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Female genital mutilation/cutting in Africa: A complex legal and ethical landscape

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Synopsis: Female genital mutilation/cutting can be progressively deterred in African countries by legal and educational means where there is a will to apply them.

ABSTRACT

While international and regional human rights instruments have recognized female genital mutilation/cutting (FGM/C) as one of the most prevalent forms of violence against women and girls, in many African states FGM/C is a deeply entrenched cultural practice. There is a consensus against FGM, as evidenced by its criminalization in several African countries. The mere fact that the practice continues despite legislative measures to protect women and girls against FGM raises the question of whether change can be legislated. The present article summarizes the trends and effectiveness of FGM criminalization in Africa, including prohibition of medicalization of FGM. Against the backdrop of emerging debate on medicalization of FGM as a harm reduction strategy, we also examine its complex legal and ethical implications. The article argues that while criminalization may not be the best means of stopping FGM, it creates an enabling environment to facilitate the overall strategy of African governments in eradication of the practice.

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1 INTRODUCTION

Female genital mutilation/cutting (FGM/C) remains a pervasive harmful cultural and traditional practice. FGM/C refers to all procedures involving partial or total removal of the external female genitalia or other injury to the female organs for non-medical reasons [1]. WHO classifies FGM/C into four types—namely, clitoridectomy, excision, infibulation, and a general unclassified genital injuries category [1].

More than 200 million girls and women alive today have been cut throughout countries in Africa and the Middle East and Asia, where FGM/C is concentrated [2]. WHO estimates that 100–140 million girls and women worldwide are currently living with the consequences of FGM. The procedure is mostly carried out on young girls between infancy and the age of 15 years. In Africa, an estimated 92 million girls aged 10 years and older have undergone FGM/C [1].

The recognition of FGM/C as a gross violation of the human rights of girls and women is well established in numerous international legal instruments, and states have made concerted efforts to use legislation as a strategy to combat FGM/C. The 2018 World Bank's Compendium of International and National Legal Frameworks on FGM shows that about 60 countries have adopted laws that criminalize FGM/C, including 24 African countries [3].

Through analysis of data from the USAID Demographic and Health Surveys and UNICEF's Multiple Indicator Cluster Surveys, studies have shown that the prevalence of FGM/C is slowly declining in countries including Cote d'Ivoire, Nigeria, Ethiopia, and Kenya [4]. However, this decline is not uniform as there has been an increase in Chad and Sierra Leone, with stable high prevalence rates in Mali and The Gambia for the past 30 years [4].

2 INTERNATIONAL HUMAN RIGHTS LAW AND FGM/C

Numerous international conventions and declarations, including the Universal Declaration of Human Rights (UDHR); International Covenant on Civil and Political Rights (ICCPR); the International Covenant on Economic, Social and Cultural Rights (ICESCR); the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW); the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT); and the Convention on the Rights of the Child (CRC), contribute to the legal framework for the protection and promotion of women and girls' human rights, which are violated by the practice of FGM/C. These rights include the right to non-discrimination, to protection from physical and mental violence, and to the highest attainable standard of health and the right

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to life. The UN Human Rights Committee in General Comment No. 2 stated that FGM/C constitutes cruel, inhumane, or degrading treatment that violates the general prohibition against torture [5] (para. 18). While CEDAW makes no specific reference to FGM/C, its Committee on the Elimination of Discrimination against Women has interpreted the Convention to prohibit traditional practices that discriminate against women and harm children in several general recommendations, including its General Recommendation No. 14 on female circumcision, General Recommendations No. 19 and No. 35 on gender-based violence against women, and General Recommendation No. 24 on women's right to health [6–9].

Rights-based advocacy to abandon the practice of FGM/C, as well as to criminalize it, dates back to at least the 1995 UN Fourth World Conference on Women held in Beijing, where 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" [10] (para. 124(i)). The UN General Assembly (UNGA) adopted resolutions calling on the international community to eliminate FGM in 2013 and 2016 [11,12]. Goal 5 of the UN Sustainable Development Goals (SDGs) includes targets calling for the elimination of violence against women and all harmful practices, such as child, early, and forced marriage, and FGM/C by 2030 [13]. These commitments obligate states to work with diverse actors, including traditional and religious leaders, organizations, and healthcare providers, in ending the practice.

Specific legal obligations are placed on states to adopt effective and appropriate measures to abolish harmful traditional practices affecting the health of children, particularly girls, including early marriage and FGM, as well as preventing third parties, including medical providers, from coercing women to undergo traditional practices, such as FGM/C [14].

At the regional level, Article 18 of the African Charter on Human and Peoples' Rights (African Charter), Article 21 of the African Charter on the Rights and Welfare of the Child (African Children's Charter), and Article 5 of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol) note the right of women and girls not to be subjected to FGM/C. Agenda 2063 (Aspirations 3, 4, and 6) of the African Union also condemns all forms of violence and discrimination against women and girls, including FGM [15].

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2.1 FGM and the Maputo Protocol

The Maputo Protocol is the continent's foremost legal instrument on women's rights, adopted by the African Union on July 11, 2003, which came into force on November 23, 2005. The Protocol is lauded as being quite a comprehensive binding legal instrument on women's rights for its breadth of coverage and innovative provisions on FGM. Article 5 of the Protocol specifically obligates states to take all necessary measures to prohibit and condemn all forms of harmful practices that negatively affect the human rights of women and which are contrary to recognized international standards. It also urges states parties to take all necessary legislative and other measures to prohibit and eliminate such practices through public awareness, and legal sanctions against all forms of female genital mutilation, scarification, medicalization, and paramedicalization of FGM. The Protocol requires states to provide necessary support to victims of harmful practices through basic services such as health services, legal and judicial support, emotional and psychological counselling, and vocational training and protection of women at risk of being subjected to harmful practices or other forms of violence, abuse, and intolerance.

Article 3 of the Protocol on violence against women also enjoins African governments to ensure that victims of violence are rehabilitated. Thus, state obligations arising from a joint reading of Articles 3 and 5 of the Protocol is tethered on a three-prong approach—namely, legal prohibition, education and awareness campaigns, and rehabilitation of victims. This approach of the Protocol is not only pragmatic but also commendable.

From the foregoing, it is clear that FGM/C is recognized as a practice that violates a number of human rights laws. As a result, states that are a party to these international human rights instruments have a duty to fulfil, protect, and promote the fundamental rights of women and girls in their jurisdiction against the practice.

3 RECENT NATIONAL LEGAL TRENDS IN SUB-SAHARAN AFRICA

A key legal duty on states is to ensure the protection of women and girls from FGM/C by putting in place legislative measures to prohibit FGM. Efforts to eradicate FGM/C have gained impetus through the growing use of legal sanctions, which are by far the most common response adopted by African governments to address FGM/C. Criminalization often involves the imposition of jail sentences or fines. Countries such as Ghana (1994), Burkina Faso (1996), Ivory Coast (1998), Senegal (1999), Djibouti (1995), and Togo (1998) have maintained a ban on FGM/C in their countries [16].

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Over the past 10 years, the trend of criminalization is increasingly found in a variety of 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 have enacted laws that punish the practice of FGM/C, by either introducing new laws or amending existing ones. In Mauritania, the Children's Code of 2015 prohibits FGM/C. Guinea also adopted a similar provision in its Children's Code, 2008. The Gambia amended its 2005 Women's Act in 2015 to prohibit FGM/C. Guinea-Bissau is the only country that adopted a separate and specific FGM law, in 2011 [3].

In addition to criminalization, states are required to adopt other measures to ensure that the rights of women and girls are protected against FGM/C. Thus, African countries have adopted other positive measures—namely, the health and alternative rites of passage and empowerment approaches [17].

3.1 Health approach

The health approach is often based on scientific proof linking of FGM/C with excessive loss of blood or hemorrhage and predisposition of the victim to HIV infections [4]. This approach tends to inform the community and other stakeholders about the negative health consequences of FGM/C. It presents evidence-based facts or information corroborating the harmful effects of FGM/C on the girl child. The health approach aims to appeal to the moral conscience of the public and has won the support of traditional and religious leaders in some African countries. For instance, the approach has necessitated the issuance of Fatwas (authoritative legal opinions) by Islamic clerics against FGM/C in countries such as Egypt, Mauritania, and some West African countries where the practice is linked to Islam [18].

One of the challenges of this focus on the health risks of FGM/C is that it unintentionally leads to numerous parents and relatives seeking safer procedures, rather than abandoning the practice totally in countries such as Egypt, Kenya, Mali, Nigeria, and Sudan [19]. This has led to the increasing trend of medicalization of FGM/C: an attempt to minimize the health risks of the procedure by having it performed by a healthcare provider either within or outside a health facility. Additionally, reinfibulation following childbirth of previously mutilated or circumcised women is still performed in various countries around the world [20,21].

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While medicalization procedures can address short-term risks, such as infection and pain, they fail to eliminate the long-term risks, including emotional and sexual problems. Medicalization can also create the illusion of 'legitimacy' despite the adverse effects on women and girls [22]. As a result, states, international organizations, and non-governmental organizations have increased their calls for the prohibition of medicalization of FGM/C. Both the UN and WHO condemn the practice of FGM/C by medical professionals in any setting, including hospitals and other health establishments [23]. The International Federation of Gynecology and Obstetrics (FIGO) also condemned the practice, in view of the ethic to 'do no harm', which obligates obstetricians and gynecologists to oppose performing acts that are deemed to be contrary to medical principles [24]. A group of prominent medical bodies from five African nations has also issued similar public statements [25]. The duty to not conduct medicalized FGM/C incumbent on healthcare professionals is also premised on ethical issues surrounding patients' autonomy and consent, since FGM/C is often practiced at ages when girls are unable to give consent. When FGM/C is imposed by medical personnel, the practice reinforces social control of women's sexuality and violates their bodily integrity and dignity [26].

It has been argued that medicalized FGM/C should not be viewed as a harm reduction strategy, given the human rights implications and the likelihood that medicalization might further entrench the practice rather than end it [27]. For instance, the maximum penalty of life imprisonment will apply if a sexual mutilation is carried out or promoted by a person in the medical or paramedical field as provided in the Penal Codes of Senegal (art. 299bis), Burkina Faso (art. 381), and Guinea (art. 259) [3]. One of the key principles of WHO's Guidelines on Management of Health Complications from FGM notes that medicalization is never acceptable as it "violates medical ethics since (i) FGM is a harmful practice; (ii) medicalization perpetuates FGM; and (iii) the risks of the procedure outweigh any perceived benefit" [28] (p.16). Therefore, it is critical that material on FGM/C is integrated into medical school curricula to inform students about its short- and long-term complications, its illegality, and how to counsel parents against FGM/C [29].

3.2 Alternative rites of passage approach

In some African communities, FGM/C is performed as a rite ceremony to signify entry into puberty or maturity. Hence, a girl who does not undergo the ceremony is often viewed as an 'outcast,' 'unsuitable for marriage', or 'impure' [30]. The shame and stigma often associated with a girl who does not undergo the ceremony is usually unbearable and many parents understandably want to avoid this stigma for their children.

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Some organizations have made attempts to organize a mock ceremony that bears the semblance of the ritual without the actual cutting. It usually takes the form of a lavish ceremony to initiate girls into puberty, thereby preserving the positive sociocultural aspects of the ritual. This approach, which has been spearheaded by civil society groups in conjunction with other stakeholders, such as community members, families, political leaders, and ritual and religious leaders, is intended to show respect for the cultural practice of the people while also ensuring that girls involved in the mock ceremony are socially accepted within the communities where FGM/C is practiced. For instance, in Kenya, as in communities in The Gambia, Senegal, Uganda, and Tanzania, organizations in conjunction with other stakeholders, such as described above, are in the forefront of arranging for mock ceremonies to initiate girls into puberty or adulthood without actual 'cutting' of the clitoris [31].

3.3 Empowerment approach

The empowerment approach takes as a starting point the belief that empowered women and girls can claim their rights and end the practice of FGM/C in a generation. The UN General Assembly in its 2013 resolution on FGM/C required states to 'promote gender-sensitive' educational programs that will equip women with the necessary knowledge of the different policies and programs on gender-based violence and discrimination [8] (para 4). In its 2018 proposal for a new and comprehensive definition of sexual and reproductive health and rights, the Guttmacher–*Lancet* Commission emphasized that countering opposition to FGM/C based on long-standing customs and beliefs requires changes in social norms and structures that will enable women and girls to understand and realize their sexual and reproductive rights [32]. These include increasing the capacity of women and girls to make decisions about their bodies through education, combined with social and economic empowerment [33].

4 EFFICACY OF LAWS CRIMINALIZING FGM/C

Criminalization of FGM/C is intended to serve as a catalyst for social change and to foster an enabling environment for the abandonment of the practice. This is because, although use of criminal law has generally been accepted, it should be seen as only one of the interventions by governments to support social movements to end it. Studies have shown that in countries such as Senegal, legislation on FGM/C complements other reform strategies [34].

The number of prosecutions or arrests in cases involving FGM varies across countries, and overall has been very few. In Kenya, the special unit for investigating FGM/C cases that was opened in 2014 following the ban in 2011 prosecuted 76 cases in its first 2

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years. In The Gambia, for example, there have been two court cases relating to FGM/C since the law was adopted in late 2015. One of the cases involved a 5-month-old baby in Sankandi Village who died as a result of FGM. In 2016, the grandfather was accused on several counts of inciting and promoting female circumcision which led to the child's death [35]. The grandmother was also charged with having knowledge about the circumcision taking place but failing to inform authorities concerned. The case is still pending [35]. In 2016, the government of Burkina Faso reported to the CEDAW Committee that, in 2009, 241 persons were convicted for excision and complicity in excision contrary to the law prohibiting FGM [36]. Those prosecuted included traditional cutters and accomplices including parents and family members, and there was one reported case involving a midwife [36]. Burkina Faso is increasingly recognized as one of the few countries where FGM/C legislation is effectively and systematically enforced. This is due in part to strong political will, translation of the law in the local languages, and involvement of members of the community through the use of mobile community courts that combine sentencing with dialogue [37]. However, in many other African countries FGM/C is performed without legal consequences for offenders, despite laws prohibiting the practice. In most countries, there are no effective mechanisms in place to report, refer, and protect girls and women at risk of FGM/C, so the number of court cases is low or non-existent.

The continued practice of FGM/C, despite criminalization, can be attributed to a number of reasons. First, change is slow because FGM/C is a deeply rooted traditional practice and is entrenched in culture. Second, there is a general lack of acceptance of the laws that condemn the practice, largely because majorities of the affected communities are usually not involved in the law-making processes. This results in a perception of these laws as foreign and as a challenge to indigenous norms and culture. In a majority of places where FGM/C is practiced, traditional and religious leaders wield more power and influence than the government. Third, there is a lack of accountability procedures and of strong national law enforcement mechanisms due to ineffective governmental coordinating bodies, weak human rights institutions, and ineffective judiciaries. Generally, the human rights protection systems are weak, and do not have adequate financial, technical, and human resources to fulfil their mandates.

Criminalization of FGM/C can be effective if there is a full commitment and political will within the government. In addition to enacting laws, governments have to put programs, structures, and resources in place to intensify sensitization against the practice.

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5. Conclusion

Although the growing trend of FGM/C criminalization, including prohibition on medicalization, is timely, it is not necessarily a guarantee that girls and women will be protected. However, the trend is an important and necessary step in providing an enabling environment for change. Laws intended to prevent the practice of FGM/C require enforcement and implementation, including awareness raising, capacity building for law enforcement, and training for alternative livelihood skills for ex-circumcisers, along with empowering women and girls, coalition building with religious and traditional leaders, and engagement with men and boys in changing social norms that drive the practice of FGM/C. Additionally, as health service providers are uniquely positioned to exert influence, the care system also needs to be ready to undertake a holistic and multi-disciplinary approach to addressing the negative physical, mental, and social health consequences of FGM/C procedures.

AUTHOR CONTRIBUTIONS

SN conceived the article and wrote the first draft of the manuscript. ASM critically reviewed the draft. Both authors contributed to revisions.

CONFLICTS OF INTEREST

The authors have no conflicts of interest.

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