims of FGM according to the Prohibition of FGM Act also offer a substantial hindrance to investigation as they are aware that they too can be prosecuted if evidence is brought forth that they underwent FGM, with or without consent.

The local chiefs who are meant to uphold the rule of law do the opposite as they are in cahoots with the elders and cutters of the communities.[32]

Nevertheless, if the assigned police officer upon conducting his investigation establishes that a crime had indeed occurred, he forwards the file to the Director of Public Prosecutions who then initiates the criminal proceedings.

4.3 Prosecution

Criminal procedures are safeguards against the indiscriminate enforcement of criminal legislation and inhuman prosecution of offenders. Prosecution falls within the ambit of the Director of Public Prosecutions. The office of the Director of Public Prosecutions draws its mandate from the Constitution of Kenya together with the Office of the Director of Public Prosecutions Act, 2013. The Office in response

31 UNICEF *Baseline study report on female genital mutilation/cutting and child marriage* (2017).

32 'Chiefs in Narok accused of abetting FGM, early marriages' *Nation* 6 January 2022, https://nation.africa/kenya/counties/narok/chiefs-in-narok-accused-of-abetting-fgm-early-marriages-3673596

to the prosecution of crimes of FGM came up with a policy on standard operating procedures and rapid reference guide on the prosecution of FGM cases. An analysis of what a prosecutor must prove is detailed below.

4.3.1 Offence of female genital mutilation

To prove this offence, the act must be proven through a medical report and there has to be a perpetrator and they must be identified, be in possession of FGM paraphernalia and if the accused is a trained or registered medical practitioner for the purposes of performing the offence, the prosecution should avail documents of proof. If death occurred, the act of FGM must be proved in addition to the identification of the perpetrator and a post mortem report indicating the actual cause of death or the causation or remoteness of the death.

In *Sarah Chumo v Republic* (2020) eKLR the accused person was charged with six counts of performing FGM and was convicted.[33] The Court sentenced her to a total fine of 800 000 shillings and in default to serve 12 years' imprisonment. Sarah Chumo appealed the conviction and sentence on the basis that there was no identification by the victims and that the evidence brought by the victims was inconsistent and unreliable. The appellant also stated that the Court erred in convicting her yet the victims indicated that they voluntarily consented to the act and she was not granted an opportunity to meet the victims.

The Court held that it was immaterial whether the victims consented to the act as one cannot license another to commit a crime. The learned judge went on to hold that the appellant was indeed identified through the witness statements of the victims and the medical doctor in his testimony stated that upon examination, all four victims had indeed undergone the cut, thus was guilty. In an unfortunate turn of events, the judge set aside the sentence of 12 years and ordered the appellant to serve 12 months for each of the four counts convicted and they were to run concurrently. Considering that the appellant had been in custody for more than 12 months, the Court ordered her immediate release.

On the death of the victim, there is much public interest in *Republic v Eunice Sintama Lesale & 2 Others* (2014) eKLR where the parents were

33 Criminal Appeal 5 of 2019.

charged with murder after the deceased (their daughter) bled to death after being subjected to FGM.[34] The courts in 2014 set bail at 2 million Kenyan shillings. The matter is still ongoing.[35]

4.3.2 Aiding and abetting female genital mutilation

The perpetrator must be identified and there must be evidence of any sort of assistance or advice given for purposes of perpetuating FGM and evidence of proof of aiding, for example, monetary facilitation, transportation of victims or buying paraphernalia to be used. On procuring FGM on oneself, the points to prove is the commission of the act and that the perpetrator is an adult.

In *IGK & 2 Others v Republic* (2020) eKLR the applicants were accused of aiding and abetting and were each sentenced to seven years' imprisonment.[36] The Court noted that they were the father, mother and grandmother of the victim and therefore had a greater responsibility to protect the child from harmful practices. The Court was also satisfied that the accused persons took the victim to be cut.

On self-procuring, the Court in *Charity Karimi & 2 Others v Republic* (2019) eKLR sentenced the accused persons to a fine of 200 000 shillings each and in default imprisonment for three years each.[37] The applicants voluntarily went and consented to being cut. The prosecution produced medical reports indicating that that they had indeed undergone the practice.

34 Criminal Case 24 of 2014.

35 The case brings a sigh of relief as the consequences of FGM has been felt throughout the community. The same is compare to *R v Katet Nchoe & Another v Republic* (2011) Eklr in which the appellants had been charged with manslaughter after the victim died as she underweight FGM. Before the Prohibition of Female Genital Mutilation Act, the only offence preferred was manslaughter, which does not impose a mandatory sentence upon conviction.

36 Criminal Revision 12 of 2019 Consolidated with Cr Rev.113 of 2020 and Criminal Revision 114 of 2020.

37 Miscellaneous Application 52 of 2019.

4.3.3 Procuring a person to perform female genital mutilation in another country

The evidence to prove this charge include proof of travel, proof that the reason for the travel was to procure FGM and that a medical report is provided to show that the act was performed.

4.3.4 Use of premises to perform female genital mutilation

There has to be clear evidence of ownership, possession or control of the premises and that the accused persons knew that the premises were being used to perform FGM and that it was performed. If tools used are traceable, they can also form part of the evidence.

In *Joan Bett v Republic* (2018) eKLR the appellant was charged with knowingly allowing her house to be used for the purpose of performing FGM.[38] She was convicted and sentenced to pay a fine of 200 000 shillings or in default to serve three years' imprisonment, on which she filed the present appeal. The appellant's grounds for appeal included that there was no evidence brought before Court that she had exclusive control of the house and that she was not found in the house. Additionally, she alleged that there was no evidence brought by the prosecution that FGM actually took place in the said house. The Court held that the assistant chief had testified indicating that the house belonged to the appellant and that the same was common knowledge. The learned judge also took into consideration that six girls had been found locked inside the house and they all identified the appellant as being the owner of the house and the fact that the medical doctor testified that the girls had undergone the cut was enough to find the appellant guilty. The appeal was found devoid of merit and the conviction and sentence were upheld.

4.3.5 Possession of tools and equipment

The points to prove to obtain a conviction include actual possession of the relevant tools and the tools were to be used for purposes of performing FGM.

38 Criminal Appeal 10 of 2017.

4.3.6 Failure to report commission of offence

For a charge to be preferred, there has to be proof that the accused person had knowledge that FGM was performed or about to be performed and that they did not report it to any law enforcement officer. The victim also has to be identified and must testify.

In *MMD & Another v Republic* (2017) eKLR the appellants had been charged with failure to report the commission of FGM and were convicted and sentenced to a fine of 200 000 shillings or one year's imprisonment.[39] In the appeal they stated that the lower court had failed to establish that they did not know that the victim had undergone the cut and that the prosecution had failed to prove beyond reasonable doubt that they knew about the procedure and the specific time at which they became aware. The Court took its time in assessing the charge drawn and held that the charge was defective and the appellants were charged with the failure to report the occurrence of the offence of FGM instead of a failure to report that an offence of genital mutilation has been committed. The Court went further to give meaning to 'being aware' and 'failure to report' and how both show gross amount of ambiguity and lack of clarity. In acquitting the appellants, the learned judge held that there was no evidence brought to show that the appellants were actually aware of the commission of the offence before they were called upon to make a report.

In *LCN v Republic* (2014) eKLR the Appellate Court acquitted the appellant who had been charged with a failure to report the commission of FGM that had been performed on her daughter.[40] The Court held that the minor testified under oath that all her mother did was take care of her after he fact and that she was not aware as it was her father who took her to the circumciser. As such, the Court held that the prosecution's evidence against the appellant was not satisfactory to meet the threshold required in establishing beyond reasonable doubt.

The Court in *SMG v RAM* (2015) eKLR also acquitted the parents of a minor who voluntarily went and underwent FGM.[41] The Court held that the prosecution did not prove that the parents knew that their

39 Criminal Appeal 4 of 2017.
40 Criminal Appeal 92 of 2013.
41 Criminal Appeal 66 of 2014.

child went and had the cut performed. Moreover, the minor testified in court that she did not inform the parents of her plans. The Court failed to take into consideration that a minor cannot consent not only to the performance of a crime but in matters relating to health where harm can be done.

4.3.7 Use of derogatory or abusive language

To prove this offence, there has to be actual abusive or derogatory words used and a translation into English where applicable and that the intention was to offend or to embarrass. This is difficult to prove as the evidence to be brought before court diminishes the trial process to be one of 'he said/she said' without tangible evidence to support either party.

A brief analysis of the above cases gives varying conclusions due to the fact that under Kenyan laws, the courts have a wide discretion in matters of probative value of evidence brought before them and in terms of sentencing. No uniformity as it pertains to prosecution of FGM will be achieved. In addition to the wide range of discretion with which the courts are empowered, another aspect that has led to minimal successful prosecution of FGM is the doctrine of burden of proof as it relates to the different crimes in the Prohibition of FGM Act. A in-depth analysis is provided below.

4.4 Beyond reasonable doubt

In the Kenyan criminal justice system, in order to ensure a conviction, the prosecution has to prove its case beyond reasonable doubt.[42] This means that not only does the evidence have to be brought before the court but the qualitative value of the evidence directly proves the commission or omission of the offence charged. In majority of the cases brought before any court of law that involves FGM, the evidence includes the victim and the victim statement, the investigating officer and the medical report from the government doctor.

Beyond reasonable doubt means that it must carry a high degree of probability. Lord Denning in *Miller vs Ministry of Pension*[43] stated:[44]

42 P Kiage *Essentials of criminal procedure in Kenya'* (2010).
43 [1947] 2 ALL ER 372.
44 Page 23.

> Proof beyond reasonable doubt does not mean proof beyond the shadow of a doubt. The law would fail to protect the community if it admitted fanciful possibilities to deflect the course of justice. If the evidence is so strong against a man as to leave only a remote possibility in his favor which can be dismissed with the sentence of course it is possible, but not in the least probable, the case is proved beyond reasonable doubt, but nothing short of that will suffice.

In the cases discussed above in the prosecution of FGM crimes, it is clear that there exists a clash when it comes to the prosecution of FGM. The Act clearly directs that no one can consent to the practice and that it is not a defence to state that the victim consented to same.[45] However, local courts have used the testimony of minors stating that they voluntarily went to the circumciser themselves and acquitted most accused persons. The courts should take judicial notice that minors cannot make such choices and there is no law that allows any person to perform an act that is seen as harmful and a form of torture and especially if it will negatively impact their health.[46] Accordingly, a simple accusation of FGM, with or without evidence, should be enough to remove girls from their parents and/or convict accused persons.

There is also a need to shift the burden of proof in cases of FGM as it exists with the Sexual Offences Act. Although different schools of thought exist on the onus of proof in sexual offence cases, the majority of matters before courts, especially in instances where the age of the victim is in contention, the onus of proof shifts to the accused person. The most controversial case in which this shift was seen was in *Martin Charo v Republic* where the Court contended that despite the fact that a child cannot consent to having sexual intercourse, the behaviour of the child should also be taken into consideration.[47] The accused person testified under oath that the behaviour of the victim intimated that she was not a minor and that she informed him that she was over 18 years of age. The Court agreed and he was acquitted.

45 Sec 29 of the Prohibition of Female Genital Mutilation Act states: 'A person who commits an offence under this Act is liable, on conviction, to imprisonment for a term of not less than three years, or to a fine of not less than two hundred thousand shillings, or both.'

46 P Arshaougni '"But I am an adult now ... sort of": Adolescent consent in healthcare decision making and the adolescent brain' (2006) 9 *Journal of Health Care Law and Policy* 316.

47 Criminal Appeal 32 of 2015.

In FGM cases, once a charge is preferred against an accused person, it should be enough that there is a medical report produced confirming that the victim did in fact undergo the cut. The onus would then lie on the accused person to prove otherwise. Insufficient evidence should not be considered a reason to acquit any perpetrator/accused person if the act has been confirmed. The courts should be mindful that the heavy evidence it requires to convict has a direct and negative impact on all those involved. In the cases studied above, the majority of the people charged are parents of the victims. The psychological torture it imposes on a child to stand in a dock and identify their parents as those who inflicted harm on them is unfathomable. Critics have pointed out that a simple accusation should be enough to remove girls from their parents.[48]

The victim breaks the family unit as positive identification means conviction. Apart from the breakdown of the family unit, the provision of basic needs for the victim and her siblings diminish as the breadwinner would be behind bars. This shift, directly or indirectly forces the victim to pick up the slack and take care of the family. On a larger scale, in areas where the cutter is known, the victim's positive identification would lead to the conviction of people who have status in the community causing a rift among the community. It is our contention that the concept of reasonable doubt acts more of problem rather than a solution. Other certain challenges to prosecution include interference by politics, the issue of victim protection.

4.5 Barriers to prosecution

It is important to highlight two recurring challenges faced during the prosecution of FGM cases before National Courts. They include inference from politicians and victim protection as discussed below.

4.5.1 Interference by politics

In a democracy, law and politics are bound to confront one another be it in legislative procedure or the implementation of said procedure. The influence of politics is ideally strongest in legislative procedure. However,

48 M Berer 'The history and role of the criminal law in anti-FGM campaigns: Is the criminal law what is needed at least for countries like Great Britain?' (2015) *Reproductive Health Matters* 145-157.

in recent time and in matters in which the interest of the chosen few are higher than the majority, politics also influence the implementation of the law. At its foundation, both politics and law serve to bring about law and order.[49] It is this mismatch that we will discuss and its impact on the autonomy of the law as it relates to Female Genital Mutilation. The Chief Justice of England and Wales once reacted sharply to politicians using their influence and interfering with the judiciary and ordered that there should be short courses for the politicians to be educated on the boundaries that should exist between parliament and the judiciary.[50] It seems that the same should be applied in Kenya as well.

Kenya is divided into different geographical and legislative sections known as counties. In every county, there exists separate levels of leaders who represent the people these include Governors, Senators, Members of Parliament, Members of County Assembly and Women Representatives. These leaders are charged with the responsibility of serving the communities and ensuring that their views are represented in the legislative process. In most cases, these leaders come from practicing communities in the prevalent counties. This will then directly influence the implementation of anti FGM laws. As stated earlier in some cases, word on the street is that the politicians are the ones who allegedly bail out offenders and who allegedly use their influence to ensure that there are no prosecutions.

In *Ltodiyan Lekanoi & 20 Others vs Hon. John Lepil Lolkile,*[51] a constitutional petition before the Nanyuki High Court, we were informed that the area Member of County Assembly had married off more than 5 young girls and impregnated them. The community wanted justice and instructed litigators to file a petition for the Member of County Assembly to be declared unfit to hold office and be prosecuted. The case was filed and prosecuted but had to come to a premature end when the court insisted the presence of the 5 young girls who by this time could not be found having migrated and hidden. Although the case

49 A Magnussen & A Banasiak 'Juridification: Disrupting the relationship between law and politics' (2013) *European Law Journal* 325.

50 C Rickard 'Unprecedented levels of political interference with courts – Chief Justice' 3 December 2020, https://africanlii.org/article/20201203/%E2%80%98unprecedented-levels-political-interference-courts%E2%80%99-%E2%80%93-chief-justice (accessed 12 June 2022).

51 Constitution Petition 4 of 2016.

did not come to the expected conclusion the effect was very strong and the MCA lost the 2017 elections despite being a strong candidate.

Another instance where politics interfere with the process of eradication of Female Genital Mutilation is in terms of elections and the quest for votes. This being an election year, politicians during their campaigns in the grassroots areas will either promise the communities that no one will be prosecuted for Female Genital Mutilation or they will not advocate for the eradication of the vice as they are trying to buy the votes of the citizens. In Samburu County, one of the cases brought before court involved the family member one of the local leaders.[52] The court ordered them to pay a fine of Two Hundred Thousand Kenyan Shillings which they posted on the same day. The politicians also use their influence to intimidate the prosecutors and families of the victims pressuring them to recant their testimonies.

4.5.2 Victim protection

Victim protection bears its roots from the Constitution of Kenya where it states that victims of crimes and abuse of power must be protected. The Victim Protection Act was also enacted and it provides better information and support services including reparations and compensation to the victim. The Act also outlines the rights of victims in criminal proceedings, which include being informed in advance of the evidence by the prosecution and also giving their views during plea bargaining and victim impact statement in sentencing if offender is convicted.

In terms of offences under the Prohibition of Female Genital Mutilation Act, the office of the Director of Public Prosecution, who is in charge of all criminal proceedings, prepared a Standard Operating Procedure Manual and Rapid Reference Guide on Prosecution of Female Genital Mutilation cases. Under victim protection, the prosecutor is to ensure that the interests of the victim are considered when making any decision in relation to the trial.[53] Additionally, the telephone numbers or any information of how to contact the witnesses or victims shall not be

52 *Republic v Janet Lenolkulal & Another* Criminal Case 4650 of 2021).

53 Office of the Director of Public Prosecution Standard Operating Procedures Manual and Rapid Reference Guide on Prosecution of Female Genital Mutilation Cases.

recorded within the body of the witness statement so as to protect their identity and prevent intimidation by the accused or their accomplices.[54] The names of the victims should also be protected by the use of their initials and the details including the full names and contacts details of the victim should not be supplied to the accused at any point.

However, according to the Prohibition of Female Genital Mutilation Act, 2011, it provides sanctions for both the victims and perpetrators. The Act states that no person can consent to the practice and that it is no defence that the person consented to it and lists the punishment as imprisonment for a term of not less than three years or to a fine of not less than 200 000 shillings or both.[55] More people are knowledgeable about the penalty than they are of the other measures that various laws have taken to protect the victims.

Moreover, the victim protection mechanism is only seen in theory as at the grassroots level, the government has not implemented the support.[56] The majority of the rescue centres that shelter victims of FGM in prevalent communities are non-governmental organisations (NGOs) such as Samburu Girls Foundation in Samburu County. The communities have had varied reactions to the establishment of rescue centres as they were developing. In 2013 the community donated 15 acres of land where the Samburu Girls Foundation is set up. The foundation has also had its share of disputes with the community over the years and instances where men came with guns demanding the release of their 'wives' that they shelter. For rescue centres that rely on good faith donations from well-wishers, this type of battles may cause the centres to go under but the vision of realising the potential of the pastoralist girl is greater.

From various interviews with the girls from the Foundation, it is clear that they defied the community by running away from their practice and they are seen as outcasts. Others are optimistic and believe that it is only a matter of time before their families accept the reality and hope that they can reunite.

The last level of state obligations to protect its citizens in the realisation of the eradication of FGM is judgment and sentencing.

54 Office of the Director of Public Prosecution (n 54).
55 Sec 29 Prohibition of Female Genital Mutilation Act.
56 Sec 27 of the Prohibition of Female Genital Mutilation Act imposes a mandatory duty on the government to provide support services to victims of female genital mutilation.

Once the prosecutor has proven its case and the accused person has also presented their case and submissions brought forth, it now is for the court to retire and upon assessing the evidence, reach a judgment and subsequent sentencing if the court finds the accused person guilty.

5 Judgment and sentencing

Upon the completion of the presentation of both sides of the case, the courts now retreat to write and give their judgment. According to Justice Lee Muthoga, a Kenyan judge at the United Nations (UN) Mechanism for International Criminal Tribunals, the judgment needs to comprise an introduction in which the judge gives a brief of the matter at hand, then a summary of the prosecution's case, a summary of the defence case, issues to be determined, evidence and factual findings, applicable law, deliberations, the actual judgment, mitigation and, finally, sentencing.[57]

As for sentencing, the courts are guided by the Judiciary's Sentencing Policy Guidelines.[58] The genesis of the policy guidelines is that sentencing has always been outrightly absurd and disproportionate in criminal cases and there was a need to limit the judicial discretion enjoyed by judicial officers. The policy sought to acknowledge the role the community and even the victim/complainant have in the criminal justice system. It allows the views of the victim to be taken into consideration and offers alternative sentencing like non-custodial orders such as the payment of compensation.

A further analysis of the case law chosen in this chapter clearly depicts that despite the existence of a sentencing policy which sought to streamline sentencing of criminal offences, judicial officers still use it whimsically leading to a low conviction rate of FGM offences.

The final part of the chapter seeks to examine the role of grassroots communities in the criminalisation of FGM. We will determine whether the impact, whether negative or positive, that FGM has had on communities and whether the grassroots communities act as a shield or a sword in the fight against FGM.

57 L Muthoga *Guidelines for judgement drafting* (2012).
58 http://www.kenyalaw.org/kl/fileadmin/pdfdownloads/Sentencing_Policy_Guidelines_Booklet.pdf

6 Role of grassroots communities in criminalisation and recommendations

The final part of this chapter focuses on an investigation into the role of grassroots communities in litigation from the ground level until the national courts the reasons as to why criminalisation has not been effective in the fight against FGM. We will focus our discussion on culture and its various aspects, including threats of curses, dowry and marriage and lastly, give recommendations.

6.1 Culture

World renowned anthropologist Sir EB Taylor defined culture as a complex whole including knowledge, belief, customs and habits acquired by man as a member of society.[59] Ralph Linton in his book describes it as behaviour held in common.[60]

What stands out from the above definition is the fact that culture is acquired and it is only acquired by man as part of a larger society or community. Article 11 of the Constitution of Kenya recognises culture as the foundation of the nation and as the cumulative civilisation of the Kenyan people. Moreover, article 44 on the right to language and culture cements the right to participate in any cultural life of a person's choosing. However, the Constitution also places the burden on Parliament to enact laws that celebrate the cultural life of the citizens as well as protect the citizens from harmful practices.

The communities that practise FGM have been practising it for generations without fail giving those involved a sense of community. Kenya's founding father, the late Mzee Jomo Kenyatta, the first President of the Republic of Kenya, in his book *Facing Mount Kenya* shared about the sense of community that came about during the ceremonies.[61]

Among certain communities, such as the Maasai and Samburu, the practice is embedded within an elaborate ritual of initiation into adulthood. Circumcision is performed on both boys and girls. The members of these communities do not understand why male circumcision is not outlawed and term it discrimination. For the Samburu community,

59 E Varto *Brill's companion to classics and early anthropology* 99-131.
60 H Berkman & C Gilson *Consumer behaviour* (1986).
61 J Kenyatta *Facing Mount Kenya* (1938).

the process starts with beading, where the young uncircumcised girls who are not yet eligible for marriage are given specialised beads by Samburu warriors to signify the beginning of a sexual relationship. After the beading, the girl is cut and, lastly, early childhood marriage follows. In the case of PR, she was only nine years old when her uncles conspired to marry her off to a rich 30 year-old man.[62] She underwent FGM and was married off the same day. Luckily, she was rescued and currently is in school under the Samburu Girls Foundation.[63] The cut signified the beginning of her new social, familial, sexual and reproductive role, and marriage often is the only economic option for the women in the communities.

Due to the sense of community that accompanies culture, circumcision is voluntary, celebrated and is a milestone in a girl's life. In Samburu community there generally is a season in which FGM is performed. The peer pressure experienced during this time is elevated. This applies to both the girls and their parents or guardians. Those who will not participate in the rite are seen as outcasts in the community. In *Dr Tatu Kamau* the respondent brought a witness, RJK, who testified that her community practised FGM as a rite of passage.[64] RJK detailed how she ran away from home at 12 years of age upon learning that she would be subjected to the cut. She returned three days later and suffered beatings at the hands of her family and her failure to undergo the cut caused her to be ridiculed and ostracised and she was forced to relocate.

Culture serves as one of the strongest inhibitors to the eradication of FGM due to various aspects, which include the threat of curses, dowry and marriage.

6.1.1 Curses

When a person seriously violates the norms of the society or community, they automatically enter into a state of sin without necessarily being cursed. The threat of being cursed and the actual curse are equally feared.

62 Name withheld as she is a minor.
63 Samburu Girls Foundation is a rescue centre where the pastoralist girl child receives education and protection from physical, mental and emotional harm for personal development through life skills in a community setting info@samburugirls.foundation.
64 Constitutional Petition 244 of 2019.

Curses is a major impediment to the eradication of FGM and the reason why the level of reporting cases is incredibly low. The threat of curses is also the reason why most people, however knowledgeable of the effects of the practice, still participate in the vice. In 2017 it made national news in the country how retired nurses were arrested and prosecuted in Embu county as they circumcised girls.[65] They stated in court that the main reason why they performed the circumcision was a fear of curses. It was their contention that they used modern surgical equipment and that, therefore, the risk of any infection was incredibly low.

In the Kuria community it is believed that curses would befall those who do not conform, for example, the death of a baby if the baby came into contact with the clitoris as the uncircumcised woman gave birth or the death of children who would walk over a spot in which an uncircumcised woman urinated.[66]

It was also reported that hundreds of girls were spared in 2017 as the Kuria community believed that seven is a cursed number and thus would not perform any circumcision ceremony.[67] In central Kenya, the magistrate's court at Chuka sentenced a woman, Florence Muthoni from Tharaka-Nithi county, to six years' imprisonment after it was discovered that she forced her twin daughters to undergo FGM. In her defence during trial, she stated that the main reason why she performed the rite on her daughters was because wanted to avoid the curse from her deceased grandfather who had instructed all the girls in the family lineage to undergo the procedure.[68]

6.1.2 Dowry

Ideally, dowry is higher if the girl has undergone the cut at the time of the marriage. The practice is seen as an elevation of the status of the girl and her family. This is due to the fact that the child is now of marriageable age,

65 J Muchiri 'Retire nurses, fear of curses complicate anti-FGM campaigns in Embu' *The Standard* 27 December 2017, https://www.standardmedia.co.ke/eastern/article/2001264221/retired-nurses-complicating-campaign-against-fgm.

66 Population Council (n 9).

67 E Batha 'Kenya's Kuria to halt female genital mutilation in "unlucky"' 1 February 2017, https://reliefweb.int/report/kenya/kenyas-kuria-halt-female-genital-mutilation-unlucky-2017 (accessed 7 June 2022).

68 N Bhala 'Kenyan woman jailed for six years for circumcising twin daughters' 23 November 2018, https://www.reuters.com/article/us-kenya-women-fgm-idUSKCN1NS1SI (accessed 12 June 2022).

signifying the payment of dowry, and in pastoralist communities this is a source of income for the family. This was the case in *Melody Lanyasunya v Office of the Director of Public Prosecution & Others at the Nakuru High Court*.[69] The petition was sponsored by a PhD holder, Dr Titus Lanyasunya, to stop his prosecution at Maralal law courts for marrying the petitioner, ML, who was a minor. Fortunately, the Court dismissed the petition and ordered the criminal case to proceed. However, the criminal case came to an end after the death of Dr Lanyasunya. His Excellency the President Uhuru Kenyatta also made an official eulogy paying his respects to Dr Titus Lanyasunya but made no mention of the cases against him for early marriages.[70]

The communities believe that once dowry is paid, it cannot be returned as the rite has already been performed. Incidents of men coming to forcefully take their 'wives' from rescue centres such as Samburu Girls Foundation are not unheard of.[71] Since the majority of these communities are pastoralists, they value animals and, therefore, once dowry is paid, the minors belong to them. Some have attempted to break in armed with weapons such as guns and spears.

6.2 Marriage

For parents or guardians, their daughters will not be considered socially acceptable, thus not marriageable, if they do not participate in the rite and that, therefore, they are not fulfilling their roles as good parents. This view is corroborated by the late Mzee Jomo Kenyatta who was of the view that no proper Gikuyu man would be seen marrying an uncircumcised girl.[72]

In the Kuria community, according to the council of elders, a girl who was not circumcised cannot be married or have a child. It is because of this pressure that one finds girls to succumb and opt to go for the cut.

69 Constitution Petition 21 of 2015.

70 The Presidency 'President Kenyatta eulogises Dr Lanyasunya, as a great researcher', https://www.president.go.ke/2018/06/12/president-kenyatta-eulogizes-dr-lanyasunya-as-a-great-researcher/ (accessed 7 June 2022).

71 The word 'wives' is only used in the context that dowry has been paid and therefore traditional customary marriage has occurred. However, we take cognisance of the fact that the girls in question are minors and under the Children Act and Marriage Act lack capacity to enter into any form of marriage.

72 The New Humanitarian Justifying tradition: why some Kenyan men favour FGM (2005).

In some instances, where the girl fell pregnant, she would be forced to deliver at home where she would be circumcised before child birth or during labour.[73]

6.3 Recommendations

In order to offer qualitative recommendations, we need to consider the impact litigation has had on the culture and then formulate our recommendations from there. These include, but are not limited to, the following:

6.3.1 Education

Pastoralist communities do not value education as much as they values marriage and cattle. The government should take up the burden of education and ensure that it is readily available and affordable in all parts of the country. There needs to be a shift from the focus of eradication to the focus on education. A lot of heavy lifting is placed on the eradication of FGM but the depth of comprehension seen from grassroots communities is rather shallow. As stated earlier, the majority of the communities have high levels of illiteracy. This means that they cannot understand what the law says and the impact of not abiding by the laws of the land. Moreover, it will enable the communities to actively participate in both in the politics of making laws and even in the implementation of the laws. The introduction to modules or short courses in the education curriculum for all levels of education can also play a role in a change of attitude towards FGM.

The role of economic development should not be taken lightly. Communities that still practise FGM involve those who do not have schools and still depend on traditional means of livelihoods, for example, pastoralism. If both the national and county government would upgrade the counties by building modern infrastructure that will force the communities to catch up, then the performance of FGM would gradually

73 Population Council 'Female genital mutilation practices in Kenya: The role of alternative rites of passage. A case study of Kisii and Kuria districts (2011), https://knowledgecommons.popcouncil.org/cgi/viewcontent.cgi?article=1103&context=departments_sbsr-rh.

disappear as the communities are focused on more economically positive endeavours.

6.3.2 Alternative rites of passage

Alternative rites of passage involve various practices in which girls can enter into womanhood without having to undergo the cut. The first alternative rite of passage in Kenya was organised in Tharaka-Nithi in 1996. The main agenda was to desensitise parents into not cutting their girls. However, parents were apprehensive that their girls would not be considered women as no initiation was done, and they came up with an alternative rite.[74] Alternative rites can include graduation for the girls.

6.3.3 Change of language

Third, the language used is seen more of a roadblock than anything else. There is a need to shy away from the harsh language that anti- FGM crusaders and advocates use. In the *Dr Tatu Kamau* case, the petitioner brought up the fact that the definition of FGM in the Act presupposes malice and intention to incapacitate and destroy. Other scholars have shared the same sentiments.[75] Caution should be taken as it is a fight against a culture that has been practised for generations and the end FGM chant comes from outsiders. It therefore is seen as an attack that will not be taken lightly.

6.3.4 Amendments to the Act

Based on case law, there is also a need to amend the Prohibition of Female Genital Mutilation Act, 2011 to prevent instances where accused persons would be acquitted based on the ambiguity in and vague nature of the offences themselves, and the shift of burden of proof should be discussed and form part of the prosecution of FGM cases. Furthermore, the Act needs to be clear on the concept of consent and when it can be utilised.

74 BV Hannelore 'The Loita rite of passage': An alternative to the alternative of rite of passage?' (2021) *SSM Qualitative Research in Health* 4-6.

75 H Lewis 'Between Irua and "female genital mutilation": Feminist human rights discourse and the cultural divide' (1995) 8 *Harvard Human Rights Law Journal* 1.

7 Conclusion

The criminalisation of FGM, although a step in the right direction, has been met with various challenges. The expectations from the criminalisation was that the trend would decrease. However, the reality of the implementation of these laws has proven to be an uphill task both at the grassroots level and in national courts. The main effect of the criminalisation of FGM is not the conviction of perpetrators but driving the practice underground.

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11

SHOULD FEMALE GENITAL MUTILATION BE DECRIMINALISED IN NIGERIA? AN EMPIRICAL JUSTIFICATION FROM STATUTORY AND RELIGIOUS PERSPECTIVES

*Mariam A Abdulraheem-Mustapha**

Abstract

Female genital mutilation has been in practice in almost all African countries, including Nigeria. It is a practice that involves the deliberate cutting of the external genitalia of girls who are under the age of 15 years. Many African cultures and religions have accepted this practice as a means towards promoting the chastity of women and as a rite of passage to womanhood. However, FGM appears to cause much more damage to the sexual and reproductive health rights of female gender. Therefore, the practice currently is seen as harmful and as a violation of human rights enshrined in the Bills of Rights and Constitutions of all African countries. It is on this basis that it is increasingly being criminalised in many jurisdictions. Arguably, this is the justification for criminalising the practice in the Nigerian laws, especially section 6 of the Violence Against Persons (Prohibition) Act, 2015. However, despite its criminalisation, FGM remains a prevalent practice and there are viable customary/religious arguments in support of the practice. As a result of this, there must be a creative means of striking a balance between the cultural/religious demands and the constitutional/criminal requirements in Nigeria. This chapter interrogates the continued relevance of the criminalisation of FGM in Nigeria and explores a socio-legal approach as a means

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of balancing culture/religions and supplementing constitutional/criminal obligations using an interdisciplinary approach embedded in socio-legal studies. The findings in this study show the prevalence of FGM to date and suggest some measures in which the criminalisation of FGM can be enforced, among which the interaction between several legal, social and political forces. Socio-legal approaches to supplement the law with advocacy, political will, educational curricula, and participation of gate keepers of FGM in the amendment of the laws are further suggested.

1 Introduction

The female gender, especially children, are the most vulnerable human beings in the world. Many decisions affecting them are made without seeking and obtaining their consents. Some decisions made around them cause more harms than gains, thus, violating most of their fundamental human rights enshrined in the constitutions of virtually all the world. One such decision is the mutilation[1] of their genital organs at a tender age.[2] The World Health Organisation (WHO) has given a broad and acceptable international definition of female genital mutilation (FGM) as 'all procedures which involves partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons'.[3]

The definition propounded by WHO covers all categories, namely, types I, II; III and IV of FGM.[4] Nigeria is one of the African countries that

1 Mutilation for the purpose of this chapter is used interchangeably with 'cutting' or 'circumcision'.

2 FGM is mostly practiced when the girl is 14 years or younger. See PS Yoder & S Wang 'Female genital cutting: The interpretation of recent DHS data' (2013) *Calverton, MD: ICF International* p 39.

3 World Health Organisation (WHO) 2018 'Classification of female genital mutilation', https://www.who.int/reproductivehealth/topics/fgm/overview/en/ (accessed 4 December 2018); WHO 'Understanding and addressing violence against women' 2018, https://www.apps.who.int (accessed 4 May 2022).

4 Type I – excision of the prepuce, with or without excision of part or all of the clitoris; type II – excision of the clitoris with partial or total excision of the labia minora; type III – excision of part or all of the external genitalia and stitching/narrowing of the vaginal opening (infibulation); type IV – pricking, piercing or incising of the clitoris and/or labia; stretching of the clitoris and/or labia; cauterisation by burning of the clitoris and surrounding tissue; scraping of tissue surrounding the vaginal orifice (*angurya* cuts) or cutting of the vagina (*gishiri* cuts);

practices FGM to date[5] despite its criminalisation under the extant laws. Nigerian viewed FGM as religious and cultural practices. This conforms with reports of the United Nations Children's Fund (UNICEF) that despite the enactment of many specific and general/other associated laws that criminalised the practice in many jurisdictions,[6] there is still an upsurge in the number of girls and women who are victims of genital mutilation.[7]

Examples abound in all African jurisdictions. For instance, in Nigeria, the report shows that the country has been rated the third-largest country in the world that indulges in the practice of FGM.[8] Studies have further shown that between 2004 and 2015, Nigeria recorded 19.9 million girls and women that have been victims of FGM.[9] As at 2017, the south-west zone of Nigeria recorded 41.2 per cent; the south-south zone recorded 23.3 per cent; the south-east zone 32.5 per cent; the north-west zone 19.3 per cent; the north-central zone 8.6 per cent; and the north-east zone recorded 1.4 per cent.[10] Although out of the 36 federating units of Nigeria, as reported above, Kebbi, Adamawa; Yobe, Gombe and Bauchi

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and introduction of corrosive substances or herbs into the vagina to cause bleeding or for the purpose of tightening or narrowing it; and any other procedure that falls under the definition given above. See WHO Female Genital Mutilation Fact Sheet 241, June 2000, http://www.who.int/topics/female_genital_mutilation/en/. (accessed 3 December 2021).

5 National Population Commission (NPC) Nigeria & ICF Macro Nigeria Demographic and Health Survey (2021) Nigeria: Nigeria Population Commission and ICF Macro, https://www.tradingeconomics.com; https://www.nigeriahealthwatch.com (accessed 5 January 2022).

6 See Law 006/PR/2002 of the Republic of Chad; Criminal Code of the Republic of Ethiopia 2004; Law 06.032 on the protection of women against violence in the Central African Republic 2006; Prohibition of Female Genital Mutilation Act 32 of 2011, Kenya; Law 2003-03 on the Repression of the Practice of FGM in the Republic of Benin; Republic of South African Children's Act 38 of 2005, and so forth.

7 See UNICEF 'Female genital mutilation/cutting: A global concern' New York UNICEF 2016, https://www.unicef.org/media/files/FGMC_2016_brochure_final_UNICEF_SPREAD.pdf (accessed 20 February 2022).

8 As above.

9 See B Shell-Ducan and others 'A state-of- the-art synthesis of female genital mutilation/cutting: What do we know?' Evidence to end FGM/C: Research to help women thrive the year? Volume New York Population Council, http://www.popcouncil.org/EvidencetoEndFGM-C (accessed 20 February 2022).

10 See NB Kandala and others 'Female genital mutilation/cutting in Nigeria: Is the practice declining? A descriptive analysis of successive demographic and health surveys and multiple indicator cluster surveys (2003-2017)' Evidence to End FGM/C: Research to help girls and women thrive (2020), https://www.popcouncil.org (accessed 20 February 2022).

states have 0 per cent, to illustrate that either there is no empirically-obtained data from those states for the purpose of avoiding prosecution, or they have banned the practice. The report and studies are confirmed in an interview granted to the author by interview participant (IP) 76 when he expressed that '[t]he knowledge and prevalence of female genital cutting, or circumcision is widespread all over Nigeria'. [11]

However, it is difficult to obtain precise data of the figures of affected victims partly because of the lack of measures to track the trends and the secrecy surrounding the procedure of the genital mutilation, resulting in a dearth of official data. The view expressed by IP 68 in an interview with the author reaffirms the secrecy of the FGM procedure when she said that 'FGM cannot be eradicated easily like that because it is practised in secret compared with that of boys in my communities, so because the practice is usually hidden, it is very difficult to know the exact victims affected in order to sensitise the actors'.[12]

Due to various challenges associated with FGM, Nigeria signed and ratified many international and regional legal instruments with the domestication of some of them with the emphasis on criminalisation of FGM under the Violence Against Persons (Prohibition) (VAPP) Act, 2015. Surprisingly, however, the criminalisation of FGM does not seem to have either eradicated the practice or solved the challenges, especially the reproductive health challenges and human rights violations. It is based on the seeming ineffective role of the law to stem the practice of FGM in Nigeria that this chapter (re)interrogates the continued relevance of criminalisation of FGM in Nigeria and the practical effects of FGM *vis-à-vis* the fundamental human rights of women and girls.

The chapter further examines the possibility of a socio-legal approach to supplement the criminalisation of FGM. This approach serves as a means of balancing culture/religious and constitutional/criminal obligations using an interdisciplinary method embedded in socio-legal studies.[13] Considering the criminalisation of FGM and the prevalence

11 Leader of the Circumcision Descendants Association of Nigeria interviewed at Benin City, Edo State (South-South Zone of Nigeria) on 25 February 2022.

12 IP 68, A circumcised businesswoman interviewed at Makurdi in Benue state (north-central zone of Nigeria) on 20 May 2022.

13 The socio-legal research approach involves 'the application of interdisciplinary perspectives through theoretical and empirical research in examining phenomena'. See he British Library 'Socio-legal studies: An introduction to collections' http://www.bl.uk/reshelp/findhelpsubject/busmanlaw/legalstudies/soclegal/ sociolegal.

of the practice, the chapter seeks to answer four research questions. First, what are the effects of FGM as a basis for its criminalisation in Nigeria? Second, are there adequate and effective legal frameworks and policies put in place to eradicate FGM in Nigeria? Third, if yes, why is FGM still prevalent in Nigeria? Four, if no, what are the measure(s) or mechanism(s) that need to be put in place for the eradication of FGM in Nigeria?

2 Methodology and data

In answering the above research questions, the chapter adopts a qualitative method. The author does a content analysis of literature and statutes while further engaging the key informants/stakeholders to obtain first-hand information and lived experiences of both the victims and perpetrators of the practice of FGM in Nigeria. Eighty-five participants interviewed for this study are selected through a purposive sampling technique from the six geo-political zones of Nigeria.

In the south-west (Lagos, Lagos-state Ibadan-Igboho-Oyo, Oyo-state, Abeokuta, Ogun-state, Akure, Ondo-state, Ado-Ekiti, Ekiti-state, Osogbo, Osun-state); south-east (Awka, Anambra-state, Enugu, Enugu-state, Owerri, Imo-state); south-south (Asaba, Delta-state, Benin-city, Edo-state, Port Harcourt, Rivers-state, Yenagoa, Balyesa-state); north-central (Abuja, Federal Capital Territory, Ilorin, Kwara-state, Makurdi, Benue-state, Minna, Niger-state, Lafia, Nasarawa-state, Lokoja and Okene, Kogi-state, Jos, Plateau-state); north-west (Kano, Kano-state, Kaduna, Kaduna-state, Sokoto, Sokoto-state); and north-east (Bauchi, Bauchi-state, Gombe, Gombe-state, Katsina, Katsina-state, Maiduguri, Borno-state, Yola, Adamawa-state).

After ethical approval was sought and obtained from the Ethical Review Committee of the University of Ilorin Nigeria, data is elicited from the participants through a semi-structured interview tool.[14]

html (accessed 16 February 2022); V Levičev 'The synthesis of comparative and socio-legal research as the essential prerequisite to reveal the interaction of national legal systems', http://www.tf.vu.It/en/science/researchers-conference-2015/rsearchers- conference-2013 (accessed 16 February 2022).

14 The interviews were conducted by the author between September 2021 and June 2022 with a set of team players of the 'Network for Vulnerable Persons in Nigeria' a non-governmental organisation recruited and trained as research assistants to join the author in conducting the interviews.

Informed consent forms were provided for the respondents to sign or thumb print after explaining to them and when they perfectly understood the purpose and objectives of the study before the interviews were conducted. The emphasis was placed on freedom to withdraw from participating in the study. Total confidentiality of the respondents' information was maintained, and they were completely anonymous with respect to their responses. The interviews run between the period of 30 July 2021 to 15 June 2022.

The participants consist of religious scholars; sex workers; obstetricians and gynecologists; community heads or leaders; healthcare providers; parents of circumcised and uncircumcised girls; circumcised and uncircumcised women and girls; husbands to circumcised and uncircumcised women; circumcisers; academics; and legislators. This is done to carefully select key informants that can provide informed responses to questions that are specific to them and to the subject matter under study. They are chosen because of their impacts and engagement with FGM and its effects. The interview tool is aimed for the purpose of eliciting information on the personal experiences of women, girls, circumcisers and the personnel on the nexus between the current laws and policies on the criminalisation of FGM, the prevalence of FGM *vis-à-vis* the violation of human rights of victims of FGM in Nigeria.

The justification for this empirical adventure is the fact that there is remarkably scant primary data in the public domain available for analysis because of the secrecy surrounding the procedure as most of the actors/operators are traditional circumcisers. There is a dearth of recent data on live experiences of victims and perpetrators of FGM in Nigeria. The only available data is a statistical survey conducted between 2003 and 2017 by *Kandala and others,*[15] and a descriptive summary of victims of FGM in only two states in the south-eastern region of Nigeria conducted by Obiora, Maree and Nkosi-Mafutha in 2020.[16] The current situation of the prevalence of FGM in Nigeria can only be verified through direct interaction with the gatekeepers/frontline actors and victims in all 36 states of the federating units on which the author embarks in this

15 As above.

16 OL Obiora and others 'Experiences of young women who underwent female genital mutilation/cutting' (2020) *Journal of Clinical Nursing*, https://www.onlinelibrary.wiley.com/doi.org/10.1111/jocn.15436 (accessed 20 February 2022).

chapter. It therefore is possible through the field research to obtain the underlying reasons for the continuous attitudes of the key actors, the effects of FGM and why the law criminalising the practice is ineffective.

The content analysis of the literature and legal instruments were blended with the thematic analysis of the data obtained from the interviews after the extracts of the transcript were studied to answer the research questions. The study limitations lie with the security situation of the country and funding constraints that limited the author to those cities as indicated in table 1 and mainly adopting audio-recording with the help of research assistance[17] for the interviews. Table 1 below shows the detail grouping of the respondents to the interviews. Analysis of the responses of the respondents interviewed reveal that the debate revolves around FGM *vis-à-vis* human rights and criminalisation. These are discussed below.

Table 1 Background information of the respondents interviewed

Participants	**Study area**	**Occupation**	**Academic and professional qualification**	**Sex**	**Unit of analysis**
IPS18 1-5	Lagos, Ilorin Kano, Kaduna and Abuja	Islamic clergies	BA	M	Islamic/Shari'a scholar/ Muslim leaders
IPS 6-10	Ilorin, Lagos, Ibadan and Port Harcourt	Business-women	ND, NCE and Secondary education	F	Sex workers
IPS 11-15	Osogbo, Ibadan, Yola and Maiduguri	Medical Practitioners	MBBS	F	Obstetrician & gynecologists

17 The author is grateful to the members of Network for Vulnerable Persons in Nigeria, a non-governmental organisation, for their assistance during the interview phase of this study.

18 Interviewed participants is abbreviated to IPS.

IPS 16-20	Igboho, Ado Ekiti, Akure and Kano	Traditional rulers	Pharmacist, Islamic education	M	Community heads/ Islamic scholar/ District heads
IPS 21-25	Ilorin, Oyo, Abeokuta and Lokoja	Circumciser	No formal education	F	FGM Operators
IPS 26-30	Lagos, Minna, Ilorin, Asaba and Benni city	Nurses	M Sci	F	Healthcare providers
IPS 31-38	Okene, Jos, Enugu and Lagos	Pastors	B Theology	M	Christian clergies
IPS 39-45	Abuja, Ilorin, Owerri and Sokoto	Civil servant	M.Ed	M and F	Mothers to uncircumcised girl child
IPS 46-50	Owerri, Lagos, Ilorin, Oyo and Kaduna	Housewives	No formal education/ Primary education	F	Circumcised women and Uncircumcised women
IPS 51-55	Awka, Ilorin, Katsina and Bauchi	Circumcisers	M Sci	F	FGM operator/ Nurses
IPS 56-60	Yenagoa, Ilorin, and Ibadan	Legal practitioners	LLB, LLM	M and F	Legislatures
IPS 61-65	Enugu, Port Harcourt and Uyo	University student	Under-graduate	F	Circumcised women and members of Civil Society Organisation/ NGOs
IPS 66-70	Akwa Ibom, Markudi and Ilorin	Business women	ND	F	Circumcised women
IPS 70-75	Jos, Lafia and Ilorin	Parents	Primary education and ND	M and F	Fathers and mothers to circumcised girl child

IP 76	Benin-city	Circumciser	Diploma in public health	F	Leader of Circumcision Descendants Association of Nigeria
IPS 77-80	Sokoto, Kaduna, Port Harcourt and Gombe	Lecturers	Professor and BA religion studies	M	Husbands to uncircumcised women
IPS 81-85	Birni Kebbi, Bauchi, Ilorin and Minna	School teachers	BA	M	Husbands to victims of mutilation

3 Review of literature on female genital mutilation in Nigeria

Over the years, the practice of FGM has been linked to cultural and religious beliefs. In Nigeria there is an ancient belief by Nigerians that a refusal to indulge in the mutilation of a girl child is a taboo and a slap to their culture and religion, hence, the prevalence of the practice to date. Instructively, Nigerian scholars, among whom Oba,[19] hold the notion that the discontinuance of the practice arises from Western domination, exploitation, and manipulation of its economy by the West.[20] Thus, the criminalisation of FGM has been seen to be counter-productive and ineffective. This part reviews the literature under two classifications: first, scholars who are pro-circumcisionists based on culture and religions; second, the anti-circumcisionists who are against FGM. The latter scholars are pro-human rights groups that argued for the criminalisation and abolition of FGM.

Among the pro-circumcisionist scholars are Rahman and Toubia; Carr; Odimegwu and Okemgbo; Bourdieu; Fran; Utz-Billing and Kentenich and Tangwa. Toubia pointed out that FGM is 'a fundamental part of collective cultural experience that relates to the essence of a girl's

19 AA Oba 'Female circumcision as female genital mutilation: Human rights or cultural imperialism?' (2008) 8 Iss.3 (Frontiers) *Global Jurist*. Article 8 http://www.bepress.com/gj/vol8/iss3/art8 (accessed 20 February 2022).

20 See R Cassman 'Fighting to make the cut: Female genital cutting studied within the context of cultural relativism' (2007) 6 *Northwestern Journal of International Human Rights* 128, citing BA Gillia 'Female genital mutilation: A form of persecution' (1997) 27 *New Mexico Law Review* 579; MJ Perry 'Are human rights universal? The relativist challenge and related matters' (1997) 19 *Human Rights Quarterly* 466.

womanhood, family honour, economic prosperity and social identity'.[21] According to Carr, the practice 'is meant to preserve the virginity of the girl and ensure genital hygiene'.[22] To Odimegwu and Okemgbo, FGM 'reduces sexual urge of a girl/woman, safeguards women against pre- and extra-marital sexual activities as uncircumcised girls are believed to be promiscuous'.[23]

In a similar vein, Bourdieu described FGM as 'a habit which has been developed over the years as a body modification which is regarded as a fruit of culture'. [24] Fran aligned his study with that of Bourdieu when he posits that 'men use FGM as tool to exercise power and control over their women'.[25] The position of Fran is in tandem with the views of Utz-Billing and Kentenich where they opined that FGM 'is a way to guarantee morality and faithfulness of women to their husbands'.[26] The position of Tangwa in support of FGM is subject to 'consent' when he postulated that circumcision that is voluntarily requested by an adult woman should be allowed as against a girl child as the latter has no capacity to consent to the mutilation compared with an adult. His perspective is drawn from the 'Nso' culture within North-Western Cameroon.[27]

The positions of pro-circumcisionists are reaffirmed in interviews conducted by the author with some respondents. For emphasis, IP 76 expressed the following:[28]

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21 A Rahman & N Toubia *Female genital mutilation: A guide to laws and policies worldwide* (2000) 4.

22 D Carr *Female genital cutting: Findings from the demographic health survey programme (1997).*

23 CO Odimegwu & CN Okemgbo 'Female circumcision and sexual activity: Any relationship?' (2000) 1 *UNILAG Sociological Review 159.*

24 P Bourdieu 'Structures, habitus, power: Basis for a theory of symbolic power' in N Dirks (ed) *Culture/power/history* (1994) A Reader in Contemporary Social Theory.

25 H Fran 'The Hosken Report: Genital and sexual mutilation of females' (1993) Fourth Revised Edition (*Women's International Network News*: Lexington MA) 114.

26 I Utz-Billing & H Kentenich 'Female genital mutilation: An injury, physical and mental harm' (2008) 29 *Journal of Psychosomatic Obstetrics and Gynecology*, https://doi.org/10.1080/01674820802547087 (accessed 20 February 2022).

27 GB Tangwa 'Circumcision: An African point of view' in GC Danniston, FM Hodges & MF Milos (eds) *Male and female circumcision: Medical, legal and ethical considerations in pediatric practice* (2022), https://www.springer.com (accessed 20 May 2022).

28 IP 76, Leader of the Circumcision Descendants Association of Nigeria interviewed at Benin-city, Edo state (south-south zone of Nigeria) on 25 February 2022.

> The knowledge of female genital cutting or circumcision is widespread all over Nigeria for the purpose of reducing sexual urge and promiscuity, beautification of female sexual organ and avoidance of pre-marital sex. We, the circumcisers rely on our traditions and customs which dominated most of the communities without regard for law eradicating the practice. The cutting of clitoris predominates in some communities while some communities practice excision and some practice infibulation. The operators range from traditional operators, Nurses/Midwives, health technicians and even at times, medical doctors.

The view of IP 20 on the prevalence of FGM based on culture was also expressed thus:[29]

> In my opinion, traditions and customs have their effect in some communities including mine. As such, tradition and custom of my community over dominated any law of the land. People do the female cutting regardless of the law due to tradition and custom. For example, people in my community do not know religious scripts whether it is allowed or not, or has shariah said that or not, but they depend on tradition and custom throughout their daily activities.

However, the studies of Adelakan and others;[30] Esere;[31] Owumi;[32] Obianyo;[33] and Ajere[34] disproved the cultural beliefs that the practice of FGM 'reduces promiscuity' and that of 'ensuring acceptable sexual behaviour including virginity and fidelity'. They argued that FGM could be one of the causes for prostitution as the circumcised women being 'frigid may require multiple sex with men before they can be sexually satisfied'. Adelakan and others' studies exposed the circumcised women 'to have more likelihood of initiating sexual intercourse at age 15 or older and that 95 per cent of those circumcised women in their studies have higher likelihood of having pre-marital sex'. This contradiction of

29 IP 20, traditional ruler interviewed at Oyo, Oyo state (south-west zone of Nigeria) on 15 November 2021.

30 B Adelakan and others 'Female genital mutilation and sexual behaviour by marital status among a nationally representative sample of Nigerian women' (2022) 19 *Reproductive Health Journal*, https://www.reproductive-health-journal.biomedcentral.com (accessed 5 May 2022).

31 MO Esere 'A cross-ethnic study of the attitude of married women towards female genital mutilation' (2003) 1 *Gender Discourse*, citing BE Owumi 'A socio-cultural analysis of female circumcision among the Urhobos of Delta' (2003) 2 *Your Task Health Magazine* 8.

32 BE Owumi 'A socio-cultural analysis of female circumcision among the Urhobos of Delta' (2003) 2 *Your Task Health Magazine* 8.

33 N Obianyo 'Harmful traditional practices that affect the well-being of women' (1997) 1 *New Impact 16-19*.

34 O Ajere 'Predisposing factors and attitudes towards sex work by commercial sex workers in Nigeria' unpublished MEd thesis, University of Ilorin, 1998.

cultural beliefs is located within the 'anomie theory' which emphasises that 'human beings are more likely to desire and delve into or indulge in those things which seem to be their legitimate rights, but they had been deprived of it'.[35]

The view expressed by IP 7 in an interview with the author confirms the above positions, especially as it relates to promiscuity when she was asked about her experience on FGM. She expressed the following:[36]

> I have been circumcised and that does not stop me from doing my business. I feel satisfied when having sex with multiple men per day. It is not true that circumcision or cutting of female genitalia reduces promiscuity because mine is different. If really the justification is correct then why am I striving for more sex from men to satisfy my sexual desire despite being circumcised.

Another pro-circumscionist scholar such as Baba Lee[37] posits that FGM is one of the age-long practices that transcends religion, while other scholars, such as Sami,[38] Imad-ad-Dean,[39] Hayford and Trinitapoli[40] viewed FGM as religious obligation. Some scholars such as Ahmed and others[41] see FGM as both religious and cultural obligations. The overall contention of these scholars is that FGM promote the 'existence of women races, reproductive continuity and sanctity'.

The position of Baba Lee that FGM is one of the age-long practices that transcends religion is linked to the 'Pharaonic circumcision' whose interest of not being destroyed by a male child ordered 'infibulation' to be carried on all pregnant women to ensure that no woman delivers

35 R Agnew 'The nature and determinants of strain' in N Passas & R Agnew (eds) *The future of anomie theory* (1997) 30.

36 IP 7, a sex worker woman interviewed at Port Harcourt, Rivers state (south-south zone of Nigeria) on 28 December 2021.

37 Baba Lee quoted in KL Savell 'Wresting with contradictions: Human rights and traditional practices affecting women' (1996) 41 *McGill Law Journal* 781.

38 A Sami Aldeeb Abu-Sahlieh 'To mutilate in the name of Jehovah or Allah: Legitimisation of male and female circumcision' (1994) 13 *Medicine and Law* 575.

39 A Imad-ad-Dean 'FGM: An Islamic perspective', http://www.minaret.org/fgm-pamplet.htm (accessed 5 February 2022).

40 SR Hayford & J Trinitapoli 'Religious differences in female genital cutting: A case study from Burkina Faso' (2011) 50 *Journal of Science Study and Religion* 252.

41 HM Ahmed and others 'Knowledge and perspectives of female genital cutting among the local religious leaders in Erbil Governorate, Iraqi Kurdistan region' (2018) 15 *Journal of Reproductive Health* 44, https://www.biomedcentral.com/ (accessed 5 December 2022).

secretly for him to hear the screaming from the pain that the pregnant woman would encounter during her birth delivery.[42]

Scholars that viewed FGM as a religious obligation supported their positions with some narrations from the sayings of Prophet Muhammed (peace be upon him) which include the following: 'A woman used to perform circumcision in Medina [*Madîna*]. The Prophet (peace be upon him) said to her: "Do not cut severely as that is better for a woman and more desirable for a husband".'[43]

In another narration, it was stated thus –Abu- Sahlieh says:[44]

> The most often mentioned narration reports a debate between Mohammed and Um Habibah (or Um 'Atiyyah). This woman, known as an exciser of female slaves, was one of a group of women who had immigrated with Mohammed. Having seen her, Mohammed asked her if she kept practicing her profession. She answered affirmatively adding 'unless it is forbidden and you order me to stop doing it'. Mohammed replied: 'Yes, it is allowed. Come closer so I can teach you: if you cut, do not overdo it (*la tanhaki*), because it brings more radiance to the face (*ashraq*) and it is more pleasant (*ahza*) for the husband.'

Abu-Sahlieh says Prophet Muhammed (peace be upon him) said: 'Cut slightly and do not overdo it (*ashimmi wa-la tanhaki),* because it is more pleasant (*ahza*) for the woman and better (*ahab*, from other sources *abha*) for the husband.'[45]

Some of the interviewed participants especially, IPs 3, 4 and 72, articulated the view as follows (IP 3): 'It was done in the past and they say it is shariah. The practice of female cutting is mixed with tradition and religion.'[46] IP 4 hinted as follows: 'The Prophet (peace be upon him) has said it. I heard that it is being practiced in old times and it has become part of Islamic practice and part of the shariah.'[47] The expression of IP 72 is thus: 'Female genital cutting is primarily related to the culture, but people think it is related to the religion and they apply it.'[48]

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42 BL Yusuf 'Female circumcision: The Islamic perspective' (2005) 1 *AT-TABIB (The Annual Magazine of the Association of Muslim Health Students*, College of Medicine, University of Ilorin) 30.

43 Sunan Abu Dawûd, Book 41, Hadith No 5251.

44 Ahmed and others (n 41).

45 Ahmed and others (n 41) 9.

46 IP 3, Islamic clergy interviewed at Lagos, Lagos state (south-west zone of Nigeria) on 5 November 2021.

47 IP 4, Islamic clergy interviewed at Ilorin, Kwara state (north-central zone of Nigeria) on 20 October 2021.

48 IP 72, parent of circumcised girl interviewed at Lafia, Nasarawa state (north-central zone of Nigeria) on 20 September 2021.

The Christian religion, especially Genesis 17:9-10, provides: 'And God said unto Abraham, thou shalt keep my covenant therefore, thou, and thy seed after thee in their generations.' 'This is my covenant, which ye shall keep, between me and you and thy seed after thee; every man child among you shall be circumcised.' Exodus 12:48 states: 'And when a stranger shall sojourn with thee, and will keep the pass over to the Lord, let all his males be circumcised, and then let him come near and keep it; and he shall be as one that is born in the land: for no uncircumcised person shall eat thereof.'

Also, Luke 1:59 states: 'And it came to pass, that on the eighth day they came to circumcise the child; and they called him Zacharias, after the name of his father.' John 7:22: 'Moses therefore gave unto you circumcision; (not because it is of Moses, but of the fathers;) and ye on the sabbath day circumcise a man.' Acts 7:8 states: 'And he gave him the covenant of circumcision: and so, Abraham begat Isaac, and circumcised him the eighth day; and Isaac begat Jacob; and Jacob begat the twelve patriarchs.' Further, Colossians 3:11 states: 'Where there is neither Greek nor Jew, circumcision nor uncircumcision, Barbarian, Scythian, bond nor free: but Christ is all, and in all.' Galatians 6:15 states" 'For in Christ Jesus neither circumcision availeth anything, nor uncircumcision, but a new creature.' Lastly, in 1 Corinthians 7:19 it is stated that '[c] ircumcision is nothing, and uncircumcision is nothing, but the keeping of the commandments of God'.

The anti-circumcisionists, such as Larsen and Okonofua;[49] Inhorn & Buss;[50] Salmon;[51] Larsen;[52] Oringanje and others; [53] Obiora, Maree and Nkosi-Mafutha[54] and Durojaye and Nabaneh[55] hinged their positions of eradicating FGM on the human rights of girls and women. According to these scholars, the effects of FGM on women and girl children are devastating. To them, FGM has both early and long-term disadvantages

49 Imad-ad-Dean (n39) 27.
50 Hayford & Trinitapoli (n 40).
51 Ahmed and others (n 41).
52 Yusuf (n 42).
53 Sunan Abu Dawûd (n 43).
54 Obiora and others (n 16).
55 E Durojaye & S Nabaneh 'Addressing female genital cutting/mutilation (FGC/M) in The Gambia: Beyond criminalisation' in E Durojaye, G Mirugi-Mukundi & C Ngwena (eds) *Advancing sexual and reproductive health and rights in Africa: Constraints and opportunities* (2021) 118.

on the female gender. The identified challenges/complications by them include acute pain, shock; hemorrhage; tetanus; necrosis; inability to urinate; damage to urinary canal; chronic vaginal; mensural irregularities; renal failure; infertility; pregnancy complications; Hepatitis B; HIV/AIDS; neonatal deaths, psychological trauma; depression; excessive bleeding and even death. Their positions are related to 'sexual and reproductive rights', 'human dignity', 'autonomy and best interests of the child' and the 'principle of equality and non-discrimination'. According to Baron and Denmark, 'FGM is an unsafe and unjustifiable practice that violates bodily integrity'.[56] They further supported the position of some feminists' anthropologists who opined that 'FGM is an inhuman form of gender-based discrimination that capitalises on the subjugation of women'.[57] The descriptive summary of the studies of Obiora, Maree and Nkosi-Mafutha from a Nigerian perspective also shows how FGM has devastating effects on the victims who had lived experiences in Ebonyi and Imo states where their studies were conducted. The study of Durojaye and Nabaneh, which was from a Gambian perspective, further reiterates the need to have complementary measures in addition to the enabling the Gambia Women's Act, 2010 (as amended) to reduce the practice of FGC/M in The Gambia.

To confirm anti- circumcisionists' positions on the adverse effects of FGM and why is it criminalised in the interviews conducted by the author, IPs 11-14,[58] obstetricians and gynecologists and IPS 26-30,[59] healthcare providers expressed that 'the most common effect of FGM is development of cyst in the virginal of the victims of mutilation'. This is in tandem with the report by NPC and Macro which identified FGM as

56 EM Baron & FL Denmark *An exploration of female genital mutilation* (2006).

57 C Parker 'Circumcision and human rights discourse' in O Nnaemeka & J Ezeilo (eds) *Engendering human rights: Culture and socio-economic realities in Africa* (2005) p 257.

58 IPS 11-15, Medical experts in the fields of obstetrics and gynecology interviewed at Osogbo and Ibadan in Oyo and Osun states (south-west zone of Nigeria), Yola and Maiduguri in Adamawa and Borno states (North-east zone of Nigeria) on 10-15 December 2021 and 10 and 15 January 2022 respectively.

59 IPS 26-30, Healthcare providers interviewed at Lagos in Lagos state (south-west zone of Nigeria), Minna and Ilorin in Niger and Kwara states (north-central zone of Nigeria); Asaba and Benin City in Delta and Edo states (south-south zone of Nigeria) on 5 November 2021, 8 September 2021; 20 October 2021; 5-8 February 2022 respectively.

'one of the leading cultural practices responsible for high maternal and infant mortality in Nigeria'.[60]

The position was re-affirmed by IP 12 when she said:[61]

> A mutilated woman may experience complications during pregnancy and childbirth thereby endangering the life and health of the unborn child. A mutilated woman may also develop psychosexual and psychological problems which may give rise to conflict between her and her husband which may lead to her husband ill health. Further, a mutilated woman may contract hepatitis B or HIV/AIDS which she may transmit to her husband and put him at health risk. In my view, I see FGM as a public health problem because the problem goes beyond the victim herself, it extends to the unborn baby and even the husband who are members of the society or public.

IP 13 further confirmed the health complications during pregnancy when she expressed:[62]

> Women who are mutilated are more prone to complications such as excessive blood in the genital organs which leads to unusual vascular in the area of the vulvar. At the long run, the tissues are infected and increase the hormones in the blood which may also increase the urinary tract infection.

Similarly, IP 15 has this to say:[63]

> The most complication and effect of FGM is 'infibulation'. Women who undergo infibulation are more susceptible to complications during labour because they are the highest at-risk during childbirth. Their introits will be so tight that it is always difficult to perform vaginal examination on them during labour and as a result, it mostly leads to bleeding from the vaginal. During the postpartum period, mutilated women may transmit HIV or Hepatitis B and it is uncommon to have tetanus.

A mother (IP 72) of a mutilated daughter further confirmed the effects of FGM on her daughter when she said:[64]

> I do not know that my daughter's health problem is due to the mutilation. She was circumcised at age of 5 years and I observed that she bleeds for some days after the

60 National Population Commission (NPC) Nigeria & ICF Macro Nigeria Demographic and Health Survey (2021) Nigeria: Nigeria Population Commission and ICF Macro, https://www.tradingeconomics.com; https://www.nigeriahealthwatch.com (accessed 5 January 2022).

61 IP 15, a medical practitioner interviewed at Ibadan, Oyo state (south-west zone of Nigeria) on 20 February 2022.

62 IP 13, obstetrician and gynecologist interviewed at Yola, Adamawa state (north-east zone) dated 11 January 2022.

63 Obstetrician and gynecologist interviewed at Maiduguri, Borno state (north-east zone) dated 15 January 2022.

64 IP 72, mother interviewed at Ilorin, Kwara state (north-central zone of Nigeria) on 20 October 2021.

> excision but I do not know that she has been effected with infections until she come of age and encountered stillbirth.

IP 72 further said 'God forbids. I pray the practice is abolished' when she was asked if she will allow the second daughter to be mutilated.

Unfortunately, IP 76 went further to lament a lack of awareness of the reproductive health rights challenges arising from FGM when he expressed further:

> Being the leader of Circumcisers Association of Nigeria, I will campaign against the tradition and religion that permit the practice of FGM now that we have been informed that FGM affects reproductive health right because what we tried to protect on the mutilated girl child include good health and that can be realised and meaningful if she is healthy and if she is not render immobile by a preventable blood borne diseases.

IP 22 does not deny her lack of awareness on the dangers inherent in the practice of FGM when she said:[65]

> I inherited the practice from my late mother and I have not encountered any problem on the victims during the process. There is no complaint from the parents of the girls and I have not heard of any health complication from them. I am hearing and understanding the adverse effect of FGM with respect to reproductive health right for the first time from the interviewer.

The view expressed by IP 76 above leads to another question as to whether FGM should be criminalized. In answering this question during the interview, IP 81 expressed the following:[66]

> One of the ways that criminalisation of FGM can be effective is to tie it to issue of reproductive health right because as husband to circumcised wife, I would not have encouraged and supported the mutilation of my daughter because of obeying the tradition of my people had it been I am aware of the reproductive health challenges/complications which may arise from the mutilation.

The views expressed by IPs 70-75 when asked about the eradication of FGM were that 'health complications from the practice of FGM call for its eradication'.

Instructively, this study differs from the analysis of the literature in many respects. The studies of the pro-circumcisionists have been reviewed to the effect that the Nigerians' justification on the prevalence based on

65 IP 22, a circumciser interviewed at Abeokuta, Ogun state (south-west zone of Nigeria) on 2 March 2022. The author appreciates the support of the research assistance in interpreting the *Egba language into English and vice versa.*

66 IP 81, husband to a victim of mutilation interviewed at Ilorin (north-central zone of Nigeria) on 20 October 2021.

culture and religion is not proportionate to the rights inalienable to the victims. Their postulations did not take into consideration the overall result of damage to health of the victims. Also, the postulation of some scholars linking the practice to Pharaonic circumcision has been observed in this chapter as a self-centred and selfish interest on the part of the promoters of the practice, as the harm and pains are more severe than the benefits attached or derived from the practice. In other words, Gruenbaum is correct when he summed up the practice of FGM and concluded that 'its continuation is against humanitarian values'.[67] It is pertinent to further interrogate this cultural belief which seems to be either repugnant to natural justice, equity and good conscience or contrary to public policy.[68] There is a need to employ the repugnancy test to serve as a doctrine of progressive change in the body of customary rules/laws in order to abolish or eradicate the practice of FGM in Nigeria.

Fundamentally, all the Islamic scholars are of the view that 'there is no single verse in the Holy Quran that can be used as a basis for FGM'.[69] It is pertinent to note that from the foregoing Hadith narrations, it is clear that the practice of FGM is not obligatory but permissible and there is no punishment attached to its discontinuance in either the Holy Quran and even the Hadith relied on by the scholars. It therefore is important to emphasise the provision of the Holy Quran Chapter 4 verse 1 where Allah (God) says:

> O mankind! Be careful of your duty to your Lord Who created you from a single soul and from it created its mate and from them twain hath spread abroad a multitude of men and women. Be careful of your duty toward Allah in whom ye claim (your rights) of one another, and toward the wombs (that bare you).

This is to show the equal recognition of male and female genders in the sight of Allah: no discrimination of any kind. We are all equal servants before Allah and no gender is superior to the other.[70] In similar vein,

67 E Gruenbaum *The female circumcision controversy: An anthropological perspective* (2001).

68 Repugnancy has been explained by AC Enikomeyi *Development and conflict of laws* (1990) 66 to mean 'any rule or indigenous law which robs a man of his inalienable right'. He further explained repugnancy as 'all indigenous laws which justify inhuman or degrading treatment'; *Dawodu v Danmole* (1962)1 ANLR 702.

69 SR Hayford & J Trinitapoli 'Religious differences in female genital cutting: A case study from Burkina Faso (2011) 50 *Journal of Science Study and Religion 252.*

70 See Quran ch 19 verse 93.

Quran Chapter 2 verse 228 pointed out the equality of right of men and women when it says: 'And women shall have rights similar to the rights against them, according to what is equitable.' In other words, both genders should relate within themselves as that of complementarity and not that of competition.[71]

The Holy Quran has also guaranteed the dignity of human person when it provides in Quran chapter 17 verse 70: 'We have dignified the children of Adam ... and favored them over much of creation.' This provision has been admitted by Holy Prophet Muhammed (peace be upon him) when he said: 'Neither inflict nor accept harm.' [72] This is a remarkable provision of the Holy Quran and Hadith which have long-standing and unshakable principles of human rights. From the biblical verses, it shows that the circumcision referred to the male child and even in the Corinthians cited above, it is no more compulsory to circumcise a male child.

The author aligns with the positions of the anti-circumcisionists on FGM. This study is purely from the Nigerian perspective while some literature reviewed is from foreign jurisdictions such as The Gambia, Cameroon, and so forth. The author also differs with respect to the empirical verification made in the course of this study with an addition of gathering data on the lived experiences of all the stakeholders and victims in all 36 states of the federation. The author's fieldwork has exceeded the studies of Obiora, Maree and Nkosi-Mafutha whose fieldwork covered only two states (Ebonyi and Imo) within the 36 states of the federation. The expansion of the author's fieldwork beyond two states reveals the current status of the prevalence of FGM, its effects, ineffective criminalisation laws and policy and the mechanisms that need to be put in place to eradicate the practice.

71 See Quran ch 4 verse 32.

72 See A Gomaa 'The Islamic view on female circumcision' (2012) *African Journal of Urology*, https://www.ees.elsvier.com/afju (accessed 7 March 2022).

4 A critical analysis of the Nigerian legal response to FGM: Human rights versus the criminalisation approach

Women and girls are subject to genital mutilation and an estimated 19.9 million of these have been reported to have been mutilated in Nigeria.[73] This shows their vulnerability and how they are being denied autonomous freedom in matters relating to their rights. Nevertheless, the Nigerian government has made significant efforts aimed at according to women and girls' protection against the harmful practices in eliminating FGM.

Among the governmental efforts are its responses to the international and regional calls for the protection of human rights. These legal instruments range from the age-old Universal Declaration of Human Rights, 1948 (Universal Declaration);[74] the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT);[75] the International Covenant on Civil and Political Rights, 1966 (ICCPR);[76] the International Covenant on Economic, Social and Cultural Rights, 1976 (ICESCR);[77] the Convention on the Elimination of All Forms of Discrimination against Women, 1979 (CEDAW); the Convention on the Rights of the Child, 1989 (CRC), the African Charter on Human and Peoples' Rights (African Charter); the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (African Women's Protocol); and the African Charter on the Rights and Welfare of the Child (African Children's Charter).[78] The Nigerian government promulgates laws and policies after ratifications and domestications of some international and regional legal instruments. Therefore, Nigeria's response shows a complementary intersection between the human rights and criminalisation approach towards FGM.

More importantly, the violation of the right to dignity, harm, cruelty, torture and degrading treatment meted on the person of the girl child cannot be equated with the benefits accrued to all the actors or perpetrators and victims of the act. Arguably, the harm and pain caused

73 Shell-Duncan (n 9).
74 See arts 1, 2, 5 & 7 of the Universal Declaration.
75 See art 2 CAT.
76 See arts 2, 3, 7, 24 & 26 ICCPR.
77 See art 12 ICESCR.
78 See art 3 African Children's Charter.

to the person of the girl child are violations to her human person. This argument is well positioned under chapter IV of the Constitution of the Federal Republic of Nigeria, 1999 (as amended). For emphasis, section 34(1)(a) of the 1999 Constitution provides that '[e]very individual is entitled to respect for the dignity of his person, and accordingly (a) no person shall be subjected to torture or to inhuman or degrading treatment'.[79]

The provision of section 34(1)(a) of the 1999 Constitution is reiterated in sections 10 and 11 of the Child Rights Act, 2003. The views expressed in the interviews conducted by the author attest to the fact that FGM is a violation to the right to dignity of the girls mutilated. IPs 21-25,[80] IPs 26-30,[81] IPs 70-75[82] and IPs 51-55[83] identified 'scissors and razors' as tools for the operation of genital cutting. Interestingly, IP 73 described the tools as 'very dangerous and frightening'.[84] These views are in tandem with the reports of Amnesty International, and a statement from the Office of the High Commissioner for Human Rights that some tools use in the process of mutilating the victim include 'blunt penknife, broken glass, a tin lid, scissors, a razor, or some other cutting instrument'.[85] More harmful and severe tools such as 'thorns and stitches' are used for type III category of FGM which is infibulation in order to

79 See similar provision in sec 11 of the Child Rights Act, 2003.

80 Interviews conducted between October and December 2021 at Ilorin, Kwara state, Oyo in Oyo state, Abeokuta in Ogun state and Lokoja in Kogi state respectively (north-central and south-west zones of Nigeria).

81 IPS 26-30, healthcare providers interviewed at Lagos in Lagos state (south-west zone of Nigeria), Minna and Ilorin in Niger and Kwara states (north-central zone of Nigeria); Asaba and Benin City in Delta and Edo states (south-south zone of Nigeria) on 5 November 2021, 8 September 2021; 20 October 2021; 5-8 February 2022 respectively.

82 IPs 70-75, parents of circumcised girls interviewed at Jos, Lafia and Ilorin in Plateau, Nasarawa and Kwara states respectively (north-central zone of Nigeria) on 17 September 2021; 20 September 2021 and 20 October 2021.

83 Interview conducted by the author with healthcare providers and nurses between August and October 2021 at Awka in Anambra state, Ilorin in Kwara state, Katsina in Katsina state and Bauchi in Bauchi state respectively (south-east, north-central and north-east zones of Nigeria).

84 IP 70, a mother to a circumcised girl interviewed at Ilorin in Kwara state (north-central) on 20 October 2021.

85 Amnesty International 'Female genital mutilation – A human rights information pack', http://www.amnesty.org/ailib/intcam/femgen/fgm1.htm. (accessed 20 December 2021).

hold together the two sides of the labia majora of the girl/victim. Among the tools listed also include a 'kitchen knife and sharp fingernail'.[86]

Some participants' views on the violation of right to dignity, harm, cruelty, torture and degrading treatment on the practice of FGM in the interviews conducted by the author are the following:

IP 19 says:[87]

> In my opinion and belief, it has no relation with religion, although it is a tradition and cultural practice, but I am aware in my community that some preachers such as *Imam* and Pastor do mention female genital mutilation several times that the practice is risky and warned parents of not disabling their children, but the people did not listen to the preachers and this is wrong.

IP 25 says: 'Yes, there is a bit of discomfort and small bleeding. The child may have a bit of urinary discomfort but not much.'[88] IP 72, a mother to a mutilated girl child, said earlier that 'I observed that she bleeds for some days after the excision'. IP 39, a mother to an uncircumcised child lamented thus: 'In my community, the practice is done by traditional birth attendants and there is a woman that is doing it. In my opinion, this is not good and I do not like it because it is harming.'[89]

Instructively, the right to dignity can be expressed within the context of equality and non-discrimination. Thus, FGM is argued to be a form of discrimination based on 'sex, gender and age'.[90] Equality and non-discrimination underscore the notion that 'all persons are equal irrespective of their standing in life and are entitled to the same set of rights'.[91] Scholars such as Rawls posited that 'sexual right of men and women must be equal as this right is a social right that deserves to be enjoyed to the fullest'. [92] Therefore, the mutilation of the female

86 Office of the High Commissioner for Human Rights, Harmful Traditional Practices Affecting the Health of Women and Children Fact Sheet 23.

87 IP 19, district head who is a pharmacist by profession interviewed at Kano (north-west zone of Nigeria) on 10 January 2022 (my emphasis).

88 IP 25, a circumciser interviewed at Lokoja (north-central zone of Nigeria) on 10 December 2021.

89 IP 35, mother to uncircumcised child at Owerri in Imo state (south-east zone of Nigeria) on 30 July 2021.

90 See UN Joint Committee on the Elimination of Discrimination Against Women, General Comment 31 and the Committee on the Rights of the Child on harmful practices, General Comment 18, paras 7 nd 15, 2014.

91 D Moeckli 'Equality and non-discrimination' in D Moeckli and others (eds) *International human rights law* (2014) 157 160.

92 J Rawls *A theory of justice Cambridge* (1971).

genitalia violates the rights to sexual fulfilment and corporeal integrity of women as the practice involves tampering with their clitoris during the procedure.[93] The author's fieldwork also aligns with this position when IPs 16-20,[94] IPs 46-50[95] and IPs 70-75[96] acknowledged the fulfilment and pleasure that men enjoyed over women in sexuality. Those participants also acknowledged that the reduction of full sexual enjoyment by women is due to the genital mutilation and is very discriminating.

In the context of this chapter, conceptualising reproductive health rights includes 'a state of complete physical, mental and social well-being of women and children'. According to the International Conference and Population Development (ICPD) 'reproductive health is not merely the absence of disease or infirmity, but in all matters related to reproductive system and to its functions and processes'. The Nigerian Federal Ministry of Health confirmed this conceptualisation when it goes further to state that 'reproductive health rights centered on human needs and development throughout the entire life cycle, that is from the womb to the tomb'.[97] According to Atsenuwa and others,[98] 'reproductive rights are hosts of recognised human rights that have positive implications for the protection of reproductive health'.

This position is re-affirmed in Principle 7.3 of ICPD and the study of Gbadamosi as 'a number of separate human rights that are already recognised in national laws, international laws and international human rights documents and other consensus documents'.[99] The definition

93 See K Boulware-Miller 'Female circumcision: Challenges to the practice as a human rights violation' (1985) 8 *Harvard Women's Law Journal* 155.

94 IPS 16-20, community and district heads interviewed at Igboho, Ado Ekiti, Akure and Katsina in Oyo, Ekiti, Ondo and Katsina states respectively (south-west and north-central zones of Nigeria) on 15 November, 10 August 2021 and 28 January, 30 January 2022.

95 IPs 46-50, housewives interviewed at Owerri, Ilorin; Lagos; Oyo and Kaduna in Imo, Lagos, Oyo and Kaduna states respectively (south-east, south-west, north-central and north-west zones of Nigeria) on 30 July 2021, 20 October 2021; 5 November 2021; 15 November 2021 and 22 April 2022.

96 IPS 26-30 (n 81).

97 Federal Ministry of Health 'National Reproductive Health Policy and Strategy to Achieve Quality Reproductive and Sexual Health for All Nigerians (2001) Federal Ministry of Health, Nigeria.

98 See A Atsenuwa and others 'Reproductive health and rights education: A compilation of resources' (2004) *Legal Research and Resources Development Centre*.

99 See O Gbadamosi *Reproductive health and rights: African perspectives and legal issues in Nigeria* (2007).

proffered by the WHO on sextual rights is very apt to the context of this chapter when it states that sexual rights include 'the right of all persons, free of coercion, discrimination and violence' and 'respect for bodily integrity', 'decide to be sexually active or not', 'consensual sexual relations' and pursue a satisfying, safe and pleasurable sexual life'.[100]

Section 17(3) of the 1999 Constitution only provides for the formulation of policies towards 'ensuring that adequate medical and health facilities are provided' for all Nigerians irrespective of age or gender. However, section 17(3) above is not ordinarily enforceable but when construed within the provision of the African Charter and the African Women's Protocol which have been signed, ratified and domesticated in Nigeria, sexual and reproductive rights are guaranteed. Arguably, this chapter calls for the amendment of the Constitution not only to respect sexual and reproductive health as rights but as fundamental human rights with those rights enforceable under chapter IV of the Constitution. This call for amendment will enhance the implementation of the ratified and domesticated international and regional legal instruments in Nigeria.

Instructively, from all indications, the practice of FGM hindered the realisation and achievement of these two sets of rights in that FGM attempts to reduce the sexual desire of women and at the same time causes complications to the reproductive health of women. The pain and agony that follow the procedure of FGM with the usage of the tools identified as dangerous and harmful hinder the achievement of sexual and reproductive health rights as this process seemingly amounts to torture and inhuman or degrading treatment of women. It also violates the principles of equality and freedom from discrimination enshrined in all the international, regional and domestic legal instruments. Arguably, the practice of FGM does not respect the sexual and reproductive autonomy and dignity of women.

Arguably, the lack of autonomy and voluntary consent of the girl child before undergoing genital mutilation are a gross violation of the rights of such child as the 'best interests of the child' are not duly considered. Instructively, section 1 of Child Rights Act (CRA) emphasises the 'best interests of a child to be of paramount consideration in all actions'.

100 See WHO Expert meeting on sexual and reproductive health rights (2002); WHO 'Declaration of Alma Ata' (2013), http://www.who.int/publications/almaata_declaration_en.pdf (accessed 17 August 2013).

Therefore, the pain, agony and long-term effects of FGM on the girl child cannot be regarded as an action done in the 'best interests of the child' under international best practices. The shield of parental autonomy on which the parents of the child may rely in mutilating their daughters cannot be proportionate to or equated with the 'best interests of the child' principle under the international standard. In support of this argument are the views expressed by IPs 31-38,[101] IPs 56-60[102] and IPs 77-80,[103] that the practice of FGM on the person of the child and the human rights of the child should override the parental autonomy. In particular, IP 63 expressed the following: 'It is necessary and important to prevent a violent crime to be committed against girl child. I have seen the damage that FGM does to girls and women. I do not give a damn about what could have been the justifications because mutilation is against fundamental human right of a child.[104]

It therefore is abnormal to hold that because of retaining a girl's virginity, morality, faithfulness, and pre- and extra-marital sexual activities, she should be mutilated, violating her right to dignity.

Studies and reports abound that the age at which the mutilation is mostly carried out is between 0 and 14 years. This tender age of the child is a period where the child is more vulnerable because her consent can never be sought and obtained. IP 76 confirms the age at which FGM is carried out when he said: 'The cutting is majorly performed on a girl child between the day she is born till around 14 years of age. I have circumcised a day born girl child and I have operated girls of 5 to 10 years of age.'

Instructively, the questions that readily come to mind are: Who owns the right to be mutilated? Is the right to mutilate that of the girl child/

101 IPs 31-38, pastors/Christian clergies interviewed between October and December 2021 at Okene in Kogi state, Lagos in Lagos State, Enugu in Enugu state respectively.

102 IPS 56-60, legal practitioners who doubled as law makers interviewed at Yenagoa in Balyesa state, Ilorin in Kwara state and Ibadan in Oyo state (south-south, north-central and south-west zones of Nigeria) on 17 June 2022, 20 October 2021 and 15 November 2021 respectively.

103 IPS 77-80, husbands to uncircumcised women interviewed at Sokoto, Kaduna, Port Harcourt and Gombe in Sokoto, Kaduna, Rivers and Gombe states respectively (north-west, south-south and north-east zones of Nigeria) on 20 May 2022, 25 April 2022 and 28 December 2021.

104 IP 63, undergraduate student interviewed at Port Harcourt in Rivers state (south-south zone of Nigeria) on 28 December 2021.

victim, parents or that of the man that will marry the girl in future? The answer from the author's perspective is that the right should be that of the child since the act is performed on her person/body. This position gains credence from the postulation of Salmon when she opined that 'FGM violates the rights of the women on whom it is performed'.[105]

In other words, FGM is a procedure that violates the principle of justice and autonomy of the child because it mutilates the body of the child to carry out social or patriarchal culture/tradition. The act is also performed on the body of the girl without her consent and even forcibly.[106] The author further sees this violation as a breach of Rule 19 of the Rules of Professional Conduct for Medical and Dental Practitioners in Nigeria, even if FGM is medicalised. Arguably, protecting the dignity of the child will be more of paramount consideration than the act of mutilation.

Similarly, a lack of implementation of the National Health and Strategy adopted in 1988 and 1998, the Policy on Population and Development, Unity, Progress and Self Reliance, 1988, Maternal and Child Health Policy, 1994, National Adolescent Health Policy 1995, National Policy on HIV/AIDS/STIs Control, 1997, National Policy on the Elimination of Female Genital Mutilation, 1998, among other policies, to improve access to basic health services which include reproductive services for all Nigerians irrespective of age or gender complicated the realisation of sexual and reproductive health rights. These rights could have been strengthened had the policies been effective. Furthermore, the medicalisation of FGM is not helpful as studies abound that the Nigerian health system is 'weak and plagued with poor coordination, insufficient resources, inadequate and decaying infrastructure and non-trained healthcare providers',[107] among other factors.

According to section 17(2)(a) of the 1999 Constitution, the 'equality of rights, obligations and opportunities before the law' of all Nigerian citizens is assured. However, the right to equality enshrined in chapter II of the Constitution is not ordinarily enforceable but an implied enforceability can be construed when section 42 of the Constitution

105 MH Salmon 'Ethical considerations in anthropology and archaeology, or relativism and justice for all' (1997) *Journal of Anthropology Research* 47.
106 See TL Beauchamp & JF Childress *Principles of biomedical ethics* (2019).
107 See Population Council 'Understanding Medicalization FGM/C' (2018).

dealing with freedom from discrimination is read together. More importantly, when relying on articles 2, 3, 18 and 19 of the African Charter on Human and Peoples' Rights (Ratification and Enforcement) Act (African Charter Act) 1983 domesticated in Nigeria as Cap A9, Laws of the Federation of Nigeria, 2004. For emphasis, article 2 provides:

> Every individual shall be entitled to the enjoyment of the rights and freedoms recognised and guaranteed in the present Charter without distinction of any kind such as race, ethnic group, colour, sex, language, religion, political or any other opinion, national and social origin, fortune, birth or other status.

Article 3 guarantees equality before the law and equal protection of the law to every Nigerian citizen while article 18 guarantees the 'protection of rights of woman and child'. Article 19 provides for 'equality' of all persons and that all persons are entitled to the 'same respect' and 'same rights'. Equality therefore is reinforcing the treatment of people equally by taking into consideration their situations and background in life. Under the social protection and human rights principle, equality aims at remedying 'social norms and power dynamics that contribute to inequality and the discrimination of disadvantaged or vulnerable persons in society'.[108]

In the same vein, the Nigerian government's response to the eradication of FGM was re-emphasised with the enactment of the Violence against Persons (Prohibition) (VAPP) Act in 2015. Going through the VAPP Act, its provisions generally refer to violence against women and children, except its section 6 which simply provides that 'circumcision or genital mutilation of a girl or woman is prohibited'. However, sections 6(2), (3) and (4) provide for punishments for those who 'perform', 'attempt' or 'aid' the performance of FGM.

However, the VAPP is bedevilled with some challenges with respect to its implementation. The Act is not explicit enough to address those that are relying on culture and religion for the continuance of the practice compared with most African countries, especially the Prohibition of Female Genital Mutilation Act, 2010 of Uganda. Section 10 of the Ugandan Act frowns on any person who raises the defence of culture and religion to perpetrate the act of FGM.

108 Social Protection and Human Rights 'Equality and non-discrimination', http://socialprotection-humanrights.org/framework/principles/equality-and-non-discrimination/ (accessed 20 December 2021).

This therefore calls for the amendment of the VAPP Act to align with the international standard especially in relation to FGM. According to section 12 of the Constitution of the Federal Republic of Nigeria, 1999, the domestication of any international or regional legal instrument will only be complied with if such instrument falls within the exclusive competence of the National Assembly.[109] However, an instrument domesticated by virtue of section 12 of the Constitution that falls within the 'concurrent legislative' competence will only be binding on the 36 states if it is approved by a simple majority of all the states or if, in the alternative, an interested state passes its own version with or without making reference to the federal statute.

Therefore, the VAPP Act being a federal enactment is only binding at the federal capital territory, Abuja. It can only be binding if all 36 states enact or approve its operation by a simple majority. Unfortunately, eight out of the 36 states are yet to domesticate the VAPP Act into law, and out of the 28 states that have domesticated it, VAPP law has not be assented to by seven states.[110] Ekiti and Lagos states have enacted the Protection Against Domestic Violence Law of Lagos state in 2007 while Ekiti state passed the Violence (Prohibition) Amendment Law in 2019 to add up to the 28 states.

Another legal instrument regulating the practice of FGM is the National Policy and Plan of Action for the Elimination of FGM in Nigeria 2013-2017. The Policy has as its core objectives to (i) reduce the prevalence of female genital mutilation in Nigeria; (ii) promote community behavioural change initiatives towards elimination of FGM in Nigeria; (iii) establish a legal framework for the elimination of FGM at national and state levels; and (iv) strengthen system for research, monitoring and evaluation towards the elimination of FGM. It provides for institutional structure at the federal, state, and local government levels for implementation.

However, despite these initiatives, the issue remains that the practice of FGM remains prevalent in Nigeria. The question remains as to whether a lack of implementation of the laws and policy can be

109 See, generally, Parts I, II and III of Second Schedule to the Constitution of the Federal Republic of Nigeria, 1999 (as amended).

110 See VAPP TRACKER-Partners West Africa Nigeria, https://www.partnersnigeria.org (accessed 1 June 2022). VAPP Law is yet to be assented to in Adamawa, Bayelsa, Ekiti, Kebbi, Kogi, Plateau and Rivers States.

attributed to a lack of political will, or whether the decriminalisation of FGM is what is needed to completely eradicate FGM in Nigeria. In answering this question, IPs 56-60[111] and IPs 77-80[112] hold the view that the VAPP Act should be accompanied by some measures to influence the cultural and religious beliefs of the people and their expectations, otherwise the law will be ineffective. IP 33 has this to say: 'There must be continued programmatic efforts by the government to refine the design of the legislative reform including adjustment of the legislative strategies to reflect evolving degrees of social security for the key actors of FGM in Nigeria.' IPs 46-48 lamented that FGM is still in practice in their communities, and this is attributed to a lack of awareness of the law prohibiting it.[113] The view of IP 68 goes further by asserting this unawareness of the law when she said: 'FGM cannot be eradicated easily like that because it is practised in secret compared with that of boys in my community. So, because the practice is usually hidden, it is very difficult to sensitise the actors.'[114]

IP 45 is of the following opinion:[115]

> Culture and religious beliefs for practising FGM could be circumvented and awareness of the law prohibiting the practice can challenge the culture and tradition status quo by providing legitimacy to new behaviours. I believe that people will change their behaviour when they understand the hazards of the practice and reason why the law eradicating it was passed. Understanding the reason behind FGM and moving towards constructive dialogue on the reason why the law is prohibiting it will make people to giving up this aspect of their culture and discontinue the practice.

IP 12 proffers the following suggestion:[116]

> There is no way to get FGM eradicated without putting law in place. Those favouring eradication must be legally justified. So, we need the law. But the problem is the ambiguity of the extant law. VAPP Act is not that explicit to

111 n 101.
112 n 102.
113 IPS 46-48, housewives interviewed at Owerri, Lagos, Ilorin, Oyo and Kaduna states (south-east, south-west, north-central and north-west zones of Nigeria) on 30 July 2021, 5 November 2021, 10 October 2021, 15 November 2021 and 22 April 2022.
114 IP 68, a circumcised businesswoman interviewed at Makurdi in Benue state (north-central zone of Nigeria) on 20 May 2022.
115 IP 45, mother to uncircumcised girl child interviewed at Abuja in Federal Capital Territory (north-central zone of Nigeria) on 15 June 2022.
116 IP 12, a gynecologist and obstetrician by profession interviewed at Osogbo in Osun state (south-west zone of Nigeria) on 10 June 2022.

> justify the advocation for the eradication based on reproductive health rights. Let us remember that all the policies formulated cannot be enforced like the Act. Government should endeavour to amend VAPP Act to be more elaborate. In so doing, women must be given a voice in the proposed amendment, the applicability and implementation.

The religious leaders such as *Imams,* pastors and even the Ifa priests should be educated to add the advocacy on eradication of FGM into the marriage curriculum and counselling so that the FGM will be killed from the inception of marriage.[117]

Instructively, therefore, the implementation of VAPP Act has been hindered due to non-domestication by all 36 states of the federation. However, no diligent personnel have been recruited to man the institutions established for the purposes of prosecution, education and advocating the eradication of FGM in Nigeria. A paucity of funds by the Nigerian government to execute the project designed for eradication of FGM is another challenge.

5 Discussion of findings

The findings in this study reveal the prevalence of FGM to date. The study provides evidence through literature review and the views of the interview participants, especially IPs 51-55 and IP 76, who expressed the way in which they normally carry out the mutilation/excision. There is a general belief from the study that FGM is a cultural and religious practice and this belief has dominated the engagements of people in all the communities where FGM is being practised. The reviewed literature and the interviewed participants confirm this position by adducing reasons why FGM remains prevalent. From the findings of the study, it is clear that the operators of FGM in Nigeria have no regard for the law as they believe more in their culture and religion for the continuation of the practice and ignore the cry of the law for the criminalisation of the practice based on its human rights violation.

However, some interviewed respondents have acknowledged the health challenges that surround the practice of FGM and are ready to eradicate it based on its human rights violations. The stands taken by IP 12 above show that when people are educated about the health hazards

117 As above.

of FGM, they could attach greater importance to tackling the reality of the menace of reproductive health rights caused by FGM instead of being inclined to follow culture and religion in perpetrating the harmful practice.

Thus, the available literature and the findings in the field work also suggest that the tools used for the procedure of genital mutilation are very frightening and as such can ordinarily cause injury or harm to the person of the victim. These findings were advanced in favour of eradicating FGM in Nigeria. Remarkably, this standpoint is canvassed by IPs 19, 72 and 76 in their responses expressed earlier during the interviews that FGM is 'risky, can disable women, causes discomfort, bleedings and urinary infections'.

The findings further reveal that the Nigerian government has made several efforts in acknowledging the adverse effects of FGM. In so doing, the study reveals that FGM becomes an offence or crime especially by virtue of section 6 of the VAPP Act, 2015. This is the legislation that specifically distilled FGM as an offence punishable under the law. Interestingly, there are some provisions in the Nigerian Constitution, 1999 that enjoin any aggrieved party to institute an action on a crime committed against the right to dignity, non-discrimination and right to reproductive health as examined in this chapter.

Despite the criminalisation of FGM, studies have shown that the practice remains prevalent. The findings reveal a lack of awareness of the law, inhibiting its ineffectiveness. As expressed by all the interviewed respondents, there should be legislation for the eradication of FGM, but people need to be educated that the hazards caused by FGM are more than the benefits envisaged under culture and religious beliefs. They also hold that the education of people for the eradication of FGM must be seen from a health rights perspective. Clamouring of reproductive health rights will convince people to give up these aspects of culture and religion and turn a new leaf. The view expressed by IP 12 is very apt.

The findings have enumerated measures in which criminalisation of FGM can be enforced. Among the suggested measures revealed in this study include interaction between several legal, social and political forces. The law in this regard cannot operate in isolation, but needs the support of societal factors to be effective. This is especially true for a phenomenon with heavy socio-cultural inclinations. The views that have been expressed during empirical engagement in this study show the need

for massive support of sociological factors to bring about the efficacy of criminal sanctions. The views expressed by IPs 13, 56-60 and 77-80 above are apt in this regard.

6 Conclusion

The research questions have been answered from the findings of this chapter. First, the author can analyse the effects of FGM and reasons why the law criminalising the practice is not effective. Second, the chapter proffers recommendations by aligning to the responses adduced. The chapter construes FGM from ethical relativism as against culture and religion because of the evaluation of the two standpoints (FGM/culture/religions versus law). This is to arrive at a logical conclusion that for Nigeria to achieve and realise its Sustainable Development Goal 5.3 on 'elimination of all harmful practices' including FGM, some aspects of culture and religion need to be forgone, especially FGM which hinders the reproductive health rights.

Suggestions of the interviewed respondents as to 'political will', creating 'awareness', 'amendment of the VAPP Act/Law' and 'education' with 'counselling' during marriage rites if adopted will bring FGM to an end. Overall, the chapter concluded that the enactment of the VAPP Act/Law or criminalising FGM is regarded as critical to effect a change of societal attitudes towards FGM. Law alone cannot change the hearts and minds of people on FGM but the socio-legal approach to supplement the law with advocacy, political will, educational curricula, and participation of gate keepers of FGM in the proposed amendment of the laws suggested in this chapter can only be a good strategy in eradicating FGM in Nigeria.

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12

A CASE COMMENTARY ON LAW AND ADVOCACY FOR WOMEN IN *UGANDA V THE ATTORNEY GENERAL*: EXPLORING THE LEGAL STEPS TAKEN IN ABOLISHING THE PRACTICE OF FEMALE GENITAL MUTILATION AND CHALLENGES WITH IMPLEMENTING THE DECISION

*Laura Nyirinkindi**

Abstract

This chapter analyses the case of Law and Advocacy for Women in Uganda v The Attorney General *in the context of the various legal steps that have been taken in Uganda to abolish the practice of female genital mutilation. Key factors in this case include the undertaking by Uganda to ratify the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW) and the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa. The Constitution of Uganda,1995, drawing from international human rights frameworks, including CEDAW, provides enabling legal provisions for gender equality and the substantive rights of women. The establishment of the Constitutional Court claims mechanisms under the Constitution entrenches a critical forum for victims of human rights abuses and violations and those acting on their behalf to challenge constitutional breaches made on a de jure or de facto basis. Apart from the legal and regulatory*

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frameworks, this chapter examines the efficacy of the domestication of international and regional frameworks at national level. The extent to which the Prohibition of Female Genital Mutilation Act 2010 and its accompanying regulations enacted in 2013 are being implemented to deter the practice of female genital mutilation and protect actual and would-be victims is discussed. The chapter further investigates the reasons why despite an enabling legal, policy and juridical environment, challenges in eradicating the practice of female genital mutilation persist in some communities in Uganda.

1 Introduction

Strategic litigation involves the identification and trial of a potentially high impact case with a view to achieving wider changes in legal systems and institutions or societal norms and practices. Strategic litigation, sometimes referred to as 'third party intervention',[1] has great utility as a tool for advocacy, standard setting and pursuing normative and structural change. In human rights terms, ending violations and clarifying and furthering the protection and promotion of rights is the goal of strategic litigation.[2] For those seeking to redress wrongs suffered as a result of gender injustice, strategic litigation offers a pathway for litigating against laws, policies, practices, institutions and processes that are blind or neutral to women's rights, concerns and experiences or perpetuate gender violence, inequality and discrimination. Since the passing of the Constitution of Uganda, 1995, various gender activists in Uganda have employed strategic litigation to promote and protect the rights of women in the area of marriage, divorce and maternal health and female genital mutilation (FGM) in Uganda.

1 Open Society Justice Initiatives 'Strategic litigation impacts: Insights from global experience (2018) Open Society Foundation; J Robinson 'Making the law work for women: Investigating feminist interventions via strategic litigation' (2020) *Engender*, https://www.engender.org.uk/news/blog/making-the-law-work-for-women-investigating-feminist-interventions-via-strategic-litigatio/ (accessed 7 June 2022).

2 Amnesty International 'Strategic litigation', https://www.amnesty.org/en/strategic-litigation/ (accessed 7 June 2022).

1.1 The practice of female genital mutilation (FGM) in Uganda

For a few decades, Uganda has battled to eradicate the harmful custom of FGM in a few communities in the eastern region, although the practice predates Uganda as a polity. The practice is limited to the Tepeth, Kadam and Pokot tribes of Karamoja region and the Sabiny in the eastern region. The Sabiny practise type I or II (clitoridectomy or partial or total excision) while the Pokot practise Type III (infibulation).[3] A 2016 government survey conducted in FGM-practising communities established that FGM is carried out among the Pokot communities on girls aged between 14 and 15 years and among Sabiny girls aged between 17 and 19 years.[4] FGM is being carried out mostly on adolescent Pokot girls as a rite of passage before marriage, as opposed to the Sabiny where FGM is conducted on older, uncut married women.[5]

The prevalence of FGM in Uganda is considered lower than in many African countries[6] but remains problematic in its persistence. The Uganda Demographic and Health Survey (UDHS) 2011 indicated that FGM prevalence was at 1.4 per cent among women aged 15 to 59 years. In 2016, this figure decreased to 0.3 per cent among women in this age group, according to the Uganda Demographic and Health Survey (UDHS). However, between 2020-2021 during the COVID-19 lockdown period, it is believed that FGM numbers increased due to girls being out of school in the two-year prolonged lockdown period in Uganda. Dubbed the world's longest school closure, schools in Uganda were shut down for 83 weeks between 16 February 2020 and 31 October 2021, and only opened formally on 10 January 2022. A 2021 December survey on FGM revealed that the Moroto in Karamoja region had some of the highest FGM prevalence rates and that FGM conducted across the border appeared to have increased during the pandemic.[7]

The reasons for FGM holding sway in practising communities are varied. While in other regions of the world, the fight against FGM is seen as an attack against religion, in Uganda this largely is not the case.

3 *28 Too Many Countries profile: FGM in Uganda* (2013).
4 Republic of Uganda *Female genital mutilation in Uganda* (2017) UBOS, UNICEF.
5 As above.
6 As above.
7 UNICEF *The impact of COVID-19 on child marriage and female genital mutilation in Uganda research report* (2022).

The tribes that subscribe to FGM adhere to it as a matter of cultural identity and traditional rites of passage for girls into womanhood. The 2016 FGM survey revealed that motivations for undergoing FGM include 'acceptability for marriage, ability to product children, being clean and fidelity to husband'.[8] Pokot tribal practices link FGM to girls' readiness for marriage; the age of 10 years is acceptable for marriage and, conversely, girls undergo FGM at marriage. The UDHS of 2011 found an inverse relationship between education and wealth and the desire to undergo FGM; women with lower education levels and least wealth were more likely to want FGM to continue. This is most likely because of the desire to marry as a way of receiving dowry, social inclusion and economic support from a husband.

FGM is claimed as a cultural identity rite and right by the communities that practise it in Uganda, thus its framing as a crime creates tensions from the outset. Many practitioners in the Sabiny region call its ban Western-imposed. Kenya's colonial history reveals the intensity of the clash of cultural codes and the extreme polemics they breed. When the Church of Scotland pushed for an end to FGM between 1929 and 1932, this provided more impetus for the Kikuyu independence struggle to mobilise their common cultural identity against the British.[9] Culture can be a melting pot for shared values and objectives but also impose a collective homogeneity regardless of the internal tensions within the cultural ecosystem, especially gender relations. While culture is always evolving based on social, political and economic factors, protagonists of FGM often seek to claim the practice as immutable. This resistance explains in part why legislating against the practice has yielded low results and, as stated, 'legislation is only one part of the jigsaw'.[10]

8 As above.

9 M Berer 'The history and role of the criminal law in anti-FGM campaigns: Is the criminal law what is needed, at least in countries like Great Britain?' (2015) 23 *Reproductive Health Matters* 145.

10 Asylum Research Consultancy 'A commentary on the December 2016 country policy and information note issued on female genital mutilation (FGM) in The Gambia' (2017), https://www.refworld.org/pdfid/5964b61f4.pdf (accessed 11 July 2022).

1.2 The socio-legal context in addressing female genital mutilation prior to Law and Advocacy for Women in Uganda v the Attorney General[11]

Prior to 2010, no FGM-specific law existed in Uganda, although there were legal texts that could be cited in support of criminalising certain aspects of FGM. In terms of soft law, the provisions of the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) on equality and non-discrimination, freedom from torture, cruel, inhuman and degrading treatment were applicable since Uganda has been a state party since 1985. Article 2(f) of CEDAW carries an imperative for member states to take legislative and other measures to modify or abolish existing laws, regulations, customs and practices that constitute discrimination against women.

However, local FGM practitioners rail against what they view as ethnic chauvinism, asserting that such norms are Western-oriented and emanate from a judgmental, superior cultural mindset. It is in this regard that the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol) was deemed transcendent when Africa's heads of states and governments clearly pronounced themselves on FGM as a practice harmful to Africa's women. The Maputo Protocol was adopted on 1 July 2003 and entered into force on 25 November 2005.[12]

Article 1 of the Maputo Protocol defines harmful practices to mean 'all behaviour, attitudes and/or practices which negatively affect the fundamental rights of women and girls, such as their right to life, health, dignity, education and physical integrity'. Article 3(1)(b) adds to that list practices that endanger the general well-being of women. Arguably, FGM fits the bill of practices that trigger the dangers and negative consequences of a cultural practice aimed at controlling women's sexuality, for both the willing and unwilling females that undergo the practice. Article 5 specifically enjoins states to enact sanctioning laws that prohibit all forms of FGM, scarification, medicalisation and para-medicalisation of FGM and all related other practices, in order to eradicate them. Uganda

11 Constitutional Petition 13 of 2005 [2007] UGSC 71 (5 April 2007).

12 African Union Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, https://au.int/en/treaties/protocol-african-charter-human-and-peoples-rights-rights-women-africa (accessed 14 May 2022).

signed the Maputo Protocol on 18 December 2003 and ratified it on 22 July 2010.

Uganda's Constitution has provisions that have been important in anti-FGM campaigns. Article 2(2) states that '[i]f any other law or any custom is inconsistent with any of the provisions of this Constitution, the Constitution shall prevail, and that other law or custom shall, to the extent of the inconsistency, be void'. This is buttressed by article 32(2) which states that '[laws, cultures, customs and traditions which are against the dignity, welfare or interest of women or any other marginalised group to which clause (1) relates, or which undermine their status, are prohibited by this Constitution'. Article 44(a) states that no person shall be subjected to any form of torture and cruel, inhuman or degrading treatment. This article has been used to denounce the torturous and inhuman aspects of FGM. Article 21(1) guarantees equality and freedom from discrimination for men and women. Unlike male circumcision practised in those communities, women are circumcised for reasons to do with controlling sexual deviation, introducing a discriminatory element. Article 27 prohibits violations on a person's right to privacy, including bodily privacy. This is pertinent given the public exposure of women's genitalia during the cutting process.

Prior to the Prohibition of Female Genital Mutilation Act (PFGMA) 2010, FGM could be prosecuted Uganda's Penal Code Act which serves as a broad framework for criminal sanctions. Section 216 of the Penal Code criminalises any act intended to cause grievous harm; any person who, with intent to maim, disfigure or disable any person does so commits a crime. Section 236 thereof provides that assaults causing actual bodily harm are offences. This law no doubt bears some applicability in the context of FGM but does not fully lend itself well to the conundrum of FGM. First, intent to harm, maim disfigure or disable is hard to prove, as is assault, especially in the peculiar context where victims sometimes offer themselves up for FGM. Second, if no physical harm occurs to the victim after the cutting act of FGM but psychological trauma follows, this law's focus on the physical would miss the point. Third, the Penal Code offers no support to girls at risk of FGM or victims. These gaps in the Penal Code underscore the importance of a law on FGM that does not delve into intent, but rather is fault based, emphasising strict liability for the *actus reus* element of the crime.

At the regional level in Kapchorwa district, there were notable steps taken by local communities to combat FGM, again lending credence to the notion that this practice is not universally supported, which weakens arguments about the inviolability of the norm. In 2009 the district leadership of Kapchorwa were presented with a petition supported by 100 community leaders from 16 sub-counties of Kapchorwa district to ban the practice, leading to the Kapchorwa Ordinance.[13] The Kapchorwa Ordinance made FGM optional in 2009 which gave covering of sorts to the unwilling, but knowledge of the ordinance was very low.[14] However , these efforts were isolated to only one district in Eastern Uganda, whereas the scope of FGM practice is wider. Furthermore, leaving it optional did not adequately address the harmful consequences of FGM nor the coercive circumstances under which a woman or girl may 'opt' for FGM.

The context in which *Law and Advocacy for Women in Uganda v The Attorney General* was lodged in the Constitutional Court of Uganda is significant. Intensive efforts had been undertaken in the regions by local activists and community leaders to end FGM, but the wave of public practice and opinion was heavily in favour of the practice. No effective law existed up to that point to prohibit the practice, which was posited as a cultural right by practitioners. Law and Advocacy for Women in Uganda (LAWU) had conducted research with results indicating extreme suffering by victims of FGM in various dimensions of human rights and worked with activists from the region on various advocacy efforts. As the Chairperson of Equal Opportunities Committee of Parliament, Dora Byamukama, the head of LAWU had already been conducting intensive advocacy over FGM trends, at one point asking the government to enact a law on the extradition of Kenyan surgeons who conduct FGM on Ugandans.[15]

LAWU in 2007 had also successfully litigated a strategic interest case in the Constitutional Court leading to the annulment of the Penal

13 CEHURD and others 'Protecting the right to health in the campaign against female genital mutilation: A rapid assessment of stakeholder interventions in Kapchorwa district, Eastern Uganda' (2015) https://www.cehurd.org/wp-content/uploads/2015/11/FGM-response-and-R2H-1.pdf (accessed 17 July 2022).

14 As above.

15 'Legislators want law on genital mutilation' *New Vision* 11 March 2005, https://www.newvision.co.ug/new_vision/news/1129357/legislators-law-genital-mutilation (accessed 17 July 2022).

Code and Succession Act provisions that discriminated against women in the instance of penalisation for adultery and provision for inheritance respectively. Armed with a good understanding of the effectiveness of strategic litigation and its wider impact, LAWU in 2007 instituted the FGM case in the Constitutional Court.

2 Law and Advocacy for Women in *Uganda and the Attorney General*: A commentary

Case law in Uganda is important in establishing points of law and fact. Previous court judgments can be used to persuade other courts during court hearings. Judgments derived from the Supreme Court set authoritative precedents on points of law, in similar cases of fact, for lower courts to follow.[16] The Constitutional Court has a specific mandate to interpret any question regard the Constitution and its decisions have wide public policy ramifications. Once this Court declares a law, act or omission null and void, it sets the tone for legal, policy and practice reforms for bureaucrats, politicians, activists and practitioners.

In 2007 a constitutional petition was filed by Law and Advocacy for Women in Uganda (LAWU), a Ugandan non-governmental organisation (NGO) that has been working on anti-FGM campaigns for over two decades. The petition cited violations of the Constitution suffered by women in those tribes, namely, torture, cruel, inhuman and degrading treatment; endangerment of the right to life through poor health or potential of spreading HIV; customs against the dignity, integrity and status of women; and violation of the privacy of the victim caused by public mutilations. The main contestation in the case was that the custom and practice of FGM as practised by several tribes in Uganda are inconsistent with Uganda's Constitution to the extent that it violates the Constitution.

Furthermore, the petition asserted that FGM lacked medical and social advantages and was not justifiable in a free and democratic society. This latter claim was pursuant to a constitutional principle that forbids any limitation on fundamental human rights under article 43(3) of the Constitution, beyond what is acceptable and demonstrably justifiable in a free and democratic society or provided in the Constitution. The

16 S Lewis 'Precedent and the rule of law' (2021) *Oxford Journal of Legal Studies* 873.

petitioners adduced evidence to show that FGM in Uganda is carried out crudely, inflicting excruciating pain and excessive bleeding and could cause consequential physical and psychosocial and psycho-sexual harm and trauma. The case cited incidences of urinary incontinence, paralysis, disability in victims. Social consequences related to the practice were also elaborated, including stigmatisation for health complications related to FGM such as urine incontinence. The petitioners sought the Constitutional Court to declare the custom and practice of FGM unconstitutional as per its mandate.

The state's initial response to the petition was to brand it misconceived, not raising any matter for constitutional interpretation under article 137 of the Constitution. This was a surprising stance, given the work that the Uganda Ministry of Gender, Labour and Social Development had put into combating FGM in the affected regions up to this point. The Attorney General later on abandoned this position and did not contest the petition at the trial stage, a move that was interpreted by the Court as 'the wisdom of the Attorney General who must have felt that the issue had no merit'. The government position seemed more like a knee jerk reaction than a genuine rejection of the grounds for the case. The Minister of State for Justice and Constitutional Affairs later in 2009 fully supported the Bill to pass the PFGMA in Parliament, explaining to the august house that during the trial,[17] '[w]e toiled with the problem of how to go about the matter until we had to concede out of court that certainly there was no need to go to court and defend female genital mutilation. So we conceded that it is unconstitutional.'

One of the effective strategies used by the petitioners was to present comprehensive data and literature on FGM in Uganda and clearly explain the applicable human rights standards for review by the Court. This was not surprising, given the intensive advocacy that LAWU has undertaken on this issue over the years. LAWU, a feminist Ugandan NGO headed by a lawyer and Member of Parliament, Dora Byamukama, had conducted extensive research and advocacy in Uganda and published an informational booklet of its findings. In fact, the petitioner's lawyer stated during the hearings that he was specifically relying on one of LAWU's publications significantly in his pleading. This was important

17 Parliament of Uganda, 10 December 2009, https://www.parliament.go.ug (accessed 17 July 2022).

because the practice is not widespread in Uganda, the judiciary would not be expected to have in-depth knowledge of the practice and its harms. The judgment highlights this, stating that a 'lack of understanding in the judiciary of the key issues at stake, biases of judges can all play a role in limiting victim's access to justice'. Given the critical issues that were at stake, providing critical information to the bench was a tactical approach in shedding more light on the ills of FGM and, indeed, the major arguments against FGM relied on by LAWU filtered significantly into the judgment.

The constitutional petition was argued successfully, and the Court found that the practice of FGM not only contravenes the Constitution but also the treaties, covenants, conventions and protocols to which Uganda is a party. Furthermore, the Court in its judgment reflected a good understanding of the associated risks and consequences of FGM, such as infections, dangers for childbirth including increased child mortality and post-partum haemorrhaging, in addition to finding that FGM is a violation of the constitutional principle of equality and non-discrimination. The practice of FGM as a custom was found wholly inconsistent with the Constitution and the custom declared null and void.

The Court also flagged the Prohibition of FGM Bill that had been tabled and passed in Parliament before the Court could deliver its judgment. Although the LAWU petition had been lodged in 2007, the Constitutional Court's judgment was delivered in July 2010. In that time, the Ugandan Parliament had passed the law in December 2009[18] and the President assented to it in March 2010. Clearly, the political climate favoured a positive ruling, which could have paved the way for the positive and politically correct outcome of the Court, as a different position would have resulted in an embarrassing scenario. As candidly pointed out by a justice of the Court, '[t]his judgment is more for the purposes of putting the record right, because whilst the petition was pending in this Court, Parliament passed the Bill outlawing the practice of female genital mutilation'.

However, the Court did not shy away from its responsibility in combating FGM. In addition to the many important pronouncements

18 'Uganda: Parliament passes female genital mutilation Bill' *AllAfrica* 11 December 2009, https://allafrica.com/stories/200912110220.html (accessed 17 July 2022).

contained in the judgment, the Court also acknowledged its key role in enforcement, stating:

> It is now incumbent upon the judiciary to play the very important role in completely eliminating any form of violence against women including female genital mutilation ... The judiciary being part of the State machinery is enjoined to address this issue aggressively whenever it comes before court by involving innovative and progressive interpretation of the laws. Failure to do so would be tantamount to a breach by the State of its international obligations.

The Court's position in this instance is well identified. In determining the case, one of the principles upon which the Court relied was non-derogation from freedom from torture and cruel, inhuman or degrading treatment or punishment as stated in the Ugandan Constitution. In General Comment 2 of 2008,[19] the United Nations (UN) Committee against Torture examines states' responsibilities to enforce the prohibition against torture and cruel, inhuman and degrading treatment through legislative, administrative and judicial preventative means. In this regard the Committee clearly identifies FGM as falling under this category of human rights violations. The Committee explains that where there is state inaction and failure to prevent, investigate, prosecute and punish non-state officials or private actors, the state should be considered as authors, complicit or otherwise responsible under the Convention against Torture (CAT). This is because a lack of due diligence by states to prevent such acts by public or private perpetrators enables a climate of impunity and is a form of encouragement and or *de facto* permission. Importantly, the Committee applies this standard where state parties fail to prevent FGM and protect victims. The Constitutional Court thus clearly pronounced the responsibility of the judiciary to prevent a climate of impunity through its adjudications.

While the Court stepped up to its duty under international, regional and national law in pronouncing FGM unconstitutional, in essence a declaration of null and void is a legal concept. In practice it is much harder to cancel a customary practice to which that significant elements in a society have consistently adhered for ages as a matter of conviction and social identity. The next part examines the steps that the legislature, law enforcers and local actors have undertaken over the years to ensure that the FGM is legally but also substantively outlawed in Uganda.

19 CAT/C/GC/2.

3 Enacting the Prohibition of Female Genital Mutilation Act 2010 and enabling laws

The Prohibition of FGM Bill was conceived in Parliament not as a government Bill but as a private parliamentary member's Bill moved by Dr Chris Baryomunsi from May 2009.[20] Uganda's Constitution allows members of parliament to move a private member's Bill and to be afforded reasonable assistance by the department of government whose area of operation is affected by the Bill. To bolster the individual efforts of parliamentarians wishing to sponsor a bill, the Attorney General's office is required to provide the representative moving the private member's Bill professional assistance in the drafting of the Bill.

Ethnic sentiment among the FGM practitioners, including in the Sabiny region in some quarters, was stirred up to denounce the anti-FGM law and its proponents as not understanding the importance of this ritual to their culture. However, combined strong and visible support from members of parliament from the region, numerous concerned parliamentarians and the elders of Sabiny as well as Sabiny anti- FGM campaigners had led to a high level of buy-in from Parliament to pass the law. During the reading of the Bill in Parliament, Dr Baryomunsi communicated strong community support from the Sabiny for the Bill, stating that the majority of the members in the community were travelling to Parliament to witness the historic event of Parliament pronouncing itself on FGM.[21] This was important in signalling to the members of the public and of Parliament that there was a significant local ground swell of support for this law, he himself not being from that community.

In building a case for a stand-alone law, Dr Baryomunsi pointed out the *lacuna* on the law on FGM despite progressive constitutional provisions, explaining that

> [s]ome people have argued that we could use the existing laws like the Constitution to prosecute those who carry out female genital mutilation. However, when you look at our Constitution in Article 28(12), it clearly states that you cannot prosecute anybody unless an offence and the penalty has been specifically created by this House. Although the Constitution outlaws harmful practices, I think it

20 M Wambi 'Baryomunsi tables private member's anti-FGM Bill in Parliament' *URN* 16 September 2009, https://ugandaradionetwork.net/story/baryomunsi-tables-private-members-anti-fgm-bill-in-parliament (accessed 24 May 2022).

21 Parliament of Uganda, 10 December 2009, https://www.parliament.go.ug (accessed 5 May 2022).

> becomes very important to create an offence and specify the penalties associated with the offence in order for anybody to be prosecuted.

As a testament to the strong political will this Bill received in Parliament and in the executive, including the Ministry of Gender, Labour and Social Development that endorsed it,[22] the Bill was introduced in May 2009 and passed by March 2010. Indeed, a national groundswell of support had been built in Parliament by parliamentary missions to the affected geographical areas, strong research and lobbying by LAWU on top of the anti-FGM constitutional petition and the hard work of anti-FGM activists on the ground in the Sabiny region. The Sabiny Elders Association and an NGO called Reproductive Educative and Community Health (REACH) stood out for mobilising the Sabiny community against FGM since 1996.[23] Uganda enacted the Prohibition of FGM Act (PFGMA) (2010) and the Prohibition of Female Genital Mutilation Regulations (2013) were adopted to operationalise the PFGMA 2010 Act.[24]

3.1 Key elements of the Prohibition of Female Genital Mutilation Act

The PFGMA 2010 not only adopts a punitive stance against offenders but also looks at the protection and care of actual girls and women at risk. Parents, husbands, guardians, health workers and those with authority over a victim who perpetuate FGM are liable to be charged with aggravated FGM. The prohibition applies to a girl or woman who carries out FGM on herself, those procuring, aiding, abetting, inducing, coercing or threating as well as those participating in events leading to FGM. This law captures the collective and individual components of FGM and is nuanced to address the pre-FGM ceremonies, key peer influencers and the aspect of coercion for those women and girls who are pressured into FGM. Importantly, the victim's consent to FGM, culture

22 R Harshbarger 'Ugandan physician-lawmaker moves to criminalize FGM' *Women eNews* 31 May 2009, https://womensenews.org/2009/05/ugandan-physician-lawmaker-moves-criminalize-fgm/ (accessed 5 May 2022).

23 Parliament of Uganda, 10 December 2009, https://www.parliament.go.ug (accessed 5 May 2022).

24 UN Committee on the Elimination of All Forms of Discrimination Against Women Combined 8th and 9th periodic reports submitted by Uganda under article 18 of the Convention (2020) CEDAW/C/UGA/8-9.

and religion are not a defence, which addresses the key pressure points for FGM being practised. The law addresses other drivers of FGM, the ostracisation of women and girls that have not undergone FGM, from socio-cultural everyday tasks or cultural events. It prohibits the discrimination against or stigmatisation of a girl or woman or any other person whose female relatives have not undergone FGM.

To stem crossing of borders for acts of FGM, the PGMA law extends to FGM-related offences committed outside Uganda, where the girl or woman upon whom the offence is committed is ordinarily resident in Uganda. This is a valid concern, given the high resort to cross-border FGM events in Kenya. However, it raises immediate questions about the adequacy of jurisdiction and cross-border enforcement, as discussed later.

The PFGMA is one of the rare gender-based violence-related laws to elaborate on victim protection and compensation in Uganda. The PFGMA touches on payment of compensation that may be made to an FGM victim. Such compensation may be paid to the victim or the parent, guardian or caretaker of the victim in trust for the victim where the parent, guardian or caretaker has not participated in the act of FGM, or the victim is a minor. Mindful of the familial dialectics around FGM, the law provides for third parties to receive compensation in trust for the victim, such as a probation and social welfare officer where the parent or guardian of the victim is the offender under the Act. In the event of death, compensation is to be awarded to the victim's next of kin.

Three years after passing of the PFGM Act 2010, Uganda made the Prohibition of Female Genital Mutilation Regulations, 2013. These regulations expand on the parent law, laying out procedures to provide a safe place to protect an unwilling girl or woman from the danger of undergoing FGM. Under the regulations, the police have strong search powers on suspicion that a woman or girl is supposed to undergo FGM or intends to or has carried out self-FGM. Health workers and local government councillors can also refer a known case of a girl or woman at risk of FGM to the police. Furthermore, potential or actual FGM victims can apply to court for a protection order, or a third party can make such an application on behalf of a girl or woman who is at risk of FGM.

The Prohibition of FGM Regulations forbid acts of reprisal or backlash against women or girls who choose not to undergo FGM. This most probably was informed by prevailing norms in the FGM-prevalent regions. In the regulations, forbidden acts against women and girls

who do not undergo FGM extend to prohibiting attendance of a son's initiation ceremony; failing to accord proper funeral rites upon death; denying attendance of a son's marriage ceremony; overt and derogatory names calling; denial from depositing or collecting food from the granary or from going to the Kraal or milking cows; prevention from attending or contributing to a talk during a meeting; or denial from attending, talking, or participating in any form of meeting. While it is beyond the scope of this chapter to establish the extent to which such communal sanctions are imposed on the aberrant, the fact that FGM is still widely practised probably reveals the fear of or continued meting out of such draconian measures to women and girls that do not undergo FGM.

A review of the law and its subsidiary regulations shows that considerable effort was put into covering the most important elements of the vice of FGM, including causes and effects and actors involved. The prohibition on FGM for girls was reiterated in the Children (Amendment) Act 2016 which forbids any person from exposing a child to any customary or cultural practice that is harmful to health, well-being, education or socio-economic development. Under the same law, every child has a right to be protected against all forms of violence, including FGM.

Uganda submitted its progressive report to CEDAW report in 2020, in which it outlined other broader regulatory frameworks to combat FGM.[25] These frameworks reference FGM in the context of violence against women and include the National Policy and Action Plan on the Elimination of Gender Based Violence in Uganda (2016); the Referral Pathway for Response to Gender Based Violence cases in Uganda (2013); the Guidelines for Establishment and Management of GBV Shelters in Uganda (2013); and Guidelines for Prevention and Response to FGM (2012). Government has put in place shelters in the Sebei and Karamoja sub-regions for victims of FGM. These measures combine a multisectoral approach that emphasises socio-legal as well as victim-centred approaches. However, not much is documented about the performance of these shelters in terms of victim utilisation and value returns.

25 As above.

In 2016 an important regional law was passed by the East African Community Legislative Assembly which once assented to by the Heads of State and Government of the Community will be binding on Uganda in the context of FGM. The East African Community Prohibition of Female Genital Mutilation Act was moved by the same actor behind the Constitutional Court case, the Kapchorwa Ordinance 2009 and stakeholder in the PFGM law, Dora Byamukama. One of the stand-out features of the law, given the cross-border nature of FGM, was the emphasis on co-operation and collaboration of member states in stamping out FGM. The Act calls for the establishment of a regional coordination mechanism to catalyse efforts of the partner states in eliminating FGM in one generation, the establishment of regional data bases on cross border FGM and strengthening of cross-border security.

4 Challenges to the implementation of the Prohibition of FGM Act

The law banning FGM and its accompanying regulations have been in place since 2010 and 2013 respectively, in addition to the constitutional judgment voiding the practice. However, implementation of the law remains a challenge for various reasons. While a number of convictions have been handed down to perpetrators of FGM, they in no way match the scale at which FGM continues to occur. In 2014, when five FGM-related convictions were made, it was branded 'rare'.[26] There is a need to some of the institutional, systemic and societal barriers that constrain the effective eradication of FGM.

4.1 Access to justice institutions for victims

Victims' accessing of justice institutions and mechanisms begins with knowledge of the applicable law, one's rights under the law and where to claim redress for breaches or violations. There are low levels of legal and rights awareness in general in Uganda[27] with regional and gender

26 'Uganda jails 5 over FGM' *The Guardian* 21 November 2014, https://www.theguardian.com/world/2014/nov/21/uganda-jails-five-female-genital-mutilation - :~:text=Five men and women in,to stamp out the practice (accessed 14 April 2022).

27 Justice, Law and Order Sector 'Fourth strategic development Plan (2017-2020) Justice, Law and Order Sector 24.

discrepancies, and women tend to be disproportionately represented in this regard. This is especially so in Karamoja which is one of the least developed regions in Uganda due to a prolonged history of insecurity and cattle rustling predating colonialism. According to the UDHS 2016, Karamoja had the lowest average number of years of education among women at 0.0 in Uganda.

FGM mostly affects the less advantaged, lower-educated and poorer women in rural areas.[28] Victims of FGM more often than not hail from poverty and high illiteracy regions and families.[29] A 2013/14 government assessment on gender and equity in the justice sector revealed that language barriers, age and gender-related hindrances obstruct remedy-seeking behaviour among the populace.[30] In and of itself, low literacy serves as a barrier to accessing justice as victims are less likely to know how to claim their rights, seek prosecution or protection orders or witness protection. This is aggravated by intersectional vulnerabilities women in situations of FGM risks face and bears weighty implications for their capacity to seek justice measures and mechanisms. In the event where a victim is an underage girl or stay-at-home mother in the rural areas, they are less likely to want to seek legal redress when they are up against an entire clan or family. Fewer women and rural residents (49 per cent and 51 per cent respectively) are aware of where to seek legal relief. This could explain why in some instances FGM victims at risk flee to Kenya instead of seeking legal recourse in Uganda.

According to the Uganda National Governance Baseline Survey 2014, only 9 per cent of Ugandans were aware of free legal aid services provided in their sub-counties, and only 18 per cent of Ugandans were receiving legal aid services annually by 2015.[31] A number of legal aid service providers, including the Uganda Association of Women Lawyers (FIDA Uganda) and the state funded legal aid scheme, Justice Centres Uganda,

28 UNICEF (n 7).

29 UBOS 'National governance, peace and security survey report 2017' Uganda Bureau of Statistics.

30 Justice, Law and Order 'Sector Strategic Investment Plan III Midterm Evaluation Final Report' October 2016, Justice, Law and Order Sector.

31 Justice, Law and Order Sector 'Judiciary urges government to facilitate legal aid policy and law', https://www.jlos.go.ug/index.php/com-rsform-manage-directory-submissions/services-and-information/press-and-media/latest-news/item/604-judiciary-urges-government-to-facilitate-legal-aid-policy-and-law (accessed 10 June 2022).

are found in the Karamoja and Sabiny regions. However, these entities are thin on the ground, with low resources and capacity to provide legal education, awareness and representation. Legal aid service providers in Uganda have for long lobbied unsuccessfully for government to pass the Legal Aid Bill 2011 and adopt the Legal Aid Policy in order to establish a far-reaching national legal aid scheme with better human and financial resources.

4.2 Limitations in justice institutional responses

Courts and police physical infrastructure and services in Uganda tend to be geographically unevenly distributed, not adequately resourced or near to the citizenry. Courts and police stations tend to concentrate in mostly in urban centres,[32] yet it is estimated that in 2020 about 75 per cent Ugandans lived in the rural areas.[33] This carries transactional burdens for users in terms of transport costs, distance and time taken to seek justice mechanism.

Apart from the limited physical presence of law enforcement institutions, the staffing of courts and police entities reveal human and financial resources capacities. The police coverage in 2011 was one police officer per 709 residents,[34] and in 2016 and 2017, one police officer per 754 people. These deficiencies stretch the preventative and responsive capacity of the police, especially in rural, hilly and porous border areas in Karamoja and Sabiny regions. Widely considered a hardship area, the police personnel in Karamoja stay for a maximum of five to seven years, which is plagued by persistent insecurity.[35]

Health workers such as nurses and doctors are required to examine victims to establish that an act of FGM occurred, as per the FGM Regulations. These reports are relied on by the police and courts during investigation and adjudication phases. However, the law does not explain who meets the costs of the medical examinations. Going by the history of medical examinations of victims of sexual and gender-based violence

32 As above.
33 World Bank Rural Population 'Uganda', https://data.worldbank.org/indicator/SP.RUR.TOTL.ZS?locations=UG (accessed 11 June 2022).
34 Justice, Law and Order Sector (n 32).
35 Justice, Law and Order 'Annual performance report 2020/2021' Justice, Law and Order Sector.

by health workers, this modality has tended to present problems for poor and vulnerable women and girls. Traditionally, victims who have sought these medical examinations which, as a precursor to proving the occurrence of the crime have been asked to pay a sum of money, which most poor and vulnerable women are unable to pay. Despite the Ministry of Health issuing guidance to public health workers to refrain from asking monies from victims, this practice has persisted, to the frustration of victims and their relations seeking these services.

4.3 Victim and perpetrator? Double jeopardy for women and girls

One of the conundrums arising out of criminalising FGM is that while self-mutilation or third-party mutilation is forbidden, these circumstances could occur under coercive circumstances yet *prima facie* appear as choice. A girl or woman undergoing FGM may opt for it due to societal, peer and family pressure, and the mother and other female relations in turn may aid the action due to similar influences. In 2015, for example, four women from Kapchorwa pleaded guilty to FGM but explained that their husbands threatened to divorce them if they refused to be mutilated.[36] As such, female perpetrators may double as victims. While the PFGM law recognises the coercive element, it does not address what happens to victims in circumstances of coercion and yet consent to FGM by a victim is not a defence under the Act. Presumably the rebuttal of consent as a defence under the PFGMA was directed at third party perpetrators but yet the provision technically criminalises a girl who consents to FGM for fear or rejection by family and society or other harsh reprisals.

Undeniably, there are victims who are complicit in undertaking FGM and will not cooperate in providing evidence.[37] One woman who broadcast her FGM ceremony, including sending it to the police, stated that her defiance was aimed at the government's failure to implement

36 'Female circumcision: Uganda still has a long way to zero tolerance' *The Monitor* 5 February 2015 – updated on 5 January 2021, https://www.monitor.co.ug/uganda/lifestyle/reviews-profiles/female-circumcision-uganda-still-has-a-long-way-to-zero-tolerance-1599444 (accessed 16 June 2022).

37 J Jacobson 'Forced genital mutilation of 120 women and girls in Uganda sparks public debate' 2010, https://rewirenewsgroup.com/article/2010/12/06/forced-gential-mutilation-girls-uganda-sparks-public-debate/ (accessed 12 April 2022).

its promises for education, better services and infrastructure.[38] However, as the saying by Benjamin Franklin goes, 'it is better 100 guilty persons should escape than that one innocent person should suffer', and it is important for the nuances of each case of FGM to be closely examined to avoid casting with a very wide net to catch even the innocent victims.

4.4 Criminalisation and the unintended consequence of suppressing female genital mutilation detection

Criminalising FGM for the most part has resulted in FGM public ceremonies and celebrations being re-assigned to undercover, clandestine FGM rituals operations. This makes detection and prevention harder and could conversely increase the communities' propensity to undertake FGM. The Sebei region is hilly and FGM is conducted furtively and at night, making detection near impossible, while the rocky, hilly and grasslands terrain of some areas in Karamoja makes access difficult. Prolonged insecurity and violence in the regions plagued by FGM in Karamoja has made law surveillance and enforcement more difficult.[39] This situation is aggravated by low enforcement because of lack of vehicles for police to patrol these vast and hilly areas.[40]Additionally, these are the same regions that share porous borders with Kenya, making cross overs for FGM purposes easy and police surveillance and tracking harder. During COVID lockdown restrictions, even the NGOs and police tracking FGM were curtailed in their activities.

Crossing borders to undergo FGM by women and girls occurs to evade detection and arrest in Uganda,[41] meaning that the threat of the law is felt. Uganda evidenced a 56 per cent rise in FGM during the COVID-19 pandemic when schools were closed.[42] Cross-border

38 C Byaruhanga 'Uganda FGM ban: "Why I broke the law to be circumcised aged 26"' *BBC Africa* 6 February 2019, https://www.bbc.com/news/world-africa-47133941 (accessed 16 May 2022).

39 N Bhalla 'UN investigating "surge" in female genital mutilation in Uganda' *Reuters* 26 January 2019, https://www.reuters.com/article/us-uganda-women-fgm/u-n-investigating-surge-in-female-genital-mutilation-in-uganda-idUSKCN1PJ0X9 (accessed 7 May 2022).

40 Jacobson (n 37).

41 T Abet 'Ugandans cross to Kenya for female genital mutilation' *The Monitor* 25 November 2021, https://www.monitor.co.ug/uganda/news/national/ugandans-cross-to-kenya-for-female-genital-mutilation-3631428 (accessed 7 May 2022).

42 As above.

movement for purposes of FGM is notable between Uganda and Kenya, particularly where similar ethnic groups on the other side of the border practise FGM.[43] Not only do FGM candidates cross the border into Kenya, but girls at risk too. In 2021 at least 70 girls from Karamoja fled to Kenya to avoid forcefully being subjected to FGM by parents and traditional leaders during the COVID-19 pandemic. This further raises questions about the efficacy of law enforcement in Uganda.[44] There is evidence to show that Uganda-Kenya cross-border partnerships have in some instances resulted in girls at risk being rescued from FGM events even during COVID-19.[45]

4.5 Active resistance to female genital mutilation-related law enforcement

Despite the hard work of anti-FGM campaigners in the practising communities, support for FGM remains significant in some pockets and the number of arrests is low. Government reports that FGM-related arrests and prosecutions have increased. Since 2013 there have been at least 62 arrests and 33 convictions across the six districts where FGM is mostly practised. This figure is low compared to the prevalence of FGM and number of girls cut, even though there is paucity of data on the convictions.

FGM is carried out by close relations and witnessed by community members, many of the latter who bear solidarity with the family actors. Information gathering for prosecution in such circumstances is a challenge because of the chilling effect of criminalisation. Communities are more likely to close ranks when legal sanctions are imposed, due to the fact that husbands, fathers and female relatives are involved in aiding and abetting the mutilation of their daughters, sisters and cousins. Effective

43 United Nations Population Fund *Beyond the crossing: Female genital mutilation across borders, Ethiopia, Kenya, Somalia, Tanzania and Uganda* (2019).

44 J Kato '70 girls flee to Kenya over FGM' Uganda *Radio One Network* 2 August 2021, https://ugandaradionetwork.net/story/70-girls-flee-to-kenya-over-fgm- (accessed 27 April 2022).

45 D Jjuuko & P Mbonye 'Uganda-Kenya cross-border partnership rescues girls from female genital mutilation during COVID' 24 September 2020, UNICEF https://www.unicef.org/uganda/stories/uganda-kenya-cross-border-partnership-rescues-girls-female-genital-mutilation-during-covid (accessed 27 May 2022).

criminal investigations and prosecutions require data collection, witness bearing and reporters of crime.

Here the community bands together against law enforcement agents, this makes prosecutions based on legal standards of beyond reasonable doubt much more difficult. Law enforcers report that Victims do not implicate relatives.[46] In one or two outstanding cases, girls who were caught in the FGM process claimed to have self-mutilated. This could possibly arise from the desire not to implicate family and friends and risk their arrest and conviction, even where the victims were coerced.

There have been public displays of defiance in some of the FGM-practising communities. While FGM abandonment has been voluntarily occurring in communities, forceful FGM is on the rise. In the wake of the PFGMA passing, it was reported that 120 women and girls were forcefully mutilated in 2010.[47] At the time, critiques decried the failure by government to raise awareness on the new law, but more recent incidents reflect a resurgence of rebellion against the ban. For example, there were 226 cases of FGM reported between December 2018 and January 2019 in the Sebei region. In this time, FGM was conducted openly in Kween district, with victims and those participating protected by machete-wielding youth, observed by the community and even the police.[48] Furthermore, these armed groups were accused of forcefully mutilating girls. Arrests of 16 men and three women involved in the saga followed reports of more than 400 girls and women being subjected to FGM by gangs of about 100 people, led by elderly women, those who prepare the girls and sing alongside the celebrations and the youth enforcing the FGM.[49] Unfortunately, some of the cut girls were also arrested, a turn of events that raises disquiet considering the collective rebellious context in which mutilation was performed.

Law enforcement officers also carry out their work at personal risk when dealing with outraged families and communities. In 2012 it

46 Jacobson (n 37).
47 As above.
48 D Cole 'The 2019 report card for the fight to end female genital mutilation' 6 February 2019, https://www.npr.org/sections/goatsandsoda/2019/02/06/691950128/the-2019-report-card-for-the-fight-to end-female-genital-mutilation (accessed 12 May 2022).
49 D Selby '19 people arrested in Uganda after reports of women forced to undergo FGM by gangs' *Global Citizen* (2019), https://www.globalcitizen.org/en/content/uganda-fgm-arrests-gang/ (accessed 7 April 2022).

was reported that residents of a rural community apprehended police who had come to arrest FGM suspects, on another occasion attacking the police who had returned with machetes, leading to a third, violent skirmish between the two entities.[50] In 2015 in Kapchorwa, when six people were convicted of FGM offences, their communities became furious with what they deemed arbitrary arrests. Accusing the police of 'working to destroy their culture', community members severely beat the suspected police informant and threatened to 'cut' the leader of a key anti-FGM campaigner if she set foot in the region.[51] Thereafter, the elders of that area lodged a petition with the Uganda Human Rights Commission over those arrests, protesting the conviction of their Sabiny community members.

There are allegations of local police officers hailing from the FGM-practising regions tipping off those in the community who may face imminent arrest.[52] It could be the case that such police pay more allegiances to their community cultural practices or that they collaborate with them in order for them and their families to live securely in their homes.

4.6 Nexus between marriage and female genital mutilation

The strategic importance of FGM features heavily around women's social and reproductive roles, especially marriage and motherhood. A recent study conducted by the United Nations Children's Fund (UNICEF) in December 2021 in Uganda found correlations between child marriage and FGM and that these two practices are mutually reinforcing, since girls who have undergone FGM fetch a higher dowry.[53] During the parliamentary debate around the passing of the PFGM Bill, a member of parliament from Kapchorwa made this similar link, saying:

> The marriage institution is blamed for sustaining the practice of female genital mutilation among these communities. Uncircumcised women face considerable pressure from relatives and in-laws to undergo the ritual. Those who reject it are isolated and considered outcasts, ridiculed and barred from carrying out domestic chores such as milking cows and collecting food from granaries, and they are

50 Berer (n 9) 145.
51 'Female circumcision: Uganda still has a long way to zero tolerance' *The Monitor* 5 February 2015.
52 As above.
53 UNICEF (n 9).

> also barred from taking part in the festivities of circumcising their sons. Their husbands have to 'borrow' wives to perform their mothers' roles. The father of the boy also misses out on gifts from his peers.

Furthermore, women who underwent FGM are more supportive of only mutilated girls for their sons, in itself a strong source of pressure.[54]

The high premium on bride price adds another layer of pressure to marry off girls, and girls in the rural areas are more challenged in the socio-economic arena especially due to lower education rates and lower opportunities for employment in the formal sector. The Ugandan government has failed to enact the Marriage Bill of 2017 that would set the constitutional minimum age of marriage at 18 years for all types of marriage under culture, religion and civil ceremonies. This creates loopholes in law enforcement whereby underage girls can get married and, as a precursor to marriage, undergo FGM.

4.7 Gaps in victim and witness protection

In 2016 data showed that the judiciary faced low levels of confidence among users, at 37.3 per cent, and the police at 49.3 per cent.[55] The reasons for this include high corruption levels and complexity of procedures for the public. In order for crime to be prevented through advance information gathering or reporting on planned crime, it is important to establish protection mechanisms in instances where such reporting may carry risks of reprisal. This certainly is relevant in cases of FGM reported by community members. Successful penetration of community practices such as FGM by law enforcers requires reliable insider information on planned FGM activities to be expeditiously shared by well-placed informers to the police. Reportedly, one solution by government to infiltrate the community has been to deploy a network of informers throughout the district's communities to strengthen surveillance on FGM.[56]

Informants could be community-based actors who have been trained, or even girls at risk of FGM themselves. However, these informants work

54 As above.
55 Uganda Justice, Law and Order Sector (n 32).
56 US Department of State *2021 Country Reports on Human Rights Practices: Uganda,* https://www.state.gov/reports/2021-country-reports-on-human-rights-practices/uganda/ (accessed 27 May 2022).

or live in risky situations that require more secure protection by law enforcement agencies. While the Regulations bestow on informants who blow the whistle on FGM activities in communities the same protection as a witness who testifies in a court, Uganda does not have a witness protection programme nor law. The passing of the Witness Protection Bill 2015 has been delayed due to the resource implications of the law. The Witness Protection Guidelines were launched in the absence of an implementing law, limiting protections for victims and witnesses, a situation the Director of Public Prosecutions described as 'awkward'.[57]

The Prohibition of FGM Regulations state that a probation and social welfare officer may issue an interim protection order in a safe place in which the girl or woman will take refuge for 14 days, pending proceedings for issuance of the court order by the family and children court. However, there is only one probation and social welfare officer per district, which stretches the capacity of the social services to protect girls and women at risk.

4.8 Failure to harmonise positions on laws with a significant bearing on female genital mutilation

Law enforcement suffers when justice is seen to be applied in a haphazard manner and should be avoided at all costs. Reportedly, in a case where the Kapchorwa chief magistrate's court convicted five people, in 2014 the convicts were pardoned by the President. In 2014 President Museveni pardoned seven people, including FGM traditional surgeons, victims and their parents under the prerogative of mercy,[58] but in so doing he vowed to continue with arrests and prosecutions against FGM.[59] It is critical for the judiciary, legislative and executive arms of government to have common positions and approaches towards preventing a climate of impunity for FGM.

57 Justice, Law and Order Sector 'DPP launches victims, witness protection guidelines', https://www.jlos.go.ug/index.php/com-rsform-manage-directory-submissions/services-and-information/press-and-media/latest-news/item/692-dpp-launches-victims-witness-protection-guidelines (accessed 4 May 2022).

58 'Museveni pardons FGM convicts' *Daily Monitor* 30 December 2014.

59 S Hayden 'Why are victims of FGM ending up in prison?' 12 March 2018, https://www.elle.com/uk/life-and-culture/culture/longform/a42138/uganda-victims-female-genital-mutilation-prison/ (accessed 25 May 2022).

The government has been slow to expeditiously enact a number of related laws in order to bolster the enforcement of PFGMA. Setting a minimum marriage age, accompanied by sanctions for non-adherence would add another layer of disincentives for parents to prop up underage girls for eligibility for marriage through the FGM rituals. Additionally, enacting a witness protection Bill is necessary to motivate victims and witnesses to report in a secure and protected manner. However, it is not a given that enacting more laws that touch on the personal status of women yet set up a clash of cultural codes between the individual and the collective will be successful, if the reluctance of communities to abandon FGM as a cultural practice is anything to go by.

5 Conclusions

The fight against FGM in Uganda illustrates the normative value of enabling legal and human rights frameworks and gender response laws and policies that can provide a platform for important strategies, including strategic litigation. Much of the success factors of the case links to the consequential processes that came into play. Following the important judicial pronouncement of the Constitutional Court, the executive and legislature executed their mandates and results were evidenced in the passage of the anti-FGM law.

In certain contexts, strategic litigation may not solely be an effective tool for social change, requiring further action. This is especially so where the principle of checks and balances requires that only Parliament can make laws, even though the Constitutional Court has the power to nullify a law or practice. LAWU observed the gaps in compelling action after court rulings on strategic litigation cases in a timely manner[60] and acted to prevent such a gap. The Private Members Bill on the prohibition of FGM that was introduced in Parliament in 2009 was drafted by LAWU[61] even as LAWU awaited the Court's judgment. Clearly, LAWU sought to close the strategic litigation loop with concrete legislative protections to protect women against FGM.

60 UN 'Expert Group Meeting on good practices in legislation to address harmful practices against women' 11 May 2009, Addis Ababa, Ethiopia EGM/GPLHP/2009/EP.10.

61 As above.

Using strategic litigation to promote women's rights can be effective when linked to other sustained activities for legal mobilisation, including public awareness.[62] Dr Baryomunsi himself made the point that[63]

> having a law will not necessarily end the practice of female genital mutilation ... we would want to urge government to allocate resources to support communities where female genital mutilation is practised so that advocacy and community mobilisation interventions can go on alongside the enforcement of the law.

There is a need for activists to continue to use the results of strategic litigation to further clarify and raise awareness around the appropriate human rights standards and codes against FGM. At an international conference held in Kenya in 2004 and in the wake of the adoption of the Maputo Protocol, anti-FGM campaigners and activists recognised that 'the use of law should be one component of a multi-disciplinary approach to stopping the practice of FGM'.[64] In the Third Girls Summit of the African Union (AU), one of the key recommendations of the Niamey Call to Action and Commitment on Eliminating Harmful Practice emphasised eliminating FGM through dialogues and social, behavioural change interventions.[65]

Engaging communities to continually examine the practice of FGM from a gender and human rights perspective remains key to promoting FGM abandonment. LAWU continued to work with the Reproductive, Education and Community Health (REACH) programme to sensitise the community on FGM. Recognising the need to transcend a legal sanction approach, government has promoted FGM abandonment campaigns and educational programmes, FGM prevention dialogue at the grassroots and conceptualisation of alternative rites of passage that do not involve FGM, working with traditional leaders and non-state actors to attain this. Intensifying legal education and awareness among

62 G Fuch 'Using strategic litigation for women's rights: Political restrictions in Poland and achievements of the women's movement' (2013) 20 *European Journal of Women's Studies* 21.

63 Parliament of Uganda (n 22).

64 No Peace Without Justice 'International Conference on Female Genital Mutilation Developing a political, legal and social environment to implement the Maputo Protocol', http://www.npwj.org/FGM/INTERNATIONAL-CONFERENCE-FEMALE-GENITAL-MUTILATION-Developing-a-political-legal-and-social-envi-0 Overview report - Nairobi, 16-18 September 2004.

65 African Union 'The 3rd girls' summit', https://au.int/en/newsevents/20211116/3rd-african-girls-summit (accessed 25 May 2022).

FGM practitioners is key in adopting cultures of legal compliance progressively.

During the parliamentary reading of the PFGM Bill, one legislator opined on the handling of FGM-practising communities that 'I think there should be very punitive measures; we should not just come like we are persuading them.' These statements can only raise fears in the FGM-practising communities that the majority with coercive power can trample over their culture. Leadership for the drive against FGM and legal compliance should be seen to strongly come from opinion leaders in the practising communities, despite the risks of backlash. The support by Sabiny elders of the Prohibition of FGM Bill[66] and their continuing work to persuade communities to abandon FGM can effectively signal the end of a harmful era for women and girls in a community that adheres blindly to a harmful, outdated culture.

LAWU's pursuit of the regionalisation of the prohibition of FGM at the East Africa legislative level was a bold and arguably logical progression of ending FGM not only in Uganda but in neighbouring countries through common legal standards. The Prohibition of FGM Bill in the East African Community draws from sustained advocacy at the national level by anti-FGM lobbyists. The timely adoption, domestication and implementation of this law can give further impetus to the drive to end FGM for national level actors. A comprehensive regional anti-FGM law could provide a reference framework for strategic litigation for those seeking to eliminate gaps in national laws in protecting women and girls from FGM. Undoubtedly, the LAWU case demonstrates the added value of strategic litigation in casting a broad, strong and remedial light on women's rights violations occasioned by FGM.

66 Parliament of Uganda, 10 December 2009, https://www.parliament.go.ug (accessed 17 July 2022).

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13

FEMALE GENITAL MUTILATION/ CUTTING AND THE POLITICS OF CULTURAL RELATIVISM

*Farnoosh Milde**

Abstract

In the context of global human rights debates, female genital cutting – the act of physically removing (intact) female genitals – has been subject to intense controversies. As this practice is regionally and culturally confined to certain parts of the world, in particular Eastern Africa, cultural relativism has for a long time been one of the most widely used ethical principles. It has indeed become a major controversial issue in global human rights debates. In the context of these discussions, the concept has been criticised for its failure to help prevent traditional practices from becoming harmful to communities, especially women. This chapter examines the complex relationship between cultural relativism, which can be evaluated based on its universal application as a means to secure the autonomy of non-Western societies, and female genital cutting, which is regarded as a challenge to cultural relativism. By highlighting these complexities, the chapter aims to provide clarity on how these debates shape and are shaped by broader social, cultural, and ethical considerations.

1 Introduction

Social science scholars reach a certain point at which they become 'trapped' within a space that is bounded, on the one hand, by the seemingly unquestioned authority of science and, on the other, by personal feelings and opinions, which are shaped by one's background

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and patterns of behaviour. As social scientists argue, a researcher's emotional inclinations are unavoidable and indisputably evident in their research. In terms of intellectual as well as emotional 'chaos', cultural relativism is known to trigger such reactions. As a meaning or method of interpreting and explaining other cultures, cultural relativism is based on the belief that each culture has its values and practices that should be respected and valued within the framework set forth by that culture, that is customs and traditions should be viewed in the light of a society's response to problems and opportunities.[1]

A theoretical and methodological premise of anthropology has been cultural relativism as a means for developing knowledge and understanding of foreign cultures. Rather than relying on a value-oriented conception of culture, anthropologists use a phenomenological notion of culture to gain a deeper insight into foreign cultures. As contrasted with the descriptive concept, which refers to culture as a way of life and a system of meaning, the value-based concept of culture assumes a value standpoint. Both the descriptive culture concept and the value-oriented culture concept are associated with two different approaches to foreign culture, namely, the cultural-relative and the ethnocentric approach.

Consider female circumcision and female genital cutting (FGC). Both these traditional concepts are associated with two different roles: the role of the researcher and the role of the missionary. Traditionally, it has been believed that anthropologists put aside their own ideological biases and approach foreign cultures with the greatest degree of unbiased and unprejudiced approach. This is to gain new insights and knowledge. They must provide information on all relevant aspects of the subject, including those that are unpleasant and those that challenge their perceptions. A cultural relativist approach aims to develop understanding, rather than legitimise all religious practices, traditions, and rituals regardless of whether they are in sync with individual beliefs. In social science research, cultural relativism has become a critical instrument and guiding principle. In addition to guarding the scientist against accusations of ethnocentrism or any other form of imperialism, it is also of paramount importance to the object of study. This is because it acknowledges and preserves its autonomy. The concept was

1 R Scupin *Cultural anthropology: A global perspective* (2012) 48.

developed by German-American anthropologist Franz Boas and became wildly popular during this decade. It did not take long, however, for human rights activists to criticise the concept. In an era of irresistible globalisation, some question whether the concept covers violations of human rights. This led to a change in views about the concept.

The story, however, does not end here. Instead, with an amendment of policy and an alteration of the method, it is transformed into a completely different story and offered to the audience from an entirely distinct perspective. In contrast, the idea was developed as a relief for liberal-minded scholars who were not in agreement with the racist and barbaric treatment of indigenous people during the period of its constitution.

The issue of FGC has become increasingly prominent in discussions concerning human rights and cultural relativism. FGC is the practice of removing (intact) female genitalia for cultural or medical reasons. The primary motive behind this practice, and motivation shared by most communities pursuing FGC, is the belief that 'it has always been done this way'. In the context of this subject, it is difficult to establish a discussion respectful of all disciplines and approaches since it is such an emotionally charged issue.

According to Macklin, feminist anthropologists must confront the dilemma of FGC. In the first instance, anthropologists must maintain a value-free position when describing and writing about different cultures. They must be committed to maintaining 'respect for the traditions' of the people they study by the professional ethics of their field. Alternatively, as feminists, they believe there is something wrong with a practice that not only deprives millions of women of sexual pleasure but induces well-documented physical harms, some of which are lifelong, in a substantial portion of those women.[2]

While this chapter is devoted to the examination of the problematic relationship between cultural relativism and FGC, its focus is not limited to this issue. The interdisciplinarity of this chapter, in contrast to many research studies conducted from an anthropological or medical perspective, has the advantage of providing a range of perspectives. This facilitates a broader framework and, therefore, enriches the discussion

2 R Macklin *Against relativism: Cultural diversity and the search for ethical universals in medicine* (1999) 68.

by incorporating various disciplinary perspectives that may assist in identifying new potential questions. Because of this, the chapter paper will also touch on some key theoretical and ethical issues modern anthropologists must confront. These include the role of the researcher and the interaction of professional and personal ethics.

1.1 Relativism emerges

In 1888 German-American anthropologist Franz Boas (1858-1942) founded the first anthropological school in the United States at Clark University, which laid the groundwork for a rethinking of modern anthropolgy in the United States.[3] It was neither claimed nor coined by Boas that he was a proponent of 'cultural relativism'. A rather simple course of action of his was to introduce more innovative ways of studying anthropological subjects. These ways were later synthesised into the term 'cultural relativity' coined in 1924 by the philosopher and social theorist Alain Locke. During the twentieth century, Boas developed the idea specifically to oppose ethnocentrism, which had dominated theories of anthropology throughout the previous century, while also offering an alternative to the so-called unilineal evolutionary theory, which he had harshly criticised for seeking to define universal phases of development through which all societies must pass. He also criticised the way in which the data was arranged to fit the theory as well as the methodology in which it was done. The theory according to Boas does not stand up to closer examination, as there is insufficient empirical evidence for it to be valid.[4] Among Boas's contributions to sociology and anthropology was the evolutionary theory known as historical particularism. This theory taught that every society is a product of its history and, therefore, must be understood as such in its own right. To combat the anthropologist's view of the Other as a primitive and early stage in the evolution of humanity, he formulated ideas and beliefs meant to change this perspective.

People were viewed as cultural objects at the 1904 St Louis World's Fair, similar to those found in museums, rather than merely as living beings. Boas' historical anthropology was rife with racist assumptions at

3 C Lindholm *Culture and identity. The history, theory, and practice of psychological anthropology* (2007) 95.
4 Scupin (n 1) 114.

the time. One of the most infamous examples of the fair was Ota Benga, one of the most notorious cannibals. Despite that, the organisers of the fair were not content with just indigenous participation. To portray everyday life in different cultures, performers and actors were required by the fair organisers. The pygmies, who originate from Central Africa, like Ota Benga, were given machetes to 'behead' one another in their regions with impunity.[5] As a result of the influx of immigrants to the United States, the racist ideologies of those days developed.

Boas's importance lies not just in the purpose of de-ideologising cultural anthropology, but also in his efforts to change a whole worldview at a time when anthropology as a discipline was just coming into existence. Outside of this racist climate that persisted in a period when anthropology only became a discipline, it is pertinent to acknowledge that Boas's importance extends beyond the quest to de-ideologise cultural anthropology. Essentially, his entire professional career emphasised sensitising the collective consciousness and establishing anthropology as a more scientific discipline by repudiating racist ideologies within the field.[6]

The term 'female genital cutting' is used to describe a variety of different surgical procedures that are designed to modify a woman's anatomy following cultural expectations. There is a challenge that comes with analysing FGC, both inside and outside of the academic world, involving philosophical and ethical questions.

It is widely acknowledged that female genital cutting has consistently challenged the anthropological ideal of cultural relativism over the last few decades.[7] A key issue has been distinguishing the concept of cultural relativism as a measurement and analytical method. There has been a distinction made between cultural relativism as a moral and political principle. To put it another way, if a practice is legally acceptable based on the legal basis for its legitimacy, what are the ethical ramifications of that practice? Due to the prevalence of cultural relativism, which is fundamental to anthropological research, the world views FGC as infringing upon human rights.

5 Scupin (n 1) 410.
6 P Fettner 'Rationality and the origins of cultural relativism' (2002) 15 *Knowledge, Technology and Policy* 198.
7 A Lewnes *Innocenti digest. Changing a harmful social convention: Female genital mutilation/cutting* (2008).

The issue of FGC in Europe began to gain traction around the year 2000. This was a result of an increase in immigrants from countries where female circumcision is a common practice. The German Federal Republic, along with many other nations within the European Union (EU) and elsewhere, has set the goal of outlawing this practice. Although legislation and procedures are in place to protect women and girls against women's genital cutting, the practice persists, and many women and girls are at risk of circumcision. Legislation alone would not be enough to put an end to the practice. Female genital cutting, in my opinion, is a socially-sensitive issue that requires an integrated approach that builds confidence, trust, and understanding between all stakeholders. At present, however, the existing approach is at odds with the need for greater understanding.

The World Health Organisation (WHO) describes female genital cutting FGC as a deeply ingrained historical, cultural and religious practice that has been the subject of much discussion. Recently, stories concerning FGC have been spreading around the world, and this topic has received considerable attention. This practice, which is traditionally included in predominantly African cultural ceremonies known as female circumcision, has been routinely portrayed as violence against girls and women by the WHO.

1.2 Human rights

There are many examples of destructive and maladaptive social behaviours, which frequently violate fundamental human rights, such as child marriage, female genital cutting, honour killing, and child labour. There are several women and girls involved in these behaviours and, therefore, one common solution is to enhance their access to education, health care, and employment.[8]

Because social scientific research is the foundation of social activity, anthropology cannot remain silent and abstain from any moral or ethical responsibilities. There is a responsibility inherent in the discipline of anthropology that, after articulating a concept such as cultural relativism, opens up a wide range of opportunities for discussion, but at the end of the discussion distances herself from the discussion by saying it is not

8 N Toubia & S Izett *Female genital mutilation: An overview* (1998).

up to her to pose such questions. In this way, Jean-Klein and Riles view anthropology and its knowledge as instruments for human rights practice and dissemination through discussions related to anthropological participation in human rights bureaucracies.[9] Moreover, they indicate:[10]

> As with our discipline, human rights organisations become active by showing an orientation toward humanitarian ethics and neoliberal ideology; by conducting research; collecting ethnographic data, or at the very least narratives and stories; and even by engaging in 'critical views' of themselves.

However, what is the situation concerning human rights? Can we address the issue of FGC in a way that is consistent with any position that all individuals have some fundamental rights? Generally, criticism directed toward the use of the supposed universality of human rights theory as a valid argument is based solely upon the assumption that there are vast differences among cultural and religious practices that cannot be adequately accounted for in the limited definition of Western human rights theory.

While James recognises three main international human rights protections that FGC may violate, namely, the right to health; the right to the child; and the right to ownership, integrity, and a sense of belonging,[11] Macklin criticises the general misuse of the term 'human rights', observing that its use is disconnected from its narrow, yet correct meaning which refers to international laws and instruments under the sponsorship of the United Nations (UN).[12] According to Macklin, the term 'human rights' refers principally to the rights outlined in documents, such as the Universal Declaration of Human Rights (1948) (Universal Declaration), the International Covenant on Civil and Political Rights (1966) (ICCPR), the International Covenant on Economic, Social and Cultural Rights (1966) (ICESCR), as well as the Convention on the Elimination of All Forms of Discrimination Against Women (1979) (CEDAW). In addition, Andrews pursues the idea that the mobilisation of anti-FGC arguments that took off in the 1990s backfired as critics of

9 J-K Iris & A Riles 'Introducing discipline: Anthropology and human rights administrations' (2005) 28 *Political and Legal Anthropology Review* 173.
10 Iris & Riles (n 9) 181.
11 S James 'Reconciling international human rights and cultural relativism: The case of female circumcision' (1994) 8 *Bioethics* 12.
12 Macklin (n 2) 193.

the practice were branded as paternalistic and neo-colonial.[13] According to Jean-Klein and Riles, many anthropologists note that it is impossible to discuss human rights without engaging with lawyers, legal scholars, and politicians – disciplines and actors anthropologists regard as powerful, thus contributing to the discussion of human rights.[14]

To emulate the procedural practices of human rights organisations, bureaucracies, and administrations and temper his or her militancy in favour of a more objective, bureaucratic tone. In this way, anthropologists perform what they so often describe: an age of decentralised politics where anyone including the anthropologist can adopt the logic of protest and participate.

Shah warns about two possible challenges when it comes to the universality of human rights in her work on international human rights law and the Koran. According to her, two of the key categories that challenge the presumed universality of human rights are feminism and cultural relativism. In addition, the anthropologist must examine both feminist and relativist arguments against the universality of human rights, although this chapter will only briefly highlight the basic gender problem with human rights as it is more interested in cultural relativism than universality. This perspective opens up new discussions that cannot be adequately addressed in a confined space such as this. The fundamental feminist argument against the human rights system is based on the premise that its universality is unfounded because it ignores issues relevant exclusively to women. Further, the human rights system is restricted to the public sphere, which is dominated by men and oriented toward them. Last but not least, feminists believe that the priority given to civil and political rights at the expense of economic and social rights is misplaced.[15]

In the context of cultural relativism, what conclusions can be drawn from different perspectives and approaches to human rights? According to Shah, there are very few options available. Alternatively, one could reject human rights completely as incompatible with the rest of the

13 ZT Androus 'Critiquing circumcision: In search of a new paradigm for conceptualising genital modification' (2013) 3 *Global Discourse* 38.

14 I Jean-Klein & A Riles 'Introducing discipline: Anthropology and human rights administrations' (2005) 28 *PoLAR: Political and Legal Anthropology Review* 180.

15 NA Shah *Women, the Koran and international human rights law: The experience of Pakistan* (2006) 199.

world, which is not Western or does not follow the Western philosophy of human rights, or one could reject certain rights or views of human rights.[16] Both these viewpoints, however, seem to be extreme positions that make it difficult to conclude regarding cultural relativism and human rights issues. Bringing together the universal and the particular would be an ideal solution.[17] In closing, Shah mentions An-Na'im:[18]

> All nations representing various cultures should be taken on board and everyone must have an equal footing in reaching a consensus on standards acceptable to all. The relativists must be careful to differentiate Western concepts such as an overemphasis on work at the expense of family from universal ones such as human dignity, in their process of finding common ground and standards acceptable to all.

2 Different disciplines regarding female genital cutting

To effectively develop an argument that does not leave any dangerous gaps unclosed, it is imperative to select the appropriate standpoint from which to approach this emotionally charged topic. As it is a matter of culture, body, health, perception, economics, and human rights (not just women's or children's), the term 'disciplining' does not indicate finding the most suitable discipline from which to approach the subject, but rather a general outlook that will form the framework, noting that FGC is a matter of culture, body, health, perception, economics, and human rights (particularly the rights of women and children).

As this chapter will demonstrate, before we delve deeper into the realms of relativism, and focus more on the complexities of genital cutting, we need to take a step back to demystify all of the possible viewpoints so that we can locate the appropriate arguments. Macklin concludes:[19]

> If female genital mutilation is not only physically harmful but also a violation of a fundamental human right, then it cannot be defended as a traditional ritual immune to criticism by outsiders of the cultures where it is practiced. If, on the other hand, as defenders argue, female genital mutilation is accepted and sought by women themselves in the cultures where it is prominent, then it is arguably not so different from American women choosing to have breast implants and other forms of cosmetic surgery to appear more feminine.

16 Shah (n 15) 207.
17 Shah (n 15) 210.
18 As above.
19 Macklin (n 2) 68.

Academics in the social sciences are prone to feeling trapped at times, especially when they are studying a particular area. In this area, there is no room for doubt, since the unequivocal authority of science is on the one hand, and the personal feeling and opinion that is conditioned by a person's cultural background and behavioural patterns is on the other hand. Research is profoundly influenced by personal opinions and viewpoints, and these influences can be felt throughout the research process. It has been well known that cultural relativism has a provoking effect on both the emotions involved as well as the intellect.

The concept of cultural relativism is a way to define and interpret other people's cultures. It maintains the position that each culture has its unique values and practices that should be respected and valued within the boundaries of the culture in question. Cultural relativism is one of the major perspectives of the contemporary world that recognises ethnic traditions as reflecting a society's response to problems and opportunities.[20] Thus, it legitimises the presence and validity of all different aspects of any religious practice, traditions, or rituals. This is regardless of whether or not they correspond to the beliefs of an individual. In any social scientific investigation, cultural relativism has become an essential instrument and guide.

By preventing the scientist to be accused of cultural or any other form of imperialism or bias, this compromise not only shields the scientist from these accusations but is also of significant importance for the object of interest, since it acknowledges its autonomy and helps preserve it.

After its conception by German-American anthropologist Franz Boas at the beginning of the twentieth century, the concept met with much positive feedback and became popular, but it did not take long to provoke displeasure among human rights activists. In truth, though ironic, the proposal came up as a relief for liberal-minded scholars who preferred not to be associated with what was perceived as racist and barbaric treatment of indigenous people at the time of the constitution. It is indeed true that at the core of the idea lies a completely neutral idea intended to facilitate understanding of a culture on its terms.[21]

20 Scupin (n 1) 48.

21 R CassmanR 'Fighting to make the cut: Female genital cutting studied within the context of cultural relativism' (2008) 6 *Northwestern Journal of International Human Rights* 8.

With heightened attention being focused on human rights following World War II, cultural relativism became a double-edged sword due to its increased importance. Although this argument was understood, it did not preclude the concept of cultural relativism from becoming the crucial framework for anthropological examination through history. This framework mentions any aspect of human rights and even attempts to establish a position concerning the complex interactions between anthropology and human rights. Even though anthropology is a humanistic science, it could have played a key role in the derivation of the Universal Declaration, as one of the leading humanistic sciences. *American anthropology*, the main journal of anthropology, published a statement on human rights in 1947 in contrast to these assumptions. Anthropologists' views regarding universals and particular societies conflicted with the view of an autonomous human being that claimed certain rights, as outlined in the Universal Declaration. By promoting the idea that man must live according to the definitions of freedom that his society has given him,[22] this statement denied the value and credibility of a statement that prevails in a world where free speech has been denied to many and is fundamentally unsustainable.[23]

In the main, people are willing to live and let live, exhibiting tolerance for the behaviour of another group different from their own. In the subsistence field, especially where there is no conflict, there was a point of view whose consequences have been catastrophic for mankind. That point of view emerged from the history of Western Europe and America. In these two places, economic expansion, control of armaments, and an evangelical religious tradition have translated the recognition of cultural differences into a summons to action. This summons to action has been emphasised by philosophical systems that have stressed absolutes in the realm of values and ends. Definitions of freedom, concepts of the nature of human rights, and the like, have thus been narrowly drawn. The history of the expansion of the Western world has been marked by the demoralisation of human personality and the disintegration of human rights among the peoples over whom hegemony has been established (statement on human rights as quoted in Washburn).

22 Herskovits in WE Washburn 'Cultural relativism, human rights, and the AAA' (1987) 89 *American Anthropologist* 940.

23 Washburn (n 22) 939.

This statement has led to the reintroduction of anthropology as the field of study for determining the most appropriate approach to studying humanity, a fight that up to this point has been led by anthropologists versus non-anthropologists. The main difference between these two opposing views is that they divide their participants into two groups: the anti-relativists and the relativists. As with any form of relativism, a cultural relativism assessment is often followed (and, sometimes, triggered, but not always implied) by inquiries about another form of relativist thought that is founded on the same principles. According to this form of relativism, referred to as ethical relativism, we cannot impose the moral principles or ideals of one community upon another.[24]

A belief in ethical relativism legitimises the morally dubious character of traditional practices, rituals, and religious practices simply because anthropologists have failed to unravel universal values and norms. Therefore, one should respect and admire the values, systems, and conditions of other societies. The discussion of ethical relativism has also been noted by many scholars, including anthropologists and philosophers, who note that it is quite contradictory in its premise, which assumes a particular moral position or moral theory that encourages people to be tolerant of all cultural values, norms, and practices.[25]

The fact that context is the primary instrument for shaping a belief does not imply that there is no other foundation. Furthermore, it is significant to note that many moral principles transcend the cultures in which they originate.[26] Therefore, advocating tolerance as a universal value has the status of a *de facto* global principle.[27]

The concept of ethical relativism, in contrast to cultural relativism, was abandoned by most scholars after the events of World War II. Essentially, the reason for this revulsion is the previously cited argument that the Nazi regime's morality in Germany during World War II cannot be condemned because, according to the theory of ethical relativity, it should be treated as any other civilisation.[28] Although the concept of

24 Scupin (n 1) 410.
25 EM Zechenter 'In the name of culture: Cultural relativism and the abuse of the individual' (1997) 53 *Journal of Anthropological Research* 319.
26 MH Salmon 'Ethical considerations in anthropology and archaeology, or relativism and justice for all' (1997) 53 *Journal of Anthropological Research* 48.
27 Zechenter (n 25) 332.
28 Scupin (n 1) 410.

'cultural relativism' is frequently portrayed in a rather black-and-white fashion, with relativism often seen as a notion that opposes universalism, there are three subtleties embedded within the notion. Among the different kinds of relativism on this scale, descriptive relativism (also referred to as weak relativism) is the lowest intensity one, followed by normative relativism (or strong relativism), and finally epistemic relativism.

Despite the rejection of the notion of ethical relativism, it must be acknowledged that it involves significant concerns. To understand moral relativism, it is necessary to recognise how moral opinions vary from country to country and how society heavily influences our beliefs. In addition, it encourages us to explore the reasons for alternative opinions, while forcing us to examine the reasons for our own beliefs and values.

The concept of descriptive relativism lies at the heart of the idea. This is based on a common sense observation of cultural diversity. However, normative relativism takes a step further and rejects the possibility of transcultural standards since all standards are products of a certain culture. Described relativism refers to the early stages of relativism, by way of Boas's struggle against ethnocentrism as well as the false sense of progress and growth that we discussed earlier.[29] Although twentieth century anthropologists (Boas, Mead, Benedict) comprehended the general pattern of socio-economic changes (which were gradual) they did not hesitate to impose value judgments on them to deconstruct the popular notion about the superiority of Western civilisation.[30] This led to the development of normative relativists who maintain that individuals in a community are incorporated into moral and cultural conventions (often unknowingly) through involuntary socialisation and enculturation, which leads to the conclusion that transcultural standards are not possible.[31] The most extreme form of relativism rejects any universal validity or objective truth, asserting that human behaviour is shaped by society alone.

It may not seem that strange to draw parallels between scientific proof and witchcraft. This is especially since the ongoing battle between religion and profane culture is one of the most pressing concerns of our

29 Zechenter (n 25) 323.
30 Zechenter (n 25) 324.
31 Zechenter (n 25) 325.

present existence. It must be noted, however, that applying this concept to a practice such as FGC is a far-reaching idea. Science has provided a sufficient degree of evidence that refutes any medical rationale for the practice. Moreover, Salmon asserts that correcting inaccurate facts does not necessarily invalidate the principles that underpin them.[32]

As well, it appears that cultural relativists have further reinforced the justifications for FGC, who firmly believe that culture is static, as opposed to the common belief that culture is rather the opposite, a dynamic organism characterised by internalisation of change, as Nussbaum notes, emphasising the constant contrast between Western and non-Western societies, depicting Western cultures as modern and changing, while non-Western cultures are regarded as static.[33] In addition, cultural relativists fail to recognise that there is evidence that many negative practices have been eliminated in many regions of the world due to natural changes. Zechenter observes that this static view of culture has ramifications that extend beyond the idea of moral relativism. Despite the significance (and presence) of social change, the article fails to acknowledge culture as a historical and institutional phenomenon. In addition, this perspective does not account for the complexity of established traditions and norms, since it assumes absolute adaptability, based on the assumption that culture is not flexible or dependent on specific factors:

In a changing environment, cultural practices routinely outlive their usefulness, and cultural values change either through internal dialogue within the cultural group or through cross-cultural influences. Any contact between cultures is likely to cause at least some modification in the customs of the contacting cultures or at least to induce a reinterpretation of these customs. It is this constant reinterpretation, reinvention, and modification of customs that allow cultures to survive and be viable over time.[34]

Vincent pointed out in his work on human rights and international relations that the concept of cultural relativism implies three factors. First, moral principles differ from place to place. Next, to appreciate its diversity, it must be placed in a cultural context. Third, moral assertions

32 Salmon (n 26) 57.
33 M Nussbaum *Women and human development: The capabilities approach* (2000) 48.
34 Zechenter (n 25) 333.

arise from and are bound up in a cultural context, which constitutes their identity.[35] The point he was trying to make was that there exist many civilisations in the world and that each civilisation has its own set of values. The universal value cannot be defined in such a simple way. Seeing things from this perspective is not subject to debate by cultural relativists. This is a feasible solution to the problem.[36]

In Vincent's simplified doctrine, the source of the problem with cultural relativism is not contained.[37] Especially in today's globalised world, cultural relativism seems relevant and intriguing.[38] However, the problem is in the boundaries set by this concept that presupposes a relativism of all values, social and otherwise.[39] The question is, where exactly do these tolerance limitations exist and, more importantly, do they exist for specific normative systems? In a pre-globalised society, Vincent's answer may have been valid and relevant.[40] However, today's interconnected world presents a more complex battlefield, where culture and economy are competing for all of the earth's resources.

Further, is relativism's adamant rejection of universal values a true statement? Do they believe that there are no universal values? In doing so, questions such as these push the boundaries of anthropology as well as human thought. They are in search of an ontological and philosophical dialogue that cultural relativists frequently dismiss, yet which continues to form the foundation of the notion of universalism.

Universalism is a philosophy that asserts that every person inherently is one with the universe, regardless of socio-cultural background, and should all possess the same fundamental human rights.[41] Zechenter describes a brief history of universalism in which he claims that the concept is rooted in natural law views based on the assumption that all persons possess intrinsic rights conferred by a higher authority (God or Providence) on them. The Enlightenment brought into focus what is known as reason and the nature of the mind. This paved the way for a widespread belief in the human capacity to reason and think rationally.

35 As above.
36 RJ Vincent *Human rights and international relations* (1986) 38.
37 As above.
38 As above.
39 As above.
40 As above.
41 Zechenter (n 25) 320.

This belief was followed by a positive outlook on people's reasoning and thinking abilities. The positivist perspective postulates that universal standards of human rights have been created by international treaties and customary international law, and are embodied therein.[42]

Nussbaum examines feminist political philosophy when studying women's positions and global development. It focuses primarily on issues that mainly affect women in Western countries, such as workplace discrimination, sexual harassment, and domestic abuse.[43] In addition, she calls for the establishment of a shift in focus in favour of focusing on the urgent needs and interests of women in the developing world. These needs and interests must be examined in more detail, in dialogue with the women themselves. This is before adequate recommendations can be made since feminist philosophy needs to add new topics to its agenda to serve the developing world effectively.

It is peculiar to this situation since we are going to ask ourselves, 'How do we know whose body this is?' The topic of FGC became widely discussed during the era of human rights activism in the 1990s, but many have argued that it is not just a matter of body integrity; it is a minor part of a much larger battle. Is circumcision against human rights? Is maintaining genital integrity the more significant principle? The discussion of female circumcision cutting can, therefore, be considered a one-dimensional topic from a legal perspective, or should it take into consideration the opinions and positions of women who undergo the procedure? The first step on our path to achieving gender equality is to identify the two concepts that make up the basis for the core framework, namely, bodily (or sexual) integrity and equality between men and women. A fight for gender equality is about fighting for a world where discrimination against women no longer is permitted in any way, whereas a fight for genital integrity aims to protect both men and women from having parts of their bodies amputated without their informed consent and can be viewed as a smaller subset of the larger fight for bodily integrity.[44]

42 Zechenter (n 25) 321.
43 Nussbaum (n 33) 7.
44 JS Svoboda 'Genital integrity and gender equity' in GC Denniston and others *Bodily integrity and the politics of circumcision – Culture, controversy, and change* (2006) 151.

Human capabilities can be described in terms of the following human characteristics in a universal sense, and include the following characteristics: life, health, self-esteem, senses, imagination, thought, emotions and practical reason, affiliates, other species, play, and control over the environment.[45] This idea has been proposed by Nussbaum as a way of overcoming some of the objections that have been raised in discussions on cross-cultural universals, since it produces a kind of universalism that is sensitive to the complexities of pluralism concerning varying cultures.[46] Nussbaum's impetus lies in the idea that a subject can be conceived as being autonomous, as a bearer of their rights.

I believe that to achieve physical integrity and gender equality at the same time, we must recognise that these goals are not mutually exclusive. Particularly in the case of FGC, we can see how complex and entangled this link is. Despite this, it appears that the need to identify distinct genital integrity is relatively recent. Although campaigns for gender equality have been ongoing for more than a century, the official war for genital integrity began on 3 March 1989. This was when the First International Symposium on Circumcision approved a Declaration of Genital Integrity. The right of every human being to maintain an intact body is an inherent right for all of us. In this regard, we affirm this fundamental human right without regard to any kind of religious or racial prejudice. In this regard, we affirm this fundamental human right without regard to any kind of religious or racial prejudice.[47]

Indeed, if there is one thing that all civilisations share, it is their attitude toward corporeality as a human feature. According to Dekkers and Others, every culture has a unique attitude toward the human body that is increasingly being guided by moral terminologies such as holiness, dignity, and physical integrity. In this respect, it is also unacceptable not to provide a cultural context to conversations about FGC. The consideration of physical integrity with male and female circumcision by Dekkers and others in this manner yields a particularly insightful finding. Their initial consideration shows how inadequate the idea underlying the phrase 'body integrity'. As they point out, the use of the term conveys a

45 Nussbaum (n 33) 78.
46 Nussbaum (n 33) 8.
47 W Dekkers and others 'Bodily integrity and male and female circumcision' (2005) 8 *Medicine, Health Care, and Philosophy* 179.

certain point of view: It is only within the context of a particular moral narrative that one can determine whether specific uses of the body are to be praised, condemned, or regarded as morally neutral.[48] Because of this sacredness of the body, the belief that circumcision must only be performed if it promotes a person's health contributes to one of the main reasons that some cultures, such as the Jews, do not consider male circumcision to be a violation of bodily integrity.[49] There is no human reasoning or inquiry allowed into the divine law since it is a law dictated by God and not created by man. It is relevant to consider that among Jewish and Islamic examinees as well, female circumcision is regarded as a violation of bodily integrity. This is because it is a ritual that promotes a sense of communal cohesion. It is without a doubt that such a procedure does not conform to any transcendental law to which it should adhere and that it does not promote physical health as some people believe.[50]

In the case of female genital modification, as I mentioned previously, the term 'bodily integrity' refers to both the individual and the community as a whole. In my view, the community is like the body. The body must be whole for the wholeness of the community, which ironically can only happen by changing the inherent imperfections of the body. According to Dekkers and others, who address a certain paradox on this matter, all opponents of circumcision, regardless of what form it takes, assert that body integrity and related concepts such as wholeness cannot be reconciled with circumcision.[51] A clear distinction is drawn between the importance of the body as an influential determinant of social identification and recognition of one's identity and the arguments against FGC. These arguments claim that bodily integrity is a fundamental human right. There are two approaches to examining bodily integrity, namely, the self-focused approach to understanding bodily integrity, as well as the body-focused approach. It has become common practice in the realm of modern medical ethics and law to apply a self-focused approach, which is based on the idea that a person has a right over their own body. According to this view, the right to protect oneself from humiliation is defined by the right to be protected against

48 As above.
49 As above.
50 Dekkers and others (n 47) 187.
51 As above.

violations by others as well as the right to have a sense of self-control over the body, which is the principal frame of discussion in Western anti-FGC discussions.[52]

The notion of a community that is founded on collective integrity is not compatible with a mindset that emphasises the individuality of the individual. There is also a similar issue with Nussbaum's idea of human capabilities. It seems that in the human capacity perspective, societal institutions are left out, despite their underlying role in invoking FGC. Instead, the focus is placed on individualism that's excessive and absent of social norms. Although exploring the concepts of health and wellness from the body-focused perspective is more appealing to the needs of cultural communities since the body's value is an integral part of those communities' identities, it may not pertain to the values of individual communities. According to Dekkers and others, the body-oriented approach seems to contradict the idea of personal autonomy over the body. This may be because the approach to the body itself carries a moral value of its own:[53]

> Even if people are considered to be owners of their bodies, they may not be able to do everything with their bodies that they might want to. From this perspective, the duty to maintain bodily integrity conflicts with the view that the body is the property of the person. The doctrine of bodily integrity thus contradicts the personal ownership or property paradigm.

A primary dispute area associated with the self-focused approach is regarding the right to sexual freedom and, more importantly, the right to sexual health, which should be an expectation of every individual. Across the pond, Boyle explains that although in the United States it is common for couples to seek treatment for such purposes as, for example, boosting women's sexual desire, in other parts of the world procedures are performed that are intended to decrease women's sexual desire. The desire for sex that a woman has may not be remedied in both scenarios, so it is also something that needs to be corrected in one of them. Regardless of circumstances, males are assumed to benefit from the intervention in both situations. In both situations, women feel embarrassed and uncomfortable expressing their sexuality.[54]

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52 Dekkers and others (n 47) 183.

53 As above.

54 EH Boyle and others 'International discourse and local politics: Anti-female-genital-cutting laws in Egypt, Tanzania, and the United States' (2001) 48 *Social*

According to the WHO, 'sexual health is the integration of the mental, physical, emotional, and social elements of a sexual being', while the World Association of Sexual Health, the Declaration of Sexual Rights has been adopted which states:[55]

> To assure that human beings and societies develop healthy sexuality the following sexual rights must be recognised, promoted, respected, and defended: the right to sexual freedom, excluding all forms of sexual coercion, exploitation, and abuse; the right to sexual autonomy and safety of the sexual body; the right to sexual pleasure, which is a source of physical, psychologic, intellectual and spiritual well-being; the right to sexual information ... generated through unencumbered yet scientifically ethical inquiry; the right to comprehensive sexuality education; the right to sexual health care, which should be available for prevention and treatment of all sexual concerns, problems, and disorders.

Further, Fourcroy asserts that physical health includes more than the absence of disease, dysfunction, or disabilities.[56] Due to the predominant use of sex as a means of reproduction and the importance of the kin overshadowing the importance of the individual in African societies, FGC is most common in these communities, where the removal of the organs responsible for sensual stimulation is required to fix certain social values and to accept rigid standards of conduct.[57] This constitutes a deliberate restriction of sexual freedom, the sense of bodily integrity, and the pleasure of intimate interaction. It emphasises once again both the cultural relevance of FGC as well as the gendered premise of the procedure. As mentioned above, one of the main goals of FGC is to reduce a woman's libido and prevent her from partaking in any pleasure. Therefore, the argument of sexual freedom (as with the universality of human rights) is not a productive one against FGC, especially when one considers the fact that recent research shows that the reduction of sexual feelings is not inevitable following FGC, as the results of the research made by the Women's Health and Action Research Centre in Nigeria demonstrate.

As Shell-Duncan argues, focusing only on the effects of FGC on the sexual aspects of violence against women weakens a comprehensive

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Problems 524.

55 JL Fourcroy 'Customs, culture, and tradition – What role do they play in a woman's sexuality?' (2006) 3 *Journal of Sexual Medicine* 955.

56 Fourcroy (n 55) 954.

57 KO Bankole 'Clitorectomy' in MK Asante & A Mazama (eds) *Encyclopedia of African religion* (2009) 172.

understanding of the more complex socio-economic contexts of broader abuses of women.[58] As a consequence, the Western understanding of the body as having a certain state of autonomy that presupposes the autonomy of the individual is not consistent with the majority of African societies and, therefore, is judged to be ethnocentric and reductionist.[59]

In the context of FGC-practising communities, it should be assumed that women are not considered independent entities, thus highlighting the role that women play in these societies. While it indeed is an accepted fact that FGC is conducted for the benefit of the man, it is rather interesting to note that practically every aspect of the procedure is planned and implemented by women: Even the question of whether a bride's suitability is acceptable is generally left to women as arranged marriage is the norm, with the groom's mother having the most prominent voice.[60] The fact that women control the procedure signifies that the patriarchal system of gender segregation remains deeply rooted. The fact that this practice is not restricted to men is of importance to relativist anthropologists. This is because they can argue the opposite, namely, that women are willing to do so and not just for their benefit. Although marriage plays a vital role in the lives of these women, it leads one to question whether or not they truly are willing to undergo genital modification.

A study conducted by Van der Kwaak argues that, in eradication programmes, the issue of female circumcision should not be seen solely in terms of its medical or clinical relevance.[61] It should become a central part of the complex discussion on how to create development policies that can reach women. This discussion should include how to reduce inequalities in access to services, land, and employment, and how to give them a major say in development interventions. For us to be able to uncouple gender identity and circumcision, we will need to accomplish the following. The viewpoint of Van der Kwaak is very similar to that of

58 B Shell-Duncan & Y Hernlund 'Female genital cutting: Social and cultural dimensions of the practice and the debates' in CR Ember & M Ember (eds) *Encyclopedia of medical anthropology. Health and illness in the world's cultures* (2004).

59 RM Abusharaf *Transforming displaced women in Sudan: Politics and the body in a squatter settlement* (2009) 160.

60 Salmon (n 26) 56.

61 A van der Kwaak 'Female circumcision and gender identity: A questionable alliance?' (1992) 35 *Social Science and Medicine* 777.

Nussbaum, who argues that women should be put above diversity as the level of desire for diversity must always come before (precede) claims of multiculturalism (of multicultural sensitivity and cultural integrity).

3 Articulating the self in the face of pain

To examine FGC during the early stages of academic research meant to condemn it without consideration of the cultural context. Radical feminist ideology dominates the public discourse. It is due to Fran Hosken's predecessor's portrayal of female circumcision that popular opinions about female circumcision have had a significant influence on the way people view the practice: 'FGCs are preparations for male aggression and are used to establish male dominance over women, not only in Somalia but also in other parts of Africa.'[62] In addition to Hosken, several radical feminists have drawn attention to the role of patriarchy in defining the motivation for external female genital intervention, as well as the need to regulate women's sexuality.[63] Historically, self-articulation narratives have been largely ignored in the feminist discourse within Western societies, which led to the creation of the so-called 'Third World Woman', which is presented as a monolithic, empowered subject[64] who represents African women as helpless with their lives gutted by a brutal patriarchal system.[65]

Apart from providing an academic perspective on 'Third World' problems, there is another reason or focus that will enable us to centre our attention on the autobiographical writings of women who were impacted by this experience. Additionally, the entire FGC sphere is dominated by men although the circumciser most often is a woman. Moreover, in cultures that practise FGC, speaking about the procedure is also considered taboo within their families. In these situations, how will women cope with the pain of such traumatic experiences? What kind of processing does she do with it or does it remain a silent part of the process of her life?

62 FP Hosken *The Hosken report: Genital and sexual mutilation of females* (1994).
63 AH Asaah & T Levin *Empathy and rage: Female genital mutilation in African literature* (2009).
64 CT Mohanty "Under Western eyes' revisited: Feminist solidarity through anticapitalist struggles' (2003) 28 *Signs* 333-334.
65 EK Silverman 'Anthropology and circumcision' (2004) 33 *Annual Review of Anthropology* 431.

Moreover, what are the effects of the notion that they have lost a crucial part of themselves in their lives and their sense of self? To answer these questions properly, it would be worthwhile to first clarify what context is implied by the word 'pain'. Nevertheless, according to the International Association for the Study of Pain, pain is 'an unpleasant and emotional experience caused by actual or potential tissue damage, or described as such damage'.[66] However, for me, the pain has a social and psychological dimension beyond its physiological manifestation. Utilising a variety of pain-research studies conducted by the eminent pain researcher, Merskey, who concluded that pain is a unique experience, which, at least, as a rule, cannot be broken down into organic and psychological components.[67] Jackson suggests that the pain experience is always both 'mind' and 'body', mental and physical since the pain experience is always embodied. Based on Jackson's interpretation of pain, physical and emotional pain are both synchronised.[68]

A powerful capacity of writing is the ability to hear the voices of those who have been suppressed. A suffering body does not have a voice, but when it finds a voice, it begins to share its story with the world. There is something that people cannot take from them, unlike parts of their bodies, and that is their soul. This is a topic that clearly illustrates the absurdity of the situation. The writer's word is such that in addition to expressing and regulating subjectivity, it might also be a means of translating it into values and principles by which all people can live their lives.[69]

There has been a recent increase in the number of female writers in Africa who are daring to address controversial issues associated with a woman's femaleness and her bodily appearance.[70] Even within the discourse of FGC in the West, the voices of women who were subjected to FGC were often overlooked.[71] The book *Possessing the secret of joy* (1992)

66 JE Jackson 'Pain and Bodies' in FE Mascia-Lees (ed) *A companion to the anthropology of the body and embodiment* (2011) 373.
67 Merskey as cited in Jackson (n 66).
68 Jackson (n 66).
69 J Harris *Signifying pain. Constructing and healing the self through writing* (2003).
70 D Naguschewski & F Veit-Wild *Preface* in D Naguschewski & F Veit-Wild *Body, sexuality, and gender – Versions and subversions in African literatures* (2005) xiii.
71 E Bekers 'Painful entanglements. The international debate on female genital excision in African and African-American literature' in I Hoving and others (eds) *Africa and its significant others. Forty years of intercultural entanglement* (2003) 45.

by Alice Walker raised public awareness that led to the production of Desert Flower (2009) by Waris Dirie and Infidel (2009) by Ayaan Hirsi Ali. It is worth mentioning that in African literature the female body appears as a 'body' on multiple levels. By articulating itself about the body of the Other – that is to say, postcolonial – through the 'writing back' movement, it attempts to move out of the gray zone of hybridity. Regardless of how central this theoretical body may be, it appears that Nuttall's consideration of the 'bodily' element of the body – as a body comprised of sensory organs – has been largely ignored in postcolonial discourse.[72]

In addition to acting as a way to retrieve and process a lost self, autobiographical writing also influences the individual's life.

4 Conclusion

As a topic that has gained increased attention over the past few years, particularly in the field of human rights, female genital alteration is gaining increasing popularity. Female genital cutting, by definition, deconstructs and reduces the female genital system to its most generalised state, which is necessary for women to be healthy: A woman without modified genitals is considered an odd woman. There were few critical discussions of FGC within the anthropology field during the 1980s. In recent years, these perspectives have been reshaped rapidly with scholars introducing FGC to the non-academic public through books such as *Desert flower* by Waris Dirie, or *Infidel* by Ayaan Hirsi Ali, weakening the influence of cultural relativists. Recently, circumcision has occupied quite a large part of the public sphere, in general. Only a short while ago, debates about male circumcision were reintroduced into the German public environment. Such shifts are the most obvious indicator that there have been some profound changes in that discipline, although there still are academic debates over anthropologists or feminists who begin to criticise Western civilisations as they become entangled in the history of colonialism and become puppets of the Western elite.[73] In Nussbaum's

72 S Nuttall 'Dark anatomies in Arthur Nortje's poetry' in Naguschewski & Veit-Wild (n 70) 188.
73 Nussbaum (n 33).

view, it does not matter whether the description is that of one who is a determined critic of colonialism or not: [74]

> Any attempt by international feminists today to use a universal language of justice, human rights, or human functioning to assess lives like those of Vasanti and Jayamma is bound to encounter charges of Westernising and colonising – even when the universal categories are introduced by feminists who live and work within the nation in question. For, it is commonly said, such women are alienated from their culture, and are faddishly aping a Western political agenda.

Although the urging problem of FGC is among the most urgent problems facing society today, it still carries a strong post-colonial anxiety that is becoming toxic to an academic discussion that tries to present an objective view. As an example, it is noteworthy to mention that Somalia is a country that is still struggling with this problem. A strong argument cannot be used to rationally defend the cultural significance and benefits of FGC, as no evidence can be presented to defend them. As a countermeasure, we need to prevent the practice from spreading among those people who come from a society where FGC is regarded as the most natural and widespread.

A successful way to confront this problem is by preventing the practice among people who come from societies where FGC is well-established and common. Every day, we witness an increase in violence against women and incidences of FGC. Therefore, in my own opinion, FGC is more than an issue of individual liberties or physical integrity, but rather is an issue beyond those simple concerns. In part, this is due to the powerful patriarchal structure dictating the operation's necessity, thereby rendering women dependent on this treatment. This issue is much more thorough in its exploration of women's rights and development policy in general. It focuses on how to eliminate disparities in health care, land, and employment for women, as well as how to integrate their voices into development initiatives. When this first step is accomplished, we will be able to separate gender identity from circumcision.[75]

The argument that FGC is a disgraceful and prohibited practice may not be following allowing women to undergo such cosmetic surgery at the same time. In my opinion, the primary challenge resides within the disagreement between academics and those who are working in

74 Nussbaum (n 33) 36.
75 Van der Kwaak (n 61) 778.

non-governmental organisations (NGOs) that are actively engaged in combating FGC. The importance of emphasising colonial history cannot be understated. This is because it gives us a better understanding of what it is like for those who hail from communities where this practice is the norm.

As a result, the conflict between scholars and radicals who advocate the rights of women, combined with our inability to unite to fulfil our goal, has distracted us from the truth that millions of underage girls are subjected to this practice annually. Moreover, no community of meaning is sufficiently significant to justify interference with the right of female children to be free from genital cutting.

From the preceding paragraph, it is not just academic researchers who are politicised. Instead, they are those who are actively seeking to prevent the practice of FGC without having sufficient knowledge of the culture of the local communities. This situation can be attributed to the lack of knowledge and understanding among activists and radical activists, and the moral values they adhere to for their activism. I am not seeking to argue that cultural relativism should be prohibited from academic discussions. Instead, I would argue that Western anthropologists, radical feminists, as well as African organisations advocating FGC are two extremes that have attempted to erode cultural relativism.

No doubt exploring the potential such a comparison can provide between conventional and non-Western methods of body modification carries with it some element of curiosity. Due to the similarity between Western body modifications such as genital cosmetic surgery and female genital cutting, I believe that the practice of female genital cutting will not be tolerated if the practice of genital cosmetic surgery is outlawed in industrialised nations. This chapter examines, despite the apparent absence of gray areas, some of the shades of the gray present in cultural relativism as well as in human rights advocates, more specifically, radical feminists.

The work of Franz Boas undoubtedly was influential on modern attitudes towards non-Western cultures and the need for a humane diversity of cultures. The fact that he influenced today's approach to non-Western cultures cannot be denied. As much as Boas introduced a form of cultural relativism to combat supremacy, contemporary relativists are no less superior in their invocation of universal tolerance. This is quite a paradox in itself. However, it is quite discouraging that the context of

cultural relativity is consistently ignored. The neglect of Western radical feminism as well as failing to challenge existing policies derived from radical feminism also is a serious problem.

Often, it appears that cultural relativism has become an alibi in modern relativistic discussions. Despite the deep roots of human kind's colonial history, it remains an ongoing argument. This has led to the creation of a mechanism of which the sole purpose is to shield Western scholars from accusations of neo-colonialism, as well as to preserve their integrity as academics. Academic integrity is pivotal when it comes to discussions about FGC. Participants seem to be in a state of uncertainty as there appears to be a lack of integrity on all sides. Anthropologists who are committed to strong relativism can lose their moral integrity, whereas those who reject FGC are bound to give up their integrity as anthropologists. Furthermore, FGC implies that women who are subjected to it sacrifice their bodily integrity. In contrast, women who refuse to have their bodies mutilated risk losing their social status and identity. Whose integrity is to be sacrificed here? It is a question worth asking.

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