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THE DISABLED GENITALIA: COUNTERING DOMINANT NARRATIVES TO ENDING FEMALE GENITAL MUTILATION IN AFRICA

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Abstract

Disability is an essential identity in the female genital mutilation discourse in two ways. First, a genitally-mutilated woman potentially is a disabled woman. For instance, because of the invasive nature of the FGM procedures, genitally-mutilated women in Africa could become 'disabled'. Indeed, 'mutilation' makes an incomplete body. Second, women with disabilities are subjected to the same harmful practices, such as FGM, that women without disabilities encounter daily. For instance, compared to women without disabilities, women with disabilities are increasingly susceptible to violent, harmful and forced practices and are more likely to be genitally mutilated in Africa. FGM, therefore, is not only gendered but also ableist and disabling. Yet, the disabled woman's experience is mainly unacknowledged, silenced and invisible in the legal and human rights responses to ending FGM in Africa. Centring the disabled woman's experience shows that FGM is both gendered, ableist and disabling, simultaneously confirming the interactions and intersections between the identity categories of sex/gender and disability. Against this background, this chapter uses the disabled woman's experience to argue for a reconceptualisation of the FGM's response in Africa. Effective responses and interventions must be attentive to how gender and disability as identity categories are mutually constitutive, intersecting and impact the FGM experience.

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Consequently, this chapter calls for an intersectional and feminist decolonial understanding where FGM is not viewed as if disability and sex/gender are entirely separate, stable, monolithic, colonial and essentialist identity categories.

1 Introduction

Approximately 140 million African women and girls have undergone female genital mutilation (FGM).[1] Furthermore, millions more women and girls are threatened and are likely to experience the practice globally and in Africa if the procedure is not entirely abandoned.[2] These staggering figures confirm FGM as one of the most severe and widespread human rights infringements committed against women and girls in Africa and worldwide, sparking renewed calls for an end to the harmful practice.

Disability is an essential identity in the FGM discourse for two reasons. On the one hand, there is FGM's potential to disable women, given the invasive nature of the FGM procedure. Unsurprisingly, 'mutilation' has been found to have the 'nuance of making a body incomplete'.[3] Indeed, the link between FGM and disability has been well established.[4] If this link is accurate, a genitally-mutilated woman in Africa potentially is either a 'disabled' or a dead woman.[5] What this

1 United Nations Children's Fund (UNICEF) 'Towards ending harmful practices in Africa: A statistical overview of child marriage and female genital mutilation' (2022), https://data.unicef.org/resources/harmful-practices-in-africa/ (accessed 27 September 2022). See also United Nations 'Ending female genital mutilation by 2030', https://www.un.org/en/observances/female-genital-mutilation-day (accessed 27 September 2022).

2 World Health Organisation 'Female genital mutilation factsheet' (2022), https://www.who.int/news-room/fact-sheets/detail/female-genital-mutilation (accessed 27 September 2022).

3 Y Iguchi & A Rashid 'Female genital mutilation and the politics of discourse: Questioning the self-evidence of the modern medical scientific gaze' (author's translation) (2019) 7 *Annual Review of Cultural Typhoon* 2.

4 In my DPhil thesis, I argued that FGM does not only cause disabilities (impairments and disabilities used interchangeably in this chapter) but it is also a form of sexual disability. See: A Johnson 'The voiceless woman: Countering dominant narratives concerning disabled women in Nigeria' (2019) Faculty of Law, University of Pretoria 36. Another author that makes this argument is M Owojuyigbe and others 'Female genital mutilation as sexual disability: Perceptions of women and their spouses in Akure, Ondo State, Nigeria' (2017) 25 *Reproductive Health Matters* 80 81.

5 CEDAW Committee General Recommendation 24: Article 12 of CEDAW (Women and health) UN Doc A/54/38/Rev.1 ch 1 (5 February 1999) para 12b.

could mean, although scary, is that if the FGM practice is not entirely abandoned, more women and girls are likely to die or become disabled as a consequence of undergoing the FGM procedure.

On the other hand, and which is rarely acknowledged, women with disabilities are subjected to the same harmful practices committed against women without disabilities, including FGM.[6] Indeed, compared to women without disabilities, women with disabilities are increasingly susceptible to encountering violent, dangerous and forced treatments, which includes FGM, in Africa.[7] This increased susceptibility to undergo FGM could lead to more severe disabilities.[8]

Yet, the disabled woman's experience is unacknowledged, silenced and invisible in the legal and human rights responses aimed at ending FGM in Africa. Few studies have investigated how disabled women undergo FGM simply because of their intersectional positioning and on the grounds of their gender and disability in Africa. Indeed, it is telling that although disabled women are more likely to undergo FGM, the number of disabled women or women with disabilities that have experienced FGM is unknown in Africa.[9]

Against this background, this chapter uses the disabled woman's FGM experience to argue for a change of approach to FGM's response in Africa. This is bearing in mind that effective responses and interventions must be attentive to how gender and disability as identity categories are mutually constitutive, intersecting and impact the FGM experience. Centring the disabled woman's experience exposes FGM as gendered, ableist and disabling, simultaneously confirming the interactions and intersections between the identity categories of sex/gender and disability.

The chapter uncovers how law's dominant interventionist narrative, which views identity categories such as sex/gender and disability as biological realities rather than mutually constitutive, socially constructed signifiers of FGM oppression, needs to be countered. In other words, to interpret FGM in terms of its gendered implications alone risks overlooking its potentially more significant ableist and disabling

6 Committee on the Rights of People with Disabilities (CRPD Committee) General Comment 3: Women and girls with disabilities (2016) CRPD/C/GC/3 para 37.
7 As above.
8 As above.
9 As above.

consequences. Similarly, efforts to end the FGM practice without considering disability reinforce disabling stereotypes around the practice.

Consequently, a change of approach in FGM's response in Africa involves a combined intersectional and feminist decolonial lens where FGM is not viewed as if disability and sex/gender are entirely separate, stable, monolithic and essentialist identity categories.

The chapter proceeds in six parts. Part 1 is the introduction. Part 2 discusses the reality of the FGM practice in Africa. This part exposes the prevalence of the FGM practice in Africa in three ways: as gendered; as disabling; and as both sexist/gendered and ableist, simultaneously manifesting in an intersectional 'disabled female' dilemma. This exposure lays a good foundation for part 3, which explores the legal and human rights responses to ending FGM in Africa.

Subsequently, in advocating a reconceptualisation of the FGM response, part 4 proposes an intersectional understanding in efforts to end FGM. Next, part 5 discusses how, for an intersectional lens to work in efforts to end FGM in Africa, it must apply a feminist 'decolonial' perspective. Finally, part 6 offers conclusive arguments that advocate legal and human rights responses that apply a feminist decolonial intersectionality lens in its efforts to abolish FGM in Africa.

2 Reality of the female genital mutilation practice in Africa

The global prevalence of FGM has been well documented.[10] However, despite its prevalence, some African countries have reported an uneven decline in FGM.[11] Furthermore, the advent of the Coronavirus (COVID-19) pandemic in 2019 and its disproportionate negative impacts on women have led to severe warnings about the pandemic's potential to overturn any decline in the FGM practice in Africa and

10 World Health Organisation (n 2); United Nations Children's Fund 'Female genital mutilation/cutting: A global concern' (2016), https://www.unicef.org/media/files/FGMC_2016_brochure_ final_UNICEF_SPREAD.pdf (accessed 27 September 2022); BM Gbadebo and others 'Cohort analysis of the state of female genital cutting in Nigeria: Prevalence, daughter circumcision and attitude towards its discontinuation' (2021) 21 *BMC Women's Health* 2.

11 UNICEF 'The decline of female genital mutilation in Ethiopia and Kenya' (2021), https://www.unicef.org/esa/media/8891/file/The-Decline-of-FGM-Ethiopia-Kenya-2021.pdf (accessed 27 September 2022). See also Gbadebo and others (n 10) 184.

globally.[12] Indeed, these warnings cite recent rises in FGM rates among young women in some African countries.[13] Thus, if the FGM practice is not abandoned, staggering numbers of African women and girls in Africa and globally remain at risk, making its abandonment crucial.

Extensive scholarly debates have been drawn around FGM. For instance, there have been conceptual debates on what FGM signifies. For example, disagreements are rife about whether the genitalia of females are cut, circumcised[14] or mutilated,[15] with implications for each scenario. These implications include the question of the practice's prevalence despite a plethora of eradication efforts and the effectiveness of these efforts and interventions, primarily legal and criminal sanctions, employed to end the practice in Africa.[16]

Despite these contentions, FGM's stark reality, severity and global prevalence have earned significant attention amidst urgent calls for its

12 UNICEF 'COVID-19 disrupting SDG 5.3: Eliminating female genital mutilation' (2020), https://www.unicef.org/media/68786/file/External-Tehnical-Note-on-COVID-19-and-FGM.pdf (accessed 27 September 2022). See also: A Johnson and A Budoo-Scholtz 'COVID-19 and women's intersectionalities in Africa' in A Johnson and A Budoo-Scholtz (eds) *COVID-19 and women's intersectionalities in Africa*' (2023) 13.

13 UNICEF 'UNICEF warns FGM on the rise among young Nigerian girls: Organisation launches community-led initiative to end harmful practice on International Day of Zero Tolerance for FGM' (2022) https://www.unicef.org/nigeria/press-releases/unicef-warns-fgm-rise-among-young-nigerian-girls#:~:text=Abuja%2C%2006%20February%202022%20%E2%80%93%20UNICEF,FGM)%20remains%20widespread%20in%20Nigeria (accessed 27 September 2022).

14 WN Njambi 'Dualisms and female bodies in representations of African female circumcision: A feminist critique' (2004) 3 *Feminist Theory* 283-285. See also WN Njambi 'Irua ria atumia and anti-colonial struggles among the gı̄kūyū of Kenya: A counter narrative on female genital mutilation' (2007) 33 *Critical Sociology* 690; WN Njambi 'Irua ria atumia and anticolonial struggles among the Gĩkũyũ of Kenya: A counternarrative on "female genital mutilation"' in O Oyěwùmí (ed) *Gender epistemologies in Africa* (2011) 179-197.

15 WHO 'Eliminating female genital mutilation: An interagency statement OHCHR, UNAIDS, UNDP, UNECA, UNESCO, UNFPA, UNHCR, UNICEF, UNIFEM, WHO' (2008) 22, https://www.who.int/publications/i/item/9789241596442 (accessed 27 September 2022). See also UNFPA 'Implementation of the international and regional human rights framework for the elimination of female genital mutilation' (2014) 12, https://www.unfpa.org/sites/default/files/pub-pdf/FGMC-humanrights.pdf (accessed 27 September 2022).

16 R Khosla and others 'Gender equality and human rights approaches to female genital mutilation: A review of international human rights norms and standards' (2017) 14 *Reproductive Health* 2.

elimination globally.[17] I discuss three manifestations of FGM in Africa below.

2.1 Female genital mutilation as gendered in Africa

FGM is a gendered act in Africa. It is commonly regarded as a private cultural and religious practice targeted explicitly at African women and girls.[18] In other words, African women and girls have their genitalia mutilated simply because of their gender. For instance, the FGM practice is done to retain the female marriageability of women and girls by ensuring that they maintain their virginity until marriage when their husbands have sexual intercourse with them.[19] Findings from Nigeria confirm how FGM is practised so that women's and girls' virginity is retained.[20] Consequently, FGM is exposed as a gendered act because it is a by-product of patriarchal and sexist tendencies and descriptions that reinforce men's sexual superiority over women in Africa.[21]

FGM is also recognised globally as a form of gender-based violence.[22] Gender-based violence refers to the 'violence directed against a woman because she is a woman or that affects women disproportionately'[23] and, as such, infringes on their human rights.

Multiple reasons advanced for the FGM practice further expose it as a gendered act. For instance, several accounts document how in African societies where FGM is practised, it is considered a cultural rite of passage to womanhood in Africa.[24] The FGM practice is so profoundly entrenched culturally that women in practising communities view FGM

17 United Nations General Assembly Resolution 75/160 'Intensifying global efforts for the elimination of female genital mutilation' (2020) (A/75/471).

18 A Idowu 'Effects of forced genital cutting on human rights of women and female children: The Nigerian situation' (2008) 12 *Law, Democracy and Development* 116.

19 O Omigbodun and others 'Perceptions of the psychological experiences surrounding female genital mutilation/cutting (FGM/C) among the Izzi in Southeast Nigeria' (2019) 57 *Transcultural Psychiatry* 213.

20 As above.

21 Omigbodun and others (n 19) 116. See also CEDAW Committee General Recommendation 19 Violence against women para 11; AO El-Tom 'Female circumcision and ethnic identification in Sudan with special reference to the Beti of Darfur' (1998) 46 *GeoJournal* 164 166.

22 Declaration on the Elimination of Violence against Women (Declaration) art 2.

23 As above.

24 L Muzima 'Towards a sensitive approach to ending female genital mutilation/cutting in Africa' (2016) 3 *SOAS Law Journal* 81.

as essential to their cultural identity as African women.[25] Additionally, FGM is still considered a prestigious and honourable custom.[26] For instance, despite strict laws in 19 of the 36 states and the federal capital territory (FCT) in Nigeria prohibiting FGM, varying sanctions and sometimes culture is used to legitimise the practice.[27] Moreover, in other African societies, the lack of laws or weak enforcement of laws on FGM is linked to its powerful cultural force.[28]

This cultural rite of passage argument thrives in several African societies because of representations of women's bodies as unruly and in dire need of sexual control.[29] This sexual control manifests by stifling or reducing women's sexual desires to guard against deviant and immoral sexual behaviour.[30] Thus, without the sexual control that FGM ostensibly proffers, true womanhood is believed to be unattainable.

Similarly, the FGM prevalence thrives on genital cleansing and sexual purity arguments.[31] In practising African communities, women who do not undergo FGM are considered unclean, dirty and corrupt.[32] As argued previously, it is held that the practice is done to retain the female marriageability of women and girls by ensuring that they maintain their virginity until marriage when their husbands have sexual intercourse with them.[33] As a rite of passage to womanhood in Nigeria, women who refuse to undergo FGM are viewed as promiscuous or unmarriageable.[34] Even when married, studies find that FGM is practised to ensure marital fidelity since the practice limits women's sexual desires due to painful

25 As above.
26 Muzima (n 24) 73.
27 CC Nnanatu and others 'Evaluating changes in the prevalence of female genital mutilation/cutting among 0-14 years old girls in Nigeria using data from multiple surveys: A novel Bayesian hierarchical spatio-temporal model' (2021) 16 *PLoS ONE* 1; see also Idowu (n 18) 116.
28 CEDAW Committee and CRC Committee Joint general recommendation 31 of the Committee on the Elimination of Discrimination against Women/General Comment 18 of the Committee on the Rights of the Child (2014) on harmful practices para 19. See also CRPD Committee Concluding Observations on the initial report of Uganda 12 May 2016 CRPD/C/UGA/CO/1 para 34.
29 AA Odukogbe and others 'Female genital mutilation/cutting in Africa' (2017) 6 *Translational Andrology and Urology* 139.
30 Omigbodun and others (n 19) 213.
31 As above 213.
32 Omigbodun and others (n 19) 223.
33 Omigbodun and others (n 19) 213.
34 Johnson (n 4) 62.

sexual intercourse, thereby reducing the potential for promiscuity and extramarital sex.[35]

Not surprisingly, when a woman fails to undergo this practice, she is stigmatised and ostracised in many African countries.[36] The outcome is that women and girls 'voluntarily' submit themselves to FGM to attain womanhood and achieve societal approval, recognition and acceptance despite proof that many women who undergo FGM are unwilling to do so.[37]

Besides, FGM is also performed to prepare women and young girls for motherhood, guard reproductive potential, increase fertility, and aid childbirth.[38] This assertion is bolstered by a widely-held belief among practising communities that women who do not undergo FGM are more susceptible to stillbirths. According to the myth, if the baby's head touches an unmutilated clitoris, death will occur.[39] Yet, paradoxically, evidence demonstrates otherwise, showing how it is women who have their genitals mutilated that are at risk of infertility.[40]

Nevertheless, some practising African communities object to the idea that FGM 'mutilates' but insist that it is part of a beautification process of women's genitalia that makes women more attractive physically and socially.[41] The FGM practice is also linked to religion. However, substantial evidence for a possible link between FGM and Christianity or Islam is unsubstantiated.[42]

2.2 FGM is disabling in Africa

As discussed above, FGM is gendered because it specifically targets women and girls in Africa. However, the truth is that exposing FGM as a gendered practice reveals its disabling oppressive nature in Africa. The

35 Gbadebo and others (n 10) 2.
36 Johnson (n 4) 62.
37 ZE Harivandi 'Invisible and involuntary: Female genital mutilation as a basis for asylum' (2010) 95 *Cornell Law Review* 600.
38 Omigbodun and others (n 19) 213.
39 PO Anuforo and others 'Comparative study of meanings, beliefs, and practices of female circumcision among three Nigerian tribes in the United States and Nigeria' (2004) 15 *Journal of Transcultural Nursing* 105.
40 C Onyemelukwe 'Intersections of violence against women and health: Implications for health law and policy in Nigeria (2016) 22 *William and Mary Journal of Women and the Law* 619.
41 Omigbodun and others (n 19) 213.
42 Omigbodun and others (n 19) 213-214.

severe health complications and consequences of violence against women in Africa are well documented.[43] For instance, research finds that forms of violence against women, including harmful practices such as FGM, are a more prominent reason for women's ill-health than traffic accidents and malaria combined' and is 'as serious a cause of death as cancer'.[44] Consequently, objections to the FGM practice have not only relied on the argument that it is a violent, sexist act targeted at women but mostly stresses its disabling medical and public health consequences.[45]

Indeed, women who have undergone FGM are susceptible to extensively documented public health challenges and are more likely to contract medically severe diseases. For instance, specific mental health outcomes, including post-traumatic stress disorders, low self-esteem, anxiety, depression, sexual dysfunction, and obsessive-compulsive disorders, have been attributed to FGM.[46] Further, women who undergo FGM will likely experience adverse reproductive health consequences, including pain and difficulties enjoying sexual relations, painful menstruation, vesicovaginal fistula, rectovaginal fistula, pelvic inflammatory disease, and obstructed labour.'[47]

Additionally, FGM may result in bleeding and infections since it is primarily done in unsanitary conditions. Studies have attributed the extent of health complications arising from FGM to the procedures used.[48] For instance, literature has shown that 'unsterilised equipment can potentially cause primary infections like urinary tract infections, staphylococcus, haemorrhaging, and excessive and uncontrollable pains'.[49] Moreover, other severe infections such as HIV, clostridium tetani, HSV 2, chlamydia trachomatis, and others have been associated with type 3 mutilation.[50]

Similarly, literature draws a correlation between FGM and disability.[51] For example, a United Nations (UN) thematic study links FGM to

43 CEDAW Committee and CRC Committee (n 28) paras 15 & 19.
44 Onyemelukwe (n 40) 616.
45 Onyemelukwe (n 40) 619.
46 As above.
47 As above.
48 GO Shakirat and others 'An overview of female genital mutilation in Africa: Are the women beneficiaries or victims' (2020) 12 *Cureus* 3 8.
49 As above.
50 As above.
51 Human Rights Council 'Thematic study on the issue of violence against women and girls and disability Report of the Office of the United Nations High

various physical and psychological impairments.[52] Research suggests that women who had no prior disabilities and impairments could potentially develop disabilities that manifest in distinct forms, for example, sexual, psychosocial and intellectual disabilities, once they have undergone this practice.[53] Apart from the health consequences of FGM, it is held that FGM type 3 (infibulation) is considered a disability perpetrated after birth in African countries.[54] Moreover, disabilities could occur due to short-term health complications of FGM exacerbated by the limited healthcare services available in African countries to deal with such difficulties.[55]

Thus, as demonstrated above, a mutilated woman is potentially a disabled woman. However, this argument does not negate scholarship that insists that while it is crucial to recognise the impact of FGM on mental health, there is a need to avoid pathologising women who have experienced violence, including FGM, given its implications.[56]

Yet, in extreme cases, FGM can also result in maternal morbidities.[57] The manifestation of short-term complications resulting from FGM could lead to avoidable deaths. As earlier indicated, this situation is exacerbated by the limited healthcare services available in Africa to deal with such difficulties.[58] Several examples in African countries have garnered prominent attention. For instance, in 2021, a 21-year-old Sierra-Leonean woman died from acute bleeding and shock after being subjected to FGM.[59] A few days later, in a different region in Sierra Leone,

Commissioner for Human Rights' 30 March 2012 (A/HRC/20/5) para 27.

52 As above.

53 Owojuyigbe and others (n 4) 80 81.

54 UNFPA 'Implementation of the international and regional human rights framework for the elimination of female genital mutilation' (2014) para 4.7, https://www.unfpa.org/sites/default/files/pub-pdf/FGMC-humanrights.pdf (accessed 27 September 2022).

55 Onyemelukwe (n 40) 627.

56 Onyemelukwe (n 40) 631.

57 Onyemelukwe (n 40) 612. See also CEDAW Committee 'Concluding Observations of the Committee on the Elimination of Discrimination against Women Djibouti' 28 July 2011CEDAW/C/DJI/CO/1-3 para 18.

58 Onyemelukwe (n 40) 627.

59 Equality Now 'Sierra Leone urged to ban FGM following death of 21 year-old woman' (2021), https://www.equalitynow.org/news_and_insights/sierra-leone-urged-to-ban-fgm-following-death-of-21-year-old-woman/ (accessed 27 September 2022).

a 15-year-old girl was admitted to the hospital for urgent treatment after suffering severe complications due to FGM.[60]

Scenarios such as these encourage the focus on FGM's adverse health consequences in a bid to end the practice. However, the focus on FGM's negative health consequences has unintentionally fuelled the medicalisation of the procedure.[61] Some states have permitted health practitioners to perform FGM ostensibly to reduce the associated harms.[62] These efforts are based on the false premise that this shift would decrease serious health complications. However, although well-intentioned, the involvement of healthcare practitioners in performing FGM behoves a false sense of legitimacy on the practice giving the impression that the procedure is beneficial for medical reasons or at least is harmless.[63]

Yet, medicalisation as a reduction strategy is unacceptable.[64] The argument is that medicalisation does not represent a holistic and human rights approach to abandoning FGM.[65] The World Health Organisation (WHO) corroborates this point by describing medicalisation as an infringement of medical ethics based on its potential to cause harm.[66]

2.3 The disabled female: FGM as an intersectional dilemma

From the above sketch, it is clear that FGM is performed on women and potentially disables them. However, women with disabilities are also targeted for FGM in Africa. A disabled woman is more likely to be genitally mutilated and, compared to women without disabilities, is twice and sometimes thrice as likely to be violated and face distinct forms of violence and forced treatments, including FGM in Africa.[67]

60 As above.
61 E Leye and others 'Debating medicalisation of female genital mutilation/cutting (FGM/C): Learning from (policy) experiences across countries' (2019) 16 *Reproductive Health* 2.
62 As above.
63 Khosla and others (n 16) 6.
64 WHO 'Eliminating female genital mutilation: An interagency statement OHCHR, UNAIDS, UNDP, UNECA, UNESCO, UNFPA, UNHCR, UNICEF, UNIFEM, WHO' (2008) 12, https://www.who.int/publications/i/item/9789241596442 12 (accessed 27 September 2022).
As above.
65 Leye and others (n 61) 2.
66 WHO (n 64) 12.
67 Human Rights Council (n 51) paras 12-27.

In the African patriarchal context, where women are often viewed as subordinate to men, women and girls with disabilities struggle to attain the feminine norms of women without disabilities, thus giving rise to increased susceptibility to different forms of discrimination and violence.[68] Literature finds that the increased exposure of women with disabilities to sexual violence often results from their intersecting identities of gender and disability.[69] FGM is no exception. Although her womanhood and identity as a woman is questioned and doubted based on her disability, a disabled woman is simultaneously female and disabled. Therefore, women and girls with disabilities are not only predisposed to FGM based on their gender but also on the severity of their disability.

Thus, women with disabilities are more likely to experience distinct forms of sexual violence, including FGM. The Committee on the Rights of Persons with Disabilities (CRPD Committee), in its Concluding Observations to Gabon, Kenya, Ethiopia and Uganda, confirm the prevalence of FGM affecting girls and women with disabilities in African countries.[70] Research reinforces how children with disabilities in rural areas in Kenya are more likely to undergo the FGM practice.[71] The Special Rapporteur on the Rights of Persons with Disabilities described how a girl or young woman with disabilities becomes vulnerable to gender-based violence, including harmful practices such as FGM, while being treated or when overmedicated.[72] The reality shows that perpetrators of FGM often are family members and caregivers who usually justify FGM under the guise of best interests.[73]

68 United Nations General Assembly 'Report of the Special Rapporteur on the Rights of Persons with Disabilities: Sexual and reproductive health and rights of girls and young women with disabilities' (2017) A/72/133 paras 33-34.

69 As above para 34.

70 UNGA (n 68) paras 33-34. See also CRPD Committee Concluding Observations on the initial report of Gabon 2 October 2015 CRPD/C/GAB/CO/1, paras 40-41. See also CRPD Committee Concluding Observations in relation to the initial report of Kenya 4 September 2015 CRPD/C/KEN/CO/1 paras 33-34. See also CRPD Committee 'Concluding Observations on the initial report of Ethiopia 4 November 2016 CRPD/C/ETH/CO/1, paras 39-40. See also CRPD Committee Concluding observations on the initial report of Uganda 12 May 2016 CRPD/C/UGA/CO/1 paras 34-35.

71 I Inguanzo 'The situation of indigenous children with disabilities' (2017) Policy Department, Directorate-General for External Policies, European Union, http://www.europarl.europa.eu/RegData/etudes/STUD/2017/603837/EXPO_STU(2017)603837_EN.pdf (accessed 27 September 2022).

72 UNGA (n 68) para 34.

73 As above.

Research has focused chiefly on FGM performed on women without disabilities, with limited information regarding the number of women and girls with disabilities that undergo FGM.[74] Besides, studies tend to focus on the forced sterilisation of women with disabilities in Africa, and lose sight, in a critical and political sense, of 'less restrictive alternatives to sterilisation, particularly FGM and menstrual suppressant drugs'.[75] Yet, like the forced sterilisation of women and girls with disabilities in African countries,[76] FGM is also a violent form of sexual control. In addition, the practice impacts bodily integrity and autonomy significantly, involving mostly non-consensual surgical mutilation, and is similarly perpetuated based on misconceptions about disability, gender, and even menstruation in Africa.

Contradictory misconceptions of asexuality, hyper-sexuality or deviant, immoral sexual behaviour of women with disabilities are used as a double-edged sword to perpetuate FGM: first, to create doubts about whether women with disabilities undergo FGM; and, second, to rationalise why women with disabilities are often forced to undergo FGM in Africa. These misconceptions surrounding the sexuality of the disabled female have meant that the genital mutilation of the disabled female has received less legal and political scrutiny. For instance, if, as shown, FGM is considered a rite of passage to marriage and motherhood in Africa,[77] women with disabilities who are often considered not human or lesser 'women' in Africa fuel the misconception that they do not undergo FGM.[78] Women with disabilities are often viewed as mentally and physically unable or incapable of meeting gendered norms that disqualify them from marriage and motherhood in Africa.[79] As such, because of this perception of women with disabilities as unable to meet

74 CRPD Committee (n 6) para 37.

75 L Steele & B Goldblatt 'The human rights of women and girls with disabilities: Sterilisation and other coercive responses to menstruation' (2020) 78.

76 AI Ofuani 'Protecting adolescent girls with intellectual disabilities from involuntary sterilisation in Nigeria: Lessons from the Convention on the Rights of Persons with Disabilities' (2017) 17 *African Human Rights Law Journal* 552.

77 Omigbodun and others (n 19) 213.

78 CJ Eleweke & J Ebenso 'Barriers to accessing services by people with disabilities in Nigeria: Insights from a qualitative study' (2016) 6 *Journal of Educational and Social Research* 118.

79 GI Grobbelaar-Du Plessis 'African women with disabilities: The victims of multilayered discrimination' (2007) 22 *South African Public Law* 406.

gendered standards of motherhood and marriage, it is erroneously believed that they are exempt from FGM.

However, this argument has been debunked. Scholarships confirm that women and girls with disabilities do get married and become mothers.[80] Examples abound about how girls with disabilities are likely to be married in regions and communities where child marriage occurs.[81] Indeed, families in African countries are more prone to force girls with disabilities into marriage because they see it as a way to ensure long-term security and protection.[82] If this is accurate, the susceptibility of women and girls with disabilities to the FGM practice becomes more apparent.

Moreover, in African cultures such as the Ethiopian culture, women with disabilities undergo FGM to avoid what sometimes is regarded as deviant sexual behaviour since a woman who does not undergo FGM is generally considered unclean.[83] This increases the likelihood of FGM for women with disabilities since they are usually assumed to be unable to control their sexuality and manage their fertility. These misconceptions could manifest in two ways.

On the one hand, the prevalence of FGM has been attributed to the need for sexual control and reduced sexual desires reinforcing the asexuality label usually imposed on 'disabled' women.[84] On the other hand, FGM also stems from the view that women with disabilities cannot control their fertility leading to the assumption that they are hypersexual or exhibiting deviant and immoral sexual behaviour.[85] In these cases, FGM is viewed as a procedure that alleviates the perceived burdens that might result from uncontrolled sexuality. In all these scenarios, FGM or, in extreme cases, forced sterilisation is practised under the guise of their best interests.

Additionally, despite the misconceived assumption of asexuality, research has documented the increased vulnerability of women with

80 J Morris *Feminism, gender and disability* (1998) 8.
81 AS Kanter & C Villarreal Lopez 'A call for an end to violence against women and girls with disabilities under international and regional human rights law' (2018) 10 *Northeastern University Law Review* 592.
82 As above.
83 DIA Hirpa 'Sexual violence and motherhood among women with disabilities in Ambo Town, Ethiopia' (2022) *Disability and Society* 5.
84 A Johnson 'The voiceless woman: Protecting the intersectional identity under Section 42 of the Nigerian Constitution' (2021) 9 *African Disability Rights Yearbook* 90-91.
85 As above 91.

disabilities to sexual violence, including FGM, for multiple reasons. For instance, on account of misconceptions about their gender and disability, women with disabilities are often denied the ability to make informed decisions on their reproductive choices, especially on their sexuality and whether or not they consent to FGM.[86] Indeed, restricting or removing legal capacity can trigger forced medical interventions.[87] Thus, FGM exemplifies an infringement of rights that many women and adolescent girls with disabilities suffer without consent or fully understanding its intentions.

Women with disabilities are often denied the opportunity to make free and informed choices or decisions on their own accord.[88] Such denial is predicated on the false assumptions that girls and young women with intellectual disabilities cannot grasp sexuality and their bodies.[89] This situation is exacerbated by family members who are scared of being held liable for allowing such sexual escapades,[90] making girls and young women susceptible to FGM as a form of monitoring sexual control.

The assumption that forced medical procedures and interventions such as FGM are essential hinges on the medical understanding of disability.[91] This understanding portrays the disabled woman as a victim of a flawed body or mind. Based on this understanding, women with disabilities are denied the ability to make reproductive choices. Their wishes are considered irrelevant and overridden if the intervention is deemed medically beneficial.[92] Yet research has shown how FGM as a non-consensual medical care intervention ostensibly done in the best interests of women with disabilities, in reality, are 'violent acts directed towards imposing a specific normative order reinforcing hierarchies.

Moreover, forced sterilisation, a representation of eugenic and holocaust tendencies, exemplifies how a harmful practice has been redefined and enforced in many African societies as necessary for medical

86 UNGA (n 68) para 28.
87 As above.
88 CRPD Committee (n 6) para 37.
89 UNGA (n 68) para 22.
90 As above.
91 BA Areheart 'Disability trouble' (2011) 29 *Yale Law and Policy Review* 348.
92 B Ribet 'Emergent disability and the limits of equality: A critical reading of the UN Convention on the Rights of Persons with Disabilities' (2011) 14 *Yale Human Rights and Development Law Journal* 164.

or therapeutic reasons.[93] Notably, attempts have been made to analogise FGM to forced sterilisation.[94] Concerning the latter, while the rationale can be said to be a purely medical procedure, the former is usually rationalised for mainly cultural reasons.[95] However, the correlation between the two practices is obvious: FGM and forced sterilisation have similar types of physical and emotional harm and similar long-term effects.[96] Moreover, women who are genitally mutilated against their will and individuals who are forcibly sterilised suffer a grievous violation of bodily autonomy.[97]

Indeed, many African governments have continued to support measures that enable forced sterilisation and other coercive interventions, including FGM targeting the sexuality of women and girls with disabilities.[98] This support is given despite clear and documented evidence that these practices infringe on the human rights of women and girls with disabilities.[99] Furthermore, perpetrators are seldom held accountable, and women and girls with disabilities who have experienced this egregious form of violence can rarely obtain any form of redress or justice. Additionally, physical and communication vulnerabilities such as the inability to defend themselves, shout for help or express their displeasure or lack of consent make women with disabilities vulnerable to sexual violence, including FGM.[100] Other challenges, such as the inability to testify in court as credible witnesses or being less likely to be aware of sexual violence as harmful or report it makes women with disabilities easy prey to sexual violence, including FGM.[101]

Additionally, research has found that men in most African societies are often willing to have sexual relationships with women with disabilities privately but are often unwilling to be publicly associated with them.[102]

93 Kanter and Villarreal Lopez (n 81) 594.
94 Harivandi (n 37) 600.
95 Harivandi (n 37) 619.
96 As above.
97 Harivandi (n 37) 621.
98 CRPD Committee (n 6) para 37.
99 As above.
100 T Meer & H Combrinck 'Invisible intersections: Understanding the complex stigmatisation of women with intellectual disabilities in their vulnerability to gender-based violence' (2015) *Agenda: Empowering Women for Gender Equity* 1.
101 As above.
102 S Dessie and others 'Sexual violence against girls and young women with disabilities in Ethiopia. Including a capability perspective' (2019) 15 *Journal of Global Ethics* 327.

FGM, therefore, is performed as a means of protection and prevention from pregnancies as it tends to cause painful sexual intercourse.[103] Women with disabilities' vulnerability to rape and sexual harassment that could result in unwanted and unplanned pregnancies would therefore encourage FGM as a means of protection and prevention from pregnancies.[104] Furthermore, girls and young women with disabilities, especially those with albinism, are more likely to experience sexual violence due to the virgin-cure practice.[105] Rape from this practice and its tendency to lead to unwanted and unplanned pregnancies make girls and young women with disabilities susceptible to undergoing FGM.

Paradoxically, the erroneous belief that women with intellectual disabilities cannot express pleasure or pain or shout for help might encourage sexual violence, including invasive procedures, including FGM.[106] Additionally, because women and girls with disabilities are prone to social isolation and dependence, they are more likely to undergo FGM, even in African countries where such practices are prohibited.[107]

Likewise, having children out of wedlock is considered taboo and fuels stigma, discrimination and exclusion in most African cultures. This belief is worsened for women with disabilities. It is held that women with disabilities who become pregnant outside of wedlock face heightened discrimination and stigma because they are not only disabled, but they now have children before marriage.[108]

Consequently, FGM is essential since, according to research, the double discrimination of being disabled and having a child before marriage could lead to increased social isolation and exclusion.[109] Therefore, women with disabilities must undergo the FGM practice to protect them from such situations.

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103 Hirpa (n 83) 5.
104 As above.
105 The 'virgin-cure' practice is when young women and girls with disabilities, especially albinism, who because of their disabilities are often believed to be virgins and sexually chaste are raped because of the misconception that having such sexual relations would cure HIV/AIDS. See generally United Nations General Assembly Enjoyment of human rights by persons with albinism: Report of the Independent Expert on the enjoyment of human rights by persons with albinism: A preliminary survey on the root causes of attacks and discrimination against persons with albinism 29 July 2016 A/71/255, para 17.
106 Meer & Combrinck (n 101) 1.
107 Human Rights Council (n 51) para. 24.
108 Hirpa (n 83) 5.
109 As above.

3 Legal and human rights responses to ending female genital mutilation in Africa

Global efforts to end FGM have grown significantly over the last decade. For instance, in July 2020, the UN Human Rights Council adopted Resolution 44/16 on eliminating FGM.[110] This call echoes Goal 5.3's mandate fundamental to the '2030 Agenda for Sustainable Development' adopted by all UN member states in 2015 to end FGM.[111] A similar obligation underpins Aspiration 6 and Goal 17 of the African Union (AU) Agenda 2063, emphasising the achievement of gender equality.[112] This mandate is reinforced by the AU Continental Initiative on Eliminating FGM (Saleema Initiative) and protects an estimated 50 million girls in Africa under 15 years at risk of FGM by 2030.

Moreover, the African Commission on Human and Peoples' Rights (African Commission) adopted a resolution on Women's Health and Reproductive Rights in Africa that urges member states to ban FGM to protect African women's reproductive rights.[113] More recently, in 2019, the AU adopted the Ouagadougou Call to Action on Eliminating Female Genital Mutilation, which aimed at fuelling enough political action by AU member states to end FGM by 2030.[114] In 2021 the African Commission adopted Resolution 493 on the Development of a General Comment prohibiting Female Genital Mutilation in Africa.[115] Efforts are underway to draft this joint General Comment by the African Commission and the African Charter on the Rights and Welfare of the Child (African Children's Charter).

110 Human Rights Council 'Resolution 44/16. Elimination of female genital mutilation' A/HRC/RES/44/16 (24 July 2020) A/HRC/RES/44/16.

111 United Nations Department of Economic and Social Affairs 'Transforming our world: The 2030 agenda for sustainable development', https://sdgs.un.org/2030agenda (accessed 27 September 2022).

112 African Union (AU) 'Our aspirations for the Africa we want', https://au.int/agenda2063/aspirations (accessed 27 September 2022).

113 African Commission Resolution 110 on the Health and Reproductive Rights of Women in Africa' ACHPR/Res.110 (XXXXI)07, https://www.achpr.org/sessions/resolutions?id=162 (accessed 27 September 2022).

114 African Union 'Ouagadougou call to action on eliminating female genital mutilation' (2019).

115 African Commission Resolution 493 on the Development of a General Comment on the prohibition of Female Genital Mutilation in Africa – ACHPR/Res. 493 (LXIX) (2021), https://www.achpr.org/sessions/resolutions?id=525 (accessed 27 September 2022).

With less than a decade to go to 2030, the elimination of FGM has been enshrined in several international, regional and national human rights instruments. When women, including those with disabilities, are genitally mutilated, many of their rights are infringed.[116] For instance, FGM violates the right to be free from discrimination and violence, the right to health, the right to bodily autonomy and rights related to marriage and family and the right to education and information. FGM is also viewed as torture and cruel, inhuman and degrading treatment.

For a long time, the law failed to recognise FGM as a form of violence against women as it was often done privately and for cultural reasons. However, for the first time, article 2 of the Declaration on the Elimination of Violence against Women (Declaration) expanded the definition of violence against women to include but is not limited to, FGM and other traditional practices harmful to women.[117] The Declaration also recognised FGM as a form of violence against women and reinforced efforts to understand gender-based violence as an infringement of human rights.

From an African women's perspective, the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)- the International Bill of Rights for Women has received near universal ratification in Africa.[118] However, despite the massive CEDAW ratification, FGM remains a prevalent cultural rite of passage to womanhood in many African countries.[119]

Like disability, FGM is not explicitly mentioned in CEDAW's text. However, FGM as discriminatory can be read into article 1 of CEDAW.[120] For example, the Committee on the Elimination of All Forms of Discrimination against Women (CEDAW Committee) recognises all forms of violence against women, including forced medical procedures

116 UNFPA 'Implementation of the international and regional human rights framework for the elimination of female genital mutilation' (2014) 12, https://www.unfpa.org/sites/default/files/pub-pdf/FGMC-humanrights.pdf (accessed 27 September 2022).

117 Declaration on the Elimination of Violence against Women (Declaration) art 2.

118 Somalia and Sudan are the only African states that have not ratified CEDAW. For the CEDAW ratification table, see https://indicators.ohchr.org/ (accessed 27 September 2022).

119 Idowu (n 18) 116.

120 CEDAW art 1.

such as forced sterilisation and FGM, as a discriminatory practice under the CEDAW and, therefore, an infringement of women's rights.[121]

Additionally, FGM is recognised under articles 2 and 5 of CEDAW as a globally harmful traditional practice. Member states of CEDAW are therefore mandated under these provisions to 'take necessary steps, including legislation, to change or abolish existing laws, regulations, customs and practices which constitute discrimination against women'.[122]

Some scholars insist that CEDAW adopts a single-issue perspective that sees women as if there is only one way to be a woman, although there are a few exemptions.[123] If this argument is accurate, it is problematic for disabled women who undergo FGM in two ways. First, because of the misconceptions around the disabled female's sexuality, the disabled female, especially in Africa, contends with the need to end the culturally-dominant models of femininity while simultaneously aspiring to achieve such femininity.[124] FGM considered a rite of passage to womanhood in many African countries, could erroneously be viewed as a way to attain such femininity. Second, the intersecting disability and gender identities that disabled women embody have meant that their experiences of FGM are not just gendered, disabling, or ableist but can be simultaneous and, thus, silenced by the law.

Other scholars argue that adopting general recommendations has addressed perceived gaps in the CEDAW text.[125] Using this reasoning to rectify its failure to name and tackle FGM, in 1990 explicitly, the CEDAW Committee adopted General Recommendation 14 on female circumcision.[126] This General Recommendation mandates state parties to protect women against violence, including FGM, which is 'harmful to the health of women and girls'. State parties are directed to take

121 CEDAW General Recommendation 35 on gender-based violence against women, updating General Recommendation 19 26 July 2017 CEDAW/C/GC/35.

122 CEDAW arts 2(2) & 5.

123 JE Bond 'International intersectionality: A theoretical and pragmatic exploration of women's international human rights violations' (2003) 52 *Emory Law Journal* 96.

124 M Lloyd 'The politics of disability and feminism, discord or synthesis' (2001) 35 *Sociology* 716 718.

125 M Campbell 'CEDAW and women's intersecting identities: A pioneering new approach to intersectional discrimination' (2015) 11 *DIREITO GV Law Review* 486.

126 CEDAW General Recommendation 14 on female circumcision (9th session, 1990), UN Doc. A/45/38 para 80.

appropriate, effective measures to end the practice. Again, consistent with General Recommendation 18, although CEDAW does not explicitly mention disabled women but mentions women, it implicitly would cover disabled women.[127]

As a form of violence against women, FGM violates women's bodily autonomy. As such, General Recommendations 19 and 35 on violence against women address FGM. Although not explicitly named in General Recommendation 35, FGM may be read into the General Recommendation. For example, the CEDAW Committee recognises violations of women's sexual and reproductive health, such as forced sterilisation.[128] It acknowledges how these violations could amount to torture and degrading treatment.[129] It mentions how intersecting factors such as disability can increase the experience of these violations and violence against women.[130] It mandates state parties to abolish all customary, religious and local laws that are discriminatory against women and tolerate any form of gender-based violence,[131] including provisions that permit medical procedures to be performed on women with disabilities without their informed consent. It urges states to develop and disseminate accessible information through diverse and accessible media and community dialogue aimed at women, particularly those affected by intersecting forms of discrimination, such as those with disabilities.[132]

Furthermore, from the Concluding Observations issued to several African countries, the CEDAW Committee recognises FGM as harmful to the health of women and children that 'carries a high risk of death and disability'.[133] In its Concluding Observations, it is common to see the concern shown on the persistence of harmful cultural practices, including FGM, that are detrimental and discriminatory to women's rights in African countries. For example, in these Concluding Observations to

127 A Bruce and others 'Gender and disability: The Convention on the Elimination of All Forms of Discrimination against Women' in A Bruce and others *Human rights and disability: The current use and future potential of United Nations human rights instruments in the context of disability* (2002) 165.
128 CEDAW General Recommendation 35 (n 122) para 18.
129 CEDAW General Recommendation 35 (n 122) paras 15 & 16.
130 As above.
131 CEDAW General Recommendation 35 (n 122) para 29(c)(i).
132 CEDAW General Recommendation 35 (n 122) para 31(d).
133 CEDAW Committee General Recommendation 24 (n 5) para 12b.

African states, the CEDAW Committee has expressed how negative stereotypes about women contribute to the prevalence of FGM.

In the Concluding Observations issued to Djibouti, for instance, the CEDAW Committee acknowledged the Djibouti government's efforts to end harmful practices but expressed concern that the FGM prevalence in the rural part of the country remained high.[134] The CEDAW Committee found that the increased prevalence was mostly because FGM cases generally were not reported, prosecuted and punished.[135] As such, the CEDAW Committee found that the state party's efforts were not enough, sustainable and systematic.[136] Consequently, the CEDAW Committee emphasised the need to prioritise sanctions against the perpetrators of FGM 'and ensure the investigation of cases, as well as ensure perpetrators are punished and prosecuted in Djibouti.'[137]

Generally, the FGM performed on women with disabilities in Africa is rarely explicitly mentioned in CEDAW's Concluding Observations. A common trend in most concluding remarks issued by the CEDAW Committee to African countries is usually the concern about the scarcity of data on the situation of women, such as those with disabilities who experience multiple and intersecting forms of discrimination.[138]

Unlike CEDAW, article 5 of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (African Women's Protocol) explicitly mentions FGM as a harmful practice.[139] Similarly, under article 4(2)(h), State parties are mandated to end all medical and scientific experiments conducted on women without their informed consent. Therefore, the 44 signatories to the treaty must eliminate all forms of FGM through legislative sanctions and other measures.[140] Article 23 of the African Women's Protocol also mentions the right of women with disabilities to special protection, including freedom from violence.

134 CEDAW Concluding Observations of the Committee on the Elimination of Discrimination against Women: Djibouti (2011) CEDAW/C/DJI/CO/1-3 para 16.
135 CEDAW Concluding Observations (n 133) para 18.
136 CEDAW Concluding Observations of the Committee on the Elimination of Discrimination against Women: Chad (2011) CEDAW/C/TCD/CO/1-4 para 22.
137 As above.
138 CEDAW Concluding Observations (n 135) para 34.
139 African Women's Protocol art 5(b).
140 As above. Art 5(b); art4(2)(h).

From the African children's perspective, the Convention on the Rights of the Child (CRC) holds a similar stance to CEDAW on harmful practices such as FGM.[141] FGM infringes on the 'best interests standard' as it violates children's rights and bodily autonomy as guaranteed under article 3 of CRC. Furthermore, article 23 of the treaty is dedicated to the rights of children with disabilities with the adoption of General Comment 9 to clarify that all provisions in CRC apply to children with disabilities.

Article 24(3) of the CRC urges state parties to eliminate 'traditional practices such as FGM that are prejudicial to children's health'. Like the CEDAW Committee, the CRC Committee has made numerous observations recognising FGM and other harmful practices as harmful to the health of women and children that 'carries a high risk of death and disability'.[142] The CRC and CEDAW Committees jointly describe how 'socially-constructed gender roles and systems of patriarchal power relations and negative perceptions or discriminatory beliefs regarding certain disadvantaged groups of women and children, including individuals with disabilities or albinism, reinforce harmful practices such as FGM.'[143] The CRC Committee has expressed several concerns about the prevalence of FGM in several African countries. This concern, for example, has ranged from a lack of recent information on preventive and eradication measures to a lack of knowledge about anti-FGM laws.[144]

The *RHM* case is insightful.[145] The case involved a Somali woman who was five months pregnant when she applied for asylum in Denmark. This application was unsuccessful. The woman had applied for asylum because her newborn daughter, YAM, would be compelled to undergo FGM in Somalia if they were deported. The Danish authorities disagreed and argued that since FGM is banned in Somalia, mothers can prevent their daughters from being subjected to FGM. After having exhausted domestic remedies and given birth to her daughter, she submitted a

141 CEDAW Committee and CRC Committee (n 28) para 9.
142 CEDAW Committee General Recommendation 24 (n 5) para 12(b).
143 CEDAW Committee and CRC Committee (n 28) para 9.
144 CEDAW Committee and CRC Committee (n 28) paras 15-19.
145 Committee on the Rights of the Child 'Views adopted by the Committee on the Rights of the Child under the Optional Protocol to the Convention on the Rights of the Child on a communications procedure in respect of Communcation No 3/2016' (2018) CRC/C/77/D/3/2016 advanced unedited version paras 2.1-2.4, 3.1-3.5.

complaint to the CRC Committee on behalf of her daughter that their deportation would violate articles 3 and 19 of CRC. The CRC Committee decided that Denmark would violate its obligations under articles 3 and 19 of CRC if the young girl facing the practice of FGM in her country of origin were forced to return. According to article 3 of CRC, the child's best interests should be a primary consideration in all actions concerning children. According to article 19 of CRC, states should take all appropriate measures to protect the child from physical and mental violence.

Similarly, article 21(1) of the African Children's Charter prohibits harmful social and cultural practices affecting the child's welfare, dignity, normal growth and development. Furthermore, it mandates states to end customs and traditions prejudicial to the health or life of the child as well as those that are discriminatory to the child on the grounds of sex or other status. Article 13 clarifies that all rights, including the freedom from harmful practices, apply to children with disabilities. Notably, Aspiration 7 of Agenda 2040 of the African Committee of Experts on the Rights and Welfare of the Child (African Children's Committee) mentions the need to ensure that every child is protected against violence, exploitation, neglect and abuse and calls for the elimination of FGM by all African states by 2020.

As the first legal treaty to ensure the human rights of persons with disabilities, the Convention on the Rights of Persons with Disabilities (CRPD)[146] recognises under article 6 that women and girls with disabilities are subject to multiple and intersecting discrimination, although FGM is not explicitly mentioned.[147] Nonetheless, FGM is a form of violence, and article 16 of CRPD guarantees protection from violence against every person with a disability, including protecting women with disabilities. The provision mandates state parties to eliminate acts of exploitation, abuse and violence committed by third parties. Moreover, FGM is recognised as torture or cruel, inhuman or degrading treatment or punishment prohibited under article 15. FGM as a form of forced treatment is prohibited under articles 12, 17 and 25.

146 Adopted by the UN General Assembly on 13 December 2006 and entered into force on 3 May 2008.

147 Committee on the Rights of Persons with Disabilities General Comment 3: Women and girls with disabilities (2016).

The CRPD Committee explicitly acknowledges that women with disabilities are subjected to the same harmful practices committed against women without disabilities, such as FGM.[148] It underscores how restricting legal capacity can encourage forced interventions such as FGM.[149] It recognises FGM as a form of intersectional discrimination against women with disabilities on account of their gender, disability and other factors that are inadequately tackled in legislation.[150] FGM is usually done against the will of women with disabilities.[151] Furthermore, in its Concluding Observations, the Committee has expressed concern about 'the persistence of violence against women and girls with disabilities, including sexual violence and abuse; female genital mutilation; and sexual and economic exploitation'.[152] From its Concluding Observations to Gabon, Kenya, Ethiopia and Uganda and other African countries, the CRPD Committee draws attention to the often unacknowledged FGM experiences that violate the rights of women and girls with disabilities in these African countries.[153] In 2019 the Committee expressed concern with the 'lack of specific legislation, policies and programmes' to protect women with disabilities from violence, abuse and economic exploitation.[154]

As in the case of CRPD, the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Persons with Disabilities (African Disability Protocol) does not explicitly mention FGM. However, the treaty explicitly protects women with disabilities and prohibits harmful practices.[155]

148 CRPD Committee (n 148) para 37.
149 CRPD Committee (n 148) para 44.
150 CRPD Committee (n 148) para 10.
151 CRPD Committee (n 148) para 32.
152 CRPD Committee (n 148) para 10.
153 CRPD Committee (n 148) paras 33-34. See also CRPD Committee Concluding Observations on the initial report of Gabon 2 October 2015 CRPD/C/GAB/CO/1 paras 40-41. See also CRPD Committee Concluding Observations in relation to the initial report of Kenya 4 September 2015 CRPD/C/KEN/CO/1 paras. 33-34. See also CRPD Committee 'Concluding Observations on the initial report of Ethiopia 4 November 2016 CRPD/C/ETH/CO/1, paras 39-40. See also CRPD Committee Concluding Observations on the initial report of Uganda 12 May 2016 CRPD/C/UGA/CO/1 paras 34-35.
154 Concluding Observations on the initial report of Senegal, CRPD/C/SEN/CO/1 (2019) para 29(a).
155 African Disability Protocol art 11, art 27.

The Preamble to the African Disability Protocol specifically mentions concern for the multiple violations women and girls with disabilities encounter.[156] It cites a grave concern for human rights violations, including the harmful practices that persons with disabilities face.[157] Harmful practices are practices 'based on tradition, culture, religion, superstition or any other reasons violating human rights or fuels discrimination'.[158] Moreover, article 11 is dedicated explicitly to harmful practices. It specifically urges state Parties to take the necessary steps, including offering support and assistance to victims of harmful practices.[159] The African Disability Protocol takes a multifaceted approach to ending harmful practices by requiring not only the enactment of legal sanctions but also education and advocacy.[160]

Similarly, article 10 provides freedom from torture or cruel, inhuman or degrading treatment or punishment. Persons, including women with disabilities, have the right to dignity and freedom from torture, cruel, inhuman or degrading treatment or punishment, which could be read to include FGM.[161] State parties are obligated to take necessary steps to ensure that persons with disabilities on an equal basis with others are not 'subjected to torture cruel, inhuman or degrading treatment or punishment'.[162] The Protocol expands the obligation by explicitly prohibiting subjection to sterilisation or any invasive procedure without their free, prior and informed consent.[163] It upholds the right of persons with disabilities by mandating that no scientific or medical intervention can be done without free, prior and informed consent.[164] Such medical interventions include sterilisation or any other invasive procedure, which could include FGM.[165] It reiterates the need for persons with disabilities to be protected from violence, abuse and exploitation.[166] However, where

156 Preamble to the African Disability Protocol para 20.
157 African Disability Protocol paras 17-18.
158 African Disability Protocol art 1.
159 African Disability Protocol art 11(1).
160 As above.
161 African Disability Protocol art 10(1).
162 African Disability Protocol art 10(2)(a).
163 African Disability Protocol art 10(2)(c).
164 African Disability Protocol art 10(2)(b).
165 African Disability Protocol art 10(2)(c).
166 African Disability art 10(2)(d).

these abuses occur, state parties must prosecute perpetrators of these acts and offer remedies to victims.[167]

Article 27 provides for the rights of women and girls with disabilities. This article outlines the rights of women with disabilities to be free from disability-based discrimination.[168] It protects them from sexual and gender-based violence with access to rehabilitation and psychosocial support.[169] It guarantees their sexual and reproductive health rights, including the right to retain and control their fertility and not be sterilised without consent.[170] Furthermore, article 28, which guarantees the rights of children with disabilities, also applies to the protection from FGM. For example, the article is against any form of trafficking or sexual exploitation, violence, abuse and sterilisation in the family, institutions or any setting.[171] It explicitly demands that children with disabilities should not be sterilised under any circumstances.[172] By giving this mandate, the Protocol drafters are alive to the lived realities of children, particularly girls with disabilities who are sterilised daily in Africa.[173] Again, although these provisions could be read to include FGM, they confirm the earlier assertion about the emphasis on forced sterilisation compared to FGM,

However, at the time of writing, the Protocol has not entered into force as it has yet to be ratified by at least 15 member states.[174] As a result, the ability for the Protocol to be used is limited until such time as it comes into force.

Despite strict laws banning FGM internationally, regionally and domestically, countries that continue to support measures that enable forced sterilisation and other coercive interventions that could include FGM targeting the sexuality of women and girls with disabilities[175] provide a leeway for the practice to continue. The unspoken legal message seems to be that FGM is outlawed, mainly to prevent disabilities, but

167 African Disability Protocol art 10(3).
168 African Disability Protocol art 27(d).
169 African Disability Protocol art 27(j).
170 African Disability Protocol art 27(k).
171 African Disability Protocol arts 28(e), (f), (k) & (l).
172 African Disability Protocol art 28(l).
173 Ofuani (n 76)552.
174 The Protocol can only enter into force once it is ratified by 15 of the 55 AU member states that have accepted to be bound by the African Charter.
175 CRPD Committee (n 6) para 37.

silent when women who already have disabilities are subjected to the practice disregarding its potential to cause even more severe disabilities.

4 Applying an intersectional understanding to the FGM intervention agenda in Africa

Crenshaw coined the term 'intersectionality' to highlight the fault in the way the antidiscrimination legal framework in the United States (US) defined discrimination as a single issue.[176] She used the employment experiences of African American women to explain how the discrimination these women encountered interacted with the multiple intersecting identities of gender and race that they embodied.[177] She argued that these discriminatory experiences are not mutually exclusive and are more than an additive equation expressed as sexism on top of racism but rather are synergistic.[178] Crenshaw's point is that although discrimination is usually presented in America and most antidiscrimination legislation, including in African countries, as separate and mutually exclusive, African American women's discriminatory employment experiences demonstrate a different intersectional reality.[179] Crenshaw focused on two identity categories, namely, race and gender. However, other categories of identities, such as sexuality, disability, ethnicity and class, also shape women's discrimination experiences.[180]

From Crenshaw's insight, understanding FGM as a form of intersectional discrimination invokes the idea that gender is not the sole reason women are genitally mutilated in Africa. Although FGM is gendered, it is also evident that other intersecting identities, such as race, disability and class, impact the FGM experience. In other words, when a woman or girl is genitally mutilated, it is most likely not only because of her gender alone but could also be because of her race as a black African. The scholarship identifying FGM as an African cultural practice and

176 K Crenshaw 'Demarginalising the intersection of race and sex: A black feminist critique of anti-discrimination doctrine, feminist theory and antiracist politics' (1989) *University of Chicago Legal Forum* 139.
177 Crenshaw (n 177) 149.
178 As above.
179 As above.
180 K Crenshaw 'Mapping the margin: Intersectionality identity politics and violence against women of colour' (1991) 43 *Stanford Law review* 1241.

statistics showing African women's increased vulnerabilities confirm this point.[181]

Indeed, this chapter underscores how when a disabled woman or girl is genitally mutilated, it is most likely not only because of her gender. It could also be because of her race as a black African and because she has a disability. Therefore, using Crenshaw's reasoning, the exclusion of disabled women from the FGM response cannot be simply solved by including disabled women's FGM experiences. Still, the intersectional lens urges an interrogation and a rethink of the legal and human rights framework through which the disabled woman's FGM discrimination experience is recognised and redressed.[182]

Employing an intersectional lens to the FGM response, I propose three ways to rethink Africa's legal and human rights frameworks. First, an intersectional lens challenges the tendency of antidiscrimination law to treat FGM discrimination as a single issue. This is the tendency to present FGM responses that focus on gender and ableist tendencies as single issues in attempting to end the practice in Africa. For instance, efforts to end FGM in most African states have emphasised ableist biases, focusing on how the performance of FGM can lead to disability, with little attention paid to the severity of disabilities resulting from the FGM performed on women with disabilities in Africa.

An intersectional perspective pays attention to how women and girls with disabilities are disproportionally affected by FGM mainly because of the intersecting identities such as gender, age, race, ethnicity and severity of the disability they embody. In other words, antidiscrimination law must recognise the complexity of the FGM experience, namely that when gender intersects with disability, it impacts the experience.

Understanding FGM as intersectional discrimination involves refusing to view FGM as discrimination from a single-issue perspective; for example, as a discrimination or distinct form of violence that affects only women without disabilities, but recognising its multiple and intersecting nature. The inattention to the synergistic nature of intersectional discrimination could explain why FGM statistics are mostly not disaggregated by disability in Africa. It could also explain, as argued above, why the number of women with disabilities that

181 UNICEF (n 1).
182 Crenshaw (n 181) 1241.

undergo FGM, especially in Africa, remains unknown. Yet, as shown above, disabled women in Africa, precisely because of their intersecting identities of gender and disability, are more likely to suffer FGM in more complex ways. Therefore, the intersectional lens renders visible and adequately remedies the wrongs of women, such as disabled women in Africa who are multiply disadvantaged by FGM.

Second, the intersectionality lens confronts the idea of the universal woman's experience of FGM. This experience presupposes a binary, essentialist view of gender difference which silences the multiplicity of identities and the intersectionality of FGM discrimination. The idea that FGM experiences, even among African women, are the same is false and invalid since intersectional experiences of FGM interlock with experiences of racism, class and ableist oppression. Therefore, an intersectional lens rejects the liberal approach to antidiscrimination law adopted by most African countries that pretend there is a universal, disembodied, 'woman of reason' experience of FGM.

Third, the intersectionality lens removes the narrow focus on identities to unequal power relationships. Ribet's example of the unequal power relationship that exists, for instance, between the disabled female patient and the medical practitioner, is apt.[183] When medical practitioners assume that a woman, based on her disability, is unfit to make decisions concerning her reproductive health and, on that basis, is genitally mutilated, it exposes the unequal power relationships

5 Applying a feminist decolonial understanding to the FGM's intervention agenda in Africa

As argued above, human rights responses to end FGM must be intersectional and think intersectionally. However, these responses must also involve feminist decolonial thinking.

Decolonial thinking is a subject that has recently started to receive significant scholarly attention. Decolonial thinking suggests a rethinking or resistance to coloniality or colonial tendencies.[184] Decolonial feminists have tried to unpack what decolonial thinking could mean. Despite the messiness that might characterise the feminist decolonial understanding,

183 I make similar arguments in my DPhil thesis. See: Ribet (n 92) 164.
184 S Tamale *Decolonisation and Afro-feminism* (2020) 18.

it allows for alternative thinking, including interrogation of unequal power dynamics and relationships.

Decolonial feminism, as understood by Lugones, is inspired by intersectionality and the coloniality of power perspective and focuses on the 'modern/colonial gender system'.[185] For her, intersectionality exposes what is hidden when categories such as gender and race – or, in this case, disability are viewed as separate.[186] She draws attention to the experiences and voices of the Global South's silenced, marginalised, and 'othered' women.[187] Lugones also introduces the coloniality of gender to highlight an essentialist concept of sex and argues that gender is socially constructed and grounded in colonial processes.[188] Her insight emphasises the experiences of silenced voices of women from the Global South, especially African women, to become agents in producing knowledge.[189] Tamale's insight on decolonial thinking is also valuable for drawing attention to the need for internalised racism, sexism and, in this case, ableism to be dismantled by decolonising the mind.[190]

Consequently, in efforts to interrogate and rethink the legal and human rights framework for ending FGM, it might be helpful to deploy a feminist decolonial lens. Applying these decolonial feminist insights to the FGM is grounded in African women's lived experiences and challenges dominant narratives about the FGM response in Africa in three ways.[191] First, it allows a rethink of the agency of African women. In so doing, we can rethink the interventions to end FGM from a dominant Western-gendered system. These decolonial contributions, for instance, foster and allow African women the agency to think of culturally sensitive rite of passage alternatives without involving mutilation or cutting applied in countries such as Kenya.[192] These arguments object to colonial responses

185 M Lugones 'The coloniality of gender' (2008) *Worlds and Knowledges Otherwise* 4. See also M Lugones 'Toward a decolonial feminism (2010) 25 *Hypatia* 743-745.

186 M Lugones 'Heterosexualism and the colonial/modern gender system (2007) 22 *Hypatia* 192.

187 Lugones (n 186) 3 4.

188 As above.

189 As above.

190 Tamale (n 185) 18, 39, 235.

191 Borrowing from the reasoning put forward by J Manning 'Decolonial feminist theory: Embracing the gendered colonial difference in management and organisation studies' 1204, 1205.

192 L Hughes 'Alternative rites of passage: Faith, rights, and performance in FGM/C abandonment campaigns in Kenya (2018) 77 *African Studies* 276.

that attempt to regulate perceived deviance and eradicate what is often viewed as barbaric cultural practices.

Second, decolonial feminist theory offers an alternative way of thinking from the perspective of 'otherness', where FGM interventions benefit from insight from different experiences and perspectives. This argument objects to the essentialist view that there is a universal woman experience and common discriminatory FGM women experience as disingenuous and false.

FGM is a controversial and 'othered' practice. This controversy manifests in the Global North and Global South contestations that characterise the practice. For example, from a human rights perspective, generally, the dominant Global North argument for ending the procedure relies on universal human rights and essentialist ideas that tend to suggest that all culture is negative.[193] Such arguments portray FGM as a vile and grotesque disfigurement of the African female body.[194] This disabling representation is underlined by patriarchal and misogynistic tendencies that FGM is a harmful practice rationalised by culture and religion that infringes on women's rights.[195] Thus, it portrays the African women and their culture that legitimises FGM as uncivilised and needing urgent Western intervention and salvation – a stark reminder of the 'colonial civilising mission.'[196] The perception of African women as victims of FGM has been rejected because it is often used to belittle African cultures. It allows for dominant colonial narratives that position the Global North feminists as the saviours.[197] Consequently, decolonial feminist thinking helps in putting up a resistance to the hostile Western gaze that seeks to control the African woman's body to make it conform to the Global North's dominant narrative of embodiment, health, and sexuality.[198]

193 TE Higgins 'Anti-essentialism, relativism, and human rights (1996) 19 *Harvard Women's Law Journal* 101-104.
194 C Mohanty 'Under Western eyes: Feminist scholarship and colonial discourses' (1984) 12 *Duke University Press* 337.
195 Muzima (n 24) 73.
196 Mohanty (n 195) 335-337.
197 As above.
198 M Lugones (n 186)743-745. See also Mohanty (n 195) 335-337.See also B Deirdre 'Decolonial African feminism for white allies' (2020) 21 *Journal of International Women's Studies* 38.

From the Global South perspective and Africa in general, the FGM practice is cultural and often relies on cultural relativism arguments to support the practice.[199] This contention is evident in *Kamau v Attorney General,*[200] where a medical doctor questioned the constitutionality of FGM prohibition in Kenya. The petitioner claimed that the 2011 Anti-FGM Act in Kenya is an 'imperialist imposition from another culture with different beliefs or norms'. Furthermore, she questioned the unfair application of the law, which prohibits FGM but still allows some harmful contemporary practices such as the consumption of alcohol and smoking. The petition confirms that FGM is still considered a cultural rite of passage perceived by its advocates and those who practise it 'as a right and an obligation in some African societies'.[201] Thus, failing to undergo this cultural practice could lead to a loss of prestige and stripping of the woman's cultural identity.[202]

Scholarship describes the outright banning of FGM as the result of Western influences and a possible misreading of these cultural practices.[203] The argument is that FGM's representation and intervention agenda attempts to impose dominant Global North and Eurocentric colonial views on what constitutes female bodily autonomy.[204] Similarly, the politics of naming the FGM practice is also worth mentioning. There are Global North and South debates on the naming of the practice. Scholarships have questioned why genital modifications are viewed as legitimate, desirable, and empowering when done in the Global North.

An example could be transsexual genital modifications that are upheld to reinforce sex-gender integrity for the subject.[205] Yet, when genital

199 Muzima (n 24) 73.

200 *Kamau v Attorney General;* Equality Now (Interested Parties); Katiba Institute (*Amicus Curiae*) (2021).

201 R Murray *'Articles 27–29: Individual duties' in R Murray The African Charter on Human and Peoples' Rights: A commentary* (2019) 594.

202 Idowu (n 18) 117.

203 J Geng 'The Maputo Protocol and the reconciliation of gender and culture in Africa' in S Harris-Rimmer & K Ogg (eds) *Research handbook on feminist engagement with international law* (2019) 12.

204 F Ahmadu 'Rights and wrongs: An insider/outsider reflects on power and excision' in B Shell-Duncan & Y Hernlund (eds) *Female 'circumcision' in Africa: Culture, controversy and change* (2000) 283-312. See also IR Gunning 'Arrogant perception, world-travelling and multicultural feminism: The case of female genital surgeries' (1992) 23 *Columbia Human Rights Law Review* 191.

205 N Sullivan 'The role of medicine in the (trans)formation of wrong bodies' (2008)14 *Body and Society* 107.

modifications are performed in the Global South, especially among African women, they are read as culturally objectionable and, as such, in need of global surveillance and interventions.[206] Again, literature echoes how similar indulgent humanist logic is denied to non-Western subjects and their culturally heterogeneous practices of genital modification.

Indeed, while African feminists agree that FGM is harmful, they have objected to the intervention agenda that frames FGM as a cultural problem.[207] Such objections to this representation from the Global South scholarship have led to the rejection of gender and cultural essentialism and arguments about the outsider/insider connotations, but, importantly, they have inspired feminist decolonial thinking.

Third, it emphasises an invocation of plural knowledge, ideas and experiences.[208] Feminist contestations about FGM have tended to ignore the violence of colonialism. Colonisation has been described as a form of gender and sexual violence.[209] Indeed, the African colonial conquest was characterised by mass rape and colonised women in Africa remained targets of the colonisers' sexuality with severe implications for colonised women.[210] This feminist decolonial thinking essentially questions cultural and colonial imperialism, including the coloniality of gender, the female body and sexuality.[211]

Centring disability analysis in the FGM intervention agenda encourages feminist decolonial thinking because it complicates and expands ideas about identity, demonstrating how a woman can embody multiple subject positions and be claimed by several identity categories. The disabled woman's experience of FGM gives African women and their multiple and intersecting identities a voice, agency or a defined perspective on their own FGM experiences. In other words, it allows thinking beyond FGM as gendered or disabling as separate issues but as intersectional.

Conclusively, the dominant narrative from the Global North about FGM demonstrated even in the interventions to end the practice is

206 Mohanty (n 195) 335-337.
207 Hughes (n 193) 276.
208 As above.
209 AAF Bernard 'Colonising black female bodies within patriarchal capitalism: Feminist and human rights perspectives' (2016) *Sexualization, Media and Society* 2.
210 As above.
211 Lugones (n 186) 743-745.

essentialist. It targets a specific type of ableist woman, evidenced by the limited scholarship on FGM when performed on disabled women. It is also culturally insensitive, usually borne out of dominant essentialist ideas of a harmful African culture that focuses narrowly on the negative aspects of FGM. Research has found that such interventions ignore the lived experiences, the multifaceted nature of the practice, and the meanings attached to the associated rituals.[212] The point is that although the FGM practice is unacceptable, African decolonial feminists reject the colonial imperialist, racist and dehumanising narratives that diminish African women's agency that mostly underpin the responses and interventions to end FGM.[213]

6 Conclusion

The above analysis has centred the disabled woman's experience of FGM, which has been mainly unacknowledged, silenced and invisible in the legal and human rights responses to ending FGM in Africa. Centring the disabled woman's experience has exposed FGM as: (a) sexist or gendered; (b) as disabling, and notably (c) as both gendered, disabling and ableist, that simultaneously manifest in an intersectional 'disabled female' dilemma. This dilemma confirms the mutually constitutive interactions and intersections between the identity categories of sex/gender and disability. This exposure necessitated exploring the legal and human rights responses to ending FGM in Africa.

In advocating a reconceptualisation of the FGM response, I have proposed that laws and human rights interventions to end FGM in African countries must be intersectional and think intersectionally. Laws and human rights interventions must avoid the single-issue approach to ending FGM and adopt an intersectional understanding. An intersectional lens rejects the liberal approach to antidiscrimination law adopted by most African countries that pretend that there is a universal, disembodied, 'woman of reason' experience of FGM. This is the tendency to present FGM interventionist agenda that focuses on gender and ableist tendencies as single issues when focusing on ending FGM in Africa.

212 S Tamale *African sexualities: A reader* (2011) 20.
213 As above. See also Deirdre (n 199) 38.

An intersectional analysis centres on the disabled woman's experience to demonstrate how a woman can embody multiple subject positions and how several different complex identities and unequal power structures intersect and impact the FGM experience in Africa. In other words, in striving to end FGM, it might be helpful to question, interrogate and unpack whose female genitalia are to be mutilated. This questioning is valid because it avoids the tendency to universalise and essentialise the female or her genitalia. It also allows the definition of the female in the FGM experience to be expanded as widely as possible.

Moreover, the chapter further suggests that it is insufficient for human rights interventions to end FGM to be intersectional and think intersectionally. Still, it must also involve feminist decolonial thinking. As shown above, feminist decolonial thinking is a subject that has recently started to receive significant scholarly attention. Decolonial thinking suggests a rethinking or resistance to colonial tendencies or coloniality. When applied to FGM, it could mean different things, including exploring alternative indigenous rites to womanhood that maintains positive African culture but rejects the cutting, mutilation and disabling of the female genitalia rooted in coloniality[214] and colonial tendencies.

Finally, for an intersectional lens to work in efforts to end FGM in Africa, it must apply a feminist 'decolonial' perspective. The insight reinforces the need for legal and human rights frameworks to use a feminist decolonial intersectionality lens and understanding in its efforts to abolish FGM in Africa. This decolonial intersectional perspective is crucial in legal and human rights responses to FGM in African countries, mainly if this procedure performed on African women, especially women with disabilities, is to be eliminated and not just remain an afterthought.

214 Coloniality is defined as an 'invisible power structure that sustains colonial relations of exploitation and domination long after the end of direct colonialism'. See, generally, Tamale (n 182) xiii.

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