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# WHAT IS FEMALE GENITAL MUTILATION?

## The different types of mutilation

Female genital mutilation (FGM) is the term used to refer to the removal of part, or all, of the female genitalia. The most severe form is infibulation, also known as pharaonic circumcision. An estimated 15% of all mutilations in Africa are infibulations. The procedure consists of clitoridectomy (where all, or part of, the clitoris is removed), excision (removal of all, or part of, the labia minora), and cutting of the labia majora to create raw surfaces, which are then stitched or held together in order to form a cover over the vagina when they heal. A small hole is left to allow urine and menstrual blood to escape. In some less conventional forms of infibulation, less tissue is removed and a larger opening is left.

The vast majority (85%) of genital mutilations performed in Africa consist of clitoridectomy or excision.
The least radical procedure consists of the removal of the clitoral hood.
In some traditions a ceremony is held, but no mutilation of the genitals occurs. The ritual may include holding a knife next to the genitals, pricking the clitoris, cutting some pubic hair, or light scarification in the genital or upper thigh area.

## The procedures followed

The type of mutilation practised, the age at which it is carried out, and the way in which it is done varies according to a variety of factors, including the woman or girl's ethnic group, what country they are living in, whether in a rural or urban area and their socio-economic provenance.

The procedure is carried out at a variety of ages, ranging from shortly after birth to some time during the first pregnancy, but most commonly occurs between the ages of four and eight. According to the World Health Organization, the average age is falling. This indicates that the practice is decreasingly associated with initiation into adulthood, and this is believed to be particularly the case in urban areas.

Some girls undergo genital mutilation alone, but mutilation is more often undergone as a group of, for example, sisters, other close female relatives or neighbours. Where FGM is carried out as part of an initiation ceremony, as is the case in societies in eastern, central and western Africa, it is more likely to be carried out on all the girls in the community who belong to a particular age group.

The procedure may be carried out in the girl's home, or the home of a relative or neighbour, in a health centre, or, especially if associated with initiation, at a specially designated site, such as a particular tree or river. The person performing the mutilation may be an older woman, a traditional midwife or healer, a barber, or a qualified midwife or doctor.

Girls undergoing the procedure have varying degrees of knowledge about what will happen to them. Sometimes the event is associated with festivities and gifts. Girls are exhorted to be brave. Where the mutilation is part of an initiation rite, the festivities may be major events for the community. Usually only women are allowed to be present.

Sometimes a trained midwife will be available to give a local anaesthetic. In some cultures, girls will be told to sit beforehand in cold water, to numb the area and reduce the likelihood of bleeding. More commonly, however, no steps are taken to reduce the pain.

The girl is immobilized, held, usually by older women, with her legs open. Mutilation may be carried out using broken glass, a tin lid, scissors, a razor blade or some other cutting instrument. When infibulation takes place, thorns or stitches may be used to hold the two sides of the labia majora together, and the legs may be bound together for up to 40 days. Antiseptic powder may be applied, or, more usually, pastes — containing herbs, milk, eggs, ashes or dung — which are believed to facilitate healing. The girl may be taken to a specially designated place to recover where, if the mutilation has been carried out as part of an initiation ceremony, traditional teaching is imparted. For the very rich, the mutilation procedure may be performed by a qualified doctor in hospital under local or general anaesthetic.

## Geographical distribution of female genital mutilation

An estimated 135 million of the world's girls and women have undergone genital mutilation, and two million girls a year are at risk of mutilation — approximately 6,000 per day. It is practised extensively in Africa and is common in some countries in the Middle East. It also occurs, mainly among immigrant communities, in parts of Asia and the Pacific, North and Latin America and Europe.

FGM is reportedly practised in more than 28 African countries (see FGM in Africa: Information by Country (ACT 77/07/97)). There are no figures to indicate how common FGM is in Asia. It has been reported among Muslim populations in Indonesia, Sri Lanka and Malaysia, although very little is known about the practice in these countries. In India, a small Muslim sect, the Daudi Bohra, practise clitoridectomy.

In the Middle East, FGM is practised in Egypt, Oman, Yemen and the United Arab Emirates.

There have been reports of FGM among certain indigenous groups in central and south America, but little information is available.

In industrialized countries, genital mutilation occurs predominantly among immigrants from countries where mutilation is practised. It has been reported in Australia, Canada, Denmark, France, Italy, the Netherlands, Sweden, the UK and USA. Girls or girl infants living in industrialized countries are sometimes operated on illegally by doctors from their own community who are resident there. More frequently, traditional practitioners are brought into the country or girls are sent abroad to be mutilated. No figures are available on how common the practise is among the populations of industrialized countries.

## The physical and psychological effects of female genital mutilation

### Physical effects

The effects of genital mutilation can lead to death. At the time the mutilation is carried out, pain, shock, haemorrhage and damage to the organs surrounding the clitoris and labia can occur. Afterwards urine may be retained and serious infection develop. Use of the same instrument on several girls without sterilization can cause the spread of HIV.

More commonly, the chronic infections, intermittent bleeding, abscesses and small benign tumours of the nerve which can result from clitoridectomy and excision cause discomfort and extreme pain.

Infibulation can have even more serious long-term effects: chronic urinary tract infections, stones in the bladder and urethra, kidney damage, reproductive tract infections resulting from obstructed

menstrual flow, pelvic infections, infertility, excessive scar tissue, keloids (raised, irregularly shaped, progressively enlarging scars) and dermoid cysts.

First sexual intercourse can only take place after gradual and painful dilation of the opening left after mutilation. In some cases, cutting is necessary before intercourse can take place. In one study carried out in Sudan, 15% of women interviewed reported that cutting was necessary before penetration could be achieved.1 Some new wives are seriously damaged by unskilful cutting carried out by their husbands. A possible additional problem resulting from all types of female genital mutilation is that lasting damage to the genital area can increase the risk of HIV transmission during intercourse.

During childbirth, existing scar tissue on excised women may tear. Infibulated women, whose genitals have been tightly closed, have to be cut to allow the baby to emerge. If no attendant is present to do this, perineal tears or obstructed labour can occur. After giving birth, women are often reinfibulated to make them "tight" for their husbands. The constant cutting and restitching of a women's genitals with each birth can result in tough scar tissue in the genital area.

The secrecy surrounding FGM, and the protection of those who carry it out, make collecting data about complications resulting from mutilation difficult. When problems do occur these are rarely attributed to the person who performed the mutilation. They are more likely to be blamed on the girl's alleged "promiscuity" or the fact that sacrifices or rituals were not carried out properly by the parents. Most information is collected retrospectively, often a long time after the event. This means that one has to rely on the accuracy of the woman's memory, her own assessment of the severity of any resulting complications, and her perception of whether any health problems were associated with mutilation.

Some data on the short and long-term medical effects of FGM, including those associated with pregnancy, have been collected in hospital or clinic-based studies, and this has been useful in acquiring a knowledge of the range of health problems that can result. However, the incidence of these problems, and of deaths as a result of mutilation, cannot be reliably estimated. Supporters of the practice claim that major complications and problems are rare, while opponents of the practice claim that they are frequent.

Effects on sexuality

Genital mutilation can make first intercourse an ordeal for women. It can be extremely painful, and even dangerous, if the woman has to be cut open; for some women, intercourse remains painful. Even where this is not the case, the importance of the clitoris in experiencing sexual pleasure and orgasm suggests that mutilation involving partial or complete clitoridectomy would adversely affect sexual fulfilment. Clinical considerations and the majority of studies on women's enjoyment of sex suggest that genital mutilation does impair a women's enjoyment. However, one study found that 90% of the infibulated women interviewed reported experiencing orgasm.2 The mechanisms involved in sexual enjoyment and orgasm are still not fully understood, but it is thought that compensatory processes, some of them psychological, may mitigate some of the effects of removal of the clitoris and other sensitive parts of the genitals.

Psychological effects

The psychological effects of FGM are more difficult to investigate scientifically than the physical ones. A small number of clinical cases of psychological illness related to genital mutilation have been reported.3 Despite the lack of scientific evidence, personal accounts of mutilation reveal

feelings of anxiety, terror, humiliation and betrayal, all of which would be likely to have long-term negative effects. Some experts suggest that the shock and trauma of the operation may contribute to the behaviour described as “calmer” and “docile”, considered positive in societies that practise female genital mutilation.

Festivities, presents and special attention at the time of mutilation may mitigate some of the trauma experienced, but the most important psychological effect on a woman who has survived is the feeling that she is acceptable to her society, having upheld the traditions of her culture and made herself eligible for marriage, often the only role available to her. It is possible that a woman who did not undergo genital mutilation could suffer psychological problems as a result of rejection by the society. Where the FGM-practising community is in a minority, women are thought to be particularly vulnerable to psychological problems, caught as they are between the social norms of their own community and those of the majority culture.

## Why FGM is practised

### Cultural identity

“Of course I shall have them circumcised exactly as their parents, grandparents and sisters were circumcised. This is our custom.”
An Egyptian woman, talking about
her young daughters 4

Custom and tradition are by far the most frequently cited reasons for FGM. Along with other physical or behavioural characteristics, FGM defines who is in the group. This is most obvious where mutilation is carried out as part of the initiation into adulthood.

Jomo Kenyatta, the late President of Kenya, argued that FGM was inherent in the initiation which is in itself an essential part of being Kikuyu, to such an extent that “abolition... will destroy the tribal system”.5 A study in Sierra Leone reported a similar feeling about the social and political cohesion promoted by the Bundo and Sande secret societies, who carry out initiation mutilations and teaching.

Many people in FGM-practising societies, especially traditional rural communities, regard FGM as so normal that they cannot imagine a woman who has not undergone mutilation. Others are quoted as saying that only outsiders or foreigners are not genitally mutilated. A girl cannot be considered an adult in a FGM-practising society unless she has undergone FGM.

### Gender identity

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. It is possible that the trauma of mutilation may have this effect on a girl’s personality. If mutilation is part of an initiation rite, then it is accompanied by explicit teaching about the woman’s role in her society.

“We are circumcised and insist on circumcising our daughters so that there is no mixing between male and female... An uncircumcised woman is put to shame by her husband, who calls her ‘you with the clitoris’. People say she is like a man. Her organ would prick the man...”
An Egyptian woman 6

Control of women's sexuality and reproductive functions

"Circumcision makes women clean, promotes virginity and chastity and guards young girls from sexual frustration by deadening their sexual appetite."
Mrs Njeri, a defender of female genital
mutilation in Kenya7

In many societies, an important reason given for FGM is the belief that it reduces a woman's desire for sex, therefore reducing the chance of sex outside marriage. The ability of unmutilated women to be faithful through their own choice is doubted. In many FGM-practising societies, it is extremely difficult, if not impossible, for a woman to marry if she has not undergone mutilation. In the case of infibulation, a woman is "sewn up" and "opened" only for her husband. Societies that practise infibulation are strongly patriarchal. Preventing women from indulging in "illegitimate" sex, and protecting them from unwilling sexual relations, are vital because the honour of the whole family is seen to be dependent on it. Infibulation does not, however, provide a guarantee against "illegitimate" sex, as a woman can be "opened" and "closed" again.

In some cultures, enhancement of the man's sexual pleasure is a reason cited for mutilation. Anecdotal accounts, however, suggest that men prefer unmutilated women as sexual partners.

Beliefs about hygiene, aesthetics and health

Cleanliness and hygiene feature consistently as justifications for FGM. Popular terms for mutilation are synonymous with purification (tahara in Egypt, tahur in Sudan), or cleansing (sili-ji among the Bambarra, an ethnic group in Mali). In some FGM-practising societies, unmutilated women are regarded as unclean and are not allowed to handle food and water.

Connected with this is the perception in FGM-practising communities that women's unmutilated genitals are ugly and bulky. In some cultures, there is a belief that a woman's genitals can grow and become unwieldy, hanging down between her legs, unless the clitoris is excised. Some groups believe that a woman's clitoris is dangerous and that if it touches a man's penis he will die. Others believe that if the baby's head touches the clitoris during childbirth, the baby will die.

Ideas about the health benefits of FGM are not unique to Africa. In 19th Century England, there were debates as to whether clitoridectomy could cure women of "illnesses" such as hysteria and "excessive" masturbation. Clitoridectomy continued to be practised for these reasons until well into this century in the USA. However, health benefits are not the most frequently cited reason for mutilation in societies where it is still practised; where they are, it is more likely to be because mutilation is part of an initiation where women are taught to be strong and uncomplaining about illness. Some societies where FGM is practised believe that it enhances fertility, the more extreme believing that an unmutilated woman cannot conceive. In some cultures it is believed that clitoridectomy makes childbirth safer.

Religion

FGM predates Islam and is not practised by the majority of Muslims, but has acquired a religious dimension. Where it is practised by Muslims, religion is frequently cited as a reason. Many of those who oppose mutilation deny that there is any link between the practise and religion, but Islamic leaders are not unanimous on the subject. The Qur'an does not contain any call for FGM, but a few hadith (sayings attributed to the Prophet Muhammad) refer to it. In one case, in answer

to a question put to him by ‘Um ‘Attiyah (a practitioner of FGM), the Prophet is quoted as saying “reduce but do not destroy”.
Mutilation has persisted among some converts to Christianity. Christian missionaries have tried to discourage the practice, but found it to be too deep rooted. In some cases, in order to keep converts, they have ignored and even condoned the practice.

FGM was practised by the Falasha (Ethiopian Jews), but it is not known if the practise has persisted following their emigration to Israel. The remainder of the FGM-practising community follow traditional Animist religions.

Testimony
“I was genitally mutilated at the age of ten. I was told by my late grandmother that they were taking me down to the river to perform a certain ceremony, and afterwards I would be given a lot of food to eat. As an innocent child, I was led like a sheep to be slaughtered.

Once I entered the secret bush, I was taken to a very dark room and undressed. I was blindfolded and stripped naked. I was then carried by two strong women to the site for the operation. I was forced to lie flat on my back by four strong women, two holding tight to each leg. Another woman sat on my chest to prevent my upper body from moving. A piece of cloth was forced in my mouth to stop me screaming. I was then shaved.

When the operation began, I put up a big fight. The pain was terrible and unbearable. During this fight, I was badly cut and lost blood. All those who took part in the operation were half-drunk with alcohol. Others were dancing and singing, and worst of all, had stripped naked.

I was genitally mutilated with a blunt penknife.

After the operation, no one was allowed to aid me to walk. The stuff they put on my wound stank and was painful. These were terrible times for me. Each time I wanted to urinate, I was forced to stand upright. The urine would spread over the wound and would cause fresh pain all over again. Sometimes I had to force myself not to urinate for fear of the terrible pain. I was not given any anaesthetic in the operation to reduce my pain, nor any antibiotics to fight against infection. Afterwards, I haemorrhaged and became anaemic. This was attributed to witchcraft. I suffered for a long time from acute vaginal infections.”
Hannah Koroma, Sierra Leone

1 Lightfoot-Klein, H., “The Sexual Experience and Marital Adjustment of Genitally Circumcised and Infibulated Females in the Sudan”, The Journal of Sex Research, 26 (3), pp. 375-392, 1989.

2 Lightfoot-Klein, H., Prisoners of Ritual: An Odyssey into Female Genital Circumcision in Africa, Haworth Press, New York, 1989.

3 Baasher, T.A., “Psychological Aspects of Female Circumcision”, Traditional Practices Affecting the Health of Women and Children, Report of a seminar, 10-15 February, 1979, WHO-EMRO Technical Publication 2, WHO, Alexandria, Egypt, 1979, pp. 71-105.

4 Assaad, M.B., “Female Circumcision in Egypt: Social Implications, Current Research and Prospects for Change”, Studies in Family Planning, 11:1, 1980, pp. 3-16.

5 Kenyatta, J., Facing Mount Kenya: The Tribal Life of the Kikuyu, Secker and Warburg, London, 1938.
6 Assaad, M.B., ibid.

7 Katumba, R., "Kenyan Elders Defend Circumcision", Development Forum, September, 1990, p. 17.