Eliminating FGM: The role of the law

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Introduction

On 26 August 1994 the UN’s Sub-Commission on Prevention of Discrimination and Protection of Minorities adopted a Plan of Action for the Elimination of Harmful Traditional Practices Affecting the Health of Women and Children (UN Centre for Human Rights, pp. 40–48). This became the Joint Plan of Action, endorsed by the World Health Organization (WHO), the United Nations Children’s Fund (UNICEF) and the United Nations Fund for Population Activities (UNFPA). The joint plan spelt out the kinds of action required at national and international level, including by UN specialized agencies, non-governmental organizations and health professionals, to eliminate “harmful traditional practices”, meaning chiefly the practice of female genital mutilation (FGM). Every year an estimated 2 million young girls and women worldwide are at risk of being subjected to this cruel and life-threatening practice, in one of its several forms, and between 100 and 140 million girls and women are believed to have undergone it, in 29 countries in Africa as well as some countries in the Middle East and some parts of Asia (WHO, 2003, *Report of the Director-General 1998–2003*, para. 89, and 1998, *Female Genital Mutilation: an overview*, Chapter 2, Prevalence and epidemiology, pp. 9–22).\(^1\)

In addition, the practice is becoming increasingly common in countries which receive immigrants, refugees and asylum-seekers from countries where FGM is practised, with the result that since the 1970s many States in other regions have had to pass legislation to prohibit FGM. In September 2001, the European Parliament adopted a wide-ranging resolution calling upon the European Union and the Member States to work together “on the harmonisation of existing legislation and, should existing legislation not prove appropriate, the drawing up of specific legislation on the subject” (European Parliament, 2001, operative paragraph 2). Member States were also asked to consider “that, from the point of view of legislation to protect children, the threat and/or risk of being subjected to FGM may justify intervention by the authorities” (operative paragraph 11). The resolution calls for the promotion of
foreign aid “to those countries which have adopted legislative and administrative measures prohibiting and punishing the practice of FGM” (operative paragraph 24).

FGM and Children

Although the language of the UN resolutions habitually refers to “women and children”, nearly all the new victims of FGM are children. The operations are usually performed on girls aged between four and twelve,² by traditional excisors paid by the parents, acting under the influence of a socially-inculcated belief that a girl will be marriageable only if she has been mutilated. According to the account in the factsheet on FGM published by the UN Centre for Human Rights:

The type of operation to be performed is decided by the girl’s mother or grandmother beforehand and payment is made to the excisor before, during and after the operation, to ensure the best service. This payment, partly in kind and partly in cash, is a vital source of livelihood for the excisors. The conditions under which these operations take place are often unhygienic and the instruments used are crude and unsterilized. A kitchen knife, a razor-blade, a piece of glass or even a sharp fingernail are the tools of the trade. These instruments are used repeatedly on numerous girls, thus increasing the risk of blood-transmitted diseases, including HIV/AIDS.” (UN Centre for Human Rights, p. 9).

There is a detailed clinical survey of the health impact of FGM in the major 1994 study by Efua Dorkenoo, Cutting the Rose (Dorkenoo, 1994). An earlier survey, written from a human rights perspective, appears in a substantial article by Alison Slack (Slack, 1988).

In the societies which practise FGM, removal of part, sometimes all, of the external genitalia is believed to preserve the girl’s virginity, and therefore her value for the purpose of marriage, by reducing sexual arousal and response. The various reasons given by the practising communities, according to a major study by WHO, “all . . . fit into an elaborate belief system that operates on different levels – all targeting the external genitalia of women and girls” (WHO, 1999, FGM Programmes to Date: What Works and What Doesn’t, p. 5). In these communities myths abound to reinforce the perceived need to excise; an example is the belief found in Nigeria, as well as among the Mossi of Burkina Faso and the Bambara and Dogon peoples of Mali, that if the head of the emerging baby touches the clitoris, the baby will die (Dorkenoo, 1994, p. 34). There is a strong correlation between the practice of polygamy and the practice of FGM, which is most predominant in societies influenced by Islam, although it is also found to occur among Christians in Egypt, Ethiopia and Sierra Leone. Another correlation is between FGM and early or forced mar-