

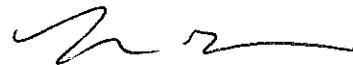
THE DISABLING IMPACT OF FEMALE GENITAL MUTILATION: AN AUTO-ETHNOGRAPHIC STUDY OF ONE WOMAN'S EXPERIENCE OF FGM

FAITH ADODO

Supervisor's Name: Dr. Rachel Gorman

Advisor's Name: Dr. Geoffrey Reaume

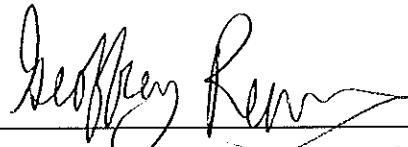
Supervisor's Signature:



Date Approved:

March 29, 2017

Advisor's Signature:



Date Approved:

March 29, 2017

**A Research Paper submitted to the Graduate Program in Critical Disability Studies in
fulfilment of the requirements for the degree of**

Master of Arts

Graduate Program in Critical Disability Studies

York University

4700 Keele Street, HNES 409

Toronto, Ontario

M3J 1P3

(February 2017)

TABLE OF CONTENTS

Abstract	1
Introduction	2-7
Chapter One: FGM, Disability and Lived Experience	8-18
Chapter Two: Patriarchy, Gender Inequality and Disability	19-36
Chapter Three: Disability, Tradition and Resistance	37-45
Conclusion	46-51
Works Cited	52-54

ABSTRACT

Drawing upon the author's personal experience of Female Genital Mutilation (FGM), this MRP examines the powerlessness and lack of agency of females who are subjected to this disabling practice. This research project explains the many negative health, emotional and psychological consequences of FGM and describes the difficult task of erasing the deep scars caused by the practice. A major aspect of this MRP is an attempt to draw linkages between the personal impacts of FGM and the social, cultural and religious factors contributing to the perpetuation of the practice in some countries. There is a particular focus on African countries and especially Nigeria. The primary aim of this research project is to demonstrate the need for critical discourses around the disabling impacts of FGM and to promote the implementation of progressive laws and policies that respect the rights of girls and women to control their own bodies. Entrenched patriarchal traditions and religious beliefs uphold FGM, and this MRP discusses the stigmatization, marginalization and barriers imposed on women who refuse to submit to bodily mutilation as a rite of passage to womanhood. The study's auto-ethnographic research methodology facilitates exploration of the disabling consequences of FGM in areas such as intimacy, marriage, parenting and family life. In order to provide historical context, this auto-ethnographic methodology is supplemented by analysis of the social and historical origins of FGM. Recognizing the intersecting factors that support FGM, the study pays particular attention to the ways in which religion, race and gender combine to marginalize and silence many women in their religious communities. Overall, this research project seeks to explain the historical origins of the practice of FGM, its ongoing disabling impacts on girls and women in some societies, and the need for transformed gender norms that empower the voices and support the self-determination rights of girls and women in deeply patriarchal countries such as Nigerian.

INTRODUCTION

Being born as a Nigerian female automatically placed me in an inferior position because the deeply patriarchal Nigerian society viewed, and continues to view, women as lacking rights and as being dependent on male control over them, and especially over their sexuality. One might think, or hope, that FGM is a relic of a past time but, according to Dorkenoo (1994), it is estimated that over 100 million girls and women in Africa alone are genetically mutilated, and the number continues to rise (p. 31). At current rates of population growth in Africa, two million girls per year - about 6,000 per day - are at risk of having FGM imposed on them (Dorkenoo, 1994, p. 31). Female identity norms strip most Nigerian women of the right to have sovereignty over their own bodies and patriarchal traditions are at the root of this gender oppression. I was born in a Nigerian community in the western part of Africa where FGM was widespread in the 1960s to the early 1980s, and it was the cultural and religious beliefs of the people who lived there that propagated the practice of FGM. Many girls and women in Nigeria have first-hand experience of the disabling impacts of FGM as this practice is performed on female children at a very early age or during early adulthood, depending on local traditions. A number of rationalizations have been put forward to support the practice of FGM.

One of the main reasons why FGM is imposed on females is the belief that removing the clitoris helps to reduce the sexual urges of young women, which are supposedly so overwhelming they cannot control themselves or behave like responsible adults. It is assumed that women who are mutilated will be more sexually responsible as young girls and when they are married. However, this view ignores the health implications, pain and trauma of FGM; fundamentally, it ignores women's autonomy and rights. Walker (1996) asserts that women should have access to protection against all forms of violence, including rape, genital mutilation,

domestic battering and sexual harassment (p. xxiii). Although some progress has been made in the area of women's rights in Nigeria due to the rise of feminist perspectives, Walker's (1996) list of women's rights has not been achieved. FGM is not as widespread as it was in the 1940s but the practice is still practiced in some rural parts of Nigeria and other African countries.

I believe that it is time to recognize and raise awareness about the harmful impacts of FGM and the complex psychological and emotional damage that disables the lives of the women and girls who are forced to experience the procedure. The main focus of this MRP is my home country of Nigeria. Madara's (2003) research on the women and children that have been mutilated in Nigeria explores three major ethnic groups amongst whom FGM is still practiced - Hausans, Yoruba and Ibo - and finds that a total of 197 (34%) of the 500 women participating in the study had some form of genital mutilation (p. 293). Of these, 27 reported hymenectomy and were excluded because the condition is not clinically detectable, and Madara (2003) suggests that the phase of life during which FGM was performed could explain why 93 of the remaining 170 women (55%) lacked knowledge of having had the procedure (p. 293). Clearly, large numbers of Nigerian girls and women continue to be subjected to FGM.

The Critical Disability Studies (CDS) literature and theories discussed in this MRP relate predominantly to issues of power and oppression, especially within patriarchal belief systems and societies that impose systemic disability on women. Among the key themes that this study examines are the roles of culture, religion and patriarchy in shaping exclusionary norms of female identity, especially within the contexts of sexuality, marriage, motherhood and the family. These issues are examined in order to highlight the multiple social-structural factors that contribute to the practice of FGM. Indeed, the concept of intersectionality is incorporated into this MRP because it accounts for the many factors that contribute to the disabling impacts of

FGM on women in Nigeria, Africa and everywhere the practice is performed. It is commonly recognized that some disabilities are physical and visible while others are mental and invisible, but multiple forms of oppression can overlap while disabling members of various social groups, and some forms of disability are invisible even to those who experience them, as in the case of adult women who do not even know they have been victims of FGM. Moreover, refusal to submit to FGM can be just as disabling as the practice itself. Women who reject dominant cultural norms that mutilate females are vulnerable to oppression and the patriarchal culture of Nigeria can accurately be said to have structural norms that discriminate against and disable the entire female population of the country. These norms have deep historical roots.

At a fundamental level, FGM has been used to differentiate between respectable women who embrace the practice and the prostitutes and slaves who do not. Fear of stigmatization and marginalization within the home and community is built right into the process and submission to patriarchal domination confers social acceptance. Lightfoot-Klein (1990) indicates that “Pharaonic circumcision” is a practice that throughout history has given circumcised women an honorable, dignified and protected social status (p.81). The phrase “Pharaonic circumcision” is substantially synonymous with the common terms “female circumcision” or “female genital mutilation.” Boddy (1982) indicates that Pharaonic circumcision involves removing the woman’s clitoris and labia minora, after which the labia majora are sewn closed except for a small opening that facilitates the release of urine and menstrual blood (cited in Lightfoot-Klein, 1990, p.688). Traditionally, uncircumcised women have been unable to marry and therefore unable to produce legitimate sons to carry on their husbands’ patrilineage. Lerner (1986) observes that in deeply patriarchal societies an unmarried woman has virtually no rights, and practically does not exist as a social entity (p. 8). Thus, FGM must be understood within the wider socio-historical context of

the oppressive impacts of patriarchy on women and particularly an abiding patriarchal concern to construct ‘respectable’ women who embrace inferiority and submit to their male masters.

Pharaonic circumcision has been performed ritually for thousands of years, but today it often takes place in clinic-like settings in urban centers where it is performed on small girls, generally between the ages of four and eight, regardless of the family’s social standing. In outlying areas, the procedure is conducted in old fashioned ways by medically untrained midwives, without any anesthesia or antiseptic. The brutality and violence of the practice is amply demonstrated by the fact that the struggling girl is held immobile throughout a 15-20 minute operation that has a high likelihood of hemorrhage, infection, trauma to adjacent structures, shock from pain, urinary retention due to sepsis, edema and permanent scarring (Lightfoot-Klein, 1990, p. 81). It seems inevitable that tremendous psychological trauma will occur in most cases of FGM, even if much of that trauma is repressed and remains buried beneath rigid, defensive layers of psychological and emotional denial.

Communities that embrace FGM place tremendous pressure on females to conform to traditional social norms. As Lightfoot-Klein (1990) observes, communities that place great pressure on girls to believe that their genitals are dirty, dangerous or a source of irresistible temptation to males will feel relieved to be made “normal” through FGM (p. 84). To be different produces anxiety and mental conflict because girls who have not experienced FGM are despised and made into targets of ridicule. Moreover, no males in the community will marry them. Such women are therefore denied the very reason for being of the female within the community - marriage and childbearing. Lightfoot-Klein (1990) confirms that uncircumcised women suffer greatly in tightly-knit social groups where female genital mutilation is the rule because they fear

the physical brutality of the event, which is both a rite of passage and a punishment of femininity:

Girls tend to approach circumcision with a mixture of dread and eagerness and it is not uncommon for them to manifest severe anxiety and a generalized phobic reaction as the time approaches. They become afraid of being touched, of knives, of social gatherings, of going to sleep... by the time their turn comes, they have experienced at a distance, if not actually seen, the circumcision of other girls, have heard the frantic screams, quite possibly seen the blood of their predecessors. The day of circumcision is considered the most important day in a girl's life, far more important than her wedding day. The principal effect of the operation is to create in young girls an intense awareness of their sexuality and anxiety concerning its meaning, its social significance. In general, the practice emphasizes punishment and social control, clearly indicating to the small child a sense of the mystery and importance of sex, at the same time creating an all-consuming terror of the evils of unchaste behavior in her (p. 84-85).

Predictably, a major symptom of FGM is depression and there is much evidence of the psychosexual and emotional distress associated with the practice. Despite this, family and community support mechanisms can reduce the emotional devastation of FGM and, out of necessity, some circumcised women learn to adapt after the procedure. However, Lightfoot-Klein (1990) emphasizes that "there are many who experience not only repeated intense physical suffering, but who periodically suffer intense emotional pain as well" (p. 88-89). In many ways, the long-term effects of FGM resemble those of PTSD; it is, after all, an extremely traumatizing event. It is clear that "Pharaonic circumcision" and all the other variations on the practice of

FGM have disabling physical, psychological, emotional and social impacts on most of the girls and women who are subjected to the practice.

CHAPTER I: FGM, DISABILITY AND LIVED EXPERIENCE

Defining FGM

There are different definitions of FGM but this MRP draws upon the above-mentioned description of FGM as a procedure through which a woman's clitoris and/or labia minora are surgically removed, purportedly in order to prevent the woman's sexual desires from being uncontrollable. The procedure is normally unsafe and can sometimes lead to death due to problems such as infection or excessive blood loss. Various traditional beliefs support FGM but the precise nature of the mutilation differs between cultures. According to Madara (2003), female circumcision can involve partial or total removal of the female external genitalia (prepuce, clitoris, labia minora and labia majora) (p. 291). Various forms of FGM exist and the World Health Organization offers the following classification:

- Type I: Consists of excision of the clitoral prepuce, and it is known in Muslim countries as the Sunnah circumcision.
- Type II: Involves excision of the prepuce, the removal of the glans clitoris or the entire clitoris with varying degrees of the adjacent parts of the labia minora. This is often referred to simply as excision.
- Type III: Termed infibulation and also referred to as Pharaonic circumcision. It is the most drastic procedure and the one resulting in the most serious adverse health effects. It involves removal of the whole clitoris, the whole of the labia minora and the medial parts of the labia majora (Madara, 2003, p. 292)

Madara (2003) further states that FGM is not practiced solely in one area of the world - of the estimated 85 to 114 million girls and women who have undergone genital mutilation, most live in Africa, a few in Asia and, increasingly, the practice is seen in the United States and Canada (p.

291). According to Madara (2003), female genital mutilation in Nigeria is documented in works by Adebajo, Oduntan and Onadeko (p. 291). The existence and extent of the practice has been studied by the Inter-African Committee on Harmful & Positive Practices Affecting Women and Children (Madara, 2003, p. 291). It is evident that the practice of FGM is widespread but it is strongest in African countries and, although there has been a great deal of advocacy rejecting FGM, people still practice it for the sake of their traditional religious and cultural beliefs.

The practice of FGM is associated with different cultural and religious beliefs but Shaw (2004) points out that it is most strongly associated with Islam since many Muslims believe that FGM is a “divinely decreed obligation” of all Muslim females that symbolizes respectable adult female status and eligibility for marriage (p. 2). Shaw (2004) also indicates that FGM is not universally practiced in Islam (or in any other religion) but is a regional practice in 28 African nations, in parts of the Middle East and Asia, and in immigrant communities that migrate to western nations (p. 2). However, according to Shaw (2004), support for FGM is in a general state of decline in all areas of the world as girls and women around the world become more aware of their rights and the need to fight for women’s right to equality and self-determination (p. 2). Shaw’s (2004) work on this topic clarifies the many rationalizations that have been put forward to justify the practice of FGM, indicating that FGM is meant:

[T]o lower the female sex drive and thereby ensure virginity and fidelity in marriage; to promote social cohesion; to ensure profitability as higher bride prices are exacted for greater male sexual pleasure; to conform to cultural roles of women being destined to suffer pain and men to inflict it; to obey cultural notions of aesthetics or hygiene; as a response to superstitions that the clitoris is unfeminine and is dangerous to the husband or rivals the male penis; and to conform to tradition for its own sake (p. 2).

Shaw (2004) emphasizes that the pressure on girls and women to be circumcised are so powerful that even women who are deeply opposed to the procedure may bow to social pressure to have it performed on themselves or their daughters (p. 2). Penalties for non-compliance can be devastating and include “ostracism by family and friends, and unmarriageable status^{as an} unclean, morally disreputable or un-Islamic woman” (Shaw, 2004, p. 2). Within patriarchal communities that promote FGM, women who refuse to have the procedure are personally and socially disabled through stigmatization and social rejection. This affects their physical health, their mental health, their sense of community belonging and their well-being as a whole.

Personal Narrative of FGM Experience

My personal experience of FGM demonstrates clearly that it has many disabling impacts on the lives of girls and women in Africa and implicates issues such as gender identities and roles, power, patriarchy, human rights and the rights of children. Friedman (1984) references the view of Spacks that “women dominate their own experience by imagining it, giving it form, writing about it... They define, for themselves... woman as she is and as she dreams” (cited in Friedman, p. 80). However, the dreams of women who have experienced FGM are often nightmares and they do *not* dominate their own experience; instead, they are dominated in almost all areas of their lives and must wage a long and difficult battle to gain the knowledge, self-awareness and agency that are required to begin shaping their own lives. Growing up as a girl in Nigeria, I had no sense that FGM was a disabling practice because the practice was accepted in our community and viewed in a very positive light. Most people believed that FGM was an important event to be celebrated in the life of a female child. It was a social norm in Nigeria - and still is to some extent, especially in rural areas - and people simply embraced the cutting off of significant portions of a girl’s genitalia as a natural and happy occasion. Indeed, it was not

until I had begun making the transition from girlhood to womanhood that I began to realize just how disabling the practice of FGM really was.

I started questioning FGM in my young adult life when I had my first sexual relationship with a man. My experience with sexual life was something I couldn't discuss with my parents because that was taboo in my family and community. I remember vividly, as if it was yesterday, how I initially hated sex because it caused great pain instead of the pleasure I was looking forward to. Unable to understand what was wrong, I thought something wasn't right with me. But I could not really disclose this to my friends because not everybody who suffers FGM has the same experience. Also, it was a personal matter and I didn't want my peers to think differently of me, as though something wasn't right with me or that I was a 'different' kind of girl in general. So, I kept that aspect of my life to myself. But the questions that remained unanswered would not let go and my desire to know what was wrong continued growing.

When I entered my mid-twenties, I decided that it was important for me to know what was wrong with me, especially since my peers were discussing the extreme fun and pleasure of their sex lives. I summoned my courage, went to a family doctor and disclosed the problems with my sexual life. My avoidance of sex had become an issue in my relationship with my boyfriend at the time - indeed, that was a factor that encouraged me to seek medical advice. I also experienced constant bladder infections and knew something was physically wrong. After the examination, the doctor informed me that the pain I experienced during sexual intercourse was associated with genital mutilation. It turned out that the type of FGM I had undergone as a girl was the WHO's Type Two version of the practice, sometimes referred to simply as "excision" (Madara, 2003, p. 292). Madara (2003) explains that this type of FGM involves excision of the prepuce of the clitoris and removal of most, or all, of the clitoris along with varying degrees of

the adjacent parts of the labia minora (p. 292). The doctor stated that most of my clitoris had been removed but I didn't even know what a clitoris was. After his explanation clarified the matter, I immediately became angry at what had happened and soon came to understand all the medical, physical, emotional and psychological implications that were associated with the practice. I promised myself that if I ever had a female child I would not allow anyone to violate her rights or the integrity of her body for the sake of an absurd patriarchal belief. But the fact of the matter is that women were and are deeply involved in supporting FGM.

After visiting the doctor I returned home and asked my mother to explain some of the details of the mutilation. She proudly declared that her father - my grandfather - had performed the procedure and reminded me that FGM was her father's profession. In most cases FGM was performed by older women within our community, but in my case my grandfather happened to be the local community 'surgeon.' Our family was very proud of the fact that he had personally mutilated over 10,000 babies in the community. Because of this, he was highly respected and celebrated in the small and highly patriarchal community. Indeed, my mother proudly told me that of all the girls and women he had mutilated through FGM, only one had died (through bleeding to death). My mother further claimed that the death was not the fault of her father; the woman had died because she was associated with witchcraft. The people in the community were convinced that the death did not result from the normal and healthy practice of FGM but from the malice of evil spirits.

I asked my mother why FGM was performed on girls when it posed potential health threats and she immediately told me to "shut up." She was mortified at the thought that I might speak such forbidden thoughts in the community and bring shame and social ostracizing onto our family. She stressed that FGM was part of a cultural tradition that could not be changed; all girls

had to undergo FGM so they could grow into adulthood as sexually responsible women. FGM was needed to bring women under control by reducing their sex drive and enabling them to remain chaste as single women. When married they would be able to limit themselves to one sexual partner - their husband. My mother said that, thanks to FGM, I would be a sexually responsible girl growing up and a responsible woman when married. She explained that I wouldn't be too sexually active like the "spoiled" girls in our community whose parents objected to the circumcision of their daughters. My mother explicitly stated that FGM was about the sexual control of women. She believed that most women could not resist the touch of a man and were constantly driven to have sex because of the uncontrollable sexual excitations of the clitoris. Of course, most young men could not find the clitoris anyway and just fumbled away 'down there' awkwardly, but I was too inexperienced at the time to make this point.

My mother did her best to justify the traditional practice of FGM but I didn't agree with her at all. I knew something was very wrong about mutilating girls and women but I wasn't educated enough to understand all the health issues as well as the cultural and religious implications of FGM. I clearly remember an occasion when the mother of my best friend Osa was showing her daughter how to wash her private parts properly and noticed that Osa had a prominent clitoris that was protruding as if in a state of excitation. Osa's mother was horrified at the sight of such a large clitoris, which was considered a very bad sign for a girl and a sure indicator of promiscuity, and immediately arranged for Osa to have FGM. Osa and I were both about ten years of age and I became caught up in the fear and drama of the situation. I couldn't help wondering why the clitoris was such a bad thing since it was a natural part of the female body that had been put there by God. I had so many unanswered questions in my head, probably because knowing how to cut off the clitoris was a well-established tradition in my family.

Before my grandfather passed away, he taught all his children how to perform FGM. Interestingly, my mother refused to learn how and claimed that she was too fragile and couldn't stand to see girls and women being mutilated. I was surprised by this. I asked my mother why she supported FGM despite her objections to the practice. She said that she had no choice but to support the practice since her father was the local surgeon responsible for performing FGM in the community. She also said that women had very limited choices and could not oppose the practice without being fined by the village council and socially ostracized for even thinking about challenging the deeply entrenched fear of the clitoris. My mother pointed out that in the future I would have the option of deciding not to mutilate my daughters but that for her there was no such option. I am the youngest child in my family and my three other sisters were also subjected to FGM. As a grown woman, one of my sisters still sees nothing wrong with FGM but the other two agree with my view that it is foolish and sustainable only by keeping women oppressed and uneducated. As a woman, I have experienced two ectopic pregnancies, one miscarriage and an extremely hard labor during child bearing. Sometimes I try to forget or deny what has happened to me, but I cannot forget the tools that my grandfather used when performing FGM.

When cutting off the clitoris and/or labia of females, my grandfather used a sharp razor blade that was not disposed of after use but reused on others without proper sterilization. Live snail, red palm oil, warm water, black soap and some other products that I don't clearly remember were also used in the procedure. I know that my grandfather normally requested that those items be brought by the parents whose child was to be mutilated. During the procedure, the snail was cracked open and the liquid inside applied to the parts that has been cut as this prevented excessive bleeding. Red palm oil was applied to the same area to prevent infection.

Black soap and warm water were used to wash the genitals after the parts to be removed were cut off. On one occasion, I witnessed my grandfather perform FGM on an infant girl and it was extremely traumatizing to see an innocent baby endure pain and suffering so harsh it seemed like military torture. It was horrifying to know that I had undergone the same procedure as a baby. It is because of my exposure to such horrors committed in the name of culture and religion that I have now chosen to share my lived experience of FGM. My story describes first-hand, personal experience of FGM and I know that I will live with the scars and disabling impacts of the procedure for the rest of my life. I firmly believe that it would help if all women who have been subjected to this terrible act of mutilation would share their stories of the disabling impacts of FGM as that would contribute to greater progress in abolishing FGM.

In some local cultures in Nigeria women receive FGM only when they are ready to marry but in my local culture the procedure was generally performed when the child was an infant and lacked any agency regarding the act. It made sense to me that FGM would not be performed, if at all, until a girl was old enough to make an informed and independent choice. But my mother explained that FGM was a cultural and religious ritual that was performed during infancy so that the individual would not remember the event or any of the pain connected to it. She clarified her point by further explaining that FGM was much more difficult to perform on older girls and she even admitted that some girls had died when experiencing FGM at an older age. The tissue around the clitoris is tougher in older girls, my mother continued, and the pain of FGM is greater, so most girls were circumcised as 7 to 14 day-old babies. As I grew in age and became better able to establish a degree of critical distance from the assumptions of my childhood culture, I wondered why there was so much fuss about female sexuality and such a strong social effort to establish male control over women and the female body.

When one grows up in a patriarchal society the superiority and privileges of males seem natural, but I increasingly began to wonder why males in our community had so many privileges while females were denied equality and rights. Like all young people, I thought about sex quite often and wondered why it was okay for men to be sexually active and enjoy sex but not okay for women. There was a belief in my culture that a young woman who had been sexually active before marriage was not suited to marriage and motherhood - she would be stigmatized as a ‘tramp’ and as a kind of self-appointed sexual object suited only for meeting the needs of any men who wanted her. This is the basic reason why mothers were strong guardians of their daughters’ chastity and some males - and females - in the family were anxious to see FGM performed on female members of the family; the whole family’s good reputation in the community was at stake in connection to a girl’s sexuality if this act was not performed.

As I continued to grow and think independently, I became increasingly aware of just how patriarchal and disabling FGM really was and is. I began to realize that it was an outrageous violation of the rights of female children and had no justification other than ridiculous and violent cultural and religious beliefs. I remain passionate about this issue to this day because my rights as a child were violated and I am still living with the scars and psychological pain of imagining what it must have felt like as a child with no voice or agency. I speak in solidarity with those girls and women who have shared the experience of FGM and I believe that this act should be completely eradicated. My goal is not only to express my experiences and emotions regarding this barbaric act but to use the sharing of my experience to allow readers to place themselves in my position and experience what it means to be vulnerable and disabled as a young girl - indeed, as a helpless baby - living in an oppressive society that is strongly dominated by males and profoundly irrational, fear-based patriarchal norms.

I hope that the narrative of my personal experiences will allow readers to share and explore subjective emotional issues connected to FGM, but later sections of this MRP discuss some of the existing literature on the health implications and disabling impacts of FGM. I would like to emphasize that I am writing not only for those who have shared my experiences of FGM but also for all those who want to advocate against the practice of FGM. Opposing FGM can be very difficult because many people in certain cultures still believe in the act of FGM, and that includes some women who are still very much in support of the procedure. That is why it's difficult to completely eradicate FGM. However, I will speak in unity with all those women and girls who share my firm belief that FGM is an inhumane practice - and, yes, a brutal and barbaric practice - that should be made unacceptable in Nigeria and in Africa at large. Indeed, I believe that FGM should be completely eliminated from every society in Africa.

My personal experience affirms that FGM is *not* a happy occasion and has many life-long disabling effects and health complications for those women who experience it. I can attest to the fact that the disabling impacts of FGM include physical, emotional, psychological and other health problems, and the struggles that women must endure in any of these areas can be very disabling. It is extraordinary that people in modern societies can support performing the procedure on infant girls who are utterly vulnerable and voiceless. Because they are born into a patriarchal society that uses its power to enforce harsh cultural and religious beliefs, small girls and babies are subjugated and forced to have their bodies mutilated. The persistence of FGM - as noted, even one of my own sisters supports the practice - raises many questions for me that are explored in this MRP. What would have been my parents' social location and position in society had they opposed social norms and prevented their children from experiencing FGM? How can we help children who are still vulnerable to this hideous act and experience it every day? What

legal rights exist to protect children from this terrible experience? What impact does FGM have on the lives of those women who have already been mutilated? What can we do to help them? What influences do religion and culture have on the practice of FGM? Can the impacts and memories of FGM ever be removed from the lives of affected women? And perhaps the most perplexing question of all: Why is it that so many women, including victims of FGM, continue to support the practice of Female Genital Mutilation?

CHAPTER II: PATRIARCHY, GENDER INEQUALITY AND DISABILITY

Disabling Impacts of FGM

In her discussion of the history behind the practice of FGM, Shaw (2004) indicates that the practice emerged in Egypt and the Nile Valley before the fifth century BC and then spread to most parts of Africa, Rome, Greece, the Middle East and parts of Asia (p. 2). FGM is generally viewed as being of pagan origin but is now practiced by members of several religions, including Christians, Jews, Muslims and traditional animists (Shaw, 2004, p. 2). However, Shaw (2004) further points out, as previously noted, that the practice is most strongly associated with Islam since Muslims believe that FGM is a “divinely decreed obligation” of all Muslim females which represents a symbol of adult status and eligibility for marriage (p. 2). Basically, FGM is intended to bring female sexuality under male control and it has many disabling impacts on the lives of women who are subjected to the procedure. Of course, these disabling impacts are the precise intent of the patriarchal norms that promote FGM.

There are many disabling factors associated with FGM and these factors can impact the physical state of the individual, the mental state, and the individual’s ability to fit into society. It is apparent that disability lies far more in the social constructions of society. According to Gilmour et al., (2011) they assert that disability is something imposed on top of our impairments by the way we are unnecessarily isolated and excluded from full participation in society (Gilmour, et al., p.15) They further point out that the “social model” conceptualizes “disability” not as a variant of human physiology, psychology or genotype, but as the manifested outcome of social barriers and deeply entrenched patterns of oppression and discrimination. (Gilmour et al., p.14) patriarchal societies different forms of oppression are interconnected, with all forms of oppression being based on unequal social power relations This point is confirmed by the lack of

power of the babies, girls and women who are subjected to FGM by dominant patriarchal social forces that impose the procedure on them.

The physically disabling impacts of FGM depend on the type and extent of the procedure that is performed in a given case. According to Mandara (2004), the most severe form of FGM, infibulation, is usually carried out by untrained people in rural settings and comes with the greatest health hazards including severe physical and psychological trauma, and even death (p. 293). Immediate complications that follow FGM include severe hemorrhaging which may result in shock. Further harm is caused by the excruciating pain of the procedure, as no anesthesia is used in most cases and urinary retention may contribute to this pain. Infection can easily set in and damage the urethra, bladder and anus through tearing of tissue and fistulae formation, both of which can be physically agonizing and cause serious psychological harm (Mandara, 2004, p. 293). Delayed complications include dysmenorrhea, vaginal stenosis, cryptomenorrhea, dyspareunia, and a corresponding inability to consummate marriage. Urinary tract infections, pelvic inflammatory disease and infertility can result from FGM. When successful pregnancies take place, delivery can be complicated by the formation of keloid or dermoid cysts of the vulva (Mandara , p. 293). Painful intercourse and sexual dysfunction can deny the female normal sexual satisfaction and further result in marital disharmony, depression and in some cases psychosis or even suicide (Mandara, p.293).

Pregnancy can occur in women who have been mutilated. However, Rymer (2003) indicates that a woman who has been subjected to FGM and suffers a miscarriage may experience a situation where the fetus is retained in the vagina with expulsion unable to occur because of the fixed perineum, causing severe infection (p. 187). Further, because vaginal examinations are not possible, it's very difficult to assess the health of a woman with FGM or the

progress of a pregnancy (Rymer, 2003, p. 187). In the case of a pregnant woman, the rigid perineum may lead to an extended and obstructed labor where the woman is highly vulnerable (especially in the second stage) to perinatal tearing, hemorrhage, fistulae formation, failure to progress, uterine rupture, uterine prolapse, fetal compromise or fetal or maternal death (Rymer, 2003, p. 187). I have personally experienced some of these health problems during pregnancy and can confirm the harsh reality of the many disabling health implications of FGM.

Social contexts that oppress women perpetuate the obviously harmful and disabling practice of FGM. Dorkenoo (1994) indicates that many women suffer silently over sexual health problems because they are reluctant to openly address this part of their private lives (p. 26). Many women are unwilling to discuss their sexual problems freely and openly because of social taboos and fear of being branded as promiscuous or as prostitutes (Dorkenoo, 1994, p. 26). Despite the manifest harms caused by FGM the impact of the practice on women's psychological health has not been adequately studied, so we do not yet know the full extent of the problems caused by FGM (Dorkenoo, 1994, p. 26). In my own lived experience as a woman living in a patriarchal Nigerian community, I feared being bullied by my peers and socially ridiculed if I openly discussed the issue of FGM. Due to such fear, Nigerian women face strong pressure to ignore the disabling physical, psychological and sexual impacts of FGM. According to the 1979 Hosken Report on genital and sexual mutilation, 50% of the 50 million Nigerian women had undergone excision or infibulation (Dorkenoo, 1994, p. 26). Because genital mutilation is often performed on neonates and infants, some females grow into adulthood lacking awareness that they have been victims of FGM. To repeat the point: FGM is a form of disability that can be invisible even to the individual with the disability.

Savell (1995) offers an interesting analysis of FGM which opposes the practice while struggling to understand the tensions between the two sides in the FGM debate. She critiques those who argue that female genital operations are an established cultural tradition that cannot be legitimately challenged, and she also critiques “outsiders” who argue that concepts of “culture” are used by supporters of FGM to mask patriarchal oppression and violence against women (Savell, 1996, p. 2-3). Savell (1995) advocates “cross-cultural dialogue” as an important aspect of social change. According to Savell (1996), cross-cultural dialogue (which seems to be her code phrase for convincing advocates of FGM that they are wrong) represents an important facilitator of “the inevitable processes of cultural change and the evolution of cultural norms” (p. 3). In other words, external criticism of FGM functions to promote the process of cultural change and an increase in women’s rights and control over their own bodies. Savell (1996) claims that cross-cultural dialogue is a two-way process but her overall discussion shows that this two-way process is really a one-way process as she clearly supports the abolition of FGM but seems unwilling to say so directly, perhaps due to unwillingness to hurt the feelings of those who support barbarism against women. Indeed, Savell (1995) argues that efforts to promote cultural change should “be sensitive to the internal nature of the struggle, endeavoring to emphasize internal values and norms rather than external ones” (p. 2). This helps to avoid the sense of western domination over non-western peoples. But it also avoids the reality of the matter.

In her article, “Female Genital Surgeries and Multicultural Feminism: The Ties That Bind; the Differences That Distance,” Gunning (1995) examines FGM within the context of the patriarchal domination of women and male control over women’s bodies. The author thus situates FGM within the context of broad social structures, norms and institutions, and specifically the linkages between patriarchal social norms and the female inequality that

facilitates FGM. Gunning (1995) acknowledges that FGM is a negative, patriarchal practice harmful to women's health, but she also points out that critics of FGM ignore the patriarchal practices within the West that continue to oppress women in many other ways. According to Gunning (1995), "Typically the approach aggrandizes Western culture by ignoring our own patriarchal practices which damage women, both in the country and abroad; conversely the approach tends to denigrate all other cultures, typically African, virtually in their entirety" (p. 19). Thus, criticisms of FGM become attached to negative stereotypes of African culture as a whole while ignoring the patriarchal forms of inequality that continue to exist and oppress women in western societies.

Gunning (1995) makes the valid point that western women lack equality with men, but she seems unwilling to admit that some of the advances of the West are admirable, especially in the area of women's rights. She appears to be anxious to criticize western colonial practices and unwilling to admit that some forms of cultural 'othering' may be legitimate, such as the othering of FGM as a cultural expression. As a Nigerian woman who has traveled to Canada and now lives in Canada, I can confirm from personal experience that the specific problem of FGM is much greater in non-western countries since western societies and cultures have made significant progress in acknowledging the rights and equality of women. Further, the fact that western cultures continue to deny women's equality rights in some ways does not justify the practice of FGM in other cultures. Critics of colonialism and the ongoing imperfections of western societies such as Canada sometimes have a tendency to deny that any progress in women's rights has been made in the West and a corresponding unwillingness to admit that disabling - and overtly physically mutilating - cultural and religious practices such as FGM are simply morally unacceptable in any society.

Despite the existence of groups that continue to advocate FGM, there is an overwhelming and growing consensus that the practice of FGM represents an unacceptable violation of women's bodies and rights. However, an interesting grey area exists in connection to the basic motive behind the practice in a patriarchal context: male control and social control over female sexuality. FGM raises the complex issue of female sexuality and specifically the way in which female sexuality should be presented and displayed within public contexts. In western societies there are some women whose sexuality can reasonably be said to be uncontrolled, and many women, typically young and rebellious women, pass through phases in their lives when they publicly express their sexuality in raw and uninhibited ways. FGM involves unacceptable forms of social, and especially male, control over female sexuality and the female body, but the issue of how to deal with female sexual responsibility is a real if contentious issue. In most cases, it is parents, and especially mothers, who must struggle to get their daughters to dress and behave in sexually responsible ways when they reach the age of sexual curiosity and their hormones begin to rage. However, as the mother of a daughter, I can confirm that this goal is achievable without cutting off a young girl's clitoris and labia.

Power, Oppression and Patriarchy

Power can be exercised in many ways and used for many purposes, and one purpose involves oppressing and maintaining control over vulnerable social groups. In the highly patriarchal societies that exist in many parts of Africa, FGM functions to maintain the power of men while perpetuating the subjugation and passivity of women. Patriarchal power is reinforced by direct physical violence against the female body and, although it is difficult to comprehend from a modern western perspective, this violence is embedded in the traditional customs and religious beliefs of many African societies. Thus, religion and culture can manifest and express

power and domination. As a woman who lived a substantial part of her life in a highly patriarchal Nigerian community, I know this to be a fact. Referencing the work of Foucault on the topic of power, Prince (2016) asserts that power originates in many different places, and that the practice of power can take very different forms (p. 2.). Power can be obvious and blatant, as in violent acts of domination or destruction, but it can also be hidden and subtle, as in forms of ideological domination that seek to shape the thoughts, desires and norms of people living within a society. Power is intricately woven into the social construction of knowledge, bodies and subjectivities in society. Foucault's (2004, 2006) notion of power/knowledge refers to the way in which power can be deployed through a specific set of truth claims. The 'truths' and perceptions of 'reality' within societies reflect unequal, exploitative power relations and typically the domination of privileged groups over groups that possess less power.

Of course, power can also be used to educate and *empower* people. As Prince (2016) states, power can involve coercion, manipulation, corruption and malevolence as well as cooperation, persuasion, ethics and benevolence (p. 2). The power used to impose FGM on women is complex and contradictory because many supporters and practitioners genuinely believe that the act is beneficial to young women despite the coercion and mutilation that is imposed on victims. According to Prince (2016), power is never absolute in its deployment and is always negotiable; just as there is assertion, subjugation and oppression, there is also contestation, opposition and resistance (p. 2). Ideological and cultural critique is required to address the issue of FGM and educate young women about their bodies, sexuality and rights. Young women living in societies that still practice FGM need to understand that gender identities are socially constructed through unequal power relations and, as such, can be deconstructed and transformed to create greater equality and autonomy for women. As we have seen, gender-based

oppression is closely linked to patriarchy. In patriarchal Nigerian cultures, young women must be educated to understand and resist the fact that males are highly favored and dominate society by constructing female identities as inferior and needing to be subjected to male control.

Chinwuba (2015) points to Nigeria along with Israel and a few other countries as perpetuating strong versions of patriarchy that continue to subjugate women (p. 158). According to Chinwuba (2015), the restrictions imposed on women by patriarchy are “consequential for more than women’s autonomy and dignity, as they have broader implications. Societies that subordinate women are more likely to be authoritarian, and their populations poor, uneducated, unhealthy, and demographically imbalanced, with high rates of population growth” (p. 309). Rakoczy (2000) indicates that patriarchy means the “rule of the father” (p. 29). Neal et al. (1999) further indicate that patriarchal social norms tend to give men a sense of “rightness,” of “knowing,” and of “needing to be competent” (p. 199). This can be observed in the traditional saying, “father knows best.” In order to create positive change, it is necessary to understand the social psychology of patriarchal societies in terms of the social construction of gender and specifically the construction of the male ego or identity. One of the psychological obstacles faced by critics of patriarchy is the fact that men who are denied dominant status can develop feelings of failure and incompetence (Dickson, 2013, p. 103). But perhaps people - of either gender - whose identities are based on the domination and exploitation of other people, rather than on social relations of equality and reciprocity, truly are incompetent and deserve to fail?

The raising and educating of children is an issue that must be explored as part of the wider effort to oppose and abolish FGM. Dickson (2013) asserts that in patriarchal societies “men have access to ways of being and performing that are closed to women. Likewise... patriarchy influences women to respond in defined ways, often accommodating and deferring to

male interests” (p.103). The construction of adult women who are submissive to men originates in the ways in which boys and girls are raised and educated. Under patriarchy, male children are socialized to be self-sufficient, competitors and achievers while female children are socialized to be submissive, cooperative, nurturing and receptive to male sexual aggression. These gender differences are widely accepted as natural. However, De Beauvoir (1949) argues that the domination of men in society is not based on biology - it is not natural - but on the institutions of patriarchal society (p. 33). Pursuing a similar line of critique, Friedan (1963) suggests that women have become so accustomed to the domestic roles of wife and mother that they tend not to question the oppression and alienation they experience when confined to the home (p. 33). Connecting patriarchal gender inequalities to the norms of thought and rationality that exist within societies, Warren (1988) associates the logic of male domination with a dualistic or binary form of hierarchical thinking in which ‘superiority’ is associated with male, masculine, man, intellectual labor and so on while ‘inferiority’ - the ‘other’ pole in the system of dialectical oppositions - is represented by women, slaves, femininity and manual or domestic labor (p. 31-44). The gendered binaries described by Warren (1988) continue to exist in the assumption that the patriarchal man should keep his ‘little woman’ at home and hope that she won’t get into too much trouble with her irresponsible sexuality and minimal level of intelligence and competence.

Many writers indicate that patriarchal societies privilege men while subjugating women but De Beauvoir (1949) further observes the inherently masculine foundations of socially constructed reality. She emphasizes that female identities do not exist independently under patriarchy but are “always set... up within the frame of the masculine universe” (De Beauvoir, 1949, p. 32). In this male universe, women belong in the home which, according to De Beauvoir (1949), teaches women to be passive and to perform domestic tasks such as cooking and other

household activities (p. 33). Freidan's (1963) notion of the "feminine mystique" confirms De Beauvoir's view of a male dominated society, or universe, but clarifies some of the specific social factors that oppress women. Freidan (1963) asserts that patriarchy constructs a "false and dehumanizing" notion of female identity that is "perpetuated by the media, advertising, business, government and educators in order to promote every interest except women's" (p. 44). The logic of male domination described by the above writers is still widely accepted in our society today. Today's women may not be entirely dependent on men for their existence in western societies, but discrimination and inequality in the workforce still places a large percentage of women in situations of subordination and poverty. In patriarchal African societies, such as Nigerian society, women are denied not only social equality and power but even the ability to maintain control over their own clitoris and labia.

Vulnerability, Gender and Change

Butler (1988) references De Beauvoir's (1949) notion that 'woman' is a social construct rather than a biologically determined identity but places greater emphasis on the arbitrary and socially relative nature of gender identities. The social construction of 'woman' involves a sustained effort to create the female body as a cultural sign by rendering one's female identity obedient to a "historically delimited possibility" (Butler, 1988, p. 522). Butler (1988) challenges the "given" nature of society's system of gendered binaries, arguing that gender identities involve a "corporeal field of cultural play" or a "script" that includes change and innovation (p. 522). Since gender identities are socially scripted, they are subjected to new articulations within different scripts. However, while Butler (1988) affirms the possibility of 'writing' new male and female gender identities, she also draws attention to the social regulation of gender identities:

It is quite clear that there are strict punishments for contesting the script by performing out of turn or through unwarranted improvisations. Gender is not passively scripted on the body, and neither is it determined by nature, language, the symbolic, or the overwhelming history of patriarchy. Gender is what is put on, invariably, under constraint, daily and incessantly, with anxiety and pleasure, but if this continuous act is mistaken for a natural or linguistic given, power is relinquished to expand the cultural field bodily through subversive performances of various kinds (p. 531).

Butler (1988) draws attention to the social punishments, such as marginalization and ostracizing, that are administered for “unwarranted” articulations of gender identity, but she also emphasizes that we must not mistake gender identities as being biologically determined or else we will limit the possibilities of subversion, change and acceptance of diversity.

According to Baum (2004), the struggle for social justice requires the recognition of multiple, intersecting identities and a critical theory of recognition (p. 4). Baum (2004) emphasizes that an effective critical theory of recognition must adequately address “the challenge posed by cultural and religious differences” (p. 4). While some groups and communities seek to establish group identities that allow for minimal deviation from dominant group norms, Baum (2004) argues that an efficacious critical theory of recognition must recognize “*not* group-specific identity but the status of individual group members as full partners in social interaction” (my emphasis, p. 113). The recognition of group identities - specifically religious and cultural groups - is not adequate because such identities can be highly oppressive of individual identities that exist within those groups. When religious and cultural groups become discriminatory and “constitute some actors as inferior, excluded, wholly other, or simply invisible - in other words, as less than full partners in social interaction - then we can speak of

misrecognition and status subordination” (Baum, 2004, p. 113). Of course, political interests also play a strong role in the social construction of identities, especially dominant groups with the power “to shape and interpret cultural traditions and values in ways that perpetuate intra-group domination - for example, that of men over women” (Baum, 2004, p. 112). Baum’s (2004) focus on the recognition of diverse individual identities that exist within cultural and religious groups, and on the political interests that shape unequal identities, can be applied to the issue of FGM in Nigerian communities.

A strong argument can be made that the practice of FGM can only exist in a social context characterized by dramatic gender inequality which forces members of the inferior gender pole (women) to internalize self-negating identities. In an analysis of the connections between FGM and gender inequality in African cultural groups, Thiam (1986) asserts that African men have forced African women “to become their own torturers, to butcher themselves... Women have rationalized excision and infibulation, associating these with prescriptive practices until they became an integral part of their traditional or ritual body of customs” (p. 75). Despite this observation and her use of terms such as “torture” and “butcher” to describe FGM, Thiam (1986) cautions against describing FGM as “sexual mutilation” on the grounds that the judgment implied by this phrase is based “on criteria which bear no relationship to the mentalities of people in the society under consideration” (p. 80). Thiam (1986) states, “Are we dealing with practices those women themselves wanted? ... It remains for the excised and infibulated women themselves, being opposed to these practices and aware of their harmful consequences, to say publicly that they want to end these ancestral customs” (p. 84–85). The problem with Thiam’s (1986) argument is that it fails to account for the lack of education and self-awareness of many of the women who experience FGM and the tremendous pressure women come under to embrace

FGM even if they don't want it. Also, the procedure is often performed on babies and girls who are hardly in positions to reject the "butchering" - but not sexual mutilation - of FGM.

Butler (2004) argues that all human beings are exposed to the threat of physical harm or destruction from many sources, including other human beings, and therefore that the omnipresent threat of violence represents "a primary human vulnerability" (p. 18). According to Butler (2004), the fact that "life itself can be erased by the willful action of another" creates a feeling of terror (p.18). Butler (2004) further observes that this vulnerability "becomes highly intensified under certain social and political conditions, especially those in which violence is a way of life and the means to secure self-defense are limited" (p.18). Adopting an optimistic tone of voice, she also suggests that the mourning which follows the experience of violence and tragic loss represents a kind of "agreeing to undergo a transformation (perhaps one should say submitting to a transformation) the full result of which one cannot know in advance" (p.18). But the main point made by Butler (2004) that applies to this MRP is her observation that human beings live in a state of vulnerability to violence right from the moment they are born. Butler (2004) states, "This is a condition, a condition of being laid bare from the start and with which we cannot argue" (p. 18). While all human beings face vulnerability, babies and children are most vulnerable. Butler (2004) draws specific attention to the vulnerability of newborn babies who do not receive "necessary support" and describes this condition as "a scene of abandonment or violence or starvation [where] their bodies are given over to nothing, or to brutality, or to no sustenance" (p. 18). Clearly, the situation of baby girls being forced to undergo FGM is one of being vulnerable to, and subjected to, violence at the hands of other human beings. A particularly devastating type of vulnerability occurs when parents and community members violently deny a child's rights and bodily integrity.

Butler (2004) also addresses the issue of the vulnerability of adult women living in patriarchal societies. Referencing the works of De Beauvoir (1997) and Firestone (1997), Butler (2004) states that the former suggests that forms “of thought and existence rooted in primordial dualisms represent the fundamental basis of women’s oppression while the latter explicitly rejects this view, locating the oppression of women in biology and the reproductive role of the female in the biological family” (p.1). Perhaps “primordial dualisms” and women’s reproductive role both contribute to the oppression of women? Be that as it may, De Beauvoir’s (1997) discussion of the primary determinant of women’s oppression asserts that we must ask: “What is a woman?” (p. 11). She indicates that women have traditionally been associated with an ideal of the feminine essence known as the “eternal feminine” but that some feminists, such as Dorothy Parker, deny a specifically feminine essence and claim that men and women are both human beings (p. 12). De Beauvoir (1997) rejects the denial of gender differences, stating that the profound differences between men and women “most obviously exist” (p. 12). However, in patriarchal societies the masculine identity represents an “absolute human type” while women are regarded as subordinate to the male (De Beauvoir, 1997, p. 13). Part of the explanation for this, according to de Beauvoir (1997), is biology. She states, “The division of the sexes is a biological fact, not an event in human history” (De Beauvoir, 1997, p. 15). De Beauvoir (1997) suggests that woman’s reproductive role functions to “imprison her in her subjectivity” and limit her nature (p. 13). Although men and women both play roles in reproduction, men dominate in society and the public sphere while women remain oppressed in the domestic realm due to the larger role they typically play in the reproduction, nurturing and rearing of children.

For De Beauvoir (1997), the main determinant of women’s oppression is not so much biology as the fundamental structure of human reality or, as Firestone (1997) says in reference to

De Beauvoir, the *a priori* categories of human thought and existence (p. 22). These are prior to biology and represent the main factor creating women's oppression. As we have seen, De Beauvoir (1997) observes that human reality is male and that women define themselves in relation to men; women do not have autonomous identities (p. 13). Man is the Subject, the Absolute, and woman is the Other (De Beauvoir, 1997, p. 13). According to De Beauvoir (1997), the dualistic thinking that structures man as subject and woman as other is not socially constructed but rather is "as primordial as consciousness itself"; it is the very nature of human reality. She states, "Otherness is a fundamental category of human thought" (De Beauvoir, 1997, p. 13-14). De Beauvoir (1997) appears to imply that for reasons no one can really understand human social reality is fundamentally masculine. As the lyrics of James Brown's famous song states, "It is a man's world."

And yet, women are not helpless infants or children who lack the ability to think, learn or take initiatives. In terms of the persistence of women's oppression, De Beauvoir (1997) asks: Why do women submit to male sovereignty? (p. 14). She suggests that women fail to challenge male authority for various reasons (De Beauvoir, 1997, p. 15). For example, women lack practical ways to organize themselves to fight male domination and they do not have the type of solidarity that can be seen in the working class, for example, because they are very diverse and may have greater allegiances to their class or race than to the interests of women as a whole (De Beauvoir, 1997, p. 15). The oppression of women is particularly puzzling since men and women exist in a situation of mutual reciprocity and interdependence. "Woman is the Other in a totality where the two components are necessary to each other" (De Beauvoir, 1997, p. 16). Returning to the lyrics of James Brown's famous song, it is a man's world "but it would be nothing without a woman."

Although men need women, De Beauvoir (1997) points out that women face a difficult choice in deciding whether or not to fight for equality: if women embrace their inferior status there is a good chance that men will provide for them financially but if women challenge male authority they risk losing what security they have (p. 16). Of course, if women are to gain financial security from men they must behave in sexually enticing and manipulative ways and they must be prepared to satisfy the sexual desires of men. As De Beauvoir (1997) states, women who seek financial security from men must be prepared “to forgo liberty and become a thing” (p. 16). Indeed, De Beauvoir (1997) observes that many women are quite pleased with their role as the ‘other’ and as things (p. 17). Given her view that women’s oppression is rooted in human reality as such, it seems somewhat paradoxical that De Beauvoir (1997) also expresses the view that women can become full members in the human race despite the gender inequality and oppression they face in a ‘man’s world’ (p. 18).

Firestone (1997) offers a view of women’s oppression that differs sharply from that of De Beauvoir. She references De Beauvoir’s (1997) view that *a priori* categories of thought and existence shape history and the experiences of men and women, creating women’s oppression, but then argues that *history* may have created the philosophical dualisms that are incorrectly cited by De Beauvoir (1997) as the primary determinant of women’s oppression (Firestone, 1997, p. 22). Like De Beauvoir (1997), Firestone (1997) acknowledges the many differences between men and women, noting that “yin and yang pervades all culture, history, economics, nature itself” (p. 20). But Firestone (1997) rejects the abstract philosophical approach evident in De Beauvoir’s writings. Instead, Firestone (1997) turns to the more pragmatic analytical method used by Marx and Engels - dialectical materialism - which refers to processes of historical change based on action and reaction that take place at the material level of “organic causes” (p.

20). While the organic causes explored by historical materialism are largely economic in nature, Firestone (1997) says it would be a mistake to understand women's oppression in terms of economic causes (p. 21). The superior status of men - or the inferior status of women - is not based on economic inequality, exploitation or economic class differences. Firestone (1997) asserts that sex differences and the subjection and oppression of women as a class run deeper than economics, stating that "there is a level of reality that does not stem directly from economics" (p. 22)

According to Firestone (1997), beneath the reality of economics is human psychosexual reality and she attempts to create a materialist view of history based on human sexuality (p. 22). Indeed, Firestone (1997) raises the possibility that sex and gender inequality is "natural" (p. 23). Firestone (1997) argues that the biological differences between men and women give rise to "biological families" where women's dominant role in reproduction and child-rearing makes them dependent on males for their survival and the survival of their children (p. 23). Moreover, human infants are dependent for an extended period of time and mother-child interdependency shapes the psychology of every male or female infant (Firestone, 1997, p. 23). Firestone (1997) rejects cultural relativity arguments that deny the fact that the biological family has existed "everywhere throughout time" and she suggests that it is women's role in this family that represents the primary determinant of women's oppression (p. 23). However, Firestone (1997) does not believe that women are eternally doomed to inferiority, oppression, diapers and housecleaning.

Firestone (1997) suggests that although sexual inequality is biologically based women are not inevitably subjected to male domination (p. 24). Human beings, she argues, are not just animals and humans are increasingly capable of freeing themselves from the biological

conditions that create male domination and female subjection (Firestone, 1997, p. 24). However, men enjoy possessing dominant power so women will have to fight for their freedom and to gain control over reproduction, their bodies, human fertility, and the social institutions of child-bearing and child-rearing (Firestone, 1997, p. 24). Firestone (1997) asserts that the goal of women's liberation is not to eliminate male privilege but to eliminate the sex distinction itself, with children being born to both sexes equally and nurtured by small groups such that "the tyranny of the biological family would be broken" (p. 25). Thus, although they have somewhat different views of the sources of women's oppression, Firestone (1997) and De Beauvoir (1997) both assert that change is possible and that women have the potential to escape male domination and to create a more egalitarian society that respects female rights and equality. One of the major goals of the struggle for female equality, this MRP argues, is the abolition of the oppressive and disabling practice of FGM.

CHAPTER III: DISABILITY, TRADITION AND RESISTANCE

Tradition and Oppression

Fischer (2009) references the notion of Gintis (2007).that Culture is passed on through socialization processes within specific groups, which requires communication of key symbols, ideas, knowledge, and values between individuals from one generation to the next. (Fischer, p.29).Cultural traditions have a huge impact on the issue of FGM because successive generations that believe in the tradition of FGM perpetuate the practice. Indeed, communities engaging in FGM present it to members of new generations in a very positive light (Rymer, 2003, p. 188). A party atmosphere is created and the girl is reminded that FGM will greatly improve her social status, improve her marriageability, and offer proof to potential male partners that she is a virgin (Rymer, 2003, p. 188). However, beyond issues of cultural tradition those performing the procedure have a vested interest in perpetuating the practice since they gain their livelihood and community status from performing FGM (Rymer, 2003, p.188). Indeed, some make substantial sums of money by also running residential courses for the girls where they learn how to look after their husbands and subordinate themselves to male domination (Rymer, 2003, p. 188). In short, it is not only cultural traditions that support FGM but also self-interest on behalf of those responsible for performing and perpetuating the procedure.

Cultural traditions can have tremendous power to influence people's thoughts and actions. However, Walley (1997) affirms that it is possible to think outside one's culture and to gain critical distance from the social norms that shape identities and behaviors (p.421). In a discussion of FGM, Forrest Sawyer, the anchor of ABC's Day One, emphasizes that it can be very difficult to break free from the weight of culture. Sawyer (1993) states, "This is a brutal, disabling ritual so tied to culture and tradition that for thousands of years women have been

powerless to stop it. In fact, the taboos are so strong that the women subjected to it will rarely talk about it at all.” Walley (1997) also emphasizes the oppressive nature of “tradition” and shows how such elements as tribal law, blood rites, threats of banishment and the power of family patriarchs in communities can influence community members (p. 421). According to Walley (1997), tribal customs can impose “fetters” on people akin to the actual fetters in modern prisons (p. 421). Popular western media accounts tend to emphasize the coercive and oppressive nature of African cultures and societies as a whole because western societies value individual rights over the collective weight of cultural traditions (Walley, 1997, p. 421). While promoters of African tribal customs may reject the imposition of western norms on their societies, I would suggest that victims of FGM should embrace the western emphasis on women’s equality rights and especially women’s right to control over their own bodies. Walley (1997) quotes the words of Tilman Hasche, the lawyer for Lydia Oluloro, a Nigerian woman who legally petitioned to remain in the United States to prevent the excision of her daughters, as stated in a New York Times article: “Frankly, I don’t give a damn if opposing this [FGM] is a violation of someone’s culture” (p. 421).

Walley (1997) asserts that invocations of the need to respect culture and tradition are often used to maintain or increase male control over women (p. 421). He describes a 1980s Kenyan legal case that pitted a socially prominent Kikuyu widow, Wambui Otieno, against her deceased husband’s Luo patrilineage for the right to bury the body. According to Walley (1997), the conflict tapped into deep tensions within Kenyan society because the case was argued through an intertwined discourse of gender and “reified” tradition (p. 421). Walley (1997) emphasizes that the lawsuit had strong linkages to the issue of FGM:

[The case] encapsulated the same potentially contradictory meanings associated with “tradition” as have female genital operations... Particularly when portrayed for international audiences, female genital operations have often been a symbol of “backwardness” and a source of “shame” to those in Third World countries who are concerned that their nations live up to Western-defined standards of modernity (p. 21).

Those advancing cultural nationalist traditions defend practices such as FGM on the grounds of promoting cultural integrity and resisting Euro-American domination. Unfortunately, many of the proponents of FGM are women who support male cultural domination over women. Walley (1997) suggests that the “association between women and hardened notions of “culture” and “tradition” is not limited to the so-called Third World” (p. 426-7). However, it is primarily in African countries, such as Nigeria, that FGM persists and must therefore be resisted.

Resistance and Human Rights

Lewis (1995) asserts that human rights scholars have generated a substantial and growing body of literature on the potential role of human rights law in the abolition of FGM (p. 28). Much of this work adopts feminist perspectives which argue that FGM should be eradicated because it represents a legal violation of the human rights of women (Lewis, 1995, p. 29). Interestingly, one of the legal issues that has arisen in this context involves the role of women as proponents of FGM. Feminist analysis of FGM as a human rights violation is complicated because FGM implicates complex cultural, gender and racial questions in human rights jurisprudence, particularly in connection to the issue of women’s oppression. One important question is this: “If FGM is a patriarchal violation of the fundamental human rights of women, how should international law respond to the fact that FGM is practiced by women on women and girls?” (Lewis, 1995, p. 29). Women’s rights are viewed in the West as universal, but does the

“universalism” associated with applying western views to Africa “violate African rights to self-determination and the preservation of cultural identity?” (Lewis, 1995, p. 8). From the perspective of those seeking to abolish FGM, arguments that support the practice by invoking “cultural relativism” represent a “smokescreen that enables governments and non-state actors to legitimize the oppression of women” (Lewis, 1995, p. 9). Of course, the denial of universal human rights comes very close to being a wholesale denial of the legitimacy of the UN, which exists very substantially for the precise purpose of upholding universal human rights. If claims of cultural relativism are considered legitimate, then the international human rights system remains inaccessible to women affected by FGS and international human rights law is reduced to “merely a collection of irrelevant theoretical constructs” (Lewis, 1995, p. 9).

Rymer (2003) affirms that FGM represents a human rights violation. The practice of FGM “denies women and children security and personal liberty, privacy and bodily integrity, freedom of conscience, and the right to health. Sadly, the practice of FGM continues in developing countries worldwide” (Rymer, 2003, p.188). Mann et al. (1994) assert that human rights are strongly linked to public health issues in the sense that human rights and public health are inherently mutually reinforcing (p. 21). Thus, promoting societal respect for human rights reinforces arguments that support enhanced public health within societies. Conversely, public health goals are seriously compromised when states fail to respect human rights norms and fail to confirm that human rights represent an essential component of human dignity (Mann et al., 1994, p. 21). Some public health efforts undertaken in developing nations have been quite coercive. For example, the public health strategies developed for diseases such as smallpox have often involved “coercive approaches and activities which may have burdened human rights” (Mann et al., 1994, p. 21). But despite the coercive nature of some public health initiatives in developing

nations it cannot be denied that positive changes have been made in addressing public health problems in developing nations.

The WHO's strategy for preventing the spread of the human immunodeficiency virus (HIV) excludes traditional practices such as isolation and quarantine, and explicitly prevents discrimination against HIV-infected people (Mann et al., 1994, p. 21). Given the recognition that some public health initiatives have been excessively coercive and the fact that changes have been made, it must be acknowledged that there is a fundamental complementarity between human rights and public health (Mann et al., 1994, p. 21). From the perspective of human rights, supporters of public health can contribute to societal recognition of the benefits and costs associated with realizing, or failing to respect, the human rights and dignity of all people. At the same time, the right of girls and women to good health can be strongly reinforced by forms of dialogue between health and human rights disciplines that place strong emphasis on the complementarity of human rights and public health initiatives. As Mann et al. (1994) state, "the importance of health as a precondition for the capacity to realize and enjoy human rights and dignity must be appreciated" (p. 21). This MRP argues strongly that the practice of FGM represents not only a violation of the universal rights of girls and women but also a denial of their right to health and a denial of public health as a whole. Abolition of FGM affirms their rights, their health and wider public health.

There may be factors in addition to cultural tradition that make it difficult to resist and abolish the practice of FGM. Whitehorn et al. (2002) address the view that the motive for FGM is men's unconscious fear of women's sexuality and a resulting need to suppress it (p. 164). Additionally, while FGM suppresses female sexuality by diminishing women's capacity to enjoy sex life, males experience increased sexual pleasure from the tightening of the vagina that takes

place in the procedure. That said, large vaginas that provide minimal friction to the penis during sexual intercourse can be surgically tightened without resorting to FGM. It is evident that there are many tensions and polarizations in the debates over FGM but a strong argument could be made that the primary conflict is between the cultural and religious beliefs that uphold FGM and the growing power of women's rights which support the rejecting of FGM. As previously noted, many people, including the author of the present study, view women's rights as universal and inalienable. From this perspective, FGM is unjustifiable on any grounds.

Savell's (1995) article, "Wrestling with Contradictions: Human Rights and Traditional Practices Affecting Women," discusses the important role played by international human rights norms and documents in criticizing traditional cultural practices such as FGM. Savell (1995) discusses the cultural differences that create tension in the debate over FGM, arguing that participants in the debate need to consider how the social meanings attached to concepts like "individual," "group" and "harmful practices" are constructed within particular cultural and historical contexts (p. 8). The author suggests that liberal and communitarian philosophies have very different views of issues like FGM. For example, while western liberals respond to FGM with "moral outrage" at what they view as "a brutal violation of an individual's rights by the group," men and women within practicing communities view FGM as "normal, necessary and healthy" (Savell, 1995, p. 8). Savell (1995) claims that cross-cultural dialogue should try to support the advocates of "enlightened perceptions and interpretations" - which translates into support for universal human rights and opposition to FGM - but also argues that this effort should "be sensitive to the internal nature of the struggle, endeavoring to emphasize internal values and norms rather than external ones" (p. 2). This 'sensitive' approach supposedly helps to avoid the sense of western domination over non-western peoples.

Women, Freedom and Control

Despite the ongoing debate over FGM, there is an overwhelming and growing consensus that the practice of FGM represents an unacceptable violation of women's rights. Shaw (2004) states that women's health is a multi-dimensional issue that encompasses physical, mental, emotional, social, sexual and psychological well-being (p. 7). Of course, it is difficult to define the complex notion of women's sexual well-being. But one aspect of sexual well-being involves women's rights. The Convention on the Elimination of Discrimination against Women (CEDAW) asserts that women have the right to health in all the above-mentioned areas as well as the right to equal input into decisions regarding their reproductive lives, such as the timing and number of any children (Shaw, 2004, p. 7). Shaw (2004) further points out that Article 1 of CEDAW enshrines women's right to be free from discrimination of any kind, including freedom from practices such as FGM (p. 7). All of these assertions imply that women have the right to be free from all forms of male violence and social violence regardless of the rationalizations behind the violence. Too often, it is people or social or cultural organizations other than women that have the power to decide what is right and healthy for women.

In her article, "Sex and the Sacred: Sterilization and Bodily Integrity in English and Canadian Law," Savell (2004) examines the issue of the compulsory sterilization of learning-disabled individuals, particularly learning disabled women, within the contexts of Canada and England (p. 1094). Savell (2004) believes that this issue is highly complex and can be viewed in different ways depending on how a given society constructs the human body (p. 1094). While English courts have supported the compulsory sterilization of learning-disabled women, Canadian courts oppose it, but Savell (2004) points out that they both claim to act on behalf of the individual's right to bodily integrity (p. 1095). Savell (2004) explains this apparent

contradiction by referencing two larger and very distinct social contexts that shape the way legal institutions view the individual human body, and especially the need to control and regulate the bodies of individual women.

Where a society's focus is on liberal human rights, the human body is understood within a larger political and legal context that supports the equality of all individuals, and from this perspective compulsory sterilization represents a violation of individual rights that cannot be justified (Savell, 2004, p. 1097). Where the focus is on the maintenance of a kind of society that emphasizes rigid constructions of normality in terms of bodily and mental health, compulsory sterilization can be seen as something that acts to safeguard, rather than violate, the integrity of the body (Savell, 2004, p. 1097). In relation to the topic of FGM, this distinction shows the difference between cultures that promote individual rights and those that prioritize community traditions. As we have seen, the latter may promote FGM with such force and aggression that women learn to accept and internalize traditional beliefs, thereby facilitating the control of their bodies by men and by patriarchal social norms. Disabling and mutilating practices such as FGM and compulsory sterilization may then be viewed as justifiable on the grounds that they support the integrity of the social body, which is deemed as more important than individual rights or the individual female body (Savell, 2004, p. 1098).

Savell's (2004) discussion is useful because it reveals the broader social context within which women's bodies are interpreted and controlled, or left to women to do with as they please, so to speak. The author reveals that a society that is strongly liberal is likely to emphasize human rights such as equality rights and thus to oppose practices such as sterilization or FGM (Savell, 2004, p. 1094). In contrast, a society that is highly conservative and traditional may justify sterilization or FGM on the grounds of protecting the health of society at large or even on the

grounds of protecting learning-disabled women - or sexually uncontrolled women - from the potential hazards connected to their sexuality at the level of the individual body (Savell, 2004, p. 1094). Savell's (2004) discussion also emphasizes the implications of how different social institutions such as the legal and medical communities define and understand the human body. If the human body is viewed from a medicalized perspective, then human health tends to be understood narrowly in terms of strict medical norms of the healthy mind and the healthy body. In cultures such as many of those in Nigeria, this can lead to discrimination against those who do not conform to dominant concepts of normality by rejecting FGM. When mutilation is the norm, women's bodily integrity is defined as a disability. As we have seen, women who have not received FGM are excluded from full participation in society because their bodies are not considered to be part of what is defined as 'normal' and 'healthy.' A tremendous perversity arises: Because they are healthy and have bodily integrity, they are viewed as disabled.

CONCLUSION

Baum (2004) draws upon information from the World Health Organization when he asserts that more than ninety million living girls and women have gone through one of the FGM procedures and that another two million will do so each year (p. 1082). The mutilation of girls and women persists despite the widely recognized fact that FGM practices are deeply oppressive to women and damaging at all levels of their lives. The practice of FGM exemplifies how religious and cultural traditions and customs are shaped by relations of power, especially male domination over women (Baum, 2004, p.1082). The fact that so many girls and women have undergone the disabling practice of FGM demonstrates clearly that many women in today's world, particularly in Africa, remain oppressed and dominated by men. This MRP has referred to a range of researchers who have made clear the many negative health implications of FGM and how it can be detrimental to generations of affected individuals.

Although this MRP is grounded in an auto-ethnographic methodology, other theoretical frameworks have been utilized in the critique of FGM and its religious and cultural elements. Feminist theory has provided a particularly valuable critical perspective because it makes vivid the power and privilege of men within patriarchy and, conversely, the many harmful impacts of patriarchal society on women's lives. As Hare-Mustin (2004) comments, "Feminist theory is concerned with interrogating and understanding the political, economic, and social inequities between women and men" (p. 16). Emphasizing the oppressive nature of patriarchy in particular, Hare-Mustin (2004) adds, "Feminism is an oppositional form of knowledge to patriarchy" (p. 16). While feminist theory constitutes critique at the broad level of society, it also creates space for individual women to reconsider the direction of their lives and to claim preferred values and commitments (Hare-Mustin, 2004, p.103). Feminism enables women to understand the political,

economic, cultural and religious factors that contribute to their oppression, and thus gives women the opportunity to develop agency and make free choices.

Savell's (2004) work has played a large role in this MRP because it implies that social norms of the healthy human body can be changed such that they embrace diversity and create more open and accepting societal understandings of normality (p. 1101). From this viewpoint, health can be understood broadly to incorporate many different versions of the functioning body and people with disabilities can be made to feel like important parts of society even if they are somewhat 'different' (Savell, 2004, p. 1102). However, I would argue that the embrace of diverse human bodies as parts of a broader societal view of the normal body must not extend to acceptance of disabling and mutilating practices such as FGM. Shaw (2004) indicates that FGM can be extremely traumatic, leave life-long emotional scars, resembles rape and represents "profound interference" in a girl's sense of bodily and mental integrity (p. 6). Of course, when FGM is practiced on infants the young girls are completely denied the opportunity to choose and to control the most intimate aspects of their own bodies. Dorkenoo (1994) confirms that FGM represents an especially egregious violation of the human rights of children when it is performed on young children and infants (p. 56). In these cases, I would argue, FGM is perilously close to being tantamount to violently raping babies. Little wonder, then, that studies reveal that FGM has a strongly disturbing effect on girls' self-identity, causes adult anxiety disorders, reactive depression or even psychosis (Shaw, 2004, p. 6). As my personal narrative as a Nigerian woman who experienced FGM as a young girl clearly shows, those who claim that FGM represents a happy occasion in the life of a woman are wrong, and the societal embrace of diverse bodies as part of an inclusive concept of social normalcy does not include normalizing or accepting the willful mutilation and disabling of the bodies of infants, girls and women.

Action against FGM must take place at local and international levels. This MRP has discussed the strong tendency amongst many writers to avoid offending people from non-western cultures through critical challenges of cultural practices that seem backward and oppressive from western viewpoints. But this study has argued that the rights of children, girls and women are *universal*, not western, and that influential agencies such as the United Nations therefore have a responsibility to aggressively criticize and attack the ongoing practice of FGM in African nations. FGM was performed on me when I was seven days old and many years later I still cannot fathom the cruelty and violence that was imposed on me for the sake of traditional African cultural values and beliefs. Of course, my physical scars will never heal. But many of my emotional scars have not healed, either, and I expect that they never will. As one might expect, I sometimes wonder what it would feel like not to be mutilated. But I will never know. And here's a complex and contradictory issue that I am still grappling with: I don't want anyone to tell me that I am not disabled. *I am disabled*. I have learned to deal with it but I am not going to bury my head in a pile of theoretical sand and deny it.

Although I am not convinced that any adult woman could freely choose to experience FGM - those who do, in my view, have passively internalized social norms that have eliminated their ability to make free, self-conscious choices - the practice of FGM does appear to implicate the issue of consent. Indeed, Dorkenoo (1994) asserts that the fundamental issue at stake in the conflict over FGM is that of informed consent (p. 56). It is self-evident that young girls or infants cannot make free choices based on informed consent. In my view, Dorkenoo (1994) correctly asserts that the practice of FGM violates Article 5 of the Universal Declaration of Human Rights which provides that no one shall be subjected to torture, or cruel, inhuman or degrading treatment (p. 56). Dorkenoo (1994) observes that these violations are discussed and sometimes

condemned by various UN commissions examining the issue of FGM. Astonishingly, the rationalizations put forward to support FGM are based solely on support for cultural tradition; there are no other reasons for advocating FGM (Dorkenoo, 1994, p. 56-57). How could there be any other reasons for supporting this violent, disabling practice?

Dorkenoo (1994) asserts that the Convention on the Rights of the Child (CRC) represents another international treaty that is relevant to the issue of FGM (p. 57). Discussing the CRC in relation to FGM, Dorkenoo (1994) states:

Article 2 protects the child's right to gender equality; Article 19.1 protects the child from all forms of mental and physical violence and maltreatment; Article 24.1 affirms the right of the child to the highest attainable standard of health; Article 37 (a) asserts that children should be free from torture or cruel, inhuman or degrading treatment; and Article 24.3 of the convention explicitly requires states to take all effective and appropriate measures to abolish traditional practices prejudicial to the health of children (p.57).

While all of these Articles of the CRC refute the legitimacy of FGM, Article 24.3 is especially apt since it requires nation states to abolish traditional cultural practices that undermine the health of children. Walker (1996) confirms that although FGM is a complex and difficult issue that involves questions of national identity, the right of women and girls to live safe and healthy lives must be respected (p. 95). Walker (1996) asserts that reluctance to interfere with other cultures leaves African girls at risk of mutilation; if we don't speak out against FGM, we collude in the perpetuation of this violence (p. 95). Walker (1996) states, "Torture is not culture" (p. 95).

Confirming that the struggle for women's health and equality is a global issue that is not confined to Africa, Walker (1996) further asserts that her fundamental concern is to eradicate the pervasive violence that all women experience across all cultures, all races and all societies

(p.95). Walker (1996) argues persuasively that we cannot accept ritualized violence against women as an intrinsic part of any culture, or any sort of violence against women (p. 95). Like this MRP, Walker (1996) embraces feminism as a valuable theoretical perspective for understanding and opposing women's oppression. She emphasizes that feminism is about creating a communal space in which women can fight to change and abolish social norms and practices that are harmful to them (Walker, 1996, p. 96). Rymer (2003) similarly states that healthcare professionals and policymakers have a duty to provide appropriate and adequate care for women who have undergone FGM (often against their will) - a sensitive and caring approach is essential to gain the trust of these women so that they will seek help if required (p. 189). I agree with this view; there is a need to be sensitive with regard to the feelings of victims of FGM, but not with regard to the cultures that create the victims.

Understanding the many damaging physical and emotional impacts of FGM on its victims opens opportunities for professionals to empower affected women with the education, advice and support they require in order to abolish a traditional practice that serves no real purpose yet carries such high morbidity and mortality (Rymer, 2003, p. 190). Dorkenoo (1994) states that the reproductive rights of women include the right to control their fertility, the right to control their bodies and their sexuality, the right to evolve meaningful systems in their communities to deal with violence against women, the right to redefine themselves as women without genital mutilation, the right to choose who they want to marry, the right to review bride price, the right to stop customary demands for proof of virginity at marriage, the right to engage in a feminist interpretation and critique of religious texts, the right to develop a women's movement with the full participation of grassroots women, the right to gather data on the abuse of women at a grassroots level, and the right to form linkages between local, regional and

international women's human rights organizations (p. 173). In my view, all of the women's rights cited by Dorkenoo (1994) are served by the personal narratives of women who have experienced violence of any kind in any culture or society. I hope that in giving voice to my own personal experience of the many disabling and life-long impacts of FGM, I have helped in some small way to ensure that future generations of girls and women are empowered to make independent, informed choices and to have lives that are free of oppression, violence and mutilation.

Works Cited

- Ashimi, A. O., Amole, T. G., & Iliyasu, Z. (2015). Prevalence and predictors of female genital mutilation among infants in a semi urban community in northern Nigeria. *Sexual & Reproductive Healthcare*, 6(4), 243-248.
- Baum, B. (2004). Feminist politics of recognition. *Signs*, 29(4), 1073-1102.
- Beauvoir, Simone de. ,(2011-2012) “The Existential Paralysis of Women.” *AP/HUMA 1950 9.0 Concepts of Male and Female in the West*. Ed. Deborah Orr. Toronto: York University. 27-37. Print.
- Boddy, J. (1982). “Womb as Oasis: The Symbolic Context of Pharaonic Circumcision in Rural Northern Sudan” in *American Ethnologist: Journal of the American Ethnological Society*. Vol. 9, Issue 4, Nov. 1982, pp. 682-698.
- Butler, J. (2004). Indefinite detention. *Precarious Life: The Powers of Mourning and Violence*, 50-100.
- Butler, J. (1988). Performative acts and gender constitution: An essay in phenomenology and feminist theory. *Theatre journal*, 40(4), 519-531.
- Chinwuba, N. N. (2015). Human identity: child rights and the legal framework for marriage in Nigeria. *Marriage & Family Review*, 51(4), 305-336.
- DE Beauvoir, S. (1997). “Introduction” to The Second Sex: Linda Nicholson (Ed.), The second wave A Reader in Feminist theory (11-18).New York, NY: Routledge
- DE Beauvoir, S. (1949) “The Existential Paralysis of Women.” *AP/HUMA 1950 9.0 Concepts of Male and Female in the West*. Ed. Deborah Orr. Toronto: York University, 2011-2012. 27-37. Print.
- Dorkenoo, Efua. Cutting The Rose. 1st ed., London, Minority Rights Publications, 1994.,
- Dickerson, V. (2013). Patriarchy, power, and privilege: A narrative/poststructural view of work with couples. *Family process*, 52(1), 102-114.
- Firestone, S. (1997).“The Dialectic of Sex”:Linda Nicholson (Ed.), The second wave A Reader in Feminist theory (19-26).New York, NY: Routledge
- Fischer, R. (2009). Where is culture in cross cultural research? An outline of a multilevel research process for measuring culture as a shared meaning system. *International Journal of Cross Cultural Management*, 9(1), 25-49.

Friedman, S. (1984). feminism as theme in twentieth-century american women's drama. *American studies*, 25(1), 69-89.

Friedan, B. (1963) "The Feminine Mystique." . Ed. Deborah Orr. Toronto: York University, 2011-2012. 43-48. Print.

Friedan, Betty. "The Feminine Mystique." *AP/HUMA 1950 9.0 Concepts of Male and Female in the West*. Ed. Deborah Orr. Toronto: York University, 2011-2012. 43-48. Print.

Gilmour, J. M., & Mykitiuk, R. (2011). The Legal Regulation and Construction of the Gendered Body and of Disability in Canadian Health Law and Policy.

Gunning, Isabelle. (1995). "Female Genital Surgeries and Multicultural Feminism:"The Ties Blind; The Differences that Distance. Volume 13 Issues 1 women's Rights and Traditional Law: A conflict.

Lerner, G. (1986) The Creation of Patriarchy. New York: Oxford University Press.

Lewis, H. (1995). Between Irua and'female genital mutilation': feminist human rights discourse and the cultural divide. *Harvard Human Rights Journal*, 8(1), 1-55.

Lightfoot-Klein, H. (1990). Rites of purification and their effects: Some psychological aspects of female genital circumcision and infibulation (Pharaonic circumcision) in an Afro-Arab I Islamic society (Sudan). *Journal of Psychology & Human Sexuality*, 2(2), 79-91.

Mann, J. M. et al. (2004) Health And Human Right Authors. 1st ed., The President And Fellows Of Harvard College, , <http://www.jstor.org/stable/4065260>.

Mandara, M. U. (2004). Female genital mutilation in Nigeria. *International Journal of Gynecology & Obstetrics*, 84(3), 291-298.

Meynell, H. (1989). On knowledge, power and Michel Foucault. *The Heythrop Journal*, 30(4), 419-432

Neath, J. (1997). Social Causes of Impairment, Disability, and Abuse A Feminist Perspective. *Journal of Disability Policy Studies*, 8(1-2), 195-230.

Prince, M.J.(2016).Reconsideration Knowledge and Power: Reflection on Disability Communities and Disability Studies in Canada. *Canadian Journal of Disability Studies*, 5(2), 1-30.

Rymer, J. (2003). Female genital mutilation. *Current Obstetrics & Gynaecology*, 13(3), 185-190.

Savell, K (1996) "Wrestling with Contradictions: Human right and Traditional Practices Affecting Women," 41 McGill L.J.781 (Hein Online).

Shaw, S (2004) “Sacred Rights: Balancing Respect for Culture and the Health Rights of Women and Girls in Islamic Canadian Communities Seeking to Practice Female Genital Mutilation.” *Journal of Law and Equality*.

Thiam, A. (1986). *Speak out, Black sisters: Feminism and oppression in Black Africa.* Pluto Press.

Walley, C. J. (2006). Feminism, Anthropology, and the Global Debates over Female Genital Operations. *Feminist Anthropology*, 19.

Walker , A.(1996)Warrior Marks: *Female Genital Mutilation and the Sexual Blinding of Women.* Publisher: Mariner Books; Reprint edition

Whitehorn, J., Ayonrinde, O., & Maingay, S. (2002) *Female Genital Mutilation: Cultural and Psychological Implications.* London: Routledge.

Warren, K. (2011-2012) “The Logic of Domination: Critical thinking and feminism”. Informal logic, 1988, Ed. Deborah Orr. Toronto: York University,. Print.