The Tipping Point: How Women's Political Empowerment may Reduce the Prevalence of FGM

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1. Introduction

Globally, over 200 million girls have been affected by Female Genital Mutilation (FGM), defined as "the partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons" (WHO, 2023, para. 2). A literature review identifies three main motives for its continued performance: (1) tradition, (2) social pressure, and (3) aesthetics. It is considered to maintain a girl's purity, signifies a move into adulthood, decrease sexual desires, and is held to represent a clean and ideal woman (Williams-Breault, 2018; Moges, 2003; & UNFPA, 2022).

Recently, efforts to outlaw the practice of FGM have gained momentum. The UN ruled that FGM is a type of violence against women falling contrary to international law under the CEDAW Convention. Furthermore, UN member-states have committed to "eliminate all harmful practices, such as child, early and forced marriage, and female genital mutilation" by 2030 (SDG Target 5.3). Nationally, many countries have established anti-FGM laws. Such legislation is most common in Africa, where 28 countries have specific laws/provisions (Equality Now, n.d.). Despite this move towards outlawing the practice, it remains highly prevalent, with the UN estimating that 4.2 million girls are at risk of FGM in 2023 (United Nations Women, n.d.). Therefore, research on FGM is of scientific and practical relevance as there is a need to investigate bottom-up approaches to bring an effective end to the practice of FGM.

Since 2000, women's political empowerment (WPE) has been at the core of development goals, indicative of this change is the 13% global increase in the percentage of parliamentary seats held by women (Hessami, & Lopes da Fonseca, 2020). WPE has been identified as a way to increase women's health and social wellbeing. It increases recognition of women's issues in politics, allows women to gain collective action power and provides them with platforms to fight gendered-norms and stereotypes. Since FGM is a social norm which cannot be eliminated simply through legislation, and women are the individuals directly affected by the issue, WPE may be a solution for reducing prevalence of this practice.

For these reasons, this thesis will focus on providing an answer to the question "*how does women's political empowerment influence the prevalence of female genital mutilation in developing countries?*".

To begin, the existing literature and theories on WPE and FGM are discussed to generate this research's hypotheses. This thesis uses a mixed-methods approach involving linear regression and process tracing to answer the research question in the context of the Sahel band of Africa. Data is collected from existing indices and merged into an all-encompassing dataset. The research finds that WPE reduces the prevalence of FGM, more specifically, the increase in women's civil society participation is pivotal in reducing the prevalence of FGM. This is of high practical and societal relevance as the current policies, taking form of education and anti-FGM legislation, have not been enough to reduce the prevalence of the practice.

2. Theoretical Framework

a. Female Genital Mutilation

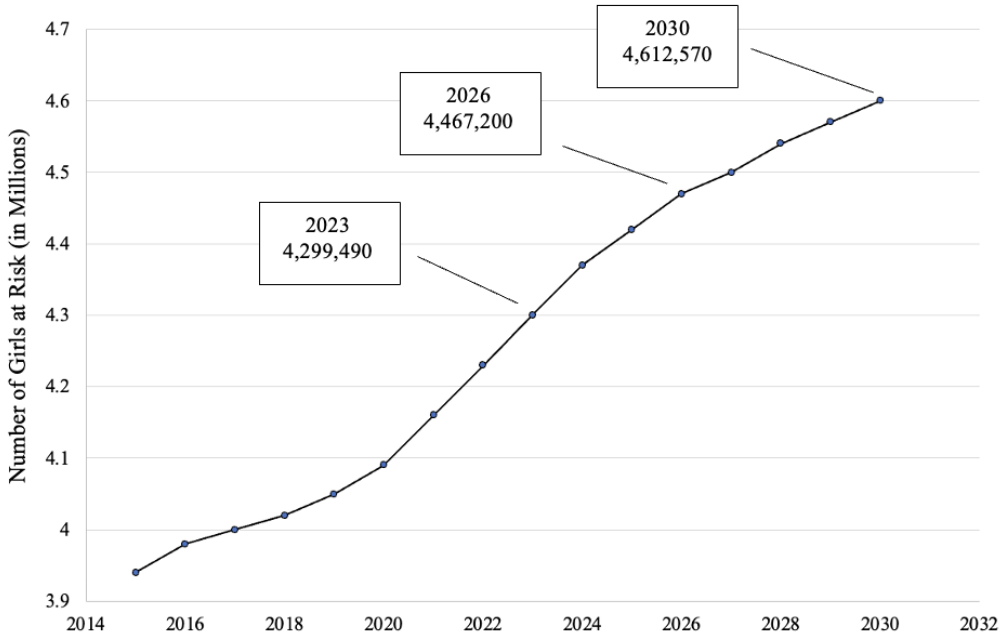
FGM is "the partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons" (WHO, n.d., para. 2). The terminology "female genital mutilation" has created controversy due to its potential offensiveness to local women/families who do not consider themselves mutilated/mutilators. Research found that usage of this terminology may estrange certain communities and delay the social change required to eliminate the practice (WHO, et al., n.d.). Nevertheless, this paper will employ the term "female genital mutilation" to align itself with the terminology established by the WHO, UNICEF, and UNFPA in 1997 and used by institutions ever since (WHO et al., n.d.).

FGM is a public health issue violating numerous human rights principles and lacking any health benefits; it is linked to several short- and long-term health consequences (Berg and Denison, 2014; Donohoe, 2006). The short-term consequences depend on the environment within which the excision was undertaken; but, lack of sterile equipment, antiseptics, antibiotics, and the re-utilizing of tools is linked with a higher risk of infections and a high risk of hemorrhage (Klein, et al., 2018; Reisel & Creighton, 2015). In the long-term, FGM is linked with physical and psychological impacts. Physically, there are severe obstetric consequences wherein FGM causes higher risks of death and infections during birth due to the narrowing of the birth canal. Psychologically, it is linked with PTSD, somatic pains, and depression (Reisel & Creighton, 2015; WHO, 2023).

As stated above, there has been a global movement towards the eradication of FGM, taking the form of anti-FGM legislation, education, and attempts at economic development. This trend of focusing on socioeconomic development as an end-all solution to FGM is also

present in literature, which has been mostly contained to studying socioeconomic development as ways to overcome the practice and provided little causal evidence to support its claims (De Cao & La Mattina, 2019).

Figure 1: Projected Number of Girls Experiencing FGM (2015 - 2030)



Source: UNFPA Population Development Branch (2018)

Figure 1 provides a projection of the number of girls (aged 0 to 14) expected to undergo FGM from 2015 to 2030. It shows that an estimated 4.6 millions girls are expected to be circumcision in 2030 compared to 4.3 million in 2015; demonstrating a failure to tackle the issue and implying that socioeconomic development and anti-FGM legislation are not sufficient to eradicate the practice.

Literature suggests that anti-FGM legislation is unlikely to decrease the issue because the traditions surrounding the practice are ingrained in societies (Population Reference Bureau, 2010). It has even been shown that outlawing FGM may perpetuate the practice by creating new forms of discrimination and increasing stigma due to colonial attitudes towards the practice (Winterbottom, Koomen, & Burford, 2009; O'Neill et al., 2020; Manderson, 2004). This 'failure' of legislation is evidenced by the fact that, half of the girls experiencing FGM across 28 African countries come from Egypt, Ethiopia, and Nigeria – countries having clear anti-FGM laws (28 Too Many, 2018). Since FGM is socially-embedded, enforcement of the law is ineffective because families protect circumcisers, and individuals are reluctant to go

against local culture by enforcing the law; therefore, legislation has driven the practice "underground" more than anything else (Aberese Ako & Akweongo, 2009, p. 52) People often fear the social punishment associated with abandoning the socially-embedded practice of FGM more than the legal repercussions attached to its performance (Williams-Breault, 2018). Furthermore, there are systematic issues of implementation/enforcement arising from a lack of state institutions required to investigate and prosecute FGM. In Ghana, insufficient funds, lack of trained personnel, and undefined roles/responsibilities contribute, in part, to the ineffective implementation of laws (Aberese Ako & Akweongo, 2009). Similarly, in Kenya, implementation of the anti-FGM law remains challenging due to difficulties in reaching remote rural areas and limited capacity of enforcement agents. Furthermore, judges are reluctant to convict individuals for FGM, leading to under-criminalization of the issue, with only 10 convictions arising from the 75 cases brought to court in 2016 (28 Too Many, 2018). Consequently, although anti-FGM laws are important, they are insufficient to eradicate the issue.

b. Norms and Social Change Theories

FGM is socially and culturally embedded, as exemplified by the recent constitutional questioning of Kenya's anti-FGM law on the basis that it is contrary to women's rights to freely practice their culture (Ahmadu & Kamau, 2022). This highlights FGM as an issue of social norms rather than solely one of patriarchy. Three motivations for its persistence have been identified:

1. Tradition: FGM is linked to traditional beliefs of maintaining a girl's purity, ensuring virginity prior to marriage and fidelity afterwards (Williams-Breault, 2018; UNFPA, 2022). Furthermore, in some traditions there are mythical beliefs such as that an uncircumcised clitoris can transform into a penis (UNFPA, 2022).
2. Social Pressure: Socially, FGM serves as a "rite of passage", signaling the move from girlhood to womanhood (Moges, 2003; Williams-Breault, 2018). It is required for marriageability in many societies where values of virginity, morality, and honor prevail. (Moges, 2003; UNFPA, 2022). There are high social costs for families who do not circumcise their daughters, such as loss of status, no marriage opportunities, stigmatization, and social exclusion (Van Rossem et al., 2015).
3. Aesthetics: FGM is associated with ideals of beauty and the ideal woman. Unmodified genitals are considered dirty and ugly, sometimes even uncivilized. However, after FGM the body is clean, beautiful, and human (Lien & Schultz, 2013; UNFPA, 2022).

These motivations reflect clear, entrenched social norms, and overcoming them requires more than education, legislation, or economic development – rather, they require political change.

Social change theories provide further insights into overcoming FGM, emphasizing the important role of political change. Social norms theory dictates that FGM persists because individuals perform it to gain social acceptance and avoid sanctions, even where they may disagree with it (WHO, 2023). However, this theory notes that norms are dynamic and can change at a "tipping point" when enough people are influenced to behave in a certain way (UN Women, 2020). Behavioural theory highlights that to reach such 'tipping point' there must be attitudinal change which delegitimizes FGM. As identified above, legislation is unable to reach this point because simply prohibiting the practice does not delegitimize it in the eyes of those whose culture it is embedded in. Education has been identified as a way to reach this point because it increases the likelihood of adopting healthy behaviors, reducing desires to perform FGM (Van Rossem et al., 2015; Ackah et al., 2022). However, studies in certain regions show no statistically significant relationship between a mother's education and FGM prevalence; implying that, although important, education is not sufficient to reach the "tipping point" and overcome the superiority of the embedded tradition (Yasin et al., 2013). Politically, it has been argued that a local authority announcing new expectations with regards to social norms provides for an effective way of reaching the tipping point, implying that politically empowered women may be effective in reaching this point (Bicchieri & Mercier, 2014).

Western-feminism views FGM as patriarchal control by men to keep women "subservient" and "pure" (Leonard, 2000, p. 162). However, this is in controversy with the finding that women are the principal performers and bearers of the tradition (Alradie-Mohamed et al., 2020). A second strand of feminist-theory argues that women use FGM to define their social status since it creates financial security through marriage and provides some authority within the family (Yount, 2002). This strand holds that legislative advancements will not bring change; instead, empowering women with new opportunities to participate at a higher-level in society is crucial for changing norms surrounding FGM (Althaus, 1997).

c. Women's Political Empowerment

The WHO highlighted the important role of WPE for "social well-being and equitable health" (CSDH, 2008, p.155). A literature review permits for the identification of three ways through

which WPE can increase women's health outcomes and reach the 'tipping point' required for norm-change: (1) women's political participation, (2) women's civil liberties, and (3) women's civil society participation.

To begin, WPE via political participation and descriptive representation has been widely discussed as important for resolving gender-specific issues. Particularly Xu et al. (2021) highlighted the significance of descriptive representation for increasing the health outcomes of the population. They argue that female leaders are more sensitive to social issues due to their position as caretakers, so are more likely to invest in public goods surrounding health. This is confirmed by other works which have found that, in developing countries, increased female representation is associated with a better provision of public goods, especially those of health and education (Bratton & Ray, 2002; Belek, et al., 2021). Women are more likely to invest in policies that directly affect women; for example, maternal and child well-being or issues of gender equality (Wangnerud, 2009; Chattopadhyay & Duflo, 2004). Furthermore, increased female representation is linked with a higher tendency for women legislators to pass legislation dealing with issues of health and issues that directly affect women/children (Duflo, 2012; Besnier, 2020; Schwindt-Bayer, 2006). To achieve more descriptive representation, over 130 countries have changed their electoral rules to implement gender quotes whereby a specified number of women must be selected for a political body (Nayar, 2021). India is one of these countries, and research on its effectiveness supports the above theoretical mechanisms that women's political participation is important for women, children, and their social/health needs. The villages assigned female leaders see a higher provision of public goods aimed at health and education, and public policies which adequately reflect the preferences of women (Chattopadhyay & Duflo, 2004; Hessami, & Lopes da Fonseca, 2020). Furthermore, implementing quotas in India has improved the chance of women being elected, even in years where there are no quotas in place, demonstrating a change of attitude towards women in power (Nayar, 2022).

The second way that WPE can improve women's health outcomes is by providing them with increased civil liberties such as suffrage rights, access to information, and the ability to assemble. Women have reported lower health satisfaction in countries having lower civil liberties (Weinstein et al., 2018). Lack of civil liberties hinges upon their autonomy and ability to assemble for a cause, pursue employment/education opportunities, and express discontentment with the current situation which, in turn, shapes health satisfaction by

preventing them from making autonomous decisions about their health (Weinstein et al., 2018). Public choice theory also holds that when women gain civil liberties this is followed by increased public spending on social services such as health and education (Aidt & Dallal, 2008). For example, in the United States, within a year of the enactment of the women's suffrage law, voting shifted so that public health spending rose by 35% (Miller, 2008). Finally, increased civil liberties in the form of access to information reduces violence towards women by empowering them to act when abused, and increases their ability to make informed decisions about their health (Neuman, 2016; Article 19, 2023). For example, informing women on sexual violence in São Paulo's metro system led to an increase of almost 200% in the rate of women who reported having experienced this violence (Neuman, 2016).

Finally, WPE through civil society participation is another important factor for overcoming social norms such as FGM. Prillaman (2023) shows how in India, women's participation in Self-Help Groups (groups of women who meet to deliberate and coordinate collective action), fostered a common interest in mobilizing against gender inequalities and female subordination. Furthermore, they generated a way for women to move against gender-discriminatory social norms through collective action, since women are more likely to act against a norm when having a network with which to act and knowing other women will also act. Therefore, it could be held that women's civil society participation can be used to overcome FGM by fostering collective action and providing them with confidence that they are not alone in resisting the tradition.

WPE is also important as it allows for women to act as 'role models' both through political participation and through civil society participation. They can actively advocate for, and encourage others, to adopt behaviors that help overcome gender-based stereotypes/norms. For example, descriptive representation creates female leaders who encourage other women to become politically active and brings a change in the attitudes towards women. Areas having increased numbers of female MPs see increased discussion/participation of women in politics (Wolbrecht & Campbell, 2007). Furthermore, it brings ideational change around the position of women in society. Beaman et al., (2009) found that reserved seats in India increased the ideational view of equality between men and women within the community, reducing the stereotypes surrounding gender roles. Civil society empowerment also generates a 'role

model' effect wherein women are provided with a platform/community through which they can share their experiences, encouraging attitudinal change towards the practice of FGM.

Based on these theoretical mechanisms, it can be expected that WPE would lead to an increase in legislation and public spending aimed at tackling FGM. It could also provide women with collective action powers, giving them security that they will not face social punishment when resisting the practice. Lastly, increased WPE may create role models through women sharing their experiences, influencing the traditional thinking that FGM is a necessary social, traditional, and aesthetic requirement. Therefore, WPE may reach the "tipping point" for norm-change, something that anti-FGM legislation and education have failed at.

However, a large literature also identifies reasons why WPE might have no effect on FGM. Reasons provided for this are: (1) women are the main bearers of the tradition, (2) the median voter theory, and (3) quotas are ineffective.

To begin, WPE may have the adverse effect of *increasing* the prevalence of FGM. This is because many women in these countries are the main bearers of the tradition, believing they are doing good for their daughters by increasing her marriageability and social-standing (Alradie-Mohamed et al., 2020). Therefore, having more female leaders could have them act as role models in the 'wrong way'; whereby, they promote the performance of FGM to the community. Furthermore, increased civil liberties and civil society participation might provide women with greater collective action power to push against legislative reforms aimed at ending FGM. This thesis proposes that the direction that the effect of women's empowerment will have on FGM depends, so whether it increases/decreases the prevalence of FGM, depends on the broad support and attitude that still remains towards FGM within society.

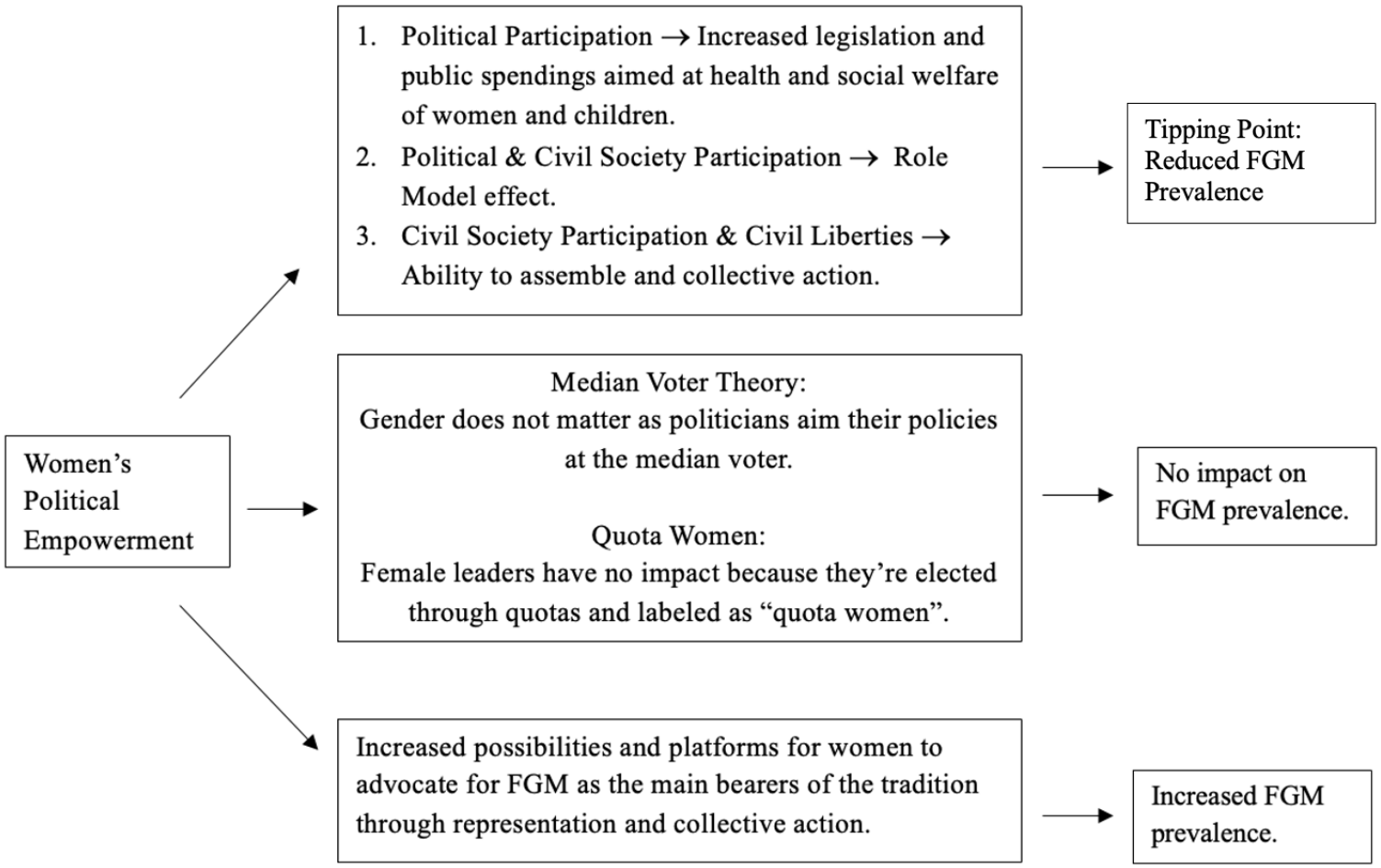
Secondly, a prominent theory in the literature is the median voter theory, which argues that the ascriptive characteristics and identities of political leaders do not actually matter for policy choices because politicians compete for the policy position of the median voter to ensure their re-election (Downs, 1957). On this basis, gender is not important for policy and legislation outcomes because politicians represent the preferences of the median voter; and therefore, women legislators are not more concerned with creating policies protecting

women's social and health outcomes (Funk et al., 2015). In this Downsian view, the political empowerment of women will have no effect on the prevalence of FGM.

Lastly, quotas for the increased descriptive representation of women in legislatures are not always effective. Certain studies have shown that women may sometimes stand as proxies for their husbands in the reserved seats. For example, Chand (2018) found that 42% of women having reserved seats in Pradhans were encouraged by their husbands in their candidature. Nayar (2022) suggests that this raises concerns that men encourage their wives to run for the reserved seats so that they can implement their decisions through their wives. Furthermore, quotas may even be harmful to women leaders because they reinforce the stereotypes about women's capacities as leaders and render them less effective in their abilities to implement change and policies because they are labeled as quota women (Franceschet & Piscopo, 2008; Nayar, 2021). Therefore, the existence of quotas for women's representation may have two effects on FGM: first, it may lead to a decrease in the prevalence of FGM by creating effective women leaders who are able to implement policies, legislation, and provide public goods in the ways identified above. However, it may also create ineffective women leaders who are simply working as proxies for their husbands or who are unable to implement their desired policies because they are simply considered to be "quota women".

Based on the theoretical views presented above, it is hypothesized that increased WPE will lead to attitudinal change towards women, increased legislation and public spending aimed at eradicating FGM, and increased possibilities for women to mobilize against the practice of FGM. Taken together, these enable women to reach the 'tipping point' identified by social norms theories for bringing norm transformation. Therefore, this leads to the null hypothesis below:

H_1: *An increase in women's political empowerment is associated with a decrease in the prevalence of FGM.*



Furthermore, the argument that women's political participation is important for increasing women's health outcomes is extremely salient in the literature. On this basis, it is hypothesized that:

H_2: *Women's political participation is the factor which drives the FGM reduction.*

It is important to study WPE's effect on FGM prevalence for two reasons: (1) current socio-economic policies have not been enough to reduce FGM, and (2) a theoretical question arises with regards to the direction that WPE will take (increase or decrease FGM?). Seminally, this thesis suggests that the direction of WPE's impact on FGM will depend on the broad support for FGM in society. Overall, this question is practically and politically relevant.

3. Research Design and Operationalization

A mixed-methods research, consisting of regression and process-tracing, is employed to answer the research question. This approach permits for triangulation of findings whereby the regression examines the existence of a relationship between the variables and process-tracing

confirms the mechanisms through which WPE affects FGM prevalence. Given the risk of confounding, the research design must include all relevant variables, such as education, ethnicity, and democracy, that might create a fake correlation between WPE and FGM prevalence. Therefore, a regression is suitable because it overcomes the challenge of confounding by determining the strength and direction of association between WPE and FGM prevalence while controlling for the confounding factors. Mixed-methods enhances the validity of the research because it compensates for individual-method weaknesses. The external validity is constrained to data from the Sahel band of Africa, so the findings are generalizable to this area. The regression lacks in internal validity since it is difficult to establish the cause-and-effect relationship between the two variables; therefore, the use of process tracing will compensate for this by allowing to study the cause-and-effect mechanisms more in depth.

a. Dependent Variable: *FGM Prevalence*

The dependent variable is *FGM Prevalence,* operationalized as the percentage of women aged 15 – 49 years experiencing FGM. This data is collected from the DHS and MICS Surveys which allow for a reliable, representative, and unbiased conceptualization of the variable since the surveys are based on randomly selected women's response to questions asked by interviewees. Furthermore, they use standardized procedures applied equally across countries, allowing for reliable cross-sectional comparisons across countries. A potential limitation is that answers are self-reported, and women are unlikely to report that they have undergone the outlawed practice of FGM. This variable is continuous, moving from a scale of 0 (no women have experienced FGM) to 100 (all women have experienced FGM).

b. Independent Variable: *Women's Political Empowerment*

Previous research placed significant attention to women's socio-economic empowerment on FGM prevalence, but no focus has been given to WPE's effect on FGM prevalence. Consequently, the independent variable is *women's political empowerment*, operationalized using the Women's Political Empowerment Index (WPEI) (Sundström et al., 2017). It is composed of three indicators:

- Women's Civil Society Participation: The extent to which women have agency and can freely engage in public debate. Looks at their freedom to discuss political issues, freedom to participate in civil society organizations, and whether they are represented among journalists. This politically empowers women by representing them in key

arenas of political debate, giving them the opportunity to voice their concerns and propose solutions.

- Women's Civil Liberties: The extent to which women can make choices. Looks at freedom from forced labor, freedom of movement, property rights, and access to the justice system.
- Women's Political Participation: Measures the extent that women are represented in the legislature and the distribution of political power across gender.

Each indicator is scored from 0 to 100 and averaged to provide the WPEI which is continuous from 0 (no political empowerment for women) to 100 (women are politically empowered). Compared to other indicators of WPE which often focus only on the number of seats held by women in parliament, the WPEI moves away from simple political participation but towards political empowerment as a concept where women enjoy agency, freedom, and representation. Furthermore, use of this variable is justified because the theoretical framework showed that each component – civil society participation, civil liberties, and political participation – is important for increasing women's health outcomes.

c. Control Variables

The literature review identified certain variables as being potential confounders. These are included in the research to control for the spurious relation that could be created through their correlating with WPE and FGM prevalence.

The first variable is *education*, a potential confounder since it increases WPE and decrease the prevalence of FGM. At the individual level, there is a negative correlation between parental education and FGM (UNICEF, 2013; Shabila, 2017; Williams-Breault, 2018). In a study across 21 African countries, UNICEF (2022) found that girls whose mother has undergone primary education are 40% less likely to be circumcised than those whose mothers have no education. Furthermore, women with a higher level of education are more likely to be in favor of ending the tradition of FGM (Ahmed, Seid, Seid, Yimer, 2022). Education of women has also been shown to increase political empowerment by providing women with increased skills and confidence that increase ambition to participate in politics (Borah, 2022). In this thesis, education is measured using the Human Development Index (UNDP, 2021)'s *Mean Years of Schooling* indicator.

The second variable is *democracy*. More democratic countries are generally linked to higher human rights protections and have more durable political regimes (Engelsma, Mackie, & Merrell, 2020). Each additional decade of regime durability is associated with a 0.5% decline in FGM. (Engelsma, Mackie, & Merrell, 2020). *Democracy* is measured using V-Dem's electoral democracy index which ranges from 0 to 1 (most democratic) and looks at free and fair elections, and freedom of expression and association.

The third variable is *urbanization.* There is a lower prevalence of FGM in urban areas (Batyra, Coast, Wilson, & Cetorelli, 2020). For example, in Cameroon, Ghana, and Tanzania, the FGM prevalence is almost double in rural-areas than in urban-areas (Population Reference Bureau, 2017). Additionally, urbanization causes people to move from their traditional environment to cities where norms and attitudes are different, creating change in practices. With regards to WPE, women in urban areas have more social, economic, and political freedoms and see more opportunities to engage in community politics at different levels (Dhamija et al., 2023). Urbanization is measured using the *Urban Population (% of Total Population)* indicator from the UN Population Division.

The final variable, *ethnicity*, is strongly correlated with FGM (Population Reference Bureau, 2017). For example, Snow et al. (2002) found that in Nigeria, ethnic group identification is the most significant predictor of whether a woman will be mutilated. To measure ethnicity, this thesis uses Fearon (2003)'s *Ethnic Fractionalization* index which ranges from 0 (perfectly homogenous) to 1 (highly fractionalized). A limitation of this control is that *ethnic fractionalization* does not represent the attitudes of the ethnic groups towards FGM; however, this was the only data readily available for research.

d. Data

This hypothesis is tested using national-level data from Africa. Africa is chosen because it is the region where FGM is most prevalent, with at least 80% of FGM victims arising in Egypt, Ethiopia, Mali, Sudan, Djibouti, and Guinea (Shakirat et al., 2020). Case selection is therefore based on a typical case-selection technique to investigate the specific causal pathway through which FGM prevalence may be reduced by WPE in Africa (Seawright & Gerring, 2008).

Figure 2: Map of Women's Political Empowerment by Country

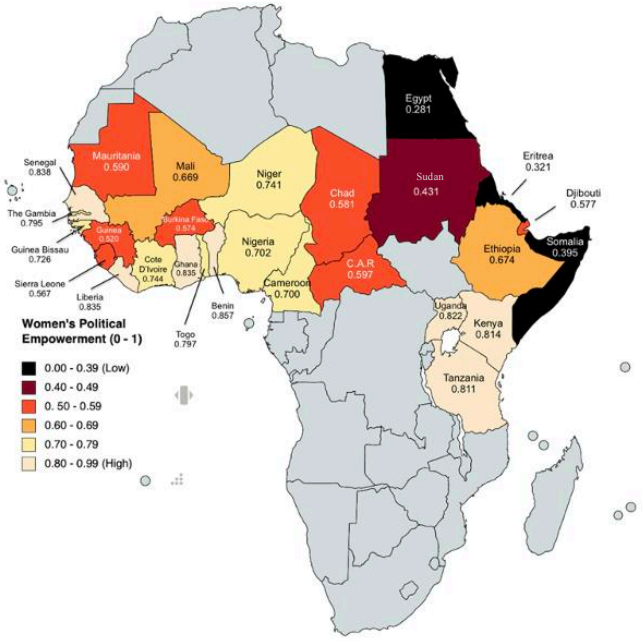


Figure 3: Map of FGM Prevalence (15 – 49 years) by Country

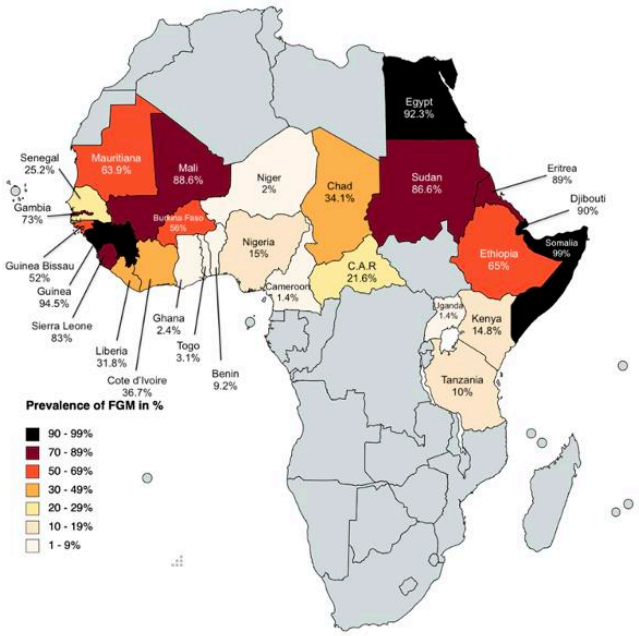


Figure 3 shows that the countries affected by FGM are spread across the Sahel band of Africa. This makes them suitable for comparison, as they are neighboring countries with similar characteristics. However, it does limit the external validity of the research since findings will only be representative of this part of Africa. The investigation is performed at the national level because WPE's effect is more readily observable nationally and because more data is available at this level.

The data comes from various indicators, manually merged into a single, all-encompassing dataset. It is comprised of 27 countries and represents an effort to gather reliable data. Excluded African countries are excluded due to data availability. Some of these countries such as the DRC, Malawi, and South Sudan have been reported to have FGM; however, data on FGM prevalence has not been systematically collected (UNFPA, 2022; Equality Now, n.d.). The illegalization of FGM has caused the practice to move 'underground', leading to underreporting of the practice, meaning that (1) data is not available for certain countries despite reports of the practice, and (2) data regarding the prevalence of FGM is unlikely to reflect the extent to which the practice is actually undertaken (Shakirat et Al., 2020).

e. Assumptions

Prior to undertaking any quantitative analysis, the assumptions of multicollinearity, linearity, heteroskedasticity, non-normally distributed errors, and outliers were tested. The collinearity

statistics of VIF and tolerance were used to test for high levels of correlation between the independent variables. To test for outliers the levels of the standard residuals were investigated, and to test for normality of the errors a P-P plot was used. All these tests were successfully met, meaning that the data is suitable for running in linear regression.

4. Results

a. Correlation Statistics

Before conducting the regression analyses, a correlation analysis is run using a scatterplot to investigate the strength and direction of the relationship between *women's political empowerment* and *FGM prevalence*.

Figure 4: Scatter of FGM Prevalence by Women's Political Empowerment

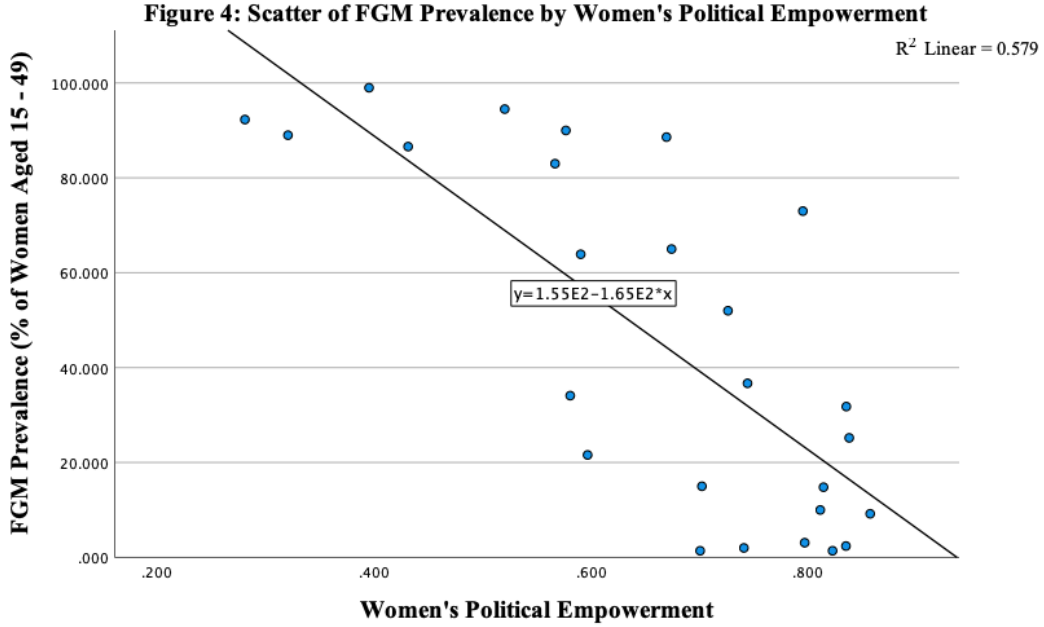


Figure 4 presents the scatterplot of the two variables. It indicates a correlation coefficient of $R^2 = 0.579$. As expected from the literature, there is a negative relationship between the WPE and FGM prevalence, meaning that as WPE increases, the prevalence of FGM decreases. This negative relation is strong as indicated by 57.9% of the variance in FGM prevalence being explained by WPE. However, we cannot treat this as a conclusion because correlation between the two variables does not guarantee causation since issues of confounding and reverse causality may invalidate the causation. Confounding arises when a third variable, which correlates with both FGM prevalence and WPE, creates a spurious relation and provides at least part of the explanation for why they are correlated. Furthermore, the causal relationship between both variables may be reversed, whereby WPE may cause a reduction in

FGM but a reduction in FGM may also cause WPE. Therefore, to overcome these issues, further investigation through the use of inferential statistics is required.

b. Inferential Statistics

To test the hypothesis that 'an increase in WPE is associated with a decrease in the prevalence of FGM', two linear regressions are run, and the results presented in *Table 1*.

Model 1 includes only the independent and dependent variable, and it can be established that FGM prevalence is lower in countries having more politically empowered women. A one-point increase in WPE is associated with a 1.615 percentage-point decrease in FGM prevalence. This result is statistically significant under the use of a 95% significance test ($t = -5.33$, $p < 0.001$) and follows what is expected based on literature.

Table 1: Linear Regression Analysis of the Prevalence of FGM

	Model 1	**Model 2**
(Constant)	152.03***	157.70***
	(20.78)	(27.53)
Women's Political Empowerment	-1.615***	-1.643**
	(0.302)	(0.556)
Urbanization (% of Total Population)		0.740*
		(0.333)
Democracy		-4.653
		(39.196)
Ethnic Fractionalization		-5.003
		(42.354)
Education		-5.162
		(2.615)
R^2	0.542	0.668
Adj. R^2	0.523	0.585
N	26	26

Note: OLS regression coefficients with standard errors in brackets
*** $p < 0.001$, ** $p < 0.01$, * $p < 0.05$

In *Model 2* the included control variables do influence FGM prevalence in a country. When controlling for urbanization, democracy, education and ethnic fractionalization, a one-point increase in WPE is associated with a 1.615 percentage-point decrease in FGM prevalence. This result is also statistically significant using a 95% significant test ($t = 5.539$, $p < 0.001$).

A country's urbanization level has an influential and statistically significant (under a 95% confidence interval) effect on the prevalence of FGM; a one-percent increase in urbanization is associated with a 0.74 percentage-point increase in FGM prevalence ($t = 2.21$, $p < 0.01$). This is contrary to what was expected based on literature, which held that FGM was less prevalent in urban-areas than in the rural-counterparts. However, this might be explained by the fact that the urbanization data is national-level data, rather than looking at rural/urban differences within-countries. The other control variables identified in the literature; democracy, ethnic fractionalization, and education do not have a statistically significant impact on the prevalence of FGM.

Since the results from *Table 1* demonstrate that WPE has on overall effect on the prevalence of FGM, a second regression was run with each of the components of the WPEI to see if the effect is produced by a specific component. *Table 2* provides these results.

Table 2: Linear Regression Analysis of the Prevalence of FGM with Specific Components

	Model 1	**Model 2**	**Model 3**	**Model 4**
(Constant)	137.76***	135.96***	151.549***	139.958***
	(28.93)	(29.325)	(35.639)	(30.739)
Women's Political Participation			-0.112	-0.233
			(0.414)	(0.357)
Women's Civil Society Participation	-0.932*			-0.678
	(0.369)			(0.402)
Women's Civil Liberties		-0.873*		-0.610
		(0.359)		(0.388)
Urbanization	0.584	0.780*	0.664	0.711
	(0.347)	(0.353)	(0.399)	(0.349)
Democracy	-21.096	-10.785	-85.290*	11.61
	(38.78)	(42.531)	(34.026)	(43.39)
Ethnic	-43.183	-63.536	-79.830	-20.66
	(37.467)	(34.772)	(49.017)	(46.47)
Education	-4.44	-4.326	-6.396	-4.123
	(2.789)	(2.821)	(3.224)	(2.86)
R^2	0.639	0.632	0.525	0.687
Adj. R^2	0.549	0.540	0.406	0.565
N	26	26	26	26

Note: OLS regression coefficients with standard errors in brackets
*** $p < 0.001$, ** $p < 0.01$, * $p < 0.05$

When controlling for urbanization, education, ethnicity, and democracy, women's civil society participation is most causally important component for reducing FGM prevalence. A

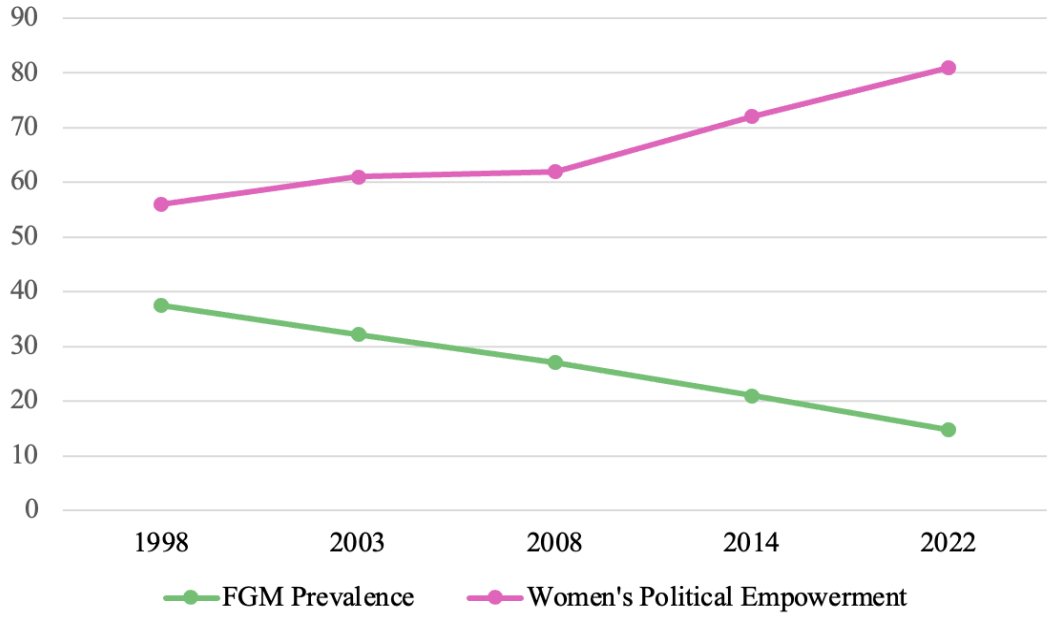
one-point increase in women's civil society participation is associated with a 0.93 percentage-point decrease in FGM prevalence. This is statistically significant under a 95% significance test ($t = -5.73$, $p < 0.05$). Furthermore, the component of women's political participation does not have a statistically significant effect on the prevalence of FGM. This finding is contrary to what was hypothesized based on the literature; demonstrating that increased women's political participation may not be as influential as hypothesized for reducing FGM. This may be due to the issues of the median voter theory or quotas which were previously discussed. However, as stated earlier, it is difficult to study cause-and-effect mechanisms through regressions. Therefore, process tracing to study each mechanism more in-depth will be undertaken prior to rejecting the second hypothesis.

Taken together, the above statistical findings lead to a failure in rejecting the hypothesis that, as WPE increases, the prevalence of FGM will decrease. Furthermore, the hypothesized relation is strong and does not see other variables significantly influencing it.

5. Process Tracing

The statistical analysis demonstrates a causal effect between WPE and FGM prevalence, leading to a failure to reject the hypothesis that WPE reduces FGM prevalence. To further test this, and to test the hypothesis that 'women's political participation is the factor which drives the FGM reduction', the theory is applied to the case of Kenya.

Figure 5: Kenya's Progress on FGM and WPE since 1998



Kenya was selected because, as observed from *Figure 5*, since 1998 it has seen a 25-point increase on the WPEI. In that time, it also managed to decrease FGM prevalence by 22.8%. The other countries studied did not have such pattern of large increase in WPE and significant decrease in the prevalence of FGM, making Kenya the most suitable case to study.

Figure 6: Kenya's Progress on WPEI Components Since 1998

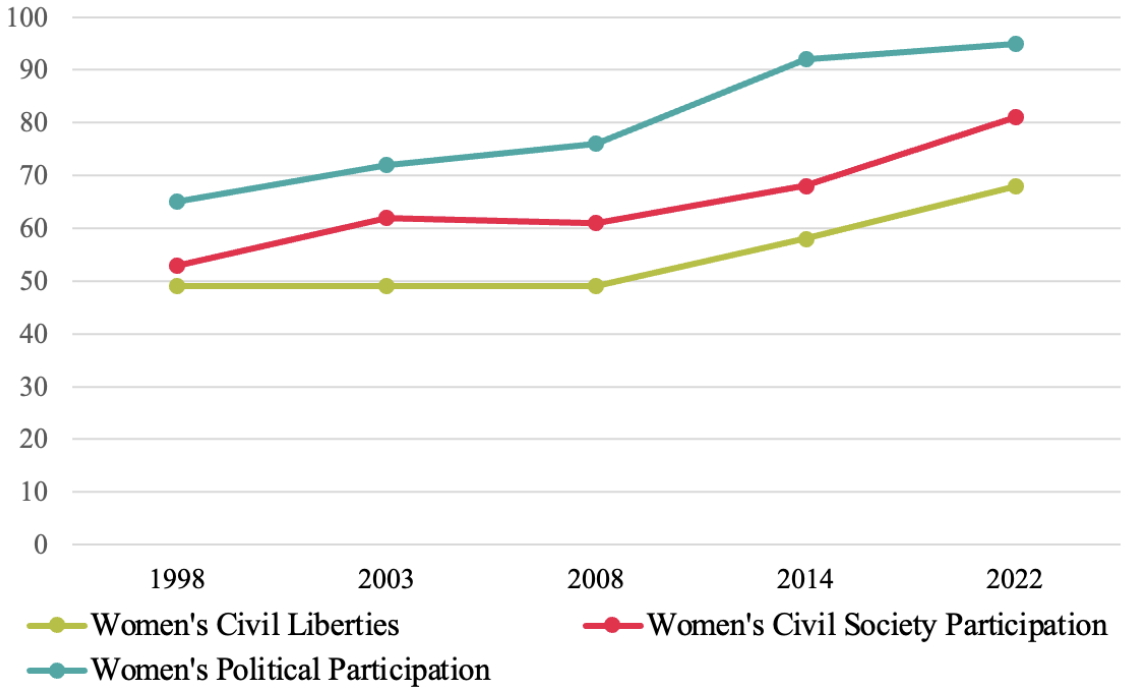
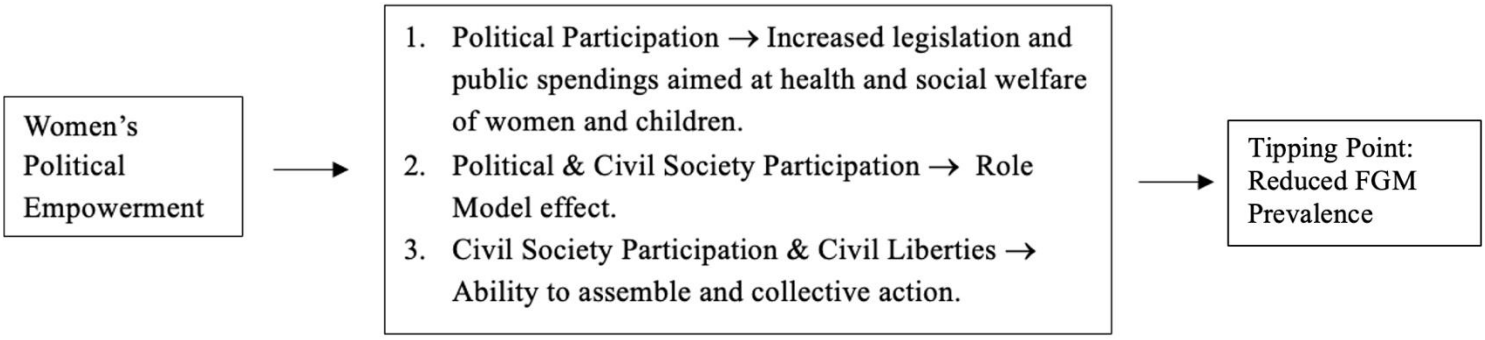


Figure 6 shows Kenya's improvements on each of the WPE Index's components. It demonstrates that women's political participation has seen the biggest rise with a 30-point increase since 1998. Not far comes women's civil society participation with a 28-point increase. This implies that women's political participation and civil society participation are the two components which drove FGM reductions in Kenya. This will be further tested through the use of process tracing below.

The theoretical review enabled the identification of three pathways through which WPE could reduce FGM prevalence. If the regression findings are sound, these pathways should be observable in Kenya. Therefore, this process tracing will go through each mechanism to find evidence supporting their presence in Kenya.



a. Women's Political Participation

The first mechanism holds that women's political participation and descriptive representation will reduce FGM prevalence because female representatives allocate more government resources, and pass more legislation aimed at addressing health and social welfare issues. If this mechanism is true, then there should be evidence of female legislators in Kenya lobbying for increased legislation and spending on public health.

There are several examples of legislation aimed at improving the health of women and children in Kenya, which have emerged as a result efforts by female legislators. The most prominent example is the *Prohibition of Female Genital Mutilation Act 2011* (PFGMA 2011). Drafted by the Kenya Women's Parliamentary Association and following "persuasive advocacy by female legislators" (UNFPA, n.d., p. 13), it is the first law to unequivocally criminalize FGM in Kenya. Consistent with literature suggesting that there is a higher tendency for women legislators to pass legislation dealing with issues of health, the "passage of the bill resulted from concerted efforts by legislators, especially women legislators who had gone through the FGM ordeal" (UNFPA, n.d., p. 14). Furthermore, women in leadership positions continue to defend this bill. This is evidence by a 2021 High court hearing where two female justices, Lydia Achode and Margaret Muigai, and one man, Kanyi Kimondo, upheld the constitutionality of the law and suggested further amendment to make it more effective after spotting issues which made its enforcement difficult (Ahmadu & Kamau, 2022; Carmel Rickard, 2021).

Kenya has also observed increased government expenditure aimed at health, and specifically aimed at combatting FGM. The percentage of GDP aimed at health expenditure in Kenya increased from 2.49% in 2000 to 4.29% in 2020 (WHO, 2023). Furthermore, political commitment to ending FGM has been demonstrated by resource allocation to the Anti-FGM

Board increasing from Ksh.42 million in 2014 to Ksh.92 million in 2016/2017 (Pepela, Kirimi, Rajema, & Mwasi, 2021).

However, despite these legislative and budgetary strives by women, it is important to note from *figure 5* that FGM prevalence had already decreased significantly by 2011 when the PFGMA came about. Therefore, the empowerment of women through political representation cannot be enough on its own to explain the reduction in FGM prevalence. Additionally, since 2010, Kenya has implemented specific gender quotas whereby no more than 2/3 of all positions is an elective/appointive body can be held by one gender. At the regional level it is explicitly stated that if the gender threshold is not met, political parties must nominate women to fill the gap (Sidha, 2023). This quota system has created issues whereby nominated women are relegated to "flower girls" for whom "there is very little respect" and who lack influence (Berry, Bouka, & Kamuru, 2021, p. 650). Furthermore, they encounter issues such as lack of ward budgets (money used for development projects) and minimal control over the regional budget. This limits their ability to address the issues they would wish to influence; "we would want to influence the budget so that it would take care of women's issues" but lack of access to funds leads to there being "nothing I can say I have done" (Berry et al., 2021, pp. 652 – 654). Therefore, women's political participation, although important, does not provide a complete explanation for the decline in FGM prevalence in Kenya.

Consequently, if Kenya's progress on FGM cannot be solely attributed to women's increased political participation, could it be that women serving as role models played a pivotal role in reducing FGM prevalence?

b. Women's Role Model Effect

The second mechanism identified is based on the theory that WPE increases women's political and civil society participation, providing them with a platform and/or community wherein they can act as role-models, influencing others abandon their traditional ideas and harmful practices. If this pathways holds, there should be evidence of increased visibility of women in Kenya who actively encourage shifts in social norms, causing an observable change in attitude towards women.

An example of such role model is Catherine Meng'anyi who works under Kenya's Ministry of Health and the WHO. She has reached over 25,000 people in advocating against FGM in a

culturally sensitive manner. In sharing personal experience with FGM, she argued that "finding the strength to speak about your experience helps others say no; it helps end the practice" (WHO, 2023, para. 7). Her open commitment to ending FGM encourages other women to challenge the traditional norm. Similarly, when Hellen Lebasha, Assistant Chief of Leraata, was first elected, community member suggested that "a man should have been considered instead". However, "her strictness and hard stance on the need to abandon outdated practices, she says, has helped change the community's perception towards women, paving way for their empowerment" and fighting for the rights of the women and girls in her community (Wairimu, 2023, para. 5 – 9). Additionally, many Kenyan women contend that this women's active engagement in politics is inspiring to young women who "…realize they can be leaders too. The barriers they once thought were insurmountable crumbles and they start dreaming big" (AMWIK, 2023, para. 29). These examples all highlight how women, acting as role models through their political and civil society participation, have created attitudinal change in norms such as the role of women in the political arena or the practice of FGM. The change in the attitudes towards female leaders is underscored by findings from the Kenyan Afrobarometer Surveys.

Figure 7: Kenya's Attitudinal Change and WPE since 2005

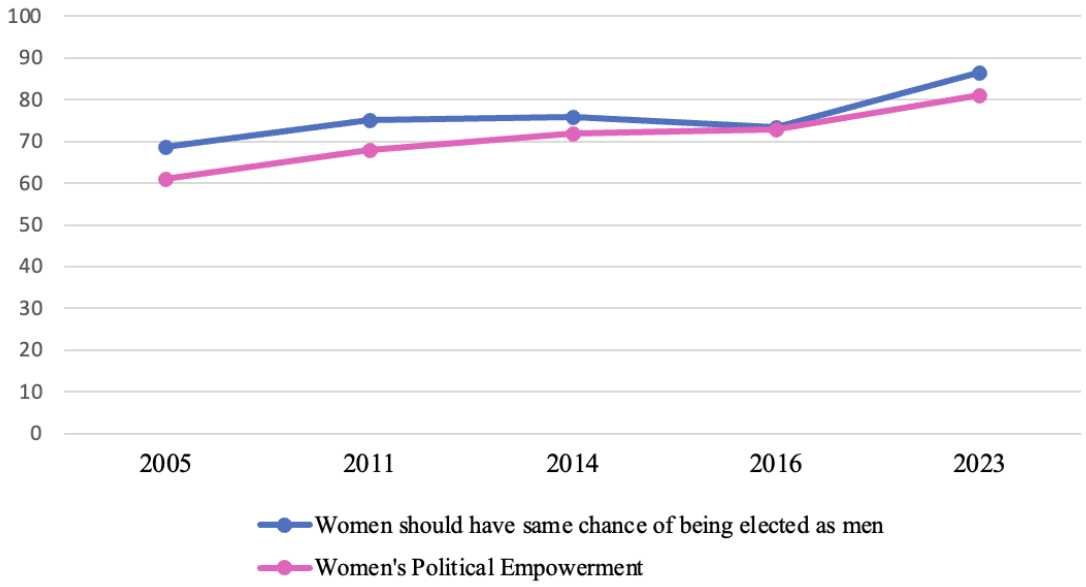


Figure 7 depicts an increase in the percentage of respondents who affirmatively responded to the statement "women should have the same chance of being elected to political office as men", increasing from 68.7% in 2005 to 86.4% in 2023. The rate of increase closely resembles the rate of increase of Kenya's score on the WPEI. Consequently, it can be argued

that the political and civil society participation arising from WPE have managed to reshape attitudes and social norms.

c. Collective Action Power

The final mechanism identifies that politically empowering women by granting them civil liberties and civil society participation, provides them with collective action powers – the ability to mobilize/assemble for their cause and fight for FGM reduction. Hence, to test this mechanism it is questioned whether, in the context of Kenya, women were able to use their civil liberties to organize collectively and push back against FGM?

There are many examples of Kenyan women organizing community groups to deliberate and coordinate collective action against FGM. Aisha Hussein, a victim of FGM who completed school and studied communications at a local university, founded 'Every Girls Dream' which is a community-based organization that brings together FGM survivors to mobilize against the practice in Isiolo county (Kenya UNFPA, 2020). They do so through youth mobilization events, and events encouraging survivors to advocate for cultural changes. A further example is Mumina Jirmo, founder of Women Rising, through which she works with young mothers to protect the future generation (Kenya UNFPA, 2020). Furthermore, her 12-year-old daughter, Sharifa, writes poetry about the dangers of FGM which she recites at school to educate others about FGM and change attitudes towards it.

Such community-based organizations and communication groups have proven very helpful. The UNFPA found that advocacy, community based programming, and other civil society approaches have been largely responsible for a decline in the national prevalence rate of FGM in Kenya (UNFPA & UNICEF, n.d.).

Overall, the process tracing identifies that the three mechanisms through which WPE reduces FGM are present in Kenya, providing support for the statistical analysis' findings. Furthermore, it demonstrates that, although women's political participation has been chief in bringing out certain key-pieces of anti-FGM legislation, it is not always effective due to the gender-quotas and is not the main driver of FGM reduction in Kenya, since FGM had already significantly reduced prior to legislation. Therefore, the second hypothesis, that 'women's political participation is the factor which drives the FGM reduction' is rejected. Rather, women's civil-society participation is identified as the critical driver of FGM reduction;

empowering women to act as role models, providing them collective action power, and reducing the social costs of opposing FGM as women will not act independently when resisting the tradition. With regards to social-norm theories, this implies that civil-society participation is the most effective element for reaching the 'tipping point' where enough people are influenced to change behaviors, creating norm change.

d. Direction of WPE

The theoretical framework identified that WPE may decreased FGM prevalence through the three mechanisms above, but that it may also lead to an increased prevalence due to women being the main bearers of the tradition. This thesis suggested that the direction which WPE women would take in reducing/increasing FGM depended upon the support/attitudes towards FGM in society. If a majority of the people's attitudes towards FGM have already changed, it is likely that women gaining civil liberties, being empowered to act collectively, and being represented in the legislature will encourage them to follow the new attitudes. In Kenya, support for FGM is relatively low, with 6% of women aged 15 – 49, who have heard of FGM, thinking that the practice should continue (Kenya DHS Surveys, 2014). This is much lower than the average support for FGM across the other countries studied in the regression, with 23% of women aged 15 – 49 thinking that FGM should continue on average across the other countries. Particularly, Kenya's neighboring country of Somalia, sees 65% of women and girls who have heard of FGM thinking that the practice should continue, Therefore, in countries where the support for FGM remains high, it is likely that WPE will go the other way and increase the prevalence of FGM.

6. Conclusion

To conclude, this thesis aimed to investigate the relationship between WPE and FGM prevalence by providing an answer to the question "*how does women's political empowerment influence the prevalence of female genital mutilation in developing countries?*". In answering this question, a mixed methods design comprised of linear regressions and process tracing was used, finding that WPE negatively influences FMG prevalence, with the research revealing a statistically significant, negative correlation between *women's political empowerment* and *FGM prevalence* across the Sahel band of Africa. This finding led to a failure to reject the hypothesis that '*an increase in WPE is associated with a decrease in the prevalence of FGM'*. Furthermore, a second regression with each component of WPE suggested that women's civil society participation is the most

important component for reducing FGM prevalence. This was supported by process tracing in Kenya, which showed that women's civil society participation played a more critical role in reducing FGM prevalence than the other components. Therefore, the second hypothesis, that *'women's political participation is the factor which drives FGM reduction'* was rejected.

Prior research focused largely on socio-economic development, through education and legislation, as a method for reducing FGM prevalence. This work extends the research on FGM by investigating how it is impacted by WPE, an aspect not previously explored. Furthermore, the use of the WPE Index to operationalize empowerment moves from the traditional focus on the number of women in parliament, towards political empowerment as a concept where women enjoy agency, freedom, and representation. The findings have high social and policy implications. They demonstrate that policy interventions for reducing FGM should not simply focus on socio-economic development, which has been shown to face issues of implementation and is unable to combat the embeddedness of the norm. Furthermore, political empowerment measures should not only take the form of increasing numerical representation of women in parliament; for example, through often inefficient gender-quotas. Rather, policies should aim to politically empower women across multiple dimensions by providing them with increased civil liberties and the ability to participate in civil society. In Kenya – where women's civil society participation is high and women have assembled in grassroot initiatives to change attitudes towards FGM – the "tipping point" identified by social change theories has been reached, leading to tangible reductions in the prevalence of FGM.

The strength of this research lies in its mixed-methods design which allows for further testing of the causal link found in the regression via process tracing of the mechanisms. However, there are also certain limitations. Due to data availability, the scope of this conclusion is limited to the 27 African countries included in this research and its generalizability is constrained by the context in which it is studied, since FGM is context-dependent and varies widely across cultures. Furthermore, the data on FGM prevalence, arising from DHS and MICS surveys, is self-reported. Therefore, it relies on women providing accurate information about their own FGM experiences, which they may not be willing to share following the outlawing of the practice. Therefore, it is likely that the prevalence of FGM is higher than reported in this thesis.

Future research on the topic should aim to take a broader geographical scope on the research; particularly by performing this research across a wider scope of cultural contexts, as it was discussed that FGM is highly context specific and therefore WPE might have different effects in different contexts. Furthermore, this thesis has seminally proposed that the direction which WPE will take with regards to reducing/increasing FGM prevalence depends on the broad support for the practice in society. It would be interesting for future research to further investigate the factors which impact the direction that WPE will take.

In summary, WPE in the form of political participation, civil liberties, and civil society participation has been identified as an important factor to help overcome the issue of FGM. This is of particular importance due to the fact that the implementations of legislation, education, and other socio-economic developments have not been sufficient to help significantly reduce the issue.

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