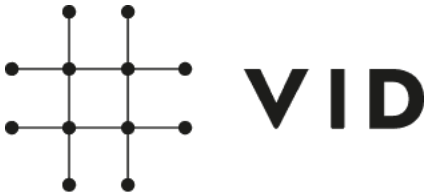

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A Master's Thesis in Female Genital Mutilation

The Impact of Leadership on the Prevalence and Practice of Female Genital Mutilation in African Countries

The Department of community development and social innovation

Value based leadership

Table of Contents

ABSTRACT

Background: Female genital mutilation (FGM) is a significant issue that has raised concerns, especially among different cultures worldwide. Although the practice of FGM is endemic to several African cultures a rising number of organizations, especially human rights activists and feminists, have been campaigning against the practice for years. Some of the arguments are that FGM violates the rights of a girl child and thus has negative implications for young girls. FGM has severe health, moral, mental, and psychological effects on the affected girls. As a result, many human rights organizations have been on the front line in creating awareness among communities practicing FGM on the dangers of the practice.

Research Aim: The main goal of this research is to provide an in-depth analysis of how leadership has impacted the prevalence of FGM in Africa.

Methods: A systematic database search was conducted in health and social care databases with the careful application of strict eligibility criteria. Data extraction and analysis was then conducted on the resulting nine peer-reviewed articles to achieve this goal .

Results: The selected review studies demonstrated that leadership can have a significant impact on the prevalence of FGM, knowledge and acceptance of the practice in the wider community. An analysis identified three major groups of leaders: religious, community and government leaders

who have become actively engaged in the fight against the practice of FGM in Africa. Collaborative action between these different groups of leaders in several African countries has been able to achieve a significant degree of change in FGM practice in these countries over the past decade. It is anticipated that there will be even more significant change in the years to come.

Keywords: FGM, fight against FGM, women, girls, and leadership.

INTRODUCTION

Cultural beliefs and practices tend to substantially affect the ethnic and community settings and social aspects of a community or ethnic group. One of these practices is female genital mutilation (FGM), which is a matter of significant public health concern. It is considered a major human rights concern that constitutes violence against women (Mackie, 1996; Kandala et al., 2019; Engelsma et al., 2020). It has been documented in over 90 countries, especially in Africa, Asia (the Middle East), and part of Europe (Turkey) (Engelsma et al., 2020). Additionally, several instances of some forms of FGM have been reported among various ethnic groups across South America. Furthermore, the increasing migration rate in the US shows the escalating number of women and girls living outside their countries. They leave their countries because they have either experienced the practice or are at risk of being subjected to it in Australia, North America, and Europe. Indeed, it is estimated that about 200 million women and girls have been victims of FGM in these countries (Abuya, 2020; Hayford et al., 2020) due in part to the fact that is performed as a cultural practice.

Moreover, more than three million girls and women are at risk of experiencing FGM annually. This is a matter of significant concern since girls below 15 also face this risk; since most women and girls experience the cut before turning 15 years of age (Engelsma et al., 2020). The prevalence of FGM is estimated using a wide-scale national survey interviewing women 15-49 years old (Engelsma et al., 2020). Based on this scale, substantial variations are obtained between the cultural groups in different states, with nine countries having a prevalence rate of as high as 80%. Furthermore, this prevalence continues to vary among various social groups and regions, with ethnicity and culture being the most influential factor.

1.1 Research question

What is the prevalence of FGM practices in Africa and how has leadership impacted these practices?

To answer the research question, the present study will make use of a systematic literature review. A preliminary exploration of the literature shows that there is a rise in the number of studies exploring issues around the practice of FGM in Africa. While this increased interest in FGM is a welcome development, studies collating or providing an overview of FGM practice, especially with a focus on the impact of leadership, are lacking in the field. current study will use a criterion plan to explore the field, guided by the research question.

CHAPTER TWO

LITERATURE REVIEW

2.1 Background

Various authors have researched Female Genital Mutilation (FGM) from different perspectives and with varying aims. Fox & Johnson-Agbakwu (2020) describe FGM primarily as the complete removal of the female external genitalia or other injuries in the female genital organ for non-medical reasons. The World Health Organisation (WHO) defines female genital mutilation as:

'all procedures that involve partial or total removal of the external genitalia, or other injury to the female genital organs for non-medical reasons' (WHO, 2022, p. 1).

It is recognised that FGM can be dangerous to girls and women because it potentially results in bleeding and even problems with urination and later cysts infection. There is also the added risk of problems with childbirth with resulting increase in the risk of adverse neonatal outcomes including but not limited to newborn mortality (Engelsma et al, 2020; Fox & Johnson-Agbakwu, 2020; WHO, 2022). According to Fox & Johnson-Agbakwu (2020), despite such a reproductive risk, women and girls have been cut in 30 countries in Africa, Asia, and the Middle East. The authors explain that FGM mainly affects young girls between 15 and infancy. As a result, it violates women's and girls' rights and is one of the reasons why the World Health Organisation (WHO) is actively engaged in the fight to eradicate the practice all over the world. These authors also note that the treatment of FGM complications is very costly and can be so hazardous that it can cause death.

The traditional healthcare providers who practice FGM believe it is safe due to their procedure. Besides performing FGM, they play other central roles in the community, such as

attending childbirth. While these providers state that their art is safe, the WHO is against it because it desecrates women's and girls' rights (Lurie et al., 2020). Additionally, these authors observe that it significantly contributes to escalated discrimination against women and girls in society, and reflects deep-rooted inequality between the sexes. Furthermore, the practice also violates the human rights to security, health, life, integrity, and protection from cruelty and torture, since it may complicate and cause death (WHO, 2021).

2.2 Theoretical Perspective

The theoretical perspective used in this study is based on the concept of leadership. The first theory that defines this perspective is based on the work of Powell and DiMaggio (1991). The two authors present the concept of neo-institutional theory that is the study of sociology linked to how institutional norms, cultures, rules, and structures limits the actions and choices of individuals especially when they form part of a political institution . This statement means that the roles within which people operate are defined by structures, cultures, norms, and rules bigger than them. Powell and DiMaggio's theory applies to this study because it explains that FGM/C is a cultural practice passed from generation to generation in the society as an economic, social, and political institution. More specifically, the theory is vital to the study because the cultural frames and belief systems that inform FGM/C restrict the actions and choices of women and girls as far as undergoing the act is concerned.

This is a perspective that echoes of Mackie (1996) who emphasises the importance of groups of trailblazers, leaders who take a strong stance against the practice in families, households

This perspective of leadership as an important determinant of effective change is one that echoes of Mackie (1996) who emphasises the importance of groups of trailblazers, leaders who take a strong stance against the practice in families, households and communities as a start of facilitating wide spread change (Mackie, 1996; Engelsma et al., 2019; Kandala et al., 2019).

It must also be acknowledged that leaders at all levels of society possess the levels of influence that comes with being decision makers and account for the development and implementation of legislations and/or policies that affect different areas of human endeavour (Crawford & Ali, 2019). It could be argued that wide-spread influence is essential for effective change in a cultural practice that is deeply rooted within the fabric of society in many African nations today (Engelsma et al., 2019; Kandala et al., 2019).

Therefore, the theory is vital to the study because the cultural frames and belief systems that inform FGM/C are imposed on women and girls in communities that practice this act. The second theory is based on value-based leaders, defined by common assumptions and beliefs between a leader and their followers. This perspective of leadership as an important determinant of effective theory is core to the study because it involves redefining FGM/C and establishing anti-FGM/C campaigns that will create cooperation between leaders toward eradicating it. The two theories apply to this study because they explain how leadership has affected FGM/C.

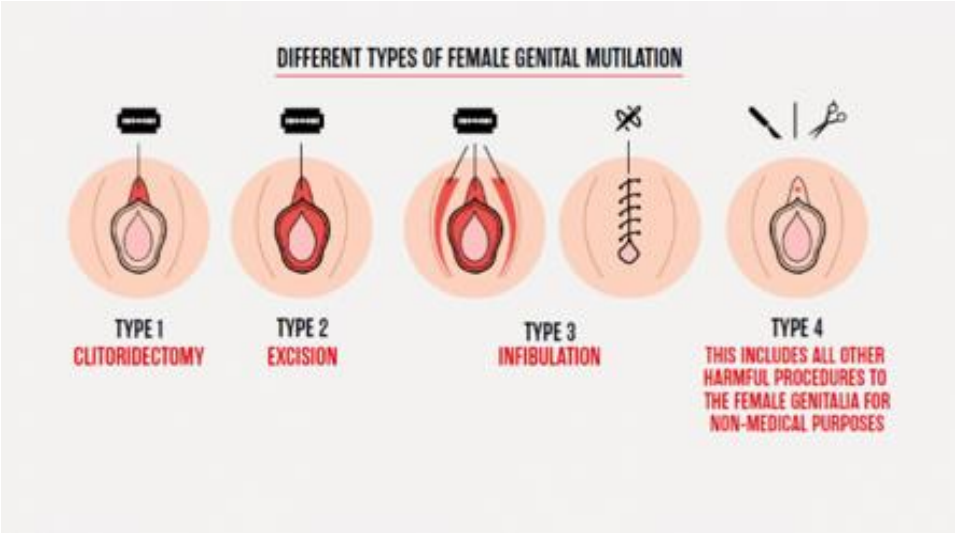
2.3. Types of Female Genital Mutilation

According to Momoh (2017), there are four categories of female genital mutilation. The first category involves the scenario where the clitoral glans are removed. The clitoral glans is the visible and external parts of the clitoris and is the sensitive part of the female genitals. It can also be the fold of the skin which surrounds the glans of the clitoris. The second category involves

completely removing the clitoral glans and the labia minora. The labia minora is the inner fold of the vulva, with or without the removal of the labia majora. Again, it is the outer part of the fold of the vulva skin. The third category is called infibulation and involves the creation of the covering seal to narrow the opening of the virginal. As far as this mutilation is concerned, the labia minora is cut and repositioned to form the seal. The fourth category is a painful process that entails cutting the female genitalia using various cuts. These forms include incising, scraping, pricking, and cauterizing the genital area. As far as these cuts are concerned, the author explains that FGM does not benefit girls and women but harms them in many ways. Generally, the practice of FGM involves removing and damaging the normal female genital tissues. It hinders the natural form and/or the normal functioning of the body of girls and women. The FGM risks rise with the increasing perils linked to the damaged tissue during the practice (Momoh, 2017).

Consequently, the author states that all FGM types are associated with the risk of growing health issues among women and girls who have been subjected to the practice. Momoh (2017) concludes that DE infibulation can be used to correct FGM because it cuts the virginal opening, which is sealed in a woman. Hence, it improves a woman's health, and well-being is necessary to allow intercourse or facilitate childbirth.

Figure 1: The Four Types of FGM (UK Says No More, 2022)



2.4. Complications of the Female Genital Mutilation

According to the WHO (2021) research, the practice of female genital mutilation does not have any health benefits since there are a range of different harmful effects on girls and women. Female health is affected because the practice entails damaging and removing the normal and healthy female genital tissue, affecting the natural physiology of the women's and girls' bodies. The observations by the WHO are also reflected in the research by Reisel and Creighton (2015), who note that FGM has historically had negative impacts on the short- and long-term health of girls and women as far as their psychological and physical well-being is concerned. The authors also state that one of the short-term complications among women and girls is that they experience traumatic bleeding and such infections as gangrene, tetanus, septicaemia, and wound infection. The findings of the research by these two authors echoes the report by the WHO (2021) where complications related to FGM are divided into short- and long-term complications. These complications are summarized in table 1 below.

Table 1: Short-Term and Long-Term Complications of FGM

Short-term Complications	**Long-term Complications**
Death	Difficulty in passing menstrual blood and painful menstruation
Severe pain in the genitals and surrounding areas	Such vaginal issues as bacterial vaginosis, discharge, and itching
Fever	Such urinary problems as urinary tract disease and urination pain
Urinary problem	Keloids and tissue scars
Shock	The need for surgeries after narrowing and sealing the vagina where surgery may be needed to open the narrowed or sealed vagina to allow women to give birth or have sexual intercourse. The repeated surgeries increase long-term health risks during subsequent childbirth and sexual intercourses
Wound healing issues	Such psychological issues as post-traumatic stress disorders, anxiety, depression, and low self-esteem
Such infections as tetanus	Pain and reduced satisfaction during sexual intercourse
Excess bleeding	Death of newborn during childbirth
Injury to the surrounding genital tissues	Obstetric tears and haemorrhage
Swelling in the genital tissues	Prolonged labour

2.5 Social and Cultural Factors involved in Performing FGM

According to WHO (2021), FGM varies from region to region and changes from time to time. It is affected by various social and cultural factors within different communities and families. The first factor is that FGM is unquestionable and almost universally performed in some communities. Second, in some communities, FGM is considered a way of bringing a girl into adulthood and preparing her for marriage. Indeed, in such communities the perception is that girls being cut increase their suitability in marriage, a belief that has led to the persistence of FGM in these communities (Kimani et al., 2020). Third, in some communities where FGM is a social convention, the pressure of conforming to what others are doing and the need to be accepted in that community causes most girls to undergo FGM. In other words, the fear of rejection in their communities motivates many women to acquiesce to undergo the practice.

Fourth, prevailing belief about appropriate sexual behaviour for women are other factors that influence the acceptance of FGM in the community. This is because it is thought that FGM aims to ensure marital fidelity and premarital virginity. Hence, FGM is likely to be practiced in areas where it is believed that it will increase fidelity, an attribute that makes the women more marriageable. Most assuredly, it is believed to reduce female libido in some communities and is hence considered a means of resisting extramarital sexual acts. Fifth, in most regions it is practiced, FGM is considered a cultural tradition, and the involved community members use this tradition to defend its practice. Sixth, different religions have varying opinions about FGM; some support it, while others advocate for its elimination. Seventh, the local structures of authority and power, including the religious and community leaders, medical personnel, and circumcisers, may uphold FGM, especially when they do not understand the inherent negative impacts on women. Lastly, the practice is linked to the ideal notion of modesty and femininity among the communities that

practice it based on the belief that girls become more beautiful and cleaner after the elimination of the parts of the genitals considered unfeminine or unclean (Kimani et al., 2020).

Hayford et al. (2020) observe that the fear of reopening the vaginal orifice after it is narrowed or covered discourages engaging in extramarital sex among girls and women who have undergone this type of FGM. Moreover, in line with the position of the WHO (2021), the authors explain that cultural ideals like modesty and femininity are associated with FGM, where some communities believe that girls are beautiful and clean when the parts deliberated to be filthy, unfeminine, or male are removed. It is argued that while there is no evidence to suggest that any religion has specifically scripted the practice, experts believe that some religion support FGM (Hayford et al., 2020). The faith leaders take different positions regarding the practice of FGM; some leaders consider it irrelevant, others encourage its elimination, and some leaders promote it (Hayford et al., 2020).

Findings from the Berg et al.`s (2018) study is echoed in both WHO (2021) and Hayford et al.`s (2020).The argument provided by these authors is that some factors contributing to the practice of FGM include male sexual enjoyment, interconnection to marriageability and sexual morals, health benefits, religion, and cultural traditions. Berg et al. (2020) also note that FGM was ingrained in the socio-cultural systems of the communities involved in their study. These communities made the practice compulsory as a means of enforcing it. It is therefore suggested that one of the strongest factors facilitating and encouraging the continued practice of FGM in the studied communities is the prevailing cultural norms and traditions. As a cultural tradition, Berg et al. (2020) therefore explain that this practice was adopted among these communities because it reflected a solid basis for the moral standards linked to marriageability; girls were considered moral if they had undergone the practice. From a religious perspective, the authors also note that

FGM was considered a duty based on Islam. In conclusion, male sexual enjoyment and health benefits were the least common factors motivating FGM in the studied communities.

Similar observations are reflected in earlier studies. An example is findings from Karanja (2003) showing that some African communities still place higher values on the practice of FGM. The continued belief in the relevance of FGM as a valuable element of their culture means that FGM is still secretly carried out on women in these communities. Many of these communities cite that abandoning the practice will make them forfeit their way of life since immemorial (Karanja, 2003). Another argument is that most of these communities believe that the practice defines feminism and gender among their girls and women. While it is recognized that there is an increasing number of neighbourhoods that are gradually abandoning the practice, it must also be acknowledged that areas and communities where the practice is deep-rooted continue exposing their women and girls to it. Women and girls from these cultures who refuse to undergo the practice are ostracized (Karanja, 2003). They are ridiculed by their cut counterparts and are not allowed to associate with them as they are deemed unclean. Thus, they lose their place in their communities, and are often viewed as being less suitable for marriage by potential male suitors.

Furthermore, a high number of these African communities still consider FGM as a crucial part of raising a girl, as it is seen as a way to prepare her for adulthood and marriage (Karanja, 2003). FGM is motivated by beliefs of acceptable sexual behaviours in their perspectives. Such communities believe that once a girl has been cut, it will limit the probability of engaging in premarital sexual intercourse and preserve premarital virginity and marital fidelity (Karanja, 2003). The belief is that after the cut, a woman's libido reduces; thus, they can resist the urge to engage in extramarital sexual acts. Communities that practice type 3 FGM, which involves

covering or narrowing the vaginal opening, believe that it will discourage extramarital sexual acts due to the fear of the pain of opening it (Karanja, 2003).

Further, in these African communities, FGM is mainly associated with cultural ideals of modesty and femininity with the notion that removing unclean, unfeminine, or male parts of a girl's body makes a girl clean (Karanja, 2003). Others hold that FGM is religious even though no religious scripts prescribe the practice. The topic is even controversial when handled by religious leaders since they often take varying positions. Some leaders promote the act; others consider it irrelevant to religion, while others support its elimination (Karanja, 2003). However, specific local structures of power and authority in these African communities, including community and religious leaders, circumcisers, and even medical personnel, contribute to upholding this practice.

2.6 International Response to Female Genital Mutilation

The WHO released a joint statement condemning the act of FGM, together with the United Nations Children's Fund (UNICEF) and the United Nations Population Fund (UNFPA) in1997. The joint statement presented the effects of FGM on human rights and public health practice. Through research, change of the public policy, passing laws, and working within the community, a great effort has been put into counteracting FGM since 1997. These various interventions have led to a lot of progress at local, national, and international levels. First, there is the involvement of the wider international community in the fight to stop FGM. Second, there is a concerted effort by United Nations and several agencies are forming international bodies which will help monitor and find resolutions to stop the practice. These bodies include international resolutions and human rights treaty monitoring bodies. Third, these bodies have mobilized growing political support and capitalized on the improving legal framework to end FGM in various countries. The framework includes regulating FGM in 26 African countries, Asia, and the Middle East. Regulation is also

required in 33 other states that have a population of migrants from countries practicing FGM. As a result of the efforts by international bodies, in most nations, the practice of FGM has reduced, and there is a gradual move from an overwhelming support for the practice to an increasing call for the elimination of the practice altogether.

Research has shown that FGM can be eliminated slowly if a vast proportion of the target community is dedicated to abandon the practice (Shell-Duncan et al, 2019; Yount et al., 2020). According to Yount et al. (2020), UNFPA and UNICEF formed a joint FGM program to increase the act's abandonment in 2007. These authors explain that fourteen years ago, WHO, in collaboration with the other nine United Nation partners, advocated for the elimination of FGM, and this advocacy was called "Eliminating Female Genital Mutilation and an interagency statement." As a result, in association with other key UN agencies and organizations, the WHO published guidelines for a global strategy to stop healthcare practitioners from performing the procedure in their facilities. At the same time, the UN general assembly embraced a determination to eliminate the practice of FGM by December 2012 (Kandala & Shell-Duncan, 2019).

Additionally, in 2016, an updated version of the 2013 report was launched by UNICEF. This report highlights the FGM prevalence in more than 30 states and their beliefs, trends, attitudes, programs, and policy responses to FGM worldwide. There was a development based on the systematic review of the evidence available on health interventions for women living with FGM. These interventions were based on the program launched by WHO in association with UNFPA-UNICEF concerning complication management (Morrone, 2020). This allows for the management of FGM and its short-, medium- and long-term complications. It helps girls and women get proper treatments when they have any difficulty and ensure that no one will die due to these

complications- the death of a mother or child during delivery, for example. At the same time, it helps women accept and take care of themselves to avoid anything that can cause complications.

According to Mwendwa and De Brun (2020), WHO also launched a handbook that girls and women affected by FGM could use to improve their skills, knowledge, and attitude toward health care. This was expected to empower them be able to manage and prevent the complications that occur during and after FGM. As a result, the collaboration of WHO with other nations will help many women and girls living with FGM to be able to understand the risks and complications that may occur during and after FGM. The handbook will help add better healthcare skills when any difficulty arises. Additionally, it will help raise awareness to ensure that women and girls affected by FGM; educate those not yet in practice and help them avoid getting into the practice. Furthermore, the collaboration of WHO with different countries will ensure that girls and women change their attitude toward FGM and agree to oppose it, whether it is traditional or cultural (Lussiez et al., 2020). Moreover, the collaboration will ensure that girls and women do not adopt others' cultures or practice FGM because they fear being discriminated against in their communities. The aim was therefore to ensure that countries fight this practice in collaboration with WHO to ensure that it protects women and girls from discrimination.

Based on the report by World Health Assembly, 61 (2008), the world health assembly passed a resolution WHA61.16 on eliminating FGM; they emphasized the need to concentrate on the action across different health sectors, finance, education, religion, justice, and woman's affairs. The World Health Assembly, 61 also outlines the efforts made by the WHO in combating FGM. First, it strengthened the health sector response to develop and implement guidelines, training, tools, and a policy to ensure that all healthcare providers can give proper medical care. Second, it counselled women and girls living with FGM and highlighted basic information about its

prevention. Third, it built evidence that generated knowledge concerning the practice, the cost, and the consequences of FGM. Fourth, it also made women and girls understand why healthcare professionals carry out the practice, know how to eschew it, and avoid complications for those who have gone through FGM. Lastly, WHO developed international advocacy and publication development and made local efforts to ensure that the practice is no longer performed.

2.7 Countries with state regulations and constitutional laws regulating FGM

Okonofua (2015) argues that the legal status of FGM varies from state to state across the globe. To a large extent, countries, where FGM has been termed as highly prevalent have made efforts to enact regulations and constitutional laws aimed at regulating or criminalizing it. Indeed, several nations, including; Egypt, Ethiopia, Nigeria, Sudan, and Kenya, where FGM practices are very high, have adopted constitutional laws aimed at criminalizing and prohibiting FGM practices (Kimani & Obianwu, 2020). However, as acknowledged by Kimani &Obianwu (2020), other nations where FGM is primarily practiced, such as Bahrain, Chad, Colombia, Liberia, Libya, and Mali, have no laws criminalizing or regulating FGM. This lack of regulation and prohibition paves the way for traditionalists to continue practicing and observing this inhumane and human rights violation cultural practice.

According to Kimani &Obianwu (2020), global efforts to end FGM have primarily been focused on Africa, where many states are well-known for customarily carrying on with FGM practices. Thanks to these efforts, tremendous progress has been made, with many African countries moving ahead to enact constitutional laws and regulations to ban FGM. For instance, a country such as Kenya, which was initially known for its high FGM prevalence rate, has moved ahead swiftly to adopt a constitutional law criminalizing the vice (Kimani &Obianwu). In its FGM

Act 2011, the Kenyan government outlawed FGM and set out an FGM board that helps arrest FGM perpetrators (Kimani &Obianwu, 2020). With this act, as one of the affected nations in the world, Kenya is legally dealing with FGM. Most assuredly, it is presently official that under Article 19(1) of the FGM Act 2011, anyone conducting the FGM, including medical professionals or midwives, commits a criminal offense punishable by law.

Nyangweso &Wangila (2014) report that FGM is practiced in 92 nations all over the world; however, it is also reported that only 51 countries have some laws regulating or criminalizing the practice. Therefore, over 30 countries are known for practicing FGM without any law to regulate or ban it (Nyangweso &Wangila, 2014). In the western world, many countries, including the UK and Croatia, have laws criminalizing FGM (Nyangweso &Wangila, 2014; Barrett, 2017; Kandala et al., 2019). In the UK, the FGM Act 2003 criminalizes FGM and is linked to the principle of extraterritoriality that bans UK-born citizens from even practicing FGM in overseas nations where FGM is legal (Nyangweso &Wangila, 2014). Furthermore, under the act, the UK government extends the length of possible imprisonment for FGM perpetrators to 14 years after their arrest, prosecution, and conviction.

However, in other developed economies, such as the United States, a significant challenge on which level of government has the mandate to regulate FGM has, in a way, derailed the process of universal enactment of FGM laws (Nyangweso&Wangila, 2014; Earp & Johnsdotter, 2020). Though FGM was federally criminalized in the US in 1996, the regulation was declared unconstitutional in 2018 by a court ruling declaring that the US federal government had no legal power to legislate on FGM (Nyangweso&Wangila, 2014; Shell-Duncan et al., 2021). With this ruling, over 38 states across the US have gone ahead to enact their FGM laws, thus making FGM

illegal. The remaining states have no law on FGM, thus making it a welcome practice (Hartley & Watson, 2018).

CHAPTER THREE

METHODOLOGY

To explore the prevalence of FGM practices among communities in Africa, a systematic review was conducted. Additionally, the review also included an analysis of the impact of leadership on these practices. The review was conducted in line with the Preferred Reporting Items for Systematic Reviews and Analysis (PRISMA) checklist.

Table 2: Population, Exposure, Outcomes Framework

Population	African communities and leadership at all levels in African Countries
Exposure	Strategies and Policies adopted in the fight against FGM
Outcomes	The prevalence and practice of FGM in these African countries

3.1 Research Question

The research question was developed using the Population, Exposure and Outcomes (PEO) format of the Population, Intervention, Comparison and Outcomes (PICO) framework (Doody & Bailey, 2016). The research population is the different African communities, as well as leaders in these countries; exposure of interest, the strategies adopted in the fight against FGM; while the outcomes examined were the prevalence of FGM in African countries. This is highlighted in table 2 above.

The resulting research question was: ***What impact has leadership had on the prevalence and practice of female genital mutilation in African countries?***

3.2 Data Sources and search strategy

The search was carried out using the following health and social care databases: CINAHL, MEDLINE and JSTOR. The databases were selected because they are valuable resources for the identification of high quality, often peer-reviewed research publications (Saunders et al., 2016). The search was restricted to studies that had been published in the last ten years (Scottish Intercollegiate Guidelines Network, 2015).

Search terms developed from the different elements of the research question above and were combined using the Boolean operators: ‘AND’, ‘OR’ and ‘NOT”. These terms included female genital mutilation, FGM, Africa, leaders, leadership and prevalence. Using these terms helped to narrow down the findings to studies that were of relevance to the area under examination (McGowan et al., 2016; Saunders et al., 2016).

3.3 Search Strategy

Additionally, other various electronic bibliographic sources were used during the study: National Centre for Biotechnology Information (NCBI), BioMed Central, Interdisciplinary Journal of Partnership Studies (IJPS), Researchgate.net, Google Scholar, Oria and ProQuest. These sources were selected because they reflected quality studies based on quality, reliable, and valid research outcomes. The research terms reflected the keywords for the study: leadership, women, girls, FGM, and fight against FGM. The research outcomes were the measures taken by the leaders (at the local, national, and international levels) in the fight against FGM. Indeed, the research outcomes were based on the research question of the study: how has leadership affected FGM practices?

3.4 Data Collection

Data were extracted from the final list of sources the author developed. The author developed a data extraction strategy from three aspects during data collection. The first aspect was the objective of each study. The second aspect was the study used to investigate this objective. The last aspect was the research outcome of this study. These aspects ensured that the researcher collected the most relevant data to respond to the research question. Therefore, the data collection process was effective because the researcher only focused on the sections relevant to the research

question. The parameters that guided this data collection process were the keywords defined earlier as reflected in the research question; the effectiveness of leaders in addressing the FGM practices.

3.5 Eligibility and Selection Criteria

Various steps were involved in the eligibility test as far as the studies used in this study are concerned. The first criterion involved looking for studies written in the English language. Therefore, the studies written in other languages, including French, Spanish, and German, were excluded from the final list of references. The second criterion assessed whether studies belonged to gray literature, ongoing clinical trials, and unpublished studies. Studies that fell into these groups were excluded since the present study only sought peer reviewed studies. In the third criterion, the researcher focused on titles relevant to the thesis question using the Rayyan software. Therefore, they removed references that did not have titles that would help respond to this question.

In the fourth criterion, the researcher examined the studies identified in the third criterion to determine if there were duplicates in terms of titles, research methods, and research outcomes. During this process, all the references duplicates of each other were eliminated. The fifth criterion involved evaluating the abstracts of the potential references to see if they had the keywords relevant to responding to the research question (leadership, women, girls, FGM, and fight against FGM) based on the Rayyan software. Any studies that did not have the keywords were eliminated. In the sixth criterion, the researcher focused on the sources with the most relevant publication years: sources published between 2015 and 2022. Therefore, they eliminated any sources whose publications years did not fall in this bracket. Lastly, the researcher developed a list of resources to be used in the study; the final list consisted of sources that met the six-criterion selection

CHAPTER FOUR

RESULTS

4.1 Summary of the Research Studies

All of the selected research studies carried out qualitative research examining the issue of leadership in relation to the prevalence of FGM in African communities. Abuya (2020) conducted a case study exploring the impact of patriarchy on the prevalence of FGM in the Abuagusii of Kenya. The author sought to determine how transformative leadership has impacted the practice in recent years. In contrast, Catania et al. (2016) carried out focus groups to examine how changes in gender views of FGM had impacted the practice of FGM in African communities. One study conducted descriptive research using semi-structured interviews (Silas-González et al, 2020). Another carried out a narrative review (Odukogbe et al, 2017). Gitau et al (2018) carried out a qualitative explorative study that combined a literature review with focus groups and semi-structured interviews to examine the impact of community leadership on the prevalence of FGM in Kenyan communities. Also adopting a mixed methods study was Kinoti (2021) whose focus was on the effect of church leadership on the practice of FGM in a community in Kenya. Mwendwa et al (2020) adopted a different approach examining data drawn from social media activity and

using thematic analysis to analyse the resulting dataset. The systematic review of literature carried out by Alradie-Mohammed et al. (2020) sought to identify stakeholders that played a key role on the decision to carry out FGM on young females in African communities. Finally, Johnson et al. (2018) carried out focus groups in each of the eighteen states in Sudan to examine the impact of the Saleema campaign on FGM on related decisions and choices. The main findings of each of these studies are highlighted in table 2 above. The findings of each of these review studies are discussed further in chapter 5 below.

Figure 2: PRISMA Flow Diagram

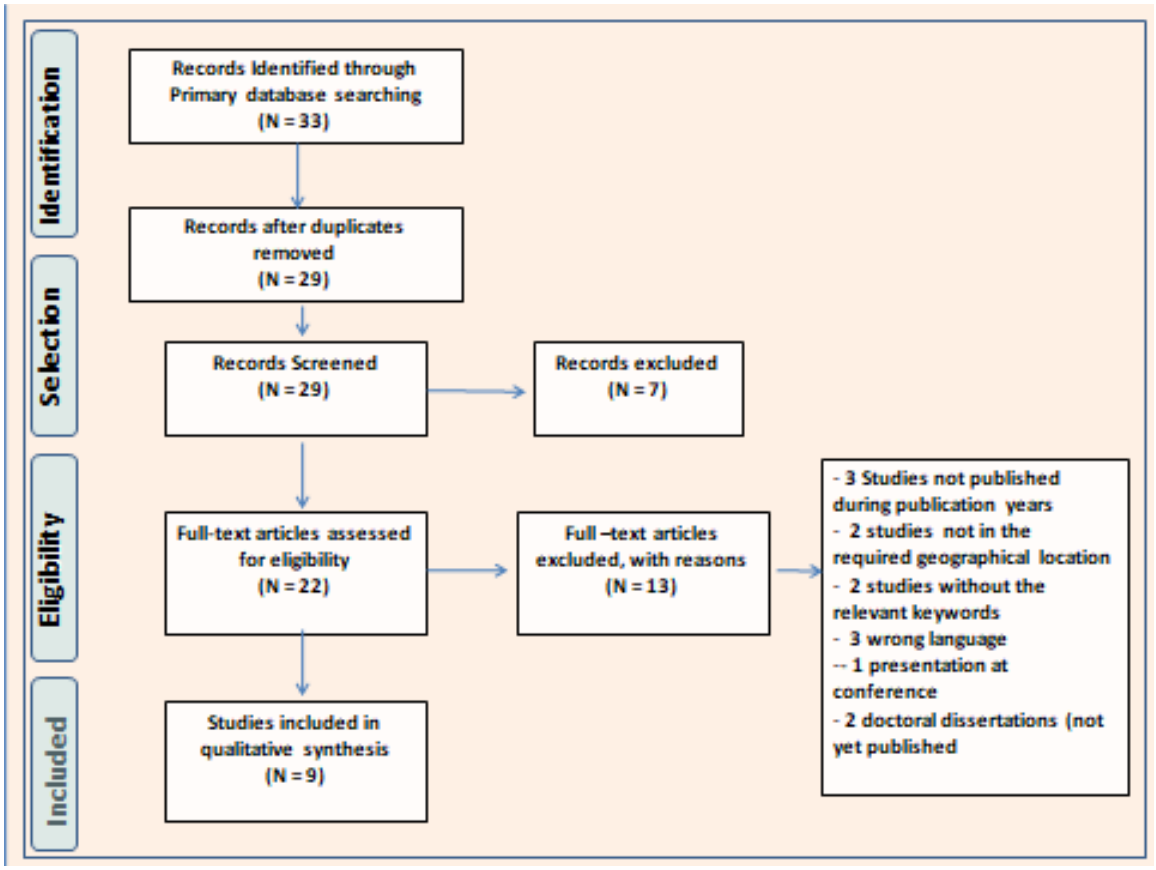


Table 3: Research Outcomes and Characteristics and Included Studies

Author (s)	Journal	Aim	Setting & Design	Participants	Results	Conclusion	CASP Score
1. Abuya, K. (2020)	Interdisciplinary Journal of Partnership Studies	To address leadership for cultural transformation in Kenya with a focus on FGM.	Descriptive Research	Individuals from East and North Africa	Different male and female leaders have successfully eliminated FGM in Kenya and beyond.	People should cooperate towards creating transformative cultural leadership that will help eliminate FGM.	***
2. Catania, L. et al .(2016)	International Journal of Human Rights in Healthcare	To investigate the beliefs, attitudes, and knowledge about FGM in Africa.	Descriptive Research	Men from Nigeria, Egypt, Ethiopia, Benin, Somalia, and Eritrea.	African countries and communities have different perceptions and attitudes against and for FGM. Involvement of leaders in these communities could enhance cultural change in the elimination of FGM	African community leaders could be involved in preventing and eliminating FGM practices in African countries.	***
3. Siles-González et al. (2020)	International Journal of Environmental	To explain the transcultural process through which	Descriptive Research	FGM victims act against the practice.	Since women are the FGM victims, they take a leading role in the	Changing the cultural context helps reduce the FGM cultural	****

	Research and Public Health	female immigrant FGM victims can become leaders against FGM practices.			fight against FGM. Cultural pressure is the leading promoter of FGM practices. Various health problems make it necessary to act against FGM.	pressure. Affected women should take leadership roles against FGM practices.	
4. Odukogbe et al. (2017)	Translational Andrology and Urology	To prevent and eradicate FGM in alignment with the inalienable rights of girls and women and for socioeconomic purposes.	Descriptive Research	Community members in the African countries where FGM is practiced.	The mortalities and morbidities of the FGM practice call for action against this practice. Leaders at the community levels (fathers and husbands) should be involved in the fight against FGM practice. Religious leaders could be involved in the fight against FGM practices because they are based on religious beliefs.	Religious and community-level leaders should be involved in the fight against FGM practices.	***
5. Gitau et al. (2018)	Royal Tropical Institute	To explore the insights of decision-	Descriptive Research	Decision-makers around the	The FGM practice is a transition to adulthood and	Government, religious, and traditional leaders	****

	Amsterdam, the Netherlands	making and leadership on FGM practice in the Maasai Community, Kenya.		FGM practices in the Maasai Community (circumcisers, religious and traditional leaders, grandparents, and parents.	promotes marriageability. FGM among the Maasai is informed by the community's social norms and traditional beliefs. Leaders play a vital role in the observation of these norms and beliefs.	should be involved in the fight against FGM. Religious and traditional leaders are passive, while government leaders actively prevent FGM.	
6. Mwendwa et al. (2020)	Journal of African Interdisciplinary Studies	To assess the facilitators and barriers to preventing and eradicating FGM in Africa.	Descriptive Research	Anti-FGM advocates from Kenya.	There have been decreased cases of FGM due to the actions taken to prevent it: supporting the 'alternative' ritualistic programs (ARPs), involving family leaders (fathers and grandfathers), including FGM in the curriculum, and involving community leaders in creating	The fight against FGM is possible. Community leaders could play a vital role in this fight by supporting the ARPs and introducing policy strategies against FGM practices. Fathers should be more involved in protecting girls against these practices. Religious leaders	*****

					policy strategies against FGM.	should act as role models and raise awareness against FGM.	
7. Kinoti (2021)	Global Scientific Journals	To establish the social-cultural factors affecting FGM practices and the church's responsibility in preventing and eliminating FGM.	Descriptive Research	Girls, women, and the Methodist Church in Kenyan counties.	FGM is hazardous to the health of women and girls and is against their human rights. Religious and cultural beliefs are the leading factors of FGM practices. FGM is a barrier to female education. Alternative rites of passage (ARP) could help prevent FGM in Africa and beyond. Lastly, Church leaders are core in preventing and eliminating FGM.	Church leaders play an influential role against FGM through perceptional changes. They are also core to other efforts in the fight against FGM.	****
8. Alradie-Mohamed et al. (2020)	International Journal of Environmental	To study the FGM decision-making	Descriptive Research	N/A: The authors used a systematic literature	Fathers, mothers, and grandparents are the main FGM decision-makers	Leaders at the family level are crucial in the prevention and	****

	Research and Public Health	process at the household level and pinpoint the main household decision-makers.		review in their study.	at the household level. Therefore, they are the leaders involved in the fight against FGM. Participation of fathers and grandfathers reduces the cultural pressure that causes FGM practices.	eradication of FGM.	
9. Johnson et al. (2018)	Reproductive Health	To examine the perceptions about the Saleema strategy in Sudan and the campaign against FGM in the country.	Descriptive Research	Community members from 18 states in Sudan.	The local leaders in Sudan have information regarding the status of FGM in the country. These leaders are vital in community discussion as far as eliminating FGM is concerned.	Leaders are best placed to promote the ideals of the Saleema strategy in Sudan and should be involved in the campaign against FGM.	****

4.2 Methodological Quality of the Selected Studies

Table 3 summarizes the references the researcher included in the final list and the characteristics that made them relevant to this study. The nine studies summarized in this table met the set eligibility and selection criteria adopting the Critical Skills Appraisal Programme (CASP) framework for qualitative research (Zeng et al., 2015; CASP, 2019). The criteria evaluated included clearly defined research aims and objectives and research methodologies suited to these aims. Clearly stated sample selection, data collection and analysis methods and accompanying rationales. In addition, each study needs to have clearly elucidated research findings, conclusions, and description of the relevance of the research to current practice (CASP, 2019). All selected studies demonstrated moderate (three stars) and high (between four and five stars) methodological quality, as reflected in table 3 CASP scores. Additionally, all the studies used descriptive research design because they were based on research on how leadership has impacted FGM. Therefore, the studies described how leadership relates to FGM eradication and prevention in African countries.

CHAPTER FIVE

DISCUSSION

5.1 Introduction

This chapter carries out a further discussion of the results that were highlighted in the chapter above. It begins with a description of the prevalence of FGM in Africa as well as the strategies that have been implemented in the bid to control the practice in the continent. It then continues to describe the different strategies that have been used to facilitate and encourage the involvement of leaders and examine the extent to which leaders have already engaged in action against the practice in their communities. A description of the different institutional pillars that facilitate change before continuing to highlight the groups of leaders that have a major influence on FGM. It then concludes with a summary of collaborative efforts that could be of benefit in the continuing fight against FGM in African countries.

5.2 The prevalence rate of FGM in Africa

Findings from the included studies in the present review show that there is still a high prevalence of the practice of FGM in African communities. According to the WHO, over 200 million girls and women have undergone FGM in countries where it is practiced globally. Moreover, it is estimated that 3 million more girls are at risk of enduring the procedure annually (McCracken et al., 2017). The practice is rampant in 30 countries, most in Africa and others in the Middle East and Asia. In Africa, it appears to be challenging to document the exact figures since it is a secretive practice and they are rarely reported. Such has been the case, especially for the last two decades, after activists have criticized the practice and various governments have criminalized it. However, criminalization has not stopped the action in multiple countries that embrace it as a socio-cultural norm. In 2015, the United Nations surveyed countries to measure the prevalence by age. The survey showed that between 2010 and 2015, girls and women aged 15 to 49 reported more cases of undergoing the cut than girls aged below 14. The

country with the highest percentage of FGM cases was Djibouti, with 93%, followed by Egypt, with 87%, and Eritrea, with 83% for girls and women above 14 years (McCracken et al., 2017). Gambia had the most significant number of victims aged below 14 years, with 56%, followed by Eritrea with 33% and Ethiopia with 24%. The latest data from UNICEF shows that FGM continues to be practiced in various parts of Africa. Somalia has the leading cases of FGM at 98%, followed by Djibouti at 94%, while Egypt and Sudan are in a tie at 87% each (McCracken et al., 2017).

5.3 Significant changes and efforts to stop the practice in Africa

Although FGM is still practiced in specific African communities, there has been a drastic reduction in the prevalence in some regions. The drop has resulted from various changes and efforts by governmental and non-governmental organizations to end the practice. Since FGM is a painful and horrific experience that numerous women and girls endure, some organizations have alternatives that communities can embrace. For example, Amref Health Africa developed the Alternative Rite of Passage (ARP) approach instead of the cut (McCracken et al., 2017). This approach retains essential aspects of the practice; only the cut is taken away. The aspects include sexual education, blessings by the community elders, and retaining girls in school. The approach is far more beneficial since the girls still undergo the rite of passage without enduring torture and pain. Indeed, girls are taught the best way to live, avoid early marriages, and continue their education (McCracken et al., 2017). In short, the approach saves girls from pain and the threat of death due to increased bleeding, provides them with much-needed life skills, and secures them a future.

Additionally, African governments also come in handy in the fight against FGM. For instance, in 2011, the Kenyan government banned the practice and announced that carrying out or assisting someone in carrying out FGM was illegal. Furthermore, stigmatizing a girl or woman for not being circumcised was outlawed (McCracken et al., 2017; Gitau et al., 2018;

Mwendwa et al., 2020; Kinoti et al., 2021). This sent a strong message to girls and women from communities where the practice was conducted as they began rejecting it with their government's support. Such efforts bore fruits since the east African region witnessed a drastic decrease in the practice of FGM.

At the same time, WHO has been spearheading anti-FGM campaigns in high prevalence regions by spreading the message that FGM has zero health benefits to the girl or woman who undergoes the cut. Moreover, the procedure can lead to severe lifelong consequences such as chronic infection, severe urinating pain, menstruating and sexual intercourse issues, and cysts (WHO, 2021). Furthermore, FGM can lead to psychological trauma and an increased risk of infertility, complications during labour, or newborn death (Karanja, 2003). In addition, the procedure can be fatal if the victim loses a lot of blood. In light of these negative FGM impacts, the WHO campaigns are receiving positive feedback from the women and girls at risk of facing the cut. Other NGOs have established shelters for women and girls who escape their homes when forced to undergo the procedure.

According to Shell-Duncan (2008), young girls frequently face FGM as a "transition to femininity." Nonetheless, since the early 1990s, FGM has been recognized as a significant health and human rights issue. It is sometimes inspired by social and cultural values rather than medical concerns. Consequently, it is not readily possible to initiate a transitional phase when the patterns of belief and behaviours of a society and its members must be modified. While this practice has diminished recently, it threatens women's rights and expertise as far as cultural and social values are concerned. Shell-Duncan (2008) states that the drop in female circumcision is linked to several global interventions directed at 'interveners, caregivers and families,' that continue the practice. However, the author notes that the lack of political will and implementation of these set anti-FGM rules are the most significant obstacles (Shell-Duncan, 2008).

Additionally, Gonzalez et al. (2014) observe that the Maputo Protocol supported women's rights and advocated for eliminating FGM at the second summit in July 2003. This protocol came into action in November 2005 and was ratified by 25 Member States by December 2008. Under UNICEF 2013, the president of Gambia executed legislation or decrees prohibiting FGM in Nigeria, Togo, Tanzania, Sudan, Somalia, Senegal, Nigeria, Mauritania, Kenya, Guinea-Bissau, Ghana, Ethiopia, Eritrea, Egypt, Djibouti, Côte d'Ivoire, Chad, Central African Republic, Burkina Faso, and Benin (Unfa, 2017). The Girl Generation was founded in 2014, a pan-African campaign to end female genital mutilation.

5.4 Strategies for the involvement of leaders in FGM prevention

Crawford & Ali (2019) argue that political and government leaders have an essential role in the battle against FGM. They are the critical opinions and decision-makers in culture and are responsible for relevant policy and legislation. Over the past decade, several organizations and individuals have participated in community-based campaigns to stop female genital mutilation. These campaigns have expanded the global awareness of FGM and brought attention to influential citizens, from village leaders to national government ministers at all levels of society in countries impacted by FGM (Crawford & Ali, 2019). Eliminating the practice will need a strong effort from anyone working on women's and children's health.

Muthumbi et al. (2015) note that national governments have made a solid and public commitment to end female genital mutilation by-laws, technological rules, and programs and have signed international resolutions opposing the procedure. At the same time, these authors observe that since adopting policies and action plans to end the practice, local policymakers have begun setting mitigation benchmarks and creating national and district indicators for monitoring and evaluating anti-FGM programs. Additionally, attempts are being made in many countries that conduct FGM to incorporate genital mutilation reduction into mainstream health

and education systems and partnerships with NGOs and minorities (Muthumbi et al., 2015). These authors also explain that various action plans would assist governments in eliminating FGM. For instance, in March 1997, the WHO African Region's "Action Plan for the Acceleration of Female Genital Mutilation Elimination in Africa" was introduced, offering the national government a boost in its commitment to eliminating female genital mutilation (World Health Organization, 2020).

According to Unfa (2017), the government and political leaders have a crucial role when it comes to making efforts to reduce FGM. These leaders have the responsibility and the power to make decisions that affect the organization and activities of the society; they also have the authority to formulate policies and legislation (Unfa, 2017). However, apart from the government, several other individuals and organizations have participated in the fight against FGM. In view of the different adverse effects that the practice has on females, eliminating FGM should be the number one option for any leader who cares about women and their health (Unfa, 2017). It is now a known fact that the fight against FGM has reached the international level, and several international bodies have joined the race to stop female genital mutilation.

According to the Istanbul Convention (2011), more than 40 states have laws prohibiting female genital mutilation as of of the year its publication. This practice is forbidden in Mauritania by ordinance 2005-2015, which bans medical professionals and public health departments from engaging in the practice. At the same time, parents and guardians are not permitted to put an undue burden on their children to compete in Egypt or Kenya. Female genital mutilation is illegal in Uganda and Kenya, as is violence against non-procedural women. Though there is no federal law banning the activity in Nigeria, there are strict states legislations prohibiting it across the country.

In addition, cross-border prevention of female genital mutilation is becoming more common in countries with many practitioners due to the criminalization of the process and the strict implementation of laws banning the practice (Istanbul Convention, 2011). Thanks to the European legislatures, according to Article 44(3) of the Council of Europe Convention on the Prevention and Mitigation of Violence against Women and Domestic Violence, state parties must guarantee that the crime is punishable if it is carried out on or against either their nationals or citizens of a third country, even if the behaviour is not deemed a criminal offence in that country (Council of Europe Convention on the Prevention and Mitigation of Violence against Women and Domestic Violence, 2011). Similarly, once a suspected survivor is found on its territories, States Parties must take the requisite steps to arrest the female genital mutilation offender. Extraterritoriality is a concept that has been incorporated into several European regulations. Sections 1 and 4 of the United Kingdom of Great Britain and Northern Ireland's Female Genital Mutilation Act (2003) made it illegal for anyone, regardless of race or residency status, to perform or be involved in female genital mutilation (Female Genital Mutilation Act 2003, 2015). In case it remains outside of Italy, Italy enacted a new criminal law statute (Law No. 7/2006) in 2006 that made it illegal for its citizens to go beyond its borders for the procedure (Female Genital Mutilation Act 2003, 2015).

In addition to implementing women's genital mutilation legislation and regulations, some political leaders also set up mechanisms to monitor progress and assign resources for compliance. Indeed these leaders supplied the requisite staff, financial, technical, and other resources for the appropriate authorities (Unfa, 2017). For example, the Kenyan anti-FGM law mandates that a body be set up with operational and advising roles, including adequate funds to counter this practice (Unfa, 2017). Special considerations on confidentiality and support to survivors and witnesses can be incorporated into national enforcement, including protection for parents and girls who condemn the proceedings. Such considerations are vital because

victims of female genital mutilation will also not support prosecution since the perpetrators are sometimes family relatives. In some circumstances, they do not provide a statement to the police investigators. There have been reports of threats against parents who choose their daughters not to undergo surgery and girls who agree to be mutilated to protect their parents (Unfa, 2017).

Many nations have addressed the rights of witnesses and plaintiffs in their rules against the practice. For example, victims of police case advertising in the United Kingdom are automatically confidential (Female Genital Mutilation Act 2003, 2015). Thus, cancelling female genital mutilation requires multi-sectoral policies at all government and general public levels, including civil society organizations, media, medical practitioners, faith leaders, and educators. It also requires participating and discussing beliefs, social opinions, and traditions in communities where they are observed.

According to UNFPA (2014) research, the Joint Initiative on Cutting/Female Genital Mutilation accelerated changes that considerably cut female genital mutilation by establishing traditional, informal, and non-formal schooling awareness initiatives. Additionally, this research shows that as women's literacy improves, the prevalence of derogatory behaviours, such as female genital mutilation, declines. According to a UNICEF survey in Egypt, 72% of women without an education want to pursue FGM, while 44% of women with a higher education want to stop (UNFPA, 2014). Furthermore, 15% of those without a high school diploma and 47% of women with a college diploma have expressed a desire to stop the practice. Similarly, according to a report conducted by Human Rights Watch in Yemen, mothers with no education or just primary school education were more prone to expose their daughters to the practice.

Moreover, there was a possibility that at least one daughter, if not more, might be subjected to the procedure as far as these mothers were concerned. In conclusion, governments,

state officials, and religious and community leaders should promote awareness about the negative impacts of FGM among religious and ethnic communities. For example, female genital mutilation in Ethiopia is not a religious obligation, according to the Ethiopian Orthodox Catholic Church, the Ethiopian Islamic Supreme Council, and the Evangelical Catholic Church (Abathun et al., 2017). These religious organizations have vowed to give their congregations timely messages about the negative FGM effectiveness.

5.5 The Extent of Leadership Involvement in FGM Prevention in African Countries

Research has demonstrated that Africa is the most affected continent in the world regarding FGM. This observation is because most African women and girls undergo FGM silently for fear of being ostracized from their communities. Hence, most cases involving FGM go unreported, leading to minimal or no action against this barbaric act against women and girls. Even then, such African governments as Kenya, Gambia, Niger, and Cameroon have taken different actions against such a health risk to women and girls.

5.5.1 East Africa

5.5.1.1 Kenya

One of the African countries affected by FGM, Kenya has been at the forefront of the fight against this practice. Indeed, under the leadership of President Mwai Kibaki, Kenya took a range of initiatives to protect her women and girls from health perils linked to the practice. Most assuredly, its administration initiated constitutional acts which were fundamental in the fight against Female Genital Mutilation (Anti-FGM Board, 2011). Additionally, the country formed the Anti-FGM board tasked with the role of reinforcing efforts against the illegal

mutilation of female genitals. The acts and the anti-FGM board have been fighting three types of FGM: infibulation, clitoridectomy, and excision (UNFPA, 2014).

Kenya formulated policies and laws that criminalized female genital mutilation; the rules have been very significant in the fight against female genital mutilation. These policies provided a human right framework that protected all individuals from political, economic, and cultural abuses (UNFPA, 2014). Additionally, the Kenyan Constitution and Parliamentary Acts provide various human rights legal frameworks to protect everybody from cultural, political, and economic abuse. In Kenya, specific legal human rights commissions are tasked with ensuring that the tradition is kept to a minimum or abolished completely (Guati et al., 2018; Kinoti et al., 2021). The foreign human rights law enshrined in Articles 1 and 2 of the United Nations General Assembly's Universal Declaration of Human Rights comprises these commissions (OHCHR, 2020). One of the acts passed in the country is the Kenyan Constitution of FGM Act2011, according to which FGM is described as the partial or total removal of female genitalia, damage to female genitals, or any other adverse genitalia processes for reasons other than medical reasons. In addition to clitoridectomy, excision, and infibulation, FGM is prohibited (Anti-FGM Board, 2011).

According to Bilder (2010), regardless of an individual's socioeconomic status, all human rights laws emphasises a central concept of human rights. Human rights law is universal, inalienable, interdependent, and indivisible. Bilder's observations are reflected in the research by Cerna (1994), who notes that human rights are supported by universal human rights doctrines that state that everyone, irrespective of where they live, has a right to human rights. Furthermore, the World Conference on Human Rights reaffirmed in the Vienna Declaration of 1993 that human rights and democracy have no shared character. The Vienna Declaration (1993) states that human rights law regimes in various countries should protect all

people from abuses such as cultural traditions, political opponents, and economic subordination. It is evident that women and girls have the right to protection from FGM.

According to Prohibition of Female Genital Mutilation (2013), although Universalists have been praised for their leadership in combating human rights abuses, they have been criticized. Universalist critics contend that the vision perpetuates imperialist techniques by emphasizing the superiority of one group over another. The approach relies on legitimacy, ethics, and value assumptions to make its argument. However, since universal human rights ideologies are already prevalent, critics focus on the colonial side of human rights but do not discuss universality. Furthermore, fundamental human rights principles seem to supersede state human rights statutes.

On the other hand, the approach to universalism relies on the equity of rules, which poses realistic concerns. A careful examination of the issues posed by the universalism critique reveals solid reasons for scepticism. Indeed, human rights must be negotiated globally, regardless of nationality, based on values, traditions, and rules that regulate citizens' acts and behaviour. Furthermore, the civilization phase has limited human actions in cultural, political, and economic practices. The government of Kenya has relied on this limitation to address FGM from the fundamental human rights perspective.

Creation of Anti-FGM board

According to the Istanbul Convention (2011), as a consequence of the national policy on abolishing female genital mutilation in 2010, the Kenya Anti-FGM Board was established in December 2013. It laid the foundation for passing the 2011 Prohibitions of Female Genital Mutilation Act. Consequently, the Anti-FGM Board is a sub-government entity with special obligations concerning women's genital mutilation in Kenya. It seeks to protect Kenyan girls' and women's dignity and equality through campaigns, educational initiatives, and advocacy against FGM (Istanbul Convention, 2011).The Anti-FGM Board monitors and directs

governmental actions to combat genital mutilation by women, provides advice to the government on the practice of female genital mutilation, and implements policies to prepare, finance, and organize activities relating to female genital mutilation. Again, the Board frequently develops programs to eliminate female genital mutilation and mobilizes funds for community-based projects and activities (Istanbul Convention, 2011). Centred on the Kenya Demographic Health Survey report and on the need to use multi-prolonged strategies to facilitate the discontinuation of FGM, the Board adopted new measures in 2014 (Istanbul Convention, 2011). The process includes developing public awareness initiatives and educational workshops for disadvantaged populations, the general public, law enforcement authorities, 'NyumbaKumi' schemes, and community-based activities.

According to Gonzalez et al. (2014), the Board conducts FGM public awareness drives in conventions such as Decentralization and teacher conferences, national music and drama festivals, artistic road festivals, and road show projects. At the Devolution Conferences, staff from the Anti-FGM Board will comment on FGM-related topics such as the presence of a 2011 FGM Act, efforts to abolish regional FGM activity, the effects that FGM practice has on girls and women, and county governments' participation in the eradication of FGM practice. The Board increases the awareness of FGM in shows such as the Agricultural Society of Kenya (ASK) by providing the general public with information on the short- or long-term impacts of the FGM practice and women and girls' health rights and their retrogression consequences (ANTI-FGM BOARD, 2011).

As noted by Profile (2013), the Board also has a mission to improve stakeholder power across various actions targeted at legislators, including members of county assemblies, prosecutors, young people, and mothers. The Board cooperates with humanitarian agencies, including the AMREF, in assemblies of the two most vulnerable countries in Kenya: Samburu and Kajiado (Profile, 2013). The Board frequently helps coordinate educational workshops

with trainers' groups, including young people, women, religious leaders, professors, and nurses (Profile, 2013). Also, the Board of Directors has ensured the establishment of advocacy organizations comprising NyumbaKumi, law enforcement officers, nurses, religious leaders, and MaendeleoyaWanawake programs to promote the funding of anti-FGM measures and facilities (Profile, 2013).

According to Van Bavel (2022), different community-based organizations have emerged due to the Board's attempts to eliminate FGM in their neighbourhoods. The Board supports Msichana Empowerment for the Kuria party, Meru community health provider, the Kisii community's Heart for Change, Illaramatak, and the Maasai youth network (Van Bavel, 2022). For example, Illaramatak and World Vision have collaborated with Samburu, Narok, and Kajiado counties to conduct FGM awareness campaigns for the elderly (Van Bavel, 2022). The FGM effort problems have erupted, including the region's vastness, issues of collaboration and poverty (Profile, 2013). The Board unambiguously commits CBOs to build partnerships along neighbourhood lines to meet the barriers to eradicating FGM and support women's economic empowerment in collaborative institutions (Profile, 2013). Thus, while much needs to be done, Kenya has effectively fought against FGM.

O'Neill et al. (2020) also note that the board encourages the empowerment of girls using international days and conferences that foster anti-FGM appreciation. The Board capitalizes on conventions such as International Zero Tolerance for FGM, International Women's Day, the Convention on the Status of Women (CSW), and 16 Days for Protection against GBV(Istanbul Convention, 2011). The United Nations General Assembly adopted the International Day of Zero Tolerance for FGM, which commits each Member State, the United Nations Systems, the civil society, and all participants to observe the 6thof February as the International Day of Zero Tolerance for FGM (O'Neill et al., 2020). The CSW is an intergovernmental body that promotes gender equality and women's advancement worldwide.

CSW reviews the advancement of gender equality, identifies challenges, sets global priorities, and elaborates concrete policies that encourage the integration of gender and empowerment of women worldwide through a UN Headquarters mandate (O'Neill et al, 2020).

5.5.1.2 Djibouti

According to the US Department of State (2009), two types of FGM are common in Djibouti: type II (excision) and type III (infibulation). Even so, infibulation is the most common type in the country and is a cultural practice among the Afar and Issa communities. Among the Djibouti communities, type III is called the pharaonic type (Gilliam, 2018). According to Gilliam, much as FGM has been illegal in this country since the late 20th century, it defines a cultural practice of most Djiboutian ethnic groups. For instance, the Afar ethnic group engages in FGM a few weeks after a child has been born. Moreover, according to the US Department of State (2009), the practice has affected between 90 and 98% of women and young girls in Djibouti. It is done on 95% of girls under ten and 41% of those under five. Such a prevalence of the practice is because it is ingrained in the country's local customs from an 'Islamic basis' even when it is not enshrined in Quran.

The country's president (Ismail Omar Guelleh) has spearheaded and approved measures against FGM. For instance, Article 10 of the country's constitution states that all people are equal before the law, and the country is obligated to respect and protect the integrity of everyone. This article protects women and girls against FGM because it interferes with such integrity (Thomson Reuters Foundation, 2018). At the same time, the country's Penal Code was established in 1995 and reflected the first legislation to have illegalized FGM and punish the FGM culprits (Thomson Reuters Foundation, 2018). Additionally, the president saw the establishment of Law No. 55 of 2009, which included FGM as one of the violent actions against women (Thomson Reuters Foundation, 2018).

Furthermore, the president was part of efforts to implement Article 333 of the Penal Code in addressing the violent impacts of FGM on women in the country (Thomson Reuters Foundation, 2018). While this article did not define what FGM was or criminalize the aiding of FGM, Article 7 of Djibouti' Law No. 55 developed two amendments that made it (Article 333) more effective in illegalizing FGM (Thomson Reuters Foundation, 2018). The first amendment defines FGM as any non-medical operation that entails the partial or total removal of female genitals for whatever reasons (Thomson Reuters Foundation, 2018). The second amendment criminalizes FGM whether one has done it or is planning to do it without informing the authorities.

Moreover, the amendment also recommended the punishment of the culprits involved in the planning and practicing of FGM (Thomson Reuters Foundation, 2018). It extended this punishment to people who aid the conducting of this practice even when they are not directly involved in the planning and practice of FGM (Thomson Reuters Foundation, 2018). At the same time, Article 2 of Law No. 55 allowed organizations to advocate for the rights of women and girls against FGM so long as they proved that they had been working for at least three years in the fight against the practice (Thomson Reuters Foundation, 2018). According to Article 333 of the penal code, any culprit of FGM is liable for a fine of 1,000,000 Djiboutian Franc and a five-year term in prison (Thomson Reuters Foundation, 2018). Similarly, failure to report cases of FGM is punishable by a fine of between 50,000 and 100,000 Djiboutian Franc or between one-month or one-year term in prison (Thomson Reuters Foundation, 2018).

Finally, people who have aided the practice are liable for the same penalties as the main culprits. Such liability is entrenched in Articles 25 and 26 of the Djiboutian Penal Code (Thomson Reuters Foundation, 2018). Other efforts in the country against FGM include raising awareness about the inherent health risks (US Department of State, 2009). For instance, the Association for the Equilibrium and Promotion of the Family (ADEPF) has effectively created

awareness about the FGM health risks and run programs to teach people about such perils (US Department of State, 2009). Other non-governmental organizations involved in the fight against FGM in Djibouti include the Caritas and the Red Sea Team International (US Department of State, 2009).

5.5.2 West Africa

5.5.2.1 Gambia

Gambian president Yahya Jammeh is greatly celebrated for his efforts to end female genital mutilation in the Gambia. In December 2015, he pronounced female genital mutilation illegal in Gambia (Abathun &Sundby, 2017). He stated the act was not acceptable both in western societies and in the Islam doctrines and ordered that anyone who would be found participating in the action would face three years imprisonment (Lyons, 2017). In 2017 after Eid-ul-Fitr and Ramadan, the Gambian president banned child marriage, where girls under 18 years were not allowed to get married. According to a (BBC Report, 2017), Jammeh declared that anyone who would be found with a wife below 18 years of age would face up to 20 years in jail.

Gambian communities have been practicing FGM, which has been part of their culture since immemorial. It is reported that more than 80% of girls in Gambia went through FGM in 2010 (Abathun &Sundby, 2017). Such an observation is because Gambia is occupied by Muslim communities who view FGM as a mandatory and essential part of their culture. Thus, many women in Gambia go through the process of type I and type II FGM. As a result, many of these women have experienced various problems associated with female genital mutilation including but not limited to pelvic pain and loss of fertility. Jammeh's decision to ban FGM was received with mixed reactions, with almost 65% of Gambian women going against it (Lyons, 2017). The Mandinka women, for instance, greatly supported the

continuation of FGM practices, and about 80% of them were against the decision made by the president (BBC Report, 2017).

According to Lyons (2017), Mandinka women do not think that female genital mutilation is wrong. Instead, they consider it circumcision, a process that all persons, including babies, must follow. It is part of their Gambian heritage and their only means of maintaining purity in their marriages. However, only affluent families can afford to circumcise their children in a surgical centre. The care after FGM is done mainly by mothers or conventional healers for girls under 5.Women exposed to FGM are more likely to reside in rural regions with fewer resources, such as health centres (Lyons, 2017). Many Mandinka women have been arrested and found guilty of FGM and have been subject to sanctions and sentences under existing legislation for up to three years (Lyons, 2017). Such arrests and arraignments are controversial and have sparked a lively debate. However, they reflect the first legitimate move in this nation and Africa to eliminate female genital mutilation. While most women prefer FGM, support for the FGM ban has recently increased (Lyons, 2017). Such support is primarily due to organizations like the Guardian, which educate citizens about the FGM prohibition and its inherent negative impacts.

5.5.2.2 Niger

Niger has promoted laws and regulations to prevent female genital mutation in the region. Article 11 of the Constitution of Niger (2010) requires the State to respect and protect its citizens (Niger, 2017). None shall, following Article 14, be liable to coercion, slavery, brutal, inhuman, or worsening abuse or treatment, which will have legal implications for anyone found guilty of those acts. Article 22 of the Constitution specifically requires the state to adopt national policies and initiatives to dismantle all forms of discrimination against women and young girls and prevent their violence publicly and privately (Niger, 2017). Again, Article

171 stipulates that the agreements or treaties agreed upon annually should replace domestic legislation (Niger, 2017).

The Penal Code does not expressly criminalize the failure to report FGM. Anyone suspected of a crime perpetrated or attempted but not immediately revealed to the competent authority shall be charged according to Article 186. A severe punishment can be given if the crime documentation has stopped or reduced the crime's effects or if the defendant is liable to perform further offences prevented by such identification. On the other side, the spouse, friends, relatives, or relatives are not obliged to confess the offence to the authorities through the marriage of the perpetrator or any accomplices. It is also an offence punishable by Articles 222 and 226 of the penal code to voluntarily cause injury, assault, or violence towards an individual, including a child. Additionally, Article 7 of Niger's Law on Reproductive Health No. 2006 16 states that every individual has the right, in general, and their reproductive organs in particular, to be exempted from cruel, inhuman, or degrading abuse (Niger, 2017). FGM constitutes such abuse, meaning that Niger's constitution is against the mutilation of female reproductive organs.

In terms of Niger's legal framework, medicalised FGM is not common. Only the orthodox practitioners of nearly all types of FGM (types I, II, and II) tend to perform it; types I and II are the commonest. It is not common because, in cases of medicalised FGM, Article 232.3 of Niger's Penal Code criminalizes and imposes sentences on offenders who are employees or paramedics of the institutions that perform FGM. Again, such offenders are liable for maximum penalties, and their right to work can be suspended for up to five years (Status of African legislation on FGM, 2017).

According to the 2020 Country Reports on Human Rights Practices: Niger (2020), FGM has been practiced secretly around borders in various countries where it is legal. Niger lacks awareness of how FGM is performed across national borders. The Tillabery district,

located near the Burkina Faso/Mali borders, and the Diffa region, near Chad and Nigeria, are clear examples of places where FGM is practiced, mainly in areas bordering neighbouring countries where FGM prevalence remains high and where laws are pretty different (2020 Country Reports on Human Rights Practices: Niger, 2021). According to previous UN reports, traditional cutters have been crossing the Niger-Burkina Faso border to conduct FGM. The high prevalence of FGM along borders is because cross-border FGM is excluded from the Penal Code and not criminalized or punished by Nigerien residents of other countries.

Nonetheless, there have been successful arrests and arraignments in courts in Niger (Niger, 2017). For example, three female practitioners were sentenced to an eight-month suspended sentence and paid 40,000-franc CFA (USD 69) fine in January 2010 (Niger, 2017). The matter was heard in the lower court of Kollo in the Tillabery district. In the same month, 45 mothers in Kollo were reportedly punished for forcing their daughters to be cut and sentenced to eight months of probation (Niger, 2017).

Similarly, according to Crianza (2019), in November 2010, a woman was accused of seven cases of female genital mutilation (FGM) in a village near Niamey. These FGM cases involved girls aged two months to 3 years whose mothers were subsequently detained (Crianza, 2019). However, the Judge and the professionals on behavioural well-being decided that the female FGM nurse would not stand trial at the hearing, and the case was discontinued (Crianza, 2019). Nonetheless, there were no particulars as to whether or not mothers had arbitrated their claims. The Niger government department responsible for the supervision of FGM elimination efforts is the Ministry of Foreign Affairs and Child Protection (Crianza, 2019). It supports CONIPRAT, Niger's National Harmful Traditional Practices Committee, to guide the national response to the FGM practice. Indeed, the government and CONIPRAT are running regional campaigns in partnership with UNICEF and other development partners and NGOs to increase

awareness among opinion leaders (including national, local, and religious leaders), children, and parents of the negative impact of FGM (Crianza, 2019).

2020 Country Reports on Human Rights Practices: Niger. (2021) explain that the use of 'intelligence caravans,' which carry FGM information (and other subjects) worldwide, has proved to be a pioneering approach to remote communities. These caravans are also followed by magistrates who advise individuals who have suffered gender violence. Community radio, local language programs, and live debates with critical religious leaders are also widely utilized (2020 Country Reports on Human Rights Practices: Niger, 2021).Through such programs and debates, observers found that the government disseminates information about FGM laws through CONIPRAT services. The police and court members also received specialist instructions on FGM issues (Crianza, 2019). The 2003 rule was applied to all the languages of Niger to meet a broader audience. Civil society organizations nevertheless point out that more work is still needed. There is little public understanding of the content and meaning of the legislation, and still a lack of enforcement of such laws.

5.5.2.3 Cameroon

President Paul Biya of Cameroon battled female genital mutilation by promoting actions and legislative interventions since 1982. Cameroon's legal code is a blend of customary law, French civil law, and English common law (Penal Code, 2012). Domestic abuse, discriminatory activities, and female genital mutilation are not included in the Republic of Cameroon's Constitution (1996), as updated in 2008 (OHCHR, 2019). According to Rene (2021), the preamble, on the other hand, declares that everybody has the right to moral and physical dignity and that "*no individual shall be subjected to violence, barbaric, inhumane, or degrading treatment under any circumstances*."

The Republic of Cameroon's Penal Code, which is codified as Law No. 2016/007 of 12th July 2016, contains a provision that expressly criminalizes and forbids "genital mutilation." The Republic of Cameroon's Penal Code (Section 277-1) does not explicitly include FGM or relate to female genitalia. However, it does extend to mutilation of a person's genital organ "by any means whatsoever" (Penal Code, 2012). It covers various genital mutilation offences, with repeat offences and those performed for monetary gain. Aiding and abetting FGM, or declining to disclose the procedure, is not, however, illegal (OHCHR, 2019). Article 350 of the Penal Code ('Assault on Minors') deals with female genital mutilation, with a harsher penalty if the perpetrator is under 15 (Prohibition of Female Genital Mutilation (FGM): International and Regional Frameworks, 2013). The Republic of Cameroon's Civil Code is currently being drafted (Penal code, 2012). It will include a Code on Child Protection, the Family, and a Code of the individual if completed and enacted. It's unclear when or how it'll address corrupt traditions such as female genital mutilation.

In Cameroon, type I and II genital mutilations are the commonest and are legal if done "by a conscientious person and for the sake of saving a life" (Section 277–1). However, the Penal Code does not distinguish between a "worthy person" and whether it should be employed to "save a life" (Penal Code, 2012). According to available data, FGM medication is not standard in Cameroon: only 4% of females aged 15–49 who have undergone FGM have had the care of a health practitioner.

Cameroon's current national regulations do not address medicalised FGM (OHCHR, 2019). While the Penal Code makes genital mutilation illegal for "qualified citizens," the Organization and Practice of Medicines Law of 1905 require anyone practicing medicine in Cameroon to register with a medical association. As a result, anybody registered with the Cameroon Medical Association under Penal Code's Section 277–1 could be considered a "free citizen." However, according to Section 43 of Law No. 90–036, on the Practice and

Organization of Medicine in the country, *'The regulatory authorities can be appealed to for any investigation of any sort of crime that might discredit or jeopardize the reputation of clinical practice in or outside state reg*ion,' or '*conviction for professional wrongdoing*,' While this statement does not explicitly mention FGM, it may come under the scope of this statute's authority. The discipline board will be referred to whether the conduct is interpreted as denying or damaging a medical profession or as a "professional error."

FGM has been forced behind closed doors and around boundaries in several countries where prosecution is prohibited. Cameroon shares borders with Nigeria, Chad, and the Central African Republic, many of which have separate legal systems (Refugees, U. N. H. C., 2015). FGM continues to be pursued through national boundaries, posing a constant challenge to the continent's effort to end female genital mutilation (Refugees, U. N. H. C., 2015).In Cameroon, information on cross-border female genital mutilation is scarce. How many families or practitioners cross boundaries into neighbouring countries or how many citizens enter Cameroon from neighbouring countries is unclear (Refugees, U. N. H. C., 2015). It's also uncertain if female genital mutilation is carried out secretly or is orchestrated by a Cameroonian living outside the region.

The penalty for genital mutilation (Section 277-1) is 10 to 20 years in jail, according to Section 277-1 of the Penal Code, which leads to "Grievous Damages." If the criminal acts for monetary benefit daily or his conduct result in murder, he is sentenced to life in jail (Section 277) (Rene, 2021). The court has the authority to impose forfeitures for genital mutilation (section 277), which includes removal from public service or jobs and a prohibition on continuing to work in any position related to the education or treatment of children (Rene, 2021). Following Article 350 of the Penal Code, the penalty for genital mutilation against a child under 15 years is life imprisonment (Assault on Children) (Penal Code, 2012). As

previously said, the court has the authority to order forfeitures. Medical malpractice legal implications include reprimand, warning, or termination of practice for up to one year, based on the severity of the crime commission, according to the drug statute of 1990 (section 48) (Weny et al., 2020). When a sanction is notified, it becomes inadmissible to serve in the Association's Council for two to three years.

According to the report by OHCHR (2019), the Ministry of Women's Empowerment and Family in Cameroon is in charge of ending and combating violence against girls and women in general as well as promoting women's participation in all aspects of politics, economics, social life, and culture. Based on this report, to improve child welfare, the Ministry of Family Promotion and Security and the Ministry of Children's Rights were created in 2012. Moreover, the report shows that the government implemented a National Action Plan to Combat Female Genital Mutilation in 2011. Similarly, the Ministries of Social Affairs, Women's Empowerment, and the Family formed local committees, especially in the far north, where the practice was more prevalent. The commissions worked with civil society organizations, traditional and religious leaders, and former excisions on information and networking programs (OHCHR, 2019). The Cameroon Council (CIDIMUC) voted in June 2013 to join forces in fighting against female genital mutilation (FGM), accidental or early marriages, and other types of violence (Refugees, 2015).

According to Refugees, U. N. H. C. (2015), there is scarce recent evidence on Cameroon's advancement toward ending FGM, making recognizing credible patterns in prevalence challenging. Although businesses are working to end the activity, there is little proof that the legislation is being followed in the areas where it exists (Refugees, U. N. H. C., 2015). In other countries that are anti-female genital mutilation, the legislation suggests that criminal FGM has been weakened. Despite this observation, no research has been conducted to explain the Penal Code's implications better following its development and implementation. In

conclusion, despite the efforts placed by the above leaders and countries, it is tragic to note that every year, more than 3 million female babies and children are at risk of FGM (Refugees, U. N. H. C., 2015).

It is recognized that significant advances have been made, spearheaded by leaders working hard to facilitate the introduction and implementation of legislation and public policy to reduce or eliminate FGM in their local, national and international communities. However, the gap between public perceptions of the risk and side effects of FGM and the extent to which the practice has been eliminated is still too wide. The fact that women and men in those regions continue to be subjected to the practice due to tradition, culture, and community, even though they all believe it should be abolished only serves to highlight how much work still needs to be done (Refugees, U. N. H. C., 2015). Therefore, every African leader must be at the forefront of the fight against the practice to save the lives of millions.

As far as the Gambian, Niger, Cameroonian, and Kenyan contexts are concerned, the local and national governments in the African nations have shown eternal commitment to the fight against FGM. Most governments have done this through programs, international solutions, and technological laws. The nations have been engaging the local policymakers in setting mitigations and developing district and national indicators for evaluating and monitoring programs (United Nations, 1948). Many African countries where the practice is rampant are trying to incorporate it into the health services and the curriculum; the states also partner with other non-governmental bodies to reduce FGM.

In 1997 the World Health Organization operating in the African region initiated the "Action Plan for the Acceleration of Female Genital Mutilation Elimination in Africa," this gave the African governments a boost in their efforts to stop female genital mutilation (United Nations, 1948). While it is recognized that there is still a lot to be done, this pattern and the

role of leadership at every level in bringing about the change only serves to emphasise the importance of good leadership in facilitating effective change.

Over 40 countries have passed laws to stop female genital mutilation in Africa. The practice is unlawful in Mauritania by ordinance, and in 2005, they passed a law that bars all public health workers and health professionals from engaging in female genital mutilation (Shell-Duncan, 2008). In Kenya and Egypt, the regulations do not allow guardians or parents to allow their children to undergo female genital mutilation. They term the action as violence against women and children. The activity is illegal in Uganda; however, some African countries like Nigeria do not have federal laws banning female genital mutilation (Shell-Duncan, 2008). Both national and local authorities in Nigeria do not have strict legislation that bars Nigerians from performing FGM.

The fight against female genital mutilation requires that African countries use multi-sectorial policies at all public levels, including media, society, religions, medical practitioners, and the education sector. The governments must engage and discuss with social, religious, and traditional leadership in the community where FGM is concentrated. UNFPA and UNICEF have joint initiatives to reduce female genital mutilation (World Health Organization, 2020). The international bodies argue that accelerated intervention will cut FGM if the laws and policies adopted involve informal, traditional, and formal awareness of the negative impacts of female genital mutilation. According to research, as the literacy level among women increases, the prevalence of harmful traditional practices like FGM decreases (World Health Organization, 2020). The Human Rights Watch in Yemen reveals that mothers with no education or those with just a primary level are more likely to expose their children to the practice of FGM (World Health Organization, 2020). It is therefore important for state officials and governments to create awareness through ethnic and religious groups on the danger of female genital mutilation. For example, Ethiopian FGM is not a sacred duty according to

Ethiopian Islamic Council, Ethiopian Orthodox Catholic Church, and the Evangelical Catholic Church. Several African leaders have made efforts to reduce female genital mutilation. Most of them have managed to enact and pass laws that have been significant in the fight against female genital mutilation.

5.5.3 North Africa

5.5.3.1 Egypt

Female Genital Mutilation is widespread and equally condemned in North Africa, including in Egypt. While various types of FGM are practiced in North Africa, the most common types in Egypt are types II and III. Since these types are practiced in the country, the United Nations Population Fund [UNFPA] (2022) indicates that FGM is so rampant in Egypt that people trying to stop it have faced different challenges. In the Egyptian Family Health Survey (EFHS) in 2021 it was discovered that 86% of Egyptian married women between 15 and 49 have been exposed to FGM as a prerequisite to marriage. The survey also showed that professional doctors in the country completed 74% of these FGM practices. This demonstrates that as much as people have attempted to eliminate FGM in Egypt, it has widespread support in the local communities. EFHS in 2021 showed that there are still mothers planning to engage their daughters in FGM as a rite of passage (UNFPA,2022). It could therefore be concluded that FGM is part of the Egyptian social fabric and is sometimes supported by religious beliefs.

President Abdel Fattah El-Sis has been leading the fight against FGM in Egypt. As much as the practice is ingrained in Egyptian culture, various attempts have been made to eliminate it. For instance, President Abdel implemented the ‘National Strategy for the Empowerment of Egyptian Women 2030,’ meant to eliminate FGM by protecting Egyptian women and girls (ReliefWeb, 2021). In addition, the president approved the formation of the National Committee for Elimination FGMA that enlists help to fight FGM from development

and civil society development partners, the relevant ministries, judicial and religious bodies (ReliefWeb, 2021). Again, twelve years ago, the Egyptian parliament criminalized the practice in the Penal Code (UNFPA, 2022).

Moreover, the president approved the creation of the National Day to End FGM to inform the Egyptian communities of the health risks to which FGM exposes women and girls. Consequently, those found to have been practicing FGM were liable to face a minimum of three months or a two-year custodial sentence. Besides such liability, the FGM culprits faced a minimum penalty of 1,000 and a maximum of 5,000 LE (Egyptian pounds) (UNFPA, 2022). Furthermore, the country's parliament developed a new Child Law that established the Child Protection Committee (CPC) at various national levels (UNFPA, 2022). The CPC was charged with different roles, including finding, monitoring, and supporting children likely to be exposed to FGM through abuse and neglect by their parents and caregivers (UNFPA, 2022).

In addition, the parliament approved amendments to legislation that increased the minimum and maximum sentences imposed on the FGM culprits. These amendments also made the medical professionals involved in FGM liable for between ten- and fifteen-year sentences. The country also conducted a regional conference called the 'Cairo Declaration + 5' to enforce the legislative measures against FGM (UNFPA, 2022). This conference was a follow-up attempt to a conference held nineteen years ago in Cairo that led to the documentation of 'The Cairo Declaration for the Elimination of Female Genital Mutilation (UNFPA, 2022). Besides making such a follow-up, the conference also sought to develop an international campaign for promoting global attention to the illegality and health issues linked to FGM as far as young girls and women were concerned (UNFPA, 2022).

The Egyptian Ministry of Health (MoH) has also been involved in the fight against FGM. According to UNFPA (2022), this ministry established a ministerial decree (271) in 2007 to ban the practice of FGM even by professional doctors in private or public clinics or hospitals.

In the same year, the Islam religion in the country came out to condemn this practice, where Grand Mufti Ali Gomaas made a 'Fatwa' that condemned FGM (UNFPA, 2022). Moreover, the Azhar Supreme Council for Islamic Research in Egypt reiterated that FGM did not have a religious basis in the Islamic religion and the Islamic Sharia Law (UNFPA, 2022). Furthermore, the Egyptian medical fraternity has joined the fight against FGM because the gynaecologists and obstetricians' union made a professional statement that FGM is not a medical procedure nor part of any medical curriculum in the country; they stated that FGM was medically illegal (UNFPA, 2022). As a result, the union suggested that FGM should be averted and physicians involved should face the full force of the law.

Besides government efforts, non-governmental organizations such as the UNFPA and UNICEF have discouraged FGM in Egypt. In 2008, the UNFPA and UNICEF launched the UNFPA-UNICEF Joint Program (2008-2021) meant to reinforce the fight against FGM through capacity building of the field workers and medical personnel, data and research analysis, legal reforms, and working with religious and community leaders in creating awareness about the importance of abandoning FGM (UNFPA, 2022). In 2018, this Joint Program introduced a third phase in which it reinforced its fight against FGM through gender and social norms reforms (UNFPA, 2022). At the same time, it was working with the Egyptian government to mobilize social reforms at the community level, enforce the FGM ban policies, and respond to the expanding challenge of averting the professionally-performed FGM in the country (UNFPA, 2022). The program was based on four outputs regarding the control and elimination of FGM in Egypt. The first output reinforces the generation of FGM evidence to support programs and policies (UNFPA, 2022). The second output is empowering women and girls to fight for their rights, including their rights to be engaged in the risks of FGM (UNFPA, 2022). The third output is supporting the prevention of FGM by protecting women and girls with a likelihood of being exposed to FGM ((UNFPA, 2022). The final output entails

strengthening law enforcement and policies against FGM in Egypt (UNFPA, 2022). These outputs reflect the commitment of UNICEF and UNFPA to discouraging FGM in Egypt and the whole of North Africa (UNFPA, 2022). These outputs have informed the different interventions the UNFPA-UNICEF Joint Program has taken against FGM: the door-to-door-campaigns, National Committee to Eradicate FGM, awareness, and training on the harmful consequences of FGM, heightened law and policy enforcement, girl empowerment, community mobilization, and anti-FGM campaigns on television (UNFPA,2022).

5.5.3.2 Sudan

Sudan is one country in North Africa where FGM has been rampant for centuries. Indeed, it is ingrained in the country's culture, and efforts to eradicate it have not been 100% effective. According to the US Department of State (2009), three types of FGM are common in the northern region of Sudan: type I (clitoridectomy or 'sunna' in Sudan), II (excision), and III (infibulation). Nonetheless, type III is the most common and is practiced across ethnic and religious lines with Christians and Muslims both practicing FGM. As far as the two religions are concerned, Elduma (2018) explains that FGM in the country is practiced by midwives who do not use antibiotics or anaesthesia. The procedure is usually carried out on girls between six and twelve. At the same time, the study demonstrated that 89% of women and girls aged between 14 and 49 were affected four years ago (the rate of FGM in the country). In addition, the author explains that most women involved in FGM were married since FGM is taken as a rite of passage in Sudan. Uneducated women are the most affected at 54.7% of this population in comparison to educated ones at 3.8%. Moreover, the prevalence of FM was higher in the rural areas at 71.5% than in the urban areas at 28.5%.

With the prevalence rate of FGM in Sudan, various actions have been taken to eradicate it. Atit and Biajo (2020) explain that under the leadership of the current Sudanese president

(Abdel Fattah al-Burhan), the justice minister in the country (NasreldinAbdulbari) stated the country had taken legal measures against FGM after the ouster of the former president (Al-Bashir). The minister explained that the new government criminalized FGM in the country to protect the rights and freedoms of Sudanese girls and women in line with the ideals that led to the ouster of the country's former president (Atit and Biajo, 2020). This law resulted from the realization that high mortality among girls and women in the country resulted from FGM (Atit and Biajo, 2020). As far as such mortality is concerned, about 9 in 10 women in the country have undergone FGM and are exposed to different psychological and physical health issues as a result of the procedure (Atit and Biajo, 2020).

After the new government enacted this law, anyone engaged in FGM was liable for three years in prison. The UNICEF (2020) research shows that the transitional government in Sudan criminalized FGM in the country. This criminalization resulted from the Criminal Law Article 141 amendment, which was welcomed by the Sovereign and Ministerial Councils on 22nd April (UNICEF, 2020). The two entities also endorsed the amendments the National Council for Child Welfare (NCCW) suggested in reflection of UNICEF's vision to protect the welfare of children (UNICEF, 2020). Such actions were based on the fact that Sudan is one of the countries where FGM is practiced the most in Africa. Based on the research outcomes of the Multiple Indicator Cluster Surveys (MICS), the rate of FGM in the country was estimated at 86.6% in 2014 (UNICEF, 2020). Given such a high rate of the practice, efforts to eradicate it have been directed by the fact that FGM is a violation of the girl child and causes a range of mental and physical health problems (UNICEF, 2020). The 'Saleema' movement (launched in 2008 by UNICEF Sudan and NCCW) was created to address FGM and ensure that all girls and women are protected from this practice while promoting their overall welfare (UNICEF, 2020). The movement did not just criminalize FGM but engaged in awareness programs to ensure that all Sudanese parents and community leaders understood its health perils.

As noted earlier, while various groups and organizations have tried to eradicate FGM in Sudan over the last five decades, infibulation is still an issue in the country. However, the move by the government to criminalize it and the intensive campaign against the practice in the country is promising as far as protecting women from it is concerned (UNICEF, 2020). Organizations that have effectively eradicated FGM include the Babiker Badri Organization and Mutawinat Group, the Organization for Eradication of Traditional Harmful Practices Affecting the Health of Women and Children (ETHP), and the Sudanese National Committee for the Eradication of Female Circumcision (SNCTP) (UNICEF, 2020). These groups cooperate with the United Nations Children's Fund (UNICEF) and United Nations Population Fund (UNFPA). The efforts by these organizations cut across providing educational materials and training people about FGM to raise countrywide awareness of the negative health outcomes related to this practice (UNICEF, 2020). At the same time, they have been holding seminars, discussions, and workshops to raise awareness about these outcomes (UNICEF, 2020).

Additionally, these groups have been working to ensure that information on FGM and the inherent health concerns are incorporated into the Sudan school curriculum. These groups have been effective in their awareness campaigns because, in 2018, 51% of girls and women aged between 15 and 49 had undergone FGM and supported efforts to eradicate it (Thomson Reuters Foundation, 2018). Besides these efforts, the country has a range of legal measures to avert a situation where women and girls are forced to undergo FGM (Thomson Reuters Foundation, 2018). For instance, Article 141 of the Criminal Act (1991) is against people who immigrate to Sudan to engage in FGM (Thomson Reuters Foundation, 2018). Furthermore, the Child Act (2010) Chapter 2 and Article 5 protect girls below 18 from violence that leads to bodily harm (the FGM in this case) (NCCW, 2010). At the same time, Article 13 of this act specifically criminalizes all forms of FGM against young Sudanese girls (below 18 years) (NCCW, 2010).

5.5.4 South Africa

Research shows that FGM is not as common in South Africa as in North, West, and East Africa. For example, the Research Directorate (2008) explains that the practice of FGM is not frequent in Namibia since only some ethnic groups make minor cuts to the female genitals. At the same time, there have been rare cases of FGM in South Africa, and while it may be practiced in some regions of the country, there is reduced evidence of its prevalence (Equality Now, 2021). The reduced cases of FGM in South Africa are attributable to different efforts to end it. For instance, Queen Martha Sekhothali Mabenahas been fighting for the reproductive and sexual health of women in the country and has succeeded in promoting gender rights and equality (UN Women Africa, 2021). The Equality Now authors rate all the Southern African countries as having anecdotal evidence regarding the occurrence of FGM except Zambia, where the prevalence rate is 1%. The Zambian administration has played a vital role in maintaining the FGM prevalence as low as 1%. In 2018, President Edgar Lungu collaborated with the traditional leaders in the country in lobbying for financial resources to fight FGM from the African Union and its partners (Zulu, 2018). As far as this fight goes, it was feared that the Covvid-19 pandemic would cause two million additional cases of FGM in the country because it led to school closures and shutting the programs that cushioned girls and women from this sexually unsafe practice (UNFPA, 2022).

As a result, the anti-FGM stakeholders began plans to protect four million girls and women with a likelihood of being exposed to FGM yearly. Indeed, protecting these women and girls necessitated collaboration among the local elders, teachers, health workers, women's rights teams, policymakers, and civil society. Additionally, the research by the Immigration and Refugee Board of Canada (2003) indicates that the FGM cases in this South Africa do not amount to assault against women. Furthermore, this board explains that FGM only becomes an assault when it leaves a fatal wound on the female genitalia, as entrenched in the Criminal Law

and Procedure Act 51 of 1977. Moreover, anecdotal evidence has also been found in central Africa, where such countries as DRC have minimal data on the occurrence of FGM (Equality Now, 2021). In addition, Mutanda and Rukondo (2016) explain that while FGM in Zimbabwe is not as high as in East African countries, FGM is practiced among the Shangani women in the far south region. Again, it is still practiced as a form of patriarchal society in this country.

Similarly, the research by Equality Now (2019) shows that FGM may be rare in Mozambique, but the government has been at the forefront in addressing a few cases of this practice in the country since 2003. In 2003, President Joaquim Chissano approved the adoption of the Maputo Protocol meant to salvage women from gender-based violence, including FGM. This protocol was committed to eliminating traditional practices that are harmful to girls and women (early marriages and FGM in this case) (African Union, 2020). The protocol also promoted the reproductive health of girls and women and was against FGM because it negatively impacted this form of health (African Union, 2020). The protocol has since partnered with other organizations, such as the Solidarity for African Women's Rights Coalition (SOAWR), to help protect the rights of women and girls in Africa (African Union, 2020). In conclusion, research shows that FGM is not a common practice in the Southern African region. Indeed, while there may be traces of the practice in the region, there is minimal evidence of its prevalence. However, the available evidence shows that the practice is most notable in Zambia at 1% prevalence.

This structure used in presenting information about the context of FGM in different African countries is vital. It has helped understand the differences and similarities in how FGM is practiced in Africa; North, East, West, and South regions. Therefore, the structure makes it easy to compare and contrast FGM practices in African countries. Indeed, research in African countries regarding FGM shows that the common types of FGM practices in East Africa are type I, II, III, and IV, with type III being the most common. Moreover, in West African

countries, the three types are common, with the commonest being type and type II in Mali, Niger, Cameroon, and the Gambia. Among the North African countries, the practiced types are types I, II, and III, with types I and II being the most common. Lastly, since countries in southern Africa rarely engage in FGM, type I is the most common form of FGM because it is the simplest. In addition, the structure of the presentation of FGM in North, East, West, and South Africa indicates that FGM is commonest in East Africa (Somalia and Djibouti), followed by the West (Guinea), North, and South African countries.

5.6 The Three Pillars of Institutions

Efforts in the fight against female genital mutilation involve leaders in the mission by including the institutions that they represent. For instance, the school heads are the most vital leaders to be included in the social movements against FGM at the community level. Since these heads represent learning institutions, it would be important to understand how institutions would be vital in eliminating FGM based on the three pillars discussed in this section. The three pillars are regulative, normative, and cultural cognitive and are considered essential elements of an institution (Lin, 2016). They are crucial because they lead to the independence and mutual strengthening of a commanding institutional social framework. The three elements are closely related to the institution's operation because they help execute institutional strategies (Lin, 2016).

5.6.1 Regulative pillar

The regulative element focuses on the ability of an institution to regularize and constrain behaviour. The scholars associated with the regulatory aspects of institutions emphasize the importance of regulatory processes such as monitoring, rule sets, and sanction actions (Laffan, 2001). Thus, this pillar's techniques consist of establishing rules, inspecting their operation with individuals, and manipulating the institutions' sanctions, punishments, or

rewards to manage the future (Lin, 2016). The sanctions operate through informal mechanisms involving shunning or shaming activities or extreme formalization and specialized assignment of actors such as the courts and police systems (Tjilen et al., 2021). Legalization is the formalization of the ruling systems that govern the institution, with values that vary in three distinct dimensions: delegation and how a third party is given the authority to resolve disputes by applying the required rules (Laffan, 2001). The regulative pillar comprises the written rules and the unwritten codes of conduct that supplement the formal rules in an institution. The punishment of the actors follows the established rules when violated (Laffan, 2001)). Therefore, the most crucial part of an institution is the costliness of violating enacted laws that lead to severe punishment.

5.6.2 The normative pillar

It is considered an essential element of an institution because it embraces the normative rules that propose privileges, rights, duties, and responsibilities. The normative rules prescribe, evaluate, and obligate dimensions into the actual social life. They include culture and norms that are desirable constructions used to compare and assess the existing institutional behaviours (Laffan, 2001). Norms, however, describe how to do things, such as the means of reaching the ends of a quest; the normative elements define the objectives and goals (Joseph, 2017). For instance, they may be used in making profits in businesses, where they define the appropriate ways of achieving this goal. Said another way, they outline the rules and regulations to be followed to achieve institutions' financial objectives (Joseph, 2017). However, some regulations are applied to all institutional systems, whereas others apply to specified individuals (Joseph, 2017). Those that apply to specific members are used in role setting, achieving appropriate goals, and activities for particular individuals in specified social positions (Joseph, 2017). Therefore, such regulations are the prescribed normative expectations that specify how the institutional staffs are supposed to behave.

These staff members are pressured to act appropriately because of the standard behavioural expectations from them by the other group members. Moreover, norms are formally constructed within an institution (Joseph, 2017). For example, a particular departmental employee is expected to use the specified resource in performing defined functions in an institution. Besides the formal construction of norms, they can also be informed through interactions and differentiated expectations guiding the individual's behaviour in an institution (Harun et al., 2018). Normative systems impose constraints on individuals' social behaviours and empower and enable social action.

The normative pillar of the institution was supported by most of the early sociologists as they analyzed the institution in the form of social groupings, communities, and social classes where standard rules and laws are considered mandatory for coexistence (Harun et al., 2018). Normative institutional element scholars mainly believe in the importance of appropriateness and instrumentality (Harun et al., 2018). Accreditations and certifications by standard-setting bodies as professional associations act as valuable indicators of the existence and generality of normative institutions. Normative conception can, at times, evoke strong feelings. These include the sense of disgrace or behaviour such as honourespect. Self-evaluation involves conforming to or violating normative principles (Harun et al., 2018). Such emotions are helpful in compliance with the norms of the institutions.

5.6.3 Cultural Cognitive Pillar

This pillar expresses the stress made in the shared conceptions that constitute the frames on which meaning is made and the nature of reality—considered centrally as the frames under which meaning is made. It acts as the significant difference between neo-institutionalism within organizational studies and sociology. Institutionalism considers the cognition of human existence (Scott, 2013). Signs, symbols, words, and gestures get their meanings from activities and objects as far as institutions are concerned. Indeed, every institution is treated as collecting

meanings and images in the objective form (Scott, 2013). Scott explains that the external cultural framework of these images and meanings influences internal decisions. Furthermore, t cultural systems work on many levels, including the shared definitions of the local conditions towards such typical patterns as culture and organizational logistics. The organization's culture shapes the individual's behaviours and may reconfigure their beliefs to align with an institutional context (Scott, 2013). Moreover, organizational culture is considered common to a group and is consistent and unitary (Scott, 2013). However, this culture is conceived as varying from one institution to another since it is not universally held as it operates in specific institutional contexts (Scott, 2013). The cultural cognitive pillar emphasizes the central part of social thoughts constructed by the commonality of meanings.

5.7 The Three Institutional Pillars and the fight against FGM

The three institutional pillars have helped reduce the rate of female genital mutilation as various institutions have put forward different regulatory policies in countries that uphold the rights of the girl child against involuntary FGM acts (Tjilen et al., 2021). These policies criminalize FGM and outreach programs, using administrative regulations and civil remedies solutions. Examples of countries using these policies are Kenya, Ghana, Chad, Ethiopia, Niger, South Africa, Tanzania, Senegal, Togo, Benin, Burkina Faso, Djibouti, Ivory Coast, Eritrea, and Egypt, among others (Mwendwa et al., 2020). The laws come with severe penalties, such as a minimum of three months in prison or life imprisonment for those violating the rules by practicing FGM illegally (Mwendwa et al., 2020). The behavioural change in cultural cognition helps integrate the community levels in the individualization of the change (Lin, 2016). The cultural and educational reforms equip society with the knowledge of the negativity of FGM, thereby reducing the practice (Lin, 2016). The normative pillar also enables the fight against

FGM by supporting the locally-led initiatives established to fight FGM (Lin, 2016). Again, this pillar supports the local advocates in forming anti-FGM initiatives.

5.8 Conclusion from the research findings

The nine studies identified helped examine the impact of leadership on the eradication and prevention of FGM in African countries. The fact that these studies were between moderate and high methodological quality means that they had the most relevant information in response to this question. Furthermore restriction to the last ten years meant that these findings were in line with most recent evidence and findings in relation to this area of practice (Zeng et al., 2015; SIGN, 2019). The summary of the findings from this review showed a degree of agreement with the premise that leadership plays a central role in efforts against FGM. Additionally, the authors agreed that leaders in the fight against FGM/C should come from the communities affected by FGM.

When leaders come from communities where FGM/C is rampant, they have information regarding the parts of a country or a region where the practice is common. At the same time, they agreed that female and male leaders must be involved in the fight against FGM/C, especially when raising awareness against this practice. For instance, Abuya (2015) notes that male and female community leaders need to be involved in developing cultural transformations that help avert and eliminate FGM/C in Kenya and beyond. In addition, this author explains that political leaders, among other government leaders, could take a major role in fighting FGM/C, they agreed that leaders should be involved in the fight against FGM/C: religious, community, and government or political leaders.

5.8.1 Religious Leaders

Religious leaders are vital in the fight against FGM because they play a major role in the fight against FGM. This is due in part to the fact that FGM is also often based on ‘religious’ beliefs

in the countries and regions in which it is practiced. According to Kimani et al. (2020), different religions have varying perceptions about the ethicality and legality of FGM/C, with some supporting and others rejecting it. Moreover, these authors explain that FGM is embedded in the community structures and expectations created by medical personnel, community and religious leaders. The opinions of these leaders hold considerable sway in their immediate communities. As a result, a clear stand against such practices could potentially have a significant impact on future patterns of FGM in these communities. In addition, Kimani et al. (2020) explain that FGM/C reflects religious beliefs in some communities because it reinforces cultural traditions in terms of cultural expectations. As far as these expectations are concerned, FGM/C is sometimes used as a way of proving to community members that one is following palatable cultural practices, including subscribing to defined religious beliefs.

Additionally, the religious leaders represent stakeholders that could be involved in the multi-pronged fight against FGM/C in this country. The multi-pronged approach in this fight is based on primary, secondary, and tertiary prevention and elimination interventions against FGM/C that need to be developed and adopted by all stakeholders based on the unique socio-cultural context (Njue et al., 2019). Religious leaders would be vital in this context because they would help implement the primary prevention and elimination methods that seek to address FGM/C before it occurs at birth or when a woman converts to Islam to get married to a Muslim (Dawson & Wijewardene 2021).

Similarly, secondary interventions involve averting FGM/C by detecting its possibility of occurrence before it happens (Dawson &Wijewardene 2021). Lastly, tertiary interventions entail managing the negative impacts of FGM when girls and women have fallen victim to it (Dawson &Wijewardene 2021).

The importance of religious leaders is also echoed in the fight against FGM /C because they are respected community members. Odukogbe et al. (2017) support Dawson and

Wijewardene 2021) religious leaders should be involved in the fight against FGM/C because they are respected and highly influence the decision made in societies. In Kinoti (2021), active engagement by the church served to increase community awareness of the risks and effects of FGM that was further demonstrated by a gradual increase in the search for alternative rites of passage for young females in the community.

Religious leaders' prowess and gifts make the theme stand out among community members (Odukogbe et al., 2017).Therefore, they have a better chance of raising awareness against FGM/C and trying to avert and eliminate this practice (Odukogbe et al., 2017). Such influence of the religious leaders means that they would be vital in preventing the mortalities and morbidities linked to the FGM/C practice. It must also be noted that the strength of existing cultural norms and beliefs might mean that such a stance by the church might be accompanied by a fall in membership in resistance to change as was initially demonstrated in Kinoti (2021). However, it could be argued that continued persistence, together with community enlightenment programmes and interventions could potentially facilitate a continued pattern of change in the community.

Besides being respected members of society, religious leaders are great decision-makers in societies as far as the fight against FGM/C is concerned. According to Gitau et al. (2018), religious leaders are decision-makers around FGM among the Maasai community members in Kenya. As noted earlier, they are influential decision-makers in matters involving FGM/C because the practice is based on the religious beliefs of these members in their traditional context (Kimani et al., 2020). The research by Gitau et al. indicates that religious leaders are core in matters of FGM/C because respondents in their research stated that they (religious leaders) were crucial decision-makers and advisers among their government and traditional leaders. Besides FGM/C being part of the traditional religious beliefs among the

Maasai communities in Kenya, Gitau et al. (2017) state that the Christian religious leaders in these communities remain clear about their stance against FGM/C.

In other words, traditional religious leaders would be vital in the fight against FGM/C because it is based on the beliefs they profess. The thought would be that Christian leaders would be against it because the practice is not supported by the bible. As far as these religious and traditional leaders in the fight against FGM/C are concerned, religious and cultural beliefs are some of the main factors preventing FGM from eradication (Kinoti, 2021). According to Kinoti (2021), rigid religions such as Islam are the culprits behind the continued practice of FGM/C in various counties in Kenya and other African countries. Among Muslims, women are expected to undergo FGM before they can be allowed to get married (Kinoti, 2021). Such a marriage principle is also reflected in various cultural aspects of the Africans in the North, East, West, and South African regions (African Union, 2020). While cultural and religious beliefs may be the main drivers of FGM practice, Kinoti (2021) explains that they are the pillars of good morals.

As a result, on a morality basis, Christian and Muslim leaders should be involved in preventing and eliminating FGM in Kenya and beyond. Indeed, these leaders are the custodians of good morals and are excellent decision-makers regarding the morality of every community member, whether male or female. Thus, Gitau et al. (2017) states that since religious leaders maintain societal moral compasses, they should be involved in sensitizing communities about the importance of eliminating FGM/C. Indeed, because these leaders are influential morality reflections, community members would most likely pay attention to their sensitization efforts against FGM/C (Gitau et al., 2017). This sensitization would constitute education against FGM/C and act as the main facilitator of a cultural shift where even girls and women who have not undergone FGM remain accepted members of society and are eligible for marriage (Gitau

et al., 2017). Again, guided by the religious' morality influence, these girls could be exposed to other strategies for transitioning from childhood to adulthood.

Additionally, Gitau et al. (2017) explain that religious leaders represent a force advocating for eliminating FGM because it is no longer relevant in modern societies. As far as this force is concerned, these authors note that religious leaders have been forming religious organizations that have been vital in communicating anti-FGM/C messages. Using the same force, these authors explain that religious leaders can take authoritative roles against FGM/C by refusing to let their girls undergo the practice. Finally, the research by these authors indicates that religious leaders can use churches as the centres for community transformation as church leaders continue preaching against FGM/C.

As noted earlier, religious leaders have been effective in the fight against FGM/C because they have spearheaded interventions against it. Mwendwa et al. (2020) agree with the research by Gitau et al. (2017) on providing education and raising awareness against FGM. In addition, Mwendwa et al. (2020) state that religious leaders have been supporting efforts made by other people in protecting women and girls against FGM/C. For instance, these leaders have supported ARPs. Furthermore, these authors explain that religious leaders could be involved in interpreting the health perils related to FGM/C among the communities that practice them in Kenya and beyond. With this interpretation, Mwendwa et al. (2020) state that the commitment and support from the religious leaders in these communities are considered a success factor in the fight against FGM/C. Hence, the support from religious leaders offers constant and progressive support against FGM/C.

Since religious leaders are close to families, they would be vital in averting FGM/C in Kenya and other African countries. Like Gitau et al. (2017), Ayodo (2018) states that these leaders are important in convincing guardians and families to quit the FGM practice. When awareness about health complications has been introduced at the most basic level of the societal

units (the family), the battle against FGM/C will be won (Ayodo, 2018). For instance, these leaders can convince parents and guardians to adopt the ARPs as a reprieve for girls who undergo illicit circumcision by explaining the inherent benefits of ARPs (Ayodo, 2018). However, Ayodo states that religious leaders need to work within the cultural heritage of communities to avoid a clash with societies that value other aspects of their cultures, except for the FGM/C practice. Ahmady (2016) also adopts this viewpoint and stresses the importance of leaders in averting FGM/C because they have more comprehensive data about the rate and whereabouts of the practice in Iran.

The importance of religious leaders has been seen in the collaboration between them and the international advocates against FGM/C in communities where it is rampant. For instance, World Vision International collaborated with religious leaders in Kenya to address the injustices facing girls in the country, including FGM/C, in 2019. This organization sought to work with religious leaders representing various churches in the country to eliminate FGM/C and other forms of violence against children. The collaboration between World Vision International and the Kenyan churches reiterated the importance of religious leaders in the fight against FGM, among other forms of violence because as explained by Mwendwa et al. (2020) among other authors involved in the systematic literature review of this study.

Besides Kenya, religious leaders in other countries have also been involved in the fight against FGM. For instance, in the wake of a meeting with The Girl Generation organization, religious leaders in Mali committed to creating a religious network to ban FGM/C in the country (The Girl Generation, 2017). Again, these leaders promised to raise the issue of FGM/C with the Imams to ensure collaboration between the Christian and Muslim leaders in averting and eliminating it (The Girl Generation, 2017). During the meeting with this organization, religious leaders decided to publicize their stance against FGM. They collaborated to ensure that they remained committed and effective in the fight against FGM/C. This collaboration was

informed by the fact that FGM/C is common among Christians at 84% and Muslims at 89% in Mali (The Girl Generation, 2017).

5.8.2 Community Leaders

Besides religious leaders, the studies identified during the systematic literature review emphasized the importance of community leaders in the fight against FGM/C in Africa. These studies presented the community leaders as the family heads (fathers or husbands), grandparents, elders, and women with leadership skills who have undergone FGM/C in the past. According to Catania et al., (2016), the fight against FGM/C needs to involve men based on the recommendations of the World Health Organization. These authors state that involving men as community leaders could initiate cultural transformations that would lead to abandoning FGM/C practices. Additionally, they explain that men have different attitudes and conceptions regarding FGM/C in the countries where the practice is common. As a result, men's role must be considered in preventing FGM/C. They reiterate that while women face the greatest pressure to practice FGM/C, involving community leaders would help reduce this pressure.

Moreover, Mwendwa et al. (2020) state that men are voices representing anti-FGM/C activities. These authors explain that the community leadership in men can be involved in implementing the ARPs and sensitizing people about educating girls regarding the negative effects of FGM/C on their health. It was argued that movements to abolish or reduce the occurrence of FGM in African countries would gain greater momentum if they were supported by male patriarchs who are the heads of families and main decision-makers in these communities (Catania et al., 2016). Like Catania et al. (2016), Mwendwa et al. (2020) state that men reflect the voice of community leaders in the fight against FGM/C because they can advocate for the abandonment of this practice in Kenya and beyond. These authors explain that men as community leaders in this abandonment include fathers, husbands, and grandfathers,

among other male leaders in communities. Importantly, these community leaders are vital in eradicating FGM/C because this elimination entails behavioural change support at the community level, persistent and open advocacy, and law monitoring and enforcement among diverse community representatives.

Community leaders are particularly important in the fight against FGM/C because they are custodians of cultures in different communities. According to Sempeho et al. (2021), since community leaders are the caretakers of the cultural heritage of communities, they are core in abandoning this practice because cultural beliefs inform it. As a result, these authors state that these leaders can be involved in the cultural shift that would contribute to eradicating FGM/C in Tanzanian. Again, being the custodians of cultural heritage means they could be involved in identifying the FGM/C cases practiced secretly and educating women and girls about the benefits of abandoning the cut as a barbaric act. Additionally, they could be involved in encouraging intertribal marriages between people who practice FGM/C and those who do not, such that the importance of the practice is progressively diminished (Sempeho et al, 2021).

Community leaders are also important in the fight against FGM/C because they are influential decision-makers in Nigeria. Adewale-Olaniru (2022) states that community leaders are core in this fight because they are the community influencers and make authoritative decisions in their communities. According to Adewale-Olaniru (2022) when the community leaders took a position against FGM/C, community members followed them. These patterns point to the fact that community leaders are role models and could influence people away from this practice. At the same time, the author states that these leaders are vital in eliminating the practice because the mastermind behind them needs community approval to practice it in Nigeria and beyond. Again, Adewale-Olaniru (2020) notes that community leaders are vital in eradicating FGM/C because they would help lessen the cultural pressure women and girls have to engage in FGM.

Community leaders are core in the FGM/C abandonment efforts because they are informed about the best measures against this practice. According to Ayodo (2018), these leaders could help activists encourage the acceptability of ARPs in communities since they are informed and trusted community members and other members would not be hesitant to listen to them. For instance, during this author's research study, community leaders explained that persuasive measures were better in dissuading people from FGM/C than legal measures that only led to secretive practice instead of abandoning it (Ayodo, 2018). Thus, community leaders are informed about the best measures that could be used in the fight against FGM/C, depending on their communities. Indeed, Johnson et al. (2018) state that these leaders remain informed about the FGM/C status in their communities. Based on their research, these authors state that their participants explained that the community leaders were the common source of their admiration and information regarding the Saleema campaign in Sudan.

Again, the authors state that these leaders effectively engage in training and advocacy to highlight the harms of FGM/C in different communities. As far as the Saleema campaign is concerned, the authors explain that their research indicates that it was entrusted to the most respected community members- the community leaders. Hence, these leaders are core to eradicating FGM in Sudan because this campaign is at the core of decreasing the frequency of this practice.

As was noted earlier, community leaders are vital in the fight against FGM because they are crucial in communicating measures against FGM. Huskey (2019) supports the research presented by the authors in the systematic literature review by stating that these leaders can be educated on the consequences and risks of FGM and share such knowledge with their community counterparts. Therefore, it is expected that with the right resources and education, these leaders can be involved in preventing and eliminating FGM/C. The observation made by Huskey (2019) is also reflected in the research by Gitau (2018), who explains that local

communities need to own the war against FGM. According to Gitau (2018), the best way of addressing this practice is by transforming the attitudes and perceptions of the community leaders (traditional healers and elders).

He states that community leaders are vital because they are the defining factor of cultural identity in communities. Again, he explains that involving these leaders has helped engage more than 15,000 girls in ARPs in Kenya's Samburu and Maasai communities (Gitau, 2018). He attributes such success to the fact that the community leaders in these communities owned the fight against FGM. Moreover, Gitau (2018) notes that there has been a community-led approach to eliminating FGM/C. Such approaches have been successful because they have involved community leaders.

As was explained earlier, a cultural shift is among the different strategies community leaders could use in the fight against FGM. This shift would be possible because they are the custodians of cultural heritage in different communities (Kinoti, 2021). In line with the research by Gitau et al. (2018), Robi (2021) states that friendly approaches should be used in the fight against FGM/C. These approaches should involve community leaders who would be vital in eliminating the customs that necessitate this practice while changing the attitudes of community members regarding the FGM/C ethicality and legality. Such attitudinal changes would comprise the cultural shift needed to progressively erase the practice from the cultural fabric of the different communities in Africa and beyond. Furthermore, Robi (2021) emphasizes that such community leaders as clan leaders would help in this cultural shift because they oversee FGM/C in these communities.

As part of community leadership, women have also been involved in the fight against FGM/C because they are the most affected by this cultural menace. In their study which echoes many of the review studies, Dawson & Wiojewardene (2021) report that many female leaders in this fight have faced the cut and wish to eradicate it because they understand the health

effects better. It must be acknowledged that is some situations, besides understanding these effects, some women are actually FGM/C culprits; mothers and grandmothers are involved in preparing girls for the cut (Dawson &Wiojewardene, 2021). It could therefore be argued that female empowerment, education and enlightenment can help raise a generation of female leaders who are dedicated to ensuring that the practice is eliminated within their communities.

An example of female leadership against FGM/C in Africa is the UN Women Africa, a group of women dedicated to women empowerment and gender equality in the continent (UN Women, n.d.). This group collaborates with the UN member states to develop policies, laws, services, and programs that help implement standards that ensure that the welfare of women and girls remains intact. Additionally, these standards ensure that girls and women in these states are empowered and enjoy the benefits of gender equality (UN Women, n.d.).

Moreover, the UN Women group works at the international level to help achieve the Sustainable Development Goals (SGDs) relevant to the welfare of women and girls in African countries and beyond. This welfare includes protection from the health complications of FGM/C. It works guided by four strategies meant to enhance women's leadership in the fight against FGM/C. Again, these strategies help women who have fallen victim to the cut before to raise awareness about it while working with their male counterparts to convince other community members of the significance of eliminating this practice.

The first strategy is ensuring women lead and engage in a government system that places them in a position of influence against FGM/C (UN Women, n.d.). The second strategy entails equipping women with economic autonomy and decent work such that they have the resources to rally for support against FGM/C among the communities where it is common (UN Women, n.d.). The third strategy is protecting women and girls from all forms of violence against them, including FGM/C (UN Women, n.d.). This protection involves creating policies, laws, and programs that help ensure that women are safe from this cut. Lastly, after women

have been placed in leadership positions, empowered economically, and protected from different forms of violence, they can be advised to use the inherent influence to promote national and international resilience and peace. Such resilience and peace only become possible when women's leadership is recognized at the national level after implementing the first three stages.

5.8.3. Government Leaders

Lastly, findings from the present study show that government leaders have also played a critical role in the fight against FGM/C. Gitau et al. (2018) argue that in addition to religious and community leaders, government leaders are important in the fight against FGM/C. These authors state that such government leaders as chiefs have been essential in the Kenyan government as far as this fight is concerned because they have been taking active roles in averting and eliminating FGM/C. Additionally, they maintain that all government leaders would be handy in eliminating the traditional customs that endorse FGM and creating creative and efficient ways of reducing FGM/C by involving girls and women. Such will especially be the case of women who have fallen victim to the cut. Moreover, government officials would also play an important role because they represent the government and community interests and implement the strategies created by the elected leaders in Africa and beyond.

Government leaders are particularly important in the fight against FGM/C because they would be vital in developing anti-FGM/C laws. Undoubtedly, these laws can only be enacted and enforced under the custodian of the national governments in Africa (Gitau et al. 2018). Moreover, these leaders develop the resources, policies, and plans in the fight against FGM/C. Besides developing such laws, government leaders would help eliminate FGM/C through community education and sensitization on the consequences and dangers of FGM/C. Again, through sensitization and education, these leaders could ensure that the community members remain aware of the laws against FGM/C and the committed government support to eradicate

this barbaric custom. Furthermore, they could eliminate FGM/C by using spies at the community level who would report any practice cases. However, much as the government leaders may be effective in eliminating FGM/C, Gitau et al. (2018) advise that cooperation should be established among these leaders, the religious leaders, and the community leaders.

While community leaders are the custodians of the cultural heritage of the communities in which FGM/C is rampant, government leaders take care of all the aspects of members of these communities. In other words, these leaders are concerned with the overall welfare of community members. According to Sempeho et al. (2021), government leaders are the main decision-makers in FGM/C, given that they have been entrusted with handling the citizens' affairs in Tanzania and beyond. Like Gitau et al. (2018), Sempeho et al. (2021) state that for the effective elimination of the FGM/C menace among women, government leaders should collaborate with religious and community leaders. Such collaboration should be reflected in public meetings, workshops, and seminars to sensitize the public against the consequences and dangers of FGM/C.

Government leaders have been essential in implementing policies, programs, and services to prevent FGM/C. In other words, these leaders have been reported to be so concerned about the negative effects of FGM/C on women that they have been active in the fight against this cultural menace against the welfare of female citizens in East, West, North, and West African countries. In East Africa, Preside Mwai Kibaki (a former Kenyan president) played a great role in the fight against FGM/C in the country and region. For instance, his administration introduced constitutional acts (the Kenyan Constitution FGM Act 2011 in this case) fundamental to creating laws and policies against this cut (UNFPA, 2014). Moreover, under the leadership of Mwai Kibaki, the Kenyan government created the Kenya Anti-FGM board in 2010 (Anti-FGM Board, 2011). This board was the genesis of the enactment of the 2011 Prohibition of FGM Act.

Besides Kenya, government leadership has also been essential in promoting anti-FGM efforts in Djibouti. For example, President Ismail Omar Guelleh led the country to enforce Article 10 of the constitution, which states that everyone should be treated equally; it promotes gender equality (Thomson Reuters Foundation, 2018). Additionally, the Penal Code (created in 1995) has been essential in stating that FGM is an illegal practice in the country (Thomson Reuters Foundation, 2018). Another action taken by the country's president against FGM was the establishment of Law no. 55 of 2009, which redefined FGM as one of the acts of violence against girls and women in the country (Thomson Reuters Foundation, 2018). Additionally, he led the county to implement Article 333 of the country's Penal Code, which addressed the effects of FGM on girls and women in the country (Thomson Reuters Foundation, 2018). Lastly, he introduced Article 2 of Law No. 55, made it possible for organizations to engage in campaigns against FGM, and introduced an amendment to Article 333 such that the penalties for those practicing or abetting FGM (Thomson Reuters Foundation, 2018).

Second, in West Africa, the Gambian president (Yahya Jammeh) pronounced FGM/C an illegal practice in the county in 2015. With this pronouncement, he declared that the cut was illegal in the Islamic doctrines and the various societies in the country Gambia (Abathun&Sundby, 2017). This criminalization of FGM was followed by the definition of penalties the culprits would face once suspected of conducting or abetting FGM (Lyons, 2017). These culprits were expected to face three-year imprisonment once found guilty in a court of law (Lyons, 2017). Thus, the president reinforced the country's judiciary to arraign and imprison those found to continue with FGM/C on girls and women even after the president's declaration (Lyons, 2017). Similarly, Mamadou Tandja introduced regulations and laws in Niger to avert the FGM/C practice in the county.

These laws include the enactment of Article 14, which was against people's coercion into such inhuman and violent acts as FGM/C (Niger, 2017). Again, Article 22 criminalized all

cases of violence against women and girls, whether privately or publicly (Niger, 2017). Moreover, the country has Article 186 that punishes people who do not report FGM/C cases even when they know that some girls or women are being forced to engage in the cut as a prerequisite to marital affairs (Niger, 2017). Furthermore, the president expressed displeasure by declaring that Article 7 of the Niger's Law on Reproductive Health No. 2006 16 states that every citizen in the country has the right to be protected from acts that would harm their reproductive organs, including FGM/C (Niger, 2017). These Articles have been associated with different arraignments and arrests to deter culprits from practicing FGM/C.

President Paul Biya introduced legislative actions and interventions in Cameroon in the 20th century. Cameroon's constitution protects all citizens from inhumane, barbaric, degrading, and violent acts (OHCHR, 2019). Therefore, this constitution is against violent actions against girls and women, including FGM. Moreover, the country's Penal Code has a provision that directly criminalizes FGM. Furthermore, the country's Civil Code protects girls and women against FGM/C because it advocates for the rights of children and their families as far as this cut is concerned (Penal Code, 2012).

Third, in North Africa, President Abdel Fattah El-Sis created the 'National Strategy for the Empowerment of Egyptian Women 2030' against FGM (ReliefWeb, 2021). Moreover, he approved the establishment of the National Committee for Elimination of FGM, which creates a team of ministries, development partners, religious and judicial leaders, and civil society to eradicate this practice (ReliefWeb, 2021). Additionally, the country illegalized FGM in 2020 under the Penal Code (UNFPA, 2022). Furthermore, the Children's Protection Committee (CPC) is based on Child Law (UNFPA, 2022). It is meant to save children likely to be involved in FGM through neglect and abuse.

Similarly, the Sudan justice ministry has been taking measures against FGM after the ouster of the former president. Again, the current president (Abdel Fattah al-Burhan)

criminalized this cut in the country to protect girls and women (Atit & Biajo, 2020). At the same time, the Sovereign and Ministerial Councils enacted Criminal Law Article 141, which banned FGM in the country (UNICEF, 2020). The National Council for Child Welfare (NCCW) was also a welcome idea in the country because it specifically focused on children likely to suffer from FGM in the country (UNICEF, 2020). In addition, the country has the Saleema movement, which protects girls and women from forceful engagement in the FGM practice (Johnson et al., 2018).

Lastly, while the FGM practice in Southern African countries is not as common as in West, East, and North Africa, few cases have been reported. The few FGM cases are attributable to increased advocacy against FGM. For example, in South Africa, FGM cases are not common because female leaders have been dedicated to protecting girls and women from this act. Indeed, such female leaders as Queen Martha SekhothaliMabena have been handy in protecting women's sexual and reproductive health (UN Women Africa, 2021). Similarly, the Zambian president supported preventing and eliminating FGM by offering financial resources for anti-FGM campaigns (Zulu, 2018). At the same time, the Maputo Protocol was passed in Mozambique to cushion women against the gender-based violence caused by FGM cases in the country (African Union, 2020). Such cushioning advantages enhanced the reproductive health of girls and women. This protocol has been working with other organizations like the Solidarity for African Women's Rights Coalition (SOAWR) to ultimately win the war against FGM in Southern African countries and Africa.

CHAPTER SIX

CONCLUSION

The present study has sought to explore the prevalence of FGM in Africa and the roles leadership in its practice. Leadership would be vital as far as FGM is concerned because it is one of the crucial factor to put an end to the practice of FGM. It is a menace because, as the name suggests, it is the mutilation of the female genitals and needs to be eradicated to ensure that girls and women do not suffer from the pain of a cut said to connect them to their communities and forefathers. Research shows that the four types of FGM/C (type I to IV) reflect unnecessary pain from which girls and women could be protected. All these types of FGM lead to dangerous short- and long-term health complications that threaten girls' and women's sexual and reproductive health in the communities that practice FGM/C. The study has shown that girls and women undergo the cut for various reasons, including cultural and social purposes. Social and cultural beliefs dictate that girls should undergo the practice for marriageability and as a rite of passage from childhood to adulthood.

Again, the present study has shown that various actions have been taken at the local and international levels to eradicate this rough cut. These actions have reflected the importance of leadership in the fight against FGM/C. To determine this importance, the researcher engaged in a systematic literature review that exposed them to thirteen peer-viewed studies. These studies showed that different leaders have been essential in preventing and eliminating FGM/C at the community and international levels.

Indeed, findings show that community, religious, and government leaders have created different strategies for responding to the call of girls and women against FGM/C. Indeed, the research outcomes have shown how each of these leaders has been involved in helping girls

and women remain immune to FGM complications. However, the researcher explains that these leaders should cooperate to enhance effectiveness in the fight against FGM/C. Further investigation needs to be conducted to determine how community and religious leaders are a bottleneck in the fight against FGM; why they may make it hard for government leaders to eliminate FGM in their communities.

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