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Strategies Implemented to Stop FGM/C: A Case Study of Kenya and Ethiopia

Esther W. Waweru
MSc in Development and International Relations (2012), Aalborg University
Email: ciikuwaweru@gmail.com

ABSTRACT. The purpose of this article is to investigate the western influence and implications for the discourses and practices of Female Genital Mutilation/Cutting (FGM/C) and this is presented with the two case studies: Kenya and Ethiopia. The article seeks to understand why FGM/C has taken such a long time to be eliminated considering it has been presented to be harmful to the lives of women. The main focus lies on the arguments of universal human rights, which is heavily depicted by those who oppose the practice whereas the right to culture is supported by cultural relativism theory. As a conclusion the author notes that the influence from "the west" has had an impact on the discourse of FGM/C. It also points out that the current argument of FGM/C being a violation of human rights may be the ideology that seems to fit in well with most countries, but it still faces criticisms and these objections reflect the slow rate of eradication of this practice.

Introduction

According to the World Health Organisation (WHO), Female Genital Mutilation/Cutting (FGM/C) is recognized internationally as a violation of the human rights of girls and women. WHO (2010) estimates that between 100 and 140 million girls and women worldwide have been subjected to this practice. Estimates based on the most recent prevalence data have shown that 91.5 million girls and women above the age of 9 in Africa are currently living with the consequences of FGM/C and it is also estimated that every year at least 3 million girls in Africa are still at risk of undergoing FGM/C.

The debate on FGM/C is one that tends to bring about an emotional response from all who understand it or have come across it. Feminists, anthropologists, health practitioners, legislators and human rights organisations have, for many years, deliberated tremendously in trying to justify the reasons why this practice should be abolished. Many believe that this practice should be eliminated from the face of the earth as it does more harm than good to the physical being of the woman. On the other hand, there are others who argue that it is a matter of culture and a sense of identity

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and that this cannot be judged by any other person apart from those within their own culture.

Looking at the debate, most of the discussions tend to stem from the perspective of human rights and that of cultural relativism. The two theoretical ideologies are what both the opposition and those who are for the practice generate their arguments from. Thus this article will focus on these two topics and derive an analytical understanding of the debate on FGM/C.

Universalism

The concept of the universal human rights came up after the Second World War and the horrific legacy that it left behind, which was a result of allowing individual states to define and pursue their own values (Morsink 1999 and Wronka 1998, as cited in Reichert 2006: 26). The Universal Declaration of Human Rights (UDHR) marked a historical moment when fascism had been defeated and when belief in the future was irrefutable. The desire to identify and understand the universal dilemmas of humankind and the search for equally universal solutions, gave way to many quarters of postmodern pessimism and disjuncture, on the one hand, and the celebration of difference and relativity, on the other. The human rights standards and procedures are intended to be neutral; in that they apply to all humans by virtue of common humanity and are not supposed to take account of sex, gender, sexual preference, skin colour, ethnicity, nationality, religion, or politics hence showcasing their universalism (Nagengast 1997: 350). However, the concept has experienced a great deal of criticism. One important criticism is that universalism insinuates colonial practices that assume the dominance of one group over others as it bases its values, ethics and power on the same assumption (Reichert 2006: 27; Ife 2001: 58). As such, the universal concept encounters a legitimate obstacle: that of local cultural, religious and legal norms. The universal human rights principles compel all nations to enforce these principles and this is where contradictions set in: that is, between the local cultural norms and the established universal human rights (Reichert 2006: 28).

Relativism

[Cultural] Relativism is essentially an anthropological and sociological concept that denotes that the manifestation of cultures hold a wide and diverse range of preferences, morality, motivations, and evaluations that no human rights principles can be said to be self-evident and recognized at all times and all places (Shestack 1998: 228). As one of the main critiques of the universalism concept, its perception is that all cultures are equal, that the universal values become secondary when examining cultural norms, and that no outside opinion is greater than that of the local culture (Reichert 2006: 29). Cultural relativism received its prominence greatly due to its principle of counter colonialism. The main theme of colonialism was that one culture was superior to the others but anthropologists in the 1900s argued that each culture had value in itself. According to the principles of cultural relativism, all points of view are equally valid and it maintains the fact that there is an irreducible divergence among cultures because each of these cultures is a unique entity with different parts intertwined within their structure and each cannot be understood or analysed without reference to the other parts and the cultural whole (Lawson 1998: 13, as cited in Reichert 2006: 29).

As mentioned earlier, FGM/C is predominately practiced in Africa. This article focuses on two case studies: Kenya and Ethiopia. The choice for these two countries

was mainly driven by the author's background being Kenyan and the desire to understand why FGM/C is still tolerated even after all the research and evidence presents it as being quite harmful to the health of women.

The case of FGM/C in Kenya saw its first opposition during the colonial era. An article written by Bodil F. Frederiksen (2008) shows the beginning of the controversy that continues even today. In her article, she presents the case of Kenya and how the practice of clitoridectomy first erupted in the mid-1920s and was perceived to be in the same line of thinking as a political approach of the colonial regime. The British political system and the Protestant missions in Kenya challenged the right of these communities to continue practising what was perceived as a "barbaric" custom. Female circumcision brought in a controversy that emerged across Britain particularly due to concerns about the consequences that the practice brought about. This foresaw colonial administrators drafting out a policy that stated that the "custom should not be interfered with as it came from an ancient origin", but that it would be an "offense if the people performed severe cutting or incision of greater extent than necessary for the removal of the clitoris during the girl's circumcision" (Frederiksen 2008: 32). This restriction of rights to a custom that involved female circumcision did not bring about the beginning of the elimination of the practice, but rather it brought about resistance from the communities who still wanted to continue with their cultural practice that they identified with and it also became "the heart of the anti-colonial struggle" (Frederiksen 2008: 25, 35).

There are other cases where the opposition did not set in until much later such as it was in Ethiopia. Ethiopia's history of FGM/C is not quite as extensive as it is in Kenya, however, female circumcision is assumed to have started before the conversion to Christianity by the emperors in the 4th century. It is also associated with the early Judaic practices at that time and it may have started at the same time as the male circumcision (EGLDAM[1] 2008: 83). Infibulation, which is mainly practiced in Afar region, can be traced back to the Turkish invasion of the Red Sea coast in the early 15th century. The practice was performed to keep girls/women from being raped and impregnated by invaders.[2] Unlike Kenya, Ethiopia was never colonized; hence did not receive as much influence from the west. But after the colonial era, the opposition of FGM/C was experienced in this country and was mainly pioneered by the western countries.

In time, the topic of FGM/C was no longer seen as just a mere local practice, it became a global concern. The very first attempt at a global discussion/study on the practice was first presented in 1958 by the Economic Council of the United Nations which requested for a study to be carried out by WHO. This motion was denied with the argument that the practice was a social and cultural issue rather than a medical matter as they had presented it. Three years later in Addis Ababa, this request was later on reiterated by African women who had attended the United Nations General Assembly. The request was again denied by WHO as they had a policy that mandated them to not interfere with domestic politics unless they were invited by the state itself (Boyle 2002: 41). This however, did not stop here, as it will be elaborated further on below, there were other numerous debates and discussions being carried out globally, which are still being applied and argued upon until today.

Given the many years of deliberations, one would assume that the goal to eliminate the practice would have been achieved by now. However, this is not the case; for as much as there were those against the practice (Hosken 1981), there were those who were for it (Njambi 2004). This made it hard for opponents of FGM/C as whatever arguments they brought to the table were always refuted with reasons as to why the

practice should still be upheld. One of the main arguments for this was the fact that the people who were mainly against the practice were of European descent and had no understanding as to why the ritual was undertaken. This was perceived as ethnocentric, with Western values pushed onto African values which tend to disregard the African perspective.

With all the controversy that comes out of FGM/C as a practice, the one standpoint that has been adapted and been implemented by various developing organisations and governments (such as Kenya and Ethiopia) is that of human rights and the fact that this practice violates the rights of the woman and child. This ideology has become embedded in different policies and particularly, adapted in countries where FGM/C is quite dominant with the aim of eradicating it. Despite legislation that have been enacted to stop it, FGM/C is still practiced and it seems that the end of it may not be near. It is therefore important to ask: "What have been the implications of Western influence for the discourses and practices of FGM/C?"

Definition and Brief History of FGM/C

Female Genital Mutilation/Cutting can be defined as the practice that involves the partial or total removal of the external genital organs of a female for "customary or any other non-therapeutic reason" (Toubia et al. 2007: 3). The customs and beliefs surrounding the various forms of FGM/C are quite widespread. The earliest recorded findings of the practice are from Egypt where the writings suggest that the "practice had been in Egypt for over 2000 years" (Cloudsley 1983, as cited in Carr 1997: 3). The Egyptian practice of excision was praised by a Greek physician who elaborated that "unless the clitoris was cut it would grow and lead to inappropriate thoughts or behaviour in young women" (Abdalla 1982, in Carr 1997: 3).

Evidence also shows that during the slave trade, traders preferred women slaves who were infibulated as they would be best for labour since they were not distracted by childbearing and thus would fetch a higher price (Cloudsley 1983, in Carr 1997: 3). Most of the theories regarding genital cutting suggested that it was a form of safeguarding the 'value' of the woman, by ensuring virginity before marriage and legitimate heirs during the marriage. All in all, there has not been any definitive evidence that documents exactly where and why the practice began (Carr 1997: 3).

Genital cutting primarily occurs in Africa; however, this does not mean that it is only restricted to this region. Research shows that as late as the 20th century Western physicians believed that some of the mental disorders found in women could be treated through the removal of external genitalia (ibid). According to Toubia's (1995) research, in the 1800s some physicians theorized that hysteria and lesbianism could be managed by modification or by the removal of the female genitalia (ibid). Although mostly perceived to be a Muslim practice, research shows that "genital cutting predates Islam in Africa" (Toubia 1995, as cited in Carr 1997: 3). Additionally, this practice has been "documented among various faiths such as Christianity, Judaism and traditional religions" (ibid).

Prevalence Rate

Figures on the prevalence of FGM/C are important since they assist researchers in understanding the extent at which this phenomenon is undertaken. Surveys have shown that there are several variations (social-economic and demographic factors)

when it comes to this practice among different groups of women. Different women are more likely to undergo genital cutting depending on these variants but the patterns have shown that these variations are not always consistent across countries (Carr 1997: 13). For the purpose of this article, six of these variations will be looked into in relation to the two country case studies. This will include religion, age, wealth, residence (urban/rural), education and ethnicity.

Current Situation in Kenya

FGM/C has been widely practiced in Kenyan communities for many years and it continues today even though the practice has been condemned as harmful as it poses a great risk to the health and the well-being of the women and girls who are subjected to it (KDHS 2003: 250).

Figure 1
Knowledge of FGM/C and Prevalence rate of circumcised women according to the background characteristics in Kenya, 2008

Background Characteristics	Percentage of women who have heard of female circumcision	Percentage of women who are circumcised	Number of women	Number of circumcised women
Age				
15-19	93.3	14.6	1,761	257
20-24	96.2	21.1	1,715	361
25-29	97.1	25.3	1,454	368
30-34	96.9	30.0	1,209	363
35-39	96.8	35.1	877	308
40-44	97.4	39.8	768	305
45-49	96.9	48.8	661	322
Residence				
Urban	97.5	16.5	2,148	355
Rural	95.6	30.6	6,296	1,929
Education				
No Education	87.5	53.7	752	404
Primary Incomplete	94.4	28.8	2,526	727
Primary Complete	97.3	26.4	2,272	601
Secondary +	98.8	19.1	2,894	553
Religion				
Roman Catholic	95.8	29.1	1,852	540
Protestant / other Christian	96.9	23.5	5,748	1,349
Muslim	93.9	51.4	626	322
No Religion	80.9	38.3	185	71
Ethnicity				
Embu	99.6	51.4	120	61
Kalenjin	99.9	40.4	1,115	450
Kamba	97.8	22.9	923	211
Kikuyu	99.4	21.4	1,642	352
Kisii	100.0	96.1	579	556
Luhya	95.6	0.2	1,373	3
Luo	90.9	0.1	1,098	1
Maasai	100.0	73.2	113	83
Meru	99.4	39.7	415	165

Mijikenda/Swahili	77.9	4.4	430	19
Somali	99.6	97.6	240	234
Taita/Taveta	99.5	32.2	79	25
Other	86.7	38.9	315	123
Wealth Quintile				
Lowest	90.2	40.2	1,393	560
Second	96.4	31.0	1,483	460
Middle	97.3	29.4	1,613	474
Fourth	96.9	25.9	1,736	449
Highest	97.9	15.4	2,220	341

(*Source:* KDHS 2008: 266)

Over the years, the Kenyan Demographic Health Survey (KDHS) has recorded a decline in the number of women circumcised. According to the 1998 report, the prevalence rate of circumcised women between the ages 15-49 was recorded at 38%. This dropped to 32% according to the KDHS report of 2003 and again to 27% in 2008 report. As explained earlier there are different socio-economic and demographic factors that determine this (see Figure 1).

Laws Regarding FGM/C in Kenya

In 2001, the government of Kenya adopted the Children Act which is a part of the legislation that condemns female genital mutilation for minors. Article 14 of the act states that: "No person shall subject a child to female circumcision, early marriage or other cultural rites, customs or traditional practices that are likely to negatively affect the child's life, health, social welfare, dignity or physical or psychological development" (Kenyan law reports). Although the government has enacted some laws, they have received criticism from anti-FGM/C activists who believe that the legislation is not strong enough in its punishment of offenders.

Maendeleo Ya Wanawake Organisation (MYWO)

In Swahili, "Maendeleo Ya Wanawake" means "progress/liberation for women." MYWO was founded in 1952 and is a non-profit voluntary women's organization with a mission to improve the quality of life in rural communities, especially for women and youth in Kenya. One of MYWO's principle programs is "Advocacy Strategy for the Eradication of Female Genital Mutilation in Kenya." Being a grassroots organization that is comprised of Kenyan women, MYWO was among the first organisations that were involved with the awareness and eradication of harmful traditions that affected the health of women. The organisation recognizes the cultural significance of female circumcision rites; however, it also strongly denounces the harmful practice of mutilation, especially on young women and children, and its aim is to eradicate FGM/C in the most culturally sensitive way possible, thus preventing the loss of tradition or cultural identity (MYWO: 2007).

Current situation in Ethiopia

Ethiopia is a country with deep historical roots that have been there for generations. Some of these traditions violate human rights, particularly the rights of girls and women. The national committee on traditional practices in Ethiopia listed 88 practices

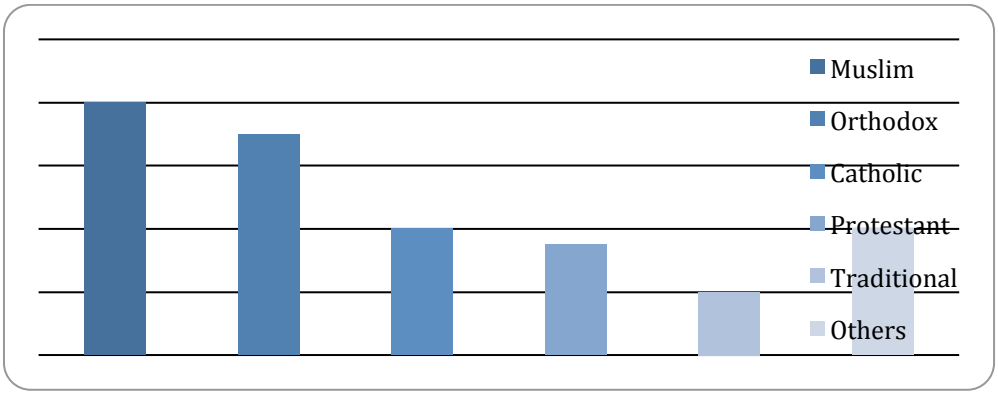
as harmful and under those mentioned FGM/C was one of them (UNICEF-Innocenti 2010: 24).

Among the African countries, Ethiopia is one of the countries with a high prevalence rate of FGM/C. The latest record of the 2005 Ethiopian Demographic and Health Survey (EDHS) shows that the prevalence rate is 74%; although the number is still quite high, there has been a gradual decline in the number. In 2000, the prevalence rate was recorded at 80% hence this shows a 6% point drop to the current statistics (ibid).

Being a highly diverse country, the prevalence rate of FGM/C in Ethiopia has been influenced in several ways. Figure 2 highlights some of the socio-economic factors that have influenced the FGM/C rates.

Figure 2

Percentage (%) Prevalence rate of FGM/C by religion in Ethiopia, 1997



(*Source:* EGLDAM 2008: 104)

Laws on FGM/C in Ethiopia

In 2005, a new criminal code was enacted and it acknowledged the suffering caused by harmful traditional practices to women and children. Article 565 on Female Circumcision states that "Whoever circumcises a woman of any age is punishable with simple imprisonment for not less than three months or fine of not less than five hundred Birr (US$ 45)". Article 566 stipulates a law against Infibulations of the Female Genitalia: "whoever infibulates the genitalia of a women is punishable with rigorous imprisonment from three years to five years". In addition, Article 569 states that "the persons who are accomplices (cooperated) to the crime as parents, guardians or in any other capacity are punishable with imprisonment not exceeding three months or a fine not exceeding Birr 500 (US$ 45)" (Dagne 2010: 6).

Figure 3
Knowledge of FGM/C and Prevalence rate of circumcised women according to the background characteristics in Ethiopia, 2005

Background Characteristics	Percentage of Women who have heard of female circumcision	Percentage of women circumcised	Number of women
Age			
15-19	90.0	62.1	3,266
20-24	92.5	73.0	2,547
25-29	91.9	77.6	2,517
30-34	91.1	78.0	1,808
35-39	93.1	81.2	1,602
40-44	94.3	81.6	1,187
45-49	92.1	80.8	1,143
Residence			
Urban	97.8	68.5	2,499
Rural	990.5	75.5	11,571
Region			
Tigray	82.9	29.3	919
Affar	98.4	91.6	146
Amhara	88.9	68.5	3,482
Oromiya	97.1	87.2	5,010
Somali	98.1	97.3	486
Benishangul-Gumuz	79.5	67.6	124
SNNP	86.7	71.0	2,995
Gambela	44.6	27.1	44
Harari	99.8	85.1	39
Addis Ababa	99.5	65.7	756
Dire Dawa	99.8	92.3	69
Education			
No Education	89.8	77.3	9,271
Primary	93.8	70.8	3,123
Secondary and Higher	99.3	64.0	1,675
Wealth Quintile			
Lowest	87.9	73.0	2,428
Second	89.7	75.9	2,643
Middle	90.4	75.4	2,732
Fourth	92.2	77.6	2,647
Highest	96.8	70.6	3,621

(*Source:* from EDHS 2005)

The National Committee on Traditional Practices Ethiopia (NCTPE)

NCTPE, currently known as EGLDAM, was established in 1997 to help overcome traditional practices harmful to women's and children's health. It is currently the strongest working network of organizations that mainly deals with FGM in Ethiopia (EGLDAM-FGM.net). In 2003-2005, NCTPE, together with Intra-health

International, established an approach known as a Five-Dimensional Approach that would assist in the eradication of FGM/C in Ethiopia. The project was aimed at encouraging FGM/C abandonment by "closing knowledge gaps, strengthening communication links among policymakers and different groups within the community, and empowering women to change their attitudes and behaviour toward FGM/C" (Feldman-Jacobs et al. 2006: 19-20).

Progression of Anti-FGM/C Discussions

As elaborated in the introduction, FGM/C has been, and still is, a contested topic for quite a long time. Having to identify the most effective and appropriate strategy for the elimination of the practice seems to be the key argument surrounding this topic. Looking at the evolution of the debates, it can be noted that the journey against this practice has not been an easy one. The first time FGM/C was brought to the international audience in 1958, the practice was deemed or categorised as a "social and cultural matter" – hence, it should be dealt with by the state involved. The United Nations Charter recognised the sovereign power of member states hence the United Nations could not intervene in matters that were within the domestic jurisdiction of any state (Boyle 2002: 44).

This did not mean the end of opposition especially for the western feminists including Fran Hosken, Mary Daly and Gloria Steinem (ibid: 45). Early in the 1970s, these feminists, together with women's international organisations were quite vocal and confrontational arguing that "FGM/C was a serious problem requiring immediate international attention" (ibid). This spurred international attention to have a second look at the topic. The feminists' argument against FGM/C was that it acted as "a tool of patriarchy and a symbol of women's subordination". They further stated that "FGM/C was sadistic and part of a global patriarchal conspiracy" (ibid: 46). Many African women found this discourse offensive. In particular, this was seen in the international women's conference in Copenhagen, where African women boycotted Fran Hosken's session, calling her viewpoint insensitive and ethnocentric toward the African woman. Despite the criticism of the feminists' viewpoint, their rhetoric did capture the attention of the international community.

The International Governmental Organisations (IGOs) finally decided to intervene and stop FGM/C, but they did not rely on the feminists' argument since it was quite controversial, instead they used the scientific argument of women's health as the justification for the eradication of FGM/C (ibid: 48). At that time, the WHO and several non-governmental organisations (NGOs) had already started intervening in national arenas to assist in birth control programs; thus, the programs to eliminate FGM/C tended to fit within this mobilisation. African nation states also rooted their eradication policies on the health discourse and there was a major joint effort from the nations named the Inter-African Committee on Traditional Practices Affecting the Health of Women and Children.

With the categorisation of FGM/C within the health rhetoric, it permitted a "compromise between rights and sovereignty"; hence international actors did not appear to be discriminating against African nations to reform. As a result, FGM/C became a health issue since medicine was neutral and exists apart from politics. In addition, medicine was closely linked to modernization and progress, hence it was argued that "It would be irrational and therefore inconceivable for a culture to reject modern medicine" (Boyle 2002: 48-49). This statement assumes that all people would

want to be modernized and that, in this case, it would become 'modern' if they had access to modern medicine.

This notion could be supported by that of Kantian and Rawlsian theories, both of which are criticized as being an aspect of universalism (Renteln 1990: 50). According to the Kantian theory, it states that the existence of a single pattern of moral reasoning will in turn be presumed to bear a single and universal result irrespective of cultural differences. The theory of Rawls had a similar notion stating that once an individual is stripped of their identity, they will inevitably choose the principles of justice by which a society should operate. Both had the conviction that human beings think alike and if faced with the same problem they would act the same. This is similar to the notion of the introduction of medicine as a discourse in the elimination of FGM/C which insinuates that all cultures would be irrational to reject modernisation. This might be plausible if they all came from the same culture and the notion to solve the problem was ideally their own, not brought or forced upon them by outsiders. But with this situation, the problem being faced (FGM/C) was not perceived as one by those involved (communities that uphold it), thus the ideology could be said to have started off on an unstable foundation.

The medical discourse was somewhat effective in making people aware of the consequences of FGM/C. However, a new trend began in response where those still upholding the practice searched for trained medical personnel to perform it. Thus, this discourse may have reduced the incidence of FGM/C but in some areas it was deemed preferable to make the practice medically safe. With this turn of events, the health discourse took a back seat and by mid-1990s there was a transition from the medical model to the human rights model (Boyle 2002: 51).

This came at a time when the international system had begun creating formal mechanisms for dealing with gender equality—notably, the Convention for the Elimination of All Forms of Discrimination against Women (CEDAW) (ibid: 52). A joint statement of WHO, United Nations Children Fund (UNICEF), United Nations Fund for Population Activities (UNFPA), and United Nations Development Program (UNDP) in 1995 labelled the medical basis for anti-FGC policies a ''mistake.'' The reason being that the medical discourse was counter-productive: instead of pushing for the practice's eradication, it made FGC/M safer. Thus in the long run the IGOs repackaged the message to: "FGC had negative health consequences, but, more importantly, it was a violation of women's rights" (Boyle 2002: 54-55). This was the message that was later on transmitted to all countries and particularly those who still do practice FGM/C. The next section will look into how this was implemented within Kenya and Ethiopia.

Enacting the Human Rights Model Within Kenya and Ethiopia Laws

Elizabeth Boyle (2002: 82) has argued that if a law is generated locally, then a nation state would ensure that these laws incorporate the unique local identities as well as the unique laws that emerge from each "local culture and power structure". This insinuates that by understanding the different local interests and power relationships, one could explain as to why such laws have been put in place and one could also foresee how local groups would react to their enactment. Boyle also argues that if these laws were an influence from the international culture, then the nation states would incorporate their laws within the interests of the universal principles – thus creating a different understanding within the local cultures where this law is enacted.

These arguments can be understood in terms of how the two case countries here adopted their laws against FGM/C. However, this contradicts with the ideology of the universal declaration of rights

The UDHR could not be termed as universal if it was not in fact that universal. The entire 193 member states of the UN have to abide by this declaration as it is part of their obligation to follow the UN Charter. Hence, as it is, enforcement of the human rights standards has also been transcended at the regional level. The regional body in Africa, The African Commission on Human and People's Rights, was inaugurated in 1987 and in the following year adopted the African Charter on Human and People's Rights (ACHPR). Article 45 under the mandate of the commission states that one of the functions of the Commission is:

> To promote human and peoples' rights and in particular: a) to collect documents, undertake studies and researches on African problems in the field of human and peoples' rights … b) to formulate and lay down, principles and rules aimed at solving legal problems relating to human and peoples' rights … and c) cooperate with other African and international institutions concerned with the promotion and protection of human and peoples' rights. (ACHPR.org)

This article is in line with UDHR and hence African states are obliged to follow the charter in place. Any act or practice that is against the article should be presented and be dealt with legally including FGM/C as a violation of human rights.

Having adopted the universalist stand, some activists insisted that FGM/C should be condemned and be punishable by legislative force. Thus, the 1990s saw the international community accepting only laws that mandated complete eradication of the practice, as such, many countries adopted this prohibition in their national laws, including Kenya and Ethiopia; especially since donor funding was seen as linked to the practice. As indicated earlier, the laws in both countries clearly state that the act is an offence and whoever is caught performing the practice should be punished, either by fine or imprisonment depending on the person's involvement. Under Kenyan law, however, the prohibition of FGM/C is only seen in the children's act protecting any one under the age of 18. These laws follow a similar phrasing as that of the U.S. law denoting that international forces have had a great influence on them (Rahman and Toubia 2000, in Boyle 2002: 93).

As much as the laws against the FGM/C have been put in place, there have been limited sources stating that these laws have been enforced. In fact, some sources have shown the retaliation against criminalisation of the practice. There have been recorded cases of deaths caused by excessive bleeding and lack of medical attention resulting from self-mutilation carried out due to fear of being arrested. In an incidence in Kenya, a girl died due to excessive blood loss after she performed the genital cutting on herself. The article states that "Pamela did the procedure on her own because she was being teased by her friends for not being circumcised...". Her mother had refused to allow her to be circumcised, as she had seen how uncircumcised girls were getting "education and doing well in life", but her daughter's friends were calling her names and that is what led to her circumcising herself (BBC News 2006). Another report shows a case of a young girl who died in the hands of a circumciser. Her parents could not take her to hospital and risk arrest (Wangila 2007: 1). According to the members of this community "abandoning this practice was and still is equated with Europeanization and deculturation", thus this has led some communities to be "patriotic and embrace the practice" (ibid: 32). This remark demonstrates one of the criticisms of the universalism of human rights. The criticism is that universalism insinuates colonialists' practices which assume dominance of one group over the

other. This could explain why some communities are still adamant in retaining this practice.

In this regard, if nation states constituted their own laws based on their citizens' interests, laws would be tailored to the specific situations of the states that pass them. An example of this was observed during the colonial era where such interests were considered. In Kenya, for instance, the British colonial system and the protestant missions challenged the right of the communities practicing FGM/C. The colonial administrators, however, drafted a policy stating that "custom should not be interfered with as it came from an ancient origin" but that it would be an "offense if the people performed severe cutting or incision of greater extent than necessary for the removal of the clitoris during the girl's circumcision" (Frederiksen 2008: 32).

The enactment of laws that criminalize FGM/C has led to things being more problematic than expected. The adoption of laws from the international community that prohibit a cultural practice can be portrayed as censoring a population and discriminating against their way of life. In turn, this has led to resistance and subsequent setbacks in the anti-FGM/C campaigns. With reference to the relativism theory (Lyons 1976: 109), it explains two categories of the ethical relativism: the agent-group relativism and the appraiser's-group relativism. According to the agent-group relativism, an act should be judged by applying the norms of the social group at which the act is being carried out. The criminalisation of FGM/C can be explained to be against the norms of the communities that practice FGM/C. It can be argued that the enacted laws did not necessarily come from the society where the act is being performed, instead they were introduced by a society where these norms are looked upon as alien or "uncivilized and barbaric" (Shell-Duncan and Hernlund 2000). This also brings about one critique of the universalism of human rights, that of it being ethnocentric, having its ideology mainly from the Western philosophers who are "prone to project their moral categories on others" (Renteln 1990: 49). It has been generally viewed that third world countries tend to have less of an option when it comes to international policy reforms (Boyle 2002: 100).

In an analysis carried out by Dezalay and Garth (1996), in Boyle 2002: 100)—which attempted to elaborate more on the international agreement system by examing why third world countries participate in these arbitrations despite Western bias—, the conclusion was that these countries "had no other options; international arbitration was the only legitimate outlet when business conflicts emerged" (ibid). The influence from the international community is not only witnessed within the laws of these countries, but it has also transcended into the organisations working against FGM/C.

Approaches Implemented by Local Organisations

It can be clearly noted that the meaning and importance of FGM/C is not only across time and cultural contexts, but also within societies whose members have diverse rationale for preserving the practice. According to Gruenbaum (2001: 49), "each region or culturally identified group is likely to have more than one explanation for any practice". She also states that "the interests in preservation or change in the practices vary starkly depending on gender, age, education, status, ethnicity and religious background" (Gruenbaum, in Shell-Duncan and Hernlund 2000: 257).

In this paper, some of these interests were taken into consideration in relation to the case studies of Kenya and Ethiopia. In comparing the two countries the prevalence rates are quite different, Kenya having a percentage as low as of 27% (KDHS 2008)

while Ethiopia having a percentage of 74% (EDHS 2005). Even though the latest recordings have a margin of three years between them, Ethiopia is still on the higher side of those practicing FGM/C. Other than that, both countries seem to have a variety of different reasons why this practice is still upheld. To help analyse this, the factors that are chosen include education, residence, wealth, age, religion and ethnicity. These factors, as explained, tended to be more similar in these two countries and they have a striking correlation with the practice. Of course, the degree of correlation differed from country to country, but there were findings that showed some similar traits.

As much as there are some similarities observed, there is quite some variation when it comes to the percentages. For instance, the cases of residence, education and wealth in Ethiopia show that their correlation with FGM/C is not high, compared to that of Kenya; difference between the highest percentage and the lower one is not as great. These results could mean that there are other social pressures or factors that have a larger influence on the practice being continued and the above factors may not have as much impact. Hence, the results show that for Ethiopia the main factors that influence the prevalence of this practice are religion and ethnicity (region). As for Kenya all the above factors have a significant contribution towards the prevalence rate, but ethnicity stands out to have greater influence on the practice of FGM/C.

Considering the above information, several organisations, both local and international, have been able to come up with strategies/approaches that would aid in diminishing the practice of FGM/C. The paper will look at the two local organisations in these countries that have been part of the leading teams in this campaign: The Maendeleo ya Wanawake Organisation (MYWO) in Kenya and the National Committee on Traditional Practices (NCTPE) in Ethiopia. These two organisations have been mainly collaborating with different international organisations that have projects that are geared to the elimination of the practice.

In most cases, the reason as to why there is the introduction of the international organisations is due to funding, however, there are other factors that could denote this. One of these factors could be the one that is illustrated by Keck and Sikkink (1998: 36) on a "boomerang effect" of international action. According to them, this is where local actors reach out to international allies to assist in pressuring the governments to change the domestic practices that may be affecting the population. When the enactment of laws has not had as much success as hoped for, the involvement of the international organisations might help in making the campaigns more effective. This argument can be justified by the results experienced from the two approaches presented.

In Ethiopia, the Five-dimensional Approach was a two-year project (2003-2005) and the target group was mainly in the regions of Harari, Oromia and Somali. The design mainly focused on communication channels, cultural and religious values, social roles (of both men and women in the community), reproductive health and gender (Feldman-Jacobs et al. 2006: 22). It is noted that the design is in accordance to the findings presented on Ethiopia as being factors that influence the prevalence rate, religion and ethnicity.

The evaluation of the project in 2005 showed that there were several successful achievements, however, some of these achievements were not a replication of the situation on ground. It is true that this approach may have reached many people and that it may have "broken the ice on FGM/C and started a community dialogue that was kept a taboo"[3] but the EDHS report of the same year 2005, shows that the regions where the project focused on still held the highest prevalence rate: Somali - 97.3%, Oromiya - 87.2%, and Harari - 85.1% (see Figure 3). Nevertheless, there have been

other approaches that have been integrated within the country to try and eliminate this practice, which may be the reason as to why there has been a steady decline of 6% in the prevalence rate between the year 2000 and 2005.

The approach used in Kenya since 1996 by MYWO, the Alternative Rite of Passage (ARP), was introduced as majority of the findings showed that ethnicity was the main variable that influenced the frequency of the practice. The communities that practiced it did so as it is seen as a rite of passage. This meant that they believed that every girl had to go through the ritual to be acknowledged as a woman. The ARP's focus are: to provide education to young girls and women on growing up, reproductive health and the transition to womanhood; and to have communities publicly recognise an alternative ceremony for the rite of passage from girlhood to womanhood (Feldman-Jacobs et al. 2006: 29).

An evaluation by the Population Council on the MYWO's approach was that the ARP intervention could be successful if FGM/C is part of a community ritual and linked to a rite of passage (Oloo et al. 2011: 10). However, another evaluation carried out in 2001 criticised the approach. It stated that the approach will have little effect unless the process is accompanied by participatory education that engages the whole community. Any initiatives that only involved the at-risk girls would not promote a collective reflection that may help in the changing of social attitudes and norms, but may instead have the social stigma of being uncut progressed and so leading to girls being pressured to undergo the cut (UNICEF - Innocenti 2010: 37).

According to the MYWO reports, the approach has proven to be successful in some of the communities involved, but not with others. One of the targeted communities, the Kuria community,[4] seemed to have a problem accepting the alternative rite passage. Reports show that the local network involved in the abandonment campaign focused more on providing rescue centres for the young girls during the circumcision season. The girls within these centres were taken through the ARP approach (i.e., education and awareness) and they attained a certificate at the end of the process. However, because the community was secluded from the process, the girls, their parents, and community did not recognise it as an alternative rite of passage, therefore, there was no public acknowledgement of the girls becoming women (Oloo et al. 2011: 29). This could confirm the criticism stated earlier that without involving the whole community, the stigma and social pressure will still linger. With the setbacks experienced within the ARP approach, the country has seen other approaches being introduced and utilised. The incorporation of other methods may be the result of the country having lower prevalence rates recorded and a continuous trend of the prevalence rate dropping.

All in all, both approaches have shown similarities as to how they are implemented. The main feature they do share is that of education. Through education they are able to relay information that concerns the consequences of FGM/C to the reproductive health of women and also enlighten the girls and women on their rights. This follows the international discourses that have taken place over the years and thus, it can be asserted that the eradication of FGM/C has mainly been influenced by international debates. As such, both countries have demonstrated that external influence has had a positive impact towards the elimination of the practice. However, there were some limitations that were reported and as in Ethiopia where even though there has been a decline, it is still one of the countries with a large number of girls/women still undergoing FGM/C.

One might question: are there other factors that have not been considered within Ethiopia concerning the continuation of the practice and that may have made progress

toward the elimination of FGM/C slow paced, such as, an earlier exposure to the West? Unlike Ethiopia, Kenya was colonised by the British and with that, the beginning of the opposition to FGM/C when the colonial administrators drafted a law against the practice. Ethiopia, on the other hand, having been a free country, has had the opportunity of not having its culture questioned by outsiders. Its customs were therefore deeply rooted within its people, thus external opposition to these customs may not have been as successful and may have caused a backlash and may explain why the numbers are still very high.

Perhaps the approaches being implemented are a catalyst to invigorate the communities to continue with the practice. That is, the enactment of the laws that criminalise the customs of the communities, as well as the approaches implemented by the local organisations that alienate girls from their traditions may be the reason as to why cases such as self circumcision and parents secretly performing the practise on their children still persist.

One thing that is certain, culture is supreme in the way that it holds a powerful moulding and shaping of an individual's perceptions (Herskovits, as cited in Renteln 1990: 65). Thus, following the customs of a given culture gives the individual a sense of belonging and in this case for a girl/woman it also represents the transition from childhood to an adult, a role that is respected and honoured. This has also been explained as the reason why the custom is still upheld. Following this argument the inclusion of human rights, as a way forward to change this practice may have been the wrong step to take following this argument. With universal human rights, the main focus is on the individual and the rights of the single unit. This, in relation to cultural settings, is quite foreign as the idea of upholding the individual is not at the forefront, rather the idea of a community is what is considered as key and that is what an individual from such a community identifies with.

Several scholars have made recommendations on how to curb this tradition. Mackie (1996: 1015) had three – two of the recommendations included education campaign and public declarations from parents and community to stop the practice, both of which have been seen in the approaches carried out in Kenya and Ethiopia. His third recommendation was that "public opinion should deplore the bad health consequences of FGM/C". He argues that the communities that practice this tradition do so because "they are good people who love their children"; therefore, "campaigns that insinuate otherwise is bound to provoke a defensive reaction from them" (ibid). This is evident in the case of Kenya where girls went to rescue camps during the circumcision season, however, the community did not acknowledge the act as the alternative rite of passage it was meant to be, despite education efforts.

This also explains the reason why there are still cases of the practice even with the laws against FGM/C being in place. It has been suggested that laws enacted in response to FGM/C should also "prevent the infringement of the rights of the individual to cultural determination" (Atoki 1995: 234). Accordingly, the law must also protect the wishes of those individuals who wish to freely exercise their right to be circumcised and ensure that this is done within the statutes of law. The law should also limit the performance to trained practitioners and only be performed in approved settings. Such a law would be more efficacious than one which completely bans the practice. Enacting a ban does not eradicate FGM/C, rather it "succeeds in driving it underground" (Atoki 1995: 234). This can be supported by Ruth Benedict's statement that suggests tolerance. She states that once an opinion is embraced as a customary belief, we arrive at a more realistic social faith that may lead to coexistence and equality of valid patterns of life that mankind has created for itself (Renteln 1990:62).

This argument could also support the critics of the notion of FGM/C as violation of human rights. The enactment of laws that completely ban FGM/C, in fact, are themselves a violation of the human rights; that is the right of right to choose what one does to one's own body, regardless of the consequences.

All in all, the introduction of FGM/C to the international arena stirred up the pot, which now the whole world has to face and in particular the countries that have a high rate of the practice. Establishing a "hands off" approach, as most of the cultural relativists scholars would suggest, is out of the picture. This is because the practice is no longer a situation that happens only in Africa, but one that has seen cases of immigrants in the developed countries that still practice it. However, as much as there is international involvement, the current notion of FGM/C being a violation of the girl/woman has still not established ground within these practicing communities.

Conclusion

The topic of FGM/C is one that is divisive and difficult to address as it raises several issues. On the one hand, there is the problem of culture and tradition clashing with a modern-international society. On another hand, there are gender and social issues to consider as well as health matters. The paper's aim was to understand the implications of Western influence in the approaches taken by local organisations and governments and this was best done through the relevant data that was collected and presented. This paper has demonstrated that there have been a lot of activities being carried out in the two country cases and that international opposition to FGM/C has had such a great influence in the approaches that have been taken to eliminate this practice in both countries. Some of these influences were achieved either through direct measures, the establishment of laws against FGM/C, or through an indirect route in the case of local organisations partnering with international organisations to exert more pressure on authorities to fight the FGM/C pandemic. Nevertheless, this influence has brought about different responses from the communities involved, and has in turn brought about a change—or decline—in the number of girls/women that have been circumcised.

Another fact that has been demonstrated is that societies may differ in their placement of the fundamental moral principle, but they do agree on the principles themselves (Andre and Velasquez 1992: para 5). In this case, both the opposers and those in favour of the practice are striving to attain their fundamental moral principle, which is the protection of the girl/woman. This could be through both identification and acceptance by a society, or through creating awareness of the rights of an individual. This is also quite evident when considering the different ideologies and debates presented in relation to FGM/C.

Research has shown that some of these ideologies have worked to an extent, but they have also faced a number of criticisms to the point of having them deemed inadmissible to the subject. The argument of FGM/C as a violation of human rights may be the ideology that seems to fit in well with all the countries (predominantly in the international opinion), but it has faced its criticism and will still gather more in the future. Therefore, an end to this harmful practice can only be achieved once a middle ground is established. The strategy for the elimination should not be focused on isolation, but instead it should involve the lives and the opinions of those affected by it, as well as the local and global discourses that have been integrated. This could be achieved through accepting FGM/C in these ways: having lenient laws that do not

obliterate the practice completely but maintain the protection of children from harm, supporting adult women who still want to have the practice done to them even after they have been made aware of the consequences that may occur, advocating for less severe methods, rather than the rigorous ones that cause more complications (i.e., infibulation), and lastly, having the option of medicalization for those who still want it done as it will provide a safer way for the procedure to be done.

Such a strategy includes the moral principles that both parties want to observe and still respects the two standpoints. Most of all, such a strategy would act as a form of weaning for the future generations and could possibly bring an end to this practice.

Notes

1. Ye Ethiopia Goji Limadawi Dirgitoch Aswogaj Mahiber (EGLDAM) is the former National Committee on Traditional Practices Ethiopia (NCTPE)
2. Unpublished reports from Dehad on Afar Leader and Asmelash CARE on the Egyptian Myth in EGLDAM 2008: 83.
3. Statement from Amal Redwan, Intrahealth Project Manager (Source Feldman-Jacobs and Ryniak, 2006: 27).
4. The Kuria community lives in Nyanza Province together with the Kisii and both have a high prevalence rate of FGM/C.

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