Forum: **The Special Commission on the African Union**

Question of: **Counteracting the legalisation of female genital mutilation in Africa**

Student Officer: **Anton Häuser Nielsen**

Position: **Main Chair**

Contact: **anton@hausernielsen.dk**

Structure

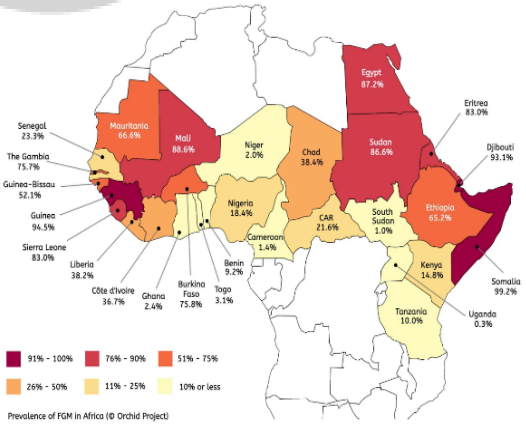
I. Description of the Issue
II. Definition of Key Terms
III. Background Information
IV. Major Countries and Organizations Involved
V. Timeline of Events
VI. Previous Attempts to Solve the Issue
VII. Possible Solutions
VIII. How to prepare as a Delegate
IX. Questions Delegates Should Consider During Research
X. Relevant Treaties and Events
XI. Useful Links and Sources

I. Description of the Issue

Since its inception, the African Union has been a leading body in promoting human rights and equality across the African continent, in accordance with various United Nations frameworks on human rights.

Despite this commitment, the African Union continues to face challenges in effectively addressing certain longstanding practices. Today, Female Genital Mutilation (FGM) remains a significant issue across parts of Africa, with particularly high prevalence in the Horn of Africa, as well as in regions of West and East Africa and certain areas of North Africa.

Various initiatives have been undertaken to address the issue. Notably, Article 5 of the Maputo Protocol mandates that all Member States prohibit, condemn, and actively work to eliminate all traditional practices and customs that negatively affect the rights of women. However, the implementation and enforcement of such legal frameworks have varied considerably across Member States. In some cases, legislation remains incomplete, while in others, enforcement is limited due to factors such as institutional capacity, local governance



challenges, and prevailing social norms. As a result, the practice continues in several communities despite existing commitments to curb it.

FGM also remains a subject of significant political and social debate. While the practice is widely criticized, various communities actively advocate for a more tolerant and less restrictive approach, often viewing restrictions on the practice as external interference in cultural traditions.

Although not mandated by any major religion, some communities draw on religious beliefs to justify the practice. In reality, the continuation of FGM is rooted far more strongly in social and cultural norms than in formal religious doctrine. In certain contexts, it is framed as a moral or spiritual expectation, often reinforced by community leaders or local interpretations of tradition. This blending of cultural practice and perceived religious obligation contributes to its persistence, even in areas where religious authorities or international organizations have explicitly condemned it.

Globally, more than 230 million women and girls have been cut, with Africa accounting for the largest share of the total, at over 144 million.[1] FGM has no associated health benefits and harms girls and women in numerous ways, particularly in rural areas with limited access to proper medical resources. The absence of a properly sterilized environment and the use of unsterilized instruments frequently cause severe bacterial infections, tetanus, and sepsis, all of which can have potentially lethal consequences. Immediate physical risks include severe blood loss, potentially leading to fatal haemorrhagic shock. Trauma to the adjacent tissue, such as accidental cutting of the urethra, vaginal wall, or clitoral artery, is also a serious risk.[2] [3] [4]

As for the long-term impact, women risk chronic urinary tract infections (UTIs), bacterial vaginosis, reproductive tract infections, and lifelong chronic pain.

FGM has also been associated with complications during pregnancy and childbirth, including but not limited to:

- Obstructed labour, as scar tissue prevents the natural stretching of the vagina and pelvic tissues;
- A significantly increased need for Caesarean sections, episiotomies, and instrumental deliveries;
- Higher rates of postpartum bleeding and an elevated risk of foetal distress, stillbirth, and early newborn death.[5] [6]

II. Definition of Key Terms

Female Genital Mutilation (FGM):

According to the World Health Organization (WHO), female genital mutilation (FGM) comprises all procedures that involve partial or total removal of the external female genitalia,

or other injury to the female genital organs, for non-medical reasons. FGM is regarded by the United Nations as a violation of the human rights of girls and women.

The four types of FGM:

- Type 1: The partial or total removal of the clitoral glans (the external and highly sensitive part of the clitoris) and/or the prepuce/clitoral hood (the fold of skin surrounding the clitoral glans).
- Type 2: The partial or total removal of the clitoral glans and the labia minora (the inner folds of the vulva), with or without removal of the labia majora (the outer folds of skin of the vulva).
- Type 3: Known as infibulation, the narrowing of the vaginal opening through the creation of a covering seal, formed by cutting and repositioning the labia minora or labia majora, sometimes through stitching, with or without removal of the clitoral prepuce/clitoral hood and glans.
- Type 4: All other harmful procedures to the female genitalia for non-medical purposes, e.g., pricking, piercing, incising, scraping, and cauterizing the genital area.[7]

III. Background Information

The history of FGM is not well understood, but the practice is believed to be more than 2,000 years old. Its origins remain unknown; however, some scholars suggest that it was practiced in ancient Egypt, potentially among certain social groups and aristocratic families, although definitive evidence supporting this theory is lacking.

Several theories have been put forward regarding the spread of FGM. One theory proposes a link to the slave trade of ancient Arab societies, suggesting that some enslaved African women were subjected to the practice before being sold. Another theory argues that the practice developed independently among certain ethnic groups in Sub-Saharan Africa as part of puberty rites. Some scholars also suggest that FGM became more widespread in the region following the arrival of Islam.[8]

Regardless of its exact origins, FGM gradually became embedded in the social and cultural traditions of various communities across Africa. In many cases, the practice became associated with marriage, social acceptance, purity, and the transition into adulthood. These longstanding social norms have contributed significantly to the persistence of FGM, even in countries where the practice has been formally prohibited.

IV. Major Countries and Organizations Involved

Somalia:

Somalia has one of the highest rates of FGM in the world, with an estimated 99% of the female population between the ages of 15 and 49 having undergone the practice.[9]

Due to ongoing conflict in and around the region, access to reliable medical facilities is limited for large portions of the population, especially those living in rural areas, thereby increasing the risk of severe harm and, in some cases, fatal consequences.

Somalia is a signatory to the Maputo Protocol, which aims to protect the human rights of women and girls across Africa, but has not ratified it. As a result, the protocol is not legally binding within Somalia, limiting its practical impact on the prevention of FGM.

Mali:

Mali has one of the highest rates of FGM in West Africa, with the practice remaining deeply rooted in many communities. Unlike many African states, Mali has not adopted any specific laws criminalizing FGM, despite repeated calls from international organizations and human rights groups. As a result, efforts to reduce the practice have relied largely on education campaigns, community engagement initiatives, and advocacy by civil society organizations rather than on legal enforcement.

Egypt:

Egypt officially criminalized FGM in 2008 and has since strengthened penalties for both practitioners and those who facilitate the procedure. Despite these legal measures, FGM remains widespread throughout the country. Concerns have also been raised about the "medicalization" of FGM in Egypt, whereby the procedure is performed by healthcare professionals in clinical settings. This has contributed to the perception that the practice can be made safe through medical supervision, despite the international consensus that FGM has no health benefits and constitutes a violation of human rights. Egypt is also one of only two African Union member states – alongside Morocco – that have neither signed nor ratified the Maputo Protocol, largely owing to prevailing religious and cultural norms.

Sudan:

Sudan officially criminalized FGM in 2020, marking a significant step forward in efforts to combat the practice. However, implementation of the law remains inconsistent due to political instability, ongoing conflict, and limited state capacity, particularly in rural areas. Although Sudan has signed the Maputo Protocol, it has yet to ratify the agreement, meaning that its provisions are not fully binding. This has created significant challenges in translating legal commitments into effective protection for women and girls.

The African Union:

The African Union plays a central role in coordinating efforts to eliminate FGM across Member States. Through legal instruments such as the Maputo Protocol and various human rights initiatives, the AU encourages Member States to adopt legislation, strengthen enforcement, and promote public awareness of the harmful effects of FGM. The organization also facilitates communication and cooperation between member governments and international and civil society organizations, supporting continent-wide efforts to end the practice.

United Nations Children's Fund (UNICEF):

UNICEF is one of the leading international organizations working to eliminate FGM worldwide. Because younger women and children are often targeted, UNICEF focuses heavily on the prevention of FGM among girls who are not in a position to choose. Through community engagement programmes, educational initiatives, and partnerships with governments and local organizations, UNICEF seeks to change the social norms that perpetuate the practice. The organization also conducts extensive research and data collection on FGM prevalence and trends, helping policymakers and stakeholders develop strategies to reduce and ultimately eliminate the practice.

World Health Organization (WHO):

As the leading international organization on matters of health, the WHO strongly opposes FGM, emphasizing its severe health risks, its harmful effects on women, and its lack of medical benefits. It plays a key role in research, data collection, and global advocacy efforts.

Equality Now:

Equality Now is an international human rights NGO dedicated to promoting and protecting the rights of women and girls. The organization actively campaigns against FGM through advocacy, the promotion of legal reform, public awareness campaigns, and support for local activists. Equality Now also works closely with governments, international organizations, and civil society groups to strengthen legal frameworks against FGM, improve their enforcement, and support survivors of the practice.

V. Timeline of Events

Year	Event
1948	The United Nations adopted the Universal Declaration of Human Rights to advocate for and protect the rights of all people in the world. Although it does not specifically address FGM, its principles of human dignity, bodily integrity, equal rights, and free will remain vital in advocating for the elimination of the practice.
1979	The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) was adopted by the United Nations General Assembly, committing states to eliminate all discrimination against women and girls and to promote gender equality.
1989	The Convention on the Rights of the Child (CRC) was adopted by the United Nations General Assembly, requiring states to protect children from all forms of physical or mental violence, injury, abuse, and harmful traditional practices.
2003	The African Union adopted the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol), including Article 5, which calls for the elimination of harmful practices such as FGM.
2008	Egypt officially criminalized FGM, marking a significant step as one of the first high-prevalence countries in Africa to introduce a nationwide ban on the practice.

20	The United Nations General Assembly unanimously adopted Resolution 67/146, calling for the global elimination of female genital mutilation.
2020	Sudan amended its Criminal Code to officially criminalize FGM and introduced penalties for perpetrators.
2024	UNICEF released updated global estimates showing that more than 230 million women and girls have undergone FGM worldwide, with Africa accounting for over 144 million cases.

VI. Previous Attempts to Solve the Issue

The Maputo Protocol (Article 5):

The Maputo Protocol, officially adopted in Maputo, Mozambique, in 2003, is a legally binding international human rights agreement of the African Union guaranteeing comprehensive and progressive rights for women and girls across the African continent. It is widely regarded as one of the most specific and far-reaching women's rights treaties in the world.

Article 5 of the Maputo Protocol specifically requires that all African nations condemn and prohibit any and all traditional and customary practices that negatively affect the human rights of women. It is the first international human rights treaty to explicitly mandate the outlawing of Female Genital Mutilation (FGM).[10]

VII. Possible Solutions

FGM is a complex and contentious topic, with differing opinions depending on religious and cultural beliefs. The United Nations has affirmed that it deplores the practice of FGM against all women and girls; however, many still view it as a legitimate practice tied to a community's history and beliefs, and risk being alienated by direct outside interference.

The establishment of regional data collection centres and increased monitoring could offer a realistic approach, allowing for joint monitoring by state actors and NGOs and enabling a rapid response in cases of non-compliance with the Maputo Protocol's provisions.

An incentive-based approach may also be considered, in which financial or developmental support is tied to a state's demonstrated commitment to reducing FGM. Such funding could include increased access to healthcare, educational programmes, or economic development support, and could be implemented through greater cooperation and partnership between national governments, the African Union, and international organizations such as UNICEF and the World Bank. This approach, however, remains controversial, as it raises concerns about its feasibility, its dependence on external funding, and the ethical implications of using financial incentives to encourage the abandonment of cultural practices.

Several African nations have enacted legislation explicitly criminalizing FGM, yet enforcement remains inconsistent, particularly in rural areas where access to resources is limited. Strengthening enforcement could prove to be a significant step forward without requiring extensive new legislation. However, while potentially effective in the short term, it risks alienating communities. In countries where state-community relations are already fragile, stricter enforcement could deepen distrust, undermining long-term behavioural change.

Community-led abandonment programmes have, to date, shown the most promising results in reducing FGM prevalence. Rather than relying on externally imposed legislative measures, these programmes empower communities to bring about change themselves, allowing social norms to shift naturally through in-depth dialogue, expanded education, and shifting influence. UNICEF has documented success in running community engagement initiatives of this kind, particularly in East and West Africa, where approaches led by external actors have historically met significant resistance from communities.

This model respects concerns about cultural sovereignty while still moving toward elimination of the practice. By positioning external bodies such as UNICEF and the AU as supporting actors rather than enforcers, these programmes reduce the perception of foreign interference that has undermined previous efforts.

VIII. How to prepare as a Delegate

Here's a single, continuous text:

Proper preparation is key to a productive and substantive debate. To ensure every delegate arrives well-prepared, each delegate is required to submit at least two position papers, though writing three is strongly recommended, as this allows for a deeper exploration of the topic and strengthens one's understanding of the country's stance. In addition, every delegate must draft at least one resolution, reflecting their country's position and proposing concrete, actionable solutions to the issue at hand. All position papers and the resolution must be sent to the Chair for review by the deadline of 27 August. It is important to note that any documents submitted after this deadline cannot be considered for correction or feedback, and will not count toward the delegate's evaluation or award eligibility. Delegates are therefore strongly encouraged to complete and submit their work well ahead of time, rather than waiting until the last moment, in order to receive helpful feedback and remain eligible for recognition during the committee.

IX. Questions Delegates Should Consider During Research

- In what ways might the continuation of FGM reflect the cultural and societal roles assigned to women?
- What role should education and awareness play in reducing FGM?
- Should community-led initiatives be prioritized over stricter legal enforcement?
- What role should the African Union play in ensuring compliance with the Maputo Protocol?

X. Relevant Treaties and Events

- The Maputo Protocol (Article 5)
- Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)

- Convention on the Rights of the Child (CRC)
- Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT)
- United Nations General Assembly Resolution 67/146

XI. Useful Links and Sources

Links:

UNICEF – A profile of female genital mutilation in Eastern and Southern Africa
PMC – Article on FGM
UNICEF – Female genital mutilation
NHS – Female genital mutilation (FGM)
UNFPA – Female genital mutilation (FGM) frequently asked questions

Sources:

UNICEF Data – Female genital mutilation
UNFPA – Female genital mutilation (FGM) frequently asked questions
Hampshire SCP – Fact sheet 02: Physical and mental consequences of FGM
FHI – Immediate complications of FGM (report)
WHO – Health risks of female genital mutilation
End FGM – New WHO study details long-term health consequences of FGM
WHO – Female genital mutilation (fact sheet)
Humanium – FGM in Somalia: a harsh daily reality for many girls
PULP – Commentary on Article 5 of the Maputo Protocol
FGM National Group – Historical and cultural background

1 UNICEF, Female Genital Mutilation: A Global Concern (2024 update).
2 UNFPA, Female genital mutilation (FGM) frequently asked questions.
3 Hampshire Safeguarding Children Partnership, Fact sheet 02: Physical and Mental Consequences of FGM.
4 FHI, Immediate complications of female genital mutilation (2014).
5 WHO, Health risks of female genital mutilation.
6 End FGM European Network, New WHO study details long-term health consequences of FGM.
7 WHO, Female genital mutilation (fact sheet).
8 FGM National Group, Historical and cultural background of FGM.
9 UNICEF/Humanium, FGM prevalence data for Somalia.
10 PULP, Commentary on Article 5 of the Maputo Protocol.