

# THE SYNERGISTIC RELATIONSHIP BETWEEN HEALTH AND HUMAN RIGHTS: A Case Study Using Female Genital Mutilation

*Kirsten Moore, BA,  
Kate Randolph, MA, Nahid Toubia, MD and  
Elizabeth Kirberger, JD, MPH*

This article explores the usefulness of the human rights paradigm for dealing with the legal, political, and social questions raised by health issues, with particular emphasis on the role of health professionals. Health and human rights, each ways of defining and advancing human well-being, have the individual as their major concern. The concept of health rights encompasses individual autonomy in decision making, access to the health care needed to implement one's decisions, and the influence of broader economic, social and cultural conditions—without which choice is unavailable to most individuals.

## **Developing a Human Rights Case on Which to Promote Health: The Case of Female Genital Mutilation**

Before bringing the human rights paradigm to bear on a health issue, careful examination of the practice or condition in question is needed to generate and understand basic facts. This examination will help determine whether a practice promotes or violates human rights. Violation of rights

---

*Kirsten Moore is a MPA candidate at the Woodrow Wilson School, Princeton University; Kate Randolph is Conflicts Manager at Cornell University Medical College; Nahid Toubia is Executive Director, Research, Action and Information Network for Bodily Integrity of Women (RAINBO); Elizabeth Kirberger is a consultant in resource development at the International Planned Parenthood Federation. Please address correspondence to the authors, care of Nahid Toubia, RAINBO, 915 Broadway, Suite 1603, New York, NY 10010, USA.*

may be found if a certain practice is caused by, results in, or in and of itself constitutes, a human rights violation.

In the case of female genital mutilation (FGM), an estimated 130 million girls and women, mostly African, are affected by this practice. However, its prevalence within and among countries varies greatly and is not associated with any particular religious distribution. Although the age range differs depending on region and cultural context, most girls are between four and 12 years of age when they undergo this operation. Thus, the fact that this operation is typically carried out on children raises a series of questions under the rubric of international human rights doctrine, including whether these children are capable of giving informed consent.

Using precise language is important in developing a clear understanding of the practice of FGM. True circumcision of the female genitals is more or less equal to that performed on males and consists of removing the prepuce or hood that covers the glans of the clitoris. However, the term "female genital mutilation" more accurately reflects the extent of the functional damage caused by the range of surgeries carried out on girls and women. In addition, although there is little scientific data on FGM's psychological and sexual affects, anecdotal and clinical evidence suggest that all forms of FGM have some impact on women's sexual response.

In recent years, legal scholars and grassroots activists have begun to use international forums and human rights mechanisms to draw attention to various women's reproductive health needs including the practice of FGM. Both formal and informal legal approaches to promoting human rights have been used in this context.

Health is often cited as the most acceptable and culturally sensitive way to talk about FGM. However, the *enjoyment* of health rights extends far beyond governments' obligations to provide health care and includes the right to make decisions about one's health. The International Covenant on Civil and Political Rights, the International Covenant on Economic, Social and Cultural Rights, the Convention on the Elimination of All Forms of Discrimination Against Women, the Convention on the Rights of the Child, and conventions dealing with slavery and torture, all include legal provisions relating to an individual's right to health.

In the case of FGM, qualitative research shows that a woman's perception of her sexuality—and consequently her attitude toward FGM—is very much related to her status as a woman within her community. For example, in a study undertaken by the New Woman Research Center in Cairo (1994-95), women gave several reasons for choosing to circumcise their daughters.<sup>1</sup> The first was belief that the procedure reduces a woman's sexual desire, thereby helping to ensure her virginity until marriage. Although, it is worth noting that a girl is circumcised so that her sexual drive may be controlled, and yet she is expected to be sexually responsive to her husband after marriage. Another reason cited was that circumcision works as a catalyst toward a woman's achievement of "full femininity." In other words, circumcision is a necessary rite of passage to womanhood. Finally, women also cited belief that the "virtue" symbolized (or imposed) by the operation gives them more bargaining power in their relationships with their husbands.

### **Creation of Health Rights: Two Case Studies**

The next section will look more closely at the politics of health, particularly health professionals' politics with regard to FGM in Egypt. The role of the medical profession in first criminalizing then legalizing abortion in the United States will be reviewed as a comparative case study.

#### **Case 1: FGM in Egypt**

A historical review of the movement against FGM shows that in many African countries, physicians pioneered opposition to the practice and revealed its negative consequences, sometimes at considerable risk to themselves or their professional standing. This continues to be true in countries such as Sudan and Somalia.

The history of policy debates around FGM in Egypt shows that anti-FGM sentiment emerged in the 1930s and gained prominence in the 1950s largely as a result of a campaign conducted by a leading women's magazine calling for eradication of the practice. The support of certain physicians in this campaign culminated in a 1959 decree by the Ministry of Health, prohibiting performance of female circumcision in public hospitals. This decree remained in effect until

shortly after the 1994 International Conference on Population and Development (ICPD), when the Minister of Health issued a directive making FGM a legitimate medical treatment, designating a number of select government hospitals to perform the operation.

Egyptian organizations working against FGM and other practices harmful to women tended to use health rather than rights as the basis for their arguments. FGM took varying degrees of prominence on the agendas of educational, health, and women's organizations who were preparing for ICPD, and it was initially of little importance to the Islamist movement. However, after a CNN film depicting the circumcision of an Egyptian girl aired during ICPD, FGM's profile rose sharply and civic, religious, and state entities and groups began to use the issue as a way to define their position on the Egyptian political and ideological map.

Immediately after the film aired, the Minister of Health and the Minister of Population made a promise to the international community to introduce legislation to bolster the 1959 decree and eradicate the practice. The religious institution Al-Azhar University then launched a media campaign, in collaboration with like-minded organizations, claiming that circumcision helps keep women free and independent and promotes their equality with men by preserving a woman's virtue and giving her more power in decision making. More broadly, the campaign depicted FGM as a part of Egypt's code of ethics and morals, as a tradition that marks Egypt's national identity.

Those advocating eradication of FGM used various arguments to support their position, including both the health problems associated with the operation and more progressive ways of interpreting Islamic Scripture. Also they opposed Al-Azhar's role in the debate, claiming that it had exceeded its mandate. In October, 1994 the Sheikh of Al-Azhar had passed a fatwa declaring that female circumcision is part of adherence to Islam. During the spring of 1995 a case against the Al-Azhar was filed in court by a consortium of nongovernmental organizations on the basis that as a religious institution it should act as an advisory body and should not issue fatwas.

After Al-Azhar entered public debate, the Minister of Health stated that in order to avoid political unrest, he would wait until after parliamentary elections to press for legislation on the matter. Despite forming an advisory committee that advised *against* legalizing FGM, the Minister of Health eventually issued a decree that made FGM a legitimate medical treatment. As stated above, this decree allowed the previously banned operation to be carried out by physicians. In the meantime, the Grand Mufti (the official government appointed interpreter of Islamic law) had declared that there was no strong Quranic source regarding the practice and that the legality of female circumcision should be decided upon in consultation with physicians. In July 1996, the new Minister of Health publicly announced a decision to ban female circumcision from being done in public hospitals and to punish individuals who violate this ban and perform this procedure. Formal legislation to ban the practice has not been introduced to date. The latest decree by the Minister of Health and Population however is considered a significant step forward as it not only bans the practice in public hospitals but also includes punishment for violations of the ban.

Unfortunately, the medical establishment is one of the great conservative institutions in Egypt and has traditionally paid little attention to women's concerns. The Egyptian Medical Syndicate (equivalent to the American Medical Association) is a highly politicized organization controlled by affiliates of the Muslim Brotherhood. In recent years, it has taken positions in favor of female circumcision. Most recently, a group of physicians challenged the decision banning female circumcision citing religion, health and the unconstitutionality of the decision. A cynic might say that this position results from the low pay of physicians who are grateful for any extra source of income—such as performing female circumcision.

Those in favor of medicalizing FGM, regardless of their motives, use the argument that the practice will occur anyway and if it is done by untrained individuals under unhygienic conditions it will result in many complications and possibly death. Some health professionals believe that by performing FGM they are following their duty to avert death and disease whenever possible. Their medical argument does

not take into account the nature and meaning of the operation. Those opposed to medicalization of FGM bring in the human rights and medical ethics perspective to counter this argument. They argue that physicians and trained health personnel should not take part in a practice based on tradition that discriminates against girls and women and causes permanent damage to the individual. Female circumcision with its resulting mutilation is thereby seen as torture — given its immediate and long-term effect on women’s reproductive and sexual health. Those opposing FGM believe that physicians who perform the operation are violating the medical code of ethics as well as the child’s or woman’s right to bodily integrity. Debate over the medicalization of FGM is a most illustrative example of the need to combine human rights values with clinical and epidemiological concerns.

## **Case 2: Abortion in the United States**

Parallels can be drawn between what is happening in Egypt and what happened in the United States with regard to access to safe and legal abortion. Historically, women’s reproductive health and rights in the United States were defined or circumscribed by medical professionals. In the latter part of the nineteenth century, American medical professionals played a leading role in criminalizing abortion, in large part to force white Anglo-Protestant women to procreate.<sup>2</sup> At the time, a majority of health professionals held conservative viewpoints regarding women’s sexuality, similar to those expressed by some health professionals in Egypt today. Health professionals were instrumental in the eugenic sterilization campaigns that targeted social undesirables, including mentally retarded, poor, and immigrant women.<sup>3</sup>

By the mid-twentieth century, however, the horrifying rates of abortion-related mortality and morbidity, particularly among poor women, led medical and legal professionals to suggest reforms in the abortion law. However, these reforms were based not on the right of women to health care or to control their fertility but on avoidance of the more serious consequences of *not* permitting them. Initial proposals carved out exceptions to the ban on abortions in case a woman’s life or health was threatened, fetal anomaly, rape, or incest. These evolved into recommendations that, up to a particular point

in pregnancy, it be a doctor's decision as to the necessity of abortion. While these reform laws were adopted in a number of states, their narrow exceptions and the fact that they generally required hospitalization and several layers of medical approval, made them close to useless to the average women. Despite these limitations, the health debate forced the public to reconsider its views, and signaled a loosening of the hold of religion over this issue. Eventually, health concerns became a crucial precursor to debates over women's autonomy and gender equity.

While there is little doubt that the medical profession is in a better position to set standards of health care than religious organizations are, it is still not the most secure foundation for women's access to reproductive rights. Two of the main dangers are the economic and ideological interests of the profession, which can override health and ethical concerns. In the United States, the medical profession has yet to wage a campaign to protect funding for poor women's abortions, and it has certified doctors without obliging them to be trained in abortion techniques. The strongest argument for safe and legal abortion in the United States would seem to be based on the human rights of women. Equal access to abortion can be understood as an integral part of women's health rights—an issue that in the United States gets lost in the abortion debate.

### **Health Rights Advocacy**

Professionals working to promote change in women's reproductive health must ask: Is the action taken in the woman's interests as well as in the profession's interests? Is it about building professional control or supporting the individuals and social groups they serve? What are the effects on the human rights of women when a practice or procedure such as FGM is medicalized or when abortion is available only to those who have financial resources to pay for it? How might negative effects be offset?

It is crucial that health professionals seek the opinions and participation of those women whom their decisions affect. Professional advocates must let their efforts be shaped and enriched by women's understanding of their rights and entitlement. Advocacy efforts within the health professions

must be based on grassroots activism. Community education about women's human rights in general and health rights in particular is needed to help women recognize their rights and challenge or expand their perception of their own entitlements.

In 1994 at the International Conference on Population and Development in Cairo, professional advocacy and women's activism were combined with remarkable results. At this conference, women used the language of human rights to make the connection between women's health and women's status. They forced the world community to connect health with social and political power, human rights, and an individual's place in the broader society. They spoke of lack of access to education; skills training; and health care services that perpetuate conditions of illiteracy, unemployment, and ill health for girls and women around the globe. They spoke of the lack of their involvement in the leadership and planning, decision making, and implementation of services that are designed *for women*, whether it be in the area of health services or economic development. Issues of custody, inheritance, citizenship, and the right to enter into a contract in one's own name without the permission of a male guardian were discussed publicly.

More significantly, they also spoke of violations within the most intimate aspects of their private lives, including issues relating to the body, sexuality, reproduction, and the family. FGM, domestic violence, sexually transmitted disease, violations that are routine occurrences in many women's lives, were discussed openly. Rather than simply looking to international human rights instruments and asking what rights these convey, women articulated their own understanding of their entitlements based on their own experiences.

Clearly there is a strong synergy between health and human rights. A human rights framework must be invoked to counteract the medical establishment's historical stronghold over health decisions. Although the technical knowledge and experience of health professionals is indispensable, and the support of progressive physicians and nurses is invaluable, health regulations and legislation should be centered around the rights of the individual and decisions should ultimately rest in her or his hands. Health issues must be



brought to public debate at both the policy and grassroots levels. Such debate inevitably raises questions over who controls the information that defines the issue: is there equitable access to health care? And what are the social, economic, and political contexts in which individuals' decisions about their health are made and carried out? Health professionals must be aware of the human rights implications of their work, and human rights advocates must be aware of the health rights connected to their causes. Both professional disciplines must develop communications with grassroots advocates to share information about health issues, and shape public debate and understanding of health rights.

### **The Role of Physicians in Promoting Health Rights**

Involvement of medical professionals in the legalization of abortion in the United States and in bringing attention to the practice of FGM in Africa suggests several positive roles health professionals can play to change medical practices and bring about legal reform to advance women's health rights.

The first is through providing accurate and scientific information through research, documentation, and dissemination of research results—which would advance public understanding of health problems, particularly when they result from gender inequities. Second, professionals can influence policy by taking positions and mobilizing support for those positions within professional groups and healthcare institutions. Third, health professionals can act as “ethical risk-takers” by pushing the frontiers of professional norms and laws and providing necessary information to question and monitor the operation of the health system by the public. Fourth, they can become directly involved as participants in health rights initiatives, including providing human rights education in the communities they serve. Finally, health professionals can undertake to educate themselves about the principles and values of human rights. This would shift the century-old emphasis on the physician's power to heal to the physician as tool for the individual to make decisions to protect and heal her-or himself.

## **Acknowledgements**

This article is based on a workshop report compiled by Elizabeth Kirberger. The one-day workshop, organized in 1995 by the Research, Action & Information Network for Bodily Integrity of Women (RAINBO), brought together a group of scholars, health and legal professionals, social scientists, and activists to examine the intersection between health and human rights using female genital mutilation as a case study. The group framed its discussion around the following questions: (1) What are the principles on which "human rights for health" are to be defined across cultures and religions? (2) What are the means through which these rights may be achieved? (3) what are the advantages and disadvantages of legislative measures versus human rights education, in establishing health rights? (4) What are the roles and responsibilities of health professionals in promoting human rights in health?

## **Workshop Panelists and Participants:**

Abdullahi A. An-Na'im, Emory University School of Law, Atlanta, GA; Rhonda Copelon, International Women's Human Rights Clinic, New York, NY; Aida Seif El Dawla, New Women's Research Center, Cairo, Egypt; Amal Abd El Hadi, Cairo Institute for Human Rights Studies, Cairo, Egypt; Lynn Freedman, Center for Population and Family Health, Columbia University School of Public Health, New York, NY; Deborah Maine, Prevention of Maternal Mortality Program, Columbia University School of Public Health, New York, NY; Anika Rahman, Center for Reproductive Law & Policy, New York, NY; Nahid Toubia, Research, Action & Information Network for Bodily Integrity of Women (RAINBO), New York, NY.

## **References**

1. New Woman Research Center, "Women's Wit Over Men's: Trade-offs and Strategic accommodations in Egyptian's Women's lives," in: *Negotiating Reproductive Rights*, International Reproductive Rights Research Action Group (eds.), (London and New Jersey: Zed Books, forthcoming in 1997).
2. L.P. Freedman, "Censorship and Manipulation of Reproductive Health Information," in: *Article 19, The Right to Know: Human Rights and Access to Reproductive Health Information*. (Pennsylvania: University of Pennsylvania Press, 1995). pp. 14-18.
3. *Ibid.*