

Female Genital Cutting (Circumcision/Mutilation)

Case Study

A mother brings her 9-year-old daughter to Dr D requesting that she be 'circumcised'. The mother explains that she wants the procedure done for fear that the daughter will not be eligible for marriage in her community if it is not done. The mother further explains that she wants the procedure to be medically performed because procedures conducted on her older daughters by a traditional birth attendant (TBA) resulted in their severe bleeding and infection of the wounds. The mother says that, unless Dr D consents to perform the procedure, her mother-in-law will insist on taking the girl to the TBA. What should Dr D do, taking into consideration medical, ethical, legal, and human rights aspects of the case?

1. Background

The terminology used to describe this procedure varies. The term 'female circumcision' has been used historically. However, as the harm that such procedures caused to girls and women became increasingly recognized, and because this procedure in whatever form it is practised is not at all analogous to male circumcision, the term 'female circumcision' gave way to the term 'female genital mutilation'. The term 'female genital mutilation' has been adopted by many women's health organizations, such as the Inter-African Committee on Traditional Practices Affecting the Health of Women and Children, and intergovernmental organizations, such as the World Health Organization. However, the use of the term may offend women who have undergone the procedure and do not consider themselves mutilated or their families as mutilators.¹

¹ A. Rahman and N. Toubia, *Female Genital Mutilation: A Guide to Laws and Policies Worldwide* (New York: Zed Press, 2000), 4.

The term 'female genital surgery' is used by some.² Health care professionals consider this usage is incorrect because they use the term 'female genital surgery' to describe surgical procedures performed for therapeutic purposes, such as for removal of tumours from the internal or external genital organs. This case study uses the term 'female genital cutting' (FGC) in an attempt to find language that is value neutral, but which adequately describes the nature of the procedure.

WHO estimates that in the world today about 2 million girls undergo some form of the procedure every year³ (see Table III.1.2). About 6,000 girls are 'circumcised' every day. The procedure is commonly performed on girls between the ages of 4 and 12 years of age, but it is also known to be performed in some communities on infants a few days after birth, and in others just prior to marriage or after the first pregnancy.⁴ Most of these girls and women live in East and West Africa, and parts of the Arabian Peninsula, although some live in Asia, and some are found in immigrant population groups living in Europe, the USA, Canada, Australia, and New Zealand.⁵ The prevalence among and within these countries varies. The variation in prevalence between countries ranges from 5 to 99 per cent.⁶

The clitoris has been a victim of assault, as a result of society's view of female sexuality. Clitoridectomy has a different history and background in the West and in the East.⁷ In England, Europe, and the USA, many clitoridectomies were performed by gynaecological surgeons in the second half of the nineteenth century on allegedly medical grounds. Clitoridectomy was considered necessary not only to cure such sexual deviations as 'nymphomania' but also to prevent masturbation and to cure a number of disorders, some of which were thought to have been caused by masturbation, such as hysteria, epilepsy, melancholia, and insanity. Also, it was unthinkable that any decent woman should derive pleasure from sex.

The origin of female circumcision is lost in antiquity. The prevailing reasons for FGC are complex, multifaceted, and interwoven with socially constructed concepts of gender and sexuality. Reasons include custom and practice,

² C. M. Obermeyer, 'Female Genital Surgeries: The Known, the Unknown and the Unknowable', *Medical Anthropology Quarterly*, 13 (1999), 79-106.

³ WHO, *Management of Pregnancy, Childbirth and the Postpartum Period in the Presence of Female Genital Mutilation: Report of a 1997 WHO Technical Consultation* (Geneva: WHO, 2001), 2.

⁴ N. Toubia, *Female Genital Mutilation: A Call for Global Action* (New York: Rainbo, 2 edn., 1995), 9.

⁵ British Medical Association, *Female Genital Mutilation: Caring for Patients and Child Protection: Guidance from the BMA* (approved by Council Jan. 1996, revised Apr. 2001, www.bma.org.uk/public/ethics.nsf, accessed 31 Nov. 2001).

⁶ *Ibid.* 3; <http://www.who.int/frh-whd/FGM>, accessed 14 July 2001.

⁷ M. F. Fathalla, *From Obstetrics and Gynecology to Women's Health: The Road Ahead* (New York and London: Parthenon, 1997).

control of women's sexuality, and social pressure.⁸ FGC is performed as a rite of passage from childhood to adulthood, connecting women to cultural traditions and family values of present and past generations. The reason for the procedure to control women's sexuality is to reduce sexual desire, thus allegedly 'saving' the girl from temptation, and preserving her chastity before marriage and fidelity after marriage. In many situations, social pressure created through social ostracism of uncircumcised girls and men's refusal to marry them perpetuates the practice.

2. *Medical Aspects*

The immediate and long-term damage inflicted on young girls and women ranges, according to the degree of removal of the female genitalia, from an insignificant cut, to removal of the clitoris, up to a major procedure in which the clitoris and labia minora are removed and the opening of the vagina is stitched together (infibulated). Since none of these procedures has a therapeutic purpose, there are no medical definitions. They are usually performed by non-professionals who do not even know the anatomy of the female genitalia. Based on observation of women who have undergone a version of these procedures, the different forms of female genital cutting are classified into four types. The categories are not distinct, as in practice they commonly overlap.⁹

Type I, usually known as clitoridectomy, involves the partial or entire removal of the clitoris;

Type II, known as excision, refers to the removal of the clitoris and the labia minora;

Type III, known as infibulation, removes the clitoris, the labia minora and sometimes the labia majora and stitches or seals together (infibulates) the vagina, leaving a small opening for the flow of urine and menstrual blood;

Type IV refers to unclassified procedures, such as pricking, piercing, cutting or stretching the clitoris and/or the labia; cauterization by burning of the clitoris and surrounding tissues; scraping (angurya cuts) of the vaginal orifice or cutting (gishiri cuts) of the vagina; introduction of herbs or corrosive materials to cause bleeding or to narrow or tighten the vagina.

It should be clear that FGC bears no relationship to male circumcision.¹⁰ In male circumcision, the part removed is the prepuce (a fold of skin that covers the tip of the penis). Its removal has a possible health benefit (such as protection against HIV infection¹¹) and carries little (though some) risk of harm.

⁸ Rahman and Toubia, *Female Genital Mutilation*, 5-6.

⁹ WHO, *A Systematic Review of the Health Complications of Female Genital Mutilation Including Sequelae in Childbirth* (Geneva: WHO, 2000), 11.

¹⁰ Fathalla, *From Obstetrics*, 210.

¹¹ UNAIDS, *Report on the Global HIV/AIDS Epidemic* (Geneva: UNAIDS, 2000), 70.

The practice of male circumcision is authorized by the Jewish and Islamic religions.

The degree of cutting in female circumcision is anatomically much more extensive than male circumcision. The male equivalent of clitoridectomy, in which all or part of the clitoris is removed, would be the cutting off of most of the penis. The male equivalent of infibulation—which involves not only clitoridectomy, but the removal or closing off of the sensitive tissue around the vagina—would be the removal of all the penis, its roots of soft tissue, and part of the scrotal skin.¹²

In addition to the physiological differences, there are also differences in how the respective procedures construct men and women in terms of their gender roles. Male circumcision affirms manhood with its superior social status and associations to virility. A purpose of FGC is to reinforce the passive gender role of girls and women by confining women socially and restraining their sexual desires.¹³

The part removed in so-called female circumcision varies widely, but the procedure commonly aims to remove the clitoris, which plays an important role in sexual arousal and female orgasm. The procedure carries no health benefit, and can be associated with physical and psychological harm and sexual and reproductive dysfunctions. Unlike male circumcision, FGC is neither supported by any religion nor bears any relationship to the geographical distribution of any religion.

All types of FGC have immediate and long-term health complications. The medical complications include bleeding, which may necessitate emergency medical interference. There are health hazards generally related to the fact that the procedure is often performed outside health care facilities by non-professionals. Serious sepsis may occur, particularly where unsterile cutting instruments are used. If the genital area becomes contaminated with urine or faeces, infection can also develop within a few days of the procedure. Infection can lead to septicemia if the bacteria reach the bloodstream, and may be fatal. Acute urine retention can result from the swelling and inflammation around the wound.¹⁴

Long-term complications can arise from all types of FGC, but the severest complications arise with the Type II and III procedures. Common complications of Type III (infibulation) include repeated urinary tract infection and chronic pelvic infections, which may cause irreparable damage to the reproductive organs and result in infertility. Excessive growth of scar tissue may be

¹² N. Toubia and S. Izett, *Female Genital Mutilation: An Overview* (Geneva: WHO, 1998), 9.

¹³ N. Toubia, 'Evolutionary Cultural Ethics and Circumcision of Children', in G. Denniston, J. M. Hodges, and M. F. Milos (eds.), *Male and Female Circumcision: Medical, Legal and Ethical Considerations in Pediatric Practice* (New York: Kluwer Academic and Plenum, 1999).

¹⁴ Toubia and Izett, *Female Genital Mutilation*, 26.

disfiguring. A cyst (implantation dermoid) at the site of the cutting can also result from inadvertent imbedding of a piece of skin in the wound. Such cysts may distress the girl and her parents, who suspect a condition of intersex.

Complications of FGC in childbirth include complications during pregnancy, and before, during, and after delivery.¹⁵ Pain usually results during and after deinfibulation, where an anterior incision of the vulva is generally needed to enable delivery to take place. Antenatal complications and complications in early labour, prolonged or obstructed labour, obstetric fistulae (holes or tunnels between the bladder and the vagina and between the rectum and the vagina) are complications that arise particularly with Type III FGC. Foetal distress and foetal death (stillbirth or early neonatal death) may also result. Foetal deaths appear to be related to the obstruction to delivery posed by the vulva scarring that occurs in Type III procedures or the extra scarring that can happen with complicated Types I or II procedures.¹⁶ Post-partum haemorrhage is significantly more common in women with FGC, usually arising from the extra incisions made and the perineal tears experienced as a result of the scarring resulting from all types of FGC.¹⁷ FGC has been reported as a contributing or causal factor in maternal death, usually resulting from unattended or inappropriately treated obstructed labour caused by the vulval scarring.¹⁸

3. *Ethical Aspects*

The International Federation of Gynecology and Obstetrics (FIGO) has taken an uncompromising position in opposition to female circumcision, describing it as 'mutilation'. A resolution unanimously adopted by the FIGO General Assembly in 1994 recognized that 'female genital mutilation is a violation of human rights, as a harmful procedure performed on a child who cannot give informed consent'.

Many countries have already passed laws or regulations forbidding the performance of the procedure, leaving little ethical choice. Nevertheless, ethical explanations and guidance can reinforce prohibitory legislation. In the United Kingdom, for instance, the Prohibition of Female Circumcision Act 1985 (Statutes, chapter 38) creates an offence but permits registered medical practitioners to undertake otherwise prohibited acts either during childbirth or for the physical or mental health of the patient. The British Medical Association has provided guidance on enforcement of the law, and also on what constitutes serious professional misconduct found by the General Medical Council.¹⁹ Where there are no prohibitory local laws or regulations, or ethical statements

by national medical associations with disciplinary sanctions, and physicians have an ethical choice, they may find several principles to be in conflict. Parents' power to impose their preference on young daughters denies the girls their right to autonomy in their future adult lives, and denies them immediate defence as children against parental insistence on the performance of a non-therapeutic, irreversible and risk-laden procedure.

There is concern about overplaying the medical complications because they are largely the result of the FGC, of whatever type, being performed by unqualified people in unsafe settings. One approach to address these complications is to ensure that FGC is done by qualified people in safe settings. However, medicalization of any type of FGC cannot be justified because it has no therapeutic purpose. The 1994 FIGO General Assembly resolution recommended that obstetricians and gynaecologists 'oppose any attempt to medicalize the procedure or to allow its performance, under any circumstances, in health establishments or by health professionals'.²⁰

The ethical principle of non-maleficence, which prohibits doing harm, requires that physicians not undertake the procedure. However, the same principle requires that any risk of harm should be minimized, and for a physician to perform a limited form of symbolic genital cutting is less harmful than for a much more invasive procedure to be performed by an untrained person, such as a traditional birth attendant. However, while this approach might reduce the medical harm to a particular individual, it still causes a profound social injury to women more generally. Performing any type of FGC is in fact an approval of the practice of societal control of women's sexuality and an affront to women's bodily integrity and dignity of the person.

The ethical approach taken by the medical profession, as indicated in the FIGO General Assembly and the World Health Assembly of WHO,²¹ is that more efforts should be undertaken to address the practice at the macroethical or societal level. The profession characterizes the procedure as individually and socially harmful to women's and girls' health and dignity, and of no compensating medical advantage. The profession remains unpersuaded by the fact that in some cultures the procedure is considered beneficial and described as 'purification', perhaps because of the inference of this description that women and girls not subjected to it are in some way impure. Accordingly, the ethical opinion of organized medicine is that physicians and health facilities should not participate in this procedure, since it implicates health care providers in a procedure of unrelieved harm.

²⁰ M. F. Futhalla, 'The Girl Child', *Int. J. Gynecol. Obstet.* 70 (2000), 7-12, at 7.

²¹ World Health Assembly Resolution: Maternal and Child Health and Family Planning: Traditional Practices Harmful to the Health of Women and Children (WHA 47.10, 1994), partially cited in Touba and Izet, *Female Genital Mutilation*, 62.

¹⁵ WHO, *Systematic Review*. ¹⁶ *Ibid.* 51.

¹⁷ *Ibid.* 46.

¹⁸ *Ibid.* 48. ¹⁹ BMA, *Female Genital Mutilation*.

The harm is twofold, in that vulnerable young girls are subjected to risk-laden cutting procedures that afford them no health, hygienic, or other benefit. The procedure also perpetuates a form of sexual control of women that demeans them as members of their communities with the same rights to protection as men. The claim that physicians should participate in order to limit injury, since if physicians refuse to perform such procedures they may be performed more harmfully by unqualified persons, is rejected, in much the same way that medical professional organizations prohibit medical participation in torture and execution of judicial sentences of flogging, amputation, and death.

4. *Legal Aspects*

There are general criminal law prohibitions against unjustified assault that can be applied to punish FGC. For instance, the Penal Code of Kenya provides that '[a]ny person who unlawfully assaults another is guilty of a misdemeanour' (section 250) and that 'any person who commits an assault occasioning actual bodily harm is guilty . . . and is liable to imprisonment for five years' (section 251). The Code defines 'grievous harm' as 'harm which amounts to a maim or dangerous harm, or seriously or permanently injures health', and provides for punishment of up to life imprisonment (section 234).

Kenya reinforced this general provision in the Children Act 2001 (No. 8 of 2001). Section 14 provides that: 'No person shall subject a child to female circumcision, early marriage or cultural rites, customs or traditional practices that are likely to negatively affect the child's life, health, social welfare, dignity or physical or psychological development.' In December 2000, the Kenya District Court for Keiyo condemned the practice on wider grounds, finding it repugnant to morality and a violation of human rights as stipulated in the national constitution, and granted a permanent injunction restraining the defendant and those associated with him from undertaking the practice.²²

Some countries, such as Burkina Faso,²³ Ghana,²⁴ Senegal,²⁵ and the United Kingdom²⁶ have also progressed beyond the application of general criminal laws by enacting laws that specifically outlaw FGC. The degree of punishment and enforcement of these targeted laws varies. Burkina Faso imprisons for a minimum of six months and up to three years, and fines at least 150,000 and up

²² Decision of 13 Dec. 2001, Keiyo District Court, Kenya, Magistrate Ochenja.

²³ Law No. 43/96/ADP of 13 Nov. 1996 on the Penal Code, Arts. 380–2, *Journal Officiel du Burkina Faso*, 27 Jan. 1997, reprinted in Rahman and Toubia, *Female Genital Mutilation*, 115.

²⁴ Criminal Code (Amendment) Act, 1994 (Ghana), reprinted in *International Digest of Health Legislation*, 47 (1996), 30–1.

²⁵ Law No. 99-05 of 29 Jan. 1999 amending various provisions of the Penal Code, Art. 299b, *Journal Officiel* (27 Feb. 1999), No. 5847, 832.

²⁶ Prohibition of Female Circumcision Act 1985 (UK) Statutes 1985, ch. 38.

to 900,000 francs (about \$240–1,440) [a]ny person who violates or attempts to violate the physical integrity of the female genital organ, either by total ablation, excision, infibulation, desensitization or by any other means'. If the procedure results in death, the minimum punishment is imprisonment for five years, the maximum ten years (Article 380 of the Penal Code). If the offender is a member of the medical or paramedical field, maximum punishments shall be imposed, and a licence to practise medicine may also be suspended for up to five years, perhaps from completion of the custodial sentence (Article 381). Further, any person having knowledge of the offence who fails to advise proper authorities will be fined 50,000–100,000 francs (about \$80–160) (Article 382).

While the law has been enforced through numerous prosecutions of perpetrators and accomplices, the sentences of imprisonment have been minimal, and in some cases suspended.²⁷ A chief law enforcement officer in the capital of Burkina Faso, Ouagadougou, working on the elimination of FGC, has observed that effective law enforcement is needed, since his experience shows that education alone is often ineffective to curb FGC. He explains that excisors 'will not stop unless they are afraid of repercussions' from law enforcement, the potential for which affords health care professionals and law enforcement officers the legitimacy to intervene when parents, excisors, and others propose FGC.²⁸

National courts are playing an increasing role in applying laws or Ministry of Health policies to prohibit FGC. For example, in 1997, the State Council, Egypt's highest administrative court, upheld a 1996 Ministry of Health order prohibiting the performance of female genital circumcision in public and private hospitals and clinics, except in cases of medical necessity. The State Council upheld the Ministry of Health order even when performance of the operation has the consent of the woman and her parents, ruling that circumcision is not an individual right that emanates from the shariah (Islamic law). It stated that there is nothing in the Quran (the Holy Book of Islam) that authorizes female genital circumcision.²⁹

Because FGC serves no medical or health-related purpose, physicians who perform it are not covered by the medical justification or explanation of surgical necessity that protects acts that, when performed by unqualified people, are criminal offences. Parental consent does not relieve physicians' liability, since parents can consent to medical interventions on their dependent children only to discharge their parental duties to provide medical and health-related

²⁷ Rahman and Toubia, *Female Genital Mutilation*, 115.

²⁸ WHO, *Female Genital Mutilations—Programmes to Date: What Works and What Doesn't: A Review* (Geneva: WHO, 1999), 16, statement of Mr Issa Kabré, June 1998.

²⁹ Decision of 28 Dec. 1997, published in *Annual Review of Population Law*, 23–4 (1996–7), 128.

care, and this procedure is outside the scope of such care. It exposes children to immediate and future risks to their health and welfare, unlike such lawful minor cosmetic procedures as ear-piercing that allows young children to wear decorations.

If a mature woman requests this procedure as her freely made choice, a physician with no conscientious objection to performing it might still face legal obstacles. Various forms of body piercing are legally tolerated, but not all forms of voluntary bodily invasion are lawful. The historic law against maim (or 'mayhem') expresses itself in legal tolerance of male circumcision, whether on religious or hygienic grounds, but prohibition of sado-masochistic mutilation.³⁰ Courts might be equally restrictive of all but the most minor voluntary genital cutting, on grounds of public policy or morals, or *ordre public*. An adult applicant for this procedure might be hard-pressed to obtain judicial approval.

Complying with a woman's request to be re-sutured following childbirth, in order to be restored to the way she was accustomed to be, may at first appear relatively non-contentious. Moreover, denying her the procedure may be difficult psychologically for the woman, because her identity and status might be embedded in her infibulated appearance. However, re-suturing is professionally opposed, on grounds of objectionable medicalization of the procedure, and may constitute an offence by a physician or other health care provider legally bound to provide services only according to health professional codes of ethical conduct.³¹

In addition to liability under the general law, physicians are legally answerable to medical licensing and disciplinary authorities for allegations of professional misconduct. Many such authorities have declared FGC to constitute professional misconduct, and others that have not so declared it may be persuaded to do so by resolutions such as FIGO adopted in 1994. Licensing bodies and medical professional associations may lawfully impose sanctions for professional misconduct that is not itself a breach of the law, which empowers their disciplinary authorities to enforce codes of ethical conduct. Accordingly, physicians can face legal sanctions for undertaking female genital cutting even where it does not clearly constitute an independent breach of the law.

5. Human Rights Aspects

FGC of any type, irrespective of the medical complications, cannot be justified. Many human rights are violated by imposition of FGC on infants,

adolescents, and others incapable of providing autonomously given informed consent. The more obvious include the rights to health and security of the person, in light of the many health problems associated with the procedure, particularly when performed by medically untrained people. The gravest is death due to excessive bleeding or infection, but others focus on obstructed urination and menstruation in Type III and possibly less invasive procedures, impaired enjoyment of sexual intercourse and of prenatal care and delivery, and enduring psychological reactions to the trauma of the procedure. Risk of death due to infection or other related factors violates women's right to life. In some contexts, it might be appropriate to argue that the procedure violates the right of girls and women to be free from inhuman and degrading treatment. At a wider level, the procedure violates the right of girls and women to be free from all forms of discrimination, since a justification of FGC is its reinforcement of women's chastity and fidelity by rendering sexual intercourse non-pleasurable for them, when men are liable to no such constraints. The Committee on the Elimination of Discrimination against Women is vigorous in its condemnation of FGC, taking countries to task for neglect of the problem and weak law enforcement.³²

Although FGC may be undertaken on adult and adolescent women, its major prevalence involves exploitation of vulnerable girl children, who are dependent on parental care and incapable of the intellectual or social exercise of choice. Beyond violations of the general human rights conventions, this violates several provisions of the Children's Convention, which reinforce prohibitions under the general conventions but also demonstrate the aggravated character of violations of rights of defenceless children. A violation is particularly outrageous when perpetrated by those on whom children depend for protection and the exercise of prudent judgement to defend their interests and physical integrity. The fact that parents believe FGC to be in their young daughters' immediate and longer term interests illustrates parental subservience to harmful and even life-endangering customs, which lack religious foundation but embody generations of acceptance of sex discrimination as normal or even desirable. The Committee on the Rights of the Child is persistent in its denunciations of countries where FGC continues unabated and urges them to combat and eradicate the practice.³³

³² See Concluding Observation on the Report of Ethiopia to the Committee on the Elimination of Discrimination against Women, 9 May 1996, A/51/38, para. 148, published in Action Canada for Population and Development, *The Application of Human Rights to Reproductive and Sexual Health: A Compilation of the Work of International Treaty Bodies* (Ottawa: Action Canada for Population and Development, 2000), 97, available at website: <http://www.acpd.ca>, last accessed 6 May 2002.

³³ See Concluding Observation on the Report of Benin to the Committee on the Rights of the Child, 12 Aug. 1999, CRC/C/15/Add. 106, para. 26, published in Action Canada, *Application of Human Rights*, 187, available at website: <http://www.acpd.ca>, last accessed 6 May 2002.

³⁰ *R. v. Brown*, [1993] 2 All ER 75 (House of Lords, England).

³¹ WHO, *Female Genital Mutilation—The Prevention and Management of Health Complications: Policy Guidelines for Nurses and Midwives* (Geneva: WHO, 2001), 11–12.

The FIGO resolution that 'Female Genital Mutilation is a violation of human rights'³⁴ supports provisions of the Children's Convention and the Women's Convention. Both contain prohibitions of non-discrimination on grounds of sex, and the latter requires parties '[t]o modify the social and cultural patterns of conduct . . . with a view to achieving the elimination of . . . customary . . . practices which are based . . . on stereotyped roles for men and women'. Where FGC is a cultural condition of women's marriage, when men are subject to no comparably invasive and harmful procedure, it violates this provision. Similarly, if the purpose of FGC is to reduce women's sexual appetite or ensure pre-marital chastity, it serves a stereotyped image of female sexual virtue or passivity that is not expected of or enforced on men.

A countervailing human rights claim that may be raised in support of parents' requirement that the procedure be undertaken is based on their religious freedom. This claim may support ritual circumcision of newborn males, for instance in the Islamic and Jewish traditions, but health risks of male and female procedures are not comparable. Under human rights conventions, states must balance competing concerns, so that any states whose legal systems allow FGC may do so, but may face opposition on behalf of girl children on the ground that such states condone violence against children and perpetuate discrimination against women. Disallowing parental requests based on their wish to enhance their daughters' prospects of marriage is not inconsistent with allowing the girls themselves to make their own decisions when intellectually capable and free from family, communal, and cultural constraints.

6. Approaches

6.1. Clinical duty

Dr D cannot comply with the mother's request, nor succumb to the fear that refusal will result in a more harmful procedure being undertaken by an unqualified provider. Dr D satisfies ethical, legal, and human rights responsibilities at the clinical level by simply refusing to perform the procedure, and strongly advising the mother to protect her daughter against exposure to the injuries her older daughters have suffered. Dr D should inform the mother and the father, if possible, of the harmful consequences of the procedure, and explain the potential legal consequences, despite parental consent. Dr D may also suggest that, if the daughter wishes to have the procedure performed when she is of an age and condition to give her free and informed consent to it, the matter may be raised at that time. Nevertheless, Dr D should observe any

³⁴ Female Genital Mutilation Resolution, FIGO General Assembly, Montreal Canada, 1994; www.figo.org/default.asp?id=00000086.htm, last accessed 6 May 2002.

applicable prohibitory laws and respect the condemnation expressed by international medical and intergovernmental agencies against individual concessions to pressures to undertake FGC that contribute to legitimising FGC as a medical procedure.

6.2. Health care systems obligations

Dr D may alert the health-care community to the immediate and long-term consequences of the procedure by, for example, helping to develop and use curricula on the prevention and management of FGC for health care providers, including nurses and midwives.³⁵ Dr D may encourage medical licensing authorities whose mandate is to protect the public against unqualified and unethical practice to urge more systematic and transparent approaches to enforcement of criminal law and other prohibitions, including the suspension of licences to practice medicine of those qualified practitioners who perform FGC.

6.3. Social action for underlying conditions

The many different programming strategies undertaken to reduce the incidence of FGC include the following.³⁶

6.3.1. The health approach

It stresses the health advantages of not doing the procedure. Using the health approach alone has led to a number of problems, including overplaying the complications and side effects associated with the procedure. This has led to disbelief about the harmful consequences of FGC among some excised women who have not experienced any complications. This approach, if not supplemented by other approaches, has tended to medicalize the practice since many people believe they can avoid side effects by taking their daughters to health clinics or hospitals which they pressure to perform the procedure.³⁷

6.3.2. The cultural approach

It examines how alternative local traditions and cultures that are not detrimental to women could be reinforced. This includes supporting and celebrating the social meaning of rites of passage that are positive for women, while condemning and eliminating FGC as a harmful act. This approach also tries to

³⁵ WHO, *Female Genital Mutilation: Integrating the Prevention and the Management of the Health Curricula of Nursing and Midwifery: A Teacher's Guide* (Geneva: WHO, 2001); WHO, *Female Genital Mutilation: Integrating the Prevention and the Management of the Health Curricula of Nursing and Midwifery: A Student's Manual* (Geneva: WHO, 2001).

³⁷ *Ibid.* 74.

support other forms of expression that celebrate women's sexuality in positive terms, not in ways like FGC that attempt to control their sexuality. For example, in some countries, traditional wedding songs are a rich source of positive cultural expressions of women's sexual life.³⁸

6.3.3. *The women's empowerment approach or the development/gender approach*

It seeks to find positive roles for adolescent girls through education, training, and, for example, sports. It can also include finding alternative sources of income and status for those traditional excisors, who generally tend to be women. This is a wider approach and needs to involve community leaders, schoolteachers, and even religious leaders.

6.3.4. *The ethical/legal human rights approach*

It provides normative languages by which to say the procedure is wrong. The authoritative nature of the ethical, legal, and human rights languages legitimizes efforts to advocate the eradication of FGC. A challenge of using this approach is, occasionally, that local activists are not familiar with these languages. In particular, local activists can be alienated by arguments based on international human rights conventions. The challenge is to train people in the use of human rights that are protected by national constitutions, local laws, and ethical norms.

Given the strengths and weaknesses of these approaches, a particular approach might be more useful in one context than in another. Moreover, the approaches are overlapping and not mutually exclusive. Each approach has different means of implementation, for instance through community education and engagement, including roles for religious and political leaders, training of youth, and the use of the media.

Where parents are deferential to religious leaders, physicians may urge such leaders to declare the practice to lack religious authority, and be harmful. Where reactionary religious leaders subscribe to the culture of male dominance and enforced female chastity, however, physicians may urge that girls be encouraged and inspired to sexual modesty and abstinence in other ways, and that males restrain themselves similarly. Families may be persuaded that their daughters' virginity can be adequately protected in ways that are not so damaging to their health, to their prospects of safe motherhood, and to survival of their children. The Convention on the Elimination of All Forms of Discrimination against Women (the Women's Convention) requires the reform of cultural practices that demean or endanger women, and Dr D and the professional society of which Dr D is a member may invoke this provision

to resist parental favour of this practice. Dr D may also collaborate with governmental and non-governmental agencies that oppose violence against women and child abuse to restrain this practice, and to educate families in its harms and service of no legitimate interest.

The FIGO General Assembly resolution of 1994 on female genital mutilation invited member societies to 'urge their governments to take legal and/or other measures to render this practice socially unacceptable by all sectors and groups in society' and to 'collaborate with national authorities, non-governmental and inter-governmental organizations to advocate, promote and support measures aiming at the elimination of female genital mutilation'.³⁹ In the same resolution, FIGO recommended that obstetricians and gynaecologists: 'explain the immediate dangers and long-term consequences of female genital mutilation to religious leaders, legislators and decision makers, educate health professionals, community workers and teachers about this harmful traditional practice . . . [and] [a]ssist in research for the documentation of the prevalence of the practice and its harmful consequences'.⁴⁰

³⁹ Female Genital Mutilation Resolution, FIGO General Assembly, 1994.

⁴⁰ See R. J. Cook, B. M. Dickens, and M. F. Fathalla, 'Female Genital Cutting (Mutilation/Circumcision): Ethical and Legal Dimensions', *Int. J. Gynecol. Obstet.* 79 (2002), 281-7.