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# Rituals Under Debate

A culturally sensitive approach against FGM/C

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# Abstract

Female Genital Mutilation/Cutting (FGM/C) has been practiced for thousands of years, but it is only recently that international organizations have committed to its eradication. Migration and growing awareness in the West have transformed a local concern into a global issue, turning what was once considered a traditional practice into a major human rights violation. Despite extensive discourse on cultural relativism, human rights, sexuality, and patriarchal oppression of women over the past decades, FGM/C remains widespread with more than three million girls at risk of being cut each year.

Starting by understanding how FGM/C is currently framed and its significance for the practicing communities, this thesis aims to critically analyse the strategies and rhetoric used by the international human rights framework to counteract FGM/C in order to identify the most effective approach. An examination of the current zero-tolerance policy reveals that a radically condemning approach and straightforward criminalization often prove counterproductive, reinforcing FGM/C as a form of protest against Western intervention. The thesis suggests that a more culturally sensitive approach, which takes into consideration the cultural and religious concerns of immigrants, could be a more effective solution to end these deeply rooted practices.

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# INTRODUCTION

The attention around the ancient traditional practice known as Female Genital Mutilation or Cutting (FGM/C) has significantly increased over the past few decades. Although it has been practiced for thousands of years and the campaign against it were brought to the international attention since the beginning of the 20th century, only in recent years international organizations became officially committed to "fight against" FGM/C. Throughout the past century, the belief that no action should be taken due to the practice's social and cultural origins started to shift until in 1979 the World Health Organisation (WHO) officially committed to eradicate FGM/C (O'Neill et al., 2020, p. 269). In 1997, a joint statement by the WHO, the United Nations International Children's Emergency Fund (UNICEF), and the United Nation Population Fund (UNFPA) was published outlining the implications of the practice both in terms of public health and human rights and stating their shared commitment to end it (WHO, 2008). Since then, many actors, including international organisations, local governments and activist groups have made significant efforts. In 2008 the joint statement was renewed and signed by a broader group of UN agencies in order to intensify and expand the efforts towards the global goal of accelerating the abandonment and the total elimination of FGM/C within a generation (WHO, 2008). Despite these numerous campaigns FGM/C is still widespread, originally practiced in 33 countries is now observed globally due to migration (WHO, 2024). Migration and the growing awareness in the West have transformed a local concern into a global issue and a traditional practice ignored by many has turned into a major human rights violation, but despite the fact that in the past decades many have wrote and discussed about cultural relativism, human rights, western imperialism, sexuality and patriarchal oppression of women, misunderstanding, confusion and controversy about this complex topic have not been resolved (Shell-Duncan & Hernlund, 2000, p. 1).

In order to untangle some of the confusion and misunderstanding around this highly controversial practice, the first chapter of the thesis will provide an overview of what FGM/C entails, including the terminology used, where it is practiced, and its possible consequences. In chapter 2, the various reasons why communities continue the practice will be explored. This chapter is fundamental to understand why a practice that is often times deemed barbaric in the Global North is instead perceived as a fundamental step in women's lives for practicing communities. The reasons for the continuation of FGM/C vary among different ethnic groups and can also change within the diaspora. Understanding these reasons

from those who practice it without judgment from a Western perspective is fundamental in order to develop more effective solutions to tackle the practice. After delving into the local reasons for the continuation of the practice, the thesis will focus on how the practice of FGM/C has evolved through history until becoming as a human rights violation. This historical background is important in understanding what which eradication methods have been put into place and how the international position has adopted the current zero-tolerance policy towards the practice. The third chapter also analyses the two major schools of thought that have long found a battleground in FGM: universalism of human rights and cultural relativism. It is precisely based on cultural relativism that many individuals support the continuation of FGM/C. However, some authors specifically discuss the current approach to FGM/C as cultural imperialistic, as they argue that the West employs double standards with similar practices that occur within its own borders. The zero-tolerance approach that has been implemented since 2003 with the aim of eliminating all forms of FGM/C globally within the next generation does not facilitate communication with the affected communities and often drives the practice further underground. With the aim of reopening dialogue with these communities and proposing culturally sensitive alternatives, Chapter 4 will analyse a proposal made in Italy in 2005. This final chapter seeks to demonstrate that alternatives to the most extensive and dangerous forms of FGM/C exist, and that if well implemented, they could serve as temporary solution to prevent millions of girls from being mutilated every year. By creating personalized approaches tailored to different contexts and underlying reasons, rather than blindly condemning all forms of FGM/C, we might find a more effective method for addressing this complex issue.

# CHAPTER 1

## Female Genital Mutilation/Cutting

*"The world has been raising awareness about FGC for the past three decades. [...] we have finally recognized that FGC is not just an African problem, but a global one. We no longer have time to lose. The lives and bodies of millions are at risk, and it is now our moral responsibility to eliminate FGC as soon as possible."* [1]

The aim of this first chapter is to present all the necessary background information to understand the complex practice of female genital mutilation. It will cover key details, starting with the main debates surrounding how international organizations portray the practice. The chapter will provide the current definition and classification of FGM/C. Section 1.1 will lay out the statistics regarding its global prevalence and the age at which it is performed. Section 1.2 will elaborate on how the practice is executed, whether it is done by traditional practitioners or increasingly through medicalization. Finally, section 1.3 will outline the potential physical and psychological complications that the practice can cause.

The World Health Organization (WHO) defines Female Genital Mutilation (FGM) as "all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons." (WHO, 2024).

The terminology used to describe this practice is very important due to its controversial nature. The term *mutilation* is appositely chosen by the WHO in order to emphasize the severity of the practice. The term *female circumcision* was more commonly used in the past and is still often used by local practitioners. However, it has been criticised for implying a similarity to male circumcision and therefore underestimating the consequences that the practice can have on women (Shell-Duncan & Hernlund, 2000, p. 6). It was also suggested that the use of the term could "indicate that there is a case for medicalization (involvement of health professionals) in some types of procedure, which is not desirable" (WHO, 1996, p. 5). Since 1991, the WHO has suggested using the term *mutilation* to highlight the

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[1] Aarefa Johari in Equality Now, 2020, *How Can Youth End FGM?* https://equalitynow.org/news_and_insights/youth_end_fgm/

violation of girls' and women's rights and to help promoting national and international advocacy towards its abandonment (WHO, 2008). On the other hand, the use of the term *mutilation* has also been criticized for being too judgmental and for reflecting a western perspective, overlooking the cultural reasons behind the practice and closing down the space for argumentation (Shweder, 2013, p. 354). In particular, the term unnecessarily stigmatizes women who have undergone the practice and can be too judgmental towards the families who continue the practice because they believe they are acting in their daughters' best interests (Shell-Duncan & Hernlund, 2000, p. 6). The term has been criticized for being imprecise and inaccurate, as it covers a wide range of practices that vary significantly. Some procedures, such as pricking or nicking, do not even involve the removal of genital tissue but are still classified as mutilations (Earp and Johnsdotter, 2021, p. 197). In recent years, criticism has also focused on the ethnocentrism of the terminology, because it applies only to non-Western forms of genital modifications, excluding those typically performed in Western contexts (Earp and Johnsdotter, 2021, p. 197). The term *Female Genital Cutting* (FGC) is also used in literature in order to accurately describe the action without imparting any judgment on women or families. Throughout this thesis, the term FGM/C will be used to include both the term *mutilation*, used at the policy level, and the term *Cutting*, avoiding judgmental terminology. Additionally, specific terms referring to different types of FGM/C will also be used depending on the context.

The World Health Organization (2024) recognises 4 different types of FGM/C:

**Type 1:** This is the partial or total removal of the clitoral glans (the external and visible part of the clitoris, which is a sensitive part of the female genitals), and/or the prepuce/clitoral hood (the fold of skin surrounding the clitoral glans). This type is also commonly referred as S*unna* which in Arabic means "tradition" or "duty" (Shell-Duncan & Hernlund, 2000, p. 4) or clitoridectomy (WHO, 2008).

**Type 2:** Involves the partial or total removal of the clitoral glans and the labia minora (the inner folds of the vulva), with or without removal of the labia majora (the outer folds of skin of the vulva). This type can also be called "excision" (WHO, 2008).

**Type 3:** Also known as infibulation, this is the narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the labia minora, or labia majora, sometimes through stitching, with or without removal of the clitoral prepuce/clitoral hood and glans. This type is also known as "pharaonic circumcision" (Shell-Duncan & Hernlund, 2000, p. 4). The woman is usually opened (defibualated) to allow sexual intercourse and for childbirth, and in some cases, the

woman is re- infibulated after each birth (WHO, 2024). This is considered the most harmful and severe type of FGM/C (Catania & Abdulcadir, 2005, p. 39).

**Type 4:** This includes all other harmful procedures to the female genitalia for non-medical purposes, e.g., pricking, piercing, incising, scraping and cauterizing the genital area.

The WHO definition is very broad: it encompasses all types of FGM/C, from pricking without any removal of any genital tissue to the most severe form of infibulation. This definition applies whether the procedure is performed by a traditional practitioner, with or without consent, and whether it is practiced on a child or an adult woman. All the procedures are similarly condemned under a zero-tolerance policy.

## 1.1 Where and when it is practiced

Over 230 million girls and women have undergone FGM/C worldwide, with more than 3 million girls estimated to be at risk every year (WHO, 2024). Africa accounts for the highest number, with over 144 million of women who have undergone some type of genital modification, concentrated mostly in the strip of countries stretching from the Atlantic coast to the Horn of Africa (UNICEF, 2024). Among the African countries with the highest prevalence there are: Somalia (99%), Guinea (95%), Djibouti (90%), Mali (89%), Egypt (87%), Sudan (87%) and Sierra Leone (83%) [2] (UNICEF, 2024). Outside Africa, the practice is also present in parts of Asia, counting over 80 million women mainly among Muslim populations, with higher prevalences in countries like Indonesia and Malaysia, and a further 6 million women are present in the Middle East in countries such as Yemen, Iraq and Saudi Arabia (UNICEF, 2024). Due to migration, FGM/C is nowadays present worldwide, including in Europe, North America and Australia. Although challenging to calculate, In Europe, an estimated 500.000 women has been cut and that 180.000 women are at risk of undergoing FGM every year (European Institute for Gender Equality, 2013). Among the European countries analysed by the European Institute for Gender Equality (EIGE), the ones with higher prevalence rates of girls at risk of FGM/C are Malta (39-57%), Greece (25-42%), Belgium (16-27%) and Italy (15-24%) [3]. The types of FGM/C performed and the reasons for it

[2] The percentages refer to FGM prevalence among girls and women aged 15 to 49 years
[3] The percentages are calculated out of the number of girls originating from countries where FGM is practiced. The research on these countries was conducted in 2016.

can vary significantly across these different regions and also within the diaspora, many times coming to an abandonment of the practice (O'Neill et al., 2020, p. 267).

The age at which the procedure is performed can also vary, usually from infancy to 15 years old (WHO, 2024). The age can depend on the type and reasons why FGM/C is performed (Abdulcadir et al., 2011, p. 2), in the communities where it is carried out as a coming-of-age ritual the girl is usually older. However, recently there has been a tendency to perform it at an earlier age due to governmental interference and eradication campaigns (Ahmadu, 2000, p. 302). Other reasons to anticipate the practice can be linked to ongoing conflicts. In such cases, communities choose to carry out FGM/C to reinforce the children's cultural identity so that they will remember their origins even if they have to flee and become refugees in another, possibly Western, country. (Ahmadu, 2000, p. 302).

### 1.2 By whom is performed: traditional practitioners and medicalisation

The practice is usually performed by traditional practitioners, who can be family members such as mothers or grandmothers, or other members of the community. This role is often passed down through generations, with knowledge transferred from grandmothers or mothers to daughters. In Futa Toro, this expertise is considered *family knowledge*, meaning it is a specific knowledge regarding a trade which is inherited only within the family (O'Neill, 2018, p. 5). Experienced practitioners will teach their sons or daughters their trade so that they can continue, and this can result in different families performing the same trade in completely different ways (O'Neill, 2018, p.5).

FGM/C is sometimes also medicalised, the WHO (2010) defines medicalisation as follows:

> 'Medicalization' of FGM refers to situations in which FGM is practised by any category of health-care provider, whether in a public or a private clinic, at home or elsewhere. It also includes the procedure of reinfibulation at any point in time in a woman's life. (p. 2)

Medicalisation rates vary greatly from country to country, among women who have undergone the practice, medicalisation rates are high in five states: Sudan (67%), Egypt (42%), Guinea (15%), Kenya (15%) and Nigeria (13%) (Shell-Duncan et al., 2018, pp. 4-5). In other countries, medicalised cutting is rare or limited to specific geographic areas. The medicalisation of the procedure lowers if not even eliminates all the potential short-term consequences (Ahmadu, 2000, p. 304; Shell-Duncan, 2001, p. 1019). However, the WHO and other professional medical organisations such as the International

Federations of Gynaecology and Obstetrics, and the United Nations International Children's Emergency Fund condemn the performance of the practice under any circumstance, and therefore also its medicalisation. Because even though it may reduce the risk of short-term complications, it is believed to perpetuate the practice rather than help eradicate it. However, Shell-Duncan et al. in "Trends and Medicalisation of Female Genital Mutilation/Cutting" (2018, p. 14) state that the data do not clearly show that medicalisation actually influences FGM/C, neither towards a decline nor towards a support for its continuation. In fact, rising rates of medicalisation can be seen both in countries with modest declines in FGM/C such as in Egypt, and substantial declines such as in Kenya. On the other hand, In Sudan, medicalisation increased while prevalence remained the same. Whether medicalisation will perpetuate the practice remains unclear, but the interesting question Shell-Duncan et al. (2018) pose is "whether this shift represents a reluctance to stop an intractable practice or signifies openness to change that can be leveraged to promote abandonment" (p. 15).

### 1.3 consequences

The potential short- and long-term consequences of FGM/C are numerous and depend greatly on different factors such as the hygienic and socio-economic conditions in which the practice is performed; pre-existing health and nutritional status of the baby or child (diseases or malnutrition); the modalities of execution (experiences of the operator, material used, availability of water, antibiotics and other medications); and the type of mutilation (Abdulcadir et al., 2011, p.3). In addition to physical short- and long-term complications, women can also suffer from psychological consequences. Immediate complications are usually attributed to the fact that the procedure is performed by traditional cutters without anaesthesia and in unhygienic conditions. These complications can include: intense pain that can eventually lead to shock, excessive bleeding (haemorrhage), injury to surrounding genital tissue, urinary problems, wound healing issues that can lead to infections and fever, and in some cases, these potential complications may also lead to death (Abdulcadir et al., 2011, p. 3; Berg et al. 2014, pp. 1, 4, 6; WHO, 2024).

The long-term complications commonly reported can include urinary problems such as painful urination and infections, painful menstruations and/or difficulty in passing menstrual blood, and other vaginal problems such as itching, bacterial vaginosis and other types of infections. Sexual problems such as pain during intercourse and decreased satisfaction are also common (Abdulcadir et al., 2011, pp. 3-4; Berg et

al., 2014, p.9; WHO, 2024). Depending on the type of mutilation, the first sexual intercourse can be extremely painful, and in some cases, defibulation is necessary to allow penetration. Pregnancy and childbirth complications may also occur, including difficulty in delivering, excessive bleeding, tears etc. When infibulation is performed, women have to be defibulated in order to deliver the baby (Shell-Duncan, 2001, p. 1015; WHO, 2024). One issue noted by Shell-Duncan (2001) is that "these accounts of the medical 'facts' is that they largely fail to distinguish differences in the types and frequency of complications associated with different types of genital cutting. […] case studies on infibulation are generalized to describe the health risks of all forms of genital cutting." (p. 1016).

Finally, women can also suffer from psychological consequences. The psychological impact can vary greatly depending on the cultural significance thought to the girls and whether they are prepared for the procedure or not (Gruenbaum, 2001, p. 7; Abdulcadir et al., 2011, p. 4). The traumatic nature of the event can lead to depression and post-traumatic stress disorder. Many women who move to Western countries can experience psychological consequences after being confronted with cultural differences between their country of origin and their host country. The realisation that FGM/C are not an international practice can generate a sense of anxiety and distress, as well as low self-esteem and feelings of incompleteness, in addition to conflicts regarding their identity and loyalty to their country and a loss of trust in the loved ones due to the feeling of betray by parents and family (Abdulcadir et al., 2011, p. 4; Gams.be, n.d.). However, when women are in an environment where circumcision is positively considered the physical, psychological and sexual complications are often denied because it is believed to be the normality (Abdulcadir et al. 2011, p. 4). In addition, women can sometimes suffer from medical and/or psychological consequences without considering them to be related to FGM/C but rather the normality of being a woman (Abdulcadir et al., 2011, p. 3).

However, not all scholars agree on the medical complications derived from FGM/C, or at least not on their occurrence. In fact, the public policy advisory network on female genital surgeries in Africa (2012) stated that "the widely publicized and sensationalised reproductive health and medical complications associated with female genital surgeries in Africa are infrequent events and represent the exception rather than the rule" (p. 22). In case these exceptions occur, they are usually the result of inadequate surgical conditions, hygiene or malpractice and, in particular the short-term complications could be reduced if not altogether eliminated through the medicalisation of the practice (Ahmadu, 2000, p. 304; Shell-Duncan 2001, p. 1019; public policy advisory network on female genital surgeries in Africa, 2012, p. 22).

As pointed out by Shell-Duncan (2001, p. 1016), often times the available data have to be interpreted with cautions because of possible selection bias. Women can be reluctant in seeking for medical attention because of taboo regarding the topic, its increasing criminalisation leading to fear of legal repercussions and, in more rural setting, because of unavailability of medical care. For these reasons, complications tend to be reported only if they are severe and prolonged. In addition, many women may not impute health problem to their genital cutting believing that is the normality or other times it is difficult to determine whether genital cutting was the cause of the consequence of the problems which may arise from other causes (Shell-Duncan, 2001, p. 1017). Moreover, it is also noted that while it might be true that cut women experience sexual and health problems such as infertility, menstrual problems, perineal damage and difficulty in reaching orgasms, these problems are often equally high among uncut women. In Africa, morbidity issues like those listed above are more common than in the Global North, a fact that is often overlook, as it is the reality that many Western women also have difficulties achieving orgasm (Ahmadu, 2007, p. 278; Public Policy Advisory Network, 2012, p. 23).

There are contrasting ideas also regarding the long-term impacts that FGM/C can have on women and their sexuality. Ahmadu (2007, pp. 278-279) points out that the association between FGM/C and sexual dysfunction is many times automatic and even unconscious. However, scholars like Ahmadu (2000; 2007), Catania and Abdulcadir (2005), Shweder (2013; 2021), and the Public Policy Advisory Network (2012) argue that FGM/C does not necessarily have negative long-term effects on women's sexual lives, including desire, arousal, and in particular concerning the ability to have orgasms. The research conducted by Catania and Abdulcadir (2005, pp. 168-183), in accordance with other studies, suggests that FGM/C does not necessarily harm the psychosexual life such as fantasies, desire, pleasure or orgasmic ability. Moreover, they also suggest that cut women develop a high sensitivity in other erogenous areas of the body as a way of compensation the lack of clitoris (p. 178).

Ahmadu (2000) adds that she has "personally interviewed several male and female Sierra Leonean gynecologists who profess that although they regard excision as 'medically unnecessary', the practice does not pose any significant adverse long-term effects to women […]. None had personally treated women with long-term problems related to excision, but all stated that they had come across 'reports' of horror cases." (p. 303). Ahmadu's personal experience, along with testimonies from other women, contradicts the common knowledge regarding the negative impact of the practice on women's sexuality. The part of clitoris removed during excision constitutes a small part of the total nerve endings responsible for sensations and therefore most clitoral nerve endings remain intact (Ahmadu, 2000, p. 305). This might

explain why many women who had sexual experiences before excision report either no difference or increased sexual satisfaction following their operation (Ahmadu, 2000, p.305).

# CHAPTER 2

## Significance of FGM/C

*"To outsiders, the practice euphemistically known as "female circumcision" is shocking. That people surgically alter the genitals of young girls and women, usually in painful unhygienic procedures that can cause grave harm to their health, seems truly horrible. Why do loving parents allow such things to happen? How can they bring themselves to celebrate these events? How can they justify the practice when occasionally a girl dies from the injuries?"* [4]

In Western cultures, FGM/C is often viewed as a horrific act of cruelty stemming from gender inequality, inflicted on young girls under barbaric conditions. However, this is not the perception within practicing communities. This chapter aims to understand why this deeply rooted tradition has been accepted by these communities for thousands of years and explores the reasons for its continuation or abandonment in the diaspora. Its importance lies in the fact that understanding the realities of the populations that perform FGM/C is crucial for developing culturally appropriate and effective eradication methods. Given the vastly different cultural perspectives on the practice, comprehending these motivations is essential to know why, despite many years of eradication campaigns by major international organizations, FGM/C remains widespread. The chapter is divided into eight sections, each explaining a different reason that drives communities to continue the practice. Although presented as separate categories, these explanations are often deeply intertwined and connected, sometimes with multiple reasons occurring simultaneously.

The origins of FGM/C are uncertain and debated, believed to date back to ancient Egyptian and Sudanese populations in the Nile Valley. The term *pharaonic circumcision* suggests its historical roots, but limited documentation makes it unclear if the practice originated from a single source or multiple influences (Gruenbaum, 2001, pp. 42-44). Undoubtedly the unclear origins of FGM/C are further obscured by the longstanding silence surrounding the practice, which has contributed to making it a taboo topic among African populations. (Catania & Abdulcadir, 2005, p. 200). Scholars are divided on the importance of understanding its origins. Some, like Boddy (1982; see Shell-Duncan & Hernlund, 2000, p. 13) argue

[4] E. Gruenbaum, 2001, The Female Circumcision Controversy: An Anthropological Perspective, University of Pennsylvania Press, p. 1

that the "custom's remote historical origins [does not] … contribute to our understanding of its present significance". Gruenbaum (1996; see Shell-Duncan & Hernlund, 2000, p. 13) adds that "the persistence of a practice that has negative consequences must be explained in terms of the present circumstances that encourage or discourage its continuation". Others, such as Mackie, even recognising that the initial reasons are not the same ones for the continuation of the practice, believe that the two cannot be completely separated (Shell-Duncan & Hernlund, 2000, p. 13). Ahmadu (2000), highlights how "the question of origin is becoming increasingly important, particularly to African women who uphold the tradition and are continually finding themselves in a position to justify the practice to outsiders, and perhaps more so, to themselves" (p. 296).

Given the practice's geographic spread and cultural diversity, there is not one single meaning but multiple reasons to explain its persistence through time and space. In order to understand why families continues these painful practices, it is crucial to analyse the deep cultural beliefs within different ethnic groups and regions.

Many of the reasons for the continuation of the practice may disappear in the context of the diaspora, leading to its abandonment in the host country (Behrendt, 2011, p. 8; Johnsdotter & Essén, 2016, pp. 18-20; Agboli et al., 2020, p. 50). However, sometimes the reasons persist even abroad due to strong attachment to the cultural traditions, or they transform into different motivations.

Even though the following explanations for the continuation of the practice are discussed separately, they are profoundly interconnected and mutually reinforcing, forming strong motivations for FGM/C's continuation (Shell-Duncan & Hernlund, 2000, p. 19)

## 2.1 Respect for custom or tradition and ritual of passage

FGM/C is often seen as a rite of passage and a tradition that has been passed down through generations, for this reason, many people believe it must continue to preserve their cultural heritage. Shell-Duncan and Hernlund (2000, p. 20) also show how in the vast majority of studies, more than half of the women stated *tradition* or *custom* as the main reason for the continuation off the practice. FGM/C represents the identification with cultural heritage, it is a mean of socialization into cultural values that connects individuals to their family, community members and previous generations (Middelburg, 2016, p. 129).

In many practicing communities, FGM/C is seen as a ritual marking the transition from childhood to adulthood. It is performed both on women and men and is often accompanied by festivities and celebrations. These coming-of-age rituals represents a celebration of courage and also underlines the cultural creation of sexual and gender identity (Ahmadu, 2000, p. 297; Shell-Duncan & Hernlund, 2000, p. 21). In "Rites and Wrongs", Ahmadu (2000) describes the qualities a girl has to acquire to become woman during the ritual in the Kono society in Sierra Leone:

> Novices are inculcated with the ideals of femininity as laid down by previous ancestresses: stoicism, which must be displayed during excision; tenacity and endurance, which are achieved through the many other ordeals a novice must undergo; and, most important, 'dry-eye,' that is, daring, bravery, fearlessness, and audacity qualities that will enable young women to stand their ground as adults in their households and within the greater community. (p. 300)

So being initiated allows individuals to fit into the society and to be respected among their peers and the entire community. A woman without initiation cannot participate in meetings concerning "women's business", speak as a woman or represent any other woman (Ahmadu, 2000, p. 301).

Even if the pressure from elder family members is generally lower in the diaspora, some might still exercise considerable influence over exile members (Catania & Abdulcadir, 2005; Johnsdotter & Essén, 2016). Moreover, immigrants might want to maintain an attachment to their culture of origin, especially those arrived recently (Johnsdotter & Essén, 2016, p. 21). Many families are also attached to the ritual significance of the practice as a transition from childhood to adulthood, perceiving it as fundamental even if living abroad (Catania & Abdulcadir, 2005). Additionally, labelling the cultural practice as barbaric can reinforce the attachment of practicing communities as a way to resist western perspectives (Breitung, 1996).

The ritual significance of the procedure, marking the passage to adulthood and preserving a connection to ancestors and cultural heritage, is what alternative proposals in the West over the past 30 years have sought to maintain while offering less severe forms of FGM/C.

### 2.2 Social integration and marriageability

The fact that everyone else is doing it drives many to continue. As previously said, the practice is considered a fundamental milestone in a woman's life, and those who do not undergo it risk social

exclusion and being stigmatised as “impure”, “unclean” or even “promiscuous”. Uncut women will not be considered women and will be prevented to carry out many tasks in the society (O’Neill, 2018, pp. 9-10). Therefore, even families who know the potential health risks and complications related to FGM/C prefer to perform it to avoid their daughters being ostracised, believing it is the best thing to do to ensure their social acceptance (Gruenbaum, 2001, p. 87; Shell-Duncan, 2008, p. 226). Many times, the girls themselves wish to undergo the procedure due to peer pressure and fear of rejection from the society.

Furthermore, also the pressure to ensure marriageability is a significant factor. Once again, families might acknowledge the potential risks of FGM/C but they view the risk of their daughters remaining unmarried as worse (Shell-Duncan, 2008, p. 226). In fact, in practicing communities, men often do not want an uncut woman as a wife. If she’s not cut, or not cut enough, men may even send her back to her family, which can severely damage her reputation, the family honour, but also other economic repercussion on the entire family. This can be particularly problematic as families often depend on the bride price. Consequently, families are pressured to everything they can to secure the marriage.

When individuals migrate to Western societies, the social integration aspect is lost. In the Global North, most of the population is not cut, the “normality” of being cut disappears, so there is no pressure to undergo FGM/C (Johnsdotter & Essén, 2016, p. 18). On the contrary, the practice is considered barbaric and perceived negatively, increasing social pressure against it (Johnsdotter & Essén, 2016, p. 19). Additionally, as it is often criminalised there is a deep fear of losing custody of the children (Johnsdotter & Essén, 2016, p. 18). Families do what they believe is best for their daughters. In their country of origin, this might mean getting them cut, but when they move to a Western country it often means the opposite.

Also the pressure to perform FGM/C in order to find a potential husbands is reduced as western men see the practice negatively. Future husbands can also be found among African men who have grown up in western countries and therefore also share the same view about the practice (Johnsdotter & Essén, 2016). Consequently, it is usually easier for uncut women to find a husband. However, it is important to note that sometimes women still marry men from practicing communities or those recently arrived in the Global North who continue to believe that a cut woman is a better wife.

### 2.3 Virginity, chastity and fidelity

Closely related to marriageability are the concepts of virginity, chastity, and fidelity. In some communities these concepts are very important in order to get married and to preserve the family and the woman's honour. In many communities it is believed that an uncut clitoris will grow excessively (until resembling a penis or even rabbit ears) and, besides being considered unesthetic, it will enhance sexual desire in women (Ahmadu, 2000, p. 184; O'Neill, 2018, pp. 7-8). To prevent uncontrollable sexual desire and ensure virginity before marriage, the clitoris is cut. This is particularly important in communities where virginity is important to uphold family honour and social status, making premarital sexual intercourse a serious threat to the family's reputation (O'Neill, 2018, p. 12).

In some ethnic groups, where polygamous marriages are present, or where men are often away for trade, FGM/C is believed to prevent women from being tempted to engage with other men, and thereby protecting their husband's honour (Middelburg, 2016, pp. 129-130; O'Neill, 2018, p. 11-12). Excision is thought to reduce temptation, enabling women to remain faithful while their husbands are away for trade or with other wives.

Additionally, the practice of infibulation is intended to prevent premarital sexual intercourse, as an intact infibulation is a proof that a girl has not had an intercourse (Gruenbaum, 2001, p. 84). For this reason, often families ask for very tight infibulations or want it repaired if the genital tissue tears.

### 2.4 Fertility

Many communities practice FGM/C due to the belief that it enhances fertility and promotes child survival, leading to various myths about fertility. Boddy (1982; see Shell-Duncan & Hernlund, 2000, p. 21) observed that in Sudan, the procedure is performed not only to make a girl marriageable but also as a necessary rite for becoming a woman and utilizing her significant gift of fertility. FGM/C is thought to symbolically and physically enclose the womb, highlighting the protection and sacredness of a woman's reproductive centre.

The belief that a closed womb is important for preserving a woman's fertility has significant repercussion when infibulated women give birth in western countries. Infibulated women often ask to be reinfibulated after birth, a procedure that is considered illegal in the Global North. Therefore, clear communication between doctors and patients is essential, explaining beforehand that reinfibulation will not be performed

(Abdulcadir et al., 2011, p. 6). Without this understanding, women can experience negative consequences (Abdulcadir et al., 2011; Catania & Abdulcadir, 2005).

### 2.5 Aesthetic and hygiene

Some ethnic groups perform FGM/C simply for reasons related to beauty, believing that a cut vulva is more attractive and feminine. By cutting the tip of the clitoris, they prevent it from growing larger and resembling the male organ. This practice creates a vulva that is considered free of excess and more aesthetically pleasing. In some parts of East and West Africa, local beauty ideals value genitals that are less hairy, less fleshy, with fewer folds and more refined, describing them as "smooth and clean" (Shweder, 2013, p. 357).

Certain cultures view both masculine and feminine genitals as dirty and they believe that by cutting some parts they ensure purity and hygiene. In particular, the fact that a girl is dirty and impure will prevent her from carrying out tasks such as preparing meals or serving food. Uncut girls will face rejection not only for their future womanhood but also for the perceived lack of cleanliness necessary for social interactions. This concept of purity and cleanliness is so entrenched in the society that paradoxically even midwives campaigning against FGM/C, who acknowledge the potential health problems, still perceive excised women as purer and cleaner than uncut women (O'Neill, 2018, p. 2, 8). They find the smell of uncut vulvae as repulsive and childbirth procedures for uncut women are seen as embarrassing.

O'Neill (2018) explains that in Futa Toro, Senegal, FGM/C is practiced on both men and women and is considered essential for true purity and cleanliness. For men, circumcision ensures no semen remains trapped in the prepuce, maintaining cleanliness before God. Similarly, it is believed that also the clitoris produces semen, and that "it is practically impossible for a woman to cleanse herself of impurities if she is not excised" (O'Neill, 2018, p. 10). The tip of the clitoris is thought to be constantly aroused, producing sexual fluids and leading women to think about sex inappropriately often. Consequently, an unexcised woman is viewed as perpetually impure and dirty in everyday life.

Local terms for the practice often connote purification or cleanliness. In the Bambara language in Mali, FGM/C is known as *bolokoli*, meaning "washing your hands," and in the Igbo language in Nigeria, it is referred to as *isa aru* meaning "having your bath." (Middelburg, 2016, p. 132). A common Arabic term for the practice is *tahara*, which translates to "purification." (Middelburg, 2016, p. 132).

### 2.6 Religion

Some communities justify performing FGM/C for religious reasons. This practice is performed by various religious groups, including Christians (both Catholics and Protestants), Jews, Muslims, and Animists. Many believe it is a religious requirement, though female circumcision is not explicitly mentioned in any religious text. For that reason, it has been argued that FGM/C is a *cultural* rather than a *religious* practice (Rahman & Toubia, 2000, p. 6) However, for Muslims, even if not mentioned in the Quran, it is referenced in the *Hadith*, the sayings of the prophet. Islamic law, or *Sharia*, encompasses all aspects of human activity, both spiritual and material, individual and social, regulated by requirements and prohibitions that observant Muslims must respect. Sharia has two types of sources. The primary sources include the *Quran* (the exact word of God), the *Sunna* (the authentic tradition and words of the Prophet Muhammad, reported in the *Hadith*), the *Ijma*' (the juridical consensus of Islamic scholars), and the *Qiyas* (reasoning used by Muslims to address issues not covered in the Quran and Sunna) (Catania & Abdulcadir, 2005, p. 196; Selim Al-Awa, n.d., p. 2). The secondary sources are utilized for topics not addressed by the primary sources.

As explained in Shweder's article "the prosecution of Dawoodi Bohra women" (2021) the Dawoodi Bohra community practice FGM/C based on the Abrahamic circumcision traditions. Their procedure for girls, called *Khafz*, involves a minor cut or nick on the genital foreskin or prepuce. This form of circumcision is seen as gender inclusive and is rooted in their interpretation of the Genesis 17 of the Hebrew Bible, which explains God's covenant with Abraham. The Dawoodi Bohra community, considering themselves Abraham descendants, interpret the biblical story uniquely, believing that the prophet Mohammed endorsed female circumcision as a manifestation of gender equality in religious commitment. They see the practice not as a mutilation but as purification ad beautification for both genders. The community's belief is enforced by a Hadith from the Sunan Abu Dawood and reads as follows: "A woman used to perform circumcision in Medina. The Prophet said to her: Do not cut severely as that is better for a woman and more desirable for a husband." (Sunan Abu Dawood, Book 41, No. 5251). Another Hadith used to justify FGM/C states: "Circumcision is a commendable act for men (*Sunna*) and an honourable act (*Makromah*) for women." (Silsilah al-Ahadith al-Da'ifah by al-Albani, No. 1935). *Sharia* also includes a recommendation that circumcision for girls should not be performed before the age of seven.

Critics argue the religion foundation of the practice since it is not mentioned in the Quran. However, proponents note that other religious practices such as the male circumcision or the requirements for prayers are not mentioned in the Quran but are still considered obligatory. Shweder (2021, p. 14) argues that religious tradition should respect pluralism without questioning the authenticity of these beliefs. For many Dawoodi Bohra women, *Khafz* connects them to God's will. Even if not mandated by religion, many individuals continue the practice due to their belief in its religious significance. The concept of religion for many women encompasses their entire way of life, with religion and tradition being inseparable (Boddy, 1991, see Shell-Duncan and Hernlund, 2000, p. 23).

Even though the belief that Islam demands circumcision is being questioned as practicing individuals in diaspora meet other Muslim communities that do not circumcise their daughters, the religious motivation for the continuation of the practice persists worldwide, both in the countries of origin and in diaspora communities. An example of a community that has upheld its religious convictions even while living in Western countries is the Dawoodi Bohra community. In recent years, this belief has often led to persecution, as seen in cases in Australia and the United States (O'Neill et al., 2020, p. 269; Shweder, 2022, p. 11).

Religious leaders are also divided on the matter: different schools of Islamic jurisprudence hold varying opinions on the practice of FGM/C and are not unanimous on the subject. There are many debates about the authenticity of the Hadiths related to FGM/C. Some Islamic scholars argue that the traditions attributed to Prophet Muhammad are authentic, while others contend that the Hadiths have a weak chain of transmission, making them unreliable (Selim Al-Awa, n.d., pp. 2-5).

Despite the condemnation of FGM/C by significant Muslim leaders in Cairo in 2006 due to the lack of scriptural support, followed by the 2007 condemnation by the Al-Azhar Supreme Council of Islamic Research in Egypt, which issued a *fatwa* (religious edict), there still is a lack of consensus (Middelburg, 2016, p. 132).

### 2.7 Economic reasons

There are economic reasons behind FGM/C as well. Girls often receive gifts and money after the operation is done, and the practitioners are also well retributed for their job. As said before, an uncut girl will have difficulty to find a husband, therefore resulting in an economic burden for her family. The

dowry, which can comprise money or other forms of payment such as animals, is crucial for the family's sustenance and sometimes it is also necessary to pay for the wives of other sons. If a family does not cut their daughters, they risk losing honour and respectability, and therefore jobs and other opportunities.

Also practitioners have financial incentives to maintain the tradition. They earn significant amounts of money from cutting women and, in societies where infibulation is practiced, also from opening the woman when she has to give birth and sewing her again afterwards. These personal economic interests may push many practitioners to keep the tradition alive. However, some scholars argue that while it is true that practitioners are the ones who cause the cut and have financial benefits from the procedure, they are not the ones creating the demand, thus they are not the cause for the continuation, the parents are (Shell-Duncan and Hernlund, 2000, p. 36).

### 2.8 Women's empowerment

Even if it might seem counterintuitive, in some communities, contrary to the usual narrative of gender-based violence intended to disempower women, women themselves are supporters of the practice because it empowers them. In these ethnic, cultural, or religious groups where these procedures are customary, women are among the strongest advocates and usually manage the female side of the process (Shweder, 2022, p. 20).

Ahmadu (2000) writes that in the Kono society in Sierra Leone, beyond the cultural beliefs about reproduction and sexuality, there is a concept of empowerment gained through the initiation process and the continuation of the practice. This society does not base FGM/C on the necessity of chastity, virginity, purity and cleanliness of women. Instead, in order to understand the importance initiation and cutting in the Kono society, it is essential to recognise the power and influence women hold. Kono society is dualistic, with very distinct and specific roles for women and men, a gender division that can only be achieved through initiation (pp. 286-288). Moreover, only initiated members of the society can then become members of the secret societies, which are crucial in order to gain the protection of the elders. Within the women's sphere of sociopolitical and religious influence, the Soko is the top woman, the mother of the community. She is the custodian of ancient ritual secrets, particularly regarding fertility and the feminine role in creation, as well as the guardian and protector of dangerous ritual "medicines" (p. 299). These medicines are used to protect novices during initiation but also to defend society against intrusive men. Because of Soko's knowledge regarding fertility and their use of these medicines, women

have power over men, including the ability to cause impotence and even death (p. 299). The acknowledgement of the power of these medicines in the hands of the Soko by all sectors of society represents a mechanism of social control wielded by women. In societies like this, FGM/C actually empowers women instead of disempowering them.

Ahmadu (2000) argues that it is precisely women's empowerment through initiation and their sense of belonging to the women's community that drive them to continue the practice. Because according to her, cultural beliefs about sex, reproduction and sexuality alone cannot fully explain the widespread continuation of the practice.

She argues that women in diaspora, who face less societal pressure due to being far from the practicing community and living in places where FGM/C is viewed negatively, could more easily abandon the practice if they wished. Instead, many women *choose* to continue it. Ahmadu further explains:

> Societal coercion and pressure to conform, however, do not explain the *eagerness* and *excitement* felt by vast numbers of participants (residents in Kono as well as outside) in initiation ceremonies, including mothers of initiates, even if these same mothers also experience anxiety over the safety of their daughters. It is difficult for me-considering the number of these ceremonies I have observed, including my own-to accept that what appear to be expressions of joy and ecstatic celebrations of womanhood in actuality disguise hidden experiences of coercion and subjugation. Instead, I offer that most Kono women who uphold these rituals do so because they want to totally relish the supernatural powers of their ritual leaders over against men in society, and they embrace the legitimacy of female authority and, particularly, the authority of their mothers and grandmothers. Also, they maintain their cultural superiority over uninitiated/uncircumcised women. (p. 301)

Ahmadu (2000) believes that numerous examples show how modernity and tradition can coexist and blend, demonstrating that initiation and "circumcision" can remain meaningful for individuals despite the rapid changes in education, modernization and migration.

In this chapter, I have aimed to provide a comprehensive overview of the various reasons for the continuation of FGM/C, which the media often simplifies under a blanket characterization. Explanations for FGM/C are "frequently simplistic, emphasizing a single, underlying explanation such as 'male dominance,' and inferring that the purpose is to prevent women's sexual fulfilment." (Gruenbaum, 2005).

Together with the previous chapter, shows the complexity and multifaceted nature of the practice, and creates a necessary foundation for analysing the international mobilization against FGM/C, which will be discussed in the following chapters. In particular, the next chapter will explore the human rights at stake in relation to FGM/C and describe the efforts of the international community to eliminate the practice, as well as highlight some of the shortcomings of the current human rights framework.

# CHAPTER 3

# FGM/C and the Human Rights framework

*"Female Genital Mutilation has nothing to do with culture, tradition or religion. It is a torture and a crime, which needs to be fought against"* [5]

The previous chapters provided a general overview of FGM/C, detailing what it is, its implications, and why practicing communities remain attached to it, even among diaspora populations. This context is essential for analysing the current international efforts to combat FGM/C. The first section of this chapter will explore how the practice became known in the Western world and how it has evolved over the years to be framed as a human rights violation. This evolution has led to the current zero-tolerance policy aimed at ending FGM/C within the next generation. Section 3.2 will delve into the human rights framework, examining the rights invoked by both opponents and supporters of the practice, highlighting the potential issues with each perspective. In section 3.4, the universalism-cultural relativism debate, which has long found a battleground in the practice of FGM/C, will be analysed with a particular focus on the concept of cultural imperialism. Finally, section 3.5 will present major criticisms of the human rights framework, underlining the shortcomings of the current approach to tackle FGM/C.

## 3.1 Historical evolution of FGM/C as a human rights violation

Until relatively recently, the international community largely ignored practices now defined as *harmful* and *unacceptable*. Efforts to combat these practices actually began during the colonial era in Africa, but the laws imposed by colonists banning "female circumcision" only politicized the issue and provoked local populations, resulting in counterproductive effects (Boyle & Preves, 2000, p. 710). For instance, European missionaries' campaigns against the practice in the early 17th century, the 1946 ban by the colonial government in Sudan, and the total ban on clitoridectomy in Kenya in 1956 all highlight the failure of early eradication efforts (Boyle et al., 2001, p. 528). Despite the rising attention towards this

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[5] Waris Dirie. In Times Colonist, 2015, Comment: International efforts fight female mutilation. https://www.timescolonist.com/opinion/comment-international-efforts-fight-female-mutilation-4618772

practice, United Nations member states were divided. Some believed that FGM/C was highly harmful to women's health and well-being and should be abolished, but they believed that education and awareness would eventually change these deeply rooted customs (Jain, 2005, p. 29). Others argued that banning traditional practices without state consent violated the domestic affairs of member states (Penn & Nardos, 2003, p. 4). Therefore, from the 1950s to the 1970s, international attention towards the practice was minimal, as it was thought that FGM/C was an integral part of African customs and traditions that should be respected (Martinez & Stuart, 2003, p. 125).

The silence surrounding FGM/C began to break during the UN Decade for Women from 1976 to 1985 where various important seminars and world conferences were organised (Althaus, 1997, p. 130). Gradually, realizing the harmful effects it could have on women, international organizations like the WHO started to address the health implications of FGM/C. At the 1979 Seminar on Traditional Practices Affecting the Health of Women and Children in Sudan, the WHO condemned FGM/C in all forms, even when performed under medically appropriate and hygienic conditions (WHO, 1979, p. 51-52). The initial belief was that educating communities about the negative consequences would lead to the cessation of the practice. However, it soon became clear that families were aware of the health risks and still considered the social consequences of not performing FGM/C more significant (Shell-Duncan, 2008, p. 226).

During the three UN conferences on women, FGM/C became a topic of discussion, and its recognition as a human rights violation began to take shape. In 1981, a human rights organization representative argued that FGM/C violated human rights and called for a report documenting its harmful physical and psychological effects to be presented to international bodies (McLean et al., 1985). This led to the establishment of a special working group on traditional practices affecting the health of women and children in 1984 to investigate and report on FGM/C and other traditional practices (Middelburg, 2016, pp. 148-149). In 1986, the working group presented a report during the 42nd session of the UN Commission on Human Rights, which evaluated various aspects of FGM/C. However, the report was vague on whether FGM/C constituted a human rights violation, using evasive language and stating only that human rights were incompatible with traditional practices without specifying which rights (Middelburg, 2016, p. 150). Only few years later, the sub-commission adopted another resolution affirming that harmful traditional practices "violate the rights of women and children" (Middelburg, 2016, p. 151). In 1990, during the ninth session of the Committee on the Elimination of Discrimination Against Women (CEDAWC), the issue of FGM/C and other harmful traditional practices were once

again discussed. However, despite expressing concern about the continuation of practices detrimental to women's health, the committee did not explicitly classify FGM/C as a human rights violation. This issue was further discussed at the World Conference on Human Rights in Vienna in 1993. The conference was a fundamental moment because it classified gender-based violence as a form of human rights violation for the first time, however, it only implicitly referenced that "certain traditional or customary practices" are considered gender-based violence and, consequently, human rights violations (UN General Assembly, 1993, para. 38). Half a year after the Vienna Declaration, the United Nations General Assembly adopted the UN Declaration on the Elimination of Violence Against Women (DEVAW). Unlike previous documents, DEVAW explicitly addresses FGM/C, in article 2(a) it clearly identifies the practice as form of violence against women (VAW):

> Violence against women shall be understood to encompass, but not be limited to, the following: (a) Physical, sexual and psychological violence occurring in the family, including battering, sexual abuse of female children in the household, dowry-related violence, marital rape, female genital mutilation and other traditional practices harmful to women, non-spousal violence and violence related to exploitation. (UN General Assembly, 1994)

In addition to reiterate that VAW is a breach of women's rights and basic freedoms (UN General Assembly, 1994). Although DEVAW is not legally binding, its inclusion of FGM/C as a form of VAW aligned the international campaign against FGM/C with the global movement against VAW (Middelburg, 2016, p. 152).

The human rights implications of FGM/C were addressed again in various international meetings, such as the International Conference on Population and Development (ICPD) held in Cairo in 1994 and the Fourth World Conference on Women held in Beijing in 1995. At these conferences, FGM/C was specifically addressed and deemed a violation of basic human rights and fundamental freedoms, presenting major lifelong risks to women's health (UN Population fund, 1994; UN, 1995). Thus, the 1990s marked a clear shift from a health framework to a human rights framework to justify intervention, and this shift coincided with changes in the global movement to fight VAW through international law (Shell-Duncan, 2008, p. 227). These conferences helped the international community to have a better understanding and awareness of the cultural and social importance of FGM/C in its communities. The WHO Director-General later stated that:

> We must work from the assumption that human behaviours and cultural values, however senseless they may look to us from our particular personal and cultural standpoints, have meaning and fulfil a function for those who practise them. People will change their behaviour only when they themselves understand the hazards and indignity of the harmful practices and perceive the new practices proposed as meaningful, functional, and at least as effective as the old ones. Therefore, what we must aim for is to convince people, including women, that they can give up a specific practice without giving up meaningful aspects of their own cultures. (WHO, 1999)

In 1997 the WHO, UNICEF, and UNFPA issued a joint statement on FGM/C, explaining that their arguments against the practice are based on universally recognized human rights. They declared FGM/C "universally unacceptable" because it infringes on the physical and psychosexual integrity of women (WHO, 1997). This joint statement was then renewed in 2008 and signed by ten UN agencies instead of three. The necessity of a new interagency statement was based on new evidences and lessons learned, and it highlighted the "wide recognition of the human rights and legal dimension of the problem" (WHO, 2008, p. 3). It clearly articulated that FGM/C is a dangerous practice and a critical human rights issue. The statement identified several human rights violated by FGM/C: the right to be free from gender discrimination, the right to life, the right to the highest attainable standard of health, the right to freedom from torture or cruel, inhuman, or degrading treatment or punishment, and the rights of the child (WHO, 2008).

The UN's longstanding efforts to end the practice culminated in its first specific resolution on FGM in 2012, calling for the adoption of national action plans and comprehensive strategies to eliminate it (European Union, 2024). The UN 2030 Agenda for Sustainable Development identifies FGM as a harmful practice, to be eliminated by 2030 (Goal 5).

To this day, international strategies to end FGM/C focus on a zero-tolerance policy. This strategy is annually celebrated on the 6th of February as the international Day of Zero-Tolerance for FGM and aims to eliminate all types of FGM worldwide (O’Neill et al., 2020, p. 267). The term has been adopted by international institutions, governmental and non-governmental organizations, and it’s commonly used in the policy language of the European Institute for Gender Equality and the European Parliament (O’Neill et al., 2020, p. 267).

### 3.2 Universality of Human Rights or Imposition of Western values?

The practice of FGM/C is highly debated between opposite schools of thoughts as regards the applicability and interpretation of human rights: universalism and cultural relativism. Cultural practices in general, and FGM/C in specific, present strong proponents of both doctrines. As was shown in the previous section, the way in which the practice of FGM/C was addressed by international actors changed over time. In the 1950s major international organisations refused to take action and invoked culture as a justification not to get involved in the practice (WHO, 1959). International organisations were struggling in understanding if they had the moral authority to condemn a practice so deeply rooted in culture. Slowly, and because of the increased knowledge regarding the consequences, in particular the health ones, the WHO and other international organizations moved from claiming the practice incompatible with human rights standards to the classification of FGM as a form of gender-based violence. In the 1990s the UN took a clear universalistic stance considering the practice unacceptable and declaring it a human rights violation (Middelburg, 2016, p.156). The international stance about FGM/C has always been criticized for western bias. In 1980, at an NGO conference held in parallel to the UN Copenhagen conference, African women boycotted a panel on FGM/C for protesting against the perceived insensitiveness to African perspectives on the topic (Boyle, 2005, p. 67).

However, the question whether international human rights law should play a role in addressing a practice so embedded in cultural beliefs is still highly debated. Some critics argue that FGM/C should not be considered a clear-cut violation of basic human rights but as an expression of cultural identity in which the international community should not interfere. The two approach are diametrically opposed, while universalists believe that human rights must apply to everyone, across national, cultural, economic, religious and political boundaries (Irvine, 2011, p. 2). Human rights belong to every human being equally and in equal measure for the simple fact of being human. Human rights are considered universal by definition.

The universality of human rights is made clear in several texts. The most important document stating the universality of rights is the Universal Declaration of Human Rights, where, in the preamble is stated that it is a common standard of achievement for all people and all nations. And in article 1 states that "All human beings are born free and equal in dignity and rights." (UN, 1948). The fact that rights are equal for everyone and that they are universal is what legitimise them. The universal nature of human rights is reiterated also in many other documents such as the Vienna Declaration and programme of action which stated that the "universal, indivisible and interdependent and interrelated" (art. 5) nature of the these rights is beyond question, and added that "while the significance of national and regional particularities

and various historical, cultural and religious backgrounds must be borne in mind, it is the duty of States, regardless of their political, economic and cultural system, to promote and protect all human rights and fundamental freedoms" (UN general assembly, 1993, art. 5).

On the other hand, relativists see human rights as a purely western concept in which western values and norm are imported and sometimes imposed on other societies (Mutua, 2000, 2002; Kennedy, 2004). Therefore, they cannot be claimed as universal values. Kennedy (2004) believes that although there are parallel developments in other cultures that provide interesting analogies, the ideas embraced by the human rights movement and codified in the UN doctrines are the product of a particular moment in place: "the post enlightenment west" (p. 18). Also Mutua (2002) argues that although the Human Rights Movement claims to be universal, apolitical, and ahistorical, it is fundamentally Eurocentric and promotes the universalization of Eurocentric ideals. Nevertheless, if human rights are constructed through Western paradigms, adjusting other societies to the human rights principles would mean believing that a culture is better than another. According to relativists, no culture is superior to another and therefore one needs to have respect for other's culture and traditions however different they might be. Rights and duties are constructed by societies in the different cultural paradigms and consequently cannot be universally imposed. They believe that there is no universal standard since cultures vary in what they accept and what they do not. The importance of culture has to be acknowledged and consequently the respect of cultural differences has to be tolerated. Relativists believe then that FGM/C has a legitimate function in the societies where it is performed, although it is considered wrong according to western standards (Trueblood, 2000, p. 438).

Oba (2008, p. 2) however believes that the appropriate context of analysis for FGM/C is not cultural relativism but cultural imperialism since the west uses double standards in critiquing non-western attitudes compared to similar western practices. She states that the cultural relativism argument is self-defeating for FGM/C because beyond doubt culture alone cannot justify human wrongs and cultural relativism cannot sanctify human rights violations (p. 2).

Several scholars such as Mutua (2002), Kapur (2002) and Kennedy (2004) have also underlined how the human rights movement has become a rescue mission from outside, using intervention as virtuous and moral imperative. The image of human rights as a western hegemonic civilizing mission would imply a static concept of human rights, instead Merry (2001, p. 31) describes them as an evolving culture of human rights, one that changes and evolves over time in response to social, political, economic, and cultural influences. In fact, in the past 50 years the concept of human rights has grown to include a wider

notion of collective and cultural human rights (Merry, 2001, p. 31). A central question remains whether third-world counties have meaningfully contributed to cross-cultural input and influence in the human rights movement. Many scholars such as Leary (1990), Welche (1995) and Glendon (2001) have pointed at the role of non-western countries in the shaping of UN doctrines in the past and how these have then been adopted by different cultures and spread around the globe and now the western influence is just one of the multitude of cultures that shape the development of international human rights standard. Mutua (2002), however, underlines how this might be true but international organisations have resisted meaningful inputs from third-world countries.

### 3.3 Human rights invoked

As previously explained, the perception of FGM/C has evolved over time finally becoming to be classified a harmful practice and a violation of human rights of girls and women. In addition to be defined as a form of gender discrimination, FGM/C is acknowledged to violate a number of other well-established human rights such as: the right to the highest attainable standard of health; the right to life; the right to freedom from torture or cruel, inhuman or degrading treatment or punishment; and the rights of the child (WHO, 2008).

- Right to be free from gender discrimination

First of all, FGM/C is considered to be a form of gender-based discrimination that hinders women's enjoyment of human rights on an equal footing with men. Arguments in the previous chapter showed how some of the reasons justifying the practice aims to control women's sexuality and to reduce their sexual desire, therefore reinforcing inequality (see Chapter 2). The fact that men can refuse to marry an uncut woman, or that she will be rejected by society, deprives girls and women of making an independent decision about an intervention with long-lasting effects on their bodies. This dynamic underscores the power imbalance between men and women. The practice is therefore recognised as a gender discrimination because it is rooted in gender inequalities and inhibits women's full and equal enjoyment of human rights (WHO, 2008). According to Coomaraswamy, special rapporteur on VAW, FGM/C is the result of "the patriarchal power structures, which legitimise the need to control women's lives" (UN Commission on Human Rights, 2002, para.14). The explicit classification of FGM/C as a form of

violence against women raises the possibility of invoking the UN convention on the elimination of all forms of violence against women (CEDAW).

However, this approach faces some criticisms. In nearly every society where FGM/C is practiced, men also undergo circumcision (Shweder, 2013, p. 351). While the differences in the consequences of the operation can be debated, many women view FGM/C as somehow gender-inclusive and question why men are permitted to undergo circumcision while women are not (Walley, 1997). Additionally, since the practice is often handled and controlled by women, it complicates the assertion that FGM/C is a violation of women's rights (Shell-Duncan, 2008, p. 228).

The right to be free from gender discrimination, in addition to be present in the CEDAW, is also protected under article 2 of the universal declaration of human rights (UDHR); article 2.2 and 3 of the International Covenant on Economic, Social and Cultural Rights (ICESCR); article 2.1, 3 and 26 of the International Covenant on Civil and Political Rights (ICCPR); article 2.1 of the convention of the rights of the child (CRC); article 18.3 and 28 of the African Charter of Human and People's rights (ACHPR); and article 2 of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (also Maputo protocol); and article 14 of the European Convention on Human Rights (ECHR); and articles 21.1 and 23 of the Charter of Fundamental Rights of the European Union.

- Right to the highest attainable standard of health and bodily integrity

As it interferes with healthy genital tissue in the absence of medical necessity and can lead to severe consequences for a woman's physical and mental health, female genital mutilation is a violation of a person's right to the highest attainable standard of health (WHO, 2008).

The health approach has long been used to counteract FGM/C, with many classifying it as an attack on women's right to health and bodily integrity. As explained in the first chapter, FGM/C can have severe long- and short- term physical and psychological complications. Subjecting women to health risks without medical necessity is a violation to the right to health. An advantage of this approach is that it is less judgemental and more politically acceptable than other claims, aligning with concerns of many African women and men on both sides of the debate (Shell-Duncan, 2008, p. 228). However, also this approach presents some problems. The first is that not all types of FGM/C cause the long-lasting consequences described, and many health issues could be mitigated if not completely solved through the medicalisation of the practice. Moreover, the health discourse contradicts itself. While it states that

FGM/C violates the right to the highest attainable standard of health, it simultaneously prohibits the medicalization of the practice, which could significantly reduce many of the complications associated with it and therefore provide a higher level of health for women. The argument of “no medical necessity” is ambiguous as well and highly criticised, especially given the rise of genital cosmetic surgeries in the Global North, which are also often performed without medical necessity.

The right to health is protected under article 25 of the UDHR; article 12 of the ICESCR; article 12 of the CEDAW; article 24.1 of the CRC; article 16 of the ACHPR; article 14 of the Maputo Protocol; and article 35 of the Charter of Fundamental rights of the European union.

- Right to life

The right to life is sometimes invoked in discussions on FGM/C, as the procedure’s potential consequences can, in severe cases, lead to death. As was explained earlier (see section 1.3), various complications can arise depending on how the procedure is carried out and which type performed. In fact, uncontrolled and excessive bleeding during the procedure can result in haemorrhagic shock, while extreme pain and trauma can also cause a shock.

Additionally, infections caused by the procedure can be severe enough to eventually bring to death. Beyond the immediate risks, FGM/C can contribute to maternal and child mortality. For instance, a prolonged and difficult delivery caused by infibulation can be life-threatening for the baby. The child may be stillborn or suffer brain damage from lack of oxygen during the difficult delivery.

Many scholars, however, argue that there is a lack of medical studies on the consequences of FGM/C (Shell-Duncan & Hernlund, 2000, p. 16). In addition, some potentially fatal outcomes, in particular those related to infections and pain management in the moment of excision, could easily be mitigated through medicalisation by using antibiotics, sterile utensils and anaesthesia.

The right to life is protected under article 3 of the UDHR; article 6.1 of the ICCPR; article 6.1 of the CRC; article 4 of the ACHPR together with the Maputo protocol; and article 2 of the ECHR.

- Rights of the child

Because FGM/C is typically performed on girls between the age of 0 and 15, it raises significant concerns in relation to the right of the child. Since children below a certain age cannot give informed consent, their vulnerability provides a compelling basis for denouncing the practice of FGM/C. One of the primary principles in the Convention on the Rights of the Child (CRC) is the "best interest of the child". This concept is stated in Article 3.1 of the Convention which clarifies that "In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration" (UN Convention of the Rights of the Child, 1989).

The WHO interagency statement (2008) acknowledges that parents believe that are acting "in the best interest of the child". In fact, parents are aware of the socio-cultural context in which they live and fear the potential consequences such as impossibility of marriage, rejection and social exclusion for their daughters if they do not undergo the procedure. However, despite the complexity of defining "child best interest", the WHO interagency statement (2008) clearly states that the parents' perception "cannot justify a permanent and potentially life-changing practice that constitutes a violation of girls' fundamental human rights". Also the Committee on the Rights of the Child has taken a clear position on the matter: it explains that "an adult judgement of a child's best interest cannot override the obligation to respect all the child's rights under the convention" (UN Committee on the Rights of the Child, 2011, para. 61). FGM/C cannot therefore ever be justified. This concept is again recognised by the Committee in General Comment n. 14:

> Although preservation of religious and cultural values and traditions as part of the identity of the child must be taken into consideration, practices that are inconsistent or incompatible with the rights established in the convention, are not in the child's best interest. Cultural identity cannot excuse or justify the perpetuation by decision makers and authorities of traditions and cultural values that deny the child or children the rights guaranteed by the convention (UN Committee on the Rights of the Child, 2013, para. 57).

Additionally, the Declaration of the Rights of the Child, adopted by the UN general assembly in 1959, states that each child shall be given the opportunity to "develop physically, mentally, morally, spiritually and socially in a healthy and normal manner and in conditions of freedom and dignity" (UN General Assembly, 1959, principle 2). However, this perspective by focusing on the physical harm and not considering the social exclusion, overlooks that in societies with high prevalence the right to develop "normally" includes being cut (Shell-Duncan, 2008, pp. 227-228).

The CRC also points out the evolving capacity of children to make decisions regarding matters affecting them and the importance of expressing those views. According to Article 12.1

> States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child." (UN Convention of the Rights of the Child, 1989)

Therefore, in the case of FGM/C, if a girl is subjected to the procedure without her consent, it is a clear violation of Article 12. However, even if girls appear to agree or desire to undergo the procedure, the question remains whether their consent is genuinely informed and meaningful. According to the interagency statemen (2008), such consent is in reality the result of social pressure and community expectations regarding being part of the community, rather than free and informed choice. This is why a girl's decision to undergo female genital mutilation cannot be called free, informed or free of coercion (WHO, 2008). However, this position is criticised because it perpetuates the stereotype of the brainwashed African woman incapable of thinking for herself (Oba, 2008, p. 34).

Rights of the child are clearly protected in the CRC, but they are also mentioned in art 25 of the UDHR; article 10 or the ICESCR; article 24 of the ICCPR; article 5(b) of the CEDAW; article 18.3 of the ACHPR; and article 24 of the Charter of fundamental rights of the European Union.

- Right to freedom from torture, cruel, inhuman, or degrading treatment

Another claim is that FGM/C is considered a form of torture or inhumane treatment. However, the classification of FGM/C as a form of torture can be quite complex. According to Article 1 of the Convention against torture and other cruel or inhuman or degrading treatment or punishment (CAT), torture is defined as:

> Any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person [...] for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions. (UN Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, 1984).

This definition includes three key elements: severe pain or suffering; intentional infliction; and the consent or acquiescence of a public official.

The first element, the presence of "severe pain and suffering" is often met in the case of FGM/C. As presented in earlier discussions, FGM/C is in most cases performed without the use of anaesthesia, resulting in severe pain. In addition, also the long-term consequences can cause severe pain and further support this first element. However, not all the types of FGM/C actually provoke such intense pain. In fact, the consequence of FGM/C can depend on the type performed, the expertise of the practitioner and the conditions under which is carried out (see Section 1.3). As it has been overwhelmingly repeated, medicalisation of the practice could avoid any immediate pain as well as some of the long-term consequences.

The second element, the "intentional infliction" of the pain, involves whether the perpetrators, typically the parents or practitioners, intend to cause harm. Parents don't actually want to harm their children, on the contrary they believe to act in their best interest, aiming to secure their social acceptance and future prospects. However, CAT has emphasised in General Comment n. 2 that "the elements of intent and purpose of article 1 do not involve a subjective inquiry into the motivations of the perpetrators, but rather must be objective determinations under the circumstances" (UN committee against torture, 2008, para. 9). The international community maintains that FGM/C constitute a form of torture because parents and cutters know that they are deliberately inflicting severe pain to alter the girl's external genitalia. Nonetheless, this element has been criticised, as some argue that the practice cannot be defined as torture if it involves consent (Shell-Duncan, 2008, p. 228).

The third element requiring the "consent or acquiescence of a public official", is particularly challenging in the context of FGM/C because it is usually performed privately without the presence or consensus of public officials. However, it has been argued that the failure of governments to ban FGM/C or enforce existing laws against it satisfies this requirement (Shell-Duncan, 2008, p. 228). In 2007, CAT's general comment n. 2 emphasized that:

> Since the failure of the State to exercise due diligence to intervene to stop, sanction and provide remedies to victims of torture facilitates and enables non-State actors to commit acts impermissible under the Convention with impunity, the State's indifference or inaction provides a form of encouragement and/or de facto permission. The Committee has applied this principle to States parties' failure to prevent and protect victims from gender-based violence, such as rape, domestic violence, female genital mutilation, and trafficking. (para. 19).

Scholars such as Breitung (1996) caution against labelling FGM as torture due to its deep cultural roots. Defining a highly valued cultural practice as "torture" could be considered as an attack to culture with

counterproductive results such as more resistance from the practicing communities rather than help in ending it.

Freedom from torture, in addition to be present in the convention against torture (CAT), is also mentioned in article 5 of the UDHR; article 7 of the ICCPR; article 37(a) of the CRC; article 5 of the ACHPR; and article 3 of the ECHR.

- Cultural relativistic stance

Cultural relativists justify FGM/C on the basis of the right to culture, minority rights and the right to religious freedom (Rahman and Toubia, 2000, p. 31). These rights are also protected by various international and regional human rights instrument. As previously discussed, the majority of the practicing communities continues it because of custom and tradition and therefore sees the ban of FGM/C as a violation of their cultural right. The right to maintain cultural values is present in many international instruments such as the UDHR, ICESCR, ACHPR and also in the Vienna declaration. In the African context, the ACHPR (art. 29.7) clearly states that individuals shall have the duty to "preserve and strengthen positive African cultural values".

Supporters of FGM/C also invoke minority rights, as many of the practicing communities belong to minority groups. These groups often see the ban on FGM/C as an infringement on their autonomy. Protection for minorities can be found in the ICCPR (art. 27) where is stated that in those states where religious, ethic, or linguistic minorities exist, individuals belonging those minorities have the right to enjoy their own culture, practice their religion, or use their language.

Lastly, supporters often invoke the right to religious freedom. Although religion is a reason for the practice's continuation in many communities, it is a contentious justification since no major religious texts prescribe FGM/C (see Section 2.6). Nonetheless, the right to freedom of religion is a significant human right and is protected by many instruments such as the UDHR, ICCPR, ACHPR and the Charter of fundamental rights of the European union.

There is therefore a collision of rights regarding the elimination or the continuation of FGM/C. The Human rights framework itself provides guidance on how to deal with conflicting rights. The right to culture, minority rights and the right to religious freedom are not absolute rights and can therefore be limited when conflicting with other rights. Both the UDHR, the ICCPR, and the ICESCR include clauses

stating that no one might invoke a right recognised in those treaties to infringe upon other human rights and fundamental freedoms guaranteed by international law.

### 3.4 Critical analysis of the FGM/C eradication efforts

While the human rights framework collects broad support, it also faces some criticism and can have potential shortcomings. In the previous sections have already been highlighted some of the criticisms related to the conflict between universalism and relativism of the human rights invoked. In particular, have been analysed the potential problems arising and the conflicting ideologies regarding the right to be free from gender discrimination, the rights of the child, the right to health and bodily integrity, and the right to freedom of from torture. In this section, it will be analysed the zero-tolerance approach adopted internationally to stop FGM/C. Particular attention will be given to the claims regarding the human rights approach and the zero-tolerance policy as a form of cultural imperialism.

At the core of the human rights discourse against FGC/M is the term *mutilation*, under which the WHO puts together a number of diverse practices performed on female genitalia. The term *mutilation* has been heavily criticised by many scholars for being stigmatizing, misleading, imprecise ethnocentric, and sexist (Earp and Johnsdotter, 2021, p. 197). First of all, the term can be harmful as it can lead to unnecessary stigmatization, offending many women who have undergone the procedure. The imprecision and inaccuracy of the term stands in its broad application to a wide number of practices, performed by different communities for different reasons. These practices can vary greatly and some of them such as pricking or nicking (type IV) do not involve any removal of genital tissue and do not cause any lasting consequence. Additionally, the term portrays a misleading representation of what the practice entails for the communities that perform it. In these communities, FGM/C is not perceived at all as a mutilation but rather as a practice that enhances the child's body according to local perceptions of aesthetic, religious or cultural norms (p. 197). Moreover, the term is considered ethnocentric, because it applies exclusively to non-western form of genital modifications and not to those that are more practiced in the west, such as labiaplasty (p. 197). It is also viewed as sexist, since it applies only to female genital modifications while ignoring other forms of child genital modifications such as male circumcision or intersex infant (p. 197). This rhetoric of mutilation and barbaric practice brought forward from the international community through the zero-tolerance policy silences the debate and shuts down any opportunity of communication with the communities involved (Shweder, 2013, p. 354).

One of the major inconsistencies in the zero-tolerance approach to FGM/C is its selective application. The zero- tolerance is strictly enforced for the customary genital practices of African and Asian women, but not for the increasingly common genital cosmetic surgeries (GCS) performed in the West (O'Neill et al., 2020, p. 268). While the approach aims to respect the physical integrity and rights of all women, it seems that the right to make decisions about one's body is unevenly distributed based on race and ethnicity (p. 270). Although FGM/C and GCS alter the same parts of the genitalia (The Brussels Collaboration on Bodily Integrity, 2019, p. 19), it is argued that the two practices are incomparable. The typical argument is that FGM/C is performed on underage, non-consensual girls, while GCS is an informed choice by an adult woman (O'Neill et al., 2020, p. 268). However, this argument has some problems. First of all, the prohibition of FGM/C in many European and African countries is extended also to adult women, and cosmetic surgeries are sometimes performed also on underage girls' genitalia.

The number of genital cosmetic surgeries in the West is rising, with procedures increasingly being requested and performed on underage girls with parental consent. Meanwhile, the ban on FGM/C often applies to adult women as well. The global human rights framework, which protects women's rights, argues that even women who seemingly consent to FGM/C are often coerced by their social environments, making their consent not truly free. But could the same argument not apply to Western women undergoing genital cosmetic surgeries? The demand for these surgeries among Western women can also be seen as a societal imposition to conform to aesthetic standards propagated by the media and internet. The growing number of genital cosmetic surgeries in the West raises questions: Do Western women suddenly have new medical reasons for altering their labia, or are these surgeries driven by a desire to conform to contemporary beauty standards? If a consensual African woman wishes to achieve her ideal of beauty and fit into her society, she is condemned, whereas a Western woman's similar choice is framed as her right to feel comfortable in her own body. This double standard perpetuates the stereotype of the brainwashed African woman who is incapable of thinking for herself and therefore must be saved (Oba, 2008, p. 34).

Another crucial part of the zero-tolerance strategy against FGM/C involves implementing global bans on the practice. However, the course of action of this framework is often debated. Critics argue that a human rights approach enforces the eradication of FGM/C primarily, though not exclusively, through legal measures and sanctions (Shell-Duncan, 2008, p. 229).

Evidence suggests that formal legislation alone is an ineffective instrument for cultural change (Shell-Duncan & Hernlund, 2000, p.33; Gruenbaum, 2001, p. 207). For instance, the 1946 law criminalizing

infibulation in Sudan sparked public uprising and following the entry into force, the prevalence has actually increased. Backlashes occurred both in anticipation of and in response to such legislation, with parents rushing to have their daughters cut (Shell-Duncan & Hernlund, 2000, p. 33). While well-intentioned, anti-FGM/C laws can inadvertently increase the danger for girls by driving the practice underground (Shell-Duncan, 2001, p. 1019). In fact, Shell-Duncan and Hernlund claim that "in a parallel to the abortion debate, it has been argued that victims of botched infibulations may simply be allowed to bleed to death rather than receive medical care when parents, circumcisers, and community members fear prosecution" (p. 33).

Despite the demonstrated shortcomings of legislation as a tool for effective change, international pressure continues to prompt the drafting of such laws (Shell-Duncan & Hernlund, 2000, p. 34). In the Global North, laws were quickly enacted to criminalize FGM/C as African immigrants began to arrive. France became the first European country to outlaw FGM/C in 1979, soon followed by Sweden with a specific law (O'Neill et al., 2020, p. 269). This Swedish initiative inspired many other countries worldwide to enact similar legislations, affecting both receiving countries in the Global North and countries of origin in the Global South.

Countries in the Global South are also enacting laws against FGM/C, although some scholars argue they do so due to Western pressure (Shell-Duncan & Hernlund, 2000, p. 33; Oba, 2008, p. 26). Parker (in Shell-Duncan & Hernlund, 2000, p. 33) claims in a 1995 article that "one of the conditions of a recent loan by the international monetary fund to Burkina Faso was that the government should agree to further its activities to bring the practice to an end".

Moreover, the laws being drafted reveal several inconsistencies. First of all, in the call for respect of children's rights which focuses exclusively on girls while overlooking other medically unnecessary genital modifications performed on intersex infants and boys, both in Western countries and FGM/C practicing countries (O'Neill et al., 2020). Earp and Johnsdotter (2020, p. 203) point out that the laws may be unconstitutional. This assertion is grounded in the principle that most Western constitutions mandate equal treatment before the law for males and females, members of different racial or ethnic groups, and adherents to different religions. However, current zero-tolerance laws disproportionately criminalize female ritual nicking, even when it involves no removal of tissue and is performed for religious purposes (see Section 2.6). This practice is deemed a criminal act regardless of whether it is conducted with pain control and sterile equipment by a medically trained provider. In stark contrast, non-consensual male circumcision is legally permitted, irrespective of whether it is performed for explicitly

religious reasons. Moreover, male circumcision is allowed even without pain control and in unhygienic conditions by medically untrained individuals, highlighting a significant disparity in legal and ethical standards. Thus, they conclude, “males and females, as well as Muslims and Jews, and – in practice – white native women and women of different ethnicities or birthplaces, are not currently being treated equally before the law.” (p. 203)

A further challenge is the credibility of anti-FGM campaigns that adhere to the zero-tolerance policy due to the contradictory messages surrounding medically unnecessary genital modifications. The WHO’s definition of FGM/C includes pricking (Type IV), which is equally prohibited as infibulation, yet these strict legislations against FGM/C stands in contrast to the lack of regulation of similar practices like genital cosmetic surgeries, genital piercings, and male circumcision (O’Neill et al., 2020, p. 270). Essen and Johnsdotter point out that in the Scandinavian countries, the line between genital cosmetic surgeries and FGM/C is very blurred. FGM/C law in Denmark states that “Any person who by committing an act of violence, with or without consent, excises or in other way removes, in part or completely, female external sex organs shall be liable to imprisonment for any teiui not exceeding six years” (Danish Criminal Code, art. 245(a)). This is particularly ambiguous because, *stricto sensu*, labiaplasty and hoodectomy would be punishable by prison sentences, regardless of consent and even when performed in medical settings by a surgeon. Yet, O’Neill et al. (2020) state that "according to our investigations, labiaplasty is performed in Denmark in public hospitals if ‘medically indicated’ and privately for those willing to pay" (p. 270). As previously mentioned, women from different ethnic backgrounds are treated differently before the law. Essen and Johnsdotter argue that ethnic background and consent should be irrelevant to the laws, and thus, if FGM/C is banned, any non-medically motivated alteration to the genitalia should also be punishable.

To conclude, the zero-tolerance policy on FGM/C as is currently formulated seems more like an attack on African culture than a genuine effort to protect the bodily integrity of women and girls. It selectively condemns non-Western, female-only genital cutting, and as O’Neill et. al. (2020) mention “race and ethnicity are benchmarks within the zero-tolerance policy for determining whether a bodily practice is a “mutilation” or a cosmetic procedure.” (p. 273). This stance disregards harm, consent, and the comparability to other medically unnecessary practices. Other scholars such as Earp and Johnsdotter (2020) have also underlined that the “current policy on non-Western FGC is ethnocentric, culturally biased, ethically incoherent, empirically unsupported, and de facto discriminatory on the basis of sex and

gender, race/ethnicity, and parental religion." (p. 206). The policy's narrow focus raises questions about its fairness and effectiveness in genuinely protecting women's and girls' rights across different cultures.

This chapter has provided a comprehensive analysis of the human rights framework surrounding FGM/C. The anti-FGM/C movement has transitioned from a health-based framework to a human rights framework, embedding the issue within the spheres of politics and law and establishing governmental legislations to end FGM/C. Various debates about the human rights framework have been discussed, from relativist criticisms of imposing Western values to the imperialist policies currently used to eradicate the practice. While I find it important to underline my personal rejection for FGM/C, my goal is to highlight the shortcomings of the current framework. To effectively combat FGM/C worldwide, we must identify and address the inconsistencies in current policies. As also Shell-Duncan (2008) perfectly states, taking from Kennedy's words (2004), "unless those in the human rights movement operate with awareness of the potential pitfalls and perils, the human rights approach can create as many problems as it seeks to resolve" (p.229).

It is crucial to understand that viewing the protection against FGM/C as a right to be enforced, granted, recognized, and implemented by the state does not de-emphasize or delegitimize approaches that recognise the previously explained cultural aspect behind FGM/C (Shell-Duncan, 2008, p. 229). The following chapter will present a different type of approach—a more culturally sensitive one—with the same aim: putting an end to FGM/C.

# CHAPTER 4

## Alternative Rituals

*"you know doctor that you had a nice idea [about the alternative ritual], too bad it wasn't accepted, if there was in Italy I would do it to my children, but since there isn't I have to do a gaudin like mine"*[6]

In the previous chapters, the meaning and significance of the practice for the communities that engage in it, as well as its relevance in the context of human rights, have been analysed. It is evident that there are two very distinct perceptions about the meaning of the practice and the value attributed to it. In this clash of rights, the perspective supported by Western society often prevails, frequently leading to accusations of the human rights approach being an imperialistic imposition of culture. However, there have been some proposal of alternative rituals that seek to find a more culturally sensitive approach to tackle the practice. This chapter will focus on those proposals, in particular on the Italian one.

In recent years, there have been various proposals to find alternative rituals to FGM/C both in Africa and in the West. In Africa, some of the alternatives include Merka initiative in Somalia (Catania & Abdulcadir, 2005, p. 97), circumcision with words in Kenya (p. 104), the effort of a Mexican nun that has managed to exchange FGM/C with confirmation since 1995 (p. 112). In the West, the Dutch Ministry of Welfare, Health and Culture was the first, in 1992, to suggest an alternative solution where doctors could perform pricking as a ritual (Abdulcadir et al., 2011, p. 6). Subsequently, in the United States, the Harborview Medical Centre in Seattle proposed an alternative for the Somali community in the area, where mothers were requesting circumcision for their daughters along with their sons (Coleman, 1998), after an initial rejection, the hospital, together with the Somali community formulated a proposal to perform a ritual or symbolic circumcision. This proposal caused a public scandal and it was never implemented. In 2004, a similar proposal emerged in Italy from Omar Abdulcadir, a Somali doctor who had worked in the country for years (Catania and Abdulcadir, 2005). This doctor, upon learning of alternative rituals in Africa and recognizing that many girls were either returning to their countries of origin for infibulation or undergoing the procedure illegally in Italy, decided to propose an alternative solution. Finally, in 2010, the American Academy of Paediatrics also suggested medically pricking the clitoris under anaesthesia as an alternative to more severe forms of FGM/C (Arora and Jacobs, 2016). In

[6] Interviewed woman. In Catania & Abdulcadir, 2005, pp.114-115

Florence, as in Seattle and in the Netherlands, major polemics and protests defending zero tolerance against every type of genital manipulation, especially from feminist associations and the media, stopped the introduction of any alternative solution (Abdulcadir et al., 2011, p. 6).

This chapter will focus specifically on the Italian case and the efforts of the Somali doctor who sought to find a compromise between the seemingly irreconcilable cultures. This cultural clash involves the values of a Western society, such as Italy, and the desire of some immigrants to maintain their cultural and religious practices. The symbolic ritual proposed aims to provide an alternative to FGM/C for those not yet ready to abandon the practice, but willing to change the situation by adopting a compromising solution. This initiative highlights the extraordinary sensitivity of Dr. Abdulcadir and his wife, Dr. Catania, in addressing the cultural and religious concerns of immigrants. It will illustrate the predictable and sometimes surprising reactions from both within and outside the community, offering valuable lessons from this episode. Through their efforts, the proposal aims to demonstrate a compassionate approach to navigating cultural differences and finding viable solutions to deeply ingrained practices.

The chapter is structured as follows: section 4.1 outlines the Italian proposal of Dr. Abdulcadir, followed an ethical, deontological and legal analysis of the ritual by the Regional Committee of Bioethics in section 4.2. Section 4.3 explains the shortcomings and the media and political outrage caused by the proposal. Finally, section 4.4 highlights the positive aspects of the symbolic alternative ritual.

## 4.1 Alternative Symbolic Ritual in Italy

In December 2003, the project describing the alternative symbolic ritual was presented to the Region of Tuscany (Italy) by Somali gynaecologist Omar Abdulcadir (Catania & Abdulcadir, 2005). Dr. Abdulcadir, who was responsible for the Centre for the Prevention and Cure of Female Genital Mutilations at the Careggi Hospital in Florence[7], proposed an alternative ritual to FGM/C based on harm reduction. The centre, officially recognized on November 10, 2003, by the Region of Tuscany, was the culmination of years of work by Dr. Abdulcadir and his wife Dr. Catania in assisting immigrants who had undergone FGM/C (Catania & Abdulcadir, 2005, pp. 123-128). This centre not only offered gynaecological consultations but also provided information about the risks associated with the rituals and possible solutions, including surgical interventions such as de-infibulation. More than just a medical

[7] Centro di riferimento regionale per la prevenzione e cura delle complicanze delle mutilazioni genitali femminili presso l'azienda ospedaliera Careggi

facility, the centre has become a place where women are listened and where they can find support and assistance with the various challenges brought on by immigration.

Dr. Abdulcadir, born in Somalia to an infibulated mother, grew up surrounded by sisters, cousins and friends who had all undergone FGM/C as a rite of passage to womanhood. From an early age, he was acutely aware of the consequences of these practices and understood their cultural implications. Because of this profound understanding of the practice he decided to dedicate his life to fight against FGM/C because "to be able to eradicate infibulation, it is necessary to know the roots, inquire the social and cultural aspect, deepen the knowledge regarding the significance, know the concept of life of those who practice it and the essence of their values in order to exalt the positive ones" [8] (Catania & Abdulcadir, 2005, p.87)

The primary goal of the doctor with the alternative ritual was to save the girls from mutilation but in a way that would still preserve their connection with tradition, culture and identity so that their families would consent. The proposal was specifically targeted for a little group of women with whom he talked that seemed irremovable from abandoning this practice. In fact, Abdulcadir believes that there are three groups of women: those who have lived in Italy for many years and with whom they have dialogued for a long time, that decided not to excise any more the girls. Those who still believes in the importance of the practice but that comes to compromise, and those who firmly believe in the importance of infibulation for the girl. It is exactly for this last group that the ritual was formulated (Migliara, 2015, pp. 62-63).

In fact, while the majority of people in diaspora abandon the practice, some remain attached to their cultural origin or still have pressure from their family back home to uphold the custom even if in a foreign country (see Chapter 2). When the belief is so strong and there are no alternatives, the risk is that the family will bring the girl back to their country of origin or that will seek illegal circumcisers in the host country (Coleman, 1998, p. 740-741; Catania & Abdulcadir, 2005, p. 114). If the girl is taken back to the country of origin, it is likely that the rest of the family, in particular the grandmother, will have something to say and will make her perform the most extensive version of FGM/C, infibulation (Coleman, 1998, p. 741; Catania & Abdulcadir, 2005, p. 115). Representative of this reality is the story of Barny, one of the patients of Dr. Abdulcadir, who states "when I will have children I will do it [FGM/C] to them, especially if I keep living here [in Italy] or in Europe. This way my daughters will know they are from Africa, or

[8] Personal translation. All subsequent Italian sources will be translated by me.

rather from Somalia, because we do *gaudin*[9] better" and regarding the proposal of Dr. Abdulcadir she replies "you know doctor that you had a nice idea, too bad it wasn't accepted, if there was in Italy I would do it to my children, but since there isn't I have to do a *gaudin* like mine" (Catania & Abdulcadir, 2005, pp.114-115). This was a concern also highlighted in the Seattle compromise, where it was recognized that simply informing new immigrants about the illegality of the practice or its contradiction with local culture was not enough to eradicate it (Coleman, 1998, p. 743). Because immigration will not make them abandon their cultural practices overnight (p. 743).

In this context, where Dr. Abdulcadir and Dr. Catania faced the daily consequences of FGM/C and listened to the stories of Somali patients at their centre, they formulated their proposal. Inspired by alternative rituals already present in Africa, they believed it was time for a new ritual that could maintain the original significance of initiation into adulthood and community belonging while gradually abandoning FGM/C.

The symbolic ritual Catania and Abdulcadir (2005, p. 42) described involved pricking the clitoral hood to release a few drops of blood. This procedure would be performed under local anaesthesia using a needle similar to those used for blood glucose tests or a syringe for injections. Since no genital tissue was removed, the procedure would not cause any complications, and the wound would heal within a few hours. The ritual could be performed on girls old enough to give their consent (maybe around ten years old), or with the prior consent of both parents.

To them, performing the ritual only in the Careggi centre or other specific healthcare facilities was also significant. It allowed for the monitoring of both the girl and her parents, ensuring the genuine willingness of the latter to adhere to the less harmful procedure (Catania & Abdulcadir, 2005, p. 42). Conducting the ritual in authorized facilities, in addition to ensuring a safe and sterile environment, would prevent parents from secretly opting for more invasive procedures under the guise of a minor ritual.

The intent of all the different alternative proposal was always the same: "to provide a relatively safe procedure to a population of young women who traditionally have had some horrendous things done to them" (Coleman, 1998, p. 745). In this regard Abdulcadir states

> To me is important to save some girls, to think that their heartbreaking cries will be gone, that only the singing and jumping for joy will remain, that they will be able to be proud without being mutilated. (…)

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[9] *Gaudin* in Somali means circumcision. This term is used by Somali women to refer to genital modifications.

> these little girls will not be wounded forever, they will not be marked by infibulation, but they will live their day of celebration (Catania & Abdulcadir, 2005, p. 90).

The doctors who proposed these alternatives hoped they would serve as a transitional measure, ultimately leading to the complete abolition of FGM/C in future generations (Coleman, 1998, p. 745; Catania and Abdulcadir, 2005, p. 42). Lucrezia Catania describes that they tried to dissuade the families through information but sometimes they didn't manage to, so "we excogitated, with women and also men, a sort of vaccine (attenuated disease to develop immunity against the more severe true disease). [...] and while experts were considering whether it was feasible, people were told not that we were making a 'vaccine', but that we wanted to spread the disease." (Catania & Abdulcadir, 2005, pp. 91-92)

Predicting whether an alternative ritual will achieve the desired outcome is challenging, but the acknowledgment and approval of the benefiting community are crucial. The project was presented to the Somali women community in Florence and to those visiting the centre since its initial development in the summer of 2003. Many women in the community showed their support for the proposal, with over 300 women signing a document describing it (Catania & Abdulcadir, 2005, p.30).

Since the practice is largely controlled by women - who decide to perform it and who bear the physical and emotional scars – men were often excluded from eradication projects. However, even though men do not directly control FGM/C, it cannot be ignored how this custom is deeply intertwined in social and gender dynamics and men have a profound effect on the decisions regarding FGM/C. Also international organisations such as the WHO and UNICEF have emphasized the importance of involving the men in the fights against mutilatory practices (Catania & Abdulcadir, 2005, p. 31). Dr. Catania and Dr. Abdulcadir's experience also underscored the importance of involving fathers in FGM/C prevention. In three years of research, the only five Somali women they encountered who were not infibulated were saved by their fathers' strong opposition (Catania & Abdulcadir, 2005, p. 31). Recognizing the need to include men, Dr. Abdulcadir decided to involve them in the project. He organized meetings to explain the proposal and seek their support. While some men signed the project immediately, others took time to consider it, but eventually, everyone involved signed the document voluntarily, which was then submitted to the Region of Tuscany (Catania & Abdulcadir, 2005, p. 31).

### 4.2 Ethical, deontological and legal evaluation of the alternative ritual

In the meantime, in December 2003, the proposal was presented to the local bioethics committee for evaluation. After thorough examination and discussion of the techniques and modalities involved, the local committee unanimously gave its favourable consent (Catania & Abdulcadir, 2005, pp. 37-38). They recognized the proposal not only for its medical benefits but also for its "value of [fostering] intercultural dialogue, fundamental for an integration without any conflicts, in the full respect of the mutual cultural identities" (Catania & Abdulcadir, 2005, pp. 37-38).

However, the president of the medical order, Dr. Panti, believed it was necessary to also seek the opinion of the regional bioethics committee regarding the ethical, deontological, and legal legitimacy of the ritual. Dr. Abdulcadir and Dr. Catania agreed and on January 9, 2004, explained the proposal to the regional committee (Catania & Abdulcadir, 2005, p. 31). While the regional committee explicitly condemned any form of manipulation of women's bodies, it acknowledged the positive aspects of Dr. Abdulcadir's work, which included, not only treating complications from FGM/C, but also educating and informing women and families. Given the widespread practice of FGM/C, a non-painful and minimal procedure, far different from infibulation or other severe forms of FGM/C needed to be considered as part of a broader prevention and eradication efforts already undertaken in many countries (Catania & Abdulcadir, 2005, pp. 56-58).

Regarding the ethics of the proposal, the committee highlighted motivations both for and against it. They recognized that this symbolic practice, which does not cause pain or long-term consequences to the girl's body, still preserves the symbolic aspects of purity, beauty, and social acceptance. With this in mind, we have to remember that the alternative ritual had to be seen as a transitional method towards achieving longer-term goals. The committee stated that assessing the ethicality of the proposal "does not mean to share its significance, which for us Westerners can still be 'incomprehensible' and/or 'unshareable'" (Catania & Abdulcadir, 2005, p. 62).

Under the deontological perspective, the committee could not avoid mentioning the importance of prevention. In fact, while treating damage caused by FGM, although an important and necessary action, is no longer a sufficient response to the problem. They stated that it was essential and necessary to seek solutions in the area of prevention (Catania & Abdulcadir, 2005, p. 62). The alternative ritual is thus inscribed in the view of damage prevention because it does not cause permanent consequence. Based on this consideration, the committee judged the proposal as deontologically approved. In conclusion to the

deontological connotation of the practice, the committee cannot omit to compare it to male circumcision on minors, noting that in Italy the latter is permitted even if it involves some risks and alters physical integrity (Catania & Abdulcadir, 2005, p. 63).

In terms of legal aspects, Professor Mantovani first assessed the legality of FGM/C in its entirety before specifically addressing the proposal. He clearly found FGM/C to be unlawful. At the time the proposal was presented, there was no specific law regarding FGM/C in Italy, so the practice was analysed under the category of grievous bodily injuries (Italian Penal Code, Art. 538/1) due to the permanent weakening of an organ. Consent could not be used as a justification for such practices because, under Article 50 of the Italian Penal Code, consent is only valid when there is no permanent impairment of the physical integrity. Moreover, parental consent was not applicable since FGM/C cannot be considered a therapeutic surgery. Also customary law could not be invoked as there was no tradition of FGM/C in Italy (Catania & Abdulcadir, 2005, p. 65).

Regarding the juridical aspect of the ritual proposal, Professor Mantovani articulated his opinion in three key considerations: principle, opportunity, and the execution of the procedure. Firstly, in evaluating the principle, Mantovani asserted that even a symbolic procedure could fall under the logic of FGM/C, thereby contravening the dignity of the person (Catania & Abdulcadir, 2005, p. 66).

In terms of opportunity, the pricking of the clitoris, as an alternative to the much more extensive forms of FGM/C, would fall under the logic of harm reduction. However, he also pointed out that this could be deemed unlawful under Article 581 of the Italian penal code, the pricking could represent an emblematic expression of the conduct of beating, under which are included all violent actions able to cause pain (which would occur when there are injuries to such a sensitive area). (Catania & Abdulcadir, 2005, p. 66).

Concerning the execution of the procedure within public healthcare facilities, Mantovani argued that it would be unfeasible. If the act is deemed illegal, any medical personnel performing it and the public authority authorizing it could face legal prosecution. Even admitted the procedure was legal, it had to be verified that the facilities could perform it, considering they are mandated to carry out therapeutic procedures, which the alternative ritual could not be classified as (Catania & Abdulcadir, 2005, p. 66).

Finally, Mantovani underlined the potential values of the compromising solution, always admitted that was performed as a last resort aimed at harm reduction and seen as a transitory phase toward the complete abandonment of the practice (Catania & Abdulcadir, 2005, p. 67).

On March 9, 2005, the regional bioethics committee recognised the lawfulness of the practice from ethical, deontological, and judicial perspectives. The committee concluded that the proposal could serve as a medical alternative only for parents unwilling to completely abandon FGM/C. It must be regarded as a harm reduction strategy since, despite causing a minor injury, it does not result in any permanent damage to the girl's physical integrity. They underlined once again that this procedure should be understood as part of a broader journey to eradicate all forms of genital modification. However, due to its ritualistic nature, it could not be included in the public healthcare services (Catania & Abdulcadir, 2005, p. 34).

### 4.3 Critiques to the proposal

On January 19, 2004, long before any official decisions were made, the Italian associations AIDOS and Nosotras issued a press release reporting the proposal for an alternative ritual to FGM/C. They defined Tuscany as "the first Italian and European region to practice mutilation of the female genitals in its medical facilities, particularly in the self-proclaimed regional centre for the cure and prevention of FGM/C" (Catania & Abdulcadir, 2005, p. 46). These associations compared the proposal to clitoridectomy performed in medical facilities and portrayed Dr. Abdulcadir, who had spent years educating, treating, and defibulating women, as someone colluding with African men to preserve patriarchal traditions of female subjugation (Catania & Abdulcadir, 2005, p. 46).

This denunciation sparked a mediatic storm. The proposed pricking of the clitoris under local anaesthesia was sensationalized as "soft infibulation" or "sweet infibulation"— terms far removed from the proposal's intentions. As Lucrezia Catania (2005) pointed out, "they make shudder anyone who knows what infibulation really is. We are still wondering which mind could have ever imagined that a mutilation could be soft or sweet!" (p. 32). The shocking headlines about a Somali doctor allegedly planning to mutilate African women's genitals under anaesthesia dominated the news. Rightfully, the revolt was general, from every direction there are cries against FGM/C, not distinguishing anymore what is right from what is not. Many people who had never previously engaged with the topic suddenly considered themselves experts on FGM/C, and politicians quickly distanced themselves from Dr. Abdulcadir, condemning the practice without differentiating between the original FGM/C and the proposed alternative (Catania & Abdulcadir, 2005, p. 32).

The media scandal culminated in the Tuscany Regional Council's negative opinion of the proposal. On February 3, 2004, without waiting for the regional bioethical committee's assessment, the council rejected the proposal (Catania & Abdulcadir, 2005, p. 32).

An interesting aspect to note is the position of the African women in the debate. As mentioned before, many women were involved in the project since the beginning but notably, those who supported the symbolic ritual were never invited to participate in public debates or meetings by the authorities. Despite their efforts, documented in multiple letters and statements, these women were excluded from the decision-making process that directly affected them (Catania & Abdulcadir, 2005, pp. 32-33). However, others, many of which were part of the feminists' organisations who reported the ritual, were clearly against the alternative proposal because they did not want the perpetuation of the practice not even in its symbolic meaning (Vantaggiato, 2004). Some women were very angry and believed there was no room for compromise, criticizing men who "signed an agreement with Dr. Abdulcadir without even asking our consent" (Vantaggiato, 2004). Abdulcadir himself acknowledged his mistake in not involving feminist organizations, recognizing their role as the voice of women (Migliara, 2015).

The reasons for this divergence among women can be traced to their varied experiences and backgrounds. The women supporting the symbolic ritual and those opposing it represented different immigrant experiences and realities, shaped by the distinct circumstances and motivations behind their experiences with FGM/C.

As soon as the media debate erupted, numerous politicians also intervened. Many were vehemently opposed to the proposal, arguing that accepting it would equate to legalizing the practice of FGM/C. Carolina Lussana, a congresswoman, was among the first to raise the issue after an article in *La Repubblica*, a prominent Italian newspaper. During a meeting of the chamber (Camera dei Deputati, 2004) on January 21, 2004, she reported the "truly disconcerting news" that a Somali gynaecologist had requested permission from the region of Tuscany to perform what was termed as "soft infibulation". She asserted that such practices could not be tolerated under any circumstances, not even under the guise of harm reduction, deeming it an uncivilized custom. She continued her intervention attacking the region of Tuscany for allowing such a tremendous proposal to happen, with what seemed more like a political attack on the region rather than an ethical judgment on the behaviour. Similarly, another congresswoman, Paoletti Tangheroni, declared, "We are a country that refuses criminal practices! (…) In our culture, [FGM/C] does not exist, and our culture must be defended at all costs." (Camera dei Deputati, 2004) The meeting was marked by continuous interruptions from various parties, debating whether the health

councillor and the region of Tuscany had acted appropriately by having the regional bioethics committee assess the proposal. Some, like Alessandro Cè, argued that the proposal should have been immediately discarded by the councillor, who should have also sought to disbar Dr. Abdulcadir from the medical register. While there was a unanimous agreement on the barbarity of FGM/C and the necessity to eradicate it, opinions differed significantly regarding how to interact with different cultures.

Organizations like AIDOS and other women's rights associations, along with many politicians, viewed the alternative ritual as a medicalization and therefore a legitimization of FGM/C. They believed that the fight against these practices admitted no compromise and that the only effective strategy was to unequivocally condemn them. They argued that merely eliminating the most painful aspects of FGM/C did not remove the patriarchal domination inherent in the practice. Even if the alternative ritual preserved the psycho-physical integrity of girls by eliminating the trauma and potential health consequences of the surgery, it still upheld the custom and perpetuated the damage to the integrity of women's bodies (Pasquinelli, 2007, p.8).

The opposition presented two primary arguments against the alternative ritual proposal: first, that permitting the centre to perform the ritual would effectively legalize FGM/C; and second, that it would perpetuate the subordination of girls.

Addressing the first argument, it is crucial to emphasize that the alternative ritual would only be used when no other alternatives are viable. Doctors would exhaust all efforts to inform and dissuade families from practicing FGM/C, but sometimes these efforts fail. While immigrants may be willing to abandon the practice, they may not be ready to do so immediately. As Coleman (1998) reminds us they might not be willing to abandon their customs overnight. The zero-tolerance policy demanding immediate cessation of FGM/C is not always practical. Time is often needed to transition away from deeply entrenched customs. Thus, this alternative ritual is not a form of legitimizing the practice but rather an intermediate measure to protect girls in the meantime.

Regarding the second argument, the claim that performing the ritual perpetuates the subordination of girls is controversial. As discussed in previous chapters, the meaning of FGM/C varies among practicing communities. In some cultures, it can actually be seen as empowering for women (see Section 2.8). Moreover, assuming the argument holds, not performing the practice at all could have equally negative consequences. Girls who are not subjected to the ritual might face rejection from their families or

exclusion from their community in the diaspora. This is a cultural issue that will take time to change, and in the interim, a harm reduction strategy seems like the most practical solution.

### 4.4 positive aspects of the proposal

An interesting aspect highlighted both by the bioethical committee and in the political debate is the comparison between FGM/C and male circumcision. Congresswoman Gloria Buffo, like many others, asserts that all forms of violence against women's bodies, even in attenuated forms, should be condemned. However, she argues that the same concern for bodily integrity should extend to male circumcision (Camera dei Deputati, 2004). Alessandro Cè quickly counters, stating that the two practices cannot be compared because male circumcision does not harm men's dignity or their ability to enjoy a sexual life, unlike infibulation (Camera dei Deputati, 2004).

Cè correctly highlights the significant differences between FGM/C and male circumcision, both medically and in their motivations. Male circumcision typically involves only the removal of the foreskin of the penis, whereas FGM/C often involves a much more extensive removal of part or all of the clitoris. The problem, however, lies in comparing male circumcision to infibulation, the most extreme form of FGM/C. The alternative ritual proposed by Dr. Abdulcadir and Dr. Catania is vastly different from infibulation, aiming to cause no physical harm and preserving the woman's ability to enjoy her sexual life.

Gloria Buffo raises a crucial point: if male circumcision is legal, why should a less invasive procedure performed on women be considered illegal? (Camera dei Deputati, 2004). The proposed alternative ritual involves only a symbolic pricking of the clitoral hood, which would not impair physical integrity or sexual function. This makes it, for the first time, a form of FGM/C that could be seen as comparable to male circumcision. In this context, both girls and boys could be similarly situated for equal protection purposes, challenging the legal and ethical grounds for deeming one procedure acceptable while condemning the other (Coleman, 1998).

In the Seattle compromise the comparison between male circumcision and the alternative ritual is one of the main points. Coleman (1998) believes that

> This very analysis reveals the wisdom of the proposal: It would have solved the practical problem opponents of FGM have failed to solve, namely, how to stop that traditional practice and actually prevent mutilations.

> And it would have addressed the theoretical critique of cultural relativists and practitioners of FGM that Western opponents of the practice are hypocritical given their acceptance of male circumcision (p. 771).

Thus, these alternatives to the original practice basically invite a re-examination of cultural practices and their regulation under the principles of bodily integrity and equal treatment.

The alternative proposal and the recognition by the bioethics committee sent a positive message about the ability and willingness of the majority culture to be sensitive to and understanding of cultural and religious differences. However, the rapid dismissal of the proposal by politicians, without even waiting for the bioethical committee's evaluation, shows that Italian culture is not yet ready for such discussions. It is crucial not to encourage practitioners of FGM/C to believe that it is legal in Italy or that it shares the same values regarding women's sexuality. Yet, the lack of openness to other cultures and the rhetoric used by the opposition could potentially stifle effective discussions about how to limit and stop FGM/C. While some congresspeople emphasized the importance of engaging with communities, the majority outright rejected this idea (Camera Dei Deputati, 2004).

Pragmatism is essential in a field inundated with rhetoric about ethnocentrism, universal values, the sanctity of Western culture, multiculturalism, and cultural relativism (Coleman, 1998). Regardless of the philosophical views of those involved in the discussion, the fact remains that traditional practices like FGM/C will not be tolerated in Italy or in other Western countries with similar views on customs that do not conform to majority culture. Coming to terms with this reality and the equally powerful truth that some immigrant traditions cannot be eradicated simply by declaring them illegal or contrary to Western culture is a critical part of the effort to change those practices.

In the end, what is really interesting about the alternative proposals is that they provide a "culturally sensitive, safe alternative to the practices of female circumcision or female genital mutilation" (Coleman, 1998, p. 781). It demonstrated that compromises accommodating both the traditional practices of non-European immigrants and the existing norms of Western societies are sometimes possible. Alternatives such as the Italian one or the Seattle compromise are not always possible but even if they do not work they provided a provocative and useful model for other western communities that seek to address the very important issue of FGGM/C.

# Conclusion

As discussed in the initial chapters of this thesis, FGM/C is a profound human rights violation that affects millions of girls and women globally, with a widespread presence and severe consequences. Recent decades have seen increased focus on this practice, with numerous initiatives aimed at its eradication. Despite ongoing debates about the cultural relativity of FGM/C, the discourse surrounding its elimination has increasingly been framed within the context of international and regional human rights law. The practice is widely recognized as a form of violence against women (VAW) and a violation of multiple human rights. Specifically, FGM/C infringes on the right to be free from gender discrimination, the right to the highest attainable standard of health, the right to life (when the procedure results in death), the right to freedom from torture or cruel, inhuman, or degrading treatment or punishment, and the rights of the child. An increasing number of countries have introduced legislation to ban FGM/C. However, despite the establishment of various legal norms addressing this practice, its prevalence remains high worldwide. Then why is it so difficult to end such an unthinkable and harmful practice? Because for many is still culturally significant.

The ways in which FGM/C is performed, the individuals involved, and the underlying reasons for the practice vary not only from one country to another but also between different communities within the same country, making it a complex issue. While criminalization of FGM/C is important and necessary, it is rarely sufficient on its own. Therefore, anti-FGM/C interventions must be tailored to be locally relevant and sensitive to the specific realities of each community. In this context, the proposal of Dr. Abdulcadir in Italy offers a valuable example. He proposed a solution that respects the local and traditional aspects of the practice while adhering to the values of a society that does not tolerate any form of mutilation of women's bodies.

Dr. Abdulcadir’s ritual proposal acknowledges the difficulty of achieving cultural change, which is essential in combating FGM/C. Transforming cultural norms, practices, and traditions, along with changing patriarchal attitudes and deeply ingrained stereotypes about the roles, responsibilities, and identities of girls and women within the family and society, requires time. This concept contrasts with the zero-tolerance approach of wanting everything immediately. This could be one of the reasons why the approach undertaken in the last few years by the international community has shown not to be the most appropriate. By raising awareness of the shortcomings in the current policies, I aim to contribute to

the further development of the human rights framework, which throughout this thesis has been revealed as a contested cultural construct.

The alternative approaches also open avenues to overcome current perceptions of cultural imperialism associated with the double standards and derogatory terms used in the human rights framework, which often fail to resonate with practicing communities. By adopting a culturally sensitive process, the cultural significance of cutting rituals can be respected, and their social role can be integrated into strategies for transformation. This method aims to gradually achieve the common objective of ending FGM/C.

The civil society response to an alternative proposal like the one presented by Dr Abdulcadir would likely be rejected today as it was in 2005 (Catania, personal communication, 2024). However, if international organizations begin addressing the current policy shortcomings using a more culturally sensitive process, the outcome of the eradication efforts could be more effective and successful than previous attempts.

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