Female genital mutilation (FGM) or female genital cutting (FGC) practices are significant as international human rights issues primarily because of their life-altering impact on the girls and women directly affected. However, contemporary world attention to this complex issue also highlights fundamental tensions in the international human rights movement. The international human rights status of FGC/FGM practices raises challenges for activists and legal scholars, including the following:

- Propriety and extent of public (governmental or international) involvement in behavior that occurs primarily in private (in homes, rural communities, or medical facilities);
- Adequacy of the international human rights legal framework to address gender-based violence and other harms based on gender status; and, most prominently,
- Legitimacy and relevance of theoretically universal human rights norms when they are applied in practice in culturally specific contexts.

This entry provides an overview of the nature and scope of FGC/FGM practices, the debates surrounding the international attention to the issue, their status under international human rights law, and contemporary strategies for ending them. Although it is clear that international human rights standards obligate to prevent and address FGC/FGM practices, substantial controversy remains over how best to implement those obligations.

It must be emphasized that the term “FGC/FGM” (and other terms used below) represent a wide range of practices affecting an estimated 100 million women in many countries and regions who are from diverse religious, ethnic, and cultural traditions. Researchers seeking to explore the issues should do so by reference to specific local and cultural contexts as well as in global perspective. Because of worldwide attention to the issue, an extensive literature exists on the subject (although there is a continuing need for further data-gathering and analysis, disaggregated by ethnic group and region).

**What Are FGC/FGM Practices?**

As used here, FGC and FGM refer to a set of diverse traditional practices involving removal or cutting of the female genitalia and that are harmful to infants, girls, and women. According to World Health Organization (WHO) estimates, between 100 million and 140 million girls and women have undergone some form of such practices and more than 2 million girls are at risk of undergoing them each year.

The WHO categorizes the practices into four main types, but also recognizes that variations within and outside the categories occur in local contexts:

- Type I: excision of the prepuce, with or without excision of part or all of the clitoris;
- Type II: excision of the clitoris with partial or total excision of the labia minora;
- Type III: excision of part or all of the external genitalia and stitching/narrowing of the vaginal opening (infibulation);
- Type IV: pricking, piercing, or incising of the clitoris and/or labia; stretching of the clitoris and/or labia; cauterization by burning of the clitoris and surrounding tissue; scraping of tissue surrounding the vaginal orifice (angurya cuts) or cutting of the vagina (gishiri cuts); introduction of corrosive substances or herbs into the vagina to cause bleeding or for the purpose of tightening or narrowing it.

The WHO notes that the most common form of the practices is excision (citing an incidence of 80 percent of affected women and girls), whereas infibulation, the most extreme and dangerous form, is performed on 15 percent of the affected population of females in practicing regions.
HEALTH RISKS
All types of FGC/FGM pose serious risks to health and well-being, including infection, severe pain, uncontrolled bleeding, loss of libido and sexual function, and infertility. There is a higher risk of disability or death associated with the most severe forms, higher rates of maternal mortality for women who have undergone the practice, and higher rates of infant mortality among the babies delivered by them (WHO, "Obstetric Outcomes," 2006).

Depending on region and group, cutting or infibulation practices may be performed in rural settings by female relatives, midwives, or traditional practitioners. Often, no anesthesia is available. Implements may not be sterilized and may be used on more than one girl at a time, thereby increasing the risk of infection. However, urbanization has also led to the practice being performed in para-medicalized situations, in which some efforts to use anesthesia and sterilization may occur, but the often secretive nature of the practices leads to wide variations in the degree to which such ameliorative measures are used in practice.

The devastating spread of the human immunodeficiency virus and acquired immune deficiency syndrome (HIV/AIDS) pandemic may be exacerbated by FGC/FGM, although data are inconclusive.

DISTRIBUTION AND PREVALENCE
The traditional practices occur in at least twenty-eight of the fifty-four countries in Africa; their prevalence within a particular country depends on the specific ethnic groups and customs within the many diverse societies represented (there are said to be more than eight hundred ethnic groups on the African continent). Female genital cutting practices also occur, to a much lesser extent, among a small number of ethnic groups in South Asia and the Middle East as well.

As a result of global migration, the practices occur within some immigrant communities in North America, Western Europe, and Australia for whom FGC/FGM had been traditional in the country of origin. In certain circumstances, girls who reach the traditional age for "circumcision" are returned to the home country to have FGC/FGM and the ritual initiation associated with those practices performed. Medical professionals who work with or in practicing immigrant communities are becoming more aware of, and sensitive to, the health and social issues involved. For example, at least one clinic focused on the specific health needs of women who have undergone FGC/FGM, the African Women's Health Center at Brigham and Women's Hospital in Boston, has been established in the United States.

The migration of practicing groups to nonpracticing regions presents its own complex issues. Noting the serious risks of infection and hemorrhage associated with several types of FGC/FGM, some commentators suggest that hospitals or medical clinics in nonpracticing regions should perform the practices in sanitary settings and with anesthesia so as to avoid the most severe complications. Such medicalization of the practices is rejected by most human rights advocates, because it does not address the violations of bodily integrity and nondiscrimination involved. It also does nothing to address the risks associated with the more severe forms throughout a woman's life. Still, ethical issues may arise in Western medical settings that serve patients from immigrant communities in which infibulation is practiced, as childbirth or other medical conditions may require defibulation and surgical repair by a medical professional (Toubia).

Infibulation, the most dangerous and debilitating of the FGC/FGM practices, is also the rarest in terms of global prevalence, representing only 15 percent of those affected by FGC/FGM. However, it continues to occur on a widespread basis among practicing groups in Djibouti, Somalia, Eritrea, and the Sudan. In addition to the extensive and extremely painful destruction and removal of body tissue involved, followed by stitching, infibulation thereafter may result in chronic urinary tract or menstrual problems. Furthermore, depending on the size of the passage created at the time of infibulation, women may have to be cut open and restitched many times during their lives in order to engage in intercourse and to bear children.

WHY IS FGC/FGM PRACTICED?
The explanations and motivations for cutting and infibulation are varied and are associated with beliefs among particular ethnic groups or religious sects as well as contemporary economic and societal pressures (Obiora). Ritual cutting and infibulation practices have been documented for centuries, including evidence of use by Egyptians during the pharaonic period, but the historical basis of their appearance in any particular region or culture is often difficult to determine. However, sociologists, anthropologists, and traditional leaders have suggested a number of explanations. Some attribute the
rituals performed on both males and females as associated with ancient creation myths. In those contexts, FGC/FGM is said to be intended to increase physical compatibility between the genders (i.e., the removal of "male" features in women and "female" features in men). Other explanations include attempts to control unauthorized reproduction in the intra-African slave trade; the removal of parts of the female body considered to be harmful to infants during the birthing process; or a painful "trial" to initiate young girls into adulthood within their ethnic or social group.

Clitoridectomy was also practiced in Europe and the United States as late as the nineteenth century by some obstetricians and gynecologists on adolescent girls or adult women, in the belief that such practices might "cure" so-called hysteria or depression, or unsanctioned sexual behavior in women. Some surgeons also experimented on enslaved African American women by surgically mutilating them. The practices do not, however, appear to have been widespread or customary in the West.

Religious requirements or traditions.
Some traditional African religions view cutting or infibulation practices as recommended or required, but the anthropological data are mixed and group-specific (Gruenbaum). Like a variety of religious customs and traditions in the West that do not necessarily have a basis in religious text, such customs may, nevertheless, be strongly defended by devout believers. In addition, the legacy of Islamic and Christian proselytizing, cross-cultural migration, and colonization affected large parts of the African continent. This often led to religious syncretism in which traditional, Christian, Jewish, or Muslim religious customs are inextricably mixed in contemporary religious expression.

Cutting or infibulation practices can be found among members of traditional, Christian, and Muslim groups in practicing regions. The distribution patterns of some forms of FGC/FGM track Islamic influence in some areas, but the dominant view among Muslim scholars and leaders is that cutting and infibulation practices are not a requirement of Islam (Office of the High Commissioner for Human Rights). As noted above, the practices predate Islam. The Prophet Muhammad, the founder of Islam, refers to them, however, in a Hadith (an informal saying of the Prophet) rather than in the Holy Qur'an (believed by Muslims to be the revealed word of Allah or God).

The relevant hadith states:
Um Atiyat al-Ansariyyah said: A woman used to perform circumcision in Medina. The Prophet (pbuh) said to her: Do not cut too severely as that is better for a woman and more desirable for a husband. (Muslim Women's League, citing Sunan of Abu Dawud, chapter 1888)

The vast majority of the world’s estimated 1.3 billion Muslims do not practice FGC/FGM although some Muslim religious leaders from practicing regions have defended them. The prevailing interpretation is that the informal saying of the Prophet merely acknowledges the existence of cutting practices among some local ethnic groups. The statement therefore advises those groups to ameliorate the impact of the practices [i.e., if cutting is done (as part of local custom rather than religious requirement), it should not be done in a severe manner].

Coming-of-age rituals/initiation.
Members of practicing communities, as well as Western and African anthropologists, have examined the association of FGC/FGM with adulthood rituals within certain ethnic groups. In some of those contexts, the practices are paired with male genital cutting (i.e., circumcision) or adulthood tests for boys as well as girls. Among certain groups in Sierra Leone, for example, girls are initiated into secret societies and maintain life-long sisterhood relationships with girls who were initiated at the same time. The initiated girls would traditionally have been segregated from the rest of the community during the healing process and would have been taught customary marital and community values and skills.

Hygiene.
Although there is no scientific basis for the belief, some practicing groups believe that both male and female genital cutting practices allow for better hygiene. Others believe that the excised body parts are themselves unclean.

Aesthetics.
Some groups believe that male and female genital cutting practices remove female body attributes from boys and male body attributes from girls so as to bring the two sexes in harmony or complementarity.

Cultural cohesion/resistance.
Although no longer commonly asserted as a basis for the practices in contemporary context, certain groups
maintained excision practices as a form of resistance to colonial prohibitions and the associated influence of early Christian missionaries. This was said to be the case, for example, in colonial Kenya, where British officials banned circumcised girls from attending British-sponsored schools.

**Enforcement of gender and sexuality norms.**

The most controversial explanation for FGC/FGM in contemporary contexts is their use as a means to preserve the chastity or spousal fidelity of girls and women. This explanation parallels many traditional and modern practices throughout the world that conflate family or community honor with the sexual "purity" of girls and women. Enforcing a stereotyped role for females has served as an excuse for domestic violence and so-called honor killings, as well as violently imposed restrictions on female dress and participation in public life.

A commonly asserted reason for FGC/FGM, therefore, is the socially imposed desire to prepare a young girl for marriage and to preserve chastity prior to marriage. A few cultures also believe that the practices may enhance sexual pleasure. In societies in which the practices are widespread and socially or religiously sanctioned, even individuals who may otherwise object to the practice fear that an unexcised girl will be ostracized and ineligible for marriage. Such exclusion from eligibility for marriage could be devastating in patriarchal communities in which women's access to land, property, and other means of subsistence are determined by relationships with males.

Some feminists from both Western and non-Western contexts see a deep-seated global norm of patriarchal control as the primary factor behind the continued practice of FGC/FGM. They note that a strong, and socially enforced, desire to control women can even assert itself against legal sanctions and increasing awareness of the health consequences. This patriarchal tendency, which takes many forms throughout the world, allows the practice to survive despite the international anti-FGM movement's educational and political influence, the imposition of domestic criminal sanctions, and the recognition of FGC/FGM as a form of gender-based persecution for which asylum could be granted. The authority of cultural patriarchy can create a strong enough pull to lead some parents in urban or immigrant communities to go underground in order to maintain the practices. Some send initiation-aged daughters away in secret to be cut, whereas others allow the rituals to be performed at infancy or a much younger age than is traditional so as to avoid detection or an older girl's ability to run away or seek asylum. Effective responses, therefore, would have to support the human dignity of girls and women as well as address the specifics of a harmful traditional practice.

**DEBATE OVER TERMINOLOGY**

"Female genital mutilation," "female genital cutting," "female circumcision," and "female genital surgeries" are among the many terms applied to the set of traditional practices. Controversies over the names used to describe them reflect deep substantive disagreements about the cross-cultural criticism discussed below. Each term is useful or most relevant in a specific social setting; the choice of terminology relates to the speaker's ethical views, perspectives on the nature of the practice or practices concerned, and other considerations. Appropriate terminology depends on context; it may be most persuasive and respectful for those from non-practicing regions to use the terminology preferred by the women or girls from a specific community or region when discussing the practices with them.

In traditional contexts, FGC/FGM is referred to by various names in the local language or dialect. A particular word can be used to refer to the entire array of rituals and training associated with the passage to adulthood as well as the cutting practices themselves. It can also refer to the initiation of boys. For example, Jomo Kenyatta used the term "irua" to describe initiation rituals for both girls and boys among the Kikuyu in Kenya. Some groups do not name a particular FGC/FGM practice at all or refer to it euphemistically as "the tradition," because they consider naming a sacred practice a cultural or religious taboo. Others, like many in the West, consider the public discussion of female genitalia inappropriate as a matter of personal privacy or social propriety. Concerns over privacy and religious taboos, for example, were important aspects of the cultural offense taken when Western feminists and other activists formed international campaigns against the practices in the 1970s and 1980s.

Some Islam-influenced regions refer to the practice as "sunna." Christian missionary and British colonial influence resulted in the widespread use of "female circumcision" among English-speakers within and outside Africa. It is still used in the early twenty-first century, but grew less common outside Africa as the global women's movement became more broadly recognized in the 1990s. Critics of the term point out that it is only the least
invasive, “pricking" forms of cutting and mutilation that could be said to bear substantive parallels to most forms of male circumcision rituals (in which the foreskin of the penis is cut away shortly after birth or on reaching the age of initiation).

Although both male and female circumcision rituals involve damage to bodily integrity, cutting and infibulation practices may leave the girl or woman with permanent physical disabilities or may be life-threatening. The similarities of the names, critics argue, mislead those unfamiliar with the practices to believe that any pain or harm involved is relatively minor and temporary. It is worth noting, however, that some activists condemn both male and female genital cutting as unnecessary and mutilating.

The term “female genital mutilation" was introduced by Western observers of the practices, although it is now used extensively by those who oppose the practices in Africa and by international and regional organizations. Some international bodies, including the United Nations Children’s Fund (UNICEF), combine the term with “female genital cutting" ("FGC/FGM" as most often used herein). Critics of the term “FGM” are concerned that it implies parents and traditional practitioners deliberately intend to deform children for sadistic or explicitly patriarchal reasons. Since FGC/FGM is generally performed with the permission of one or both parents or guardians, the term seems to imply the criminal intent associated with child abuse. The socially sanctioned and widespread nature of the practice among some ethnic groups makes such assumptions particularly problematic. At the same time, other observers within and outside practicing regions (and some who have experienced the practice) use the term intentionally to make central the serious physical and psychological harms experienced and to emphasize its status as a form of gender-based violence.

Terms such as “female genital cutting" and “female genital surgeries" and the technical names for its specific forms (excision, clitoridectomy, and infibulation) seem to lend descriptive distance or objectivity to the discussion, although no such objectivity is fully possible given the highly charged nature of the practices across and within cultures. The benefits of these terms can include greater specificity and some degree of accuracy depending on the particular practice or context involved. Such terms also attempt to avoid the more culturally, racially, or individually offensive associations of “mutilation.”

The drawbacks include that very claim to accuracy or clinical objectivity with regard to behaviors that may result in serious injury, death, or emotional damage to girls and women. Most troubling for many is the fear that some such terms will lead listeners to believe that most instances occur under clinical, sanitary conditions in health clinics or hospitals. Although the medicalization of traditional practices sometimes occurs in urban centers, most reports indicate that the majority of cutting and mutilation rituals are performed by traditional practitioners. In traditional contexts, no modern antiseptic or anesthesia is used (traditional pain-suppression methods such as cold water, herbs, and performing the procedure on a girl just after being awoken from sleep may be employed). Given the pain and risks of infection and uncontrolled bleeding associated with the practices, critics argue, observers should not be lulled into associating most forms of cutting and infibulation with minor medical procedures.

As noted above, it seems most appropriate to use each term in a specific context in ways that are understandable and effective in promoting cross-cultural dialogue and strategies for ending the practices.

GLOBAL FEMINIST RESPONSES TO FGC/FGM: DIVISIONS AND SOLIDARITY

Because FGC/FGM practices are abhorrent to most Western observers and yet widely accepted, even required, among members of practicing cultures, some cultural relativists argued that they are an illustration of the impropriety and futility of a universal approach to human rights standards. Such a strong form of cultural relativism is largely rejected on the contemporary international stage, but a weak form that calls for context-sensitive approaches to human rights remains relevant.

The rise of global feminism was an important backdrop against which the universalism versus cultural relativism debates over FGC/FGM played out. The controversies over international approaches to cutting and infibulation became most visible on the world stage in the 1970s and 1980s as a global feminist human rights movement asserted itself. This movement, which has been described under various umbrella terms such as “violence against women” (VAW) and “women’s rights as human rights,” drew energy from and tracked the major world conferences on women’s issues, human rights, and population issues organized by the United Nations (UN). The controversies over cutting and infibulation often played a central role in the discourse and development of the global feminist movement itself.
The UN designated 1975 as International Women's Year and organized the First World Conference on Women in Mexico City, Mexico. It then launched the Decade for Women (1976–1985). Significantly, this period saw the entry into force of the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW or “the Women's Convention”). CEDAW reflects the global feminist movement's politics and priorities of the late 1970s and early 1980s, including concerns about the discriminatory impact on women of traditional practices.

The 1985 Nairobi World Conference to Review and Appraise the Achievements of the United Nations Decade for Women: Equality, Development, and Peace attracted more than 14,000 women from 150 countries to the non-governmental (NGO) forum. Many attendees were from grassroots women's NGOs that did not previously have access to such a cross-cultural gathering of women. The location of the conference also enabled many African women's NGOs to participate in global feminist agenda-setting for the first time.

Nairobi and other global women's conferences broke new ground by bringing world attention to the previously marginalized status of women. Yet they were often also contentious, and FGC/FGM was a topic of significant controversy. Broadly described, divisions existed between Western feminists and third world feminists (Mohanty et al.) about the propriety of addressing cutting and mutilation on the world stage at all, eradication strategies, or the relative priority of ending harmful traditional practices in comparison with overall economic development.

Many Western feminists argued for immediate criminalization and condemnation of FGC/FGM as sexist and patriarchal practices and for greater implementation of Western reproductive health education models. For the strongest advocates of this approach, there were to be no accommodations to the practices in a cultural context, just as there should be none for the traditional forms of political torture or child abuse that human rights activists otherwise condemn. They saw the practices as clear examples of the patriarchal domination of third world women by third world men.

By contrast, other feminists believed a more contextualized and indigenous approach was needed. The Western focus on a cultural tradition generally performed by women on girls and infants in private seemed to some African defenders of the practices, for example, to involve just another form of cultural imperialism and invasion of privacy. Some indigenous anti-FGC/FGM groups represented the outside interventions of well-funded Western feminist and aid organizations, some of which tried to work on the issue without consulting local activists. Finally, others rejected a focus on traditional practices altogether as a diversion from the more pressing needs for overall education, health care, and economic development. These tensions even resulted in protests and walk-outs at world conferences, particularly when some Western feminists exhibited graphic photographs or videos of the excised or infibulated genitalia of women from practicing regions.

Despite these conflicts, FGC/FGM was referenced in the outcome document, the *Nairobi Forward-Looking Strategies for the Advancement of Women: Equality, Development, Peace*, which encouraged measures to combat all forms of violence as obstacles to women's advancement on all levels, including economic and social development. The Nairobi gathering opened a cross-cultural dialogue that continued at subsequent local, regional, and international levels, setting the stage for continued progress and constructive dialogue on FGC/FGM and many other women's human rights issues (Lewis).

The UN Second World Conference on Human Rights, held in Vienna, Austria, in 1993, proved to be another watershed moment for the global women's movement and for advocates hoping to eliminate FGC/FGM. Prior to the conference, women's NGOs and officials working within the UN system developed a media, legal, and organizing strategy aimed at advancing the status of women in a way that could overcome some of the previous divisions (Bunch).

Advocates identified and prioritized key women's issues, including FGC/FGM, that could be categorized under the single rubric “violence against women” (VAW), a focus of the Nairobi conference's *Forward-Looking Strategies*. The VAW strategy was explicitly aimed at making women's issues central at the official UN conference through interventions from within and through NGOs gathered at an associated forum. Advocates realized that violence, in the form of war, torture, and civil unrest, often galvanized media attention and that of powerful international bodies such as the UN.

By focusing on VAW, organizers hoped that they might attract significant media attention to the fact that women were subject to the same kinds of violence as men, as well as unrecognized forms of gender-specific violence such as FGC/FGM. The resulting media and popular attention also influenced the government officials and UN diplomats who attended the Vienna event and subsequent official conferences.
Furthermore, by placing many issues affecting women both North and South under the single umbrella term “violence against women,” activists helped to defray the cross-cultural conflict resulting from the characterization of cultural practices in the third world as uniquely oppressive to women. Women and men from all regions, races, and social classes could share experiences of violence and identify similarities in nature, causes, and consequences. Honor killings, for example, could be viewed as one end of a continuum of gender-based violence in the home that bears striking resemblances to domestic violence in the West. Similarly, some compared FGC/FGM with societal pressures in the West for women to undergo cosmetic surgery in order to enhance their attractiveness to men.

The successful interventions of women at the Vienna conference resulted in several developments that were instrumental in placing the issue of FGC/FGM on the international human rights agenda: the adoption of a UN Declaration on the Elimination of Violence against Women and the appointment of a UN special rapporteur on violence against women charged with issuing periodic reports. Later, the Committee on the Elimination of All Forms of Discrimination against Women adopted General Recommendation No. 19, a highly influential statement that explicitly interpreted violence against women as a form of discrimination prohibited under the Women’s Convention. The UN Fourth World Conference on Women was held in Beijing, China, in 1995 and resulted in another galvanizing opportunity for thousands of women to organize, engage in cross-cultural dialogue, and influence international and domestic action. These instruments and statements, as well as the Beijing Declaration and Platform for Action, condemned FGC/FGM as a form of violence against women and recommended measures for its eradication. These documents reflect a growing consensus on the need for eradication and on more sophisticated and contextualized strategies to be undertaken.

**STATUS OF FGC/FGM UNDER INTERNATIONAL HUMAN RIGHTS LAW**

Governments are responsible under international law for taking appropriate measures (which may include legislation and other means) to eliminate FGC/FGM practices as well as other forms of violence against women that occur within their jurisdictions. This responsibility has been recognized in the plain text or in interpretations of widely ratified human rights treaties. This obligation may also be a matter of international customary law, as reflected in authoritative statements such as the Universal Declaration of Human Rights and as supported by influential soft law recommendations and declarations.

A growing number of states have adopted national or subnational legislation aimed specifically at the elimination of cutting and infibulation practices. Although criminalizing legislation is one means by which international legal obligations to end FGC/FGM may be implemented, many international organizations or NGOs addressing the practice also advocate an integrated approach to eradication involving a combination of law, education, and health policy.

**INTERNATIONAL BILL OF RIGHTS**

The International Bill of Rights establishes a general framework against which FGC/FGM practices can be measured. Comprised of the Universal Declaration of Human Rights (UDHR), the International Covenant on Civil and Political Rights (ICCPR), and the International Covenant on Economic, Social, and Cultural Rights (ICESCR), the International Bill of Rights provides an important basis for the status of cutting and infibulation as violations of international human rights. As feminist human rights scholars and activists point out, however, the International Bill of Rights, with its very broadly stated standards focused on the public sphere, did not fully address the specific needs of women, or did so only narrowly to the extent that women were also wives and mothers. Nevertheless, these documents outline the fundamental human rights universally applicable to women and men wherever they live and whatever their socioeconomic status. They provide a fundamental floor of rights that include both negative prohibitions on state actions that violate protected rights, as well as create positive obligations on states to take steps to respect, protect, and fulfill elaborated rights.

A laundry list of the rights under the International Bill of Rights that arguably apply to FGC/FGM practices includes:

- The right to nondiscrimination on the basis of sex in the application of other fundamental human rights;
- The right to equal treatment under the law;
- The right to life, liberty, and security of the person;
- The right not to be subjected to torture, or to cruel, inhuman, or degrading treatment or punishment;
- The right to freedom of thought, conscience, and religion (including the right to change one’s beliefs);
• The right to the enjoyment of the fullest attainable standard of physical and mental health;
• The specially protected status of motherhood and childhood;
• The freedom, either alone or in community with others and in public or private, to manifest one's religion or belief in teaching, practice, worship, and observance;
• The right freely to participate in the cultural life of the community;
• The right of individuals who belong to ethnic, religious, or linguistic minorities to enjoy their own culture and to profess and practice their own religion, in community with the other members of their group.

The ICESCR contains the most fully developed elaboration of a right to health, and it has been on the issue of health that the anti-FGC/FGM human rights strategy has its most widely accepted basis. Article 12 outlines measures that states should take to achieve the realization of this right, including the steps necessary to reduce the infant mortality rate and promote healthy child development as well as the "prevention, treatment and control" of epidemic diseases. To the extent that cutting and infibulation practices increase infant mortality rates, contribute to the spread of epidemic infections such as HIV/AIDS, and otherwise interfere with the highest attainable standard of health, states parties are under a legal obligation to take steps to address these problems effectively.

The status of FGC/FGM as a set of cultural or religious traditions poses a potential conflict for states. Must they choose between respecting cultural and religious freedoms or individual rights? As discussed above, cutting and infibulation practices are not required by organized religions, but may well reflect strongly held cultural beliefs among practitioners of traditional and organized religions nevertheless. However, despite the apparent tension between the right to bodily integrity, for example, and the right to participate in and manifest cultural beliefs, the latter rights can be limited to the extent that they interfere with the rights of others or endanger public health and safety.

THE WOMEN'S CONVENTION:
A REVOLUTIONARY APPROACH TO FGC/FGM?

Despite the fact that FGC/FGM practices violate human rights defined under the International Bill of Rights, the application of the traditional human rights framework in this context raises a number of challenges. The practices are performed largely by women on female infants and children, usually with the approval of loving parents or guardians. They are often performed in secret or in private homes or villages, not (necessarily) by or with the overt encouragement of government officials. They are generally sanctioned by the community and, sometimes, even requested by girls nearing the age of initiation in order to obtain the status and privileges of adulthood. Cutting and infibulation practices are also associated with apparently religious or cultural traditions that are deeply ingrained and significant to the social groups involved, with some taking precedence even over the legal requirements of the state.

All these aspects of FGC/FGM made their full condemnation under the traditional human rights standards in the International Bill, with its focus on direct state action as potential violations and state interventions as potential remedies, problematic. Women and girls are formally covered to the same extent as men and boys, but their particularities seem largely invisible.

It was, therefore, the entry into force of the Convention on the Elimination of All Forms of Discrimination against Women in 1981 that provided the most specific international legal bases for the status of FGC/FGM as violations of international human rights law. CEDAW defines "discrimination against women" very broadly to include the following:

any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field. (Article 1)

The treaty, legally binding on states parties, addresses violations that occur both intentionally and by effect, embraces an equality standard with regard to the treatment of women and men, and recognizes the interrelatedness of civil, political, economic, social, and cultural spheres and rights. FGC/FGM's potential to "impair or nullify" many aspects of the lives of girls and women therefore qualifies as prohibited discrimination.

Article 2 of the convention requires that states parties "pursue, by all appropriate means and without delay" the elimination of discrimination against women. In doing so, states not only are required to refrain from engaging in discriminatory acts, they are also required to take appropriate measures to address discrimination, including
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legislation. CEDAW also crosses the public/private divide by not only addressing discriminatory state action but also discrimination by private individuals and organizations. This approach would allow states to take action to address the "private" violations involved in FGC/FGM.

Article 2(f) and Article 5 provide specific language establishing a state's legal obligation with regard to the elimination of FGC/FGM practices. Article 2(f) requires states parties to "take all appropriate measures, including legislation, to modify or abolish existing laws, regulations, customs and practices which constitute discrimination against women."

Furthermore, Article 5 states that

States Parties shall take all appropriate measures:
(a) To modify the social and cultural patterns of conduct of men and women, with a view to achieving the elimination of prejudices and customary and all other practices which are based on the idea of the inferiority or the superiority of either of the sexes or on stereotyped roles for men and women.

The idea that states could now be under an affirmative obligation to intervene in the private sphere of community, culture, and even family was not without controversy. Critics of this language feared that governments would use their enormous power to interfere significantly in the private and cultural lives of disfavored individuals and communities. This caused particular sensitivity with regard to the indirect financial pressures governments in developing countries could face in adopting aggressive anti-FGC/FGM measures or using FGC/FGM as a pretext for ethnic persecution.

On the other hand, CEDAW requires throughout that the measures and means taken by the state must be appropriate, taking into account the contexts in which they are used. Abuses of state power in this regard would also violate other well-recognized international human rights and humanitarian standards.

Article 12 of CEDAW provides for the right to health care in the form of access to information and services, rather than the more extensive right to health outlined in the ICESCR. Nevertheless, health care and health education are crucial in both the prevention and treatment of FGC/FGM.

CEDAW Committee and an Integrated Approach to FGC/FGM

The CEDAW Committee, the expert body charged with overseeing the interpretation and implementation of the Convention (and its 1999 Optional Protocol to address complaints), has assertively engaged cutting and mutilation issues and violence against women in general as human rights issues. First, it issued in 1990 General Recommendation No. 14: Female Circumcision, which calls on states parties to take "appropriate and effective measures" to eradicate the practices.

General Recommendation No. 14 outlined an integrated approach to the roles of governments in helping to eliminate FGC/FGM, but did not explicitly endorse criminal measures. The committee emphasized that states should develop training and education programs to increase awareness of the harmful effects of the practices as well as take advantage of information and resources on the issue available through international organizations.

It also recommended the inclusion of eradication strategies in national public health policies and the retraining of indigenous midwives and other traditional health practitioners who could then educate their patients on the harmful effects of the practices. Furthermore, states were urged to collaborate with indigenous women's organizations already working to eliminate the practices and to work with community, cultural, and religious leaders to encourage change, including through the media. Significantly, states were asked to gather more data on the practices and include information on anti-FGC/FGM strategies in their periodic reports to the committee.

This holistic approach to the issues tracked and developed similar efforts and recommendations by the WHO, the UN's Special Rapporteur and Working Group on Traditional Practices Affecting the Health of Women and Children, the Inter-African Committee on Traditional Practices Affecting the Health of Women and Children, and domestic efforts by some women's NGOs.

By 1992 the CEDAW Committee issued its groundbreaking and comprehensive General Recommendation No. 19: Violence Against Women, which specifically interpreted violence against women (which was not explicitly mentioned in CEDAW's text) as a form of discrimination against women based in widespread attitudes about the inferiority of women or their stereotyped roles. The document identifies FGC/FGM practices squarely as a denial of women's civil, political, economic, social, and cultural rights based on gender prejudice and patriarchal control. The General Recommendation recognizes that structural barriers to women's economic, social, and cultural participation and advancement provide a basis for many of the forms of individual or collective physical violence that women face.
General Recommendation No. 19 discusses FGC/FGM in its interpretations of the CEDAW provisions under, among other provisions, Articles 2(f) and 5 addressing traditional practices:

11. Traditional attitudes by which women are regarded as subordinate to men or as having stereotyped roles perpetuate widespread practices involving violence or coercion, such as family violence and abuse, forced marriage, dowry deaths, acid attacks and female circumcision. Such prejudices and practices may justify gender-based violence as a form of protection or control of women. The effect of such violence on the physical and mental integrity of women is to deprive them of the equal enjoyment, exercise and knowledge of human rights and fundamental freedoms. While this comment addresses mainly actual or threatened violence, the underlying consequences of these forms of gender-based violence help to maintain women in subordinate roles and contribute to the low level of political participation and to their lower level of education, skills and work opportunities.

DECLARATION ON THE ELIMINATION OF VIOLENCE AGAINST WOMEN

Months after the 1993 Vienna World Conference on Human Rights, the UN General Assembly adopted the Declaration on the Elimination of Violence against Women. The declaration strengthened the growing international consensus that public or private gender-based violence (including FGC/FGM) is a human rights violation that should be prohibited by states and eliminated through law and other appropriate measures. It specifically includes "female genital mutilation" in its definition of violence against women in Article 2. Under Article 4, the declaration recognizes an affirmative "due diligence" duty on states to prevent, investigate, and punish violations even by private actors. It does not allow states to hide behind the invocation of custom, tradition, or religion as a justification for failure to address VAW.

Article 5 of the Declaration recognizes a full range of state implementation measures, including "penal, civil... and administrative sanctions in domestic legislation," the development of national plans for and comprehensive approaches to the prevention of violence against women in all aspects of society, and provisions for the economic assistance and rehabilitation of women subjected to violence. It also echoes CEDAW's requirement that the state take appropriate measures to modify social and cultural patterns and eliminate practices based on gender stereotypes.

To address cross-cultural tensions and charges by some national leaders that attention to women's issues was a mark of Western cultural imperialism, Article 5(o) and (p) specifically recognize the role of the international women's movement and indicate that states should collaborate with national and regional women's NGOs.

FGC/FGM AND CHILDREN'S RIGHTS

Although the International Bill of Rights and other treaties recognize the human rights of children within the family and the need for child protection, the Convention on the Rights of the Child (CRC), entered into force in 1990, also elaborates rights for children in their capacity as separate persons. It addresses cutting and infibulation practices and other traditional practices that harm children. Although the CRC provides for and respects the autonomy of children to a greater degree than most other human rights treaties, it also respects the primary role of parents, extended family, and communities in raising and caring for children.

With regard to those provisions most relevant to FGC/FGM, Article 19(1) requires states to protect children "from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation... while in the care of parent(s), legal guardian(s) or any other person who has the care of the child." Article 24, which, like the ICESCR, protects children's right to "the enjoyment of the highest attainable standard of health," also requires states parties to "take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children" (Article 24[3]).

CEDAW and the CRC are among the most widely ratified human rights instruments and therefore very significant sources of law on the human rights status of FGC/FGM. The CRC, for example, has been ratified by all UN member states except the United States and Somalia.

REGIONAL HUMAN RIGHTS RESPONSES

As a result of indigenous, regional, and international attention to the issues, and more effective cross-cultural dialogues in the late 1990s and early twenty-first century, African regional human rights treaties now indirectly or explicitly identify FGC/FGM practices as human rights violations to be eliminated in favor of more positive indigenous values and traditions. The foundational regional human rights instrument, the African [Banjul] Charter on
Human and Peoples’ Rights, provides generally for the right to health in Article 16. Article 18(3), discussing the right to protection of the family, requires states parties to “ensure the elimination of every discrimination against women and also ensure the protection of the rights of the woman and the child as stipulated in international declarations and conventions.” The Banjul Charter imposes duties on individuals as members of society. For example, it requires in Article 29 that individuals “preserve and strengthen positive African cultural values,” thus presumably leaving room for the eradication of those values that are harmful.

The African Charter on the Rights and Welfare of the Child, entered into force in 1999, imposes provisions similar to those of the CRC and also addresses traditional practices like FGC/FGM directly. For example, Article 1(3) provides that “any custom, tradition, cultural or religious practice that is inconsistent with the rights, duties and obligations contained in the present Charter shall to the extent of such inconsistency be discouraged.”

Furthermore, Article 21 requires states parties to take appropriate measures “to eliminate harmful social and cultural practices affecting the welfare, dignity, normal growth and development of the child.” It includes “those customs and practices prejudicial to the health or life of the child” and “those customs and practices discriminatory to the child on the grounds of sex or other status” as harmful practices.

The Protocol on the Rights of Women in Africa (commonly known as the Maputo Protocol) entered into force in 2005. It defines harmful practices to mean “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” (Article 1). It also includes a broad definition of “violence against women” that can be interpreted to include cutting and infibulation practices and requires states parties to take appropriate and effective measures, including legislation, to prohibit and prevent them. Along the same lines as a provision in CEDAW, Article 2(2) requires states to “commit themselves” to modify social and cultural patterns that perpetuate harmful traditional practices.

Article 5 further illustrates an integrated approach to the elimination of FGC/FGM practices that recognizes the need for a multidimensional response:

States Parties shall prohibit and condemn all forms of harmful practices which negatively affect the human rights of women and which are contrary to recognised international standards. States Parties shall take all necessary legislative and other measures to eliminate such practices, including:

(a) creation of public awareness in all sectors of society regarding harmful practices through information, formal and informal education and outreach programmes;
(b) prohibition, through legislative measures backed by sanctions, of all forms of female genital mutilation, scarification, medicalisation and para-medicalisation of female genital mutilation and all other practices in order to eradicate them;
(c) provision of necessary support to victims of harmful practices through basic services such as health services, legal and judicial support, emotional and psychological counselling as well as vocational training to make them self-supporting;
(d) protection of women who are at risk of being subjected to harmful practices or all other forms of violence, abuse and intolerance.

DOMESTIC APPROACHES

The translation of international standards into domestic law and policy is a crucial aspect of the effective implementation of human rights. This is particularly true of the prohibition, prevention, and elimination of cutting and infibulation practices. As a result of both international and regional pressure, a growing number of countries have adopted legislation criminalizing or otherwise banning or condemning the practices (Rahman and Toubia).

Most of the applicable international and regional instruments and provisions relevant to FGC/FGM contemplate the use of legislative measures. They also require that measures taken be “appropriate.” Criminal bans may well fall into that category, but criminalization does not constitute the full range of potentially effective measures at the domestic level.

Although national criminalization sends an authoritative message that the practices will no longer be tolerated by the state and that private practitioners are subject to penalties, significant challenges also exist with regard to the efficacy and appropriateness of such an approach if it is not combined with other measures as part of an integrated plan of action. For example, where the practices are almost universal or are widespread, the enforcement of criminalization statutes may prove impossible. Similarly, where governments merely try to make an example of a particular parent or traditional practitioner, they may
thereby violate his or her rights to due process or equal treatment under the law.

Similarly, criminalization creates special concerns in countries where FGC/FGM is practiced only among immigrant groups (such as the United States, France, or the United Kingdom). Individual practitioners or parents may be subjected to sensational trials or ethnically discrimination that may drive FGC/FGM further underground or encourage parents to send their daughters to the home country for cutting. Some such statutes, however, include provisions requiring that immigrants from practicing regions be informed of the criminal ban and educated as to the harmful effects of FGC/FGM upon entry.

Under the integrated approach recommended by the CEDAW Committee, the Declaration on the Elimination of Violence against Women, and the Maputo Protocol, legislation should be combined with other forms of public and private supports if FGC/FGM is to be effectively and appropriately eliminated. For example, the clear statements of national, cultural, and religious leaders against these practices can send a strong signal. Domestic and international commitments to the education of girls, boys, and adults can also reduce its prevalence. Similarly, affirmative measures that are integrated with other pressing needs may be more effective, such as the provision of accessible and affordable health and reproductive education, the training of traditional and modern health-care workers, and supports for the economic and social status and self-sufficiency of girls and women.

All these approaches require the participation and leadership of indigenous women and men. One successful effort in Senegal, for example, involved a community-based process of education, followed by a communitywide decision to end the practices. Communities that decide to do so then influence surrounding communities to do the same (Kwoka). Some groups in other practicing regions adopt alternative coming-of-age rituals in which FGC/FGM is not performed and instead emphasis is placed on training girls in the social, religious, or other positive aspects of the transition to adulthood. Such integrated approaches have been adopted by African women's NGOs, immigrant women's groups in the West, and international human rights NGOs.

**HUMAN RIGHTS, INTERDEPENDENCE, AND AN END TO FGC/FGM**

International and regional leaders and activists widely recognize that cutting and mutilation practices are a serious violation of the human rights of women and girls. The negative impact on public health, economic and social development goals, community cohesion, and the individual autonomy of girls and women support this growing consensus.

The international human rights movement takes a clear position that cutting and mutilation practices are a form of violence against women and children and therefore an appropriate subject of international human rights concern and action. To be effective, such action must occur on international, regional, national, and local levels and must prioritize the participation of the communities most directly affected, not only as survivors but as leaders in the elimination of the practices.

Discrimination against women in all spheres of social, political, and economic life, and failure to respect, protect, and fulfill fundamental rights such as the right to health, education, food, and housing undermine the ability of women and girls to make important decisions about their own lives and those of their families and communities. Poor women and girls, for example, are more likely to believe that they must perform or undergo FGC/FGM to maintain social and economic supports and community relationships. In contrast, women whose fundamental rights are respected are better able to reach their full potential as individuals and to make sustainable and positive contributions to their communities. Effective approaches to eliminating FGC/FGM practices, therefore, require a broad-based, multidimensional commitment to the sustainable advancement of girls and women (Woods and Lewis).

*See also AIDS/HIV; Collective/Group Rights; Colonialism; Communitarianism and Community; Culture and Human Rights; Right to Development; Right to Health and Health care; Inter-African Committee on Traditional Practices; Islam; Minority Rights: Overview; North-South Views on Human Rights; Religious Freedom; Universality; and World Health Organization.*

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