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FGM: In-Depth Analysis Of Human Rights, Legal Requirements At International Levels, And The Road To Its Eradication

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Abstract

FGM comprises all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons. It is a profound and pervasive form of gender-based violence, a violation of fundamental human rights, and a deeply entrenched harmful practice that affects millions of women and girls globally. Despite a near-universal consensus on its harm and widespread legal prohibition, the practice persists, sustained by deeply rooted social norms, gender inequality, and systemic failures to protect the most vulnerable. This research paper undertakes a comprehensive analysis of FGM from an international human rights and legal perspective. Starting with a deconstruction of the definition, typology, and the dangerous trend of medicalization, it then investigates the complex web of historical, socio-cultural, and economic drivers that perpetuate the practice, systematically debunking the myths used to justify it. Situated at the core of the paper is a detailed legal-doctrinal analysis framing FGM as a clear violation of non-derogable rights, including the right to life, the right to be free from torture, the right to health, and the specific rights of the child and women. The paper examines the evolution of the international and regional legal frameworks, including the Maputo Protocol and the Istanbul Convention, before turning to national-level case studies-a trio of Egypt, Kenya, and the United Kingdom-highlighting the persistent and tragic "implementation gap" between law and reality. It covers primary challenges to eradication, including cross-border FGM and the co-option of health professionals. The paper concludes that legal prohibition, while essential, is insufficient. Legal enforcement needs to be combined with community-led social norm change, robust education, the economic empowerment of women, and active engagement by men and boys in a multi-sectoral approach.

Keywords: FGM, gender-based violence, harmful traditional practice, human rights, integrity of the person's body, right to health, rights of the child, the Convention on the Elimination of All Forms of Discrimination Against Women, CEDAW, the Maputo Protocol, medicalization, cross-border FGM, social norms, gender inequality, eradication.

Introduction

More than 200 million girls and women alive today are estimated to have undergone some form of FGM. Four million girls are at risk each year. While such statistics are shocking, what they cannot convey is the individual experience of excruciating pain, trauma, and lifelong suffering that each victim is made to endure. FGM is not a "distant cultural" issue but a global human rights crisis. While it is heavily concentrated in 30 countries in Africa and the Middle East, migration has established diaspora communities in Europe, North America, and Australia, making FGM a public health and child protection issue for the whole world

This is a stark manifestation of deep-rooted gender inequality. It is a violent act designed to control female bodies and sexuality, emanating from patriarchal structures that look upon women and girls as property, rather than as human beings with agency. Often miscast as a "tradition" or "culture," this is a defense that surely crumbles under the weight of universal human rights law. There can never be a culture, tradition, or religion that justifies the torture and mutilation of a child.

The thesis of this research paper is that the continued prevalence of FGM into the 21st century represents a catastrophic failure of the international community and national governments to uphold their most basic legal and moral obligations. However well-intentioned, the legislative progress of the last several decades has created a dangerous illusion of action, masking the grim reality of unenforced laws and unprotected girls. The gap between the de jure prohibition of FGM and its de facto continuation is the central problem this paper seeks to address.

Definition, Typology, and Medicalization

WHO's definition is the most commonly accepted, and it classifies FGM as "all procedures that involve the partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons." The term "mutilation" is a deliberate use of the word instead of the more euphemistic terms "cutting" or "circumcision," because it denotes the gravity of the act and the resulting harm, by putting the language into a framework similar to that of human rights and criminal law. The practice is most often carried out on girls between infancy and age 15. The WHO classifies FGM into four major types, which are not mutually exclusive:

Clitoridectomy- partial or total removal of the clitoral glans and/or the clitoral hood.

Type 2 (Excision): Partial or total removal of the clitoral glans and the labia minora. The labia majora may or may not be removed.

Type 3 (Infibulation): Narrowing of the vaginal entrance by cutting and repositioning the labia minora and/or the labia majora, with or without excision of part or all of the clitoral glans, often by stitching. This procedure sometimes is called "sealing" and results in the leaving of only a small opening for the flow of urine and menstrual blood. The sealed vaginal opening is often opened forcibly ("de-infibulation") for intercourse and childbirth.

Type 4: All other procedures performed in the genital area which cause injury to the female genitalia for purposes other than medical, including pricking, piercing, incising, scraping and cauterizing the genital area (for example, "gishiri cutting" in Nigeria) or applying corrosive substances.

This practice is usually carried out by a traditional practitioner, who is often an elder woman of high social status with no training in medicine. The instruments are often not sterilized and vary from knives and razors to pieces of glass or sharp stones. Anesthesia is almost never applied, and the child is restrained bodily, often by several adults

Over the past decades, a dangerous and counterintuitive trend has evolved: medicalization. This is the performance of FGM by trained health-care professionals-doctors, nurses, midwives-in a clinical setting. Advocates may falsely argue this is a "harm reduction" strategy that makes the procedure "safe." This argument is unequivocally rejected by every major global health and human rights body. The WHO, UNICEF, and UNFPA have issued joint statements condemning medicalization as a violation of medical ethics ("first, do no harm") that gives a false veneer of legitimacy to a human rights violation. Medicalization does not reduce the harm; it normalizes the mutilation. It does not prevent the long-term health consequences and fails to address the underlying gender discrimination. In some countries, such as Egypt, a majority of procedures are now conducted by medical professionals, which acts to create an enormous barrier to eradication by co-opting the very health systems that should be protecting girls.

The Socio-Cultural and Economic Drivers of FGM

Understanding the complex web of social, cultural, and economic factors that maintain this practice, it is necessary for eradicating female genital mutilation. It persists not because parents are malicious but because they are in a powerful social dilemma, often feeling that FGM is necessary for their daughter to ensure her social acceptability and marriageability and her future.

Control of Female Sexuality: This is the most widely cited and is considered a fundamental driver. FGM is essentially equated with patriarchal attempts to control female sexuality, which is often considered "insatiable" or "dangerous" if left unchecked. The practice is supposed to reduce or eradicate libido, with the effect of ensuring premarital virginity and marital fidelity. Infibulation-the most radical form, classified as

Type 3-is a physical, brutal "chastity belt." This driver echoes a social order that has subordinated women's bodily autonomy to the imperatives of male lineage and honor.

Social Norms and Conformity: FGM is a strong social norm in many communities today. It is a type of "social convention" in which the behavior of every person is interdependent. The decision of a family not to cut their daughter is not an isolated decision. They may encounter intense social pressure, ridicule, stigma, and exclusion. Their girl child may be bullied, termed "unclean," and unmarriageable. The fear of social ostracism proves a more powerful motivator than the fear of a distant legal sanction. This "game theory" dynamic explains why families who may privately wish to abandon the practice continue to perform it.

Rite of Passage and Social Identity: Many cultures incorporate FGM into a social ritual that marks the passage from girlhood to womanhood. The "cut" is the central event in a ceremony that may also include feasting, gifts, and education on the roles and responsibilities of wife and mother. Abandoning the cut, without replacing the accompanying social ritual, leaves a vacuum. The scar itself becomes a physical marker of belonging to the community and of having attained the status of an "adult woman."

Myths of Hygiene, Aesthetics, and Health: Demonstrably false beliefs are put forward to justify FGM. These include the belief that the female genitalia are "unclean," "masculine," or "ugly" in their natural state. There is a myth in some cultures that if the clitoris is not removed, it will grow to the size of a penis, or that it is harmful to a newborn child during delivery. All these are medically baseless.

Misappropriation of Religion: No major religion calls for FGM. It is a cultural habit that pre-dates both Christianity and Islam. However, in many communities, it has been "Islamized" or "Christianized" and is falsely believed to be a religious requirement for piety or purity. This is a critical barrier. But it is also an opportunity: when religious leaders are engaged and interpret correctly religious texts, they become the most powerful agents of change. The pronouncements against FGM by high-level Islamic scholars-most notably from Al-Azhar University in Egypt-and Christian councils have been pivotal in delinking the practice from faith.

Economic Drivers: FGM is a source of income and status for its practitioners. Traditionally, in many villages, the "cutter" - usually an older woman - often obtains her entire livelihood from the procedure itself, plus various rituals that must be performed in connection with the practice. This produces an economic disincentive for change. Any successful eradication program must therefore include provisions for alternative income generation for these practitioners.

The Devastating Consequences of FGM

FGM causes harm that is immediate, irreversible, and lifelong. It has no health benefits and is a direct cause of immense suffering. The consequences can be classified into immediate, long-term, and psychological categories.

Immediate Complications: The procedure is very painful since it is usually done without anesthesia. The immediate risks are serious and life-threatening. These include:

Hemorrhage: This is a common cause of death due to uncontrolled bleeding from severing the clitoral artery or other blood vessels.

Shock: The child can go into neurogenic shock from the intense pain or hypovolemic shock from blood loss.

Infection: Unsterilized instruments and the application of ash or dung to the wound consistently result in high rates of localized and systemic infection. The latter includes sepsis and tetanus, both of which can be fatal.

Urinary retention-swelling and pain may render urination impossible, leading to acute problems of the bladder.

Injury to Adjacent Tissues: The urethra, bladder, or anus may inadvertently be damaged by the practitioner.

Fractures: The child may sustain broken bones or dislocated joints from being forcibly held down during the procedure.

Long-term Physical Complications: When the wound heals, it can generate a lifetime of physical problems.

Gynecological: chronic, recurrent pelvic infections; PID - Pelvic Inflammatory Disease; and infertility.

Urinary: Chronic UTIs; dysuria, or painful urination; and in extreme cases, urinary incontinence

Menstrual: The small opening left by infibulation may block menstrual flow, causing hematocolpos, or the retention and accumulation of menstrual flow, which is very painful and may cause infections.

Sexual: FGM, especially clitoridectomy, amputates or destroys the primary organ of female sexual pleasure. Consequently, dyspareunia, a lower or absent libido, and anorgasmia may occur. Infibulation is extremely painful during penetration and impossible without a "de-infibulation" procedure where the scar is cut open.

Obstetric Complications: One of the most dangerous long-term effects is the fact that scar tissue is inelastic, obstructing the vaginal opening and leading to a high risk of. Prolonged labour and obstructed labor may lead to fetal distress and death. Emergency Caesarean Sections: Rates are considerably higher. Postpartum hemorrhage The loss of more than 500 milliliters of blood following delivery; may be life-threatening.

Obstetric Fistula: An opening between the vagina into the bladder or rectum as a result of prolonged, obstructed labor. This causes the woman to involuntarily leak urine or feces, often leading to a suite of social exclusion and medical complications.

Perinatal Death: Significantly increased risk of stillbirth or early neonatal death

Psychological and Emotional Trauma: The psychological effects tend to be as serious as the physical. The child suffers from an acute feeling of betrayal by her parents and community. The long-term aftereffects include PTSD, chronic anxiety, depression, flashbacks, sleep disorders, and a deep feeling of bodily violation and loss. This trauma is often carried in silence, since survivors are discouraged from speaking about their experience.

FGM as a Violation of International Human Rights Law

FGM is not a "cultural choice." It represents a fundamental violation of human rights law, to which all states are bound. Any defense based on "cultural relativism" stands legally and morally empty when brought face to face with practices that amount to torture or deny the very core, non-derogable rights of human beings.

The Right to Freedom from Torture: FGM clearly fits the legal definition of torture under the UN Convention Against Torture and Article 7 of the ICCPR, since torture is defined as an act by which severe pain or suffering, whether physical or mental, is intentionally inflicted. FGM is intensely painful and intentionally inflicted to serve a purpose wholly rooted in discrimination-to control the girl. Even when it is not performed by a state official, it meets the definition when the state, through acquiescence or failure to act, fails to protect its citizens from this known harm. UN bodies have repeatedly affirmed that FGM constitutes a form of torture.

The Right to Non-Discrimination: FGM is a quintessential act of gender-based discrimination. It happens to girls because they are girls. It is a practice based "on the idea of the inferiority. of [the female] sex." The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) is central here. Article 2 obligates states to "condemn discrimination against women in all its forms" and to pursue policies to eliminate it, including "by all appropriate means and without delay." Article 5 specifically mandates that states take all appropriate measures "to modify the social and cultural patterns of conduct of men and women, with a view to achieving the elimination of prejudices and customary and all other practices which are based on the idea of the inferiority or the superiority of either of the sexes or on stereotyped roles for men and women."

The Rights of the Child: Because FGM is almost invariably performed on a minor, it constitutes a serious violation of the Convention on the Rights of the Child, the most widely ratified treaty in history. Article 24(3) enshrines an explicit and inescapable obligation: "States Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children." FGM is the archetypal example of such a practice. Article 19 protects children against "all forms of physical or mental violence, injury or abuse. while in the care of parent(s), legal guardian(s) or any other person who has the

care of the child. Article 37 says, "No child shall be subjected to torture or other cruel, inhuman or degrading treatment or punishment."

Right to Health: The ICESCR, in its Article 12, recognizes the right of everyone to "the enjoyment of the highest attainable standard of physical and mental health." FGM is a procedure with no health benefits and a guarantee of health complications. It is a direct assault on this right. The state has a "positive obligation" to protect its citizens, especially children, from this foreseeable harm.

The Right to Life: ICCPR, Article 6. The prospect of immediate death because of hemorrhage or sepsis and the long-term, elevated risk of maternal and infant mortality make FGM clearly violate a fundamental right to life.

Legal Frameworks: Progress and the Implementation Gap

In response to these clear human rights obligations, a robust legal framework has emerged at the international, regional, and national levels. Yet the existence of a law does not equate to its enforcement.

International Framework: The global consensus is absolute. The SDGs adopted by all UN member states have, under Target 5.3, called for the "elimination of all harmful practices, such as child, early and forced marriage and female genital mutilations" by 2030. The UNFPA-UNICEF Joint Programme on the Elimination of FGM is a large, multi-country initiative working to accelerate abandonment of the practice.

Regional Frameworks:

Africa: The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (The Maputo Protocol) of 2003 is arguably the most powerful legal instrument. Article 5 (Elimination of Harmful Practices) is unambiguous, calling for states to "prohibit and condemn all forms of female genital mutilation" and "take all necessary legislative and other measures for their elimination." This is a legally binding treaty, an African-led solution to an African-identified problem.

Europe: The Council of Europe Convention on preventing and combating violence against women and domestic violence (The Istanbul Convention) provides the most all-encompassing framework to date (2011). Article 38 requires states to criminalize FGM, while Article 39 requires criminalization of "aiding or abetting" the commission of the act.

National Legislation: Case Studies on the Implementation Gap

Case Study 1: Egypt. Egypt has one of the highest rates of FGM in the world. It criminalized the practice in 2008, with penalties significantly strengthened in 2016 and 2021. Enforcement, however, remains weak, and prosecutions are few and far between. The biggest challenge is medicalization, wherein over 70% of FGM is estimated to be performed by doctors or nurses. This reveals a deep disconnect between the legal norm and the social norm, with the medical establishment itself being complicit.

Case Study 2: Kenya. Kenya presents a more optimistic model. It has one of the most comprehensive laws in the world on the Prohibition of Female Genital Mutilation Act (2011); it criminalizes the practice, "aiding and abetting," and failing to report. It has extra-territorial jurisdiction-to prosecute "vacation cutting"-and established the Anti-FGM Board to coordinate all national efforts. Challenges notwithstanding, this has created a potent combination in Kenya of a strong law, a dedicated government body, and a vibrant civil society-which promotes Alternative Rites of Passage (ARPs)-leading to its significant decline in prevalence.

Case Study 3: United Kingdom This is a "diaspora" country, and its challenge is different. The FGM Act (2003) makes the practice illegal, and an amendment in 2015 criminalized failure to protect a girl at risk. The law also has extra-territorial jurisdiction. Yet, for 16 years, there were no successful prosecutions. The main challenge is "cross-border FGM" or "vacation cutting," where girls are taken to their countries of origin. In response, the UK introduced FGM Protection Orders (FGMPOs), a civil-law tool which can be used to seize passports and prevent travel. The first successful prosecution finally occurred in 2019, but it highlights the extreme difficulty of tackling a practice which is hidden, normalized within families, and involves child victims who cannot or will not testify against their parents.

Recommendations and the Path to Eradication

The persistence of FGM demonstrates that a single-vector approach-for example, just passing a law-is doomed to fail. Elimination must be approached in a "whole-of-society" manner that attacks the problem from all angles at once.

Strengthening Legal Implementation: Laws must have teeth. This requires a dedicated "justice chain" approach: **Training**: Police, prosecutors, and judges should be trained to regard FGM as a grave crime and not a "cultural" matter. **Resources**: Child-protection services should be funded for the identification and support of girls at risk. **Accountability**: National budgets should clearly indicate the budgetary allocations to national FGM eradication boards and programs. **Community-Led Social Norm Change**: This is the most important factor. Change has to come from within.

Community Dialogues: Support for programs, like those pioneered by Tostan in Senegal, that facilitate non-judgmental, human-rights-based dialogues within villages. These allow communities to collectively discuss the health and human rights harms and come to their own conclusion to abandon the practice.

Public Declarations: Encouraging entire villages or regions to make a "public declaration of abandonment" helps shift the social norm en masse, ensuring no single family is left behind.

Alternative Rites of Passage: These "celebrate without cutting" programs, successful in Kenya and elsewhere, retain all the positive aspects of the rite of passage-education, celebration, feasting, transition to womanhood-but replace the mutilation with education on health, rights, and financial literacy.

Education and Empowerment: Girls' Education: One of the most effective long-term strategies has to do with keeping girls in school. Educated girls are more likely to understand their rights, marry later in life, and refuse to have their own daughters circumcised. Women's Economic Empowerment: Economic independence provided to women, such as through microfinance or vocational training, empowers their status in the family and society, thus helping them to decide about their own bodies and their daughters' health.

Engaging Men, Boys, and Leaders: FGM is not a "women's issue." It is a societal issue. Men as Allies: Men and boys need to be involved as partners. Programs, which persuade men to publicly declare that they will marry "uncut" women, can immediately break the "marriageability" driver. Religious and community leaders serve as guardians of tradition. Engaging them for public advocacy against FGM, lending their moral and religious influence to dispel myths surrounding the practice, serves as a strong catalyst for change.

Resisting Medicalization and Standing in Solidarity with Survivors: Zero Tolerance in Healthcare: Medical professional bodies must have strict "zero-tolerance" policies with clear sanctions, such as loss of license for any provider who performs FGM.

Services centered on survivors: The 200 million women and girls who are currently living with FGM must not be forgotten. They require non-judgmental holistic services, which include psychological counseling and specialized physical health care such as de-infibulation and fistula repair.

Conclusion

FGM is a profound, indefensible violation of human rights and is absolutely non-negotiable. FGM is also a practice born of and sustained by the systemic devaluation and control of women and girls. It is a scar on our collective conscience, a relic of patriarchal control that has no place in the 21st century.

The legal frameworks to end it are in place; the human rights conventions are unequivocal, the medical evidence of harm uncontested. What remains are deficits of political will, the dead weight of social convention, and a failure collectively to recognize and value girls' bodily integrity and human dignity.

A future free of FGM is not some far-off utopian dream; it is a concrete policy goal, enshrined in the Sustainable Development Goals. To eradicate it in 2030 is ambitious, but it can be done. Doing so requires us to go beyond simple denunciation to funded, coordinated, sustained action. Doing so means supporting the movements being led by the community, empowering the women and girls on the front lines, passing the laws we have written, and holding accountable those who would harm a child in the name of "tradition." The rights, health, and very lives of millions of girls depend on it.

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