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Rethinking Human Rights and Culture Through Female Genital Surgeries

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Abstract

The article revisits the relationship between culture and human rights through the analysis of one traditionally condemned cultural practice known in human rights law as female genital mutilations. The analysis draws on anthropological and medical literature and demonstrates importance of interdisciplinary analysis to any enquiry within the area of relationship between culture and human rights. An analogy between the traditional practice of female genital mutilations and the less widely publicised female genital aesthetic surgeries practiced in many Western countries serves as a methodological tool. Laws and attitudes towards both practices are compared demonstrating many similarities and thus the difficulty of drawing a clear-cut line between a cultural and a-cultural practice. In this light human rights' insistence on condemnation of the practices of the Other exclusively appears as hegemonising, racialising and ultimately discriminatory in its effects. Some suggestions as to how a more adequate human rights approach could look like are made as well as the constant necessity for interdisciplinary enquiry in human rights law is emphasised.

1. Introduction

At least since the time of the adoption of the Universal Declaration on Human Rights the tension between cultural values and human rights' claim of universal validity has been

haunting the actual application and development of human rights law.[1] Despite many attempts at addressing this tension it remains one of the predominant preoccupations of human rights lawyers. However, in recent years the interest in this issue in the mainstream human rights literature faded. The majority of human rights lawyers would assume that human rights law learned lessons from the critique about its universalising turn and that it became sensitive enough to cultural differences. This article revisits the cultural relativism – universality tension but not in order to attempt to resolve it. The aim of this article is to demonstrate how relevant it remains to today's international human rights law and practice. It also suggests that the modern human rights law still fails to deal with this tension in a non-imperialistic and dialogical manner. The article attempts to uncover ways for such state of affairs in the modern international human rights law thus pointing to some possible ways of improving the situation.

The analysis is based on the study of human rights' response to one particular cultural practice know in human rights discourse as female genital mutilations ("FGM"). A detailed analysis of the legal response to this practice is compared to the response (or better to say the absence of any response) to a very similar and at times identical Western practice of female genital aesthetic surgeries. The comparison is informed by the knowledge about both practices available in anthropological and medical literature. The question which initiated and guided this research can be formulated as follows: What does it mean for human rights law to deny a woman operation on her genitalia if she desires this surgery in order to conform to the

[1] See e.g. the statement of the American Anthropological Association submitted during the drafting process of the Universal Declaration of Human Rights: *Statement on Human Rights Submitted to the Commission on Human Rights, United Nations by the Executive Board, American Anthropological Association* 47 AMERICAN ANTHROPOLOGIST 539 (1947) and the surrounding discussions e.g. in Karen Engle, *From Skepticism to Embrace: Human Rights and the American Anthropological Association from 1947 -1999,* 23 HUM. RTS. Q. 536 (2001).

precepts of her traditional cultural practice while this very same operation will become possible for her if she formulates her desire for this surgery in terms of aesthetics and personal well-being.[2]

The issue of FGM has been subject of numerous articles, books, and media reports. Today, almost everybody assumes that we know well what FGM is and what it means. The overall response of the international community is also very clear. States are urged 'to condemn all harmful practices that affect women and girls, in particular female genital mutilations, (…) to prohibit female genital mutilations and to protect women and girls from this form of violence, and to end impunity'.[3]

This article will challenge both of these assumptions: Firstly, it will be demonstrated that knowledge about FGM refelcted in human rights law discourse and practice is very biased and racialised. Secondly, I will argue that the response of the international community to these practices is not always coherent and honest and that there is an urgent need to rethink the way these practices are addressed at least in some circumstances. At the following stage it will be argued that this re-thinking of human rights' approach to the practice needs to be informed by findings of research in such disciplines as anthropology and medical science. Thus, human rights need to rediscover interdisciplinarity as the source of multifaceted and as much as possible informed knowledge. Failing this, human right will always remain vulnerable to accusations of imperialist and colonising attitudes and discriminatory in its effects.

[2] The article does not argue that this is always possible for all types of FGM as described below. However, it will be demonstrated that this situation is not uncommon in relation to some types of FGM as defined by the World Health Organization ("WHO").

[3] Intensifying Global Efforts for the Elimination of Female Genital Mutilations, G.A. Res. 67/146, U.N. Doc. A/RES/67/146 (21 Dec. 2012) [hereinafter Resolution] para 4.

2. Female Genital Surgeries

A. The Other's surgeries

Definitions of female genital mutilations can be formulated using various perspectives: legal, medical, cultural. The most encompassing but also the easiest to start with is the following: 'Female genital mutilation comprises all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons.'[4] This definition is provided by the WHO and therefore puts emphasis on surgical aspects of the procedure and the reasons for this procedure. It is important to emphasise from the outset that interpreting this WHO's definition *a contrario* leads to the conclusion that cases exist in which the performance of FGM can be required for medical (hence health-related) reasons.

However, the concrete forms which FGM takes in each particular cultural setting can vary very significantly. The WHO classifies the various forms of FGM in the following categories:

1. 'Clitoridectomy: partial or total removal of the clitoris (a small, sensitive and erectile part of the female genitals) and, in very rare cases, only the prepuce (the fold of skin surrounding the clitoris).
2. Excision: partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (the labia are "the lips" that surround the vagina).
3. Infibulation: narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the inner, or outer, labia, with or without removal of the clitoris.

[4] WHO, FGM FACT SHEET NO 241 (Feb. 2013) [hereinafter Fact Sheet].

4. Other: all other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterizing the genital area.'[5]

The practices listed under various categories are united by the only fact that they somehow affect female genitalia. However, they are very different as to their nature and the precise impact on the genitalia. For example, scraping or piercing of genital area can hardly be compared to the total removal of labia minora and/or labia majora.

It should be emphasized that according to the WHO statistics the vast majority (about 90%) of practiced forms of FGM fall under categories 1, 2 or 4.[6] Thus, the most severe form of FGM (type 3) is performed in only 10% of cases.[7] Unfortunately, there are no other more detailed statistics on different types of FGM performed although for the purposes of further discussion it would be useful to have a more precise breakdown by type.[8]

In medical and human rights discourse any of the above mentioned types of operation on female genitalia is labelled as a harmful practice in need of eradication. For example, the

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[5] *Id*.

[6] WHO, Female Genital Mutilations and Other Harmful Practices. Prevalence of FGM, http://www.who.int/reproductivehealth/topics/fgm/prevalence/en/index.html.

[7] *Id*. In providing these statistics, the WHO refers to P. STANLEY YODER & SHANE KHAN, NUMBER OF WOMEN CIRCUMCISED IN AFRICA. THE PRODUCTION OF A TOTAL. USAID DHS WORKING PAPER, DEMOGRAPHY AND HEALTH RESEARCH, PAPER NO 39 (MARCH 2008).

[8] There is a variety of studies on FGM. However, this does not mean that they provide much insight as to the types of FGM performed. If they pay any attention at all to breakdown by type, they would only distinguish the most sever form of FGM (type 3) from all other types without breaking down all other types of FGM which are still very diverse. Even the most detailed categorization I found includes just a very formalistic distinction between three categories of FGM: nicked, no flesh removed; flesh removed; sewn closed. Making no distinction between different amounts of flesh removed is particularly problematic. For this study see Population Reference Bureau, FEMALE GENITAL MUTILATION/CUTTING: DATA AND TRENDS (2010).

WHO states 'FGM has no health benefits, and it harms girls and women in many ways. It involves removing and damaging healthy and normal female genital tissue, and interferes with the natural functions of girls' and women's bodies.'[9] The position adopted in the recent UN General Assembly resolution is very similar: 'female genital mutilations are a harmful practice that constitutes a serious threat to the health of women and girls, including their psychological, sexual and reproductive health.'[10]

The WHO further affirms that 'FGM is recognized internationally as a violation of the human rights of girls and women. It reflects deep-rooted inequality between the sexes, and constitutes an extreme form of discrimination against women.'[11] The attitude of international law and national legislations of some countries will be considered in more detail below. For the moment it is sufficient to emphasize the unanimity in unqualified condemnation of all above mentioned types of operations on female genitalia.

An important element in the discussion about FGM is the question of age of persons who undergo the surgery. The above definitions and the overall response of international community make no distinction in their approach to FGM depending on the age of girls and women. The dominant image in the Western media would represent FGM as being performed almost exclusively on minor girls. However, the age at which FGM is performed varies from shortly after birth to the labour of the first child.[12] This means that FGM is also performed on adult young women in some cases. However, again despite the wealth of literature on FGM

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[9] Fact Sheet, *supra* note 4.

[10] Resolution, *supra* note 3, para 8 of the preamble.

[11] Fact Sheet, *supra* note 4.

[12] See information provided at the web-page of an NGO working on issues related to FGM in UK: The Foundation for Women's Health, Research and Development – FORWARD. FORWARD, Female Genital Mutilation (FGM), http://www.forwarduk.org.uk/key-issues/fgm.

there are no precise statistics and it is difficult to say what is the percentage of adult women undergoing FGM.[13]

B. Our Surgeries

A Google search using the term 'female genital surgeries' made on 19 March 2013 returned around 2170000 results. In the third place on the list was a web-site of a medical practice based in New York and Los Angeles stating:

> Physicians have neglected aesthetic surgery of the female external genitalia. However, awareness of female genital aesthetics has increased owing to increased media attention, both from magazines and video. Women may feel self-conscious about the appearance of their labia majora (outer lips) or, more commonly, labia minora (inner lips). The aging female may dislike the descent of her pubic hair and labia. A large pubic fat deposit may be unsightly. Because very few physicians are concerned with the appearance of the female external genitalia, many women seeking help are frustrated.[14]

If you continue looking through the list of entries appearing under this Google search, you will find a significant number of similar medical clinics which will propose to women a panoply of genital surgeries aimed at enhancing their well-being. Interestingly, while some of the surgeons and clinics specialize in aesthetic surgeries as such and represent female genital surgeries as a part of possible aesthetic improvements of women's bodies, others present themselves as gynaecological, obstetric practices and practitioners thus linking these surgeries to women's reproductive health. For example, very telling is the title of the

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[13] The available statistical data usually contain breakdown by age with regard to the prevalence of FGM. However, they do not specify at what age the women were circumcised.

[14] Gary J. Alter, Female Genital Surgery, http://www.altermd.com/female_genital_surgery.htm.

Regency clinic in London, UK: 'The British Fertility and Virility Centre Limited.' As the clinic proudly announces:

> Our title "The British Fertility & Virility Centre" was approved by The Honorable Secretary Of State For Trade & Industry as none can use the sensitive word "British" without the approval. To get the approval, you have to be a British company offering unique service and be supported by authorities in the field. We are very proud of our title.[15]

What are these genital surgeries which are so important for women's health and well-being and so unique that the government supports them by granting a special permission for using the world 'British' in the title? How are they different from what the WHO defined as FGM?

American College of Obstetricians and Gynecologists (hereinafter: ACOG) defines these surgeries as follows: 'A range of procedures that aim to change aesthetic or functional aspects of women's genitalia *but that are not medically indicated*'.[16]

What is interesting in this definition is the fact that these surgical procedures are no more medically indicated than FGM in the definition given by the WHO: both Other's surgeries as well as our surgeries on female genitalia are not medically indicated. Is there any other justification for a differential treatment of these two types of surgeries? Let us consider for a moment the nature of our surgeries on female genitalia: What exactly is cut or modified? In an article published in 2010 an author attempted to establish a list of all know

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[15] Regency Clinic, We are a World Leader in Testosterone Replacement, Therapy, Impotence and Infertility, http://www.regencyclinic.co.uk/about.html.

[16] ACOG Committee Opinion No 378: Vaginal rejuvenation and cosmetic vaginal procedures. 110 OBST. GYNECOL. 737, 737-738 (2007), emphasis added.

surgical operation on female genitalia performed by Western medical practitioners.[17] The findings can be summarized in the following list:

- Labia minora reduction
- Vaginal tightening (rejuvenation)
- Labia majora ‘augmentations’
- Pubic liposuction (mons pubis, labia majora)
- Clitoral hood reductions
- Hymen ‘reconstruction’
- Perineum ‘rejuvenation’
- G-spot amplification

Already this enumeration of various practices demonstrates many similarities existing between their and our surgeries. Moreover several procedures are simply identical. For example, clitoral hood reduction is nothing else than one of the forms of clitoridectomy while combined with labia minora reduction it is one of the forms of excision. It is interesting to note already at this stage how the change in the use of language suggests a change in our attitude towards the surgery: while with regard to FGM the WHO talks about ‘partial or total removal’, the health-professionals’ language in the West chooses the term ‘reduction’. The question which needs to be asked is the following: Can woman’s labia minora be reduced without being partially removed? Furthermore, some practices classified under FGM (type 4) are even less intrusive than some of our aesthetic surgeries.

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[17] Virginia Braun, *Female Genital Cosmetic Surgery: A Critical Review of Current Knowledge and Contemporary Debates*, 19 J. WOMEN’S HEALTH 1393 (2010). While reporting and analyzing available information the author notes the concerns with reliability of date, e.g. she emphasizes that “U.S. data are limited by who collects them and who reports, with a focus on plastic surgeons (rather than gynecologists, for instance); the U.K. data are limited to those performed free on the national health service.” (at 1394)

How does national and international law respond to our female genital surgeries? Despite the growing number and popularity of our surgeries, there is no specific regulation of this practice and the WHO also has not addressed it in any way. Thus, writing in 2009 one medical practitioner noted: 'At the present time, the field of female cosmetic genital surgery is like the old Wild, Wild West: wide open and unregulated.'[18] The saying is as true today as it was at the time when it was written. Moreover, it captures so good the state of art with regard to the regulation of female genital cosmetic surgery that is has been taken up and repeated by other authors and medical practitioners writing on the subject.[19]

However, there are several interesting lessons which can be learned through the analysis of international and national law dealing with the Other's surgeries and the language used by these laws and regulations.

3. Laws, Female Genitalia and Culture

A. International Law and Female Genitalia

In terms of international human rights law the prohibition of FGM and its condemnation as a violation of women's and girls' rights is not contained in any treaty. Both the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)[20] and the Convention on the Rights of the Child (CRC),[21] the two most specific treaties as far as FGM

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[18] Michael P. Goodman, *Female Genital Cosmetic Surgery*, 113 OBSTET GYNECOL 154 (2009).

[19] See e.g. Braun, Female Genital Cosmetic Surgery, *supra* note 18, at 1393 or Lih-Mei Liao, Sarah M. Creighton, *Female Genital Cosmetic Surgery: A New Dilemma for GPs*, 61 BRIT. J. GEN'L PRAC. 7, 8 (Jan. 2011).

[20] Convention on the Elimination of All Forms of Discrimination Against Women, *opened for signature* 1 Mar. 1980, 1249 U.N.T.S. 13 [hereinafter CEDAW].

[21] Convention on the Rights of the Child, *opened for signature* 26 Jan. 1990, 1577 U.N.T.S. 3 [hereinafter CRC].

is concerned are silent on the issue. However, the treaty-monitoring bodies addressed the practice when considering States' reports[22] or in their general recommendations. For example, the Committee on the Elimination of Discrimination Against Women, the CEDAW's treaty-monitoring body adopted in 1990 a general recommendation No 14 addressing specifically the issue of FGM using the term of female circumcision.[23] In this general recommendation the CEDAW Committee expressed its concern about the continuation of practice, pointed out satisfactory measures adopted by government, NGOs and national women's organizations and the fact that these actors remain seized with the issue. It also recommended that States parties take all appropriate and effective measures with a view to eradicating the practice.

Relevant to the issue of FGM is also the CEDAW Committee's general recommendation No 19 on violence against women adopted in 1992.[24] Two paragraphs are of particular significance. In paragraph 11 of this general recommendation the Committee notes:

> Traditional attitudes by which women are regarded as subordinate to men or as having stereotyped roles perpetuate widespread practices involving violence or coercion, such as family violence and abuse, forced marriage, dowry deaths,

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[22] For an analysis of the comments on female genital mutilations made by the Committee on the Rights of the Child within the CRC see Sonia Harris-Short, *International Human Rights Law: Imperialist, Inapt and Ineffective? Cultural Relativism and the UN Convention of the Rights of the Child*, 25 HUM. RTS. Q. 130 (2003); for observations made by the CEDAW monitoring body see MARSHA A. FREEMAN, CHRISTINE CHINKIN, BEATE RUDOLF, THE UN CONVENTION ON THE ELIMINATION OF ALL FORMS OF DISCRIMINATION AGAINST WOMEN, A COMMENTARY (2012), 458-459.

[23] General recommendations 1 to 25 of the CEDAW committee are contained in the document International Human Rights Instruments. Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, U.N. Doc. HRI/GEN/1/Rev.9 (Vol.II) (27 May 2008) at 318-373. General Recommendation No 14 is at 326.

[24] Ibid. at 331-335.

> acid attacks and female circumcision. Such prejudices and practices may justify gender-based violence as a form of protection or control of women.[25]

The immediately following paragraph 12 continues: 'These attitudes also contribute to the propagation of pornography and the depiction and other commercial exploitation of women as sexual objects, rather than as individuals. This in turn contributes to gender-based violence.'[26]

These two paragraphs link violence against women to traditional and stereotyped attitudes towards women. Reading together these paragraphs reveals the fact that traditional attitudes exist not only in the Other's societies but also in our own societies which very often are regarded as being 'tradition'-neutral or a-cultural.

A few paragraphs later the CEDAW Committee establishes a link between cultural and traditional practices and the health of women and girls in the following terms:

> In some States there are traditional practices perpetuated by culture and tradition that are harmful to the health of women and children. These practices include dietary restrictions for pregnant women, preference for male children and female circumcision or genital mutilation.[27]

While the Commettee acknowledges in paragraph 12 that Western societies also might have problems with their attitudes towards women, the examples chosen to examplify how some practices affect women's and girls' health point exclusively towards the cultures and practices of the Other.

The link between stereotypical attitudes, status of women and persistence of the harmful practice of FGM is also clearly established in the recent UN General Assembly resolution.

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[25] *Id.*, at 332.

[26] *Id.*, at 333.

[27] *Id.*

This link is not only stated in several paragraphs of the preamble, but also clearly follows from the sequence of actions States are called to adopt: empowerment of women and girls, awareness-raising and education in addition to condemnation and prohibition.[28]

Despite the overlapping nature of surgeries performed as a part of FGM and as a part of our 'cosmetic' surgeries, it is clear from the text of all relevant international documents that they blame and advocate for eradication only of the surgeries of the Other. While in the work of the CEDAW traces of realisation that our own culture could also be harmful can be found, there is no express reference to our surgeries as if they would not exist while the surgeries of the other are constantly blamed and put forward as the best and the most obvious example of a harm done to women by culture. In this regard the use of language in various descriptions of surgeries is very telling. For example, when the WHO describes FGM it uses such terms as 'excision', 'removal', 'cutting' and obviously 'harmful'. When various medical practitioners describe our surgeries, they talk about 'augmentation', 'reduction', 'rejuvenation' and 'amplification', the terminology which does not even give a sense of surgery being real. As if female genitalia are modified without something being cut off. The above definition of the ACGO also uses a very cautious language describing the surgeries as a 'change' and associating them with aesthetics which obviously has a series of positive connotations in Western cultures. It is also significant that many surgeons but also patients who undergo the surgery in the West refer to it as a way of achieving a feeling of beauty and youth. For example, one of the testimonies goes as follows: 'Ever since I had the surgery, I feel young and free and prettier…'[29] Similarly, the motto on the top of one of the surgeon's

[28] See e.g. para. 1, 2 and 4 of the Resolution, *supra* note 3.

[29] Sandy Kobrin, *More Women Seek Vaginal Plastic Surgery* (14 Nov. 2004) at 4, http://www.urogyn.org/articles/MoreWomenSeekVaginalPlasticSurgery.pdf,

web-site is: 'Feel Beautiful.'[30] Therefore the surgery – bodily modification – becomes a way of getting access to some positive emotions associated with beauty. It also suggests that it is not enough to be beautiful in order to experience these emotions, but that there is a need for surgical intervention in order to get access to these feelings even for the most beautiful women.

International human rights law and the WHO do not address the issue of female genital cosmetic surgeries in any way. Thus, despite the shift in the WHO's research from considering only FGM as a health issue towards a more general perspective on vaginal practices there is no indication of the awareness of the female genital cosmetic surgeries in the West. Thus, in 2012 the WHO released a study entitled 'A multy-country study on gender, sexuality and vaginal practices: Implications for sexual health'.[31] Although the title appears neutral and suggests some sort of a large-scale study, in fact what is considered in this report, are practices in two African (Mozambique and South Africa) and two Asian countries (Indonesia and Thailand).

It is also interesting to note that CEDAW Committee and CRC Committee came up with an initiative of a joint general recommendation on harmful traditional practices. While the recommendation is still in drafting, the available documentation submitted in this regard is very telling.[32] The Committees received thirty-one communication from schoalrs and various NGOs. Thirteen of these communications dealt exclusively or primarily with FGM. Two others while focusing on another harmful practice mentioned FGM as an example par

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[30] Web-site of Steve Laverson, MD, FACS see http://www.feelbeautiful.com .

[31] WHO, A MULTY-COUNTRY STUDY ON GENDER, SEXUALITY AND VAGINAL PRACTICES: IMPLICATIONS FOR SEXUAL HEALTH (2012). Policy brief *available at* http://www.who.int/reproductivehealth/topics/fgm/other_harmful_practices/en/index.html.

[32] For information on this initiative and available documents see: http://www2.ohchr.org/english/bodies/cedaw/JointCEDAW-CRC-GeneralRecommendation.htm .

excellence of the harmful practices to be addressed. This means that nearly half of submissions put FGM forward as a practice to be condemned. Only five submissions dealt with some types of Western harmful practices. The submission that come closest at addressing issues relevant to the practice of female genital cosmetic surgeries is a report by Coalition Against Trafficing in Women. In this report the NGO raises concerns at sexual exploitation of women and girls in all its forms and develops on its links to pornography. When addressing the effects of sexualization of girls it notes:

> Another troubling indication of the increasing emphasis on women's and girls' physical appearance and physical objectification is the correlation of a rise in cosmetic surgeries in various countries throughout the world. The most blatant form of this trend is female genital cosmetic surgery, which "is being driven by pornographic images of women." and raises concerns as to a new form of female genital mutilation in more affluent societies.[33]

Unfortunately, there is no evidence that official UN human rights bodies or other UN agencies such as WHO took note of this troubling development. The focus remains on FGM.

Thus, despite identical nature of several types of FGM as compared to our cosmetic genital surgeries, despite the broadening agenda of the WHO which does not only focus on FGM but also considers other vaginal practices, despite the timid but existing recognition of the fact that our own societies can also perpetrate traditional stereotypical attitudes towards women, international community and international documents remain silent and indifferent towards our own Western surgeries. The situation is even more revealing and alarming if we

[33] Coalition Against Trafficking in Women, Submission (2010) 8, available at: http://www2.ohchr.org/english/bodies/cedaw/docs/cedaw_crc_contributions/CoalitionagainstTraffickinginWomen.pdf

consider national laws aimed at criminalising FGM and adopted to comply with human rights' call for eradication of FGM.

B. National Laws and Female Genitalia

Many countries adopted national laws condemning and criminalising FGM. However, there is until now not a single state which adopted any type of regulation with regard to the female genital cosmetic surgeries. Nevertheless, it is interesting to note that the adoption of the laws prohibiting and criminalising FGM led in some instances to a discussion and consideration of the practice of female genital cosmetic surgeries. Although these cosmetic surgeries finally are not addressed in the legislation directly, they left their imprint on the laws prohibiting FGM. Moreover, parliamentary debates addressing genital cosmetic surgeries are oftentimes very instructive and shed new light on our attitude towards the Other.

Below are considered in a comparative perspective the language and effects of three laws: the UK 2003 Female Genital Mutilations Act,[34] the Irish 2012 Female Genital Mutilations Act[35] and the relevant section of the Canadian Criminal Code.[36] These laws are adopted in response to the calls of various international organs analysed above to condemn and proscribe this practice. The attitude adopted with regard to FGM by the three countries selected is directly influenced by their human rights agenda and their image of human rights abaiding and promoting states.

(i) The UK Legislation

[34] Female Genital Mutilation Act, 2003, c. 31 [hereinafter 2003 FGM Act].

[35] Criminal Justice (Female Genital Mutilations) Act, 2012, No 11[hereinafter Irish FGM Act].

[36] Criminal Code (R.S.C., 1985, c. C-46) [hereinafter CrC].

The UK FGM Act adopted in 2003 is a second piece of legislation in the UK legal system aimed at combating these genital surgeries of the other. It replaced the 1985 The Prohibition of Female Circumcision Act.[37]

Section 1(1) of the 2003 FGM Act defines FGM by stating that 'A person is guilty of an offence if he excises, infibulates or otherwise mutilates the whole or any part of a girl's labia majora, labia minora or clitoris.' The following section of the Act creates some exceptions to this general definition. More specifically, section 1(2)(a) states that no offence is committed if an approved practitioner performs 'a surgical operation on a girl which is necessary for her physical or mental health.' However, section 1(5) emphasises that 'For the purpose of determining whether an operation is necessary for the mental health of a girl it is immaterial whether she or any other person believes that the operation is required as a matter of custom or ritual.' The question thus arises: if we exclude cultural pressure and influence of community and tradition as an issue of mental health in what circumstances and what kind of mental health issues can justify or even require performance of FGM? The answer is provided in the discussions in the House of Lords leading to the adoption of the predecessor of the current Act.[38] In fact, it was brought to the attention of Lords that if a simple prohibition of FGM which does not allow for any exceptions is created, it will also criminalise and prohibit performance of a series of legitimate surgical operations. Some of these operations and their legitimacy was not debated at all but simply mentioned and

[37] Prohibition of Female Circumcision Act, 1985, c. 38 [hereinafter 1985 Act].

[38] In fact, the new 2003 FGM Act was adopted in order to introduce the possibility to criminalize a surgery performed outside of the UK in countries where this practice is not prohibited. The previous 1985 Act made the punishment of a surgery performed abroad conditional about the very same act being a criminal offence in the country in which the surgery was performed. Therefore the remainder of the 2003 FGM Act was not subject to discussion during the procedure of adoption its. Thus, the insights gained from the history of adoption of the 1985 Act remain valid.

acknowledged by all. These cases included ‘cancerous or pre-cancerous conditions and others for which surgery is clearly indicated on physical health grounds’[39] Another type of operations which did not raise any major opposition or difficulty relate to surgeries performed on perfectly healthy but deformed or abnormal genitalia.[40] However, the possibility of allowing for exception to the criminalisation of FGM on mental health grounds led to heated debates. As summarised by Lord Gelnarthur:

> The cases which present a problem – and they are a small but nevertheless significant number – are those in which a girl or a woman, otherwise perfectly healthy, becomes anxious and depressed about the shape or size of her external genitalia. This distress – which may become very acute and could lead to mental illness – can only be relieved by surgery. Such surgery (…) cannot be said to be necessary for physical health.[41]

Three main issues came to the forefront of discussions in relation to this latter type of exception. Firstly, it is difficult to define normality or abnormality in relation to shape and size of female genitalia. While some cases are clear and allow for an easy classification as abnormality or deformity which allow for a legitimate operation on physical health grounds according to the concept of the UK Act, there also exists panoply of cases which cannot be clearly defined as either normal or abnormal: ‘there is no exact definition of “normality” by which they (women requesting operations) could be said to be abnormal. The range of “normal” is very wide (…)’[42] Thus, it will be difficult to frame demands for surgery as either physical or mental health problems based on an unidentified normal female genitalia. This

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[39] HL Deb, Vol 447, col 74 (23 January 1984).

[40] *Id.*, col 77, Lord Kennet and col 87, Lord Glenarthur and Lord Kennet.

[41] *Id.*, col 74.

[42] *Id.*, col 87, Lord Glenarthur.

issue of normality was not debated as such but emerged and shaped discussions of the two other aspects presented below. However, the language of normality occupies an important place in the current discourse around female genital cosmetic surgeries. Its significance will be discussed later, but it should be emphasised that the issue appeared very early in the debates surrounding female genital surgeries.

Second type of the debated issues related to the question of the legitimacy of allowing performance of operations on women and girls 'who falsely believe, mistakenly believe that their genitalia are abnormal and who get depressed about it.'[43] While defenders of the exception believed that only surgery can relive the distress of these women and girls as clearly stated by Lord Glenarthur, opponents of the proposal questioned this position and insisted among others an a prior recourse to 'support, counselling, sympathy, possibly psychotherapy, but not surgery.'[44] Based on this division of views regarding the appropriateness of surgeries as a healing for mental health problems, the following proposal was made: if the mental health is to be retained as a ground for allowing surgeries, a clause should be introduced into the Act which would require a woman or girl to undergo prior to surgeries a psychological counselling. The proposed section reads as follows: 'in determining for the purposes of this section whether an operation is necessary for the mental health of a person a certificate to that effect shall be required from a member of the Royal College of Psychiatrists and a member of the Royal College of Gynaecologists.'[45] The section found no way into the final text of the Act. Discussions in the House of Commons reveal a strong pressure from medical practitioners who did not want their decision making power to be lost

[43] Ibid. col 77, Lord Kennet.

[44] *Id*. See also comments made by Baroness Jeger, col 80, 81.

[45] *Id*., col 76, Lord Kennet.

or diminished. Thus, a letter from Professor Macnaughton, president of the Royal College of Obstetricians and Gynaecologists read in the House of Commons states the following:

> Firstly, we are at one with you in seeking to prohibit female circumcision of any kind being performed in this country. However, there are a variety of surgical operations that are necessary for the physical and mental health of women, which have nothing whatever to do with circumcisions performed for traditional or cultural reasons. I wish to make it clear that *the College would be opposed to any statutory limitations on these legitimate procedures*.[46]

Finally, the way the issue of mental health was introduced into the Act led to a discussion about discriminatory effects of the Act which would privilege the mental health of white women over the mental health of brown and black women. The debates in the House of Lords reveal that majority of its members felt that there is something wrong with allowing mental health to be a basis for exception opening a way to surgeries while excluding from the definition of mental health any reference to culture or tradition. The following statement by Lord Kennet captures well this view:

> I turn now to the means which the Government has chosen to secure the freedom of surgeons to continue with this tiny group of operations. (…) the means that they have chosen is to permit mental health as a ground for the operation but to exclude from the definition of mental health any depression or mental illness which is based on custom or ritual. I submit that this is what should stick in Parliament's throat. Quite simply, it means that white mental health is a good ground for the operation but black mental health is not.[47]

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[46] HC Deb, vol 77, col 583 (19 April 1985), emphasis added.

[47] HL Deb, vol 447, col 78 (23 January 1984).

Lord Kennet also presented an opinion from the Commission for Racial Equality which shared this concern and affirmed that this clause 'could be indirectly discriminatory in effect.'[48] The previously discussed proposal to have the existence of a mental health problem requiring a surgery to be attested by a psychiatrist and a gynaecologist was a means – however imperfect – proposed in replacement of the section which simply excludes any invocation of culture and tradition as a mental health issue and thus produces discriminatory effect. However, the above mentioned position of medical professionals who felt that their unrestricted practice in this field might be limited and thus opposed any limitations on aesthetic surgeries simultaneously prevented any discussion and thus remedy of the discriminatory effects of the Act. Thus, despite the fact that all these problematic issues had been discussed very actively during the adoption process, the applicable Act reflects nothing of these discussions and leaves the discriminatory provisions untouched.

Moreover, the current version of the Act (the 2003 FGM Act which replaced the 1985 Act) adds to these discriminatory effects of the law in two ways: firstly, it replaces the more neutral term 'circumcision' with the term 'mutilation' which has a very negative and judgmental connotations and obscures further the many similarities existing between the Other's genital surgery and our female genital cosmetic surgeries. Furthermore, while the 1985 Act used the term 'person' to refer to women and girls whom the Act intended to protect, the 2003 FGM Act constantly refers to 'girls' only. While a reader could tend to understand that adult women should be able to make decisions about their bodies and thus the Act prevents surgeries on minors who cannot yet express their consent, section 6 of the Act dissipates any doubt. Paragraph 1 of this section entitled 'definitions' states 'Girl includes woman.' Firstly, this way of phrasing a law: using a very specific term: 'girl' to refer to a more generic category of female of any age despite the existence of other suitable terms:

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[48] *Id.*

‘person’, ‘female’, ‘women and girls’, or even ‘women’ raises a series of questions about the intention of the legislator. Most importantly, it returns back to an era when women were considered minors and unable to make their own decisions on any aspect of their lives. This use of terminology surfaces the worst forms of patriarchy and subordination of women. Combined with the previously depicted discriminatory effects of the Act which excludes from the Act white surgeries and intentionally targets only the surgeries of the Other this terminology acquires additional discriminatory meaning: it labels black and brown women as minors in need of saving, it silences their agency and deprives them of decision-making power with regard to their bodies.

(ii) The Irish Act

Irish 2012 Act criminalizing FGM defines the offense in terms very similar to the UK 2003 FGM Act employing the usual terms negatively associated with the traditional cultural surgeries of the Other. Thus according to section 1 of the Irish FGM Act: ‘“female genital mutilation” means any act the purpose of which, or the effect of which, is the excision, infibulation or other mutilation of the whole or any part of the labia majora, labia minora, prepuce of the clitoris, clitoris or vagina of a girl or woman.’

The Irish FGM Act also contains an exception for surgical operations necessary for the protection of women’s or girls’ physical or mental health in its section 2(2)a). However, it adds two other explicit exclusions which are not contained in the UK 2003 FGM Act. According to section 2 (2) c) the person performing the operation is not guilty of any offence if ‘the person is the girl or woman on whom the act of female genital mutilation is done.’ This exclusion is very interesting as it recognises the existence of the practice of self-mutilation. This explicit recognition is very important step as it enriches and deepens our understanding of traditional practices. Section 2 (2) d) stipulates that no offence is committed

if ‘the act concerned is done to a woman who is not less than 18 years of age and there is no resultant permanent bodily harm.’ This section is also an important step forward towards a better understanding of complexity and multiplicity of traditional practices and forms of female genital surgeries. As explained previously, the WHO’s definition of FGM includes a variety of procedures reaching from clitoris, labia minor and labia major reduction or removal to pricking, piercing and scraping of female genitalia. The discussion in the Irish Parliament (Seanad) highlights this multiplicity and diversity of practices. Thus, it was emphasised that ‘An exemption was added to protect the freedom of choice over cosmetic or other procedures that do not violate women’s human rights.’[49]

The Irish FGM Act also aims at eliminating the possibility of invoking culture or practice as a justification for performing the operation. However, the wording of the relevant section is slightly different from that used in the UK 2003 FGM Act:

> For the avoidance of doubt, it is hereby declared that it shall not be a defence to proceedings for an offence under this section for the accused person to show that he or she believed that the act concerned was consented to by the girl concerned or her parents or guardian, or the woman concerned, as the case may be, or required or permitted for customary or ritual reasons.[50]

The most obvious difference as compared to the section 1 (5) of the UK 2003 FGM Act relates to the absence of any reference to the mental health. Thus, according to the Irish FGM Act, custom and tradition cannot be invoked as a defence for performing acts falling under the definition of FGM. This wording does not suggest that culture and tradition can never justify an operation on mental health reasons. Thus, this formulation does not have the same

[49] Criminal Justice (Female Genital Mutilation) Bill 2011: Second Stage (Resumed), Tuesday, 2 June 2011, Seanad Éireann Dbate, vol 208, no. 3, col 138.

[50] Section 2(3).

discriminatory connotation as the UK 2003 FGM Act. However, does this mean that in interpreting the Irish FGM Act Irish authorities will be willing and open to the possibility of performing at least some forms of female genital surgeries on women in extreme situations of distress linked to their cultural life? This is difficult to imagine taking into account that when addressing exceptions to the offence as defined in the Irish FGM Act, Irish parliamentarians basically concentrated on aesthetics as did the supporters of the current version of the UK 2003 FGM Act.

In sum, while the Irish FGM Act uses a more neutral and careful wording, it will not necessarily lead to different results in application. It escapes some most obvious negative and discriminatory language of the UK 2003 FGM Act without a sincere attempt to reach more egalitarian results. Therefore, the discussion surrounding the adoption of the 1983 Act in the UK remains very significant as it reveals what neutral phrasing conceals: discriminatory and racialising effect of the Western and as we will see international human rights' law approach to female genital surgeries.

(iii) Canadian Law

Finally, the approach chosen by the Canadian legislator will also be briefly considered below. Canadian legislator chooses to address FGM within a general offence of aggravated assault in section 268 of its Criminal Code. Paragraph 3 of this section stipulates: 'For greater certainty, in this section, "wounds" or "maims" includes to excise, infibulate or mutilate, in whole or in part, the labia majora, labia minora or clitoris of a person.' This definition or clarification is followed by two exceptions. Firstly, a surgical procedure performed by a qualified professional does not constitute a crime if it is required 'for the benefit of the physical health of the person or for the purpose of that person having normal reproductive

functions or normal sexual appearance or function.'[51] The second exception reads as follows: 'the person is at least eighteen years of age and there is no resulting bodily harm.'[52] Thus, the list of exceptions in the Canadian Criminal Code makes no reference to the controversial mental health issue. However, the dichotomy between two exceptions which are construed as alternatives suggests that the second paragraph allows adult women to request certain less intrusive types of surgeries irrespective of the reasons for such a request. While the first exception allows for performance of some surgeries on minors in order to achieve 'normal sexual appearance or function'. If we remember that the issue of normality of sexual organs is closely tied to the possibility of invoking mental health in order to request the surgery, it becomes obvious that the underlying tension and possible discriminatory effects of the legislation are not eliminated but hidden and silenced.

Canadian approach to elimination of FGM is distinct from both Irish and UK approaches in that it makes no express reference to culture or tradition. However, again a discrete reflection of the possible invocation of culture and tradition can be detected when reading the following restriction on the possibility to consent to a genital surgery contained in paragraph 4 of section 268: 'For the purposes of this section and section 265, no consent to the excision, infibulation or mutilation, in whole or in part, of the labia majora, labia minora or clitoris of a person is valid, except in the cases described in paragraphs (3)(*a*) and (*b*).'

This provision restricts the possibility of using the consent to justify the performance of female genital surgeries to the two above mentioned cases of exceptions defined by the Canadian legislator. Thus, an adult woman could not give her consent to the operation which she desires to be performed because she wants to conform to practices of her culture. She

[51] Section 286 (3) a) CrC.

[52] Section 268 (3) b) CrC.

would need to frame her request for surgery either as having no resulting bodily harm or as being required for normal sexual appearance or function.

4. Thinking about Genital Surgeries with Anthropologists

This part of the article will attempt to inform the issues discussed in relation to laws and human rights policies using insights and research results available in anthropological and medical literature. It is impossible to go into detail of all relevant questions within the framework of this article. Therefore two main areas which are the most commonly invoked in human rights law discourse are identified for further analysis: First, the issue of consent and age is discussed as it is often put forward as the main difference between any cosmetic procedure performed in the West and FGM which are commonly perceived to be done on minor girls or if they are performed on adult women, it is suggested that they have no freedom of choice and are coerced to undergo FGM. The second issue which will be discussed concerns the mental health exception and exclusion of culture from this exception. Although this issue is not directly featured in human rights law and discourse itself,[53] it is an

[53] There exists a series of human rights instruments on ethical issues in medicine (see in particular UNESCO Universal Declaration on Bioethics and Human Rights adopted on 19th Oct. 2005 and Council of Europe Convention for the Protection of Human Rights and Dignity of the Human Beings with Regard to the Application of Biology and Medicine: Convention on Human Rights and Medicine adopted 4 April 1997, ETS No 164). These instruments could potentially become relevant to the discussion of the relationship between FGM and genital cosmetic surgeries. However, they do not address relevant issues directly. The instruments just contain a provision on non-discrimination which could potentially be used to criticize differential treatment of medically identical procedures (art 11 of the UNESCO Declaration and art. 1 of the Council of Europe Convention). However, UNESCO Declaration also contains in art. 12 a provision excluding invocation of culture in a way which would infringe human rights, thus, again potentially mirroring the discussion on cultural exception in the context of national laws. Taking into account the generality of these instruments and the scope of this article, they will not be discussed further.

integral part of all national laws on FGM discussed above and as will be demonstrated below is relevant to the understanding of human rights attitude towards FGM.

A. Consent, Age and Culture

The dominant representation of FGM in human rights discourse imposes the vision of this operation as being almost exclusively performed on minor girls who by definition are unable to give their consent to the operation. When at times it is admitted that FGM are also performed on adult women, the issue of consent is not discussed seriously as it is presumed that these women have no choices but to undergo operation and that anyway it is inconceivable that any reasonable and educated woman would ever consent to this type of surgery. I will first address the issue of surgeries on minors and their consent before continuing with a more general debate about consent to FGM and other types of surgeries by adult women.

First of all, it is important to emphasize that female genital cosmetic surgeries performed in Western countries are also often requested by minor girls (accompanied or not by their parents or legal representatives). Reported cases reveal that girls subject to female genital cosmetic surgeries are aged as young as 10.[54] In a study published in 2011 based on data obtained in a London gynaecology clinic authors reveal that 15% of patients requesting female genital cosmetic surgeries are under the age of 10 and 30% between ages 11 and 15.[55]

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[54] See e.g. Braun, *supra* note 18 at 1394; Jothilakshmi PK, Salvi NR, Hayden BE, Bose-Haider B, *Labial Reduction in Adolescent Population – a Case Series Study*, 22 J. PEDIATR. ADOLESC. GYNECOL. 53 (2009); Naomi S. Crouch, Rebecca Deans, Lina Michala, Lih-Mei Liao, Sarah M. Creighton, *Clinical Characteristics of Well Women Seeking Labial Reduction Surgery: a Prospective Study* 118 BRIT. J. OBSTET. GYNEACOL.: AN INT'L J. OBSTET. GYNEACOL. 1507, 1509 (2011).

[55] Crouch et al., *supra* note 52, at 1509.

Therefore, the performance of female genital surgeries on minors is not a phenomenon limited to the culture of the Other and is not exceptional in Western societies.

At this point some would bring up the argument about FGM being performed on babies or very young children, a practice they would say which has no parallels in Western aesthetic surgeries. Without going into a detailed discussion, I would just suggest that intersex surgeries provide another very telling parallel. The purpose of intersex surgeries is the well-being of children and their future as projected from their parents' point of view. They want a 'normal' life for their children. The dominant preoccupation of parents and especially mothers whose daughters undergo FGM is also the well-being and future of their children.[56] Moreover, in societies practicing FGM being 'normal' means having undergone the surgery. Anthropologists provide sufficient evidence of how girls who have not been subjected to the surgery are teased and excluded by other girls.[57]

If we turn now to the broader category of women undergoing surgeries in their adulthood, we need to consider the requirement of a free and informed consent. This requirement unites to some extent the issue of surgeries performed on minors and on adults because the problematic nature of surgeries on minors is a consequence of our acknowledgement that children are not yet able to form a free opinion and thus give a free and informed consent on some matters until certain age. The requirement of the free and informed consent represents today a fundamental component of medical practice in Western societies. However, the determination of the precise boundaries of this concept as well as of

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[56] See for example accounts about mother's preoccupations reported in Ellen Gruenbaum, *Sexuality Issues in the Movement to Abolish Female Genital Cutting in Sudan* 20 MED. ANTHROPOLOGY Q. 121, 131-132 (2006): 'We don't want the girl to be dirty, open, with smelly underwear.' Compare also Ylva Hernlund & Bettina Shell-Duncan, *Contingency, Context, and Change: Negotiating Female Genital Cutting in the Gambia and Senegal*. 53 AFRICA TODAY 43, 53(2007).

[57] Gruenbaum, *supra* note 54 at 126; Hernlund & Shell-Duncan, *supra* note 54 at 53.

its content remains a debated issue.[58] Thus, in many jurisdictions it is recognized that 16- and even 14- year olds can give a free and informed consent to certain types of medical intervention independently of their parents or guardians.[59] In several countries laws, regulations and judicial decisions would attempt to define how much detail the medical practitioner needs to provide to his patient in order for the consent to become informed. However, there are no uniform standards in these areas and the amount of information available to patients may vary significantly.[60]

If we turn now back to the issue of FGM, the dominant opinion of the human rights discourse and practice would represent not only adolescents but also adult women as being under such a pressure from their culture in the form of family or community that they are not able to give any free or informed consent. Thus, the need for educational and awareness-raising measures, as well as for change and modification of cultural practices and traditions is vigorously advocated.[61] However, if we take a closer look at both the experiences of Other women with regard to their surgeries which we call FGM and the experiences of women in the West when they are faced with the possibility of getting a female genital cosmetic surgery, we will again discover many similarities. Firstly, it needs to be emphasized that the

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[58] See en general e.g. Peter H. Schuck, *Rethinking Informed Consent*. 103 YALE L.J. 899 (1994); Lauth Doyal, *Informed Consent: Moral Necessity or Illusion?* 10 (suppl. I) QUALITY IN HEALTH CARE i29 (2001).

[59] For an overview of the situation in Canada see David C. Day, *The Capable Minor's Healthcare: Who Decides?* 86 CAN. BAR REV. 379 (2007); for a summary of the situation in the UK see Mike Shaw, *Competence and Consent to treatment in Children and Adolescents.* 7 ADVANCES IN PSYCHIATRIC TREATMENT 150 (2001).

[60] For examples of difficulties and issues discussed in some specific contexts see Richard Fuller, Nigel Dudley, John Blacktop, *How Informed is Consent? Understanding of Pictorial and Verbal Probability Information by Medical Inpatients*. 78 POSTGRADUATE MED.J. 543 (2002); O. O'Neil, *Some Limits of Informed Consent.* 29 J.MED. ETHICS 4 (2003).

[61] See e.g. reference to education and awareness-raising measures in para 2, 3, 5, 6, 9, and 10 of the Resolution *supra* note 3.

practice of FGM is not something of which girls and women are passive victims. The dynamics surrounding the surgeries of the Other in many traditional societies are described by anthropologists also in terms of assertion of women's agency and authority through the practice of FGM.[62] The authors demonstrate how both women and girls will claim and ascertain their desire for FGM as their own choice. This experience of women and girls with FGM is very similar to what is reported in feminist literature about women and girls undergoing various types of aesthetic surgeries in the West. These women will also claim that the surgery is required in order for them to feel normal or more powerful, to express better their identity.[63]

It is difficult to speak about an informed consent regarding a matter where information is incomplete or simply lacking. With regard to female genital surgeries the following difficulty arises: as already mentioned, the decision in favour of many genital surgeries is based on the perceptions of normality of female genitalia. However, medical research reveals very significant variations in size, shape and colour of female genitalia.[64] What is defined as normal by one researcher, does not necessarily correspond to the image of normality presented by another researcher.[65] Therefore, it is difficult for both women and medical practitioners to get a real image of normality with regard to female genitalia.

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[62] See e.g. very powerful testimony of Ahmadu in *Disputing the Myth of Sexual Disfunction of Circumcised Women. An Interview with Fuambai S. Ahmadu by Richard A. Shweder.* 25 ANTHROPOLOGY TODAY 14 (2009) and *Ain't I a Woman Too? Challenging Myths of Sexual Dysfunction in Circumcised Women* in Hernlund & Shell-Duncan (eds.), TRANSCULTURAL BODIES: FEMALE GENITAL CUTTING IN GLOBAL CONTEXT 278 (2007).

[63] For an interesting discussion of the related issues including a review of relevant literature see Cressida J. Heyes, *Normalisation and the Psychic Life of Cosmetic Surgery*. 22 AUSTRALIAN FEM.STUD. 55 (2007).

[64] See e.g. Lloyd, Crouch, Minto, Liao, Creighton, *Female genital appearance: 'normality' unfolds*, 112 BRIT. J. OBSTET. GYNAECOL. 643 (2005).

[65] See e.g. differences noted by Braun, *supra* note 18, at 1400.

Moreover, taking this diversity into account, it is more adequate to suggest that there exist no normal genitalia at all or that all diverse types of genitalia are normal. What is defined as normal either by women requesting a surgery or medical practitioners performing such surgeries is necessarily a culturally defined normality influenced by space and time. Taking this complexity into account it is even more difficult to imagine how a sixteen-year old girl could give an informed consent if she has not been exposed to this diversity. However, in the majority of Western countries it is presumed that sixteen-year olds are able to consent themselves to this type of operations.

This issue of genitalia's normality plays a central role not only within the context of informed consent but also as one of the reasons invoked by women to justify their choice of female genital cosmetic surgeries. These reasons are discussed in the next part of the article.

Thus, while the issue of consent and age certainly makes the discussion of and comparison between the surgeries of the Other and our surgeries more complex, there is again no clear dividing line: the surgeries of the Other are often performed on adult women while many minor girls are subject to our genital surgeries. On the other hand the requirement of a free and informed consent is not a clearly defined concept and can be theorised as problematic in both Other`s societies with regard to FGM as well as with regard to the so-called aesthetic surgeries on female genitalia in our societies.

B. Mental Health and Culture in a Different Language

The review of laws applicable in the three selected countries puts to the forefront of discussions about FGM the questions concerning the nature of mental health problems which might, according to legislators and medical practitioners require surgical intervention on physically healthy female genitalia and the closely related issue of normality in relation to the sexual appearance or function. Once we understand this mental health exception, it will be

possible to enquire to what extent the exclusion of culture from these mental health issues is justified. In this way we will return to our point of departure, namely the issue of the relationship between culture and human rights. This will also allow us to enquire to what extent FGM is an exotic cultural practice of the Other.

A hint towards the understanding of these mental health issues which justify performance of our surgeries on female genitalia is already given in the speech of Lord Glenarthur in the House of Lords leading to the adoption of the UK 1985 Act: the concern relates to cases 'in which a girl or a woman, otherwise perfectly healthy, becomes anxious and depressed about the shape or size of her external genitalia.'[66] In order to get more insight into these cases and reasons invoked by women, it is very helpful to turn to a few existing medical studies which attempted to clarify different types of health benefits invoked to justify performance of our genital surgeries.

The reasons revealed by research can be grouped in three large categories facilitating understanding of the complexities of this issue.[67] It should be kept in mind that the same woman can invoke to justify her request for surgeries a variety of reasons from different categories. The first category comprises what can be called aesthetical concerns: a woman would invoke the fact that she dislikes her vulvar appearance and would ask the surgeon to modify her vulva to fit certain image she prefers. The reasoning employed by women and medical practitioner in this case is identical to that of any other request for a purely cosmetic surgery. In this context a very important trend is revealed. Many women reportedly 'want

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[66] *Supra* note 40 and accompanying text.

[67] This classification was proposed and applied in Braun, *supra* note 18 at 1399.

Playboy-pretty outer vaginas (aesthetically-pleasing vulvar structures)'[68] or ask for a 'neat' vulva that resembles that of a prepubescent girl.[69]

Closely related to these aesthetical concerns is the second group of reasons which encompasses psychological distress or anxieties. This group of reasons is distinct from purely aesthetic considerations because a woman might desire a certain vulvar appearance without relating her aesthetic preference to any social or sexual embarrassment, anxiety or distress. However, the majority of cases where an individual is so concerned about her appearance that she is willing to undergo a modifying surgery the person requesting the surgery had at least some psychological influence either direct or indirect from society, community or family. On the other end of the spectrum can be situated women whose reasons for requesting the surgery are purely psychological: as for example women reporting embarrassment caused by jokes about their labia minora.[70]

The final group of reasons can be described as functional. This group encompasses women reporting discomfort when cycling, exercising or during intercourse. However, it is difficult to determine how much of this discomfort is real. For example, some women invoked discomfort when wearing tight clothes. Firstly, this reasoning is based on a very strange logic: the wearing of tight clothes appears as a matter of such an importance that women choose to tailor their genitalia instead of simply buying a different type of clothing. Secondly, this also raises the question about how much of the reported discomfort is related to the size of genitalia as opposed to the type of clothes women wear when exercising or cycling. Thus a woman influenced by some external image of 'perfect' genitalia might be less

[68] Matlock, *Sex by Design* (2004).

[69] Lloyd et al., *supra* note 62.

[70] Jothilakshmi et al., *supra* note 52.

tolerant to sensations related to her existing genitalia which do not correspond to this idealized image:

> clearly women and girls are not the only people to accommodate genital discomfort during activities and/or in contact with certain garments. Most men have a far greater share of this inconvenience and, because they do not seek reduction of their genital mass as a solution, some women's intolerance of the physical sensations of their labia is at least partly informed by a psychological "discomfort" about how their genitals present.[71]

The above description of reasons demonstrates how difficult it is to distinguish functional, aesthetical and psychological motivations. It also highlights how dependent choices of real women are on the traditional Western perception of female genitalia. The most disturbing is the nature of this dominant perception which pushes women towards genital cosmetic surgeries: women need to look unnaturally young and confirm to some standards set by pornography.

If we turn now to anthropological studies of FGM and the reasons which push women and girls towards this practice we will discover many similarities which are not invoked in the dominant human rights discourse.

It is important to emphasize from the outset that all anthropologists insist that 'there is in fact no single reason or consistent set of socio-cultural determinants for female genital cutting.'[72] As with female genital aesthetic surgeries, the reasons invoked by women and girls can overlap. However, it is possible to identify some recurrent reasons which will play

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[71] Liao et al*., supra* note 20 at 7.

[72] Ellen Gruenbaum, *Socio-Cultural Dynamics of Female Genital Cutting: Research Findings, Gaps, and Directions.* 7 CULTURE, HEALTH AND SEXUALITY: AN INT'L J. FOR RESEARCH, INTERVENTION AND CARE 429, 435 (2005).

different roles in various settings and for different women and girls. One of the reasons invoked for maintenance and performance of FGM in many cultural settings is related to beauty ideals and aesthetics. Female genitalia after surgeries are viewed as more smooth which is considered to be beautiful.[73] This beauty ideal overlaps to some extent with the aesthetic preferences expressed by women and girls who wish to undergo female genital aesthetic surgeries in the West.

Another recurrent pattern of explanations for confirming to the practice of FGM in the cultures of the Other stands in parallel to what was described as psychological discomfort in relation to our aesthetic surgeries. Thus, it is reported that uncircumcised girls and women will feel excluded by other circumcised girls and women and therefore wish to undergo the surgery in order to become fully respected members of women's community.[74]

The apparent or real discomfort with their genital some Western women invoke as their reason for requesting the surgery is echoed in the hygiene as a reason for maintenance of FGM in many communities practicing female genital surgeries traditionally.[75]

Through this short review of anthropological research it becomes clear that the Other's cultural reasons for performing FGM are very similar and at times identical to reasons invoked in support of the necessity to maintain the mental health exception to laws prohibiting FGM. Therefore, the distinction between FGM and female aesthetic surgeries is not justified anymore. The Other's culture and our mental health conflate into one another so

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[73] Ibid. See also Richard A. Shweder, *What About "Female Genital Mutilation"? And Why Understanding Culture Matters in the First Place.* In Shweder et al. (eds.) ENGAGING CULTURAL DIFFERENCES: THE MULTICULTURAL CHALLENGE IN LIBERAL DEMOCRACIES 216, 221 and 224 (2002); Gruenbaum, *supra* note 54 at 125-126.

[74] See e.g Hernlund and Shell-Duncan, *supra* note 42 at 52-53; Gruenbaum, *supra* note 70 at 433.

[75] See e.g. Ahmadu, Disputing the Myth, *supra* note 60 at 17; Gruenbaum, *supra* note 54 at 132; Shweder, *supra* note 71 at 221.

that the distinction becomes hardly justifiable. At this point some human rights activists would raise their concern about some types of FGM which go much further than any type of female genital aesthetic surgery and thus have negative consequences for women's and girls' health. They would certainly refer to the practice of infubilation (type 3 FGM according to the WHO classification). In this regard it is important to remind that according to research findings of Carla Obermeyer, Associate Professor of Population and International Health at Harvard University, the information available about health consequences of all types of FGM but even more so of type 3 FGM is only poorely supported by serious and well-designed studies.[76] Rather the widely-held belief about health consequences of FGM is perpetuated by constant repetition and citation of more advocacy- than health- oriented studies.

Thus, far from representing a deviant and exotic culture of the Other FGM symbolise and perpetrate exactly the same values which are protected and portrayed in our societies though a series of very similar and at times identical practices. Therefore, the focus of human right on the surgeries of the Other to the exclusion of any consideration of human rights effect of Western genital aesthetic surgeries is unjustified and discriminatory.

4. What Role for Human Rights?

The review of laws prohibiting FGM in UK, Ireland and Canada reveals a pattern of discrimination which also results in the racialisation and estrangement of black and brown women. As long as a black woman is able to get a surgery on her genitalia if she presents her concerns as aesthetic or psychological, while she will be refused the very same surgery if she

[76] Carla M. Obermeyer, *Female Genital Surgeries: the Known, the Unknown, and the Unknowable*. 13 MED. ANTHROPOLOGY Q. 1305 (1999) and Carla M. Obermeyer, *The Consequences of Female Circumcision for Health and Sexuality: An Update on the Evidence.* 7 CULTURE, HEALTH, AND SEXUALITY: AN INT'L J. FOR RESEARCH, INTERVENTION AND CARE 443 (2005).

invokes her culture, the pattern of discrimination remains alive and visible despite careful and silencing language of some laws. This discrimination is triple-edged: it is a discrimination based on gender, race and culture. However, these three factors interact in a variety of complex ways. Negative connotations of 'cultural practice' associated with FGM facilitate racial discrimination as illustrated by the discussions surrounding the issue of mental health in the UK House of Lords. De-culturalised and normalised vision of our 'aesthetic' surgeries and Western societies more generally facilitates condemnation of the culture of the Other. Gender discrimination subsists on two fronts: black and brown women have fewer choices with regard to traditional practices they wish to follow while white women are directed towards surgical modifications of their genitalia to fir the imposed idealised image of a female. These intersecting patterns of discrimination are justified with reference to the necessity of achieving gender equality. For black and brown women equality is conceived as coming from outside and these women are presented as being unable to make choices which are best for themselves. For white women equality is presented as being realised in the possibility for them to make choices of most suitable surgeries.[77] This possibility of using equality rhetoric as a device for maintenance of discriminatory and racialised laws and practices is troubling.

Moreover, this approach puts into place a series of process which contribute to the maintenance and reinforcement of the division between 'us' and 'them', which sustain and reinforce the Otherness of women of colour. By presenting the culture of the Other as a static and unified block defined by its most conservative practices and traditions it contributes to

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[77] For an interesting discussion of the issue of choice as a device for allowing differential treatment of FGM as opposed to female genital cosmetic surgeries see Virginia Brown, *The Women are Doing it for Themselves* 24 AUSTRALIAN FEM. STUD. 233 (2009).

the alienation of the Other by making them feel misunderstood. It also creates additional hurdles for internal contestation of conservative practices and discourses within cultures.

This process leads to the bipolarisation of discourses and visions: practice, culture, the Other or We can be either good or bad, to accept or to reject. As a consequence, nuances and multiplicity disappear. Firstly, multiplicity of Other's practices, their meanings and forms is forgotten and hidden, but sometimes even eliminated. It is important to mention in this regard that in reaction to the simplified and grotesque vision of its culture the Other adopts a defensive position which can lead to the presentation of this most conservative vision of its culture as the only authentic. This in turn facilitates simplistic presentation of Other's culture as a unified block characterised by its most conservative practices: the vicious circle is created. Secondly, multiplicity of visions of gender equality also becomes impossible: Since we are quite 'good' on equality compared to 'them' we stop questioning and developing a critique of our visions of equality. Being preoccupied with all these 'horrible' practices of the Other we do not view our own persisting problems as worthy of being addressed, as serious enough. Deficiencies of 'Our' gender equality disappear from political agendas and media discourse.

How does international human rights law respond to this challenge? Does it address this challenge at all? What role should international human rights play in this context? In order to answer these questions, it is necessary to briefly recall how international human rights law addresses the issue of female genital surgeries.

Despite the knowledge of the diversity in practices of female genital surgeries as performed by the Other (WHO typology), all the different types of practices are addressed as a whole thus contributing to the simplification and elimination of multiplicity. Moreover, the WHO started addressing other vaginal practices of the Other.[78] However, there is no

[78] See the WHO Study, *supra* note 32.

reference at all to our female genital surgeries either in the discourse of the WHO or in various documents of other human rights bodies. Addressing only the practices of the Other despite the existence in Western countries of exactly the same not medically indicated[79] but performed for different societal and individual reasons operations, maintains discriminatory effect visible in national laws analysed above.

Thus, for the time being, international human rights law does not perform any role in breaking the process and vicious circles described above. Rather, by focusing on FGM exclusively, international human rights law contributes to the perpetuation of discriminatory attitudes and alienation and racialisation of the Other.

In order to answer the question about appropriate role for human rights in this context, I will start by formulating some proposals about the way international human rights bodies could start addressing the practice of female genital surgeries. As a next step some more general suggestions about the role of human rights as a devise for promotion and protection of human dignity of any human being will be formulated.

The first step towards a more constructive approach to female genital surgeries, an approach which will be the first step towards breaking down the process of alienation and racialisation of the Other, is to address all female genital surgeries (either ours or the surgeries of the Other) within a single framework. Within this single framework various surgeries can be addressed differently according to the degree to which they might affect women's genitalia. However, if the surgery is the same technically: e.g. labia minora reduction which is one of the most common types of our genital cosmetic surgery and also one of the forms of the FGM defined by the WHO, then regulations should be the same irrespective of the existence or not of a cultural motivation in an adult women's decision. It is simply hypocritical to affirm that any form of FGM (including labia minora reduction) 'has

[79] Remember the definition formulated by the ACOG *supra* note 17 and the accompanying text.

no benefits, only harm' and prohibit it even for adult women just because she desires to follow some of her culture's practices while allowing the very same surgery to be performed for motivations acceptable to Western public. If labia minora reduction causes only harm this is true for any woman in any circumstances. If we allow for exceptions in some circumstances (mainly based on the women's choice), we should allow for these exceptions in all comparable circumstances.

In order to regulate all different types of genital surgeries in a coherent manner a lot more research needs to be done on health consequences of various types of both cosmetic and traditional genital surgeries. As already stated, the defining element in adopting appropriate regulations should be the nature of the surgery and its health consequences but not the question of whether the request for surgery is motivated by the unacceptable culture of the Other or our own familiar cultural standards. Similarly, reasons and motivating factors in women's and girls' choices should be explored in more depth. This is particularly true for our surgeries. As far as the Other's surgeries are concerned, human rights lawyers and activists should be careful in not projecting their imagined picture of the situation on the reality of these women's and girls' experiences and agency.

A hint towards such a global approach to genital surgeries is given in the CEDAW's general recommendation No 19 on violence against women.[80] When explaining the causes of violence against women and linking violence to traditional attitudes and stereotyped roles the CEDAW Committee first enumerates a series of practices which rather point out the culture of the Other: family violence and abuse, forced marriage, dowry deaths, acid attacks and female circumcision.[81] However, immediately follows a paragraph emphasising our own comparable traditional attitudes: pornography and the depiction and other commercial

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[80] *Supra* note 22.

[81] *Id.*, para. 11.

exploitation of women as sexual objects, rather than as individuals.[82] While the Committee does not list female genital cosmetic surgeries as such, the link could be easily established especially for the part of surgeries motivated by pornographic culture. This approach of the Committee clearly demonstrates that Western societies also have their own traditional practices and attitudes contributing to the persistence of violence against women. Female genital cosmetic surgeries are just one of the examples.

Unfortunately, the CEDAW Committee does not develop further this point and when addressing female genital surgeries, it only focuses on the surgeries of the Other as all international bodies. However, these few sentences demonstrate the potential and possibilities of international human rights law in adopting a holistic approach to same or similar human rights violations.

Finally before turning to some more general remarks about the role of human rights in addressing culture, I will emphasise that the age of women and girls undergoing genital surgeries either here or there is an important consideration to bear in mind in designing appropriate ways in addressing these practices. However, the approach chosen needs to be uniform across different places where same or comparable types of surgeries are practiced. In this sense, the focus of the human rights law only on the harm done to girls through the practices of the Other has become inappropriate and outdated after the knowledge about the perfomance of genital aesthetic surgeries on minors in the West became available.

Before formulating a few more general suggestions about the role of international human rights in addressing culture as a human rights issue but also in fulfilling its promise of protection of all human beings equally, it is necessary to mention some underlying causes which allowed human rights to become complicit in this discriminatory attitude to female genital surgeries. The starting point for understanding the role and position of human rights is

[82] *Id.*, para. 12.

the following sentence from a book by Costas Douzinas: 'The end of human rights comes when they lose their utopian end.'[83] The above review of the attitude toward female genital surgeries demonstrates that for the majority of Western states international human rights lost their utopian end. Western societies regard themselves as having already achieved all what human rights require, as having realized human rights despite some minor remaining issues. This uncritical view of oneself becomes only possible because the societies and cultures of the Other are portrayed as barbaric and horrific. This in turn is possible because human rights law and activism is only poorely informed by interdisciplinary analysis and a serious effort of understanding cultures (both Other's and our own). As already explained above, the racialisation and alienation of the Other makes bipolarization and simplification of discourses possible.

In order to reverse and interrupt this vicious circle there is an urgent need for Western societies to rediscover human rights not as substantive values to be achieved but as a space where negotiation and dialogue are made possible. Within this dialogical space conditions should be created and maintained to make everybody's voice heard, including the voice of persons affected and specialists in other fields and not only officials and activists of international organisations and dominant NGOs.. In this context the process of rethinking of state-centered international structures is crucial. Finally, both states, but also human rights activists, NGOs and other actors involved in the field should constantly remind themselves that there are no human rights in the substantive sense, but only goals and values to re-define, re-defend, and re-discover.

[83] Costas Douzinas, THE END OF HUMAN RIGHTS (2002), last sentence.