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## Circumcision or Mutilation - Voluntary or Forced Excision - Extricating the Ethical and Legal Issues in Female Genital Ritual

Obiajulu Nnamuchi

*Centre for Health, Bioethics and Human Rights, Enugu, Nigeria*

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### Recommended Citation

Obiajulu Nnamuchi, *Circumcision or Mutilation - Voluntary or Forced Excision - Extricating the Ethical and Legal Issues in Female Genital Ritual*, 25 J.L. & Health 85 (2012)  
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**“CIRCUMCISION” OR “MUTILATION”?  
VOLUNTARY OR FORCED EXCISION?  
EXTRICATING THE ETHICAL AND LEGAL ISSUES  
IN FEMALE GENITAL RITUAL**

OBIAJULU NNAMUCHI\*

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I. INTRODUCTION

The genesis of the procedure most commonly described as female circumcision (FC) or female genital mutilation (FGM) is rooted in antiquity.<sup>1</sup> The ritual has

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\* Obiajulu Nnamuchi, LL.B (NAU, Nigeria), LL.M (Notre Dame), LL.M (Toronto), M.A. (Louisville), S.J.D. (Loyola, Chicago). Interim President & Chief Counsel, Centre for Health, Bioethics and Human Rights, Enugu, Nigeria. To all those whose suggestions and critiques, in one way or another, aided the refinement of the ideas espoused in this paper, particularly Prof. Nancy N. Potter and colleagues at the University of Louisville Bioethics and Medical Humanities Program where this paper was first presented, I owe an immeasurable debt of gratitude. And to Prof. Mark A. Rothstein, for his extraordinary support, colleagues at the Loyola University Chicago Law School, and AdaObi Nnamuchi, my able assistant, I am eternally grateful. All errors and omissions, of course, remain exclusively mine.

<sup>1</sup> Though the origin of FGR is unknown, the Greek historian Strabo found evidence of the procedure among ancient Egyptians in early first century A.D. *See* DAVID L. GOLLAHER, *CIRCUMCISION: A HISTORY OF THE WORLD’S MOST CONTROVERSIAL SURGERY 195-96* (2000). His finding was corroborated in a fourth century papyrus from St. Ambrosius of Milan, which recorded, as did Strabo, that Egyptians circumcised both males and females. *Id.* From this early beginning, FGR spread to different parts of Africa, the Middle East, Asia, and Latin America. Rationales for the practice are as diverse as the communities in which it has been firmly established, but practitioners typically justify their action as a religious or cultural prescription aimed at promoting cleanliness, ensuring virginity, preventing promiscuity, enhancing aesthetic beauty of the vagina/surrounding tissues, and improving marital prospects. *See* ELLEN GRUENBAUM, *THE FEMALE CIRCUMCISION CONTROVERSY: AN ANTHROPOLOGICAL PERSPECTIVE* (2001) (providing a comprehensive analysis of the cultural context of FGR and its underlying rationales and assumptions).

Historically, the procedure was known, like its male counterpart, simply as circumcision or “FC”; but over the last two decades, additional terms, carefully crafted to serve one agenda or the other, have been added to the corpus of descriptive terms. The pejorative term “FGM” is most widely used, though many commentators have explicitly rejected its usage, choosing,

existed for centuries amongst different cultures but is currently practiced primarily in twenty-eight African countries, parts of the Middle East, and increasingly among immigrant populations in Europe, North America, and Australia.<sup>2</sup> The World Health Organization (WHO) estimates that between 100 and 140 million girls and women have undergone the procedure,<sup>3</sup> out of which 91.5 million are in Africa.<sup>4</sup> Of these 91.5 million girls and women, more than half are in three countries ranking amongst the highest in prevalence rates: Egypt, Ethiopia, and northern Sudan.<sup>5</sup> Desegregated figures show that the prevalence rates vary dramatically amongst practicing nations, from as high as 96% in Egypt to as low as 0.6% in Uganda.<sup>6</sup> Globally, around two million girls are at risk of undergoing the procedure annually.<sup>7</sup> Because FGR is inextricably embedded in the cultural ethos of practicing nations, outsiders' attempts to reconceptualize the practice as unnecessary, unjustifiable, or harmful have proved largely unfruitful. Even in countries that have been successfully goaded into criminalizing the procedure, often by external forces, compliance has not matched

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instead, to adopt more culturally sensitive appellations. Cook and colleagues, for instance, prefer "female cutting," which they perceive to be neutral and less offensive to people whose culture endorses the ritual. See REBECCA J. COOK ET AL., *REPRODUCTIVE HEALTH AND HUMAN RIGHTS: INTEGRATING MEDICINE, ETHICS AND LAW* 263 (2003). Similarly, Gruenbaum uses "FC," although somewhat grudgingly, "to avoid the connotations of evil intentions or wanton mayhem associated with the term "mutilation." See *id.* at 4. Nancy Ehrenreich & Mark Barr, on the other hand, settled on three terms, namely, "female genital cutting," "FC," and "female genital surgery," unapologetically rejecting "FGM," which they consider unnecessarily inflammatory. See *Intersex Surgery, Female Genital Cutting, and the Selective Condemnation of "Cultural Practices,"* 40 HARV. C.R.-C.L. L. REV. 71, 72 n.4 (2005).

While I share these sentiments, in that I consider "FGM" to be an unnecessarily offensive, outrageous and counterproductive descriptive term, the nature of my discourse makes employing the term imperative since a critical part of my main argument centers on the term itself. But, aside from specific circumstances where a different term would be clearly inappropriate, I endorse the terms identified above, in addition to "female genital ritual" (FGR)—a designation which is used throughout this discourse as a constellation of all forms and versions of the procedure.

<sup>2</sup> E. Turillazzi & V. Fineschi, *Female Genital Mutilation: The Ethical Impact of the New Italian Law*, 33 J. MED. ETHICS 98, 98 (2007).

<sup>3</sup> *Female Genital Mutilation, Fact Sheet No. 241*, WHO 2 (2001), <http://www.who.int/mip2001/files/2270/241-FemaleGenitalMutilationforMIP.pdf> [hereinafter WHO].

<sup>4</sup> P. Stanley Yoder & Shane Khan, *Numbers of Women Circumcised in Africa: The Production of a Total*, MACRO INTERNATIONAL INC. (Mar. 2008), <http://www.measuredhs.com/pubs/pdf/WP39/WP39.pdf>. But note that the figure excludes girls younger than 10 and covers only 20 countries for which data was available. Compared to earlier reports, prevalence is declining. For instance, although Egypt remains the country with the highest proportion of FGR, the figure is falling—from 97% in 1998 to 95.8% in 2005—whereas the current prevalence rate of 0.6% in Uganda represents a steep drop from the 1998 level of 5%. See *Female Genital Mutilation: An Overview*, WHO (1998), <https://apps.who.int/dsa/cat98/fgmbook.htm> (last visited Dec. 29, 2011) (providing 1998 estimates).

<sup>5</sup> Yoder & Khan, *supra* note 4, at 7.

<sup>6</sup> *Id.* at 8.

<sup>7</sup> WHO, *supra* note 3.

expectation.<sup>8</sup> For centuries, the practice, like many others that are culture-driven, was not a subject of international concern—that is, until recently. There is a growing consensus that the influx of Africans and Arabs into Western countries contributed to international involvement in what, heretofore, was generally regarded as a legitimate cultural practice worthy of deference and respect. With escalating conflicts and internal strife in many African and Middle Eastern countries, an appreciable number of inhabitants are forced to seek refuge in Western countries. One of the more visible results of this tragic exodus was that the aftermath of a cultural ritual, once confined to distant lands, began to be seen in social welfare offices and health clinics in Europe and North America. And this, not surprisingly, raised some eyebrows.

In a move reminiscent of the scramble for the partition of Africa, commentators of various disciplines are, with the publication of each new “finding,” edging closer to unanimity in their strident denunciation of the ritual.<sup>9</sup> Their condemnations fall

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<sup>8</sup> A good illustration is Uganda’s Prohibition of Female Genital Mutilation Act 2010, which became operational April 9, 2010. The law, which severely punishes activities related to FGR (a term of imprisonment not exceeding ten years for anyone who performs the ritual and not less than five for procuring, aiding, and abetting or attempting the ritual), has only succeeded in driving the practice underground. See Fredrick Womakuyu, *FGM Thrives Despite Government Ban*, NEW VISION (Uganda) (Jan. 7, 2011), <http://www.newvision.co.ug/D/9/183/743102> (reporting that “[g]irls are now being mutilated secretly in huts and in caves. They are also cut in the wee hours of the morning. Strangers are no longer welcome at the venues.”); see also Alison Slack, *Female Circumcision: A Critical Appraisal*, 10 HUM. RTS. Q. 437, 478 (1988) (noting that one of the reasons anti-FGM legislation failed in Kenya, Sudan, and Egypt is that “[m]ost of the laws were the by-products of external pressure and did not reflect the desire of the local people to suppress the tradition”).

<sup>9</sup> What I have in mind approximates Thomas Pakenham’s description of the invaders of the continent “as outsiders of one kind or another but no less ardent” in their crusade, a crusade “they all conceived of . . . in terms of romantic nationalism,” hoping to “save Africa from itself.” Replace “romantic nationalism” with “cultural romanticism” and the similarity with the tenor of a vast majority of commentaries against FGR becomes striking. See *THE SCRAMBLE FOR AFRICA: WHITE MAN’S CONQUEST OF THE DARK CONTINENT FROM 1876-1912*, xxii (1992). As a University of Chicago anthropologist elucidates:

[i]f you read and believe those statements or most of the other things you find written about “FGM” in the popular press (which, for the most part, are recapitulations of the advocacy literature) then you must conclude that Africa is indeed a “Dark Continent,” where for hundreds, if not thousands of years, African parents have been murdering and maiming their daughters and depriving them of the capacity for a sexual response. You must believe that African parents (mothers and fathers) are either (a) monsters (“mutilators” of their children); or (b) fools (who are incredibly ignorant of the health consequences of their own child rearing practices and the best interests of their children); or (c) prisoners of an insufferably dangerous tradition that they themselves would like to escape, if only they could find a way out; or else (d) that African women are weak and passive and live under the patriarchal thumb of cruel, loathsome or barbaric African men.

See Richard Shweder, *When Cultures Collide: Which Rights? Whose Tradition of Values? A Critique of the Global Anti-FGM Campaign*, GLOBAL JUSTICE AND THE BULWARKS OF LOCALISM: HUMAN RIGHTS IN CONTEXT 181, 184 (Christopher Eisgruber & Andras Sajo eds., 2005).

under three broad strands: the ritual is extremely hazardous to the physical and mental health of affected girls and women; the ritual violates their human right to bodily integrity insofar as fully informed consent was neither sought nor obtained; and the ritual perpetuates gender inequality and subjugation in practicing communities.<sup>10</sup> Although there are stark differences between FGM and FC, there has been a tendency to lump them together and proceed, on the basis of the conflation, to prescribe the same response to the two procedures: eradication.<sup>11</sup>

This Article is a repudiation of the one-size-fits-all approach. It argues that owing to several factors, particularly the unbridled passion surrounding the subject, several important issues have fallen prey to intensely misguided pejoration, mischaracterizations, and distortions; yet, extricating and coherently realigning these issues in a meticulously nuanced way is a key component of resolving what is already a highly-charged polemic. Unlike previous discourse on the subject, this Article will not defend either procedure, will not lump the procedures together, and, as has previously been achieved, perhaps unwittingly, will not contribute to further obfuscation of the subject.<sup>12</sup> Instead, this Article has two objectives: first, to classify

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<sup>10</sup> Carla Makhoul Obermeyer, *Female Genital Surgeries: The Known, the Unknown, and the Unknowable* 13 MED. ANTHROPOL. Q. 79, 79 (1999).

<sup>11</sup> The claims made here pertaining to FC apply with equal force to other less invasive forms of FGR (insignificant cuts), such as pricking the clitoris to draw blood. Their shared characteristic is that they are generally harmless and are therefore worthy of consideration as alternatives to more severe forms of FGR.

<sup>12</sup> There is vast literature on the subject. See generally ASMA EL DAREER, *WOMAN, WHY DO YOU WEEP? CIRCUMCISION AND ITS CONSEQUENCES* (1982); EFUA DORKENOO, *CUTTING THE ROSE: FEMALE GENITAL MUTILATION: THE PRACTICE AND ITS PREVENTION* (1994); EFUA DORKENOO & SCILLA ELWORTHY, *FEMALE GENITAL MUTILATION: PROPOSALS FOR CHANGE* (1992); *FEMALE CIRCUMCISION: MULTICULTURAL PERSPECTIVES* (Rogaia Mustafa Abusharaf ed., 2006); ELLEN GRUENBAUM, *supra* note 1; Ylva Hernlund, *Cutting Without Ritual and Ritual Without Cutting: Female "Circumcision" and the Re-Ritualization of Initiation in the Gambia*, *FEMALE "CIRCUMCISION" IN AFRICA: CULTURE, CONTROVERSY, AND CHANGE* 235-253 (Bettina Shell-Duncan & Ylva Hernlund eds., 2000); FRAN P. HOSKEN, *THE HOSKEN REPORT* (1979); HANNY LIGHTFOOT-KLEIN, *PRISONERS OF RITUAL: AN ODYSSEY INTO FEMALE GENITAL MUTILATION IN AFRICA* (1989); Obioma Nnaemeke, *If Female Circumcision Did Not Exist, Western Feminism Would Invent It*, *EYE TO EYE: WOMEN PRACTISING DEVELOPMENT ACROSS CULTURES* 171-189 (Susan Perry & Celeste Schenck eds., 2000); E.D. PRIDIE ET AL., *FEMALE CIRCUMCISION IN THE ANGLO-EGYPTIAN SUDAN* (1945); ANIKA RAHMAN & NAHID TOUBIA, *FEMALE GENITAL MUTILATION: A GUIDE TO LAWS AND POLICIES WORLDWIDE* (2000); LILIAN PASSMORE SANDERSON, *AGAINST THE MUTILATION OF WOMEN: THE STRUGGLE TO END UNNECESSARY SUFFERING* (1981); NAHID TOUBIA, *FEMALE GENITAL MUTILATION: A CALL FOR GLOBAL ACTION* (1995); ARNOLD VAN GENNEP, *THE RITES OF PASSAGE* (1960); *WARRIOR MARKS: FEMALE GENITAL MUTILATION AND THE SEXUAL BLINDING OF WOMEN* (Alice Walker & Parmar Pratibha eds., 1993); Sami Aldeeb Abu-Sahlieh, *To Mutilate in the Name of Jehovah or Allah: Legitimization of Male and Female Circumcision*, 13 MED. & L. 575 (1994); Rogaia Mustafa Abusharaf, *Rethinking Feminist Discourses on Female Genital Mutilation: The Case of Sudan*, 15 CAN. WOMEN STUD. 52-54 (1995); Frances A. Althaus, *Female Circumcision: Rite of Passage or Violation of Rights?*, 23 INT'L FAM. PLAN. PERSP. 130 (1997); Hanny Lightfoot-Klein, *The Sexual Experience and Marital Adjustment of Genitally Circumcised and Infibulated Females in the Sudan*, 26 J. SEX RESEARCH 375 (1989); L. Amede Obiora, *Bridges and Barricades: Rethinking Polemics and*

and rank the procedures on morally informed grounds, and second, based on the ranking, to argue for different perspectives on, and treatment of, the two procedures. Along the same trajectory, this Article considers the issues surrounding voluntary FGR and explores whether sanction is a morally defensible response. An argument for a distinction between forced and voluntary FGR as a basis for apportioning sanction is made and defended.

This Article consists of seven sections. Following the introduction, Part II reconstructs the debate as to whether FGR is a legitimate cultural practice or a human rights violation, and it sets forth the major arguments. Part III delves into, and debunks, the moral relativist argument regarding FGR. Part IV seeks to determine whether FGM is evil. A foray into the theory of evil, the section draws critical distinctions between FC and FGM and explains why the distinctions are of paramount moral importance. Part IV also concludes that FGM is evil, and thus, among the issues related to the betterment of women worldwide, FGM deserves more attention. Part IV seeks to determine whether FGM is evil. A foray into the theory of evil, the section draws critical distinctions between FC and FGM and shows how the distinctions are of paramount moral importance. The section argues that FGM (real cases and without consent) is evil, deserving of priority attention in the overall scheme of attending to the overall wellbeing and betterment of women while, at the same time, maintaining that FC, even when performed on non-consenting women, is distinctly not evil.<sup>13</sup> Part V addresses whether there are ethical bases for opposing bona fide cases of FGM. Relying on the principles of beneficence and non-maleficence, in addition to ethics of care, Part V returns an affirmative response. Part VI examines the antidotal adequacy of the existing human rights framework. Because human rights norms, in their current incarnation that prohibit FGR fail to draw a distinction between consenting adults and those forced to undergo the procedure and fail to recognize the difference between FC and FGM, Part VI argues that the framework is defective. Because, in their current incarnation, human rights norms prohibiting female FGR fail to draw a distinction between consenting adults and those forced to undergo the procedure, and fail to recognize the difference between FC and FGM, Part VI argues that the framework is defective. Part VII asserts that education and awareness campaigns are more productive paths to eradication than criminalization.

## II. RECONSTRUCTING THE DEBATE

Before plunging into the tasks of this Article, some basic knowledge about the nature of FGR seems instructive. What follows is the story of a Somali-British teenager, reported to have undergone the procedure a few years ago.<sup>14</sup> Lali was three when her family migrated to London from war-torn Somalia.<sup>15</sup> Like her

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*Intransigence in the Campaign Against Female Circumcision*, 47 CASE W. RES. L. REV. 275 (1997).

<sup>13</sup> The argument made in this section regarding FC applies with equal force to other less invasive forms of FGR such as ceremonial pricking of clitoris, all of which come under the rubric "moral wrong."

<sup>14</sup> Jo-Ann and David Jones, *The Unspeakable Practice of Female Circumcision That's Destroying Young Women's Lives in Britain*, DAILY MAIL (Jan. 3, 2008).

<sup>15</sup> *Id.* The child's name was changed to Lali to protect her identity.

contemporaries, Lali learned English quickly and adjusted to her adoptive country.<sup>16</sup> But her happiness was short-lived. At age eleven, Lali was taken to an undisclosed location to be circumcised, together with other Somali girls whose mothers, like Lali's, had flown a cutter from their country of origin to circumcise their daughters.<sup>17</sup> Upon arriving at the house, Lali was wrestled to the floor by a group of women which, to Lali's dismay, included relatives, family friends, and her own mother.<sup>18</sup> Once pinned to the floor, and without the aid of an anesthetic, the cutter was invited to perform the ritual.<sup>19</sup> The pain was excruciating and quite difficult to bear, especially for a young girl.<sup>20</sup> As Lali later recalled: "They held me down, and when the woman began cutting[,] I screamed, so my friend's sister put her hand tightly over my mouth."<sup>21</sup> More disturbing, as Lali further explained: "I had known her and these other women all my life, and now they were doing . . . this[ to me]."<sup>22</sup> For girls like Lali, the scar left by the betrayal of people divinely assigned to her stewardship can have serious psychological consequences and, possibly, medical complications.

Revulsion at this sort of experience is at the root of widespread clamor for the eradication of FGR. Yet, there seems to be little, if any, agreement on the basic elements of the procedure. It remains unsettled whether the appropriate descriptive term for the procedure is FGM or FC. Even its medical and psychological consequences are mired in controversy.<sup>23</sup> Nonetheless, if meaningful progress is to be made in the march toward proscription of the practice, factors disrupting reasonable and effective dialogue on these issues need to be unraveled. Distortions must be fleshed out and meaningfully analyzed; otherwise, progress toward containment may prove unsustainable.

Not long ago, the term FC was used universally, including in medical literature. However, its use is increasingly discarded in favor of the term FGM, a preference based upon the idea that the term FC falsely analogizes FGM to male circumcision, thereby confusing two remarkably distinct practices.<sup>24</sup> The term FGM is meant to

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<sup>16</sup> *Id.*

<sup>17</sup> *Id.*

<sup>18</sup> *Id.*

<sup>19</sup> *Id.*

<sup>20</sup> *Id.*

<sup>21</sup> *Id.*

<sup>22</sup> *Id.*

<sup>23</sup> Yoder P. Stanley et al., *Female Genital Cutting and Coming of Age in Guinea*, MACRO INTERNATIONAL INC., 3 (Dec. 1999), <http://www.measuredhs.com/topics/gender/FGC-CD/pdfs/FGCinGuinea.pdf>.

<sup>24</sup> *Eliminating Female Genital Mutilation: An Interagency Statement: UNAIDS, UNDP, UNECA, UNESCO, UNFPA, UNHCHR, UNHCR, UNICEF, UNIFEM, WHO, WHO 22* (2008), [http://www.un.org/womenwatch/daw/csw/csw52/statements\\_missions/Interagency\\_Statement\\_on\\_Eliminating\\_FGM.pdf](http://www.un.org/womenwatch/daw/csw/csw52/statements_missions/Interagency_Statement_on_Eliminating_FGM.pdf) [hereinafter WHO]; MARTHA NUSSBAUM, *SEX AND SOCIAL JUSTICE* 119 (1999).

more aptly capture the gruesome and harmful nature of the procedure.<sup>25</sup> More importantly, the new term recasts the procedure more concretely as a human rights violation, thereby providing a more robust ground upon which to campaign for its abolition.<sup>26</sup> Casting FGM as a human rights violation removes the practice from the arena of culture (and its attendant legitimacy) and makes it more susceptible to objective moral criticism. The term FGM was adopted in 1990 at the third conference of the Inter-African Committee on Traditional Practices Affecting the Health of Women and Children (IAC), an international private organization based in Dakar, Senegal.<sup>27</sup> Since 1991, when WHO recommended that the United Nations (U.N.) adopt the term FGM,<sup>28</sup> its use has spread like wild fire. The new term is embraced not only by the U.N. and its agencies, but also by a plurality of scholars, pundits, and activist groups pushing various agendas.

WHO defines FGM as "procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons."<sup>29</sup> Implicit in this definition is the notion that so long as the purpose is non-therapeutic, excision of any part of external female genitalia is mutilation, regardless of the degree and size of the tissue removed. This overly broad definition is at the root of the controversy surrounding the practice, for it erroneously ascribes mutilation to virtually all forms of FGR, even those that cannot reasonably be described as such. Three variations of FGR are commonly practiced. In type I (a clitoridectomy), the clitoris and/or clitoral hood is partially or totally removed.<sup>30</sup> Type II (excision) involves the partial or total removal of the clitoris and the labia minora, with or without the removal of the labia majora.<sup>31</sup> Type III (infibulation or pharaonic circumcision) involves cutting the labia minora and/or the labia majora, with or without the removal of the clitoris, followed by stitching and narrowing of the vaginal orifice.<sup>32</sup> Of the three types, types I and II are the most prevalent, undergone by approximately 85% of genitally cut women throughout the world.<sup>33</sup>

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<sup>25</sup> Richard A. Shweder, *Disputing the myth of sexual dysfunction of circumcised women*, 25 ANTHROPOLOGY TODAY 14, 17 (Dec. 2009), available at [http://www.arts.uregina.ca/dbfm\\_send/637](http://www.arts.uregina.ca/dbfm_send/637).

<sup>26</sup> WHO, *supra* note 24, at 22.

<sup>27</sup> *Id.*

<sup>28</sup> UNICEF, *Changing a Harmful Social Convention: Female Genital Mutilation/Cutting*, INNOCENT DIGEST 2 (2005), [http://www.unicef-irc.org/publications/pdf/fgm\\_eng.pdf](http://www.unicef-irc.org/publications/pdf/fgm_eng.pdf).

<sup>29</sup> *Id.* at 1.

<sup>30</sup> WHO, *supra* note 24, at 4.

<sup>31</sup> *Id.*

<sup>32</sup> The procedures are ranked in order of severity, from least to most severe. WHO specifies a fourth (type IV) category which comprises pricking, piercing, incising of the clitoris and/or labia, and other harmful procedure to the female genitalia for non-medical purposes. Type IV procedures, however, are generally not included in FGM discourse. See WHO, *supra* note 24, at 4; Nussbaum, *supra* note 24, at 120.

<sup>33</sup> NAHID TOUBIA, *Female Genital Mutilation*, in WOMEN'S RIGHTS, HUMAN RIGHTS: INTERNATIONAL FEMINIST PERSPECTIVES 224, 226 (J. S. Peters & Andrea Wolper eds., 1995).

The remaining 15% are subjected to type III, the most radical and dangerous of the three types, commonly practiced in only three countries: Djibouti, Sudan, and Somalia.<sup>34</sup>

This taxonomy, which has been adopted by a vast majority of local and international organizations, has attracted criticisms from several quarters, especially third-world scholars with an intimate knowledge of the procedures. Writing in opposition to a bill that would outlaw FGR in Nigeria, Nowa Omoigui, a Nigerian-born cardiologist practicing in the United States, questioned the wisdom of mischaracterizing circumcision as mutilation, and, as a result, lumping together all forms of FGR under the pejorative umbrella: FGM.<sup>35</sup> “There is a huge difference between [c]ircumcision and [m]utilation,” Omoigui argues.<sup>36</sup> “To group all forms of age old religious circumcision into one large category under the guise of medical enlightenment and ‘civilization’ is very unfortunate.”<sup>37</sup> Omoigui attacks the idea that every genital ritual connotes the same horror or has the same consequences as clitoridectomy, excision, or infibulation.<sup>38</sup> Referring to Edo women in Nigeria, for whom circumcision is limited to the removal of the prepuce (preputium clitoridis)—the fold of skin that covers the clitoris and which has no sexual or reproductive value—Omoigui notes that, for these women, circumcision involves the mutilation of neither the clitoris nor any other part of the genitalia.<sup>39</sup> “In fact, in many cases the ‘removal’ is symbolic and part of a traditional marriage ceremony.”<sup>40</sup> A similar argument has been advanced regarding the Ibos, one of the most populous ethnic

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<sup>34</sup> Borgna Brunner, *The Abolition of Female Genital Mutilation: The Abolition of Female Genital Mutilation Has Become a Worldwide Human Rights Cause*, INFOPLEASE (2007), <http://www.infoplease.com/ipa/A0001524.html>.

<sup>35</sup> Nowa Omoigui, *Protest Against Bill H22 Outlawing “FGM” in Nigeria*, J. CULTURE & AFR. WOMEN STUD. 1 (2001), <http://www.africaknowledgeproject.org/index.php/jenda/article/view/38>. Some writers have even gone as far as labeling the procedure “sexual castration.” See, e.g., Mohamed Badawi, *Epidemiology of Female Sexual Castration in Cairo, Egypt*, Paper Presented at The First International Symposium on Circumcision, Anaheim, California (Mar. 1-2, 1989), <http://www.nocirc.org/symposia/first/badawi.html>; FRAN P. HOSKEN, *THE HOSKEN REPORT: GENITAL AND SEXUAL MUTILATION OF FEMALES* 353 (1994).

<sup>36</sup> Omoigui, *supra* note 35.

<sup>37</sup> *Id.*

<sup>38</sup> Nahid Toubia seems to be the only one among leading commentators on the subject cognizant of this distinction. See Toubia, *supra* note 33, at 225.

<sup>39</sup> Omoigui, *supra* note 35.

<sup>40</sup> To the contrary, it could be argued that not removing the prepuce is a hindrance to maximizing sexual rights of women. This follows from the fact that women whose prepuces have been removed enjoy greater sexual satisfaction—more intense and, in some cases, multiple orgasms. See Gruenbaum, *supra* note 1, at 143-44; Michael P. Goodman et al., *A Large Multicenter Outcome Study of Female Genital Plastic Surgery*, 7 J SEX MED. 1565 (2010); G. J. Alter, *Aesthetic Labia Minora and Clitoral Hood Reduction Using Extended Central Wedge Resection*, 122 PLAST. RECONSTR. SURG. 1780 (2008); *infra* note 51.

groups in Nigeria, for whose people circumcision often involves the removal of only the prepuce.<sup>41</sup>

Though the procedure Omoigui describes does not involve mutilation as the word is ordinarily understood, the WHO type I classification nonetheless holds otherwise, characterizing as mutilation any removal of the prepuce, even if the clitoris is left untouched.<sup>42</sup> The operative words in the WHO classification are: *partial or total removal of the clitoris and/or the prepuce*.<sup>43</sup> This mischaracterization is widespread. For instance, although in her book, *Sex and Social Justice*, Martha Nussbaum, professor of philosophy at the University of Chicago, claimed that her discussion is "confined to cases that involve substantial removal of tissue and/or functional impairment," her subsequent discussion deviates from her self-imposed limited focus in favor of the popular paradigm.<sup>44</sup> She makes no attempt to draw distinctions between procedures that are truly mutilatory and those that are not. Instead, she uses the term "amputation" to describe an act that destroys nothing other than prepuce, a tissue that serves no useful function: "The male equivalent of the clitoridectomy would be the amputation of most of the penis."<sup>45</sup> The removal of limbs or other appendages can be accurately described as "amputation," but not insignificant tissues such as prepuce or toenails. For instance, because clipping a toenail involves removing the outgrowth nail only, it is a simple process that is associated with nothing as gory as amputation. Thus, it would be silly to describe it as such. Moreover, using terms that convey extremely exaggerated meanings serve no purpose other than to obfuscate the issues. And that, for better or worse, has been the contribution of the terms "amputation" and "mutilation" to the debate regarding the legitimacy of FGR as a cultural practice.<sup>46</sup>

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<sup>41</sup> See Omoigui, *supra* note 22. These less serious forms of FGR are not exclusive to Nigeria. Gruenbaum describes a type of procedure she observed among the Zabarma people in Sudan: "the Zabarma believe that only the sunna circumcision should be done, and as they described it and showed me on a little girl, they take almost nothing off." See Gruenbaum, *supra* note 1, at 121-22.

<sup>42</sup> WHO, *supra* note 3, at 1.

<sup>43</sup> *Id.*

<sup>44</sup> Nussbaum, *supra* note 24, at 119.

<sup>45</sup> Nussbaum says that in clitoridectomy, the clitoris or part of it is amputated. See *id.* at 120. But even if it granted that clitoridectomy somehow amounts to clitoral amputation, the generalization to include prepuce removal is certainly an exaggeration. Like Nussbaum, Obermeyer questions the accuracy of the term FC since it "implies that the surgery is equivalent to that which removes the prepuce of the penis, when it is in fact a good deal more extensive, removing as it does part or all of the clitoris." See Obermeyer, *supra* note 10, at 84. This observation (or reversal thereof) is precisely the bone of Omoigui's contention—that, in fact, there exists a form of female ritual that terminates in prepuce removal, without tampering with the rest of the clitoris/genitalia; see also Gruenbaum, *supra* note 1, at 121-22 (describing a type of FGR in which "almost nothing" is taken off).

<sup>46</sup> Other scholars have followed Nussbaum's lead. See, e.g., Althaus, *supra* note 12, at 131 (stating that "the amputation of the clitoris and other sensitive tissue reduces a woman's ability to experience sexual pleasure") (emphasis added). But this claim has been challenged by more recent studies. See, e.g., Lucrezia Catania et al., *Pleasure and Orgasm in Women with Female Genital Mutilation/Cutting (FGM/C)*, 4 J. SEX MED. 1666, 1673 (2007) (finding that a vast majority of women that have undergone FGR of all types, even those that have been

Dubbing as “mutilation” all forms of FGR was, of course, no happenstance. Purveyors clearly intended to convey a grisly and ghastly image, and to shock the moral sensibilities of everyone, which forced worldwide action. They seem poised to succeed, as evinced by the deluge of newspaper, television, and scholarly articles lambasting FGR and its practitioners. But, in reality, FGM is a far cry from what prepuce removal entails. Mutilating the clitoris, in the sense of damaging or chopping it off, is not the same as removing its hood. One does not need to approve of FC to appreciate these distinctions. Yet, a plurality of commentators gloss over these facts.<sup>47</sup> Omoigui was struck by this hypocrisy, leading him to question the rationale behind ascribing “mutilation” to what he considers to be female circumcision.<sup>48</sup> On the other hand, whereas abortion, since it involves “crushing and scooping of the body parts of an unborn fetus” – a genuine instance of mutilation, is never called “fetal mutilation”.<sup>49</sup> Ultimately, the trend toward misinformation and distortions, evident in the erroneous ascription of physical and psychological connotations to a significantly less severe form of FGR is counterproductive; such attitudes estrange, rather than persuade, practicing societies to rethink the ritual.<sup>50</sup> The appropriate medical nomenclature for FC is “clitoridotomy” or hoodectomy, a distinct procedure from a “clitoridectomy.” FC is comparable to male circumcision and is commonly offered by physicians, even by physicians in the United States.<sup>51</sup> Rather than cause harm, a clitoridotomy is, in fact, beneficial. By allowing for maximum exposure of the clitoris, the procedure makes it possible for women to experience multiple, quicker, and more intense orgasms.<sup>52</sup> Certainly, sexual freedom—the right to enjoy sex without third-party interference—is a human right.

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infibulated, achieved orgasm and that the procedure “does not necessarily have negative impacts on psychosocial life (fantasies, desire, pleasure, ability to experience orgasm)”).

<sup>47</sup> See, e.g., COOK ET AL., *supra* note 1, at 262. Although not explicitly stated, the authors appear to appreciate the distinction between real cases of clitoridectomy and prepuce removal. This is evident from the fact that although they adopted WHO’s categorization of FGM, they carefully omitted the phraseology “[e]xcision of the prepuce” (in the Type I definition) as part of the class of prohibited procedures. See *A Systematic Review of the Health Complications of Female Genital Mutilation Including Sequelae in Childbirth*, WHO 11 (2000), [http://whqlibdoc.who.int/hq/2000/WHO\\_FCH\\_WMH\\_00.2.pdf](http://whqlibdoc.who.int/hq/2000/WHO_FCH_WMH_00.2.pdf). In attempting to distinguish FC from male circumcision, the authors point out that in the latter, only the prepuce is removed. COOK ET AL., *supra* note 1, at 264.

<sup>48</sup> See Omoigui, *supra* note 35, at 3.

<sup>49</sup> See Omoigui, *supra* note 35, at 3; see also Ehrenreich & Barr, *supra* note 1, at 72 n.4 (warning that “one should hesitate to call African genital cutting practices ‘mutilation’ unless one is willing to apply the same term to genital cutting practiced in [the United States]” and, perhaps, other Western countries).

<sup>50</sup> Ronan M. Conroy, *Female Genital Mutilation, Whose Problem, Whose Solution?: Tackle “Cosmetic” Genital Surgery in Rich Countries Before Criticizing Traditional Practices Elsewhere*, 333 BRIT. MED. J. 106 (2006).

<sup>51</sup> Royal Benson, III, M.D., a board certified obstetrician/gynecologist, affiliated with The Southwest Center for Female Genital Refinement, Texas, provides the procedure at a cost of \$2,000 – 3,000. See CLITORALUNHOODING.COM, <http://www.clitoralunhooding.com/dr-benson.html> (last visited June 8, 2011).

<sup>52</sup> See Gruenbaum, *supra* note 1, at 143-44.

So, why classify all ritualistic genital procedures as FGM? Omoigui argues that such rigid classifications are an example of one culture attempting to dominate another, under the subterfuge of health and safety concerns.<sup>53</sup> He casts the issue as a "cultural war against female circumcision" by ill-informed human rights activists who, while condemning non-western cultural values, condone same-sex marriage—an institution, he says, that is prohibited virtually everywhere else.<sup>54</sup>

What do you say to people whose cultural practice is impugned and misrepresented in such a blatant fashion? More importantly, how do you enlist their support in eradicating what is deemed by outsiders to be a "harmful cultural practice?" Whatever the rationale for the extant approach, one of its consequences has been the alienation of people whose support is needed to make headway in abolishing FGM. This explains why, in many countries with laws on the books criminalizing both FGM and FC, the practice continues to flourish. One need not mischaracterize FC as mutilation to condemn it, for it too is condemnable on a different basis. Steve Nwabuzor, Nigerian scholar and political commentator, pines: "[the simple] fact that the West does not perform [female] circumcision as a norm is not enough reason to attack [non-Western] values."<sup>55</sup> Like Omoigui and others before him, Nwabuzor is concerned about trivializing and demonizing cultural values simply on account of their non-comportment with Western norms.<sup>56</sup>

Female circumcision—the removal of the clitoral hood—is comparable to male circumcision.<sup>57</sup> The clitoral prepuce is anatomically analogous to the penile prepuce, and both serve relatively similar functions. Regarding female circumcision, neither the procedure nor its consequences resemble a clitoridectomy or other types of FGM. A suggestion worth considering is contained in the following recently released study. Having discovered that there are forms of FGR that do not fit within the WHO's classification of mutilation, physician Susan Elmusharaf and her colleagues recommend that instead of pigeon-holing every conceivable form of ritualistic genital procedures within the WHO's classification, a better approach would be to classify rituals according to the anatomical extent of the procedure.<sup>58</sup> In other words, Elmusharaf argues for the creation of a novel classification system that accurately reflects the true anatomical extent of the different forms of the procedure.<sup>59</sup> Such novel classification is, in a sense, the demand of Omoigui and his cohorts.

### III. CULTURAL RELATIVISM AND FEMALE GENITAL RITUAL

Defenders of FGR view the effort to eradicate female genital rituals as an unjustified attempt by the West to impose Western cultural values on others while

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<sup>53</sup> Omoigui, *supra* note 35, at 4.

<sup>54</sup> *Id.*

<sup>55</sup> Steve Nwabuzor, *Opposition to Proposed HB 22 on Female Genital Mutilation*, J. CULTURE & AFR. WOMEN STUD. 1 (2001), <http://www.africaknowledgeproject.org/index.php/jenda/article/view39>.

<sup>56</sup> *Id.*

<sup>57</sup> Omoigui, *supra* note 35.

<sup>58</sup> Susan Elmusharaf et al., *Reliability of Self Reported Form of Female Genital Mutilation and WHO Classification: Cross Sectional Study*, 333 BRIT. MED. J. 127 (2006).

<sup>59</sup> *Id.*

ignoring the moral deficiencies of Western norms. In other words, the Western effort to eradicate FGR is like removing the speck in a stranger's eye while ignoring the log in your own eye.<sup>60</sup> Under the theory of cultural relativism, the practice of excising parts of female genitalia is a cultural practice just like any other; the fact that the practice is alien to Westerners does not *ipso facto* make it morally wrong. The underlying principle of moral relativism is that moral judgments are not universal nor objectively valid.<sup>61</sup> Omoigui argues that Western cultural imperialists actively support and condone practices, like abortion and homosexuality, which his own culture prohibits and deems morally repugnant; yet, these abolitionists still pass judgment on practices sanctioned in his culture.<sup>62</sup> Valid or not, Omoigui's contention represents a classic example of cultural relativism, the theory that moral truth is culture-bound, that each culture sets its own standards (moral truths), and that no culture can ascribe superiority to its own standards.<sup>63</sup>

Before grappling with cultural relativism and its application in defense of FGR, we must define "morality;" defining morality is crucial here because morality functions as the polemic center when analyzing FGR in a philosophical context. In its basic form, morality is how we normatively think about, and assign qualities of right or wrong to, human actions or inactions; it provides the lens through which we judge a particular conduct to be wrong or right.<sup>64</sup> Morality comprises a set of principles, rules, or precepts upon which judgments about the rightness or wrongness of actions are based.<sup>65</sup> This is the popular understanding of morality, and one upon which both cultural absolutists and cultural relativists agree. For John Cook, professor of philosophy, morality "consist[s] of principles, and because these are conceived of as saying what one ought or ought not to do, morality gets represented as pertaining essentially to human actions, to what someone can be ordered or forbidden to do."<sup>66</sup> In the context of FGM, the moral debate has centered on whether

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<sup>60</sup> Cheryl Chase, "Cultural Practice" or "Reconstructive Surgery"?: U.S. Genital Cutting, the Intersex Movement, and Medical Double Standards, in *THE REPRODUCTIVE RIGHTS READER: LAW, MEDICINE, AND THE CONSTRUCTION OF MOTHERHOOD* 47, 55 (Nancy Ehrenreich ed., 2008) (expressing concern that in Western feminist discourse, "African genital cutting" is depicted "as primitive, irrational, harmful, and deserving of condemnation," while genital cutting among Westerners is represented as "modern, scientific, healing, and above reproach"). *But see* Isabelle R. Gunning, *Arrogant Perception, World-Travelling and Multicultural Feminism: The Case of Female Genital Surgeries*, 23 *COLUM. HUM. RTS. L. REV.* 189, 189 (1991-92) (providing a more practical way to state the case for cultural relativist and asking "by what right did I, as a Western feminist, have to criticize as right or wrong the practices of an entirely different culture?").

<sup>61</sup> James Rachels, *The Challenges of Cultural Relativism*, *BIOETHICS: AN INTRODUCTION TO THE HISTORY, METHODS, AND PRACTICE* 119 (Nancy S. Jecker et al., eds., 2007) (suggesting that "the idea of universal truth in ethics . . . is a myth").

<sup>62</sup> Omoigui, *supra* note 35.

<sup>63</sup> David Agler, *Cultural Relativism Handout*, [http://www.davidagler.com/retired/teaching/ethics/Handout\\_4\\_Cultural\\_Relativism.pdf](http://www.davidagler.com/retired/teaching/ethics/Handout_4_Cultural_Relativism.pdf).

<sup>64</sup> *See* JOHN W. COOK, *MORALITY AND CULTURAL DIFFERENCES* 125 (1999).

<sup>65</sup> *See* COOK, *supra* note 64, at 117 (citing RAYMOND FIRTH, *ELEMENTS OF SOCIAL ORGANIZATION* 183 (1951)).

<sup>66</sup> *Id.* at 127.

it is morally right for one culture to persevere in an act deemed reprehensible by another and whether it is morally right to force change through the coercive powers of criminal law.

But defining morality solely in terms of human action or inaction does not provide an adequate account of the term because it neglects other important ways in which we think about moral matters.<sup>67</sup> We make moral assessments of not only people's actions but also of how they think; "the differences between, for example, callousness and sensitivity, insightfulness and obtuseness, reasonableness and perversity, fair-mindedness and prejudice, self-deception and self-criticism, wisdom and fanaticism."<sup>68</sup> Thinking of morality in this expanded form acknowledges the inner struggle that underlies moral decision-making, for the action upon which we eventually settle does not capture this internal conflict. Bigotry, selfishness, callousness, willful ignorance, and the like are normal human predicaments, and we constantly struggle against yielding to these temptations. Yet, our ability to resist temptation is a crucial determinant of our actions and an indicator of the quality of our characters. Cook argues that if we come to think seriously about our inner struggles to resist temptation, it would become obvious that these inner struggles are at the core of morality.<sup>69</sup> How we think about moral matters, the evaluations and discernments we make, is the essence of morality.

Cook's account of morality prioritizes thoughts over actions—a view that finds support in Iris Murdoch, Oxford University philosophy professor and novelist. For Murdoch, the concern of morality is essentially with change and progress,<sup>70</sup> which means a person's capacity for insight. Murdoch holds that because all people do not possess the same degree of insight and understanding, all moral views do not hold equal weight.<sup>71</sup> In other words, that a particular conduct is regarded as legitimate by a given culture says nothing about its rightness. If true, Murdoch's view rejects moral relativists' claim that all moral views are of equal weight. But her view does not seemingly affirm absolutism either.

If Murdoch is right, then, with what are we left? What is the source of dispute between opposing moral perspectives? Relativists like Edward Westermarck, Finnish sociologist and philosopher, think of moral disagreements in terms of a clash of principles; people that share the same principles will invariably arrive at the same moral conclusions.<sup>72</sup> Cook rejects this notion and argues that where there are conflicting claims in relation to a moral matter (such as FGM), the source of the conflict is not that the disputants are operating from different moral horizons, but that at least one of the opposing parties lacks "a sufficiently developed moral consciousness."<sup>73</sup> Cook, thus, rejects Westermarck's notion that we are all equal in our moral reasoning; that, in cases of two conflicting "moral principles," neither can

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<sup>67</sup> *Id.*

<sup>68</sup> *Id.*

<sup>69</sup> *Id.*

<sup>70</sup> IRIS MURDOCH, *THE SOVEREIGNTY OF GOOD* 29 (1971); COOK, *supra* note 47, at 127.

<sup>71</sup> MURDOCH, *supra* note 53, at 17-18; COOK, *supra* note 65, at 128.

<sup>72</sup> COOK, *supra* note 47, at 114; *see also* EDWARD WESTERMARCK, *ETHICAL RELATIVITY* (1932).

<sup>73</sup> COOK, *supra* note 65, at 117.

be considered the “right” one since there is no legitimate basis to argue that one principle is the result of a “superior moral consciousness.”<sup>74</sup> As Cook sees it, a person lacks a sufficiently developed moral consciousness when he fails to reflect on moral matters in an honest and careful way.<sup>75</sup> Such people are not morally thoughtful or insightful.<sup>76</sup> The difference between those who are thoughtful and those who are not thoughtful does not arise from a clash of principles; rather, the difference arises in the ways that they evaluate moral matters, in “how earnestly, honestly, and diligently they think.”<sup>77</sup>

Regarding FGM, the source of moral conflict has nothing to do with “different moral principles.” Instead, the source is a failure on the part of FGM defenders to honestly and carefully evaluate morally relevant issues raised by the practice, such as the need to seek and obtain consent prior to the procedure. If FGM defenders educate themselves and think seriously about the broad implications of the ritual, they would come to realize that FGM harms women’s physical and mental health, and therefore, FGM is morally indefensible on that ground alone. They would come to see that, by all accounts, the harm suffered by women greatly outweighs the perceived benefits. Clearly, thinking critically about the harm that FGM inflicts is the key to changing the minds of FGM defenders. But successfully eradicating a centuries-old practice, one deeply ingrained in collective psyche as an ineliminable part of cultural identity, will not be easy. The difficulty that this will entail is captured by anti-segregationist Lillian Smith’s observation in 1963: “[i]nsight was not a quality their [Southern United States] culture valued; nor intellectual honesty; nor self-criticism; nor human rights.”<sup>78</sup> Although Smith was writing about the racist southern United States, her account accurately depicts the dominant cultural climate in some FGM societies. It is with these societies that we are concerned.

#### IV. FGM: AN EVIL OR SOMETHING ELSE?

FGM can be faulted on multiple grounds. The procedure is usually performed under unsanitary, painful, and violent conditions.<sup>79</sup> Often the woman is forcibly restrained by several people while the operation is performed.<sup>80</sup> The women are typically not anesthetized, and they do not receive post-operative treatment to cope with the physical, emotional, and psychological problems associated with the procedure.<sup>81</sup> The fact that the vast majority of people that perform the surgery are illiterate, and lack basic medical training, is a distinct hazard in itself. Their instrument of choice is a razor blade or a knife, many with dull edges and usually

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<sup>74</sup> *Id.* at 116.

<sup>75</sup> *Id.*

<sup>76</sup> *Id.*

<sup>77</sup> *Id.* at 117.

<sup>78</sup> COOK, *supra* note 65, at 129 (quoting LILLIAN SMITH, *KILLERS OF THE DREAM* 47-53 (1963)).

<sup>79</sup> See generally Thoraya Obaid, *Frequently Asked Questions on Female Genital Mutilation/Cutting*, <http://www.unfpa.org/gender/practices2.htm#8> (last visited Jan. 5, 2012).

<sup>80</sup> See generally *id.*

<sup>81</sup> See generally *id.*

unsterilized.<sup>82</sup> Not surprisingly, the procedure has been linked to immediate and long-term physical and psychological health problems, the severity of which is dependent upon the type of procedure performed.<sup>83</sup> Infibulated women suffer the most severe consequences. The following health complications are common: pain; trauma; hemorrhage; difficulty urinating; painful menstruation; painful sexual intercourse (dyspareunia); sexual dysfunction; infections resulting from contaminated instruments; an increased risk of HIV transmission due to the use of unsterilized instruments; unintended labia fusion; proliferation of scar tissue at the site (keloid); and infertility.<sup>84</sup> These complications are the major drivers of calls for abolition of the practice. However, there is a growing body of literature that question the accuracy of these claims. These recent studies—filled as they are with contradictory conclusions—are critical because they have a foundational impact on the entire debate regarding the elimination of FGM.<sup>85</sup> Nonetheless, let us assume *arguendo* that the consequences claimed to result from the procedure are not controversial. It is these consequences that make the procedure amenable to human rights jurisdiction.<sup>86</sup>

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<sup>82</sup> *Id*

<sup>83</sup> *Id.*

<sup>84</sup> See WHO, *supra* note 24, at 33-35 (discussing the complications of such procedures); see also Nussbaum, *supra* note 24, at 120.

<sup>85</sup> See Fuambai S. Ahmadu, *Disputing the Myth of the Sexual Dysfunction of Circumcised Women*, 25 ANTHROPOL. TODAY 14, 15 (2009) (an interview) (arguing that the problem with categorizing all forms of FGR as “mutilation” is that the term seems to imply the inevitability of some serious and irreversible harm, yet there is no evidence to support such conclusion); Linda Morison et al., *The Long-Term Reproductive Health Consequences of Female Genital Cutting in Rural Gambia: A Community-Based Survey*, 6 TROP. MED. & INT’L HEALTH. 643, 651 (2001) (finding that morbidities such as infertility, anemia, damage to the perineum or anus, vulval tumors, painful sex, prolapse and so forth have no significant association with FGR and cautioning that by “basing health information on sound data rather than implying that severe long-term health consequences are common, activists are likely to make their claims more credible to practising communities and therefore more effective”); Obermeyer, *supra* note 10, at 92 (concluding, following a comprehensive search and retrieval of the medical and demographic literature on FGR, including all sources in English or French, that “[o]n the basis of the vast literature on the harmful effects of genital surgeries, one might have anticipated finding a wealth of studies that document considerable increases in mortality and morbidity. This review could find no incontrovertible evidence on mortality, and the rate of medical complications suggests that they are the exception rather than the rule. This should be cause to ponder, because it suggests a discrepancy between the forceful rhetoric, which depicts female genital surgeries as causing death and disease, and the large numbers of women who, voluntarily or under pressure, undergo these procedures”); Carla Makhoul Obermeyer, *The Health Consequences of Female Circumcision: Science, Advocacy, and Standards of Evidence*, 17 MED. ANTHROPOL. Q. 394, 394-412 (2003); Carla Makhoul Obermeyer, *The Consequences of Female Circumcision for Health and Sexuality: An Update on the Evidence*, 7 CULT. HEALTH & SEX. 443, 443-461 (2005) (arguing that while some negative health conditions are associated with FGR, for many of those conditions, there is no evidence of statistically significant association).

<sup>86</sup> As used here, the phrase “amenable to human rights jurisdiction” suggests that in absence of harmful health hazards, it would be extremely difficult, if not impossible, to make a compelling case for intervention through the instrumentality of human rights. On the other hand, one might argue that the very act itself (FGM), given accompanying pain and suffering, constitutes human rights infraction in that it infringes the prohibition against torture, cruel,

While the status of FGM as a human rights violation has gained widespread acceptance, it is not clear the appropriate moral weight to be attached to the procedure. Is FGM a moral wrong, like any other? Or, are there some other circumstances worthy of consideration that set it apart from other wrongs? If the response to the latter question is affirmative, are the circumstances sufficiently reprehensible to warrant calling the procedure evil? These are, by no means, insignificant concerns, because whether FGM is classified as evil will influence the overall scheme of employing human rights as a tool to redress gendered injustice. As to why this is important, feminist philosopher Claudia Card's observation is poignant: "evils are of greater importance than mere [wrongs]," and therefore, "should receive priority of attention."<sup>87</sup> Card recognizes that we cannot possibly attend to all the moral wrongs worthy of our attention, at least not to the same extent nor contemporaneously.<sup>88</sup> We are constantly confronted with many competing demands, but the resources needed to effectively respond to these demands are finite because of the limited amount of resources at our disposal. For this reason, Card argues that we should attend to real cases of evil before deploying resources to eradicate mere moral wrongs.<sup>89</sup> Understanding and appreciating the degree of suffering that procedures like FGM inflict would steer people to "choose to do something significant to alleviate or prevent them, rather than make relatively greater progress with lesser projects."<sup>90</sup> Instances of such lesser projects would include FC and other less invasive forms of FGR. And this brings to the fore the need to distinguish FGM from FC: FGM inflicts significantly greater harm and suffering than FC and is therefore more deserving of our attention. What, then, is evil?

Card defines evil as "foreseeable intolerable harms produced by culpable wrongdoing."<sup>91</sup> Implicit in this definition is that not all harms constitute evil; only harms that are intolerable and effectuated in a blameworthy manner would satisfy the definition. Therefore, even if an act produces intolerable harm, it would not be evil if its occurrence was accidental or the result of a natural event. How, then, are evils distinguished from ordinary wrongs? Card explains that a wrong becomes an evil when the harm "(1) [is] reasonably foreseeable (or appreciable); (2) [is] culpably

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inhuman, or degrading treatment, as well as the prohibition against all forms of physical and mental violence, injury, and maltreatment. *See* International Covenant on Civil and Political Rights, art. 7, G.A. Res. 2200A (XXI), U.N. Doc. A/6316 (Dec. 16, 1966) (*entered into force* Mar. 23, 1976) [hereinafter ICCPR]; Convention on the Rights of the Child, art. 19(1), Nov. 20, 1989, 1577 U.N.T.S. 3 (*entered into force* Sept. 2, 1990) [hereinafter CRC]. But then, one might respond to this argument by suggesting the adoption of a public health approach—that is, efforts should be directed toward enlisting the services of medical professionals whose skills and use of anesthesia would nullify the "pain and suffering" argument. In which case, there will be no question of violating any of the aforesaid human rights and, therefore, the case for human rights involvement would become suspect. [This argument is the subject of a forthcoming article.]

<sup>87</sup> CLAUDIA CARD, *THE ATROCITY PARADIGM: A THEORY OF EVIL* 97 (2002).

<sup>88</sup> *See generally id.*

<sup>89</sup> *See generally id.*

<sup>90</sup> *Id.* at 111.

<sup>91</sup> *Id.* at 3.

inflicted (or tolerated, aggravated, or maintained); and (3) deprives, or seriously risks depriving, others of the basics that are necessary to make a life possible and tolerable or decent (or to make a death decent).<sup>92</sup> She cites, as examples of such basics, "uncontaminated food, water, and air; sleep; freedom from severe and prolonged pain and from debilitating fear; affective ties with other human beings; the *ability to make choices* and act on them; and a sense of one's [own] worth as a person."<sup>93</sup> "A 'tolerable' life is one that is at least minimally worth living for its own sake," which is judged from the perspective of the person whose life it is, and not as a means to the end of others.<sup>94</sup>

Evidently, therefore, the distinction between ordinary wrongs and evils lies in the nature and severity of the harm.<sup>95</sup> While evils tend to ruin lives, ordinary wrongs—because they are less severe—do not have life-lasting consequences. Regarding FGM, opponents claim that in addition to adverse health complications, the procedure damages relationships. Women who have undergone the procedure lose the capacity to fully enjoy sexual relationships.<sup>96</sup> And because of the irreversible nature of the procedure, such women are doomed to a life of unfulfilled sexual desires.<sup>97</sup> This could lead to divorce or, for unmarried couples, estrangement. According to a study conducted in Sudan that surveyed the preferences of men married to infibulated women, an overwhelming majority of the respondents expressed a sexual preference for non-infibulated women.<sup>98</sup> Some of the men surveyed married a second wife owing the remarriage to penetration difficulties encountered with their first wives.<sup>99</sup> Thus, the scar of FGM is not transient; rather, it is a life-long perpetual denial of affected women's human right to sexual freedom, an encounter with the face of evil.

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<sup>92</sup> *Id.* at 16.

<sup>93</sup> *Id.* (emphasis added). The ability to make choices is innate to humanity and, depending on the nature of the subject, an unjustifiable attempt to limit the exercise thereof could rise to the level of evil. It is precisely because girls and women in most FGM societies are denied this freedom that enables us to immediately conclude that the procedure is evil. The corollary, then, is that it would be logically foolhardy to arrive at the same conclusion in cases where choice is clearly respected.

<sup>94</sup> *Id.*

<sup>95</sup> *Id.* at 3.

<sup>96</sup> Althaus, *supra* note 12, at 131.

<sup>97</sup> Mohammed H. El-Defrawi et al, *Female Genital Mutilation and Its Psychosexual Impact*, 27 *J. Sex Marital Ther.* 471, 471-72 (2001).

<sup>98</sup> Althaus, *supra* note 12 (citing A. A. Shandall, *Circumcision and Infibulation of Females: A General Consideration of the Problems and a Clinical Study of the Complications in the Sudanese Women*, 5 *SUDAN MED. J.* 178, 178-212 (1967)). But note that this finding is not conclusive as there have been studies that arrived at a different conclusion regarding fulfilling sexual relationships and other associated hazards. See Fuambai S. Ahmadu, *Ain't I A Woman Too?: Challenging Myths of Sexual Dysfunction in Circumcised Women*, in *TRANS-CULTURAL BODIES: FEMALE GENITAL CUTTING IN GLOBAL CONTEXT* 278-310 (Ylva Hernlund & Bettina Shell-Duncan eds., 2007); Catania et al., *supra* note 46, at 1666-78; Obermeyer, *supra* note 10, at 79-106; Ahmadu, *supra* note 85, at 14-17

<sup>99</sup> Althaus, *supra* note 12 (citing A. A. Shandall, *supra* note 98, at 178-212).

Moral wrong is different. For example, falsely accusing a fellow student of seeking favors from a professor, will not likely impact the life of the falsely accused student in any significantly damaging manner; thus, it, does not rise to the level of what can be appropriately termed evil. To be evil, the wrongdoing must be serious; it must be of such a character that reasonable people would agree that the damage it inflicts crosses the threshold of the sort that we would ascribe to the harm suffered by the student whose reputation was unfairly maligned. Does this account support the claim by Omoigui and Nwabuzor that it is a stretch to classify FC or removal of clitoral prepuce as the same as FGM? Recall that their argument was based on the fact that the two procedures and their consequences are starkly different; specifically, that the painful nature of FGM as well as its attendant risks, are conspicuously absent in FC.<sup>100</sup> The implication is that if, as the two authors argue, FC clitoridotomy, *not* clitoridectomy) is anatomically equivalent to male circumcision, then it becomes difficult to group it with true cases of FGM.<sup>101</sup> Circumcised males throughout the ages have lived normal and fulfilling lives and have not suffered any of the consequences associated with FGM. Because there is no evidence that the lives of circumcised men became intolerable as a consequence of having lost penile prepuces (foreskin), it is reasonable to assume that circumcised females would be similarly situated. Therefore, though it may be a moral wrong, we cannot label as evil subjecting non-consenting women to a clitoridotomy unless we are prepared to also ascribe evil to male circumcision.

What about real cases of FGM: clitoridectomy, excision, and infibulation? Are they, like FC and other less invasive forms of FGR, ordinary wrongs? Clearly, they are not. Rather, they fall within Card's definition of evil.<sup>102</sup> The harm inflicted, namely, the health and psychological suffering enumerated previously, was the reasonably foreseeable consequence of the procedure. And this is the critical point of departure that enables us to conclude that FC is not evil and yet hold differently with respect to FGM. Although most perpetrators of FGM are illiterate, and thus, might not understand the full ramifications of their actions, the validity of such a claim is becoming increasingly tenuous given the large-scale dissemination of such information. Moreover, if they are truly ignorant, it behooves them to seek information, oral would suffice, about the possible consequences of their actions. Further evidence of culpability is provided by human rights. Women, unarguably, possess an inherent right to health (including sexual and reproductive health). Although there may be no positive obligation on a third-party to ensure that their right to health is realized, there is certainly an obligation on everyone to refrain from obstructing the enjoyment of their right.<sup>103</sup> Because FGM seriously compromises the

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<sup>100</sup> See *supra* notes 35-41.

<sup>101</sup> Omoigui, *supra* note 35.

<sup>102</sup> CARD, *supra* note 87, at 3.

<sup>103</sup> See E.S.C. Res. ¶21 U.N. Doc. E/C.12/2000/4 (Aug. 11, 2000), reprinted in *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, UN. Doc. HRI/GEN/1/Rev.6 at 85 (2003) [hereinafter *General Comment No. 14*] (stating that to realize women's right to health, it is "important to undertake preventive, promotive, and remedial action to shield women from the impact of harmful traditional cultural practices and norms that deny them their full reproductive rights"). While the primary subjects of human rights are states, non-state entities are obligated to respect human rights, and a state that fails to ensure compliance of individuals and corporations within its

health of girls and women, perpetrators, like anyone else that interferes with actualization of human rights, are morally and legally culpable.

As is often the case with controversial subjects, there has not been a dearth of possible solutions to the challenges posed by FGM. Suggestions have been made to redirect our efforts toward education.<sup>104</sup> Scholars theorize that since even women in FGM societies disagree about the propriety of the procedure, perhaps a compromise would be to make the procedure elective.<sup>105</sup> According to this view, the procedure would be performed only on consenting adults. This compromise is a sensible suggestion, but it raises the question whether such consent makes the ritual any less evil. Does consent negate evil? Does FGM cease to be evil simply because the victim is a consenting adult? For some, the answer is yes. Nineteenth century British philosopher John Stuart Mill, for instance, holds that self-regarding harms (harm to oneself) "are not properly immoralities, and to whatever pitch they may be carried, do not constitute wickedness."<sup>106</sup> Such acts may be foolish or evidence of a lack of self-respect, Mill argues, "but so long as they do not constitute harm to others, they are not immoral."<sup>107</sup> "[T]he only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant."<sup>108</sup>

Under Mill's view, individual autonomy that does not harm others does not warrant moral condemnation. As autonomous entities, human beings are entitled to engage in actions that they consider promotive of their interests, without interference by a third party, provided that their actions do not negatively impact others' interests. But, as Cook forcefully argues, moral judgment is not limited to an assessment of human actions; rather it must extend to the way people think: "[W]e must assign priority to moral assessments of how we think about matters and how we perceive and represent them to ourselves; moral assessments of actions must take second

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jurisdiction with human right norms is violating its international obligations. *See* SERAC v. Nigeria, African Commission on Human and Peoples' Rights, Comm. No. 155/96 (2001) (holding that the Nigerian government violated Article Sixteen's right to health, violated Article Twenty-Four's right to a satisfactory environment, and violated the African Charter on Human and People's Rights for failing to protect the Ogoni people from environmental degradation and health problems caused by the Shell Petroleum Development Corporation's oil drilling).

<sup>104</sup> *See Female Genital Mutilation: A Matter of Human Rights: An Advocate's Guide to Action*, CENTER FOR REPRODUCTIVE RIGHT 9 (2006), [http://reproductiverights.org/sites/crr.civicactions.net/files/documents/FGM\\_final.pdf](http://reproductiverights.org/sites/crr.civicactions.net/files/documents/FGM_final.pdf) (noting that anti-FGR legislation enacted as far back as the 1940s and 1950s by authorities in Sudan and Egypt have had no impact—a failure attributed to the authorities' inability to create an environment (such as through community mobilization and outreach campaigns) that would by encouraging attitudinal changes, yield the desired result).

<sup>105</sup> John Tierney, "Circumcision" or "Mutilation"? *And Other Questions About a Rite in Africa*, N.Y. TIMES BLOG (Mar. 19, 2008), <http://tierneylab.blogs.nytimes.com/2008/03/19/a-compromise-on-female-circumcision/> (citing Fuambai Ahmadu).

<sup>106</sup> JOHN STUART MILL, ON LIBERTY AND OTHER ESSAYS 51 (John Gray ed., 1998); *see also* CARD, *supra* note 87, at 19.

<sup>107</sup> MILL, *supra* note 106, at 51.

<sup>108</sup> *Id.* at 10.

place.”<sup>109</sup> In this sense, lacking self-respect is not a private matter. According to Cook, exhibiting a lack of self-respect provides a measure of one’s morality.<sup>110</sup> Thus, Card was right: since self-respect provides a moral basis for change, it follows that its absence must provide a basis for moral indignation.<sup>111</sup> The consequences of condoning disrespectful treatment does not end with the person disrespected. A woman in a violent relationship, who subjects herself to prolonged abuse at the hands of a spouse or partner, is inflicting evil not only upon herself, but also upon others. By not demanding respectful and humane treatment, she legitimizes (albeit unwittingly) domestic violence—a weapon of gender subjugation.<sup>112</sup> The implicit message her behavior sends to women in abusive relationships is one of affirmation that violence and cruelty against women should be tolerated. No reasonable person would desire such a result, and the negativity such posture connotes makes it a morally imprudent course of action.

This principle—to forbear from a conduct on the ground that non forbearance would lead others to do wrong—has a strong foundation in Christian ethics. Writing at about 56-57 A.D., the apostle Paul summed up the doctrinal position on the propriety of eating foods sacrificed to idols: “[a]ll food is clean, but it is wrong for a person to eat anything that causes someone else to stumble.”<sup>113</sup> In other words, while a Christian is at liberty to eat whatever she likes, the liberty is not absolute. She is forbidden to exercise the right where doing so would lead another to sin. Liberty or not, “[i]t is better not to . . . do anything else that will cause your brother or sister to fall.”<sup>114</sup> As to how precisely the consumption of food offered to idols by one Christian would lead another to sin, Paul offers this explanation: “[f]or if someone with a weak conscience sees you, with all your knowledge, eating in an idol’s temple, won’t that person be emboldened to eat what is sacrificed to idols?”<sup>115</sup> This Christian adjuration presents an appropriate prism from which to examine the claim that consent to FGM somehow negates the moral stigma attached to the procedure. Applying Paul’s injunction to FGM might yield the following gospel: by consenting to the procedure, for whatever reason, the woman implicitly lends legitimacy to a conduct that is inherently immoral, and this, in itself, is evil.

But this postulation—that forbearance, for the sake of self-respect and out of concern for possible effects on third-parties, is the appropriate course of conduct—does not end the inquiry. There is no consensus that forbearance is always the right action to take. As a result, the idea should be understood as one of the ways to attend to an ethical dilemma and not, in any sense, as a way to dispose of the matter. To hold otherwise would be tantamount to prioritizing the right of the “other” or the community over that of the individual whose interest is primarily at stake. This is not to suggest, however, that such tradeoffs are never appropriate. Rather, the point is

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<sup>109</sup> COOK, *supra* note 65, at 127.

<sup>110</sup> *Id.*

<sup>111</sup> CARD, *supra* note 87, at 19.

<sup>112</sup> See generally Jeffrey R. Baker, *Trifling Violence: The U.S. Supreme Court, Domestic Violence, and the Golden Rule*, 42 CUMB. L. REV. 1 (2011).

<sup>113</sup> *Romans* 14:20 (New Int’l).

<sup>114</sup> *Romans* 14:21 (New Int’l); 1 *Corinthians* 8:9-1 (New Int’l).

<sup>115</sup> 1 *Corinthians* 8:10 (New Int’l).

that such circumstances are rare. Instances where such trade-offs have been appropriate are usually exceptional cases, and, even in those limited cases, they are typically problematic.<sup>116</sup>

Insight into the locus of forbearance and non forbearance in moral decision-making can be gleaned from the evolution of bioethics as an independent discipline. In terms of advancing human well-being and its unwavering commitment to patient autonomy, the evolution of bioethics is extolled as one of the most remarkable events of the last century. As scholars from such disparate backgrounds as philosophy, medicine, theology, and law converged to explore the foundations and contours of the new subject, it soon became obvious that the era of benign paternalism—by which physicians independently determined what was in the best interest of patients—must give way to something better.<sup>117</sup> Albert Jonsen, Emeritus Professor of Ethics in Medicine, notes that they settled on “a principle unfamiliar to traditional medical ethics but familiar to philosophers: the freedom of persons to judge what is in their benefit without interference from others.”<sup>118</sup> Just as belief in a supreme God, at least in monotheistic traditions, is at the core of moral theology, patient autonomy is the foundation of bioethics. Individual autonomy is the altar at which seekers of bioethical wisdom and guidance must manifest obeisance.<sup>119</sup> But, autonomy is not only a moral principle; it is also a human right.<sup>120</sup> Therefore, autonomy may be invoked by anyone, whether patients in hospitals or women seeking fulfillment in ways that appear to others to be unfamiliar or, perhaps, even strange. How is demanding forbearance from women intent on partaking in a revered cultural rite different from paternalism—a deficiency in patient well-being that was the impetus for the emergence of bioethics in the corpus of organized academic disciplines? There does not appear to be any difference.

For women interested in this rite of passage, the appropriate moral direction might be the ancient catechism: “let your conscience be your guide.” This returns us full circle to Mill’s argument that self-regarding harms are not an appropriate subject for moral criticism.<sup>121</sup> To do otherwise, Mill argues, is a serious infraction on

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<sup>116</sup> This can be illustrated with the crime of prostitution. Although autonomy entitles everyone to employ their bodies to whatever end they may choose, so long as the employment does not result in injury to another person, most societies have laws that proscribe prostitution. These laws were enacted not out of concern for the safety or other interests of the prostitutes, but to preserve community morality. The fact that of all fifty states in the United States, only Nevada permits prostitution is indicative of the difficulty of balancing individual rights with communal rights.

<sup>117</sup> See generally ALBERT R. JONSEN, *A SHORT HISTORY OF MEDICAL ETHICS* 117 (2000).

<sup>118</sup> *Id.*

<sup>119</sup> See Josiah A. M. Cobbah, *African Values and the Human Rights Debate: An African Perspective*, 9 *HUM. RTS. Q.* 309, 314 (1987).

<sup>120</sup> *Id.* (tracing modern human rights regime to western liberalism expressed in political manifestos of the 17th and 18th century, namely, the English Petition of Rights (1627), the U.S. Declaration of Independence (1776), the U.S. Constitution (1787), the French Declaration of the Rights of Man and Citizen (1789), and the U.S. Bill of Rights (1791)—all of which “were based on the image of the autonomous man”).

<sup>121</sup> MILL, *supra* note 106, at 1.

individual autonomy—the most important of all fundamental rights.<sup>122</sup> Although originating from an unrelated context, the plea of Patrick Henry, one of the most influential of the founding fathers of the United States, is particularly compelling: “Liberty the greatest of all earthly blessings—give us that precious jewel, and you may take everything else.”<sup>123</sup> The liberty to independently direct one’s own actions makes it possible for human beings to be valued, in the Kantian sense, as ends in themselves, and not merely as means to another’s end.<sup>124</sup> And this is so whether the subject is collective or individually-directed courses of action, or in the political realm or one’s private life.

Liberty is the foundation of all human rights, the fountain from which other human rights draw nourishment. When we say that a person has a right to this or that, we mean, in essence, that the person has liberty to do anything he chooses. For instance, a right to health means that one has liberty to do all that is necessary to ensure optimal health. Regarding individuals asserting their autonomy, the only question one needs to ask is whether the individual is sufficiently competent. Has the agency, rationality, or independence of the individual been compromised in any discernible way? Where expectations to comply with societal mores are great, external influences might weaken independent action so that seemingly freely expressed “consent” is, in reality, coerced.<sup>125</sup> But the influence of coercion on

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<sup>122</sup> *Id.*

<sup>123</sup> THE ANTI-FEDERALIST PAPERS AND THE CONSTITUTIONAL CONVENTION DEBATES 199-200 (Ralph Ketcham, ed. 2003) (Speeches of Patrick Henry), available at [http://www.municipalism.com/html/henry\\_5\\_.html](http://www.municipalism.com/html/henry_5_.html).

<sup>124</sup> See generally Thomas Scanlon, *Means and Ends* (Spring 2008), <http://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=0CB4QFjAA&url=http%3A%2F%2Fphilosophy.fas.nyu.edu%2Fdocs%2FIO%2F1881%2Fscanlon.pdf&ei=FAkGT7buCM72sQKWxfWQCg&usq=AFQjCNEpaEfaalCC7Qiy-9y7QwVGfLapFg&sig2=5IKtEe8rsfYtjcsjgt5U Xw> (critiquing Kantian Ethics).

<sup>125</sup> This is known as “false consciousness.” This is the idea that although on the surface an act appears voluntary, the perceived voluntariness was, in fact, a byproduct of some conditioning (which may be economic, religious, or cultural) that leads one to unexaminedly accept something (even if harmful to him or her) as normal. See generally Daniel Little, *False Consciousness*, Univ. of Michigan-Dearborn, <http://www-personal.umd.umich.edu/~delittle/iess%20false%20consciousness%20V2.htm> (last visited Jan. 5, 2012). The corollary is that an individual without the same conditioning would likely find the same thing objectionable. See *id.* The following account is illustrative:

Because traditional patrilineal communities assign women a subordinate role, women feel unable to oppose community dictates even when those affect them adversely. Many women even go to great lengths to support those dictates by organizing groups which mete out punishment to nonconforming women, and conduct hostile campaigns against passive observers. Women championing many of the cultural practices adopted by their communities do not realize that some of the practices they promote were designed to subjugate them, and more importantly, to control their sexuality and to maintain male chauvinistic attitudes in respect to marital and sexual relations. Most African women have still not developed the sensitivity to feel deprived or to see in many cultural practices a violation of their human rights. The consequence of this is that, in the mid-1980s when most women in Africa have voting rights and can influence political decisions against practices harmful to their health, they continue to

individual autonomy should not be overplayed. There are many situations in which community expectation subtly coerces an individual to act differently than he would have chosen, yet the action is not condemned. For example, a parent with many children who is able to provide for his family through extraordinary means receives no moral condemnation, even though the parent's perceived need to avoid denunciation by his community may have strongly motivated his conduct. It follows then that where a fully-informed, competent woman decides in favor of the benefits and voluntarily submits to the FGM, it would be difficult to find her blameworthy.

#### V. SOME ETHICAL CONSIDERATIONS

There are at least two principal ethical issues that are of concern regarding FGM: first, harmful health complications awaiting women who have been subjected to the procedure; and second, the non-consensual nature of the procedure. Non-consensual FGM occurs when girls lack capacity to give informed consent and when women are forced to undergo the procedure against their will. The right to bodily integrity is not only a legal precept, but it is also an ethical prescription that forbids anyone from invading another's bodily space without permission.<sup>126</sup> The protection offered by this right, as explained by Justice Benjamin Cardozo in 1914, is all-encompassing: "Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without

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uphold the dictates and mores of the communities in which they live; they seem, in fact, to regard traditional beliefs as inviolable.

See HANNY LIGHTFOOT-KLEIN, PRISONERS OF RITUAL: AN ODYSSEY INTO FEMALE GENITAL CIRCUMCISION IN AFRICA 75 (1989) (citing OLAYINKA KOSO-THOMAS, THE CIRCUMCISION OF WOMEN: A STRATEGY FOR ERADICATION I (1987)). This conditioning might be the result of what has been described as "gender indoctrination"—meaning, the alignment of socioeconomic and political forces in a way that normalizes and makes acceptance of gendered oppression somewhat automatic. *Id.* Sociologists as well as psychologists use the term "internalized oppression" to define a process whereby an oppressed group comes to believe and live out negative stereotype, myth or unfounded image of themselves (concocted, of course, by the oppressor) as if it were true. *See id.* In the context of FGR, this is effectuated by socializing women, from childhood, into believing that the practice is indispensable to fulfilling socially predetermined roles in the family (wives and child rearers). Women, thus socialized, would come to see the practice as something to be celebrated, not resisted. *See* Abusharaf, *supra* note 12, at 53. Accepting this view makes it easy to adopt a dismissive attitude toward women who do not share in the clamor for FGR abolition, branding them as confused or ignorant of their own or others' suffering. But those who adopt this attitude may themselves be the ones who are operating out of ignorance—ignorant because they impose judgment on experiences they do not understand and they do so on the assumption that their own experiences provide sufficient guide for judging others. This is highly contestable. Non-adherents of Catholic faith might view the exclusion of women from pastoral duties as instantiating gendered oppression and might even conceive of gendered assignment of roles in the church as one that calls for internally generated revolution. But there is no evidence that this view reflects the position of millions of Catholic women around the globe. Are these women victims of "false consciousness" or "gender indoctrination"? *See* Christine Littleton, *Women's Experience and the Problem of Transition: Perspectives on Male Battering of Women*, 1989 U. CHI. LEGAL F. 23, 26-27 (1989) (criticizing, from a feminist perspective, the concept of false consciousness).

<sup>126</sup> *See generally* Schloendorff v. Soc'y of N.Y. Hospital, 105 N.E. 92, 93 (N.Y. 1914).

his patient's consent, commits an assault, for which he is liable in damages."<sup>127</sup> The two principal ethical issues noted above—health and non-consent—are incompatible with the human rights principle articulated by Justice Cardozo. Law, as well as ethics, prescribe that permission must be sought and obtained before performing any medical procedure on an individual, regardless of the type of procedure.<sup>128</sup> Whether performed by traditional practitioners, midwives, or physicians, FGM is a medical procedure. Therefore, FGM is subject to the rules and principles of medical ethics.

The ethical principle of non-maleficence is directly related to the first concern. The principle requires health professionals to “first, do no harm,” *primum non nocere*.<sup>129</sup> This is an absolute obligation, from which no derogation is permitted. Although the harmfulness of FGM remains mired in controversy, there is little disagreement that some harm is involved. On the basis of fidelity to non-maleficence, therefore, health professions must refrain from lending their skills and service to the performance of FGM. Many professional medical organizations have issued statements emphasizing respect for this obligation. The General Assembly of the International Federation of Gynecology and Obstetrics, for instance, is cognizant “that [FGM] is a violation of human rights, as a harmful procedure performed on a child *who cannot give informed consent*” and urges gynecologists and obstetricians to “oppose any attempt to medicalize the procedure or to allow its performance, under any circumstances, in health establishments or by health professionals.”<sup>130</sup> The second relevant principle is beneficence, defined as “a moral obligation to act for the benefit of others.”<sup>131</sup> This is a broad concept and includes virtues such as mercy, kindness, altruism and love.<sup>132</sup> As an action-guiding norm, beneficence requires genuine demonstration of empathy toward the suffering of others, including girls and women at the risk of FGM.<sup>133</sup>

Closely related to beneficence, though itself an independent moral theory that most profoundly speaks to FGM, is care ethics. Compared to more established moral traditions, care ethics is still evolving. Its evolution originated from feminist

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<sup>127</sup> Schloendorff, 105 N.E. at 93.

<sup>128</sup> See *Slater v. Baker*, 95 Eng. Rep. 860, 862 (K.B. 1767) (suggesting the origin of this rule where the Court stated that “it is reasonable that a patient should be told what is about to be done to him, that he may take courage and put himself in such a situation as to enable him to undergo the operation”). In the United States, the rule was established by Justice Cardozo (then in the New York Court of Appeals) in *Schloendorff v. Society of New York Hospitals*, 105 N.E. 92, 93 (N.Y. 1914).

<sup>129</sup> *Primum non nocere*, MERRIAM-WEBSTER DICTIONARY (2012), <http://www.merriam-webster.com/dictionary/primum%20non%20nocere>.

<sup>130</sup> *Resolution on Female Genital Mutilation*, INTERNATIONAL FEDERATION OF GYNECOLOGY AND OBSTETRICS (1994), [http://www.igo.org/projects/general\\_assembly\\_resolution\\_FGM](http://www.igo.org/projects/general_assembly_resolution_FGM) (emphasis added).

<sup>131</sup> TOM L. BEAUCHAMP & JAMES F. CHILDRESS, *PRINCIPLES OF BIOMEDICAL ETHICS* 166 (5th ed. 2001).

<sup>132</sup> *Id.*

<sup>133</sup> See *generally Beneficence v. Nonmaleficence*, UCSF SCH. OF MED., [http://missing.link.ucsf.edu/lm/ethics/Content%20Pages/fast\\_fact\\_bene\\_nonmal.htm](http://missing.link.ucsf.edu/lm/ethics/Content%20Pages/fast_fact_bene_nonmal.htm) (last visited Jan. 5, 2012).

psychologist Carol Gilligan's seminal 1982 book and subsequent writings, and has since been expounded by a litany of other commentators, feminists, and non-feminists alike.<sup>134</sup> Gilligan's thesis was that the moral horizons of men and women differ significantly. Whereas men tend to think in terms of reason and rules, women exhibit more nuanced ways of thinking, prioritizing caring and relationships.<sup>135</sup> Gilligan's findings compartmentalized ethics into two distinct blocks.<sup>136</sup> The first is ethics of justice, which is detached, abstract reasoning based on objective rules, duties, and obligations.<sup>137</sup> The second is ethics of care, which is marked by relationships and characterized by emotions and sentiments.<sup>138</sup> At the core of care ethics is the importance of relationships: affinity, community, and togetherness, or, as made more explicit by Alisa Carse, Georgetown University professor of philosophy, "a concern for the good of others and of community with them, of a capacity for imaginative projection into the position of others, and of situation-

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<sup>134</sup> CAROL GILLIGAN, *A DIFFERENT VOICE: PSYCHOLOGICAL THEORY AND WOMEN'S DEVELOPMENT* (1982); *see also* ANNETTE BAIER, *MORAL PREJUDICES: ESSAYS ON ETHICS* (1994); GRACE CLEMENT, *CARE, AUTONOMY, AND JUSTICE: FEMINISM AND THE ETHIC OF CARE* (1996); VIRGINIA HELD, *FEMINIST MORALITY: TRANSFORMING CULTURE, SOCIETY, AND POLITICS* (1993); VIRGINIA HELD, *THE ETHICS OF CARE: PERSONAL, POLITICAL, GLOBAL* (2006); EVA FEDER KITTAY, *LOVE'S LABOR: ESSAYS ON WOMEN, EQUALITY, AND DEPENDENCY* (1999); DARYL KOEHN, *RETHINKING FEMINIST ETHICS* (1998); NEL NODDINGS, *CARING: A FEMININE APPROACH TO ETHICS AND MORAL EDUCATION* (2003); NEL NODDINGS, *STARTING AT HOME: CARING AND SOCIAL POLICY* (2002); FIONA ROBINSON, *THE ETHICS OF CARE: A FEMINIST APPROACH TO HUMAN SECURITY* (2011); SARA RUDDICK, *MATERNAL THINKING: TOWARD A POLITICS OF PEACE* (1989); MICHAEL SLOTE, *THE ETHICS OF CARE AND EMPATHY* (2007); SALLY E. TALBOT, *PARTIAL REASON: CRITICAL AND CONSTRUCTIVE TRANSFORMATIONS OF ETHICS AND EPISTEMOLOGY* (2000); JOAN TRONTO, *MORAL BOUNDARIES: A POLITICAL ARGUMENT FOR AN ETHIC OF CARE* (1994); ROBIN WEST, *CARING FOR JUSTICE* (2000); Annette Baier, *Hume: The Woman's Moral Theorist?*, *WOMEN AND MORAL THEORY* (Eva Feder Kittay & Diana Meyers eds., 1987); Helga Kuhse et al., *Reconciling Impartial Morality and a Feminist Ethic of Care*, 32 *J. VALUE INQUIRY* 451 (1998); Hilde Lindemann Nelson & Alisa L. Carse, *Rehabilitating Care*, 6 *KENNEDY INST. ETHICS J.* 19 (1996); Bill Puka, *The Liberation of Caring: A Different Voice for Gilligan's "Different Voice,"* 5 *HYPATIA* 58 (1990); Susan Sherwin, *Feminist and Medical Ethics: Two Different Approaches to Contextual Ethics*, 4 *HYPATIA* 57 (1989); Rosemarie Tong, *The Ethics of Care: A Feminist Virtue Ethics of Care for Healthcare Practitioners*, 23 *J. MED. & PHIL.* 131 (1998).

<sup>135</sup> Carol Gilligan, *Moral Orientation and Moral Development*, *WOMEN AND MORAL THEORY* 22-23 (Eva Feder Kittay & Diana Meyers eds., 1987).

<sup>136</sup> *Id.*

<sup>137</sup> *Id.*

<sup>138</sup> *See* Tong, *supra* note 134, at 131-32 (listing, as key differences between the two orientations, the following: "(a) justice ethics takes an abstract approach while care ethics adopts a contextual approach; (b) justice begins with an assumption of human separateness while care ethics begins with an assumption of human connectedness; (c) justice ethics emphasizes individual rights while care ethics emphasizes communal relationships; (d) justice ethics works best in the public realm, whereas care ethics works best in the private realm; (e) justice ethics stresses the role of reason in performing right actions while care ethics stresses the role of emotions in constituting good character; and (f) justice ethics is male or masculinist while care ethics is female or feminist").

attuned responses to others' needs."<sup>139</sup> These are core values, and a gross deficiency in them diminishes one's moral standing. Care ethics judges the rightness of an action as well as the goodness of the action's agent; under the theory, the two are inseparable.

A distinctive feature of care ethics is its emphasis on relationships and the nature of their resulting moral obligation: benevolence, empathy, and compassion, each borne out of a sense of interdependence and interconnectedness.<sup>140</sup> The thrust of care ethics is that "we are [all] in it together."<sup>141</sup> This togetherness is breached when we unjustifiably detach ourselves from others who need our help. The level of blameworthiness for unjustifiable detachment rises or falls in tandem with the proximity of the relationship. For example, apathy toward the well-being of one's child is more egregious than when the "other" is a colleague at work. Vulnerability foists a special demand on us to act. As a matter of moral responsibility, the unfairly disadvantaged deserve priority over those not similarly situated. The temptation to remain ambivalent in the face of injustice is replaced by a call to action, to the rescue of the weaker party.

Does care ethics provide moral instructions for FGM? Certainly, the response must be affirmative. Recall that FGM involves people in very close relationships.<sup>142</sup> Girls and women undergo the procedure with the full knowledge and active support of their parents, uncles, aunts, and so forth—all of whom perceive themselves as standing in solidarity with members of their family as they celebrate a treasured cultural rite.<sup>143</sup> The paradox here is the gulf between intent and reality. Regarding intent, families encourage or force their daughters and sisters to undergo the procedure believing that their action will promote the best interest of their loved one. The reality is that the procedure involves a real risk of more harm than good. In this seemingly confused state, the standard articulated by Professor James Rachels, philosopher and medical ethicist, seems instructive. Referring to controversial social practices, Professor Rachels recommends the following evaluative process:

Does the practice promote or hinder the welfare of people whose lives are [most] affected by it? And, as a corollary, we may ask if there is an alternative set of social arrangements that would do a better job of promoting their welfare. If there is any, we may conclude that the existing practice is deficient.<sup>144</sup>

Based on the negative consequences flowing from FGM, the response to the first question is that FGM hinders welfare. As to the second question, alternative rites of passage that involve no cutting would better promote welfare.<sup>145</sup> For instance, in

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<sup>139</sup> Alisa L. Carse, *The "Voice of Care": Implications for Bioethical Education*, 16 J. MED. & PHIL. 5, 18 (1991).

<sup>140</sup> See Tong, *supra* note 134, at 148 (suggesting that without these virtues, true human community and bona-fide relations cannot evolve).

<sup>141</sup> See *id.*

<sup>142</sup> See Jo-Ann and David Jones, *supra* note 14.

<sup>143</sup> See *id.*

<sup>144</sup> Rachels, *supra* note 61, at 128.

<sup>145</sup> See Chi Mgbako et al., *Penetrating the Silence in Sierra Leone: A Blueprint for the Eradication of Female Genital Mutilation*, 23 HARV. HUM. RTS. J. 111, 131-134 (2010)

Kenya, an alternative rite of passage known as *Ntanira na Mugambo* or "Circumcision through Words" has been practiced since 1996.<sup>146</sup> After a weeklong counseling program on family and role of women, there is a community celebration of singing, dancing, and feasting to affirm young girls' transition into adulthood.<sup>147</sup> *Ntanira na Mugambo* retains all aspects of Kenyan traditional FGR, except cutting.

#### VI. HUMAN RIGHTS PROHIBITIONS: ARE THEY SUFFICIENTLY ANTIDOTAL OR WARRANTED IN ALL CASES?

Initially, among those pushing for the eradication of FGM, the rallying cry was the procedure's adverse health consequences. The idea was that highlighting the physiological and psychosocial harm resulting from the procedure would arouse sufficient public outcry and galvanize efforts toward its elimination. This idea, however, generated unintended consequences. Instead of seeking the services of traditional cutters—maligned for using crude instruments, for operating in unsanitary conditions, and for their inability to manage complications resulting from the operation—parents and family members of girls and women due for the procedure began enlisting the services of qualified medical personnel. This led to the evolution of the "medicalization" argument,<sup>148</sup> which argues that merely shifting the location

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(discussing steps that could yield a successful transition to alternative rites in FGR communities, including the need to: precede the introduction of the alternative rites with educational workshops on the negative consequences of FGR; consult and integrate community members that perform the procedure into the project; and, select the type of alternative ritual that would be satisfactory to new initiates and the community).

<sup>146</sup> Chelala Cesar, *An Alternative Way to Stop Female Genital Mutilation*, 352 LANCET 126 (1998).

<sup>147</sup> Jane Njeri Chege et al., *An Assessment of the Alternative Rites Approach for Encouraging Abandonment of Female Genital Mutilation in Kenya*, FRONTIERS IN REPRODUCTIVE HEALTH 4-5 (2001), [http://www.popcouncil.org/pdfs/frontiers/FR\\_FinalReports/Kenya\\_FGC.pdf](http://www.popcouncil.org/pdfs/frontiers/FR_FinalReports/Kenya_FGC.pdf); Malik Stan Reaves, *Kenya: Alternative Rite to Female Circumcision Spreading in Kenya*, AFRICA NEWS SERVICE (Nov. 19, 1997), <http://allafrica.com/stories/200101080370.html>. But whether programs such as these, that seek to attain the same goal as FGM while sparing young girls the horror of cutting, have staying power remains to be seen. As a government official remarked during a recent celebration, "You cannot change Culture overnight." *Id.* Troublingly, a report by the human rights group "Equality Now" shows that despite availability of harmless rites such as *Ntanira na Mugambo*, FGM is still on the rise in the country. See Equality Now, *KENYA: Female Genital Mutilation Cases Rise*, CHILD RIGHTS INFORMATION NETWORK (Dec. 28, 2007), <http://www.crin.org/violence/search/closeup.asp?infoID=15918>.

<sup>148</sup> "Medicalization" (of FGR) means employing suitably qualified health professionals to perform the procedure. See JEANNE WARD ET AL., *BROKEN BODIES - BROKEN DREAMS: VIOLENCE AGAINST WOMEN EXPOSED* 52 (2005); Gemma Richardson, *Ending Female Genital Mutilation?: Rights, Medicalization, and the State of Ongoing Struggles to Eliminate the FGM in Kenya*, THE DOMINION (Feb. 11, 2005), [http://www.dominionpaper.ca/accounts/2005/02/11/ending\\_fem.html](http://www.dominionpaper.ca/accounts/2005/02/11/ending_fem.html). Remarkably, this approach is similar to the rationale behind decriminalizing abortion (that is, access to physicians would reduce mortality and other health complications resulting from back alley abortions). See *id.* But medicalization has been discredited as legitimizing FGR, in that the end result would be making FGR safer as opposed to putting an end to it—the professed goal of anti-FGR efforts. See *id.* The need to plug this deficiency was the rationale for the current framework; that is, a human rights approach that

of the operation to hospitals and clinics does not wash away the sins of FGM; rather, regardless of who performs the procedure or where it is performed, FGM is wrong and must be abolished. This argument led to the emergence of the human rights approach as a more productive framework.

A rights-based approach is predicated on the human-rights' principle that the protection of human well-being, in all its dimensions, is accomplished not just by condemning conduct inimical to this objective, but by also holding perpetrators accountable. Several aspects of the wellbeing of women and children are violated by FGM and this is manifested in a plethora of human rights instruments, some more narrowly focused than others. Foremost amongst these instruments are the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)<sup>149</sup> and the Convention on the Rights of the Child (CRC).<sup>150</sup> In addition to the omnibus prohibition of discrimination against women, State Parties to CEDAW (currently 187)<sup>151</sup> specifically undertake to "take all appropriate measures, including legislation, to modify or abolish existing laws, regulations, customs, and practices which constitute discrimination against women."<sup>152</sup> Because FGM is exclusively performed on women, it is *prima facie* discriminatory. Further, because the procedure is embedded in the culture of affected communities, its eradication is clearly mandated by this provision. This obligation is made more concrete in Article 5 of CEDAW, which requires "social and cultural" practices to be modified "with a view to achieving the elimination of prejudices and customary and all other practices" based on gender-related stereotyping or subjugation.<sup>153</sup> The CRC, on the other hand, requires State Parties to "take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children."<sup>154</sup> Furthermore, Article 19(1) of the CRC imposes an obligation on State Parties to protect children from all forms of violence, injury, abuse, or maltreatment.<sup>155</sup>

Africa—the region with the highest FGM prevalence—has its own regional framework. Two treaties are particularly relevant: the Protocol to the African Charter

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focuses on breach of individual rights resulting from the procedure and not solely on health concerns. *See id.*

<sup>149</sup> Convention on the Elimination of All Forms of Discrimination Against Women, Sept. 3, 1981, 1249 U.N.T.S. 13 [hereinafter CEDAW].

<sup>150</sup> CRC, *supra* note 86, at art. 19(1). The Convention on the Rights of the Child was acclaimed as the most widely ratified human treaty, with a total of 193 countries as of July 2010. UNICEF, THE STATE OF THE WORLD'S CHILDREN: SPECIAL EDITION ii 2 (2009); U.N. Treaty Collection, Convention on the Rights of the Child, (June 24, 2010), [http://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg\\_no=IV11&chapter=4&lang=en](http://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV11&chapter=4&lang=en). Only the United States and Somalia are yet to ratify the CRC though both countries signed the treaty.

<sup>151</sup> *See Chapter IV: Human Rights*, CEDAW (Jan. 21, 2011), [http://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg\\_no=IV-8&chapter=4&lang=en](http://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-8&chapter=4&lang=en) (listing the State Parties to the treaty).

<sup>152</sup> CEDAW, *supra* note 151, at art. 2(f).

<sup>153</sup> CEDAW, *supra* note 151, at art. 5(a).

<sup>154</sup> CEDAW, *supra* note 151, at art. 24(3).

<sup>155</sup> CRC, *supra* note 86, at art. 19(1).

on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol)<sup>156</sup> and the African Charter on the Rights and Welfare of the Child (ACRWC).<sup>157</sup> Among human rights treaties dealing with FGM, the Maputo Protocol may be described as a pace-setter; it was the first international treaty to make explicit reference to FGM: "[A]ll forms of female genital mutilation, scarification, medicalization, and para-medicalization of female genital mutilation" shall be prohibited in member countries through the adoption of appropriate legislative and other measures.<sup>158</sup> Like CEDAW, the Maputo Protocol obligates State Parties to combat all forms of discrimination against women by enacting appropriate legislative, institutional, and other appropriate measures.<sup>159</sup>

The ACRWC, on the other hand, prohibits the practice of any custom, tradition, culture, or religion "that is inconsistent with the rights, duties and obligations contained in the . . . Charter;" it stipulates that such practices "shall to the extent of such inconsistency be discouraged."<sup>160</sup> The ACRWC explicitly states that decisions or actions by any person or authority concerning the child shall be judged by whether such decision or action is promotive of the best interest of the child.<sup>161</sup> The implication, then, is that since FGM is harmful to children,<sup>162</sup> the practice runs afoul of the "best interest of the child" principle. Therefore, regardless of semantics, FGM-practicing nations who are parties to the ACRWC could be subjected to sanctions for failing to meet their obligation under the treaty.

Discrimination aside, those clamoring for abolition point out that FGM violates affected children's and women's right to health, life, liberty, and security<sup>163</sup>—all of which are protected by a battery of international human rights norms. FGM is a violation of the right to "the highest attainable standard of physical and mental health,"<sup>164</sup> not only due to associated health complications, but also because it

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<sup>156</sup> Adopted at the 2nd Ordinary Session of the Assembly of the African Union, Maputo, July 11, 2003, OAU Doc. CAB/LEG/66.6, *reprinted in* 1 AFR. HUM. RTS. L. J. 40, (*entered into force* Nov. 25, 2005) [hereinafter Maputo Protocol].

<sup>157</sup> African Charter on the Rights and Welfare of the Child (ACRWC), Nov. 29, 1999, OAU Doc. CAB/LEG/24.9/49 [hereinafter ACRWC].

<sup>158</sup> Maputo Protocol, *supra* note 156, art. 5(b).

<sup>159</sup> ACRWC, *supra* note 157, art. 2.

<sup>160</sup> ACRWC, *supra* note 157, art. 1(3).

<sup>161</sup> ACRWC, *supra* note 157, art. 4(1).

<sup>162</sup> See Maputo Protocol, *supra* note 156, art. 1(g) (defining "harmful practices" to include "all behaviour, attitudes and/or practices which negatively affect the fundamental rights of women and girls, such as their right to life, health, dignity, education, and physical integrity").

<sup>163</sup> WHO, *supra* note 24, at 9; see also NUSSBAUM, *supra* note 24, at 120.

<sup>164</sup> International Covenant on Economic, Social, and Cultural Rights, art. 12, *opened for signature* Dec. 16, 1966, G.A. res. 2200A (XXI), U.N. GAOR, 21st Sess. Supp. (No. 16) at 49, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 3 (*entered into force* Jan. 3, 1976) [hereinafter ICESCR]; see also Universal Declaration of Human Rights, art. 25, G.A. res. 217A (III), U.N. Doc A/810 at 71 (1948), *adopted* Dec. 10, 1948; International Convention on the Elimination of All Forms of Racial Discrimination, art. 5 (e)(iv), G.A. res. 2106 (XX), Annex, 20 U.N. GAOR Supp. (No. 14) at 47, U.N. Doc. A/6014 (1966) 660 U.N.T.S. 195 (*entered into force* Jan. 4, 1969); CEDAW, *supra* note 151, art(s) 11(1)(f), 12; CRC, *supra* note 86, art. 24;

violates the right “to control one’s health and body, including sexual and reproductive freedom.”<sup>165</sup> The procedure could lead to death, thereby breaching the obligation of States to respect and promote the right to life.<sup>166</sup>

The International Covenant on Civil and Political Rights (ICCPR) recognizes the right to liberty and security of the person and forbids State Parties from restricting these rights, except in accordance with the law.<sup>167</sup> Liberty connotes freedom to make decisions or choose actions that maximize individual preferences, and security means non-interference with freely made decisions or chosen actions. When forced or performed on children, FGM violates these rights. The procedure is also inhuman and degrades those upon whom it is forced. Still, protection against inhumane and degrading treatment<sup>168</sup> is provided by the Universal Declaration of Human Rights,<sup>169</sup> the ICCPR<sup>170</sup> and the Convention against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment.<sup>171</sup> Regardless of the sporadic nature of States’ compliance, the importance of these treaties lies in their norm-setting standards, as a

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International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families, art(s) 28, 43(1)(e), 45(1)(c), 70, G.A. res. 45/158, annex, 45 U.N. GAOR Supp. (No. 49A) at 262, U.N. Doc. A/45/49 (1990) (*entered into force* July 1, 2003); African [Banjul] Charter on Human and Peoples’ Rights, art. 16, *adopted* June 27, 1981, OAU Doc. CAB/LEG/67/3 rev. 5, 21 I.L.M. 58 (1982), *entered into force* Oct. 21, 1986; Maputo Protocol, *supra* note 156, at art. 14; ACRWC, *supra* note 157, at art. 14.

<sup>165</sup> See General Comment No. 14, *supra* note 103, ¶8.

<sup>166</sup> See ICCPR, *supra* note 86, art. 6.

<sup>167</sup> *Id.* at art. 9.

<sup>168</sup> The term “inhuman and degrading” treatment is not defined by CEDAW nor any related treaty. But the European Court of Human Rights (in relation to Art. 3 of the European Convention on Human Rights, which prohibits torture and inhuman or degrading treatment or punishment) provides some guidance. See *Ireland v. United Kingdom*, Judgment of Jan. 18, 1978, Series A No. 25, p. 66 ¶167; *Soering v. United Kingdom*, Judgment of July 7, 1989, Series A No. 161, p. 39, ¶100; see also *Tyrer v. United Kingdom*, Judgment of Apr. 25, 1978, Series A No. 26, p. 14-15, ¶29-30; GILLES DUTERTRE, KEY CASE-LAW EXTRACTS: EUROPEAN COURT OF HUMAN RIGHTS 57 (2003). To constitute “inhuman” treatment, the court must consider the action being challenged to have caused “if not actual bodily injury, at least intense physical and mental suffering.” See *id.* “Degrading” treatment, on the other hand, must generate feelings of fear, anguish and inferiority resulting in humiliating or debasing the moral worth of its victims. See *id.*

<sup>169</sup> Universal Declaration of Human Rights, *supra* note 164, at art. 5.

<sup>170</sup> *Id.* at art. 7.

<sup>171</sup> Convention against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment, G.A. res. 39/46 art. 16, U.N. Doc. A/39/51 (1984), *entered into force* June 26, 1987. Section one of Article 16 states:

(1) Each State Party shall undertake to prevent in any territory under its jurisdiction other acts of cruel, inhuman, or degrading treatment or punishment which do not amount to torture as defined in article 1, when such acts are committed by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity.

*Id.*

basis for condemning or upholding conducts perpetrated or sanctioned by national authorities.<sup>172</sup> For instance, in its consideration of the latest periodic report by Sudan, the Human Rights Committee, the implementing body of the ICCPR, noted that despite the country's efforts to criminalize FGM, the most serious form (infibulation) still runs rampant.<sup>173</sup> The Committee urged Sudan to enact legislation prohibiting FGM and to ensure that perpetrators are punished.<sup>174</sup>

The transformation of the anti-FGM approach from health-based to human rights-based was not driven solely by pragmatic considerations. The transition to a human rights framework also has a moral undertone. Underlying the framework are the cherished liberal principles of individual liberty and human (gender) equality.<sup>175</sup> These principles are universal values shared by all humanity—a universality that is transgressed by the imposition of FGM on children and “others incapable of providing autonomously given consent.”<sup>176</sup> But what about lucid adult women who opt for FGM, such as women in Kono and Sierra Leone?<sup>177</sup> Are these women liable

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<sup>172</sup> Submission of reports required by various human rights treaty monitoring bodies is *ipso facto* a good faith demonstration by State Parties of their desire for recognition as being in compliance with their treaty obligations. In this way, even countries with a poor human rights record, and countries perennially condemned for deficits in their legal and policy frameworks, would slowly improve their performance. This is significant for it will certainly contribute to the advancement of human rights and other rules of international law.

<sup>173</sup> U.N. Human Rights Committee (HRC), *Concluding Observations of the Human Rights Committee: The Sudan*, Aug. 29, 2007, CCPR/C/SDN/CO/3, ¶15.

<sup>174</sup> *See id.*; *see also* U.N. Committee on the Elimination of Discrimination Against Women, *Concluding Observations of the Committee on the Elimination of Discrimination Against Women: Uganda*, Oct. 4-22, 2010, CEDAW/C/UGA/CO/7, ¶¶21-22 (criticizing Uganda, while extolling the country for promulgating the Prohibition of Female Genital Mutilation Act 5 (2010), for the continued prevalence of the practice and recommending intensifying its awareness-raising and education strategy in addition to enlisting the support and coordinated action of civil society and religious organizations in stamping out the practice).

<sup>175</sup> Anna Elisabetta Galeotti, *Relativism, Universalism, and Applied Ethics: The Case of Female Circumcision*, 14 CONSTELLATIONS 91, 92 (2007).

<sup>176</sup> COOK ET AL., *supra* note 1, at 271.

<sup>177</sup> Fuumbai Ahmadu, an associate professor of Comparative Human Development at the University of Chicago, has written extensively on this subject. A Pro-FGR (she herself was circumcised according to Kono rites at the age of twenty-two), her observation challenges popular belief:

So, contrary to much of the rhetoric of the anti-FGM campaigns, the female sex and female sexuality are not oppressed in, through or by these ritual practices. On the contrary, female sexuality and reproductive powers are celebrated and reified in the masquerades, as the origins of creation, of nature and of culture, and feared as potent weapons of death and destruction. This cultural and symbolic context of female initiation and excision explains how it could be that Kono girls and women [speak] in positive, almost reverential terms, about the practice, their bodies and the experience of womanhood.

Ahmadu, *supra* note 85, at 14-15; *see also* Fuumbai S. Ahmadu, *Rites and Wrongs: An Insider/Outside Reflects on Power and Excision*, in FEMALE “CIRCUMCISION” IN AFRICA: CULTURE, CONTROVERSY, AND CHANGE 283-311 (Ylva Herlund & Bettina Shell-Duncan eds., 2000); Fuumbai S. Ahmadu, *Hurray for Bondo Women in Kailahun*, THE PATRIOTIC

in much the way as others who were coerced? Does consent matter? If consent is of any significance (a view defended below), then it must represent a cogent reason for decoupling the two situations in ethical and legal discourse. But this decoupling is conspicuously absent in virtually all the regional and international treaties dealing with FGM.

The same result is obtained in national anti-FGM legislation. This confusion is best represented by Ghana's attempt to criminalize FGM. Ghana's statute<sup>178</sup> assigns the same punishment to consensual and non-consensual FGM:

Section 69A

(1) Whoever excises, infibulates or otherwise mutilates the whole or any part of the labia minora, labia majora, and the clitoris of another person commits an offence and shall be guilty of a second degree felony and liable on conviction to imprisonment of not less than three years.

(2) For the purposes of this section "excise" means to remove the prepuce, the clitoris, and all or part of the labia minora; "infibulate" includes excision and the additional removal of the labia majora.<sup>179</sup>

This unnecessary conflation is troubling. Laws proscribing FGM must draw a clear distinction between forced and voluntary procedures, and the distinctions must determine the severity of sanctions.<sup>180</sup> In other words, in respect to those who voluntarily submit to the procedure, there should be no punishment whatsoever.<sup>181</sup>

Failure to make this distinction is a serious deficiency, one that touches upon the very foundation of human rights. Since there is no legitimate reason to punish voluntary FGM, treaties and criminal codes purporting to do so violate the human right of rational adults to effectuate autonomous choices regarding their most prized possession: their bodies. The French Parliamentarians, in 1789, conceived of individual liberty as consisting "in the freedom to do everything which injures no one else," stressing that "the exercise of the natural rights of each man [and woman] ha[ve] no limits except those which assure to the other members of the society the enjoyment of the same rights."<sup>182</sup> The ambit of this liberty is sufficiently broad to

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VANGUARD (Mar. 13, 2008), [http://www.thepatrioticvanguard.com/article.php3?id\\_article=2434](http://www.thepatrioticvanguard.com/article.php3?id_article=2434).

<sup>178</sup> Ghana's statute was enacted Aug. 4, 1998. The state is an Act (484 of 1994) to amend the Criminal Code, 1960 (Act 29) to include in the Code the Offence of Female Circumcisions and for Connected Purposes.

<sup>179</sup> The Act amended Ghana's Criminal Code by inserting a new provision: § 69A.

<sup>180</sup> Other countries with national legislation outlawing FGR are Burkina Faso, Central African Republic, Djibouti, Ghana, Guinea, Ivory Coast, Senegal, Tanzania, and Togo. In Nigeria, there is no national prohibition of the practice, but at least five states have enacted such legislation. See Abiodun Raufu, *Nigeria Recommends Jail Terms to Eradicate Female Genital Mutilation*, 324 BRIT. MED. J. 1056 (2002).

<sup>181</sup> See COOK ET AL., *supra* note 1, at 272 (arguing against parental right to have their daughters cut, but holding that such right belongs to the girls themselves who could exercise them once of age and intellectually capable of making such decisions).

<sup>182</sup> The Declaration of the Rights of Man and of Citizens, J. OFFICIEL DE LA REPUBLIQUE FRANCAISE art. 4 (Aug. 26, 1789).

shield from the long arms of the law women who voluntarily embrace FGM. To punish conduct that is non-coercive and harms no third party is surely an infraction on liberty and an affront to the pluralistic ideals of liberal democracy.

The existence of positive law coercing action or inaction should not confuse us. Such law does not mean much, for it says nothing about the rightness or wrongness of the conduct proscribed. And, even if enforced, the enforcement does not *ipso facto* legitimize laws that lack a moral justification.<sup>183</sup> A philosophy professor once

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<sup>183</sup> This sort of conflict (arising from awareness of each individual’s civic duty to comply with a duly enacted law, and yet being restrained from compliance by knowledge that the law lacks moral foundation) is most evident in emerging democracies and dictatorships in third world countries. It is common knowledge that governments in these countries quite often subscribe to international agreements to appease foreign powers, upon which many of them especially poorer ones, rely for economic survival—not, as one would expect, out of internally-generated or home-grown desire to cure some mischief or remedy some defects in their domestic legal frameworks. The aphorism “he who pays the piper dictates the tune” is no truer than in international relations. The African Charter on Human and Peoples’ Rights, for instance, is generally considered historic for being the only human rights treaty to recognize the three genres of rights. See *Indigenous Peoples in Africa: The Forgotten Peoples?*, AFRICAN COMM’N ON HUMAN AND PEOPLES’ RIGHTS & INT’L WORK GROUP FOR INDIGENOUS AFFAIRS 20-24 (2006), <http://www.achpr.org/english/Special%20Mechanisms/Indegenous/ACHPR%20WGIP%20Report%20Summary%20version%20ENG.pdf>. The Charter was adopted in 1981 and, by 2009, all fifty-three member nations of the African Union had deposited their instruments of ratification or accession. *List of Countries That Have Signed, Ratified/Accessed to the African Union Convention on African Charter on Human and Peoples’ Rights*, AFRICAN UNION (May 26, 2007), [http://www.achpr.org/english/ratifications/ratification\\_african%20charter.pdf](http://www.achpr.org/english/ratifications/ratification_african%20charter.pdf). Because ratifying governments were only paying lip service to the letters of the treaty, the Charter, much to the dismay of the human rights community, has contributed nothing meaningful to the protection of human rights in the region. Had it been otherwise, there would have been no need for the adoption, in 2000, of the Maputo Protocol, now glorified in some circles for, *inter alia*, being the first international treaty to explicitly recognize abortion as a human right. See generally Anthony Kuria Njoroge, *The Protocol on the Rights of Women in Africa to the African Charter on Human and Peoples’ Rights* 1 (Feb. 2, 2005), <http://www.emmabonino.it/campagne/stopfgm/djibouti/njoroge.pdf>; *The Maputo Protocol: Clear and Present Danger*, HUMAN LIFE INTERNATIONAL 6-7, 17 (2009), <http://maputoprotocol.org/maputo-protocol.pdf>. Yet twenty-three of the sixty-eight countries (nearly one-third) with the most restrictive abortion legislation (that “either permit abortion only to save a woman’s life or ban the procedure entirely”) are in Africa. *The World’s Abortion Laws*, ISIS INT’L (Aug. 12, 2008), [http://www.isiswomen.org/index.php?option=com\\_content&task=view&id=1079&Itemid=200](http://www.isiswomen.org/index.php?option=com_content&task=view&id=1079&Itemid=200). And here is the paradox. As of October, 2010, twelve of these same African countries (Angola, Democratic Republic of Congo, Kenya, Lesotho, Libya, Malawi, Mali, Mauritania, Nigeria, Senegal, Tanzania, and Uganda) had also ratified the Protocol which, in § 14(2)(c), permits abortions “in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the foetus,” notwithstanding the apparent conflict with their respective national laws. *List of Countries Which Have Signed, Ratified/Accessed to the Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa*, AFRICAN UNION (July 22, 2010), <http://www.africa-union.org/root/au/Documents/Treaties/List/Protocol%20on%20the%20Rights%20of%20Women.pdf>; see also *The World’s Abortion Laws, Fact Sheet*, CENTER FOR REPRODUCTIVE RIGHTS 1 (2009), <http://reproductiverights.org/en/document/world-abortion-laws-2009-fact-sheet>; *Protocol on the Rights of Women in Africa*, EQUALITY NOW (July 14, 2011) <http://www.equalitynow.org/node/368>.

observed: “Morality can and should overrule both law custom and practice, in fact, morality can and should overrule every other thing except its own very rationale.”<sup>184</sup> At the base of human corporate existence, the relationship that binds one unto another, the cardinal prism from which human conduct and behavior ought to be assessed, is morality.<sup>185</sup> Therefore, whether a law exists or not in respect to a particular conduct is not an argument for the legitimacy of the law. On the other hand, a practice which cannot be faulted on any morally ground is legitimate, even if condemned by the law. This is the fate of anti-FGR human rights framework, especially regarding consenting rational adults.

Another area of deficiency in the anti-FGR human rights framework is its failure to distinguish between FC and bona fide cases of FGM. Part IV of this paper established that although related, FC is not the same as FGM because FGM is morally evil, but FC is not. Just as human rights law does not distinguish, in terms of punishment, between consenting adults and those forced to undergo FGM, it does not distinguish between FGM and FC. The result is that all forms of FGR, regardless of severity, attract the same punishment. But the lesson of Part IV is that when faced with evil and mere moral wrongs, priority should be given to the evil. Because FC and other less invasive forms of FGR are mere wrongs, the punishment should not be the same as the punishment for FGM. The law should reflect these crucial distinctions by imposing minor punishments for less severe cases of FGM and impose no punishment for voluntary FGM.

#### VII. CONCLUSION

The history of human civilization is strewn with repugnant and unconscionable cultural practices—practices once treasured as part of people’s ineliminable identity, but which, over the years, have been consigned to the abyss of history. For centuries, killing twins was an acceptable cultural practice in Southeastern Nigeria.<sup>186</sup> Because twins, or other multiple births, were viewed as curses by Ibos and Ibibios, newborns

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<sup>184</sup> Godfrey B. Tangwa, *Globalisation or Westernisation? Ethical Concerns in the Whole Bio-Business*, 13 *BIOETHICS* 218, 221 (1999).

<sup>185</sup> Morally deficient laws (laws lacking moral justification) will ultimately fail. But because such laws are supported in most cases by the majority, the laws are not transient and may subsist for centuries, all the while wrecking havoc on the lives and well-being of the minority. For instance, it was not until 1865 that the Thirteenth Amendment to the United States Constitution abolished slavery in the country (by providing that “[n]either slavery nor involuntary servitude, except as a punishment for crime whereof the party shall have been duly convicted, shall exist within the United States, or any place subject to their jurisdiction”). But the first batch of African slaves arrived in the United States (Virginia) in 1619. *African Americans at Jamestown*, NAT’L PARK SERV.: U.S. DEP’T OF THE INTERIOR, <http://www.nps.gov/jame/historyculture/african-americans-at-jamestown.htm> (last visited Jan. 5, 2012). Recall that the decision, over two centuries later, by the United States Supreme Court, that black slaves and their descendants could never become citizens of the United States and, therefore, could not sue in federal court was approved by the public. *See Dred Scott v. Sandford*, 60 U.S. 393 (1857). Now virtually every reasonable person in the country considers slavery to be an unquantifiable evil, a stain on the collective conscience of the nation—but only after untold suffering, pain, and destruction of millions of African Americans.

<sup>186</sup> *See D. Lyons, The Material Culture of Twins in West Africa*, SIMON FRASER UNIV. (2000), <http://www.sfu.ca/archaeology/museum/ndi/mystudy.html>.

were immediately killed or cast away in the evil forest, while the mother underwent a period of purification.<sup>187</sup> The arrival of Christianity and the efforts of missionaries, over time, ensured the demise of the practice.<sup>188</sup> Through persuasion, education, and reasoned dialogue, the people gradually realized the error of their ways.<sup>189</sup> Criminal prohibition came later, after the groundwork had been laid. A similar approach may be needed to tackle the problem of FGM.

This Article has demonstrated that demonizing all forms of FGR as FGM fails to advance eradication of the practice. Instead, it estranges the very people whose full and unwavering support is critical to the eradication process. We must distinguish between permanently harmful cultural practices and less severe ones, and the law must explicitly reflect this distinction. Because a clitoridotomy is clearly different from a clitoridectomy, grouping them together, as the WHO classification does, is a mistake. The Latin maxim *culpa poenae par esto* (let the punishment fit the crime) is a legal and ethical principle requiring that sanctions be apportioned according to the severity of the crime.<sup>190</sup> As such, anti-FGR treaties and legislation must be amended to reflect this principle. Along the same trajectory, forced FGR must be decoupled from voluntary cases. There is no reason whatsoever to punish the conduct of adults that has no adverse impact on third-parties.

Regarding forced FGM cases, criminalizing the procedure is commendable, but hardly adequate by itself to trigger needed change. A mechanism designed to change attitudes and behavior seems to be more productive. The value of education in this process cannot be underestimated; FGM and FC are more resisted by the educated class. Dissemination of information about the adverse consequences of the practice holds even greater prospect for success. Beneath all the abstractions, the people whose sufferings drive the debate are the mothers, aunts, sisters, and daughters of those insistent on perpetuating the practice.<sup>191</sup> Care ethics, as shown in Part V, demonstrate that most people would wish no harm on their relatives, even if culture prescribes otherwise. But first people must have a full dose of information.

What man, with full knowledge of the causal link between FGM and the gynecological problems suffered by his wife, would condemn his daughter to the same fate?<sup>192</sup> Even amongst cultural aficionados, many would be less ferocious in

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<sup>187</sup> See generally GEORGE T. BASDEN, *AMONG THE IBOS OF NIGERIA* (1921).

<sup>188</sup> *Id.*

<sup>189</sup> *Id.*

<sup>190</sup> *Latin Quotes: Crime & Criminals*, The Latin Phrases Dictionary, <http://latin-phrases.co.uk/quotes/legal/crime/> (last visited Jan. 5, 2012).

<sup>191</sup> See Jo-Ann and David Jones, *supra* note 14.

<sup>192</sup> This too is problematic. If one accepts the authenticity of recent studies debunking earlier ones that claimed that gynecological health issues await women that have undergone FGM, then the case for its proscription becomes suspect—especially because it is based largely on the adverse health consequences presumed to result from the procedure. See Birgitta Essén et al., *No Association Between Female Circumcision and Prolonged Labour: A Case Control Study of Immigrant Women Giving Birth in Sweden*, 121 EUR. J. OBSTET. GYNECOL. REPROD. BIOL. 182, 185 (2005) (finding that there is no association between FGM and obstructed and prolonged labor); Birgitta Essén et al., *Is There an Association Between Female Circumcision and Perinatal Death?*, 80 BULL. WORLD HEALTH ORGAN. 629, 630 (2002) (finding that none of the perinatal deaths in the study had any relationship to the mothers' circumcision); Andrew Browning et al., *The Relationship Between Female Genital*

their demand for compliance under such circumstances. People must realize that whatever cultural significance FGR holds for them, it can be achieved through means that are free of deleterious health consequences.<sup>193</sup> Through sustained education, people would come to realize that regardless of whether a particular cultural practice has existed for centuries, “societies can and do endorse grave injustices [and] that societies, like their members, can be in need of moral improvement.”<sup>194</sup> After all, as WHO aptly notes: “culture is not static; it is in constant flux, adapting and reforming.”<sup>195</sup> This means that attitude will only change when the practitioners “understand the hazards and indignity of harmful practices and when they realize that it is possible to give up harmful practices without giving up meaningful aspects of their culture.”<sup>196</sup>

On whose shoulders should this heavy lifting lie? Because it has more resources at its disposal, the government has primary responsibility to mobilize the people. Others must take a secondary, though no less important, role, such as civil society organizations (CSOs), faith-based organizations (FBOs), community-based organizations (CBOs), traditional leaders, and media organizations.<sup>197</sup> CSOs are well-suited to translate official government policies into a workable formula. In 2007, the African Union Conference of Ministers of Health called for countries in

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*Cutting and Obstetric Fistulae*, 115 *OBSTET. & GYNECOL.* 578, 580-82 (2010) (finding no evidence that FGM is causally linked to obstetric fistulae); S. Wuest et al., *Effects of Female Genital Mutilation on Birth Outcomes in Switzerland*, 116 *BJOG: AN INTL. J. OBSTET. & GYNECOL.* 1204 (2009) (finding no difference in duration of labor for women who were subjected to FGM (mostly infibulations) in comparison to the control group).

Similarly, there are studies which contradict claims that FGM interferes with sexual intimacy. See Uche Megafu, *Female Ritual Circumcision in Africa: An Investigation of the Presumed Benefits Among Ibos of Nigeria*, 60 *EAST AFR. MED. J.* 793, 795 (1983) (finding that clitoris excision does not impair sexual urge); Catania et al., *supra* note 46; F. E. Okonofua et al., *The Association Between Female Genital Cutting and Correlates of Sexual and Gynaecological Morbidity in Edo State, Nigeria*, 109 *BJOG: AN INTL. J. OBSTET. & GYNECOL.* 1089, 1089 (2002) (finding, on the basis of a study involving questionnaires and medical examinations of 1,836 healthy premenopausal women, that there was no statistically significant difference between cut and uncut women in terms of frequency of sexual intercourse, sexual arousal, or frequency of orgasmic experience during sex, and concluding that “female genital cutting cannot be justified by arguments that suggest that it reduces sexual activity in women . . .”).

<sup>193</sup> Chi Mgbako et al., *supra* note 145, at 112 (citing S. RICH & S. JOYCE, *ERADICATING FEMALE GENITAL MUTILATION: LESSONS FOR DONORS* 3 (1997)) (noting that the failure of advocacy programs to acknowledge the complexities and cultural context of FGR has been detrimental to the cause, and incidentally, a new approach involving “culturally sensitive strategies such as education, sensitization, and community collaboration” has been adopted by civil society organizations).

<sup>194</sup> Rachels, *supra* note 61, at 131.

<sup>195</sup> *Female Genital Mutilation: A Joint WHO/UNICEF/UNFPA*, WHO 1–2 (1997), [http://www.childinfo.org/files/fgmc\\_WHOUNICEFJointdeclaration1997.pdf](http://www.childinfo.org/files/fgmc_WHOUNICEFJointdeclaration1997.pdf).

<sup>196</sup> *Id.*

<sup>197</sup> African Union, *The African Health Strategy: 2007 – 2015 CAMH/MIN/5(III)*, ¶114 (Apr. 9–13, 2007), [http://www.africa-union.org/root/UA/Conferences/2007/avril/SA/9-13%20avr/doc/en/SA/AFRICA\\_HEALTH\\_STRATEGY.pdf](http://www.africa-union.org/root/UA/Conferences/2007/avril/SA/9-13%20avr/doc/en/SA/AFRICA_HEALTH_STRATEGY.pdf) (defining CSOs).

the region to enlist the participation of these organizations in their national programs.<sup>198</sup> Merging the capabilities of CSOs (in terms of technical expertise, proximity to the people, and familiarity with the terrain) and the government (in terms of resources) will bring the much needed attitudinal change. Ultimately, once people reflect honestly on the ramifications of FGM—and this is most effectively possible through massive awareness campaign and education—they will realize that the procedure, when forced on individuals, is indefensible as a legitimate cultural practice, but the government must respect the autonomy of those who voluntarily submit to the procedure.

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<sup>198</sup> *Id.*