

*Betraying Their Daughters:
Women's Roles in Female Genital Mutilation*

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*“If Genital Mutilation were a problem affecting men,
the matter would long be settled.”*

- Waris Dirie

ABSTRACT

This project begins with a brief outline of the perspectives of both sides of the female genital mutilation debate.

It then explores more fully the position of the people who oppose the practice of FGM, including a consideration of the consequences that the mutilation has on the quality of life of women and girls who have experienced the procedure. It is also important to offer some balance to the anti-FGM side of the debate, to truly understand why it is done, instead of simply criticising the fact that it is done. So this is followed by a consideration of FGM as a cultural issue, how it relates to values, religious systems and beliefs (including both superstitions and cultural beliefs, and ones relating to health), its role in marriage politics and aesthetics, and finally the economic reasons for its continuance across such a wide variety of African cultures.

The reason why such a macro perspective was chosen is that it is important not only to get a broad overview of why FGM is performed, as well as an idea of how complex and interwoven the practice is with the identity of the peoples who perform it, but also to situate the phenomenon in its global context.

In order to understand why genital mutilation is still so prevalent, it is important to understand what measures have already been taken to attempt to eliminate it, from international policy through to community-level campaigns.

It is important too, as well as to understand the broader, national and international contexts of FGM, to also understand the women involved on a more individual level. There is a discussion of why women would choose to perpetuate FGM on their daughters, knowing, as they do, the impact that it is going to have on the rest of their lives. This is followed by the viewpoints of female genital mutilation that has been shared by women who have emigrated from Africa, to offer some perspective, as women who are still in Africa are enmeshed in the culture and tradition which makes FGM necessary.

Female genital mutilation has been identified in this report as being a symptom of the larger problem of the oppression and inequality of women, universally. When women are given alternatives to needing to be circumcised to marry, or alternatives to having to get their daughters married off in order for them to survive, then they take them, indicating that the elimination of FGM is something that they desire.

Finally, a more holistic approach to the anti-genital mutilation movement is proposed, in order to attempt to offer a bigger impact than has been achieved thus far, in reducing the prevalence of FGM.

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CHAPTER 1 - INTRODUCTION

Female genital mutilation (FGM) is a practice that seems to strike a very instinctually emotional chord in everyone who discusses it, regardless of whether their own people practice it or condemn it. There is a deep dichotomy in the way in which FGM is viewed by these two groups; it is seen either as an act intrinsic to cultural identity, or as a gross human rights abuse. This classification depends on which side of the issue one approaches from, but rarely in the study of FGM have these two attitudes been combined (Antonazzo, 2003:471; Johansen 2002:313; Lane & Rubenstein 1996:31). The name of the procedure itself has reflected this divide, as it has been called 'female circumcision' (arguably somewhat euphemistically¹) or simply 'cutting' by the people who practice it, traditionally peoples mainly concentrated in Central, West and North Africa, but also reaching into the Middle East and parts of Asia. It has been called by medically relatively neutral terms, such as 'excision' and 'infibulation. And finally it has been called a mutilation and disfigurement, mostly by (but not limited to) Western scholars and commentators.

Largely, the cultural practice of FGM has been geographically limited to the areas in which it has been historically practiced. However, this pattern has been steadily changing with globalisation and refugee and population movements, and, increasingly, women from countries that practice FGM are emigrating to the West (Bosch 2001:1177,

¹ This is because much more tissue is removed in the female version; the equivalent of normal male circumcision would be to remove just the prepuce (the covering hood of skin) of the clitoris, but in practice part (or most of) the clitoris is removed, usually with the *labia minora*, and sometimes the *labia majora* are removed too and sewn together, leaving only a very small hole. This is called infibulation and will be discussed in more detail further in the project.

Dorkinoo 1994:128; WHO 2009)², bringing the tradition with them, and necessitating policies and laws which deal with FGM in these Western countries.

1.1 The arguments about FGM

Genital modification is an age-old practice, and FGM is no exception. While there seems to be little concrete evidence as to precisely when it was first practiced and where, what is unarguable is that it has been performed for millennia (Assaad 1995:21; Cloudsley 1983:9; Ford 2001:1778) and was documented by the Ancient Greeks and Egyptians. There are many motivations put forth for its existence and continuation, but there is no consensus about this across the groups who perform FGM, just as there is no consensus among these groups as to why it is done. Every ethnic group has their own reasons for doing so, and different ways of doing it. For some, the reasons for the custom are religious ones, regardless of the degree (or lack thereof) to which this may be borne out by scripture, to some it is cultural and is a matter of upholding tradition, to some it is a way of raising a girl's value by ensuring that her virginity (and therefore marriageability) is kept intact, something that girls are often taught is their greatest asset. Still others practice FGM because of superstitions, believing variously that contact with the intact female genitals of either a man's penis or a newborn's head will cause the instant death thereof, or that the genitals will keep on growing and growing until removed. Often the decision to practise FGM is not a conscious one, but rather one made by or for a woman or girl because 'this is the way it has always been done'. There is simply no other viable option, if the idea even occurs, which it probably doesn't very often because FGM *is* seen as the 'natural way' to be a woman (Gruenbaum 2001:69).

But, regardless of the reasons for FGM, there can be little denying that having it done carries with it some inherent risks, and the opponents of FGM argue that, regardless of the benefits of FGM as they may be perceived on a societal level, on an individual level the risks and the losses are too great, quite apart from the fact that it is

² This phenomenon has been increasingly studied by authors such as Affara (2000), Berggren et al. (2006), Johansen (2002), Jonsdottir & Essen (2004) and Theirfelder et al. (2005).

one of the most painful experiences a woman could go through (Assaad 1995:23, Johansen 2002:313,315-7,324). These may include the long and short term medical consequences on a woman's general, sexual and reproductive health and the psychological trauma from the experience and its consequences (Johansen 2002:331, Toubia 1995:13). It is this argument that has framed and shaped the FGM debate, and which leads one to the conclusion that FGM must be abolished.

However, the issue of female genital mutilation is a complex one, and one which must be well-understood and sensitively approached if the dialogue between those who want it to continue and those who want it to be abolished, is to be a constructive one.

1.2 Pervasiveness of FGM

In spite of the fact that there have been denouncements of FGM since it was first discovered by the West in 1906 and lobbies and movements against it since the 1920s (Thomas 1996:132), religious and legal bans (Ny'ang'a 1995:35), and education and community campaigns (Bosch 2001:1178; WHO 1999), and its abolition has also been a condition of jobs and bursaries (Ny'ang'a 1995: 35) aid and development packages, the practice of FGM has not only remained a tradition that is an intrinsic part of most of the regions and cultures in which it has been practiced, but has continued to grow, even in the face of modernisation (Mackie 2003:999).

The World Health Organisation estimated that in 1994 upward of 85 million women had been circumcised, and this has risen to between 100 and 140 million women in 2009 (WHO 2009). Now there are 3 million women and girls who undergo various forms of FGM every year.

This is in spite of the measures that have been taken by various elements of society to eliminate FGM, including international organisations like Amnesty International, the United Nations and the World Health Organisation, countries' own legal systems (Antonazzo 2003), community-based organisations and NGOs (WHO 1999). Campaigns have been launched in various arenas, such as the media, but attempts have also included health practitioners and religious leaders. Clearly, these efforts have

had varying degrees of efficacy as, although there have been some people who have chosen to stop practicing FGM, it is still an extremely prevalent practice, occurring in 45 countries (although a common occurrence in 28), making it not only a practice resistant to change, but also one that is extremely widespread. In 2002, at the UN General Assembly Special Session on Children, there was an agreement by governments to abolish female genital mutilation by 2010, a goal that, at their current rates of impact on the prevalence of FGM, there is no hope of them achieving.

1.3 The two sides of the debate on FGM

This points to the reason for the extensive debate that has long-surrounded female genital mutilation; there is a gulf between the two perceptions of the same event. People from countries in the West, and those in which FGM is not the cultural norm, are often surprised and horrified that FGM is still so prevalent (WHO 2006:5), and take it for granted that it should be abolished. The medical consequences of both the surgery itself and the horrific (physical and psychological) short and long-term complications which could arise are seen as enough justification to ban the practice entirely (Ford 2001:1179). Added to this, the unnecessary removal of a perfectly healthy and functioning organ is considered to be a mutilation.

From a more ethical perspective, FGM is defined variously as violence against women and children (Shell-Duncan & Hernlund 2001), as torture (Annas 1996, as cited by Shell-Duncan & Hernlund, 2001), and as part of the systematic oppression and subjugation of women by men (Hosken 1994, Toubia 1995) by some hard-line members of the anti-circumcision movement. However, the latter point could be countered by pointing out that it is usually women who perpetrate the circumcision, and who perpetuate the culture of circumcision. This raises the extremely interesting question of why women would be complicit in the oppression of their own gender, and is the main question which this thesis will attempt to answer.

However, on the other side of the debate, there are a lot of people who would ask, 'if cutting is a cultural practice, what right someone has to pass judgement on it and attempt to alter the belief system and practices of anyone else?' 'Cutting' is obligatory

and a somewhat routine event to the people who practise it, and that it is necessary goes virtually unquestioned (Gruenbaum 2001:39; Johansen 2002:323; Shweder 2000:220). It is often seen as a woman's path to social acceptance and adulthood status (Cloudsley 1983:109; Johansen 2002:323; Ng'ang'a 1995:33), it ensures a girl's virginity, both by limiting her sexual desire and, in the case of infibulation, making penetration extremely difficult, and therefore ensures that she is marriageable (Assaad 1995:22, Blaffer Hrdy 2000:260, Gruenbaum 2001:46, WHO 2006), and increases male sexual pleasure by increasing friction (Johansen 2002:318; Orubuloye et al 2001:83). Also, in some cultures, the clitoris is seen as dangerous or dirty, in others the genitals as simply ugly, and they must therefore be removed. It is the moral thing to do. In fact, a mother might be perceived as neglectful if she did not circumcise her daughter, who would then be a social outcast, never able to participate in the rites and decisions that the other women in her tribe would take for granted as their right.

It is extremely difficult to find common ground between these two perspectives, and this could account for the fact that, although 90 years have been spent trying to eradicate FGM, it is still very-much present.

1.4 Western Approach to FGM

The continued presence of FGM on the scale in which it is still found, leads one to the conclusion that the campaigns against FGM have thus far been largely ineffectual. The study of FGM has, in the past, been quite fragmented because of the nature of the practice itself. Often, although not a secret, it is a private occurrence that would not usually be discussed with strangers and outsiders, and, increasingly, the people who practice FGM have come to feel judged and vilified by Western scholars who have condemned them, and the Western media that has splashed pictures of their genitals over magazine pages and large screens in the name of education. This feeling of antagonism is also partially because of the aggressive approach to 'eradicate' FGM, taken by some from the West starting in the 1970s (Shell-Duncan & Hernlund 2001), exacerbated by the media sensationalism (Dorkinoo 1994:127; Toubia 1995:19) which has alienated and offended practitioners of FGM and engendered accusations of unjustifiable western interference in a traditional African cultural practice.

The other problem is with using FGM as a blanket-term, because there are many ways in which it occurs. Not only are there differences in how much is cut, but also in the motivations for doing the circumcision, the way in which it is done, who does it, at what age it is done and whether or not there is ritual attached to the practice. Trying to generalise from one group or area to another is simply not effective, and part of the reason why the Western approach to FGM has raised so many hackles is that it has been much too uniform, and has therefore shown very little true understanding of the practice. A better approach would be to get a very broad overview of all of the reasons why it is performed across the world, and then use sensitivity and respect and applying the programme to the specific culture involved.

What can be generalised, however, is the fact that in almost all cultures that practice FGM, it is the women: midwives and female circumcision experts (Abushara 2000:121; Hosken 1979:3.1.12; Ny'ang'a 1995:38, Toubia 1995:14,) who carry out this surgery. It is the girl's female relatives who arrange for the circumcision to take place and who hold her down. Even as they acknowledge that the pain they went through during their own infibulations was the most excruciating and traumatic of their lives (Ahmadu 1995:293, Assaad 1995:23, Johansen 2002:313,315-7,324, Toubia 1995), they force the same pain on the next generation. Little girls are brought up to expect the pain, and sometimes even to look forward to it. This seems counter-intuitive to the broad philosophy in which it is assumed that parents, and especially mothers, generally try to give their children better opportunities than they had themselves and try to protect them as much as is possible and reasonable.

1.5 Problem Statement

Therefore, there are two questions that this thesis will attempt to understand. Firstly, why does female genital mutilation continue to be so widely practiced? And why would female genital mutilation be perpetuated by women who have gone through the experience themselves?

1.6 Methodological approach

Although there have been genital mutilations in Europe and the United States since they were first proposed as a Victorian cure for all sorts of women's afflictions, the scope of the FGM discussed in this thesis is limited to that which is a culturally-sanctioned procedure that is practiced by groups today. There is no geographic division between groups which perform female circumcisions and those which don't, so it is therefore more useful to discuss FGM in terms of the different ethnic groups themselves. The division between who practices FGM and who does not is an ethnic one, and FGM can also be used as a marker to delineate different ethnic groups (UNICEF 2005:11). Because the overwhelming majority of genital mutilations happen in Africa, this project will focus on FGM as it occurs on this continent, but many of the reasons why it is performed and the understanding of women's motivations for its continuance, could be extrapolated across those which occur in the Middle East and Asia too.

Because the aim of this study is to understand why women perpetuate FGM, especially on their own children, analysing the contexts in which FGM occurs is extremely important. An understanding of the influences on a societal level that motivated people to develop, and motivate them still to continue with the practice of these traditions is crucial to understanding the nature of the circumcision itself. Not only will this set the parameters for approaching this issue critically, it will also help to remove the biases which could potentially creep in when academically discussing such an emotionally-sensitive topic.

This will be followed by a brief review of the history of anti-FGM movements, in order to get a basic understanding of their general scope. This will also allow an understanding of why many have not been as effective as they might have hoped.

Lastly, once the societal and international contexts in which FGM is positioned are understood, an exploration of the individual motivations of women to perpetuate FGM, to make their children and grandchildren go through the same horrific experience they have been through, will follow. It is important that this more micro-scale view is balanced with the more traditional macro view that is used by most scholars trying to understand and explain FGM, because although there are societal pressures on women

to believe in and support FGM, ultimately they are the *individuals* who are making the choices for their children. Understanding why they make these choices, and if they would make alternative ones if they could, is a crucial part of the complete comprehension of the phenomenon of FGM.

The research in this report will mainly be based on written sources in which women's first-hand FGM experiences, and their opinions, feelings, discussions and rationalisations of FGM are documented. These will come from a variety of sources, including both academic and non-academic books, interviews, journal articles, and from community and non-governmental organisations' publications from both in and around Africa and Europe. From this will come an appreciation of how women are individually influenced and affected by FGM. It is very important to find out what women's own experiences of FGM are, because this will allow an objective understanding of it, instead of an emotion-tinged one.

The report will focus on why women, who are most often the ones involved in the process of circumcising other women, continue a practice that most feminist writers on the subject have considered to be, at its very best outdated and unnecessary, at its worst barbaric and cruel (Abusharaf 2001:115). It will look at FGM in the contexts in which it occurs natively and is most prevalent, in an effort to more fully understand the practice. It also will look at the role that women have in educating and socialising the next generation (especially the next *female* generation) and at how mothers who are likely to be circumcised themselves, and who have emigrated to the West, view their *own* circumcisions and what choices they are making for their daughters.

It is crucial to understand how women who have emigrated see FGM, because, unlike their counterparts still at home, they are more readily able to experience a reality in which FGM is no longer compulsory, a reality in which it is a part of their culture, but is possibly no longer a fundamental step on their daughters' or sisters' roads to adulthood. Because they can see that a viable alternative to circumcision is possible, they are more likely to be able to objectively reflect on their own experiences, and to make more objective choices for their daughters than other women may be. Finding out how emigrant women feel about FGM is therefore a key facet in understanding its place in women's lives.

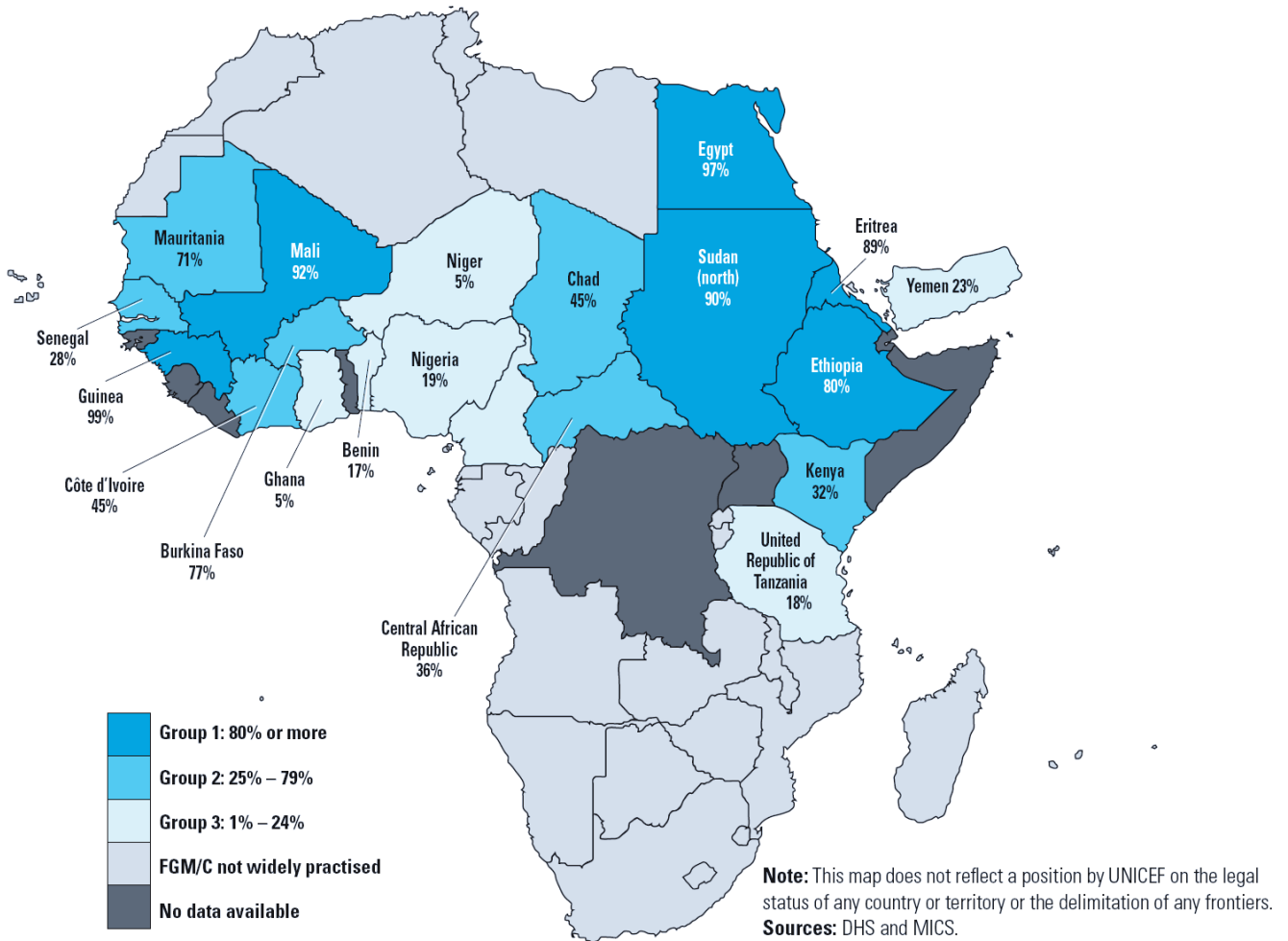
Finally, once a deeper understanding of FGM globally has been achieved, the study aims to use this combined macro and micro approach to propose some hopefully more effective methods that could be used to counter FGM practices. However, understanding why FGM occurs is only part of potentially stopping it. Before any halting of FGM is possible, the critical question that needs to be asked is how women who have been circumcised see themselves. Do they see themselves as having been mutilated and assaulted, or are they willing participants who are embracing their own cultural traditions? Do they want the mutilations to stop? Asking and understanding this will allow suggestions for how an *effective* programme might be developed.

CHAPTER 2 - UNDERSTANDING FEMALE GENITAL MUTILATION

For the sake of clarity in understanding the scope of the issues to be discussed in this project, the following section contains a brief overview of the types of FGM and discussion of where it occurs. Subsequently there is a discussion of the terminology that is used to discuss this practice in the writings, looking also at the prevalence and extent of the custom. It also seeks to briefly outline the perspectives of both sides of the circumcision debate, and then to explore more fully the position of the people who oppose the practice of FGM. This will include a consideration of the consequences that the mutilation has on the quality of life of women and girls who have experienced the procedure.

2.1 Where FGM is practiced

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Prevalence and distribution of FGM in Africa

More than 80% of the world's genital mutilations are done in Africa (Dorkenoo 1994:126) and they are known to be a culturally-condoned practice in communities in 28 countries. Excision is by far the most common and most widely-practiced form of FGM (Hosken 1979:1.1.5); the vast majority (well over 90%, according to the WHO, but although there is a high degree of correlation in the data between sources, slight differences in the exact figures can be found) of women in Eritrea, Guinea and Sierra Leone have been excised. However, although infibulations are by far the dominant form of FGM practiced throughout Somalia and northern and central Sudan, Djibouti, and in

parts of Egypt, Mali, Nigeria and Kenya, it is also practiced by other ethnic groups elsewhere.

There has been some evidence of a generational trend in which there are slightly fewer circumcisions being performed in many countries as time goes by, but in the four places that have a more than 96% rate of prevalence of FGM, namely Egypt, Guinea, Mali and northern Sudan there has been no reduction in this figure (UNICEF 2005:7), meaning that circumcision is constant in the younger generation. This means that, in spite of these countries being as much the target of NGO campaigns as the others, they seem to be having almost no effect. UNICEF (2005:28) says that, even though there may be the data to indicate a slight decline in some countries, with more younger women saying that they do support FGM, it is not yet possible to conclude that there is an overall global drop in the prevalence of FGM, and no definite trends have yet emerged.

2.2 Types and prevalence of FGM

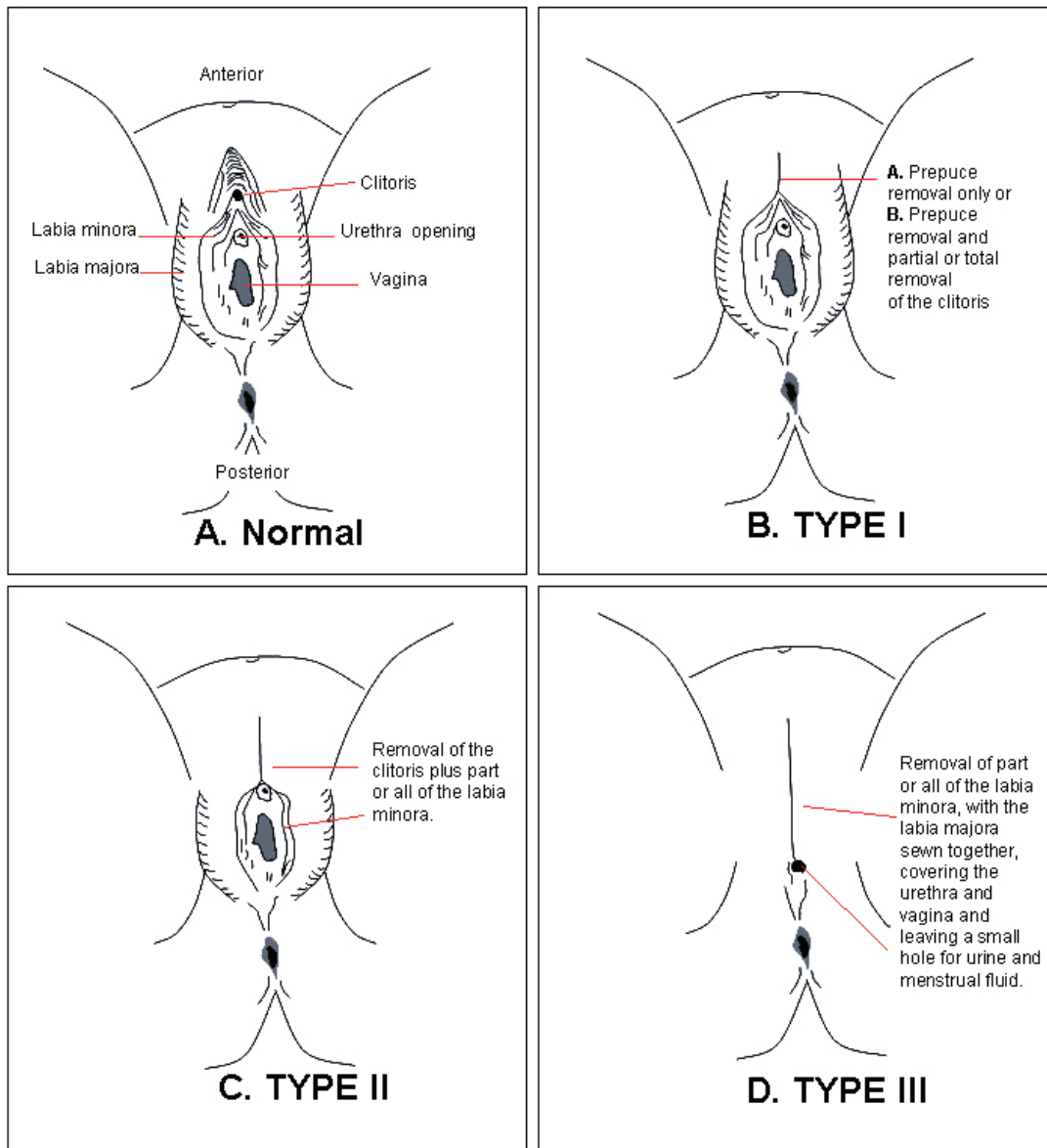
As was briefly explained in Chapter 1, there are various degrees to which female circumcision is done, and none of the three terms: FGM, circumcision and cutting, give any indication of this degree. Because the practice is so wide-spread there have been many names given to these various types, but for the purpose of this thesis, in the cases where differentiation is necessary, the medical terms will be used. Circumcisions are usually performed with a knife, a razorblade, scissors, a piece of glass, a sharp stone or even (according to Efua Dorkenoo, 1994:8) fingernails used to “pluck out the clitoris of babies” (in some areas of the Gambia). They are classified according to the amount of flesh which is removed.

Clitoridectomy (which the WHO classifies as Type I) is the amputation of part of, or the entire clitoris.

Excision (which the WHO classifies as Type II) includes a clitoridectomy and also the removal of all or part of the labia minora. Because of the nature of female circumcision and the female anatomy, both because of the fact that often the girl is thrashing around too much to make a slow, careful operation possible, and that if she is young she may be too small to be able to cut very precisely anyway, it is often difficult to separate the above two categories. Circumcision has been described as a continuum (Shell-Duncan & Hernlund 2001) and so the term ‘excision’ is most commonly (and for the purpose of this thesis) used to mean both. Approximately 80 - 85% of women (Toubia 1995, UNICEF, UNFPA, WHO 1997) who have undergone circumcision (that is approximately 80 - 120 million women) have undergone this type of procedure.

Lastly, *infibulation* (or Type III) is the complete removal of all of the clitoris and the labia minora, as well as part of or all of the labia majora. The edges of the wound are then stitched together, leaving a sealed “hood of skin” (Toubia 1995) over the vagina and urethra. Only a small hole is left open for urine and menstrual blood to pass through, and intercourse is only possible through a gradual and painful dilation process, if at all. Otherwise (and for every birth) the scar must be cut open. Infibulation accounts for the remaining 15 - 20 % of the total number of women (or 15 – 28 million women) who have

undergone FGM. The vast majority of these women, however, are from Somalia, Sudan and Djibouti (Toubia 1995, Shell-Duncan & Hernlund 2001).



Types of FGM

Once the operation has been performed, the girl is stitched up, sometimes with long thorns, and her legs are bound together very tightly, and will very gradually be loosened slightly to allow her more and more movement. Urinating over the fresh wounds is excruciating, and the extreme fear of this sometimes results in retention. She will be made to lie down as much as possible so as to try not to disturb the scars, which

is not always avoidable, and will only be able to walk with the aid of sticks for a few weeks until the scar is healed.

People have argued that males in a lot of cultures go through medically-unnecessary circumcisions too, but the two are simply not comparable in magnitude or effect. Even clitoridectomy, the mildest form of genital mutilation traditionally practiced, is the equivalent of cutting most or the entire penis off, severely damaging or destroying the organ of sexual pleasure.

2.3 Terminology

FGM is a collective term which is used to describe all of the forms of genital modification above. However, as previously pointed out, the terminology of writings reflects the intense debate. While the term “female genital mutilation’ was originally coined in recognition of the harmful effects of the procedure, the word ‘mutilation’ (and especially when it is connected to the word ‘genital’) is an extremely emotive word with lots of negative connotations, albeit one that is technically accurate. Its use arouses a sense of outrage and horror in the reader. Developed by feminist writers on the subject (Shell-Duncan & Hernlund 2001), FGM has become the most-widely used term to describe this procedure in the literature, and as such, has lost some of the deeply negative associations and is simply used to factually denote the operation.

However, its use is not without contention. Some people, and especially those whose traditions and rites are being denounced by the use of the word ‘mutilation’ understandably find this offensive (Ford 2001:1179; Shell-Duncan & Hernlund 2001, Johansen 2002). Understandably, most people become defensive when something fundamental to their personality and identity is attacked. Most of the people who have this practice refer to it as ‘female circumcision’, or as ‘genital cutting’, words which reflect the comparatively neutral status it has in their cultures. Alienating and making these people defensive has been counterproductive to the anti-circumcision movement, because they should be at the frontline of the eradication movement (Toubia 1995:15). Also, the ‘teaching or preaching’ approach that has often been taken, with Westerners coming in and trying to ‘correct their maladaptive practices’ is “elitist and ethnocentric”

(Gruenbaum 2001:17) and this is also counterproductive, and is ultimately extremely ineffectual.

All three terms: female genital mutilation, female circumcision and genital cutting, will be used in this project. FGM will mainly be used in its more neutral form and when analysing the viewpoint of the anti-circumcision movement, and 'circumcision' and, rarely, 'cutting' will be used either when elucidating the perspective of those who support FGM or when used by women to recount their own experiences.

2.4 Arguments against circumcision

There are many reasons put forth by anti-circumcision campaigners as to why FGM needs to be abolished. They focus on the damage and harm that is done to a circumcised woman or girl, be it physical or psychological, sexual or as a violation of her rights as a human being. It is important to break down these arguments logically, so that they are not overshadowed by the instinctual and emotional trap that it seems to be so easy to fall into.

The basis on which many scholars object to FGM is the fact that it is such a harmful procedure, the sheer scale of which, it is argued, no amount of cultural justification can atone for, as it fundamentally, permanently and irreversibly alters women's lives. These arguments will be explored in this section along five lines, namely both the short and long term effects and complications of the surgery, the potential psychological consequences, and discussions of FGM as subjugation of women, as child abuse and as torture.

Immediate and short-term effects and complications

The first and most obvious results of genital mutilation are the excruciating pain which occurs as some of the body's most sensitive nerves are amputated, followed by severe haemorrhaging, as there are a lot of large blood vessels in this area. Many women refer to the intensity of this pain as being the worst of their lives, even more so

than childbirth, and remember blood spraying the face of their circumciser before being stopped. The magnitude of the pain and blood loss mean that they could soon be followed by post-operative shock, a condition which is fatal and can only be treated with prompt, modern medical care and blood transfusions. Also likely to immediately follow the operation is acute urine retention, with the accompanying risk of bladder or kidney infections, because the pain of urinating over these types of open wounds means that it is likely to be the last thing any girl wants to do.

This is providing that the operation goes completely to plan, which, given the circumstances under which it is done (often with extremely limited surgical resources and a lack of professional medical training on the part of the circumciser, and the fact that the only thing that is likely to be holding down the panicking 'patient' is a group of women) it often doesn't. Extraneous nerve damage is common, as is damage to the extremely delicate surrounding tissue: the urethra, vaginal walls, glands and rectum can all be damaged, caused either by the poor eyesight of the circumciser or the violent struggles of the child to get away.

Other short term complications include the ulceration of the genitals from the acidity of the urine on sensitive tissue, blood infections such as septicaemia, infections of the wounds caused both by the non-sterile conditions in which the operation is performed and the substances used to pack the wound, often things like mud or animal dung, or the sticks or straws used to keep the new tiny meatus open during the long healing process. And, of course, there are the risks of exposure to HIV infections – a particular hazard in parts of Africa, where the rates of HIV infection are so high – as well as that of tetanus, and other transmissible diseases.

Also, other injuries have been reported being caused during the procedure (Dorkenoo 1994:56) especially upon children, including broken bones caused by the adults trying to hold down the panicking children, bitten-through tongues, convulsions and even death as a result of suffocation or shock. Also, the emotional trauma and terror of such a horrific experience, in which one is being subjected to immense pain, is powerless to stop it, and is having it done to one by the very people that a child should be able to rely on most for protection (namely their family) should also not be underestimated.

Long-term effects and complications

It is important that the complications of female genital mutilation are divided into those resulting from which type of surgery was done: excision or infibulation, as each type, while having some commonalities, has different effects. Because of the lesser extent of the excision surgery, after the initial surgery is over there are generally fewer complications generally associated with this type than with infibulation.

Excision

Obviously, the most common complication of excision is the limitation of sexual sensation because of the removal of the clitoris and labia minora. Scar tissue can cause all sorts of problems as it heals, especially if it extremely painfully traps the nerves as it shrinks or if it grows into large cysts. It can also cause problems with the retention of blood and urine, and can interfere with childbirth if the scarring is extensive.

Infibulation

Similar problems as occur with scar tissue in excisions occur in infibulations, but childbirth complications are simply unavoidable. The scar tissue cannot stretch during labour, and so the baby's passage is obstructed, which, if not opened in time, could lead to the baby asphyxiating and dying or receiving brain-damage. This necessitates that the woman is cut open again (or otherwise results in extensive tearing of the perineum which leads to fistulas), again putting the rectum or cervix, and this time the baby too, at risk of being injured again. Gruenbaum, 2001 (104) tells of two nomadic groups in Sudan who say that they only make their women have excisions and not infibulations, because they do not know if they will be able to get to a midwife in time for births. Infibulation has been associated with an increased number of stillbirths (Balk, 2001:58). These risks increase with each new pregnancy and birth a woman endures.

One of the biggest problems resulting from infibulation is the inability to pass urine and menstrual blood through the very tiny hole that is left for this purpose after the surgery has closed everything else. Girls speak of the agony and frustration of trying to empty their bladders one drop at a time, or even of appearing several months pregnant because of the build up of menstrual blood and tissue that has no way to leave the body. This, of course, leads to chronic bladder, vaginal and uterine infections and endometriosis, as well as discomfort and odour. Between this and the fact that infibulation interferes with sex by making it extremely difficult until the scar has been stretched or cut open sufficiently, and therefore reduces chances of getting pregnant, infertility can be the result.

Psychological effects and complications

Circumcision can bring women a whole host of psychological problems, caused both by the actual operation itself, and because of having to live the rest of their lives with the consequences thereof. The trauma from the excruciating pain and the feelings of anxiety and helplessness that are created by the circumcision procedure itself make a big impact on women. They all remember the day that they were circumcised, most extremely vividly, and this can manifest itself in symptoms such as anxiety, depression, insomnia and a lack of self esteem, among others (Nwajei & Otiono 2003).

And, of course, having these memories is bound to have a negative effect on these women sexually, especially as they must be evoked in the long, slow and painful process of stretching the scar tissue covering the vagina enough for penetration, over several weeks or months, or of having the scarring cut open again. This association is extremely unlikely to foster an enjoyment of sex, and can result in vaginismus. But once they've managed to overcome the pain, many women experience immense frustration at their reduced ability to achieve orgasm, and so may then feel abused every time they have sex (Dorkenoo 1994:125).

Circumcision may reduce the pleasure of sex, but it cannot completely eliminate the desire for sex, which is psychological and not physical. In fact, in spite of the intention of FGM practitioners to reduce sexual desire, they may actually end up

achieving the opposite, as it is possible that a woman may seek out more than one partner in an attempt to find satisfaction.

There doesn't really seem to be a definite agreement from women on how much of their pleasure in sex is dampened, as some women say that they enjoy sex and can achieve orgasm, others that circumcision stops them from wanting sex or gives them the ability to hold out on sex until their husbands behave the way they want them to. Presumably this variation could be accounted for by how much of the tissues in and around the vagina was removed during the circumcision. Circumcision does make vaginal intercourse more desirable to many women than clitoral stimulation, which is seen as being more 'adult', but women who have been circumcised do transfer their focus of pleasure from the clitoris to other erogenous zones (Nwajei & Otiono 2003:578) such as their breasts, indicating that there is also a neurological change that accompanies the amputation of those nerves.

Sexual dysfunction caused by female circumcisions is just not limited to women, causing them mental health strain; often men are equally traumatised by knowing that they are causing so much pain and injury to their wives when they try to have sex with them by penetrating through an open wound (see Johansen 2002:317 and Mackie 2003:1003). This happens when they are first married and again after the birth of every child as she is re-infibulated every time, and several studies have linked this to drug taking, like hashish smoking and quat chewing in men (Dorkenoo 1994:23).

Clearly, having been circumcised can have some very serious psychological complications, and very often women feel that the psychological implications of their circumcisions are not taken seriously by their families or communities (Toubia 1995:12). They feel like they cannot talk to anyone about the problems they are having (Dorkenoo 1994:24) emotionally or sexually, and often feel that they have lost something of themselves, something irreplaceable and irretrievable that the mutilation has taken away from them forever (Dorkenoo 1994:26, 124; Johansen 2002:324).

Subjugation of women

Female genital mutilation is far from being the only example of the ways in which women are subjugated, but it is a particularly clear example of the horrific things that are done to women, and the lengths to which they are prepared to go in the name of society and tradition.

According to the most basic of human rights, everyone has the right to health and bodily integrity, and FGM severely threatens both of these. Not only is the injury caused by genital mutilation incredibly serious, but it has far reaching, permanent consequences on one of the most important aspects of a woman's life. As surgery with this sort of impact is not routinely performed on men anywhere in the world, and least of all in FGM performing cultures, clearly this is discrimination of the most basic kind. The UN Convention on the Elimination of All Forms of Violence against Women (1993) defines discrimination as:

any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field.

Circumcision impairs the sexual enjoyment to which men are entitled, curtails their freedoms and choices, and nullifies the recognition of them as entire, normally-functioning human beings. It subjugates and controls women's sexuality (UNICEF 2005:21). By 'guaranteeing their chastity against their will', (Gruenbaum 2001:80) as circumcision is meant to prevent women from someday wanting to stray, there is an implicit understanding that they will be prevented from being able to make their own decisions because of this procedure. What Fran Hosken calls the "sexual castration" of women denies them the basic fulfilment and enjoyment of their sex lives.

There is a definite connection between FGM and the high illiteracy rates among the women in cultures who practice it (Dorkenoo 1994:46; Ny'ang'a 1995: 35). The more education a woman receives, the less likely it is that her daughters will be circumcised. Because very often circumcised women do not have access to much education, they

also do not have access to the health-based information which would allow them to make more scientific and objective decisions about circumcision. They are told that they will be infertile, or their genitals will kill their babies if they are not circumcised, and they do not have the knowledge to overcome these fears. The ability to have children is a woman's most important currency in these types of societies, and not being able to have them successfully is almost a kiss of death.

When women support the continuation of the practice of FGM, studies have shown that this often goes hand-in-hand with a perception of women's inferiority to men. Women who support FGM are up to 3.6 times more likely to indicate that it's acceptable for a man to beat his wife for doing things like arguing with him, burning his food, or refusing to have sex with him, than their compatriots who don't support FGM (UNICEF 2005:25). This indicates that these women have accepted male dominance as the normal state of gender relations, and also, more than 95% of these women have low self-esteem (Refaat et al. 2001:595), which means that they are even more likely to allow themselves to be abused. Men have dominated the opposition to anti-FGM programmes (Ahlberg et al. 2000: 41) often being the most vocal in arguing that circumcision is their tradition and should continue to be practiced, somewhat negating their claims that circumcision is "women's business" in which they do not get involved.

Child abuse

All actions concerning children should be undertaken in the best interests of the child ... children should have the opportunity to develop physically in a healthy way, receive adequate medical attention and be protected from all forms of violence, injury or abuse.

Convention on the Rights of the Child (as cited by UNICEF, 2005)

Because female genital mutilation hampers normal childhood physical development and is both violent and injurious, it clearly should be classified as child abuse when performed on infants and young children. The vast majority of the time, genital mutilations are performed on children who, by definition, cannot give informed consent. Often it is performed on young children, and the younger they are the better, as

they are said to remember it less when they are young (Hernlund 2001:242) – although the fact that so many women report extremely clear memories of their circumcisions would seem to negate this somewhat too – and of course, they resist less. Some peoples, such as the Falasha Jews in Ethiopia, circumcise newborns, but this carries with it the risk of doing much unintentional damage because the genitals are so tiny.

Also, the age at which circumcisions are performed has been steadily falling across many cultures who used to do it later (Dorkenoo 1994:12); for example, it has been drastically reduced from menarche to approximately 6 years old in Kenya (Ny'ang'a 1995:35) and around 5 in Sudan (Johansen 2002:316), and many refugees seeking asylum in the West have their daughters circumcised at an even younger age than usual, before they emigrate, so that they can get around the increasing amounts of anti-FGM legislation they face when coming to the West.

Torture

Another way in which this issue has been approached is also by defining FGM according to the Universal Declaration of Human Rights, which states that no-one shall be subject to torture, or cruel, inhuman or degrading treatment. Torture is defined as “any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person.” FGM can definitely be classified as inhuman treatment and, no-matter that it is well intentioned, performing FGM on anyone, but especially a child, is clearly violating the spirit of this Declaration. While it is perfectly acceptable for an adult woman to make the decision to be circumcised, knowing that it is irreversible and will have lifelong consequences and knowing the potential complications, it is simply not acceptable to carry out something of this magnitude on a child with no choice.

CHAPTER 3 - REASONS FOR PRACTICING FGM

In the following chapter there is an exploration of a broad variety of perspectives of why FGM is performed across a wide variety of African cultures. The reason why such a macro perspective was chosen is that it is important not only to get a broad overview of why FGM is performed, as well as an idea of how complex and interwoven the practice is with the identity of the peoples who perform it, but also to situate the phenomenon in its global context. It is also important to offer some balance to the anti-FGM side of the debate, to truly understand why it is done, instead of simply criticising the fact that it is done. This chapter contains a consideration of FGM as a cultural issue, how it relates to values, religious systems and beliefs (including both superstitions and cultural beliefs, and ones relating to health), its role in marriage politics and aesthetics, and finally the economic reasons for its continuance.

Because FGM is such a diverse practice, the reasons for doing it are myriad and complex. But, although there aren't simple, clear-cut, and easily applicable to all situations explanations, it is important for us to understand the reasons why it is done, if we are to have enough insight to be able to propose possible ways to abolish FGM. Although the following reasons for the practice of FGM are discussed separately, they are, in fact "interconnected and mutually re-enforcing and, taken together, form overwhelming unconscious and conscious motivations" (Ahmadu 2001)

Culture and Custom

Most of the people who practice female circumcision cite custom and tradition as their main reason for performing it (UNICEF 2005:17). Female circumcision is a practice that is intrinsically deeply rooted in culture and custom (Assaad 1995:22; Hosken 1979:3.1.3; Toubia 1995:13) and culture is the most commonly given reason for its practice. Throughout Africa, there is a very strong tradition of upholding customs and these can be traced back through many, many generations, always being passed on to the next. This can, however, sometimes lead to accusations of doing things because

“that is how they have always been done” with no questioning of why this is so (Hosken 1979:3.1.3; Mackie 2003:1004).

The procedure of female circumcision has been inextricably linked with the various cultures of those who do it. Elaborate rituals, ceremonies and celebrations have traditionally surrounded circumcision operations in many ethnic groups, as circumcision is often (but not always) seen as a part of the process of becoming an adult (Gruenbaum 2001:71). These may involve special rituals, songs and dances, gifts of money, clothes and food, and times where girls are taught how to be good wives and mothers. To the Rendille in Kenya, for example, bearing the pain of the circumcision stoically is a fundamental part of demonstrating the maturity to be considered an adult (Shell-Duncan & Hernlund 2001:16), and circumcision is done because it is “the only thing which separates [them] from animals.”

In some places these rites have now somewhat fallen by the wayside because of the influence of globalisation and because extended families have broken up with a modern way of life (Dorkenoo 1994:39; Hosken 1979:3.1.8; Ny’ang’a 1995:35), or because the rituals disappeared with the banning of FGM (Ahlberg et al. 2000:35). Many girls (especially those who are circumcised in hospitals or those done before puberty, as is becoming more common) now go through the circumcision without much ritual at all.

However, the mystic power of the ritual to transform girls into women, the kudos that they get from having had it done, or the condemnation, stigma and ridicule that they would face if they hadn’t, mean that women really have very little choice in whether or not they want the procedure done.

Religion

Many people who practice FGM believe that God sanctifies circumcision (Toubia 1995:15; Gruenbaum 2001:49) and a large proportion of women believe that there is a religious obligation for them to be circumcised (UNICEF 2005:17). In fact, the operation is called *tahari* in many places (Hosken 1979:3.1.10), and this comes from the Arabic

word *tahara*, meaning 'purification' (Abusharaf 2001:115), with its accompanying religious connotations. It seems impossible to escape the belief that female circumcision is done for religious reasons, although there is very little evidence for this apart from the strength of belief. And, although there is no religious duty to perform circumcisions in any of the religious texts, they are performed by peoples from many religions: Catholics, Protestants, Copts, Muslims and Falasha Jews.

FGM is also seen as being a particularly Muslim domain. There is a general perception among many Muslim groups that circumcisions are custom that is required by Islam, however, it is not mentioned in the Koran. There is also no consensus about whether or not there is obligation or encouragement to do it in interpretations of the Hadith (sayings attributed to the Prophet Mohammed), in which he said about circumcisions, "Do not go deep. That is enjoyable to the woman and is preferable to the husband," (as cited by Gruenbaum 2001:64). What is very clear that it is the practice of infibulation that is being forbidden, while that of excision may be preferable or even obligatory, depending on your interpretation. While circumcision is not sanctioned by many Islamic scholars (Gruenbaum 2001:63), neither is it condemned by Muslim (or Christian for that matter) leaders.

Circumcision is practiced by Christians from many denominations, and the Catholic Church in particular has come under fire for not speaking out against the custom, and in fact actually condoning the practice, so as not to lose its followers.

Because there has not been a strong call to end female circumcision practices by any major religious leaders, the practice continues, and continues in the name of religion.

Morality

In cultures which practice FGM, being a virgin at marriage is vitally important. Interestingly, in Sudan, there is a perception that virgins are not born, but made. Circumcision is mainly done, especially according to men when they are surveyed (Gruenbaum 2001:79), for the sexual repression of women and to safeguard a girl's

virginity, namely to “save her from temptation, suspicion or disgrace and preserve her chastity” (Assaad 1995:22). Infibulation is so effective at preventing sex that in some ethnic groups, just prior to the wedding, an examination of the bride is done. The smaller the hole left by her infibulation the more desirable she is, and the higher her bride price will be.

Being found not to be a virgin on her wedding night is grounds for a husband to divorce his bride, and the resultant shame is brought down on her whole family. This is the worst kind of shame a woman can possibly incur. Even rumours of a girl losing her virginity prenuptially can be cause for honour-killing in some instances, as once honour is lost it can never be restored. Therefore, circumcision is way of ensuring that both a woman’s and her family’s honour is preserved, and family honour really is an incredibly strong force in the Middle East and Africa.

There is a belief in many of these cultures that girls and women who have not been circumcised are promiscuous (Hosken 1979:3.1.9) and cannot control their sexual desires, and a woman’s sex drive is often seen to be something shameful (Friedman & Schustack 2006:415). It is said that an uncircumcised woman is weak and cannot help but try to fulfil these ‘animal desires’ to have extramarital or premarital sex, and so, by circumcising a woman you reduce her desire (Abushara 2000:124; Gruenbaum 2001:78) and therefore protect her from her own oversexed nature (Assaad 1995:22). Also, as many of the cultures which practice FGM also practice polygamy, it also helps the men if their wives are not too sexually demanding. Circumcision is also used as a tool to both cure and prevent sexual deviance (Toubia 1995:15).

Girls who have not been infibulated may therefore find themselves being passed over in favour of those who have (Gruenbaum 2001:46) because they do not come with the same guarantee of either virginity or marital fidelity that circumcision supposedly offers.

Also, if circumcision is necessary for marriage, then having it done ensures that a woman will have the support, respect and honour in her old age in a society whose only security system in this regard is her children.

Marriage

Women in cultures which practice FGM generally have very little education and very high rates of illiteracy. Because the women have so little access to education, they are completely reliant on their marriages (which are often arranged ones) to provide them with their basic needs, as there are extremely few employment and other opportunities available to them (Gruenbaum 2001:88). In many communities the only land a woman has access to, and can work for food, is her husband's. Marriage is so critical to the women in these societies because it is the only way that they have of gaining social status, acceptance, and economic security, and circumcision legitimises their reproductive capabilities.

For these women, their entire value is tied up in their ability to have children – especially sons – and they often stand a much higher chance of being divorced if they do not provide children for their husbands (Balk 2001:61). Also, their children will provide them with the only security in their old age, as there is no real government-provided social security system in many African countries. Marriage in these kinds of cultures is absolutely critical for a woman's current and future survival, and if being circumcised increases her marriageability then there is no real choice to be made.

Beauty and Cleanliness

Body modifications in the name of beauty have been with humans for as long as we have had a sense of cultural and ethnic identity, and the genitals have certainly not been exempt from this. In fact, they have often received special attention when it comes to body modifications and cosmetic surgeries.

Circumcisions are often performed because of a sense of aesthetics: a woman who is circumcised is said to be more beautiful, more 'finished', and more hygienic, than one who has not (Assaad 1995:22; Gruenbaum 2001:79; Toubia 1995:14). Abusharaf (2001:122) tells of the saying used by the relatives of girls about to be circumcised in Douroshaba, to remind the circumciser what needs to be done: *sawihoo amalas wa samih zai dahar elhamama*, "make it smooth and beautiful like the back of a pigeon."

Being circumcised is a desired thing for girls, because it is the “fashionable thing to do to become a real woman” (Assaad 1995:15), an idea which, although it seems strange to Westerners that something like genital mutilation could be considered a fashionable thing to have done, connects both the desire of children to reach adulthood and their desperate wanting to fit into their peer groups.

Male Protection and Approval

The common thread running through all the ethnic groups in Africa practising FGM is that they are patrilineal-based societies. In other words, these cultures are male-dominated societies where resources and power are generally under male control.

Efua Dorkenoo (1994:45)

In societies which practice FGM, the right to own property is generally limited to men, and many of them are polygynous. It is necessary for women to marry, in order to have a home, and many women become second or third wives in order to secure their futures. Generally, these sorts of cultures benefit the men, but place enormous strain on the women, as they and their children compete for shared of resources and favour. Many women who are first wives find themselves in the position of having to have child after child in order to satisfy their husband’s desire to have many children, in an attempt to ensure that he does not marry a second woman. Those that are unable to have children find themselves divorced and out in the cold after a few years. As difficult as it may be to be in a marriage like this for a lot of women, it is an absolute necessity in a culture where you do not have rights of your own, and being circumcised is necessary in order for women to get married.

Men say that circumcision is a women’s issue that they have nothing to do with, but it is performed for their benefits. Apart from the fact that circumcision is often a recognition of a woman’s initiation as a member of more status in the tribe and it allows her to become eligible for marriage, another reason that is commonly given for circumcision is the belief that it enhances masculine pleasure by increasing the friction provided (Gruenbaum 2001:128; Hosken 19797:3.1.15; Toubia 1995:15), and, in some

ethnic groups, it is said that women's circumcision is necessary in order for men to enjoy sex. Many men say that they would never marry an uncircumcised woman, because they are promiscuous and are prostitutes, and so they drive the 'marriage-market', as it were, towards women who have been circumcised. Also, there have often been migrant workers who make their wives undergo infibulation so that they cannot be unfaithful while their husbands are away. Clearly, men *are* sitting on the fence when it comes to the issue of female circumcision.

Health

Many women do not have access to much education and in many FGM-practicing communities they are taught that circumcision prevents and protects from both maternal and infant mortality (Toubia 1995:15; Hosken 1979:3.1.13) even though the opposite is true. Some groups, such as the Tagouna of the Ivory Coast believe that a woman who has not been circumcised can not conceive (Dorkenoo 1994:36). Understandably, there are very few women who are willing to put these theories to the test, as their livelihoods very often ride on their fecundity.

Superstitions

Traditional beliefs often run very deeply, and they can have a big impact on the way people perceive the world. The Mossi of Burkina Faso and the Yoruba in Nigeria believe that if the clitoris touches a newborn's head during the birth process, it would kill it (Orubuloye et al. 2001:73), while the Bambara of Mali believe that the clitoris secretes a poison that could kill a man on contact with the penis (Dorkenoo 1994:34; Mackie 2003:1009). In many areas of Ethiopia they believe that the female genitals will keep on growing and growing unless removed (Assaad 1995:22; Dorkenoo 1994:34; Gruenbaum 2001:67; Hosken 1979:3.1.14), and so women are frightened into getting rid of their sexual organs. Fear is one of the very strong undercurrents that pin FGM, as women are not only afraid of the pain, which is, of course, blatant, but the whole process is shrouded with mystery and a sort of magic that transforms them to adulthood and its accompanying elevation in status.

Many cultures, from Kenya to Egypt and Sudan also share the belief that all people are in some way hermaphroditic. Boys are born with female attributes (foreskins, analogous to the labia) and girls with male ones (the clitoris, analogous to the penis). These must be removed in order for the person's gender to be clearly delineated.

Economics

Many people (including barbers, midwives and doctors) make a lot of money from doing the circumcision operations (Gruenbaum 2001:105; Hosken 1979:3.1.12) as it is an extremely regular income and they are paid for doing each one. Also midwives (who comprise most FGM practitioners across Africa) do not want to settle in areas where FGM is not performed, as they cannot make enough money without them, which makes it very difficult for those communities who do not circumcise to get timeous help with childbirth.

Most importantly, however, the midwives who perform circumcisions are also usually eminent figures in their communities, such as counsellors and religious advisers. This role is very intimidating and, as Eufa Dorkenoo (1994:51) points out, "It is not surprising that any attack on these women is perceived by many people as an attack on the respected older women of the community."

While it is clear that FGM is performed for many reasons, the lesson to be learned here is that there is always a very complex ideology that surrounds it. Entire belief and value systems are based on it, and it forms the basis of cultural, sexual, gender and maternal identity for millions of women. What is important is that, while efforts are being made to reduce and eventually eliminate FGM completely, the voices of the people who practice it are heard, and their fears and worries need to be appeased. Such a complex issue requires a very sensitive and multi-faceted approach if its elimination is to stand any chance of being successful.

CHAPTER 4 - ANTI-FGM INITIATIVES

In order to understand why genital mutilation is still so prevalent, it is important to understand what measures have been taken to eliminate it. This chapter will contain a very brief review of the movements that have tried to eliminate FGM, from international policy through to community-level campaigns.

Although female genital mutilation has been around for millennia, the globally organised counter campaigns have only been in force extremely recently, much more recently than might be expected. Although the importance of international involvement in the protection of human rights was recognised by the UN in 1949, women's issues were simply not recognised at that point.

Women's rights and health issues went unnoticed for many years and the case of FGM was further complicated, because it "is not a disease, rather...it is part of the social control of girls and women in many developing countries – but with profound health consequences – and as such it is a very 'sensitive' and difficult area in which to work" (Dorkenoo 1994:67).

Even though there were clearly health issues involved, the UN and other organisations were extremely reluctant to get involved in a problem that they thought was under firmly the jurisdiction of the states' sovereignties, and were even more reluctant to interfere in, or even recognise as a problem, something that they considered to be a cultural practice. It took until the late 70's & early 80's for the United Nations', UNICEF's, the World Health Organisation's and Amnesty International's human rights policies and declarations specifically on women's health and, only later female genital mutilation to materialise (Dorkenoo 1994:63), only after they had decided that the human rights violation overrode the cultural justification.

Another problem was with getting FGM onto the table: often the way organisations decided which issues to focus on, relied on the member states to raise the

issues which concerned their country. Because of the culturally-sanctioned nature of FGM, it was simply not recognised as being a concern of anybody's, pertaining to human rights or otherwise, and many African delegates – both men and women – so strongly objected when it was put on the agenda for the first time that they walked out of conferences. It was seen as much less important or relevant an issue than the provision of medicines and food, for example.

FGM was not recognised as being gender-based violence and approached as such until 1993 (Dorkenoo 1994:65). Now, however, FGM is a part of the mainstream development organisations' consciousness. NGOs and international forums have raised the issues and developed programmes to deal specifically with genital mutilations, and researchers and scholars have written about and explored FGM in an effort to publicise and understand it.

However, the fact that there are 3 million girls who undergo female circumcision every year indicates that these global awareness campaigns and development programmes are only having a limited impact. While there does seem to be some data to indicate that in some places there may be a reduction in FGM, there is not enough of a decrease yet to indicate a global trend (UNICEF 2005) or to make any kind of announcement about this slight reduction.

It is important to have a general look at what efforts made to eliminate FGM have met with success, and weigh these with the reasons why FGM is performed, in order to see why they have had an impact.

Firstly, there have been many international and local publicity campaigns over the years, and the media has been instrumental in bringing the issue to the public consciousness, as well as starting to open up the debate among communities which practice FGM. It is still important for the media to keep changing international, national and local attitudes towards it.

However, when one does away with a tradition that has been an important marker of achievement in peoples' lives for many, many years, there is the danger that a void will be left, and the change abandoned. In places where FGM is equated with

coming-of-age ceremonies and rights, particularly in Kenya, alternative rituals, what Hernlund (2001) calls “ritual without cutting” (235) have successfully replaced the actual circumcision. The ‘cutting with words’ instead of with blades means that people feel that their traditions are still being upheld, and the important celebration still happens, so that stopping the circumcisions doesn’t make people feel like they’re having to sacrifice their culture. A similar situation, in which replacing circumcision with an alternative ritual has happened, has been effective where FGM is used as part of the initiation into secret societies or other women’s groups.

Another effective tactic has been when programmes involve the health- and other community-care professionals, such as doctors, nurses and social workers, as well as teachers: people who are at the forefront of the education and support of those affected by FGM, who are capable of monitoring the children of the community over long periods of time to ensure their parents compliance with the anti-FGM laws, and who have built up relationships of trust with the people in the community.

Laws in place to criminalise FGM and to protect children from it are an obvious step to take because so many of the countries in which FGM is a common practice have not actually criminalised it, but the simple fact of their existence in a country’s legislature is not enough. Laws have only been effective in helping to reduce the prevalence of FGM as long as they are actually monitored and enforced, and where, when violations are found, they are appropriately punished by the judicial system.

Of course, another obvious step that many NGOs who have been involved in trying to reduce FGM, is, in order to try to eliminate the economic causes of FGM, to teach other skill-sets to those who earn their living from circumcisions. However, retraining cutters has had limited success, and in some instances has been almost completely ineffective (Mackie 2001:272). This is because circumcision in the areas where this retraining has not worked has remained a service that is very much in demand. If this is the case, there is always the temptation for the cutters to continue to make money in their old professions as well as in their new ones, but even if cutters comply, as long as the service is in demand, other people may step in to take their places. The retraining of circumcisers needs to be accompanied by a decrease in

demand, and this comes through a much wider-focussed series of programmes, one that approaches the broader community too.

In Senegal, in the approximately 3000-strong village of Malicounda Bambara, a pledge was drawn up and a collective declaration was made to immediately stop FGM Mackie (2001:256). It all started with a women's education programme, one which taught critical-thinking (among other useful skills that could be used to improve economic opportunities), and did not directly focus on FGM itself. When the discussion module about FGM was proposed, months into the programme and after having gained the trust of the women involved, they completely refused to discuss it. It took days before they would even start talking about it, but once they did they realised that they shared a lot of common experiences, and that a lot of the problems that they had never attributed to FGM were, in fact, caused by it. The education programme was non-directive, and this is what makes it extremely effective: "Nondirective education works. Harsh propaganda backfires" (Mackie 2001:256). Of course if an outsider comes into a village and starts telling people that their traditions are wrong, they are going to be extremely resistant to the message, and will likely end up ignoring it completely. What made this particular campaign so effective is that the people were never told what to do. They made their own decisions, and their shared negative experiences with genital mutilations are what led these women to decide for themselves to do away with FGM in their village. When the genital mutilations ended, the people made their own decisions to do so, although they were, in part, influenced by the anti-FGM campaign.

This shows that education campaigns, while extremely effective in raising awareness, also need to make the communities take action, and for that they need a platform where they can be their own agents. Respect, for the people, their beliefs and traditions, and their views and opinions, needs to be at the heart of anti-FGM campaigns and programmes, if they are going to have the impact they desire and be effective.

CHAPTER 5 - MICRO SCALE UNDERSTANDINGS OF FGM

It is important too, as well as to understand the broader, national and international contexts of FGM, to also understand the women involved on a more individual level. In this chapter, there is a discussion of why women would choose to perpetuate FGM on their daughters, knowing, as they do, at least partially, the impact that it is going to have on the rest of their lives. This is followed by the perspective of female genital mutilation that has been shared by women who have emigrated from Africa, to offer some perspective, as women who are still in Africa are enmeshed in the culture and tradition which makes FGM necessary.

5.1 Why women would perpetuate FGM

In all societies, there are very clear sex roles (Blaffer Hrdy 2000:259-261), and gender is not only an extremely important component of our identities, but the idea of what is 'feminine' can also be translated across cultures (Hook et al. 2002:330). Women as a gender are seen as passive and weak in a lot of cultures, and these traits are observed by and actively encouraged in girls whose cultures practice FGM (Weiten 2001:478). They are also not as favoured or desired as boy-children. There are often no celebrations when the child born is a girl, but for a boy, gifts are given and a party is held. A wife who gives her husband sons has a higher status than those that produce only daughters, or even worse, no children at all.

Girls are treated differently to boys: working physically harder and starting their responsibilities of caring for the family younger while their brothers are still playing. Often there is a big discrepancy between the literacy rates of men and women too, with boys being allowed to stay in school much longer than girls. This gender polarisation means that girls are socialised to behave modestly and chastely, and to be self-effacing,

obedient and humble (Blaffer Hrdy 2000:259-260; Dorkenoo 1994:54), especially sexually, and this means that many of the freedoms that boys take for granted are curtailed for girls. They are groomed to spend their lives yielding to male authority and desires, and ignoring their own. They are also married off young, often just at the age of menarche, while men marry much later and enjoy many more years of freedom.

Marriageability is an intrinsic part of gender identity, and is the source of social status and economic security in cultures which practise FGM (Abushara 2000:131) and in these, like the vast majority of others, women are almost always seen as inferior to men (Ruddick 1980:115). Men have always felt a need to tame and 'break-in' the women that they make their wives (Blaffer Hrdy 2000:262), and to control and dominate them. In many cultures, wives and daughters have also been sequestered, kept away from the masculine world for the 'protection' of their modesty and virginity (Blaffer Hrdy 2000:260; Cloudsley 1983:26) and FGM, an important part of the socialisation process and gender identification (Balk 2000:69; Bosch 2001:1178), is a physical extension of the sequestration, making a woman a "chastity belt made of her own flesh" (Toubia 1995:12).

But women who are mothers do have a strong influence over one sphere in their lives: their children. Without the dedicated care of their mothers, a baby (especially one where resources are limited) is extremely unlikely to survive, so women do exercise an important power in this arena, even if they can exercise very little elsewhere in their lives, being suppressed by men, family and society. Mothers spend more time with their children than anyone else, and so should have more of an influence over their children's beliefs and values than anyone else, even if the status of her role in their lives is inferior to that of the father. When a woman socialises her children, she is doing it to both boys and girls, teaching them to be men and women, in effect training the next generation of the oppressed and oppressor.

Also, a mother is under another pressure when it comes to the choices she makes in raising her children. Even if a mother does not want her daughter to suffer through FGM, she may not have much say in the matter. In order to be a 'good' mother, she must raise her children to believe in the values and ideals of the society, even though this means colluding in her own subordination and that of her daughters. In order

to raise a child that becomes “the sort of adult that she can appreciate and others can accept” (Ruddick 1980:111) she would find herself in the position of training her daughters to be powerless, too.

The strain of colluding in one’s powerlessness, coupled with the frequent and much greater strain of betraying the children one has tended would be insupportable if conscious. ... In addition, she may blind herself to the implications of her obedience, a blindness excused and exacerbated by the cheeriness of denial.

Sara Ruddick (1980:115)

Regardless of her own horrible experience with genital mutilation, a mother, in denial of the harm she will do her daughter, can justify to herself that having her daughter circumcised will be for her own good as well as that of her society. Proof of this sort of confusion about their emotions concerning the circumcision of their children can be found, for example, in the mothers who want to let a girl get a bit older before circumcising her because, “She’s too young”, or in an account by a Sudanese woman called Aziza (in Abushara 2000), in which she says, that, although she is going to have her own three daughters circumcised because it is a good thing to do, she will not have the ‘pharaonic one’ (infibulation), like her own, done, because it “is very cruel”.

Because she is influenced not only by her mother’s behaviour and beliefs, a girl child will also want to conform to the external influences of society’s ideals of how she should behave. She will be pressured too, by her extended family: grandmothers, aunts, sisters and cousins, and her peers: other women and girls who tell her that to be circumcised is a good thing. Even if her mother is resistant to having the girl circumcised, it may be something she desires for herself, in order to feel ‘normal’, with no real understanding of the consequences that it will bear.

The only way to try to make sense of the fact that mothers who circumcise their daughters know they are going to cause them great pain, and then do it anyway, is to assume that mothers who circumcise their daughters are doing what they believe to be best for their daughters. They are, from their point of view, in fact protecting them (Blaffer Hrdy 2000:260) by ensuring that they have access to the most basic of

resources, which are only available through marriage (Bosch 2001: 1178). Mothers are put in the incredibly difficult position of knowing that they are going to cause extreme pain to their daughters, in order to make them socially acceptable.

The fact that circumcisions continue to be perpetuated on successive generations of women is also a result of power inequalities and community pressure (Bosch 2001:1178). Most (virtually all) of the people involved in the performing of FGM are women, and specifically they are the older women. It seems counter-intuitive that a woman who has gone through the trauma of a circumcision themselves would encourage, or even force, a younger woman or girl to do the same thing, and yet this is exactly what happens. Why?

In order to answer this, one has to look at the structure of the family in the cultures that practice FGM. Aziza, a woman interviewed by Abushara (2000:125) (mentioned previously) says that she will lie to her family and in-laws and tell them that her excised daughters have already been infibulated, because otherwise she fears that they will take the girls to be infibulated themselves. When a young woman becomes a bride she lives with her husband's extended family, has a very low social rank, her behaviour is very tightly controlled and monitored by the other women in the family, and she does not have much complete say over anything, not even what happens to her own children. It is only after she has passed menopause and can no longer bear children that there is no longer any need to control her, and it is at this point that, for the first time in her life, that she becomes a full member of society, finally gaining the respect and equality that men have had all their lives.

It is no wonder that, having finally gained this little bit of power, women in cultures which practice FGM are determined to make the most of it. The area over which they have the most control is the family, and specifically they have most control over the younger women and girls in their family. Gruenbaum (2001:19) interviewed a man named Mohammed in Khartoum who was reluctant to leave the country to go to a conference because he thought that his mother and mother-in-law would have his daughters circumcised in his absence, even though they knew it was against his wishes. The fact that they would have dismissed what he wanted by saying, "It's not men's

business,” may also be a reflection of one generation of women making a very strong stamp of female authority over another (Abushara 2000, 122; Ahmadu 1995).

The odd dichotomy here is resolved – although it is the women driving the circumcisions and making the choices, having the “upper hand in determining when, how and where a girl will be excised” (Abushara 2000:121) not the men, they do it with such enthusiasm because of the trauma they themselves have suffered. In fact, younger women may actually increase their own social standing and gain approval from the elder women in the family when they have their daughters circumcised.

However, there needs to be the recognition that, although women are the ones who directly perpetuate this practice, they do it *because* of their powerlessness in their male-dominated societies.

5.2 Emigrant Experiences: Making Different Decisions

There were more than 500 000 women and girls who were directly affected by FGM in the European Union in 2006 (Poldermans 2006:1), and this number has continued to grow rapidly as more women emigrate to, or become refugees in the EU from communities that practice FGM. Many of them have already been circumcised, but some of the younger girls have and will continue to be sent back to Africa to have their circumcisions done. The women from these communities find themselves in a very difficult situation, as they are torn between the two conflicting ideologies they now find themselves living in.

Because female circumcision is such an intrinsic part of their culture, many women who emigrate do not simply abandon it just because they come to the West, but instead of being openly celebrated as before, it has become a closely guarded secret (Dorkenoo 1994:127). Genital mutilations are covertly performed by doctors and nurses from emigrant communities, or girls are secretly sent to relatives and friends back home during school holidays to have theirs done. There have even been cases, some tragic which is how they ended up being reported, of parents attempting to perform them themselves.

In the UK, the most vulnerable age for girls to be circumcised is between the ages of 5 and 10, while in France girls under 5 are most commonly circumcised (Dorkenoo 1994:131).

The West has responded with a rash of laws which aim to protect young girls from these emigrant communities. There are specific laws that ban and criminalise female circumcisions in the United Kingdom, Norway, Denmark, Sweden, Belgium, Austria, Switzerland, the United States and Canada (Afbusharaf 2001:115; Bosch 2001: 1178; Poldermans 2006:2; UNICEF 2005:2). In France and Italy, as well as in an increasing number of other countries, FGM is dealt with under the child-abuse and assault laws (Dorkenoo 1995:47).

But this puts emigrant women in a difficult position. Suddenly something that has been a cornerstone of their very gender and cultural identities, something which has been both routine and something to be proud of, is condemned as illegal, and morally wrong. Many of them have never even considered that there is an alternative to getting circumcised and having their daughters circumcised, and only realise for the first time that female circumcisions aren't something necessary for women to have done, and that it is something that isn't done in every country, when they come to the West and are exposed to an alternative school of thought. (Berggren et al. 2006:52; Hosken 1979:3.1.9; Johansen 2002).

This realisation often brings with it an enormous emotional conflict for immigrant women. Their "taken-for-granted cultural and social norms have become explicit and subject to question, thus calling forth a more articulated and conscious consideration of personal experience, cultural models, and the relationship between the two" (Johansen 2002:314). They are forced to re-examine their very identity, both as individuals and that of their culture, and try to make sense of it again.

This means that many emigrant women start to look at and re-assess their own circumcisions. Many of them now begin to question the relevance and meaning of their own circumcisions, and start to ask questions about why they had to go through the immense pain of being closed only to have to go through that of being opened again

(Johansen 2002:323) often time and time again. The pain of their circumcisions, which was simply seen as a necessary and non-negotiable (and sometimes desirable) occurrence in their lives, is now re-interpreted in their new contexts.

The younger generation of women emigrants also experience circumcision differently than they would at home. They are exposed to two conflicting ideologies, not only on identity but also on sexuality (Johnsdotter & Essén 2004:1) and are not as conditioned as their mothers to unquestioningly accept their cultures, and so examine the necessity of circumcision even more. Young adolescents who have been circumcised need special support, places where they can talk to each other outside of their communities, and strong female role models that they can look up to (Dorkenoo 1994: 159) in order to be able to cope with their experiences.

Although some of the women who have emigrated to the West understandably don't want to talk about FGM outside of their communities (Bosch, 2001: 1778; Berggren et al. 2006:51) because of the fear of being judged, others find that being in the West allows an opening of dialogue that was simply not possible before. Whereas it most likely was never spoken about before, probably because when everyone shares a similar experience then it becomes completely unremarkable, it now is something that provokes a lot of new thought.

This new re-assessment can be extremely painful, as a lot of the trauma comes to the fore. R. Elise B. Johansen (2002) speaks of Somalian emigrants in Norway who admit that they have never been able to forget the pain and have been extremely traumatised by their circumcisions. Not only do they remember the pain, but many are also haunted by the memory of the smell and sight of their own blood, and the sounds of their flesh being cut. Emigrant women admit what few women still in their own countries dare to, that the pain is an "unnatural pain" (Johansen 2002:324) and going through it is like experiencing death. Many women actually saw the circumcision at the time as a betrayal by their mothers (Berggren et al. 2006:53), something which would simply not be understood in a context where their mother feels that she is doing the best for her daughter. Also, many emigrant women admit that they have had flashbacks to the circumcision experience when de-infibulated for their marriages or during their labours, classic indications that they have been severely traumatised by their experience.

Something else that would never be acceptable for women to admit at home, is the immense sense of loss that some of them feel about their circumcisions too. Many feel, as well as feeling like they have lost a lot of their sexual pleasure, like their body parts are missing, and they feel an urge, a longing, to be able to find them again.

They find themselves in an odd conundrum, feeling a “double shame” (Berggren et al. 2006:52), as being uncircumcised is shameful in their countries of origin, but now, being circumcised is shameful in the new culture they’re trying to adapt to in the country they’ve emigrated to. The context of being in the West changes their perception of their circumcision from that of “purification” to “amputation” (Johansen 2002:325).

From the experiences of emigrant women, it is possible to see that experiences of genital mutilation are extremely distressing, regardless of the justifications, explanations, beliefs and fears which drive the process forward. Because the consequences, be they social, metaphysical or otherwise, are so dire though, millions of women go through their lives not admitting the deep pain that their mutilation has caused them, and continuing to perpetuate it on each successive generation.

Once they are given another option, many women confront their fears and choose to stop the cycle of female genital mutilations.

We have sufficient proof that once women, especially young mothers, learn about themselves, their body and the undue suffering they may cause to their little daughters, once they are reassured about the future of their daughters and that there is no connection between this operation and their moral behaviour or physical growth, they immediately say “NO” to FGM. We can cite many examples of younger sisters who have been saved because their mother or older sister learned the truth.

Ng’ang’a, 1995

CHAPTER 6 - EFFECTIVELY ELIMINATING FGM

This chapter combines the reasons for FGM's presence in so many cultures, with the efforts that have been made in the past to try and reduce it, in order to try to propose a more holistic approach to the anti-genital mutilation movement, which would have a bigger impact on reducing the prevalence of FGM.

There is no denying that female genital mutilation is an extreme form of gender discrimination, and one which needs to be put to a stop. The United Nations Declaration on the Elimination of Violence against Women (1994) obliges states 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 inferiority or superiority of either of the sexes or on stereotyped roles for men and women.

Eliminating FGM needs to be the focus of a concerted effort, not just on the part of international organisations and NGOs, but particularly on the part of the governments of the countries in which FGM is an acceptable occurrence. Too often they have paid lip-service, banning FGM, and then a few years later banning it again, and again, because they have not done anything in the meanwhile to actually help communities to facilitate the end of the practice. The most important aspect of developing a programme is engaging with the community, and getting the people who will be affected involved.

From the experiences told by emigrants, it is clear that the first thing which needs to be done in the effort to combat FGM is to break the silence surrounding it. Once women are no longer afraid to talk about and share their experiences with genital mutilation, then they can begin to become active agents in the change, for their lives and for those of their children.

Education for women is also absolutely crucial, because it leads to empowerment (Assaad 1995:25-25; Dorkenoo 1994:47). Generally, the more education a woman has received, the less likely she is to have had her daughter/s circumcised (UNICEF 2005:9,16). Also a re-education in specific healthcare is necessary, as often women are “wrongly educated”, having been instilled with beliefs and superstitions that they are too afraid to test, but which can be medically disproven. Because women who have already been circumcised and those who have low levels of education are more likely to circumcise their daughters (UNICEF 2005; Nwajei & Otiono 2003:575) campaigns need to be specifically targeted at them. But the education in this process should not just be a female domain. Men, because they help to drive the process, also need to be educated about the consequences of FGM.

The link between FGM and chastity must be destroyed if it is ever to be eliminated, and women must have viable alternatives to getting married and to marrying off their daughters. The cycle of needing to be married to survive, and needing to be circumcised to be married, needs to be broken, which means empowering them on all sorts of levels.

There is also an important focus that needs to be placed on emigrant families and communities too. There needs to be an understanding that, like all emigrants, they will want to try to preserve their culture from home, and they may even idealise it, and some of them may still see FGM as a positive tradition that should be held on to, regardless. Of course, emigrant families are also under a different pressure, in that they may feel that they (and especially their daughters) are embedded in a more sexually decadent and therefore threatening culture than the one they left behind, and may therefore want to hold onto their previous customs even more. Dealing with the worries of parents in this situation is going to need particular attention and care.

Clearly there needs to be funding for widespread anti-FGM campaigns, and specific programmes to focus on FGM, but these also need to take into consideration the very complex ideologies of the specific communities involved. There have been (spectacularly ineffectual) campaigns that have used a one-size-fits-all approach, which have, of course, been deemed to be completely irrelevant by the communities involved. Often the programmes have been too local, with not enough regional reach, and many

community and NGO programmes do not reach large sections of the people who practice FGM (WHO 2006). Because FGM is often perceived to be a religious obligation, men and women with religious influence, who are respected in the community, must be involved in the campaigns and programmes.

Programmes must be representative of the specific ethnic and regional groups in which they are based, their socio-economic circumstances, and their specific practices. Communities must be involved in and must drive the process, as the only way that something so fundamental to identity can be changed is if it is voluntary. What campaigns do not need is patronising interference. Change has to come with a community-wide change in attitudes, and this, again, means empowering women and girls on all levels (UNICEF 2005:28).

Because for a lot of ethnic groups the circumcision is a special, ritual-rich, and culturally significant time, alternative celebrations that include the same elements (such as initiations) need to replace the custom entirely (Dorkenoo, 1994:51). Simply eliminating the circumcision and leaving a void would be extremely ineffectual, would obviously be resisted, and could lead to instances such as the one where the adolescent girls in Meru, Kenya, ended up circumcising each other in order to defy the ban on it (Thomas 2001:129). It is up to the communities involved to decide on which significant rituals they would like to replace the circumcision with.

However, although a community-scale effort is needed, in order to eliminate FGM there also needs to be a more macro-scale intervention. More countries to bring in anti-FGM laws are needed, but deciding what kind of law is appropriate will require careful thought (Toubia 1995:17). The basic starting points are *the Universal Declaration of Human Rights*, the *UN Convention on the Rights of the Child* and the *Convention on the Elimination of All Forms of Violence against Women* (See Dorkenoo 1995:48-50), but national laws are even more important, as they are used to ensure compliance with the international ones. Laws concerning FGM in Africa have gone largely unenforced when they even exist (Dorkenoo 1995:47) by governments who have turned a blind eye. There need to be sanctions and financial consequences for governments who don't fulfil their responsibilities to international laws.

There need to be clear policy declarations and monitoring to make sure that policies are being implemented in Africa. The usual response to FGM in the West has been to criminalise it, which has had the undesirable effect of driving it underground instead of reducing its occurrence (Dorkenoo 1995:45). There do need to be laws that prosecute parents and practitioners who violate anti-FGM law, to ensure compliance, but the welfare of the child must remain paramount at all times. Lastly, there needs to be more international co-operation and accountability of these laws, so that it not possible to travel back to Africa (exploiting the current legal loophole) to have girls circumcised, the way it is now.

Circumcision should be classified as child abuse, but it is a complex issue, and it needs to be dealt with with sensitivity and the understanding that, even though they are causing the injury of their children, parents are doing it because they love them and want to improve their chances of success. Their position needs to be understood and their voices heard (Shweder 2003:228) but the resolve to protect girls at risk should remain firm. Regardless of the well-meaning intentions of the parents, the end result is indisputably grievous bodily harm.

As well as country- and community- scale interventions, assistance on an individual level is necessary too. Couples need sexual and relationship counselling to deal with the problems that FGM (and other gender-related issues) cause in their relationships, and to help husbands and wives to relate to each other on more equal footing. There must also be counselling and education to help mothers understand that their daughters, and men their wives, will not be 'abnormal' if not circumcised. Only if this message is widely appreciated, can change begin to happen.

The media, whether in the West or in Africa, because it reaches so many people, has an important obligation to play a large role in the education and anti-FGM campaigns, but they have generally not been living up to this. Although they have made people in the West aware of genital mutilation and therefore helped with awareness and funding, they have, because of their usual sensationalising tactics (Dorkenoo 1994:62), been some the major contributors to the alienation of African women from Western ones, in this regard. They must "broaden the scope of their presentation of FGM ... to increase the in-

depth understanding of this practice” (Dorkenoo 1994:62) again, recognising that the voices of the people involved are relevant and deserve to be heard too.

There has been much controversy surrounding the medicalisation of the circumcision practices, and many campaigners have rejected it for fear that doing so will legitimise circumcision. Although this is a valid fear, even relatively minor medical interventions, such as sterile equipment and local anaesthetics, can drastically reduce the incidences of complications (Ahmadu 1995:303; Shell-Duncan et al. 2001:126), potentially saving and easing many lives. This should be seen as an intermediate step, allowing time for campaigns to take effect. Furthermore, because the industry of circumcisions is also driven by the economic needs of the midwives and circumcisers who do the operations, there also needs to be alternate sources of income, training and wider financial incentives for communities, in order to stop the practitioners from continuing to promote the practice.

However, what is clear is that female genital mutilation is a (albeit extreme) symptom of the fact that women are oppressed and discriminated against, and part of the reason why there has not yet been a large reduction in FGM in spite of campaigns is that the bigger picture is not being tackled. FGM is only one more example of the ways in which women are subordinated and subjugated. Until women are fully empowered, FGM and other ways of oppressing women will continue, as women do whatever they have to, to survive in patriarchal cultures.

It is important to emphasize that FGM is a part of a persistent global situation in which women remain powerless because they lack access to resources, jobs, and education and in which women’s bodies are controlled by a male-dominated social ideology. A global action against FGM cannot undertake to abolish this one violation of efforts to address the social and economic injustice women face the world over. If women are to be considered as equal and responsible members of society, no aspect of their physical, psychological, or sexual integrity can be compromised.

Nahid Toubia (1995:19)

CHAPTER 7 - CONCLUSION

The traditional practice of female genital mutilation has become an escalating political and ethical problem in countries the world over, as the West is increasingly becoming home to more African emigrants who bring the tradition of FGM with them.

This project sought to answer two questions: why FGM would still be so prevalent, in spite of the fact that that it had been the target of much funding and rhetoric in the development community, and also, why women who have been through the experience would continue to perpetuate it, seemingly counter-intuitively. It did this by first outlining why the practice is so prevalent and why it is so embedded in the value-systems and cultures of so many diverse ethnic groups, in spite of the fact that many of them have completely different ideologies and reasons for their practices. It then looked at the motivations for the women continuing this tradition, doing so because of their powerlessness in their own communities, as well as the fact that many women who have been circumcised have been severely traumatised by the experience and live their lives in denial, without the ability to effectively confront their pain and move past it.

The lack of concrete results of anti-FGM programmes was attributed to the one-size-fits-all nature which some of them have had, and mainly to the fact that they have been very condescending in telling people that their long-standing traditions are wrong. From the holistic understanding of the nature of FGM practices that has been obtained by looking at FGM on global, regional and individual levels, proposals were put forward to help make these programmes more effective, including the most important factor for programmes to incorporate: the self-agency of communities. If communities are involved in making the changes and decisions for themselves then, when they decide to do away with FGM, the change is swift, permanent, and it spreads to the surrounding region.

Female genital mutilation has been identified in this report as being a symptom of the larger problem of the oppression and inequality of women, universally. When women are given alternatives to needing to be circumcised to marry, or alternatives to

having to get their daughters married off in order for them to survive, then they take them, indicating that the elimination of FGM is something that they desire. Until women are given basic necessities like equal education opportunities and land-ownership rights, they are going to continue to be exploited and oppressed, and they are going to continue to go to extraordinary lengths, like having their genitals cut off, so as to survive in these patriarchal societies. Until women are fully recognised and empowered, they will not be able to achieve their just potential.

The lack of empowerment of billions of women is not a small issue to try to remedy, but it nonetheless is one of the most vital issues that the development community and governments have an obligation to deal with, the continued violation of women on a simply massive scale being the biggest human rights violation in the world today.

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