



PROMOTING SOCIAL CHANGE: THE CASE OF FEMALE GENITAL MUTILATION

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Addressing human rights issues internationally raises multiple challenges. Putting the existing legal framework of conventions that detail specific rights to be promoted and protected into effect as policy and practice is rarely straightforward: conflict between the internationally agreed values and differing cultural contexts may arise and need to be met.

Working internationally on human rights issues presents a multitude of challenges. While there is an established legal framework of conventions detailing specific rights to be promoted and protected including the [Covenant on Civil and Political Rights](#), the [Covenant on Economic, Social and Cultural Rights](#) and the [Convention on the Rights of the Child](#), their implementation into policy and practice is often less straightforward. Realising human rights on a global scale entails aligning these rights with varying cultural contexts, sometimes provoking conflict between the internationally agreed values on one hand and differing cultural contexts on the other hand. Issues that tend to be of a particularly contentious nature often involve customs and traditions that are in violation of women's rights.

FEMALE GENITAL MUTILATION (FGM)

The practice of female genital mutilation (FGM) is common in Egypt, Yemen and in many countries in Sub-Saharan Africa. FGM can take diverse forms and have different effects on women and girls. In every case it entails the cutting, stitching or removal of part or all of the female external genital organs for non-therapeutic reasons. There are several forms of FGM and these differ from community to community. The most recent [World Health Organisation \(WHO\) classification from 2008](#) divides FGM into four types:

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Type I: Partial or total removal of the clitoris and/or the prepuce (clitoridectomy).

- Type II: Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision).
- Type III: Narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation).
- Type IV: All other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, piercing, incising, scraping and cauterisation.

The immediate medical consequences of FGM can include excessive bleeding, infections and sometimes death. In addition to severe pain during and following the procedure, women often experience a variety of negative long-term effects –physical, sexual and psychological. The health consequences continue throughout the woman's life, often resulting in additional trauma at the time of child labour. Obstetric complications include an increase in caesarean sections and postpartum haemorrhage which pose significant challenges in low-resource settings. Recent WHO research¹ suggests that FGM is also linked to increased maternal and infant mortality rates. The practice of FGM is recognised internationally as a gross violation of the human rights of women and girls. Specifically it denies them their right to: physical and mental integrity; freedom from violence; the highest attainable standard of health; freedom from discrimination on the basis of sex; freedom from torture, cruel, inhuman and degrading treatment; and life (when the procedure results in death).

PROMOTING CHANGE: THE CONTEXT

There is a mistaken notion that the practice of FGM is prescribed by Islam but it in fact has no real foundation in any religion. Instead FGM is practiced due to a broad variety of beliefs seeing it as beneficial to a girl's health or hygiene, or important for traditional and cultural gender-related reasons. In many communities a woman needs to undergo FGM to become a "real" woman, it is a rite of passage and a badge of honour. FGM is often seen as a way to keep the girl a virgin until marriage and further to curb her sexual appetite and thereby counteract any promiscuity that may cause her to stray outside the marital boundaries.

While the decision to subject a girl to FGM is usually taken by close family members, it is important to keep in mind that this is predominately a choice made with the girl's best interest at heart. Further, if the choice was

made to leave the girl uncut, the family and the girl would risk encountering strong critique and opposition from the community as the practice is deeply entrenched within social, economic and political structures. Lessons learned through work done by UN agencies and NGOs working to combat FGM² show that spreading information on the harm and physical danger connected with the practice does not necessarily lead to a change in behaviour. The social consequences of daughters remaining uncut are often considered worse. The goal of abandoning the practice therefore often requires a collective choice from within a community so that girls who remain uncut, and their families, are not shamed and alienated. As with many other types of socially constructed behavioural change, a supportive environment of allies in media, civil society and government is of great importance.

The practice of FGM is also prevalent in a multitude of ethnic communities residing in Europe, the US and Australia. Any efforts to combat FGM in countries of origin should be linked to these communities as a collective agreement is needed to abandon the practice. Social custom can and do change, but the process needs to be holistic. The pressure to subject girls to FGM comes from family members and the surrounding community both in countries of origin and in the Diaspora. A cross-border practice needs a cross-border approach, linking and coordinating a large variety of stakeholders.

DESIGNING A STRATEGY: COMMUNICATION CHALLENGES

The communication challenges start already at the very first step, naming the issue. The practice of FGM was originally known internationally as “female circumcision”. The choice to abandon this terminology in favour of the now commonly used “female genital mutilation” was taken to distinguish the practice from male circumcision and also to fully support the view of it being in violation of human rights. However, many organisations and stakeholders feel that the word “mutilation” is too condemning and therefore prefer to use “female genital cutting” or “female genital mutilation/cutting”. Naturally there is also a plethora of names for FGM in local languages, all highly relevant for any activities undertaken in the local context. The choice of how to name and frame the issue would be dependent on the aim of the strategy and its intended audience.

FGM is, as noted earlier, seen internationally as a human rights violation. It is included as such in the Convention on the Rights of the Child, in the CEDAW Convention on the Elimination of all forms of Discrimination Against Women, in the [Cairo Agenda](#) and in the [Beijing Platform for](#)

Action. However, these international agreements and conventions may mean little or nothing in a local or national context. It is therefore very useful to know that the eradication of FGM is also called for in the **African Charter on Human and Peoples' Rights** (the Banjul Charter) and its **Protocol on the Rights of Women in Africa** (the Maputo Protocol). Furthermore –and perhaps most importantly for setting the legal and advocacy context for a strategy- many countries where FGM is prevalent have enacted national legislation against the practice. The choice of legal foundation would therefore also to a large extent depend on the aim of the strategy and its intended audience.

Finally, the main communication challenges would most likely stem from FGM being a practice that is not often spoken about, a taboo and secrete rite that many men claim they know nothing about, seeing it as a women's issue. In many societies addressing issues that pertain to female genitalia and/or sexual and reproductive health is highly sensitive. Raising them in a public context can therefore be very difficult. It is essential to have stakeholders from the community – such as religious and community leaders, women's groups, teachers – involved in the design and implementation of any strategy and/or activities aimed at combating FGM for it to be successful and culturally appropriate.

1 <http://www.who.int/reproductivehealth/publications/fgm/fgm-obstetric-study-en.pdf>

2 United Nations Children's Fund, "Changing a Harmful Social Convention: Female genital mutilation/cutting", Innocenti Digest, 2005

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