

# **Female Genital Mutilation: Policies to Encourage Abandonment**

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## Abstract

*Female Genital Mutilation (FGM) also known as Female Genital Cutting (FGC) captured my interest the first time I heard about the practice. I assumed, wrongly, that it was only practiced in remote areas of Africa where educational opportunities were few and outside influences were nil. After researching the topic it is clear that is not the case. FGM is practiced in many countries in Africa, the Middle East, and around the world. It is a barbaric practice that has no religious significance and is incredibly harmful to women and their health, both mentally and physically.*

*I focused my research on Egypt. It demonstrates high numbers of FGM among a fairly educated and contemporary culture. I analyzed data gathered by the Demographic and Health Surveys of the U.S. Agency for International Development. Preliminary results show banning or outlawing FGM does nothing, but that awareness and education are slowly changing the tide and promoting the abandonment of FGM.*

## Introduction

“Female Mutilation has no cultural, no traditional and no religious aspect. It is a crime which seeks justice.” (Dirie & Miller, 1999)

Female Genital Mutilation (FGM) also known as Female Genital Cutting (FGC) is a severe violation of girl’s and women’s human rights and is extremely hazardous to their health, both physically and mentally. FGM is practiced in many countries in Africa, the Middle East, and around the world. It is a barbaric practice that has no known religious significance and is incredibly harmful to children and women. Its practice is strictly cultural and not for any useful or constructive purpose. Incredibly, it is usually performed and encouraged by the women in the villages rather than the men. These women feel they are doing their daughters and granddaughters a disservice if they do not cut them. (Dirie & Miller, 1999) While outlawing the practice seems the obvious solution, studies show that outlawing alone does not stop the practice, it just continues in private by unskilled hands.

*The child, completely naked, is made to sit on a low stool. Several women take hold of her and open her legs wide. After separating her outer and inner lips, the operator... with the kitchen knife pierces and slices open the hood of the clitoris. Then she begins to cut it out. [T]he operator digs with her fingernail a hole the length of the clitoris to detach and pull out the organ entirely. The little girl held down by the helper screams in extreme pain; but no one pays attention... The operator finished... by entirely pulling out the clitoris and then cut it to the bone with her knife. Her helpers wipe off the spurting blood with a rag. (Steele, 1995)*

By studying the social and political considerations in policies designed to combat the practice of FGM, I intend to show that the best solution is to raise awareness of the dangers of FGM and to better educate communities, both on alternative cultural options and higher education in general.

## Literature Review

### Culture

In order to understand FGM, people first need to understand the origins of FGM, what the procedure entails, and the justifications for the practice. The practice dates back as far as 3000 BCE and is practiced by both Islamic and many non-Islamic cultures. (Ballenger, 2008) It was possibly performed to replace human sacrifices that would normally be practiced to placate hostile spirits. Some believe that female circumcision was rooted in the Pharaonic belief in the bisexuality of the gods. Mortals reflected this trait of the gods; every individual possessed both a male and a female soul. For healthy gender development, the female soul had to be excised from the man and the male soul from the woman. Circumcision was thus essential for boys to become men and girls to become women. There are several theories on why FGM became such a prevalent tradition: religious fulfillment, good hygiene, male dominance over women, and removal of the male “soul” from the female body. It has been credited in some cultures with curing nymphomania, insanity, epilepsy and other “illnesses.” There is even a myth in parts of Africa that states that “if the clitoris is not removed, it will grow sharp teeth and consume a penis.” (Steele, 1995)

When looking at eradicating the practice, we must first look at what causes the practice. FGM is a dominant tradition in many cultures. “Culture is the whole complex of distinctive spiritual, material, intellectual and emotional features that characterizes a society or a group. It includes creative expressions, community practices and material or built forms.” (Serageldin, 1996)

A multitude of reasons are given for communities continuing these traditions. It insures virginity and chastity: this justification arises in all societies that practice FGM. Some societies say it is a coming-of-age ritual, or it ensures “marriageability” or is justified by insuring economic survival for the girl’s family. Others say it guarantees male superiority by branding their woman and by making sure the “uncut clitoris” does not continue to grow to rival the man’s penis; effectively guaranteeing there will be no competition between husband and wife. Female genitalia are believed to be unclean, and one rationale is for FGM is woman’s health and safety. However, FGM for any of these reasons effectively neuters women and reduces them to property.

(Broussard, 2008)

Religious justifications have been often used for FGM, however, while trying to find data to support that there was no religious justification, I found absolutely no data anywhere to support that it was true; no passages in the Qur’an, Bible or any other religious text.

As discussed above, communities that practice FGM report a variety of social and religious justifications for continuing its practice. However, from a human rights perspective, the practice reflects a deeply rooted inequality between the sexes, and constitutes an extreme form of discrimination against women. Female genital mutilation is nearly always carried out on minors and, according to the World Health Organization, is therefore a violation of the rights of the child. The practice also violates the victim’s rights to health, security, physical integrity, as well as the right to be free from torture and cruel, inhuman or degrading treatment, and the right to life when the procedure results in death. (World Health Organization, Department of Reproductive Health and Research, 2008) The practice is predominantly performed by untrained

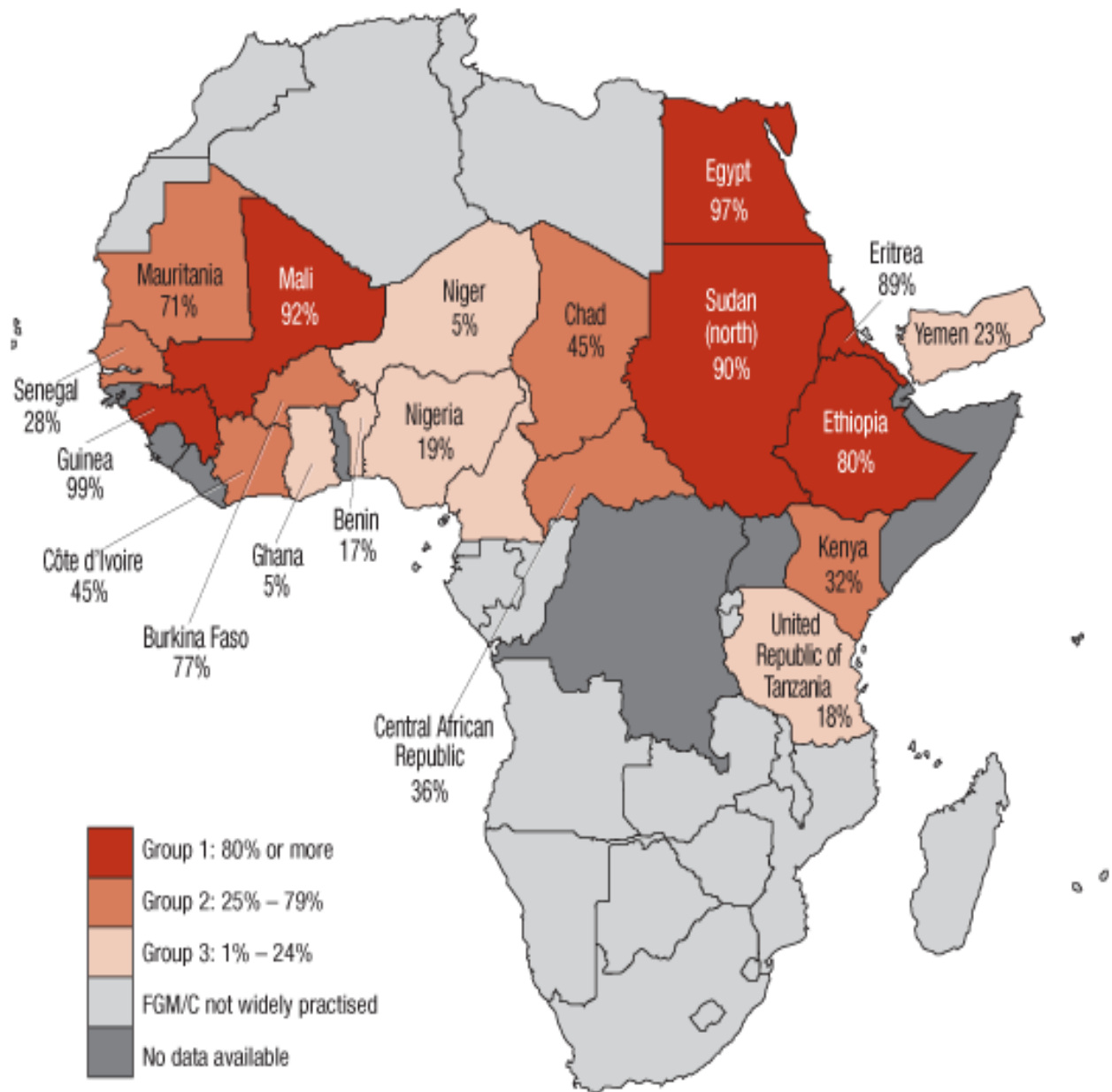
women in the villages and often with homemade tools under unsanitary conditions. (Jones, Ehiri, & Anyanwu, 2004) However, a larger percentage of physicians in urban areas are performing this practice illegally for parents who want their daughters circumcised, but would like to minimize negative outcomes. (El-Gibaly, 2002)

## **Practice and Incidence**

The World Health Organization estimates that somewhere between 100 and 140 million girls and women in the world have undergone FGM procedures, and three million girls are estimated to be at risk of undergoing the procedures every year. The highest risk areas are where it is a deeply rooted tradition, such as parts of sub-Saharan Africa, the Nile valley and most of Egypt. In fact, it is nearly universal in Egypt excluding a few educated, urban elites, as well as most Bedouin populations. (El-Gibaly, 2002)

Among countries with representative data, Egypt has the highest prevalence of female genital cutting on the African continent with 97% of ever married females stating they are circumcised. (Yount, 2002) Other countries with extremely high numbers include Guinea at numbers comparable to Egypt, Mali at 92%, northern Sudan at 90% and Eritrea at 89%. Ethiopia, Burkina Faso and Mauritania follow with rates in the 70-80% range. (Unicef, 2005)

Figure 1



## Classifications

FGM is classified into four main types as defined by the World Health Organization.

**Type I:** Clitoridectomy - Partial or total removal of the clitoris and/or the prepuce.

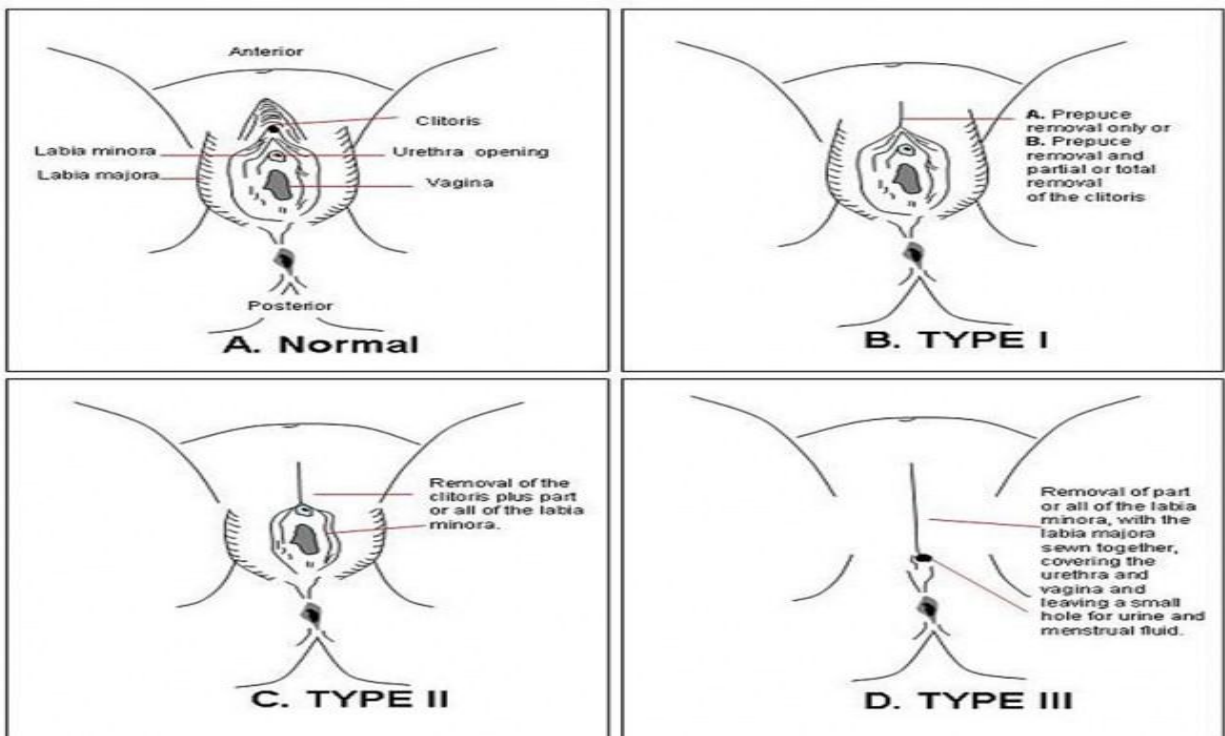
**Type II:** Excision - Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora.

**Type III:** Infibulation - Narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris.

**Type IV:** All other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, piercing, incising, scraping and cauterization.

(World Health Organization, Department of Reproductive Health and Research, 2008)

**Figure 2**





## **Health Impacts**

Female genital mutilation has no known health benefits, but rather is recognized by the World Health Organization (WHO) as being only harmful. First and foremost, it is painful and traumatic. “The removal of, or damage to, healthy, normal genital tissue interferes with the natural functioning of the body and causes several immediate and long-term health consequences. For example, babies born to women who have undergone female genital mutilation suffer a higher rate of neonatal death compared with babies born to women who have not undergone the procedure.” (World Health Organization, Department of Reproductive Health and Research, 2008) Immediate complications can include severe pain, shock, hemorrhage (bleeding), tetanus or sepsis (bacterial infection), urine retention, open sores in the genital region and injury to nearby genital tissue.

Second, long-term health consequences of FGM can include keloids, fistulas, cysts, infertility, persistent infections such as urinary or bladder and increased risk of childbirth complications, including increased risk of death for both baby and mother. In some extreme forms of Type III FGM, women must be opened and then reclosed after intercourse and childbirth. This is usually done with a knife or sharp piece of glass.

Third, the health consequences are not only physical but also can cause deep emotional scarring including impaired cognition, nightmares, panic attacks and post traumatic stress syndrome. (Masho & Matthews, 2009)

## **Outsider Reactions and Policy Options**

FGM was first openly discussed outside of Africa in the late 1930's by the British Parliament. Shortly afterward, educated Sudanese men met with the wives of British officials in Sudan and a formal educational campaign was launched. Then in 1946, a law was passed forbidding infibulations in Sudan. All that was accomplished by passing the law was to politicize the issue, which led to the circumcisions happening secretly. (Boyle & Preves, 2000) Just like with outlawing abortion in the United States, it did not eradicate the practice.

If the western world is seen as banging their hammer and attacking another culture and their way of life, then no benefit will come of it. (Steele, 1995) "There is a fine line between respecting and challenging a community's prerogative and becoming a cultural imperialist." (Steele, 1995) But, "it is possible to criticize a tradition which harms a society without denigrating or demonizing the culture as a whole. Indeed, slavery, in addition to being an economic institution, was arguably a 'tradition' in the United States for over two-hundred years." (Broussard, 2008) When outsiders criticize a tradition, the members of that society often take affront and say it is none of their business. However, when outsiders criticize a culture for practicing certain traditions, they are not necessarily criticizing the culture, rather they are just acknowledging that not all traditions are worthy of continuation and change is necessary. The key is not to offend and thus lose the ability to communicate with those societies.

Some feel that a non-directive strategy, or "sensitive persuasive" approach, is the best way to address FGM. Program planners feel that a successful program must not only motivate the community to change, but also provide the means for it to happen. Target audiences are not just

the women and girls involved in FGM but the parents, the practitioners and the community as a whole. (Jones, Ehiri, & Anyanwu, 2004) In Senegal the World Health Organization has implemented this approach. Communities are involved in a year-long educational intervention where they are taught human rights, women's health risks and the dangers of FGM. Interestingly, participants were never asked to abandon FGM, but usually chose to do so on their own.

## **Egypt's Response**

Laws passed in Egypt have done little to prevent FGM. There is still a ban and the numbers are falling slightly, but, as shown below, counseling, education of parents, girls, and communities will lead to reduced practice of FGM and thereby advance women's health and human rights.

*A multivariate analysis performed in Egypt indicates that girls who have been or are currently in school, who live in urban governorates, and who are older are more likely to believe that circumcision is not obligatory. When the analysis includes boys as well as uncircumcised girls, a large gender gap emerges, with boys considerably more supportive of the practice of cutting than are their female counterparts. (El-Gibaly, 2002)*

Likewise, involvement with community education, improvements in women's socioeconomic status and traditional and religious leaders will be critical for FGM eradication. (Hassanin, 2008)

In 1998, the Centre for Development and Population Activities (CEDPA) headed the "Positive Deviance Approach" to FGM abandonment and worked closely with local NGO's and communities in Egypt to advocate that the practice of FGM is wrong and harmful to women. The positive deviance approach focuses on individuals who have deviated from socially accepted behavioral norms resulting in a positive outcome, and is an assets-based development approach that identifies best practices already in use and builds on them. With financing from the USAID-

funded ENABLE, the project expanded into 24 communities in Egypt through its first three phases.(McCloud, Aly, & Goltz, 2003)

The development of this innovative model created a strong base for an expanded version which was implemented during 2003-2004 in Alexandria and Qena governorates under the USAID-funded “Towards New Horizons” project, and was implemented in Assiut, Qena, Sohag and Minya governorates with funding from UNICEF/Egypt. As of 2005 the program had expanded to 42 communities in Egypt. Basing results on benchmarks and post-research, it is quite obvious that the Female Genital Mutilation Abandonment Program (FGMAP) has broken the societal custom of silence about FGM. It highlights how community and religious leaders, physicians, and NGO’s have played an invaluable role in the community mobilization and advocacy process of FGMAP. (The Abandonment of Female Genital Mutilation, 2005)

### **Statement of Hypotheses**

I expect to find that the higher the level of education the mother has, the less likely she is to circumcise her daughter, also the higher level of education of the mother’s husband, the less likely she is to circumcise her daughter. Also, I believe that urban mothers are less likely to circumcise their daughter than rural mothers.

Lastly, the level at which the entire community is educated on the negative health consequences of the procedure and given alternate options for coming of age rituals or traditions, the more likely they will be to question the necessity of the procedure.

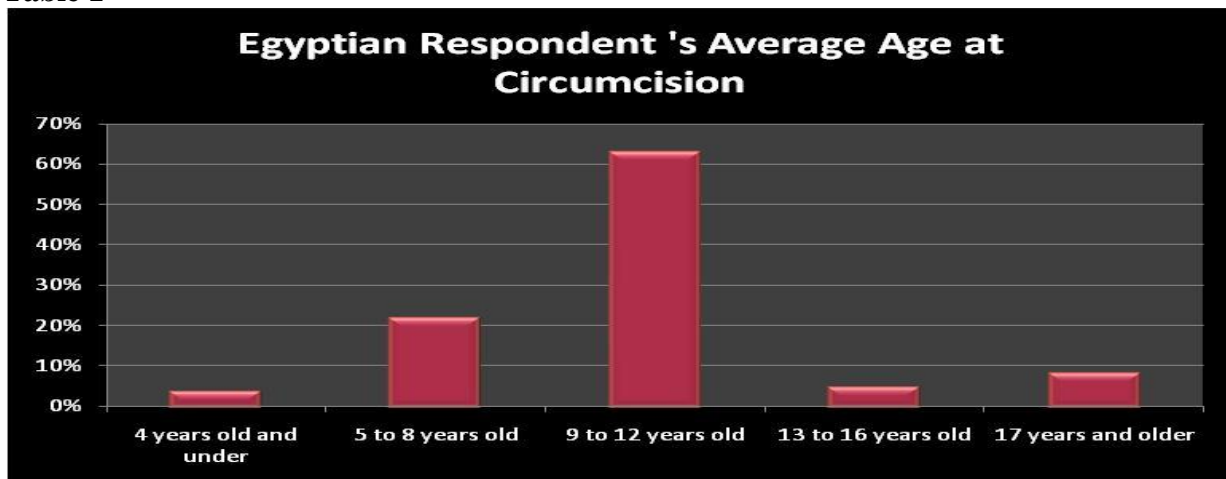
## Method and Findings

My data is from the Measure DHS – Department of Health Surveys’ website, which is funded through USAID (United States Agency of International Development). Data was collected by the Ministry of Health and Population/El-Zanaty and Associates from March to June 2008 by surveying 16,527 Egyptian “ever married women” ages 15 – 49 (ever married women refers to any woman that has been married at any time). Of the 16,527 women surveyed, 15,605 admit to being circumcised, 918 say they are not and four are missing. (Demographic and Health Surveys)

My unit of analysis is the *Respondent (Mother)*. I chose *Intent to Circumcise Daughter* as my dependent variable and my independent variables include *Respondent’s Region*, *Highest Level of Education of Respondent (mother)*, *Highest Level of Education of Husband* and *Percent of Wealth Index of Respondent*.

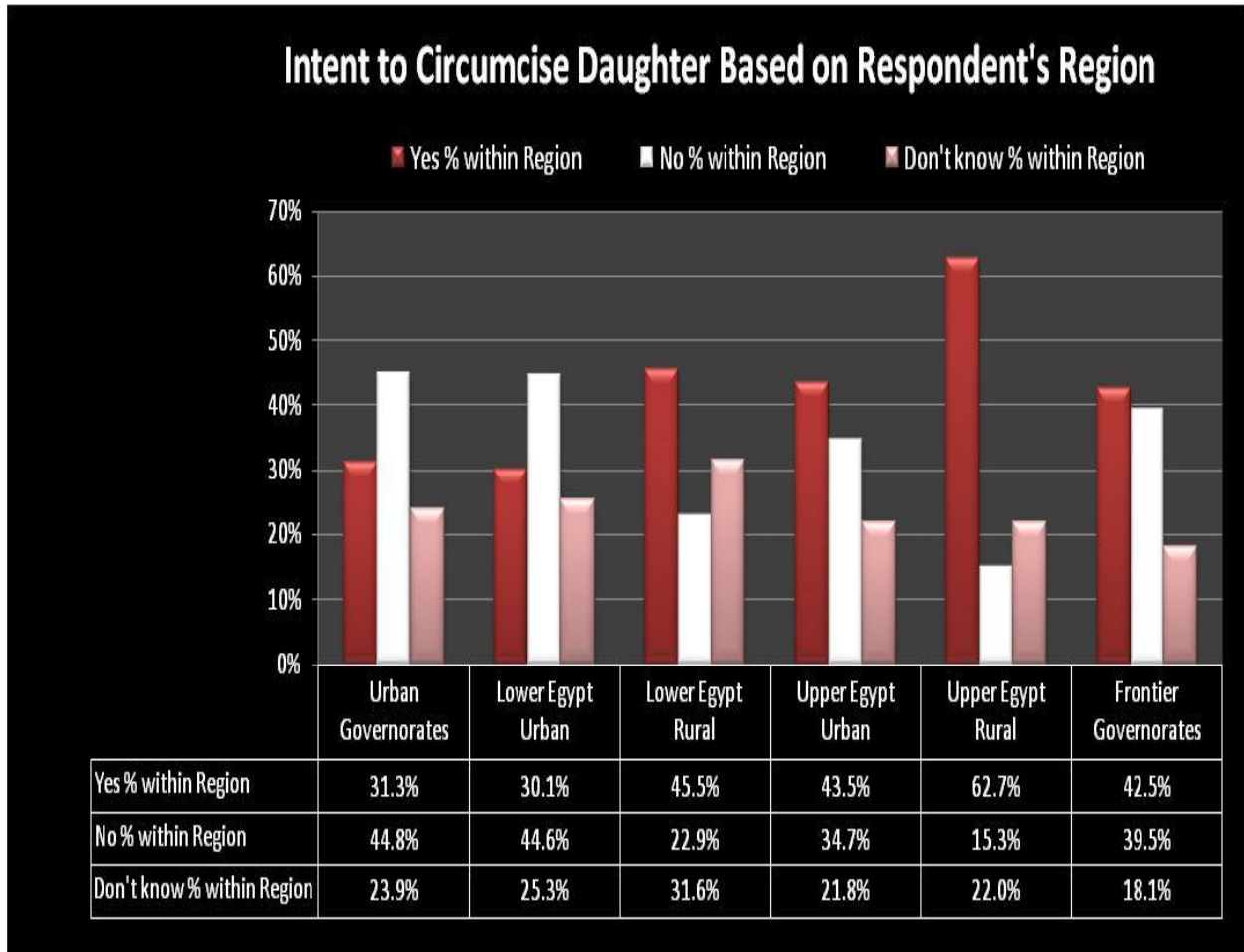
Ages of circumcision differ by country but the common age of circumcision in Egypt takes place between the ages of nine and twelve as shown in Table 1.

**Table 1**



*Intent to Circumcise Daughter based on Respondent's Region* has a fairly large statistical significance level at Phi, Cramer's V and Chi-Square and with  $p < .005$ , we have to reject the null hypothesis, meaning these outcomes would not happen by chance. Using data from DHS that splits Egypt into six regions, the table shows that daughters in Urban Governorates and Lower Egypt Urban have significantly less chance of getting circumcised than in other areas. Those two areas are by far the most densely populated areas of Egypt.

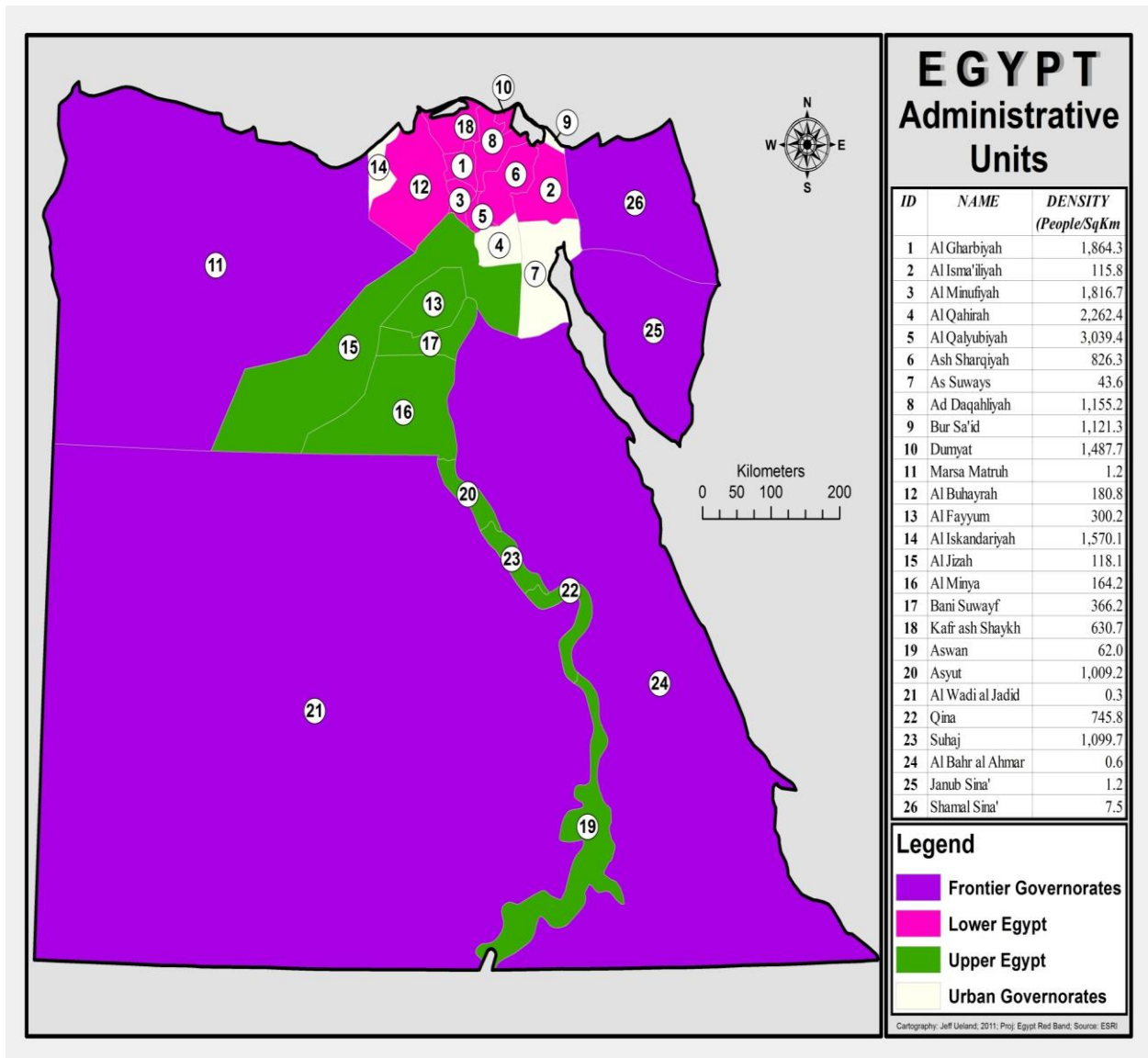
**Table 2**



Phi = .295,  $p < .000$   
 Cramer's V = .209,  $p < .000$   
 Chi = 690,  $p < .000$

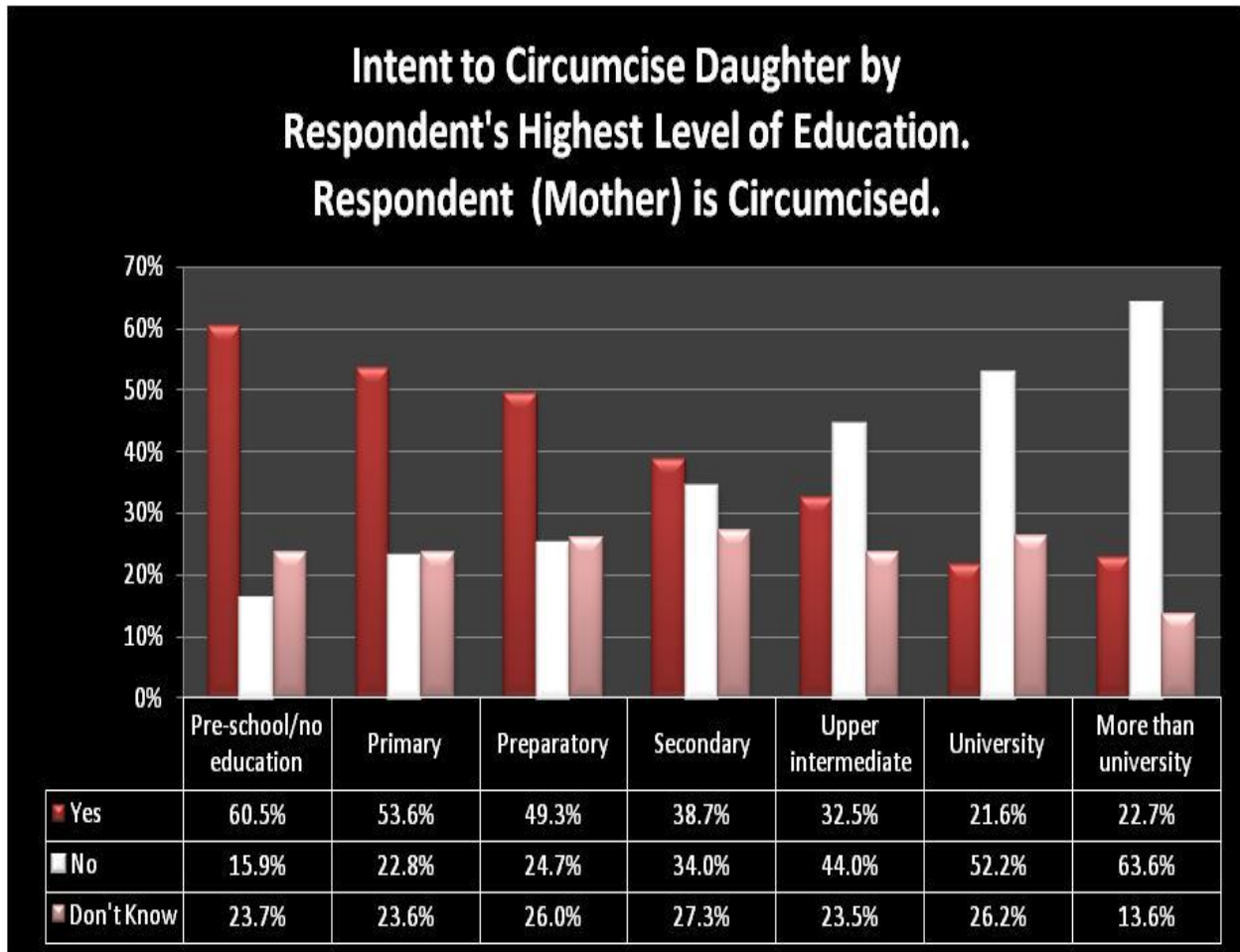
In reference to Table 2, Figure 3 shows Egypt separated into four regions, Upper Egypt, Lower Egypt, Urban Governorates and Frontier Governorates. Upper and Lower Egypt are further separated into urban and rural. Lower Egypt is located in the upper part of the map and is comprised of most of the major larger cities other than Cairo and Alexandria which are located in the Urban Governorates.

**Figure 3**



I ran crosstabs on *Intent to Circumcise Daughter* by *Respondent's Highest Level of Education* and *Respondent is Circumcised* and put into a table. The data shows a strong correlation on the level of education and mother's intent to circumcise. It is statistically significant at the  $p < .005$  level again for Phi, Cramer's V and Chi-Square and therefore we cannot reject the null hypothesis.

**Table 3**

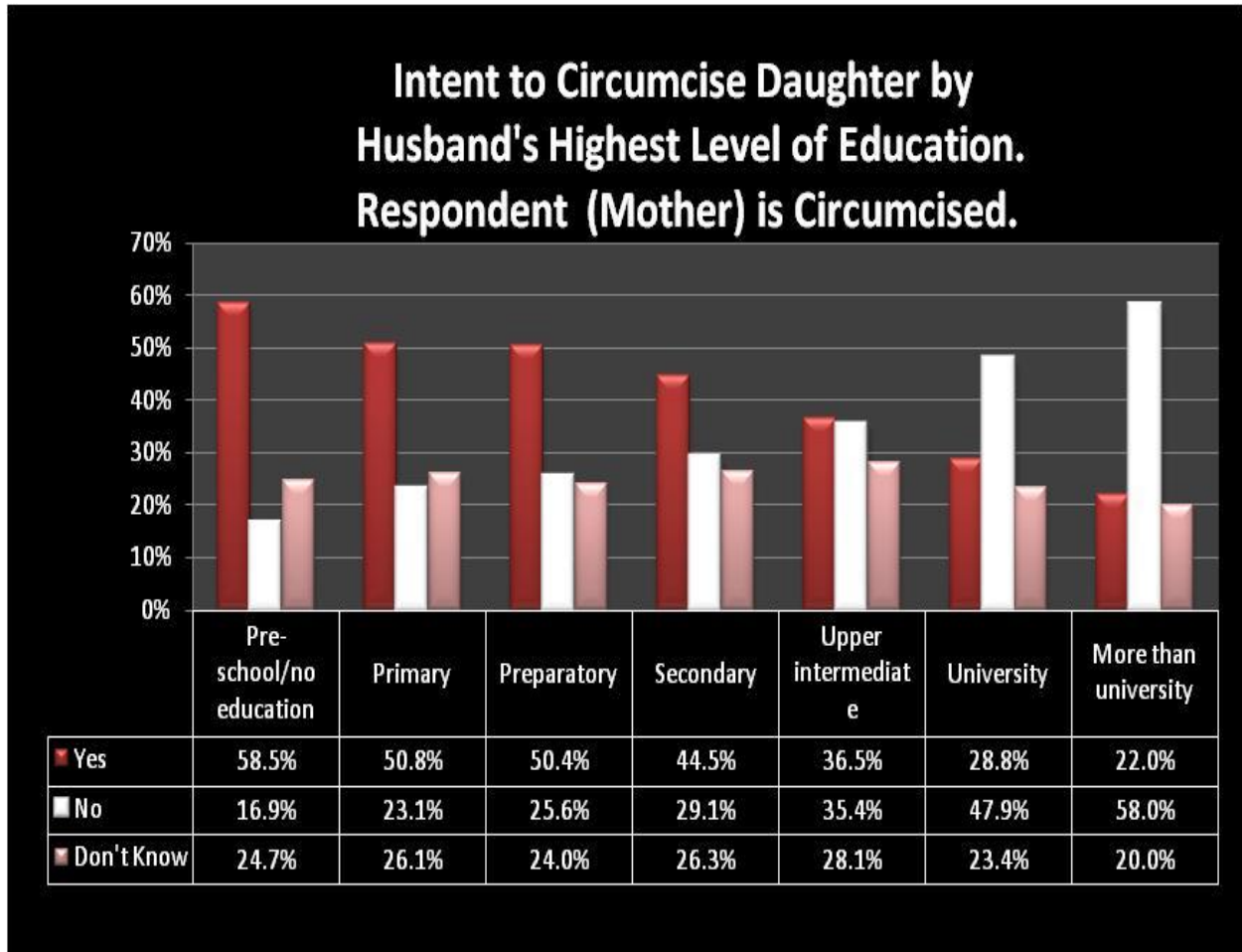


Phi = .285,  $p < .000$   
 Cramer's V = .202,  $p < .000$   
 Chi Square = 643.9,  $p < .000$



Similarly, I ran crosstabs on *Intent to Circumcise Daughter* by *Husband's Highest Level of Education* and *Respondent is Circumcised* and put into a table. It also has a fairly large statistical significance level at Phi, Cramer's V and Chi-Square and with  $p < .005$  and we again have to reject the null hypothesis.

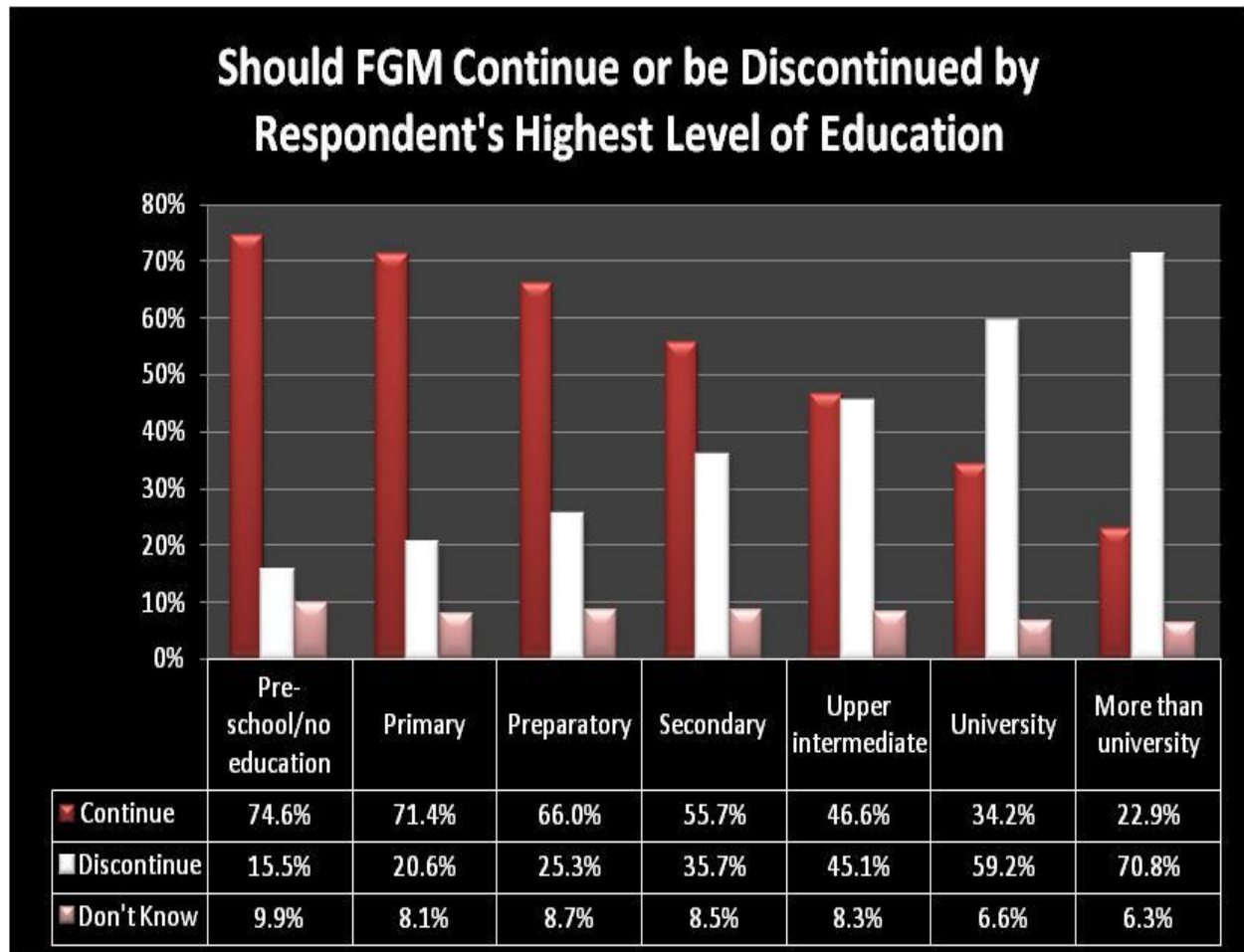
**Table 4**



Phi = .229,  $p < .000$   
 Cramer's V = .162,  $p < .000$   
 Chi Square = 413.8,  $p < .000$

I was curious to see whether the Respondent's opinion on whether FGM should *Continue or Discontinue* based on *Highest Level of Education* would differ when it wasn't specific to their daughter and it does. It is a slightly higher percentage to Discontinue FGM and I suspect that is due to the fact that it is easier to have an opinion when you aren't directly affected by the result. It is a fairly large statistical significance level at Phi, Cramer's V and Chi-Square with  $p < .005$ , we have to reject the null hypothesis.

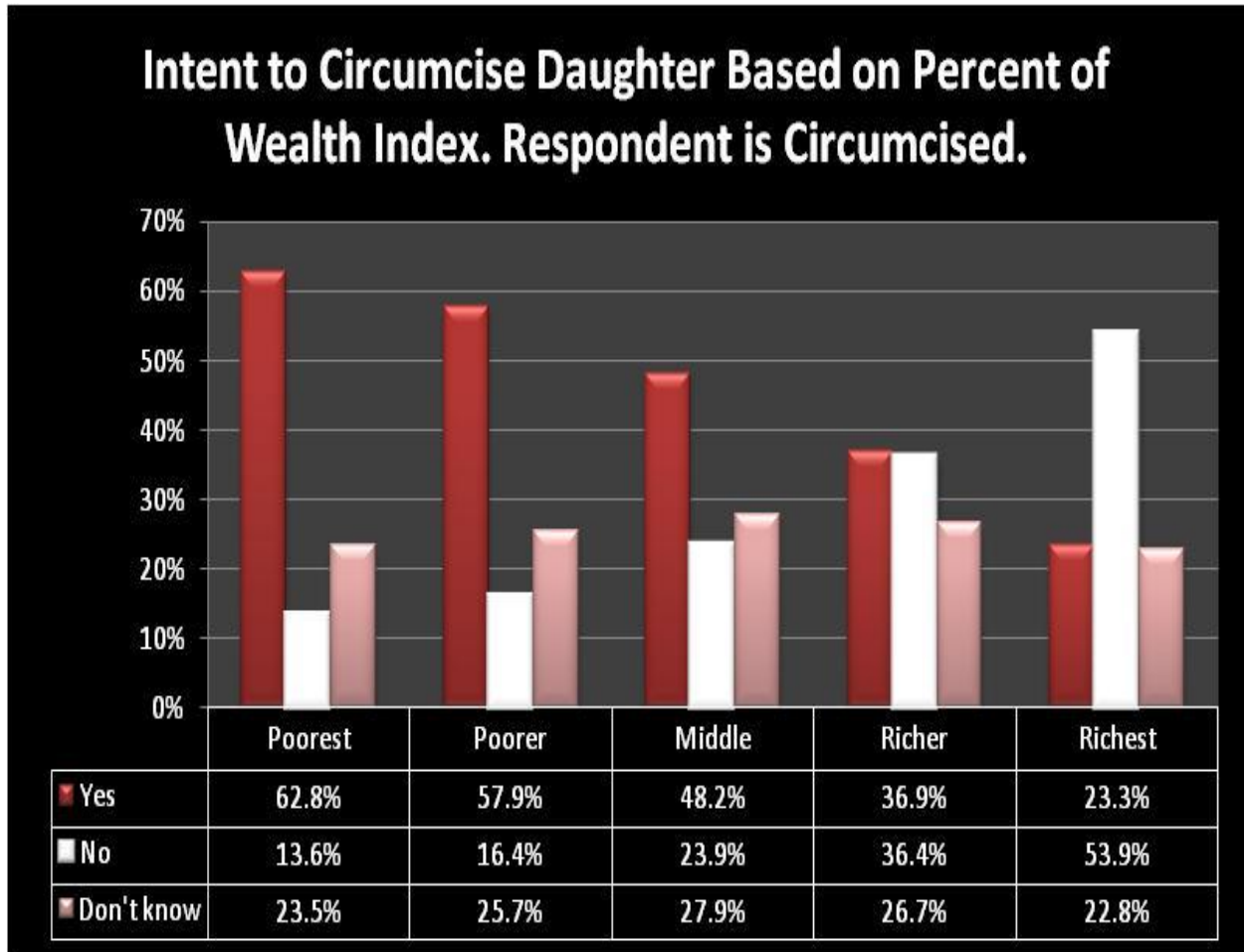
**Table 5**



Phi = .310,  $p < .000$   
 Cramer's V = .219,  $p < .000$   
 Chi Square = 1586.8,  $p < .000$

Higher levels of education are often related to higher levels of wealth, but not always. I ran a crosstabs of *Intent to Circumcise Daughter* based on the *Percent of Wealth Index*, and included the fact the *Respondent was Circumcised*. The data shows a strong correlation on the level of *Percent of Wealth Index* and mother's *Intent to Circumcise*. It is statistically significant at the  $p < .005$  level again for Phi, Cramer's V and Chi-Square and once again we cannot reject the null hypothesis.

**Table 6**



Phi = .346,  $p < .000$   
 Cramer's V = .245,  $p < .000$   
 Chi Square = 950.0,  $p < .000$

## **Conclusion**

Abandonment of FGM is not going to be an easy task. This has been a long standing cultural tradition and it will take a lot of time, money and effort to raise the awareness necessary to convince communities that abandonment is in the best interests of their children. Education by partakers of the experience is a necessity. Others can help to educate, but, as in most things, it is easier to believe and learn from someone who has been there, especially when they are from the same culture as the people they are hoping to educate. There needs to be a much larger focus on the harm to women's health and the negative life-long implications that FGM can cause.

Midwives, physicians, religious leaders and community leaders need to be recruited, since they are held in high regard in their community. Educators need to help communities find alternate rites of passage that will hold meaning without inflicting torture and mutilation; they need to help women find alternate economic options until the men in the culture can also come to understand the necessity to end Female Genital Mutilation. (Steele, 1995) FGM is something that children suffer and women endure for a lifetime.

“We must continue to fight female genital mutilation until every African mother knows that she has the right to say ‘I will not circumcise my daughter.’” We need to raise the status of women and children worldwide. FGM is no longer just a problem of third world countries. It has “reached the shores of the United States,” and we can no longer say that we are not aware of this practice. The world has the tools and resources to end this form of torture and mutilation against women, and it must end today. (Broussard, 2008)

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