HÖGSKOLAN DALARNA

Building a Human Rights Culture

South African and Swedish Perspectives

Karin Sporre &
H Russel Botman [eds.]

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A PROFILE OF FEMALE GENITAL MUTILATION (FGM) AND HUMAN RIGHTS

BY KATHY NADASEN

Although there is a worldwide movement towards the recognition of Female Genital Mutilation (FGM) as a form of torture and a violation of human rights there are still protagonists who believe that the practice of FGM is justified. While researching the phenomenon FGM, it has become increasingly evident to me that certain pronouncements are being made regarding the practice. For example it is often stated that FGM is not a form of torture or a human rights violation and that it is an important cultural rite which must be enforced. These statements were usually made by those who personally did not undergo FGM and/or have a vague notion of what it is. Although the sincerity of these views might be respected it is apparent that they are not always grounded on any detailed insight or knowledge regarding the procedures involved or the suffering endured. This study is an attempt to fill that hiatus. Through a detailed descriptive analysis of the phenomenon FGM I will show that FGM is indeed a form of torture.

In order to situate this study vis-à-vis FGM as a form of torture it will be instructive to provide a definition of torture. The Oxford English Dictionary defines torture as "severe physical or mental pain" and synonyms include "agony, misery, suffering, wound, deform, disfigure". Furthermore the Declaration On The Protection Of All Persons From Being Subjected To Torture And Other Cruel, Inhuman Or Degrading Treatment Or Punishment notes that "Torture constitutes an aggravated and deliberate form of cruel, inhuman or degrading treatment... " (United Nations, 1983).

Using the above as a convenient point of departure, I will a) show how and why FGM constitutes a form of torture; b) delineate which human rights are violated; and, c) list some of the legal measures that have been adopted by certain countries in relation to FGM. It must be stated at this juncture that what follows is a general overview of FGM and while some countries may perform the mildest form of FGM, in other countries the most extreme type may predominate.

Brief Historical Overview

Historically, this ancient ritual was practised in Egypt, Asia and by some Australian aboriginal tribes (Abdalla, 1982:6). It 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). It is estimated that 130 million girls and women have experienced similar practices (Toubia, 1995:5). According to FORWARD (1996:1) five women every minute and two million girls are added to this figure annually, making it, "...the widest form of brutal female torture in contemporary society."

Female circumcision or female genital mutilation (FGM) is not a nascent phenomenon and many writers attest to its ancient provenance. According to Walker & Parmar (1993:82) the first documented case was estimated to have been performed approximately 6000 years ago. This ancestral custom was known and discussed by physicians of the Roman Empire (Rathmann, 1959:115). In Egypt it dates to the Pharonic times, approximately 1500 B.C and predates the advent of Islam (Lancaster, 1997:6; Slack, 1988:443).

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). Conversely, among present day practising communities, circumcision is defended as a 'social leveller' in that it maintains equality as it is performed on all females irrespective of educational, religious or socio-economic status (Lamb, 1992:13).

FGM has survived through 6000 years because it was a closely guarded rite and was usually enshrouded in absolute secrecy and superstition. This strict adherence to the laws of secrecy made it virtually impossible to obtain definite information on FGM. Koso-Thomas (1987:20) is of the view that it was only during the 19th century that researchers were able to obtain decisive information on FGM. This conspiracy of silence is also evident in the fact that circumcised women are themselves unaware of the different types of FGM as this subject is taboo and any discussion of it 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 viz. *female circumcision, female sexual castration, female genital cutting, female genital surgery* and *female genital mutilation.* Since the early 1990's the term FGM has been adopted by the United Nations and is used internationally to refer to

traditional practices performed on women (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 human rights violation it would be pertinent at this juncture to offer a description of the various types of FGM and the procedures involved.

Incision or Prick

This is the mildest form with little chance of adverse or long term debilitating effects. The incision into the clitoris is more of a symbolic nature and does not damage any part of the female genitalia (Reyners, 1993:23). This form is encouraged by immigrants especially to the USA and Europe who seek alternative rituals to compensate for not performing FGM at all (Bartels & Haaijer, 1992:16). These alternatives ensure that they satisfy their religious and cultural obligations.

Clitoridectomy

This type 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 type is regarded as the most extreme form and is also referred to as severe circumcision. Infibulation involves the complete removal of the clitoris and the labia minora as well as the inner surface of the labia majora (Koso-Thomas, 1987:17) The two sides of the vulva are stitched together with one of the following: acacia thorns – which are soaked in 'mammal' a special oil mixture, silk, catgut, horsehair, pins or other metal objects, so that 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). Consequently the entrance to the vagina is completely obliterated, which is the initial purpose of this procedure. Nevertheless, a false vaginal opening, which eventually is no larger

than a corn kernel or a grain of rice (Warsame et al, 1985:2), is maintained by the insertion of a sliver of wood, reed, matchstick or straw to allow for the flow of urine and menstrual blood and in some cases women have actually conceived through this tiny aperture (WHO, 1996:2; Allen, 1995:1; Walker & Parmar, 1993:367).

Toubia (1995:10) mentions that the opening:

> [...] is sometimes as small as the head of a match stick or the tip of the little finger. 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.

The smaller the hole the more prestigious the procedure. The family honour is dependent on making the opening as small as possible which increases the value of the girl which in turn raises 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 in order to allow a little blood to flow. 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 the marriage, once the husband or a female member of the family has inspected and confirmed that the wife is a virgin or 'closed' (Bartels & Haaijer, 1995:84). In some instances where the opening is the size of a pinhole, penetration can take up to fifteen days or more with much pain and bleeding (WHO, 1994). Often, full penetration only occurs after three to 24 months (Khalifa, 1994:21). If the husband is still unable to attain full penetration, he uses either the assistance of certain instruments such as a knife, piece of glass, or his fingernail (Slack1988: 453) which can result in further complication, or the circumcisers and other female members are approached to assist.

In yet a different tribe the husband's mother or grandmother measures his penis, makes a wooden replica of the same size and cuts the infibulated opening of the bride accordingly (Slack, 1988:453). How this is of assistance is not clear. In still another variation, the bridegroom has a friend who is present during the wedding night. While the friend ties down the bride, the groom

opens the bride with a razor either upwards or downwards. Thereafter, sexual intercourse occurs (Khalifa 1994:16–34). Whether the friend is still present at this point is also not clear.

Another reason for defibulation is that during birth it is impossible for the foetus 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). It is a simulation 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)

Reinfibulation is therefore seen as a symbolic regeneration of purity and honour. 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). Reyners notes that the term *'vulva reconstruction'* is also used but he argues that this is not a suitable description as it involves reconstructing the tiny aperture only and does not entail the re-construction of the vulva to its original form (Reyners, 1993:26). In traditional societies because virginity is highly prized, it is believed that this physical state could be regained through reinfibulation. Widows and divorcees therefore often 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).

From the above account it takes little imagination to note that whatever the type of FGM there is certainly pain, anxiety and suffering that accompanies the procedure.

Other Practices

Besides the above mentioned types of FGM, the World Health Organisation recommends that the following debilitating 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 herbs into the vagina with the aim of tightening or narrowing the vagina
- any other procedure that falls under the definition of female genital mutilation. (WHO, 1996:6)

Conditions for the practises

To carry out any of the above procedures Hosken (1999:1) adamantly states that it requires a great deal of skill, good light, proper surgical tools, a correctly anaesthetised body together with a detailed knowledge of the female anatomy. The reality is that the procedure is ordinarily performed by a variety of untrained persons which include barbers, elderly female laypersons, priestesses, male priests, wandering gypsies, fortune-tellers, blacksmiths and also 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, pottery and razor blades are often used (WHO, 1996:2; Pielou, 1998:87). These instruments are regularly reused immediately on several girls without even rudimentary cleansing thereby increasing the risk of the transmission of a number of diseases and infections. Neither anaesthetic nor antiseptic is utilised. Consequently the young girl is fully conscious of what is happening to her. The girls are required to undergo the full procedure without any traces of fear or crying, if they do they bring dishonour to their families and some societies stipulate that the girls must dance after the procedure (Burnett, 1997:1).

Some societies have certain means of desensitising the affected area e.g. initiates are commanded to sit in a cold stream so that the genital areas are numbed in order to decrease the initial pain, the actual pain is therefore experienced later (Koso-Thomas, 1987:2). In other societies the clitoris is cauterised with fire or stung repeatedly with nettles to deaden the nerve endings (Morgan & Steinem, 1984:292). Another variation to this procedure is that prior to the excision, each girl is given a stupefying mixture to drink so that the immediate effects are not fully experienced (Koso-Thomas, 1987:22). The amount of flesh that is removed also depends on the dexterity and skill of the circumciser, her eyesight, the sharpness of the instruments and the co-operation of the initiate (Koso-Thomas, 1987:23). A girl who resists or struggles may have other parts of her genitalia accidentally removed. 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). After the procedure the girl's legs are tied together with ropes of goatskin. The girl is bandaged from the knees to the waist and is left undisturbed for two weeks. She remains immobilised during this period and any excrement remains in the bandage (Hosken, 1999:3).

Besides experiencing the shock and trauma of the above mentioned procedure the young girl or woman is then faced with the possibility of enduring some debilitating effects which are the direct result of the mutilation.

It is my contention that the above constitutes an aggravated form of cruel, inhuman or degrading treatment.

FGM – a form of torture

Consequences of FGM

Before embarking on the negative effects of FGM it would be pertinent to ascertain if there are any positive effects that can be ascribed to FGM.

Arguments surrounding the health benefits of FGM are not unique to Africa. In the mid-19th century some Western countries also used various forms of FGM to ostensibly cure a variety of female sexual 'deviancies' e.g. nymphomania, excessive masturbation or the unnatural growth of the clitoris (Abusharaf, 1997:19). A circular reasoning in practising countries is that FGM is credited with curative powers and that a direct positive consequence of FGM is that women seldom complain of ill health, and where there is any indication of ill health, this disappears after the procedure (Koso-Thomas, 1987:9). Other ostensible benefits are that it enhances fertility and makes childbirth easier (Robertson, 1996:622). But these pronouncements are not based on any medical facts but rather are enshrouded in the mysticism of a particular cultural or religious belief system (Amnesty International, 1999a:6). Health benefits are therefore not the most frequently cited justification for FGM. A more likely explanation that is offered is that FGM prepares women to be strong and uncomplaining about illness (Amnesty International, 1999a:6). If women in traditional societies are therefore socialised into believing that they are strong and can endure any form of illness then very little of their actual suffering will be reported. This is further exacerbated by the fact that the com-

plications of FGM are not seen as a direct result of the procedure but is viewed as a natural course of a woman's life. As such, serious life threatening infections are insufficient reasons for defibulating an unmarried girl as this will decrease her chances of marriage or lower her bride price (van den Berg, 1992:16). It seems therefore that in practising communities suffering and death are the more acceptable choices.

Most practising countries are silent about any negative consequences of FGM. The secrecy surrounding FGM, the delicacy of the subject, and the protection of the circumcisers make it difficult to collect accurate data on the effects of FGM. Where information has been collected it is done retrospectively, i.e. a long time after the event and women in traditional societies do not readily associate their illness to something that occurred during their childhood (Amnesty International, 1999a:3). Women therefore have different perceptions of illness than researchers. Symptoms that researchers ascribe directly to FGM may be considered 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). These women do not see the link between FGM, the pain, infections and infant mortality, situations which she may experience only later in life (WHO, 1994:B1; Amnesty International, 1999a:3). 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 part 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, it is noted that the physical damages of FGM and the subsequent harm that follows is indisputable medically (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 a growing number of 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 viz.:

Circumcisers

Many of the circumcisers have no medical training or formal knowledge of the female anatomy, they have poor eyesight and are sometimes intoxicated and the damage that could result could be immeasurable (Amnesty International, 1999a:6).

Instruments

Unsterilized equipment is utilised both for cutting and binding of the wound. This increases the propensity and the transference of infections (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 broach this sensitive subject with medical personnel (Kouba & Muasher, 1985:95).

So even before the actual procedure, the girls are already potentially at risk, which is unavoidable. 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. As such, it can be divided into the immediate, intermediate, long term, obstetrics, and sexual and psychological consequences. While the immediate consequences are experienced during the performance of the different types of circumcision, the intermediate, long term and other consequences are usually experienced with the most severe forms of circumcision.

Immediate consequences

As an immediate response to having one's genitals cut off most girls and women experience at least 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 anaesthetising the area but this is insufficient to curb the excruciating pain. The acacia thorns that are used to bind the wound are thought to have anaesthetic properties but this has not been proved medically. Even in settings where anaesthetic

is available it is difficult to administer because the clitoris has a dense concentration of nerve endings and to therefore anaesthetise the area, 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 of having parts of her hacked off, coupled with unimaginable pain and the feeling of flowing blood, is sufficient to leave girls in a state of post-operative shock (Smith & Werde, 1992:22).
- *Haemorrhage*: Haemorrhaging and FGM are inextricably connected. Excision of the clitoris involves severing the clitoral artery which has a strong flow of blood at high pressure. Packing, tying or stitching to curb the bleeding may prove to be ineffective. Haemorrhaging is the most common and life-threatening complication of FGM as extreme or protracted bleeding can lead to anaemia or shock and in extreme cases, death. (WHO, 1996:7; Reyners, 1993:30).
- *Transmission of infections:* Unsterilised instruments commonly result in the transmission of infections, e.g. tetanus which can be severe enough to result in death. Noting that the procedure results in the flow of blood and in light of the fact that one instrument is used for a number of girls this may result in the transmission of blood borne diseases, e.g. HIV and Hepatitis B. (Smith & Werde, 1992:24; WHO, 1996:7; Koso-Thomas, 1987:25; Kouba & Mausher, 1985:101).
- *Septicaemia* (blood poisoning): The traditional circumcisers very often do not wash their hands before the procedure; the water that is utilised is often already infected and this is transferred to the open wound. The wound is also contaminated with urine and faeces because of the binding of the legs for long periods of time (WHO, 1996:7).
- *Acute urine retention:* The pain and the burning sensation on the raw wound usually result in conscious retention of urine (Reyners , 1993:30).
- *Fractures*: Fracture to the femur, the clavicle or dislocation of the hip joint is not infrequent due to the pressure of a number of heavy women in immobilising the struggling girl (WHO, 1996:7).
- *Injury to adjacent tissue:* A circumciser not gifted with precision and with poor eyesight, coupled with a patient who physically wrestles against the procedure, can inflict serious damage to areas surrounding the genitals, e.g. the urinary canal and the perineum and can result in incontinency (Rushwan

et al, 1983:68).

- *Death*: Quite a number of girls are estimated to die due to shock, haemorrhaging and the lack of immediate medical attention (Koso-Thomas, 1987:26).

Intermediate consequences

These effects usually occur some time after the actual procedure.

- *Delayed healing:* Due to infection, irritation from urine, friction when walking or an underlying condition, e.g. malnutrition, can lead to a purulent weeping wound which sometimes never heal (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 vigorous and violent thrusts, 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).
- *Dysmennorhae:* 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:* There are a number of ways in which the girls can become infected. Infections often arise as a result of girls trying 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 the demand of absolute chastity does not extend to men. Thus HIV infected bridegrooms may have an increased risk of infecting their 'chaste' brides and in instances where anal sex is an alternative the risks are higher (WHO, 1992:153; IAC, 1990:75–91).
- *Urinary infection:* This is caused by the retention of urine and the usage of unsterilised equipment and unhygienic dressing, such as cow dung and ash. These dressings are excellent growth medium for the bacteria which ascends into the bladder and kidney (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 could also arise as a 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 leading to production of excessive connective tissue on the scar. The keloid are so enlarged that it obstructs walking (Slack, 1988:452).

Long term consequences

These long term consequences 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. According to Dorkenoo & Elworthy (1992:8):

  > Dr Ollivier [...] describes a 16 year old girl brought to the hospital with unbearable abdominal pains. She had not menstruated for several months and had not had intercourse, but her abdomen was swollen and sensitive, with the signs of a uterus in labour. She was infibulated, with a minuscule opening. Penetration would appear to have been impossible and there was no sign of beating of a foetal heart. Dr Ollivier performed a disinfibulation [...] and released 3.4 litres of blackish foul smelling blood.

  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 the infection of the ovaries and the Fallopian tubes. It is reported that a quarter of the cases of infertility in Sudan is 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).
- *Incontinency:* Frequent bladder infection often leads to chronic urine incontinence where women are continually dribbling urine. Rectal intercourse also causes anal incontinence. These incontinences can lead to the casting off or alienation of these women from the community because they are constantly smelling of urine (Dorkenoo& Elworthy, 1992:8; Koso-Thomas; 1987:26; Smith & Werde, 1992:23).
- *Calculus formation:* Vaginal stones are common because of the retention of urine. Most women report substantive difficulty in urination:

  > The average period of time required by an infibulated person to urinate is 10–15 minutes. She must force it out drop by drop. Some women report requiring up to 2 hours to empty their bladders. (Lightfoot-Klein, 1983:356)

- *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 effects the development of sexuality (Smith & Werde, 1992:24; WHO, 1996:10).

Years after the procedure women still suffer immense pain as reported by Scott (1995:9):

> When the weather is too hot, its like fire between the legs, its torture, inside it is a burning sensation.

Obstetrics

FGM is not only debilitating to women themselves but also has far reaching implications for babies at birth. Women experience various problems associated with childbearing:

Fear

It has been reported that women eat less because they fear that the baby may grow too large to pass through the tiny vaginal opening. Many women drink only sweet tea or eat small stones which can be detrimental to the health of both mother and child (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 timorously may fatally obstruct the second stage of labour. Dilation is obstructed increasing the chances of asphyxia and subsequent brain damage to the infant. Such children are unable to fulfil their intellectual and social potentials. It is noted that there are significantly more severely asphyxiated babies among mutilated women than 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 God's wishes but never on the unnatural build up of inelastic scar tissues. (WHO, 1996:9; Lee, 1994:40; De Silva, 1989:235; Slack, 1988:454).

Fistulas

Fistulas are holes that develop between the bladder and the vagina or between the rectum and the vagina. This occurs 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 from this condition constantly smell of urine and this offensive malodorous condition can put off any potential male

partners. In the unlikely event of conception recurring the urine can poison the foetus and repeated miscarriages can occur (Koso-Thomas; 1987:27).

Women do not only have negative physical consequences but the psychological effects can be just as debilitating.

Sexual and psychological consequences

According to Smith & Werde (1992:10) all forms of FGM effectively rob women of experiencing sexual enjoyment. The clitoris with its specific sensory apparatus is a prime erogenous zone. 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).

According to one woman (Housten, 1979:51):

> [...] we are not allowed to show any pleasure in lovemaking. That is the reason for clitoridectomy – so that we don't have any desires. But if it were to happen that you felt something you couldn't say anything, since that would mean you had had a previous experience – that you were a bad woman. So even if you do feel something you just keep quiet.

Shandall (1967:188) found that some women in Sudan had no idea at all of orgasm and that women were also meant to enjoy sex. In societies where FGM is performed to curb sexual desires, sexual intercourse is not something women expect to enjoy. Women experience extreme pain and this takes away any joy they might experience and women are in fact afraid of sex (Slack, 1988:455). Waris (Fritz-Patrick,1996:47) 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, it's unacceptable, it changes your whole life.

Psychological complications are considered to be life long. Depression, anxiety, psychoses, sexual dysfunctions and marital disharmony form part of the psychological consequences (Lee, 1994:40). Immediately after the procedure there is reference to the experience of pride in being like everyone else, in being made clean and in having suffered without screaming (Dorkenoo & Elworthy, 1992:10). How can a child scream if she is made to believe that if she does her mother will die? (McLean, 1980:10). But these feelings of euphoria are short lived because the existential realities reveal a different picture. Research show

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 huge 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). All the above anxieties are further exacerbated by the fact that they are forced to watch the mutilation of other girls. According to Grassivaro Gallo & Moro Moscolo (1984:187) most girls cannot forget the moment of FGM, they remember the precise day, the time and the circumciser. This procedure is therefore a traumatic experience and leads to life long nightmares and fears.

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 the extent of death and to admit that it is directly related to FGM.

Death

According to WHO (1996:5) the mortality rate of females as a consequence of FGM is unknown as inaccurate records are kept and death due to FGM are rarely reported. It is nevertheless estimated that 500,000 women die annually due to complications in pregnancy or childbirth following FGM (Leeuw van der, 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 (*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 since the secrecy that enshrouds the practice makes it easier to conceal unsuccessful attempts from strangers and health authorities and a very small proportion of cases with complications reach the hospitals (Dorkenoo & Elworthy, 1992:8). Deaths are also rarely seen as a direct result of FGM and are usually blamed on the act of either an enemy, evil spirits, failure to appropriately appease the ancestors or it may be the will of God. The most common reason is that the girls are blamed for being promiscuous (Kouba & Muasher, 1985:103).

The extensive description above is necessary in order to lay the basis for determining whether I can show that what the women undergo, the agony, anxiety, prolonged suffering, the psychological turmoil is tantamount to a form of torture.

FGM – a form of torture – conclusions so far

In light of one of the meaning of torture whereby torture is constituted by the infliction of severe physical and mental pain it will follow from the above that a woman exposed to FGM is subjected to a form of torture. This torture, in my view, is experienced throughout her life. Pain is experienced from an early age when the actual FGM occurs. This pain is aggravated by the fact that the woman is fully conscious and no anaesthetic is used. If any infections occur she is subjected to serious suffering, misery and agony. Through the removal of her genitals she is clearly deformed and disfigured. Then through the occlusion of the vagina she may suffer severe abdominal pain during the onset of menses. 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, notwithstanding the trauma of giving birth, she has to contend with the fact that her vagina has to be opened once more. After delivering her child 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 and it manifests itself as severe depression, irritability, frigidity and feelings of incompetence (WHO, 1994).

From the aggravated and prolonged suffering described above there is little doubt that FGM is indeed a form of torture. What then is being done nationally and internationally to protect girls and women from such practices?

Human Rights

Violations of 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 the present moment 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 with concentrated and visible efforts of organisations and institutions to address it as a human rights concern (IAC Newsletter, 1998:2). The urgency to fight

FGM as a human rights issue is that although the conferences of the early 90s have brought into sharp relief that women's rights are human rights, these rights still continue to be universally abused and infringed on a normative scale (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 have been adopted where increased attention has been given to harmful traditional practices which have 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). Since the late 1970's a series of international and regional conferences and meetings have taken place where the prevention and eradication of FGM was the core issue and strategies for national coherent policies were discussed and adopted (Ministry of Foreign Affairs Danida, 1996:24). These declarations include, UN Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW) 1979; United nations Commission on Human Rights 1981; The 1992 London Declaration on FGM; UN Declaration on the Elimination of Violence Against Women 1993; International Conference on Population and Development 1994; Beijing Declaration and Platform for Action 1995; African Ministries of Health 1995; Dakar Declaration 1997; Addis Ababa Declaration 1997 and 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.
- 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, it is noted that the following rights of women are violated when they undergo FGM:

A. Rights afforded to women

During FGM women are subjected to dangerous health comprising and unnecessary operations. Women are discriminated against on the basis of the fact that they are female, men do not have to undergo the same procedure. Women undergo FGM because of their inferior positioning in FGM practising countries, they are subjected to the control of their husband and other male members of the family.

B. Right to life / Right to reproductive life

Morbidity and mortality are reported to be quite high in FGM practising countrie (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).

C. Right to health

When FGM is performed, untrained old people with poor eyesight generally do it in unsanitary conditions and and these factors can adversely affect the physical and mental well being of the woman.

D. Right not to be subjected to torture

When young women are subjected to having their external genitals removed without any antiseptic and then stitched together with acacia thorns and being subjected to the disastrous effects of complications, this can be considered as being subjected to torture and to cruel inhuman and degrading treatment.

E. 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 it is considered 'ugly' and 'dirty' and it should be reconstructed so as to ensure that the male receives more pleasure. By totally destroying her natural organs, especially the clitoris which assists in orgasm, the woman is denied the right to bodily and sexual integrity.

F. Right to protection

By states refusing to enact definite legislation on FGM or where legislation is not properly implemented women are denied proper protection from the state. The fact that some communities advance FGM show 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.

A major shortcoming of international declarations and instruments is the lack of enforcement mechanisms by which the above rights can move from theory to practice. States in which FGM is practised are hardly likely to embark upon incorporating these international instruments into their domestic law which may entail the need for greater resources or which may stir up political controversies as a result of perceived state interference in cultural or religious practices. Nevertheless, we shall note later that some states have indeed legislated against the practice, but the question (which falls outside the scope of this study) still remains "how does one ensure the enforcement of these declarations?

Religious communities and the rights of the individual

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 the 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 the UN and other international human rights organisations have identified FGM 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, argue that traditions 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 practices 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 have 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 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, Mr 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 CEDAW 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 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 the practice that countries can expect the international community to accept, immaterial of the deep cultural roots these practices may have. According to her (IAC Newsletter, 1995:5) this is where universal human rights take over because FGM does not become sacrosanct just because it is part of a cultural pattern.

In the case of FGM, 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 to life, bodily and sexual integrity, protection, health, etc. in order to ensure that the collective values, norms, identity and cohesiveness of the group is upheld?

One response to this question is the following from The President of the Court of Appeal in Togo (IAC Newsletter, 1995:10) stating that:

> People have the right to protect and promote their cultural values but such moves should 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 cause of their own lives as a denial and rejection of their responsibility to others or the collective. Freedman (1997:331) states further that:

> 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 therefore 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 to the rights and purity of adulthood. According to Lamb (1992:17) the individual is socialised into firmly 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 the 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 so clearly plays itself out in the complexities of FGM: where 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).

Having noted the above dilemmas regarding religious/cultural dominance versus individual rights, women's rights versus collective/community rights etc what then have particular states done to ensure the protection of women?

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:

- the problem of ethnicity and prosecution are remnants of the colonial time and FGM was seen as a national symbol of freedom and this has remained to the present time; and
- 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 even further (Ministry of Foreign Affairs Danida, 1996:25).

Notwithstanding the above fears some countries have adopted definite steps in legislating against FGM. For instance, Burkina Faso has passed a law against FGM in February 1997 and 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 declared that FGM is 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 and can have 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 adopted that FGM is a form of violence against women and is against the right to dignity which is guaranteed in the Constitution of Nigeria. On June 17, 1999 the National assembly of Senegal effectively passed legislation viz. Article 299, which completely bans the practice of FGM and 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. Perpetuators can be prosecuted when the child returns to Canada (Hussein 1995:2). In Paris, 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) Since the President of the USA signed the Omnibus Appropriation Bill in 1996, FGM has become illegal in all states as from March 1997, punishable by up to five years imprisonment (Dugger, 1996b:1–2) According to the US legislation political asylum can be granted to women who 'fear' persecution through FGM (IAC Newsletter 1996:10)

That the above countries have deemed it necessary to have laws relating specifically to FGM supports the thesis that FGM is harmful and causes severe physical or mental pain.

Conclusion

From my description above I am prepared to state that FGM is a form of torture and a human rights violation. It is encouraging to note that some countries have legislated against the continuation of the practice. Until recently Western anti-FGM lobbyists were attacked for being ethnocentric, racists and cultural imperialists for attempting to protect young girls and women from FGM. It is encouraging to note that African women and men in FGM practicing countries are now themselves involved in the campaign to eradicate FGM. As such, intensive educational programmes have had positive results in some countries. These campaigns and lobbying have influenced some governments to ban the procedure completely. But the *de facto* reality is that out of the 26 African countries that practice FGM approximately 12 have taken definite legislation against FGM. If it were to be true as some observers have predicted that it will take another 300 years to completely eradicated the practice then this is a serious indictment on the world community to continue to allow young girls and women to endure such suffering.

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