

**“Why does female genital mutilation persist? Examining the failed criminalization
strategies in Africa and Canada”**

By

Sally Effie Ogoe

A Thesis submitted to the Faculty of Graduate Studies of

The University of Manitoba

In partial fulfillment of the requirements for the degree of

MASTERS OF ARTS

Department of Sociology

University of Manitoba

Winnipeg, Manitoba

Copyright © 2015 by Sally Effie Ogoe

ABSTRACT

Female genital mutilation is an important human rights and health issue in both Canada and Africa. The Canadian government has made efforts towards eradicating this practice by making it a criminal offense, a “remedy” popularly used in Africa as well. Despite the efforts made by governments, law enforcement, along with international human rights organizations, female genital mutilation persists among African immigrants living in Canada and is still practiced by some in Africa. Using international and government laws and policies, documents, case study reports and articles, this thesis questions why the criminalization of female genital mutilation has not reduced this practice among Africans and immigrants living in Canada. Using qualitative case study research methodology as well as the theories of cultural relativism and feminist human rights, this thesis suggests that cultural practices are resistant to change, even among families who move to societies where the practices are legally criminalized and socially rejected. As such, the strategy of eradicating this cultural practice through criminalization has been largely unsuccessful because of strong social forces as exemplified in myths, cultural reasons and the medicalization of female genital mutilation. This thesis concludes by proposing the need to address the status of females among groups who perpetuate this practice and adopting other measures to supplement the laws which are already in place.

ACKNOWLEDGEMENTS

I would like to express my gratitude to my supervisor Lori Wilkinson (PhD), for her constant guidance, ideas, feedback and support in putting this thesis together successfully and also for giving me the confidence in how far I can go in academia. My sincere gratitude and appreciation also goes to Susan Prentice (PhD) and Michael Baffoe (PhD), who are members of my advisory committee, for providing me with meaningful suggestions and improvements right from the onset of this thesis, to them I say thank you. I would like to acknowledge Gary Strike, the Data Librarian at Elizabeth Dafoe Library for helping me get the right resources and secondary data for this thesis. I am also fortunate to have my parents, siblings and friends from the Ghanaian community urging me on with encouragement. I say thank you to all of them. Most of all, I cannot thank God enough for seeing me through this Master's program, there has been lots of bumps, but through it all, He has given me a transcendental walk. I am most grateful.

TABLE OF CONTENTS

ABSTRACT	i
ACKNOWLEDGEMENTS	ii
TABLE OF CONTENTS	iii-v
LIST OF TABLES	vi
CHAPTER 1-Introduction	1-9
1.1 Background.....	1
1.2 Variations of Female genital mutilation.....	2-4
1.3 Female genital mutilation: An international issue.....	4-6
1.4 Research Question.....	6-7
1.5 Justification of Study.....	7-8
1.6 Thesis outline.....	8-9
CHAPTER 2- Theoretical Review	10-27
2.1 Debates on appropriate terminologies associated with the cultural practice.....	10-14
2.2 Feminist debates.....	14-18
2.3 Cultural Relativism Theory.....	18-22
2.4 Feminist Human Rights Theory.....	22-26
2.5 Summary.....	26-27
CHAPTER 3-Methodology	28-37
3.1 Description of the study group.....	28-29
3.2 Research Design.....	29-30
3.2.1 Selection of study countries.....	30
3.2.2 Representative literature.....	31-34

3.3 Data analysis and interpretation.....	34-36
3.4 Benefits and Limitations to Methodology.....	36-37
3.5 Summary.....	37
CHAPTER 4-Understanding The Context of Female genital mutilation in Africa and Canada.....	38-65
4.1 Demographics of Female Genital Mutilation.....	38-42
4.2 The extent of awareness of females who subject to female genital mutilation.....	43-46
4.3 Migration of female genital mutilation to Canada.....	46-52
4.4 The health consequences of female genital mutilation.....	52-54
4.5 Myths: why female genital mutilation persists.....	54-58
4.6 Cultural issues: the price women pay for undergoing female genital mutilation.....	58-61
4.7 Medicalization.....	61-64
4.8 Summary.....	64-65
CHAPTER 5- Female genital mutilation and Legal Issues in Canada and Africa.....	66-92
5.1 Legal issues: legislations, laws and policies.....	66-67
5.1.1 Moral comparisons and international responses.....	67-75
5.1.2 Legislations and legal opinions from the view of African legislation.....	76-82
5.1.3 Legislation and legal opinions in Canadian legislations.....	83-92
5.2 Summary.....	92
CHAPTER 6- Conclusion.....	93-103
6.1 How cultural relativism explains the persistence of female genital mutilation.....	93-96
6.2 How feminist human rights perspective rejects the practice of female genital mutilation.....	97-99

6.3 Possible solutions to eradicating female genital mutilation.....99-101

6.4 Strengths, weaknesses and areas for future research.....102-103

6.5 Conclusion.....103

REFERENCES.....104-126

LIST OF TABLES

Table 1: Countries in Africa by type of female genital mutilation procedure most widely practiced.....	39
Table 2: FGM prevalence data by age and country by country.....	41-42
Table 3: Immigrants to Canada by Country of Origin, Year of Arrival (2004-2013), Percentage of immigrants and Prevalence of FGM among the female population.....	46-47
Table 4: Three United Nations Treaties by Country, Signature and date of Ratification.....	71-74
Table 5: AU member states who have signed and ratified the <i>African Charter on the Rights and Welfare of the Child</i>	77-79
Table 6: National Laws prohibiting female genital mutilation by country and date of enactment.....	81-82

CHAPTER 1-Introduction

1.1 Background

Female genital mutilation (FGM) was first identified by Agatharchides of Cnidus between the 2nd and 5th centuries BCE among Egyptians (Hughes 1995, Gruenbaum et al 2001, Costelloe 2010, Shell-Duncan & Hernlund 2014). The root of this widely spread practice is based on the belief of the bisexuality among the Pharoanic gods of which humans reflected (Danial 2013). According to these beliefs, every human had both a male and female soul. Interestingly, the location of the sex organs in the soul was interchanged: “(t)he feminine soul of the man was located in the prepuce of the penis; the masculine soul of the woman was located in the clitoris” (Danial 2013:3). To correct this “anatomical error” of the gods, circumcision was carried out in both males and females to grow them into healthy men and women respectively (Boddy 1989, 2007).

This belief and variations of it have subsequently spread to other parts of Africa and the Middle East. For instance, Malians and Sudanese, who were slaves of the Egyptians in the 15th century, eventually adopted this practice (Mackie 1996, Schultz and Lien 2013). The female slaves in that period were circumcised by infibulation in order to reduce their sexual desires and prevent conception. Suppressing the sexuality in this way was believed to make female slaves more profitable as women would not be “burdened” by family relationships and unwanted children (Mackie 1996, Boyle 2002). Communities thereby replicate this legendary belief of healthy sex organ development with the understanding that humans are born “unfinished” (Schultz and Lien 2013).

It is useful for readers to understand that, female genital mutilation actually refers to many different forms and the next section outlines the major procedures in greater detail.

1.2 Variations of Female genital mutilation

There are documented records of type I (circumcision method), type II (excision method), and type III (infibulation method) female genital mutilation among 28 countries in Africa (Costelloe 2010, Dorkenoo 2012). The least invasive method is called Type I. Here, the hood of the clitoris is cut off partially or totally and is referred to in the medical literature as a clitoridectomy. The excision method or Type II is more severe where the clitoris and all or part of the labia minora is removed (known as excision). Amongst many of the Islamic communities in Africa and some in the Middle East, this second method is termed “sunna”. It is erroneously believed that the procedure is non-invasive and that procedure of clitoral removal is much like the procedure used for removing the foreskin of a penis in male circumcision (Oosterveld 1993). The infibulation method, Type III, is the most severe amongst all the procedures and it involves the removal of the clitoris and the labia minora, as well as the inner walls of the labia majora. This method is followed with stitching leaving only a small hole, having an approximate size of a match stick for urination and menstruation (Gordon 1997, Costelloe 2010).

Other forms of mutilation are described in the literature. For instance, Bettina Shell-Duncan and Ylva Hernlund (2000) identify “intermediate circumcision”, locally referred to as *matwasat* in Sudan. It is similar to infibulation (type III) but the stitching is done only on the anterior two-thirds of the outer labia, leaving a larger opening. This is considered by many as a “safer” type of circumcision and is currently permitted by the 1946 legislation in Somalia that criminalizes other forms of the practice (Shell-Duncan & Hernlund 2000). Singateh (1985) also identifies another method called “sealing” which is a modified version of infibulation. With this procedure, there is cutting and sealing of the vagina by means of allowing the blood to harden to form an artificial hymen.

Regardless of the type of procedure, the WHO (2014) considers any other harmful procedures such as piercing, scraping or pricking of the female genitalia for non-medical purposes to be a form of female genital mutilation. Some of these procedures, according to Hosken (1993:1947), are prominent in communities where child marriage is practiced. There are “gishiri cuts” which is the cutting of the vaginal wall to ease penetration. There is also a “zur zur cuts of the cervix” which is intended to ‘fix’ obstructed labor (Mandara 2000). With symbolic infibulation, the clitoris is pricked multiple times, enough to bleed. The practitioner then, administers anesthesia and then binds the legs of the female together to imitate infibulation. Between 1996-1998 the “Water for Life” project in Somalia estimated that 1,000 females in Somalia had undergone this “symbolic infibulation” (Pia Gallo c.f. Shell-Duncan and Hernlund 2000:5), a practice also found in Indonesia and Malaysia (Hosken 1993).

The practice of female genital mutilation is often unhygienic. Instruments such as scissors, a sharp stone, shards of glass, razor blades, cactus spines, rigid plant materials, knife, or scissor specially made for the cutting of the genitalia are used to conduct the procedure without any anesthesia or in a healthy and safe environment (UN 1985, Slack 1988, Amnesty International 1995, Costelloe 2010). A study of 859 Somali females reveals that seventy per cent had the procedure done with a machete (Ntiri 1993).

Often, the practice is not carried out by trained medical professionals, but instead by traditional birth attendants or women from the blacksmith class. However, in some ethnic communities in Nigeria and Egypt, male barbers also conduct the procedure (Costelloe 2010). In Gambia, drums and loud singing accompanies the circumcisions in order to suppress the screams from the females. Additionally, the patients are blindfolded such that they would not be able to identify who circumcised them to others, especially to frightened uncut females (Schultz and

Lien 2013). Again, the blinding may be a form of sanity protection mechanism to ease the fear and pain they are going through during the procedure. The severity of the complications resulting from these practices depend on the skill of the circumciser, her eyesight, acuity, experience, sharpness and cleanliness of the instrument used and the submission of the female victim (Starin 2008) and in most cases, luck.

It is believed that females who struggle experience more pain and potential injury than those who remain calm; herbal ointment is used to aid the healing process and the cuts stitched with catgut or silk in some communities rather than using thorns (Shell-Duncan & Hernlund 2000, Costelloe 2010). In other cases, animal dung and mud are used to stop the excessive bleeding (Slack 1988). Furthermore, the stitches that remain after the procedure need to be reopened during sexual intercourse as well as childbirth (de-infibulation). This is again re-stitched immediately after childbirth(s) or when a woman is divorced or widowed (Shell-Duncan & Hernlund 2000).

1.3 Female genital mutilation: An international issue

Canada has become the home of refugees and immigrants from African countries (Gutbi 1995). According to the 2011 Census, there were over 766,000 people of various African origins in Canada, mainly in Ontario, Quebec, British Columbia and Alberta (Statistics Canada 2013). Even though a large majority of female genital mutilation is of African origin, it has become an issue of concern in Canada according to Society of Obstetricians and Gynaecologists of Canada (SOGC) (Kielburger & Kielburger 2013, FORWARD 2002-2014). Some Africans who have undergone the practice or who come from communities where it is accepted, still subject their daughters to the procedure despite their intention to live in Canada long term.

The longevity of this practice, even after moving to Canada, is due to culture (Hussein et al. 1995). This is not surprising given the prevalence of female genital mutilation. In countries such as Egypt, Guinea, Somalia and Sudan, the prevalence rate is as high as eighty per cent (UNICEF 2013, FORWARD 2002-2014). This practice has become a way of life and their cultural, societal and religious expectations are naturally brought with them to Canada. To them, the pressure to conform to their previous societal norms still remains, as well as the beliefs associated with it. Cultural practices can take generations to change and female genital mutilation is not immune to these social forces.

Several policies and laws have been enacted in both African and in Canada where there are cases of this cultural practice. International bodies such as World Health Organization, the United Nations, the World Medical Association, the International Federation of Gynecology and Obstetrics, and scholars have contributed greatly to the decisions that inform these policies. They are united in the belief that female genital mutilation results in physical and mental harm to females and is unethical. Lawyers and ethicists also express the human rights dimension since the consent of females to engage in this practice is violated, especially when they are infants, children, or young teens who lack the ability to give consent. Feminist researchers also point out the gender imbalances that exist in African communities as a result of patriarchy (Obermeyer 1999) and insist that female genital mutilation contributes to male patriarchy in these places.

As a result, many African countries have taken steps to address female genital mutilation in their communities through movements formed by feminists, and the enactment of government laws, legislations, policies and acts. Countries such as Ghana, Guinea, Togo, Burkina Faso, Central African Republic, and Djibouti have legally banned female genital mutilation (Starin 2008). The increasing number of immigrants internationally, as well as those seeking asylum

from countries where female genital mutilation is still practiced, has led most countries in the west to enact their own laws prohibiting the practice (Hosken 1989, Dorkenoo and Elworthy 1992, WHO 1998). The Canadian government has also made separate efforts towards approaching female genital mutilation within the country. Prohibitions against female genital mutilation have been enshrined in the country's Criminal Code, but there remain known instances of females undergoing the procedure within Canada or among children removed from the country to undergo the procedure elsewhere.

There is much debate about the merits, if any, of this practice. Among Africans, there is a great deal of dissention, with some countries having no or very small incidences of the practice while others record almost unanimous consent to the practice. Even among western scholars, there is no consensus as to the 'rightness' or 'wrongness' of this practice. Like all cultural practices and beliefs, the extent to which like-community members participate in female genital mutilation is not one hundred per cent. Communities that perpetuate and those that condemn it have different perspectives on body modifications, expression of sexuality, expression of love, and how to be a law abiding member of the group. The local and global debates amongst feminists and groups that perpetuate this cultural practice are fraught with diversity (Boulware-Miller 1985, Gunning 1991, Chase 2002, Njambi 2004). Just as Africans in Africa are intolerant of the term "mutilation", the same is seen among the immigrants in Canada. In addition, some immigrants reject how the consequences of female genital mutilation are described (Hussein et. al 1995).

1.4 Research Question

My interest in female genital mutilation was sparked by a human rights class I took during my first semester at the University of Manitoba. The topic was not new to me when it was

discussed during my studies since it is practiced in Ghana where I grew up. Upon further readings after the class, I was amazed to discover that this practice has been reported in Canada. This got me thinking and wondering how this is possible; is it as a result of recent immigration of Africans into the country?, Is it as a result of intermarriages or is it because medically, the benefits are worth it such that it has gained grounds in this country? In essence, this curiosity has resulted in this thesis research to discover why this cultural practice is being preserved and the grounds it had gained in contemporary society. Based on my awareness that there are laws against this practice, I wondered why female genital mutilation still persists, which is how I came to identify my thesis topic.

The objective of this study is to determine whether framing female genital mutilation as a crime is an effective way of eradicating the practice among Africans and immigrants in Canada. In light of this, the thesis addresses the following question: *“Why has criminalization of female genital mutilation not been successful in changing the practice among Africans and African immigrants in Canada?”* To answer this question, my research explores from a sociological perspective, the cultural justifications of Africans who still practice it both in Africa and in Canada. The research also examines how female genital mutilation affects females’ social, sexual and economic lives positively as well as negatively. Furthermore, this thesis also highlights the existing institutions, laws and legislations that have been adopted by governments and organizations to manage societal concerns around the practice of female genital mutilation.

1.5 Justification of Study

If female genital mutilation persists despite the international criminal sanctions associated with it, how can governments, communities, religious groups and families better resist this practice? There is the need to understand why within some African countries, communities still

practice female genital mutilation despite the controversies and legislations criminalizing the practice and why these practices are brought to Canada. As such, this thesis contributes in filling this gap by exploring specifically what factors are in play and thereby hindering the cause of the law. I realize that international criminal sanctions serve very little purpose but to shame nations into action, but with time, I hope that international criminal law will become strong enough to discourage this practice permanently.

This thesis also furthers the debate on social phenomenon and their latent functions. Using the theories of cultural relativism and feminist human rights theory, I am able to make contributions from a sociological perspective on what factors are preserving and perpetuating female genital mutilation and how the laws can work effectively with the new insights that will be obtained from this thesis to eradicate it among practicing communities and groups. The idea is to assess whether criminalization has been effective or ineffective as well as the ripple effects on females who are subjected to female genital mutilation.

1.6 Thesis outline

This thesis is organized as follows: after this introductory chapter to the thesis is a theoretical review captured in chapter 2. Chapter 3 describes the methodology employed in this thesis. It contains details how this research will be conducted and identifies some of the sources used for the data collection, outline of the research design, details about the data analysis and limitations of the study. Chapter 4 encompasses findings and discussions from the data collection directed at answering the central research question. Chapter 5 focuses on the diverse legal discusses explored in this thesis. Lastly, chapter 6 concludes on the key findings, highlights the theoretical linkages with policy implications, possible solutions to eradicating female genital

mutilation, the strength and weaknesses of the study and suggestions for future research projects in this area.

CHAPTER 2- Theoretical Review

There is a need to situate this thesis in a theoretical framework to assist in contextualizing female genital mutilation. In this chapter, I identify two sociological theories that can help us understand the persistence of female genital mutilation in Canada and Africa. Cultural relativism helps us to understand the endurance and attraction of this practice. Conversely, the feminist human rights theory identifies the medical, physical, mental and emotional harm, along with other outcomes of this practice and is the central theory for my research. Before discussing the two theoretical perspectives, this chapter explores some crucial terms associated with this cultural practice and debates surrounding female genital mutilation in communities and countries at large.

2.1 Debates on appropriate terminologies associated with the cultural practice

The removal of genitalia has been labeled variously as female genital mutilation, female circumcision, female genital surgery or female genital cutting with each term carrying with it, political and social connotations of how we understand the practice. Labeling is further complicated by the different kinds of procedures involved, ranging from some tissue removal to extensive removal and even closing of the vulva. For years, this cultural practice has been influenced by culture, religion, country of origin, and social setting and it takes many forms, even within the same community and society. To make matters more complicated, political, and cultural ideologies determine how the practice is named and this section explores this issue in further detail.

According to Meyers (2000), some scholars prefer to use the term “female circumcision” because the tone is less insulting to the women who are subjected to the practice as part of their culture. The Premier Group des Femmes d’Afrique supports this term because it eliminates what they perceive to be insensitive western attacks on African cultural practices (Savanne 1979). The

argument in support of describing this practice as circumcision is rooted in resistance to cultural imperialism where the Western voice is seen as a form of colonialism and attached to a Western agenda to civilize African societies (Meyers 2000). Furthermore, this term is said to be preferred by some writers who are not comfortable discussing issues of sexuality and the sex organs publicly (Lewis 1995).

Meyers (2000) and Costelloe (2010) caution, however, that the term “female circumcision” has also been equated to male circumcision which falsely equates the two procedures. To its detractors, male circumcision is a “risk free procedure which does not interfere with sexual pleasure” (Meyers 2000:470), while the opposite is experienced by females who are circumcised. It is beyond the scope of this thesis to compare the two or to discuss the issue of male circumcision. Nevertheless, it is worth knowing that male circumcision is practiced more widely and is more socially and culturally ‘accepted’ than female circumcision is.

There are other labels for this procedure. Their use depends on the individual’s political position on the practice. “Female genital surgeries” has been argued to be culturally-neutral and non-judgmental. In this case, emphasis is placed on the medical procedure rather than the pain and the trauma associated with it (Kanywani 2002); instead preferring to describe the practice as a medical modification of the body or the “curing of a disease” (Lewis 1995). This viewpoint can be related to the perceived healing properties associated with the procedures and as such, once a female is subjected to it, she becomes free from any health problems, abnormalities or impairment. For instance, in Nigeria and Ghana undergoing this practice is believed to cure infertility, and in Sudan, it is believed to cure diseases in infancy as well as promote their health (Leye and De Bruyn 2004, Leye 2008, Morjaria 2012).

In these instances, the term becomes appropriate since “surgery” according to the *Oxford Dictionary* (2014), involves treatment of body disorders by incision or manipulation using instruments. In addition, Gunning (1992), asserts that using “female genital surgery” gives the platform to compare traditional and modern forms of female surgeries and thereby draws attention to the human rights arguments surrounding them. Although theoretically incorrect, Gunning (1992) supports her argument by comparing practices such as cosmetic surgeries including hymen reconstruction, vaginal wall tightening, tattooing, piercing that have become “fashionable” in the west as modern forms of surgical and cosmetic enhancement, and therefore are not considered “mutilation”. In her case, the surgeries cannot be considered as human rights violations. In contrast, traditional practices like female genital mutilation are readily documented in international human right laws and in majority countries laws as a human rights issue. As is discussed later on, these misguided arguments miss some crucial social pressures that remove individual choice and thus, western beauty “modifications” and surgeries are not equivalent comparisons to most cases of female genital mutilation.

The health benefits raised by both forms of female surgeries are accepted only if it is coming from modern form of body modification whilst the arguments in support of the traditional body modifications are questioned. This shows the preconceived and biased opinions that groups and organizations draw on traditional body modifications when the same is being overlooked in modern forms of cosmetic surgery for women. African scholars such as Mojubaolu Okome (1999) prefer ‘female genital surgery’ over ‘female genital mutilation’ simply because using the term ‘mutilation’ is seen as a deliberate act on the part of Africans to cause physical pain and scar to females. Cultures and religions that encourage the practice of female genital surgery feel the practice does not physically or emotionally harm, wound or scar women.

This has led to women forming groups in parts of Egypt to propagate and support the medicalization of the procedures associated with this practice (Banda 2003). However, despite these stand points, Meyers (2000) further adds to the controversies arguing that the medical term creates the image that the procedure always occurs in a sanitary environment, under sanitary conditions, by a surgeon, and with the use of proper anesthetics, but studies done on this cultural practice prove otherwise (Hosken 1993).

Some organizations use the term “female genital cutting” in order to avoid the tug of war which arises from parents and communities who feel that their private space is being disrespected when the term “mutilation” is used. These groups prefer this term so as not to appear condescending or ethnocentric in dealing directly with communities to eliminate this cultural practice. They also use the term “cutting” as their way of disapproving the practice. The belief is that practicing communities may become more welcoming to interactions and suggestions as they perceive that these organizations understand their reasons as well as values associated with it. However, such groups are also opposed to the use of the term “female circumcision” based on the defense that using this terminology will create a wrong impression that both male and female circumcision are equivalent when that is not the case (Kanywani 2002, Costelloe 2010).

Despite all the variations, “female genital mutilation” remains the most common descriptor of the practice among western medical specialists, human rights activists, and western scholars. The term was officially adopted in 1990 by Inter African Committee on Traditional Practices Affecting the Health of Women and Children and a year after, United Nations and World Health Organizations adopted it as well (Costelloe 2010). Advocates of the term “female genital mutilation” feel that reference to this practice as anything other than mutilation trivializes

its physical and mental health implications and human rights violations. (Baden 1992 c.f. Bransfield 2003, Costelloe 2010). However, just like every term associated with this practice, critics opposed to this term argue that the word “mutilation” creates a focus on notions of torture, abuse, physical pain, and de-emphasizes the cultural history of this practice.

Acknowledging widespread disagreements over appropriate terminology, I have decided to use “female genital mutilation” for this research because it addresses this practice from a human rights perspective, embraces health implications, and includes feminist perspectives (Kanywani 2002). More importantly, using this term clarifies my standpoint on this cultural practice that regardless of the controversies, female genital has to be brought to the spotlight, paying attention to all the details of this practice to better understand why it still persists. In this sense, focus will not only be on the western point of view or the African point of view on this practice but an acknowledgement of the dynamic perceptions, myths, an understanding of human rights and values all of which can be freely discussed under this terminology.

2.2 Feminist debates

Feminists have not come to a consensus regarding the appropriate term for this practice, mostly because feminists themselves have no agreement regarding its utility. Boulware-Miller (1985) points out that in many African societies, the practice is widely debated and there is no unified stance for or against it in most of the African countries where the practice remains. This section examines these debates in greater detail and begins with a discussion of the reasons why some feminists support the practice.

Some African feminists support the practice and cite some interesting observations. In patriarchal societies where the practice is widespread, it is the women who do the cutting on other females (Bransfield 2003). Other supporters suggest that the practice represents an

important aspect of their tradition (Boulware-Miller 1985). Why is the practice defended? Shweder (2000) points out that these cultural rites are generally controlled by women who believe it is a cosmetic procedure with aesthetic benefits and as such it is a practice which the females themselves want and encourage.

Other African feminists have argued that the language used by the Western societies regarding this practice is very judgmental and condescending. They criticize western feminists who equate “female genital mutilation” to barbarism, and this link is perceived as disrespectful to the dignity of girls and women who have undergone this procedure (Greer 1999, Shell-Duncan & Hernlund 2000, Rahman & Toubia 2000). The problem is that by condemning the practice, western feminists contribute to the shaming, disrespect and second class treatment of those who have experienced it. These supportive African feminists also draw attention to inherent contradictions within western society particularly the West’s endorsement of their own forms of genital modification such as cosmetic surgeries for women such as “vaginal rejuvenation”. They see the procedure in Africa as very similar to these cosmetic procedures in the rest of the world. The irony of supporting cosmetic procedures involving the vagina while condemning African practices as “barbaric” is not lost on many African feminists (Greer 1999 pg. 94-95 c.f. Bransfield 2003).

Cheryl Chase (2002:145-6) in the American book *Genital Cutting and Transnational Sisterhood*, asserts that; “(w)estern feminism has represented African genital cutting as primitive, irrational, harmful, and deserving condemnation. The Western medical community has represented its genital cutting as modern, scientific, healing and above reproach”. She also suggests that laws enforcing the criminalization of female genital mutilation should also apply to these practices in the west. She goes as far as suggesting that surgeries that “correct” intersexed

persons should also be considered as criminal offenses given the similarity with female genital mutilation. Another contribution to this debate is Gunning's (1991:199-202) "arrogant perception" arguments. She lays the foundation between the self and the "other" indicating that the "other" (non-western societies) is viewed as "unlike me" (western societies). This arrogant perception has resulted in most western second wave feminists defending their negative view of female genital mutilation (in her case circumcision) as evil to the world thereby failing to view the African woman from " 'her world and sense of self through her eyes', an understanding of her historical content and lastly otherizing" Africans in a way similar to how women were othered in previous generations.

Supporting this view is the Women's Caucus of the African Studies Association's *Position Paper on Clitoridectomy and Infibulation* (2002/1983) where the writers make a case against western interpretation of female genital cutting by stating:

Operations such as caesarean sections, tubal ligations, hysterectomies, and radical mastectomies are sometimes performed on women for questionable medical reasons ought to single out any other group's customs for special attention. Western cultures have in the recent past practiced clitoridectomy on young women as a cure for masturbation and nymphomania and certainly do not regard the sexuality of women as a benign or positive force (1983:2).

In other words, these feminists critique the west's view on the basis that there are many practices within the west that are very similar to (in their view) female genital mutilation which are not criticised.

Equating practices in Africa and the west is fairly common in the justifications for this practice. Leonard (2000:227) and Gunning (1991) both suggest that body modifications such as piercing and tattoos are similar to female genital mutilation because both are all "about young girls copying each other". This similarity, according to Narayan (1997:104), has been overlooked

by most scholars who regard non-western societies, their religion, culture and way of life as inferior. As such, African culture is always seen as representing ideas of “Third World backwardness”. Mohanty (1991:56) sums up this inferiority in her description of a western view of African women:

‘average third world women’ who leads an essentially truncated life based on her feminine gender (read: sexually constrained) and her being "third-world" (read: ignorant, poor, uneducated, tradition-bound, domestic, family oriented, victimized etc.) This... is in contrast to the (implicit) self-presentation of Western women as educated, as modern, as having control over their own bodies and sexualities, and the freedom to make their own decisions.

As such, Western feminists’ obsession with banning the practice of female genital mutilation is seen as yet another example of the colonization of African society, an issue first raised at the 1985 United Nations (UN) Decade for Women conference in Kenya (Pickup 2001).

Other arguments have been made that portray African women as “victims” of female genital mutilation and are juxtaposed against a view of western women who are portrayed as empowered, educated, as well as having control over their own body. As a result, the overwhelming narrative is that African women need saving and are incapable of making right decisions (Meyers 2000, Pedwell 2011). This echoes the colonization arguments raised by many African feminists. In addition, Waririmu Ngaruiya Njambi (2004:229) argues that the “imperialistic impression that only those with some social, political and economic power and who live in the west have the right to take risks with their bodies” is only applied to western women. As a result, body modifications in Africa are always viewed unfavorably to those in the west.

Similarly, the Association of African Women for Research and Development (AAWORD) also suggests that the criticism of female genital mutilation is a form of

colonization, pointing out that it is not their place to label female genital mutilation as a human rights violation since there are cultural reasons why the practice continues in Africa even though this organization rejects the practice. AAWORD members believe that change must come from within Africa and must not be dictated by those on the outside (Davis 1983 c.f. Gordon 1997). This is supported by the Women's Caucus of the African Studies Association who indicate that "changes in the practice of clitoridectomy and infibulation in Africa must be initiated and carried out by members of those African cultures in which the custom exists" (2002/1983:2) and that this is a more effective way of changing practices rather than condemnation or criminalization. Even when Africans disagree with the practice, they raise the issue using more respectful tones and by recognizing the cultural elements of this practice, African critics of female genital mutilation can better position themselves to lobby for the eradication of the procedure (Boulware-Miller 1985).

Now that I have discussed the debates and critiques of labeling this technique, I can discuss the theoretical framework. This thesis uses two theories: cultural relativism theory and feminist human rights theory, to better understand the context through which female genital mutilation is practiced and understood among the African communities in Africa and Canada, as well as the needs for laws to address it. The following section outlines the major aspects of each theory beginning with cultural relativism.

2.3 Cultural Relativism Theory

Cultural relativism supports the "right" of Africans to continue the practice of female genital mutilation. At its base, the argument is that outsiders should "mind their own business" and that any criticism from outsiders is bound to create unfair comparisons between the west and Africa. Cultural relativism as introduced by anthropologist Franz Boaz seeks to explain "the idea

that cultural traits must be explained in specific cultural contexts instead of a broad reference to evolutionary trends” (Moore 2009:34 c.f. Robbins 2010). In other words, when researchers and authors compare cultures, the outcome is unfair and unbalanced because the values held by the researcher culture tend to trump those of the different culture no matter how objective the researcher tries to be. For anthropologists following the cultural relativist perspective, the goal is to understand how diverse ethnic communities and their cultures are different and as such, their values, standards and practices should not be judged against each other (Brennan 1989).

Katherine Brennan’s (1989) view of cultural relativism highlights how most international human rights advocates tend to criticize and criminalize cultural practices that have been in existence for years because, these bodies fail to recognize that many of their organizations are rooted in western culture. Most organizations are located in the west and do not adequately account for the cultural, social, or religious differences in ethics and way of life in Africa. As a result, there is often inadequate consultation or voice from an African perspective within many of these organizations and any “remedies” they suggest tend to marginalize and minimize the role Africans themselves play in changing this practice.

In Edward Said’s post-colonial perspective, western societies have always been based on the assumption of having superiority and dominion over the non-western societies which has been reflected through interplay of power relations, western colonialism, race, and other issues (Seidman 1966, Pedwell 2011). In the Orientalist point of view, cultural meanings which were “Eurocentric” are central in western imperialism and stereotypical thinking towards the non-western societies. The west, therefore, has always had their opinions and ideas about what the non-western societies ought to be rather than what they really are (Seidman 1966) and these opinions always devalued the “Oriental other”. With this understanding, the arguments of

cultural relativists urge individuals and societies not to pass judgments on other cultures and ethnic backgrounds and to be mindful of their thoughts and standpoints in order not to marginalize other groups, their beliefs and traditions.

Cultural relativists would argue that those outside of Africa cannot enter into the debate about female genital mutilation because western societies bring too much cultural baggage and superiority to the argument. Gunning (1991:211) points out that western societies who present female genital mutilation (in her case cutting) as “barbaric”, “patriarchal”, and a “practice of the other” are wrong to do so as female circumcision is “part of our own history”. She argues that it is essential to avoid generalizations and stereotyped standards of what we expect people to be; cultural practices such as female genital mutilation should be just as much respected as cosmetic surgery is in the west. Besides, the west is not that far removed from the practice of female circumcision themselves. In the 19th century, female circumcisions were used as a “remedy” for mental illness and until the mid-twentieth century, forced sterilization was used routinely as a sanctioned practice of the eugenics movement and to prevent promiscuity among women and treat mental issues in Canada (Grekul 2009).

Anthropologists have long studied how body modification and beautification differs among societies. For instance, Weil Davis (2002) suggests that women, regardless if they live in western or non-western societies, have differing conceptions of the ideal female body. While some African women seek and feel that circumcision beautifies their genitalia and helps them conform with society expectations, other western women seek labiaplasty, again for esthetic reasons. Some also argue that what Africans do is not much different from what the western societies do anyway. Writers such as Meyers (2000), James and Robertson (2002) make comparisons between female genital mutilation (in their cases circumcision) and intersex

surgeries of babies for more elegant genitalia which is appealing to the ideals of one's culture. Meyers (2000:472) further asserts that even though these societies are different on various levels, surgical "demasculinizing" is a necessity to meet the standards of female identity.

The idea of body beautification as Eve Ensler (2004), creator of the *Vagina Monologues*, reflects in her play, "The Good Body", that "everything women do is about being good...this imperative to be 'good' is linked with particular ways of controlling women through 'mutilating, hiding, fixing, reducing, shrinking' female bodies: There's skin lightening in some countries, female genital mutilation in another, fattening a bride in another, and dieting and anorexia in another" (Pedwell 2011). Therefore, there is no need for the condescending stance that societies that do not engage in these practices. Instead, we require a closer look and appreciation from the point of view of the engaging participants.

For this reason, the cultural justifications of Africans who practice female genital mutilation must be understood from their own perspective and addressed with caution in order to help us understand why the practice is brought to Canada. With this in mind, we must remember that some cultural practices will not be understood. Some may even be labeled as "backwards" and "cruel". Every culture has their own perceptions about health practices, conception of beauty, what is right or wrong in terms of violations, and female genital mutilation is one such cultural practice. It has, therefore, become imperative to be mindful in addressing these differences and not to judge them by our own cultural standards.

One of the major cultural differences between the west and east regards individual versus community rights. Cobbah (1987) explains that Africans embrace community rights rather than individual rights. To him, this explains why human rights discussions are very different. Family members and especially parents, understandably become defensive, resenting the implication that

they are “mutilating” their daughters (World Vision International 2014). Some Africans feel that they are “wards” of western society, like they are being treated as children with regards to the judging of the “rightness” or “wrongness” of their culture and way of life.

However, if we consider this practice as sacrosanct as cultural relativist theorists would believe, then we fail to see the larger picture of the realities of its human rights and health consequences on females as well as, culture being dynamic therefore subject to change to meet current needs. The limitation of this theory is that it pays too much attention to the cultural comparisons and as a result, it fails to identify the real physical threats this practice entails. Those who criticize cultural relativism are described as racist, cultural imperialists, and judgmental of eastern cultures. Any criticism of cultural practice is rejected, even when these practices cause serious physical and psychological harm. While cultural relativism is a good theory to help us understand why this practice persists, it cannot provide justification of human rights abuses. This is why this thesis needs to identify a second theoretical framework to discuss female genital mutilation. The next section examines feminist human rights perspective as an alternative to understanding this debate.

2.4 Feminist Human Rights Theory

The many theories we collectively term “feminist theory” have been defined as an “attempt to develop a comprehensive account of the subordination of women including its supposed essence and origin” (Weiss 2010). A feminist based theory is based on the premise that knowledge about women can be used to improve the lives and situations of women in the society (Crossman 2014). This helps in a deeper and a more focused understanding of some of the cultural practices women have to endure thereby, laying the foundation for the advancement of different types of feminism projecting views on women from different dimensions.

Feminist human rights theory focuses on the power men exert over women in a particular society and the resulting human rights abuses. According to this perspective, female genital mutilation “reflects a deep-rooted inequality between the sexes, and constitutes an extreme form of discrimination against women” (Dorkenoo 2012:6), a finding supported by Costelloe (2012). The social structure, according to this theory, is framed in a way that the systems, rules, laws and political organizations are biased towards women (Lewis 1995).

The focus on patriarchy by feminists is essential in understanding the perpetuation of female genital mutilation. This is because the family structure in communities which still practice this act is still male dominated. In the case of female genital mutilation, women’s sexuality, their reproductive systems, imperfect bodies and their health are subject to male control. Nawal El Saadawi (1985) states that female genital mutilation is associated with patriarchal social systems, family practices, and social structures which were established over 5,000 years ago. For her, the argument against female genital mutilation must not focus on cultural or religious judgments (as is suggested by cultural relativism), instead we must combat male patriarchy within the family and in the community.

Economic dependence of females is another contributor to the maintenance of female genital mutilation. Conforming to social ideals regarding femininity and virginity can determine economic outcomes among women in many societies. According to a study in Somalia, a prospective husband’s family is given the legitimate right to inspect the infibulated scarring to ensure the woman’s virginity. Those who passed such examinations receive a high bride-price (Slack 1988, Pickup 2001). What complicates discussions that repudiate female genital mutilation is the fact that this practice is performed and supported by other females. In fact, feminists have found that the coercion, injudicious teachings and the social pressures of these

communities are as much a product of patriarchy as they are of pressure by women themselves to continue the practice (Lewis 1995). The practice therefore has an oppressive demand expected of females in male dominating communities leading them “to attach special importance to female circumcision, motherhood, and housekeeping, in order to maintain male domination in patriarchal societies” (Koso-Thomas 1987:97).

Most western feminists view female genital mutilation as a violation of human rights. There is a widespread recognition that women’s rights are human rights. Every human being has inalienable rights and because women’s rights are threatened both privately and publically, “government accountability in these areas requires a considerable reorientation of human rights law” (Friedman 1995:20 c.f. Okin 1998, Bunch 1994). Minority Rights Group finds that countries having the highest mortality rates of children (over thirty per cent between the ages of 1- 4 years) are also the same countries where female genital mutilation is practiced (Dorkenoo & Elworthy 1992). This is no accident. These are also countries where human rights violations, particularly against women, are most prevalent. As a result, Engle (1992) and others argue that recognition of these abuses, including female genital mutilation, must come from recognized and respected international bodies so that they can pressure governments to start prohibiting and outlawing these practices.

One of the major issues around rights and female genital mutilation is the fact that the procedure is most often performed on young children who are not able to fully consent (Lewis 1995). How can an infant or young child give consent to a non-medically invasive procedure? This is one of the major controversies surrounding the practice. It is another reason why the arguments forwarded by cultural relativists cannot be sustained. The cultural relativists do not acknowledge that young people have the right to refuse such procedures. Instead, culture trumps

age and informed consent. Essentially, a feminist human rights framework encompasses appropriate laws that address the needs and the promotion of the well-being of females which is necessary for this research.

The basic tenants of feminism which centers on patriarchy, sexual inequality and women's rights, are essential in deriving answers to the research question by placing focus on the role culture plays in male dominated societies and how it preserves practices such as female genital mutilation. Also, a feminist human rights perspective gives voice to females who have to go through this practice or come from communities that carry out this act showcasing how their social, sexual and economic lives are impacted and the fact that the solution to maintain or abolish this practice will rely a great deal on these females who are affected by the practice (Ierodionou 1995). Furthermore, a feminist human rights theory is useful for determining the effectiveness of existing institutions and public policies that have been adopted by governments to manage societal concerns directed towards the continual practice of female genital mutilation. This is because this theory addresses questions and issues which are directly women-centered and the need for action to change their disadvantage position.

Nevertheless, we must be cautious not to be judgmental of societies still engaging in this practice. Feminist human rights represent these females as victims of the cultural practice without pointing out the roles some of these females play in it due to the power and economic values they gain. These 'advantages' include respect and authority for the elder female circumcisers, the ability of women to determine the timing and the conditions of the procedure, and the passing of culture and history to younger members of society. Even though feminist human rights theory accepts that some women participate in activities that are oppressive to other

women, the theory has difficulty coming to terms with the extent to which their voluntary participation may contribute to further gender inequality. .

2.5 Summary

This chapter explores the ongoing feminist and cultural relativist debates on female genital mutilation with highlights on the key theories which informs subsequent discussions in this research. It also identifies the variations in terms used to describe this practice. Clearly, as an African immigrant, I am faced with a dilemma of being respectful of African culture but at the same time, recognizing the harm this practice causes. I settled on “female genital mutilation” as it best fits with the feminist human rights perspective which shapes this thesis, but I also recognize that the persistence of this practice means that the proponents prefer a different terminology. For this reason, I include the perspectives of a wide variety of individuals and organizations including Meyers, Gunning, Toubia and AAWORD.

The theories employed in this chapter highlights female genital mutilation as a practice that needs to be respectful of historical differences from the cultural relativist point. In addition, exploring arguments from Katherine Brennan, Edward Said, Gunning and others reminds us of the cultural hegemony imposed by western societies over eastern societies. The feminist human rights theory frames the experiences of women and helps us to highlight the human rights issues that affect survivors of this procedure. Together, these theories to me help to produce a holistic view of female genital mutilation, as we are able to come to terms with why practicing groups require respect for their practices and also why there is the need to advocate for the preservation of the rights and well-being of females from some traditional practices.

The next chapter describes the research methodology and includes an outline of the research design as well as details about the data analysis.

CHAPTER 3-Methodology

This chapter provides a detailed account of the thesis methodology. The chapter begins with a description of the problem, outline of the research design, details about the data analysis, and concludes with an examination of the limitations of the study.

3.1 Description of the study group

Female genital mutilation is described as an initiation rite which females must experience in order to be accepted in the societies that practice it (Gillia 1997). Females living in largely rural areas where they lack access to formal education and resources, poor and are under patriarchal influence tend to engage in the practice, although there are some countries where the practice is widely spread in urban and rural areas. For affected women, the need and desire to belong outweighs any long-term physical or mental effects the procedure may have (Mitchell and Eke 2008). Over forty countries in Africa practice female genital mutilation and there are stark differences in the rates at which women undergo this procedure (Slack 1988 cited in Gordon 1997). In some countries, like Egypt, nearly all women have been circumcised. In others, such as Ghana, a very small number have been exposed. The existence of this practice has also been recorded in Canada (OHRC 2009 revised) which is why it is also important to consider this within the Canadian context.

According to the WHO (2014) and Amnesty International (2009), three million girls and women are at risk of mutilation, with approximately 8,000 girls undergoing this procedure daily. This practice has both short and long-term health implications as well as unconvincing justifications for the practice. Uncircumcised females constitute the populations who have little or no social support and status within their communities (Finke 2006). Concerns have been raised with regards to the ability of these girls and women to make an informed choice given that

the procedure is done mainly on infants and small children and thus cannot give consent. Therefore, focusing on this group of females (regardless of their age) will determine the extent of intervention organizations and governments could play in addition to bringing some clarity on difficulties in eradicating this practice among these groups.

3.2 Research Design

This research examines existing research and debates on female genital mutilation and its persistence in Africa and Canada. Items are selected based on their meeting the purpose of this research and how instrumental they are in achieving the set objectives. The main purpose of this study is to assess why has criminalization of female genital mutilation not been successful in changing the practice among Africans and African immigrants in Canada.

I employ a qualitative case study as it offers the opportunity to achieve the objectives of this study. The motivation for adopting the case study research design is that it is particularly good for examining the “why”, “how” and “what” aspects of a research study (Yin 2003). As such, in this research, the “why” helps to examine why communities engage in this cultural practice as well as why do these females who are exposed to it also tend to perpetuate it, why has criminalization not achieved complete eradication of the practice? The “how” explores how the procedures are carried out such that it has become an issue of international concern, how does this practice affect all aspects of the lives of females? The “what” question helps us identify the major arguments within existing research including, what existing research has failed to address, what makes criminalization of this practice effective or ineffective. In conducting a comparative study of female genital mutilation and the strategy of criminalization in Canada and Africa, case studies and reports provide the opportunity to have an understanding of the peculiar social values

and experiences of the subjects under study within their natural setting and in different social settings.

3.2.1 Selection of study countries

To answer the research question, Canada and several African countries such as Sudan, Ethiopia, and Somalia are selected for inclusion in this thesis. With the exception of Canada, the African countries stated are selected based on the prevalence rates, and available research that is within Canada. In addition, how relevant the studies done with females from these countries in Canada are considered before inclusion. This is to aid effective comparison of the females in their natural settings and in a host country. It should be noted, however, that the political situations of the African countries that are included in the research is not considered. This is because studies on female genital mutilation in Canada have been done with such little diversity of African immigrant females, as such to exclude countries with unstable political standing would limit the ability of this research to examine this cultural practice in Canada.

The expatriate African population is growing in Canada. For instance, according to the 2011 National Household Survey, there were 4,005 people of Sudanese-only origin and another 1,505 with dual citizenship, 7,600 people of Ethiopian-only origin and 835 with dual citizenship, and 5,115 people of Somalian-only origin and 1,655 with dual citizenship currently living in Canada (Statistics Canada 2010). More importantly, these African countries have prevalence rates of female genital mutilation being 88 per cent, 91 per cent, and 98 per cent respectively such that one wonders whether or not the practice continues when they move to Canada. (SHHS 2010 c.f. UNICEF 2013, DHS/MICS 2012 c.f. UNICEF 2014). This makes their inclusion in the research paramount.

3.2.2 Representative literature

Secondary data, including journals, articles, laws, policies and newspapers in Africa and Canada, are used to answer the research question. Scholarly articles and reports from key scholars in the area including Efua Dorkenoo, Olayinka Koso-Thomas, Nahid Toubia, Carla Makhoul Obermeyer, Fran Hosken, Anika Rahman, Bettina Shell-Duncan, Scilla Elworthy, Jon-Håkon Schultz, and Inger-Lise Lien are key to identifying the competing viewpoints on female genital mutilation. These writers have been influential in the discussions on female genital mutilation both locally and internationally such that the inclusion of their reports and points of view will give more authenticity to this research, deepening the analysis and conclusions drawn.

In classifying these articles, the strategy adopted is gathering articles that have similar themes such as culture, human rights, laws, and legislation. Those that confirm a particular standpoint are also separated into groups such as those supporting the cultural relativist perspective and feminist human rights perspective. Other topics include male dominance, lack of knowledge on implications of some cultural practices and those that reaffirm or debunk widely accepted beliefs or articles are categorized based on their theoretical perspective. For instance Efua Dorkenoo is known for her research on themes such as human rights, laws, and policies as related to female genital mutilation in Africa as well as among immigrants so her research is largely considered within the feminist human rights perspective.

The Convention on the Elimination of (All Forms of) Discrimination Against Women (CEDAW), African Charter on the Rights and Welfare of the Child, The Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, International Covenant on Civil and Political Rights, The Universal Declaration of Human Rights, and Convention on the Rights of the Child (CRC) are key international documents provide a firm

ground for the human rights arguments raised in this research. Various newspapers such as *Toronto Star*, *The Vancouver Sun*, *Winnipeg Free Press*, *Calgary Herald*, *The Globe & Mail* and several others are also useful as they help to throw light on how the media is drawing the public's attention to this cultural practice and the social concerns raised.

African newspapers for the immigrant communities in Canada such as *The Weekly Jamaica Gleaner with North American Extra*, *Sharenews*, *Pride News Magazine* are also partially included in this study. I select these newspapers based on their accessibility especially in the case of the African newspapers where access to hardcopies of these papers is difficult to obtain. As such, the index to directory of African Online Newspapers provided by OnlineNewspapers.com is used to search the database for these newspapers. Not many newspapers from northern, southern, eastern, western and central Africa are employed in this research. This is due to fact that they do not add new information to what has already been discovered from well discussed documents and also some of the information are not within the objectives of this study.

Most of the scholarly articles, reports, and fact sheets are obtained from the University of Manitoba Libraries, Journal of Obstetrics and Gynaecology Canada, Library and Archives Canada, Networked Digital Library of Theses and Dissertations (NDLTD), Google Scholar, Hindawi Journal of Obstetrics and Gynecology International, Statistics Canada, Credo, ProQuest, and HeinOnline. The key search terms include “female genital”, “-mutilation”, “-circumcision”, “-surgery” or “-cutting”, “infibulations”, “excision”, “clitoridectomy”, “feminist theory”, “cultural relativism”, “human rights”, “human rights and female genital mutilation,” and other like terms in their titles and or content. These words and phrases are used in the search as they are central and recurring keywords in this research.

In order to achieve the goals of using secondary data credibly, the information derived is subjected to the four criteria of documents usage in qualitative research. These are authenticity, meaning, credibility, and representativeness (Scott 1990 c.f. Bryman 2008:516). According to Scott (1990), authenticity pertains to that element of genuineness and clarity derived from literature as well as the source. Employing this criterion to this research, documents which do not make sense and hence not comprehensible are discarded, same document which has different versions in terms of content as well as documents having several internal inconsistencies as a result of the biased interest of the writer (Platt 1981) are considered as inauthentic. Such documents are excluded from the research in order to produce results that have much integrity and free from potential errors which can happen if the documents are not screened.

To achieve authenticity, documents specifically those that are obtained from international organizations such as WHO, are verified by cross-checking the copyright attached to their published documents as well as the unique logo placed on their reports. Furthermore, credibility is the reliability of the information derived from the literatures. That is, the information in the documents should be one that has not been compromised, contain no distortions and are error free (Scott 1990). Based on this criterion, it should be noted that there is no personal vested interest in the documents that were selected except for the fact that they are relevant to the objective of the study. In addition to this, I have no personal relation or connection to any of these writers or organizations and therefore, the information they have produced in their documents are not for my benefit or to further any hidden agendas.

The use of secondary data is of great advantage since there is significant amount of literature available which can be identified and probed further to derive information which is of relevance to the study. I can also compare different writers and their debates on female genital

mutilation. However, it is worth noting that synergy may be relative and dependent upon several conditions such as the prevailing governance conditions and ethics that exists in the different countries. As such, this research may not necessarily yield the same conclusions and findings as a similar case study in another social setting. Nevertheless, as Bryman (2008) observes, the purpose of a case study is not to make conclusive generalizations, but rather to generate an extensive and intensive examination of a particular case that the researcher adopts for study. The latter is the main objective of this study.

3.3 Data analysis and interpretation

Epistemologically, the study assumes an interpretive rather than positivist approach. Ontologically, the qualitative nature of the study implies that the data generated from the secondary materials is subjected to subjective interpretation to examine the phenomenon under study which in this case is female genital mutilation practice. This research identifies recurring themes which serves as the foundation for subsequent interpretation and analysis. This data is organized and analyzed in order to make it easy to retrieve relevant information to fill in the knowledge gap. Furthermore, themes would be identified by looking for theory-related material. This is identified by the content of the data in the already selected literatures from other studies done on female genital mutilation to serve as starting blocks to build this research. In particular, this research makes use of cultural relativism and feminist human rights theories to help identify themes such as the cultural perspective on female genital mutilation, benefits derived from female genital mutilation, health implications as well as human rights perspective.

The study seeks to utilize the collected data for analysis from which conclusions can be drawn. In the process of data analysis, this study mainly employs the thematic analysis method. This helps to seeks out similarities and differences on how female genital mutilation is being

discussed in documents, articles, reports and policies and the different themes related to the data that has been previously produced to come up with new information. The categories of data for analysis that are collected for this research are those that utilize descriptive and interpretive approaches in discussing this cultural practice, data that focus on the health implications of female genital mutilation, articles that take on a feminist critique approach to female genital mutilation in contrast to cultural relativist articles. As well, articles from feminists with different backgrounds and points of views are incorporated to get diversity in the analysis different writers are making. With the main basic tenants of feminist theory being social inequality, patriarchy and oppression, these attributes become the guiding themes which are identified even before the documents are organized and relevant aspects utilized.

The cultural relativist articles center on the justifications for female genital mutilation, benefits of this cultural practice and the freewill to exercise one's personal rights without being judged negatively by others. This is essential for this research as it helps to incorporate the views and reasons why Africans preserve this practice. Therefore, the bias of presenting just one negative side information on this cultural practice is avoided. Also, other categories of data collected focus on human rights violations with particular emphasis on the rights of children and women, international and local laws. A small amount of data from orientalist discourses is also incorporated.

The benefit that this orientalist perspective brings to the research is drawing awareness to the colonial divide as well as cultural imperialism that exist between the western societies and the non-western societies. With this, we get to understand why Africans are apprehensive and intolerant of the west as well as international organizations, on having a say in which cultural practice is appropriate with a mentality of them having a hidden agenda to overpower Africans.

As such, themes that focus on drawing attention to how different cultural practices, body modifications and sexuality are responded to differently depending on which part of the world perpetuates it is discussed from the cultural relativist and orientalist point of views.

Based on the volume of data that exists on this cultural practice, it may not be evident that enough data has been collected. Nevertheless, since the data will be organized thematically, assurance that adequate amount of relevant data has been collected is realized when recurring and central themes, patterns, and categories become persistent. The analyzing and data organization stages will further add to this clarification as it will indicate how best they meet the study's objectives.

3.4 Benefits and Limitations to Methodology

There are many advantages to this approach. Access to resources for data gathering are readily available which makes it also convenient for the proposed completion time frame of this study. In addition, this approach is cost-free since all the data are retrieved from secondary documents as such, no travel expenses, no cost to organize interviews and incentives for participants to take part in this thesis topic which is controversial and stigmatized. Also, since there is reliance on secondary sources, participants are not directly contacted and issues of ethics approval are not required. This saves time to focus on other aspects of the research. Furthermore, this methodology prevents meddling directly into a very sensitive subject such that the uncomfortable situation of having female genital mutilation participants discuss and relive their traumatic experiences during interview processes is prevented. Being sensitive to cultural differences is a tricky thing to navigate as personal perceptions tends to influence ones analysis which is avoided in the case of this research.

However, there are some limitations in the use of this method. In analyzing the data collected, this process can be time consuming as a lot of data relevant and irrelevant may be generated from previous studies done on female genital mutilation. A major limitation is that the voices of women are not heard and therefore, limits to some extent the validity of the conclusions research by organizations and researches included in the research.

3.5 Summary

This chapter outlines the details of the methodology used to collect data and carry out this research. The various sections present detailed description of the group under study, their characteristics and why there is a need to study this particular group. The research design adopted is a descriptive research using a qualitative methodology. Furthermore, a diverse range of relevant documents, reports, articles and newspapers are explored in the data analysis and interpretation to make this research as concise and accurate as possible. There is an acknowledgement of limitations which this research process will face as well.

The next chapter is based on the findings where the focus is on the analysis, interpretation, organization and discussion of the major data.

CHAPTER 4-Understanding the Context of Female genital mutilation in Africa and Canada

Exploring the practice of female genital mutilation among various ethnic groups helps us to understand how culture influences practice. Communities who engage in this practice do not view female genital mutilation as abuse or as a human rights violation. Instead, they tend to view it in terms of a rite of passage, a social norm that must be upheld. Despite internal and external condemnation, the practice remains widespread in many countries. This chapter examines the context and occurrence of female genital mutilation in Africa and Canada. The chapter begins with a discussion of the demography on female genital mutilation, the different procedures carried out in countries, the extent of the practice on target groups of females as well as the extent of awareness of females who subject to female genital mutilation. This is followed by a discussion of the context in Canada. The last two sessions examine the question of why female genital mutilation persists based on belief in myths, cultural reasons and medicalization.

4.1 Demographics of Female Genital Mutilation

Female genital mutilation, according to the World Health Organization (WHO 2014: no page), involves the “partial or total removal of the external female genitalia” for no medical justification. It is a cultural practice that in most African countries has been carried out for centuries and like many cultural beliefs, it has a powerful influence in the lives of the people. Africa is the second largest continent and consists of 56 countries (World Population Review 2014). It is dynamic ethnically, politically, religiously and culturally with a population of 1.033 billion as of 2013 (World Population Review 2014). This cultural practice has been described as an initiation rite which ushers females into womanhood, preparing them for their expected societal roles and duties (Gillia 1997).

Currently, over 50 percent of females living in 18 African countries undergo the procedure (Rahman & Toubia 2000). About 98 percent of Somalians, 91 percent of Egyptians, 88 percent Sudanese, 50 percent Guinea Bissau and 4 percent of Ghanaian females have been circumcised, although there are variations among ethnic and religious groups within the same country (UNICEF 2013). Records also indicate the prevalence of type I (circumcision method), type II (excision method) and type III (infibulation method) female genital mutilation in 28 countries in Africa as summarized in the Table 1 below (Costelloe 2010, Dorkenoo 2012, adapted from Macfarlane 2014). Types I and II are the most prevalent, with the most “invasive” type occurring in Sudan, Somalia, Eritrea and Djibouti.

Table 1: Countries in Africa by type of female genital mutilation procedure most widely practiced.

Almost universal FGM, and over 30 percent FGM Type III	Sudan (north), Somalia, Eritrea, Djibouti.
High national prevalence of FGM, WHO Type I and II	Egypt, Ethiopia, Mali, Burkina Faso, Gambia, Guinea, Sierra Leone
Moderate national prevalence of FGM, WHO Type I and II	Central African Republic, Chad, Cote D’Ivoire, Guinea Bissau, Kenya, Liberia, Mauritania, Nigeria, Senegal, Togo
Low national prevalence of FGM, WHO Type I and II	Benin, Cameroon, Ghana, Niger, Democratic Republic of Congo, United Republic of Tanzania, Uganda, Yemen
FGM not reported	Morocco, Western Sahara, Algeria, Tunisia, Libya, Gabon, Angola, Congo, Namibia, South Africa, Botswana, Zimbabwe, Mozambique, Madagascar, Malawi
No data on FGM	Equatorial Guinea, Burundi, Rwanda, DRC Congo

Adapted from Macfarlane (2014). Pg. 6 “Author’s analysis of Crown Copyright data from the Office for National Statistics”. Adapted from UNFPA-UNICEF joint program c.f. Wiklander (2012).

Young girls between the ages of four to fourteen years are the target group for most female genital mutilation procedures (Oosterveld 1993, WHO 2008, WHO 2010, Dorkenoo 2012), although recent research reports show that some newborn babies are also subjected to it in

Nigeria and Ethiopia (Hosken 1993, Oosterveld 1993, Starin 2008, Desert Flower Foundation 2014). Whereas infants and toddlers were not subject to this practice historically, this group is increasingly victimized by the practice in recent years. This has been attributed to the belief that, the wounds incurred during the procedure heal faster and pain is lower for babies than for older children and youth (Kaplan et al 2013).

Another reason given for the early timing of this procedure is that babies would not remember the pain (Hosken 1994:21). In some countries such as Mali and Kenya, the procedure is carried out much later in life, on the wedding night of the females or after the birth of their first child (Oosterveld 1993, Dorkenoo 2012). This shows the variations that exist in African countries as well as the indigenous communities on when and how they conduct female genital mutilation (Oosterveld 1993, Costelloe 2010).

Based on documents from WHO (2001, 2008), estimates between 100 and 140 million females worldwide have gone through the 3 types of procedures. A further 2 million girls are at risk annually as reported by Integrated Regional Information Networks (IRIN 2004) and based on a more recent report by UNICEF (2013), in Africa alone, about 3 million females are at risk annually, implying an increase in the practice and worldwide rates. Furthermore, despite the existing literature that highlights the prevalence of the procedures being done on females ranging between 0-10 years, accumulated data that supports this is not readily unavailable. Data presented in Table 2 provides us with some estimates of the extent to which female genital mutilation is present in particular countries by age group. I have included some other countries here for comparative purposes.

Table 2: FGM prevalence data by age and country by country.

Country	Source	Year	Age of women							Overall
			15-19	20-24	25-29	30-34	35-39	40-44	45-49	
Djibouti	MICS	2006	89.5	93.7	93.3	95.9	94.7	93.1	94.4	93.1
Eritrea	DHS	2002	78.4	87.9	90.9	93.4	92.7	94.1	95.2	88.7
Somalia	MICS	2008	96.7	97.9	97.9	98.8	98.9	97.9	99.1	97.9
Sudan*	SHHS	2010	83.7	86.8	89.5	88.3	89.7	89.8	89.1	87.6
Burkina Faso	DHS	2010	57.7	69.8	77.5	82.8	85.2	88.2	89.3	75.8
Egypt	DHS	2008	80.7	87.4	94.3	95.2	96.4	96.2	96.0	91.1
Ethiopia	DHS	2005	62.1	73.0	77.6	78.0	81.2	81.6	80.8	74.3
Gambia, The	MICS	2010	77.1	76.8	77.5	74.7	73.2	75.3	79.0	76.4
Guinea	DHS	2005	89.3	94.6	96.6	97.4	98.6	98.1	99.5	95.6
Mali	MICS	2010	87.7	88.2	87.9	89.1	90.2	89.4	88.5	88.5
Sierra Leone	MICS	2010	79.8	86.9	92.2	93.2	95.8	95.3	96.4	88.3
Central African Republic	MICS	2010	17.9	22.1	24.5	25.5	28.4	29.9	33.8	24.2
Chad	MICS	2010	41.1	43.0	46.1	45.4	45.7	44.6	47.2	44.3
Guinea-Bissau	MICS/RHS	2010	48.4	49.2	51.0	49.8	49.0	54.1	50.3	49.8
Ivory Coast	DHS	2012	31.3	35.1	36.8	40.3	45.4	44.6	46.9	38.2
Kenya	DHS	2008-09	14.6	21.1	25.3	30.0	35.1	39.8	48.8	27.1
Liberia**	DHS	2007	35.9	51.1	61.3	63.4	66.7	71.2	79	58.3
Mauritania	MICS	2011	65.9	66.2	67.4	71.3	72.0	76.2	75.2	69.4
Nigeria	MICS	2011	18.7	21.5	26.1	29.7	31.5	34.9	38.0	27.0
Senegal	DHS	2010-11	24.0	24.3	26.1	24.9	29.0	26.9	28.5	25.7

Country	Source	Year	Age of women							Overall
			15-19	20-24	25-29	30-34	35-39	40-44	45-49	
Yemen*	DHS	1997	19.3	22.2	21.3	22.9	23.6	25.1	25	22.6
Benin	DHS	2006	7.9	9.9	13.6	14.3	16.3	17.0	15.8	12.9
Cameroon	DHS	2004	0.4	2.5	1.6	1.1	1.2	1.8	2.4	1.4
Ghana	MICS	2010/11	1.5	1.8	3.0	4.4	5.5	6.6	6.4	3.8
Niger	DHS	2006	1.9	1.6	2.4	2.1	2.9	2.9	2.8	2.2
Tanzania	DHS	2010	7.1	11.0	11.7	19.1	21.6	22.2	21.5	14.6
Togo	MICS	2010	1.0	2.4	3.6	4.6	6.3	5.2	6.5	3.8
Uganda	DHS	2011	1.0	0.8	1.9	2.1	1.3	1.7	1.9	1.4

*Sample consisted only of ever-married women

** Women were asked if they had been initiated into a secret society.

Source: Adapted from Macfarlane (2014). Pg. 6 “Author’s analysis of Crown Copyright data from the Office for National Statistics”.

From the table, we realise that the rate of this practice is not universal in African countries.

While some countries such as Djibouti, Eritrea, Somalia, Sudan, Egypt, Guinea, Mali and Sierra Leone have prevalence rates over 80 percent, other countries such as Cameroon, Ghana, Niger, Togo and Uganda have rates under 10 percent. This reinforces how rooted this practice is in some countries as well as drawing attention to other countries, such as Egypt, which have tried to eradicate this practice, have experienced difficulty.

4.2 The extent of awareness of females who subject to female genital mutilation

Some females are fortunate to receive some form of education in preparation for the procedure (Schultz & Lien 2013). This aspect is rarely discussed in academic and government reports, but is very necessary to understanding why the practice is still ongoing and not completely eradicated by the existing legislation. From the perspective of countries such as Egypt, the goal is to eradicate the process, but in the meantime, it is important to educate those performing the procedure so that women are not further harmed by unhygienic, unsafe conditions. In general, the international organizations against this practice tend to use a judgmental tone and do not support education in this area because they fear it just encourages the practice.

It is a difficult conundrum. Do countries simply ban the practice and look the other way when untrained persons perform this risky procedure? Many international organizations support this suggestion. We find international organizations celebrating persecutions of medical personnel who are persecuted for female genital mutilation operations; a recent BBC article (2013) describes how an Egyptian medical doctor was punished under their law when a girl died after an illegal female genital mutilation procedure. The report, “Equality Now” called the ruling a “monumental victory” (BBC 2013). Others feel that the practice will take time to die away, thus it is important that in the meantime the “practitioners” get as much information as possible to prevent the spread of infection and needless deaths.

Why, despite criticism and criminalization, does this practice persist? Female genital mutilation is encouraged by some mothers and grandmothers who see it as their duty to ensure that females in the community become accepted members of society. Their rationalization is rooted in the mentality that they are doing it out of love therefore in situations where there are

health implications, these negative outcomes are blamed on evil spirits and witches (Starin 2008). It also has to do with the preserving the “purity” or virginity of women in some countries which goes to reaffirm their religious obligations and cultural expectations of remaining chaste till marriage. Boddy (2007) and Schultz and Lien (2013) indicate that, the practice is defined as morally right because it is believed to preserve their virginity and is part of the process of being accepted as an adult in the larger society. In essence, “(t)hey are expected to realize that their bodies are being ‘purified’, made discrete by the social group” (Boddy 2007 c.f. Schultz and Lien 2013:166). Likewise, in communities that circumcise these females when they are babies, the teaching process comes at a later age.

How prevalent is this practice among expatriate communities? A detailed study was conducted with immigrant populations from Somalia and Gambia living in Norway. Somalian girls are cut between the ages of 6–8 years which means that the girls would have been exposed to some information and education prior to the procedure. One of the rationales given to the girls is that the procedure “makes the girl like her mother and grandmother” (Schultz and Lien 2013: 170). According to these authors, education “normalizes” the procedure and that communities use a variety of education methods, either a partly open information strategy or a closed information strategy. What differentiates the two approaches, according to Schultz and Lien (2013), is how much knowledge about the procedure is given to females and how this information is obtained. The Somalian strategy is the partly open strategy where the learning process starts a year before the ceremony, and the females are taught that uncircumcised females are unclean. They are taught that uncircumcised females will not get suitors and will not be accepted in the community. This is supplemented with information from older girls who have been circumcised and is keenly monitored by their mothers.

In the case of Gambians, the strategy is the closed type where the females gather the knowledge from the experience itself and the learning stages which take place after the circumcision. This learning process called the “explanation phase” also depends on the age of the female and also on the type of circumcision, that is, whether it is individual or group circumcision. Gambian girls, conversely, are generally cut at 4 years of age and are given less preparation beforehand. They are generally told that the vagina is unclean and that cutting corrects this. During and after the procedure, they are informed that they should prepare their minds for the pain.

However, after the procedure has taken place, girls are no longer allowed to ask questions as this is regarded as taboo. A Gambian woman commented during the study saying; “(i) remember as a teenager I was afraid to ask my questions because she (mother) could interpret it to mean that I was interested in having sex. We couldn’t talk about it at all” (Schultz and Lien 2013). The goal during this informal learning period which is organized and orchestrated by the mothers, older sisters, grandmothers, and other influential women, is to emphasize cleanliness and honor. They place much emphasis on teaching these females that after the circumcision, it is their responsibility to “keep it beautiful, clean, and closed” until marriage (Schultz and Lien 2013:170). These qualities in the practicing African communities are deemed essential and vital to the survival of females in the community.

From this background, it is clear that female genital mutilation does not just happen in Africa, it is an ingrained practice brought with migrating communities. It has progressed from one generation to the other such that it has become well rooted in their sense of self, identification, community belongingness and autonomy, which is difficult to separate. Even the education these young females are exposed to shows that it is increasingly difficult to come up

with laws and expect an end of this practice. Socio-demographic factors, particularly ethnic group and religious affiliation influence the persistence of this practice. Among women in Gambia, there is a perception that this practice is deeply rooted in culture and religion, but there is no consensus as to why it is necessary today (Ogunlola et al 2003, Sakeah 2006, Abdalla et al 2012).

4.3 Migration of female genital mutilation to Canada

Despite the fact that female genital mutilation is largely associated with Africa, since more and more Africans are moving to Canada, the practice is being seen here (Garcia 1992, Taylor 1992, Kielburger & Kielburger 2013). Table 3 shows the country of origin of recent immigrant arrivals to Canada. In 2011, almost 29,000 women from Africa and the Middle East became permanent residents of Canada (Kielburger & Kielburger 2013). Burkina Faso, Djibouti, Egypt, Eritrea, Ethiopia, Gambia, Guinea Republic, Mali, Sierra Leone, Somalia, Sudan are the countries with the highest rates of female genital mutilation (over 70 percent) and from Table 3 below, number 50 percent of immigrants to Canada (CIC 2013, Macfarlane 2014). What this means is that not only is there continual arrival of immigrants into the country but more importantly, they constitute the group from countries where at least three-quarters of women have been exposed to at least one form of the procedures associated with this practice. For this reason, it becomes an issue Canada cannot ignore.

Table 3: Immigrants to Canada by Country of Origin, Year of Arrival (2004-2013), Percentage of immigrants and Prevalence of FGM among the female population.

Country	Year (2004-2013)	Percentage of immigrants	Prevalence of FGM
Benin	2,311	1%	16.8%
Burkina Faso	1,693	0.7%	72.5%

Country	Year (2004-2013)	Percentage of immigrants	Prevalence of FGM
Cameroon	13,769	6.1%	1.4%
Central African Republic	415	0.2%	25.7%
Chad	987	0.4%	44.9%
Cote d'Ivoire	6,810	3%	41.7%
Djibouti	1,003	0.4%	93.1%
Egypt	36,641	16%	95.8%
Eritrea	9,210	4.1%	88.7%
Ethiopia	27,753	12%	74.3%
Gambia	256	0.1%	78.3%
Ghana	6,653	3%	3.8%
Guinea Republic	3,585	1.6%	95.6%
Iraq	38,305	17%	8.1%
Kenya	5,872	2.6%	32.2%
Liberia	2,032	0.9%	45.0%
Mali	1,455	0.6%	91.6%
Mauritania	823	0.4%	71.3%
Niger	756	0.3%	2.2%
Nigeria	28,613	13%	19.0%
Senegal	5,832	2.6%	28.2%
Sierra Leone	1,233	0.5%	94.0%
Somalia	13,691	6.1%	97.9%
Sudan	7,826	3.5%	87.6%
Tanzania	2,257	1%	14.6%
Togo	2,684	1.2%	3.8%
Uganda	2,016	0.9%	0.6%
Yemen	1,570	0.7%	22.6%

Source: FGM figures adapted from Macfarlane (2014). Immigration figures from Citizenship and Immigration Canada (2013)

According to Macklin (2006), despite the fact that there are reports indicating the performance of female genital mutilation in Canada with the belief that most of these procedures are carried out by health care professionals, its extent of prevalence is largely unknown (Macklin 2006, Ferguson & Ellis 1995). The national and international academic communities face a dilemma when it comes to issues pertaining to female genital mutilation. The major concerns that have been raised against this cultural practice are issues of health and human rights violations. According to WHO (2008), female genital mutilation has no health benefits but causes short and sometimes long term complications for those undergoing the procedure.

International organizations, in addition, argue that these females specifically children, have no formed judgment and therefore cannot give informed consent, but simply undergo the mutilation which in this case is irrevocable (WHO/UNICEF/UNFPA 1997, WHO 2008). Even in the case of adult females, the extent of informed consent is questionable. Estimates vary, but Chalmers and Omer-Hashi (2002) reported from a study done with Somalian females in Canada that almost half of the participants would like to have the procedure done for their daughters.

Do their opinions on the procedure change after they arrive in Canada? According to Sexuality Education Resource Centre (SERC) Manitoba (2010), some immigrants are conflicted about the preservation of certain cultural practices after they migrate. Female genital mutilation is one of these practices. Vissandjée and her colleagues (2013) suggests that there is evidence that some, but not all, immigrants continue the practice in Canada on the basis that girls must undergo this procedure so that they can remain “eligible” brides for males from the same country.

In Canada, the media has criticized the propensity of immigrants to bring this practice with them to their new country. The first large scale media coverage of this cultural practice was

in 1983 by *The Globe & Mail* publication which was titled “Female Circumcision Necessary, say African Women in Canada” (Roberge 1983). In this article, women indicated how this cultural practice is not just a rite of passage and to have it questioned by “outsiders” is unfair. “It’s our business, and we will decide what to preserve and what to be rid of. No law will change this” (Roberge 1983, no page) said Marie Jeanne Ki, wife of a past ambassador to Canada from Upper Volta (now Burkina Faso). In short, criticisms of Africans bringing the practice into Canada smack of colonialism, at least among the staunch supporters.

Since then, the widespread condemnation of this practice has been featured in *The Ottawa Citizen*, *The Ottawa Sun*, *The Globe & Mail*, *The Toronto Star*, *The Toronto Sun*, *L’Express*, *La Presse*, *The Montreal Gazette*, *Le Devoir*, *Le Soleil*, *The Lethbridge Herald*, and *The Hamilton Spectator*, *Macleans* and several others (Ferguson and Pamela Ellis 1995). In addition, newspapers for the immigrant communities in Canada such as *The Weekly Jamaica Gleaner with North American Extra*, *Sharenews*, *Pride News Magazine* have contributed to the public’s knowledge on this cultural practice (Simms 2003, Admin 2012, Fortin 2013). These newspapers report similar information found in non-governmental organizations reports adding an additional voice to the ongoing public rejection of the practice.

Not everyone in Canada condemns the immigrants who bring the practice with them. Some activists who support the cultural relativist position indicate need to be respectful of this cultural practice. In an article by Zosia Bielski (2007) in the *National Post*, the writer points out how Janice Boddy, a professor in the Department of Anthropology at the University of Toronto, emphasizes the cultural reasons which Africans attach to this practice rather than criticizing it. She is among a handful of Canadian supporters. However, a majority of voices in the media, among health practitioners and international human rights organizations have taken a more firm

tone with regards to the Canadian attitude towards this cultural practice. From *The Vancouver Sun* (2012), the head of the society's Social and Sexual Issues Committee made a public statement; "(w)e want to raise awareness that there are more and more women we are seeing with this procedure because of immigration", and urge doctors in Canada to report instances among young girls born here because the practice is illegal. According to *Winnipeg Free Press* (2010), the Sexuality Education and Resource in Winnipeg are working closely with females and African community leaders on the most appropriate measures to handle female genital mutilation.

Very little research has examined why the practice is maintained after immigrants arrive in Canada. One study in 1995 in Ottawa and Montreal concludes that cultural preservation is the main force in preserving the practice (Hussein et al 1995). To newcomers still practicing, there is the fear of losing their cultural identity in a foreign land and the concern is that if they have to return home, their daughters would have to undergo the procedure anyway so it is best to have it done in their childhood years. Pressure from extended family members not living in Canada, especially from men and elderly members also reminds these Africans what is expected of them and the need to maintain this ritual. The power of the social pressure to conform varies based on how connected these Africans are with their ethnic communities in Canada and in their country of origin. Among elderly Somalians for instance, the pressure to preserve their way of life encourages younger immigrants in Canada to continue this practice (Hussein et al 1995). Parents feel they have to "do what is right and necessary" for their daughters if they expect them to marry an African with similar cultural expectations.

Another reason why some maintain the practice is because of the need to "accurately and precisely preserve" all aspects of their culture. This type of extreme cultural preservation can be

seen among other expatriate groups. For example, third- and fourth-generation Sikhs living in Vancouver practice a very different kind of religion than new arrivals from India. This is because their grandparents and parents sought to preserve what they believed to be an “authentic” version of Sikhism. This has now caused social cohesion problems within this community as the religion, like all other religions, changes as time passes. New practices and beliefs slowly begin to change the religion, so the Sikhism of 21st century India does not look much like the Sikhism practiced by those who can trace their ancestry to the mid-nineteenth century in Canada (Buchignani 2008).

For Africans coming from communities that practice female genital mutilation but now live in Canada, there remains a strong obligation to remain “true” to their culture and religion in their ancestral country. Religion remains central in the lives of many African newcomers as it serves as a means of comfort and encouragement in hard times and especially in a foreign land. It partly explains the persistence of this practice despite the fact that it is not a requirement in any religious doctrine. One religious Somalian leader indicated that the misinterpretation of the *Quran* to the practice may be as a result of believers carrying their obligation of male circumcision in Islam to females as well (Hussein et al. 1995). Research conducted with African immigrants living in Montreal showed that most of them were oblivious to the lack of religious support for this practice and instead, believed that uncircumcised females cannot take part in religious acts like praying (Hussein et al. 1995). Research in Ottawa with African men reveals continued support of this practice because of the belief that circumcised women had honor, were virgins and therefore more preferable marriage partners. This belief carried on through their daughters as uncircumcised females are considered morally corrupt and unclean. Others also

indicated that circumcision serves as a safeguard of females against rape because it is not easy to penetrate circumcised females (Hussein et al. 1995).

How do non-Canadians tend to view this practice? In Canada, medical professionals, many researchers and most of the public ascribe to the Western stance or feminist human rights perspective that this cultural practice is a rights violation with associated health risks. In December 1991, the Council of the College of Physicians and Surgeons of Saskatchewan was the first medical association to produce a statement criticizing the practice which was followed by five other medical associations in the country (Ferguson & Ellis 1995). Some immigrants from Africa have rejected any social and psychological trauma which has been attached to this practice as those who had gone through female genital mutilation state that they are healthy and that it was a necessary practice. Therefore they do not see any reason why the practice should not be perpetuated even in a host country.

4.4 The health consequences of female genital mutilation

There is consensus among medical professionals that this cultural practice is of no benefit physically and emotionally to females. Based on reports from WHO (1996), there are short- and long-term implications, mental health and emotional health consequences, as well as sometimes fatal medical complications associated with female genital mutilation. The short-term complications include injury to adjacent tissue, potentially fatal hemorrhage and shock, pain, acute and chronic infections. One long-term complication includes difficulty in passing urine. Slack (1988) indicates that an infibulated female can use up to 10-15 minutes to urinate. There are also reports of urinary tract and pelvic infections, infertility, keloid scars, abscesses and cysts, menstrual difficulties, painful sexual intercourse, serious complications in pregnancy and childbirth and sometimes, transmission of infectious diseases such as HIV (Ferguson & Ellis

1995, Reymond, Mohamud & Ali 1997, Larsen & Okonofua 2002). Restitching is required for those undergoing the infibulation procedure since the wound must be re-stitched after childbirth or sexual intercourse (Costelloe 2010).

The mental consequences are severe. Research by Oosterveld (1993), Reymond, Mohamud and Ali (1997) reveals circumcision induces psychological problems like fear of having sex, anxiety, psychosis and depressive episodes. Alice Muir-Leach, in her study of Sudanese females in Canada, finds that pre-circumcision, females were friendly and were not afraid to be medically examined but that anxiety and fear of medical health professionals tends to arise between 2 months and 2 years post-infibulation. According to Fergusson and Ellis (1995) these females now;

stood trembling with fear at the open door, or else bolted into the examination room and crouched in the far corner, and it was with difficulty that she was persuaded to remove even her outer garments. Others with more courage, approached trembling and stood weeping silently. They were terrified at the sight of a metal instrument such as a stethoscope or spatula. In all cases the sound of a metal spatula being lifted from the tray caused a slight trembling even if the examination had proceeded normally till then. In others, the sight of the spatula in my hand brought on a nerve storm, and it was impossible to continue. This seems to indicate an unreasoning fear of surgical instruments. (Ferguson and Ellis 1995:6-7).

Furthermore, female genital mutilation, when defined as abuse, violates several rights of females (WHO 2008). These include their right to health, making decisions independently, the right to life as well as integrity. This practice is carried out predominately on young children and babies (WHO/UNICEF/UNFPA statement 1997, 2008) who have no formed judgment and therefore cannot give informed consent and with little understanding of the consequences. The association of the procedure with trauma, lack of knowledge of the pain is evident; for instance,

it takes up to six adults to hold down one female during the painful procedure (Dorkenoo 1995). Pain management during and after the procedure are not often available. Females are advised to stay motionless for a period of about 2-4 weeks in order for their wounds to fully heal (Oosterveld 1993, Costelloe 2010). Very few females seek medical attention after the procedure, and those who do, are often experiencing serious complications.

Supporters of this practice tend to emphasize the social benefits and minimize the individual negative outcomes. In some cases, when a complication arises, community members rather tend to blame the victim rather than the procedure or the competency of the person performing it. Even when physical complications are avoided, most suffer deep psychological consequences. Some women believe there is something wrong with their bodies or female bodies in general which needs to be corrected. This belief sustains the patriarchal elements within their society.

4.5 Myths: why female genital mutilation persists

A number of myths support the practice of female genital mutilation. In some communities, the belief that it is a “good tradition” is the main force perpetuating this practice (Obermeyer 1999). Religious obligation, economics, cultural identity and patriarchy (Ierodionou 1995) are the main reasons cited for the perseverance of this practice. There are several myths about the “benefits” of female genital mutilation and I discuss the main ones here.

First, it is a myth that female genital mutilation improves the health and appearance of females. The belief is that female genitalia, if left in its natural state, produces very unpleasant discharges making the female unclean. There is also a belief that the clitoris will grow to the size of a penis if not cut. As a rite of passage to womanhood, practicing communities see female genital mutilation as necessary since it (they falsely believe) increases the fertility rate of

females, facilitates smooth child birth and contributes to various healing powers (OHRC, Oosterveld 1993).

Even Europeans practiced it in the 19th century. J. Marion Sims, the “father of gynaecology” and gynecologist surgeon Isaac Baker Brown (1866) suggested that, circumcised females had lower rates of mental illness, reduced masturbation and less hysteria, nymphomania and homosexuality. These health myths persist today. In Tanzania, there is the belief that female genital mutilation cures “lawalawa” which is a bacterial infection (Wilson 2013). In the Southern part of Nigeria, practicing communities believe that if the clitoris is not removed, newborns will suffer spinal injuries during birth (Myers et al., 1985). Epelboin & Epelboin (1979) have also pointed out that some communities believe the female genitalia is poisonous and evil and hence, must be removed to prevent illness among women.

Another cultural justification for female genital mutilation is economic. The economic dependence of females in these societies is as a result of the belief that women cannot be financially independent. Women who reject this practice are seen to be too independent. Independence is a male quality and should be discouraged among females, particularly because it limits their chances of marriage. For this reason, women must be submissive and undergoing female genital mutilation is an important signal to prospective marriage partners that she will obey her husband (Ierodionou 1995).

Another economic perspective involves female genital mutilation as a profit. The maintenance of this practice is due to the fact that it serves as means of livelihood for the women who carry out these procedures. Most of those performing the procedures are paid by wages, compensation or some form of incentive from families. Dr. Jamila Al-Raiby, the Ministry of Health’s General Director of Women’s in Yemen (Al-Ariqi 2007) reveals that female genital

mutilation is predominately done by *rayissas* (women specialized in the circumcision) and women specialized in ear piercing and that 97 percent of Yemeni women undergoing this procedure do so with a *rayissas* at home, while only 3 percent have it done in hospitals (Al-Ariqi 2007).

Women themselves are also a major source of this practice. It should be noted that some of these women do not have many opportunities where they can exercise much power, the procedure is done by women as a community service and this gives them some power (Oosterveld 1993). Ibrahim Diatta, a father of a female genital mutilation survivor reports that; “(i)n the Diola Ethnie the woman has her affairs where she doesn’t have to consult her husband. So when it was the matter to cut Fatou (his daughter) I didn’t know about it. I was just informed (afterwards) that she got cut...” (Global Alliance against Female Genital Mutilation 2011:no page). In summary, this is one aspect of life women have control over and some relish in this power.

In Abusharaf’s (2001:116) case study of Douroshab township in Sudan, she points out how females in this community regard female genital mutilation as a “virtuous act” which serves to separate them into a higher status in the society compared to uncut females. The endurance of this practice is because “it gives voice to gender and collective ethnic identity, serving to distinguish the border between themselves as pure *taharat* (Arabic for circumcision which signifies purification) and others as polluted *nijسات* women. The politics of conformity go beyond keeping clean; they have to do with one’s character, sociality, and personal and collective identity” (Abusharaf 2001:127). Female genital mutilation is glue that binds a community. Losing that aspect of their identity as females which they believe is established through their

participation in this cultural practice would mean removing the little power and control they have in a male dominated community (Slack 1988).

There is also a belief that women who have been circumcised are better sexual partners for men. Reports from Kenya and Uganda also suggest that the practice serves to suppress the sexual desires of females. Furthermore, the pain which many post-female genital mutilated women experience during intercourse means that some try to reduce the frequency of sex and this gives men the “excuse” to have several sexual partners. Women in these communities who do not undergo the procedure are regarded as morally weak and promiscuous and thus, a shame towards the family honour (Bransfield 2003). In Egypt, those who fail a pre-marriage virginity check may face ostracism, become ineligible for marriage, and in some cases, be murdered by their own family (Dillon 2000). In addition to marriage rejection, women who refuse the procedure face derogatory songs, public humiliations, social exclusion, forced excisions, and instillation in adulthood (Oosterveld 1993, FORWARD 2002-2014). Studies done by Onadeko & Adekunle (1985) showed cases where educated women in Nigeria against female genital mutilation still had to undergo the procedure because of family and societal obligations.

As a religious requirement, female genital mutilation is falsely believed to prevent promiscuity, excessive clitoral growth and a means of preserving the virginity of females (WHO 1995). In essence, females have to be protected from their nature of lack of sexual control, immorality and their health must be safeguarded. Nevertheless, despite the widely accepted myths and cultural justifications given by communities who preserve and perpetuate female genital mutilation, there is very little religious justification of such practices. According to Hosken (1982) and Lightfoot-Klein (1989), this practice is not documented in any religious teachings including in the Islam, African Coptic Christian nor among Judaic traditions. Many

who cite religious responsibility as a reason for continuing this practice do not have access to education. Their inability to read and locate religious or scientific information on the topic limits proper understanding of this practice. Furthermore, the practice persists because people actually believe these myths, it is more of a reality for them than any health dangers.

4.6 Cultural issues: the price women pay for undergoing female genital mutilation

What I have learned to this point is that “FGM is a social convention, the social pressure to conform to value system of that society is a strong motivation to perpetuate the practice” (UNICEF c.f. Danial 2013:4). Groups who engage in female genital mutilation may be motivated by religious beliefs, myths, social obligations and culture (Danial 2013). This practice is woven into the social fabric and mindset of the community members such that those who are circumcized receive praise, respect and inclusion while those who do not are cast out which for these females is a huge price to pay as opposed to breaking the law and rejected. The fear of no longer having that family support, society and dependency which every individual needs in their life thereby becomes motivational factors to engage in female genital mutilation.

Studies have also revealed a strong element of peer pressure among generations to fit in and be accepted among their immediate group; to receive that honor that is associated with the practice (Shaw 2004). This is supported by an empirical study among Somalian immigrants, where a participant recalled her circumcision experience at age 6;

I was ready. I begged my mother to let me be circumcised soon. I was afraid of it, but I was more afraid of being bullied at school. I had seen 15-year-old uncut girls being bullied. All the children were divided into two groups, the cut and the uncut. I wanted to belong to the group that had been circumcised. (Schultz and Lien 2013:168)

For females born into communities where the practice is nearly uniform, the pressure to conform is further influenced by older siblings, cousins, mothers and aunts as epitomizing the “ideal” women. For these females, sexual desirability is of much importance to them especially in communities which places much emphasis on such ideals (a circumcised female is clean, virtuous, chaste et cetera) to determine their worth (Wellerstein 1999).

Another cultural influence that contributes to its longevity is the influence of history. Participating in female genital mutilation is a sign that women genuinely “put community cohesion above individual inclination” (Shaw 2004:40). Female genital mutilation, therefore, becomes a significant aspect in defining communities because of the investment they make in sustaining the practice through elaborate ceremonies, celebrations, mentoring and teachings (Shaw 2004). It is a cultural practice that serves to bind individuals to society and preserves community cohesion and the fear is that laws eradicating it will bring an end to the practicing groups sense of being and togetherness (Shaw 2004, Ogunbanjo & Knapp van Bogaert 2005, Ruderman 2013).

What can be concluded is the fact that the cultural pressures to conform, to be regarded as “normal” and “clean” has led most women to minimize the risks and ignore the post-operative pain and undergo the procedure (Ferguson & Ellis 1995, Larson 1996). As a consequence, the women who participate in female genital mutilation feel part of the community and are not stigmatized. According to Senator Al Gore (1993) and Kellner (1993:121), “(n)o matter how hard we may try, or may want to try, to break out of a tradition, it is genuinely hard to break out of patterns of thought and action that are integral to our culture.” In other words, the fear of stigmatization and ostracism is great and the culture appears to be so immovable that the practice simply remains. In light of this, we realize that most Africans, like all other peoples, have strong

historical sentiments and cultural attachment not only to their ancestry but also in engaging in female genital mutilation.

Parental pressure is also a major factor influencing the persistence of this practice. Ruddick (1983) indicates that one of the factors that qualifies one as a good mother in the society is ensuring that your daughter(s) becomes an accepted member of society and one clear way of signifying this is to ensure your daughter is circumcized. This may be one way to explain the longevity of the practice, particularly as parents witness the pain their daughters must endure. To parents and the communities that continue this practice, the intention is not cruelty towards young girls (Shweder 2000). The parental compassion and love to protect their daughters from social exclusion, stigma and ridicule blinds them from any contrary implications that may arise from engaging in the practice especially in the case when the daughters themselves are facing the same pressures in the communities to conform (Boulware-Miller 1985).

Marriage plays a very prominent role in the lives of many Africans. Marriage is seen as honorable, respectful and elevates a woman's status within the community (McGee 2005). Circumcision becomes inextricably linked to marriage and therefore honour (Office of the Senior Coordinator for International Women's Issues 2001). In essence, female genital mutilation has become the foundation on which marriage in some African communities is built. Without submission to it, a woman risks remaining unmarried, will likely remain childless, and the family does not receive a bride price. A woman without a child faces the worse fate such as name calling, ridicule, lack of financial support as well as security for pension (Moges 2003/2009). In this context, participating in female genital mutilation becomes unavoidable. Participating in the circumcision is also a signifier of virginity, an important aspect of marriage. Virginity, as with

being circumcised, is a signifier of family honour. By going through this practice, the female preserves her body.

Groundless as these cultural issues associated with female genital mutilation may be, these societies have the understanding that they have a lot to lose by eradicating this practice or bringing an end to it. Female genital mutilation has, therefore, become associated with femininity, cleanliness, purity, beauty, and marriageability (Gage & Rossem 2006, UNICEF 2014). Aside from this, associated myths and superstitions are a byproduct that contributes to the continuation of the practice, particularly among those less educated.. It is the persistence of the myths, however, that have the greatest influence on the perpetuation of the practice, more so than lower education (Shweder 2000).

4.7 Medicalization

In an effort to eradicate this cultural practice there has been the adoption of laws both locally and internationally criminalizing female genital mutilation. Efforts to change and eradicate the practice have been stymied by cultural, social and religious forces. Despite efforts to eradicate it, female genital mutilation is actually being medicalized in the sub-Saharan regions of Africa (Shell-Duncan & Hernlund 2000, 2001) as the practicing communities are now focusing on the promotion of the healthy, sanitary practices to reduce health risks. This is a poor strategy as it implicitly condones the procedure and ignores all the physical harm and reinforces patriarchy and domination.

In Egypt, reports show over 70 percent of the procedures are now being conducted by trained medical personnel, and other countries are following suit (UNICEF 2013). Nigeria (50 percent), Kenya (34 percent), Sudan (36 percent) and in Guinea (9 percent) all report increases in trained professionals undertaking the procedure (Shell-Duncan & Hernlund 2000, Shell-Duncan

2001, Yirga et al 2012). UNICEF (2014) reports that the number of girls undergoing this procedure has been reduced by over two-thirds in the past three decades. It has been argued that training medical professionals who do these procedures saves lives, reduces the risks of infection and post-operative complications (Cassman 2007). Unfortunately, this further encourages the practice and unintentionally legitimizes it (UNICEF 2014).

Within existing literature, it has been noted that in some African countries, authorities are recommending medicalization. For instance in Somalia, the National Committee on Female Circumcision indicated their support for “sunna” circumcision to be performed in hospitals (Obiara 1997). In Sudan and Somalia, training programs for traditional birth attendants includes aseptic and anesthetic procedures for the circumcision (Gruenbaum 1982, Van der Kwaak 1992). In addition, trained midwives carry out “sunna” circumcisions in clinics (Badri 1999). Similar observations can be made about conditions in Nigeria and Mali (Orubuloye et al. 2000 and Gosselin 2000). In Kenya, the Local Native Councils in Meru and Embu Districts have made it law that circumcisions must be undertaken in clinical settings (Thomas 1996). It is interesting to note that at the same time, the councils of Meru and Embu have passed laws criminalizing the practice which leads to confusion and contradiction about the legality of the practice.

The medicalization of the practice in Africa has meant economic gains among some medical professionals there. Nurses in Burkina Faso and Western Kenya have made it a lucrative side business to perform female genital mutilation in their homes (Njeru and PATH 1996). Families have also become very receptive of this arrangement as now, they have no fear of medical complications or infections due to sterile instruments being used as well as local anesthetic to bring down the pain and swelling (Warzazi 1991). As well, female genital mutilation performed in the home is more intimate and far less costly for families than seeking

the procedure in a professional setting. Regardless of all the prohibitions in place, “as many as 30 million more girls alive today may be cut in the next decade alone. And this number will continue to grow as the population of girls in affected countries rises.” (UNICEF 2013:1). Despite these challenges, it must be acknowledged that some countries have successfully reduced the number of girls undergoing female genital mutilation. In Ethiopia and Niger, the number of circumcised women has dropped from 73 percent to 57 percent (UNICEF 2013). Ethiopia has hired Designated Child Protection Officers in the police force to engage spreading knowledge on the impact of this cultural practice with religious organizations and schools and this has been instrumental in the decrease in this practice.

The strategy adopted in Ethiopia is successful due to the fact that, under the umbrella of existing laws, there has been the incorporating and the engagement of females who are actually exposed to the practice to take up lead roles in bringing down the practice. Again, an environment of safety has been created for discussions on this cultural practice, getting the necessary information, a network of informants and “safe people” (Williams & Robinson 2014) that females can approach if they do not want to engage in female genital mutilation. In essence, there is community and group involvement which has resulted in their success story. However, there may be some challenges in adopting this strategy elsewhere. This may be due to unity in the community to report cases, lack of transportation for police and other officials to do proper investigation and also pressure on the existing resources to meet the changing roles of females if they disengage in this practice particularly in African countries (Williams & Robinson 2014).

Although the conditions for undergoing the procedure have become more sanitary in many countries, there are places where the practice remains particularly dangerous. What are the conditions like in Canada? According to Dr. Margaret Burnett, Chair of the SOGC’s Social and

Sexual Issues Committee as of 2012, there were no guidelines on how exactly health personnel were to deal with these requests for female genital mutilation in this country (SOGC 2012). What this means is that there is no mandatory reporting of request for female genital mutilation procedure as well as mandatory reporting of patients having already had the procedure.

As a result, it is up to medical officers based on their awareness of Canada's legal standpoint on the practice and knowledge of policy statements of the medical associations in the provinces, to decide whether to re-stitch after delivery or advise a patient to have the procedure done in another country. There have been cases in Canada where medical personnel have advised African immigrants to seek the services of African doctors in the country instead. Cited in "Female Genital Mutilation and Obstetric Care" report (c.f. IWHP 2009), a survivor of this practice stated; "(i) had previous birth, which was normal, but when the doctor examined me he said, '(y)ou are like a time bomb that can explode. Please seek one of your own people who can handle your birth" (IWHP 2009). It becomes difficult to assess the case of conditions on female genital mutilation in the health sectors in Canada as the criminalization of the practice puts fears in these practitioners to much detail.

4.8 Summary

This chapter provided a description on female genital mutilation in relation to countries where the practice exists and provides detail on the ages of females who are subjected to the practice. It also examines some of the tactics countries have used to try to eradicate the practice. We now have a better insight as to why the practice persists in Africa and among immigrants in Canada which has presented the opportunity to understand this practice from the point of view of practicing groups. The chapter also discusses the anti-female genital circumcision position of most international organizations. The results reveal the tenancy of the practice and the reasons

why it has been difficult to eradicate despite the willingness of some countries to pass laws to criminalize it.

The next chapter focuses on a discussion of existing laws, how these laws are being adopted in the various countries to manage societal concerns on female genital mutilation and the implications of the existing criminalization.

CHAPTER 5- Female genital mutilation and Legal Issues in Canada and Africa

Now that we have an understanding of how culture, religion, social pressures and medicalization have contributed to the longevity of the practice, we must examine the issues of this practice. As a social and human rights issue, female genital mutilation has become synonymous to “abuse, violence and health risks” such that, legal standpoints pertaining to what is “right” for the individual, who determines it and ensuring that this right is exercised is vital to determine why, despite all these prohibitions, the practice still persists. This chapter examines the legal issues to contextualize its effectiveness and or ineffectiveness as an eradication strategy.

Throughout the chapter, I examine existing laws, legal issues and opinions as it relates to female genital mutilation from four angles; moral comparisons and international responses with highlights on legislations including the *Universal Declaration of Human Rights*, *Convention on the Elimination on all forms of Discrimination against Women*, *Convention on the Rights of a Child* and *International Covenant on Civil and Political Rights*. Legislation and legal opinions from Africa and Canada are also discussed with the last section focusing on the implications of the criminalization laws.

5.1 Legal issues: legislations, laws and policies

Clearly, legislation criminalizing the practice has largely been unsuccessful in challenging the perceptions on female genital mutilation largely because the practice is strongly embedded in cultural values of society. The real issue is that while the laws appear rigorous “on paper”, the reality is that, groups are rarely punished and when they are, the practice continues anyway. This next section examines various issues related to morality, law and international responses. Table 4 below provides a list of African countries, the relevant international treaties

and the dates of signature and ratification which are important for understanding the context of criminalization of female genital mutilation.

5.1.1 Moral comparisons and international responses

Internationally, female genital mutilation is identified as an abuse of human rights. Why is it, given that the practice infringes on the natural sexuality of women does it persist (Dorkenoo, 1995)? The United Nations, the Inter-African Committee on Traditional Practices (IAC) and various local non-governmental organizations have collaborated to fight the practice of female genital mutilation in a number of African countries (Danial 2013). These organizations all rely on the universal human rights enshrined in the *Universal Declaration of Human Rights* (UDHR) in their campaigns and programs working with practicing communities to bring an end to unacceptable cultural beliefs and practices.

Article 25 section 1, Article 3, and Article 26 section 1 of the UDHR mostly serves as the foundations of their arguments as these articles focus on the right to health, life, liberty and the security of personhood, and the right to an adequate education that includes proper knowledge of the cultural practice respectively (James 1994, Danial 2013). In addition, Article 5 speaks of inhuman treatment as well as torture which have best and constantly been used in describing female genital mutilation. The general understanding is that the procedures associated with this practice cause both mental and physical pain (Annas 1996), in addition to loss of sexual feeling and function, and in some cases, death. As such, females regardless of where they are situated in the world have to be protected from the practice.

In the mid-1990s, several high profile international conferences on female genital mutilation were organized. In 1993, the World Conference on Human Rights was held in Vienna and the International Conference on Population and Development was held in Cairo 1994. Both

addressed the thorny cultural question of eradicating this practice (Edouard et al 2013). The objective was to bring into the spotlight violence against women and need for the realization and protection of the rights of females from harmful customs as well as traditional practices. There are several other venues where large numbers of countries have voted to ban the practice. The 1995 Fourth UN World Conference on Women in Beijing in particular, was a platform where unity in criminalizing and eradicating female genital mutilation by enshrining the notion that this cultural practice is not only a danger to the life of these females but also, a serious human rights issue (Gollaher 2000). More recently, at the General Assembly of the United Nations in December 2012, a consensus decision to ban female genital mutilation worldwide with the aim of giving support to policies and interventions set up at the local levels to achieve the eradication objective was reached (WHO 2010). Even though this UDHR is not legally binding, it serves as a standard which signatory countries are to exemplify (OHCHR 1996-2015).

The *Convention on the Elimination of (All Forms of) Discrimination Against Women* (CEDAW) plays a significant role by highlighting the social and cultural pressures faced by women. The fact that this document is legally binding to countries which have signed it makes it mandatory for member state countries to enforce stiff laws “against the perpetrators of practices and acts of violence against women, such as female genital mutilation” (Gollaher 2000:194-5, UN 1999). The CEDAW has been signed globally by 99 countries but only 9 African countries (Benin, Cote d’Ivoire, Ethiopia, Egypt, Ghana, Guinea, Senegal, South Africa, Tanzania) have enacted laws criminalizing female genital mutilation in addition (see Table 4 below). Of these 9 countries, female genital mutilation remains widespread in Ethiopia, Egypt, and Guinea where rates remain extremely high for women in Egypt (91.1 percent), Guinea (95.6 percent) and Ethiopia (74.3 percent) (WHO 2008, Macfarlane 2014). Notably, the United States, Sudan,

Somalia, Iran, and Palau, and Tonga have not ratified this document (National Women's Law Center 2013).

There are other international declarations, including the *Declaration on the Elimination of Violence against Women* which also address female genital mutilation as a human rights issue. In the *Declaration on the Elimination of Violence against Women*, the issue of power inequality and culture is discussed along with the eradication of discrimination in the health care sector (UN 1980, Center for Reproductive Rights 2005, UN WOMEN 2000-2009) and prevention of discrimination of women with regards to marriage and family relations (Ierodionou 1995). Article 1 of this convention defines “discrimination against women” and makes specific recommendations to states in addressing female genital mutilation (CEDAW 1990, 1992). CEDAW Article 5 which articulates that;

State Parties shall take all appropriate measures: (a) to modify the social and cultural patterns of conduct of men and women, with a view to achieving the elimination of prejudices and customary and all other practices which are based on the idea of the inferiority or the superiority of either of the sexes or on stereotyped roles for men and women (CEDAW 1979).

These are a reminder to countries that, “tradition, religion, social cohesion, morality, or some complex of transcendent values” (Afkhani 2001:234) cannot be used as excuses to maintain gender-based practices.

The *Convention on the Rights of the Child* (CRC) is another international treaty which is beneficial in examining this cultural practice and has also been globally ratified by 195 countries, most recently by South Sudan in May 2015 and by Somalia in January 2015, making it one of the most widely ratified international human rights treaties (UN News 2015). Of these 195

countries, only Benin, Burkina Faso, Central African Republic, Chad, Côte d'Ivoire, Djibouti, Egypt, Eritrea, Kenya, Ghana, Mauritania, Niger, Senegal, South Africa, Tanzania, and Togo have laws criminalizing the practice of female genital mutilation. (Center for Reproductive Rights 2005). Article 19(1), Article 24(1) and Article 37(1) of the CRC explicitly prohibits all forms of mental and physical violence and maltreatment and emphasizes a child's right to the highest attainable standard of health. Also, it requires states to take effective and appropriate measures to abolish traditional practices prejudicial to the health of children (OHCHR, CRC 1989). Children and adolescents exposed to this cultural practice have no ability to provide informed consent to the procedure.

Article 26 of the *International Covenant on Civil and Political Rights* also emphasizes the right to equality, equal protection under the law, and freedom from sex-based discrimination which can be applied to the criminalization of female genital mutilation. This treaty has been signed by all African and Middle East countries where female genital mutilation has been reported (see Table 4 below). *Article 2(1) of The Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* was drafted in 1987 and states that; "(e)ach State Party shall take effective legislative, administrative, judicial or other measures to prevent acts of torture in any territory under its jurisdiction" (OHCHR 1987).

Fewer countries in Africa (see table 4) have signed *The Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* and have therefore adopted laws and policies with regards to how female genital mutilation is viewed and should be dealt with as a nation. It should be noted that some of these non-signatory countries have very high prevalent rates of female genital mutilation practice; Burkina Faso (75.8 percent), Djibouti (93.1 percent), Egypt (91.1 percent), Eritrea (88.7 percent), Ethiopia (74.3 percent), Mali (88.5 percent) and

Somalia (97.9 percent) (Macfarlane 2014, Data collected from UN 2015). Female genital mutilation, according to most laws, is an act of torture which also highlights elements of discrimination against this sex. This is because the practice in most cases is associated with extreme physical pain and psychological trauma which the females endure during and after the procedure is carried out on them (Oosterveld 1993).

Table 4: Three United Nations Treaties by Country, Signature and date of Ratification

	<i>The Convention on the Elimination of (All Forms of) Discrimination Against Women</i>		<i>International Covenant on Civil and Political Rights</i>		<i>The Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment</i>	
Country	Date of Signature	Ratified	Date of Signature	Ratified	Date of Signature	Ratified
Algeria	-	22/05/1996	10/12/1968	12/09/1989	26/11/1985	12/09/1989
Angola	-	17/09/1986	-	10/01/1992	24/09/2013	-
Benin	11/11/1981	12/03/1992	-	12/03/1992	-	12/03/1992
Botswana	-	12/08/1996	08/09/2000	08/09/2000	08/09/2000	08/09/2000
Burkina Faso	-	14/10/1987	-	04/01/1999	-	04/01/1999
Burundi	17/07/1980	08/01/1992	-	09/09/1990	-	18/02/1993
Cameroon	06/06/1983	23/08/1994	-	27/06/1976	-	19/12/1986
Cape Verde	-	05/12/1980	-	06/08/1993	-	04/06/1992
Central African Republic	-	21/06/1991	-	08/05/1981	-	-
Chad	-	09/06/1995	-	09/06/1995	-	09/06/1995
Comoros	-	31/10/1994	25/09/2008	-	22/09/2000	-
Congo	29/07/1980	26/07/1982	-	5/10/1983	-	30/07/2003
Côte d'Ivoire	17/07/1980	18/12/1995	-	26/03/1992	-	18/12/1995

	<i>The Convention on the Elimination of (All Forms of) Discrimination Against Women</i>		<i>International Covenant on Civil and Political Rights</i>		<i>The Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment</i>	
Country	Date of Signature	Ratified	Date of Signature	Ratified	Date of Signature	Ratified
Democratic Republic of Congo	17/07/1980	21/10/1986	-	01/11/1976	-	18/03/1996
Djibouti	-	02/12/1998	-	05/10/2002	-	05/11/2002
Egypt	16/07/1980	18/09/1981	04/08/1967	14/01/1982	-	25/06/1986
Equatorial Guinea	-	23/10/1984	-	25/09/1987	-	08/10/2002
Eritrea	-	05/09/1986	-	22/01/2002	-	25/09/2014
Ethiopia	08/07/1980	10/09/1981	-	11/06/1993	-	14/03/1994
Gabon	17/07/1980	21/01/1983	-	21/01/1983	21/01/1986	08/09/2000
Gambia	29/07/1980	16/04/1993	-	22/03/1979	23/10/1985	-
Ghana	17/07/1980	02/01/1986	07/09/2000	07/09/2000	07/09/2000	07/09/2000
Guinea	17/07/1980	09/08/1982	28/02/1967	24/01/1978	30/05/1986	10/10/1989
Guinea Bissau	17/07/1980	23/08/1985	12/09/2000	01/11/2010	09/12/2000	-
Kenya	-	09/03/1984	-	01/05/1972	-	21/02/1997
Lesotho	17/07/1980	14/08/1981	-	09/09/1992	-	12/11/2001
Liberia	-	17/07/1984	18/04/1967	22/09/2004	-	22/09/2004
Libya	-	16/05/1989	-	15/05/1970	-	16/05/1989
Madagascar	17/07/1980	17/03/1989	17/09/1969	21/06/1971	01/10/2001	13/12/2005
Malawi	-	12/03/1987	-	22/12/1993	-	11/06/1996
Mali	05/02/1985	10/09/1985	-	16/06/1974	-	26/02/1999
Mauritania	-	10/05/2001	-	17/10/2004	-	17/11/2004

	<i>The Convention on the Elimination of (All Forms of) Discrimination Against Women</i>		<i>International Covenant on Civil and Political Rights</i>		<i>The Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment</i>	
Country	Date of Signature	Ratified	Date of Signature	Ratified	Date of Signature	Ratified
Mauritius	-	09/07/1984	-	12/12/1973	-	09/12/1992
Mozambique	-	21/04/1997	-	21/07/1993	-	14/09/1999
Namibia	-	23/11/1992	-	28/11/1994	-	28/11/1994
Niger	-	08/10/1999	-	07/03/1986	-	05/10/1998
Nigeria	23/04/1984	13/06/1985	-	29/07/1993	28/07/1988	28/06/2001
Rwanda	01/05/1980	02/03/1981	-	16/04/1975	-	15/12/2008
Sahrawi Arab Democratic Republic	-	-	-	-	-	19/08/2004
Sao Tome and Principe	31/10/1995	03/06/2003	31/10/1995	-	06/09/2000	-
Senegal	29/07/1980	05/02/1985	06/07/1970	13/02/1978	04/02/1985	21/08/1986
Seychelles	-	05/05/1992	-	05/05/1992	-	05/05/1992
Sierra Leone	21/09/1988	11/11/1988	-	23/08/1996	18/03/1985	25/04/2001
Somalia	-	-	-	24/01/1990	-	24/01/1990
South Africa	29/01/1993	15/12/1995	03/10/1994	10/12/1998	29/01/1993	10/12/1998
South Sudan	-	30/04/2015	-	-	-	30/04/2015
Sudan	-	-	-	18/06/1992	04/06/1986	-
Swaziland	-	26/03/2004	-	26/03/2004	-	26/03/2004
Tanzania	17/07/1980	20/08/1985	-	-	-	-
Togo	-	26/09/1983	-	24/05/1984	25/03/1987	18/11/1987
Tunisia	24/07/1980	20/09/1985	30/04/1968	18/03/1969	26/08/1987	23/09/1988

	<i>The Convention on the Elimination of (All Forms of) Discrimination Against Women</i>		<i>International Covenant on Civil and Political Rights</i>		<i>The Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment</i>	
Country	Date of Signature	Ratified	Date of Signature	Ratified	Date of Signature	Ratified
Uganda	30/07/1980	22/07/1985	-	21/06/1995	-	03/11/1986
Yemen	-	30/05/1984	-	09/02/1987	-	05/11/1991
Zambia	17/07/1980	21/06/1985	-	10/04/1984	-	07/10/1998
Zimbabwe	-	13/05/1991	-	13/005/1991	-	-

Data collected from UN (2015), African Commission on Human and Peoples’ Rights (2015)

Clearly, there is a problem with enforcing these treaties because many of the countries where female genital mutilation is still widely practiced have also signed and ratified these treaties. For instance Sudan, Burkina Faso, Gambia, Mali, and Sierra Leone still have over 50 percent of the female population undergoing the procedure (Macfarlane 2014). It may look good for a country to sign and ratify a human rights based treaty, but it is more difficult to eradicate deeply rooted practices that violate one’s dignity. If signing a treaty is not enough, international health organizations such as the WHO and International Federation of Gynecology and Obstetrics (FIGO) have become involved in condemning the practice (WHO/FIGO 1992). Since the 1979 seminar on “Harmful Traditional Practices Affecting the Health of Women and Children” in Khartoum, the WHO has been a frontrunner campaigning against female genital mutilation. In 1993, a WHO Resolution reinstated the need for an abolishment of “traditional practices affecting the health of women and children” to add as a voice in changing practices that discriminate against females in the society (WHO 1993 c.f. Ierodiconou 1995:586).

FIGO also regards all forms of female genital mutilation procedures as a violent act, which all their members under their authority are prohibited from practicing. This is clearly

stated in the FIGO Committee for the Ethical Aspects of Human Reproduction and Women's Health group's statement on Violence Against Women section 2. It states that, "(v)iolence against women is condemned, whether it occurs in a societal setting (such as female genital mutilation) or a domestic setting (such as spousal abuse). It is not a private or family matter" (FIGO 2000). It includes female genital mutilation as violence. In 1996, WHO, UNICEF, UNFPA and UNDP released a joint statement addressing female genital mutilation as a women's right issue using a human rights model (Boyle 2002:55). According to the WHO and UNICEF, female genital mutilation has no positive medical benefits and instead, exposes females to health risks which sometimes lead to catastrophic permanent physical injury and even death. This places countries which have the practice of female genital mutilation been carried out accountable to protect these females and to safe guard their interests.

Finally, the *Universal Declaration of Human Rights* recognizes the right to freedom of thought, conscience and religion in Article 18, and the right to freely participate in the cultural life of a community stated in Article 27 (Danial 2013). Female genital mutilation is alternately identified as a cultural practice, a religious requirement and simply, a pattern followed by generations. As such, communities who engage in the practice also regard criminalization as a violation of their personal and communal rights. With this in mind, the conflicts have arisen in the enforcement of the universal rights arguments to criminalize the practice among practicing communities as these communities are more mindful of cultural and group rights as opposed to individual rights. In reality, none of the international conventions or laws have any effect on eradicating the practice and they are rarely enforced by local, regional and national governments.

5.1.2 Legislations and legal opinions from the view of African legislation

In addition to the work done internationally, individual African countries have worked to eradicate the practice. In 1984, twenty African countries, as well as representatives of international organizations held a conference in Dakar on “Traditional Practices Affecting the Health of Women and Children”. Female genital mutilation was among the topics discussed and one of the outcomes of the conference was the goal to abolish the practice (OHRC). In Africa, some women have taken initiative along with the Inter African Committee Against Harmful Traditional Practices (IAC), hoped to draw their governments’ attention and to abolish the practice. As a result, Sudan, Egypt, Ghana, Benin, Niger, Togo, Benin, Burkina Faso, Kenya, Cote d’Ivoire, Ethiopia, Senegal, and Guinea have passed laws that criminalize the practice of female genital mutilation at the national or local levels (Center for Reproductive Rights 2005). Some countries have further strengthened their laws in an attempt to eradicate the practice. For some, however, the practice remains despite government- and community-level support.

The *African Charter on the Rights and Welfare of the Child* (AU 1999) is another effort to try to abolish the practice. It has been signed and ratified by all the African Union countries (see Table 5 below) with the exception of Central African Republic, Democratic Republic of Congo, Sahrawi Arab Democratic Republic, Sao Tome and Principe, Somalia, South Sudan, and Tunisia. The African Children’s Charter states to “take all appropriate measures to eliminate harmful social and cultural practices affecting the welfare, dignity, normal growth and development of the child and in particular: those customs and practices discriminatory to the child on the grounds of sex” (AU 1979).

Table 5: AU member states that have signed and ratified the *African Charter on the Rights and Welfare of the Child*

Country	Date of Signature	Ratified
Algeria	21/05/1990	08/07/2003
Angola	27/01/2012	11/04/1992
Benin	27/02/1992	17/04/1997
Botswana	10/07/2001	10/07/2001
Burkina Faso	27/02/1992	08/06/1992
Burundi	21/05/2004	28/06/2004
Cameroon	16/09/1992	05/09/1997
Cape Verde	27/02/1992	20/07/1993
Central African Republic	04/02/2003	-
Chad	06/12/2004	30/03/2000
Comoros	26/02/2004	18/03/2004
Congo Brazzaville	28/02/1992	08/09/2006
Côte d'Ivoire	27/02/2004	01/03/2004
Democratic Republic of Congo	02/02/2010	-
Djibouti	28/02/1992	03/01/2011
Egypt	30/06/1999	09/05/2001
Equatorial Guinea	-	20/12/2002
Eritrea	-	22/12/1999
Ethiopia	-	02/10/2002
Gabon	27/02/1992	18/05/2007

Country	Date of Signature	Ratified
Gambia	-	14/12/2000
Ghana	18/08/1997	10/06/2005
Guinea	22/05/1998	27/05/1999
Guinea Bissau	08/03/2005	19/06/2008
Kenya	-	25/07/2000
Lesotho	-	27/09/1999
Liberia	14/05/1992	01/08/2007
Libya	09/06/1998	23/09/2000
Madagascar	27/02/1992	30/03/2005
Malawi	13/07/1999	16/09/1999
Mali	28/02/1996	03/06/1998
Mauritania	-	21/09/2005
Mauritius	07/11/1991	14/02/1992
Mozambique	-	15/07/1998
Namibia	13/07/1999	23/07/2004
Niger	13/07/1999	11/12/1999
Nigeria	13/07/1999	23/07/2001
Rwanda	02/10/1991	11/05/2001
Sahrawi Arab Democratic Republic	23/10/1992	-
Sao Tome and Principe	01/02/2010	-
Senegal	18/05/1992	29/11/2001
Seychelles	27/02/1992	13/02/1992

Country	Date of Signature	Ratified
Sierra Leone	14/04/1992	13/05/2002
Somalia	01/06/1991	-
South Africa	10/10/1997	07/01/2000
South Sudan	2014	-
Sudan	24/01/2013	30/07/2005
Swaziland	29/06/1992	05/10/2012
Tanzania	23/10/1998	16/03/2003
Togo	27/02/1992	05/05/1998
Tunisia	16/06/1995	-
Uganda	26/02/1992	17/08/1994
Zambia	28/02/1992	02/12/2008
Zimbabwe	-	19/01/1995

Sudan Tribune (2014), Data collected from African Commission on Human and Peoples' Rights (2015)

United Nations Population Fund (UNFPA, no date) records 24 African countries with laws opposing female genital mutilation. Nigeria recently passed a national legislation against the practice adding to the number of African countries who have national laws addressing female genital mutilation (The Guardian 2015). The Table 6 below gives a summary of legislation dates in various African countries with regards to female genital mutilation. In Kenya for example, the *Children Act* of 2001 section 14 states that; “(n) o person shall subject a child to female circumcision”. Similar legislations has been passed in countries including Ghana in 1994, Djibouti in 1995, Burkina Faso in 1996, Cote d’Ivoire in 1998 and Senegal in 1999 (Rahman &

Toubia 2000). This has been accompanied with some degrees of persecution to eradicate the practice with punishment ranging from monetary fines, to 6 months imprisonment to life time sentences (Muteshi & Sass 2005).

These laws however, have done little to curb the practice. For example, in Egypt a country with high rates of female genital mutilation (91.1 percent), a rural barber was arrested and persecuted after the death of a 10 year old female who died due to excessive blood loss from the cutting and being overdosed on painkillers, while the second girl, 12 years was hospitalized in a serious condition with heavy bleeding (Guzda 1995). Yet Egypt has been working for decades to eradicate or curb the practice (CNN 2015). Midwives were the primary group conducting these procedures (Lightfoot-Klein 1989) but were banned from the practice in 1978 (Hosken 1982). Despite the ban, midwives continue to commit female genital mutilation in secret which contributes to even more unsanitary, unsafe conditions (Oosterveld 1993). Other countries such as Guinea have also enacted laws against female genital mutilation for 20 years yet over 60 percent of their females still undergo this procedure (Hosken 1992, Oosterveld 1993, UNICEF 2013).

In Sudan, barbers and medical professionals have been tried in court and convicted (Rahman &Toubia 2000) for continuing the practice. Despite being the first African country to have legislation criminalizing the Type III (most invasive) procedure, Sudan has no specific laws against female genital mutilation (Orchid Project 2013). The Penal Code, which was ratified in 1956, imposed a penalty of fine and or 5 years imprisonment for those conducting Type III procedures (US Bureau of Public Affairs 2009). According to Hosken (1994), Sudan's introduction of this amendment banning Type III infibulation (Lightfoot-Klein 1989) had little legal clout as circumcisers were permitted to still engage in removing parts of the clitoris even

though infibulation itself was not permitted. As a result, performing other forms of female genital mutilation became legitimate.

According to Lightfoot-Klein (1989:43), “the custom is still an integral, positive-functioning component of the familial complex, and so, indirectly of the entire socio-cultural system”. Meaning that, millions of women have undergone this procedure in the decades since it has been criminalized. There is a glimmer of hope. The government has introduced a strategy to bring an end to this practice by 2018 (Orchid Project 2013) through campaigns such as the International Day of Zero Tolerance to FGC, where groups show their solidarity against this practice (Orchid Project 2013). It will be interesting to know if Sudan is finally successful in achieving its goal in 2018.

Table 6: National Laws prohibiting female genital mutilation by country and date of enactment.

Country	Data source	National Law
Benin	DHS 2006	Yes
Burkina Faso	MICS 2006	Yes
Cameroon	DHS 2004	General provisions of criminal codes that can be applied to FGM.
Central African Rep	MICS 2008	Yes
Chad	DHS 2004	General provisions of criminal codes that can be applied to FGM.
Côte d’Ivoire	MICS 2006	Yes
Djibouti	MICS 2006	Yes
Egypt	DHS 2008	Yes
Eritrea	DHS 2002	Yes
Ethiopia	DHS 2005	Yes
Gambia	MICS 2005/06	No

Country	Data source	National Law
Ghana	MICS 2006	Yes
Guinea	DHS 2005	Yes
Guinea-Bissau	MICS 2006	General provisions of criminal codes that can be applied to FGM.
Kenya	DHS 2008-09a	Yes
Liberia	DHS 2007	No
Mali	DHS 2006	General provisions of criminal codes that can be applied to FGM.
Mauritania	MICS 2007	Yes
Niger	DHS 2006	Yes
Nigeria	The Guardian 2015	Yes
Senegal	DHS 2005	Yes
Sierra Leone	MICS 2006	No
Somalia	MICS 2006	No
Sudan	no information	
Tanzania	DHS 2004/05	Yes
Togo	MICS 2006	Yes
Uganda	DHS 2006	Yes
Yemen	PAPFAM 2003	Yes

a. Preliminary report.

b. DHS=Demographic and Health Surveys, MICS=Multiple Indicator Cluster Surveys, PAPFAM=Pan Arab Project for Family Health

Source: Adapted from Felman-Jacobs and Donna Clifton (2010), The Guardian (2015).

5.1.3 Legislation and legal opinions in Canadian legislations

Since there are over 766,000 African immigrants in Canada (Statistics Canada 2013), it is important to discuss the context here. Even though the country prides itself as a human rights supporter and that female genital mutilation has been criminalized, there is evidence to suggest that the practice is alive and well here (Fraser 1994). According Kellner (1993), it was not until the arrival of larger numbers of immigrants from Africa that we began to learn of the procedure. As early as 1994, the Parliament of Canada released a statement on female genital mutilation:

We are well aware that this practice is carried on in Canada by immigrants to this country' (Canada 1994:6298). Criminalisation is seen as a panacea: 'It must be made clear to Canadians and those who come to our country that genital mutilation is not only unacceptable as a matter of principle, but also not accepted and severely punished, since it is in fact a crime (Canada 1995: 15075).

Val Meredith, former Member of Parliament, indicates that this cultural practice involves “a wide variety of concerns: legal, medical, immigration and multicultural” (Canada 1995:15073). In 1994, the Canadian Advisory Council on the Status of Women persuaded the Minister of Justice to enact measures against practice (Ferguson & Ellis 1995, Hussein et al. 1995).

Surprisingly, this is not a hidden epidemic in Canada. The WHO identified Canada as one of 40 countries currently and implicitly supporting female genital mutilation due to the large number of immigrants from countries that routinely practice it (Priest 1994, Thompson 1994). The government has responded by stating categorically that any person who engages or facilitates in the carrying of this practice should be charged and persecuted (Perron et al 2013). The 1997, Bill C-27 was passed to amend the Criminal Code by specifically defining any form of female genital mutilation as an aggravated assault punishable by up to 14 years imprisonment

when performed on females under the ages of 18 and for non-therapeutic reasons (House Government Bill C-27, Vienneau 1996, Buhagiar 1997, Shaw 2004). The *Canadian Criminal Code* 119 also identifies it as an illegal and criminal act and bans the procedure even by qualified health personnel (Perron et al 2013). In addition, Canada has signed and ratified *The Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, CEDAW and CRC to aid in addressing the rights of females exposed to female genital mutilation (UN Treaty Collection 2015).

It is not surprising that as the numbers of African immigrants began to increase in 1992, Canadian health organizations such as the Council of Physicians and Surgeons of Ottawa and Ontario reported an increase in the number of immigrants arriving in the country and the number of requests for this practice (Taylor 1992, Ferguson & Ellis 1995). They cautioned their licensed members that engaging in female genital mutilation by any means would be considered professional malpractice and prosecuted as such (Buhagiar 1997). The Federal Interdepartmental Working Group on Female Genital Mutilation also considers this practice as a physical abuse of a child and should be reported to child protection authorities for action (Perron et al 2013).

The provinces have followed the federal government's lead and there are statutes such as Ontario's *Child and Family Services Act*, Quebec's *Youth Protection Act*, and British Columbia's *Child, Family and Community Services Act* adopted by the provinces to protect the fate and rights of children (Ferguson & Ellis 1995). In Manitoba, specific legislation has not yet been passed. However, the *Child and Family Services Act* requires that anyone with knowledge that, or who has reason to believe that, a child has been physically, sexually or emotionally harmed or is at risk of experiencing such harm must report this child abuse (C. Laurie 2015 personal communication with Lori Wilkinson).

The Ontario FGM Prevention Task Force which was created in 1994 and led by Marion Boyd, former Minister Responsible for Women's Issues brought together stakeholders including concerned citizens, policy analysts, Ontario Provincial Police, and other legal bodies (Ferguson & Ellis 1995). They were tasked to make accessible information on how to educate the society on all the implications of female genital mutilation as well as guidelines for charging perpetrators (Ferguson & Ellis 1995). In addition, the Federal Interdepartmental Ad-Hoc Working Group on Female Genital Mutilation (a federal/provincial/territorial group) made up of members from Citizenship and Immigration Canada, Status of Women Canada, Departments of Justice, Human Resources Development Canada, Canadian Heritage and Health Canada had the same objective of eradicating this practice among immigrants. Interestingly, this group has not met regularly and is currently disbanded (Hussein et al. 1995). This may be an indication of the waning interest of the federal and provincial governments on this issue.

Although the country's interest in female genital mutilation is high, particularly among media organizations, there has been little in terms of large-scale research in Canada on the prevalence, maintenance and eradication of the practice. The concern of many studies is that, we do not impose our values on their cultural values and practices as we prefer an integrationist approach to settlement rather than an assimilation model. Another reason for the lack of research interest in the topic is due to its extremely sensitive nature. Victims of female genital mutilation are often reluctant to talk to researchers least they be judged or publicly identified. This fear means the practice is driven further underground in Canada.

Shaw (2004) points out that, some African immigrants in Canada desire to preserve their traditions and integrate into Canadian community, which results in a clash between "their values" and "our values". This may explain the government's reluctance to prosecute those who

continue the practice here in Canada. In 2002, the *Globe and Mail* featured a case in St. Catharines, Ontario where a couple was accused of hiring a circumciser to perform the procedure on their 11 year daughter in their home two years earlier. While the parents were arrested and charged with a crime, they refused to identify the person who conducted the procedure and the person remains at large. This is one of only a few successfully persecuted cases in Canada and is an indication of the government's reluctance to persecute others.

Evidence suggests that the procedure still takes place in Canada and may also be perpetuated when parents take their children on summer holidays to their country of origin for the express purposes of having the procedure done. The title of a recent article by CNN (2015) explains it all "Female genital mutilation: why Egyptian girls fear the summer". Summer holidays is a popular time for immigrants to return to their homeland with their female children so they have time to recuperate from the procedure before school begins in September.

Emphasis on eradication seems to focus on educating African immigrants. The focus now is, educating immigrants from Africa to have knowledge of Canadian laws, particularly section 19 of the Criminal Code which makes it clear that "ignorance of the law by a person who commits an offence is not an excuse for committing that offence" (R.S., c. C-34, s. 19). There is also criticism of the education-first model. Members of Parliament support this view stating that "(e)ducation and prevention are fine, but that is just not enough. Monitoring needs to be instituted to find, denounce and, more importantly, punish offenders for real" (Canada 1995: 15075). We must tread carefully when "educating" the immigrant population. There are several instances where education and criminalization of immigrants and their values has backfired. In 2007, Hérouxville Québec received international media attention due to the publication of the

Immigrants' Code of Conduct which tried to 'educate' immigrants about behavior that was mostly cultural differences.

According to the former Quebec Immigration Minister Yolande James, "immigration into Quebec is a privilege not a right" (Chung 2009) and that, immigrants should be required to follow the laws of Canada. One of the list of standards stated; "we consider as undesirable and prohibit any action or gesture that would be contrary to the above statement such as: killing women by lapidation or burning them alive in public places, burning them with acid, excising them, infibulating them" (Municipality of Hérouxville 2007). On the surface, this legislation seems reasonable, but if we were to read more closely, we find a rather xenophobic, patronizing and disrespectful tone regarding immigrants and culture. For instance, within the document, women are allowed to dance, drive, and make their own decisions.

The declaration was subsequently criticized by most human rights organizations in Canada and internationally, but the tone is reflected in the now-resurrected *Quebec Charter of Values*, discussions which are currently ongoing under the provincial government (Assemblée Nationale Quebec 2014). What these and similar laws and proclamations do, however, is further marginalize the African community even if members do not practice female genital mutilation because they are embedded within a context of condemnation rather than education and understanding. Furthermore, these proclamations presume all Africans want to continue this practice which is clearly incorrect.

As we have seen with the African experience, the move to eradicate the practice through criminalization has not been successful. Similarly in Canada, criminalization has not worked and neither has public shaming through codes of conduct such as those in Hérouxville and in Quebec. Salam Elmenyaw, president of the Muslim Council of Montreal has expressed her concerns on

the Hérouxville code that “regular laws that govern the majority sometimes cause injustice if applied to a minority” (Coggins 2007). So while we understand and define female genital mutilation as a crime and as a human rights injustice, embedding other cultural issues within such codes of conduct is doomed to failure. From the immigrants’ stand point, what this code and others achieve is to criticize entire cultural belief systems and is an example of Canadian intolerance of cultural difference in general.

There are other instances where culture has been criminalized. The more recent bill S-7, the *Zero Tolerance for Barbaric Cultural Practices Act* attempts to address various immigrant cultural practices and values which are “incompatible with Canadian values” (The Canadian Press 2014, Browne 2015). First, including the word “barbaric” within the title is not only disrespectful, but it is also racist. NDP immigration critic Jinny Sims suggests that the title implies that entire cultures are incompatible with being Canadian (Teitel 2013). Using sensationalistic, emotionally laden words serve to further marginalize immigrant and minority groups and do little to address what are clearly human rights abuses such as female genital mutilation.

Much like in many African countries, issues of sexuality and female genital mutilation are regarded as private matters which should not be discussed openly (Perron et al 2013), and this pattern seems to follow to Canada, to a certain extent. Canada is signatory to many international conventions that criminalize this practice and we have enshrined its prohibition within our own criminal law, but we do very little to enforce it.

Mary Jane Ierodiaconou (1995) reminds us that there are some unintended consequences of criminalizing female genital mutilation. First, criminalizing the practice may result in some women who begin to view their circumcised mothers and grandmothers as criminals. Second,

these laws also chastise these females who have been exposed to the practice as passive “victims” of this cultural practice who may have to hide their shame. This is a real and life-changing consequence. As in Shell-Duncan (2001) finds, criminalization has meant that those who experience complications from the procedure avoid the hospitals and other health centers so that they are not reported to the police. Similar situations have been documented in Indonesia and Senegal where the practice has gone underground, “in secret, sometimes unhygienic, back-street operating rooms – creating a big risk of infection.” (IRIN 2010).

Interference in cultural practices without the explicit cooperation of members of the group tends to put women in danger (London Black Women's Health Action Project 1989). The London Black Women’s Health Action Project has shown that criminalizing the practice has not reduced the number of females in the United Kingdom who undergo the procedure. Instead, it has made the procedure more dangerous as untrained “traditional” circumcisers now conduct the procedure completely in secret (Armstrong 1991, Kellner 1993). Those experiencing complications are scared to go for medical treatment because of the criminalization and judgment associated with the practice and this happens regularly in Canada (Izett & Toubia 2000, Scott & Murphy 2000).

It does not help when medical practitioners and organizations describe women who are in need of specialized obstetric attention because of botched underground circumcision procedures are “referred to as mutilated, thought of as pawns and have been the subject of ‘inappropriate’ sympathy” (Shaw 2004:50). Ierodiconou (1995) further shows that immigrant parents of circumcised females fear of sending their daughters to the hospitals with issues unrelated to female genital mutilation because they are unsure of the reception they would receive. They

feared being reported to the police and child welfare services since the practice has been criminalized which further jeopardizes the health of these girls.

Lafave & Scott (1972) assert that “(t)he broad purposes of the criminal law are, of course, to make people do what society regards as desirable and to prevent them from doing what society considers to be undesirable”. Rightly so, the laws and policies criminalizing female genital mutilation practice serves as governments’ way of addressing deep social injustices and human rights violations. The problem that arises however is that, immigrants who engage in female genital mutilation do not consider the practice to be undesirable. To them these laws appear to be oppressive and critical to their sense of identity. As such in Canada, this results in stigmatization and victimization of African immigrants as misfits setting them apart from the Canadian norms and social integration (Shaw 2004).

Sigurdson (1993) introduces the term “Charterphobia” to make his argument that perpetrators of this practice can legally use the multiculturalism as a basis to defend and uphold female genital mutilation and other practices. Supporters of this practice point out that, cultural practices are protected in the *Canadian Charter of Rights and Freedoms* and *Canadian Multiculturalism Act* (Shaw 2004). The *Canadian Multiculturalism Act* in addition indicates in section 3(1) that, it is the policy of the Government of Canada to “recognize and promote the understanding that multiculturalism reflects the cultural and racial diversity of Canadian society and acknowledges the freedom of all members of Canadian society to preserve, enhance and share their cultural heritage”. In essence, there must be sensitivity towards different cultures, respect, recognition and acceptance (Canada 1995:15074).

Scholars concerned with this cultural practice and the debates surrounding it have questioned the extent to which groups should be allowed to engage in a practice which is

popularly perceived as a rights violation, an abuse with associated health implications. In a multicultural state, does multiculturalism mean there should be tolerance and acceptance of practices which conflicts with their values and beliefs? If this is the case, then there is a risk of having a unified and well-grounded Canadian society as there would be no integration but “cultural walls” which separates Canadians from immigrants, Canadian culture from African or Asian culture, Christians from Muslims, among others (*Globe and Mail* 2010). Such fear resulting from multiculturalism is what Phil Ryan (2010) terms as “multicultiphobia”.

The fears of concerned Canadians are not entirely baseless as sensitivity towards foreign cultures, beliefs and practices has the tendency to cause problems, tensions and challenges in conforming to a particular rule. From the view point of the media, government, authors and media, appreciation of multiculturalism creates “ethnic ghettos”, “anything-goes relativism”, “cultural genocide”, and a “masochistic celebration of Canadian nothingness” (*Vancouver Sun* 2010 no page, Drouin 2007) such that sensitivity breeds a breakdown of what Canada may stand for. Anti-multiculturalists have pointed out how diversity in the state of Canada’s situation encourages free expression of all manner of behaviours, practices, values, and agendas which are mostly displayed by minority cultures and communities (Ryan 2010). In the case of female genital mutilation, criticizing the practice has been described as an attack on African immigrants by western societies.

There is a danger that criticism of such practices, if not done with understanding, could be considered as a form of racism. Phil Ryan (2010) finds that some valid criticisms of multiculturalism are attacked as “racists” or “xenophobic.” The conundrum with multiculturalism is this, on one hand, the policy is intended to recognize and support minority cultures multiculturalism, promotes social inclusion and helps integrate minorities into the

mainstream which is essential for the social inclusion and cohesion, a view shared by a majority (Ryan 2010). Females entering Canada who have already undergone the procedure need to feel safe in their new home and to be able to integrate without judgment. On the other hand, we need to recognize that there are limits to liberty. Beliefs around the appropriateness of female genital mutilation are one area of concern. On one hand, we want to be inclusive, particularly to women who have been subjected to this practice. On the other hand, we do not want to be judgmental about cultural norms and differences. Clearly female genital mutilation is a human rights violation, so how can we as Canadians criticize it in such a way that does not exclude its victims and is respectful of cultural norms around sexuality? This has proven to be very difficult to enforce as girls continue to be victimized by the procedure even after they move to Canada.

5.2 Summary

This chapter identified existing laws in Africa and Canada and international declarations to assist us in understanding why female genital mutilation persists. The next chapter concludes with a summary and an examination of how cultural relativism and feminist human rights perspective can help us to understand why the practice persists despite widespread condemnation.

CHAPTER 6- Conclusion

This chapter concludes by detailing how the theories of cultural relativism and feminist human rights help to explain the persistence of female genital mutilation in Canada and in African countries that have banned the practice. It summarizes the case against the cultural relativist position and the case for a feminist human rights perspective in the female genital mutilation debates. I will highlight some areas for future research along with policy implications and conclude with a discussion of the strengths and weaknesses of the present study.

6.1 How cultural relativism explains the persistence of female genital mutilation

Cultural relativist theory and the feminist human rights perspective are useful in understanding the maintenance of female genital mutilation and in determining its worth. Proponents of cultural relativism, including many anthropologists, suggest that the practice is a vital part of cultural identity, prestige and self. Cultural relativism reminds us that we cannot use our own culture as the comparison point for judging others. Every culture has different views of marriage, family systems, social cohesion, expressions of love and body modifications, and female genital mutilation can be considered as one of those differences.

In many cultures, female genital mutilation serves a very necessary role in the present and future lives of some African females. The argument by communities and individuals who engage in this practice is important as cultural differences need to be respected, no matter how abhorrent (Mendelsohn 2004). To cultural relativists, African immigrants should be given the right to continue this practice as outsiders should not judge the utility of another's culture (Goldstein 1994, Sams 1986). They believe that cultural preservation is important and should not be influenced by outsiders.

Supporters of the practice acknowledge that not all women have bad experiences or face the associated health risks of this practice. Hence, their commitment to historical, religious and cultural traditions supports their continued engagement in it. This sentiment likely goes a long way towards helping us understand the persistence of this practice. Koso-Thomas' (1987) early reports on female genital mutilation presents the argument that, some of these women do not feel victimized by the practice as it does not take away anything valuable from them. For practicing groups, it is about making the best choices about their health and well-being which is guaranteed by going through the necessary female genital mutilation procedures in order to avoid a worse fate (Kopelman 1994) such as social stigmatization, isolation and loneliness (due to lack of being able to find a suitable mate within the community).

Rightly or wrongly, many who support cultural relativism equate the practice with the circumcision of male infants and suggest that criticism of the practice with females is rather contradictory given the prevalence of male circumcisions in other cultures and religions. Many detractors of female genital mutilation, conversely, will point to disastrous results such as loss of sexual feeling, loss of penile tissue or even the penis itself and that in rare cases, a minority of boys die of infections caused by circumcision. The bottom line for those who practice female circumcision is that it is the accepted way of doing things. Its supporters argue that every female around them undergoes the procedure; it is an integral part of their culture and religion and anything that challenges it is met with opposition. Any criticism by outsiders is seen as an unlawful intrusion on their culture and an imposition of colonization on their way of life. Some Africans who engage in this practice see it as their right to decide what is best for them, their well-being and their families. For parents, especially mothers, the act is one born of love; the love they have for their daughters cannot be compromised even if going through female genital

mutilation is painful, they would rather subject them to the procedure than to have their daughters ostracized and partnerless for life.

Scholars also point out the hypocrisy of western societies in condemning such practices when its own women seek genital modifications such as vaginal rejuvenation. They deem this cultural practice is similar to female genital mutilation because it is done to enhance an individual's sense of self-worth, health, sexuality, values, and power. They point to the increase in vaginal cosmetic surgeries. Sometimes nicked-named "designer vaginas", vaginal plastic surgery is becoming more popular despite the fact it has no medical benefits (similar to female genital mutilation), has potential risks (similar to female genital mutilation), and is extremely costly (unlike female genital mutilation). For many women, this procedure is deemed necessary as overly large labia minora are considered as embarrassing since, in extreme cases, the labia can stretch downward as far as one's thigh (Summerfield 2004). For supporters of the cultural relativist perspective, we need to acknowledge that, perceptions about body modifications are relative and based on what one seeks or believes to get out of it. For these females, the "designer vagina" has become a matter of personal decision much like the decisions made about female genital mutilation in African societies.

Questions about who has the right to make decisions, particularly when related to culture and medicine, are tricky and have gained widespread media attention recently. We can draw an interesting parallel in Canada regarding consent, medical decisions and culture. Two (unrelated) First Nation families have successfully sued the Ontario provincial government for forcing medical treatment of their young children, both who were diagnosed with acute lymphoblastic leukemia in 2014. Both families successfully argued that it was their right as First Nations persons to seek traditional healing and to not have medical decisions forced upon them by

western medical professionals. Both families and their children felt that western treatments were exacerbating their leukemia symptoms and negatively affecting their quality of life. One of the mothers felt that the regime of chemotherapy was akin to “poison” and refused to consent to her daughter receiving further treatment (Walker & Luke 2014).

In his ruling for one family, Justice Gethin Edward stated that that the McMaster physician treating one of the girls simply wanted to “impose our world view on First Nation culture” (Hopper 2014). In support of the family, the judge states that “it is a decision made by a mother, on behalf of a daughter she truly loves, steeped in a practice that has been rooted in their culture from its beginnings and that right is not dependent on the treatments being proven to work according to the ‘Western medical paradigm’” (Blackwell 2014). Sadly, one of the girls died in January 2015. The other remains on the strict traditional medicine regimen but her medical records remain anonymous. A cultural relativist would ask how are these cases of the Aboriginal families and female genital mutilation different? In both cases, the decisions made by family members are done with love and best interest for their daughters. In the leukemia cases, the families rejected western medicine, and in the female genital mutilation case, they reject western society’s definition of beauty and normality. In both cases, parents are simply thinking of the best interest of their children.

Cultural relativists would argue that we need to medicalize the procedure to protect the girls who experience it. Making it medically accessible and acceptable will mean fewer complications and fewer deaths. To some, closing the door to sterile medical intervention is the real human rights tragedy. Yet it remains difficult to support the arguments forwarded by cultural relativists in support of the practice. At some point, the negative aspects of a cultural practice must be honestly acknowledged.

6.2 How feminist human rights perspective rejects the practice of female genital mutilation

There are indeed real human rights abuses related to this practice. There are several “inconvenient truths” that are ignored by supporters of this practice. This is where feminist human rights perspective can help in the eradication of female genital mutilation, if not only for rights issues but for health and wellbeing of those exposed to the practice. This perspective rejects the arguments forwarded by cultural relativists, they point to several flaws in their arguments. First, according to Macklin (1999:24), “if a cultural practice produces manifest suffering or produces lifelong physical disability, there are good grounds for judging that practice to be ethically wrong”. We can point to the hundreds of injuries and deaths linked to this practice which even though it cannot be equated to circumcision in males because the procedure for females no matter how it is done, is significantly more invasive. I have discussed these already in previous chapters.

The feminist human rights theory has also helped to understand how and why international bodies frame and present female genital mutilation as a violation of human rights. This theory is well grounded in addressing female rights arguments as it develops laws to focus on issues that affect women directly. Female genital mutilation, from the feminist human rights perspective, violates most internationally accepted human rights. These international documents highlight elements of torture, or other cruel, inhuman, or degrading treatment or punishment as a violation of women’s rights which violators must be held accountable for (Lewis 1995) and, unlike elective “designer vaginal” surgeries, those undergoing the procedure are well below the age of consent thus, violating various national and international laws.

Feminist human rights perspective helps us identify the elements of gender inequality and patriarchy embedded within this practice. This practice perpetuates inequality and patriarchy and

according to feminist human rights theory, is forced upon girls in order to become “acceptable and recognized” members of a community while males do not. Feminist human rights perspective also points out to the patriarchal basis of the procedure. One of the rationales of the practice is to reduce the libido of females and those without the procedure are doomed to a label of promiscuous which is never used on men. The social forces which drive this practice in communities when critically examined reveal that the practice is more for the benefit of men. Circumcised women bring honour to their fathers, are a signifier of chastity before marriage because men prefer virgins, bring increased sexual fulfillment for men (because of a belief that circumcised females bring more sexual pleasure), and because females who have undergone the procedure are deemed to be morally upright. As such, feminist human rights perspective sheds light on the patriarchy embedded within this practice and how women continue to be exploited socially, culturally and financially because of it.

The feminist human rights perspective also questions why men get to decide what is appropriate and is in the best interest of females. Having control over women allows men to hold more power, resources and determine the affairs of their families and the societies in which they live. As some research has found, even in societies where women conduct a majority of the infibulations, patriarchy is part of the reason it persists. When asked why women mutilate other women, the response is that this is one of the few times where women get to exercise some power in society. By being the primary cutters, women determine who and when circumcisions are conducted, but it is the men who demand that the practice continue by enforcing strict standards of virginity, chastity, and visions of the “ideal” vagina among potential brides.

Feminist human rights perspectives can help inform policies to eradicate this practice once and for all. It recognizes that norms of societies and religions constantly change and that

arguments forwarded by cultural relativists in support of the practice do not recognize that culture, society, religion and opinions change and that, some historical and cultural practices are indeed very harmful. Furthermore, feminist human rights perspectives will be helpful for medical associations as they work to incorporate culturally sensitive approaches in dealing with females who have gone through female genital mutilation as these survivors need support and re-education on what constitutes actual proper health and well-being. As such, policies and laws which focus on criminalizing this practice need to be supplemented with other women-centered solutions to produce more realistic outcomes.

6.3 Possible solutions to eradicating female genital mutilation

One of the major observations I can make is the extent to which both women and men support patriarchy and the hatred of women. Supporters of female genital mutilation insist that women's genitals are ugly, too masculine, dangerous and unclean, and these labels are used only to describe female genitalia. Similarly, the labels linked with female sexuality include the words "dangerous" and "promiscuous" and women in their "natural state" (uncircumcised) must be prevented from endangering the morality of men. One of the only ways I think this practice can be wholly eradicated is by educating men and women, particularly in regards to a better understanding of the physiology of sex and the right to sexual fulfillment. Women have a right to their sexuality and a right to enjoy sex. They also have a right to consent to any form of body modification. Neither of these conditions exist when a female is circumcised.

Perhaps the medical profession can be used as a primary educator, especially among immigrants. From their direct contact with females during physical examinations, they can offer more informed information with regards to possible complications and health risks based on proper training and learning they would have received themselves. They should also be reminded

of their professional oath to ensure the health and well-being of people so as to desist from engaging in the practice. They can also educate men about the importance of sexuality and the myths regarding female genitalia. Several community service organizations who help immigrants settle have also engaged in educating the newcomer population against this practice. For instance, in Winnipeg, the Sexual Education Resource Centre, has several programs that help educate newcomers about the dangers and human rights abuses associated with the practice. These organizations, however, tend not to be well funded so programs tend to die for lack of stable funding.

Only with the eradication of this practice can we talk about women and equality. Many of the countries that continue to have high rates of female genital mutilation tend to be those with the fewest economic opportunities for women. For instance in Sudan, a country with one of the highest rates of this practice, women earn significantly lower salaries than men regardless of the levels of education. More alarmingly, only 12 percent of women are employed (Shimeles & Verdier-Chouchane 2012, African Development Bank Group 2012). In addition, the inconveniences that females face tends to even affect their full engagement and movement in the work-field, as women in some tribes are forbidden to be seen in public with men other than family members or *muharram* (guardians appointed by the family).

Hence, governments, therefore, must work towards alleviating the poor socioeconomic status of these women as they are addressing other issues related to equality. This begins with changing the culture of society and engaging women in this process. Giving women a sense of purpose will go a long way to give them a sense of self-worth and power. Empowering women through education, work, and health will help alleviate the practice as well. Support should be given to encourage dialogues among African females and immigrants in Canada to provide a safe

and free environment to talk about female genital mutilation and the challenges faced. By supporting the independence of the women, this will enable them to appreciate their rights and fight for them both privately and publicly. These essential changes in the dynamics of the community setup will better the fate of most females and most importantly, a break away from this cultural practice. Communities must be involved in this process because change needs to occur from the ground up. Otherwise, it will be very easy for those supporting female genital mutilation to reduce these programs to interference by western-backed colonial feminists.

Changing preferences about beauty and what is sexually acceptable may take several generations to implement but is central to this process. Part of this can be accomplished by encouraging communities to change their language and thoughts about beauty and that the “natural” female form is one that ought not to be changed. After that, serious discussion of health, wellbeing and rights with regard to female genital mutilation can be conducted. Cultural relativism has helped perpetuate the practice and feminist human rights perspective has been unable to convince the masses of the violations involved in this practice. The rationale for preserving this practice for most Africans is that group rights must supersede individual rights. Our fear of questioning tradition, values and norms of another culture should not prevent us from criticizing the practice as there are real human rights violations.

The feminist human rights perspective reminds us to be mindful that this is a deeply embedded cultural and patriarchal practice contributing to gender discrimination, coercion, child abuse, physical, mental, and sexual abuse. We must not be afraid to point out the human rights violations and forcefully prosecute those who break national and international laws. Prosecution must have strength and meaningful punishments otherwise the practice will continue.

6.4 Strengths, weaknesses and areas for future research

As with all research, this thesis has some strengths and weaknesses. Its greatest strength is that it synthesizes a large body of research and international laws to try to understand the longevity of this practice. Along the way, I have developed uncovered new data that highlight various aspects of this practice worldwide. As a result, this work helps to understand why criminalization of this practice has not been successful. Its weaknesses can be associated to the fact that because secondary sources are used means that the voices of the women themselves have not been heard. In essence, not interviewing survivors of female genital mutilation in Canada or Africa, as well as interviewing community service providers, or physicians about the practice means relying on the limited data available.

This research however, is a necessary first step towards a larger research project which can tackle the viewpoints of the women themselves as well as men. In light of this, future research can examine the relationship between socio-economic factors, country of origin, religion and ethnicity on the practice of female genital mutilation, whether the changing status of women is beneficial in breaking the hold that female genital mutilation has on females and lastly a study on the impact that laws and policies has had on second generation African immigrants with regards to changing their perceptions on this cultural practice. It would also be interesting to find out the role of medical practitioners in Canada in curbing or furthering the engagement in this practice as there is much grey area in the exiting literatures. For immigrants who are still strongly attached to this practice, how are they handling integration in the Canadian society when the very values that define part of their identity is challenged? Furthermore, based on the controversies surrounding the negative impact of female genital mutilation procedures on

females, more grounded research can be done in this area to examine the extent of these complications and implications.

6.5 Conclusion

Strange as it may seem, some people remain willing to defend a harmful practice (Reymond et al. 1997). For some, the issue of female genital mutilation is clear; it is a human rights violation and must be eradicated. For others, the issue is cultural preservation and the recognition that practices should not be judged as right or wrong.

Scholars, researchers, activists, and policy makers worldwide have for the most part, condemned the practice of female genital mutilation yet it persists both in Canada and in Africa. Some of the reasons the procedure persists are due to religiously based myths, patriarchy, and criminalization. Criminalization of female genital mutilation has not been successful because of the inability of these laws and legal systems to address the roots of the elements which opposes it; the economic security that this cultural practice guarantees these females, community belongingness, the social and political relevance it also gives these females and in essence failing to recognize the fact that if the law takes female genital mutilation away, it is actually taking away these factors.

It is helpful to acknowledge that perceptions among some Africans have changed and that some communities have been successful in reducing the number of girls exposed to the procedure. However, this research shows that clearly, the strategy of criminalizing has not eradicated this practice anywhere.

REFERENCE

Abdalla M., A. Omer, and K. Elmusharaf. 2012. "Female genital mutilation in Sudan: what do men think?" *Contraceptions*, vol. 85(3) article 317.

Abusharaf, Rogaia Mustafa. 2001. "Virtuous Cuts: Female Genital Circumcision in an African Ontology" in *differences, A Journal of Feminist Cultural Studies* 12(1):112-140.

Admin. 2014. "New laws aimed at protecting immigrant women." Sharenews. Available at <http://sharenews.com/new-laws-aimed-at-protecting-immigrant-women/#sthash.tl2inpGg.dpuf>

Afkhami, Mahnaz. 2001. "Women, Gender, and Human Rights: A Global Perspective" in *Gender Apartheid, Cultural Relativism, and Women's Human Rights in Muslim Societies*, M. Agosin, ed. (New Brunswick, New Jersey: Rutgers University Press) 234- 245.

African Development Bank Group. 2012. South Sudan Interim Country Strategy Paper 2012-2014. Available at;
www.afdb.org/fileadmin/uploads/afdb/Documents/Project-and-Operations/2012-2014%20-%20South%20Sudan%20-%20Interim%20Country%20Strategy%20Paper.pdf

Al-Ariqi, Amel. 2007. "YEMEN: 24 percent of Yemeni women experience genital mutilation." *Yemen Times*. Available at
<http://www.fgmnetwork.org/gonews.php?subaction=showfull&id=1171338119&ucat=1&>

Annas, Catherine L. 1996. "Irreversible Error: The Power And Prejudice Of Female Genital Mutilation", *Journal of Contemporary Health Law and Policy*. 12:325-340

Armstrong, Sue. 1991. "Surgical child abuse: the battle to stop female circumcision in Britain", *New Scientist*, at 46 (quoting Efua Dorkenoo, Director, Foundation for Women's Health Research and Development (FORWARD))

Badri, R. 1999. "Letter to the editor". *Awaken* 3(3):1

Banda F. 2003. *National legislation against female genital mutilation*. Eshborn, Germany: German Technical Cooperation

Bielski, Zosia. 2007. "Cautious criticism; A Growing Number Of Activists Are Hesitant To Decry Female Genital Mutilation," *National Edition. National Post [Don Mills, Ont]* August 25:A6

Blackwell, Tom. 2014. "Aboriginal woman has right to take cancer-stricken daughter out of chemotherapy, judge rules." *National Post*. Available at <http://news.nationalpost.com/2014/11/14/aboriginal-woman-has-right-to-take-cancer-stricken-daughter-out-of-chemotherapy-judge-rules/>

Boddy J. 1989. *Wombs and Alien Spirits: Women and Men in the Zar Cult in Northern Sudan*. Madison, WI: University of Wisconsin Press

Boddy J. 2007. "Gender crusades: the female circumcision controversy in cultural perspective". In: Hernlund Y and Bettina Shell-Duncan, eds. *Transcultural Bodies. Female Genital Cutting in Global Context*. New Brunswick, NJ: Rutgers University Press

Boulware-Miller, Kay. 1985. "Female Circumcision: Challenges to the Practice as a Human Rights Violation." *Harvard Women's Law Journal* 8:155-158.

Boyle, Elizabeth Herger. 2002. *Female Genital Cutting. Cultural Conflict in the Global Community*. Baltimore: John's Hopkins University Press.

Bransfield, Elizabeth. 2003-2004. "Female Genital Mutilation- An MA Thesis in Gender, Anthropology and Religion." Available at <http://www.users.globalnet.co.uk/~lavie/fgm/dissertation.html>

Brennan, Katherine. 1989. "The Influence of Cultural Relativism on International Human Rights Law: Female Circumcision as a Case Study." *Law and Inequality*.7 (367): 367-398.

Brown, I.B. 1866. *On the curability of certain forms of Insanity, Epilepsy, Catalepsy, and Hysteria in females*. London.

Browne, Rachel. 2015. "Against their will: Inside Canada's forced marriages", *Macleans*. Available at <http://www.macleans.ca/news/canada/against-their-will/>

Bryman, A. 2008. *Social Research Methods*. 3rd ed. New York: Oxford University Press.

Buchignani, Norman. 2008. "Sikhism". Revised by Doris R. Jakobsh. 2014. Available at; <http://www.thecanadianencyclopedia.com/en/article/sikhism/>

Buhagiar, Lawrence C. 1997. "Criminalising Female Genital Mutilation in Canada: The Excision of Multiculturalism?", *Current Issues in Criminal Justice* 9(2). School of Criminology, Simon Fraser University

Bunch, Charlotte. 1994. "Strengthening human rights of women." In World conference on human rights, Vienna, June 1993: *The contributions of NGOs: Reports and documents*, ed. Manfred Nowak. Vienna: Manzsche Verlag Universitatsbuchhandlung.

Canada. 1995. "House of Commons Debates", *Hansard* pp. 15073-15076.

Cassman, Rachelle. 2007. "Fighting to Make the Cut: Female Genital Cutting Studied within the Context of Cultural Relativism", *Northwestern Journal Of International Human Rights* 6(1):128-154

Center for Reproductive Rights (formerly the Center for Reproductive Law and Policy (CRLP)). 2005. *Female Genital Mutilation: Legal Prohibitions Worldwide*. New York: Center for Reproductive Rights.

Chalmers, B and Omer-Hashi, K. 2002. "What Somali women say about giving birth in Canada". *J Reprod Infant Psychol* 20:267–82.

Chase, Cheryl. 2002. "'Cultural Practice' or 'Reconstructive Surgery'? US Genital Cutting, the Intersex Movement and Medical Double Standards' in James S. and Robertson C. (eds.) *Genital Cutting and Transnational Sisterhood*. Disrupting US Polemics Chicago: University of Illinois.

Cheryl, Laurie. 2015. Manitoba's department of Status of Women. Personal communication with Lori Wilkinson.

Chung, Andrew. 2009. "Quebec culture lessons for immigrants questioned". Available at http://www.thestar.com/news/canada/2009/12/30/quebec_culture_lessons_for_immigrants_questioned.html

Cobbah, Josiah. 1987. "African Values and the Human Rights Debate: An African Perspective." *Human Rights Quarterly* 9:309-325.

Coggins, Jim. 2007. "Quebec struggles with accommodation of minorities". Available at <http://canadianchristianity.com/national-updates/>

Committee on the Elimination of Discrimination against Women's General. 1990. Recommendation No. 14 (Ninth session), UN GAOR, UN Doc. A/45/38. Available at: United Nations <<http://www.un.org/womenwatch/daw/cedaw/recomm.htm>>.

Costelloe, Sinéad. 2010. "A Comparative Analysis of the Strategies for Eradication in France and The Netherlands." MA Thesis, Department of Political Science, University of Victoria, British Columbia-Canada.

Crossman, Ashley. 2014. "Feminist Theory." Available at <http://sociology.about.com/od/Sociological-Theory/a/Feminist-Theory.htm#>

Danial, Sandra. 2013. "Cultural Relativism vs. Universalism: Female Genital Mutilation, Pragmatic Remedies." *Prandium - The Journal of Historical Studies* 2 (1): 1-10

Dillon, Susan A. 2000. "Healing The Sacred Yoni In The Land Of Isis: Female Genital Mutilation Is Banned (Again) In Egypt." *Houston Journal Of International Law* Vol. 22:2

Dorkenoo, Efua and Elworthy, Scilla. 1992. *Female Genital. Mutilation: Proposals For Change*. 3rd eds.

Dorkenoo Efua, 1995. *Cutting the Rose. Female Genital Mutilation. The Practice and its Prevention*. London: Minority Rights Publications.

Dorkenoo E., 2012. *Report Of A Research Methodological Workshop On Estimating The Prevalence Of FGM In England And Wales*. 10 Dean Farrar Street, London Sw1h 0ny.

Drouin, André. 2007. "Solution offered to Premier Jean Charest". Hérouxville public notice.

Edouard, E.,O. Olatunbosun,L. Edouard. 2013. "International efforts on abandoning female genital mutilation", *African Journal of Urology*. doi:10.1016/j.afju.2013.01.005

El Saadawi, Nawal. 1985. "Prisoner of Conscience" in Julie Riggs and Julie Copeland, eds. *Coming Out! Women's Voices, Women's Live*.

Engle, Karen. 1992. "Female Subjects of Public International Law: Human Rights and the Exotic Other Female", *26 New Eng. I. Rev.* 1 509.

Enslar, Eve. 2004. *The Good Body*. 1st ed., Villard

Epelboin, S. and Epelboin, A. 1979. "Special Report: Female Circumcision", *People*, 6 (1), 28.

Federal Interdepartmental Working Group on Female Genital Mutilation. 2000. FGM and health care: current situation and legal status—recommendations to improve health care of affected women. Ottawa: Health Canada. Available at: http://www.cwhn.ca/en/resource_en/results/FGM.

Felman-Jacobs, and Donna Clifton. 2010. Female Genital Mutilation/ Cutting: Data and Trends. Available at <http://www.prb.org/pdf10/fgm-wallchart2010.pdf>

Female Genital Mutilation: A joint WHO/UNICEF/UNFPA statement, World Health Organization, Geneva. 1997, reiterated in 2008.

Ferguson, Ian and Pamela Ellis. 1995. “Female genital mutilation: A review of the literature”. Ottawa: Department of Justice. Available at: http://publications.gc.ca/collections/collection_2011/jus/J3-8-1995-15-eng.pdf

FIGO. 2000. *Recommendations on ethical issues in obstetrics and gynecology*. London: FIGO. Pp.7

Finke, Emanuela. 2006. “Genital mutilation as an expression of power structures: ending FGM through education, empowerment of women and removal of taboos”, *African Journal of Reproductive health* 10(2):13-17

Fortin. Jacey. 2013. “Africa’s Growth Story Brightens.” *Pride News Magazine*. Available at <http://pridenews.ca/?s=female+genital+mutilation>

Fraser, D. 1994. “Heart of darkness: the criminalisation of female genital mutilation”, *Current Issues in Criminal Justice*, 6 (1), 148-151.

Gage A. J., and R. van Rossem. 2006. “Attitudes toward the discontinuation of female genital cutting among men and women in Guinea”, *International Journal of Gynecology and Obstetrics* 92(1):92–96

Garcia, Patricia 1992. "Female Genital Mutilation - A Health and Human Rights Issue". Inter-African Committee on Traditional Practices Affecting the Health of Women and Children Conference, Kenya.

Gillia, Beth Ann. 1997. "Female Genital Mutilation- A Form of Persecution". *New Mexico Law Review*, 579(27).

Goldstein, Taryn F. 1994. "Comment, Cultural Conflicts in Court: Should the American Criminal Justice System Formally Recognize, a 'Cultural Defense?'" *Dick. L Rev.* 99:141-143

Gollaher, David L. 2000. *Circumcision. A History of the World's Most Controversial Surgery*. New York: Basic Books.

Gordon, Natasha M. 1997. "'Tonguing the Body': Placing Female Circumcision within African Feminist Discourse." *A Journal of Opinion*, 25(2): 24-27. African Women in the Age of Transformation: Women's Voices from the Continent, Published by African Studies Association.

Gosselin, C. 2000. "Handing over the knife: Numu women and the campaign against excision in Mali". In B. Shell-Duncan, & Y. Hernlund, *Female circumcision in Africa: Culture, controversy and change* (pp. 193-214), Boulder, CO:Lynne Reinner Publishers.

Grekul, Jana. 2009. "The Right to Consent? Eugenics in Alberta, 1928-1972" in Janet Miron, ed. *A History of Human Rights: Essential Issues* Canadian Scholars' Press.

Gruenbaum, E. 1982. "The movement against clitoridectomy and infibulation in Sudan: Public health policy and the women's movement". *Medical Anthropology Newsletter*, 13:4-12.

Gruenbaum et al, Ellen. 2001. *The Female Circumcision Controversy: an anthropological perspective*. Philadelphia, Pennsylvania: University of Pennsylvania Press

Gunning, Isabelle R. 1991. "Arrogant Perception, World-Travelling and Multicultural Feminism: The Case of Female Genital Surgeries" *Columbia Human Rights Law Review* 23:189-248.

Gunning, Isabelle R. 1992. "Arrogant Perception, World-Travelling and Multicultural Feminism: The Case of Female Genital Surgeries." *23 Colum. Hum. Rts. L. Rev.* 189

Gutbi, Omayma. 1995. Preliminary Report on Female Genital Mutilation (FGM) (Ontario Violence Against Women Prevention Section of the Ontario Women's Directorate, [unpublished].

Guzda, M.K. 1995. "Fight Against Female Circumcision Faces Chauvinist Hurdles." *The Globe and Mail*.

Hopper, Tristin. 2014. "Florida alternative health centre that treated Canadian aboriginal children for cancer a 'scam': former employees." *National post*. Available at <http://news.nationalpost.com/2014/12/11/florida-alternative-health-centre-that-treated-canadian-aboriginal-children-for-cancer-a-scam-former-employees/>

Hosken, Fran P. 1982. *The Hosken Report: Genital and Sexual Mutilation of Females*. 3rd ed. Lexington, MA: Women's International Network News.

Hosken, Fran P. 1989. "Female genital mutilation: strategies for eradication." "Presented at The First International Symposium on Circumcision, Anaheim, California.

Hosken, Fran P. 1992. "Estimated Total Number of Mutilated Women and Girls in East, West, and Central Africa." ed., Women's *International Network News* 29

Hosken, Fran P. 1993. *The Hosken Report: Genital and Sexual Mutilation of Females*. 4th ed. Lexington, MA: Women's International Network. Pg. 3

Hosken, Fran P. 1994. *The Hosken Report: Genital And Sexual Mutilation Of Females* 24:21-35. 4th ed.

Hughes, Karen. 1995. "The Criminalization of Female Genital Mutilation in the United States" *J.L. & Pol'y* 4(321):322-23.

Hussein et al. 1995. "Female Genital Mutilation: Report on Consultations Held in Ottawa and Montreal." Available at <http://publications.gc.ca/site/eng/394210/publication.html>

Ierodiaconou, Mary-Jane. 1995. "Listen To Us! Female Genital Mutilation, Feminism And The Law In Australia." *Melbourne University Law Review* Vol 20:562-87

Integrated Regional Information Networks News (IRIN). 2004. "Somalia: Campaign against FGM launched on Women's Day".

Integrated Regional Information Networks (IRIN). 2010. "Indonesia: female genital mutilation persists despite ban". Available at: <http://www.irinnews.org/Report/90366/INDONESIA-Female-genital-mutilationpersists-despite-ban>

Izett, Susan and Nahid Toubia. 2000. "Female Circumcision/ Female Genital Mutilation" in Marlene B. Goldman, and Maureen C. Hatch, eds., *Women and Health*, Boston: Academic Press.

James, Stephen A. 1994. "Reconciling International Human Rights and Cultural Relativism: The Case of Female Circumcision", *8 Bioethics* 1(16)

James, Stanlie, and Robertson Claire. 2002. "Introduction: Reimagining Transnational Sisterhood" in James S. and Robertson C., eds. *Genital Cutting and Transnational Sisterhood* Chicago: University of Illinois Press.

Joint WHO/FIGO Task Force. 1992. "Female circumcision (female genital mutilation)". *Int J Gynecol Obstet* 37:149

Kanywani, Maroushka F. 2002. "Talking Taboo: Representations Of Female Genital Mutilation (FGM) in Feminist Debates, Human Rights Discourse & the Media." Graduate Program in Communications. McGill University, Montreal.

Kaplan, A., Babucarr Cham, Lamin A. Njie, Ana Seixas, Sandra Blanco, and Mireia Utzet. 2013. "Female Genital Mutilation/Cutting: The Secret World of Women as Seen by Men", *Obstetrics and Gynecology International*. Article ID 643780. Available at <http://dx.doi.org/10.1155/2013/643780>

Kellner, Nancy Irene. 1993. "Under The Knife: Female Genital Mutilation As Child Abuse". *Journal Of Juvenile Law* 14:118-132

Kielburger, Marc. and Craig Kielburger. 2013. "We need to talk about genital mutilation" *Edmonton Journal*. Edmonton, Alta.

Kopelman, Loretta M. 1994. "Female Circumcision/Genital Mutilation and Ethical Relativism." *Second Opinion* 20(2):55-71

Koso-Thomas, Olayinka. 1987. *The Circumcision of Women: A Strategy for Eradication*. London: Zed Books Ltd.

Lafave, Wayne R., and Austin W. Scott. 1972. Jr., *Criminal Law*, ch. 2, section 2.14, at 172 (2nd ed. 1986)

Larson, Lori Ann. 1996. "Note, Female Genital Mutilation in the United States: Child Abuse or Constitutional Freedom?", 17 *Women's Rts. L. Rep.* 237-38.

Larsen, Ulla, and Friday E. Okonofua. 2002. "Female circumcision and obstetric complications." *International Journal of Gynecology & Obstetrics* 77(3): 255-265

Leonard, Lori. 2000. "We Did it for Pleasure Only: Hearing Alternative Tales of Female Circumcision" *Qualitative Inquiry* 6(2):212-228.

Lewis, H. 1995. "Between Irua and Female Genital Mutilation: Feminist human rights discourse and cultural divide." *Harvard Human Rights Journal* 8, 1-55.

Leye, E., De Bruyn, M., and Meuwese, S. 2004. "Proceedings of the expert meeting on female genital mutilation". Ghent-Belguim November 5-7, 1998, International Centre for Reproductive Health, Ghent. ICRH Publications no. 2 Lokeren: The Consultory, Lokeren.

Leye, E. 2008. "Female Genital Mutilation: A study of health services and legislation in some countries of the European Union". International Centre for Reproductive Health, Ghent University.

Lightfoot-Klein, Hanny. 1989. *Prisoners of Ritual: An Odyssey into Female Genital Circumcision in Africa*. New York: Harrington Park Press.

London Black Women's Health Action Project. 1989. "Does Female Circumcision Constitute Child Abuse?", *Report On The First National Conference On Female Genital Mutilation: Unsettled Issues For Health And Social Workers In The U.K.*¹⁴ (organized by Foundation for Women's Health Research and Development (FORWARD) [hereinafter LB. W.H.A.P.].

Macfarlane, A. J. & Dorkenoo, E. 2014. *Female Genital Mutilation in England and Wales: Updated statistical estimates of the numbers of affected women living in England and Wales and girls at risk Interim report on provisional estimates*. London: City University London.

Mackie, Gerry. 1996. "Ending Footbinding and Infibulation: A Convention Account" *American Sociological Review* 61:999-1017.

Macklin, Ruth. 1999. *Against relativism*. New York, NY: Oxford University Press.

Macklin, Audrey. 2006. "The Double-Edged Sword: Using the Criminal Law Against Female Genital Mutilation in Canada." *Female Genital Mutilation: Multicultural Perspectives*, pp. 207-223, Abusharaf, R. ed., University of Pennsylvania Press, 2006. Available at SSRN: <http://ssrn.com/abstract=1662145>

Mandara, M. U. 2000. "Female genital cutting in Nigeria: Views of Nigerian doctors on the medicalization debate". In B. Shell-Duncan, and Y. Hernlund, *Female "circumcision" in Africa: Culture, controversy and change* (pp. 95-108). Boulder, CO: Lynne Reinner Publishers.

Martin, Melissa. 2010. "Female genital cutting needs more dialogue: researchers" *Winnipeg Free Press* [Winnipeg, Man] November 14: A.4.

McGee, Shayla. 2005. "Female Circumcision in Africa: Procedures, Rationales, Solutions, and The Road To Recovery", *Wash. & Lee Race & Ethnic Anc. L.J.* 11:133-142

Mendelsohn, Naomi. 2004. "At the Crossroads: The Case For and Against a Cultural Defense to Female Genital Mutilation", *Rutgers L. Rev.* 56:1011

Meyers, Diana T. 2000. "Feminism and women's autonomy: The challenge of Female Genital Cutting." *Metaphilosophy* 31:5, 469-491.

Mitchell, Lillian, and Chibuzo Eke. 2008. "Alternatives to Female Genital Mutilation in Western Africa". Available at http://web.stanford.edu/group/womenscourage/FGM/chibuzo_lily_FGM_paper.html

Moges, Ashenafi. 2003/2009. "What is behind the tradition of FGM? FGM-Myths And Justifications", Eighth International Meropolis Conference Vienna

Mohanty, Chandra Talpade. 1991. "Under Western Eyes: Feminism and Colonial Discourse". Mohanty C. T. et al. (eds.) *Third World Women and the Politics of Feminism*. Bloomington: Indiana University Press.

Moore, Jerry. 2009. *Visions of Culture: An Introduction to Anthropological Theories and Theorists*. 3rd ed. Lanham and New York: Alta Mira Press.

Morjara, M. 2012. *Female Genital Mutilation: A handbook for healthcare professionals*. Available at: <http://www.sexualhealthoncall.org/Portals/10/FGMbooklet-maha>.

Mustafa, Asim Z. 1966. "Female Circumcision and Infibulation in the Sudan". *J. Obstetrics Gynaecology Brit. Cwlth.* 73: 302-303.

Muteshi, J. and Sass J. 2005. *Female Genital Mutilation in Africa: An Analysis of Current Abandonment Approaches*. Nairobi: PATH.

Myers et al., 1985. "Circumcision: Its Nature and Practice Among Some Ethnic Groups in Southern Nigeria." *Social Science and Medicine* 21(5): 581-85

Narayan, Uma. 1997. *Dislocating Cultures: Identities Traditions, and Third-World Feminism*. New York: Routledge.

Njambi, Waririmu Ngaruiya. 2004. "Dualisms and female bodies in representations of African female Circumcision-A feminist critique" *Feminist Theory* 5(3):281-303.

Njeru, H. N., & PATH/Kenya Staff. 1996. *Female circumcision in Nyeri, Embu, and Machakos Districts of Kenya: Report on key informant interviews*. Program for Appropriate Technology in Health.

Nonato, Sheila Dabu. 2012. "Genital mutilation 'unacceptable'; Canadian MDs reaffirm stance as requests for procedure on women rises," *The Vancouver Sun*. Vancouver, B.C. February 22: B.2

Ntiri, Daphne Williams. 1993. "Circumcision and Health among Rural Women of Southern Somalia as Part of a Family Life Survey." *Health Care for Women International* 14(3): 215-16

Obermeyer, Carla Makhlouf. 1999. "Female Genital Surgeries: The Known, the Unknown, and the Unknowable." *Medical Anthropology Quarterly* Vol. 13(1):79-106

Obiora, L. Amede. 1997. "The Little Foxes That Spoil The Vine: Revisiting The Feminist Critique of Female Circumcision", *Can. J. Women & L.* 9:46-73

Office of the Senior Coordinator for International Women's Issues. 2001. *Kenya: Report on Female Genital Mutilation (FGM) or Female Genital Cutting (FGC)* [hereinafter Kenya: Report on FGC]. Available at <http://www.state.gov/g/wi/rls/rep/crfgm/10103.thm>

Ogunbanjo, G.A., and Knapp van Bogaert D. 2005. "Ethical Issues in Family Practice: My Culture - Right or Wrong?" *SA Fam Pract* 47(4):47-48

Ogunlola I. O., E. O. Orji, and A. T. Owolabi. 2003. "Female genital mutilation and the unborn female child in southwest Nigeria," *Journal of Obstetrics and Gynaecology*, vol. 23(2):143–145.

Okin, Susan Moller. 1998. "Feminism, Women's Human Rights, and Cultural Differences." *Hypatia* 13:2.

Okome, M. O. 1999. "Listening to Africa: Misunderstanding and misinterpreting Africa: Reformist western feminist evangelism on African women." *42nd Annual Meeting of the African Studies Association* Pennsylvania. Available at <http://www.africaresource.com/scholar/okom/women5.html>

Onadoko, Modupe O and Adekunle, Lola V. 1985. "Female Circumcision in Nigeria: A Fact or a Farce?" *Journal of Tropical Pediatrics* 31(4)

Oosterveld, Valerie. 1993. "Refugee Status for Female Circumcision Fugitives: Building a Canadian Precedent." *University of Toronto Faculty of Law Review*. 51: 277-303.

Orchid Project. 2013. Report on North Sudan

Orubuloye, I. O., Caldwell, J. C., and Caldwell, P. 2000. "Female 'circumcision' among the Yoruba of southwest Nigeria: The beginning of change". In B. Shell-Duncan, & Y. Hernlund, *Female "Circumcision" in Africa: culture, controversy and change* (pp. 73-94). Boulder, CO: Lynne Reinner Publishers.

Pedwell, Carolyn. 2011. "Gender, Embodiment and Cultural Practice: Towards a Relational Feminist Approach". Gender Institute, London School of Economics. PhD dissertation, Gender Institute, London School of Economics.

Perron, Liette, Vyta Senikas, Margaret Burnett, and Victoria Davis. 2013. "Female Genital Cutting", *J Obstet Gynaecol Can.* 35(11):e1–e18

Pickup, Francine. 2001. *Ending Violence Against Women: A Challenge for Development and Humanitarian Work* Oxford: Oxfam

Platt, J., 1981. "Evidence and Proof in Documentary Research", *Sociological Review*, Vol. 29(1):31-52.

Priest, Lisa. 1994. "Our MDs Involved in Genital Mutilation", Toronto Star at A9, available in WL 7994094

Rahman, Anika and Toubia, Nahid. 2000. *Female Genital Mutilation: A Guide to Laws and Policies Worldwide* London: Zed Books Ltd

Report of the Committee on the Elimination of Discrimination Against Women. 1992. General Recommendation No. 19: Violence Against Women, U.N. GAOR, 17th Sess., U.N. Doc. A147/38; Report of the Committee on the Elimination of Discrimination Against Women. 1990. General Recommendation No. 14; Female Circumcision, U.N. GAOR, 45th Sess., U.N. Doc. A/45/38.

Reymond, Laura, Asha Mohamud, and Nancy Ali. 1997. "Female genital mutilation-the facts. Program for Appropriate Technology in Health." Available at http://www.path.org/publications/files/path_the_facts_fgm.pdf

Robbins, Peter. 2010. Available at <http://anthrotheory.pbworks.com/w/page/29518607/Boasian%20Anthropology%3A%20Historical%20Particularism%20and%20Cultural%20Relativism#footnote-anchor-2>

Roberge, Paulette. 1983. "Female Circumcision Necessary, say African Women in Canada." *The Globe and Mail*. Toronto.

Ruddick, Sara. 1983. "Maternal Thinking" in *Mothering: Essays In Feminist Theory*. Joyce Trebilcock ed. 213-221

Ruderman, Rachel. 2013. "Female Circumcision: The Ethics of Harm Reduction Policies." *The Michigan Journal of Public Affairs*. 10:95-107.

Ryan, Phil. 2010. *Multicultiphobia*. 1st ed. University of Toronto Press, Scholarly Publishing Division.

Said, Edward. 1978. *Orientalism* London: Routledge and Kegan Paul.

Sakeah E., A. Beke, H. V. Doctor, and A. V. Hodgson. 2006. "Males' preference for circumcised women in northern Ghana," *African Journal of Reproductive Health*, vol. 10(2):37-47.

Sams, Julia P. 1986. "The Availability of the Cultural Defense as an Excuse for Criminal Behavior", *Ga. J. Int'l & Comp. L.* 16:335-336

Savanne, Marie-Angelique. 1979. "Why We are Against International Campaign." *International Child Welfare Review* 37.

Senator Al Gore. 1993. "Earth In The Balance: Ecology And The Human Spirit" 12

Sexuality Education Resource Center (SERC). 2010. "Our selves, our daughters: community-based education addressing female genital cutting (FGC) with refugee and immigrant women in Winnipeg—final activity and evaluation report". Winnipeg

Schultz, Jon-Håkon, and Inger-Lise Lien. 2013. "Meaning-making of female genital cutting: children's perception and acquired knowledge of the ritual", *International Journal of Women's Health* 5:165–175

Scott. 1990. *A Matter of Record: Documentary Sources in Social Research*. Cambridge: Polity Press.

Scott, Sarah and Lisa Murphy. 2000. 'The Deepest Cut of All', *Chatelaine* 191-2

Seidman, Steven. 1966."Empire and knowledge: more troubles, new opportunities for sociology." *Contemporary Sociology*, vol. 24, no. 3, May, 1996. Pp 313-316

Shaw, Jacquelyn. 2004. "Sacred Rites, Sacred Rights: Balancing Respect for Culture and the Health Rights of Women and Girls in Islamic Canadian Communities Seeking to Practise Female Genital Mutilation", *Journal of Law & Equality* 3(1):31-68

Shell-Duncan, Bettina, and Ylva Hernlund, eds. 2000. "Female 'Circumcision' in Africa: Dimensions of the Practice and Debates".

Shell-Duncan, Bettina, and Ylva Hernlund. eds.. 2000. *Female "Circumcision" in Africa: Culture, Controversy and Change* London: Lynne Rienner Publishers

Shell-Duncan, Bettina. 2001. "The medicalization of female 'circumcision': harm reduction or promotion of a dangerous practice?", *Social Science & Medicine* 52:1013-1028.doi: 10.1016/S02779536(00)00208-2

Shimeles, A.,and Verdier-Chouchane, A. 2012. "Poverty Situation and Prospects in South Sudan. African Development Bank - Africa Economic Brief". Available at ; www.afdb.org/fileadmin/uploads/afdb/Documents/Publications/Africa%20Economic%20Brief%20-%20Poverty%20Situation%20and%20Prospects%20in%20South%20Sudan.pdf

Shweder, Richard A. 2000. "What about 'Female Genital Mutilation'? And Why Understanding Culture Matters in the First Place" *Daedalus, The MIT Press on behalf of American Academy of Arts & Sciences*. Vol. 129, No. 4, pp. 209-232. Available at <http://www.jstor.org/stable/20027671>

Sigurdson, R. 1993. "Left-and Right-Wing Charterphobia in Canada: A Critique of the Critics" *International Journal of Canadian Studies* 7:95-115.

Simms, Glenda. 2003. "Female sexuality - The battle for control." *Jamaica Gleaner*. Available at <http://jamaica-gleaner.com/gleaner/20031026/focus/focus2.html>

Singateh, S. 1985. "Female circumcision, The Gambian experience", The Gambia Women's Bureau, Banjul, The Gambia.

Slack, Alison T. 1988. "Female Circumcision: A Critical Appraisal" *Human Rights Quarterly*, 10(4):439

Society of Obstetricians and Gynaecologists of Canada. 2012. "Female Genital Cutting/Mutilation". SOGC Policy Statement *J Obstet Gynaecology Can* 34(2):197–200

Standards of Living for Residents of Hérouxville. 2007. "Standards of Living for Residents of Hérouxville", Hérouxville: Hérouxville City Council

Starin, Dawn. 2008. "Time Will Tell." *Journal of the Royal Society of Medicine*, 101: 609–610

Summerfield, Robin. 2004. "A Private Perfection" *Calgary Herald*. [Final Edition]

Taylor, P. 1992. "MD's Unite Against Surgical Ritual: Circumcision of Females Banned" *The Globe and Mail*. Toronto.

Teitel, Emma 2013. "Cultural barbaric practices here and there". *Macleans*. Available at <http://www.macleans.ca/authors/emma-teitel/cultural-barbaric-practices-here-and-there/>

The Canadian Pres. 2014. 'Feds brace for backlash against new immigration rules'. *Macleans*. Available at <http://www.macleans.ca/news/canada/feds-brace-for-backlash-against-new-immigration-rules/>

Thomas, L. M. 1996. "'Ngaitana (I will circumcise myself)': The gender and generational politics of the 1956 ban on clitoridectomy in Meru, Kenya". *Gender and History*, 8:338-363.

Thompson, Allan. 1994. "'Mutilating Girls' Genitals Illegal, Copps Says", *Toronto Star* at A10, available in WL 7993953.

Traditional Practices Affecting the Health of Women and Children: Report of the UN Economic and Social Council, Commission on Human Rights, First Session.1985; Female Genital Mutilation: Information Kit, Division of Family Health World Health Organization. 1994. Geneva; Amnesty International. 1995. Human Rights are Women's Rights, London.

UN Document. 1993. A/RES/48/104. *Declaration on the Elimination of Violence against Women*. Article 2 and Article 4. 85th Plenary Meeting.

Universal Declaration of Human Rights (UNDHR). 1948. G.A. res. 217A (III), U.N. Doc A/810 at 71. Article 3 and Article 5.

United Nations Children's Fund. 2014. *Female Genital Mutilation/Cutting: What might the future hold?*, UNICEF, New York.

UN WOMEN. 2000-2009. *Convention on the Elimination of All Forms of Discrimination against Women*. Available at <http://www.un.org/womenwatch/daw/cedaw/>

United Nations Children's Fund. 2013. *Female Genital Mutilation/Cutting: A statistical overview and exploration of the dynamics of change*, UNICEF, New York.

Van der Kwaak, A. 1992. "Female circumcision and gender identity: A questionable alliance?" *Social Science and Medicine*, 35:777-787.

Vienneau, David. 1996. "Sex with Kids Abroad Illegal Under New Bill-Canadians Would Be Tried Once They Return Home", *Toronto Star*. Available in WL3361409.

Vissandjée B, Kantiebo M, Levine A, and N'Dejuru R. 2003. "The cultural context of gender, identity: female genital excision and infibulation". *Health Care Women Int* 24(2):115-24

Walker, Connie, and Luke Marnie. 2014. "'Doctor' treating First Nations girls says cancer patients can heal themselves - Aboriginal - CBC: 'Doctor' treating First Nations girls says cancer patients can heal themselves 1 child with leukemia has relapsed and is critically ill.", CBC News. Available at <http://www.cbc.ca/news/aboriginal/doctor-treating-first-nations-girls-says-cancer-patients-can-heal-themselves-1.2832760>

Warzazi, Halima Embarek. 1991. *ECOSOC Study on Traditional Practices Affecting Women and Children: Final Report by Special Rapporteur*. E/CN.4/sub.2/1991/6.

Weil Davis, Simone. 2002. "Loose Lips Sink Ships". *Feminist Studies* 28(1):7-35.

Weiss, Dennis M. 2010. "Theory, Feminism, and Feminist Theory." Available at <http://www.faculty.ycp.edu/~dweiss/phl380.../what%20is%20feminist%20theory.pdf>

Wellerstein, Jaimee K. 1999. "Comment, In the Name of Tradition: Eradicating the Harmful Practice of Female Genital Mutilation", *Loy. L.A. Int'l & Comp. L. Rev.* 22:99-100

Wiklander, Julia. 2012. "Mapping FGM/C". Available at; <http://girlsglobe.org/2012/03/10/mapping-fgmc/>

Williams, Nell and Lorriann Robinson. 2014. "Tackling FGM/C in the UK: Lessons from Africa". World Vision UK.

Wilson, Dr. Ann-Marie. 2013. Press Release: FGM remains a danger for Tanzania's girls despite laws against the practice. Available at <http://28toomany.org/news/press-release-fgm-remains-danger-tanzanias-girls-despite-laws-against-practice/>

Women's Caucus of the African Studies Association. 2002/1983. "Prologue: Position Paper on Clitoridectomy and Infibulation" in James S. and Robertson C. (eds.) *Genital Cutting and Transnational Sisterhood*. Disrupting US Polemics Chicago: University of Illinois.

World Health Organization. 1995. *Female Genital Mutilation: Report of a WHO Technical Working Group*. Geneva.

World Health Organization. 1996. *Female Genital Mutilation. Report of a WHO Technical Working Group*. Geneva.

World Health Organisation. 1998. *Female Genital Mutilation: An Overview*. WHO., Geneva.

World Health Organization. 2001. *Female Genital Mutilation: Integrating the Prevention and the Management of the Health Complications Into the Curricula of Nursing and Midwifery: A Student's Manual*. Geneva. pp 25–27

World Health Organization. 2008. *Eliminating Female Genital Mutilation. An inter-Agency Statement*, OHCHR, UNAIDS, UNDP, UNECA, UNESCO, UNFPA, UNICEF, UNIFEM, WHO. Geneva

World Health Organisation. 2010. Fact sheet N°241

World Health Organization. 2014. "Female genital mutilation". Fact Sheet no.241. Available at <http://www.who.int/mediacentre/factsheets/fs241/en/>

Yin, R. K. 2003. *Case study research: Design and methods*. 3rd ed. Vol. 5. Thousand Oaks, CA: Sage.

Yirga et al. 2012. “Female genital mutilation: prevalence, perceptions and effect on women’s health in Kersa district of Ethiopia”, *Int J Womens Health* 4:45–54.

<http://www.achpr.org/>

<http://www.achpr.org/instruments/child/ratification/>

<http://www.assnat.qc.ca/en/travaux-parlementaires/projets-loi/projet-loi-60-40-1.html>

<http://www.bbc.com/news/world-middle-east-30983027>

<http://www.un.org/womenwatch/daw/cedaw/text/econvention.htm#article5>

<http://www.cic.gc.ca/english/resources/statistics/facts2013/permanent/10.asp>

<http://edition.cnn.com/2015/06/25/middleeast/egypt-female-genital-mutilation/index.html>

<http://www.desertflowerfoundation.org/en/what-is-fgm/>

<http://www.endfgm.eu/en/female-genital-mutilation/what-is-fgm/where-is-it-practised/>

<http://www.forwarduk.org.uk/key-issues/fgm/human-rights>

<http://www.global-alliance-fgm.org/en-gb/home.aspx>

<http://www.theglobeandmail.com/news/national/parents-charged-in-genital-mutilation/article4131391/>

<http://www.theguardian.com/society/2015/may/29/outlawing-fgm-nigeria-hugely-important-precedent-say-campaigners>

<http://iwhp.sogc.org/index.php?page=female-genital-cutting>

<http://laws-lois.justice.gc.ca/eng/acts/C-46/page-6.html>

<http://www.nwlc.org/tags/cedaw>

<http://www.ohchr.org/en/professionalinterest/pages/crc.aspx>

<http://www.ohchr.org/EN/ProfessionalInterest/Pages/CAT.aspx>

<http://www.ohrc.on.ca/en/policy-female-genital-mutilation-fgm/4-fgm-canada#fn28>

<http://www.ohrc.on.ca/en/policy-female-genital-mutilation-fgm/3-fgm-internationally-recognized-human-rights-issue>

<http://www.ohchr.org/EN/Issues/SRHRDefenders/Pages/Declaration.aspx>

<http://www.oxforddictionaries.com/definition/english/surgery>

<http://www.parl.gc.ca/HousePublications/Publication.aspx?DocId=2329459&File=16>

<https://treaties.un.org/Home.aspx?lang=en>

http://www.unfpa.org/resources/female-genital-mutilation-fgm-frequently-asked-questions#banned_by_law

<http://worldpopulationreview.com/continents/africa-population/>

<http://www.un.org/en/documents/udhr/>