CLASSIC

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CROSS-CULTURAL

68 Female Genital Mutilation

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In recent decades, numerous women's organizations around the world have focused on a variety of health-related issues and problems, including domestic violence, rape, sexual harassment, and poverty. In this selection, Efua Dorkenoo and Scilla Elworthy examine the complex cultural issues surrounding female genital mutilation, a practice that has received international attention since the early 1990s.

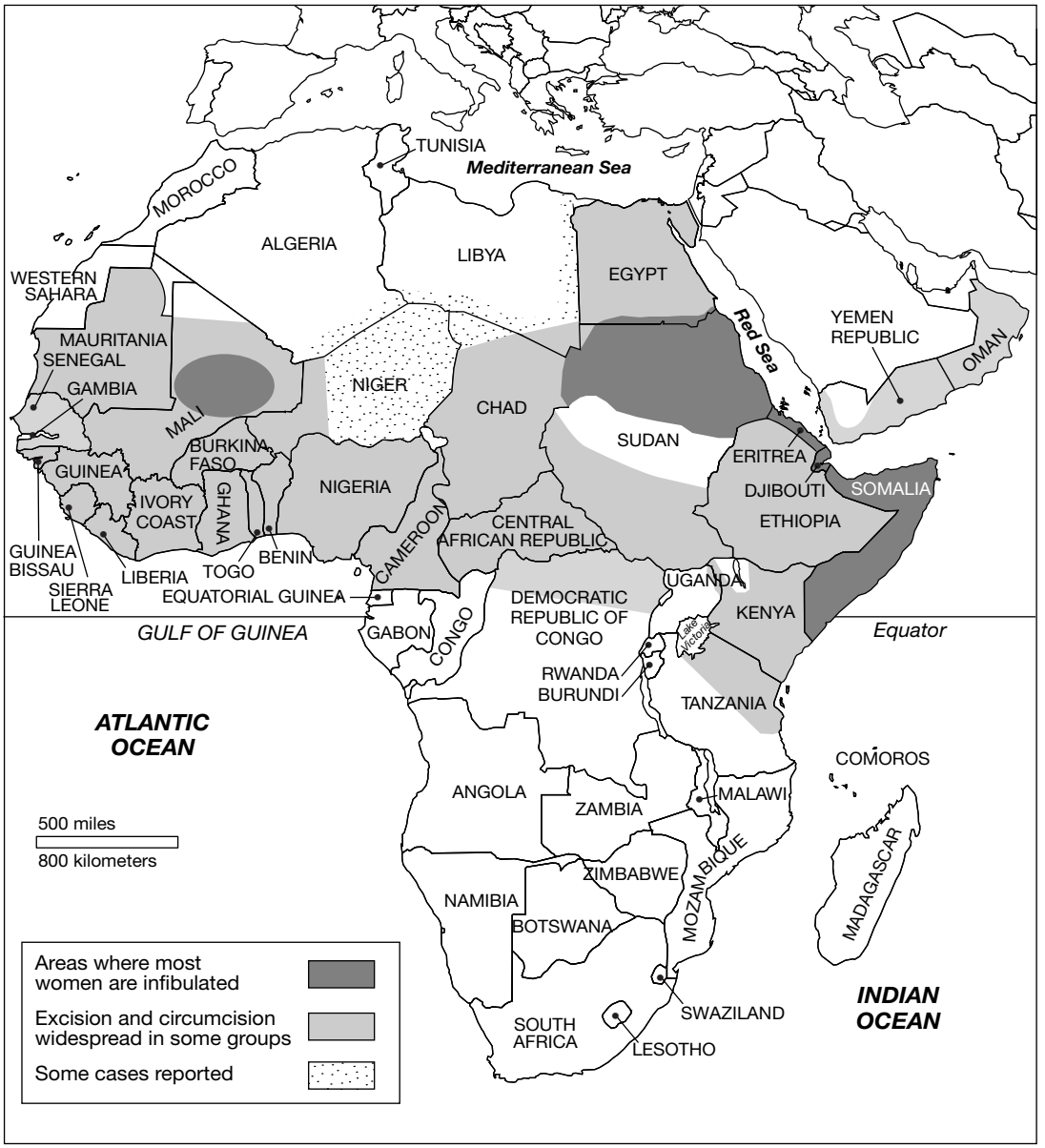
THE FACTS

. . . [F]emale genital mutilation covers four types of operation:

1. *Circumcision*, or cutting of the prepuce or hood of the clitoris, known in Muslim countries as Sunna (tradition). This, the mildest type, affects only a small proportion of the millions of women concerned. It is the only type of mutilation that can correctly be called circumcision, though there has been a tendency to group all kinds of mutilations under the misleading term 'female circumcision.'
2. *Excision*, meaning the cutting of the clitoris and of all or part of the labia minora.
3. *Infibulation*, the cutting of the clitoris, labia minora, and at least part of the labia majora. The two sides of the vulva are then pinned together by silk or catgut sutures, or with thorns, thus obliterating the vaginal introitus except for a very small opening, preserved by the insertion of a tiny piece of wood or a reed for the passage of urine or menstrual blood. These operations are done with special knives, with razor blades or pieces of glass. The girl's legs are then bound together from hip to ankle and she is kept immobile for up to forty days to permit the formation of scar tissue.
4. *Intermediate*, meaning the removal of the clitoris and some parts of the labia minora or the whole of it. Various degrees are done according to the demands of the girl's relatives. . . .

Most frequently these operations are performed by an old woman of the village or by a traditional birth attendant and only rarely by qualified nurses or doctors. The age at which the mutilations are carried out varies from area to area, and according to whether legislation against the practice is foreseen or not. It varies from a few days old (for example, the Jewish Falashas in Ethiopia, and the nomads of the Sudan) to about seven years (as in Egypt and many countries of Central Africa) or—more rarely—adolescence, as among the Ibo of Nigeria. Most experts are agreed that the age of mutilation is becoming younger, and has less and less to do with initiation into adulthood.[1]

Source: "Female Genital Mutilation," by Efua Dorkenoo and Scilla Elworthy from *Female Genital Mutilation: Proposals for Change,* an MRG Report, pp. 92–93. Reprinted with permission.



Female Genital Mutilation in Africa

Physical Consequences

Health risks and complications depend on the gravity of the mutilation, hygienic conditions, the skill and eyesight of the operator, and the struggles of the child. Whether immediate or long term, they are grave.[2] Death from bleeding is not uncommon, while long-term complications include chronic infections of the uterus and vagina, painful menstruation, severe pain during intercourse, sterility, and

complications during childbirth. Though evidence has yet to be collected, it is also likely that bleeding or open wounds increase the likelihood of HIV transmission and AIDS.

There is great difficulty in obtaining accurate research on the sexual experiences of mutilated women, because the majority are reluctant to speak on the subject and are generally ambivalent on questions of sexual enjoyment.[3] However, in all types of mutilation, even the "mildest" clitoridectomy, a part of a woman's body containing nerves of vital importance to sexual pleasure is amputated.

Psychological Consequences

Even less research has been done to date on the psychological consequences of these traditions. However, many personal accounts and research findings contain repeated references to anxiety prior to the operation, terror at the moment of being seized by an aunt or village matron, unbearable pain, and the subsequent sense of humiliation and of being betrayed by parents, especially the mother. On the other hand, there are references to special clothes and good food associated with the event, to the pride felt in being like everyone else, in being "made clean," in having suffered without screaming.

To be different clearly produces anxiety and mental conflict. An unexcised, non-infibulated girl is despised and made the target of ridicule, and no one in her community will marry her. Thus what is clearly understood to be her life's work, namely marriage and childbearing, is denied her. So, in tight-knit village societies where mutilation is the rule, it will be the exceptional girl who will suffer psychologically, unless she has another very strong identity which she has lost.[4]

There is no doubt that genital mutilation would have overwhelming psychological effects on an unmotivated girl, unsupported by her family, village, peers, and community. To those from other cultures unfamiliar with the force of this particular community identity, the very concept of amputation of the genitals carries a shock value which does not exist for most women in the areas concerned. For them, not to amputate would be shocking.

These observations concern social-psychological factors rather than the central question, namely, what effects do these traumatic operations have on little girls at the moment of operation and as they grow up? The fact is that we simply don't know. We do not know what it means to a girl or woman when her central organ of sensory pleasure is cut off, when her life-giving canal is stitched up amid blood and fear and secrecy, while she is forcibly held down and told that if she screams she will cause the death of her mother or bring shame on the family.

THE PRACTICE

The Area Covered

The countries where one or more forms of female genital mutilation are practised number more than twenty in Africa, from the Atlantic to the Red Sea, the Indian Ocean, and the eastern Mediterranean. Outside Africa, excision is also practised in Oman, South Yemen, and in the United Arab Emirates (UAE). Circumcision is practised by the Muslim populations of Indonesia and Malaysia and by Bohra Muslims in India, Pakistan and East Africa.[5]

On the map of Africa, an uninterrupted belt is formed across the centre of the continent, which then expands up the length of the Nile. This belt, with the exception of the Egyptian buckle, corresponds strikingly with the pattern of countries that have the highest child mortality rates (more than 30 percent for children from one to four years of age).[6] These levels reflect deficiencies of medical care, of clean drinking water, of sanitary infrastructure, and of adequate nutrition in most of the countries.

The gravity of the mutilations varies from country to country. Infibulation is reported to affect nearly all the female population of Somalia, Djibouti, and the Sudan (except the non-Muslim population of southern Sudan), southern

Egypt, the Red Sea coast of Ethiopia, northern Kenya, northern Nigeria, and some parts of Mali. The most recent estimate of women mutilated is 74 million.[7]

Ethnic groups closely situated geographically are by no means affected in the same way: For example, in Kenya, the Kikuyu practise excision and the Luo do not; in Nigeria, the Yoruba, the Ibo, and the Hausa do, but not the Nupes or the Fulanis; in Senegal, the Woloff have no practice of mutilation. There are many other examples.

As the subject of female genital mutilation began to be eligible at least for discussion, reports of genital operations on nonconsenting females have appeared from many unexpected parts of the world. During the 1980s, women in Sweden were shocked by accounts of mutilations performed in Swedish hospitals on daughters of immigrants. In France, women from Mali and Senegal have been reported to bring an *exciseuse* to France once a year to operate on their daughters in their apartments.[8] In July 1982 a Malian infant died of an excision performed by a professional circumciser, who then fled to Mali. In the same year, reports appeared in the British press that excision for nonmedical reasons had been performed in a London private clinic.

Legislation

In Africa. Formal legislation forbidding genital mutilation, or more precisely infibulation, exists in the Sudan. A law first enacted in 1946 allows for a term of imprisonment up to five years and/or a fine. However, it is not an offence (under Article 284 of the Sudan Penal Code for 1974) "merely to remove the free and projecting part of the clitoris."

Many references have been made to legislation in Egypt, but after researching the available materials, all that has been traced is a resolution signed by the Minister of Health in 1959, recommending only partial clitoridectomy for those who want an operation, to be performed only by doctors.[9]

In late 1978, largely due to the efforts of the Somali Women's Democratic Organization (SWDO), Somalia set up a commission to abolish infibulation. In 1988 at a seminar held in Mogadishu, it was recommended that SWDO should propose a bill to the competent authorities to eradicate all forms of female genital mutilation.

In September 1982, President Arap Moi took steps to ban the practices in Kenya, following reports of the deaths of fourteen children after excision. A traditional practitioner found to be carrying out this operation can be arrested under the Chiefs Act and brought before the law.

Official declarations against female genital mutilation were made by the late Captain Thomas Sankara and Abdou Diouf, the heads of state in Burkina Faso and Senegal respectively.

In Western Countries. A law prohibiting female excision, whether consent has been given or not, came into force in Sweden in July 1982, carrying a two-year sentence. In Norway, in 1985, all hospitals were alerted to the practice. Belgium has incorporated a ban on the practice. Several states in the U.S.A. have incorporated female genital mutilation into their criminal code.

In the U.K., specific legislation prohibiting female circumcision came into force at the end of 1985. A person found guilty of an offence is liable to up to five years' imprisonment or to a fine. Female genital mutilation has been incorporated into child protection procedures at local authority levels. As yet no person has been committed in the English courts for female circumcision, but since 1989 there have been at least seven local authority legal interventions which prevented parents from sexually mutilating their daughters or wards.

France does not have specific legislation on female sexual mutilation but under Article 312–3 of the French Penal Code, female genital mutilation can be considered as a criminal offence. Under this code, anybody who exercises violence or seriously assaults a child less than fifteen years old can be punished with imprisonment from ten to twenty years, if the act of violence results in a mutilation, amputation of a limb, the loss of an eye or other parts of the body, or has unintentionally caused the death of the child.

In 1989, a mother who had paid a traditional woman exciser to excise her week-old daughter, in 1984, was convicted and given a three-year suspended jail sentence. In 1991 a traditional exciser was jailed for five years in France.

Contemporary Practices

Opinions are very divided as to whether the practice is disappearing because of legislation or social and economic changes. Esther Ogunmodede, for instance, believes that in Nigeria, Africa's most populous country, the tradition is disappearing but extremely slowly, with millions of excisions still taking place. She reports that in areas where the operations are done on girls of marriageable age, they are "running away from home to avoid the razor." This confirms Fran Hosken's assertion that operations are being done at earlier and earlier ages, in order that the children should be "too young to resist." Fran Hosken does not think that the custom is dying out, and she indisputably has the best published range of information concerning all the countries where the practice is known.

An interesting development took place in Ethiopia during the years of civil warfare which only ended in 1991. When the Eritrean People's Liberation Front (EPLF) occupied large areas from January 1977 to December 1978, among many other reforms they categorically and successfully forbade genital mutilation and forced marriage. In fact, the reason given for the large numbers of young women in the EPLF army was that they were running away from home in other parts of Ethiopia to avoid forced marriage and the knife.[10] Although it appears the practice continues in remote areas, because the consciousness of Eritrean women has changed dramatically during the war years, it is easier to persuade men and women to let go of this practice.

Since 1983, the number of educational programmes initiated to raise public awareness of the health risk associated with female genital mutilation at local, national, and international levels have increased. The media have played a major role in bringing this issue from the domestic to the public domain. As a result of these efforts it can be said that the taboo surrounding even public mention of the practice has at last been broken. There is an increase in public awareness of the harmful effects of female genital mutilation.

It has been noted that female genital mutilation is becoming unpopular amongst the urban elite in some African countries. In Sierra Leone, for example, Koso-Thomas claims that urban men are willing to marry uncircumcised women, in particular when the marriage is not pre-arranged.[11]

In general, among urban educated women, reasons often cited against female genital mutilation include the pointlessness of mutilation, health risks, and reduction of sexual sensitivity. The last reason points to a changing attitude towards women's fundamental human rights amongst urban Africans.

In the main, the practice continues to be widespread among large sectors and groups within Africa. Those in favour of the practice are noted in the 1986 U.N. study to be a passive majority who refer back to traditional society, without necessarily sharing that society's values.[12] In some cases, the practice appears to be spreading to population groups who traditionally never practised female genital mutilation, as observed with city women in Wau, Sudan, who regard it as fashionable, and among converted Muslim women in southern Sudan who marry northern Sudanese men.[13] Furthermore, even in areas where some groups are turning against the practice, the absolute numbers affected may be increasing. Rapid population growth in Africa means greater numbers of female children are born, who in turn are exposed to the risk of mutilation.

THE ISSUES

Female genital mutilation is a complex issue, for it involves deep-seated cultural practices which affect millions of people. However, it can be divided into (at least) four distinct issues.

Rights of Women

Female genital mutilation is an extreme example of the general subjugation of women, sufficiently extreme and horrifying to make women and men question the basis of what is done to women, what women have accepted and why, in the name of society and tradition.

The burning of Indian widows and the binding of the feet of Chinese girl children are other striking examples, sharp enough and strange enough to throw a spotlight on other less obvious ways in which women the world over submit to oppression. It is important to remember that all these practices are, or were, preserved under centuries of tradition, and that foot-binding was only definitively stopped by a massive social and political revolution (replacing the many traditions which it swept away by offering an entirely new social system, revolutionary in many aspects: land ownership, class system, education, sex equality, etc.) which had been preceded by years of patient work by reformers.

Thus, to be successful, campaigns on female genital mutilation should consider carefully not only eliminating but also replacing the custom. (The example of Eritrea, previously quoted, is illuminating here.) Furthermore, such success may be predicated on long-term changes in attitudes and ideologies by both men and women.

A major international expression of the goal of equal rights for women was taken in December 1979, when the U.N. General Assembly adopted the Convention on the Elimination of All Forms of Discrimination Against Women. This came into force in September 1981. The comprehensive convention calls for equal rights for women, regardless of their marital status, in all fields: political, economic, social, cultural and, civil. Article 5(a) obliges states' parties to take:

> . . . all appropriate measures to modify the social and cultural patterns of conduct of men and women, with a view to achieving the elimination of prejudices and customary and all other practices which are based on the idea of the inferiority or superiority of either of the sexes or on stereotyped roles for men and women.

To succeed in abolishing such practices will demand fundamental attitudinal shifts in the way that society perceives the human rights of women. The starting point for change should be educational programmes that assist women to recognize their fundamental human rights. This is where UNESCO, the U.N. Centre for Human Rights, and international agencies could help by supporting awareness-building programmes.

Rights of Children

An adult is free to submit her or himself to a ritual or tradition, but a child, having no formed judgement, does not consent but simply undergoes the operation (which in this case is irrevocable) while she is totally vulnerable. The descriptions available of the reactions of children—panic and shock from extreme pain, biting through the tongue, convulsions, necessity for six adults to hold down an eight-year-old, and death—indicate a practice comparable to torture.

Many countries signatory to Article 5 of the Universal Declaration of Human Rights (which provides that no one shall be subjected to torture, or to cruel, inhuman, or degrading treatment) violate that clause. Those violations are discussed and sometimes condemned by various U.N. commissions. Female genital mutilation, however, is a question of torture inflicted not on adults but on girl children, and the reasons given are not concerned with either political conviction or military necessity but are solely in the name of tradition.

The Declaration of the Rights of Children, adopted in 1959 by the General Assembly, asserts that children should have the possibility to develop physically in a healthy and normal way in conditions of liberty and dignity. They should have adequate medical attention and be protected from all forms of cruelty.

It is the opinion of Renée Bridel, of the Fédération Internationale des Femmes de Carrières Juridiques, that "One cannot but consider Member States which tolerate these practices as infringing their obligations as assumed under the terms of the Charter [of the U.N.].[14]

In September 1990, the United Nations Convention on the Rights of the Child went into force. It became part of international human rights law. Under Article 24(3) it states that "States Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children." This crucial article should not merely remain a paper provision, to be given lip service by those entrusted to implement it. Members of the U.N. should work at translating its provisions into specific implementation programmes at grassroots level. Much could be learned (by African states in particular) from countries with established child protection systems.

The Right to Good Health

No reputable medical practitioner insists that mutilation is good for the physical or mental health of girls and women, and a growing number offer research indicating its grave permanent damage to health and underlining the risks of death. Medical facts, carefully explained, may be the way to discourage the practice, since these facts are almost always the contrary of what is believed, and can be shown and demonstrated.

Those U.N. agencies and government departments specifically entrusted with the health needs of women and children must realize that it is their responsibility to support positive and specific preventative programmes against female genital mutilation, for while the practice continues the quality of life and health will inevitably suffer. However, this approach, if presented out of context, ignores the force of societal pressures which drive women to perform these operations, regardless of risk, in order to guarantee marriage for their daughters and to conform to severe codes of female behaviour laid down by male-dominated societies.

The Right to Development

The practice of female genital mutilation must be seen in the context of underdevelopment,[15] and the realities of life for the most vulnerable and exploited sectors—women and children. International political and economic forces have frequently prevented development programmes from meeting the basic needs of rural populations. With no access to education or resources, and with no effective power base, the rural and urban poor cling to traditions as a survival mechanism in time of socioeconomic change.

In societies where marriage for a woman is her only means of survival, and where some form of excision is a prerequisite for marriage, persuading her to relinquish the practice for herself or for her children is an extraordinarily difficult task. Female (and some male) African analysts of development strategies are today constantly urging that the overall deteriorating conditions in which poor women live be made a major focus for change, for unless development affects their lives for the better, traditional practices are unlikely to change.

DIRECTIONS FOR THE FUTURE

The mutilation of female genitals has been practised in many areas for centuries. The greatest determination, combined with sensitivity and understanding of local conditions, will be needed if it is to be abolished. In every country and region where operations are carried out, the situation is different, as is the political will, whether at local or national levels. In Western countries the way forward is relatively clear. In Africa the problem is more profound and the economic and political conditions vastly more difficult, while international agencies have hardly begun to explore their potential role.

What all three have in common is that, to date, nearly all programmes have been individual or *ad hoc* efforts, with little integration into other structures, with minimal evaluation or monitoring, and lacking in long-term goals and strategies. To achieve real change will require more resources, more detailed planning, and more real, sustained commitment from governments and international organizations.

CRITICAL-THINKING QUESTIONS

1. What are the four types of female genital mutilation? How widespread are these practices?
2. What do Dorkenoo and Elworthy mean when they describe female genital mutilation as a "complex" issue? Do they feel that this practice can be abolished or not?
3. Many Western countries have denounced female genital mutilation as barbaric. But what about comparable practices in the United States and other Western nations? Even though they are voluntary, are silicone breast transplants, facelifts, or liposuction more "civilized" in making women's bodies more acceptable to men?

NOTES

1. Fran Hosken, *The Hosken Report—Genital and Sexual Mutilation of Females* (third enlarged/revised edition, Autumn, 1982, published by Women's International Network News, 187 Grant St., Lexington, Mass. 02173, USA). This is the most detailed and comprehensive collection of information available.

2. The consequences of sexual mutilations on the health of women have been studied by Dr. Ahmed Abu-el-Futuh Shandall, Lecturer in the Department of Obstetrics and Gynaecology at the University of Khartoum, in a paper entitled, "Circumcision and Infibulation of Females" (*Sudanese Medical Journal,* Vol. 5, No. 4, 1967); and by Dr. J.A. Verzin, in an article entitled "The Sequelae of Female Circumcision," (*Tropical Doctor,* October, 1975). A bibliography on the subject has been prepared by Dr. R. Cook for the World Health Organization.

3. Readers interested to read more about research on the sexual experience of circumcised women may want to read Hanny Lightfoot-Klein, *Prisoners of Ritual: An Odyssey into Female Genital Mutilation in Africa* (New York: The Haworth Press, 1989).

4. These feelings of rejection are clearly articulated by Kenyan girls in "The Silence over Female Circumcision in Kenya," in *Viva,* August, 1978.

5. Q.R. Ghadially, "Ali for 'Izzat': The Practice of Female Circumcision among Bohra Muslims," *Manushi,* No. 66, New Delhi, India, 1991.

6. See map of Childhood Mortality in the World, 1977 (Health Sector Policy Paper, World Bank, Washington, D.C., 1980).

7. See Hosken for details and estimates of ethnic groups involved.

8. *F Magazine,* No. 4, March, 1979, and No. 31, October, 1980.

9. Marie Assaad, *Female Circumcision in Egypt—Current Research and Social Implications* (American University in Cairo, 1979), p. 12.

10. "Social Transformation of Eritrean Society," paper presented to the People's Tribunal, Milan, 24–26 May 1980, by Mary Dines of Rights and Justice.

11. Koso-Thomas, *The Circumcision of Women: A Strategy for Elimination* (London: Zed Books, 1987).

12. UN Commission on Human Rights, Report of the Working Group on Traditional Practices Affecting Women and Children, 1986.

13. Ellen Ismail et al., *Women of the Sudan* (Bendestorf, Germany: EIS, 1990).

14. *L'enfant mutilé* by Renée Bridel, delegate of the FIFCJ to the UN, Geneva, 1978. See also Raqiya Haji Dualeh Abdalla, Sisters in Affliction (London: Zed Press, 1982) and Asma El Dareer, Woman, Why Do You Weep? (London: Zed Press, 1982).

15. Belkis Woldes Giorgis, *Female Circumcision in Africa,* ST/ECA/ATRCW 81/02.