

FEMALE GENITAL MUTILATION

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ABSTRACT**FEMALE GENITAL MUTILATION**

Female Genital Mutilation (FGM) is a procedure involving partial or total removal of genitalia for cultural or non-therapeutic purposes. It is practiced for economic, traditional and religious reasons in different countries around the globe. What policies and legislation have been used to prevent the practice and how Australia deals with it is among some of her migrant population is the purpose of this study.

The study shows that the practice of FGM in other countries must be viewed with caution, within the context of social, economic and traditional structures of these societies. Faced with the dilemma of one's right against the norm of the tradition, western societies has now embarked on preventative measures through education and changes in behaviour.

INTRODUCTION

Female oppression adopts many guises in different countries. From foot binding to cosmetic surgery, all have impact on the female psyche. However, Female Genital Mutilation has attracted a passionate response from many Western Feminists and Health Authorities in various developed nations during the nineties. In the past, little action against the practice has taken place by world organisations as it was deemed culturally sensitive towards some nations. However, FGM is a frequent occurrence with potentially devastating effects upon human life. It is also a direct assault on the physical representation of Female identity.

To understand the effect of the practice often described as 'tradition', it is of benefit to understand the reasons for its occurrence. By utilising the relevant literature this study explores the reasons given for the continuance of FGM. With these reasons in mind, attention is then directed towards preventative measures adopted by world organisations and specific countries such as Egypt, France and Australia.

DEFINITION

FGM is often referred to as Female Circumcision. Definition of 1995 World Health Organization (WHO) states that:

“Female Genital Mutilation comprises all procedures that involve partial or total removal of the female external genitalia and/or injury to the female genital organs for cultural or any other non-therapeutic reason.” (Dorkenoo, p2, 1996)

The procedure is further classified into the following types:-

- Type I – Excision of the prepuce with or without excision of part or all of the clitoris;
- Type II – Excision of the prepuce and clitoris together with partial or total excision of the labia minora;
- Type III – Excision of part or all of the external genitalia and stitching/narrowing of the vaginal opening (infibulation);
- Type IV – Unclassified:
 - ~ pricking, piercing or incision of the clitoris and/or labia
 - ~ stretching of the clitoris and/or labia
 - ~ cauterisation by burning of the clitoris and surrounding tissues
 - ~ scraping (angurya cuts) of the vaginal orifice or cutting (gishiri cuts) of the vagina
 - ~ Introduction of corrosive substances into the vagina to cause bleeding or herbs into the vagina with the aim of tightening or narrowing the vagina
 - ~ any other procedure that falls under the definition of female genital mutilation given above

(Dorkenoo, 1996).

Type I is also referred to as 'Sunna' which means "tradition" in Arabic. (Elchalal, Ben-Ami, Gillis and Amnon, 1997). Type III is sometimes referred to as Pharaonic, Sudanese or Somalian circumcision (Wright, 1996). In Mali, the term "excision" is frequently used (McConville, 1998). Elchalal et al (1997) also refers to "Introcision" – an uncommon form of FGM that involves the incision and inward folding of the vaginal introitus. Introcision is classified under type IV (World Health Organization , p14, 1998).

The procedure is generally termed FGM in the west. Women who practice this tradition take offence to the title of FGM, preferring to use other terms such as female circumcision and excision (McConville, 1998). The age at which FGM occurs varies between cultural groups and communities. Literature suggests it happens from a very early age (Wright, 1996) with 95% of cases occurring as early as 0-16 years of age (Wright, 1996). Cultural significance influences the age at which FGM takes place. For example, within some communities FGM is associated with initiation into womanhood and therefore occurs around the age of 8-9 years or with the onset of menarche (Royal Australian College of Obstetricians and Gynecologists, 1997). Sometimes it occurs just prior to marriage (Royal Australian College of Obstetricians and Gynecologists, 1997); however it must be remembered that marriage may occur at an earlier age than that which is predominant in Western societies. In general it is perceived that the age at which FGM takes place is decreasing as the association with adulthood initiation also diminishes (Royal Australian College of Obstetricians, 1997).

Various tools are used to perform the procedure. Knives, scissors, razor blades, coal or a burning piece of wood are examples of instruments utilised to mutilate the female genitalia, (Elchalal et al, 1997; Dorkenoo, 1995). Long Acacia thorns maybe used to sew the edges of the vulva, a paste consisting of gum arabic, sugar and egg or alternatively consisting of herbs, coffee, ash, dung or mud maybe applied in an attempt to impede clitoral artery bleeding (Elchalal et al, 1997). To encourage the formation of scar tissues, the female child or young adult will often have her legs bound together from either ankle to hip or knees to waist thus immobilising her for from 10 to 40 days. (Elchalal et al, 1997). Analgesia is not routinely given, however, some Midwives may

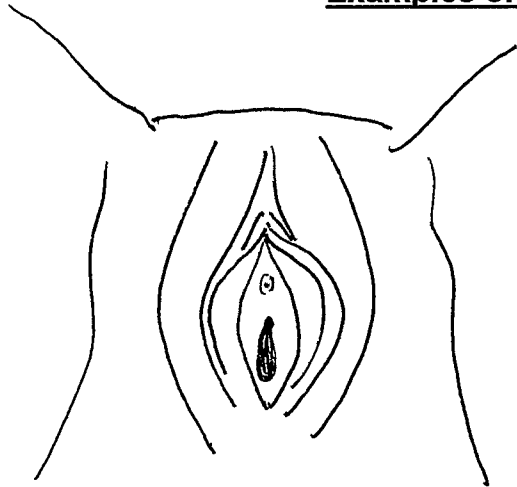
use a local anaesthetic. (Elchalal et al, 1997). Whilst the origins of FGM are dated back as far as 6,000 years ago, Herodotus documented that Egyptians, Phoenicians, Hittites and Ethiopians practiced Female circumcision 500 years before the birth of Christ (Elchalal et al, 1997). However Clitoridectomy has been surgically performed in the west. Reasons given for Clitoridectomy include as a cure for insomnia, sterility, "unhappy marriages", nymphomania, promiscuity, masturbation and psychiatric disorders (Elchalal et al, 1997; Royal Australian College et al, 1997; Wright, 1996). Whilst this practice is not surgically performed today it was only in 1953 in USA that the last case is documented and other mutilating surgery continues such as unnecessary hysterectomies and caesarian sections. (Wright, 1996). While condemning other cultural practices, our own society continues to impress a negative impact on female sexuality.

Those who perform the cutting vary between countries, however, it usually is women who are the excisors. (Wright, 1996). In Africa, the older women know as a 'Gedda' in Somalia or a 'Daya' in Egypt or Sudan perform the ritual (Elchalal et al, 1997). In Mali, Senegal and the Gambia, FGM is traditionally the task of the Blacksmiths' clan (Wright, 1996). Often trained or untrained Midwives will perform the cutting (Elchalal et al, 1997). Only in parts of Egypt the Male Barber will attend the FGM (Elchalal et al, 1997).

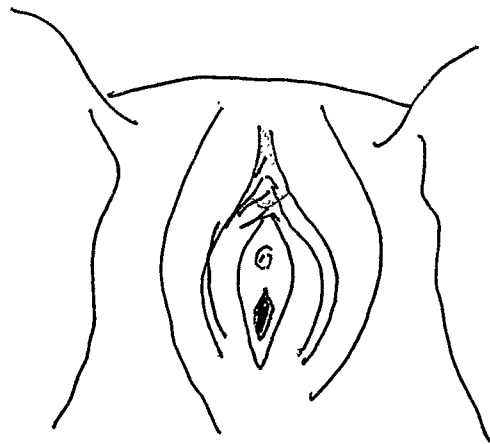
There are many countries in the world that allow FGM procedures. Several ethnic groups in 28 African countries and some population groups in the Arabian peninsula and along the Persian Gulf practice FGM (Dorkenoo, 1996). Increasing incidence amongst immigrant groups is becoming apparent in Europe, Canada, the United States,

New Zealand and Australia. Type I form of FGM has been reported amongst the Daudi Bohra Muslims in India and amongst some Muslim groups in Malaysia and Indonesia (Dorkenoo, 1996). However, it must be stated that despite the widespread association between FGM and Islam, FGM predates its advent and is not a prescribed requirement of the Koran, Sharia or Hadith (McConville, 1998). Some forms of Type IV may possibly be practiced within widespread communities throughout the world (Dorkenoo, 1996). Wright (1996) makes reference to some indigenous groups in Mexico, Brazil, Peru and Colombia as practicing type IV FGM. Type III is common in Northern Sudan, Djibouti and Somalia and has been documented in Ethiopia, Eritrea, Northern Kenya, areas of Mali and Northern Nigeria.

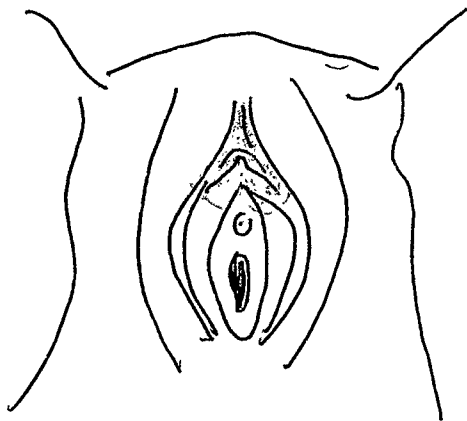
Examples of FGM Types – Figure 1



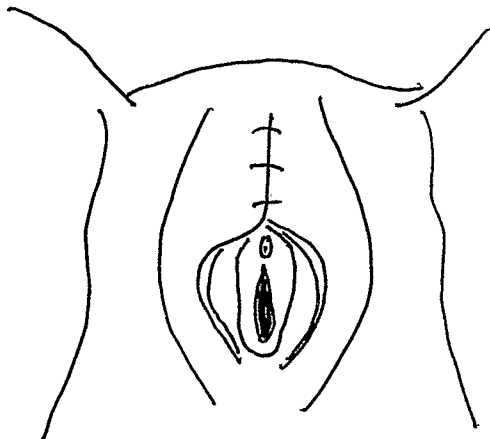
UNALTERED FEMALE GENITALIA



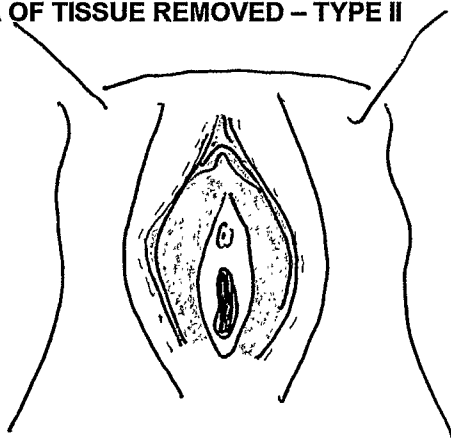
AREA OF TISSUE REMOVED – TYPE 1



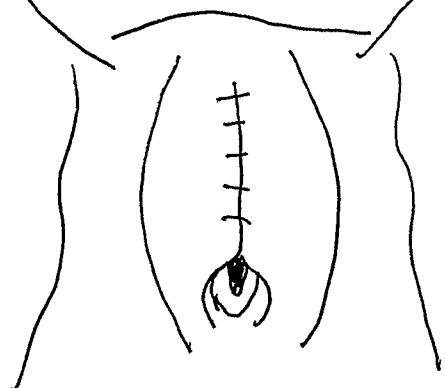
AREA OF TISSUE REMOVED – TYPE II



APPEARANCE OF TYPE II POST SUTURE



AREA OF TISSUE REMOVED – TYPE III



APPEARANCE OF TYPE III POST SUTURE

PREVALENCE

Estimates from the literature suggest that the incidence of FGM is increasing globally. The World Health Forum (1994) stated that between 85-114 million females have been subjected to FGM. Dorkenoo (1996) postulates that over 120 million girls and women have undergone some form of FGM. Most recent estimates establish the figure at over 130 million worldwide (WHO notes and News, 1997). However, when attempting to establish the incidence and demography of FGM, consideration must be given to the concurrent general increase in the global population. Based on this assumption, there may in fact be non concrete evidence of a true increase in number of FGMs carried out globally.

The most common types of FGM are Type I and Type II, which encompass 80% of all cases (Royal Australian College of Obstetricians and Gynaecologists, 1997). Type II FGM accounts for 15% of all cases (Royal College of Obstetricians and Gynaecologists, 1997). Though exact prevalence of FGM has been difficult to ascertain, due to limited research. The Royal Australian College of Obstetricians and Gynaecologists (1997) provide the following prevalence estimates:

Table 1: Global demography of FGM

Region	Countries	Prevalence Estimates
Asia	Indonesia, Malaysia	Practice has been reported but no data available
	India	Less than 10%
Africa	Djibouti, Sierra Leone, Somalia, Egypt	90% and over
	Eritrea, Ethiopia, Gambia, Sudan	80-89%
	Burkina Faso, Chad, Guinea, Liberia, Mali	60-79%
	Ivory Coast, Central African Republic; Ghana, Benin, Guinea Bissau, Kenya Nigera, Togo	30-59%
	Senegal, Niger, Mauritania, Cameron	10-29%
	Congo, Tanzania, Uganda, Zaire	Less than 10%
Middle East	Oman, United Arab Emirates, Yemen	Practice has been report but no data is available

Source: Royal Australian College of Obstetricians and Gynaecologists, 1997.

As can be ascertained from the above table, the highest incidences of FGM occur within the African countries, however, due to rising immigrant population groups from the above mentioned countries to Europe, Australia, Canada and the USA it is possible that the incidence of FGM in the latter countries could rise. It may be presumptuous to

assume that a woman from a country where FGM is commonly practiced would subject herself to FGM in a new country. However, the possibility remains and has major ramifications for health policy and special needs of such immigrants in their new homeland.

At present, there is no demographic data regarding the incidence of FGM in Australia.

Nevertheless, with the continuous increase of migrants from countries where FGM is culturally ingrained, the potential for a real incidence of FGM in Australia exists (Dixon, 1996). However, isolated incidents of FGM have been reported within Australia. Dixon (1996) identifies two cases of FGM which were reported to Australian authorities in March 1994. In that same year, two sisters aged between 2-4 years of age were found to have been infibulated resulting in both children being placed under a Victorian Health and Community Services Department Supervision Order for eighteen months.

Both needed to be monitored on health grounds. Additionally, Dixon reported that women have been known to approach Doctors in the Australian Capital Territory and in Western Australia requesting operations for their daughters (1996). Two cases of FGM in New South Wales have been reported to authorities in recent years.

THE EFFECTS OF FGM

Physical

The extent of physical complication is determined by many factors such as the age at which the procedure took place, the type of mutilation, the instruments used to perform the procedure and the level of hygienic measures undertaken. Dorkenoo (1995)

categorised the physical effects into the following two areas:-

"Immediate: - haemorrhage, shock, infection, urine retention and injury to adjacent tissue

(and;) Long term: - recurrent urinary tract infections, incontinence, pelvic infections, infertility, vulval abscesses, problems in pregnancy and childbirth, sexual dysfunction and other" (p3).

Psychological Effects

FGM is usually a traumatic experience in view of the extreme physical pain and helplessness associated with the procedure, particularly if it has occurred in a traditional setting without analgesia. Girls may be fearful prior to the procedure given the associated pain and then may feel that they had been deceived by parents and friends after the event (Royal Australian College et al, 1997). Elchalal et al also documents anxiety, hallucinations, reactive depression and psychosis as occurring after FGM (1997). It is also suggested that psychological trauma may be less acute if positive associations coincide with the procedure. Where FGM is perceived as a rite of passage, present giving and feasting are associated with the ritual. These are experiences which a girl may look forward to despite the trauma associated with FGM (Royal Australian College et al, 1998).

Sexual Effects

Though research is sparse regarding sexuality, the following problems have been documented in many reports and documents: painful intercourse, reduced sensitivity

or extreme hypersensitivity with the formation of neuroma resulting in decreased female libido (Royal Australian College et al, 1998; Elchalal, 1997). Women may be concerned that their ability to please their husband is effected as coital difficulty is common. Additionally, inability to have vaginal intercourse may occur with stenosis of the vagina in pharonically circumcised women (Elchalal et al, 1997).

WHY FGM OCCURS

Tradition

As cited by Wright (1996), tradition is the most common reason given for the preservation of FGM in many cultures. FGM is accepted as a normal part of a woman's development within the community. The event maybe marked with celebrations and festivities (Royal Australian College of Obstetricians and Gynaecologists, 1997). Social pressure encourages compliance as a girl may risk being ostracised from her community. Elchalal et al (1997) also suggests that as FGM is considered a traditional practice, it is rarely questioned. Additionally, for many illiterate people globally, FGM is believed to be a universal practice with many having never seen an uncircumcised adult woman (Elchalal et al, 1997).

Religion

Religion is often given as a reason for why FGM is performed. It has been practiced by Christians (Protestants, Catholics and Copts), Muslims, Jews, Animists and Atheists (Royal Australian College et al, 1997). Despite this, FGM predates all religions that

practice it (Wright, 1996). As previously discussed, a notable misconception is that FGM is an obligatory prescribed practice of Islam (Royal Australian College et al, 1997). However, commentators frequently fail to note that FGM is not practiced in Saudi Arabia – the epicentre of Islam (Wright, 1996). The Koran does not support FGM, however, despite this, it has been interpreted by some Islamic women as ‘Sunna’, a religious requirement described within the teachings of the Prophet Mohammed. (Royal Australian College et al, 1997). Much association of religion and FGM has been attributed to incorrect teaching and/or misunderstanding of religious texts. Historical concurrence has also been influential in perpetuating misconceptions regarding FGM and religion (Royal Australian College et al, 1997).

Social Cohesion

As parents will desire their offspring to grow up as an accepted part of their community, FGM will usually provide social acceptance (Elchalal et al, 1997). In many ethnic groups, a woman who is not circumcised becomes ostracised from the community, often losing rights and privileges usually available to other members of a community (Elchalal et al, 1997). This loss of rights often extends to the male head of the family and shames all family members (Elchalal et al, 1997). The ultimate insult in some parts of Africa where FGM is practiced is to be called ‘The son of an uncircumcised woman’ – such is the implication of immorality in a community if FGM is not maintained in families (Elchalal et al, 1997).

It has also been suggested that FGM fosters social cohesion between groups of girls who are circumcised at the same time, as they will identify with these girls who

underwent the same experience (Royal Australian College et al, 1997).

Economics

The practice of female circumcision provides some members of the community with income. For traditional birth attendants or 'excisors' not only do they perform the FGM operation, but also the opening of the vaginal introitus in preparation for marriage and birth. (Royal Australian College et al, 1997). Each procedure provides income with power and status being additional benefits acquired by those who perform this role. Men of cultures and communities that practice FGM will not marry a woman who has not been circumcised. As FGM is often considered in the negotiation of the bride price, it is considered to contribute to the local economy (Royal Australian College et al, 1997).

Modern clinical settings have commenced performing FGM operations on the belief that FGM will inevitably take place, as it is beneficial to have the procedure attended under aseptic conditions with anaesthesia. FGM provides a profitable source of income for these clinics. This initiative contributes to the continuation of the practice (Royal Australian College et al, 1997). Furthermore, it is assumed in Western countries that there is a potential for backyard operators to perform FGM. (Royal Australian College et al, 1997).

Marriageability

FGM is thought to enhance marriageability by ensuring virginity, chastity and status (Elchalan et al, 1997). In many countries that practice FGM, it is considered a

prerequisite for marriage on the basis of tradition and the previously mentioned qualities it provides (Elchalal et al, 1997). It is believed that FGM is thought to ensure the lineage of any children by limiting pre-marital sex and concurrently encouraging fidelity during marriage, as FGM will decrease sexual desire (Royal Australian College et al, 1997). It is also believed that FGM enhances fertility (Wright, 1996; Royal Australian College et al, 1997) and increases a man's sexual pleasure. Both these qualities are deemed to increase the value of a woman as a wife (Royal Australian College et al, 1997). In marriage a woman gains access to economic security.

Aesthetics and Hygiene

In many cultures where FGM is practiced, Female genitalia is considered ugly with an offensive odor (Elchalal et al, 1997; Royal Australian College et al, 1997; Dixon, 1996).

A smooth, flat and hairless area of skin with no evidence of a cleft is considered more attractive (Elchalal et al, 1997). FGM is also associated with personal hygiene (Elchalal et al, 1997). As the clitoris is thought to produce an offensive odour and discharge, the removal of the clitoris is perceived as a form of cleansing (Royal Australian College et al, 1997). The Arabic word for female circumcision is 'Tahur' which is defined as purity and cleanliness (Royal Australian College et al, 1997). It is also believed by some cultural groups that the clitoris emits 'pollutants' which harm the foetus physically and spiritually during childbirth, hence a justification for FGM (Dixon, 1996). Additionally a woman who has not undergone Infibulation is believed at risk of acquiring an infection due to air passing into the vagina (Royal Australian College et al, 1997).

Femininity

In many cultures the clitoris is paralleled to the penis, therefore to be considered a true woman, FGM is considered necessary (Dixon, 1996). It is believed that women who do not undergo FGM, that they will develop male associated characteristics such as aggression and promiscuity (Royal Australian College et al, 1997). Another common belief, specifically amongst the Temnes of Sierra Leone is that the, clitoris, if not excised in a young girl, will like the penis, grow with development (Dixon, 1996), a belief which harbours great revulsion (Lightfoot-Klein, 1989). Though mythical, FGM is believed to enhance fertility (Dixon, 1996).

A Feminist Perspective

Cultures in which FGM are practiced are essentially patriarchal in nature (Marshall, 1994). When virginity is a pre-requisite for marriage and marriage is the means of economic survival, the preservation of female genital mutilation is reinforced. Marshall cites that it is a practice that was started by men and continues to benefit men. However, it is women who maintain the practice (Dixon, 1996). FGM has been defined as an 'extreme example of misogyny and (male) societal control over female bodies' (Dixon, 1996). It is perceived as a direct attempt to control the sexual desire and expression of women (Royal Australian College et al, 1997). Literature cites the reduction in the female libido and increased sexual pleasure for men as reasons for its practice (Wright, 1996; Dorkenoo, 1995; Lightfoot-Klein, 1989; Morris, 1996; Dixon, 1996; Royal Australian College et al, 1997). FGM implies the expectation that girls display behavioural characteristics such as docility and obedience. These

characteristics are perceived as desirable female qualities (Dorkenoo, 1995; Royal Australian College et al, 1997).

FGM emphasizes the gender inequalities and discrimination experienced by women within societies that practice FGM. It is reinforced that women maintain a traditional role of mother and wife with identity restrained to these roles. Their role is one of total submission to the male. (Lightfoot-Klein, 1989). However, it must be stated that this role is deemed of high status within these societies, despite their diminished significance within Western society. As these roles are determined as the appropriate identity to embrace for women, the only means of economic security is through marriage. The expected female role renders a woman politically and economically barren.

From a feminist perspective, one of the most vocal feminist viewpoints regarding FGM would be that of Mary Daly (Daly in Wright, 1996). She suggests that FGM is one of many 'phallogocentric' and gynocidal practices developed to transfer power to the male and preserve the female strictly for their own pleasure and reproductive purpose.' (Daly in Wright, 1996, p257). Daly makes comparisons between Chinese footbinding, European witch-burning, Indian widow burning, African Genital Mutilation and American Gynaecology (Wright, 1996).

What is apparent when researching FGM, is the division of opinion between various women groups (Tamir, 1998; Wright, 1996). Wright identifies the differences primarily occurring between black/white and Eastern and Arab/African cultures (1996). An

example of this occurred at the 1985 United Nations Decade for Women Conference in Nairobi, Kenya. Western Feminists raised the issue of FGM which attracted an angry response from African women who advised Feminists to 'stop groping about in our panties' (Wright, 1996, p256). Though there may be shared aspirations for the advancement of women, culturally this goal may be obtained differently and perceived differently. The feminist viewpoint regarding FGM, though well intentioned, is nonetheless xenophobic and biased. As Wright suggests, other forms of oppression and human rights abuse are often forgotten in the debate. The effects of war, poverty, literacy and inadequate health care are on many occasions ignored by feminists (1996).

While Western Feminists may argue FGM opposes female sexuality, western society participates in condemning female sexual enjoyment in direct and covert ways. The incidence of rape, childhood sexual abuse, domestic violence against women and unrealistic standards of beauty as depicted by children's fairy-tales all reinforce female bodily self hatred and encourage suppression of female sexuality (Tamir, 1998).

PREVENTATIVE MEASURES

In an attempt to eliminate the practice of FGM, many world organisations and countries have looked at strategies to meet this goal. Education and legislation have been the primary tools. Whilst education is used globally, legislation in association with education has been implemented throughout Western countries with variable success.

World Organisations

The World Health Organization is the most prominent organisation and the first such body to bring FGM into the public arena. However, it was not until 1979 at a health seminar organised by WHO regarding "Traditional Practices Affecting the Health of Women and Children" that this issue was discussed openly (Dorkenoo, 1996). In 1958, at the invitation of the Economic and Social Council of the United Nations, the study on ritual operations performed on girls was discussed in detail. However, the WHO assembly at the time had rejected the report (Wright, 1996). The 1979 conference acknowledged that FGM constituted a health hazard, yet again, as governments and UN organisations feared political discontent, no formalised plans for prevention manifested until the last decade (Dorkenoo, 1996). Most of the initiatives for prevention have been from Non-Government Organisations (NGOs) and womens' groups at a local level (Dorkenoo, 1996; Wright, 1996).

Recently, the World Health Organization (WHO) collaborated with UNICEF (The United Nations Children's Fund) and UNPFA (the United Nations Population Fund) to undertake a joint plan aimed to decrease the incidence of FGM within the next 10 years and to eradicate the practice within three generations (World Health Forum, 1997). National Interagency teams at a country level assist governments in establishing policies for the abolition of FGM and, where deemed appropriate, legislation to impede its practice. Education to change public opinion regarding the harmful effects of FGM is also a focus of the approach (Who Health Forum, 1997).

NGOs have contributed greatly in educating communities about the harmful effects of FGM. In Africa, where incidence of FGM is high, Plan International has initiated several projects. In Mali, Plan in conjunction with a local women's NGO, AMSOPT (The Association of Malian Women Against Harmful Traditional Practices) have established a project focusing on FGM and reproductive health (McConville, 1998). The intention is to educate communities about the adverse effects of FGM, whilst also promoting the traditional practices that have a positive impact such as prolonged maternal lactation. This project was marked by the July, 1996 ceremony where 25 excision practitioners symbolised their abandonment of FGM by laying down their circumcision instruments (Plan International, 1998).

Another Plan International initiative is happening in Sanmategna, Burkina Faso (West Africa). This involves a Health and Training Project which possesses a large FGM awareness component. Research has been undertaken into knowledge, attitudes and practices related to FGM in 10 villages. Educational Tools have been utilised such as a video performed by local villagers, educational/sensitisation campaigns and female community members who are known as 'social change women' have been trained to actively make widespread information on FGM (Plan International, 1998).

Like WHO and Plan, many organisations are working towards the prevention and eradication of FGM. They include:- the United Nations Children's Fund (UNICEF), the Inter-Africa Committee on Harmful Traditional Practices (IAC) and the United Nations Population Fund (UNPFA); Royal Australian College et al, 1997). Additionally, health, social and religious organisations have either issued statements or are working to

support the cessation of FGM. These organisations include: - the World Medical Association, the International Federation of Gynaecology and Obstetrics (FIGO) and the Foundation for Women's Health Research and Development (FORWARD) (Royal Australian College et al, 1997).

SPECIFIC COUNTRY INITIATIVES

Egypt

This nation has a high prevalence of FGM and an overwhelming historical antecedence of FGM that entrenches the practice as part of the mainstream culture of Egyptian society. Despite this long legacy of FGM, activists opposed to FGM have been vocal since the late 1970s. Initially the main focus of argument had been the adverse health effects associated with FGM which has been reflected in the initiatives put forward by the government in the past. Following a United Nations conference in Cairo, President Mubarak was coerced into establishing legislation that banned FGM (Wright, 1996). However, legislation was withdrawn within a few months and the focus was turned towards ensuring medical personnel perform the "operation". FGM was permitted to be performed in public hospitals (El Hadi, 1997) despite condemnation of physicians by the World Health Organization and the World Medical Association (Wright, 1996). In 1994, the Task Force Against Female Mutilation was established and flourished as a national movement (El Hadi, 1997). With this movement, the emphasis of FGM as a human rights violation came to the fore, thus the initiative to perform FGM in hospitals to minimise physical complications was perceived in conflict with this view (El Hadid, 1997).

The Task Force, in conjunction with NGOs, has done much to encourage the cessation of FGM. A national campaign was launched which provided public seminars throughout Egypt, publication of letters and articles in the print media, holding of meetings with NGOs and government representatives and the collection of signatures for a petition to reverse the 1994 decision to permit FGM in public hospitals. In response to these initiatives the Egyptian Government put forth a decree that prohibited physicians from performing FGM in health facilities (El Hadi, 1979).

In addition, religious authorities have reinforced that FGM is not an Islamic practice. Activists had previously taken legal action against a religious leader who had declared that all Muslim women should be circumcised (El Hadi, 1997). Government owned media is also more critical of practitioners of FGM. Deaths from FGM have been reported in the news since 1995 (El Hadi, 1997). Political lobbying and the dissemination of information about FGM through the media and via national campaigns are gradually changing countries' conscience about this practice.

France

Within France, it is primarily African immigrant women who have been subjected to FGM (Who Health Forum 1997; Gallard, 1995). It was with the increase of migrants from African countries that initiatives dealing with FGM increased in number. Around 1977, the concern had previously focused on Womens' rights, the French Family Planning Association complained to WHO about its silence regarding FGM and also brought the issue before the medical commission of the Regional Council of the International Planned Parenthood Federation (Gallard, 1995).

Initial reaction to FGM was not to intervene in what was described as a cultural tradition.

However with more exposure to the ramifications of FGM in a health and social context by paramedical staff, legal representatives, the general public and finally with the death of two young girls from FGM, that authorities established concrete plans of action.

The Family Planning Association established the following initiatives. An information booklet on FGM and its health consequences was produced for health professionals and interpreters. Discussion groups were organised for women who attended the centre (Gallard, 1995).

The then Minister for Women's rights, Yvette Roudy, established a working party that proposed immigration candidates be given information via French Consulates and upon arrival via immigrant worker's association. The information would be in the form of leaflets on family legislation in France and on the prohibition and punishment of FGM (Gallard, 1995).

Penal repression has been introduced. Whilst there is no specific legislation that addresses FGM, it falls under Article 312 of the Penal Code which refers to "grievous bodily harm to a minor under 15" (Gallard, p1591, 1995). Imprisonment can be from 3 months upwards with fines (Gallard, 1995). Excisors, Fathers and Mothers have all been charged (Gallard, 1995).

To the present day, the Government and public institutions are involved in the goal to eradicate FGM. Prevention Kits have been produced and distributed throughout the Paris area where a majority of immigrants reside. These leaflets have been circulated nationally (Gallard, 1995).

Health and Welfare teams report children at risk of, or who have suffered FGM, to the appropriate bodies. School Authorities are notified if the child is at risk and of school age (Gallard, 1995).

Other Countries

Many of the initiatives previously discussed are implemented in other countries in an effort to combat FGM. Legislation, with varying degrees of success (primarily due to its sensitive nature and the still marked secrecy) exists in Kenya, however, approximately 50% of girls continue to be circumcised (Wright, 1996). In Somalia, a commission was established to abolish infibulation (the most severe form of FGM) however its recommendations were not enforced (Elchalal et al, 1997).

In Western countries, Sweden and the United Kingdom have passed specific legislation that makes all forms of FGM illegal (Elchalal et al, 1997). FGM is covered under existing child abuse laws in the following countries:- Belgium, Canada, Holland, Italy and the United States (Elchalal et al, 1997). Elchalal et al (1997) states that Australia covers FGM in the same capacity, however, the FGM act was established in New South Wales in 1994. Wright also includes Norway, Denmark and Switzerland as countries who have legislation against FGM (1996).

Australia

According to Marshall, (1994) the women in Australia who are effected by FGM are predominantly those who have migrated from the countries and regions around the horn of Africa. Whilst this may reflect national trends, statistics of New South Wales present a high incidence of migration from Indonesia and Egypt – two countries where FGM is practiced widely (Western Sydney Area Health Service, Multicultural Health Unit, 1998). Many of these women have Refugee status (Marshall, 1994). Additionally, Introcision has been documented as occurring amongst some indigenous people in Australia (Elchalal et al, 1997).

In 1994 a Report to the Attorney-General was prepared by the Family Law Council which recommended that education and legislation be the means to prevent the practice of FGM in Australia (Family Law Council, 1994). It is from this report that present initiatives have been established. Whilst it has been recommended that education focus on members of the community who come from countries who practice FGM, other target groups for education include: child protection workers, care providers (including doctors, midwives, nurses, educators, child and ethnic care workers, social workers, community workers), police, the courts and the legal profession (Family Law Council, 1994). Legislation was recommended as the report expressed that education in itself would not result in the elimination of FGM without the duration of FGM being prolonged (Family Law Council, 1994).

Education

As part of the Family Law Council's recommendations, the National Education Program on Female Genital Mutilation was established in 1995 (Royal Australian College et al, 1997; Western Sydney Area Health Service, Multicultural Health Unit, 1998). Funding is provided by the Commonwealth Department of Health and Family Services with implementation based at State/Territory level (Royal Australian College et al, 1997)..

Western Sydney Area Health Service formulated the New South Wales Implementation Plan and was then contracted by the New South Wales Department of Health to implement the strategy (Western Sydney Area Health Service, Multicultural Health Unit, 1998). A holistic approach has been adopted in relation to the issue of FGM and in incorporating communities affected by the practice. The program includes:

- "ongoing community consultation, education and support;
- development of education programs for health service providers;
- facilitating access to health services for women and girls affected by FGM and assistance with the development of services responsive to their needs;
- coordination of interdepartmental activities across the state." (Western Sydney Area Health Service, Multicultural Health Unit, 1998)

Demographic/socio-cultural profiles of priority communities and their location have been formulated by the health service in hope that the information acquired will assist health service providers to assess the relevance of the implemented service to the specific demographic compilation of that area. The profiles intend to provide information on socio-cultural issues which affect given communities by providing a summary on how affected communities are living in Australia. Emphasis is also placed on migration

issues which effect these communities and how this impacts on health status and access to health services (Western Sydney Area Health Service, Multicultural Health Unit, 1998).

Other sources of education will include a training program for health service providers by the New South Wales education program on FGM and written information such as that compiled by the Royal Australian College of Obstetricians and Gynaecologists for Health Professionals (Royal Australian College et al, 1997). Many educational and preventative initiatives have also been established by communities affected by FGM (Royal Australian College et al, 1997). Education has been instigated as the main tool to combat FGM in Australia. However, as Dixon (1996) states, it will only be once the cultural group as a whole perceives FGM as harmful and unnecessary that it will be eradicated.

Legislation

On the recommendations of the Family Law Council Report specific legislation in reference to FGM was implemented. The Crimes (Female Genital Mutilation) Amendment Act (New South Wales) 1995, took effect on May 1995. It was the first formal criminalisation of the practice in Australia (Dixon, 1996). An example of specific legislation, previous prosecution in New South Wales regarding FGM fell under the provisions of the Crimes Act 1900 (Dixon, 1996). Specific legislation has been deemed beneficial as it is clear, provides an educational tool for community workers when explaining the law to effected communities and also provides some support for women from effected communities who wish to end this practice within their community (Dixon,

1996). However, an ongoing fear remains with legislation that the practice will go 'underground' and result in further risking the lives of those subjected to this practice (Family Law Council, 1994). Other criticisms involve the concern that women from affect communities will not access health services in fear that their daughters will be taken away from them and the possibility that active community participation in education initiatives may decrease (Marshall, 1994). Thus there is a need for more widespread education about FGM, a tradition practice of another culture(s) within a new cultural environment such as Australia, where patriarchal influence is present, but human rights are valued.

Except for Queensland and Western Australia, all other states and Territories have specific legislation prohibiting FGM. Western Australia is in the process of developing legislation while Queensland continues to incorporate FGM under general offences related to assault (Royal Australian College et al, 1997).. Under the legislation, a person who intentionally performs FGM on a person can be imprisoned for up to 7 years as can a person who takes a child from a jurisdiction with the intention of having FGM performed on the child (Royal Australian College et al, 1997). Provision for medical procedures which are deemed therapeutic has been made in the legislation (Royal Australian College et al, 1997).

CONCLUSION

This paper has explored the reasons given for the occurrence of Female Genital Mutilation using the relevant literature, a definition of FGM, its prevalence and effects have been outlined. Preventative measures utilised by world organisations and specific

country initiatives were discussed. Specifically, Australia's response to FGM was reviewed in terms of education and legislation. Despite the fact that FGM is a culture specific practice, it causes physical, sexual and psychological trauma. It has on occasion resulted in death. It is my belief that it is wrong, given its potential to determine life. It is also medically unnecessary.

Condemnation of FGM by those outside the cultures who practice it can be perceived as intolerance and possibly racist, by the cultures who do practice FGM, which in some respects, is justified when we don't condemn aspects of our own society which distemper or neglect women. However, it is an unnecessary and harmful practice that can be changed by human belief and behavior. It is only when those who perpetuate the practice view it as unnecessary and discover alternative solutions to acquire economic security and reinforce womanhood in young girls that FGM will cease to exist.

Education and legislation have been seen as ways of initiating that change. Support in bringing about that change is another.

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