

Issue Paper on
Female Genital Mutilation

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SWEDISH INTERNATIONAL DEVELOPMENT
COOPERATION AGENCY

Department for Democracy and
Social Development
Health Division

Sida's Health Division has during the period 1996–97 elaborated three policy documents.
These include;

- A Position Paper on Population, Development and Cooperation
- A Policy for The Health Sector
- A Strategy for Sexual and Reproductive Health and Rights

It was during this process that Sida commissioned a series of Swedish experts to formulate Issue Papers on specific areas as a basis for policy discussions. Considering that these papers are of interest to a wider audience the Health Division has now decided to publish some of them.

The views and interpretations expressed in this document are the authors,
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Introduction and Background

Female genital mutilation (FGM) is a controversial subject. The practice has persisted despite a growing body of knowledge about its health and psychological consequences for girls and women. The question therefore is why FGM persists. Is it merely because it is deeply embedded in the cultures where it is practised and can therefore never be eradicated? Or are the strategies and approaches inappropriate? Are they based on wrong assumptions?

Initially the aim of this review was to delineate what has been achieved so far, focusing on the main actors, their specific programmes and approaches. However, a search of the literature show there is a good deal of fairly recent documentation of activities of specific international and national agencies (Silberschmidt 1994, Andersson-Brolin 1990, WHO 1994, DANIDA 1996, Lane and Rubinstein 1996).

The main questions to be addressed are:

- What is FGM and how is it socially organised?
- What is the prevalence and what are the major health consequences on girls and women?
- What has been done?
- What are the gaps?
- What are the possibilities for improvement?

What is female genital mutilation?

The concept- FGM – has been coined and used to refer to what is otherwise commonly known as female circumcision in part to reflect the amount of genital organs removed and therefore the pain and damage it inflicts on girls and women. Unlike male circumcision which entails only the removal of the foreskin in the penis, FGM in almost all cases involves removal of genital organs ranging from clitoridectomy- the removal of the prepuce or hood of the clitoris; excision- the removal of the clitoris and all or part of the labia minora; to infibulation which involves the removal of the clitoris, the labia minora and most of the labia majora. In the last procedure, the two remaining sides of the vulva are sewn together leaving only a tiny opening for the passage of urine and menstrual blood (Toubia 1993). Approximately 85% of women who are subjected to FGM undergo clitoridectomy and excision while 15% are infibulated (Toubia 1993).

FGM is supposed to transform a girl to a woman although the age at which it is done varies from society to society but ranges from a few weeks to puberty. In societies where the ritual takes place at puberty, it enacts a symbolic rebirth into adulthood, a process by which the society passes on knowledge and codes of conduct expected in adulthood. This is thus an initiation rite. There are however cases, as in the Chisungu in Zambia where the initiation rite does not involve removal of the genital organs (Richards 1982).

The Prevalence of FGM

It is estimated that 80-115 million women have been mutilated world-wide and two million girls are at risk each year. FGM is practised in 27 countries in Sub-Saharan Africa and Egypt, Yemen and Oman, scattered parts of India and Malaysia and South America. FGM has not been unique to these areas. Clitoridectomy was performed, as recently as 1940s, on European and American women as cure for female nervousness and masturbation. Among the Baluhya people in Western Kenya, only girls who are defined to be possessed are subjected to clitoridectomy.

And with the increasing international movement of people since the turn of the century, African migrants have introduced FGM to previously non-FGM areas including Europe. Governments and NGOs in these areas undertake educational, advocacy and legislation as preventive strategies.

The consequences of FGM

The consequences of FGM are numerous. As a physical surgery without anaesthesia, the pain must be excruciating. Moreover, bleeding and infections the latter due to the use of unsterilised tools are life threatening risks. Many other problems including, stress, shock and trauma; complications during sexual intercourse especially in the case of infibulation; complications during pregnancy and childbirth; urine retention, damage to the urethra and obstruction of menstrual flow arise (Toubia 1993, WHO 1994, Dorkenoo and Elworthy 1994, Heise, Pitanguy and Germain 1994). As an irreversible operation, the physical and psychological damage inflicted on girls and women affect their sexual and reproductive health throughout life.

The social and cultural basis of FGM

To be able to locate some of the dynamics and factors that promote persistence of FGM, a closer examination of its social and cultural basis is necessary. However, because of the great variation in societies where FGM is practised, it would be pretentious to do any deep analysis within a paper this size.

Mechanisms for justifying existence and enforcing persistence of FGM

It has become increasingly clear that FGM is neither an Islamic ritual although the Koran has for example, been interpreted by some religious leaders in areas where it is practised to be the basis of FGM (Toubia 1993, Lightfoot-Klein 1989), nor is it a Christian ritual. Lane and Rubinstein (1996) note that FGM predates the advent of both Christianity and Islam and because of being such an ancient custom, it is considered a norm. FGM is thus deeply embedded in the cultural fabric of the societies where it is practised. Reasons for the existence of FGM vary from society to society, but generally they include custom or tradition, religious demands, purification, family honour, cleanliness, good health, fertility, virginity protection, prevention of promiscuity, enhancement of sexual pleasure for the husbands, maturity, social discipline and enhancement of group or community solidarity.

Pressure is put by creating fear about and discrediting female genitals. These fears are internalised by children, youth and adults through the socialisation process. Among the Somali and many other societies, the clitoris is for example, considered to be an evil part (McLean and Graham 1985, Warsame: personal communication 1996). If not removed, it would endanger the life of the woman. In Egypt, it is believed that if not cut, the clitoris would grow and dangle like a penis (Dorkenoo and Elworthy 1994). This kind of belief is interesting especially if it is compared to some societies in Uganda who elongate the clitoris. In other areas, it is believed that an uncircumcised woman cannot conceive or give birth and if she does, she experiences birth complications.

In this context, uncircumcised women are considered as unclean, impure and childish. Among the Kikuyu of Central Kenya, an uncircumcised woman is referred to as *kirigu* - a thing or object of low value. Dorkenoo and Elworthy (1994) speak of similar valuations in Egypt where uncircumcised women are socially ostracised. There is thus considerable social pressure on women to be operated in order to be acceptable members of the society.

Apart from such pressure, the operation is followed by ritual ceremonies including, songs and dances, feeding the initiates on special foods and offering them gifts. In a study of four communities who practice FGM in Kenya, PATH/Kenya (1993) found that:

"Girls.... look forward to circumcision period because it is a time of joy, happiness and festivities both at home and in the community. There are many visitors, feasting, dancing, freedom, and an abundance of good food. It is a time when requests are honoured and promises kept. They are also given special treatment, showered with gifts and granted favours. These privileges includeseparate rooms from those who are not circumcised, privilege to abuse those who are younger, and permission to loiter without being reprimanded by parents. Circumcised girls felt superior to the uncircumcised since they receive information on boy-girl relationships during the healing period."

Hayes (1975) observes that her informants in the Sudan described similar ceremonies and gifts meant to make the girl happy. In Somalia on the other hand Warsame, Ahmed and Talle (1985) note that although the operation is an event of great significance in the life of women, and women may allow themselves some nice food during the day of operation, there are no elaborate celebrations.

The celebrations have been interpreted variously. It is argued for example, that the singing straight after the operation is for drowning the screams from the girl (Hayes 1995). This is understandable especially where the operation is done on infants and very young girls. In some societies such as the Kikuyu and the Masai where FGM is a puberty ritual, crying during the operation is one of the most feared things because it lowers the honour and status for the girl and her family.

Women are nonetheless strongly conditioned to believe that FGM is necessary. Highly educated women are also known to support FGM and as Khalifa (1994) has observed, in Sudan, educated women too frequently undergo what she calls recircumcision for the purpose of tightening the opening.

Prevention efforts: Getting FGM into the international agenda

FGM has until recently been a neglected issue. Among agents who made early attempts to prevent it were the Christian missionaries in collaboration with colonial administration. They attempted to ban FGM in many African countries where it was practised. However, although they created some awareness about the health consequences, their attempts were almost always abandoned due to resistance from the people.

Anthropologists continued to study the issue after the Second World War, but it was not until 1958 when WHO initiated a study on the persistence of FGM. More concern and commitment among international and national agencies and governments assumed increasing momentum from the 1970s. In the 1980s, a chronology of events and developments have helped put FGM in the agenda as well as broaden the perspective.

The United Nations Decade for Women 1975-1985 was in particular important for getting FGM well into the international agenda. Regional meetings held in Khartoum 1979, Dakar 1984 and Addis Ababa in 1987 have not only helped in raising awareness about FGM and related problems, they have also led to the formation of the Inter-African Committee for eradicating traditional practices harmful to the health of women and children.

During the years following the UN Women's Decade, international conferences and declarations on diverse issues have helped promote awareness and put FGM firmly on the agenda. In 1993, the United Nations Human Rights Conference in Vienna focused on FGM explicitly stating that the human rights of women and the girl child is an inalienable, integral and indivisible part of the universal human rights. The UN Convention on the rights of the child included abolition of FGM and the African Charter on the Rights and Welfare of the Child, now adopted by the Organisation of African Unity, similarly advocates for elimination of harmful practices. The issue of violence against women including FGM featured prominently in the International Conference on Population and Development in Cairo in 1994 and the Fourth UN Women's Conference in Beijing in 1995.

These events have resulted in not only increased publicity and awareness of the need to prevent FGM. They have also provided a better understanding of the dynamics involved, in turn helping to broaden the perspective. FGM is now increasingly seen in the context of status of women, sexual and reproductive health, human rights including the rights of the child, violence against women and gender power relations.

Despite all these efforts, an estimated 85-115 million women have undergone the operation throughout the world with a further 2 million girls being at risk of being mutilated each year (WHO 1994). This means there are gaps in past preventive activities and more innovative interventions need to be made to change the prevailing situation.

Major gaps in FGM prevention activities

FGM is a practice deeply embedded in the culture of the people where it is practised and unlike other problems, communities may not see FGM as a problem. Most often, the operation is performed as an indication of love and care for a

daughter. Prevention of FGM thus demands more efforts on the part of the agencies in dialoguing and negotiating with the communities.

Great strides have been made and there are indications that the practice is being abandoned (DANIDA 1996). However, other developments including the increasing religious fundamentalism, nationalism and escalation of economic crisis and conflicts especially in Africa may well increase violence against women, thus drowning what has been accomplished.

More serious commitments will thus be required on the part of policy makers at the national and international levels if the new and broader perspectives in FGM prevention will not remain only a rhetoric. The following section examines some of the dynamics and factors which have been problematic in past efforts and suggests some of the changes which require to be made.

Lack of knowledge and isolation of parts of the practice

Although this has improved especially in recent years, many agencies have little knowledge of the social context and the dynamics involved when they intervene. This was particularly so with the early prevention efforts especially by the Christian missionaries. The impact of these early missionary interventions continue to be felt today and it is therefore reasonable to elaborate on their activities. The missionary intervention was perhaps the first time the existence of a custom which according to Lane and Rubinstein (1996) predates the advent of both Christianity and Islam was questioned.

Some of the problems experienced in the prevention efforts at that time, reflected the general colonial and denominational power struggles and competition. The missionaries were not in consensus on whether FGM was wrong. In parts of Central Kenya for example, the practice is still prevalent in Catholic dominated areas (Ahlberg 1996) because Catholic missionaries compromised and let the practice continue undisturbed.

Most problems had however to do with lack of knowledge of the practice and the contexts within which it took place. Because of this, missionary approach and strategy was problematic. The missionaries used what can be called separation or isolation approach. Practices were removed from their social and cultural contexts, with components of one custom being isolated from the whole.

In Central Kenya, missionaries banned female circumcision on the ground that it was a barbaric, useless and dangerous custom. The Kikuyu people resisted violently, and the missionaries compromised by allowing the physical operation - the cutting - to take place within missionary hospitals under trained nurses. This was perhaps the first time FGM was medicalised. In early seventeenth century, Catholic priests who settled in Egypt forbade FGM on the grounds that it was a Jewish custom. However, when female children of their converts were turned down in marriage by the male Catholics who instead married non-Catholic women, the College of Cardinals in Rome was forced to rescind its decision to allow FGM among Egyptian Catholics (Lane and Rubinstein 1996). In Sudan, the colonial administration attempted to abolish infibulation. Midwives performing infibulation were subject to a fine and imprisonment for up to seven years. The first arrests were as in Kenya met with violent resistance forcing the government to amend the law (Dorkenoo and Elworthy 1994).

It is interesting to note that in the three countries, men took the leading role in the violent resistance, using tradition as justification for continuing FGM and refusing marriage to women who were not operated.

In the case of Central Kenya, the missionaries nevertheless successfully banned the ceremonies, the public dances and songs which they considered to be extremely obscene (Ahlberg 1991). These public ceremonies were easy to ban using the local chiefs to disperse and fine those who were found celebrating. The same procedure of forbidding the public celebrations using the chiefs, continues to be implemented today although it is much left to the discretion of the chief (Andersson-Brolin 1990). The physical operation and related public celebrations which gave meaning to the operation were thus separated from one another. Being no longer publicly visible, preventing FGM has become more difficult.

Studies in Central Kenya show that teachers in primary schools for example, get to know or suspect that girls have undergone the operation during school holidays, only after they observe a change in the girl's behaviour and networks of friends (Ahlberg 1996). Similar processes of forcing the practice into hiding and invisibility are reported in many other countries including Egypt (Et 1995) and Sudan especially after attempts to outlaw it. Similarly, in European countries where FGM is outlawed, it still continues and effective implementation of laws is hindered by this invisibility. When FGM becomes invisible, preventing it becomes a problem. The invisibility has, however, largely resulted from implementing uninformed interventions or having perspectives and interpretations other than those understood by the people who practice FGM and the social and political contexts within which FGM takes place. As in the early missionary interventions, controversies and resistance continue to this day.

The conflict which for example, flared between western feminists and African women during the Second UN International Conference on Women in Copenhagen in 1980, can be understood in this context. When western feminists brought up the issue of FGM at the conference, there was a walk-out by African women who insisted that their problem was not FGM or sexuality, but rather lack of development.

Controversy similarly broke out during the UN International Conference on Population and Development in 1994. The Egyptian Population Minister spoke publicly at the conference in favour of passing legislation to criminalise FGM. CNN Television network thereafter aired a segment of female circumcision showing actual operation on an Egyptian girl. This seriously angered the Egyptian public, forcing the Grand Shaik of Al Azhar Gad el-Haq, one of the country's powerful religious leader to issue a *fatwa* that FGM is an Islamic duty for all Muslim women. The Minister of Health too issued a public statement rescinding the 1959 ban and allowing FGM to be performed in governmental health facilities (Lane and Rubinstein 1996). In June 1997, however, the ban was lifted by a court decision in Cairo.

Wider changes taking place in societies where FGM is practised complicates the environment for preventive interventions. Among the Mwera of Southern Tanzania, the age at which girls undergo FGM has, because of the needs of schooling, been reduced from 12 years to 7 or just before the girls start school (Shuma 1994). There are clearly large differences between a twelve and a seven year old in terms of what it means to undergo the ritual which in this society is a puberty

rite. Moreover, the ritual at puberty made sense because girls married soon after and maintaining chastity and virginity was then not a problem. Today, although early marriages are still prevalent in many societies, in some, due to demands of education, girls stay outside marriage for longer periods. It is therefore clear that the meanings of circumcision have increasingly changed and it is also this type of changes which needs to be understood in order to formulate and make appropriate interventions.

Focus on women and women's health

In addition, most efforts have been directed at women as victims and as perpetrators of the practice. There is a tendency to blame women for apparently being the perpetrators and mutilators of other women (Walker 1994). Through the socialisation processes, women learn to internalise and to see FGM as an important part of their life. Moreover, in the context of the division of roles, FGM is a woman's duty, although as in the case of barbers in Egypt or as FGM becomes increasingly medicalised, men are more and more performing the surgery.

The major problem it seems, is that a great deal of efforts are directed at women. Rarely is the meaning and value of FGM in relation to sexuality - especially male sexuality - or in the context of gender power dynamics taken into consideration. This is one of the missing links in the prevention efforts. To be able to prevent the practice, more serious efforts have to be made to involve men as well as women. Some efforts have recently been made to involve men. However, there still are no appropriate methods of reaching men, nor are there well thought out issues where men are to be involved.

In most of the FGM eradication efforts, the health and psychological consequences suffered by women are the main highlights although Babalola and Adedapo (1995) found in their study in Nigeria that FGM is a phenomenon which goes beyond health. The focus on health has nonetheless raised a great deal of awareness about the harm the operation inflicts on women, leading to governments taking legal measures against FGM, (Silberschmidt 1994). The practice however seems only to change its form, usually going deeper underground (Walder 1995).

This is not to imply that the issue of health should be thrown away. Rather, it should form part of other issues of concern to the community in order to make sense to both women and men. Since men do not suffer the health consequences of FGM, the issue of health may not be appropriate as the entry point to reach and influence them. Moreover, where FGM is a minor operation, even women have been found to have problems identifying the health complications often used in educational campaigns (PATH/Kenya 1993).

Gender power and male sexuality

Most efforts have narrowly focused on women and women's health. There has been little focus on men although studies imply that women mutilate other women for the benefit of the men (McLean and Graham 1985, Khalifa 1994, Lane and Rubinstein 1996). Justifications including ensuring chastity, maintaining virginity, preventing female promiscuity, enhancing sexual pleasure for the husband and ensuring marriage for a girl indicate that FGM largely benefits men.

Paradoxically, men argue that it is women who make decisions on these issues. Emerging evidence however indicate that even though mothers, aunts and grandmothers take the actual decisions to mutilate a daughter, at the background are fathers and other male relatives. Evidence suggest that where fathers are opposed to FGM, daughters most often escape the operation or women have to perform it in utmost secrecy for example, sending the girl away from home (Dorkenoo and Elworthy 1994). In her study in the Sudan, El Dareer (1982) observed that only 12% of men interviewed opposed circumcision. Moreover, if men firmly insist on a particular type, women obey. Thus contrary to men's allegations that circumcision is solely a woman's affair, they play a crucial role.

In the PATH/Kenya (1993) study, men are reported to have said they prefer uncircumcised females as sexual partners, because such women have sexual feelings and share the joy of sex with their male partners. Men in this study consider women as the biggest block to prevention. Women enjoy and look forward with great anticipation to the circumcision season, which is a time for them to dance, visit, and entertain friends and relatives.

Sexuality is perhaps the most contested issue in FGM and men in this Kenyan study may just have been telling what they thought the researchers wanted to hear. Nonetheless, without seriously involving the men, their real perspective, can never be understood. Moreover, in the contexts where women are overburdened with family welfare and farm production activities, any chance to escape the drudgery is often welcome.

Women, including married women, are evidently being forced to undergo the operation for various reasons. Although systematic research has not been carried out, there is evidence in the context of HIV/AIDS that women are increasingly being forced to undergo FGM in part to reduce their sexual lust, thus preventing transmission of HIV. Et (1995) report of two married women from Egypt who were mutilated during an operation to remove an appendix and one during childbirth. One of the two women was mutilated on the request of her husband, while the other on the medical doctor's advice. In Sudan, women, including highly educated women reinfibulate themselves to narrow the opening. This is considered important for enhancing the husband's sexual satisfaction. Moreover, the practice is becoming more common now when husbands increasingly live elsewhere as migrant labourers (Khalifa 1994, Lane and Rubinstein 1996).

The PATH/Kenya (1993) study indicates that some men feel that FGM should continue so as to make women more reserved and submissive, less sexy and morally upright. The same is reported from Egypt where even gynaecologists are known to endorse FGM on the same grounds that it is important for checking a woman's sexual drive. From studies in Central Kenya, a question frequently asked by adolescent boys who have little sexual experience is: "who gives more sexual pleasure, a circumcised or uncircumcised girl?" (Ahlberg 1996). In the same studies, women make two distinctions among girls. Those who undergo the operation start sexual activity immediately because of the peer pressure that they have become adults. Those who do not undergo the operation take longer to start sexual activity. But once they start, the women say it is very difficult to stop them.

The PATH/Kenya report furthermore shows that the circumcision period is an important occasion for fathers to exhibit their wealth thus gaining status in the community. The same report shows that unlike the common belief that women

are the custodians of the practice, Samburu, Masai and Meru women regard men and elders as the custodians of laws and traditions.

At the centre of FGM is male sexuality and control over women. Thus, to prevent FGM, the gender power dynamics which mask the reality within which it takes place must be uncovered. Interventions which seriously address the current male seeming passivity in FGM would be an important point of departure.

Some concluding remarks

In the light of what has been discussed, it is evident that a great deal has been achieved. There is more knowledge about problems related to FGM; the issue is now firmly in the international agenda; and there is increased consensus that FGM must be seen from a broader perspective. But, perhaps more than before, there is greater need for concerted efforts not just to keep the momentum that has been gained, but more significantly to implement more innovative interventions in the area of research, training, information, advocacy, legislation and policy formulation.

This puts Sida at a strategic position with its pioneering work and perspective of seeing sexual and reproductive health in a broader context and including this perspective in its bilateral support. Most of Sida support in FGM prevention has been through NGOs and UN agencies particularly WHO. However, as discussed in this report, social and cultural variations in FGM demand that interventions increasingly need to be localised. In this way the specific dynamics are captured. For example, where FGM takes place during infancy or early childhood, what are the important factors to be addressed. Where FGM is a puberty rite of passage, what are the justifications, how is it organised? Where religion is the main point of controversy, what methods are appropriate, what arguments would be appealing, which local actors are appropriate? These and many other aspects can only be captured through actions at the local level. Sida can increase this local focus by including FGM in the bilateral support especially to areas where SRH programmes are supported. The following is a list of some specific recommendations:

Conclusions

Local level interventions

- support programmes and approaches which facilitate participation of women of all ages, men, health workers, and religious leaders in the local communities.
- support and strengthen local NGOs, grassroot organisations and national committees involved in prevention of FGM.
- support intersectoral approach involving government Ministries of Health, Education, Youth, Culture, and Women.
- empower women through better access to education, employment, control over resources etc. as a means of preventing FGM.
- support advocacy work at the family and community, national policy levels.
- promote and support policy development and legislation.

- include FGM in Sida's bilateral country support.
- support integration of FGM in curricula development for health professionals and school teachers.
- support educational strategies and development of IEC material which reflect specific or local beliefs and justifications.

International level interventions

- promote co-operation and co-ordination with relevant UN agencies and NGOs in the setting of guidelines and maintaining the broad perspective.
- help to keep the interest that has gained momentum for the eradication of FGM.
- support women's groups and organisations involved in health and human rights issues at international level.
- support advocacy work at the international policy level.

Research

- support multi-disciplinary, community-based, action research. This will help generate information on the cultural dynamics including forms of pressure put on women, the gender power perspectives, links to female and male sexuality, important actors, forms of language used and changes taking place in different areas. All these are important in defining what needs to be done as well as how it should be done.
- support research which explores methods for reaching and working with men on issues of FGM.
- support research that will continuously provide the epidemiological picture of FGM, for example regular situational analysis, and inclusion of data on FGM in national demographic and health surveys.

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