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RITES VS. RIGHTS: THE CASE OF

FEMALE GENITAL MUTILATION

by

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ABSTRACT

Female Genital Mutilation or FGM as it is commonly referred to is a painful and dangerous procedure whereby part or all of the female child's external genitalia are excised. FGM is a practice that affects about 130 million women in 28 African countries, North America and Europe making it one of the world's major public health problems amongst females. In light of this fact, this thesis purpose is to illustrate the how this practice is a blatent violation of human right by providing painful and explicit details of the variety of severities of this procedure along with painful interviews of women who have undergone this procedure at tender young ages.

By presenting all the details in a concise manner, this thesis had made it very clear that Female Genial Mutilation is a persistant cultural trait that any efforts to eradicate this practice goes well beyond the scope of this thesis to a much global level.

However, this thesis is just one dent in the human rights discourse that will not permit this dreadful practice to be shrouded in a cloud secrecy. We as the international public must join in the fight to dismantle the walls of silence surrounding this practice.

LIST OF ABBREVIATIONS

ACDHRS	African Centre for Democracy and Human Rights
AIDOS	Italian Association for Women and Development
CCPR	Covenant on Civil and Political Rights
CEDAW	Convention on the Elimination of Discrimination Against Women
ECOSOC	Economic and Social Council
FGM	Female Genital Mutilation
IAC	Inter-African Committee
ICPD	International Conference on Population and Development
NGO	Non-Governmental Organisation
OAU	Organisation of African Unity
PID	Pelvic Inflammatory Disease
RAINBO	Research Action and Information Network for the Bodily Integrity of Women
SWDO	Somali Women's Democratic Organisation
UDHR	Universal Declaration of Human Rights
UN	United Nations
UNCHR	United Nations Commission on Human Rights

List of Abbreviations continued....

UNDP	United Nations Development Program
UNESCO	United Nations Education, Scientific and Cultural Organisation
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Children's Fund
WHO	World Health Organisation

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Chapter One

INTRODUCTION

The little girl, entirely nude is immobilised in the sitting position on a low stool by at least three women. One of them has her arms tightly around the little girl's chest, two others hold the child's thighs apart by force, in order to open wide the vulva. The child's arms are tied behind her back and immobilised by two other women guests...

Then the old woman takes her razor and excises the clitoris. The infibulation follows: the operator cuts with her razor from top to bottom of the small lip and then scrapes the flesh from the inside of the large lip. This nymphectomy and scraping are repeated on the other side of the vulva.

The little girl howls and writhes in pain, although strongly held down. The operator wipes the blood from the wound and the mother, as well as the guests "verify" the work sometimes putting their fingers in... The opening left for the urine and menstruation blood is minuscule.

Then the operator applies a paste and ensures the adhesion of the large lips by means of an acacia thorn, which pierces one lip and passes into the other. She sticks in three or four in this manner down the vulva... Paste is again put on the wound. However, both applications are not sufficient to ensure the coalescence of the large lips; so the little girl is then tied up from her pelvis to her feet: strips of material rolled up into

a rope immobilise her legs entirely. Exhausted, the little girl is then dressed and put on a bed. [1]

How can it be that a cultural and religious practice, which has been practiced for nearly 2500 years, has only recently found a place on the international human rights agenda? In any given day, there are at least eight to ten million girls who would be at risk of undergoing one form or another of female genital mutilation.[2]

Female Genital Mutilation (FGM) or female circumcision, as it is commonly called, is viewed by many in the West as a blatant violation of human rights. It is not only considered a form of violence against women in general, but also a form of violence against the girl child that will affect her life as a woman. The United Nations Charter states that one of its goals is to strive for the realisation of the human rights and fundamental freedoms for all, without discrimination. Every major human rights instrument prohibits discrimination on the basis of gender. One may ask, why then does this practice continue to exist amidst human rights awareness? But then one may well ask, why then have all forms of gender-related abuse been neglected? Why then do we see so much evidence in the world today of women being subjected to intimidating treatment and violence? The reasons are many and complex.

One reason is the sheer magnitude of human rights abuses against women. The demand for international attention and action is so immense that it overshadows the progress that is made. Due to the overwhelming nature of this demand, there has been a tendency to resort to the excuse that women's issues can be extricated from the human

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[1] Dorkenoo, Efua. Cutting The Rose: Female Genital Mutilation: The Practice and Its Prevention. London: Minority Rights Publications pg. 4

[2] Female Genital Mutilation: An Introduction. http://www.hollyfeld.org/fgm/intro/fgmintro.html

rights agenda since they can be perceived to belong elsewhere on a woman's agenda. Moreover, at a practical level, there is a lack of awareness of the types of laws and mechanisms that relate to women's human rights, resulting in the constant violation of these rights.

A further major reason why women's human rights are ignored on the international human rights agenda is also due to the fact that few governments are committed to women's equality as a basic human right. While an increasing number of governments base their aid and trade decisions on a country's human rights record, it is a fact that no government determines policy towards another country on the basis of that country's treatment of women. The separation of women's rights from human rights has perpetuated the secondary status of women and highlights the importance of recognising women's human rights concerns.[3] When governments are approached to address women's rights as a concern that demands attention, the following types of excuses for inaction are offered:

(1) issues of survival require more serious attention than sexual discrimination which is of far less importance;

(2) abuse of women is a religious, cultural, private or individual issue and not a political matter requiring state action;

(3) women's rights are not considered to be human rights per se; and

(4) the abuse of women, even though recognised, is considered inevitable or so pervasive that any consideration of it would be futile or would overwhelm other human rights questions.

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[3] Bunch, Charlotte. '*Transforming Human Rights from a Feminist Perspective*' in **Women's Rights as Human Rights**. New York: Routledge. 1995 pg. 12

It is important to challenge these responses. The role of the United Nations in this process is to set standards and norms for the international community and to facilitate the transformation of rhetoric into action.[4] The United Nations, over time, has sought increasingly to challenge these types of excuses and responses through various human rights frameworks, but the process has proved to be very slow and difficult.

The United Nations Universal Declaration of Human Rights, adopted in 1948, is the basic framework that addresses the concept of human rights. It defines human rights broadly and symbolises a world vision of respect for the humanity of all people, "where no distinction should be made on the basis of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, or other status."[5]

Although not much is said about women in the Universal Declaration of Human Rights, one of the main reasons for its early failure to influence gender inequality significantly has been the way in which this convention has been interpreted and implemented. The Universal Declaration on Human Rights has created a hierarchy of rights, emphasising civil and political rights. Some important aspects of women's human rights do fit into the civil liberties framework, but much of the abuse of women is embedded in the larger socio-economic web that entraps women, making them vulnerable to abuse.

Similarly, the United Nations Geneva Convention on Refugees, adopted in 1951, was a second instrument that neglected to specify the rights of women. Since the adoption of these two human rights instruments, five decades ago, the global community has debated various interpretations of human rights in response to global developments.

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[4] Ibid.
[5] Ibid.

The most insidious myth about women's rights is that they are trivial or secondary to the concerns of life and death. It is a fact that sexism kills. There is a substantial amount of research that supports the fact that being female is life-threatening. Rape and son preference are but two vivid examples.

Rape can occur anywhere, even in the family, where it can take a variety of forms such as marital rape or incest. It occurs in the community, where a woman can fall prey to any abuser. It also occurs in situations of armed conflict and in refugee camps. In the United States, national statistics indicate that a woman is raped every six minutes. In Mexico, a woman is raped every nine minutes.[6]

Son preference occurs mainly in India and in Asia. Its consequences can range from fetal infanticide to neglect of the girl child over her brother in terms of such essential needs as nutrition, basic health care and education. Amniocentesis is used for sex selection leading to the abortion of female foetuses. The problem of son preference is present in countries such as India, and the United States. The former United States boxing champion Muhammed Ali told an interviewer who asked him how many children that he had, he replied that he had: "one boy and seven mistakes."[7]

The above examples are just the tip of the iceberg. Sex discrimination kills women daily. When combined with race, class, and other forms of oppression, it constitutes a deadly denial of women's right to life, and liberty on a large scale throughout the world.

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[6] Ibid. pg. 490

[7] Women and Violence. http://www.un.org/rights/dpi1772e.htm, Published by the United Nations Department of Public Information DPI/1772/HR--February 1996

Although, gender violence has not been specifically covered in major human rights instruments, violent acts have been condemned in general. The Universal Declaration of Human Rights in Article 3 states that "everyone has the right to life, liberty and security of person" and in Article 5 "No one shall be subjected to cruel or degrading treatment or punishment". Similarly, the International Covenant on Civil and Political Rights (CCPR) repeats these rights in Articles 6 and 9. In the same vein, Article 20(2) of the Covenant states: "any advocacy of national, racial, or religious hatred that constitutes incitement to discrimination, hostility or violence shall be prohibited by law."[8]

It was not until 1979 that the question of gender was addressed specifically. The year 1979 marked a watershed in human rights discourse as many international legal instruments on human rights further reinforced individual rights, and also protected and prohibited discrimination against specific groups, in particular women. The adoption of the United Nations Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) infused the specific experiences of women from human rights abuses and discrimination against women into the traditional human rights agenda. The Convention emphasises that such discrimination violates the principles of equality of rights and respect for human dignity.[9] Altogether, it provides a framework for challenging the various forces that have created and maintained discrimination based on sex. To date, 161 countries have ratified this Convention.[10]

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[8] Pietila. Hilda and Vickers, Joanne. **Making Women Matter: The Role of the United Nations.** London: zed Books 1990 pg. 62

[9] Kerr, Joanna. **Ours by Right. Women's Right as Human Rights.** Ottawa: North South Institute. 1993. Pg. 4

[10] World Campaign for Human Rights: **Harmful Traditional Practices Affecting the Health of Women and Children Fact Sheet No. 23.**

Like the human rights instruments that preceded CEDAW, this Convention, which seeks to address women's rights in international human rights discourse, makes no direct reference to violence against women. The closest it comes to mentioning this is in its definition of discrimination against women in Article 1, which states:

> "for the purposes of the present Convention, the term discrimination against women shall mean any distinction, exclusion or restriction made on the basis of sex which has the effect or purposes of impairing or nullifying the recognition enjoyment, or exercise by women, irrespective of their marital status, on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, cultural, civil or any other field."[11]

When interpreted from the perspective of women's lives, many of the gender-based violations of women's rights such as rape, battering, and female genital mutilation can readily be forbidden under existing clauses in the basic instruments, such as "No one shall be subject to cruel or degrading treatment or punishment."[12] The problem lies in the fact that there is little elaboration of these rights that has been made from a woman's point of view and therefore there is no significant body of law and practice in this area. These human rights instruments have excluded much of women's experiences because women have not been prominent in human rights discourse.

Human rights, like democracy, is not static nor confined to the purview of any one group, although both of these concepts are a product of history and were defined in terms

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[11] **The Convention on the Elimination of All Forms of Discrimination Against Women.** Adopted in 1979.
[12] Ibid

of the needs of a limited sector of the population at that time. Their dynamism and ongoing relevance stems from the fact that more people are claiming them, and in the process, expanding the meaning of rights to incorporate their own hopes and needs. Much of the expansion of human rights has come from addressing such areas as racial discrimination, disappearances, socio-economic rights, and the collective right to sustainable environment. [13] In this same vein, women, too, are transforming the concept of human rights to address the degradation and violation that are not only a fundamental threat to human dignity, and to the right to life, liberty and the security of the person, but also a threat to more than half of the world's population.

The examples of human rights abuses suffered by women that were mentioned earlier could be examined through the lens of various treaties on torture, slavery, and other aspects of human rights abuses. What each of these examples has in common is that they are forms of torture in the lives of millions of women throughout the world. This issue has concerned the United Nations to some degree since the organisations' founding. As early as the 1950s the United Nations specialised agencies and human rights bodies began to examine the harmful traditional practices that affected the lives and health of women, in particular, female genital mutilation. However, these practices have not received consistent, broad consideration, and action leading to substantial change has been slow or superficial.

Prior to 1993, the international community had not explicitly acknowledged the alarming global dimensions of female targeted violence. Most governments that had ratified the Convention on the Elimination of Discrimination of Women (CEDAW),

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[13] Ibid.

tended to regard violence against women largely as a private matter between individuals and not as a pervasive human rights problem requiring state intervention.[14]

Yet despite the apparent slowness of action to challenge and eliminate harmful traditional practices, the activities of human rights bodies in this field did bring about progress. Traditional practices became a recognised issue concerning the status of human rights of women and female children. In an effort to focus attention on and ultimately put an end to these abuses, the slogan "Women's Rights are Human Rights" was adopted at the World Conference on Human Rights in Vienna in 1993, and the Declaration on the Elimination of Violence against Women, was adopted at the United Nations General Assembly in the same year. This Declaration is the first international human rights instrument to exclusively and explicitly address the issue of violence against women. It affirms that the phenomenon violates, impairs or nullifies women's human rights and their exercise of fundamental freedoms.

The Declaration provides a definition of gender-based abuse, calling it "any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats to such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life."[15] The definition is amplified in Article 2 of the Declaration, which identifies three areas in which violence commonly takes place:

(1) Physical, sexual and psychological violence that occurs in the family, including

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[14] Women and Violence. http://www.un.org/rights/dpi1772e.htm, Published by the United Nations Department of Public Information DPI/1772/HR--February 1996

[15] Women and Violence. http://www.un.org/rights/dpi1772e.htm, Published by the United Nations Department of Public Information DPI/1772/HR--February 1996.

battering and sexual abuse of female children in the household; dowry related violence; marital rape; female genital mutilation and other traditional practices harmful to women; non-spousal violence; and violence related to exploitation.

(2) Physical, sexual and psychological violence that occurs within the general work, in the community, including rape; sexual abuse; sexual harassment and intimidation at work, in educational institutions and elsewhere; trafficking in women; and forced

(3) Physical, sexual and psychological violence perpetrated or condoned by the State, wherever it occurs.[16]

Noting the severe cases of violence against women on a global basis, the Commission on Human Rights adopted Resolution 1994/45 of March 4, 1994. This resolution allowed for the appointment of a Special Rapporteur on violence against women, including its causes and consequences. The Special Rapporteur has a mandate to collect and analyse comprehensive data and to recommend measures aimed at eliminating violence at the international, national and regional levels. In her preliminary report, the Special Rapporteur pointed out that:

> "blind adherence to these practices and State inaction with regard to these customs and traditions have made possible large scale violence against women. States are enacting new laws and regulations with regard to the development of the modern economy and modern technology and to developing practices which suit a modern democracy, yet it seems that in the area of women's rights change is slow to be accepted."[17]

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[16] Ibid

[17] United Nations document (E/CN.4/1995/42, para.67)

These more recent initiatives by the international community have finally propelled the problem of violence against women into the complex web of human rights discourse.

In examining the problem of violence against women, the purpose of this thesis is to examine this problem by focusing mainly on one of its most prevalent, and in the view of Westerners, one of its most brutal violations of the fundamental rights of girls and women-female genital mutilation (FGM). In exploring this subject, this thesis will argue that FGM is a brutal traditional practice that affects the fundamental rights of girls and adult women and if this practice is to be eliminated for the twenty-first century, effective measures must be put into place for its inevitable demise from the human rights agenda.

The first chapter will look at female genital mutilation as a practice, including a definition of FGM, and the differences between female and male genital mutilation. The next chapter will focus on discussions of female genital mutilation as a human rights issue. It will examine the arguments put forward in support of, and against this practice, including the effects of FGM on girls and women who have undergone this procedure. Chapter three will take a more analytical approach. The efforts by the United Nations, and non-governmental organisations such as Amnesty International, coupled with the initiatives of the Governments of Somalia, Ethiopia and the Sudan, will be examined and evaluated as to whether these initiatives have been instrumental in heightening awareness and education and promoting action to stop this practice. Chapter four will discuss eradication efforts. This chapter will focus mainly on The United Nations Children's Funds (UNICEF) by examining their eradication efforts. What good is a study of FGM without providing possible strategies for the future? The concluding chapter will provide

ways to heighten awareness and educate the world community on the dangers of FGM and will suggest possible areas in which human rights organisations and national governments could include in their campaigns in order for them to become effective.

However, before an analysis of this topic can be given it is necessary to provide a legal base for the explanation of human rights and in particular Female Genital Mutilation. Human rights scholars have generated a substantial and growing body of literature on the potential role of human rights law in the eradication of FGM. However, this literature reflects deep conflicts about whether international human rights systems should foster cross-cultural engagement in order to eradicate FGM. The analysis of FGM as a human rights violation is complicated because FGM exists at the "intersection" of complex cultural, gender and racial questions in human rights jurisprudence. This leads to the question that if FGM is a violation of the fundamental human rights of girls and women, how should international law respond to the fact that FGM is practiced by women on women and girls?

International institutions, Western governments and Western non-governmental organisations, have focused on protesting violations of individual civil and political rights that directly result from state action. Female genital mutilation differs in several respects from the rights infringements that have formed the focus of traditional human rights advocacy efforts. First, FGM practitioners are private citizens operating without express state sanction. Second, FGM is generally performed with the consent of the parents of minor girls. Third, FGM is usually performed by females on other females. Finally, FGM has both deep cultural roots and powerful political implications for practicing groups. Therefore, many human rights advocates have had to give careful thought to the legal

framework that respects the unique features of FGM, while still rendering it a blatant violation of existing human rights standards. This brings to mind one element of jurisprudence framework: the role of the international human rights system in meeting the needs and goals of women.

Many human rights scholars have challenged the notion that the distinction in traditional human rights law between the violation of rights through direct governmental action in the "public sphere" and the violation of rights through less direct state participation in abuses perpetrated by individuals in the "private" sphere. As a result of this, human rights activists have developed several techniques to promote the recognition of women's rights as human rights. Some of these techniques include calling attention to state-sponsored human rights violations (such as rape of women political prisoners) and arguing that human rights violations take place in the context of home or community (such as domestic violence, dowry deaths and of course, FGM), should be placed on the international human rights agenda.

It is also argued that FGM along with other gender-based abuses, can be viewed as violations of the human dignity of women. Instead of straining to fit FGM under standards of legal systems that were created in patriarchally constructed, women should be empowered to define the sources of their own oppression, including FGM.

Chapter Two

FEMALE GENITAL MUTILATION: THE PRACTICE

Female genital mutilation is a term used to describe a spectrum of surgical excisions of the female genitalia, for cultural or other non-therapeutic reasons. There have been many debates about the terminology used to describe this practice. In some cases, the term female circumcision is used as opposed to female genital mutilation. There has been much misinformation perpetuated through the use of different terms but what is absolutely clear that in medical terms what is described in this chapter is mutilation rather that the softer concept of circumcision. Gerard Zwang, author of Mutilation Sexualles Feminines, defines this point noting that:

> "Any definitive and irremediable removal of a healthy organ is a mutilation. The female external genital constitutes the vulva, which comprises the labia majora, the labia minora or nymphae, and the clitoris is covered by its prepuce, in front of vestibule to the urinary meatus and the vaginal orifice. Their constitution in female humans is genetically programmed and is identically reproduced in all the embryos and in all races. The vulva is an integral part of the natural inheritance of humanity. When normal, there is absolutely no reason, medical, moral, or aesthetic, to suppress all or any part of exterior genital organs."[18]

There are substantial bodies of evidence that support the fact that wide variations

[18] Dorkenoo Efua. Cutting The Rose- Female Genital Mutilation: The Practice and Its Prevention. London: Minority Rights Publications. Pg. 4

of mutilations are performed on the normal female vulva in many different countries.

As shocking and horrifying as this practice sounds, what must be understood is where the procedure is practiced and the complex social systems in which it occurs. Awa Thiam, the noted Senegalese writer and activist, maintains that female genital mutilation in a variety of forms is practised in the Middle Eastern countries such as Yemen, Saudi Arabia, Iraq, Jordan, Syria, the United Arab Emirates and Oman, and in more than twenty countries in Africa. (See Table I). It is also practised amongst Muslim populations in Indonesia, Malaysia and Melanesia.

The practice is not solely confined to the Eastern Hemisphere of the globe. FGM is also practised in North America, Latin America and in some countries in Europe. In the United States, FGM was practised from the 1890s to the 1930s as a cure for masturbation and as a means of controlling female sexuality. [19] The first publicised case of FGM in the United States dates back to 1986 in Atlanta, Georgia. A nurse was charged with child abuse for severing the clitoris of her two-year-old niece.[20] Today, in the United States, FGM is performed among some immigrant populations who seek to maintain their culture in a foreign land. The Center for Disease Control has estimated that the primary locations with populations at risk for female genital mutilation include 12 states: New York, California, Texas, New Jersey, Maryland, Florida, Illinois, Georgia, Virginia, Pennsylvania, Ohio, Massachusetts, and the District of Columbia.[21]

FGM is performed also in Canada. Recently, several doctors in the Toronto area, where a large Somali community resides, have reported to the College of Physicians and

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[19] Ibid. pg. 461
[20] Meserak "Mimi" Ramsey, "Cruel Tradition" http://www.forwardusa.org/CruelTrad.html. FORWARD USA
[21] Posterski, pg. 5

Surgeons of Ontario that they have been approached by patients to have the procedure performed. There are no specific laws in Canada that state that female genital mutilation is illegal. In April 1994, Justice Minister Allan Rock announced that legislation on FGM would not be introduced because the procedure is already banned under the Criminal Code. Regardless, the College of Physicians and Surgeons in Ontario, British Columbia and Alberta have felt the specific need to ban female genital mutilation after receiving inquiries from doctors who were approached by their patients to have the procedure performed.[22]

The practice has also been traced in Eastern Mexico, Peru and Brazil. It has been reported that an Amerindian tribe known as the Conibos, in north-eastern Peru, perform circumcision in the following way:

> "As soon as a girl has attained maturity, a feast is arranged, in which mashato, an intoxicating drink brewed from manioc roots, plays a large part. The girl is made insensibly drunk and then subjected to the operation. An old woman, in the presence of a roaring tribe, performs it with a bamboo knife while the girl lies stretched out on three posts. She cuts around the hymen from the introitus vaginae, severs the hymen from the labia, at the same time exposing the clitoris. Then she paints the bleeding parts with medical herbs and after a while introduces into the vagina a slightly moistened penis made from clay which conforms exactly in size and in shape to that of the betrothed."[23]

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[22] Ibid.

[23] Abdalla, Raqiya Haji Dualeh. **Sisters in Affliction: Circumcision and Infibulation of Women in Africa**. London: Zed Press 1982 pg. 73

It seems that from the descriptions, the vagina is forcibly opened to ensure easier penetration for the penis. In most cases the clitoris is not removed, nor are the girls sewn up to ensure virginity, but the intention to secure domination of women's sexuality is clear.

In Europe, FGM is also known to be practised among some immigrant groups in such countries as England, France, Germany Norway and Sweden. Women in Sweden have recently been shocked by accounts of mutilations performed in Swedish hospitals on daughters of certain immigrants. In France, women from Mali and Senegal are reported to bring an excisor to France once a year to operate on their daughters in their apartments. In the last decade, reports appeared in the British press that excision for non-medical reasons had been performed in a London private clinic.[24] In Germany, before 1995, the subject of FGM was largely unknown. One reason was that the issue was specifically excluded from the work of major aid organisations because they did not want to interfere with the culture, religion and traditions of other nations. This view is slowly changing. Whether at UNICEF, Terre des Femmes, or Amnesty International, female genital mutilation is becoming an increasingly important issue. Even though it was being practised amongst immigrant populations in Germany, the human rights violation of female genital mutilation became known to a large part of the German population for the first time in 1995, as a result of media reports of the World Conference on Women in Beijing.[25]

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[24] Elworthy, Scilla. **Female Circumcision, Excision and Infibulation: The Fact and Proposals for Change.** London: Minority Rights Group. Pg. 6

[25] Dennison, George C. et al. **Sexual Mutilations a Human Tragedy**. New York: Plenum Press. 1987 pg. 159

The types of FGM procedures have been classified over the years. The physical operation can now be classified into four basic categories according to the severity of the excision. These are:

-Ritualistic Circumcision. This procedure involves the nicking of the clitoris. Ritualistic circumcision is the mildest type of mutilation.

-Sunna Circumcision. This comprises the removal of the prepuce or hood of the clitoris. This type of circumcision is known in Muslim countries as "sunna", meaning following the tradition of the prophet Mohammed. It is thought to be the type recommended by Islam.[26] It consists of removing only the tip of the prepuce of the clitoris, and is therefore, analogous to male circumcision. In some tribes this is accomplished by applying a heated piece of stone or pearl to the prepuce of the clitoris and burning it away.

-Excision/Clitorecdectomy. This type of FGM involves partial or total cutting of the clitoris and all or part of the labia minora. In some cases the labia majora are removed but with no stitching. Excision is the most widespread type of mutilation, as approximately 80 per cent of all female genital mutilations practised are of this type.[27]

-Infibulation/Pharonic Circumcision. This is the most extreme form of FGM, which causes the most damage to girls and women in the immediate and long term. It accounts for approximately 15 percent of all procedures. Infibulation involves the cutting of the clitoris, labia minora, labia majora and the prepuce. The two sides of the vulva are stitched together with silk or catgut sutures, or thorns. A small opening is left for the passage of urine and menstrual blood. The girl's legs are bound together from hip to

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[26] El Dareer, Asma. **Women, Why Do You Weep? Circumcision and Its Consequences.** London: Zed Press 1982. Pg. 2

[27] Ibid

ankle and she is kept immobilised for forty days to permit the formation of scar tissue over the wound. In some communities, there is no stitching. To facilitate healing, the raw edges of the wound are brought together by adhesive substances such as eggs, sugar, or acacia tar and the girl is kept immobile. In rare cases, animal excreta is placed on the wound. Some tribes in Western Sudan have placed animal excreta on the wound.[28]

The procedure of female genital mutilation is carried out with various types of sharp instruments (See Table II). Special knives, which are used amongst some tribes in Mali; kitchen knives; razor blades known as 'Moos el Surfa'; broken glass; scissors, and on rare occasions, sharp stones have been reported to have been used in eastern Sudan. Burning or cauterisation is practised in some parts of Ethiopia. Fingernails have also been used in The Gambia to pluck out the clitoris of young female babies.[29] These instruments are rarely sterilised before the operation is performed. As a result, much unintended damage is caused. Also, anaesthetics and antiseptics are rarely used in the process. Only on rare occasions is the operation performed in a medical clinic; then a scalpel used and anaesthesia administered.[30] Once the external genitals are removed, mixtures made of herbs, local porridge, ashes and animal dung are rubbed into the wound to stop the bleeding.

In the majority of the countries where it is practised, female genital mutilations are performed in the villages by women in the roles that are traditionally ascribed: local midwifes, known as 'Daya' in Egypt and Sudan, or by elderly women known as 'Gadda' in Somalia. Most men are rarely present during the operation. In Mali, Senegal and The

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[28] Dorkenoo, pg. 5
[29] Ibid. pg. 8
[30] Slack, Allison. **Female Circumcision. Human Rights Quarterly.** Volume 10 Number 4. November 1988. Pg. 442

Gambia, it is traditionally performed by a woman of the blacksmith's caste gifted with knowledge of the occult. In The Gambia they are referred to as 'ngansingbas'.[31] In northern Nigeria and Egypt, barbers also carry out the task, but usually, it is performed by a woman, rarely by the mother. Today, in urban areas, female genital mutilation is performed in hospitals or in private by Western trained doctors, nurses and midwives.[32] (See Table III)

The World Health Organisation took a stance on the medicalisation of FGM, in 1982. It issued a statement condemning the procedure being performed by medical health professionals under any circumstances. In 1993, in the United Kingdom, a doctor was struck off the medical register for misconduct for agreeing to perform female genital mutilation.[33]

The age at which girls are circumcised varies both geographically and ethnically. The mutilations are performed on newborns in tribes in Mauritania, Nigeria, and Ethiopia and among the nomads in Sudan. It is commonly performed on pre-pubescent girls; on women on their wedding night in Kenya and Tanzania; on widows in the Darasa ethnic group in Ethiopia; and on women who have had their first child.[34] FGM is so deeply rooted that in some cases if an uncircumcised woman dies, relatives may insist on performing the procedure before burial.[35]

Most experts maintain that the age at which FGM takes place is falling, indicating a weakening of the link to initiation into adulthood. To illustrate this point, some refugees

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[31] Dorkenoo, pg. 9
[32] Ibid.
[33] Ibid. pg. 10
[34] Ibid. pg. 12
[35] Ibid.

seeking asylum in North America and Europe have mutilated girls at a younger age than customary, before leaving, so as to overcome legislative pressures against FGM in their new countries. In Australia in 1993, two sisters, both under the age of three were found infibulated. FGM is also practised at an early age so as to avoid resistance by older girls. Aminata Diop, a 23 year old woman fled her village in Mali and eventually sought asylum in France to avoid undergoing FGM. An interview with a 22-year-old woman, who lives in Ohio, illustrates this point. The woman explained that:

> "the experience was just that, an experience. They call it a ceremony but I still don't see it as that. I was coming in from in the pool and going to take a shower. As I walked into the bathroom, I started to take a shower when my grandmother caught me off guard and walked behind me. Before I knew what was happening, my hands were tied behind my back. Now at this time I was told that I was going to become a women. I knew what was going to happen next because my mom always told me a little about this when I was six or seven. Before I knew it I was asked to lay on my back. My father who stood behind me, spread my legs apart and pulled them back to the side. Next I felt a deadly cutting from what I heard that took 2-4 minutes. I don't remember screaming for the pain was too sharp to do anything. The next part freaked me out the most. My grandmother who was doing the cutting called my father to come look. He rubbed his finger through it. All I remember was seeing blood on his right arm. When he pulled it up, my legs were pulled back and then they wiped and cleaned the area off with rubbing alcohol I think. Then my grandmother started

> sewing it up from the top only leaving a quarter at inch at most. I don't remember anything until the next day when I woke up in my bed. My arms were still tied but now my legs were free. Later my grandmother came in and told me that my mother would be proud. My mother was shocked. She did not want this to happen because it happened to her. She could not have done anything because she was out of town."[36]

In examining the procedures of female genital mutilation, the most frequent question that arises is what is the difference between female and male circumcision? The practice of female genital mutilation, which many Westerners regard as barbaric and irrational, has its parallels throughout history in secular male circumcision as practised in North America and Europe.

One of the biggest differences in these two sexual mutilations is the fact that unlike female circumcision, male circumcision is usually performed in hospitals on the second or third day after birth, by trained physicians before the mother and infant are discharged from the hospital. Female circumcision, on the other hand, is usually performed by local persons who are not trained. Male circumcision remains an acceptable practice in North America, and parts of Europe because it is thought to have hygienic benefits and it is a minor surgery, and has no long-lasting physical, psychological or other effects that are detrimental. However, female circumcision, in many cases, goes far beyond this. The effects of FGM will be explored in the subsequent chapter.

Female genital mutilation is a procedure that transcends international boundaries and it is not an issue that can be easily resolved. Although the international community has come to the conclusion that FGM is a human rights violation, there still exists a

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[36] Interview with Beth McConnell. September 29, 1998

dilemma as to the means of eliminating this practice in a culturally sensitive manner. The second chapter of this study shifts the focus by examining this practice as a human rights violation and asking the question, "why is female genital mutilation practised?"

Chapter Three

FEMALE GENITAL MUTILATION: A HUMAN RIGHTS ISSUE

As shocking and horrifying as Female Genital Mutilation sounds to many Westerners, it is purported to have different functions and meanings including the control over female sexuality and the maintenance of patriarchy. As much as we feel compelled to create universal laws to eradicate it, we must first understand its importance and the degree in which this practice is embedded in the cultural context in which it occurs. Female Genital Mutilation is practised in mainly traditional 'patrilineal' closed societies where women possess limited rights and are assigned a subordinate role under male control.

> "Patriarchy is based upon the principle of the dominance of the father over the mother with respect to the parentage of the children and by the extension, the primacy of the male in human society which implies the subordination of the female."[37]

Women are defined in terms of their own patrilineage and that of their husbands. Polygamy is common in many of these cultures and women have little or no right to ownership and inheritance, while being relegated to authority of their fathers, brothers and husbands. As a result of the traditional patrilineal society assigning women a subordinate role, women feel unable to oppose community dictates, even when these affect them adversely. Women championing many of the cultural practices adopted by their communities do not realise that some of the practices they promote were designed to

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[37] Dorkenoo, pg. 35.

subjugate them and more importantly, to control their sexuality while at the same time maintaining male chauvinistic attitudes in respect of marital and sexual relations.[38]

The consequence of this is that in the mid 1980s when most women in Africa have voting rights and can influence political decisions against practices that affect their health, they continue to uphold the dictates and mores of the communities in which they live. They seem to regard traditional beliefs as inviolable.[39] It is only among the educated in the urban areas that women are becoming aware, from outside sources, that other opinions exist. Once they become more knowledgeable about this practice in terms of the effects and consequences of FGM, a sense of outrage is noticed. This is where they encounter repressed rage, the rejection of the feminine role that were assigned to them in their communities, and the rejection of sexuality. It is at this point that a woman must grapple with the realisation that she has been not only a non-consenting victim, but also an uninformed and un-consulted one.

Also, the practise of FGM is closely linked to virginity, chastity and fidelity, which are considered pre-requisites for marriage in FGM practising societies. Thus, it has been documented that women, because of this, undergo FGM in order to be eligible for marriage. This is because, within these communities, marriage and motherhood are the only attainable status for young women and marriage provides women with a path to social and economic survival and advancement. A bride price can not be obtained if the girl has not been circumcised and is 'not pure'. A woman's status is increased in marriage, especially as the bearer of sons for the purposes for inheritance. In recent times,

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[38] Koso-Thomas, Olayinka. **The Circumcision of Women: The Strategy for Eradication.** London: Zed Books. 1987 pg. 1

[39] Ibid.

however, African feminists have started to question the bride price as a human rights issue and have called for its abolition.

If the girl is found not to be circumcised and not a virgin, the husband to be has the right to reject her and to reject the marriage. A young Somali woman describes what commonly occurs on the day of the wedding:

> "Women from the groom's family visit and examine the bride. They check to ensure that infibulation has been done and that she is a virgin. The genital area should be as smooth as the palm of one's hand. To make intercourse easier, the vulva may be cut open slightly. Otherwise, the groom widens the opening with his penis which is painful for the bride and the groom. On the wedding night, a cloth is placed under the bride's genital area. After intercourse, the cloth is displayed to the members of the groom family as proof of the bride's virginity. Having too large an opening can be grounds for divorce. If the groom refers to the sexual experience as 'falling into a ditch' he may annul the marriage the next day."[40]

Many men adhere to this belief. In the movie, "Fire Eyes"[41] many of the men interviewed maintained that they did not wish to marry an uncircumcised woman which accentuates a woman's active support of this practise. As long as women derive

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[40] Dorkenoo, pg. 48

[41] This powerful film is the first to present an African viewpoint on a culturally explosive issue. Somali filmmaker Soraya Mire knows firsthand about the traditional African practice of female genital mutilation. At thirteen, she was subjected to it and spent the next twenty years recovering physically and emotionally from its cruel legacy. In this video, several women who have been subjected to this "rite of passage" voice varying points of view on perpetuating the practice. Testimony from doctors detail the various forms of female circumcision and the horrendous ob/gyn problems that result. Date: 1994, Color, 60 minutes, Filmakers Library

economic security and survival from their roles as wives and mothers, they will continue to defend this practise. In this context FGM is viewed as a license to marry.

In rural Africa, illiteracy perpetuates the continuance of this practice, thus compounding their powerlessness. The majority of women in these societies lack education and training. As a result, many women must rely on the interpretations and words of men in processing and understanding the information they receive. Those who have a vested interest in maintaining the status quo have relied on the ignorance of women to allow certain religious convictions and interpretations to be accepted without question. [42] Women are rarely asked for their opinion, and their contribution to society is hardly acknowledged, except when women in these societies threaten the status quo.

Common to cultures that practise FGM is the importance placed on the family unit and the protection of the family honour. Despite various regional and cultural differences, the family form, which is the most common, is the extended family system where several generations of the family live together. This usually includes the patriarch, the father, who is the head of the family, and is revered. The extended family has close ties and members are very supportive of each other. The extended family serves as the social security for all members of the family.

When discussing the relationship of FGM and the family, the concept of family honour must be included. The concept of family honour prevails strongly in the Middle East, northern Sudan, Djibouti, Egypt and the Horn of Africa.[43] Family honour is maintained by conforming to specific norms of behaviour. When an individual deviates from these norms, the family, not the individual is shamed. Family honour depends on

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[42] Slack, Allison. **Human Rights Quarterly.** Volume 10 Number 4. November 1988. Pg. 446
[43] Dorkenoo, pg. 47

the behaviour of the woman. Women who do not adhere to the codes of behaviour of the family, not only threaten the reputation of the family but they also put their own life at risk. Once a woman's honour is lost, it cannot be restored. In Muslim society, men are economically, morally and legally responsible for the women of their kinship. Since Muslim men are supported by religious and legal systems in their responsibilities to women, the authority to impose upon women whatever sanctions they deem necessary to protect the reputation of the family.

Economics is another reason cited for the continuation of FGM in these societies. In many communities, women's access to land and to economic resources is through the male members of their family and husbands. This implies that they are unable to directly inherit land or be in control of major resources especially outside midwifery and the sale of small craft items. FGM is seen as an irreplaceable source of revenue for excisors, who are mainly women. In some societies in which FGM is strongly embedded in the culture, the role of circumcisor, is the highest possible status obtainable by women. Excisors who receive money for her services contributes to the village economy. One can see that women who rely on FGM as a source of income will promote and perpetuate the practice.

The current economic aspect of FGM and excisors is a modern development resulting from the advent of cash into traditional subsistence economies. The role of excisors varies within different ethnic groups that practised FGM. In Somalia, excisors are not respected, while in West Africa, they wield considerable power and have considerable status within traditional power structures. These communities regard attacks on these excisors as an attack on the respected older women in the community.

Paradoxically, excisors are gatekeepers of traditional power bases for women called "secret societies" in West Africa. However, it may be difficult to understand how a power base for women could condone mutilation. It is easier to view this as a space for women within a wider male dominated society. Some anthropologists have interpreted this as a remnant of matriarchy. The evidence given is that when certain age groups undergo this procedure together, bonding and sisterhood develops which can last a lifetime. [44]

The practice of FGM in most societies is viewed in a functional aspect. It is surrounded by various ceremonies, celebrations and coming of age rituals. An excerpt from a young girl who has been circumcised:

"I remember that day all too vividly. I was dressed up in my finest clothing and jewellery and paraded through the streets where singing, dancing, heavy drinking, and gifts from family and friends were presented to me to celebrate my newly attained womanhood status." [45]

In communities where it is performed on girls in the same age groups, specific periods of the year are designated for the execution of FGM. In the Sudan, the time of year when FGM is practised occurs usually after the harvest. Thus, it has become a focus for communities coming together to celebrate and reinforce their identity, giving a comprehensive element to the practise of FGM. Today, however, many of the elaborate celebrations surrounding FGM have disappeared. This is due to the fact that girls are being circumcised too young to celebrate a rite of passage. Yet, despite the diminished nature of elaborate celebrations surrounding FGM, this practice still remains a common

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[44] Ibid.
[45] Koso-Thomas. Pg. 23

cultural tradition in many African societies. To avoid creating a social vacuum in these communities, campaigns for eradication will have to seek an alternative focus for celebration in the communities.

The justifications of FGM are at first glance bewildering, at times conflicting, and always at odd with biological fact. This section of the chapter examines these justifications in detail because they are believed with such tenacity. The question that comes to mind then is why are they believed in? Justifications for the practise of female genital mutilation can be categorised under five headings. These include: psychosexual, religious, sociological, hygiene/aesthetics and the need to maintain tradition that has been with these cultures for thousands of years.

Psychosexual: Within the communities that practise FGM, there exists the widely held belief that women have an extensive sexual appetite and thereby need their sexuality controlled. The main reason given for the control of sexuality is to discourage promiscuity by reducing a woman's sensitivity and desire for sexual intercourse. In Islamic countries, there seems to be an implicit belief that a woman's sexuality is irresponsible and wanton and therefore must be controlled by men.[46] This is a contrast to male circumcision, which is in no way an attempt to inhibit or stifle sexual pleasure, performance, ability, or desire.

The control of a woman's sexuality is not a new concept. In ancient Roman times, rings were forced through a girl's labia and closed by wire or padlocks. Later the West incorporated chastity belts to control women's sexuality. In the same vein,

[46] Slack, pg. 445

clitoridectomy and ovariotomy were common solutions to women's perceived behavioural problems such as masturbation, obsessive eating, attempted suicide, hysteria and dysmennorhea.[47] Infibulation, which is the severest form of FGM, is mainly performed to secure a bride's virginity. According to a Somalian woman, it is the most effective means to keep a girl's virginity intact and as noted earlier, virginity is viewed in Africa as a prerequisite for marriage. A tightly sewn vagina reassures a woman's husband that he is the only man to have intercourse with her. In polygamous societies, FGM is beneficial to men. Men with several wives might find it impossible to satisfy the needs of all of their wives. Female Genital Mutilation diminishes a wife's pleasure and desire thus lessening the demands placed upon men to perform.[48]

Another dimension of the psychosexual dimension has to do with the beliefs surrounding FGM. These beliefs or myths run very deep and may appear to us Westerners as irrational and a sign of ignorance of biological, medical and religious facts. African beliefs surrounding FGM have been dismissed as mere superstitions, whereas deeper analysis points to a complex set of ideas which underpins a social system. The following are few examples of such beliefs. The Bambara and Dogon tribes of Mali believe that: "When human beings first arrive in the world, they are both male and female and possess twin souls. The boy's female soul is in the prepuce or foreskin, the female element in the genitals, and the girls male's soul is in the clitoris the male element."[49] According to the myth, adolescents can not be admitted into the adult world until they

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[47] Dorkenoo, pg., 34

[48] McLean, Scilla and Graham, Stella eds. **Female Circumcision Excision and Infibulation**. The Minority Rights Group. Report no. 47, 1985

[49] Lightfoot, Klein. Hanny. **Prisoners of Ritual: An Odyssey into Female Circumcision in Africa**. London: Harrington Park Press 1989 pg. 38

have been rid of the physical characteristics of the opposite sex. Hence the justification of male and female circumcision.

The Bambara also believe that the clitoris is poisonous and will kill a man if his penis comes into contact with it during intercourse. Similarly, the Mossi of Burkina Faso, believe that if a baby's head comes into contact with the clitoris during childbirth, it could cause the death of a baby. In some areas, notably Ethiopia and the Ivory Coast, people believe that if the female genitals are not excised, they will grow and dangle between the legs like a man's testicles and will grow to be the size of a penis.[50] Oliyinka Koso-Thomas points out that it is often argued that circumcision maintains good health in a woman. Evidence is often quoted of girls who were always sick, but after being circumcised became healthy. When circumcised women do fall ill, it is believed to be caused by supernatural causes. Moreover, circumcision is often been credited with healing powers. It is claimed to have cured women suffering from melancholia, nymphomania, hysteria, insanity and epilepsy as well as kleptomania.[51]

The psychosexual justification has some flaws. Any attempt to justify FGM on the basis of controlling the sexuality of girls and the perseverance of virginity is irrational. According to an interview conducted by Allison Slack of a Sudanese woman explained that her sexual sensation and response had been substantially reduced due to her infibulation. She notes that "With the Pharonic (Infibulation), you can not really feel your man."[52] A study of 200 prostitutes in the Sudan found that 170 of the women examined had been infibulated.[53]

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[50] Slack, pg. 447
[51] Lightfoot-Klein. Pg. 39
[52] Slack, pg. 456
[53] McLean *& Graham. Pg. 45

A common justification for FGM is that it would guarantee a bride's virginity before marriage. In reality, it is possible to open a woman with a knife anytime and to be re-infibulated at any time. In many countries, circumcised women after giving birth have themselves re-infibulated so as to maintain the attraction of their husbands. It is also possible for an unmarried girl to have sexual intercourse and be re-infibulated. In this case, the loss of virginity would be hidden and her honour, as well as her family's, would be protected.

The suggestion that death could occur during delivery if the baby's head touches the clitoris and that a man could die if his penis comes into contact with an uncircumcised women is false. So much evidence exists of normal, healthy delivery of babies from uncircumcised women and too much evidence that men who have had sexual intercourse with uncircumcised women are still alive, that no reasonable person who has knowledge of such evidence could accept this argument. Of the 300 men interviewed by Koso-Thomas in Sierra Leone area, 266 confessed that they enjoyed sexual intercourse more with uncircumcised women than with circumcised women. [54]

An examination of the belief that a circumcised woman is better equipped to maintain good health reveals some irrational elements. In practice, circumcised women rarely complain of their ailments. Yet, the defenders of circumcision seem to compare illnesses between uncircumcised and circumcised women. The problem with this argument is that there is such a substantial majority of circumcised women in these communities that to find a greater number of ailments amongst the uncircumcised would be virtually impossible.

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[54] Koso-Thomas pg. 11

RELIGION: Excision and infibulation are practised by followers of a number of religions including Islam. In Africa, FGM is performed by Christians including Catholic and Protestants.[55] There exists no evidence that supports FGM in the various religious texts, however, the practise of FGM has been interpreted to the people in FGM practising communities. A number of studies reveal that the most common responses given for the justification of FGM involved the adherence to religion.[56] In some parts of Africa, the importance of being circumcised is emphasised by Islamic male religious leaders who reinforce genital operations by telling people they are demanded by the Koran, and have religious significance.[57]

Islam is the only religion that has incorporated this practise into its religious doctrine even though FGM is not mentioned in the Koran. It is carried out by some Muslim communities who are of the belief that it is demanded by the Islamic faith. The Muslim population of the Sudan, provides a case in point. Communities in the Sudan are largely ignorant of the precepts of their own religion, believe that Pharonic type of FGM is to be included in the Koran demands. Islam's stern emphasis on chastity and its general suppression of sexuality have provided a fertile ground for FGM. The Koran notes that "virginity is still considered the most precious possession of the unmarried woman." [58]

In Christianity, FGM is not mentioned in the Bible, but it is still practised by Christians of all denominations. In the 17th Century, Ethiopia, Roman Catholic missionaries attempted to discourage FGM, but found out that the number of converts

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[55] Dorkenoo, pg. 36
[56] Slack, pg. 446
[57] Ibid.
[58] Ibid.

quickly diminished. In Kenya in the 1920s, it has been documented that while the Scottish Presbyterian Church and Anglican Church were trying to stop FGM, the Roman Catholic Church did not dismiss it in efforts to avoid losing converts. In Kenya, the Protestant missionaries' attempts to stop FGM met with resistance and it became a political issue. The late President Jomo Kenyatta of Kenya, wrote in **'Facing Mount Kenya'** that no proper Kikuyu (Kenyan Tribe), would dream of marrying an uncircumcised girl. His successor, President Arap Moi abandoned this practise in Kenya in 1982. However, the most active Christian church in Africa campaigning against FGM is the Coptic Orthodox Church in Egypt. It is clear that religion has no strong basis in either Islam or Christianity. It is a fact that 80 percent of those in the Islamic world do not practise FGM, especially in Saudi Arabia and Iran.[59] The religious argument is given by chauvinistic religious leaders who endorse the subjugation of women and has relied on the ignorance of their followers. Since many of the women in the communities that practise FGM are illiterate they have to rely on the interpretations of others, hence the misconception.

SOCIOLOGICAL: Many scholars explain the practise in terms of the initiation rites of development into adulthood. In many areas, an elaborate celebration surrounds the event. Ceremonies are rich in symbolism and include songs, dance and chants intended to teach the young girl her duties and the desirable characteristics of a good wife and mother. The event is rich in ritual with special convalescent huts for the girls attended by the instructors. In these huts the girls are isolated from the family and society until they emerge healed, as marriageable women, or in the case of very young girls, with

[59] Lightfoot-Klein. Pg. 41

gifts of clothing and food. [60] However, some aspects of the initiation rites are weakening. Assistan Diallo in her thesis entitled *"L'Excision en milieu Bambara"* discovered in her research in ritual rites in Mali that these ceremonies have disappeared. She notes that the traditional songs are no longer taught to the girls, and not one of her respondents received any instructions concerned with the initiation into adulthood.[61]

Also, FGM is weakening as an initiation rite because the cost of maintaining training programs is too expensive for most parents to afford. African women are beginning to question the content of what used to be initiation rites. They believe that it is in these initiation rites that the patriarchal ideology is strengthened thorough songs, speeches and actions throughout the term in the initiation chamber. As long as the ceremonial aspect of female circumcision continues to decline, and girls continue to be circumcised at a younger age, the defence of FGM as a puberty rite loses its validity.

HYGIENE/AESTHETICS: It is a measure of pride amongst many African women to be clean. In some countries such as Egypt, the Sudan, Somalia and Ethiopia, the female genitals are considered to be dirty due to the fact that the secretions produced by the clitoris, labia majora and minora are thought to be foul smelling and unhygienic leaving the female body unclean. In communities that require women to cleanse their genitals with soap and water after micturition, it is thought that the hands used to wash the genital area may become contaminated in food and water. The removal of the genital organs is used to promote cleanliness.[62] In Egypt an unexcised girl is called "nigsa" which means unclean, thus the genital body hairs are removed to attain a smooth and

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[60] Dorkenoo, pg. 39
[61] Diallo, Assilan. **L'Excision en milieu Bambara.** Thesis Published for the Ecole Normale Superieure. Bamako, Mali pg. 20
[62] Koso-Thomas pg. 7

therefore clean body. The same sentiment appears in Somalia and Sudan where the aim of FGM is to produce a smooth skin surface. Most women in these countries believe that the removal of genital hairs made them cleaner.[63]

This argument is comparatively justified with male circumcision. Since the prepuce or the foreskin is primarily removed for aesthetic reasons, it is believed that the clitoris, which is homologous to the penis, should be removed for the same reason. Men in some cultures consider uncircumcised female genitalia unpleasant to the sight and touch. This view is common amongst the Temnes, Madingos, Limbas and the Lokkos of Sierra Leone. A flat, smooth area of skin, without the fleshy encumbrances appears to these groups to be more pleasing to the sight and touch.[64]

Yet in practice, female genital mutilation has the opposite effect for the promotion of hygiene. Upon circumcision, urine and menstrual blood can not escape naturally thus increasing the discomfort, odour and infection. There is no evidence that the clitoris produces a hormone or any other substance that emits an odour offensive enough to warrant its removal or the entire area around it. Similarly there are a number of glands in the body that produce offensive odours such as the sweat glands under the armpits. These odours can be eliminated when cleansed on a regular basis. There are no societies where the flesh under the arm is removed to eliminate the odour of sweat. In a like manner, there is no reason for the mutilation of the female genitalia.

TRADITION: The dominant justification for the practise of FGM is the importance of tradition. In a questionnaire survey given in five rural communities in Nigeria, 280 men and women were asked about their experiences with the practise and why the practise still

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[63] Dorkenoo pg. 40
[64] Koso-Thomas pg. 7

exists. Amongst the different reasons cited, the dominant one had to do with tradition and the maintenance of tradition.[65] One reason why tradition was the prevalent answer has to do with the fact that traditions are firmly woven into the social fabric. Nayra Atiya interviewed five Egyptian women who spoke of female genital mutilation with a strong sense of compliance with tradition.

> "It is true that God created us this way, but when we woke up to ourselves, we found this custom handed down to us from our grandfathers and theirs from those of whom we are not even aware and those we no longer know. We emerged into this world and found this habit already existed. It's just so. My people do this, and so I must do like they do."[66]

The strength of tradition in FGM practising societies has served as a power that helps to bind the community together and provide a source of cultural identity that is an important factor in rural communities. A study of the FGM in Somalia found that for the Somali woman, the excissory practice is an important factor in cultural identification even today. [67]

The concept of tradition as a means of support of FGM, have been argued from a standpoint that this is a practise which is deeply embedded in the FGM practising communities and is sewn in the complex cultural system. Thus, it is believed that to eliminate this practise would be to impose Western cultural values on societies subject to political or economic domination thus disturbing the delicate cultural balance. FGM serves as a rite of passage and the abolition of such a practise could result in the abolition

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[65] Slack, pg. 448
[66] Ibid. pg. 449
[67] Ibid.

of an entire institution.

The power of traditional adherence to cultural practices can be seen in Western cultures as well. Male circumcision clearly illustrates this point. Many Westerners especially in the United States, have their sons circumcised ignoring the fact that the practise is unnecessary. This phenomenon shows a need to maintain tradition. The following quote emphasises this point: "when approved by a certain culture, ritual can become standardised, repetitive, and prescribed. That is, cultural rules command that the ritual be performed."[68]

In arguing that it is an inherent right to preserve tradition, many people belonging to cultures that still genitally mutilate women, maintain that it is their right of cultural self-determination to continue this tradition. In their view, they believe that it is wrong for outsiders to make ethical judgements about behaviour in cultures other than their own. In defence of FGM, in Kenya, it is believed that: "it is unintelligent to discuss the emotional attitudes of either side, or to take sides in the question without understanding the reasons why the educated intelligent Gikuyu (prominent tribe in Kenya) still cling to this practice."[69] These communities believe that the argument of cultural self-determination rejects Western liberal concepts of human rights and support non-western ideas and beliefs. Jomo Kenyatta sums up this belief by noting that:

> "The overwhelming majority of the local people in Kenya, believe that it is the secret aim of those who attack this centuries old custom to disintegrate their social order and thereby hasten their Europeanisation."[70]

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[68] Ibid.
[69] Ibid. pg. 463
[70] Lewis, Hope. ***Between Irua and Female Genital Mutilation:*** Feminist Human Rights Discourse and the Cultural Divide. Cambridge, Massachusetts: Harvard Law School 1995 pg. 31

The other side of the argument, human rights universalists maintain that the fundamental human rights standards must apply across cultural and national boundaries in order to have force and meaning. Universalists argue that the international community has an obligation to protest human rights violations where ever they are perpetuated.[71] This belief provides the foundation of the international human rights system.

From the universalist human rights perspective, the primary ethical basis of universal concern about FGM is that it involves the infliction of great physical pain for women and children. This concern prompts the question of whether a society has the right to execute a tradition simply for the sake of tradition, even when it is dangerous or fatal. This question has raised many contradictions.

In trying to reconcile the debate between universalism and cultural relativism, it would be remiss of me not to include how other non-western cultures would perceive and judge western culture. I felt compelled to ask the question of whether or not the West engages in any activity that is comparable to female genital mutilation? Of course there are examples. Such comparisons are alterations to women's bodies for cosmetic purposes. How can we as Westerners condemn non-western societies that practise FGM, when we ourselves work hard to achieve the ideal of the perfect body and face by removing ribs to appear thinner, breast augmentation with saline substances to make breasts appear larger and noses to appear smaller? How would it be if Western women were told that their actions are barbaric or immoral or prohibited by law to undergo such operations? This argument can be refuted by maintaining that western women have a choice of whether they want their bodies augmented or put their health at risk in attempts to become thinner. When both sides of the argument are presented, it must be noted that

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[71] Ibid.

the Western world is not without imperfections. This leads to the question of, at what point should a practice be considered dangerous enough to be a violation of human rights justifying external influence.

While it is hypocritical to pass judgement on another culture, the tragic circumstances and effects of female genital mutilation cannot be ignored. Female Genital Mutilation severely affects the health and welfare of women who undergo this procedure. The effects are so numerous that they have been utilised as arguments against the practise. In examining the arguments against female genital mutilation, it is necessary to analyse these effects not only as arguments that have been put forward against the practise but also these effects must be examined within the context of a violation of the human rights of women and children.

There are many effects of FGM, but they are mainly categorised into health or physical, psychological and sexual. The health effects are the most severe (See Table IV). This is due to the fact that the women who have undergone the most severe forms of FGM are most likely to suffer from health complications for the rest of their lives. The severity of the problem depends upon the skill and eyesight of the excisor, the type of circumcision performed, the hygienic conditions under which the operation is performed and the health and co-operation of the child at the time of the circumcision.[72] Dr. Mark Belsey of the Division of Family Health, World Health Organisation, Geneva, remarked in a 1993 documentary interview that " there is no single practise which has such dramatic negative effects on health in the broadest sense as female genital mutilation."[73]

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[72] Koso-Thomas pg. 25
[73] Dorkenoo, pg. 13

Generally the health or physical problems related to FGM are divided into mainly three categories, immediate; intermediate, and long-term.

IMMEDIATE: Haemorrhage other than pain, is the most common and unavoidable immediate complication. Amputation of the clitoris involves cutting across the high-pressure clitoral artery, which results in severe bleeding. Sudden blood loss has caused shock, and in some cases, death may occur in the case of massive haemorrhage. Haemorrhage can also result in long-term anaemia. Other immediate complications include urinary infection, which can be contracted via two means. Infection could be caused by the unhygienic conditions and the use of unsterilised instruments or crude tools. Infection can also be contracted by the traditional medicines used for healing the wound.

Many girls also experience urinary infection as a result of urine retention for hours or days. Urinary retention is caused because many genitally mutilated girls and women are afraid to pass urine on the raw wound. [74]

The practise of binding the patient's legs together after an infibulation may aggravate an infection by preventing the drainage of the wound. Thus, the infection may spread internally to the uterus, fallopian tubes and ovaries causing chronic pelvic infection and infertility. In a report on Pelvic Inflammatory Disease (PID) is one of the persistent clinical problems that faces Sudanese gynaecologists. It is reported that one-third of women reporting to gynaecology clinics in Sudan, suffer from PID. [75] Infection may also include tetanus, which is usually fatal due to the use of unsterilised instruments.

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[74] Rushwan, Hamid. ***Ethiologic Factors in Pelvic Inflammatory Disease in Sudanese Women.*** Journal of Obstetrics and Gynaecology. Pg. 877

[75] Ibid.

Occasionally a girl's clavicle, femur or humerous bones are fractured due to heavy pressure when the girls put up a struggle.

INTERMEDIATE: Intermediate complications include delay in the healing of the wound, which results from infection, anaemia and malnutrition. Other intermediate effects include pelvic infection, which is caused by an infection of the uterus and vagina. The most common form of intermediate complications is the formation of dermatoid cysts in the line of the scar. The vaginal duct's mucus secretion accumulates forming cysts, which later become infected and form abscesses on the vulva. The formation of keyloids is yet another disfiguring complication that not only leads to the production of excess connective tissue in the scar, but also it causes anxiety, shame and fear in women who think that their genitals are growing in monstrous shapes.

LONG TERM COMPLICATIONS: Long term complications are associated with infibulation more than with clitoridectomy alone because of interference with the drainage of urine and menstrual blood. Long-term complications include haematocolopos in which the menstrual blood accumulates over many months in the vagina and uterus; infertility and recurrent urinary tract infection. A common bodily function like urinating can be a time consuming and painful experience for women. A woman who has been infibulated can take anywhere between fifteen and thirty minutes to empty her bladder.[76]

The most common long-term consequences are problems in pregnancy and childbirth. In the event of a miscarriage, the fetus may be retained in the uterus or the birth canal. Tough scar tissue, which forms after genital mutilation, prevents dilation of the birth canal, and result in obstructed labour. Obstructed labour is hazardous and health

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[76] Toubia, Nahid. ***Female Circumcision as a Public Health Issue***. New England Journal of Medicine. Pg. 713

consequences may be fatal for mother and baby. The mother will suffer lacerations and formation of the fistulas, as well as severe blood loss. The baby may suffer from neonatal brain damage or death as a result of the pressure of the baby's head on the posterior wall of the urinary bladder and the anterior wall of the rectum during prolonged labour. Deinfibualtion is necessary in order to allow the passage of the baby. Re-infibulation is often demanded by the husband and the woman concerned. Repetition of de-infibulation and re-infibulation weakens scar tissue.

A recent phenomenon that concerns gynaecologists of women who were infibulated is the transmission of HIV and the exposure of AIDS. The United Nations Development Programme identified this as a health risk. The risk of HIV transmission may be increased for women who have undergone the procedure of FGM due to scar tissue, and the small vaginal opening prone to laceration during sexual intercourse or as a result of anal intercourse due to inability to penetrate the vagina. HIV may also be transmitted when groups of children are simultaneously mutilated with the same instrument.[77]

Genitally mutilated women also suffer from psychological and sexual problems. In contrast to the numerous studies and case reports on the physical effects of FGM, little scientific research is available on the sexual and psychological effects of FGM. It is evident that severe pain can result in deep psychological wounds, leaving painful memories and emotional scars. Nahid Toubia, maintains that during her clinical experience in Sudan many infibulated women have a syndrome of chronic anxiety and depression arising from worry over the state of their genitals, intractable dysmenorrhea,

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[77] World Health Organization, " Female Genital Mutilation Report of a WHO Technical Working Group" Geneva, 17-19 July 1995. http://www.who.int/frh-whd/publications/p-fgm.htm

and the fear of infertility.[78] Other reports confirm that many women feel a sense of a loss of trust and confidence in those that are caregivers, especially their mother.

Some reports maintain that women fear the act of sex, experience pain from sex and receive little or no physical pleasure during sex. An interview with a young 22-year-old girl who was circumcised at age 14 add light to this point. She noted that " I am afraid to enter in a relationship with a guy because I don't want to scare him away and I don't know if he would understand."[79] Another story of Amina from Somalia deep sexual effect goes deeper than this. She notes that :

> "I was eight when it happened. I still feel hurt and aggrieved about it like there is something missing and I am not a real girl... My aunt, her sister, my mother and some neighbours held me down... and they didn't give me any anaesthetic."[80]

Amina confides that she is now 28 and is still grieving about what happened to her. She finds it difficult to keep a fulfilling relationship because of pain and inability to feel any sensation during intercourse. Most of the time she has intercourse, she feels used and she goes into severe depression. Many women traumatised by FGM have no acceptable means of expressing their feelings and fears due to social taboos and the fear of being branded as promiscuous or as prostitutes. They also suffer in silence especially over sexual health problems. Nahid Toubia observed amongst the female patients in the

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[78] Ibid.
[79] Interview with Beth McConnell. September 29, 1998
[80] Dorkenoo, pg. 26

outpatient department of the gynaecology clinic in Sudan:

> "Thousands of women present themselves with vague complaints all metaphorically linked to their pelvises, which really mean their genitals since they are socially too shy to speak of their genitals. They complain of symptoms of anxiety and depression, loss of sleep, backache and many other complaints uttered in sad monotonous voices. When I probe them a little, the flood of their pain and anxiety over their genitals, their sexual lives, their fertility and all other physical and psychological complications of their circumcision is unbearable. These women are holding back a silent scream, so strong that if uttered it would shake the earth. Instead, it is held back depleting their energy and draining their confidence in their abilities. Meanwhile the medical establishment treats them as malingers and a burden on the health system and resources."[81]

The psychological effects of female circumcision among immigrants differ from those where the practise is prevalent. Genitally mutilated women living in societies where the procedure is not generally performed may have serious problems in developing in their sexual identity. If this is not resolved, health professionals may be called in to deal with such problems.

Examining and rendering a decision on whether or not other cultures have a right to criticise or condemn this practise is a difficult task. There are numerous factors to take into consideration including the aforementioned arguments. When the international community became involved in addressing the issue, there was difficulty in determining

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[81] Ibid.

whether this practise was a human rights violation. The repercussions of the practise were studied and the benefits of female circumcision did not outweigh the consequences.

The international community for a number of years pressed the United Nations to put and end to the suffering of women and girls by traditional practices. In 1982, the United Nations Sub-Commission on the Prevention of Discrimination and Protection of Minorities took up the issue. In 1982, upon endorsements by the Commission on Human Rights and the Economic and Social Council, the Sub-Commission was mandated to study all of the aspects of the problem of female genital mutilation, including the extent and causes of the problem and how it might be eliminated. The study, which was published in 1986, analysed FGM from a cultural, historical and human rights perspective. Finally, the Sub-Commission concluded that female genital mutilation is a violation of human rights. Since then, the issue of female genital mutilation has been considered a human rights violation.

The following approaches supporting the arguments of FGM as a human rights violation addresses some of the specific covenants set forth in the Universal Declaration of Human Rights (UDHR), The Declaration on the Elimination of Discrimination Against Women and the Declaration of the Rights of the Child, and the Declaration of the Elimination of Violence against Women. FGM appears to transgress all of these.

THE RIGHTS OF THE CHILD

The Declaration of the Rights of the Child, adopted by the United Nations in 1959, asserts that children must be guaranteed the opportunity to develop physically in a healthy and normal way. Article 2 and Article 9 makes this point clear. Article 2 states that:" The child shall enjoy special protection... to develop physically, mentally, morally,

spiritually, and socially in a healthy and normal manner." Article 9 states that " the child shall be protected against all forms of neglect, cruelty and exploitation."[82]

In the process of being genitally mutilated, girls are routinely tied down, forced to display their sexual organs, and subjected to an intensely painful operation when they are too young to understand why the operation is performed or to give meaningful consent.[83] The subjection of girls to a procedure violates Principle 2 and 9 as this procedure harms their genital causing unnecessary medical problems, which stifles their development in a healthy and normal manner.

Challenging FGM as a violation of the rights of the child will likely garner more support than arguments made against the practise on behalf of adult women. Children are viewed as innocent and helpless, whereas adults are capable of making rationale decisions. Since children do not fully understand the operation, they are unable to give meaningful consent to the operation. This argument poses a problem with the approach of the rights of the child. Mothers who may not wish to see their daughters harmed, are viewed as unfit, abusive and uncaring because they adhere to rearing their children according to their cultural norms and traditions by acting in the best interest of their daughters. The success of this approach depends on how it is implemented. If mothers feel offended by such implications, the Rights of the Child argument will be rejected.

Another problem with this argument is that the Rights of the Child focuses mainly on the physical harm done to a child when she is circumcised. It does not address the positive feelings she may have as a circumcised woman. In African communities with

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[82] Convention on the Rights of The Child. Adopted by the General Assembly 1989, http://www.unhchr.ch/html/menu3/b/k2crc.htm.

[83] Boulware-Miller, Kay. ***Female Circumcision and Human Rights.*** Harvard Women's Law Journal. Volume 8 1985 pg. 166

strong cultural and traditional ties, the need to be circumcised mitigates the memory barbaric event. Girls who undergo FGM are initially hurt, betrayed and degraded by the operation. However, later they come to feel socially and morally acceptable because they have been circumcised.

RIGHT TO HEALTH: Article 25 of the UDHR states that "Everyone has the right to a standard of living adequate for the health and well being for himself."[84] As examined earlier, FGM produces menacing health problems to women and female children who are subjected to this procedure. Since there are no medical reasons for the partial or full removal of the female genitalia, FGM puts the health of a woman and female children at an unnecessary risk. In this perspective, FGM violates the right to health. This can be used as a compelling argument in the campaign to eradicate it. Challenging FGM as a health issue will likely receive greater acceptance by FGM practising societies. If this approach is presented in the form of health education and family planning, people in FGM practising societies will not tend to view this approach as imperialism from the West.

RIGHT TO CORPORAL AND SEXUAL INTEGRITY: UDHR Article 3 States that: "Everyone has the right to life, liberty and the security of the person."[85] The argument for sexual and corporal integrity stresses that female circumcision violates a woman's right to control her own body and is intended to deprive her of her sexuality. Most advocates of this approach challenge this practise because they are of the view that any attempt to diminish a woman's sexual drive just because she is a woman is

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[84] Universal Declaration of Human Rights. Adopted by the General Assembly 1948, http://www.unhcr.ch/udhr/index.htm.
[85] Ibid.

repugnant. Many advocates are also of the view that the practise restricts and disfigures women's anatomy.

The fact that death is one possible consequence of FGM, suggests that the procedure is a potential violation of the right to life. Another possible consequence of FGM as a possible violation of the right to life is the occurrence of haematocolpos. Haematocolopos is the accumulation of menstrual blood in the vagina. This condition persists for months even years and causes abnormal swelling in the abdomen. In certain circumstances this "swelling" has been misinterpreted as pregnancy out of wedlock. Since an unmarried pregnant woman is considered bereft of honour, there are some cases where a woman has been put to death by her family.[86]

FGM is also seen as a violation of the right to life when viewed from the perspective of reproduction. FGM mutilated the organs that allow human beings to reproduce thus increasing infant mortality, unnecessary complications during childbirth and in some cases sterility and infertility. FGM is also viewed in the context of a form of torture. The unbearable pain and the condition in which the operation is performed, and the resulting medical and emotional problems is a form of torture. However, presenting FGM as a form of torture is may create hostility from African men and women because they suggest that they willingly condone the act of torture against the girl child.

While this is an important argument, it is probably the most difficult one in finding acceptance by members of countries where FGM is practised. The dilemma in presenting this argument is that it is based on a western view of the equal rights of women, a concept which is unfamiliar in the East. Another problem with this approach is

[86] McLean and Graham. 1985 pg. 48

in the manner in which it is presented. Westerners and Feminists who argue that circumcision which mutilates and leaves women unfulfilled and incomplete, are viewed by many African women with reproach.[87] By conducting radical campaigns, western feminist run the risk of alienating the very people whom they seek to liberate. Many African women are offended by western feminists because of their exploitation of a practise that is important to the cultural identity of many African women. Thus, many African women look at the right to sexual and corporal integrity as a judgmental and imposing approach. [88]

DISCRIMINATION AGAINST WOMEN: FGM has also transcended The Convention on the Elimination of All Forms of Discrimination against Women. Article 1 states that: " ... Discrimination against women shall mean any distinction, exclusion, or restriction made on the basis of sex... and Article 3 states that: "States Parties shall take in all fields, in particular in the political, social, economic and cultural fields, all appropriate measures, including legislation to ensure the full development and advancement of women..."[89] FGM is a direct violation of Article 1. It deprives women of their natural sexual desires. In so doing, FGM impeded the full development and advancement of women on a basis of equality with men.

Although it may seem that FGM is a blatant violation of human rights, and there are several dilemmas that are encountered in examining FGM as a violation of human rights and more specifically as a violation of the specific covenants that it transcends, the overall dilemma of FGM as a violation of human rights is the fact that most non-western

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[87] Boulware-Miller, pg. 169
[88] Ibid. pg. 170
[89] Convention on the Elimination of All Forms Of Discrimination Against Women. Articles 1 and 3, http://www.unhchr.ch/html/menu3/b/e1cedaw.htm.

societies look at these arguments primarily as a western concept. The United Nations and the UDHR are frequently known to uphold western ideals. They are viewed by non-western societies as being embedded in to the western idealism. This brings up the question of what right does the West have to impose their moral aspiration on others? This question has produced an ongoing debate. The fact that countries have voluntarily become members of the United Nations suggests that they support the ideals of the United Nations including the UDHR. This illustrates that some member states of the United Nations have only paid service in theory and not in practice to the goals of the UDHR.

FGM is a complex issue that cannot be easily resolved. Members of the international community have accepted the fact that FGM is a violation of human rights. However, they are still faced with the problem of how to effectively eliminate this practise when delicate cultural issues such as the justifications for this practise described in this chapter surrounds this issue. The personal aspect of FGM has contributed to it being viewed as an issue that warrants discussion and effective frameworks for its elimination. Such an eradication of the intimate violation of human rights can only be effective through a slow process. If change occurs too drastically, it can hurt the very cause that it sought to help. Thus, the biases must be attended to, so that an effective elimination strategy could be put in place.

Chapter Four

DISMANTLING THE WALLS OF SILENCE

'In fact the solution of the problem of women will be collective and international.'

Awa Thiam, Senegal

International efforts to combat FGM have a long history. As early as the eighteenth century, there were attempts by Christian missionaries and colonial administrators in Africa to prevent the practice. However, these efforts were perceived as a colonialist attempt to destroy the local culture.[90] During the 1940s, the British Colonial administration, jointly with Sudanese professional and religious bodies, made attempts to ban FGM in the Sudan. These efforts also met with resistance due to fears of destruction of the local culture. As a result, the colonial missionaries backed off from further intervention so as not to alienate their converts over the issue.

The years following the end of the Second World War were a watershed that marked the beginning of the process of decolonization and the creation of a universal framework for the protection of human rights, based on the belief that a concept of human rights ought to be available to all peoples and nations.[91] It was in this context, that FGM first appeared, though fleetingly, on the agenda of the United Nations under the auspices of the Economic and Social Council (ECOSOC). The Economic and Social Council invited the World Health Organisation (WHO) to "undertake a study of the persistence of customs which subject girls to ritual operations, and also to undertake a

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[90] Amnesty International, "FGM: Section SEVEN- United Nations Initiatives", http://www.amnesty.org/ailib/intcam/femgen/fgm7.htm.

[91] Dorkenoo, pg. 60

study of the measures adopted or planned for putting a stop to such practices and to communicate the results of that study to the Commission on the Status of Women before the end of 1960."[92] The twelfth World Health Organisation Assembly, in 1959, rejected this request on the grounds that "the ritualistic operations in question are based on social and cultural backgrounds, the study of which is outside the competence of the World Health Organisation."[93] The World Health Organisation was then asked by the African participants in a UN seminar in Addis Ababa 'on the participation of women in public life' to undertake a study of FGM. Following this request, the Economic and Social Council again asked the World Health Organisation to undertake a study, as formulated in Resolution 821 11(xxxii), adopted in July 1961. Both requests were denied and, as a result, the UN did not take up the issue of FGM in earnest for nearly two decades.

THE UNITED NATIONS DECADE FOR WOMEN

International interest in FGM resurfaced amongst NGOs during the United Nations Decade for Women (1975-1985) which placed women's issues on the international agenda. The decade brought into perspective the status of women in societies, in particular, the depressed status of women in developing countries.[94] During this decade, three world women's conferences were held. However, it was not until the mid-decade UN World Conference on women, held in Copenhagen in July 1980, that the subject of FGM was again raised. This conference reviewed past progress concentrating on the sub-themes of health, education and employment. In the 'Review and Evaluation of Progress Achieved in the Implementation of the 1975 World Plan of Action', the

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[92] Ibid.
[93] Ibid. pg. 61
[94] Fraser, Arvonne. **The UN Decade for Women: Documents and Dialogue.** Boulder: Westview Press 1987 pg. 1

subject of FGM was mentioned once, under the sub-headings 'Cultural Practices Affecting Women's Health' in Paragraph 45, which noted that 'Female Circumcision and Infibulation can lead to complications during pregnancy.' A year earlier, the second regional conference on the Integration of Women in Development, held in Lusaka from the 3-7 December 1979, condemned sexual mutilation practices, and called upon governments and women's organisations to seek solutions to the problem.'[95]

In the main policy document of the Lusaka Conference, the Programme of Action for the Second half of the UN Decade of Women promoted the objectives of equality, development and peace with special emphasis on the sub-themes, employment, health and education, as significant components of development. The subject of FGM was never referred to by name. It was not until the Programme of Action recognised that the considerable efforts that were made towards the objectives of the Decade of Women were still insufficient that the subject of FGM was brought into focus. Priority areas for action were taken in connection with the sub-themes of the World Conference. Paragraph 129 of the sub-theme emphasised the promotion of extensive health education programmes, including special efforts to encourage positive traditional practices, especially breast-feeding, and to combat negative traditional practices detrimental to women's health.

Many of the governments involved still did not see the need to deem FGM as a human rights violation. During the conference no African country took up the issue of FGM. Under pressure from the Swedish public, the Swedish delegation finally tried to crack the taboo on the subject. The delegation indicated that Swedish authorities were prepared to support activities undertaken by the countries concerned but they were reluctant to take any initiative of their own on this issue. This action met a dead end

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[95] Dorkenoo, pg. 61

because none of the FGM practising countries would acknowledge that FGM was a human rights issue.

It was the 1980 Copenhagen non-governmental forum, held during the UN World Conference, that really propelled the subject of FGM on to the international agenda. The informal NGO forum brought together more than 8,000 eclectic women from 120 countries to share their experiences and ideas on issues of importance to women, through workshops and round table discussions on specific subjects.[96] The result was a dramatic increase in the amount of networking that took place at the conference. Following the conference there were a noticeable increase in awareness of the complexity of women's issues and heightened international attention given women's organisations. The forum served as the vehicle for the women to begin to understand that by gathering together in organisations at the local, national and international levels, women could begin to analyse their mutual problems and concerns, devise strategies to address those concerns, and assert their collective power.[97]

Through the non-governmental forum, women also learned how to articulate new ideas and envision new possibilities. Topics such as domestic violence, sexual abuse, FGM, contraceptives and abortion that were considered to be taboo were openly discussed and debated at the forum. One result of the dialogue among women about health and sexual matters was the announcement by the United Nations Children's Fund (UNICEF) of a pledge to collaborate with governments to help eradicate the practice of FGM. Following the reintroduction of the subject of FGM onto the international agenda, the UN Commission on Human Rights in 1981, adopted several resolutions respecting

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[96] Ibid. pg. 63
[97] Fraser, pg. 151

traditional harmful practices and held two regional seminars in Burkina Faso in 1991, and one in Sri Lanka in 1994. These seminars were organised to assess the human rights aspects of FGM and other traditional practises affecting women and children. The seminars provided the opportunity for the exchange of information and experience between national officials in the regions in question, the specialised U.N. agencies concerned, and non-governmental organisations.

Both of these regional seminars echoed the same sentiments, that despite the seriousness of the problems and the numerous resolutions and recommendations adopted at the regional, national and international levels, the question of FGM and other harmful traditional practises had not received the attention they deserved from the states concerned. The participants of the seminars were of the view that such practices persist because of the lack of political will on the part of many states and the failure to inform and educate the population.

The United Nations Commission on Human Rights (UNCHR) took the initiative to propose the following plan for the introduction of concrete and positive changes to redress the situation at both the national and international levels. At first the UNCHR recommended national action. The key features of its recommendations were that:

- a clear expression of political will and an undertaking to put an end to traditional practices negatively affecting the health of women and girl children, particularly female genital mutilation, is required on the parts of governments concerned;
- international instruments, including those relating to the protection of women and children, should be ratified and effectively implemented;

- legislation prohibiting practices harmful to the health of women and children, particularly female genital mutilation, should be drafted;

- governmental bodies should be created to implement the official adopted policy.

The UNCHR also recommended action at the international level, the key features were that:

- The Commission on the Status of Women should give more attention to harmful traditional practices;

- intergovernmental organisations and specialised agencies and bodies of the UN system should integrate into their activities the issue of confronting harmful traditional practices;

- all the organs of the United Nations working for the protection of children and for the promotion of human rights in particular, (i.e. the International Convention of the Elimination of All Forms of Discrimination Against Women; the Convention on the Rights of the Child; and the Covenants on Human Rights and the Convention Against Torture) should include the issue of harmful traditional practices that jeopardise the health of women and of girls and discriminate against them.

Finally recognising the participation of non-governmental organisations as crucial for the elimination of harmful traditional practices, the Commission made two recommendations:

(i) National and international non-governmental organisations concerned with protecting the health of women and children should include in their programmes, activities relating to traditional practices affecting the health of women and girl children;

(ii) Other non-governmental organisations should continue to reinforce their activities in favour of protecting the human rights of women and girl children.[98]

The proposed plan initiated by the UNCHR laid the foundations for the United Nation's World Conference on Human Rights, in Vienna 1993. This Conference was unlike the first World Conference on women, in that it was a significant step towards the internationalisation of women's human rights. For the first time, gender-based violence, which included FGM, was recognised as a human rights issue. At this Conference, the Vienna Declaration and the 1994 Programme of Action were introduced. Both of these documents devoted several pages to the 'equal status and human rights of women as a priority for governments' and it sounded an historic call for the elimination of violence against women in public and private life as a human rights obligation.[99]

The year 1994, was an important year for the international community in raising public awareness and combating FGM. It was in March 1994 that the Special Rapporteur on violence against women was appointed by the UNCHR. Ms. Radhika Coomarswamy from Sri Lanka, in her capacity as the Special Rapporteur had a mandate to collect and analyse comprehensive data and to recommend annually to the Secretary-General, measures aimed at eliminating violence against women at the international, national and regional levels.

Also in 1994, a Plan of Action for the elimination of harmful traditional practices affecting the health of women and children was introduced. The Plan of Action stated that FGM was " a human rights violation and not only a moral issue...it is an expression

[98] Dorkenoo, pg. 65
[99] Ibid., pg. 66

of the societal gender subordination of women."[100] The Plan of Action contained sixty-two measures for governments to implement at a national level. These measures included: giving a clear undertaking to end traditional practices, and in particular, FGM; ratifying and implementing relevant international instruments; drafting legislation prohibiting such practices; and creating bodies and mechanisms to ensure adopted policies are implemented.[101]

At the international level, the Plan of Action recommended the inclusion and integration of FGM in the work of the various UN specialised agencies and other UN bodies including the Commission on the Status of Women and relevant treaty bodies such as the Committee on the Rights of the Child. It also urged NGOs to integrate and reinforce their activities.[102] In order to follow up the Plan of Action and to allow more in depth analysis of the issue to take place, the mandate of the Special Rapporteur was extended. The Special Rapporteur's July 1997 report examined the status of implementation of the Plan of Action in a number of countries and surveyed more other recent international efforts to combat the practice.

The United Nations has also sought to address the subject of FGM within its specialised agencies. In April 1997, three agencies, The World Health Organisation, the United Nations Children's Fund and the United Nations Population Fund, unveiled a joint plan to reduce FGM in ten years and to eliminate the practice within three generations. [103] A key element of this interagency effort is to assist governments in developing and

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[100] http://www.amnesty.org/ailib/intcam/femgen/fgm7.htm
[101] Ibid.
[102] Ibid.
[103] Ibid.

implementing clear national policies for the abolition of female genital mutilation, including, where appropriate, the enactment of legislation to prohibit it.

WHO, UNICEF AND UNPF

The WHO and UNICEF are the two largest UN specialised agencies concerned with health, and in the case of UNICEF, specifically with children's health. Both WHO and UNICEF were very slow to respond to the issue of FGM. WHO did not become active until 1976 when its regional office for the Eastern Mediterranean undertook a review of the medical literature on FGM followed, in 1979, by a seminar on FGM in Khartoum. This incentive was prompted by repeat requests from the UN Economic and Social Committee (ECOSOC) and concerned individuals. UNICEF, did not address the issue of FGM until even later. This is surprising given the fact that FGM is a practice that affects millions of young girls in Africa, a continent where UNICEF has been quite prominent. It was not until March 1980, that UNICEF really became active in the fight against FGM. This brings up the question of why both of these powerful UN specialised agencies, charged with health around the world, had refused for many years to acknowledge the existence of FGM or deal with the health problems resulting from the damaging mutilations.

Several reasons may account for this. One is that the UN specialised agencies are intergovernmental and take their mandates from the UN member states. For the most part, women's sexual, gynaecological and mental health needs were not appreciated in the past nor given the priority which they deserved by member states. The focus of

women's health programmes was on child bearing and fertility control. WHO, UNICEF and UNESCO could not be pro-active on FGM without a mandate from member states.[104]

Another reason has to do with the efforts of women themselves who eventually did make WHO and UNICEF put the issue of FGM on their agendas. Female human rights in the context of gender-based violence against women is only now beginning to be fully recognised internationally as women continue to broaden the understanding of human rights and make linkages between health and human rights. Women have had to campaign to put their needs on various agendas, and this has been a slow process.

Also, FGM was unlike any other straightforward health issue such as immunisation or the control of diseases such as malaria with which WHO and UNICEF were familiar. FGM is not a disease, but as it has been shown, is an act of social control over girls and women that has profound health consequences. FGM is also a sensitive issue and difficult to address. Women who have undergone FGM, tended to be its strongest defenders and it was not until they began to see FGM as a health issue that WHO and UNICEF felt they could be active in the campaign to decrease and eventually abolish this practice.

In order to avoid risking a backlash from women and governments in the countries directly involved, WHO, UNICEF and UNESCO began in a diplomatic way to generate interest in the subject of FGM through conferences, meetings and workshops. As noted earlier, the Khartoum Seminar on the Traditional Practices Affecting the Health of Women and Children was the first such opportunity for discussion of FGM, provided by WHO. This was followed by other conferences in 1987, 1990 and 1994 related to the traditional practices affecting the health of women. At these conferences,

[104] Dorkenoo pg. 67

recommendations were made that governments should adopt clear national policies to abolish FGM, and to intensify educational programmes to inform the public (women and men) about the harmfulness of FGM. In particular, women's organisations at local levels were encouraged to become involved, since without women themselves being aware and committed, no changes were likely. [105]

WHO has assured governments of its readiness to support their national efforts against FGM, and to continue collaboration in research and dissemination of information. Special attention is given to the training of health workers at all levels. Over the last fifteen years the activities of WHO with regard to FGM have included:

- preparation of informal material by staff members and consultants, particularly on the health consequences and the epidemiology of FGM;
- support to incorporate this material into appropriate training courses for various categories of health workers;
- technical and financial support to national surveys;
- collaboration in conferences and seminars and consultations to clarify and unify approaches; and,
- dissemination of information on FGM.[106]

WHO has also co-operated with the NGO Sub-Committee on the Status of Women, and the Working Group on Traditional Practices Affecting the Health of Mothers and Children, to co-ordinate the action of NGOs on this subject. A seminar was held in 1984 in Dakar in February on Traditional Practices Affecting the Health of

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[105] World Health Organizations, " Female Genital Mutilation Report of a WHO Technical Working Group Geneva, 17-19 July 1995", http://www.who.int/frh-whd/FGM/Technical_Working_Group/English/Technical_Working_Group.htm

[106] Ibid.

Women and Children in Africa, to which WHO gave substantial financial, technical and administrative support. As a result of the seminar, the Inter-African Committee on Traditional Practices was created and WHO began working closely with this group and other groups to facilitate follow up activities.

These efforts culminated in the adoption by the World Health Assembly in 1994, of Resolution WHA 47.10, urging governments to take measures to eliminate traditional practices harmful to the health of women and children, particularly FGM. The Resolution reiterates WHO's position on FGM and further reaffirms its support for the UN Convention on the Rights of the Child and the UN Economic and Social Council Resolution 1992/251 on traditional practices affecting the health of women and children. The Resolution urges member states to assess the extent to which these practices constitute a social and public health problem, and to establish national policies and programmes that will abolish FGM.[107]

In light of this Resolution, WHO is strengthening its technical support and co-operation with countries in implementing all measures stated in the Resolution. The Organisation will continue global and regional collaboration with NGOs and other UN agencies in establishing strategies and sustaining action for the elimination of FGM.

UNICEF also in recent years has made significant steps in combating FGM. UNICEF, along with WHO, in March 1980 introduced a joint plan of action, endorsing a primary health care approach and laying down as an essential principle that all activity should be undertaken through citizens of the countries involved.[108] The plan recommended:

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[107] Ibid.
[108] Dorkenoo pg. 69

- strong advocacy efforts by WHO/UNICEF staff, national policy- makers, all health and health-related personnel, and the general public;

- the identification and support of organisations with national structures and credibility in the field;

- the fostering action-oriented research on epidemology, and socio-cultural studies encompassing behaviour, values and attitudes; and,

- the dissemination of the results of successful action and research in practising countries.[109]

UNICEF stressed that the implementation of these recommendations was to be the responsibility of each UNICEF country or area representative and the appropriate government authorities. Like WHO, UNICEF supported the creation of the Inter African Committee on Harmful Traditional Practices (IAC) in 1984. At the country level, UNICEF has given funding support to the IAC in its mobilisation and awareness-creating activities in the anti-FGM campaign. It has also supported efforts to combat FGM in Egypt. Recently, UNICEF has established a five-year, $250,000 programme to promote education, awareness-raising and other activities. UNICEF is also assisting efforts to end FGM in numerous other countries including the Gambia, Sudan, Ethiopia, Eritrea, Somalia, and Kenya. In Burkina Faso, UNICEF's support has helped secure passage of legislation that makes FGM punishable by prison terms ranging from six months to ten years, and fines up to $1,800.00.[110]

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[109] Ibid.

[110] UNICEF, "UNICEF Chief hails curb on female genital mutilation", http://www.unicef.org/newsline/98pr01.htm

The United Nations Fund for Population Activities (UNFPA) has also joined the list of UN specialised agencies that have created initiatives to help in the eradication of FGM. UNFPA, is presently funding FGM-related activities including support for the formation of IAC, and has provided funding for its development activities in the field.

RECENT WORLD CONFERENCES

Not only have the UN specialised agencies become active in the fight against FGM, but also two recent world conferences have marked a critical development in the United Nation's role with respect to FGM. In 1994, the International Conference on Population and Development (ICPD) held in Cairo heightened the interconnections between women's health and women's human rights. The Conference Declaration urged governments to prohibit FGM and to give support to community organisations and religious institutions working to eliminate this practice.[111]

The other major conference was the fourth World Conference on Women, which was held in Beijing in 1995. This conference represented an historic attempt to overcome the traditional neglect and indifference surrounding women's human rights. The Beijing Declaration and Platform of Action underscored the obligations of governments to combat violence against women, including FGM as a priority.[112]

NON-GOVERNMENTAL ORGANISATIONS

Non-governmental organisations are very important in the fight to eliminate this practise. Many international NGOs had found it difficult in the past to work on FGM as a human rights issue for many of the same reasons as the UN and its agencies, one of them being that FGM was not considered to be a form of torture. As more has been written

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[111] Amnesty International, http://www.amnesty.org/ailib/intcam/femgem/fgm7.htm.
[112] Ibid.

about the harmful consequences of FGM, it is considered a form of torture. FGM, as a human rights issue, falls in to the category of citizen upon citizen abuse. It is not governments who are forcing girls to be mutilated, but individual citizens of states. However, governments are held responsible for not taking action to protect girls from this practise and other forms of torture and violence. This raises the question of how do international NGOs respond to FGM. FGM is one of those issues that require a strategic approach to prevention. Some international NGOs have started the process. Amnesty International, and the Inter African Committee on Traditional Practices Affecting the Health of Women and Children are just two NGOs that have been active in the fight against FGM.

Amnesty International, one of the world's best-known non-governmental organisations has been concerned with the human rights implications of FGM for over 15 years. The issue was first tabled at the 1981 International Council Meeting in the wake of interest aroused worldwide by the WHO Khartoum Seminar. A decade following Amnesty International's first discussion of FGM, the organisation's work remained focused on a narrow range of repressive acts carried out by certain states, acts which were in breach of states legal obligations under international human rights standards.[113] Amnesty International campaigned solely against violations by governments because only governments are considered to be bound by international human rights treaties, treaties that provided a framework and justification for Amnesty to intervene and hold governments accountable.

[113] Ibid.

Amnesty International could not ignore the fact that female genital mutilation, represented a grave attack on the rights that the organisation sought actively to protect (such as the right to physical integrity and to non-discrimination). In August 1995 at its International Council Meeting, it included FGM in its promotional work. In doing so, Amnesty International recognised the urgency of taking a position against this widespread form of violence against women prior to the Fourth World Conference on Women, held in Beijing in September 1995.

The aim of Amnesty International's promotional work is to raise public awareness of FGM as a human rights issue and urge governments to ratify and implement international human rights treaties that are of relevance in eradicating the practise. In doing so, Amnesty International has worked with other NGOs at local, national and international levels. Amnesty International's first initiative in raising public awareness raising of FGM, was a meeting held in Ghana in April 1996, attended by Amnesty's members from Western Africa and Ghanaian NGO representatives. The seminar addressed means of increasing public understanding of FGM, focusing on a grassroots approach to its prevention and elimination. This seminar was interesting in that it considered the practise of FGM from various perspectives including gender, human rights, health, religion and the law.[114] Discussions also covered the factors that give rise to FGM and approaches to its prevention. One of the outcomes of the meeting was a commitment to devise a national plan of action to eradicate FGM in Ghana.

This seminar was followed by another one in May 1997 in Tanzania. This East African Seminar concluded that the eradication of FGM would only be achieved by

[114] Ibid.

governments, religious institutions, international organisations, NGOs and funding agencies joining forces in a vigorous and multidimensional approach to tackling the problem.

More recently, Amnesty International has explored the possibilities for addressing the failure of governments to prevent or punish abuses by private individuals, as a breach of their legal obligations. This reflects a significant evolution in the conceptualisation of human rights within the international human rights movement.

Numerous critiques have illustrated that traditional interpretations of international standards have created an artificial hierarchical distinction between violations by states' forces in the realm of public political activity and similar abuses in the private sphere. One of the results has been that the international legal regime has offered scant protection to women from systematic, grave and gender-based abuses inflicted upon them by non-state actors. The public/private distinction overlooks the fact that systematic abuse in the private sphere has a public dimension, in that it arises from more or less officially sanctioned prejudices, discrimination or intolerance. It precludes these abuses from being considered as a human rights issue.

Amnesty International's recent steps in trying to eradicate FGM have been modest but encouraging. Working against FGM is a major challenge for Amnesty International. Efforts at eradication require a creative and thoughtful approach to this multifaceted human rights problem that is systemic in nature and deeply rooted in cultural tradition. It demands a rethinking of Amnesty International techniques. It needs to reorient its lobbying and awareness-raising efforts towards other key sectors of society. In addition to its focus on governments, the steps taken by Amnesty International suggest that this

organisation has a valuable role to play in helping to protect millions of women and girls from the risk of mutilation.

Amnesty International is not the only non-governmental organisation that is active in the fight to abolish FGM. Over the past decade, non-governmental activities aimed at the abolition of female genital mutilation have increased dramatically. In nearly all the countries where the practice of FGM persists, there now exist anti-FGM groups. The Inter-African Committee on Traditional Practices Affecting the Health of Women and Children has set up national committees in twenty-four African countries. The IAC focus in these countries is to:

(a) provide intensive health care education with the help of visual aids;

(b) promote training of Traditional Birth Attendants so they can play an important role in the campaign against harmful traditional practices; and,

(c) to produce educational materials, including a newsletter.

The IAC collaborates with WHO, UNICEF, UNFPA, the UN Centre for Human Rights, the Organisation of African Unity (OAU) and the Economic Commission for Africa. It now has consultative status with the UN ECOSOC and observer status with the OAU.[115]

The groundwork achieved by groups such as Amnesty International and the IAC has been impressive, but what have been the results of their efforts? FGM, as has been noted, is a practice that has existed within communities for many centuries and because it has been surrounded by taboo, it has been difficult for the individual to challenge the practice. One of the major strides in the fight against combating FGM has been that many

[115] Dorkenoo, pg. 74

people are now openly discussing it. NGO's can take much of the credit.

AFRICAN FAILURES AND SUCCESSES

Nowhere has the taboo surrounding FGM been stronger than in many of the African countries where millions of girls are still being circumcised. Bringing about public awareness and change in practices at the grassroots level will require creativity, concerted effort, patience and commitment.[116] Over the years, there have been both failures and successes and lessons can be learned from a critical examination of some of these experiences. It may be useful to review three African case studies from countries that have the highest rates of FGM.

SOMALIA

Somalia has one of the highest rates of female genital mutilation. Over eighty percent of females undergo the most radical form of genital mutilation, infibulation. In 1977, the Somali Women's Democratic Organisation (SWDO), the women's wing of the collapsed government of Siad Barre, was formed. This organisation became the implementing agency appointed by the Somali government for the abolition of female genital mutilation. FGM was carried out in hospitals under general anaesthetic, to eliminate the damage posed by the traditional operators. This was intended to win support for the eradication of the drastic mutilation of infibulation. The health education campaign conducted by the SWDO, caused the procedure to be banned in all hospitals, but not in the rural areas. The case proposed by SWDO was that there was no rationale reason for mutilation claiming that it was not only unhealthy but it did not even guarantee virginity.[117]

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[116] Ibid. pg. 84
[117] Ibid., pg. 118

In the early 1980s a Centre based within the Somali Academy of Arts and Sciences and funded by the Swedish Agency SAREC was set up to conduct studies on the physical, psychological and social aspects of FGM. This led to north-south co-operation in 1987 between the SWDO and the Italian Association for Women and Development, (AIDOS). AIDOS provided technical and methodological support to its Somali counterpart, while SWDO was responsible for the content and direction of the campaign. A centre was established at the SWDO headquarters. In December 1987, the centre arranged workshops and seminars. In 1989, an International Conference was organised in Mogadishu on the theme 'Female Circumcision: Strategies to Bring About Change'. The conference ended with firm resolutions that were intended to provide a framework for ongoing action in Somalia.

In 1991 the technical base established for the SWDO-AIDOS project was destroyed due to the clan conflicts and anarchy that Somalia was experiencing. Not only was the technical base overthrown, but hopes of eradicating FGM in Somalia were destroyed as well. In the present unstable and insecure environment, with no functioning government, it is doubtful that anything constructive can be done to eliminate FGM in Somalia. But the millions of Somalis, forced to flee their homeland who are now refugees in many Western countries, stand to gain from a campaign for the eradication of FGM.

ETHIOPIA

In Ethiopia, a 1985 UNICEF-funded survey carried out by the Ministry of Health in five regions of Ethiopia revealed that about ninety percent of Ethiopian women had undergone some form of FGM. Later estimates placed the number of affected girls and

women at nearly 30 million.[118] These dramatic numbers prompted the Ethiopian Ministry of Education to conduct a radio broadcast in 1995 on the harmful effects of FGM. This message was again repeated in women's meetings organised by the Democratic Women's Association of Tigray under the sponsorship of the National Committee on Traditional Practices in Ethiopia, an organisation that is making a major impact on the lives of girls and women. The Committee, which was established in 1987, comprises Government officials, NGOs and UN agencies, including UNICEF.[119]

The Committee aims to eradicate harmful traditional practices such as FGM and at the same time promote beneficial practices such as breast-feeding. It sponsors sensitisation workshops for large numbers of trainers who work in communities, drawn from health professionals, clergy, traditional birth attendants, women's and youth associations, the media and schools. About 1,350 people had attended sensitisation workshops by mid-1996.[120] Reaching young people is one of the most important goals. In high schools, sensitisation workshops, introduced in 1994, teach boys and girls about FGM and encourage them to express their opinions on the subject. By 1996, 38,000 students had participated.[121]

In addition to workshops, the Committee has sponsored radio programmes as a relatively inexpensive means to reach communities throughout the nation. The Committee has also produced films in several local languages on FGM, early marriages

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[118] UNICEF, " In Ethiopia, women say no to female genital mutilation", http://www.unicef.org/features/feat176.htm.
[119] Ibid.
[120] Ibid.
[121] Ibid.

and other traditional practices. The Committee's work has been financially supported by UNICEF.[122]

The Ethiopian government has supported the campaign by banning FGM in its Constitution, in 1994. The Constitution prohibits laws, customs and practices that oppress women or cause them mental or physical harm and requires the Government to protect a woman's right to be free of harm. Though no survey has been conducted to assess the progress in eliminating FGM and other harmful practices, informal feedback is encouraging.

SUDAN

In the Sudan, attempts have been made to combat FGM for the past 50 years, yet to date, more than eighty percent of women in Northern Sudan continue to be infibulated. Lessons may be learnt from Sudan, since it was the first country in Africa to pass legislation against the practice.[123] Furthermore, there have been several educational campaigns to combat FGM and some major scientific studies, which add credence to past campaigns. During the 1940s a medical committee was set up by the then Governor-General to study the problem of FGM. This in effect led to legislation being passed in 1946. Parents hurried to have their children infibulated before the law came into effect, resulting in a higher level of medical complications and deaths. The law itself was never enforced.

From the 1950s to 1970s general education for both sexes advanced significantly but no major anti-FGM campaigns were undertaken. A milder, legal form of female

[122] Ibid.
[123] Dorkenoo, pg. 84

genital mutilation was taught in midwifery schools, on the premise that if it was to be done, it should be done in an aseptic manner and inflict the minimum damage.

Campaigns against all forms of female genital mutilation recommenced in the . the Sudan's Family Planning Association, along with the Faculty of Medicine, in co-operation with the Ministry of Health and the World Health Organisation started a field research project. The results of the project showed that FGM was going to be difficult to eradicate in the Sudan as females were still being infibulated at an alarming rate. In spite of the efforts in the health field, FGM persisted for socio-cultural reasons, largely because it had a ritual importance, but also for economic reasons as it was a source of income for the midwife.[124] Men continued to demand it of their prospective wives, and women continued to have it done because men demanded it.

Further efforts took place in the mid 1980s. In 1984, the Sudanese Minister of Internal Affairs allowed for the creation of the National Committee for the Eradication of Female Genital Mutilation in the Sudan. The United Nations Children Fund (UNICEF), medical doctors, psychiatrists, educators, religious leaders, social workers, women's representatives and members of voluntary associations were included on the committee. Its mandate was to mobilise all forces within Sudanese society to fight FGM and to recommend legislation and other measures that the government should adopt to eradicate female genital mutilation. However, the Committee was unable to fulfil its mandate and in 1988, a new Sudanese National Committee for the Eradication of Traditional Practices Affecting the Health of Women and Children was formed. It had NGO status and it developed a plan of action focused on training and information campaigns.[125]

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[124] Ibid. pg. 85
[125] Ibid.

Neither the governmental policy allowing less radical forms of FGM to be practised, nor legislating against infibulation, have had any measure of success. The failure of Sudanese efforts can be mainly attributed to weak government involvement and to a lack of planned and sustained educational programmes.

GAPS IN THE AFRICAN CAMPAIGN

One of the major gaps in the African campaign is that governmental childcare monitoring systems are not fully developed, either in the primary health care system or in schools. Thus, it is difficult to work effectively and to respond quickly to protect children from traditional forms of abuse such as FGM. A second gap is mass education but such a campaign needs to be well planned and sustained over a long period and will, therefore, require resources and technical input. Since most African countries are still developing financially, this requirement is difficult to meet. This is one area where the international community's financial assistance and goodwill will be most effective.

SUCCESSES OF THE AFRICAN CAMPAIGN

An effective means to encourage discussion of the issues surrounding FGM at the grassroots level in Africa has proved to be through street theatre, such as songs, dance, slide shows and audio tapes. The Care for Girls Committee has commissioned plays, picture books, posters and slide shows as part of their programme to address FGM. The Committee has brought together numerous groups of church and community leaders for formal consultations. The Committee has also arranged many local meetings in villages in African countries where FGM is most prevalent. Performances of plays are followed by a discussion with the audience takes place in order to maximise the impact of their message.

The NGO organisation WOPED[126], joined forces in 1998, with the UNIFEM Trust Fund for Actions To Eliminate Violence against Women[127] by holding anti-violence workshops in two regions of Nigeria, using dramatic methods, relying mainly on songs, dance and video. The workshops were a success. Many participants became emotional and confessed that they were ignorant of the effects of certain practices on women and children, especially girl children which they have helped to perpetuate in their daily lives without fully grasping the implications of their actions on the victims. The victims, too, came forward and publicly acknowledged they were victims.

This outpouring was unusual, for Nigeria is a society where women would rather suffer in silence to the point of death than give out uncomplimentary information about their husbands or their people. Many testified to the fact that they were constantly beaten, and others who were circumcised said they did not feel any sexual arousal anymore, a condition, which they attributed to FGM. This strategy of public education has the singular strength of loosening tension among participants and creating an environment conducive to speaking out and openly acknowledging pains and frustrations.[128]

Due to the success of the workshops, UNIFEM Nigeria has invited WOPED to co-ordinate three further public performances of the theatre with different target groups, including market women, commercial drivers, and academia. These are scheduled to be conducted during the forthcoming sixteen days of Activism against Gender Violence. In addition to the above, WOPED is also working with schools and colleges to carry out

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[126] The Women's Centre for Peace and Development (WOPED), Nigeria, http://www.prepcom.org/participants/africa/org102.htm.
[127] UNIFEM, The Trust Fund in Support of Actions to Eliminate Violence against Women. http://www.unifem.undp.org/trst_pj2.htm.
[128] Theresa Akumadu, Director WOPED. November 3, 1998.

peer to peer education outreach, using visual aids, pamphlets and public speaking in school assembly grounds. Poster concept and poetry competitions have been launched in six schools and the materials will be used in further public education efforts for children and youths.

The effectiveness of any initiative, by the UN, NGOs, and African Governments towards eliminating female circumcision will depend on how receptive the African women and men are towards change. Unfortunately, there is limited research on the attitudes of African women and men on FGM. The views that have been documented do not reflect a collective voice but illustrate a diversity of opinions on this issue.

African women are beginning to make their voices heard. The walls of silence are coming down against FGM by sharing their feelings of betrayal, and their psychological and physical pain. By doing this, they are challenging themselves not only to look at the motives for this practise but also to question a deep cultural tradition. In breaking the silence, women are asking for a suitable replacement for female circumcision. They wish to observe a ritual practice that honours and celebrates a girl's transition into womanhood, without causing damage to her health and well being.[129]

Women have begun to question why, as young girls, they embraced the idea of being circumcised. They recall how girls who were circumcised were ostracised from the community and taunted by their peers. Mothers assured their daughters that the procedure would not be painful but would give them honour and that all women in the world had undergone FGM. Many of the women who are circumcised and understand the harmful

[129] Mire, Soraya. **Fire Eyes.** Persistent Production, 1994

consequences of this practice, must now come to terms with their feelings of betrayal and outrage.[130]

Soraya Mire, a Somali woman who was circumcised when she was a young girl, is dedicated to seeing the elimination of female genital mutilation. In her film, **'Fire Eyes'**, she interviews Somali women, men and medical personnel about FGM. Her film serves as platform for speaking out against female circumcision, and as a means for empowering other women. Several women interviewed in the film recalled their fear of being circumcised and the physical pain they endured. The women interviewed challenged the practice. They were conscious of their experience, and the pain and suffering they have endured because of it. However, there are many women who are of the view that the practice of FGM must continue. These women want to keep the tradition alive because it is an ancient custom that they think must continue through the generations. They believe that no man will marry an uncircumcised women. According to one woman, " not to be circumcised is to be ostracised and excluded from the group".[131]

Some of the men interviewed felt very strongly about the continuation of the practice. One man compared a woman's body to a door by noting that "when you leave your apartment for the day would you leave it unlocked?" When asked how he felt about eliminating the practice, one man felt it was virtually impossible, stating that "Somalia has a culture that can not change."[132]

Not all men share the same views. Some men who were interviewed expressed the desire to see the procedure eliminated or replaced with a less harmful ritual. One man

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[130] Thiam, Awa. **Black Sisters, Speak Out Feminism and Oppression in Black Africa.** London: Pluto Press, 1986 pg. 35.
[131] Mire, 1994.
[132] Ibid.

spoke of his disapproval of the procedure by stating that "it presents a mutilation of a human being, induces a life long pain and causes a lot of problems for women...whatever causes pain to them causes pain to us."[133] Another man spoke of female circumcision as a form of social control in society, maintaining that people need to be informed that FGM is not a religious requirement. However, the majority of the men interviewed failed to understand why women are suddenly challenging the practice. One of the interviewees told Soraya that "circumcision has been around for a long time, what amazes me most is that women like you have begun to complain and refuse continuation of it."[134]

Is the goal to eliminate female circumcision realistic? Will African women and men embrace efforts to eliminate an ancient cultural practice? The answers to these questions will not be revealed until Westerners step aside and allow leadership by individual African men and women in the development of their own strategies for challenging FGM. This is not to suggest that the international community must relinquish its efforts to eradicate FGM, but they must listen to the voice of African women and men, and continue to encourage and support their efforts to develop and employ their own strategies against FGM. Objectivity comes from learning to see faithfully from another's point of view. It comes from listening to the voices of the subjugated. Who better than African women and men would know which approach for stimulating change will be accepted by the African people? Thus, we must not only look to international initiatives but also focus on the voices of African women and men as they play an integral part in trying to bring about the elimination of this harmful practice.

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[133] Ibid.
[134] Ibid.

Chapter Five

FGM AND CHILDREN'S RIGHTS

Until recently, the focus concerning Female Genital Mutilation has been on the continent of Africa, where over eighty percent of FGM occurs.[135] However, in the past decade it has become apparent that the practice continues even when people have migrated to societies in which these practices have died out or little is known. Today, awareness of this practice in the West is growing and some action is being taken at governmental level in many Western countries to formulate policies regarding FGM. In France, for example, in February 1999 a court convicted more than two dozen parents for mutilation. This initiative by the French has pitted French law against African tradition.[136] The prosecution was the largest to date brought against the practice of FGM in France and the first to be tried by a woman, Judge Martine Varin.[137]

Not only have some governments in the United States, Canada, France and the United Kingdom taken steps to eliminate this practice but also organisations such as UNICEF, the United Nations Population Fund, the World Health Organisation and many other notable non-governmental organisations such as The Research Action & Information Network for the Bodily Integrity of Women (RAINBO) have worked and continue to work with sheer tenacity in not only bringing awareness to the practice of FGM but also these organisations have raised FGM as a public health and a women and children's human right issue. It is within this regard, that this chapter will focus on FGM

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[135] Dorkenoo pg. 126
[136] BBC World News Wednesday February 17, 1999
[137] Ibid.

and children's rights by presenting a case study of UNICEF's actions in the fight to bring awareness and hopeful elimination of FGM. However, before this can be achieved, it is necessary to provide a blueprint of the relation between FGM and children's rights so that the action of UNICEF could be better facilitated.

FGM: UNICEF's STRATEGY TO BRING ABOUT CHANGE

Although FGM has been discussed at international and national levels as a woman's health and human rights issue little thought has been given to it as an abuse of children. In 1994 as a response to the call to Global Action UNICEF issued and executive directive declaring that FGM is a health hazard to children and a violation of their human rights.[138]

No systemic research has been done on the meaning of FGM to children or the effect it has on them. Although a girl's response to the ritual cutting of her genitals may vary, there is little doubt that the loss of sexual organs affects physical health, psychological well being, and future sexuality. In 1979, at the World Health Organisation's (WHO) Seminar on Traditional Practices Affecting the Health of Women and Children, Dr. A. H. Taba, former Regional director of the WHO Eastern Meditterean Region, made the following statement concerning the health risks of FGM:

> "It is self-evident that any form of surgical interference in the highly sensitive genital organs constitutes a serious threat to the child, and that the painful operation is a source of major physical a psychological trauma. The extent and nature of the immediate and long-time mental disturbances will depend on the child's inner defences, the prevailing psychological

[138] Toubia Nahid. A Call to Global Action published by RAINBO pg. 39

environment, and a host of other factors. The family no doubt does its best to mitigate the painful effects of the operation; nonetheless, the child necessarily an overwhelming experience." [139]

Even before the operation, the threat of 'cutting' and the fear-provoking situation may disturb the mental state of the child to the degree that it causes worry, anxiety, sleeplessness, nightmares or panic. As anticipatory precautions against these anxieties, the family commonly uses various forms of traditional magic-religious practices such as fumigation or wearing of amulets.

There is abundant evidence from clinics and hospital wards of suffering experienced by girls from complications of infibulation. The physical scars get bigger, thicker, more painful or more callous with intercourse and childbirth. These scars also have a parallel set of invisible psychological scars.

With children who have undergone the practice of FGM, the conflict of feelings created in the child is quite considerable. On the one hand, there is a desire to please the parents, grandparents and other relatives by undergoing something that is highly valued and approved of. Before the event there is the desire to be normal that is to be like other members of society particularly the peer group. Finally, there is the experience itself, being held down by force while part of the body is cut off. The story of Oumi a 12-year-old girl in "Circumcision in Gambia" by Saffiatou K. Singhateh makes this fact all too real:

"After the circumcision and a month of confinement Oumi was returned home. Yassin, her mother noticed that Oumi behaved very strangely; she was easily irritated, her appetite had gone, and she often kept herself in

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[139] Ibid.

isolation. She also noticed that she was not comfortable when she sat for lunch. She asked what was wrong and the answer was 'Nothing'. Oumi was too embarrassed to mention her genitals in front of other children. When Oumi's gloominess and discomfort got worse, and her visits to the toilet became frequent, her mother persuaded her to let her examine her genitals. There was inflammation and soreness at the site of the circumcision. It was three months after the operation. For a while Yassin tried the treatment of the Ngasimba (the traditional circumciser), but the wound got septic. She took her to the hospital where they dressed the wound and gave her antibiotics. The wound healed eventually, but the infection keeps recurring. Oumi has to visit the hospital two or three times a year. Yassin is accused by Ngasimba of sabotaging the (secret) society and exposing its secrets."[140]

The effects of FGM go far beyond the obvious effects on sexuality. The procedure of FGM has an indirect impact on shaping young girls self-images. It has been argued that the long-term effects of FGM can influence a child's ability to assume leadership roles in the future. Since development initiatives require the mobilisation and empowerment of women, FGM could be considered a hindrance to economic growth. Further complicating the issue is the fact that children also suffer if they are participating in peer groups. As the following account states:

"When girls of my age were looking after the lambs, they would talk among themselves about their circumcision experiences and look at each other's genitals to see who had the smallest opening. If there was a girl in

[140] Ibid. pg. 40

the group who was still uninfibulated, she would always feel ashamed since she had nothing to show the others. Every time the other girls showed their infibulated genitals, I would feel ashamed I was not yet circumcised. Whenever I touched the hair of infibulated girls, they would tell me not to touch them since I was unclean because I had not yet been circumcised. After the infibulation, the girl's hair is shaved and washed in a special way as a rite of purification, but my hair was dirty. One day I could not stand it anymore. I took a razor blade and went to an isolated place and tried to cut off part of my clitoris... After some weeks, I was infibulated together with seven other girls. I was seven years old, but some of the other girls were older. After a few days the wound healed and the thorns were removed. When I was able to resume my normal work, I felt proud, and whenever some girls asked me if I was infibulated, I did not have to hide my genitals."[141]

UNICEF AND CHILDREN'S RIGHTS

The social penalties and individual pain that can result from nonconformity are serious considerations for those who are pioneering change for children's rights. It is within this regard that The United Nation Children's Fund (UNICEF), has made a profound impact on the fight against FGM especially with respect to children. However, this chapter deals with FGM and children's rights one may be inclined to ask what does UNICEF really do to protect children from this harmful traditional practice? Over the past 15 years, UNICEF and other agencies concerned with health and development have been confronted with socio-cultural attitudes and practices that have had negative effects

[141] Ibid. pg. 41

on the physical, mental and psychosocial development of girls and women. The practice of FGM has been an issue of concern and discussion at both UNICEF's headquarters and field offices for over a decade. As noted earlier in Chapter 2, the harmful practice of FGM threatens the health and development of women from the time the ritual is performed on the young girl straight throughout her childbearing years. Thus, the attention given to FGM is an integral element of UNICEF's policy on the health and well being of women and girls. The Executive Board of UNICEF in 1990 recognised that many of the disadvantages facing women are rooted in the neglect of and discrimination against female children. In 1991, UNICEF endorsed the recommendation (1991/17) that it explicitly address the status of girls and their needs particularly in the areas of health, nutrition and education, with a view to eliminate gender disparities.[142]

In 1980, UNICEF expressed concern about FGM during a joint consultation with the World Health Organisation (WHO) and the United Nations Fund for Population Activities (UNFPA), the result of which was a classification of the practice of FGM as a public health problem. Since that time, UNICEF has supported several global and regional conferences on the issue. UNICEF country offices have formed partnerships with non-governmental organisations (NGO's) and support projects aimed at eliminating FGM, primarily through education, training and advocacy. However, these efforts have been random and have also been hampered due to the lack of co-ordination and limited investment of resources in FGM programs and country offices. This has created a great need for systemic action to address FGM as a practice, which violates the right of women and children and undermines many goals for their health and well being.

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[142] UNICEF Position Paper. "Harmful Cultural Practices: Female Genital Mutilation"

Recognising the need for co-ordination among UN agencies in this area, WHO, UNICEF and the UNFPA has emphasised in its April 1997 joint policy statement a complementary of the three organisations to effectively address issues related to the elimination of FGM although each area has its own area of expertise and focus.

UNICEF ACTION & PROGRAMMING APPROACHES

ADVOCACY

Since the 1980s, UNICEF has supported the Inter-African Committee (IAC) and other organisations and agencies in organising several regional and inter-regional consultations and conferences, meetings and seminars in Africa and the Middle East to raise awareness on the consequences of the harmful practice and advocacy for its eradication. UNICEF country programs of co-operation increasingly included specific activities for advocacy, public education, social mobilisation and action by community-based women's groups. Advocacy has paid dividends in terms of national commitments. The Governments of Burkina Faso and Sudan included in their National Programme for Action for Children, the eradication of such harmful practices among the goals for children by the Year 2000. More recently, the National Plan of Action for Advancement of Women in Ethiopia has identified this as an area for action. National committees in 22 countries have been established by IAC efforts. Several of these committees as well as related women's organisations are being supported by UNICEF offices in Burkina Faso, Djibouti, Ethiopia, Guinea, Guinea Bisseau, Mali, Niger, Nigeria, Somalia, and Tanzania.

RESEARCH

In support of advocacy and program development, UNICEF collaborated with national technical institutions and non-governmental organisations in the conduct of

surveys to obtain information on the nature and magnitude of the practice. In the 1980s, a comprehensive study was undertaken on harmful traditional practices, which provided information on the nature, extent and geographical spread within the country.

PROGRAMME INTERVENTIONS

In line with the above, initiatives were taken in the health sector. In many country programs this has resulted in special attention being given for the inclusion of FGM in the training of health personnel, paramedic workers, traditional birth attendants and other personnel. Activities by UNICEF include the revision of syllabi, development of specific modules, production and dissemination of information, education and communications materials, and workshops. In Sudan, the educational and training materials cover FGM from the social, health and religious perspectives.

Similarly in Burkina Faso the strategy includes sensitisation activities at the community level, targeted at parents and community leaders. In Nigeria, UNICEF gives attention to FGM as an integral component of the Safe Motherhood Project within the health sector. In Kenya, a UNICEF assisted program targets education to the peripheral workers, who actually perform FGM, as they are ones who need to be influenced for change in attitudes and practices at family and community levels. In Uganda, the strategy includes actions within UNICEF-assisted projects in both health and women-in-development sectors.

Although there have been significant gains made in recognition of FGM as an issue of women's equality and human rights as well as a public health issue there are no evaluations to show the extent of change in this practice. It is believed that such practices will emerge from ongoing UNICEF efforts to address this in a systematic matter. It is

generally observed that as a result of the above initiatives and those of other agencies in generating awareness, there is generally more awareness amongst the public, the health workers and to a lesser extent among parents on the harmful implications of FGM. UNICEF has realised that for sustained implementation and impact there is a need for a multi-pronged strategy, which covers all sectors and addresses the issue at several levels, from the policy level to the community action. In October 1994, UNICEF issued an executive directive entitled "Guidelines for UNICEF Action on Eliminating Female Genital Mutilation." For the first time UNICEF articulated a policy approach to FGM and provided analysis on how FGM elimination fits within UNICEF's mandate and strategic goals for women and children. It also outlined how anti-FGM activities were integral to UNICEF's objectives and program priorities.

Following this directive UNICEF proceeded with developing another document titled "Strategic Framework and Programming Guidelines to Eliminate Female Genital Mutilation." This second document outlines a strategic approach on FGM for all UNICEF's programs as well as assist UNICEF's staff with guidelines on how to support and develop anti-FGM activities and acquire experience in addressing this sensitive and challenging area. The ultimate goal for UNICEF is to integrate action plans on FGM into the country program of co-operation.[143]

The review of past experiences and taking into account contemporary policies towards women's and children's health and rights, two strategic principles were identified for UNICEF and anti-FGM action. FGM must be simultaneously addressed as both a health and human rights issue and efforts to protect women's rights and children's

[143] Plan for UNICEF Activities for Ending Female Genital Mutilation (FGM)

rights will place emphasis on: (a) avoiding the health hazards on girls and women; and (b) protecting the rights of the girl child as a human rights issue.

By addressing FGM at all levels, UNICEF drafted in 1996 a five-year plan to actualise the strategic vision. The activities started in 1996 with a two-year launching phase where the Gender and Development Section at the UNICEF headquarters substantively guided and supported anti-FGM activities while at the same time stimulating regional and country offices to start their own initiatives. Over the five years emphasis will shift to the regional and country offices with the goal of fully integrating FGM into National Programme Plans by the year 2000. UNICEF's five year 1996-2000 activities on FGM are as follows:

UNICEF HEADQUARTERS

The role of the team at Headquarters is to stimulate and support activities at inter-regional, regional and country levels. It also links UNICEF activities on FGM to those of other UN agencies and international NGO's. The Headquarters has provided:

- policy guidelines and strategy formulation
- guidelines on communication strategies
- a technical support group from different divisions and programs
- a catalyst to start-up phase through technical support and fund raising
- a link to international activities on other children's health and human rights efforts
- information on successful programs
- monitoring and evaluation of projects.

REGIONAL OFFICES

The three UNICEF regional offices, which have countries where FGM is widely practised, are Eastern and Southern Africa, Western and Central Africa and Middle East and North Africa regions. The regional offices are involved through:

- co-ordination of in country activities
- exchange experience and information within the region
- the conduct of technical workshops and seminars and
- monitoring and evaluation of country activities.

COUNTRY OFFICES

A number of countries have been identified for UNICEF anti-FGM activities over the first five years. Three from the Eastern and Southern Africa region, three from Western and Central Africa region and two from Middle East and North Africa region. Activities at the country level have been based on the "Strategic Framework and Programming Guidelines" developed by UNICEF and includes:

- goals and priorities of the plan of action
- stimulation of policy debates
- workshops and seminars
- the provision of financial and technical support to projects.

UNICEF country offices, where the activities on ending FGM have been implemented, have integrated anti-FGM project activities at the community level with the rest of other basic services. The activities have also helped to build capacity in the eight model countries in conducting situation analysis, developing, implementing and monitoring activities for ending FGM. The experienced gained in the eight model

countries will be documented and used to facilitate expansion of similar services in other countries where FGM practices are ongoing.

Anti-FGM activities by UNICEF provide a chance to develop the thinking and approaches on a single problem that will sow the seeds for rapid and effective action on a broader range of reproductive health issues. As the issue of FGM affects women at several stages of their life cycle (infancy, girlhood, adolescence and adulthood), it can teach the organisation a great deal about changing attitudes and behaviours about girl's and women's health.

Chapter Six

RECOMMENDATIONS AND A GLOBAL CALL TO ACTION

> "Violence against women shall be understood to encompass, but not be limited to, the following...female genital mutilation and other traditional practices harmful to women ...States should condemn violence against women and should not invoke any custom tradition or religious consideration to avoid their obligations with respect to its elimination. States should pursue by all appropriate means and without delay a policy of eliminating violence against women."

(Declaration on Violence Against Women adopted by the UN General Assembly in December 1993)

Historically, all societies have devised different methods for the repression of female sexuality, the most extreme and brutal of which is the topic of this thesis- Female Genital Mutilation. The roots of the practice can be found in the patriarchal family and in society at large. As the second chapter pointed out, religion is a reason used by chauvinists to reinforce the practice. As the second chapter has also noted, the practice of female genital mutilation has major short and long-term physical and psychological health risks. In the past it has been a sensitive issue and very difficult to tackle. It had remained in a cultural cul-de-sac and minimal action has been taken by governments and international organisations involved with women and children's well being towards ending the practice. The United Nations was the first to raise FGM at an international

level but nothing really happened until Western feminists took up the issue during the UN Women's Decade (1975-1985). Although this provoked a backlash it brought the subject back into the international arena and, since that period, there has been slow progress in breaking down the walls of silence surrounding the practice. The contributions of individuals, feminists and NGOs to this process have been remarkable and gradually the subject has emerged from its cultural ghetto to become an item on the health and human rights agenda.

The most pleasing development is that women and men from African countries are now leading the campaign for its abolition. With few resources, they have embarked on awareness raising campaigns and have managed to break the taboo surrounding FGM in their communities and within countries. As a result there is an increase awareness of the practice in Africa and the subject is very much open for discussion. This is no more evident than in Senegal where the Parliament of Senegal, as a response to a campaign by a private Senegalese organization Tofhan which means breakthrough, banned in January 1999 the practice of FGM in a step towards eradicating the traditional practice. Other countries such as Egypt have banned the operation all together, but there is significant opposition to change because of the traditional nature of the process. Yet more than half a dozen African nations south of the Sahara have now instituted bans, which are enforced with fines and jail terms.

In parts of the Middle East, the Far East and in Latin America, where FGM has been reported, work has hardly begun to study the extent of the practice and to initiate the education campaigns for its abolition.

FGM is no longer a practice that is only confined to the continent of Africa, as chapter three has vividly discussed. Civil war and ethnic strife has forced people to migrate to countries where the practice of FGM has been abandoned or was unknown. This has presented new challenges for health care and social work professionals. Chapter three documents what western countries have done for preventive work on FGM. However this preventative work is more advanced in the UK and France where women's organisations have been campaigning against the practice for more than a decade. Work is just beginning in other Western countries such as the United States and Canada.

Chapter five focused on the genital mutilation of girls, which has become an international issue, a public health hazard and a children's human rights problem. It is in this context that international agencies are just beginning to explore their potential role. This chapter focused mainly on the role of the United Nations Children Fund (UNICEF) which has made a profound contribution to the achievement of children's rights but also in ending FGM as this practice affects millions of girl children.

To date, nearly all programmes have been at the individual, governmental, non-governmental or ad hoc efforts, with little integration into existing structures. In every country and region where mutilations are carried out, the situation is different, as is the political will to deal with FGM vary greatly at both the local and national level. Also, there is little integration in the way of long-term goals and strategies. To achieve real change will require more planning, and a more sustained commitment from governments and international organisations. Thus, a global call to action is needed to not only heighten awareness but also to press for the eradication of FGM.

A GLOBAL CALL TO ACTION

The eradication of FGM requires global action. There are many people the world over who would like to see the genital mutilation of girls stopped. Their concerns and efforts must be linked so that resources and knowledge could be shared, and so women are not forced to fight isolated battles against their own social and economic powerlessness-a powerlessness that allows FGM to persist.

This thesis has reported much about what FGM is and the efforts to combat this practice. There are rough estimates of how many girls and women are subjected to it and where they live. It is up to the abolitionists of this practice to go beyond the information contained in this thesis to learn more. The challenge is to obtain exact information on prevalence, physical and psychological effects, and religious requirements. Most of all the information must be disseminated on a wide scale and must be accessible to a broad range of people.

FGM must be separated from the notion that it has a religious basis while efforts to preserve cultural integrity must be honoured. The task is difficult because individuals and committees are being asked to take action against a long-standing practice that is embedded into a heritage that of which they are proud.

Eradication efforts must be emphatic not alienating. The efforts must accommodate all forms of cultural manipulation and mutilation of women's bodies whether physical or psychological. As Chapter two has noted, some of the defensiveness and anger expressed by Africans is caused by the manner in which opposition to FGM has been expressed. The people of the countries where FGM is practised resent references to the term "barbaric practices imposed on women by male dominated societies,"

especially when they look at the Western world and see women undergo their own feminisation rites such as cosmetic surgery. It is very important to note that both the message and facts of FGM will be lost if anti-FGM advocates use the language of superiority-the language of coloniser or slave holder.

Noting these important implications, actions to stop FGM can be taken on many levels. Actors include international organisations such as the United Nations, influential aid and development agencies, national governments dealing with indigenous or immigrant communities, professional bodies, grassroot women's and youth groups and other community organisations. The following are possible areas in which each level and groups could become more active participants in the fight against FGM.

AFRICAN COUNTRIES

❖ the abolition of female genital mutilation is the responsibility of governments and requires political will. Governments are the only ones which can initiate and co-ordinate action.

❖ Governments should adopt a clear national policy for the abolition of FGM.

❖ Governments should establish mass education programmes using all available channels of communicating information to the public. This information should be targeted and tailored to the community and should use appropriate cultural mediums to formulate a strong and unambiguous message against the practice. This can be achieved through adult literacy programmes, through already existing community organizations, women's group, through specific workshops on radio and television.

❖ Legislation to back up the information campaign will be needed but it can only function with the development of a parallel child protection system which identifies

children at risk of mutilation and moves swiftly to protect them. This can be a potential area for prevention.

❖ The Prevention of FGM should be integrated into primary health care, in Maternal Child Health clinics, health promotion, family planning and public health information.

❖ As FGM is performed to please men, men should be brought into the campaign. They should be informed as to the undesirability of FGM and sex education for men that breaks down the myths and fears surrounding female sexuality should be promoted.

❖ There should be intensive education against the practice in schools, colleges, teacher training programs etc. There should also be the integration of a programme of education on the human rights of children and women, using means such as literacy programmes, gender training, extension workers in schools etc.

❖ Every year there should be a government-backed day of action on women's health, including the issue of violence against women.

WESTERN COUNTRIES

❖ Western governments should adopt a clear policy on the abolition of female genital mutilation and give directives to local governments, local authorities, states, counties, and districts to act.

❖ Local governments should adopt an anti-racist policy on female genital mutilation. A specific department such as the Social Services department should be given a mandate to co-ordinate activities within a given area on female genital mutilation.

❖ Local response to female genital mutilation should be multi-pronged with education as the foundation of any strategy to abolish FGM.

❖ There should be a clear and unambiguous legislation against the practice of female genital mutilation. Where it is incorporated into existing laws against assault, this must be made clear to the communities directly concerned and to professionals involved with child health and child protection. Any ambiguity will foster the idea in the community that FGM is an acceptable practice and professionals will be unable to work on the issue.

❖ As a priority, local government or local authorities should act as catalysts and open space within communities practising female genital mutilation for community education. Communities should be empowered and given resources to engage in community education for themselves on the practice of FGM, child protection laws in the country and information for women with complications arising from FGM.

INTERNATIONAL AGENCIES

More governments are openly condemning female genital mutilation and FGM is progressively becoming less sensitive as a policy issue. Still financial and technical support from international agencies will be needed for the campaigns to eradicate FGM.

As chapter four notes, the WHO, UNICEF and the UNFPA have all made some contribution to the eradication of FGM. As chapter five has documented UNICEF has made significant contributions in bringing awareness and change in the fight to eradicate FGM. However, they can do more. WHO, UNICEF, UNFPA, UNESCO and the UNDP should each allocate a portion of their budgets to combat female genital mutilation. The following are a few extra measures that can be taken.

WHO

It is a fact that WHO's strength lies in its research related to the prevalence, types and consequences of FGM and disseminating information about the findings. In light of this WHO has the potential to reach out to the other international development agencies and field officers with special information packages which will advance the campaign.

WHO should also support the training of health workers at all levels, including obstetricians, gynecologists, pediatricians, midwives and nurses to raise their awareness of the health consequences of FGM, how to deal with complications arising from FGM and assist professionals in the integration of prevention into primary health care.

Setting standards and providing guidelines on many confusing aspects of current work on FGM, e.g. classification of the different types, research methodology and co-ordination of research.

Initiating pilot research programmes on the eradication of FGM and convening evaluation workshops to strengthen current approaches to the eradication of FGM.

Strengthening NGO activities with training and back up with information material.

UNICEF

Practices such as genital mutilation and forced early marriages have to do with the rights of the girl child. As it has been noted in chapter one, these practices persist not solely out of ignorance but through gender discrimination. In light of this fact, child health monitoring systems will need to be strengthened.

UNICEF can support efforts to abolish FGM through the following interventions:

1. UNICEF should provide support to women and youth NGOs which are often the safest and most effective environments to promote discussion and debate about the issue of FGM. Frank discussions about why FGM is practised, what is positive and negative about it, why should it be stopped and how this can be done will help young parents make more informed decisions for their own children. Where culturally appropriate, young men and women talking about the issue together may result in the identification of non-harmful alternatives that could continue the importance of the positive aspects of the culture of initiation into and training for adulthood and responsibility.

2. UNICEF should work closely with religious leaders and institutions that have an important role to play in educating their communities on the dangers of FGM. Their stance on this issue is critical because of its strong cultural roots and perceived links to religion. Religious institutions may also serve a monitoring function for the community. Their commitment to abolishing FGM could include ensuring that no family in their community continues the practice. The community surveillance can also be used for other sensitive problems such as violence against women and child abuse.

3. UNICEF can also work with the media on campaigns to heighten the understanding of and attitudes towards FGM. There is a great need for public information on this issue and effective media approaches may range from discussion programmes, films and radio campaigns to plays, puppet shows and story telling. UNICEF country offices can make linkages between ongoing media campaigns on health, education, girls and women in order to incorporate information on FGM.

4. UNICEF can also integrate information about FGM into ongoing UNICEF programmes. This can be an effective mechanism for getting credible information out to communities. This should include information on the negative health effects of FGM in training activities for doctors, nurses, midwives, and other health care providers whose practice and opinion on health issues sets the standard in many communities. UNICEF can play a major effective role in moving FGM from a marginalised issue, affecting those least powerful in society, to the centre stage of international health and human rights concerns.

UNICEF can also collaborate with governments in the following areas:

1. Strengthening social services departments and children's societies to develop their infrastructure on child monitoring and to protect children from harmful traditional practices such as FGM at the grassroots level. This can go hand in hand with the education measures.

2. Strengthening the training of staff from social services departments so they can protect girl children from all harmful traditional practices.

3. Supporting the funding of specific posts within social services departments to focus on harmful traditional practices affecting girls.

4. Supporting the funding in country programmes for the abolition of FGM.

THE INTERNATIONAL PUBLIC

As this thesis has documented, the genital mutilation of girls is primarily a violation of the fundamental human rights of girls and later of adult women. The abuse of children can never be a private issue, because children do not have a voice to speak for themselves in the international arena. Therefore, we as the international public should be

more dedicated to fighting this and any other abuse of children and we should not be intimidated. Many nationalistic struggles such as the dismantling of apartheid in South Africa would not have been possible without the contribution and support of the international public.

The efforts of the international public as noted in chapter four are noteworthy, but more needs to be done. What the international community must do is listen to the viewpoints of African women and men and not just point fingers, pass judgement and lay blame, as these tactics will likely put people in FGM practising societies on the defensive. Some of the defensiveness and anger expressed by Africans is caused by the manner in which opposition to FGM has been expressed.

The international community must also empower African men and women to develop solutions on their own. The role of the international community could be to offer advice, education, medical assistance and monetary funds if necessary, in helping African people implement the strategies, which they develop.

Moreover, we as individuals could do our part in the fight against abolishing FGM. Persons who want to be active in the campaign can join anti-FGM organisations, which offer scope for international membership. Organisations such as RAINBO (Research for the Bodily Integrity of Women), and the ACDHRS (African Centre for Democracy and Human Rights Studies) are just two of the anti-FGM organisations that will allow people who are interested in joining the anti-FGM campaign to contribute effectively and also to support those nationals from countries directly concerned.

We must bear in mind that the overriding consideration for all activities is that they be guided by the knowledge and wisdom of individuals from the communities

involved, with special attention paid to the concerns of women. Unguided interference from outsiders could create a backlash in favour of FGM.

Finally, it is important to emphasise that FGM is a part of a persistent global situation where women remain powerless because they lack access to resources, jobs, and education. A global action against FGM cannot endeavour to abolish this one violation of women's rights without placing it firmly within the context of efforts to address the social and economic injustice women face the world over. If women are to be considered as equal and responsible members of society, no aspect of their physical, psychological, or sexual integrity can be compromised.

Thus, it is my hope that female circumcision is brought to the attention of all people everywhere. By continuing to bring this practice to the attention of the public, the discourse will continue and more people will begin to question and challenge it. We must not permit this custom to remain shrouded in a cloud of secrecy, as silence only perpetuates the practice.

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TABLES

TABLE I

ESTIMATED PREVALENCE OF FEMALE GENITAL MUTILATION IN AFRICA

Country	Estimated Prevalence	Number of Women (000s)	Source of prevalence rate
Benin	50%	1,370	
Burkina Faso	70%	3,650	Report of the National Committee (1995)
Cameroon	20%	1,330	Estimated prevalence based on a study (1994) in southwest and far north provinces by the Inter-African Committee, Cameroon section.
Central African Republic	43%	740	National Demographic and Health Survey (1994/1995). Signs of decline amongst younger age groups. Secondary or higher education can be associated with reduced rates of FGM. NO significant variations between rural and urban rates. The prevalence of FGM is highest amongst the Banda and Mandja groups where 84% and 71% of women respectively have undergone FGM.
Chad	60%	1,930	1990 and 1991 UNICEF sponsored studies in three regions.
Cote d'Ivoire	43%	3,020	National Demographic and Health Survey (1994). A reduced rate of FGM amongst younger women. No significant variations occurred between urban and rural rates. Secondary and higher education can

			be associated with reduced rates of FGM. The highest prevalence of FGM appears amongst the Muslim population 80% compared with 15% amongst Protestants and 17% of Catholics.
Djibouti *	98%	290	Type III widely practiced, UN ECOSOC Report (1991).
Egypt *	80%	24,710	Type I and Type II practiced by both Muslims and Christians. Infibulation reported in areas of South Egypt closer to Sudan
Eritrea *	90%	1,600	
Ethiopia	85%	23,240	A 1995 UNICEF sponsored survey in five regions and an Inter-African Committee survey in twenty administrative regions. Type I and II commonly practiced by Muslims and Coptic Christians as well as by the Ethiopian Jewish population, most of whom now live in Israel. Type III is common in areas bordering Sudan and Somalia.
Gambia	80%	450	A limited study by the Women's Bureau (1985). Type II commonly practiced.
Ghana	30%	2,640	Pilot studies in the Upper East region (1986) and amongst migrant settlement in Accra (1987) by the Ghana Association of Women's Welfare.
Guinea *	50%	1,670	
Guinea-Bisseau	50%	270	Limited 1990 survey by the Union Democratique des Femmes de la Guinea-

			Bisseau.
Kenya	50%	7,050	A 1992 Maendeleo Ya Wanawake survey in four regions. Type I and II commonly practiced. Type III by few groups. Decreasing in Urban areas, but remains strong in rural areas.
Liberia *	60%	900	
Mali *	75%	4,110	
Mauritiana *	25%	290	
Niger *	20%	930	
Nigeria	50%	28,170	A study by the Nigerian Association of Nurses and Nurse-midwives conducted in 1985-1986 showed that 13 out of 21 States had populations practicing FGM, prevalence ranging 35% to 90%. Type I and Type II commonly practiced.
Senegal	20%	830	Report of a national study by ENDA (1991)
Sierra Leone	90%	2,070	All ethnic groups practice FGM except for Christian Krios in the western region and in the capital, Freetown. Type II commonly practiced.
Somalia	98%	4,580	FGM is generally practiced; approximately 80% of the operations are infibulation.
Sudan	89%	12,450	National Demographic and Health Survey (1989/1990). A very high prevalence, predominantly infibulation , throughout most of the northern, north-eastern and north-western regions. Along with a small overall decline in the 1980s, there is a shift from infibulation to

			clitoridectomy.
Togo *	50%	1,050	
Uganda *	5%	540	
United Republic of Tanzania	10%	1,500	
Zaire *	5%	1,110	
Total		**132,490**	

- Anecdotal information only, no published studies
- Number of women calculated by applying the prevalence rate to the 1995 total female population reported in the United Nations Population Division's population projections (1994) revision. Totals may not add due to rounding.

TABLE II

DISTRIBUTION OF ADULT WOMEN IN NIGERIA BY OBJECTS USED FOR FGM OPERATION (000s)

State	Local Knife	Special Knife like blade	Scissors	Black Soap	Small hooded knife	Snail	Surgical instrument
Edo	73.2	13.4	11.3	-	0.7	-	-
Lagos	55.2	13.8	24.1	-	3.4	3.4	-
Ogun	88.2	9.2	2.6	-	-	-	-
Ondo	76.2	8.7	12.6	0.4	-	0.9	1.3
Oyo	84.2	11.8				-	-
Osun	92.7	5.5	1.8	-	-	0.5	-
Abia	53.7	44.9	1.4	-	-	-	-
Anambra	60.6	39.4	-	-	-	-	-
Enugu	46.3	50.7	1.5	1.5	-	-	-
Imo	44.5	52.7	1.1	-	-	-	1.1
Akwa Ibom	27.0	72.3	0.7	-	-	-	-
Cross River	17.2	81.9	0.3	-	0.3	-	-
Delta	50.3	12.7	34.2	0.3	-	2.4	-
Rivers	31.8	65.1	3.1	-	-	-	-
Benue	60.0	40.0	-	-	-	-	-
FCT	60	40	-	-	-	-	-
Kwara	88.9	9.3	-	-	-	3.0	1.1
Kogi	-	100	-	-	-	-	-
Niger	93.0	5.9	-	1.2	-	-	-
Plateau	66.7	16.7	-	16.7	-	-	-
Adamawa	1000	-	-	-	-	-	-
Borno	17.8	68.9	13.3	-	-	-	-
Bauchi	72.0	20.0	4.0	4.0	-	-	-
Yobe	60	40	-	-	-	-	-
Taraba	1000	-	-	-	-	-	-
Kaduna	97.0	-	-	-	-	-	-
Katsina	88.6	9.1	-	-	-	2.3	-
Kano	98.9	1.1	-	-	-	-	-
Kebbi	100	-	-	-	-	-	-
Jigawa	89.5	7.9	-	-	-	2.6	-
Sokoto	98.1	1.9	-	-	-	-	-

TABLE III

DISTRIBUTION OF ADULT WOMEN IN NIGERIA BY WHERE THE OPERATION WAS CARRIED OUT (000s)

State	Clinic	Circumcisers	Home	Village & Bush	Men's home	DK
Edo	23.2	5.6	67.3	2.8	3.1	-
Lagos	12.3	2.2	75.6	4.4	12.3	-
Ogun	2.4	2.2	91.7	-	2.4	-
Ondo	12.5	4.4	64.6	2.9	14.8	-
Oyo	5.9	7.9	83.9	1.8	0.6	-
Osun	17.8	4.7	76.0	-	1.6	-
Abia	26.2	-	61.3	-	2.5	-
Anambra	8.4	-	86.8	-	3.5	-
Enugu	28.4	3.4	61.7	3.3	3.3	-
Imo	7.9	1.8	84.6	-	5.0	-
Akwa Ibom	3.7	0.3	89.4	-	6.9	-
Cross River	6.6	0.8	81.4	9.3	1.1	-
Delta	25.0	1.9	68.7	0.3	0.3	-
Rivers	34.1	0.7	47.1	4.5	12.3	-
Benue	-	-	100.0	-	-	-
FCT	-	-	-	-	-	100.0
Kwara	21.9	1.6	72.1	0.3	3.8	-
Kogi	1.8	-	0.2	0.2	0.2	97.6
Niger	-	-	100.0	-	-	-
Plateau	-	-	100.0	-	-	-
Adamawa	-	-	50.0	-	50.0	-
Borno	17.4	-	82.6	-	-	-
Bauchi	24.0	4.0	64.0	-	8.0	-
Yobe	0.6	-	0.9	-	-	98.6
Taraba	-	-	66.7	-	33.3	-
Kaduna	6.9	-	92.3	1.0	0.6	-
Katsina	4.5	-	90.9	-	4.5	-
Kano	3.4	0.3	45.4	-	0.3	50.7
Kebbi	-	-	0.2	-	-	99.8
Jigawa	4.8	-	94.0	-	-	-
Sokoto	1.4	-	11.2	-	0.4	87.0

TABLE IV

DISTRIBUTION OF ADULT WOMEN IN NIGERIA BY COMPLICATIONS OF FGM (000s)

State	Bleeding	None	Can't Remember	Infection	Tetanus	Scars
Edo	72.1	26.7				
Lagos	75.0	25.0				
Ogun	66.0	30.2		1.9		
Ondo	71.8	27.0		0.8	0.4	
Oyo	93.2	6.4				0.3
Osun	94.5	3.0	0.4		0.4	
Abia	72.7	26.8		0.5		
Anambra	75.4	24.6				
Enugu	51.6	48.4				
Imo	48.1	51.3				0.6
Akwa Ibom	56.7	43.3				
Cross River	95.8	3.2		0.9		
Delta	56.9	43.1				
Rivers	40.4	58.5				
Benue	83.3	16.7				
FCT	100.0					
Kwara	13.0	87.0				
Kogi	63.6	36.4				
Niger	78.0	20.7	1.2			
Plateau	91.7	8.3				
Adamawa	50.0	50.0				
Borno	74.2	25.8				
Bauchi	33.3	52.4		14.3		
Yobe		100.0				
Taraba	100.0					
Kaduna	27.2	72.3				
Katsina	72.5	21.6		3.9	2.0	
Kano	89.8	9.3			0.8	
Kebbi		100.0				
Jigawa	60.0	38.9	1.1			
Sokoto	79.5	18.2		2.3		