



Review Article

Is It Possible to End Female Circumcision in Africa?

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Abstract

Female genital mutilation / cutting remains a widespread practice throughout Africa. There has been a worldwide effort to do away with FMG/C, but tensions exist between those who aim to abolish FMG/C and those who desire to perpetuate the tradition. While many Western and African experts and organizations agree on the health risks and human rights concerns with FMG/C, others fear that Westerners are imposing their ideas and lack of cultural understanding, trying to eliminate a practice central to the identity of many Africans. The issue must be approached respectfully and collaboratively, with great effort on the part of Westerners to understand the cultural context and rationale of this tradition. Ultimately, if FMG/C is to be eradicated in the foreseeable future, whole African communities and international support agencies must be engaged and empowered to collectively evaluate the implications of the practice and accelerate its demise.

Introduction

When anthropologist Bettina Shell-Duncan attended the wedding of a woman from the Rendille tribe in Kenya, the bride underwent excision of the clitoris and inner labia. The woman was proud and stoic, unflinching. As guests celebrated, Shell-Duncan raced to her hut to find codeine tablets for the woman. The woman politely refused the codeine: "This is not our way... if I didn't do that, I wouldn't be a woman [1]." Female circumcision, involving mutilation of the vulva and clitoris, is a procedure many women undergo in Africa.

Every year, three million African and Middle Eastern girls and women undergo FGM/C [2]. Approximately 130 million living girls and women have undergone FGM/C [3], and 63 million more are expected to be affected by 2050 [4]. FGM/C is practiced in 28 African countries, despite being illegal in 18 of these countries [2]. The modern prevalence of FGM/C highlights how culturally entrenched FGM/C is in many African countries.

Despite its prevalence, FGM/C is a subject of intense debate within Africa and abroad. Even differences in terminology reflect contrary stances. When first described, the practice was called female circumcision; however, this term is confusing, as female and male circumcision are quite distinct. The expression "female genital mutilation" emerged in the 1970s, emphasizing the gravity of the act. The label "mutilation" can be problematic, as parents resent the suggestion that they are mutilating their daughters. Local languages often use "cutting" as a less judgmental label. After the United Nations (UN) addressed the risk of demonizing certain cultures and traditions in 1999, the term "cutting" has been increasingly used to avoid alienating communities [2].

Proponents of the procedure believe it is best not to "meddle... [b]ecause circumcision is part of [their] culture [5]." As far back as 1938, Jomo Kenyatta, the first president of independent Kenya, said clitoridectomy is "the *conditio sine qua non* of the whole teaching of tribal law, religion and morality [6]." By no means do all women and men in



Africa embrace FGM/C, however. In 2013, the UN International Children's Emergency Fund (UNICEF) reported that 86% of surveyed Kenyan girls thought FGM/C should end [7]. Elimination of FGM/C has been called for by numerous inter-governmental organizations, including the African and European Unions, the Organization of Islamic Cooperation, and the UN. In 2015, the UN set sustainable development goals, including ending FGM/C by 2030 [8]. There is a global movement which transcends Western and African divides to eradicate FGM/C as a violation of human rights and out of concern for health risks.

Despite this worldwide effort to do away with FGM/C, tensions exist between those who aim to abolish FGM/C and those who desire to perpetuate the practice. While many Western and African experts and organizations agree on the health risks and human rights concerns with FGM/C, others fear that Westerners are imposing their ideas and lack of cultural understanding, trying to eliminate a practice central to the identity of many Africans. The issue must be approached respectfully and collaboratively, with great effort on the part of Westerners to understand the cultural context and rationale of this tradition. Ultimately, if FGM/C is to be eradicated in the foreseeable future, whole African communities and international support agencies must be engaged and empowered to collectively evaluate the implications of the practice and accelerate its demise.

Literature Review

FGM/C is a procedure in which external genitalia are removed or altered for nonmedical reasons [2]. There are four types of FGM/C. Type I involves "excision of the prepuce, with or without excision of part or all of the clitoris. Type II involves clitoridectomy and partial or total excision of part or all of the labia minora. Type III (infibulation) includes removing part or all of the external genitalia and reapproximation of the remnant labia majora, leaving a small neointroitus. Type IV involves other forms of injuries to the genital region including pricking, piercing, stretching, burning, scraping, or any other manipulation of external genitalia [9]." Type I is the most common type of FGM/C, but countries and ethnic groups often perform specific versions of the procedure. In Burkina Faso, 56% of FGM/C is Type III or IV [2]. Although type and severity range by region and ethnic group, FGM/C continues to be performed throughout Africa.

The circumstances under which girls undergo FGM/C vary. The procedure is often performed by a traditional practitioner, ranging from an older woman in the community to a trained medical professional [2]. Many women undergo the practice pinned down by family members in a hut while a woman performs the procedure with a rusty knife or razor blade [3]. "Twigs or rock salt [may be] inserted [for] a small opening for urine and menses." Soil can be used to cover the area, and the girl is "sewn with thorns or gut and has her legs bound for three weeks [10]." Increasingly, the procedure is being done in hospitals by surgeons using sterilized equipment and anesthesia. According to the World Health Organization (WHO), 18% of FGM/C procedures are done in hospitals [7]. Egyptian girls are 30% more likely to undergo FGM/C by a medical practitioner than their mothers were [7]. FGM/C is usually performed on young girls between infancy and age 15 [2]. Some women undergo the procedure on their wedding day to represent marital commitment [1]. The conditions surrounding FGM/C are particular to certain regions of Africa.

The prevalence of FGM/C by region and ethnic group varies widely. FGM/C is performed most commonly in a band across north-mid Africa, including Benin, Burkina Faso, Central African Republic, Chad, Côte d'Ivoire, Egypt, Eritrea, Ethiopia, Ghana, Guinea, Kenya, Mali, Mauritania, Niger, Nigeria, Sudan, and Tanzania. Among the countries in which the practice is performed, prevalence ranges from 5% in Niger to 99% percent in Guinea [2]. Even these percentages can be broken down into

prevalence among different ethnic groups. In the Central African Republic, prevalence ranges from 5% among the Mboum and Zande-N'zakara to 75% among the Banda. Despite discrepancies in prevalence, overall, FGM/C is common throughout Africa.

The ancient history behind FGM/C is difficult to determine, as its origins are unclear. FGM/C dates back at least 2000 years across multiple continents [11]. In Egypt long ago, it was a sign of aristocratic distinction. The Romans performed FGM/C to prevent pregnancy in slaves. The Russian Scoptsi sect performed FGM/C to ensure virginity [11]. In present day Africa, many women from primarily Islamic countries believe the practice is a religious imperative, although neither Islam nor any religion condones FGM/C. Despite its ambiguous beginnings, FGM/C's history runs deep as a representation of purity, cleanliness, and availability for marriage. Physician Jean Fourcroy likens FGM/C to "a chastity belt of a woman's own tissue." A girl accused of indiscretion may publicly expose her genitals to prove herself chaste [12]. Without having undergone FGM/C, women from certain tribes or villages will be ineligible for marriage. In Somalia, a husband's family has the right to inspect the bride's body prior to marriage [12]. Among the Chagga of Arusha in Tanzania, the bride price for a girl who has undergone FGM is much higher than for a girl who has not been cut [12]. FGM/C also allows women to become members of their communities; uncut women are stigmatized and isolated. Women who have not been circumcised are "made fun of. People won't eat the food they prepare. They're called dirty and spiritually impure [13]." Delving further into the symbolism of FGM/C, anthropologist Janice Boddy notes, "Houses, families, and bodies require openings, yet openings – doors, marriages, bodily orifices – make people vulnerable: to other villages, foreign colonizers, and powerful spirits. Illnesses result when physical and architectural defenses are breached [12]." FGM/C as a form of bodily closure is considered by some to be health-promoting and curative. Indeed, the practice of FGM/C is deeply entrenched in African society, permitting community acceptance and representing honor and virtue.

More than being a tradition associated with womanhood and maturation, FGM/C has been a powerful political symbol and statement in the last century. FGM/C and colonial struggles have been intertwined. In 1895, the British established the East Africa Protectorate in Kenya, displacing the native Kikuyu people and exploiting their lands [6]. In 1929, the "Church of Scotland Mission to Kikuyu" banned from their schools children whose parents would not renounce clitoridectomy [6]. In opposition to the ban, many Kikuyu formed their own schools so they could continue practicing FGM/C. In 1956, the Kenyan Meru District governor declared FGM/C illegal. Defiantly, adolescent girls bought razor blades and went into the forests to circumcise themselves. These girls who resisted the authority of colonial-appointed chiefs and colonial rule itself became known as "ngaitana – I will circumcise myself [6]." The ngaitana made an incredible political statement in their refusal to be governed and to have their native identity extinguished. In colonial times, FGM/C was a rebellious act, a cultural declaration, and a means for Africans to assert themselves.

Understanding the cultural relevance and historical context of FGM/C, health organizations across the world acknowledge serious associated medical risks. FGM/C is not medically necessary. Short term complications include "pain..., hemorrhage, shock, infection, septicemia and death." Longer-term effects consist of "chronic infections, fistula, incontinence, urethral stenosis, delayed hematocolpos, menstrual disorders, vaginal stenosis, infertility or... sterility [14]." FGM/C has consequences not only for the girls and women who undergo the procedure but also for their husbands and children. FGM/C can make intercourse difficult and painful. Some men who cannot achieve intercourse with their wives resort to suicide, fearing scorn by peers and family members [12]. Because the vaginal opening can be so small, there is risk for extensive tearing when giving birth. If a midwife is not available to reopen the vaginal opening at the time of delivery, there will be "more difficulty in delivering the child's head,

resulting in a higher chance of anoxic brain injury in the child and death in the mother [15].” Healthcare workers around the world recognize the dire medical ramifications of FGM/C for women, their husbands, and even future generations of Africans if birth trauma occurs.

Discussion of Efforts to Address and Eradicate FGM

Acknowledging potential health consequences of FGM/C, international organizations have struggled with how to best approach the issue to protect girls and women from potential harm. Western efforts to halt FGM/C trace back to the 1920s, when colonist women spoke out against FGM/C [15]. According to Boddy, “Missionaries in Kenya, parliamentarians in England, British nurses, midwives, and teachers in Sudan – all publicly condemned the ‘barbaric, backward’ practice of [FGM/C] and worked within their own conceptual horizons to hasten those customs’ demise [12].” In Sudan during the 1920s, British midwives developed an attenuated version of FGM/C called “intermediate purification” which largely replaced the more radical form in northern Africa [12]. In the 1960s, Western women’s organizations began to lead campaigns to raise awareness about FGM/C [2]. The WHO organized the first regional seminar in Sudan in 1970. There, FGM/C was condemned in all its forms, and the IAC was established [2]. Initially, the campaign against FGM/C was led by Western organizations; however, the effort has increasingly become a priority among Africans.

The first anti-FGM/C programs focused on detrimental health effects, but this approach proved to be ineffective. In 1984, the IAC established grassroots educational projects, concentrating on medical risks associated with FGM/C [12]. This approach was important at first for legitimizing intervention, since the topic of FGM/C has been fraught with distrust and conflict. Sociologist Elisabeth Boyle writes, “Human rights...calls for international organizations to interfere into national politics [12].” However, in post-colonial Africa, sovereign autonomy, or local rule without outside interference, was highly valued [12]. A Western-initiated discourse focusing on health provided a compromise that “promoted international intervention without undermining sovereignty [12].” Over time, however, education focusing on adverse health effects has actually not been found to be helpful in affecting FGM/C rates. People in favor of FGM/C are often already aware of possible poor health outcomes but feel the “risk is worth taking in light of the social and cultural importance of the practice [12].” Moreover, health information is often drawn from extraordinary cases, which can undermine the credibility of the campaigns. Researcher Carla Obermeyer states, “Any pain and suffering that accompany or follow... operations that are not medically prescribed, and even the lowest rates of complications are unacceptable...[but] this assessment is not universally shared [12].” Until the people who perform and undergo FGM/C reach a point of agreeing that no risk is acceptable or worth taking, focusing on potential health complications will not be an optimal approach to eradication.

More recent efforts at abolishing FGM/C focus on human rights violations, based on prohibition against torture and three other claims in particular: the rights of the child, the right to sexual and corporal integrity, and the right to the highest attainable standard of health [12]. Per the Center for Reproductive Rights, “[FGM/C’s] damaging physical, sexual, and psychological effects make it an act of violence against women and children [16-18].” FGM/C disrupts a woman’s physical wholeness, with associated risks for morbidity and mortality. An intrinsic right for children is that they be protected from any form of physical or mental injury or abuse. UNICEF regards the practice as “a fundamental violation of the rights of girls” and a perpetuation of existing inequality between men and women in African cultures since boys do not have to undergo similar procedures [16]. While parents often submit their daughters to FGM/C, perceiving that the procedure is in their daughters’ best social interests, these perceptions do not justify infringements on their daughters’ basic human rights, per the UN [2].



The most successful initiatives addressing FGM/C are community-based, participatory in nature, and guide communities to define the problems and solutions themselves [2]. Hailegnaw Eshete, advisor at the Population Media Center-Ethiopia, notes, “We need a consistent type of interaction with the traditional people to bring sustainable change in the country [19].” In Senegal, UNICEF funds Tostan, a non-formal, 30 month education program, in which communities establish management committees which develop projects addressing community-identified needs [2]. Tostan “has had a major impact with an education that seeks to build consensus, African-style, on the dangers of [FGM/C] [3].” When people from the same community come together to acknowledge the ramifications of FGM/C and take responsibility for the issue, chances of eradication increase dramatically.

UNICEF has outlined six key elements that can contribute to transforming the social convention of FGM/C and encouraging abandonment of the practice. First, a non-coercive and non-judgmental approach must be established, with the primary focus being fulfilment of human rights and empowerment of women. Next, communities must be made aware of harm caused by FGM/C. The decision to stop FGM/C must then become the collective choice of groups that intermarry or are otherwise closely connected. This way, women who opt against FGM/C will not be disgraced. The fourth element involves a public community affirmation of the collective decision to do away with FGM/C: a written statement or public declaration, for example. The fifth step involves a process of organized diffusion in which communities work with neighboring communities to spread and sustain the extinction of FGM/C. Per UNICEF, “Where previously there was social pressure to perform FGM/C, there will be social pressure to abandon the practice [2].” As an example of organized diffusion, a Senegalese religious leader named Keur Simbara realized it would be impossible to denounce FGM/C as a village because there were twelve other villages that intermarried with his own. After a few months, all thirteen villages denounced FGM/C together, relieving social pressure from women to undergo the procedure for marriage prospects [3]. Organized diffusion has allowed the people of Senegal to take major steps toward eliminating FGM/C. The last step UNICEF recommends is creation of an environment that enables and supports change using advertisements, legislation, and media awareness efforts [2]. These steps which UNICEF has outlined provide an organized approach communities can use to tackle FGM/C.

Even programs adhering closely to this community-based structure face challenges. One hurdle for many of the organizations that have helped facilitate the conversation about FGM/C is that these programs are extremely expensive and cannot be continued beyond their planned times. For each village, Tostan’s program costs \$21,000 and only lasts two to three years. International funding is essential to sustain the programs financially [3]. A further problem as organizations work to eradicate FGM/C is that the message is not always consistent, and the approaches are not always streamlined. For example, through traditional storytellers (griots) and popular singers, organizations have been able to promote awareness and provoke conversation in appropriate, culturally sensitive ways [3]. Not all griots agree that FGM/C is harmful, however. Djeneba Gamara, a griot in Mali, believes that FGM/C has a positive impact on girls’ lives and helps girls maintain sexual purity and cleanliness [5]. Conflicting opinions among the traditional storytellers are problematic as organizations work to relay a uniform anti-FGM/C message. Yet another example of inconsistency detracting from the effort to end FGM/C is that some organizations advise implementation of alternative rites of passage. Girls often enjoy gifts, money, and parties at the time of FGM/C. Some organizations believe women may be compelled to bypass FGM/C if they can still enjoy the festivities and gifts of a celebration without the procedure [2]. Not all authorities agree; some firmly state that alternative rites of passage should not be proposed [10]. Without a standardized approach to the problem, effectiveness of these programs is hindered. To facilitate permanent and effective change, organizations



need to work in a more unified way. As the programs are implemented currently, it will be impossible to fully eradicate FGM/C unless funding improves and the approach to the issue becomes less scattered.

Conclusions

Many activists and western organizations believe that FGM/C can be eliminated in a generation, as footbinding was eliminated in one generation in China. There are some similarities between these traditions which point towards the possibility of eventual elimination of FGM/C, but perhaps not as quickly as in a generation. Footbinding fell by the wayside in China as social opportunities for women arose via economic development and modernization was favored [10]. The Communist Party under Mao Zedong finally eliminated the practice in 1960 during the Great Leap Forward [20]. As girls and women suffer physical and mental health consequences as a result of FGM/C, they are unable to achieve their fullest potential, detracting from the ability of the entire populace to move forward. As there becomes increasing awareness in Africa that FGM/C impedes progress of the entire nation, FGM/C may fall into disfavor as footbinding did.

President Obama touched upon the very issue of traditions which hinder girls, with consequences that affect entire communities and countries, when he visited Kenya in 2015. He described how every country and culture has unique traditions that help define that country, “but just because something is part of your past doesn’t make it right; it doesn’t mean it defines your future...Treating women as second-class citizens is a bad tradition: it holds you back. There’s...no reason that young girls should suffer genital mutilation [21].” Obama’s speech met with approval among Kenyans, as many Africans wish to end the practice of FGM/C [22]. Many Africans welcome and participate in the international scrutiny of this practice. In past years, per Amnesty International, “There was... reluctance to impose universal values on what was widely perceived to be a cultural tradition [which] contributed to the collective identity of the communities who practiced it [2].” Over time, with globalization, people of different nations, cultures, and religions have become part of a worldwide community and have come to know more about one another. Per writer William Wishard, “Wherever we come from, from now on, we are ‘one people’ with one destiny [23].” With globalization comes shared human responsibility for the wellbeing of all inhabitants of planet earth. Since FGM/C is not medically necessary, carries risks, and jeopardizes human rights, it is imperative for all countries including Africa to decry the procedure.

Organizations working to eradicate FGM/C must be infinitely patient as they are constantly reminded of how deeply ingrained this procedure is in many African communities. Obama’s message is challenging to disseminate, a rate-limiting factor to eliminating FGM/C. “His speech will not reach the grassroots,” said Eshete from the Population Media Center-Ethiopia. “People do not have access to TV and will not hear the message for a change in attitudes....There are people still doing it in hiding [21].” The shift away from FGM/C will only be possible with persistent international efforts to fund and encourage culturally sensitive, comprehensive, and consistent programs within communities in Africa. The hope is that as communities come together to abandon the practice, individuals will no longer have to question whether they will be disadvantaged by remaining uncut, and eventually the practice of FGM/C will become obsolete.

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