Africa Health Organisation
Plan Of Action on Female Genital Mutilation (FGM)

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Partners


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Table of Contents

Introduction

On 20 December 2012, the United Nations General Assembly adopted the resolution to ban female genital mutilation (FGM) worldwide, a practice that has affected around 200 million women thus far. This resolution was cosponsored by two thirds of the General Assembly, including the entire African Group. This action reflects not only the increasing trend towards greater understanding of Women's Rights but also the modern willingness of the African states to cooperate on a matter thus far considered "taboo". This in itself represents a great window of opportunity for Africa Health Organisation (AHO) to potentially exploit and create links of understanding with the member states most concerned by the issue.

Despite this apparent improvement however, the decision was only "cosponsored", and hence not biding of any legal action. This was reflected in the fact that amongst the members which agreed to the drafting of the resolution, some states such as Mali or Liberia have failed to enforce any law banning the custom, whereas in the countries where it was implemented (such as Eritrea), lack of knowledge concerning the law in place implies that residents carry on with the practice. Thus, the measures that followed were never truly serious enough to ensure any significant decrease of FGM. This crisis has highlighted the need for organisations such as AHO to offer its resources an expertise to governments who have thus far been limited in their influence.

Purpose of plan & mission of AHO

As an international health agency, AHO's goal is to prevent (or at the very least limit) female genital mutilation to the best of its ability within the next 10 years.
This is to be achieved through four main goals: raising awareness, fostering greater international cooperation, changing traditions and eradicating the sexist practices that lead to FGM in the first place.
This plan is to be carried through AHO's strict values of excellence, compassion, integrity, diversity and equality.

Background

What is FGM

In order to better delve into the topic of FGM that AHO plans to address, it is necessary to understand what exactly it consists of.
According to the United Nations, FGM comprises “all procedures that involve altering or injuring the female genitalia for non-medical reasons”.
It is a form of violence that stems from the cultural (and not religious) belief that a woman’s body and her sexuality belong to her family/husband. In some communities, it is considered a girl's initiation into womanhood and marriage. While in others, it is believed to ensure premarital virginity and marital fidelity.

There exists 3 main types of FGM:

TYPE 1: partial/total removal of the clitoris glans and the prepuce/clitoral hood	**TYPE 2: partial/total removal of the clitoris glans and labia minora with/ without removal of the labia majora**	**TYPE 3: Narrowing of the vaginal opening with the creation of a seal. The seal is formed by repositioning the labia minora/ labia majora**
1a: Removal of the prepuce/clitoral hood only	2a: Removal of labia minora only	3a: Removal and repositioning of the labia minora to create the seal
2a: Removal of clitoris glans with prepuce/clitoral hood	2b: Partial/total removal of clitoral glans and labia minora	3b: Removal and repositioning of the labia majora to create the seal
	2c: Partial/total removal of clitoris glans, labia minora and labia majora	

*TYPE 3: The covering of the vaginal opening is done with or without removal of the clitoral prepuce/clitoral hood and glans (Type I FGM).

A fourth and final type of FGM is considered to be all other harmful procedures to the female genitalia for non-medical purposes (including but not limited to: pricking, piercing, incising, scraping and cauterisation).

Current frameworks

There are programs already in place in Africa which just like AHO, aim to fight FGM. They are important to take into account because they represent potential partners for AHO. The most significant one is:

- “Ban FGM- campaign for UN resolution”: The specific aim of this campaign is for a UN resolution which required all states to adopt and implement legislation to ban female genital mutilation and to take all necessary legislative, political and operational measures aimed at ending the practice. Ban FGM is a coalition of partner organisations and NGOs worldwide including “No peace without women”, “The Na-

tional Union of Eritrean Women" and "Save the Somali Women and Girls". This is the most significant step for the worldwide movement to ban FGM.

Situational analysis

There is an array of factors that AHO must reflect upon before proceeding with any given strategy. Both opportunities and challenges reflect the current social climate in Africa and hence must be taken into account in order to draw realistic conclusions that will facilitate the implementation of the plan.

Potential opportunities

Amongst the potential existing opportunities, changes in social conditions seem to be an increasing trend in the region, which AHO could well exploit given its emphasis on the social determinants of health.

- The mentalities of some African countries are beginning to change, and their respective leaders are coming to the understanding that FGM is an issue that must be eradicated. Despite the fact that the practice has been slow to decrease in certain states, it is important to recognise that it has not increased substantially either. In fact, over the past 30 years there has been an overall 15% decline in FGM for girls aged between 15 and 19 years old (UNICEF global databases). This is a great opportunity for AHO to create links with countries who are more willing to accept help than they previously were.
- Due to the seriousness of the situations, a vast range of organisations already work on suppressing FGM. This is an opportunity for AHO to potentially unite forces with them to maximise the positive long-term impact they can have on the region.
- Set aside the governments, increasingly more women themselves believe that the practice should end, which should facilitate AHO's work as cooperation should be easier to acquire.

Potential challenges

- It is undeniable that FGM holds a big place in certain cultural practices, and traditions are never easy to change. More importantly, many are the women who believe that beyond culture, FGM is an important religious practice, making it even harder for external actors such as AHO to combat it.

Countries in which FGM is most prevalent:

Country	FGM prevalence in women aged 15-49	Law in place	Viability of the law
Benin	7,3%	Law no. 2003-03 of the Penal Code, March 2003	Lack of evidence that FGM cases are actually being prosecuted
Burkina Faso	75,8%	Article 380 of the Penal Code, 1996	Largely viable
Cameroon	1,4%	Section 277 of the Penal Code, July 2016	Lack of evidence that FGM cases are actually being prosecuted
Central African Republic	24,2%	Law No. 10.001 of the Penal Code, 6 January 2010	Lack of evidence that FGM cases are actually being prosecuted
Chad	38,4%	Law 006/PR/2002, The Reproductive Health Law, March 2002	Still awaiting signature from the President to be passed
Côte d'Ivoire	36,7%	Law no. 98-757, 23 December 1998	Evidence suggests that FGM cases brought under this law are very rare
Djibouti	93,1%	Article 333 of the Penal Code, 1995	Ineffective implementation of the law
Egypt	87,2%	Article 242-bis and Article 242-bis(A) of Law No. 58 of 1937 promulgating the Penal Code	The law is not comprehensive and there have been few prosecutions
Eritrea	82,2%	Proclamation No. 158/2007	It is not possible to obtain specific details on any prosecutions made in Eritrea to date.
Ethiopia	65,2%	Proclamation No. 414/2004, the Criminal Code 2004	Weak law enforcement with few cases reaching court
Ghana	3,8%	Article 69A of the Criminal and Other Offences Act 1960, further amended in 2007	There is limited information on prosecutions to date

Country	FGM prevalence in women aged 15-49	Law in place	Viability of the law
Guinea	94,5%	Law No. 2016/059/AN of the Criminal Code 2016	Few cases have reportedly reached court to date, and sentences are lenient
Guinea Bissau	44,9%	Federal Law to Prevent, Fight and Suppress Female Genital Mutilation – Law No. 14/2011	Lack of information on cases brought to court
Kenya	21,0%	The Prohibition of Female Genital Mutilation Act, October 2011	Although it is the most comprehensive in Africa, enforcement remains a challenge
Liberia	44,4%	no legislation	
Mali	91,4%	no legislation	
Mauritania	66,6%	Article 12 of Law No. 2005–015 on the Criminal Protection of the Child (2005)	Weak law enforcement with few cases reaching court
Niger	2,0%	Law No. 2003-025 of the Penal Code, June 2003	Few prosecutions for FGM in Niger; knowledge of the law and enforcement remain weak
Nigeria	24,8%	Uneven laws across the different states	
Senegal	24,0%	Law No. 99-05 of the Penal Code (Article 299 bis), January 1999	Few prosecutions for FGM and lack of data
Sierra Leone	89,6%	no national legislation	
Somalia	98,0%	no national legislation	
Somaliland	99,1%	no national legislation	
South Sudan	no recent surveys, but the prevalence was previously reported at 1%	Penal Code Act 2008 and the Child Act 2008	Absence of information
Sudan	86,6%	Article 141 Female Genital Mutilation of the Criminal Act, 22 April 2020	Not implemented in all states and weak enforcement
Tanzania	10,0%	Article 21 of the Sexual Offences Special Provisions Act 1998	Enforcement of the law is variable, and cases rarely reach court

Country	FGM prevalence in women aged 15-49	Law in place	Viability of the law
The Gambia	74,9%	The Women's (Amendment) Act 2015, Section 32A and 32B	Few prosecutions and lack of data
Togo	3,1%	Law No. 98-016, dated 17 November 1998	Lack of data and weak law enforcement
Uganda	0,3%	The Prohibition of Female Genital Mutilation Act 2010	Roughly viable (although the practice continues in very remote areas)

- This data helps us identify the challenges of the situation in two main ways: firstly, more than simply highlighting the countries in which FGM is practiced, it calls to attention that AHO's help is further needed in places where legislation was already implemented (and not just in states where there is no legislation at all), as in only 1 case in all the countries listed was the law in place already viable.

- Moreover, the "surface" work of drafting up laws was actually undertaken in most of the countries, so why hasn't FGM significantly decreased yet? Aside from the fact the local populations remain reluctant to tackle it, it is presumable that local law enforcements also view it as a custom too taboo to address, which would also justify that in some states, the locals are unaware those laws even exist. A top-down approach of simply drafting up a law doesn't appear to be enough. It is thus important to foster an understanding of the nature of the ban amongst the people present to enforce it as well.

- Secondly, from the above data we can see that the issue isn't simply the practice in itself, but the lack of appropriate infrastructure too (especially on the data recorded), that would otherwise create a clear sense organisation to adequately assess the extent to which FGM is practiced and punished by the law. This calls for greater administrative organisation too: if the cases are poorly managed, there is little chance the fight against FGM will succeed.

Objectives and tactics

OBJECTIVE 1: Raise awareness

First and foremost, it is paramount to eradicate the stigma surrounding FGM. Without a clear ability to address the issue, the chances of solving it are very slim. It is however important to understand that to many, FGM is a cultural practice, and AHO must approach this sensitive topic in a constructive manner.

Tactic: How can we raise awareness?

A. Enable FGM to become part of the school curricula in order to foster discussion and generate awareness from a very young age amongst not just girls but also boys, so that the the consequences of the practice are clearly understood and talking about it becomes acceptable.
B. Invite survivors of FGM to speak out about their own experience in order to sensitise people on the psycho-physical effects of the practice and to legitimise AHO's project amongst the local populations.
C. Invite religious leaders of influence to speak out on the fact that FGM is not a religious practice. One of the core reason why the practice is still carried out to this day is because many women confuse religion with traditions, believing that it is a necessary step that young girls must undergo. This calls for the need to clarify the practice.
D. Ensure that local law enforcements are properly trained to deal with the issue. The table on page 6 highlighted that in 53% of the countries, the actual enforcement of the law was poor and little to no cases ever reached court. Although no formal research has been on on the matter, this potentially highlights the fact that officers are themselves reluctant to enforce FGM legislation, potentially because it is still viewed as a taboo topic or because they perceive it as an important element of their own culture.

Indicators, baselines and targets:

Indicator	2020 baseline	2025 target	2030 target
Number of schools who address FGM in Africa	Unknown	15%	30%
Cases of poor anti-FGM law enforcement	53%	45%	35%

OBJECTIVE 2: International cooperation with governments

AHO could take advantage of the on-ground operations it has already set up in some countries (Zimbabwe, Zambia, Malawi, Tanzania, DRC, Uganda, Rwanda, Burundi, Ethiopia, Ghana, Nigeria and South Sudan) to work with the governments to improve their legislation on FGM. It should also aim to at the very least improve the legislations of the countries worst hit by this social pandemic and in which it is yet to set up physical operations.

Tactic: How can AHO foster international cooperation?

A. Get in contact with the governments in question and offer to help in the long-term goal of having officials co-sponsor AHO's work in the region.
    - Aside from the medical and social expertise that AHO could provide, it should encourage the governments to develop a specific administrative plan that focuses on the matter. Based on the table on page 6, 33% of the countries lack data on their own cases, hence highlighting the need for greater organisation on the matter.
B. AHO can begin by joining efforts with other organisations in order to minimise costs and gain greater coverage in the region (with organisations such as 28-toomany or African Women's Organisation).
C. Identify why in some countries the legislation surrounding FGM remains weak so that the social determinants can be addressed directly rather than just remedied. This will require establishing direct links with the governments.

Indicator	2020 baseline	2025 target	2030 target
Percentage of countries with viable laws on FGM*	7%	15%	30%
Percentage of countries with no laws on FGM*	17%	10%	5%
Countries with a lack of infrastructure to deal with FGM*	33%	23%	13%

*Based upon the table on page 6

OBJECTIVE 3: Change traditions

Changing traditions is paramount. Change needs to come from within and pressure cannot simply be applied from outside. As FGM is mainly forced on youngsters by older women themselves, its important to manage their perceptions on the practice.
The main objective is hence to attempt to generate a consensus within villages that FGM is harmful to those who do not agree to it, hopefully to be achieved by 2030.

Tactic: How can we change traditions?

A. Organise talks within villages especially directed at the elders, as they are often the ones to pass on the practice.
B. Ensure that there is significant infrastructure in place so that the people in charge of trials understand the need to eradicate the culture of secrecy and accordingly sanction the perpetrators of the practice.
C. Offer local actors (eg: young girls/ women having suffered from FGM) to participate in AHO's plan (such as by being the ones organising talks). This is key in ensuring AHO is not viewed as an "external actor" and to encourage other local participants to join its work.
D. Create safe havens in which a range of psychological help directed especially at women who have suffered from FGM can be offered (including but not limited to: therapy sessions) hence encouraging them to speak out and change their perspective on a practice they may have themselves later on forced upon their young female relatives.

Indicator	2020 baseline	2025 target	2030 target
Percentage of women (15-49) who have heard about FGM and believe it should end*	67%	75%	85%

*Source: UNICEF global databases, 2020, based on DHS, MICS and other national surveys, 2004-2018. Based upon 28 African states and 2 Middle Eastern countries.

OBJECTIVE 4: Confront the discriminatory practices that lead to FGM in the first place

This includes sexist practices (such as but not limited to: excluding women from economic life, unequal access to education and hence poor understanding of their own rights and capacities). The desired outcome would be to enable girls/women to understand their rights and the fact they can refuse/stand up against the practice.

Tactic: How can we confront the discriminatory practices that lead to FGM?

A. Ensure that both girls/boys have equal access to education.
B. Educate indirect actors of FGM practice. This includes teaching boys from a young age that FGM is harmful, so that they do not grow up to encourage it and/or view it as a way to ensure marital fidelity.
C. Work with governments to prevent gender inequality practices.
D. Implement classes that teaches young girls about their rights.

Indicator	2020 baseline	2025 target	2030 target
Percentage of girls who do not have access to primary education (Sub-Saharan Africa)	25%	20%	15%
Percentage of girls who do not have access to secondary education (Sub-Saharan Africa)	36%	30%	25%

Time frame

This Plan of Action ought to be implemented between 2020 and 2030, with evaluations undertaken at regular intervals in order to assess the nature of AHO's progress.

Finances

In combatting FGM, the main expense could be boiled down to human capital: hiring trained individuals able of undertaking tasks such as negotiating with governments, reaching out to survivors and organising meetings.

This would preferably need to be people from the region, as their expertise along with their own knowledge of cultural values could be highly beneficial to AHO. Many of them are likely to need training, which will be an additional cost AHO will need to take into consideration.
An additional but less significant cost with be that of travel expenses for some of AHO's members to travel from the main London office to the countries where some operations will develop, in order to maintain a degree of coordination between the different AHO bases.

Monitoring, analysis and evaluation

In order to put in place a realistic and achievable plan, a number of factors shall be set up:

I. A yearly checkup of how AHO's progress compares to the above indicators.
II. Measurement of the local actors' response to AHO work.
III. Regular checkups with the central governments so that the organisation familiarises itself with those who have the ability to achieve most legal change, and so that its work is not put aside.
IV. Monitor the rate at which countries update their FGM cases.
V. Assess the number of governments which have accepted to work with AHO and offered their help.

Summary

Although FGM has decreased over the past decades, its impact on society still remains highly significant. AHO plans to expand in the African region over the next 10 years in order to combat this injustice.

AHO calls for:

A. The understanding that cultural practices become challengeable when they infringe on one's physical and psychological well-being.
B. Actively involving all actors in challenging the practice, including the judicial branch of governments so that the change becomes not just cultural but also legal.
C. The respect of human rights in the African region.
D. A multi-level coordination (communitarian, regional and national) to combat FGM.

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