LEGISLATIVE AND POLICY FRAMEWORK OPTIONS FOR SOMALIA

Lessons from the frameworks and structures common to successful Female Genital Mutilation/Cutting (FGM/C) campaigns in neighbouring countries

ORCHID PROJECT

WORKING TOGETHER TO END FEMALE GENITAL CUTTING

IFRAH FOUNDATION

December 2023

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This was a joint endeavour, with the Ifrah Foundation. We are grateful to UNFPA Somalia for their support.

Publication Date: December 2023

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About Ifrah Foundation

The Ifrah Foundation is a Somali-Irish Non-Governmental Organisation with its mission to eliminate Female Genital Mutilation in Somalia. Established in 2014, we work through our 3 pillars of action: advocacy, awareness raising and community empowerment. We do this through our Dear Daughter campaign to end FGM, with direct actions and in close partnership with others. This research has been commissioned with the support of UNFPA Somalia.

About Orchid Project

Orchid Project was registered in 2011 with a single mission: to catalyse the end of FGM/C. Orchid Projects strategy 2023-2028 will see a focus on three key objectives (1) To undertake research, generate evidence and curate knowledge to better equip those working to end FGM/C (2) To facilitate capacity strengthening of partners through learning and knowledge sharing, to improve programme designs and impacts for the movement to end FGM/C (3) To influence global and regional policies, actions and funding towards ending FGM/C.

In terms of research, Orchid Project aims to play a catalytic role in building a knowledge base by undertaking and curating research and evidence and making it accessible to all. As a result of their merger with 28 Too Many, which produced Africa-focused research for the past decade, they possess the expertise to generate and curate knowledge, as well as the connections to amplify this knowledge across the sector, from grassroots, community-based organisations and activists to global institutions, governments and academia.

Executive Summary

This research, undertaken by Orchid Project, was commissioned by Ifrah Foundation with the purpose of scoping the parameters which have been present, and potentially influential, in reducing FGM/C prevalence in countries neighbouring Somalia. The purpose is to better understand the structures which have influenced and/or supported the introduction of FGM/C legislation and policy.

As with many African ethnic groups, Somalis live across a number of country borders. It is estimated that 12,693,796 (2023 estimate) people live in Somalia and 85% are ethnic Somalis (10,789,727).[1] Nearly 3 million Somalis are internally displaced due to conflict and insecurity in Somalia and approximately 600,000 Somalis are hosted in neighbouring countries as refugees (Kenya, Ethiopia Yemen, Egypt, Djibouti and Uganda).[2] Approximately 4.5m Somalis live in Ethiopia,[3] 2.8m live in Kenya,[4] 585,000 in Djibouti.[5]

FGM/C is widely practiced in Somalia. The most recent estimates place prevalence at 99.2% of women aged 15-49 years (2020).[6] The prevalence rate in Somalia has not changed since 2006 when it was 97.9%.[7]

72% of Somali women in Somalia who believe that FGM/C is a requirement of their religion.[8] This is higher than women who identify as Somali in Ethiopia where 57% believe that FGM/C is required of their religion.[9] Interestingly, the belief that FGM/C is a requirement of religion is highest among Somali women in Kenya (82.3%).[10]

Prevalence of FGM/C in surrounding countries within the Horn of Africa are lower than the prevalence in Somalia. However, prevalence among Somali communities in the surrounding countries is largely the same as within Somalia.

Somalia (2020)[11]	Kenya (2022)[12]	Ethiopia (2016)[13]	Djibouti (2007)[14]	Tanzania (2015-16)[15]
99.2%	14.8%	65%	93.1%	10%

Present day Somalia operates under three legal systems: traditional (Xeer), Sharia (Islam) and secular law.[16] Different aspects of society are managed under the different systems with family law falling largely under Sharia law, land and conflict management under Xeer and criminal laws under the secular system.[17] In practice, these areas overlap and distinctions exist between rural and urban communities around which systems are used. This creates tensions as Xeer and Sharia law are more commonly used in rural areas and among pastoral communities and secular law used more commonly in urban areas.[18]

The Constitution of Somalia does not refer specifically to FGM/C. Article 8 addresses Equality of Citizens and provides at (2) that 'programmes aimed at eradicating long lasting bad practices shall be a national obligation'. Article 24 states that everyone shall have the right to security of his person, that injury to the person is prohibited, and that crimes 'against human rights' such as torture and 'mutilation' shall have no limitation periods.

There is no legislation that specifically bans FGM/C in Somalia. In the absence of national legislation prohibiting FGM/C, the Somali Penal Code remains applicable and makes it a criminal offence to cause hurt to another that results in physical or mental illness, and sets out the associated punishments. Under Article 440(3), hurt is deemed 'very grievous' if it results in (b) 'loss of a sense' or (c) 'loss of a limb, or a mutilation which renders the limb useless, or the loss of the use of an organ or of the capacity to procreate.'

A national law targeted at ending FGM/C needs to at least cover the following aspects:

- provide a clear definition of FGM/C;
- criminalise the performance of FGM/C;
- criminalise procuring, arranging and/or assisting in acts of FGM/C;
- criminalise the failure to report incidents of FGM/C;
- criminalise the participation of medical professionals in acts of FGM/C; and
- criminalise the practice of cross-border FGM/C.

Key elements of a successful policy framework and national coordination

1. National costed action plan in place and promoted by government ministries
2. National coordination mechanism established
3. National budget allocation for implementation of the action plan and for strengthening of the coordination mechanism

Legislation and policy frameworks are correlated with reductions in prevalence of FGM/C, however, the relationship between them varies. What can be seen clearly from the data is that the legislation and policy frameworks have not had an influence in Somali communities where prevalence has remained high over time.

- There is evidence that suggests that criminalisation of FGM/C drives the practice underground and does not actually reduce prevalence.
- There is evidence that legislation must align with social norms. If people believe that FGM/C should not continue, then legislation will support that change
- There is literature that points to an implementation gap between legislation and enforcement by police and judiciaries. This links to the evidence that legislation drives the practice underground and that it must align with social norms.
- Evidence suggests that traditional laws and legal systems have an important role and must be considered

Legislation against FGM/C creates the opportunity for regulatory provisions such as the right to education for girls, responsibilities of healthcare workers and roles and functions of religious and community leaders. It also creates a mandate for coordination of the FGM/C response between a wide variety of stakeholders.

However, given the strong prevalence rates and support for continuation of the practice of FGM/C, a zero tolerance law is likely to have unintended negative consequences — driving the practice underground, increasing medicalisation and reducing the age of cutting.

Learning from the influence of the fatwa in Somaliland and the apparent influence on the type of cutting, a harm reduction approach may be more beneficial in Somalia. The resistance from religious leaders in Puntland to a zero tolerance law and their argument for a harm reduction model may create more likelihood for passage of the bill through the House of Representatives into enacted law. An integrated approach of harm reduction legislation and statements from religious leaders could influence social norms toward less severe forms of cutting in the short term and potentially to elimination of the practice in the long term.

Introduction

This research, undertaken by Orchid Project, was commissioned by Ifrah Foundation with the purpose of scoping the parameters which have been present, and potentially influential, in reducing FGM/C prevalence in countries neighbouring Somalia. The purpose is to better understand the structures which have influenced and/or supported the introduction of FGM/C legislation and policy.

An expert group meeting[19] organised by the Office of the United Nations High Commissioner for Human Rights in Addis Ababa in 2019 concluded that the following actions are pivotal:

- developing comprehensive and rights-based policy frameworks;
- enforcing laws including across borders and in the context of population movements;
- scaling up innovative interventions that address social norms and strengthen social accountability; and
- collecting more reliable and accurate data including using new technologies.

The expert group also found that leadership, political commitment, and a long-term vision are major factors of success.

The UNICEF-UNFPA joint programme FGM/C Policy Brief has collated data, where available, from national legislation, strategies and plans, coordination as well as budgets and funding in 31 countries.

This research will:

- use the Joint Programme Policy Brief as a guide, focus on Djibouti, Ethiopia, Kenya and Tanzania to identify similarities in their FGM/C frameworks which have supported a decrease in FGM/C prevalence;
- bear in mind where there are large populations of Somalis cross-border;
- through desk and on-line research, identify what research already exists in this area with a particular focus on East Africa;
- provide a sample of case studies to highlight learnings from elsewhere.

Part 1: Mapping FGM/C prevalence and Somali populations in selected countries

Understanding Somali ethnicity[20]

As with many African ethnic groups, Somalis live across a number of country borders. It is estimated that 12,693,796 (2023 estimate) people live in Somalia and 85% are ethnic Somalis (10,789,727).[21] Nearly 3 million Somalis are internally displaced due to conflict and insecurity in Somalia and approximately 600,000 Somalis are hosted in neighbouring countries as refugees (Kenya, Ethiopia Yemen, Egypt, Djibouti and Uganda).[22] Approximately 4.5m Somalis live in Ethiopia,[23] 2.8m live in Kenya,[24] 585,000 in Djibouti.[25]

Ethnic Somalis are made up of five dominant clans, which include the Hawiye, Darod, Isaaq, Dir and Rahanweyn. The map below shows the Somali clan distribution within Somalia and across borders in the Horn of Africa.

[Image reference[26]]

The Hawiye clan live mainly in Southern and Central Somali, including Mogadishu and trace their heritage back to Irir Sammale. The Hawiye clan has sub-clans which include the Degodia, Ceyr, Murosade, Ajuran and Hawadle.

The Darod clan live in the autonomous region of Puntland and have their own President and system of administration. This clan traces their history back to Abdirahman bin Ismai'il al-Jabarti, who is known to be a descendant of Prophet Muhammad (pbuh). The Darod also have sub-clans which include the Harti, Ogaden and Marehan.

The Dir clan live mainly in the northern parts of Somalia and also have sub-clans, which include the Akisho, Gurgure, Surre, Issa Barsuug and Biimaal. The Dir clan also live outside of Somalia in Ethiopia, Djibouti and Kenya.

The Isaaq clan live predominantly in Somaliland and trace their heritage back to Shayk Ishaq ibn Ahmad al-Hashimi.

The Digil Rahanweyn are part of the larger Rahanweyn clan and live mainly in coastal areas. This clan also has sub-clans which include the Garre, Geledi, Tunni, Bagadi and Jiida. The Mirifle Rahanweyn clan are pastoralists and farmers. This clan has 21 sub-clans.

Conflicts between clans have been prominent since Somalia's independence. Distrust and insecurity have driven clans to resist unification and to maintain their clan unity and identity over time.

FGM/C in Somalia

FGM/C is widely practiced in Somalia. The most recent estimates place prevalence at 99.2% of women aged 15-49 years (2020).[27] The prevalence rate in Somalia has not changed since 2006 when it was 97.9%.[28]

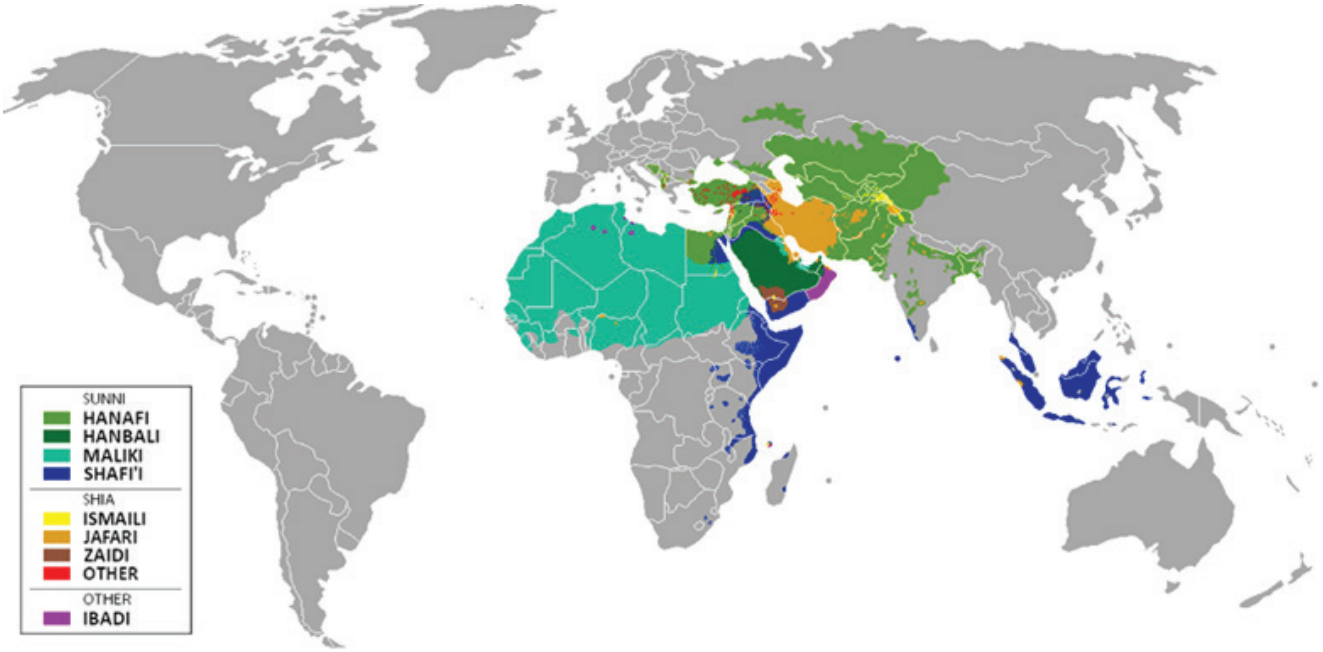
The Somali Health and Demographic Survey (SHDS) 2020 breaks down FGM/C into three types: Sunni, Intermediate and Pharaonic, which are defined as simplified versions of the World Health Organization's classifications.[29] Pharaonic cutting continues to be the most common type of FGM/C at 64.2%.[30] Younger women are less likely to have experienced Pharaonic FGM/C (46.2% of women aged 15–19) than older women (82.4% of women aged 45–49), as are women with higher levels of education and those in higher wealth quintiles.[31] It is necessary to note, however, that there is much confusion in the region over the difference between Sunni and Pharaonic cutting, which may affect these figures.

Among Somali women in Ethiopia, 75.6% report undergoing Pharoanic FGM/C (sewn closed).[32] Interestingly, this is higher than the percentage of Somali women in both Somalia and Kenya who have undergone this type of cutting in Somalia (64%)[33] and Kenya (32.3%).[34]

In general, support for the continuation of FGM/C is strong among women aged 15–49 in Somalia and Somaliland (76.4%)[35] and support has increased from 2006 when it was 64.5%.[36] Wealthier women and those with higher levels of education are less likely to support its continuation.[37] Almost three-quarters (72%) of women aged 15–49 believe that FGM/C is a requirement of their religion.[38]

The Role of Religion

The Somali ethnic group were one of the first to adopt Islam on the African continent. However, unlike much of the rest of Africa, Islam in the Horn of Africa is dominated by adherence to the Shafi'i school[39], which is also dominant in Yemen, Iraqi Kurdistan, Indonesia and Malaysia.[40]



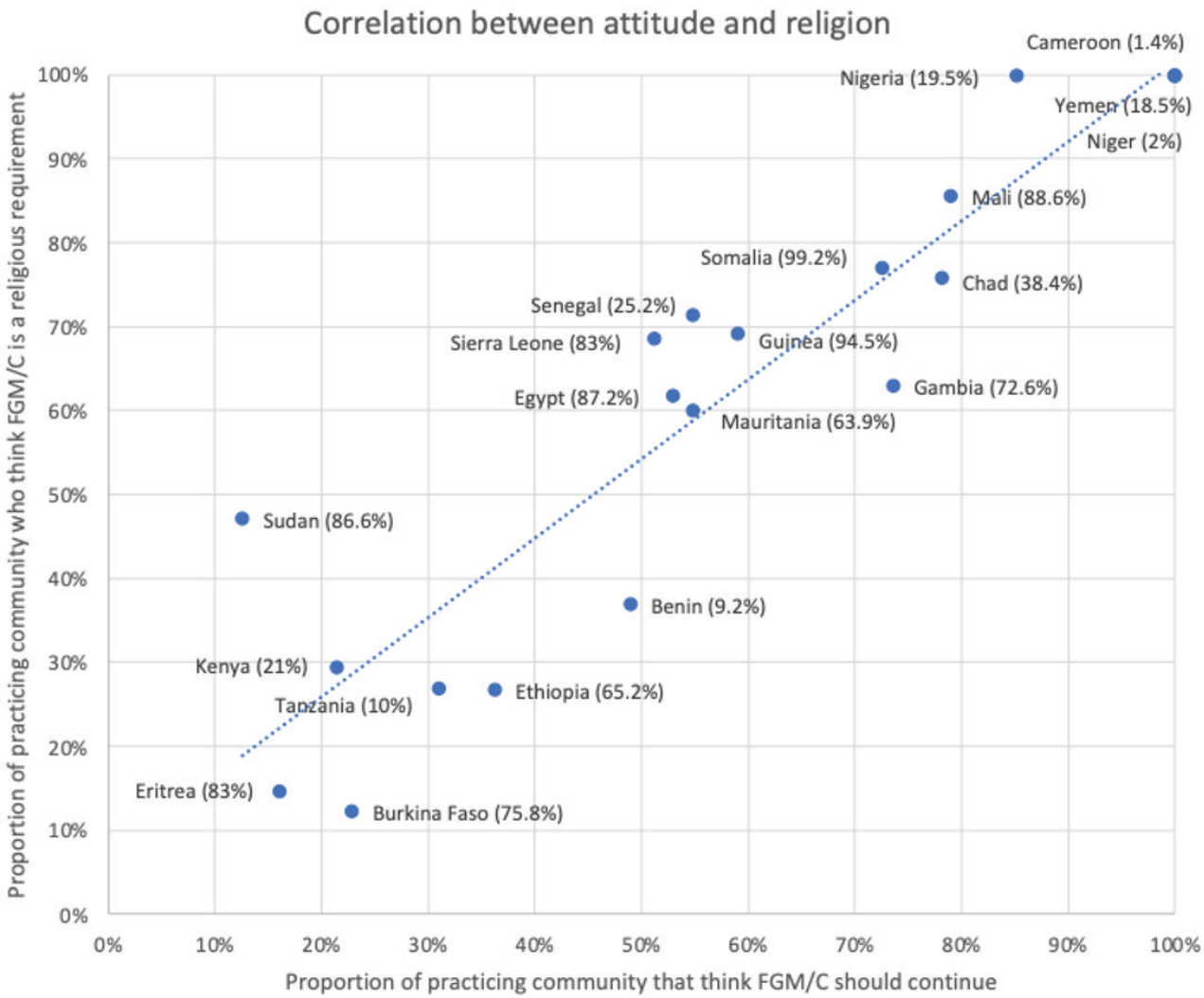
[Image reference][41]

72% of Somali women in Somalia who believe that FGM/C is a requirement of their religion.[42] This is higher than women who identify as Somali in Ethiopia where 57% believe that FGM/C is required of their religion.[43] Interestingly, the belief that FGM/C is a requirement of religion is highest among Somali women in Kenya (82.3%).[44]

In Somalia, the belief that FGM/C is required by religion is influenced by wealth quintile and level of education. While 74% of women with no education believe that FGM/C is a requirement of religion, only 44% of women with secondary education or higher believe the same.[45] Similarly, 77% of women from the lowest wealth quintile believe that FGM/C is a requirement of religion, while only 59% of women from the highest wealth quintile hold this belief.[46]

In Somalia, 76% of women believe that FGM/C should continue.[47] In Ethiopia, 51.4% of Somali women hold this belief[48] and 81.2% of Somali women in Kenya.[49] In Somalia, this belief follows a similar pattern to that of religious requirement and is influenced by wealth quintile and level of education.[50]

There seems to be a correlation between belief that FGM/C is a religious requirement and support for its continuation in multiple countries as shown on the graph below:



[Figure reference][51]

The Shafi'i legal school of Islam (madhhab) rests on the authority of both divine law through the Quran and human interpretation of the law. Shafi'i jurists argue for unquestioning acceptance of the Hadiths (stories) and use these as the basis for legal judgments and qiyas (analogical reasoning) where no clear direction can be found in the Quran.[52] This is important in the discussion of FGM/C as there is no reference to FGM/C in the Quran, the qiyas or any ijma.[53] However, circumcision of women is mentioned in five Hadiths. In some Islamic traditions, these Hadiths have been discredited or interpreted to refer to something other than FGM/C.

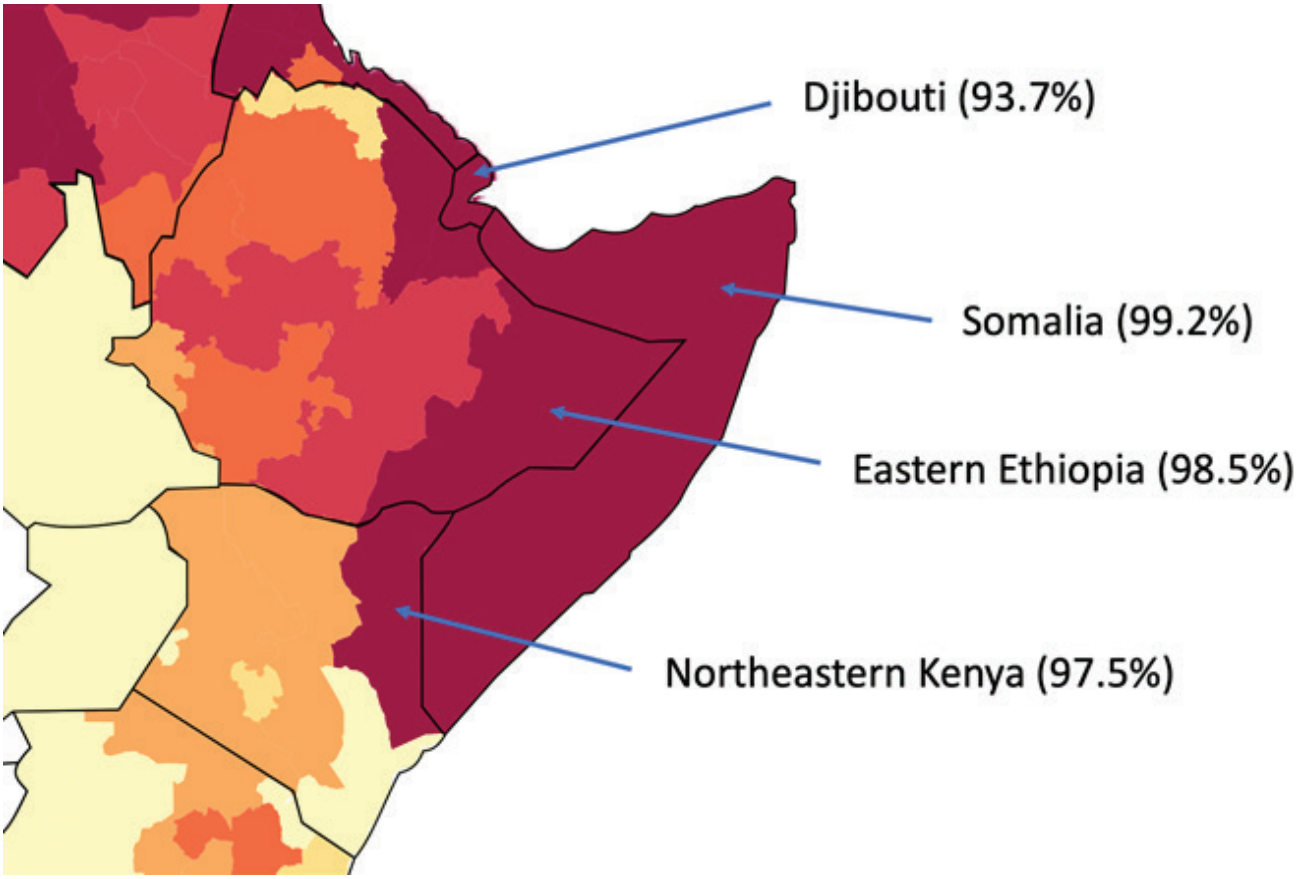
Regional FGM/C prevalence

Prevalence of FGM/C in surrounding countries within the Horn of Africa are lower than the prevalence in Somalia.

Somalia (2020)[54]	Kenya (2022)[55]	Ethiopia (2016)[56]	Djibouti (2007)[57]	Tanzania (2015-16)[58]
99.2%	14.8%	65%	93.1%	10%

However, it is important to note that among Somali women and girls, prevalence rates are similar across all countries and that these rates have not changed very much over time.

Country	National prevalence among women and girls (15-49)	Change over time among women and girls (15-49)	Prevalence among Somali women and girls (15-49)	Change over time among Somali women and girls (15-49)
Somalia	99.2%	97.9% in 2006 99.2% in 2020	99.2%	97.9% in 2006 99.2% in 2020
Kenya	14.8%	37.6 in 1998 14.8% in 2022	94%[59]	97% in 2003 94% in 2014[60]
Ethiopia	65%	80% in 2000 65% in 2016	99.7%[61]	99.7% in 2000 98.5% in 2016
Djibouti	93.1%	98.1% in 2002 93.1% in 2007	Not specified but since 60% of the population are Somali, it can be assumed that the prevalence among Somalis in Djibouti is similar to the national average	
Tanzania	10%	17.9% in 1996 10% in 2015-16	Not applicable	Not applicable



Part 2 : Mapping FGM/C legal frameworks in the selected countries

Understanding Somalia's legal systems

Present day Somalia operates under three legal systems: traditional (Xeer), Sharia (Islam) and secular law.[62] Different aspects of society are managed under the different systems with family law falling largely under Sharia law, land and conflict management under Xeer and criminal laws under the secular system.[63] In practice, these areas overlap and distinctions exist between rural and urban communities around which systems are used. This creates tensions as Xeer and Sharia law are more commonly used in rural areas and among pastoral communities and secular law used more commonly in urban areas.

Xeer constitutes a system of norms and rules that are most often passed on orally and upheld by clan leaders.[64] Built into the Xeer system are diya payments which provide compensation to clans for conflict and injury. Sometimes referred to as blood compensation, diya payments are an important part of conflict resolution and delayed payments can often be the source of continued conflict between clans.[65] Diya-paying groups are united by marriage and genealogy and many members of diya-paying groups feel a duty to protect each other and to pay and receive diya for their group.[66] The payment of diya, as well as the norms and rules of Xeer, are decided upon by councils of elders and have been strongly influenced by Sharia.[67] Xeer has been said to " enshrine the norms and values of Somali society."

Somalia's constitution

The Constitution of Somalia (2012)[68] states at Article 4, 'After the Shari'ah, the Constitution of the Federal Republic of Somalia is the supreme law of the country.' It protects human dignity and equality under Articles 10 and 11 respectively, and, most significantly in relation to FGM/C, sets out under Article 15(4) that: Circumcision of girls is a cruel and degrading customary practice, and is tantamount to torture. The circumcision of girls is prohibited.'

Article 29(2) further provides, 'Every child[69] has the right to be protected from mistreatment, neglect, abuse or degradation.' There is currently no national legislation in Somalia that expressly criminalises and punishes the practice of FGM/C.

National legislation

The Penal Code, Law No. 05/19623 (the Penal Code), which came into force on 2 April 1964, is applicable to all jurisdictions in Somalia (and Somaliland) does not specifically mention FGM/C. In the absence of national legislation prohibiting FGM/C, the Somali Penal Code remains applicable and makes it a criminal offence to cause hurt to another that results in physical or mental illness, and sets out the associated punishments. Under Article 440(3), hurt is deemed 'very grievous' if it results in (b) 'loss of a sense' or (c) 'loss of a limb, or a mutilation which renders the limb useless, or the loss of the use of an organ or of the capacity to procreate.'

A bill against FGM/C was prepared by the Committee on the Rights of the Child in Somalia and presented to the Somali National Council in 2022 with hopes that it would be examined and passed.[70]

Somaliland and Puntland

In 1991, Somaliland declared independence from Somalia. Somaliland has its own government, but its self-declared independence remains unrecognised by the United Nations, and Somalia continues to consider Somaliland as a federal member state.

The Constitution of Somaliland does not refer specifically to FGM/C. Article 8 addresses Equality of Citizens and provides at (2) that 'programmes aimed at eradicating long lasting bad practices shall be a national obligation'. Article 24 states that everyone shall have the right to security of his person, that injury to the person is prohibited, and that crimes 'against human rights' such as torture

and 'mutilation' shall have no limitation periods. There is no legislation banning FGM/C in Somaliland.

In 1998, Puntland was declared an autonomous state of the Federal Republic of Somalia.

Puntland issued an inter-ministerial decree against FGM/C developed by the Ministry of Health and signed in 2014 which states that there will be no medicalisation of FGM/C[71] and it has the authority to shut down clinics and hospitals that continue the practice, and arrest perpetrators. It also entitles the Government of Puntland to cancel the licences of medical professionals who practice FGM/C in their clinics, and doctors' associations have been asked to hold their members accountable for practising FGM/C by revoking their memberships. In June 2021, Puntland President Said Abdullahi Deni and his cabinet approved a bill to be presented to parliament to criminalise FGM/C.[72] At the time of writing, the bill has not been approved by the House of Representatives according to the Official Gazette.[73]

Fatwas

Fatwas (Islamic rulings) against FGM/C has been signed in Puntland[74] and Somaliland.[75]

In 2012, religious leaders in Somaliland objected to early attempts at an anti-FGM/C policy calling for zero tolerance. It took them years to shift that position. In February 2018, the Ministry of Religious Affairs in Somaliland eventually issued a fatwa banning the most severe type of FGM/C, pharaonic (sewn closed).[76] It is possible that this fatwa may have had more of an influence in Kenya and Somalia than among Somali communities in Ethiopia to shift the type of cutting away from type 3 (pharaonic/sewn closed). Likewise, in November 2013, 18 prominent religious leaders signed a fatwa against FGM/C, which was witnessed by the then Puntland Minister of Justice, Religious Affairs and Rehabilitation, the Deputy Minister of Health and the Deputy Minister of Women and Family Social Affairs. The fatwa had been drafted by a committee of seven members and justified the abandonment of all forms of FGM/C on health and religious grounds. [77]

International and regional treaties

Three treaties create the international framework related to FGM/C: the Convention of the Elimination of all forms of Discrimination Against Women (CEDAW)[78]; the African Charter on Human and Peoples' Rights on the Rights of the Women in Africa (Maputo Protocol)[79]; and Cairo Declaration on the Elimination of FGM/C (Cairo Declaration).[80]

CEDAW was adopted by the UN General Assembly on 18 December 1979.[81] The Convention defines equality and how it can be achieved and establishes an international bill of rights for women and an agenda for actions for the countries that ratify it.[82]

The Maputo Protocol, also known as the Protocol To The African Charter on Human and Peoples' Rights on the Rights of Women in Africa, was adopted by the African Union on 11 July 2003 and went into effect in November 2005.[83] State Parties commit to combatting all forms of discrimination against women through appropriate legislative, institutional and other measures.[84] This includes specific reference to harmful practices such as FGM/C.[85]

The Cairo Declaration emerged from the Afro-Arab Expert Consultation on Legal Tools for the Prevention of Female Genital Mutilation held in Cairo in 2003 and organised by the Organisation of Islamic Co-operation.[86] The Cairo declaration includes 17 recommendations for governments to follow with the aim of preventing and prohibiting FGM/C, including the enactment of specific legislation addressing FGM/C.[87]

Somalia has not adopted CEDAW or the Cairo Declaration and has signed but not ratified the Maputo Protocol. However in July 2014, both the Somalia and Puntland Governments signed the Girl Summit Charter on Ending FGM, Child, Early and Forced Marriage.[88]

Exploring legal frameworks against FGM/C

Model Law Against FGM/C

In 2019, 28 Too Many, in collaboration with TrustLaw, the Thomson Reuters Foundation's global, legal pro bono service, partnered with international law firms Reed Smith LLP, Cleary Gottlieb Steen & Hamilton LLP and Latham & Watkins LLP to draft a model law on FGM/C.[89]

The Model Law is divided into two parts: I. Offences and Penalties; and II. State Obligations.

Part I of the Model Law is based around six features that are the minimum necessary for anti-FGM/C legislation to be effective. These are as follows:

1. **Provide a clear definition of FGM/C -** Only a few countries give fully comprehensive definitions of all types of FGM/C, while most countries give more general, shorter definitions, which are less detailed and may not cover all types of FGM/C. Some countries' laws do not include a definition of FGM/C at all.
2. **Criminalise the performance of FGM/C -** Most countries criminalise the performance of FGM/C on all women and girls, irrespective of age, but there are exceptions (for example, Mauritania and Tanzania only prohibit the performance of FGM/C on girls under 18 years of age).
3. **Criminalise procuring, arranging and/or assisting acts of FGM/C -** As well as prohibiting the performance of FGM/C, legislation needs to prohibit the act of requesting and arranging (procuring) or assisting, aiding and abetting the practice.
4. **Criminalise the failure to report incidents of FGM/C -** Currently only half of the 22 African countries that have anti-FGM/C laws actually require FGM/C to be reported to the relevant authorities.
5. **Criminalise the participation of medical professionals in acts of FGM/C-** One of the significant challenges to the current worldwide campaign to end FGM/C is the trend towards medicalised FGM/C in some countries.
6. **Criminalise the practice of cross-border FGM/C -** The movement of families and traditional practitioners across national borders for the purpose of FGM/C remains a complex challenge for the campaign to end the practice. As a result, women and girls living in border communities are particularly vulnerable. Omission of this from the majority of legislative frameworks continues to undermine efforts of government authorities and civil society to tackle the problem.

Comparative analysis of legal frameworks against FGM/C in selected countries[90]

Features of 'Best Practice' Law to End FGM/C[91]

A national law targeted at ending FGM/C needs to at least cover the following aspects:

- provide a clear definition of FGM/C;
- criminalise the performance of FGM/C;
- criminalise procuring, arranging and/or assisting in acts of FGM/C;
- criminalise the failure to report incidents of FGM/C;
- criminalise the participation of medical professionals in acts of FGM/C; and
- criminalise the practice of cross-border FGM/C.

Comparing the laws in the selected countries outlined above, the table below demonstrates the strengths and weaknesses of each law.

	Provides Clear Definition of FGM/C	Criminalises Performance of FGM/C	Prohibits Procurement, Arrangement or Assistance of FGM/C	Criminalises Failure to Report FGM	Criminalises Participation of Medical Professionals in FGM/C	Criminalises Practice of Cross-Border FGM/C
Somalia	✗	✗	✗	✗	✗	✗
Tanzania	✓	✓	✓	✓	✗	✗
Kenya	✓	✓	✓	✓	✓	✓
Ethiopia	✗	✓	✓	✗	✗	✗
Djibouti	✓	✓	✓	✓	✗	✗

The strongest law against FGM/C in the selected countries is the law in Kenya as it clearly defines FGM/C, criminalises performance, prohibits procurement of FGM/C, criminalises participation of medical professionals in FGM/C and criminalises practice of cross-border FGM/C.

However, it is important to remember that enforcement of the law is critical to having any impact on elimating the practice of FGM/C. A high-standard FGM/C law is only useful if it is effectively implemented and enforcement of FGM/C laws has historically been low. Statistics below are provided by the UN Joint Programme on the Elimination of FGM/C (UNJP) and show the variations in legal enforcement and convictions across the selected countries.[92]

Country	Year	Arrests	Cases taken to court	Convictions/ sanctions
Tanzania	2018-2021	Data not available	Data not available	Data not available
Kenya	2018-2021	303	300	55 (data not available for 2021)
Ethiopia	2018-2021	146	99	54
Djibouti	2018-2021	19	13	13

While the statistics are highest for Kenya, the number of convictions/sanctions remains low across the board. This is a critical area for consideration in the implementation of legal and policy frameworks to eradicate FGM/C and requires capacity building of police and judicial systems, resource mobilsation for case identification and prosecution, and capacity building of legal professionals to take reported cases forward to court.

International and regional treaties

As outlined above in analysis of Somalia's engagement with international and regional treaties, three treaties create the international framework related to FGM/C: the Convention of the Elimination of all forms of Discrimination Against Women (CEDAW)[93]; the African Charter on Human and Peoples' Rights on the Rights of the Women in Africa (Maputo Protocol)[94]; and the Cairo Declaration on the Elimination of FGM/C (Cairo Declaration).[95] Comparison of engagement with these treaties in the selected countries is outlined in the table below.

Country	Convention of the Elimination of all forms of Discrimination Against Women (CEDAW)	African Charter on Human and Peoples' Rights on the Rights of the Women in Africa (Maputo Protocol)	Cairo Declaration on the Elimination of FGM/C (Cairo Declaration)
Ethiopia	Signed and ratified with reservations	Signed	Signed
Tanzania	Signed and ratified	Signed and ratified	Signed
Kenya	Acceded	Signed and ratified	Signed
Djibouti	Acceded	Signed and ratified	Signed
Somalia	-	Signed	-

'Signed' – a treaty is signed by countries following negotiation and agreement of its contents.

'Ratified' – once signed, most treaties and conventions must be ratified (i.e. approved through the standard national legislative procedure) to be legally effective in that country.

'Acceded' – when a country ratifies a treaty that has already been negotiated by other states.

FGM/C Law in Tanzania

Tanzania's legal system is based on English common law; judicial review of legislative acts is limited to matters of interpretation.

The main law criminalising FGM/C in Tanzania is the Sexual Offences Special Provisions Act 1998 (SOSPA), which amended Section 169 of the Penal Code and prohibits FGM/C on girls under the age of 18 years.[96]

Article 21 of the SOSPA does not give a definition of FGM/C; it inserts a new Section 169A(1) into the Penal Code prohibiting the performance and procurement of FGM/C as follows:

- The Penal Code is hereby amended by inserting immediately after section 169 the following: 169A.-(I) Any person who, having the custody, charge or care of any person under eighteen years of age, ill treats, neglects or abandons that person or causes female genital mutilation or procures that person to be assaulted, ill treated, neglected or abandoned in a manner likely to, cause him suffering or injury to health, including injury to, or loss, of sight or hearing, or limb or organ of the body or any mental derangement, commits the offence of cruelty to children.
- Therefore, anyone committing FGM/C on a person under 18 years of age who is under their custody, charge or care will be subject to punishment. Failure to report FGM/C that has taken place or is planned is not directly addressed under this law.
- In addition, the Law of the Child Act 200997 protects persons under the age of 18, and Article 13(1) makes it a criminal offence to 'subject a child to torture, or other cruel, inhuman punishment or degrading treatment including any cultural practice which dehumanizes or is injurious to the physical and mental well-being of a child.' As a child protection law, Article 18 also allows the court to issue a care order or an interim care order to remove the child from any harmful situation

Section 169A neither explicitly criminalises nor punishes FGM/C carried out on or by Tanzanian citizens in other countries. However, Article 6(b) of the Tanzani Penal Code does state that the jurisdiction of the Courts of Tanganyika for the purposes of the Code extends to 'any offence committed by a citizen of Tanganyika, in any place outside Tanganyika.'

The new Section 169A (2) in the Penal Code, as stated in Article 21 of SOSPA, sets out the following penalties for anyone performing and procuring FGM/C in Tanzania:

- imprisonment for not less than five years and not exceeding 15 years; \
- a fine not exceeding 300,000 shillings (approx. US$135); or
- both the fine and imprisonment.

The perpetrator will also be ordered to pay compensation to the victim of the crime of an amount determined by the court. In addition, any person in violation of Section 13(1) of the Law of the Child Act 2009 shall under Section 14 be liable on conviction to a fine not exceeding five million shillings (approx. US$2,200), or to imprisonment for a term not exceeding six months, or both.

Enforcement of the law in Tanzania

No data available.

FGM/C Law in Kenya

Kenya has a mixed legal system comprising English common law, Islamic law and customary law. The country has a quasi-federal structure with two distinct but interdependent tiers of government at national and county levels.

The Prohibition of Female Genital Mutilation Act, 2011 (FGM/C Act 2011),[98] which came into effect on 4 October 2011, is the principal legislation governing FGM/C in Kenya. It is a federal act and criminalises all forms of FGM/C, regardless of the age or status of a girl or woman.

The FGM/C Act 2011 is a comprehensive piece of legislation that established the Anti-Female Genital Mutilation Board and sets out the offences and punishments for FGM/C in Kenya. Article 2 of the FGM/C Act 2011 clearly defines FGM/C as 'all procedures involving partial or total removal of the female genitalia or other injury to the female genital organs, or any harmful procedure to the female genitalia, for non-medical reasons', and includes (a) clitoridectomy, (b) excision and (c) infibulation (with accompanying definitions of each). The only exceptions are a 'sexual reassignment procedure or a medical procedure that has a genuine therapeutic purpose'; the law does not, however, define the meaning of 'therapeutic' in this context.

Part IV (Articles 19–25) of the FGM/C Act 2011 outlines the criminal offences related to the following aspects of FGM/C:

- **Article 19** – the performance of FGM/C, including by medical practitioners;
- **Article 20** – procuring, aiding and abetting the practice of FGM/C;
- **Article 21** – procuring a person to perform FGM/C in another country;
- **Article 22** – allowing the use of premises for FGM/C;
- **Article 23** – the possession of tools and equipment for the purposes of FGM/C;
- **Article 24** – failure to report awareness of FGM/C to a law enforcement officer, whether the procedure is in progress, has already occurred or is planned; and
- **Article 25** – the use of derogatory or abusive language against a woman for having not undergone FGM/C (or against a man for marrying or supporting that woman).

Consent is not a defence to the crime of performing FGM/C in Kenya; nor is it a defence to argue that the person charged thought such consent had been given (Article 19 [6]). The FGM/C Act 2011 also allows any law enforcement officer, under Article 26, to enter any premises for the purposes of ascertaining whether it is connected to any violation of the law around FGM/C.

In addition, the following Kenyan laws address FGM/C:

- The Children Act 2001 (revised 2016),[99] states in Article 14: 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. A child is defined as anyone under 18 years of age. Article 119(1)(h) of the Children Act also provides for a Children's Court to issue a protection order if the child 'being a female, is subjected or is likely to be subjected to female circumcision

or early marriage or to customs and practices prejudicial to the child's life, education and health.' The application must be made by a qualified person, defined under Article 113(2) as the child, the parents, guardian or relative of the child, or the Director of Children's Services or authorised officer.

- The Protection Against Domestic Violence Act (2015)100 defines domestic violence under Article 3(a)(ii) to include 'female genital mutilation' and under Article 19(1)(g) it provides the facility to set up protection orders covering potential victims against engagement, or threats to engage, 'in cultural or customary rites or practices that abuse the protected person'.
- Finally, Kenya's Penal Code (revised 2014)101 under Article 4 outlaws the deliberate infliction of 'grievous harm', which includes 'any permanent or serious injury to any external or internal organ, membrane or sense'.

The minimum punishment for FGM/C in Kenya is three years imprisonment and a $2,000 fine.[102] Shortly after the law was passed, an anti-FGM/C board was established as a national coordination mechanism and provided with a national budget contribution.[103]

Anyone who performs FGM/C, including those who are under the supervision of a medical professional or a midwife, commits a criminal offence under Article 19(1) of the FGM/C Act 2011, although there are two exceptions under Article 19(3): (a) Surgical operations performed by a medical practitioner that are necessary for the person's physical or mental health. However, necessity cannot be determined based on a person's culture, religion, custom or other practice. (b) Surgical operations performed by a medical practitioner, midwife or medical student in training, on those who are in any stage of labour or have just given birth, for purposes connected with the labour or birth. FGM/C is not specifically identified as an offence under the Medical Practitioners and Dentists Act (revised 2012)10, but under Article 20(1) disciplinary proceedings may be brought against a medical practitioner who commits an offence under the Penal Code or engages in 'any infamous or disgraceful conduct in a professional respect', which will result in removal from the medical register or cancellation of their licence. Similarly, the Nurses Act (revised 2012)11 does not specifically address FGM/C, but a nurse may be removed from the register if found guilty of misconduct by the Nursing Council of Kenya.

Articles 21 and 28(1) of the FGM/C Act 2011 criminalise cross-border FGM/C by stating that it is an offence for any citizen or permanent resident of Kenya to 'take another person from Kenya to another country, or arrange for another person to be brought into Kenya from another country' for the purposes of FGM/C. Article 28(2) further qualifies that a person may not be convicted of the offence if such a person has already been acquitted or convicted in the country where the offence was committed.

Penalties Article 29 of the FGM/C Act 2011 establishes criminal penalties for all offences set out in Articles 19– 24 as follows:

- imprisonment for a minimum of three years; and/or
- a fine of at least 200,000 shillings (US$1,953).
- If the FGM/C procedure results in death, Article 19(2) states that the maximum sentence is life imprisonment.
- Under Article 25, the use of derogatory or shaming language is subject to punishment of a minimum of six months' imprisonment or a fine of at least 50,000 shillings (US$488), or both.

Enforcement of the law in Kenya[104]

Year	Arrests	Cases taken to court	Convictions/ sanctions
2018	98	98	15
2019	76	76	10
2020	56	56	30
2021	73	70	No data

FGM/C Law in Ethiopia

Ethiopia has a civil law system, with some Islamic and customary law; civil procedure is influenced by UK common-law principles.

FGM/C is illegal in Ethiopia. The main law governing FGM/C in Ethiopia is Proclamation No. 414/2004, also known as The Criminal Code of the Federal Democratic Republic of Ethiopia 2004 (the Criminal Code).[105] This is a federal act that makes it a criminal offence to perform or procure FGM/C in Ethiopia. In addition, as well as being a criminal offence, performing any action that causes bodily harm is a civil offence under the Ethiopian Civil Code (1960).[106] Articles 565 to 570 of The Criminal Code of the Federal Democratic Republic of Ethiopia (2004) contain provisions against FGM/C.

The provisions include:[107]

- **Article 565** - Female Circumcision.
- **Article 566** - Infibulation of the Female Genitalia.
- **Article 567** - Bodily Injuries Caused Through Other Harmful Traditional Practices.
- **Article 568** - Transmission of Disease through Harmful Traditional Practices
- **Article 569** - Participation in Harmful Traditional Practices
- **Article 570** - Incitement Against the Enforcement of Provisions Prohibiting Harmful Traditional Practices

Articles 561–570 of Chapter III of the Criminal Code deal with 'Crimes Committed Against Life, Person and Health through Harmful Traditional Practices'. They criminalise the performance and procurement of FGM/C in Ethiopia, but do not provide a clear definition of the practice. Specifically, the Criminal Code sets out the following offences:

- Articles 561 and 562 refer to endangering life or causing bodily injury or mental impairment of a pregnant woman or new-born child as a result of the application of harmful traditional practices known by the medical profession to be harmful.
- Articles 565 and 566 respectively set out punishments for the performance of FGM/C on 'a woman of any age' and infibulation of 'the genitalia of a woman'.
- Article 568 states that the transmission of communicable disease through harmful traditional practices is subject to penalties.
- Articles 569 and 570 cover the procurement of, and aiding and abetting, FGM/C by making it a criminal offence for 'a parent or any other person' to commission the practice or encourage someone to disregard the legislation prohibiting harmful traditional practices. They also criminalise organising or taking part in any movement that promotes FGM/C. The Criminal Code does not specifically criminalise the failure to report FGM/C, whether it is planned or has taken place.
- However, more generally, Article 443 sets out the punishments for failing to report certain crimes. The Criminal Code also fails to protect uncut women (and their families) from verbal abuse or exclusion from society, which is included in the laws of some other countries in East Africa (such as Kenya and Uganda).
- Regarding the liability of traditional practitioners, Article 2067(1) of the Civil Code may be applied to FGM/C performed on women and girls. It states the principle, 'A person shall be liable where by his act he inflicts bodily harm on another'. As such, under Ethiopian law, victims of FGM/C could bring about actions that seek compensation from practitioners.

While the law in Ethiopia does not directly address crossborder FGM/C, Articles 11–22 of the Criminal Code deal with crimes specified in the Code that are carried out by either a foreigner acting in Ethiopian territory or nationals acting in another country. Specifically, Article 11 states, 'This Code shall apply to any person whether a national or a foreigner who has committed one of the crimes specified in this Code on the territory of Ethiopia.' Article 18 provides that the Code shall apply to any person who commits a crime outside Ethiopia against an

Ethiopian national and to any Ethiopian national who commits a crime under the Code outside of Ethiopia, with provision for extradition.

The Criminal Code establishes the following penalties for its violation:

- Article 565: Performing FGM/C on a woman of any age is punishable by imprisonment (where performance of this sentence can be suspended by the courts) for not less than three months or a fine of not less than 500 Birr (US$188).
- Article 566(1): Infibulating the genitalia of a woman carries a punishment of imprisonment (which cannot be suspended) for a period of three to five years. Article 566(2): Where FGM/C results in injury to body or health, the punishment is imprisonment (which cannot be suspended) for a period of five to ten years.
- Article 569: A parent or any other person who participates in the commission of FGM/C is punishable by imprisonment (which can be suspended) for a period not exceeding three months or a fine not exceeding 500 Birr (US$18).
- Article 570: Encouraging another to disregard the law prohibiting FGM/C or organising or taking part in any movement that promotes FGM/C is punishable by imprisonment (which can be suspended) for a period of not less than three months or a fine of not less than 500 Birr (US$ 18), or both. (The fines set out in the Criminal Code of 2004 have not been updated, however, to reflect dramatic inflation in Ethiopia since that date, and this undermines any fine's punitive role.) Regarding obligations to report a crime generally, Article 443(1)(a) states that anyone who has knowledge of any crime that is punishable by death or imprisonment (which would include FGM/C), or who knows the identity of perpetrators of the crime, is punishable by a fine not exceeding 1,000 Birr (US$36) or imprisonment (which can be suspended) for up to six months.

As part of the government's efforts to eradicate FGM/C by 2025, medicalisation of the practice was banned in January 2017 by the Ministry of Health.[108] There is, however, no national legislation that explicitly criminalises health professionals who perform the practice.

Enforcement of the law in Ethiopia[109]

Year	Arrests	Cases taken to court	Convictions/ sanctions
2018	13	8	4
2019	35	13	5
2020	53	20	1
2021	45	58	44

FGM/C Law in Djibouti

Djibouti's legal system is based primarily on the French civil code (as it existed in 1997), with features of Islamic religious law (in matters of family law and successions), and customary law.

The Penal Code of Djibouti (the Penal Code)[110] came into effect in 1995 and was the first principal legislation criminalising and punishing FGM/C in Djibouti. It was further complemented by Law No. 55 of 2009 (Law No. 55)[111] relating to violence against women, including FGM/C.

The Criminal Procedure Code of Djibouti 1995 (the Criminal Procedure Code)[112] is also relevant to FGM/C.

FGM/C was initially criminalised and punished under Article 333 of the Penal Code, which addresses violence that results in 'genital mutilation'. The Penal Code did not, however, provide a definition of

genital mutilation or FGM/C, nor did it criminalise the procurement, aiding or abetting of FGM/C.

Article 7 of the Criminal Procedure Code sets out how any organisation whose statutory objective for at least the previous five years has been the fight against FGM/C may exercise on behalf of victims their rights regarding the offences set out in Article 333 of the Penal Code.

In 2009, Article 1 of Law No. 55 introduced two amendments to supplement Article 333 of the Penal Code as follows:

1. The law now provides a legal definition of FGM/C as 'any non-therapeutic operation which involves total or partial removal and/or wounds performed on the female genital organs, for cultural or other reasons.' It does not, however, provide a definition of 'non-therapeutic operation' in this context.
2. It criminalises and punishes anyone with knowledge of FGM/C, whether planned or already performed, who does not immediately notify the public authorities. The law also tightens penalties for the 'instigators and accomplices' of FGM/C (i.e. those who aid and abet the practice).

Article 2 of Law No. 55 also amended Article 7 of the Criminal Procedure Code so that organisations with at least three years' experience working against FGM/C may now exercise on behalf of victims their rights regarding the offences set out in Article 333 of the Penal Code.

The Penal Code does not currently address cases of cross-border FGM/C, and there do not appear to be any other specific regulations or laws relating to FGM/C carried out on or by citizens of Djibouti in other countries.

The Penal Code does not explicitly criminalise and punish FGM/C performed by health professionals or in a medical setting. Given the wide scope of Article 333, however, it would seem to apply universally and should therefore encompass any health professionals who perform FGM/C.

Under Article 333 of the Penal Code, anyone who is found guilty of performing FGM/C will be punished with a five-year prison sentence and a fine of 1,000,000 Djiboutian Francs (approximately US$5,6177).

The failure to report FGM/C, whether performed or planned, is punishable with between one month and one year of imprisonment and a fine of 50,000–100,000 Djiboutian Francs (approximately US$281–5628). Those who aid and abet the practice of FGM/C are punishable under Articles 25 and 26 of the Penal Code, which state that accomplices to a crime are liable to the same penalties as the main offender.

Enforcement of the law in Djibouti[113]

Year	Arrests	Cases taken to court	Convictions/ sanctions
2018	2	0	0
2019	2	0	0
2020	2	0	0
2021	13	13	13

Regional FGM/C laws

There are many Somalis living in the border regions of Ethiopia and Kenya, and the absence of national legislation banning FGM/C in Somalia allows the practice to continue, as families move across borders to avoid prosecution. There is no accurate data on the number of girls who are taken across borders to be cut. It is also suggested that many Somali women and girls from the Western diaspora (for example, in the USA, Australia, the UK and other European countries) are taken to Somalia for FGM/C because there is no risk of prosecution

Inter-Ministerial Declaration to end cross-border FGM/C

A regional inter-ministerial meeting was held in Mombasa, Kenya in 2019 with representatives of the governments of Ethiopia, Kenya, Somalia, Tanzania and Uganda.[114] Representatives signed the Inter-Ministerial Declaration to end cross-border FGM/C[115] which aims to accomplish the following:

1. Improvement of legislative and policy frameworks and environment to end cross border female genital mutilation,
2. Effective and efficient coordination and collaboration among national governments to end female genital mutilation within their borders,
3. Communication and advocacy on cross border female genital mutilation prevention and response, and
4. National governments, academia and statistical offices have better capacity to generate and use evidence and data for addressing cross border female genital mutilation.

East Africa Community Regional FGM/C Law

Regional FGM/C Law In 2016 the East Africa Community (which includes Kenya, South Sudan, Tanzania and Uganda) enacted the East African Community Prohibition of Female Genital Mutilation Act (EAC Act) 15 to promote cooperation in the prosecution of perpetrators of FGM/C through harmonisation of laws, policies and strategies to end FGM/C across the region. The EAC Act aims to raise awareness about the dangers of FGM/C and provide for the sharing of information, research and data.

The EAC Act defines FGM/C at Article 2 as 'all procedures that involve partial or total removal of the external female genitalia, or other injury to the female organ for non-medical reasons' and sets out its objectives in Article 3, which include

(a) prohibiting FGM/C as a 'trans-national crime' across member states,
(b) setting minimum penalties for FGM/C,
(c) establishing institutions to foster cooperation and
(d) developing and harmonising policies, laws, strategies and programmes to prosecute offenders, prevent FGM/C and provide services to victims and girls at risk of FGM.

The content of the regional law is similar to the Kenyan FGM/C Act 2011 and sets out the following penalties in Part II (Female Genital Mutilation and Related Offences):

- **Article 4(1) –** performance of FGM/C carries a punishment of a minimum of three years' imprisonment;
- **Article 4(2) & (3) –** 'aggravated' FGM/C carries a punishment of imprisonment for life. 'Aggravated' FGM/C occurs if the procedure results in the death or disability of the victim, or if she is infected with HIV, or if the perpetrator is a parent, guardian or health worker;
- **Article 10 –** anyone using derogatory or abusive language or ridiculing a woman (or her male partner) for undergoing or not undergoing FGM/C will be imprisoned for a minimum of six months;
- **Article 11 –** imprisonment for a minimum of three years or a fine of not less than US$1,000, or both, applies to anyone procuring, aiding or abetting the practice of FGM/C (under Article 5), participating in cross-border FGM/C (under Article 6), using premises for FGM/C (under

Article 7), possessing cutting tools or equipment (under Article 8) or failing to report FGM/C that has taken place, is taking place or is planned (under Article 9)

- Further protective measures are set up in Article 12, which states that compensation may be sought from the perpetrator for the victim of FGM/C, and in Article 13, under which, if EAC state members are satisfied that a girl or woman is at risk of undergoing FGM/C, they may issue protection orders.
- Part IV (Miscellaneous Provisions) of the EAC Act requires member states to adopt comprehensive FGM/C laws and include in their national budgets resources to protect women and girls from FGM/C, provide support services to victims, and undertake public-education and sensitisation programmes on the dangers of FGM/C.
- A regional database on cross-border FGM/C will be established, supported by an exchange of criminal intelligence, training of key personnel and strengthening of cross-border security.
- Finally, the law states at Article 16, 'This Act shall take precedence over other Partner State laws to which its provisions relate' (i.e. the penalties may be higher than those that currently exist in member states).

An equivalent regional FGM/C law does not exist in the Horn of Africa. However, a cross-border costed action plan was developed and launched in 2019 which includes Somalia, Ethiopia, Kenya, Tanzania and Uganda. The costed action plan 2019-2024 aims to bring a multisectoral and strategic approach to cross-border FGM/C between the countries.[116]

Part 3: Mapping FGM/C policy frameworks in the selected countries

Key elements of a successful policy framework and national coordination

1. National costed action plan in place and promoted by government ministries
2. National coordination mechanism established
3. National budget allocation for implementation of the action plan and for strengthening of the coordination mechanism

	National costed action plan to eliminate FGM/C in place	National coordination mechanism established	Budget allocation promised by national government	Budget allocation received by relevant ministries and the national coordination body
Somalia	In development	✗	✗	✗
Tanzania	✓	✓	?	?
Kenya	✓	✓	✓	✓
Ethiopia	✓	✓	✓	?
Djibouti	✓	✓	?	?

Kenya has the strongest policy frameworks around FGM/C with a national costed action plan, a national coordination mechanism, government budget allocation and available funds for relevant ministries and the national coordination body.

Budget allocation and provision is critical to the effectiveness of any policy framework or action plan on the elimination of FGM/C and should be closely monitored by activists and lobbied for within government ministries and parliament.

FGM/C policies and structures in Somalia

The leading government departments responsible for work to end FGM/C in Somalia are the Federal Ministry of Women and Human Rights Development (MOWHRD) in Central South and the Ministry of Women's Development and Family Affairs (MOWDAFA) in Puntland. In addition, across all zones, the Ministry for Religious Affairs and Endowment, Ministry of Health (MOH) and Ministry of Youth all contribute to the work to end FGM/C. Since 2015, the federal MOWHRD and the MOH have co-chaired an FGM/C taskforce meeting to coordinate anti-FGM/C work.[117]

The Joint Programme supported the development of the first costed national action plan to end FGM/C in Somalia, led by the Ministry of Women and Human Rights Development.[118] The action plan is key to improving coordination, collaboration and action to end FGM/C in Somalia. It is also critical for implementing the regional cross-border action plan on FGM/C with Ethiopia, Kenya, Somalia and the United Republic of Tanzania. At the time of writing, this action plan is in development with the Ministry of Women.

FGM/C policies and structures in Tanzania

The Ministry of Health, Community Development, Gender, Elderly and Children is responsible for issues relating to violence against women and girls in Tanzania. The strategy to tackle harmful practices, such as FGM/C and child marriage, is set out in the National Anti-FGM/C Strategy and Implementation Plan (2020/21-2024/25), which provides guidance to accelerate the end of FGM/C in Tanzania, and a coordination framework to increase the impact of interventions. The strategy aligns with the goals in the National Plan of Action to End

Violence Against Women and Children by 2030.[119] Key interventions include running campaigns on the health consequences of FGM/C for girls and women, recruitment of change agents from within the communities and the enforcement of legal mechanisms.[120]

National coordination mechanisms in Tanzania

The Tanzania Coalition against Female Genital Mutilation (TCAFGM) operates as the main coordination mechanism for work to eliminate the practice in Tanzania, in coordination with the Ministry of Health, Community Development, Gender, Elderly and Children.The coalition is made up of the Legal and Human Rights Centre (LHRC), Christian Council of Tanzania (CCT), World Vision, Women Wake-up (WOWAP), Tanzania Media Women Association (TAMWA), Anti-Female Genital Mutilation Network (AFNET), and Dodoma Inter-African Committee (DIAC).[121]

FGM/C policies and structures in Kenya

In 2019, President Kenyatta committed to ending FGM/C by 2022.[122] This commitment was followed up with an action plan by the Ministry of Public Service and Gender together with the UN Joint Programme on the Elimination of FGM/C — the action plan is known as the Presidential Costed Action Plan to End FGM/C in Kenya by 2022.[123]

National coordination mechanism

In 2021, the Government of Kenya provided funding to the Anti-FGM Board in the amount of 102,000,000 KES (approximately US$735,000). This was below the budget request from the anti-FGM board of 500,000,000 KES (approximately US$3.6m).[124]

FGM/C policies and structures in Ethiopia

In support of this law, the government of Ethiopia, in partnership with UNICEF, developed a roadmap to end child marriage and FGM/C in August 2019.[125] Within this roadmap, Ethiopia has committed to eliminate FGM/C and early marriage by 2025.[126]

The roadmap uses five pillar strategies to reach this goal, which include the following:

1. Empowering adolescent girls and their families;
2. Community engagement (including faith and traditional leaders);
3. Enhancing systems, accountability and services across sectors;
4. Creating and strengthening an enabling environment;
5. Increasing data and evidence generation, and use.

The National Roadmap 2020-2024 builds on the National Strategy and Action Plan Harmful Traditional Practices against Women and Children in Ethiopia, which was launched in 2013 by the Ministry of Women, Children and Youth Affairs (MOWCYA).[127] The strategic pillars of this action plan included: Prevention, through improving community awareness; Protection, by strengthening and improving the legal and policy framework and ensuring effective law enforcement; and Provision, which included rehabilitative services and support for women and girls.

National coordination mechanism

National Alliance to End FGM/C and ECM (early child marriage) with support from the Ministry of Women, Children and Youth are the main coordination mechanisms for the national costed action roadmap to end child marriage and FGM/C in Ethiopia.

Within the National Costed Roadmap to End Child Marriage and FGM/C, the government of Ethiopia committed to a 10% increase in budget allocation toward elimination of these two issues.[128] On February 6, 2023, UNICEF and UNFPA issued a joint press release calling for increased investment from the government of Ethiopia to accelerate progress toward the goals.[129]

FGM/C policies and structures in Djibouti

The Government of Djibouti leads the implementation of the National Strategy for the Abandonment of FGM/C through the Ministry of Women and the Family.[130] The strategy focuses on strengthening the institutional coordination mechanism for the response to FGM/C; the protection framework against FGM/C, including medical care and legal assistance; the intensification of community actions through advocacy; the development of an information management system; and conducting surveys and operational research on FGM/C trends.

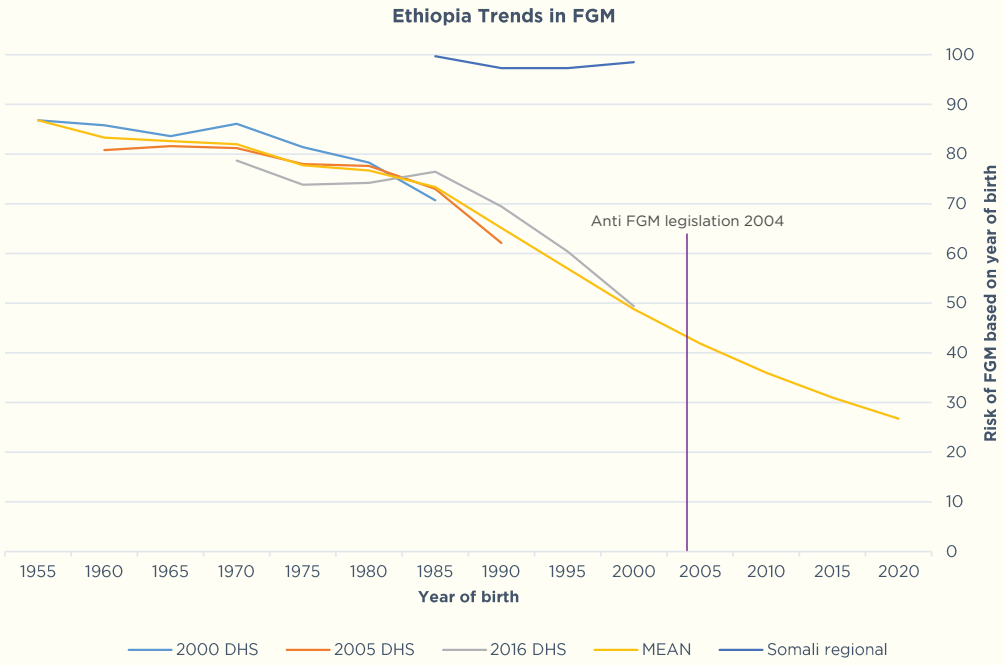
The Government of Djibouti incorporated awareness about FGM/C into its national programme to promote safe motherhood.131

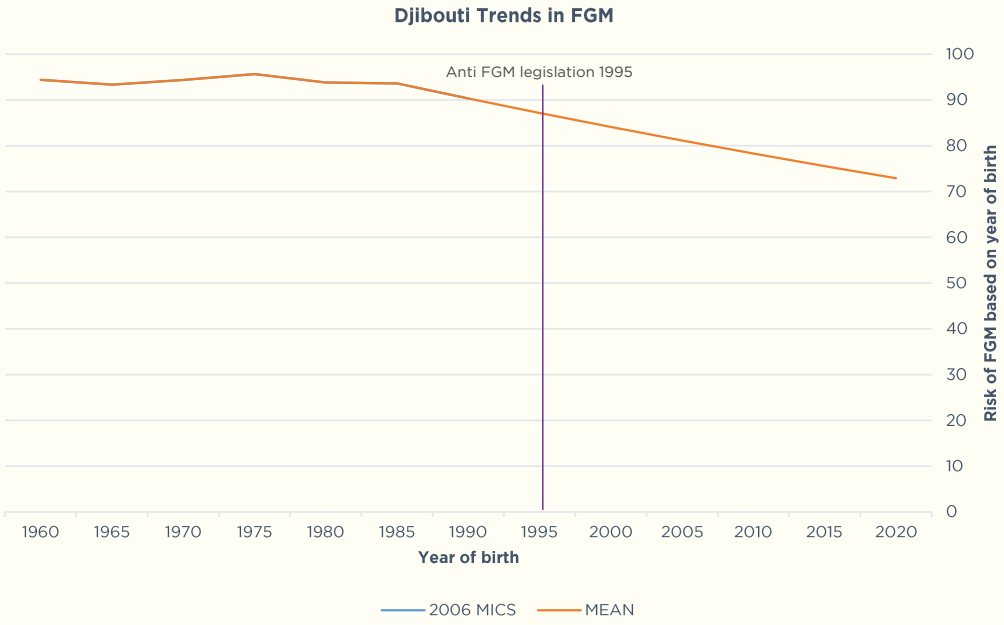
National coordination mechanism

Djibouti established the National Committee to Combat Female Genital Excision in 1992. In 2009, the National Steering Committee for the Abandonment of All Forms of Excision was established.[132]

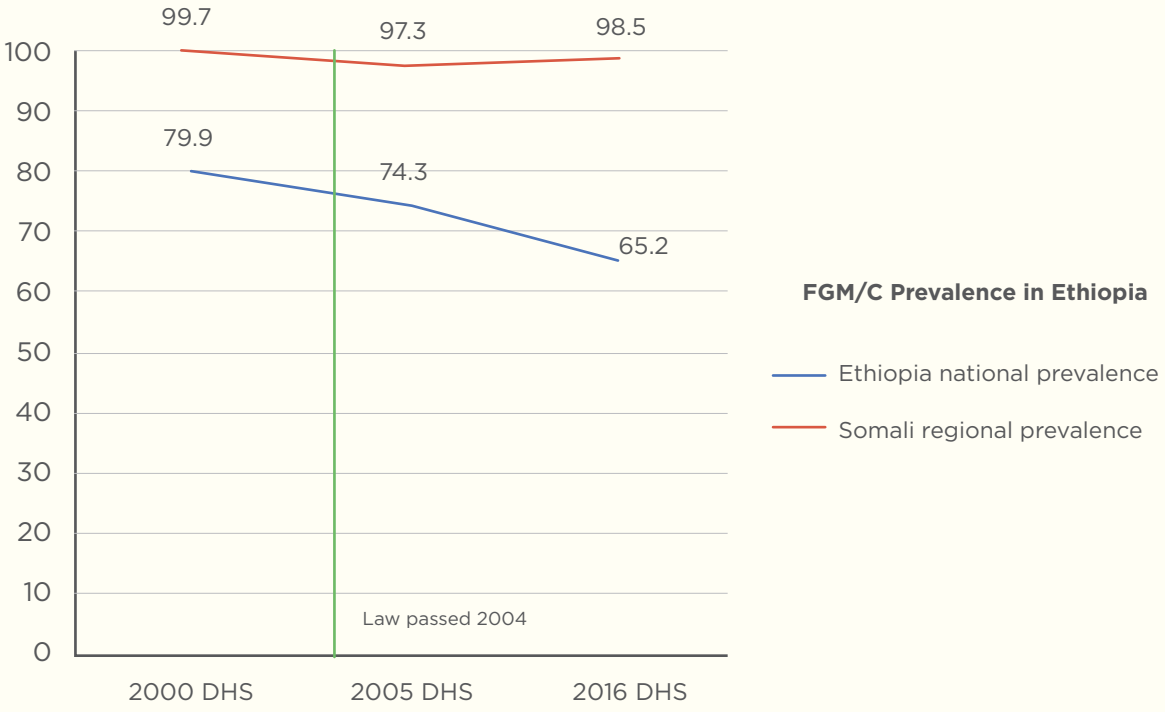
Part 4: Understanding the influence of legislative and policy frameworks in selected countries

Legislation and policy frameworks are correlated with reductions in prevalence of FGM/C, however, the relationship between them varies. The graphs below show the changes in prevalence in the selected countries: Tanzania, Kenya, Djibouti and Ethiopia according to DHS and MICS surveys. What can be seen is a drop in prevalence prior to the passing of a law against FGM/C and the establishment of policy frameworks and coordination bodies in these countries, which continued after these instruments were established. It is possible that these instruments contributed to some acceleration of the reduction in prevalence, but this is not clearly demonstrated in the literature.





In the following graphs, prevalence among Somali communities has been added to the overall prevalence trends for Kenya and Ethiopia. Data on prevalence among Somali communities in Djibouti and Tanzania is not available. What can be seen clearly is that the legislation and policy frameworks have not had an influence in Somali communities where prevalence has remained high over time.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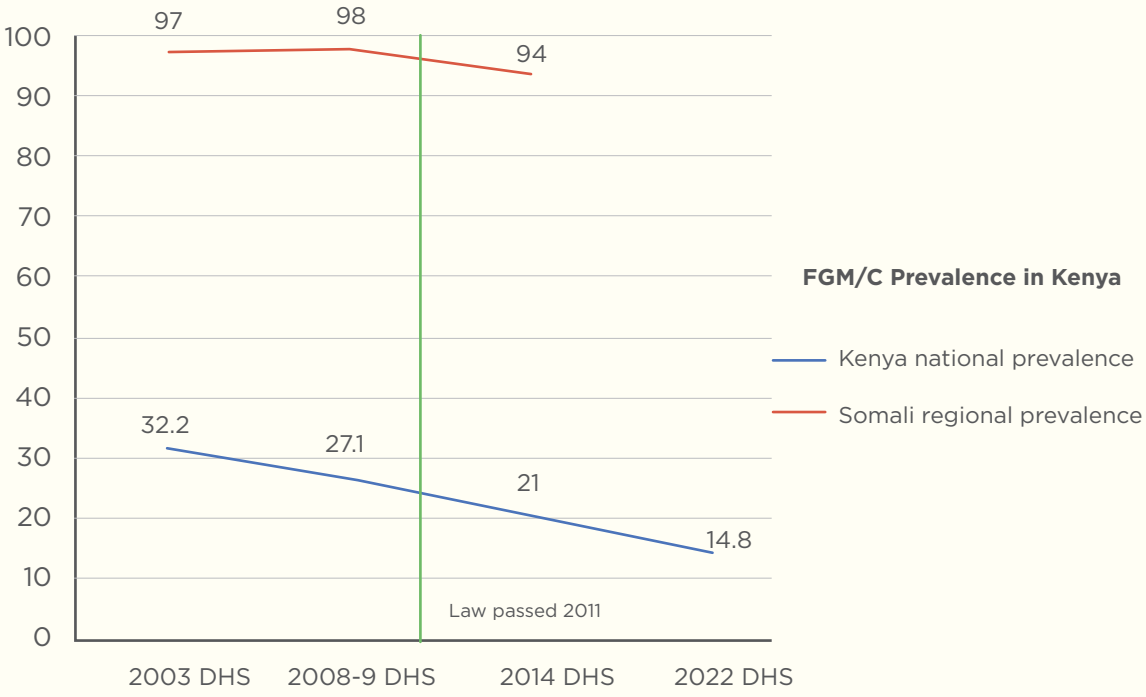
FGM/C Prevalence in Ethiopia
Ethiopia national prevalence
Somali regional prevalence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2003 DHS
2008-9 DHS
2014 DHS
2022 DHS
FGM/C Prevalence in Kenya
Kenya national prevalence
Somali regional prevalence

In order to understand in more depth what influence legislative and policy frameworks have had in selected countries, a literature review was conducted using the following terms:

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

Regions: Africa; Tanzania; Kenya; Djibouti; Ethiopia

Date range: 2003-2023

There is evidence that suggests that criminalisation of FGM/C drives the practice underground and does not actually reduce prevalence.

Kenya has the most robust legal and policy frameworks against FGM/C among the selected countries in this report. Kenya passed the Prohibition of FGM Act in 2011, has human rights for women embedded within their Constitution and has ratified international treaties such as the Maputo Protocol and CEDAW. Provisions against FGM/C are also present in the 2001 Child Act and in the 2015 Protection Against Domestic Violence Act. The Evidence to End FGM/C Research Programme in Kenya conducted a study that assessed the role of legislation in reducing the practice in Kenya.[133] Representatives from the Office of the Chief Justice of the Republic of Kenya, the Office of the Director of Public Prosecutions, the Kenya Law Reform Commission, the Law Society of Kenya, UNICEF-Kenya, and the Anti-FGM Board were collated to develop recommendations for strengthening.[134] The study found since the anti-FGM/C law was passed, FGM/C is being practised on younger girls in Kenya, most of whom have not yet started attending school, on adult women who are already married, or across borders.[135]

A study conducted in Ghana found embedding FGM/C into the Domestic Violence Act (2003) and the Criminal Code (1994) led to girls being cut either in secrecy or in infancy to avoid being caught.[136] As the law in Ghana criminalised only the circumciser and not any other actors, families began to bring in circumcisers from neighbouring countries who could go back to their home countries and avoid prosecution.[137]

A study conducted among the Kisii, Masaii, Abagusii and Somali ethnic groups in Kenya found that FGM/C practice has changed since the anti-FGM/C law was passed to be done more commonly in secret, using less severe forms of cutting, at younger ages and by health professionals (medicalisation).[138]

There is evidence that legislation must align with social norms. If people believe that FGM/C should not continue, then legislation will support that change.

The Evidence to End FGM/C Research Programme study in Kenya found that in decision-making around FGM/C there are competing forces which include culture, religion and law.[139] When penal sanctions are used that compete with culture and/or religion, this can drive people to conduct FGM/C in secret, out of fear of the law. Criminal prosecution of the law is also complicated by these factors, as community members may feel disloyal for reporting incidences of FGM/C from within their community and many times, police and members of the judiciary are embedded in the community as well. When the law is placed in competition with culture and/or religion, culture and/or religion will have the stronger influence over behaviour.[140]

A study conducted in Tanzania found that loopholes in the legislation provided opportunity for continuation of the practice.[141] Families wanted to avoid prosecution but held a strong belief that FGM/C contributes to personal hygiene and avoidance of disease, thus continued to practice.[142] The legislation in Tanzania does not provide a clear definition of FGM/C and does not prohibit FGM/C for women above the age of 18.[143] These loopholes have been utilised by families who want to continue the practice but fear consequences of the law.

There is literature that points to an implementation gap between legislation and enforcement by police and judiciaries. This links to the evidence that legislation drives the practice underground and that it must align with social norms.

In a study assessing the impact of FGM/C laws across 28 countries, only two countries saw a decline in prevalence of FGM/C as a result of the law — Burkina Faso and Eritrea.144 In Burkina Faso, strong political will, awareness-raising about the law, a strong coordination body (CNLPE) and strict enforcement of the law contributed to a decline in the practice. Between 1996 and 2002, a gap of over 50% lower prevalence of FGM/C began to form between mothers (adult women) and their daughters (0-10 years).[145]

In Eritrea, monitoring of violations of the FGM/C law as well as establishment of enforcement mechanisms at the community level has contributed to compliance.[146] Anti-FGM/C committees have also been established in communities in Eritrea to support local law enforcement with raising awareness on FGM/C, as well as monitoring and reporting violations of the law.[147] Prevalence among girls under the age of 15 was 33% in 2012 compared to 89% of women aged 15-49.[148]

In both cases, strong coordination, enforcement, awareness-raising and political will were critical to creating an impact through legislation.

The study conducted by the Evidence to End FGM/C Research Programme in Kenya found that limited resources pose a challenge to implementation of the law. In rural areas, there are often few police stations or available courts and as a result, investigating and prosecuting cases requires a lot of travel, time and cost.[149] This creates a significant barrier to reporting and implementation of the law.

Use of mobile courts, FGM/C desks within police units and building capacity of lawyers to prosecute cases of FGM/C were recommended by experts within the study to improve implementation.[150]

A study conducted in Egypt found statistically significant decreases in FGM/C prevalence from 94% in 2008 to 88% in 2014. Egypt passed an anti-FGM/C law in 2008 which may have contributed to the decline, but is not solely responsible for the shift in prevalence. Medicalisation is common in Egypt (72% of girls under the age of 17 years were cut by health professionals in 2008).[151] In order to create accelerated change in the prevalence of FGM/C in Egypt, the study authors recommend shifting social norms and use of religious edicts, in addition to the legislation and other approaches.[152]

Evidence suggests that traditional laws and legal systems have an important role and must be considered.

As evidenced in the examples of positive impact of legislation on FGM/C, a critical component is the establishment and action of local enforcement mechanisms. In Eritrea, local anti-FGM/C committees were established. In Kenya, county and sub-county mechanisms were established and in Burkina Faso, local awareness raising and positive promotion of the law contributed to its effectiveness.

Part 5: Case studies

The case studies below highlight challenges that have been made against existing legislation and the outcomes of those cases. They are included to highlight the opposition to legislation that can arise and mechanisms for mitigating that opposition.

Case study 1: Kenya

A petition was filed against the Prohibition of FGM Act in Kenya by a medical professional named Dr. Tatu Kamau in 2017, claiming that it was unconstitutional.[153] Dr. Kamau launched a suit against the Anti-FGM Board and the Attorney General in Kenya.[154] Her petition was against the prohibition of medicalised FGM/C as she claimed that it denied adult women the freedom of undergoing the procedure with a licensed medical practitioner.[155] Dr. Kamau also argued that FGM/C is part of cultural heritage in Kenya and that the prohibition of this act was a denial of the right of women to practice their cultural traditions and in violation of Kenya's constitution.

The trial enlisted witnesses to present evidence on the risks of FGM/C for women's reproductive and sexual health, challenges with infections and sexually transmitted diseases, and increased risks of child and maternal mortality. Medical experts, survivors and activists working to eliminate FGM/C were called to testify.[156]

In a judgement in 2021, the High Court in Nairobi upheld and validated the law as constitutional. One of the presiding judges, Justice Achode, said,

- The Constitution grants the freedom for one to exercise their culture. However, that freedom has to be carried out in line with other constitutional provisions. From the law, we observe that culture entails various modes of expression, and therefore what is limited is any expression that will cause harm to a person or by a person to another person. FGM/C falls into the latter category.

Case Study 2: Puntland

On June 10, 2021, the Puntland President, Said Abdullahi Deni and members of his cabinet, endorsed a zero tolerance bill against FGM/C, which bans all forms of the practice.[157] The bill classifies anyone who practices FGM/C (traditional cutters, healthcare professionals, parents and those who assist) as perpetrators, and includes criminalisation of those who promote FGM/C or influence people to have their daughters cut.[158]

The bill was first presented in 2011, but faced strong resistance from religious leaders. The leaders were in agreement that FGM/C should be banned, with the exception of less severe types, known as Sunna. Religious leaders argued that the bill should allow for the practice of Sunna and not criminalise this form of FGM/C.[159]

One Sheikh was quoted as saying, "The law banning FGM contravenes our religion and values. There are valid traditions in support of female circumcision." Another said, "We have other priorities in Somalia, such as building hospitals... Pre-1991 Somali governments never entertained banning female circumcision."[160]

A senior public health worker named Sadio Adan Mire summarised by saying "I believe religious leaders and Puntland government object to FGM but they disagree on how to go about addressing it."

At the time of writing, the bill has not been approved by the House of Representatives according to the Official Gazette.[161]

What does this mean for legislative and policy action against FGM/C in Somalia?

FGM/C prevalence in Somalia is very high at 99.2% of women aged 15-49 years (2020).[162] The prevalence rate in Somalia has not changed since 2006 when it was 97.9%.[163]

Support for the continuation of FGM/C is strong among women aged 15–49 in Somalia and Somaliland (76.4%)[164] and support has increased from 2006 when it was 64.5%.[165] Wealthier women and those with higher levels of education are less likely to support its continuation.[166] Almost three-quarters (72%) of women aged 15–49 believe that FGM/C is a requirement of their religion.[167]

It is important to acknowledge the role of social norms when considering legislative action in Somalia. With prevalence of the practice almost universal and support for its continuation increasing, it is highly likely that a zero tolerance law would only serve to drive the practice underground to be conducted in secret or at younger ages.

Present day Somalia operates under three legal systems: traditional (Xeer), Sharia (Islam) and secular law.[168] Different aspects of society are managed under the different systems with family law falling largely under Sharia law, land and conflict management under Xeer and criminal laws under the secular system.[169] Xeer and Sharia law are more commonly used in rural areas and among pastoral communities and secular law used more commonly in urban areas.[170]

Xeer constitutes a system of norms and rules that are most often passed on orally and upheld by clan leaders.[171] The norms and rules of Xeer, are decided upon by councils of elders and have been strongly influenced by Sharia.[172] Xeer has been said to " enshrine the norms and values of Somali society."

In 2012, religious leaders in Somaliland objected to early attempts at an anti-FGM policy calling for zero tolerance. In February 2018, the Ministry of Religious Affairs in Somaliland issued a fatwa banning the most severe type of FGM/C, pharaonic (sewn closed).[173] After this fatwa, there was a notable shift in the type of cutting away from type 3 (pharaonic/ sewn closed). Among women aged 15-49, 64.2% had experienced Pharaonic cutting in 2020.[174] When broken down into age categories, 82.4% of women aged 45-49 had experienced this type of cutting, while only 46.2% of girls aged 15-19 had experienced the same.[175] This suggests a decrease in this type of cut between generations.

Likewise, in November 2013, 18 prominent religious leaders signed a fatwa against FGM/C, which was witnessed by the then Puntland Minister of Justice, Religious Affairs and Rehabilitation, the Deputy Minister of Health and the Deputy Minister of Women and Family Social Affairs. The fatwa had been drafted by a committee of seven members and justified the abandonment of all forms of FGM/C on health and religious grounds. [176]

Is a zero tolerance law the right approach for Somalia?

Legislation against FGM/C creates the opportunity for regulatory provisions such as the right to education for girls, responsibilities of healthcare workers and roles and functions of religious and community leaders. The study mentioned above by the Evidence to End FGM/C Research Programme in Kenya recommended that regulatory provisions be added to the Prohibition of FGM Act in Kenya to increase its effectiveness. [177] It also creates a mandate for coordination of the FGM/C response between a wide variety of stakeholders.

However, given the strong prevalence rates and support for continuation of the practice of FGM/C, a zero tolerance law is likely to have unintended negative consequences — driving the practice underground, increasing medicalisation and reducing the age of cutting.

Learning from the influence of the fatwa in Somaliland and the apparent influence on the type of cutting, a harm reduction approach may be more beneficial in Somalia. The resistance from religious leaders in Puntland to a zero tolerance law and their argument for a harm reduction model may create more likelihood for passage of the bill through the House of Representatives into enacted law. An integrated approach of harm reduction legislation and statements from religious leaders could influence social norms toward less severe forms of cutting in the short term and potentially to elimination of the practice in the long term.

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