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FEMALE GENITAL MUTILATION: THE PLACE OF CULTURE AND THE DEBILITATING EFFECTS ON THE DIGNITY OF THE FEMALE GENDER

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Abstract

Female genital mutilation (FGM) has four major types which arise from the degree to which the external genitalia of the female are affected. Its origin is shrouded with mysteries but historical evidences point to Egypt as the source country, before its spread through countries in sub-Saharan Africa, Asia, the Middle East, as well as some migrants in Europe, United States and Australia. Reasons for carrying out the practice range from ethnic and tribal cultures, family relations, tribal connections, class, economic and social circumstances; and education etc. The effects on the affected young girls and women may be short term (severe pain, shock, haemorrhage (bleeding), tetanus or sepsis (bacterial infection), urine retention, open sores in the genital region and injury to nearby genital tissue and sometimes death); or long term (physical, sexual and psychological). Different nations in the affected regions have enacted one law or the other at a point in time in their history to curb this degrading menace but the prevalence data shows that the practice is far from being eradicated. The discourse brings to the fore, the implications of FGM practice on the dignity of the female gender and proposes an annihilation of this dastardly act.

Keywords: Female genital mutilation (FGM), dignity, culture, historical origin

Introduction

FGM is an age long practice which dates back to several hundreds of years ago. According to Okeke, Anyaehie and Ezenyeaku (2012), FGM is

widely recognized as a violation of human rights, which is deeply rooted in cultural beliefs and perceptions over decades and generations with no easy task for change. The practice is defined by World Health Organisation (WHO) (2010) as, "*all procedures that involve partial or total removal of the external female genitalia, other injury to the female genital organs for non-medical reasons*". WHO (2010) classifies FGM into four major types:

Type I (Clitoridectomy): partial or total removal of the clitoris (small, sensitive and erectile part of the female genitals) and, in very rare cases, only the prepuce i.e. the fold of skin surrounding the clitoris.

Type II (Excision): this involves the partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (the labia are "the lips" that surround the vagina).

Type III (Infibulation): This, the most severe form, is the narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the inner or outer labia, with or without removal of the clitoris. An Amnesty International Document – (AID, 2013a), states that the repositioning of the wound edges consists of stitching or holding the cut areas together for a certain period of time (for example, girls' legs are bound together), to create the covering seal. A small opening is left for urine and menstrual blood to escape (Ahmadi, 2013; Okeke *et al*., 2012).

Type IV (Others): all other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterizing the genital area.

Historical Perspectives

Kouba and Muasher (1985) states that though the exact date of female circumcision and when female genital mutilation started is not very clear, existing documents and Greek historians and geographers, such as Herodotus (425 – 484 B.C.) and Strabo (64 B.C. – 23 A.D.) show that female circumcision happened in Ancient Egypt and the time of the Pharaohs. Consequently, Egypt is considered as the source country of female circumcision. Female circumcision has prevailed during the years of 1400 B.C. to 2000 B.C. in Egypt (Drummer, 2010), and apparently it was done in religious ceremonies and rites (Ahmadi, 2013). According to existing evidences, the Egyptians are considered as the pioneers of this tradition although female circumcision has also moved to other regions of the world – especially Africa. Momoh (2005) states that female circumcision was present a long time ago and among other nations of the world including the Romans who in order to avoid their female slaves from pregnancy, installed some rings on the two sides of the outer lips of the uterus.

The procedure, according to AID (2013b), is carried out at a variety of ages, ranging from shortly after birth to sometime during the first pregnancy. It most commonly occurs between the ages of 0 to 15 years and the age is decreasing in some countries. The practice has been linked in some countries with rites of passage for women. FGM is usually performed by traditional practitioners using a sharp object such as knife, razor blade or broken glass.

Prevalence by Countries in Different Regions

According to Wikipedia (2014), FGM is practiced in Africa, the Middle East, Indonesia and Malaysia, as well by some migrants in Europe, United States and Australia. It is also seen in some populations of South Asia namely – Afghanistan (EWIC, 2005); Maldives (HRW, 2012); Malaysia (Rahman, Rahman, Isa, Shuib, Shukri & Othman, 1999) and Indonesia (Feillard and Morcoes, 1998). The highest known prevalence rates are in 30 African countries, in a band that stretches from Senegal in West Africa to Ethiopia on the east coast, as well as from Egypt in the north to Tanzania in the south. According to **AID (2013b)**, Countries with high prevalence rates (> 85%) are for example Somalia, Egypt and Mali. Low prevalence rates (< 30%) are found in for example Senegal, Central African Republic and Nigeria.

As a result of immigration, FGM has also spread to Europe, Australia, and the United States, with some families having their daughters undergo the procedure while on vacation overseas. As Western governments become more aware of FGM, Legislation has come into effect in western countries to make the practice a criminal offense. In 2006, Khalid Adem became the first man in the United States to be prosecuted for mutilating his daughter by cutting off her clitoris with a scissors (Gulf News, 2012).

According to Ahmadi (2013), female genital mutilation is presently carried out in vast regions of the African continent and some Asian countries, with the highest statistics regarding female circumcision being related to the African countries of the Sub Sahara, such as the countries located in the famous region of Horn Africa (Sudan, Somalia, Eritrea, Ethiopia and Djibouti). From illustrations shown in Fig. 1and statistics shown in Table 1, it is obvious that some countries of the West Africa (Niger, Nigeria, Togo, Benin, Ghana, Mali, Senegal, Cote d'ivoire (Ivory Coast), Cameroon, Burkina Faso, Mauritania, Liberia, Sierra Leone, Guinea-Bissau, and Equatorial Guinea) have the highest percentage of FGM around the world.

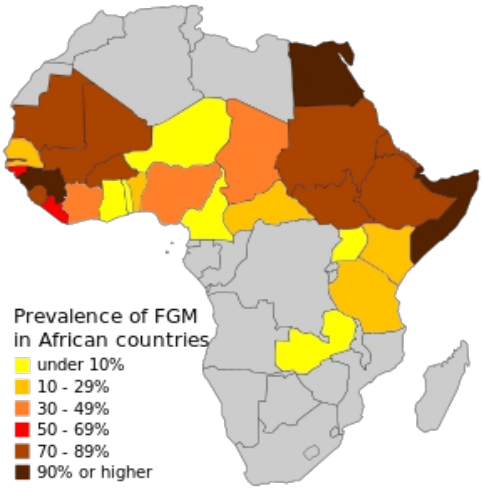

Fig. 1 – Prevalence of FGM in African Countries
(Source: http://data.unicef.org/child-protection/fgmc – Wikipedia, 2014)

Table 1: Female Genital Mutilation (FGM) Practices in Parts of West Africa, Asia and the Middle East

Country	Prevalence	Type
West Africa		
Benin	5-50%	Excision
Burkina Faso	up to 70%	Excision
Cameroon	local	Clitoridectomy and excision
Côte d'Ivoire	up to 60%	Excision
Gambia	60-90%	Excision and infibulations
Ghana	15-30%	Excision
Guinea	65-90%	Clitoridectomy, excision and infibulations
Guinea Bissau	local	Clitoridectomy and excision
Liberia	50%	Excision
Mali	94%	Clitoridectomy, excision and infibulations
Mauritania	25%	Clitoridectomy and excision
Niger	local	Excision
Nigeria	60-90%	Clitoridectomy, excision, some infibulations
Senegal	20%	Excision
Sierra Leone	90%	Excision
Togo	12%	Excision
Middle East		
Iran	55 – 60 %	Type I and II
Iraq	>80%	Type I, II and III common
Kuwait	38%	Type II and III common
UAE (United Arab Emirate)	31 – 34 %	FGM practice common
Yemen	13 % (Type I); 97 % (Type II)	Types I and II common
Asia		
India	90 %	FGM practice common
Malaysia	62 – 90 %	Types I and IV common
Indonesia	90 %	Types I and IV common

Culled from Ahmadi,(2013); Wikipedia, (2014).

Cultural, Religious and Social Causes

Different races and cultures have a variety of reasons for carrying out FGM. In West Africa, this may be related to different ethnic and tribal cultures, family relations, tribal connections, class, economic and social circumstances, and education etc. (Ahmadi, 2013).

- Amongst the factors that encourage families to circumcise their daughters is the family's concern about the girl's inability to marry if she is not circumcised. La Barbera, (2010) states that an important part of this goes back to the recognition of women who are not circumcised as indecent which has resulted in the fact that African women do strongly support the action of female genital mutilation in spite of the pain and agony and consider it so vital for their daughters' future, especially for their marriage.
- Some indigenous Africans believe that circumcised girls might control their sexual desires accordingly after maturity and it protects them from sins and faults, while a great number of Africans also believe that women, who have not gone through circumcision in their childhood, face multiple physical problems at birth (La Barbera, 2010).
- it is believed that uncircumcised women have lower fertility powers compared to circumcised women and are not able to control their sexual desires (Ahmadi, 2013). On the other hand, in the majority of West African countries, female circumcision represents their purity and innocence (Erlich, 1986).
- Female circumcision in West African countries also has a close relationship with the maturity ceremonies and celebrations which familiarize the girls with their responsibilities as future women of the society; and these ceremonies are cherished in West Africa – as they are usually accompanied with celebrations, coupled with dancing, singing and cooking special dishes – as a part of their oral culture (Joseph, 2003).
- Virginity, in a lot of African communities, is valued as a pre-requisite for marriage and equated to female honour. FGM, infibulation in particular, is defended in this context as it is assumed to reduce a woman's sexual desire and lessen temptations to have extramarital sex thereby preserving a girl's virginity (AID, 2013e).
- Hygiene: There is a belief that female genitalia are unsightly and dirty. In some FGM-practicing societies, unmutilated women are regarded as unclean and are not allowed to handle food and water (AID, 2013e).

- Gender based factors: FGM is often deemed necessary in order for a girl to be considered a complete woman, and the practice marks the divergence of the sexes in terms of their future roles in life and marriage. The removal of the clitoris and labia – viewed by some as the "male parts" of a woman's body – is thought to enhance the girl's femininity, often synonymous with docility and obedience (AID, 2013e).
- Religion: FGM predates Islam and is not practiced by the majority of Muslims, but it has acquired a religious dimension. Where it is practiced by Muslims, religion is frequently cited as a reason. Many of those who oppose mutilation deny that there is any link between the practice and religion, but Islamic leaders are not unanimous on the subject. Although predominant among Muslims, FGM also occurs among Christians, animists and Jews (AID, 2013e).
- Cultural identity: In certain communities, where mutilation is carried out as part of the initiation into adulthood, FGM defines who belongs to the community. In such communities, a girl cannot be considered an adult in a FGM-practicing society unless she has undergone FGM (AID, 2013e).

Effects of FGM

The WHO Fact Sheet (2014), states that FGM has no health benefits and it harms girls and women in many ways. Immediate complications could include severe pain, shock, haemorrhage (bleeding), tetanus or sepsis (bacterial infection), urine retention, open sores in the genital region and injury to nearby genital tissue. According to AID (2013d), the **i**mmediate consequences of FGM include: severe pain and bleeding, shock, difficulty in passing urine, infections, injury to nearby genital tissue and sometimes death. In addition to the severe pain during and in the weeks following the cutting, women who have undergone FGM experience various long-term effects which may be physical, sexual and psychological:

- Women may experience chronic pain, chronic pelvic infections, development of cysts, abscesses and genital ulcers, excessive scar tissue formation, infection of the reproductive system, decreased sexual enjoyment and psychological consequences, such as post-traumatic stress disorder.
- Additional risks for complications from infibulations include urinary and menstrual problems, infertility, later surgery (defibulation and reinfibulation) and painful sexual intercourse. Sexual intercourse can only take place after opening the infibulation, through surgery or penetrative sexual intercourse (***defibulation*****).** Consequently, sexual intercourse is frequently painful during the first weeks after sexual

initiation and the male partner can also experience pain and complications.

- *When giving birth, the scar tissue might tear, or the opening needs to be cut to allow the baby to come out*. After childbirth, women from some ethnic communities are often sown up again to make them "tight" for their husband (***reinfibulation***). Such cutting and restitching of a woman's genitalia results in painful scar tissue.
- According to a WHO study in six African countries, it was shown that *women who had undergone FGM, had significantly increased risks for adverse events during childbirth, and that genital mutilation in mothers has negative effects on their newborn babies*. According to the study, an additional one to two babies per 100 deliveries die as a result of FGM (AID, 2013d).

Some complications of FGM are implantation dermoid cysts and keloids (Akpuaka 1991); chronic pelvic infection, acquired gynatresia resulting in hematocolpos, vulval adhesions, dysmenorrhea, retention cysts, and sexual difficulties with anorgasmia, injury to rectum, and purperial sepsis (Okeke *et al*., (2012).

Nations' Actions against FGM

According to Wikipedia (2014), Sudan was the first country to outlaw FGM in 1946, under the British, although there is currently no law forbidding it. The Togolese government in 1998 voted unanimously to outlaw the practice of FGM (US Dept., 2001). Penalties ranging from a prison term of two months to ten years and a fine of 100,000 francs to one million francs (approximately US$160 to 1,600) are approved by the law. A person who had knowledge that the procedure was going to take place and failed to inform public authorities can be punished with one month to one year imprisonment or a fine of from 20,000 to 500,000 francs (approximately US$32 to 800).

In July 2003, at its second summit, the African Union adopted the Maputo Protocol promoting women's rights and calling for an end to FGM. The agreement came into force in November 2005, and by December 2008, 25 member countries had ratified it(US Dept., 2001).

Togo ratified the Maputo Protocol in 2005(Wikipedia (2014); and as of 2013, 18 African countries have outlawed FGM/Cutting practice, including Benin, Burkina Faso, Central African Republic, Chad, Côte d'Ivoire, Djibouti, Egypt, Ghana, Guinea, Kenya, Niger, Nigeria, Senegal, Somalia, Sudan, Tanzania, Togo and Uganda (Lazuta, 2013; FRS, 2013).

In Uganda, anyone convicted of carrying out FGM is subject to 10 years in prison. If the life of the patient is lost during the operation a life sentence is recommended (BBC News, 2009). Uganda signed the Maputo

Protocol in 2003 but has not ratified it. (UGPulse, 2008). In early July 2009, President Yoweri Museveni stated that a law would be passed prohibiting the practice, with alternative livelihoods found for its practitioners (The New Vision, 2007).

In Nigeria, of the six largest ethnic groups, the Yoruba, Hausa, Fulani, Ibo, Ijaw and Kanuri, only the Fulani do not practice any form of female genital mutilation (Online News, 2005). Reasons for the increase have been attributed amongst others to the definition of FGM used, which included Type IV FGMs. In some parts of Nigeria, the vagina walls are cut in new born girls or other traditional practices performed - such as the *angurya* and *gishiri* cuts - which fall under Type IV FGM classification of the World Health Organization (FMECD, 2011). Presently, there is no federal law banning the practice of FGM in Nigeria, although Nigeria ratified the Maputo Protocol in 2005. A few states of Nigeria, including Abia, Bayelsa, Cross River, Delta, Ogun, Osun and Rivers State have passed laws to address FGMs. Perpetrators of these dastardly acts usually dare any law enforcement agent to arrest them as they go about carrying out their "*business*". These laws are being mocked by excisers who conduct FGMs, and they dare any law enforcement agent to arrest them (UN, 2009). On January 26th 2015, BBC News reported the jailing of an Egyptian medical doctor charged with manslaughter, for performing female genital mutilation operation on a teenage girl, Suhair al-Bataa, who died after undergoing the surgery in 2013.

Conclusion

The eventual, total eradication of FGM in the countries that practice it, especially in the West African sub-region and Sub-Saharan Africa as a whole, is still much of a mirage. The enactment of appropriate laws and enforcement of sanctions may go a long way in helping to reduce the prevalence of this menace, but it will not completely eradicate it. Creation of awareness as to the obvious dangers emanating from the practice will, in the long run, help in curbing the excesses of parents and traditionalists who obviously do not want to do away with this barbaric custom which, from all evidence, does no good but harm to the physical and psychological dignity of the female gender.

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