A Profile of Female Genital Mutilation and Human Rights: Towards Outlawing the Practice

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Although there is a worldwide movement towards the recognition that Female Genital Mutilation (FGM) is a form of torture and a violation of human rights, there are still protagonists who believe that the practice is justified. In the course of this research, claims were often encountered that FGM is neither a human rights violation nor a form of torture but an important cultural rite. Attempts to justify and enforce FGM have a strong cultural and religious bias. Although the sincerity of these views was respected, it was apparent that these views were seldom grounded in any detailed insight or knowledge regarding the procedures involved or the suffering endured. This article aims to fill that hiatus. Through a detailed descriptive analysis of the various procedures and the consequences of FGM, this article will a) show exactly how and why FGM is regarded as a torturous experience, b) delineate which rights are violated, and, c) list the measures that have been adopted by various countries in relation to FGM. What follows is a general overview, and while some countries may perform the mildest form of FGM, in other countries the most extreme type may predominate.

Brief Historical Overview

FGM is still a prevalent custom in some 26 African countries, in some parts of the Middle East, South East Asia and African. Immigrants to the North and West continue to maintain this tradition (Mekuria 1995:1) and is estimated that 130 million girls and women have experienced similar the practice (Toubia 1995:5). According to *FORWARD* (1996:1) five women every minute and two million girls annually are added to this figure, making it, '*... the widest form of brutal female torture in contemporary society*'.

Female circumcision or female genital mutilation (FGM) is not a nascent phenomenon. According to Walker & Parmar (1993:82) the first documented case

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was performed approximately 6000 years ago. In Egypt it dates back to approximately 1500 B.C. The mummies of Cleopatra and Nefertiti show evidence of the clitoris being removed (Daly 1978:162). This custom was known and discussed by physicians of the Roman Empire (Rathmann 1959:115). FGM predates the advent of Islam (Lancaster 1997:6; Slack 1988:443) and it is evident that pre-Islamic Arabs performed this practice. With the introduction of trade, it is possible that the practice of FGM spread from Arabic countries and the areas around the Red Sea to Sudan, and with the spread of Islam it eventually enveloped other parts of Africa (Smith & Werde 1992:7).

In ancient times FGM had a definite class component as it was performed only on women from the upper socio-economic echelons and on relatives of priests and rulers (Daly 1978:162). Among contemporary practising communities, circumcision is defended as a 'social leveller' which maintains equality as it is performed on all females irrespective of educational, religious or socio-economic status (Lamb 1992:13).

FGM survived because it was shrouded in secrecy and superstition. According to Koso-Thomas (1987:20) it was only during the 19th century that researchers were able to obtain decisive information on FGM. This conspiracy of silence is also reflected in the fact that this subject is taboo and any discussion brings dishonour to the families (Bartels & Haaijer 1995:72). In certain tribes there are no actual words that can be used to name the procedure (Mekuria 1995:3).

Various terminologies have been utilised to describe the procedure: 'female circumcision'; 'female sexual castration'; 'female genital cutting'; 'female genital surgery'; and 'female genital mutilation'. Since the early 1990's the term Female Genital Mutilation has been adopted by the United Nations and is used internationally (WHO 1996:4). There have been some negative reactions and resistance to this forceful and controversial term, but it is the term that is generally accepted.

Types of FGM

In order to understand fully why FGM is regarded as a form of torture and a violation of human rights, it is pertinent to provide a description of the various types of FGM.

Incision or Prick

This is the mildest form with little chance of adverse or long term debilitating effects. The incision into the clitoris is largely symbolic and does not damage the female genitalia (Reyners 1993:23). Immigrants to the USA and Europe who seek alternative rituals for FGM (Bartels & Haaijer 1992:16) encourage this form, which ensures that they satisfy their religious and cultural obligations.

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Clitoridectomy
This includes the total removal of the prepuce and the clitoris and it has been suggested that this form is 'true circumcision' because it is analogous to male circumcision (WHO 1996:4). Following this procedure, the chances of complications such as excessive bleeding and infections are extremely high (Reyners 1993:23).

Excision
The clitoris and the labia minora are removed completely. The labia majora are left intact and the vagina is not closed.

Infibulation
This is as the most extreme form of FGM and is also referred to as severe circumcision. Infibulation involves the complete removal of the clitoris, the labia minora and the inner surface of the labia majora (Koso-Thomas 1987:17). The vulva is stitched together with acacia thorns soaked in 'mammal' a special oil mixture; silk; catgut; horsehair; pins or other metal objects. When the skin of the remaining labia majora heals, a bridge of scar tissue forms over the vagina (WHO 1996:2; Yidu 1998:13; Crul 1992:99). The entrance to the vagina is obliterated but an opening no larger than a grain of rice (Warsame et al 1985:2) is maintained by the insertion of a sliver of wood or straw to allow for the flow of urine and menstrual blood. In some cases women have actually conceived through this aperture (WHO 1996:2; Allen 1995:1; Walker & Parmar 1993:367). Toubia (1995:10) records that: 'If the opening is more generous, sexual intercourse can take place after gradual dilation, which may take days, weeks or even months. If the opening is too small to start the dilation, recutting has to take place before intercourse'. Family honour and prestige is dependent on making the opening as small as possible, which increases the value of the girl and of the bride price (Hosken 1999:3).

Gishiri Cuts
According to Reyners (1993:26) and WHO (1996:2) the term Gishiri is used to describe ostensible problems associated with the reproductive system e.g. infertility, painful intercourse, and amenorrhoea. This process entails the scratching of either the anterior or posterior vaginal wall with a sharp knife. Following the flow of blood it is believed that the problems will abate.

Defibulation
This term refers to the opening of the infibulated vulva. It occurs after marriage, once the husband or his female has confirmed that the wife is a virgin or 'closed' (Bartels & Haaijer 1995:84). In some instances where the opening is very small, penetration can fifteen days or more with much pain and bleeding (WHO 1994). Often, full

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penetration only occurs after three to 24 months (Khalifa 1994:21). If the husband is still unable to attain full penetration, he uses instruments such as a knife, piece of glass, or his fingernail (Slack 1988: 453) which can result in further complications, or the circumcisers and female family members are approached to assist. In some instances, on the wedding night, the bridegroom has a friend who ties down the bride, while the groom opens the vagina with a razor (Khalifa 1994:16-34).

Another reason for defibulation is that during birth it is impossible for the baby to emerge through the tiny aperture and the mother has to be defibulated (Reyners 1993:26). This process recurs with each new birth.

Reinfibulation (Recircumcision)

This process entails the suturing of the raw edges after the woman has given birth and is also done to repair an interrupted circumcision (Lamb, 1992:17). Reinfibulation is seen as a symbolic regeneration of virginity and entails 'the closing of the vulva to its post-wedding night size and is repeated after each child is born' (Forms of FC 1999:1). According to Lamb (1992:28), in Sudanese Arabic reinfibulation is referred to as *Adlat El Rujal* (men's circumcision) because it is designed to bring greater pleasure to the man. After the baby has been weaned the woman is opened again for intercourse (Hosken 1999:2). Widows and divorcees also undergo this process in the hope of regaining their 'virgin status', thereby increasing their status as prospective brides. Girls try to procure this procedure after premarital sex (Allen 1995:2).

The World Health Organisation (WHO 1996:6) recommends that the following practices should also be included in any classification or definition of FGM:

* stretching the clitoris and /or labia;
* cauterisation by burning of the clitoris and surrounding tissues;
* scraping (angurya cuts) of the vaginal orifice;
* introduction of corrosive substance into the vagina to cause bleeding; or
* putting of herbs into the vagina with the aim of tightening or narrowing the it;
* any other procedure that falls under the definition of female genital mutilation.

The above procedures require skill, good light, proper surgical instruments, an anaesthetised body and knowledge of female anatomy (Hosken 1999:1). In societies where FGM is practised, the procedure is performed by untrained persons, including barbers, elderly women, priests and priestesses, wandering gypsies, fortune-tellers, blacksmiths and traditional midwives, nurses and physicians (Koso-Thomas 1987:21; Toubia 1995:29; Tracy 1997:3; Lightfoot-Klein 1989:36). Unsterilised instruments such as knives, scissors, scalpels, pieces of glass, broken bottles, tin, sharp rocks,

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pottery and razor blades are used (WHO 1996:2; Pielou 1998:87) and are reused immediately on other girls without even rudimentary cleansing, thereby increasing the risk of the transmission of any number of diseases and infections. Neither anaesthetic nor antiseptic is used. Young girls are fully conscious of what is happening to them and are required to undergo the full procedure without fear or crying: any sign of this brings dishonour to their families (Burnett 1997:1).

Some societies attempt to desensitise the affected area, for example initiates are commanded to sit in a cold stream so that the genital area is numbed to decrease the initial pain (Koso-Thomas 1987:2). In other societies the clitoris is cauterised or stung repeatedly with nettles to deaden the nerve endings (Morgan & Steinem 1984:292). Sometimes, girls are given a stupefying drink so that the immediate effects are not fully experienced (Koso-Thomas 1987:22). A girl who resists or struggles while undergoing FGM may have other parts of her genitalia accidentally damaged. Pastes containing herbs, porridge, ash, alcohol, lemon juice, cow dung, eggshells, sugar, eggs, gum arabic and oils are frequently applied to the wound to arrest the bleeding (Hosken 1999:2; Koso-Thomas 1987:21; Bartel & Haaijer 1995:42). Afterwards, the girl's legs are tied together and she is bandaged from knees to waist, remaining immobilised for two weeks while any excrement remains in the bandage (Hosken 1999:3).

Besides the shock and trauma of this procedure, the young girl or woman is faced with the debilitating results of the mutilation.

Consequences of FGM

Arguments surrounding the health benefits of FGM are not unique to Africa. In the mid-19th century some Western countries claimed that forms of FGM could cure a variety of female sexual 'deviancies' e.g. nymphomania, excessive masturbation or the unnatural growth of the clitoris (Abusharaf 1997:19). In practising countries, it is argued that FGM has curative powers and that a direct positive consequence is that women seldom complain of ill health (Koso-Thomas 1987:9). Other benefits claimed for FGM are enhanced fertility and easier childbirth (Robertson 1996:622). These pronouncements are not based on medical facts but are enshrouded in the mysticism of a particular cultural or religious belief system (*Amnesty International* 1999a: 6). Health benefits are not the most frequently cited justification for FGM. It is most frequently argued that FGM makes women strong and uncomplaining about illness (*Amnesty International* 1999a: 6). If women in traditional societies are socialised into believing that they are strong and can endure illness, then very little of their actual suffering will be reported. Moreover, the complications of FGM are not regarded as a direct result of the procedure, but as part of the natural course of a woman's life. As such, serious life-threatening infections are not seen as a deterrent for defibulating an unmarried girl as this will decrease her chances of marriage or lower her bride price

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(van den Berg 1992:16). It seems therefore that in practising communities, suffering and death are more acceptable choices.

Most practising countries are silent about any negative consequences of FGM. The secrecy surrounding FGM, and the protection of the circumcisers makes it difficult to collect accurate data. Where information has been collected, time has lapsed after the event, and women in traditional societies do not readily associate present illness with something that occurred during their childhood (*Amnesty International* 1999a: 3). Symptoms that researchers ascribe directly to FGM may be considered by women to be natural and normal in societies where FGM is a universal practice (Carr 1997:37). Women are also reluctant to seek medical assistance and complications usually go unreported (Kouba & Muasher 1985:95). Large parts of the population in practising communities fail to perceive the hazardous health consequences of FGM and males, especially, are '... ignorant, content to dismiss damages arising from FC as of the natural, inevitable consequences of being born a woman. Many women share this predisposition' (Rushwan et al 1983:7). In instances where research has been done, the physical damage caused by FGM is medically indisputable (Rushwan et al 1983:7). To this effect Pereria (1989:11) states that 'No single medical voice can be heard stating that mutilation is good for the physical or mental health of girls and women and growing research show serious permanent damage in health'.

Potential health risks

In societies where FGM is a universal practice, females are at risk for a number of interrelated reasons:

Circumcisers

Many of the circumcisers have no medical training or knowledge of the female anatomy, they have poor eyesight and are sometimes intoxicated (*Amnesty International* 1999a: 6).

Instruments

Unsterilized equipment is utilised both for cutting and for binding the wound. This increases the risk of infection (Carr 1997:38).

Context

FGM is generally performed outside recognised medical facilities. Post-operative care is virtually non-existent and if complications arise, families are reluctant to seek medical help (Kouba & Muasher 1985:95).

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Even before the actual procedure, the girls are already at risk. Even if they survive this round, there are other serious debilitating consequences which await them.

Physical consequences
The physical consequences are numerous and occur at different stages of a woman's life. They can be divided into the immediate, intermediate, long term, obstetrics, and sexual and psychological consequences

Immediate consequences
As an immediate response, most girls and women experience some of the following:

Excruciating pain: During the process, the dorsal nerve of the clitoris is severed, resulting in the whole genital area becoming permanently and unbearably painful. Some groups recommend cold baths as a means of anaesthetic but this is insufficient to curb the excruciating pain. The acacia thorns used to bind the wound are thought to have anaesthetic properties but this has not been proved. Even in settings where anaesthetic is available it is difficult to administer because the clitoris has a dense concentration of nerve endings and multiple painful application of the needle is required. (WHO 1994:E2; Reyners 1993:30).

Shock: The young girl may have some idea of what she is to undergo but the actual procedure is sufficient to leave girls in a state of post-operative shock (Smith & Werde 1992:22).

Haemorrhage: Excision of the clitoris involves severing the clitoral artery which has a strong flow of blood at high pressure. Haemorrhaging is the most common and life-threatening complication of FGM, as extreme or protracted bleeding can lead to anaemia or shock and death. (WHO 1996:7; Reyners 1993:30).

Transmission of infections: The flow of blood and the fact that one unsterilised instrument is used for a number of girls may result in tetanus, HIV and Hepatitis B. (Smith & Werde 1992:24; WHO 1996:7; Koso-Thomas 1987:25; Kouba & Mausher 1985:101).

Septicaemia (blood poisoning): Traditional circumcisers very often do not wash their hands before the procedure; the water that is used is often already infected. The wound is also contaminated with urine and faeces because of the binding of the legs for long periods of time (WHO 1996:7).

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Acute urine retention: The pain of the raw wound usually results in conscious retention of urine (Reyners 1993:30).

Fractures: Fracture to the femur or the clavicle, or dislocation of the hip joint is not infrequent, due to the pressure of a number of heavy women immobilising the struggling girl (WHO 1996:7).

Injury to adjacent tissue: A clumsy and poorly sighted circumciser coupled with a struggling patient can result in serious damage to areas surrounding the genitals, e.g. the urinary canal and the perineum and this can result in incontinency (Rushwan et al 1983:68).

Death: Many girls die from shock, haemorrhaging and the lack of medical attention (Koso-Thomas 1987:26).

Intermediate consequences
These effects usually occur some time after the actual procedure.

Delayed healing: Infection, irritation from urine, friction when walking or an underlying condition such as malnutrition, can lead to a purulent weeping wound which sometimes never heals (WHO 1996:9).

Pelvic infection: Pelvic infection can be caused from the infected genital wound and through the poor urinary flow (Lee 1994:39).

Painful intercourse: Due to vaginal stenosis (tight or narrow vaginal opening) and recurring damage caused by intercourse, vaginal penetration is always painful and can sometimes be impossible. This condition is non-existent in non-mutilated women (Lee 1994:39; Ozumba 1992:106).

Dysmenorrhoea: Girls experience extreme painful menstruation due to the total occlusion of the vaginal opening, accompanied by chronic stomach-aches and abnormal swelling of the stomach. A normal menstrual cycle of three to five days may continue for ten days, disabling the girl with pain and toxicity (Rushwan 1994:7; Lightfoot-Klein 1993:190).

Infection: This occurs in a number of ways. Girls try to dislodge the accumulated clots, using their infected fingernails, if the opening is large enough (Dorkenoo & Elworthy 1992:8). The consummation of marriage is bloody and as the demand for

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absolute chastity does not extend to men, HIV infected bridegrooms may infect their brides. In cases of anal sex, the risks are higher (WHO 1992:153; IAC 1990:75-91).

Urinary infection: This is caused by the retention of urine, the use of unsterilised equipment, and unhygienic dressings such as cow dung and ash, which are an excellent growth medium for bacteria (Koso-Thomas 1987:25).

Dermoid inclusions: Cysts and abscesses are caused by the edges of the wound being turned inwards. These cysts form on the scar line and also arise as the result of an accumulation of skin and products secreted by the skin, e.g. fats and hair cells. These dermoids are sometimes as large as a grapefruit (Rushwan 1994:7; Sanderson 1981:37).

Keloid formation: Slow and incomplete healing of the wound and infection leads to production of excessive connective tissue on the scar, often so enlarged that it obstructs walking (Slack 1988:452).

Long term consequences
These have extremely serious physical and social effects.

Haematoculpos: The closure of the vaginal opening by the scar tissue causes severe retention of menstrual blood. This causes the stomach to become severely enlarged (Dorkenoo & Elworthy 1992:8). This sometimes leads to the girl being murdered by her family because she is suspected of being pregnant thereby dishonouring the family (Smith & Werde 1992:23; Koso-Thomas 1987:26).

Infertility: Infertility is frequently caused by infection of the ovaries and the Fallopian tubes. A quarter of the cases of infertility in Sudan are due to FGM. Infertility is discovered many years later and is usually not seen as a direct result of FGM (Smith & Werde, 1992:22; Mustafa, 1966:304; Slack, 1988:454).

Incontinence: Frequent bladder infection often leads to chronic incontinence.. Rectal intercourse also causes anal incontinence. Women can be cast out of the community because they constantly smell of urine (Dorkenoo& Elworthy 1992:8; Koso-Thomas 1987:26; Smith & Werde 1992:23).

Calculus formation: Vaginal stones are common because of urine retention. Most women report difficulty in urination, which may take 10-15 minutes on average to two hours in extreme cases (Lightfoot-Klein 1983:356).

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Partially erected clitoris: The erection of the partially mutilated clitoris stretches the scarred erectile tissue and stimulates damaged clitoral nerve tissue. This can be painful and is mentally inhibiting because it impairs arousal which inhibits sexual foreplay and affects the development of sexuality (Smith & Werde 1992:24; WHO 1996:10).

FGM is not only debilitating to women themselves but also has far reaching implications for babies at birth.

Obstetrics
Women experience various problems associated with childbearing:

Fear: It has been reported that women eat less during pregnancy because they fear that the baby may grow too large to pass through the tiny vaginal opening (Kwaak 1992:780).

Prolonged labour: Prolonged and obstructed labour is caused by the tough scar tissue which must always be slit to allow the baby to emerge. The tough obliterated vulva loses its elasticity and if not opened in time may fatally obstruct the second stage of labour. Obstructed dilation increases the chances of asphyxia and subsequent brain damage to the infant. There are significantly more severely asphyxiated babies among mutilated women than among non-mutilated women. Women in Sierra Leone know that the scar tissue will not yield for the first child and therefore promote the belief that it is usual to lose the child at birth. An obstructed birth where both mother and child die will probably be blamed on fate or attributed to God but never to the unnatural build up of inelastic scar tissues. (WHO 1996:9; Lee 1994:40; De Silva 1989:235; Slack 1988:454).

Fistulas: These are holes that develop between the bladder and the vagina or between the rectum and the vagina and occur when there is constant pressure of the baby's head on the posterior wall of the bladder causing necrosis (death) of the vagina and bladder walls. Sufferers constantly smell of urine and this condition can put off male partners. In the unlikely event of conception recurring, the urine can poison the foetus and repeated miscarriages can occur (Koso-Thomas 1987:27).

In addition to negative physical consequences, the psychological effects can be just as debilitating for women.

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Sexual and psychological consequences

According to Smith & Werde (1992:10) all forms of FGM rob women of sexual enjoyment. The clitoris is a prime erogenous zone and when it has been reduced to scar tissue no orgasm can be released (Mclean et al 1980:5). Research suggests that although FGM does not necessarily attenuate women's sexual desire it may affect her capacity for sexual gratification showing that there is a correlation between FGM and sexual frustration (Rushwan et al 1983:91). Shandall (1967:188) found that some women in Sudan had no idea at all of orgasm. In societies where FGM is performed to curb sexual desires, sexual intercourse is not something women expect to enjoy. Women experience extreme pain and are in fact afraid of sex (Slack 1988:455). One woman, in talking about her own experiences of FGM states:

> Men invented it so that sex is just for men. Some women are cut and sewn again and again like a piece of cloth. Its cruel, its unfair, its humiliating, its unacceptable, it changes your whole life (Fritz-Patrick 1996:47).

Psychological complications including depression, anxiety, psychoses, sexual dysfunctions and marital disharmony can be lifelong (Lee 1994:40). Immediately after the procedure, girls report a sense of pride in being like everyone else, in being made clean and in having suffered without screaming (Dorkenoo & Elworthy 1992:10). But the euphoria is short-lived because the existential realities are different. Research shows that personal accounts contain references to feelings of anxiety prior to the procedure, terror at the moment of being seized and pinned down by several adult women, unbearable pain and the feeling of humiliation and betrayal by parents especially the mother who is part of the proceedings (Dorkenoo & Elworthy 1992:10). According to Grassivaro Gallo & Moro Moscolo (1984:187) most traumatised girls cannot forget the moment of FGM: they remember the precise day, the time and the circumciser.

In light of the immediate, intermediate and long term consequences, the occurrence of death seems to be ever-present in practising communities, but few are willing to disclose deaths or to admit that they are is directly related to FGM.

Death

According to WHO (1996:5) the mortality rate as a result of FGM is unknown as no accurate records are kept and death due to FGM is rarely reported. It is nevertheless estimated that 500,000 women die annually due to complications in pregnancy or childbirth following FGM (Leeuw 1993:14). Doctors in Sudan estimate that one third of girls die because of FGM and health ministers were alarmed by the increasing number of deaths due to unhygienic and unsafe methods both in rural and urban areas

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(*Daily News* 25.7.1996:20). It has also been shown that there is a positive correlation between high rates of infant mortality and countries that practice FGM (Slack 1988:450).

It is therefore difficult to estimate the number of deaths because the secrecy that enshrouds the practice makes it easy to conceal, and a very small proportion of cases with complications reach the hospitals (Dorkenoo & Elworthy 1992:8). Deaths are also rarely viewed as a direct result of FGM and are usually blamed on an enemy, evil spirits, failure to appease the ancestors or the will of God. Most frequently, the girls are blamed for being promiscuous (Kouba & Muasher 1985:103).

Any definition of torture refers to the infliction of severe physical and mental pain. It is self-evident that a woman born in a FGM practising society is subjected to intense physical and psychological pain. Pain is experienced from an early age when the actual FGM occurs. Through the occlusion of the vagina she may suffer severe abdominal pain during the onset of menses. If the wound is not properly treated she may be susceptible to various infections. On her wedding night the couple may not be able to consummate the marriage and the young bride has to be slit open again. If infection has not rendered her infertile, the young expectant mother is subjected to intense fear because she is aware that the baby cannot be delivered through the tiny aperture. During labour, she has to contend with the fact that her vagina has to be opened once more. After delivery, the mother is stitched again and this cutting and restitching will recur with each new birth. Besides the physical suffering, FGM can have substantial consequences for women's self image and sexual lives including severe depression, irritability, frigidity and feelings of incompetence (WHO 1994).

If it is accepted that FGM is torture, what then is being done nationally and internationally to protect girls and women?

Human Rights

The subordinate position historically occupied by women within the patriarchal family, country and society has meant that abuses such as FGM have been ignored for centuries. It is only recently that many anti-FGM activists have concentrated largely on health arguments to campaign against its continued practice. At present the human rights dimension is also being debated as another major reason to bring this practice to an end (*IAC Newsletter* 1993:3). As a consequence of this debate FGM is now emerging as an international issue attracting concentrated and visible efforts by organisations and institutions to address it as a human rights concern (*IAC Newsletter* 1998:2). The urgency for fighting FGM as a human rights issue is that although the conferences of the early 1990s emphasised that women's rights are human rights, these rights continue to be universally abused and infringed on a normative scale

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(*IAC Newsletter* 1997:2). Mackie (1996:999) reports that rather than diminishing with modernisation, FGM is spreading and some observers predict that eradicating the practice will take up to 300 years.

Since the Second World War, various declarations and conventions giving attention to harmful traditional practices including FGM, have been adopted. In these, FGM has been declared a violation of human rights and injurious to the health and well being of women and girls (Ministry of Foreign Affairs Danida 1996:iii). At the same time a series of international and regional conferences have taken place where the prevention and eradication of FGM was the core issue, and where strategies for national coherent policies were discussed and adopted (Ministry of Foreign Affairs Danida 1996:24). These deliberations have resulted in the following declarations:

* The Universal Declaration on Human Rights 1948;
* UN Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW) 1979;
* United nations Commission on Human Rights 1981;
* The African Charter on the Rights and Welfare of the Child 1990;
* The 1992 London Declaration on FGM;
* UN Declaration on the Elimination of Violence Against Women 1993;
* The Vienna Declaration 1993;
* International Conference on Population and Development 1994;
* Beijing Declaration and Platform for Action 1995;
* World Summit on Social Development 1995;
* African Ministries of Health 1995;
* WHO and UNICEF 1996;
* Dakar Declaration 1997;
* Addis Ababa Declaration 1997;
* The Banjul Declaration 1998.

By ratifying any one of the above international instruments on human rights, countries have in effect agreed to uphold the following:

* Everyone has the right to life, liberty and the security of the person.
* No one shall be subject to torture or to any cruel inhuman or degrading treatment or punishment.
* Every human being shall be entitled to respect for his/her life and the integrity of his/her person. No one may be arbitrarily deprived of this right.
* All forms of exploitation, inhuman or degrading punishment and treatment shall be prohibited.

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* Every individual shall have the right to enjoy the best attainable state of physical and mental health.
* The state shall ensure the elimination of any discrimination against women and also ensure the protection of the right of the women and the child as stated in the international Declarations and Conventions.
* States shall take appropriate measures to modify the social and cultural patterns of conduct of men and women in order to eliminate prejudices and customary practices which are based on the notion of inferiority or superiority of either of the sexes.

(Slack, 1988:464-5; Ministry of Foreign Affairs Danida, 1996:23; Dorkenoo, 1995b:49.)

Taking the above into account, the following rights of women are prejudiced when they undergo FGM:

* Rights afforded to women
* During FGM women are subjected to dangerous health-compromising and unnecessary operations. Women are discriminated against on the basis of the fact that they are female. Women undergo FGM because of their inferior position in FGM practising countries, where they are subjected to the control of their husband and other male members of the family.
* Right to life / Right to reproductive life
* Morbidity and mortality are reported to be high in FGM practising countries (Ministry of Foreign Affairs Danida 1996:3). It could also be argued that the reproductive organs of the woman, which give life to future generations, are mutilated thereby denying women the right to reproduce life (Slack 1988: 446).
* Right to health
* The unsanitary and unsafe conditions in which FGM is usually performed can adversely affect the physical and mental well being of the woman.
* Right not to be subjected to torture
* When young women are subjected to FGM and its complications, this can be considered as being subjected to torture and to cruel, inhuman and degrading treatment.
* Right to bodily and sexual integrity
* FGM is conducted primarily to curb the sexuality of a woman thereby denying her any sexual pleasure. Her external genitals are altered because they are considered ugly and dirty and in need of reconstruction to ensure male pleasure. By totally destroying her organs, especially the clitoris which assists in orgasm, the woman is denied the right to bodily and sexual integrity.
* Right to protection

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When states refuse to enact definite legislation on FGM or where legislation is not implemented, women are denied proper protection from the state. The fact that some communities advance FGM shows that these states have not modified the cultural and social patterns of conduct of both men and women in those communities, and this only serves to perpetuate the discrimination against women.

At what point do human rights apply universally and at what point can religion and culture take precedence over human rights? In the case of FGM, which is declared to be a violation of universal human rights by the world community (IAC 1994:28), can practising communities argue that it is an important part of their cultural and /or religious obligations and should be respected at such? Butegwa (1993:16) is of the view that:

> Human rights are universal in that they apply to all human beings. The international community of states recognise human rights for all persons throughout the world. All persons are seen as equal and valuable beings endowed with certain inalienable rights.

Maher (1996:14) states that:

> The theory of universality holds that there are human rights so fundamental to every human being that they transcend all societal, political and religious constraints. Various human rights instruments have codified this theory.

Maher (1996:4) confirms unequivocally that FGM has been identified by the UN and other international human rights organisations as a violation of those fundamental human rights such as the right to life, integrity, protection etc.

On the question of the violation of rights there are two opposing views. Protagonists of FGM declare an absolute right to cultural self-determinism and state that cultural practices that result in death cannot be attacked as a violation of human rights (Slack, 1988:439). What then, is the responsibility of the world community to those who are threatened by suffering and possible death through those practices? Anti-FGM lobbyists, on the other hand, argue that a tradition that harms and kills an individual is a violation of fundamental rights, and cultures should be barred from continuing such practices (Slack 1988:439).

Practising communities could argue that engaging in any cultural and /or religious practice is the prerogative of that society and external societies have no right to impose contrary morals and beliefs on them. It is clear that with the present persistent continuation of FGM, the concept of universal human rights has therefore not been readily accepted by all members of the international community of states. Some states with strong cultural and religious obligations opine that individual

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human rights must be subjected to traditional and/or religious rules which take precedence over everything else (Slack 1988:435). Accordingly, there is no need to respect or protect the rights of specific groups, e.g. women who undergo FGM, because practising communities do not view it as a problem or a human rights violation, but rather see it as a cultural and/or religious injunction. The Secretary General of the UN, Kofi Annan, discounts the above view and reaffirms the universal nature of human rights by stating that the rights of women and girl children are not something that could easily be explained away by cultural specificity (*IAC Newsletter* 1998:10).

At the international conference on human rights in Vienna in 1993 the indivisibility of human rights, regardless of the cultural and social context, was presented and adopted (IAC 1994:39). According to Cook (1993:45) the CEDWA convention clearly mentions that state parties should take appropriate measures including legislation to abolish existing laws, regulations, customs and practices which constitute discrimination against women. States were also urged to modify the social and cultural patterns of conduct of men and women in order to eliminate prejudices which are based on the inferiority or superiority of either of the sexes (Cook, 1993:45). The draft *Declaration on the Elimination of Violence against Women* also proposes that states should condemn violence against women and should not allow custom, tradition, religion or any other consideration to deter it from eliminating such violence (Cook 1993:46). Despite the ratification of several human rights instruments, lack of adherence in some countries remain in the name of morals, culture, religion and many myths, taboos and beliefs are the very foundation used to justify the continuation of women's inferiority and lack of protection by basic human rights (*IAC Newsletter* 1997:3). The Norwegian Prime Minister condemned FGM as 'a stain on the world map' (*IAC Newsletter* 1995:5) and mentioned that there are limits to what the international community can accept, immaterial of the deep cultural roots of certain practices. This is where universal human rights take over: FGM does not become sacrosanct just because it is part of a cultural pattern. When it comes to the question of people's right to cultural collectivity and an individual's right to self-determination, does a woman give up her rights. in order to ensure that the collective values, norms, identity and cohesiveness of the group are upheld? The President of the Court of Appeal in Togo (*IAC Newsletter* 1995:10) stated that people have the right to protect and promote their cultural values provided that t these did not violate the rights of women.

According to Freedman (1997:331), in international discourse the problem of rights is often viewed as a dichotomy between the individual verses the collective, and antagonists of women's rights characterise any efforts by women to direct the course of their own lives as a denial and rejection of their responsibility to others or the collective. Freedman (1997:331) states further that:

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> This basic conception of the 'uncontrolled' woman as a dangerous and destructive force explains, in part, why human rights, with its apparent defence of the individual as against the collective, has become so explosive, particularly when applied to women's reproduction and sexuality, the area in which control over women is guarded most jealously.

According to Lamb (1992:17), where collective identity depends on cultural solidarity, FGM is regarded as a necessary and honourable tradition which allows the young girl to become fully integrated into the community. It is therefore extremely difficult for a young woman to try and develop an individual sense of worth and identity that is in direct contrast to the collective expectation (Lamb, 1992:17). In FGM practising countries, women who refuse to undergo the procedure are ostracised, dishonoured and alienated from all ceremonial process with the group (Oukbih 1992:6). Women will be accepted as full members only if they abide by the collective will of the group and undergo the mutilation. FGM therefore still remains a prerequisite for adulthood. According to Lamb (1992:17) the individual is socialised into believing that the community, the collective, takes precedence, and that the individual's honour is bound to that of the family. Any assertion of individuality by women is readily regarded as the betrayal or reckless abandonment of the collective, and women are therefore forced to choose between a sense of themselves and the assertion of the group and its religious and cultural identity (Freedman, 1997:333).

The conflictual nature of the two versions of rights, one based on the Enlightenment ideal of the sovereign individual subject and the other grounded on the notion of collective identity cemented by cultural solidarity therefore clearly plays itself out in the complexities of FGM. Here, it illustrates total cultural conflict between the rights of the woman to bodily integrity on the one hand and the need to be accepted and integrated into the community on the other . Faced with this dilemma, there is undisputed consensus that women lack control over their sexual and reproductive lives and this is one reason why the collective values and norms predominate over women's individual rights (Garcia-Moreno & Claro 1994:47-52).

Legislation

The adoption of legislation as a means to eradicate FGM has been a subject of intense debate because of the complexities engulfing FGM. Although some countries have adopted specific legislation against FGM (*IAC Newsletter* 1998:3), other governments have been reticent to legislate against it, citing the following reasons for their reluctance:

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> the problem of ethnicity and prosecution are remnants of colonialism when FGM was seen as a national symbol of freedom and this has continued to the present time; in countries where the majority of the population practice FGM, to legislate against it may further exacerbate the situation as people will then resort to backstreet procedures thereby increasing the health risks of women and girls (Ministry of Foreign Affairs Danida 1996:25).

Notwithstanding the above fears, some countries have adopted definite steps against FGM. For instance, Burkina Faso passed a law against FGM in February 1997, in terms of which any person harming the physical integrity of the female genital organs can be imprisoned for three years. In the Democratic Republic of Congo, the Ministry of Health has declared FGM a violation of the rights and freedom of girls and women. In Egypt, after a long protracted battle, FGM has been declared as physical mutilation and is punishable by law. Activists in Ghana have succeeded in amending the Criminal Code 1960 (Act 29) to include FGM as an offence carrying a sentence of three years imprisonment. In May 1989 the government of Guinea issued a declaration against harmful traditional practices including FGM under Article 6 of the constitution which notes that the State should safeguard the moral and physical integrity of any individual (*IAC Newsletter* 1996:9). At a conference on jurisprudence of FGM in Nigeria it was recognised that FGM is a form of violence against women and denies them the right to dignity which is guaranteed in the Constitution of Nigeria. On 17 June 1999, the National assembly of Senegal passed legislation which completely bans the practice of FGM: any defaulter can be imprisoned for six months to five years (*Awaken* 1999:11). The government of Sudan integrated the anti-FGM strategy in the government's ten-year plan of action: in 1990 the President ratified the Convention on the Rights of Children which indicates the intention to eradicate FGM. Togo is the third member of the Economic Community of West African States, in addition to Ghana and Ivory Coast, to ban FGM. In Australia each state and territory was requested to develop legislation against FGM. Canada has amended the Criminal Code to prohibit FGM and any practice that causes harm to a child and which has been procured in another country. Perpetrators can be prosecuted when the child returns to Canada (Hussein 1995:2). In Paris, a 53-year old Malian women described as the 'superstar of circumcision' was convicted and sentenced to eight-year imprisonment for performing FGM on 48 young girls (Herbert 1999:5). It is estimated that 20,000 women in Germany have undergone FGM and political asylum was granted on the basis of FGM to a woman in 1996. Approximately 5000 women from Somalia have sought political asylum in the Netherlands and the Dutch government was confronted with the dilemma of medicalising FGM, but it decided to oppose all forms of FGM (*IAC Newsletter* 1994:14). In 1992 FGM was made illegal in Sweden with the signing of the FGM Act (Nath 1994:1) FGM has been illegal

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throughout the United States since March 1997, and is punishable by up to five years imprisonment (Dugger 1996b:1-2) According to US legislation, political asylum can be granted to women who fear persecution through FGM (*IAC Newsletter* 1996:10).

That Female Genital Mutilation is a widespread form of torture and a violation of human rights cannot be denied. Until recently, Western anti-FGM lobbyists were attacked for being ethnocentric, racists and cultural imperialists. It is encouraging to note that African women and men in FGM practising countries are now themselves involved in the campaign to eradicate FGM. Intensive educational programmes have had positive results in some countries. These campaigns and lobbying have influenced some governments to ban the procedure completely. Nevertheless, the *de facto* reality is that out of the 26 African countries where FGM is practised, only 12 have definite legislation against it. Some observers predict that it will take another 300 years to completely eradicate the practice: this is a serious indictment o the world community's commitment to protect young girls and women from such suffering.

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