

5-2012

Assessing the Controversy: Female Genital Mutilation or Legitimate Rite of Passage?

Morgan Haley Brockington

Follow this and additional works at: <https://digitalcommons.library.umaine.edu/honors>



Part of the [Social and Cultural Anthropology Commons](#)

Recommended Citation

Brockington, Morgan Haley, "Assessing the Controversy: Female Genital Mutilation or Legitimate Rite of Passage?" (2012). *Honors College*. 36.

<https://digitalcommons.library.umaine.edu/honors/36>

This Honors Thesis is brought to you for free and open access by DigitalCommons@UMaine. It has been accepted for inclusion in Honors College by an authorized administrator of DigitalCommons@UMaine. For more information, please contact um.library.technical.services@maine.edu.

ASSESSING THE CONTROVERSY: FEMALE GENITAL MUTILATION OR
LEGITIMATE RITE OF PASSAGE?

by

Morgan Haley Brockington

A Thesis Submitted in Partial Fulfillment
of the Requirements for a Degree with Honors
(Anthropology)

The Honors College

University of Maine

May 2012

Advisory Committee:

Henry Munson, Associate Professor of Anthropology, Advisor

Kim Huisman, Associate Professor of Sociology

David Gross, Adjunct Associate Professor in Honors (English)

Melissa Ladenheim, Adjunct Assistant Professor in Honors (Folklore)

Nilda Cravens, Lecturer of Nursing

© 2012 Morgan Haley Brockington

All Rights Reserved

Abstract

Female genital cutting/circumcision, the partial or total removal of the external female genitalia, is a common practice in many parts of Africa. To those who perceive female circumcision as a legitimate rite of passage, the practice is culturally approved and steeped in tradition. The negative reactions and harsh judgments of Westerners who then seek to eradicate the practice are seen as ethnocentric. On the other hand, opponents of female genital cutting emphasize that the practice is a ritualized form of violence and a detriment to women's health. The practice deprives girls and women of the basic rights to physical wellbeing and bodily integrity. This thesis will provide a cross-cultural overview of the ethical debate on this controversial subject, including both the justifications for the continuation of the practice and those advocating its cessation. I will discuss the different factors that support the persistence of the practice and then formulate a culturally sensitive plan of action for the eradication of female genital cutting/circumcision. Ultimately, I assert that female circumcision is really genital *mutilation* and a violation of basic human rights with severe physical and emotional consequences.

For Meredith, Mom, and Dad.
Thank you for your infinite support and love.

Table Of Contents

Assessing the Controversy: Female Genital Mutilation or Legitimate Rite of Passage?

Chapter 1: Introduction	1
▪ Linguistic Difficulties	2
▪ Types of FGC	4
▪ History of FGC	5
▪ Facts about FGC	6
▪ Justifications for the Practice	8
Chapter 2: Femininity and Meaning	
▪ Introduction	10
▪ Ideals of Femininity	10
▪ Smoothness and Closedness	11
▪ Cleanliness	11
▪ The Azawagh Arabs of Niger	12
▪ Changing the Ideal: A Success Story	13
Chapter 3: Religion	
▪ Introduction	16
▪ FGC in Islam	16
▪ Right to Sexual Pleasure	18
▪ Using Religion for Change	19
Chapter 4: Morality and Marriageability	
▪ Introduction	20
▪ Premarital Sexual Intercourse	20
▪ Morality and Virginity	21
▪ Marriageability	21
▪ Male Double Standard	23
▪ Problems with “Guaranteed” Virginity	23
Chapter 5: Patriarchy	
▪ Introduction	26
▪ Male Values	26
▪ Male Sexuality	27
▪ Lack of Knowledge About FGC	28
▪ Men’s Role in the Eradication of FGC	29
Chapter 6: Health Consequences	
▪ Introduction	31
▪ Physical Consequences	31
▪ Physical Consequences: Ethnographic Spotlight	33
▪ Psychological Consequences	34
▪ Reproductive Consequences	35
▪ Sexual Consequences	36

▪ Sexual Consequences: Ethnographic Spotlight	37
▪ Waris Dirie’s Story	38
Chapter 7: Male Circumcision	
▪ Introduction	40
▪ History of Male Circumcision	41
▪ Religious Justification for Male Circumcision	41
▪ Health Benefits and Risks	43
▪ Male Circumcision Versus Female Genital Cutting	45
Chapter 8: Advocacy and Change	
▪ Introduction	48
▪ International Response to FGC	48
▪ World Health Organization Response	50
▪ Education and Women’s Empowerment	51
▪ Men’s Role in the Process	53
▪ Cultural Sensitivity	54
▪ Change from an Insider’s Point of View	56
▪ Alternative Rites of Passage	57
▪ Tostan and Other Successful Models	58
Chapter 9: Blueprint for Eradication: A Holistic Approach	
▪ Key Components to Keep in Mind	60
▪ Phase 1: Cultural Sensitivity and Permission	64
▪ Phase 2: Identifying “Positive Deviants” and Organizing Workshops	64
▪ Phase 3: Alternative Rites of Passage and Positive Outcomes	66
Chapter 10: Conclusion	68
References Cited	71
Author’s Biography	76

Chapter 1: Introduction

“The cutting of healthy genital organs for non-medical reasons is at its essence a basic violation of girls’ and women’s right to physical integrity. This is true regardless of the degree of cutting or the extent of the complications.” Anika Rahman and Nahid Toubia (Darby and Svoboda 2007:302)

Female genital cutting (FGC) is defined as all procedures involving partial or total removal of the external female genitalia or other purposeful injury to the female genital organs for non-medical reasons (Kaplan *et al.* 2011:1). The practice is common in many parts of Africa and has become a subject of great controversy. To those who take a “culturally relativistic” stance, such as some anthropologists, feminists, and other social scientists, female circumcision is a legitimate rite of passage that is deeply embedded in the cultures of the societies that practice it. While opposition can be found within FGC-practicing societies, the actions taken by Westerners to eradicate the practice are often condemned as ethnocentric and imperialistic. Relativists assert that outsiders do not have the right to impose cultural change upon others and that the practice of female circumcision should be left up to the practitioners to “argue it out for themselves” (Scheper-Hughes 1991:26).

The other side of the debate over female genital cutting/circumcision, which I will be supporting in this thesis, is that female circumcision is, in fact, genital *mutilation* and an extreme form of oppression against women. Even among anthropologists traditionally inclined toward a relativist stance, the moral advocacy position has elicited a strong amount of support. The view that “cultural relativism has its limits and female genital cutting is an issue where [one] ought to draw the line” has tended to prevail (Obermeyer 1999:79-80). Although the practice is not intended to harm the female victims, the

physical, psychological, sexual, and reproductive health consequences and the destruction of healthy bodily organs are internationally recognized by the United Nations as a violation of basic human rights (United Nations Department of Public Information 1996). In this thesis, I argue that cultural relativism does not pertain when human rights are being violated, as in the case of female genital cutting.

Linguistic Difficulties

The controversy surrounding the practice is reflected in how it is named. Those who are against the practice and are working toward its eradication use the term *female genital mutilation* (FGM). Mutilation is defined as “disfigurement or injury by removal or destruction of a conspicuous or essential part of the body” (Stedman’s Medical Dictionary 1995). Thus, deeming female genital cutting as mutilation is technically accurate. This phrasing is problematic, however, because it implies deliberate intent of the parents, relatives, and practitioners to harm the girls undergoing the procedure. Mutilation is a loaded term and defining the practice of female genital cutting as such also calls other body altering procedures (e.g. cosmetic surgery reduction) into question. To clarify, cosmetic surgery is by definition mutilation, unless there is a medical purpose behind the procedure. Examples of such medical procedures include breast reduction for chronic back pain or vulvectomy, which removes the same tissues as FGC, for cancer of the vulva (Female Genital Mutilation/Cutting in Somalia 2004:17). While non-medical cosmetic surgeries are technically mutilation, the risks associated with these procedures are not comparable to FGC. There would certainly be more widespread fury and concern over cosmetic surgery if the risks were on par with FGC.

Female circumcision is the term used by those who practice it (Einstein 2008:85). This terminology downplays the severity of the procedure. Moreover, *female circumcision* is inaccurate because it implies that the surgery is analogous to male circumcision (removal of the foreskin of the penis), when there are no religious ties or health benefits associated with the female version of the practice. Female circumcision is much more extensive, painful, and dangerous.

Female genital cutting (FGC) is the terminology used by unaligned parties or activists interested in avoiding loaded language (Einstein 2008:85). In this thesis I will use *female genital cutting* (FGC) to refer to the procedures involving partial or total removal of the external female genitalia. As an anthropologist, I do not wish to imply that the parents and practitioners purposefully harm their children. I understand that they are simply following a culturally prescribed procedure that relates to social ideals of femininity, marriageability, health and morality. With that being said, the procedure performed on the young female victims of FGC is in fact mutilation because it deprives the girls and women of basic rights to bodily integrity, sexual pleasure, and health.

In Arabic, the term *tahara* is used to refer to FGC and means “purification” (Obermeyer 1999:84). This is problematic because while purification is a positive descriptor, FGC is a negative action. Using the word *khafd*, which can be translated as “reduction,” (Obermeyer 1999:84) is also problematic because it resonates with the Islamic hadith where the Prophet Muhammad is alleged to have said, “Reduce but do not destroy,” that is often used to justify FGC (Kassamali 1998:44). On the other hand, it is worth noting that there has been an effort to come up with a positive word for the uncircumcised state,

such as *salmah*, which implies healthy, beautiful, intact genitalia (Gruenbaum 2006:122). Using this kind of affirmative terminology for uncut genitalia is imperative in anti-FGC movements.

Clearly, the difficulties in naming and defining FGC underscore the fact that a great deal of ambiguity surrounds these practices (Obermeyer 1999:84). It is crucial that efforts are taken to universally redefine female genital cutting and avoid the implication that the practice is a legitimate medical procedure analogous to male circumcision.

Types of FGC

According to the World Health Organization, there are four types of female genital cutting. Type I (clitoridectomy/*sunna*) is the partial or total removal of the clitoris. According to Toubia (1994), no operations conform to the description of *sunna*, which refers to the removal of the prepuce/foreskin, because part of the clitoris is always removed (Obermeyer 1999:82). Thus, no form of FGC is ever physically analogous to male circumcision. Type II is the partial or total removal of the clitoris and the labia minora with or without excision of the labia majora. Type III (infibulation/*pharaonic circumcision*) is the most severe form and involves the partial or total removal of all the external genitalia and narrowing of the vaginal opening through the creation of a covering seal. Type IV is all other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterizing the genital area (WHO). While severity increases from Type I to Type III, each type of cutting involves risks of detrimental health consequences for the young victims of FGC. All

forms should be taken as a serious health and human rights concern. The types of FGC will be outlined in greater detail in Table 1.

Table 1. The WHO classification of female genital cutting (Raouf *et al.* 2011:42)

Type I: Partial or total removal of the clitoris and/or the prepuce (clitoridectomy)
Type 1a: removal of the clitoral hood or prepuce only
Type 1b: removal of the clitoris with the prepuce
Type II: Partial or total removal of the clitoris and labia minora, with or without excision of the labia majora (excision)
Type IIa: removal of the labia minora only
Type IIb: partial or total removal of the clitoris, and the labia minora
Type IIc: partial or total removal of the clitoris, the labia minora and the labia majora
Type III: Narrowing of the vaginal orifice with creation of a covering seal by cutting and repositioning the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation)
Type IIIa: removal and apposition of the labia minora
Type IIIb: removal and apposition of the labia majora
Type IV: All other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, piercing, incising, scraping, and cauterization

Table 1 demonstrates the variety of procedures associated with female genital cutting. Cultural groups across Africa and other areas practice diverse types of FGC to achieve various cultural “goals,” which is why FGC is difficult to define and eradicate in a culturally sensitive way.

History of FGC

Although the exact origin of female genital cutting is unknown, FGC is an ancient tradition that dates back to at least the fifth century BCE and perhaps as far back as the sixteenth century BCE (Einstein 2008:86). There have also been scattered references to its existence in the Nile Valley at least since the ancient civilizations of Egypt and Sudan existed. According to one origin story, an ancient pharaoh who was endowed with a small penis demanded that women should be infibulated to narrow the vaginal opening and enhance his sexual pleasure (Huelsman 1976:123). Stories like this one may provide

valuable insight into the patriarchal, oppressive and sexist origins of FGC. Of course, there is no ancient origin story that tells how FGC enhanced female sexual pleasure, because it has no such purpose.

Facts about FGC

Where is FGC practiced?

Female genital cutting is currently practiced in twenty-nine countries, primarily in northern East Africa (Tanzania, Kenya, Djibouti, Eritrea, Ethiopia, Somalia, Mauritania) and West Africa (Benin, Burkina Faso, Gambia, Ghana, Guinea, Guinea-Bissau, Liberia, Mali, Niger, Nigeria, Senegal, Sierra Leone, Togo). FGC is also practiced in parts of Arabia, Yemen, Oman, and the United Arab Emirates; Indonesia, Malaysia, and India; and more recently in parts of Europe and North America due to immigration (Einstein 2008:86). In sub-Saharan African both male and female circumcision have been found in nearly all societies north of the equator except in matrilineal societies and the main AIDS belt. Infibulation, often with stitching, is the strongest force propelling the movement against FGC and constitutes 15 percent of female genital cutting practices. Infibulation is found mainly in the Sudan, Somalia, Djibouti, and parts of Eritrea, Ethiopia, and Mali (Caldwell *et al.* 2000:235). Much of the ethnographic data in this thesis will be based on Ellen Gruenbaum's fieldwork in the Sudan because of the high prevalence of FGC and infibulation there.

The high rate in Africa and the diffusion of FGC across countries and cultures make this practice not simply an African problem, but a global one. Therefore, doctors, public

health workers, global policy makers, and activists need to be made aware of this international issue in order to approach it in an informed and culturally sensitive way.

Who is affected?

Every ten seconds, a girl is held down and her genitals are cut (Kristof and WuDunn 2009:221). It is estimated that one hundred to one hundred and forty million girls and women are currently living with the consequences of FGC worldwide (World Health Organization). Ninety-two million of them live in Africa. Girls between the ages of infancy and age fifteen are at the highest risk. The most common age to undergo the practice is between seven and ten years old (WHO). Many times, the girls are not given any warning of their circumcision. Edna Adan, Somalia's first nurse-midwife, first lady, and founder of the Edna Adan University Hospital in Somaliland recalls: "I was not consulted. I was caught, held down, and it was done. My mother thought it was the right thing to do. My father was out of town. When he came back and heard, that was the only time I ever saw him with tears in his eyes" (Kristof and WuDunn 2009:123-4).

Who performs FGC and with what?

Female genital cutting is most often performed by elderly women without any formal medical knowledge and untrained midwives (Utz-Billing 2008:226). Due to the medicalization of the practice, however, trained midwives and physicians sometimes perform the procedure, as well. FGC usually occurs in the girl's home, on a bed or a dirt floor, and the removal of the genitalia is accomplished with unsterilized knives, razors, scalpels, pieces of broken glass, or other accessible sharp objects. Again, as a result of the movement towards the medicalization of FGC, sterilized instruments are used when

performed under medical conditions (Utz-Billing 2008:226). Once FGC is complete, the raw edges of the vulva may be pasted together with gum Arabic, sugar, or egg. Sometimes, the vulvar edges are pinned together with long acacia thorns, but surgical silk or catgut sutures are sometimes or rarely used (Epstein 2001:277). While performing FGC under unsanitary conditions involves greater risk of health complications, the medicalization of FGC mitigates public condemnation and thus needs to be avoided in order to eradicate the practice.

Justifications for the Practice

The cultural practice of FGC is variously justified as a religious duty that preserves purity, virginity and thus, marriageability. It is also defended as a way of maintaining ethnic identity and femininity.

These justifications for the continuance of FGC will be explored and questioned in the following chapters. Chapter 2, “Ritual Meaning, and Ethnicity,” will question and explore the cultural notions of femininity in the cultures that practice FGC. This chapter will also demonstrate how the ideals of smoothness, closedness, and cleanliness drive the cutting of young girls. Lastly, an example of the Azawagh Arabs of Niger will provide hope that culturally-embedded ideals can be changed to improve the health and lives of the girls and women in these societies. Chapter 3, “Religion,” will discredit the belief that FGC is a religious rite and demonstrate that there is no proof of the Prophet Muhammad prescribing FGC as *sunnah*, a religious requirement. This chapter will demonstrate that both men and women have a right to sexual pleasure and discuss how religion may be used in FGC advocacy and eradication efforts. Chapter 4, “Morality and

Marriageability,” introduces the importance of virginity and purity upon marriage in FGC-practicing societies and highlights the double standard that encourages premarital sexual relations for men while forbidding it for women. This chapter also argues that FGC does not guarantee virginity upon marriage. Chapter 5, “Patriarchy,” discusses male preferences of and values for the female body and reveals the horrifying lack of male knowledge concerning FGC. The shock and disgust felt by men upon discovering the damage done to the female genitalia during FGC may be used in part for successful eradication efforts. Chapter 6, “Health Consequences,” describes the wide range of physical, psychological, reproductive, and sexual health consequences and risks that are associated with FGC. In this chapter, ethnographic data and personal narratives are used to underscore the horrendous penalties of FGC. Chapter 7, “Male Circumcision,” contrasts the debate over female genital cutting with male circumcision. The history of male circumcision and an overview of the religious justifications for the practice are provided. Finally, the scientifically tested health benefits and minimal risks of male circumcision are stressed. These data support the argument that female genital cutting is *mutilation* and a human rights violation, whereas male circumcision is a justified, beneficial rite of passage. Finally, in Chapter 8, “Advocacy and Change,” the worldwide efforts to change and advocate against FGC will be discussed. Successful eradication efforts will be surveyed and used to formulate a multifaceted, culturally sensitive plan for the eradication of female genital cutting.

Chapter 2: *Femininity and Meaning*

Introduction

In many societies, female genital cutting is a marker of ethnicity or social status. Female genital cutting serves to define a woman as feminine and pure. These cultural notions are deeply embedded within FGC-practicing societies. Female genital cutting's function as a marker of female or ethnic identity within a society helps explain the tenacity of the practice and offers another hurdle that needs to be addressed by those persons involved in eradication efforts.

Ideals of Femininity

FGC is strongly associated with cultural notions of bodily aesthetics and definitions of femininity. Conceptions of the body are deeply embedded in cultural meaning, and hold particular significance for notions of marriageability and fertility. Furthermore, in every culture there are universal and socially accepted notions of femininity that are shaped by traditional values, mores, and ideals. In the case of FGC (and many other body-altering procedures), failure to comply with cultural norms may result in social ostracism and decrease in marriageability in some societies. According to Caldwell, mothers are justifiably worried about their daughters being treated as different and being unmarriageable. These fears are not unreasonable and advocacy programs will have to take them into account when formulating eradication plans (2000:251). However, in one survey, the majority of male and female respondents, both young and old, in Senegal and The Gambia stated unequivocally that, "circumcision has nothing to do with a woman finding a husband" (Hernlund 2007:51). If that is the case, the argument of practitioners

and the fear that women who have not undergone circumcision will have a more difficult time finding a husband should be less of a cultural concern and driving factor for FGC.

Smoothness and Closedness

In the societies that practice FGC, the smoothness of the infibulated (sewn shut) vulva is thought to be the ideal standard for female genitalia by both men and women. In fact, “women praise the smooth, clean character of the idealized infibulated vulva...[and] express revulsion at the imagined dirty, smelly, and wet folds of the open, uninfibulated vulva...The uninfibulated vulva is sometimes imagined as a large gaping hole, perhaps capable of accommodating both penis and testicles” (Gruenbaum 2006:125). In these cases, the uninfibulated vulva, a “gaping hole,” an open body orifice, connotes promiscuous sexual behavior and is considered to be abnormal. These culturally ingrained ideals play a strong role in the continuance of FGC.

Cleanliness

In a study of five hundred Nigerian women, when asked why FGC is performed, 95 percent of them answered that FGC is performed for cultural and traditional reasons (which include religious reasons); 49 percent claimed that FGC prevents promiscuous behavior; 18 percent believed that the unmutilated vulva is ugly; 11 percent thought that FGC prevents death of male newborns; and 9 percent reported pressure of relatives as a reason to perform FGC (Utz-Billing 2008:236). As we will see, FGC does not prevent promiscuous behavior or the death of newborns, and is not supported by religious justification.

Members of FGC-practicing societies without any medical knowledge often view uncut genitalia as unclean and harmful to infants during childbirth. Some societies believe that the tip of a mother's clitoris is toxic and if it touches an infant during birth, the baby will die (Nour 2008:137). Also, FGC acts as a marker of a child's sex by removing the parts of the body considered to be "male" (e.g. the clitoris). According to Obermeyer, "FGC is in fact frequently connected to a popular belief that unless the clitoris is "reduced," it will grow into a penis. This underscores the symbolism of the operation as reshaping women's anatomy to emphasize differences between the sexes" (1999:84). Of course, anyone with formal medical education knows that the clitoris will not grow into a penis if left uncut and removing the sensitive organ is an unnecessary way to distinguish between male and female genitalia.

The Azawagh Arabs of Niger

Based on ethnographic research by Rebecca Popenoe, one classic example of idealized body standards that differ from Western notions of femininity is the preference for extreme obesity found among the Azawagh Arabs of Niger. In this culture, fatness is considered so beautiful that young girls are force-fed to reach a desired body weight (Popenoe 1999:5). While force-feeding young girls may potentially lead to diseases such as hypertension and diabetes, I assert that this example of body aesthetics may be viewed with more cultural relativism than FGC because there are less severe risks involved. While force-feeding has the *potential* to harm these girls, FGC is *guaranteed* to harm their bodily integrity by removing healthy tissues and endangering their overall wellbeing. Again, FGC is one practice to which cultural relativism should not be applied. Unlike fatness among the Azawagh Arabs, the threat FGC poses on the health and

wholeness of its victims is too great and that must be kept in mind when addressing this controversial subject.

Changing the Ideal: A Success Story

Notions of femininity are deeply embedded in cultural codes and thus are difficult to change within a society. When a person has grown up in a society where certain body-altering practices are considered “normal” (e.g. FGC, foot binding, facial scarification, or cosmetic surgery) a great deal of effort is needed to redefine what it means to be a true woman.

While changing individual and cultural preferences surely may be difficult, it is not impossible. The suppression of women’s facial scarification customs in FGC-practicing cultures exemplifies this fact and offers a success story of hope. In Sudan, deep facial scars that were cut in girlhood were the norm. Pattern variations indicated membership of tribal groups and other scars were meant to symbolize protection and luck. Then, a popular singer wrote a song about the beauty of the untouched, unscarred female face. The song spread and its popularity is said to have accelerated the discontinuation of the harmful practice of facial scarring (Gruenbaum 2001:73). Without a doubt, notions of femininity and beauty are deeply influenced by the media across the world. In Africa, a popular song was able to change the deep-seated notion that a scarred female face is a beautiful face. In the United States and worldwide, movies, television, magazines and the Internet bombard women with images of the “ideal” woman and distorted perceptions of beauty. Such images often provoke harmful eating disorders, plastic surgery, and extremely low self-esteem in order to conform to what is “beautiful.” If media can define

cultural notions of femininity and lead to harmful disorders, it may also be used to redefine femininity in FGC-practicing communities in order to discontinue injurious outcomes. While media often simply reflect and reinforce notions that already prevail in a culture, this example demonstrates that cultural ideals are not static. Perhaps femininity and beauty should simply be defined as an untouched, intact state across all cultures.

Like all cultural customs and ideals, body aesthetics are subject to change through time and are influenced by fashion, media, public health, religion, or lifestyle. While the facial scarification example demonstrates the malleability of cultural body aesthetics, Gruenbaum argues that, “For the unaltered vulva to be considered beautiful, in the way that many women speak of the infibulated vulva, [there] will probably be a process of change that takes somewhat longer, perhaps requiring a more subtle message conveyed by poetry, music, or art” (Gruenbaum 2001:75). That being said, it is important to keep the success story of the suppression of facial scarring in FGC-practicing societies in mind when formulating a culturally sensitive plan of eradication for female genital cutting.

The film *Moolaadé* offers another example of how media can be used to address controversial subjects. Directed by Ousmane Sembene, “African cinema’s founding father,” the film offers an insider’s perspective on the controversy of FGC. The film is set in Burkina Faso and tells the story of Collé Ardo, a revolutionary woman in the village. Collé chooses to leave her daughter Amsatou uncircumcised and offers *moolaadé* (“magical protection”) to four girls that escape ritual purification. The *moolaadé* causes a cultural divide on the subject of purification between the traditional elders and the younger generation. In the end, Amsatou marries Ibrahima, a rich and

intellectual man, despite being *bilakoro* (unpurified) and the community denounces FGC after the suicide of two girls and the death of another (Sembene 2004). These two examples highlight the importance of cultural change from within. Neither the song about facial scarification nor the film on female genital cutting would have been as effective if they had been written and performed by a Westerner, a Caucasian person, or a male. A native with an insider's point of view best facilitates cultural change, especially with respect to controversial or taboo topics like female genital cutting.

Chapter 3: *Religion*

Introduction

Many studies have indicated that religion plays a significant role in cultural justifications for FGC. In a survey conducted by Dirie and Lindmark that only allowed respondents one choice of reasons to justify female genital cutting, they found that of the two-hundred and ninety female interviewees in their survey (of medium to high socioeconomic status) 70 percent stated “religion,” 20 percent said “to remain [a] virgin in order to get married,” and 10 percent said “tradition” (Gruenbaum 2001:50). This chapter will investigate religion as a problematic justification for the harmful practice of female genital cutting.

It is an incorrect belief that female genital cutting is required by any one religion, particularly Islam. In fact, most Muslims worldwide do not circumcise girls. FGC is not practiced in 80 percent of the Islamic world, including Saudi Arabia, Jordan, Iran, and Iraq (Yount 2004:1064). The societies in which the genital cutting of girls is frequently practiced include both Muslims and non-Muslims of numerous ethnicities (Gruenbaum 2006:122). In fact, “Muslims, Christians, Jews, animists, and atheists perform FGC” (Utz-Billing 2008:226).

FGC in Islam

Despite the lack of religious mandate, religion as popularly understood unfortunately plays a strong role in the continuance of female genital cutting. Historically, Muslims who practice FGC have considered it to be a part of Islam, believing it to be a required or at least permitted practice. However, according to Gruenbaum, many influential Islamic

scholars “disavow a connection between Islam and female circumcision” (2006:122). Indeed, this assertion is supported by the fact that when ten high-ranking Islamic scholars met at the Al-Azhar-University of Cairo in November 2006, they agreed to declare FGC a violation of the highest values of Islam and a punishable criminal act (Utz-Billing 2008:228). If ten of the highest-ranking Islamic scholars deny a linkage between FGC and Islamic religious duty, it is troubling that a majority of FGC practitioners survey that religion (usually Islam) is the sole justification of the practice. However, it is worth acknowledging that religious texts are open to interpretation and understandings are not monolithic. There is often a discrepancy between religion as codified and religion as practiced and this divergence should be kept in mind. Nevertheless, for FGC to be culturally justified and understood as a religious obligation when the highest-ranked religious scholars refute it is problematic. The widespread cultural misunderstanding must be exposed and discredited for anti-FGC advocacy campaigns to be effective.

In fact, neither male nor female circumcision is a product of Islam. Both were practiced at the beginning of Egyptian civilization and had probably evolved in sub-Saharan Africa millennia earlier (Caldwell *et al.* 2000:236). Advocates of the practice can interpret Hadiths to justify it, but in reality FGC is not advocated for in any religious texts. On the other hand, as we will see, male circumcision is believed to be required by God for both Muslims and Jews. Male circumcision versus female genital cutting will be explored further in Chapter 7.

Islamic religious leader Shaykh Ali Sarraj, who spent time with Sudanese elders discussing the lack of scriptural support for any form of FGC in Islam, is able to cite

many verses of the Qur'an and Hadith that directly oppose damaging the body and reveal that FGC is actually forbidden (*haram*) in Islam (Gruenbaum 2005:106). The Hadith that states, "Reduce, but do not destroy," is what the Prophet Muhammad is claimed to have told a midwife who was performing circumcisions in the early Muslim community (Kassamali 1998:44). This is a weak hadith, which means that its chain of transmission does not certify its authenticity (Gülen 2005:147), and is the only one in the Qur'an that may be (erroneously, according to Islamic scholars) interpreted as supporting FGC. Gruenbaum found one interpretation of the Hadith that asserted that the Prophet was expressing disapproval of the severity of female circumcision practices in Arab society prior to the rise of Islam. Furthermore, after a class Gruenbaum teaches, one Muslim-American student who had studied Islam in depth told her, "That's the first time I ever heard anyone say [FGC] was Islamic!" and within the next few days she checked with several other religious teachers to confirm her view that [this] interpretation was incorrect (Gruenbaum 2001:66). If this interpretation that FGC is non-Islamic and perhaps even *haram* can be turned into a widespread belief, there would likely be a large reduction in the incidence rates of FGC when 70 percent of FGC is arguably undertaken for religious reasons.

Right to Sexual Pleasure

Due to the harmful effects on female sexuality caused by FGC, sexual enjoyment for both men and women is beginning to be advanced as a reason for stopping the practice. It is true that most of the rights related to sexuality were traditionally understood to belong to husbands in Islam—and most world religions. But, according to Sa'diyya Shaik, "Within the Islamic view of marriage, an individual has the right to sexual pleasure" (2003:114).

As we will see in Chapter 6, FGC may have severe effects on a woman's ability to have sexual intercourse without pain, experience sexual pleasure, and reach orgasm. FGC also poses difficulty in penetration for the husband. A right to sexual satisfaction for both husband and wife in marriage that is justified by the religious teaching of Islamic scholars and the Qur'an would effectively strengthen reform efforts.

Using Religion for Change

Human rights actions that coincide with religious texts and teachings have the best chance of being implemented in FGC-practicing societies. Often there is a discrepancy between Islam, for example, as formulated and presented in the Qur'an and Islam as understood and practiced in particular societies. It should be the goal of religious authorities in opposition to FGC to reformulate religious teachings and bridge the gap between how the practice is culturally presented and how it is practice. Gruenbaum asserts that as more people come to understand that God is not going to reward them for circumcising their daughters, and as the religious arguments against FGC become clearer, more people will be convinced to stop (Gruenbaum 2006:128). It is not FGC that guarantees purity, morality, or virginity upon marriage. Shaykh Muhammad Sayyid Tantawi agrees, "A young girl's modesty does not stem from 'circumcision' but rather from a good religious and moral education" (Bodman and Tohidi 1998:43). It is imperative to use religious texts as evidence against FGC and find other ways to uphold the culturally honored ideals of morality and purity. With the support of well-known and respected religious scholars, FGC eradication efforts will be more successful.

Chapter 4: *Morality and Marriageability*

Introduction

In the societies that practice female genital cutting, “circumcision” is closely tied to cultural values of morality and marriageability. Infibulation, in particular, is associated with the culturally honored practices of endogamy, virginity and purity, and is thought to “guarantee” virginity, which continues to be considered a prerequisite for females upon marriage. In fact, in Sudan and other cutting societies it is believed that “virgins are made, not born” (Hayes 1975:622). It is this oppressive belief that women are inclined to be sexually promiscuous if not circumcised and need to be “made” a virgin through infibulation that motivates the continuance of FGC and poses a serious human rights concern.

Premarital Sexual Intercourse

FGC/infibulation is believed to reduce the risk of girls engaging in premarital sex due to the closedness of the vaginal opening and is in fact believed to “guarantee” virginity upon marriage (Slack 1988:456). By closing the vaginal opening, penetration during sexual intercourse becomes difficult and painful; thus, it is assumed that due to circumcision, intercourse will be saved until marriage. In addition, by reducing genital sensitivity, FGC practitioners and supporters believe that sexual desire and promiscuity are reduced as a result. The recognition of the role of the clitoris in female satisfaction is now more widely known in FGC-practicing communities, so in less severe forms where the “barrier” of infibulation is eliminated, the reduction of the clitoris is the only means left to “preserve virginity” (Gruenbaum 2006:121). FGC is falsely believed to guarantee a

girl's virginity. In societies where a family's honor is crucial and highly valued, the conduct of the family members is regulated by these ideals.

Morality and Virginity

In the societies that practice FGC, female virginity is a prerequisite for marriage. The goal of FGC is to “attenuate women's sexual desire so that they are better able to control their sexual urges...and ensure not only female premarital virginity but also, more important, fidelity in marriage” (Ahmadu 2007:293). Again, to be circumcised is to be pure, virginal, and moral. This cultural belief obviously poses a major challenge to groups seeking to change the practice and prevent the mutilation of young girls.

Often times, uncircumcised girls are tormented by circumcised girls and called, “Ya, ghalfa!” which suggests that “the open one” is an immoral slut (Gruenbaum 2006:126). It is worth noting that there has been cultural resistance through the invention of creative responses to the name-calling. The uncircumcised girls answered their circumcised attackers with “Ya, mutmara!” which refers to the underground grain storage pits that are continuously opened and closed, just as the vulvar scar tissue is (Gruenbaum 2001:130). This cultural resistance exemplifies a significant step taken by the young uncut girls and symbolizes bravery, defiance of oppression, and positive deviance from harmful cultural norms.

Marriageability

Without a doubt, morality and virginity are directly correlated with a girl's marriageability status within FGC-practicing societies. Interestingly, however, whether or not a girl is circumcised is not customarily discussed when marriages are arranged, and

males do not commonly state that their potential wives must be circumcised (Hernlund 2007:51). If this is the case, then uncircumcised girls should not fear that they would not find a husband and the benefits of marital security. While men may simply assume that young women have been circumcised, there is no guarantee. As we will see, morality and virginity play a stronger role in marriageability than circumcision status itself.

Because FGC is believed to guarantee virginity, which is a prerequisite for marriage, the practice is also assumed to be prerequisite within most FGC-practicing societies. However, studies of Senegalese and Gambian women found little evidence to support the claim that circumcision is a prerequisite for marriage or relate to marrying well: all 1220 interviewees were asked if FGC was necessary for a girl to find a “good” husband and most, whether from a circumcising tradition or not, agreed that it was not necessary for marriage or getting a richer or better husband (Shell-Duncan *et al.* 2001:1278). Furthermore, Shell-Duncan found that “when respondents did assert that circumcision was important for a good marriage, it was most often not because men refused to marry uncircumcised women, but because an uncircumcised woman marrying into a circumcising family would face difficult relationships with other women in her marital home. In fact, 72 percent of respondents disagreed with the statement, “A girl who is not circumcised will have difficulty finding a husband” (2001:1278). The real concern over marriageability relates to cultural ideal of virginity. Shell-Duncan discovered indirect support for a link between FGC and marriageability via its usefulness for protecting virginity until marriage: 51 percent of respondents agreed that “female circumcision helps a girl remain a virgin until she marries” (2001:1278). Therefore, the concern that

an uncircumcised woman will be unmarriageable relates more directly to ideals of purity and virginity upon marriage than to a man's refusal to marry an uncircumcised woman.

Male Double Standard

While virginity, morality, and purity are socially expected for girls and women in FGC-practicing societies, the opposite is true for men. In fact, sexual experimentation is believed to be expected and inevitable for men. Because of this, prostitution is considered a "social necessity." According to some men, prostitutes, the "other class of women," provide an outlet for men's sexuality so they "don't cause moral young women to stray" (Gruenbaum 2001:84). This is an appalling double standard. While girls are expected to be innocent virgins upon marriage, and are thus forced to undergo the painful and harmful procedure of FGC, men are socially expected to be sexually experienced prior to marriage. Even more, men are encouraged to behave promiscuously and are offered the opportunity to engage with prostitutes, who form "another class of women" unrestricted by the oppressive practice of FGC (2001:84). Within FGC-practicing societies, boys are allowed to stray from premarital celibacy, while girls are expected not too. Indeed, "the ideal of virginity is in fact enhanced by the existence of prostitution" (Hicks 1993:77). This belief is rooted in sexism. Patriarchal dominance, the oppression of women and control of female sexuality are blatantly obvious in this gendered double standard of sexuality.

Problems With "Guaranteed" Virginity

In FGC-practicing societies, circumcision status is believed to affect marriageability. According to Smith, Senegalese interviewees most often emphasize that women are by

definition wives and mothers: women are women only though their roles as child-bearers, which when done appropriately requires marriage first. Thus, FGC enhances this woman-as-mother identity and can be seen as inscribing these social norms upon women; FGC physically and symbolically protects the body from premarital sex by presumably reducing sexual sensation in the case of excision, and by creating a physical barrier to penetration in the case of infibulation (Smith 2011:35). As we will see, FGC does not guarantee to protect a woman from engaging premarital sex.

The problem with the belief that FGC (particularly Type III) “guarantees” virginity upon marriage and that the reduction of the clitoris prevents premarital sexual promiscuity is that there is in fact no guarantee. The removal of the sensitive clitoris is believed to reduce a girl’s sexual desires and promote chastity by lowering the temptation to seek sexual experience prior to marriage (Esere 2007:115). While sexual desire may be reduced and penetration is less likely, neither effect could actually stop a girl from having sex before marriage. In FGC-practicing societies, circumcised girls and women have adopted techniques in order to have secret premarital sexual encounters and simulate virginity upon marriage (Gruenbaum 2006:129).

In her interviews, Gruenbaum found that a girl’s circumcision does not prevent her engaging in premarital sexual behavior. Sometimes, secret marriages are contracted solely for the purpose of pleasure. Secondly, Efua Dorkenoo, a Ghanaian campaigner argues that, “FGC makes it easier for a woman to fake virginity or fidelity, since a reinfibulation looks just like the original one” (Dorkenoo 1996:35-6). Feminist reformers point out that these tactics effectively refute the cultural justification that many people

give for FGC. “Infibulation can always be resewn, allowed to heal, and present the appearance of a virginal woman upon marriage when [the woman in question] has, in fact, behaved ‘dishonorably’ by engaging in premarital sex” (Gruenbaum 2006:129). Once reinfibulated, there is no way to know if a woman is truly a virgin, but it is important to at least make these secret techniques known. Infibulation and FGC do *not* guarantee feminine morality, purity, and virginity upon marriage, and through secret marriages and reinfibulation, the cultural premium of these cultural values is undermined.

Chapter 5: *Patriarchy*

Introduction

Men play a significant role in the continuance of this female genital cutting. While it typically occurs in the female cultural sphere, men are becoming more aware of the practice and its harmful effects on girls and women. More importantly, though, is the ability of men to contribute to FGC eradication efforts and protect their daughters, sisters, and wives from harm.

Male Values

Like many women who believe that the uninfibulated vulva is a grotesque and gaping hole and prefer the smooth, closedness of the infibulated vulva, cultural codes for femininity and body aesthetics are similarly ingrained in the male mind. Certainly, the closeness with which infibulation and other FGC practices are tied to male values about body aesthetics and attractiveness and a woman's ability to bestow (although through FGC not necessarily achieve) sexual pleasure plays into much of the cultural resistance against FGC. The sexual attraction felt by men towards circumcised females and the embedded revulsion toward the uncircumcised genitalia play a dominant role in the justification of FGC.

While cultural preference may be coded for the smooth, infibulated vulva, oftentimes men in FGC-practicing societies have never even seen uncut female genitalia and are not aware of the damage done by FGC. For men who have never been confronted with the amount of damage done, or who have never seen an uninfibulated vulva, reactions are varied. Upon viewing images of an uninfibulated vulva, one man was surprised by how

beautiful it was, saying it was “like a flower,” when he had expected it to be ugly (Gruenbaum 2006:134). Increasing male knowledge about the anatomy of untouched female genitalia will make men aware of the damage done to their sisters, daughters, and wives, and will alter the cultural preference of males for circumcised female genitalia. Raising awareness about the damage done during FGC and exposing men to pictures of intact genitalia will begin to change the male preference for FGC and thus affect circumcision as a cultural prerequisite for marriage.

Male Sexuality

While there are many cultural justifications, in the opinion of Sister Battool, a well-known Sudanese midwife in Wad Medani, men’s desire for a tight opening for sex is the main reason that the practice of FGC continues (Gruenbaum 2001:154). Both men’s desire for a tighter opening and women’s awareness of this fact perpetuate FGC. Gruenbaum found in her ethnographic research that when one Sudanese woman learned of the researcher’s uncircumcised state, she was confident in the superiority of her narrow opening. The Sudanese woman went so far as to tell Gruenbaum that if her husband ever had a chance to experience sex with a circumcised wife he would divorce the uncircumcised anthropologist immediately (Gruenbaum 2006:127). In another instance, a polygamous husband persuaded his young, uninfibulated wife to be infibulated because he preferred how it felt during sex. Finally, the wife acceded to his wishes but admitted later to regretting the decision, saying it made sex and childbirth “*harr*” (hot, painful) (Gruenbaum 2001:130). The preference of men for a tighter vaginal opening is oppressive and obviously not a supportable reason for the extremely destructive practice of FGC to be continued.

Lack of Knowledge About FGC

Because FGC and sexuality are taboo subjects and are not openly discussed in FGC-practicing societies, most men do not know what the procedure consists or understand the extent of damage done to the female genitalia as a result. In male-focused FGC awareness-raising presentations, graphic, bloody videos have been used to shock the men who watch them. In a UNICEF-supported video, the screen alternates between two sorts of images: smiling schoolboys with anti-FGM shirts and conservatively dressed young men in *jalabiyas* singing in front of a mosque, on the one hand, and painful scenes of a scary looking midwife, a terrified young girl, and the girl's bloody genitals being cut, on the other hand (Gruenbaum 2006:134-5). While gruesome, these images will be implanted in the minds of men who were previously unaware of the severity of FGC practices. These types of awareness-raising campaigns are likely to be very effective in motivating support for eradication of the practice.

Another awareness-raising technique uses home visits as the setting for screening visually shocking videos of FGC to family groups. In some cases, men who saw the videos became physically ill and sometimes cried with shock and anger. After his involvement in awareness-raising presentations, a Kubur Abdal Hameed man cried, "We were duped!"—He had no idea how much damage was done to women during FGC practices (Gruenbaum 2006:135). The shock and repulsion felt by men within FGC-practicing societies when presented with images of what really happens to their wives, sisters, and daughters during their circumcisions are feelings that need to be utilized for successful advocacy campaigns.

Men's Role in the Eradication of FGC

While women always perform FGC, males can play a significant role in the eradication of the harmful and dangerous cutting practices. It is assumed that men have a sexual preference for the circumcised genitalia, but the men who have had sexual experiences with uncircumcised women say differently. In a study of three hundred polygamous Sudanese men (each of whom had one wife who had been infibulated and one or more who had not), 89 percent expressed sexual preference for the uninfibulated wife and 20 percent of these said they married a second, uninfibulated wife because of the penetration difficulties experienced with their first wife (Woldemicael 2009:22). Similarly, there are relatively few men who have had experienced sex with an uncircumcised woman, but those who have experienced both admitted, "Believe me, there is a big difference" (Gruenbaum 2006:132). The fact that men who have sexually experienced both infibulated and uninfibulated women prefer the latter undermines the view that men prefer sex with circumcised women. Although a taboo subject, if this fact were made known through educational workshops or open community dialogues, undoubtedly more men would seek out uncircumcised wives for increased sexual pleasure and women wouldn't feel the need to circumcise their daughters for fear that they wouldn't find a husband.

While sometimes men prefer the tightness of the infibulated vulva, there is an increasing recognition of the improved sexual pleasure for both men and women when the women are uncircumcised. In her research, Gruenbaum found that several men in the city of Kubur Abdal Hameed, Sudan supported ending FGC in all forms. They said sex is better with uncircumcised women because they learned from an educational workshop that the

uncircumcised woman is more responsive than the infibulated woman (Gruenbaum 2006:132). It is fair to assume that most men would prefer that their wives enjoy sexual intercourse rather than experience pain and discomfort during the act.

Clearly, men can play a significant role in eradication efforts if they advocate for the fates of their sisters and daughters and assert that they would prefer to marry uncircumcised wives. Abusharaf agrees: “The attitude of unmarried young men toward female circumcision is an important gauge of social change. By 1999, a majority of unmarried men ages eighteen and over in Kenya said they would be willing to marry an uncircumcised woman. Unmarried young men gave a variety of positive reasons for marrying an uncircumcised woman: 46 percent cited having fewer complications during delivery, and 45 percent said that uncircumcised girls might be better sexual partners” (Abusharaf 2006:98). Men who are fathers of happily married uninfibulated daughters and men who are happily married to uninfibulated women can be extremely effective advocates for the eradication of FGC and the protection of young girls’ human rights.

Chapter 6: *Health Consequences*

Introduction

In the debate over female genital cutting, the severe physical, psychological, sexual, and reproductive consequences cannot be denied on either side of the argument. The dire effects of this practice are undoubtedly the central reason that FGC is categorized as a human rights violation. The removal of the female genitalia during FGC often scars the victims both physically and mentally. FGC deprives its victims of the basic human right to bodily wholeness and health, sexual pleasure and a lifetime without psychological disorders or chronic pain.

Physical Consequences

The physical side effects of FGC are just one aspect of the negative outcomes associated with the practice. It is worth noting, however, that a Demographic and Health Survey (DHS) of Egypt found that while [FGC] was nearly universal, less than one-third of respondents had heard of any adverse effects (Caldwell *et al.* 2000:241). This data speaks to the lack of education concerning taboo subjects (i.e. sexuality, reproductive health) in FGC-practicing societies. The lack of general knowledge concerning the potentially life-threatening and certainly life-altering effects of FGC unquestionably plays a significant role in the continuance of the practice. It is sensible to assert that if the other two-thirds of the Egyptian population were made aware of the severe health consequences of FGC, incidence of the practice would be reduced.

When performed under unhygienic conditions, as most female genital cuttings are, there is a high rate of infection, which not only includes infections of the uterus, ovaries, and urinary tract, but also tetanus, gangrene, or sepsis that may lead to death (Utz-Billing 2008:227). About 15 percent of all circumcised females die of bleeding or infections and other reports estimate that out of 1,000 females who undergo female genital mutilation 70 women die as a result (Iweulmor 2005:36). Dysmenorrhea (pain during menstruation) can result from chronic pelvic infection or pelvic congestion. Menstrual flow may be retained due to the tiny vaginal opening (Elnashar 2007:242). Furthermore, chronic infections of the uterus and ovaries may lead to sterility, which is significant because a woman's ability to reproduce in the societies that practice FGC is linked to her social standing, gender roles and economic stability. After Type III FGC, the risk of infertility is 25-30 percent (Utz-Billing 2008:227). Women after FGC also have a higher risk for HIV infection because of the practice itself, the deliveries and reinfibulations done with unsterilized instruments and an increased risk for injuries from sexual intercourse due to the inflexibility of scar tissue and the tightness of the vaginal opening (Utz-Billing 2008:227).

Repeated defibulation (opening of the vaginal closure) and reinfibulation (sewing the vagina closed after defibulation) may cause chronic anemia and the formation of keloid scars that can cause severe pain, dermoid cysts, and the development of abscesses. In fact, deinfibulation during labor and delivery and reinfibulation after childbirth are among the major causes of infection, bleeding, fibulae, and death in Eritrea (Woldemicael 2009:22). Incontinence can result by injury of the adjacent genital tissue (urethra, vagina, perineum, and rectum) during FGC (Utz-Billing 2008:227). Other

reported adverse physical outcomes include: formation of rectovaginal or vesicovaginal fistulae, formation of neuromas (profusions of exposed, free nerve endings), extreme urinary pain, hemorrhaging, swelling of the stomach, violent pain or shock (Einstein 2008:87). One African study reported that upwards of 80 percent of women suffered from at least one medical complication after undergoing FGC (Mgbako 2010:115).

It is worth noting that physical complications of infibulation may also arise for males, including difficulty in penetration, wounds and infections of the penis, and psychological problems (Gruenbaum 2006:128).

Physical Consequences: Ethnographic Spotlight

[There was] a case in Sudan in which a young girl was suspected to be pregnant, much to the shame and fear of the girl's family, until the true nature of the problem was discovered: the fifteen-year-old girl, who had never menstruated, had such a small opening she had difficulty passing urine and her menstrual discharge had been completely obstructed, perhaps because of the vulvo-vaginal atresia (absence of an opening) (Gruenbaum 2001:5).

An elderly Mandinka woman living in an urban area in The Gambia knows about the personal tragedy that can result from FGC: "If [FGC] is done in the wrong way, the person can bleed to death...I once had a granddaughter who, because of this, she died" (Hernlund 2007:49).

Psychological Consequences

Along with the physical consequences of FGC, there are serious psychological outcomes, as well. Women after FGC are at a higher risk for psychiatric diseases such as depression, psychosis, neurosis, and psychosomatic disorders. In an interview with forty-seven Senegalese women, over 90 percent of patients described FGC as a traumatic experience and recount feelings of helplessness, fear, horror, and severe pain. Of those women, 78 percent of them did not expect the intervention, and close to 80 percent had severe fear, intrusive flashbacks of their circumcision, or affective disorders after the procedure (Utz-Billing 2008:227).

In another study of twenty-three circumcised and twenty-four uncircumcised Senegalese women in Dakar, the circumcised women showed a significantly higher prevalence of post-traumatic stress disorder (30.4%) and other psychiatric syndromes (47.9%) than the uncircumcised women. In fact, the high rate of PTSD in this group is comparable to the rate of PTSD that results from early childhood abuse, which has an average range from 30-50 percent (Behrendt 2005:1001).

For some women, the result of FGC is an embarrassing condition (both physical and emotionally damaging) that renders them unable to retain urine and produces constant leakage. In rural areas where pads or absorbent cotton are not available in the market or are unaffordable, those women may be unable to preserve basic hygiene and may suffer the consequences of social avoidance, ostracism, or divorce (Gruenbaum 2001:6).

Reproductive Consequences

Infertility can be a socially disastrous condition for a woman in the societies that practice female genital cutting, and the risks that FGC poses on female reproductive health are great. According to Gruenbaum, anything that interferes with a woman's ability to reproduce (e.g. female genital cutting) in a socially acceptable way...would undercut her economic security. A childless woman might face a future of poverty or dependency in one of the undesirable social roles such as childless widow or old maid aunt or cousin, entitled to live with kin, but with no one to look out for her interests and provide her with more than the bare necessities (2001:46).

In June 2006, the World Health Organization published the findings of a study stating that women "who have had FGM are significantly more likely to experience difficulties during childbirth and...their babies are more likely to die as a result of the practice (Prazak and Coffman 2007:vi-vii). According to Prazak and Coffman, 5 percent of babies born to women without FGC were stillborn or died shortly after delivery. This increased to 6.4 percent in babies born to women with FGC. Another study claims that women subjected to the more severe form of FGC (Type III) will, on average, have 30 percent more cesarean sections compared with those who have not undergone genital cutting (Prazak and Coffman 2007:vii). Women with Types II and III FGC had a significantly higher risk of a postpartum blood loss of more than 500 milliliters of blood compared with women without FGC (Utz-Billing 2008:227). Also, the obstruction of the birth canal due to infibulation can lead to a prolonged delivery with the consequence of a higher infant mortality and damage to the brain due to a lack of oxygen (Utz-Billing 2008:227).

An Apgar score, the first test given to a newborn baby in order to quickly evaluate the newborn's physical condition, is calculated on a scale of 0-2 per for each category: Appearance (skin color/complexion), Pulse rate, Grimace (reflex irritability), Activity (muscle tone), and Respiration (The Nemours Foundation 2012). Babies were distressed (Apgar score < 7) in 23.7 percent of circumcised mothers, while in only 2.1 percent of those non-circumcised. More reproductive complications of FGC include prolonged second stage, episiotomy (surgical incision to enlarge vaginal opening), perineal tears, bleeding, incontinence, and febrile illnesses (Elnashar 2007:243). A prolonged second stage of labor is associated with increased maternal and neonatal morbidity and mortality (Baloch *et al.* 2008:88-9).

Sexual Consequences

"I have to tell the truth: circumcision does not allow women to want sex."
(Einstein 2008:90)

It is blatantly apparent that for many women who have undergone FGC, there is little physical pleasure, and often pain, from sexual intercourse. The 2002 Egypt Demographic and Health Survey found that women with infibulation are about nine times more likely to experience complications during sexual relations and delivery than women with clitoridectomy (Woldemicael 2009:20). Furthermore, in a study of newly married Egyptian women, 43 percent of circumcised wives were sexually unsatisfied, compared with 10.9 percent of those non-circumcised (Elnashar 2007:243). Additionally, circumcised women complained more significantly of dysmenorrhea (80.5%), vaginal dryness during sexual intercourse (48.5%), lack of sexual desire (45%), being less

pleased by sex (49%), being less orgasmic (39%) and with less frequency of orgasm (60.5%) than the uncircumcised women (Elnashar 2007:243).

According to sex researchers Masters and Johnson, clitoral stimulation (whether direct or indirect) is almost always involved in a woman achieving orgasm (Gruenbaum 2001:137). As a result, the removal of the clitoris, along with the surrounding tissue, simultaneously eliminates a woman's ability to have unmodified sexual pleasure. One pharaonically-circumcised woman said she has no pleasurable genital sensations that would lead to orgasm, and she has never experienced one (Gruenbaum 2006:127). A Sudanese physician who is very opposed to female genital cutting—and is himself saddened by his own wife's pharaonic circumcision—said it is more likely that a woman will experience pain rather than pleasure during sex (Gruenbaum 2006:127). Similarly, Dr. Malik Amin Malik of Um Sayyala Hospital in Bara Province, North Kordofan, Sudan, states that the degree of pain some wives experience during sexual intercourse is distressing to some of the husbands he has seen in his practice. Dr. Malik argues, “No sane man could ever enjoy sex that causes his wife pain” (Gruenbaum 2006:128). However, clearly the widespread, socially accepted double standard that men should experience sexual pleasure and women should not in order to prevent promiscuity is a factor that plays into the patriarchal and oppressive maintenance of FGC.

Sexual Consequences: Ethnographic Spotlight

A rural Gambian man of Wolof ethnicity who was married to a woman from an FGC-practicing ethnic group, related: “It brings problems. My wife's younger sister was sealed after being circumcised. This is because they wanted her to maintain her virginity

at marriage. On the day she got married, the husband couldn't penetrate. An *ngangsingba* (circumciser) was called to perform some operation, and later she was given to her husband. The young one suffered a lot of serious pain, so that she was rushed to the hospital. Just imagine what troubles they had caused her! For a girl to keep her virginity till marriage is a good thing, but it has to be achieved through discipline by parents, and not through this maltreatment of human beings" (Hernlund 2007:49).

A forty-five year old infibulated woman from El Obeid in Kordofan, Sudan recalled: "My first sexual experience was very painful because I was so tight, and the following experience was equally painful. On one occasion my husband tried to force penetration and the flesh tore. This wound became infected, so sexual intercourse became even more painful for me...I hated to have sexual relations, and my husband complained about this. I was so pleased when I became pregnant, because the tradition in our tribe is that a husband may not have sexual intercourse when his wife is pregnant. When I was delivered the opening became wider and I could have normal sexual relations. But my sex life is still of no enjoyment or interest to me, I perform it merely as a duty" (Gruenbaum 2001:142).

Waris Dirie's Story

In the Type III form of FGC, the young girl is bound from her hips to her ankles for up to forty days in order for scar tissue to form. Waris Dirie, an African model living in the United States, describes this graphic ordeal. The following is an excerpt from her book, *Desert Flower: The Extraordinary Journey of a Desert Nomad*:

The next thing I felt was my flesh...being cut away. I heard the sounds of the dull blade sawing back and forth through my skin. When I think back, I honestly can't believe that this happened to me. I just sat there as if I were made of stone, telling myself the more I moved around, the longer the torture would take. Unfortunately, my legs began to quiver of their own accord, and shake uncontrollably, and I prayed, Please, God, let it be over quickly. Soon it was, because I passed out. When I woke up, I thought we were finished, but now the worst of it had just begun. My blindfold was off and I saw the Killer Woman had piled next to her a stack of thorns from an acacia tree. She used these to puncture holes in my skin, [and] and then poked a strong white thread through the holes to sew me up. My legs were completely numb, but the pain between them was so intense that I wish I would die. The memory ends at that instant, until I opened my eyes and the woman was gone. My legs had been tied together with strips of cloth binding me from my ankles to my hips so I couldn't move. I turned my head toward the rock; it was drenched in blood as if an animal had been slaughtered there. Pieces of my meat...lay on top, drying undisturbed in the sun (Epstein 2001:277-8).

In Waris Dirie's book, she relays the uncomfortable experiences of prolonged urination and painful menstruation that plagued her for seven to ten days every month. She also shares the feeling of freedom she experienced after she was surgically deinfibulated (Epstein 2001:279). These personal narratives demonstrate the wide range of physical and psychological consequences of FGC. The stories of the young girls and women who have undergone the pain and horror of FGC provide a brief glimpse into the horrific events innocent girls are subjected to every day throughout the world.

Chapter 7: *Male Circumcision*

Introduction

In the debate over female genital cutting, male circumcision must also be considered. Recently, some anthropologists and other activists have asserted that male circumcision also falls under the category of *genital mutilation* and is a human rights violation. Opponents of male circumcision argue that the procedure constitutes genital mutilation when performed with parental consent but not the infant's assent and recommend that male circumcision be delayed until eighteen years of age when the man can provide individual informed consent to the procedure. Recently, scientific research has provided insight into the health benefits of male circumcision. Thus, consenting to male circumcision is similar to advocating for a minor to receive preventive procedures such as immunizations. In the case of male circumcision physicians argue that parents are acting in the best interests of their children and are not subjugating their sons to the same health risks as FGC (Tobian and Gray 2011:1480).

While male circumcision may unnecessarily remove healthy bodily tissue as in female genital cutting, the harm and risks of this procedure are much less frequent and severe than FGC. Doriane Coleman argues that any analogy between the two forms of genital alteration "has been rejected as specious and disingenuous [since] traditional forms of FGM are as different from male circumcision in terms of procedures, physical ramifications and motivations as ear piercing is to a penilectomy" (Darby and Svoboda 2007:302). In fact, recent scientific research has even found health benefits to male circumcision, which will be discussed later in this chapter. As Chapter 6 points out, there

are no health benefits to female genital cutting, only physical, psychological, reproductive, and sexual consequences. Furthermore, unlike female genital cutting, male circumcision has documented religious ties to the Jewish and Muslim faiths.

History of Male Circumcision

Anthropologists do not agree on the origins of male circumcision. However, it is known that circumcision has been practiced in the Near East, patchily throughout tribal Africa, among the Muslim peoples of India and of Southeast Asia, as well as by Australian Aborigines, for as long as the archaeological record exists. The earliest Egyptian mummies (2,300 BCE) were circumcised and wall painting in Egypt show that it was customary several thousand years earlier than that (Dunsmuir and Gordon 1999:1). Ritualistic circumcision has been carried out in West Africa for over five thousand years, and in the Middle East for at least three thousand years. In the United States and Canada, circumcision appeared as part of the medical culture during the late nineteenth and early twentieth centuries, and by the early 1970s, about 40 percent of Canadian and 80 percent of American newborns were being circumcised (Moses *et al.* 1998:368). Currently, about 25 percent of the male population worldwide is circumcised, and percentages are largely concentrated in the United States, Canada, countries in the Middle East and Asia with Muslim populations, and large portions of Africa (Moses *et al.* 1998:368).

Religious Justifications for Male Circumcision

In Judaism, male circumcision is a rite of passage that is prescribed in religious texts. The rite of circumcision is known as *brit milah*, which means “the covenant of circumcision” and is based on the verses in Genesis 17.9-14 where circumcision is the

“sign of the covenant” that God made with Abraham (Hoenig 1963:322). And God said unto Abraham:

And as for thee, thou shalt keep my covenant, thou, and thy seed after thee throughout their generations. This is my covenant, which ye shall keep, between me and you and thy seed after thee: every male among you shall be circumcised. And ye shall be circumcised among you, every male throughout your generations, he that is born in the house, or bought with money of any foreigner, that is not of thy seed. He that is born in thy house, and he that is bought with the money, needs be circumcised; and my covenant shall be in your flesh for an everlasting covenant. And the uncircumcised male who is not circumcised in the flesh of his foreskin, that soul shall be cut off from his people; he hath broken my covenant. (Genesis 17:9)

For 3,500 years Jewish people have observed the ritual of circumcision as the fundamental sign of the covenant between God and Israel. *Brit milah* is considered to be more than a simple medical procedure to those of the Jewish faith—it is the sign of a new born child’s entry into the Jewish tradition. This ritual has been practiced by Jews worldwide and is known as the ultimate affirmation of Jewish identity (Rabbi Shulman). Female genital cutting, on the other hand, plays no role in religious identity.

While the Qur’an does not mention either female or male circumcision, the Prophet Muhammad is thought to have said that male circumcision is “*sunnah* for the men,” which means that it is customary or traditional (Aldeeb Abu-Sahlieh 1995:79). Thus, male circumcision is not compulsory as a symbol of a man’s covenant with God, but the Prophet Muhammad recommends it. Male circumcision is nonetheless culturally required in Islamic societies. In both Islam and Judaism, circumcision is a fundamental marker of male identity (Joint United Nations Programme on HIV/AIDS 2010:7). As shown in Chapter 3, it is known that there are no legitimate religious passages that justify female genital cutting in Judaism, Islam, or Christianity.

Health Benefits and Risks

While male circumcision has a history of being a religious ritual, scientific research has recently discovered that the removal of the foreskin of the penis also possesses a variety of health benefits.

Human immunodeficiency virus:

Unlike FGC, which poses significant health risks to the girls who undergo the practice, circumcision may, in fact, reduce the risks of HIV, sexually transmitted diseases, some cancers, and infections. Three randomized trials in Africa demonstrated that adult male circumcision decreases human immunodeficiency virus (HIV) acquisition in men by 51 to 60 percent (Tobian and Gray 2011:1479).

Sexually transmitted infections:

In addition to HIV, male circumcision has been shown to reduce the risk of heterosexually acquired sexually transmitted infections (STIs). There is strong evidence for an association between ulcerative STDs and lack of circumcision. Furthermore, there is good concordance for an association between lack of circumcision with syphilis, genital herpes and gonorrhea (Moses *et al.* 1998:370). Two trials demonstrated that male circumcision reduces the risk of acquiring genital herpes by 28 to 34 percent, and the risk of developing genital ulceration by 47 percent. Additionally, the trials found that male circumcision reduces the risk of high-risk sexually transmitted infection human papillomavirus by 32 to 35 percent (Tobian and Gray 2011:1479).

Penile carcinoma:

A more recent study demonstrates a strong association between penile carcinoma and not being circumcised neonatally. It is estimated that about 750-1000 cases of penile carcinoma occur per year in the United States, virtually all among men who have not been circumcised at birth, and mortality may be as high as 25 percent. Neonatal circumcision reduces the risk for penile carcinoma by at least ten-fold, and most likely much more (Moses *et al.* 1998:370).

Urinary tract and other infections:

Neonatal male circumcision provides other potential health benefits during childhood such as the prevention of infant urinary tract infections, meatitis, balanitis, and phimosis. Studies show that uncircumcised infants are more likely to develop urinary tract infections than circumcised ones. Adherence of bacteria to the foreskin may explain the increased risk. And although these infections are easily treated, they are associated with expensive and at times invasive procedures, and occasionally renal injury (Moses *et al.* 1998:371).

Pain during circumcision:

It should be noted that infants undergoing circumcision without anesthesia demonstrate physiological responses suggesting that they are experiencing pain and behavioral changes. However, it has been reported that circumcised infants exhibit a stronger pain response to subsequent routine vaccinations than uncircumcised infants. Nevertheless, local anesthesia should be applied in all cases of neonatal circumcision (Moses *et al.* 1998:371).

Sexual and psychological issues:

Male circumcision has little or no effect on male sexuality or psychology. In fact, a longitudinal study which began in Britain in 1946 and followed more than five thousand individuals from birth to age twenty-seven found no difference between uncircumcised and circumcised males in relation to a number of developmental and behavioral indices (Moses *et al.* 1998:371). However, William Stowell and a few others provide rare cases of boys who sued their physicians for circumcising them as newborn (Circumcision in Law 2000). Some of the cases were due to malpractice, but whether the other lawsuits were a result of psychological issues resulting from the circumcision or the desire for monetary gain is unknown. Studies found no significant differences in male sexual satisfaction or dysfunction among circumcised and uncircumcised men. Although, in some cases, circumcised men reported increased penile sensitivity and enhanced orgasms (Tobian and Gray 2011:1480).

Male Circumcision Versus Female Genital Cutting

FGC supporters argue that female circumcision and male circumcision are synonymous. However, the equivalent of FGC would be the amputation of the penis, since male circumcision involves removing the foreskin of the penis whereas FGC removes a genital organ (Mgbako 2010:114). Clearly, male circumcision and female genital cutting are two incomparable practices. As discussed in Chapter 6, there are many severe health consequences and risks associated with FGC and no legitimate religious justifications for the practice. While religious authorities and scholars have asserted that FGC is not required or justified in any religion, passages from Jewish and Islamic sacred texts have been identified that clearly support and prescribe male circumcision as a legitimate rite of

passage. Therefore, it is easier to take a culturally relativistic approach when it comes to the question of whether male circumcision is also genital mutilation.

Male circumcision is a justified rite of passage and has recently been deemed a beneficial medical procedure. While perhaps circumcision may be deemed unnecessary because healthy tissue is still being removed, male circumcision does not have the same risks associated with it that FGC does. While FGC is known to have physical, psychological, reproductive and sexual consequences, male circumcision has very little. FGC may cause severe infections or other health problems, but male circumcision is scientifically shown to reduce the risk of HIV, sexually transmitted infections, penile carcinoma, urinary tract and other infections. Furthermore, the removal of the female genitalia causes pain at the time of the procedure and the chance of lifelong chronic pain to follow. Local anesthesia is typically used for male circumcision, and while there may be minimal pain at the time of the procedure, studies have shown that the pain tolerance threshold for circumcised males is increased as a result.

Lastly, FGC reduces a woman's capacity for sexual pleasure through the removal of the nerve-rich female genitalia. Male circumcision, on the other hand, has little or no effect on a man's sexual pleasure and has, in fact, been shown to increase penile sensitivity and orgasms. To equate FGC with male circumcision is simply absurd. FGC poses extreme health risks on the young girls who undergo the painful and dangerous procedure, while male circumcision may reduce the risk of certain diseases and infections. Unlike FGC, male circumcision is *not* genital mutilation. Female genital cutting is mutilation because

it destroys health bodily tissues, risks severe health consequences, and reduces female sexual pleasure. Overall, male circumcision does none of these things.

Chapter 8: *Advocacy and Change*

Introduction

As this thesis has established, female genital cutting is *mutilation* and a violation of human rights. The practice removes the right of young girls to bodily wholeness and integrity, life without pain, freedom from harm, and sexual pleasure. The practice of FGC has been recognized as a human rights concern and threat to the health of girls worldwide and many organizations have worked to eradicate this harmful practice. Chapter 8 will explore the international responses and the various advocacy organizations that have made successful progress in the process of change and eradication of FGC.

International Response to FGC

International response to FGC has been seen cross-culturally in societies across Africa and throughout the world. In 1982, following the deaths of fourteen girls as a result of genital cutting, then-president of Kenya Daniel Arap Moi issued a statement condemning the practice and ordering that murder charges be brought against practitioners who carry out genital cuttings that result in death (Prazak 2007:23).

According to the World Health Organization website on female genital mutilation, the WHO issued a joint statement with the United Nations Children's Fund (UNICEF) and the United Nations Population Fund (UNFPA) in 1997 against the practice of female genital cutting/mutilation. In February 2008, a new statement was issued to support increased advocacy for the abandonment of FGC/M. The 2008 statement included evidence collected over the past ten years about the practice and highlighted the increased recognition of the human rights and legal dimensions of the problem. The statement also

incorporated data on the frequency and scope of FGM and summarized research about why FGM continues, how to stop it, and its damaging effects on the health of women, girls, and newborn babies.

United States senators Joe Biden and Richard Lugar introduced the International Violence Against Women Act in 2007. This act provides \$175 million a year in foreign aid to try and prevent all forms of violence against women, including honor killings, bride burnings, FGC, acid attacks, mass rapes, and domestic violence (Kristof and WuDunn 2009:67).

In 2010, the WHO published a “Global strategy to stop health care providers from performing female genital mutilation” in collaboration with other United Nations agencies and international organizations. Since the original statement in 1997, many efforts have been made to counteract FGM through research, work within FGM-practicing communities, and changes in public policy. According to the WHO, progress at both international and local levels include:

- wider international involvement to stop FGM;
- the development of international monitoring bodies and resolutions that condemn the practice;
- revised legal frameworks and growing political support to end FGM (this includes a law against FGM in twenty-two Africa countries, and in several states in two other countries, as well as in twelve industrialized countries with migrant populations from FGM practicing countries);
- in most countries, the prevalence of FGM has decreased, and an increasing number of women and men in practicing communities support ending its practice. (<http://www.who.int/mediacentre/factsheets/fs241/en/>)

As of 2010, eighteen African countries had passed legislation criminalizing FGC. They include Benin, Burkina Faso, Central African Republic, Cote d’Ivoire, Djibouti, Egypt, Eritrea, Ethiopia, Guinea, Kenya, Niger, Senegal, Tanzania, and Togo (Mgbako

2010:138). Of these laws, Burkina Faso's anti-FGM law is considered one of the most comprehensive and effectively implemented, and punishes "any person who violates or attempts to violate the physical integrity of the female genital organs by total ablation, excision, infibulation, desensitization or by any other means" (Mgbako 2010:139). If the procedure results in death, the punishment is imprisonment for five to ten years.

World Health Organization Response

Joy Phumaphi, Assistant Director-General of Family and Community Health, World Health Organization, says, "FGC is a practice steeped in culture and tradition but it should not be allowed to carry on. We must support communities in their efforts to abandon the practice and improve the care of those who have undergone FGM. We must also steadfastly resist the medicalization of FGM. WHO is totally opposed to FGM being carried out by medical personnel" (Prazak and Coffman 2007:vii). Furthermore, in 2008, the World Health Assembly passed a resolution (WHA61.16) on the elimination of FGM, emphasizing the need for concerted action in all sectors—health, education, finance, justice, and women's affairs. WHO's efforts to eliminate female genital mutilation focus on:

- advocacy: developing publications and advocacy tools for international, regional and local efforts to end FGC within a generation;
- research: generating knowledge about the causes and consequences of the practice, how to eliminate it, and how to care for those who have experienced FGM;
- guidance for health systems: developing training materials and guidelines for health professionals to help them treat and counsel women who have undergone procedures.

The WHO is concerned about the increasing trend for medical personnel to perform FGM and strongly urges health professionals not perform such procedures (World Health Organization).

These international responses and advocacy techniques will be explored further in the following pages. Campaigns have found success focusing on education, women's empowerment, economics, alternative rites of passage, cultural sensitivity, and change from within a community.

Education and Women's Empowerment

Without a doubt, education and an increase in the social status of women in FGC-practicing societies are key components in the movement to eradicate FGC. A successful campaign should raise awareness of the health risks of FGC and inform both men and women. For example, in interviews with one hundred and fifteen mothers who had left their daughters uncircumcised, 30 percent said that they responded directly to education campaign, and nearly all the rest had responded to discussions or viewpoints that were not heard earlier. Among the latter, 30 percent of all the non-circumcising mothers had been influenced by the argument that the operation is dangerous...a further 19 percent were influenced by the argument that FGC made childbirth more difficult. Finally, 10 percent heeded the message that circumcision would restrict their daughters' sexual pleasure and another 10 percent that it had no scriptural warrant (Caldwell *et al.* 2000:247).

According to Prazak, most parents in FGC-practicing communities see that circumstances in their communities are changing and regret the fact that women and girls have been left

behind in education and national development as a result of limited education achievement, genital cutting, and early marriage (Prazak, 2007). Statistics show that circumcision levels are much lower among the younger than the older generations, much lower in urban than rural areas, and are declining steeply with the education of the mother (Caldwell *et al.* 2000:242).

As education increases in Africa, younger generations and those in urban areas will come to know the health consequences of FGC more readily. Research has already begun to show this trend. Written polls administered to students in community schools solicited students' opinions on a range of issues in 1988, 1993, and 2003. One true/false item stated: "It is good for girls to be circumcised." The percentage of both sexes finding this assertion false has grown significantly over the years: in 1988, half the respondents found that not to be true, and by 2003, the percentage had risen to 80 percent (Prazak 2007:31). Certainly, targeting youth through education is one way to make future generations more aware of the harmful effects of FGC on young girls and women. In southwest Nigeria, nearly all uncut girls in urban areas had parents with at least some secondary education (Woldemicael 2009:5). Uncircumcised mothers are seven to eight times more likely than circumcised mothers to leave their daughters uncircumcised, and mothers with secondary schooling are twice as likely to leave their daughters uncircumcised (Caldwell *et al.* 2000:249).

Educated families that were worried about publically denouncing infibulation are more comfortable now than in the past. For example, an educated family in a Sudanese community quietly switched to pharaonic sunna (clitoridectomy) in the 1970s. Fifteen

years later, when they felt more comfortable revealing that they had not had their daughters infibulated, their example could begin to serve as evidence that the feared unmarriageability would not necessarily result from not infibulating one's daughter (Gruenbaum 2005:104). It is success stories like this one that need to be made more publically known through educational campaigns, community dialogues, and workshops.

Higher levels of education in FGC-practicing communities allow girls and women to argue more effectively against FGC. Education will help community members comprehend the complex health consequences of the practice for a more widespread understanding of the harmfulness of FGC. Improving the social status of women within society and increasing women's empowerment is also vital to anti-FGC campaigns. According to Prazak, while they are in school, "girls may idealize becoming educated and converting that education into paid employment, but once they are initiated (cut), married, and have children, they adapt to the social identity they fit most easily: they become the *abakari*—young, married mothers, establishing their house and their husband's homestead" (Prazak 2007:33).

Men's Role in the Process

According to Gruenbaum, male leadership imposing change does not have the same liberating force as the strategy of women's empowerment (Gruenbaum 2005:107). FGC is women's issue and women should have a say in what happens to their bodies. However, men certainly can collaborate with women in their communities to significantly aid in eradication efforts. There are a few ways men can help in the effort to change FGC. As husbands, brothers, and fathers, men in FGC-practicing societies, after being made

aware of the health consequences, can pledge to not circumcise their daughters or not marry circumcised women. This was the case in North Kordofan, Sudan, where over one hundred men took a pledge to marry uncircumcised women and not circumcise their daughters after being convinced by a speaker and educational campaign (Gruenbaum 2005:106). This technique must also work to ensure that circumcised women are not simultaneously made unmarriageable through such pledges. Eventually, the desired goal would be that all girls approaching the age of marriage are left uncircumcised within a couple of generations of the men taking the pledge.

Cultural Sensitivity

Cultural sensitivity is a key idea to keep in mind when formulating an advocacy campaign against FGC. Cultures that practice FGC should not feel attacked, belittled or inferior from these efforts. There are two sides to culture sensitivity when it comes to FGC: cultural relativism and universalism. Indigenous activists and anthropologists often argue for cultural relativism: that every culture is to be understood according to its own terms, not judged by outsiders' criteria; the members of each culture should be able to enjoy the right to self-determination, and should have the principal say with regard to their own practices and traditions (Prazak 2007:20-1). On the other side of the argument, a universalist stance asserts, that "oppression of women must cease, always, everywhere, in every culture, as a matter of basic human rights" (Prazak 2007:21).

In this thesis, I take a universalist stance. Female genital cutting is, without a doubt, a human rights violation and a threat to the bodily integrity of girls and women worldwide. However, with that being said, the practice can, and must, still be approached in a

culturally sensitive way in order to effectively change the occurrence of the practice. Some anthropologists are castigated for “lapsing into a paralyzing cultural relativism.” Because of this, advocates suggest that “forces of change”—described as “courageous women and men of conscious”—within societies that practice FGC can prevail if they can introduce suitable cultural substitutes for the practices they seek to eliminate, and if they can be assured that in their fight they are no longer alone” (Prazak 2007:21).

According to anthropologist Regina Oboler, “it is essential to respect the motives of the people participating in the maintenance of female genital modification,” and a “rhetoric of blame and shame must be avoided at all costs” (Prazak 2007:25). This is especially important and is the reason why the terminology *female genital cutting* is used in this thesis as opposed to *female genital mutilation*. While FGC is technically mutilation, the term implies the intent of the family members and practitioners to purposefully harm the young girls undergoing the procedure when, in fact, this is not the case. Similarly, Prazak asserts that for many in FGC-practicing communities, it is difficult to support a campaign to eradicate genital cutting that belittles those who practice it, and by positioning the tradition as irrational, ignorant, or backward. Elitist and ethnocentric attitudes do not offer much hope for productive dialogue and create an upheaval that stands in the way of “community self-determination, the process of advancing a dialogue between community members who identify alternatives to fill social functions and satisfy needs now related to genital cutting” (Prazak 2007:37).

Change From an Insider's Point of View

“We must deal with female circumcision ourselves. It is our culture, we understand it, when to fight against it and how, because this is the process of liberation”

– Nawal El Saadawi, 1980 (Gruenbaum 2005:89)

In some FGC-practicing societies, the prevalence of FGC has increased as a sign of cultural resistance to imperialism and ethnocentrism by Westerners. During the era of colonial rule in Africa, some governments attempted to ban female circumcision and met with resistance. In Sudan, when a law prohibiting infibulation was about to be put in place in 1946, many parents rushed to midwives to have their daughters circumcised before the ban was enacted. Some midwives were arrested for performing circumcisions and anticolonial protests broke out. Fearing a nationalist revolt like the ones in Egypt and Kenya, the British colonial government let the law go unenforced (Althaus 1997:132).

As this example demonstrates, change must come from within a society and incorporate an insider's point of view on female genital cutting for the process to be effective. Otherwise, advocacy efforts are deemed imperialist and ethnocentric, and campaigns are met with cultural resistance perhaps in the form of an increase in the cutting practices. This is where human rights activists and others working to change FGC must be careful. Without a doubt, the communities in which female genital cutting occurs need to be involved in discussing and implementing change efforts. Such efforts will not work if they are solely dictated by Westerners traveling to Africa with no understanding of the culture of FGC-practicing societies. As Oboler prescribes, “an appropriate approach to the eradication of female genital modification is to find those that have a strong interest in eliminating these practices and, having found them to work diligently with them to formulate a program that draws on their insider perspectives. The program will be most

effective if the major impetus for change comes from within the community rather than from outside it” (Prazak 2007:25).

Alternative Rites of Passage

Campaigns for the eradication of FGC have also been successful in using alternative rites of passage to replace FGC as a coming-of-age ritual or symbol of womanhood and marriageability within a society. Alternative rites of passages recognize the cultural significance of FGC within a society and aim to preserve that significance while discontinuing the cutting itself and replacing it with a culturally significant alternative.

In 2004, two hundred and eighty-nine Kurian girls in underwent an alternative rite of passage after several years of campaigning by international non-governmental organizations in Kenya. Instead of going through genital cutting, the girls were brought for workshops from three of the four clans (*ibiaro*) that comprise the district and were instructed by teachers, doctors and “priests from different denominations” on topics such as counseling, effects of FGC, myths and misconceptions, religion, communication, problem handling, the reproductive system, peer pressure, STD/HIV, and gender” (Prazak 2007:24). Unfortunately, all but eighty of those girls were forced by their relatives or pressured by their peers to undergo the genital cutting, and, according to Prazak, “the practice persists despite the efforts being made by government, NGOs, and church agents and *because* of elders’ commitment to ensure transitions into adulthood for their children and grandchildren” (Prazak 2007:25-27).

When alternative rites of passage are implemented in eradication efforts it is best to target younger generations within the community. Along those lines, Prazak asserts that, “The leaders of the move toward alternative rites of passage and the banning of genital cutting do not come from this group [of elders]. These “alternative leaders” are less senior in the age hierarchy...The leaders behind the alternative rites of passage [must be] the first generation of formally educated people: the retired government officials, aging teachers and headmasters, and previous employees of banks and multinational corporations” (Prazak 2007:27).

Tostan and Other Successful Models

The vision of a world free of female genital cutting is not an unimaginable one, as evidenced by the many successful campaigns that have either greatly reduced or eradicated the practice where it is most prevalent. Tostan, “a West African group that takes a very respectful approach and places FGC within a larger framework of community development,” is arguably the most successful organization effort to end FGC (Kristof and DuWunn 2009:224). Notably, Tostan has facilitated anti-FGC education programs that have led to twelve hundred Senegalese villages’ public declarations to abandon FGC, and their success continues to diffuse into still more villages (Prazak and Coffman 2007:x). Furthermore, Tostan recognizes women’s empowerment as a key element for ending FGC practices and engages women and girls in building their own capacities to change their lives and communities (Gruenbaum 2005:104).

According to Mgbako, in 1997, Tostan successfully helped the village of Malicounda Bambara in Senegal to make a public pledge to end FGM in its community. Tostan

conducted a series of educational workshops for community members exploring topics such as health, hygiene, and human rights. Tostan workshop leaders made the decision not to explicitly raise the issue of FGC within the workshops so as not to antagonize the communities. Instead, they allowed the workshop participants to raise the topic themselves. Since 1997, 3,791 communities in Senegal, 364 in Guinea, 14 in Somalia, and 23 in Burkina Faso have followed Malicounda Bambara in declaring an end to the practice of FGM (Mgbako 2010:124).

Furthermore, in Senegalese communities that have been targeted by Tostan, several respondents remarked that they wished to leave the practice of FGC after learning about the law banning the practice, but could not do so because of the pressures from others to circumcise their daughters. Under the direction of Tostan, a significant number of people in the community agreed to abandon FGC and, thus, lifted the pressure formerly placed on people who wished to comply with the law (Hernlund 2007:48).

Chapter 9: *Blueprint for Eradication of FGC: A Holistic Approach*

Much of this thesis has provided information on the cultural significance of FGC and given examples of successful anti-FGC campaigns and eradication efforts. Chapter 9 will use what I have learned about the practice of female genital cutting to formulate a “blueprint” for human rights organizations and advocacy groups when addressing the controversial subject of female genital cutting.

Key Components to Keep in Mind

1. As demonstrated in Chapter 2, mass media are a powerful tool that can be utilized for successful eradication campaigns, as was the case with the Azawagh Arabs of Niger. Even though cultural notions of femininity, beauty, cleanliness, and purity are all deeply embedded within a society, these ideals are still malleable. Television, music, radio, the Internet, and print media are all resources that can be capitalized on in the fight against female genital cutting. It is important to keep in mind, however, that this media should come from within the society. If a song is written about the beauty and femininity of an uncircumcised woman, that song should be written and performed by someone from within an FGC-practicing culture that opposes that practice. A song concerning the same subject matter written by a Westerner may be interpreted as ethnocentric and imperialist and may be met with cultural resistance and even an increase in the harmful practice.
2. Because religion is often cited as the main justification for FGC, it is important to make it widely known that FGC is not prescribed or advocated for in any religions, as demonstrated in Chapter 3. Religious scholars (again, from within particular FGC-practicing societies) sitting down with their community members and openly discussing

the religious myths of FGC, and the misinterpretations of the weak Hadith of the Prophet Muhammad that is often used to justify the practice may be very effective.

3. As discussed in Chapter 4 and 5, marriageability is a pressing concern and strong factor in the decision of parents whether or not to circumcise their daughters. Caldwell points out that, “campaign aimed at parents, especially mothers, rather than at communities and their leaders, narrows the circle of decision-making within a society” (2000:249). Furthermore, identifying men (husbands, fathers, and brothers) within a society that have been educated on the harmful health consequences of FGC and having them pledge not to circumcise their daughters or marry circumcised women reduces the cultural fear that an uncircumcised woman will be unmarriageable. Opening up discussion of FGC into the male sphere, where the subject has always been taboo, allows for a more open dialogue about health disparities and other cultural issues that may need improvement and builds a mutual understanding between the sexes on the subject of FGC. Prominent religious authorities, community leaders, or male physicians may facilitate such discussions.

4. Community educational campaigns not only focusing on the health consequences, but also on FGC as a human rights violation need to be implemented. Mgbako argues that campaigns focusing exclusively on the health consequences of FGC and not properly addressing FGC as a violation of human rights merely leads to the medicalization of the practice, where parents take their daughters to be cut by medical professionals working with sterile and cleaner instruments (Mgbako 2010:115). A successful campaign must discuss the negative health consequences but also make the harmful sexual, reproductive,

psychological consequences made known. Furthermore, a successful campaign should debunk the religious myths surrounding FGC and the ways that women get around FGC “guaranteeing” virginity.

5. Cultural sensitivity must always be a concern when creating an eradication plan. According to Mgbako, “today, most organizations disfavor the use of the “discourse of oppression” and are developing programs with a better understanding of the socio-cultural context in which FGC occurs” (Mgbako 2010:112). Rather than asserting ethnocentric viewpoints through an outsider’s “discourse of oppression,” this discourse would be one of community-based empowerment.

6. The subject of FGC not only needs to be addressed, but also the opportunities for women to increase their social standing within a society need to be provided. Economic security plays a significant role in a woman’s ability to escape her socially prescribed role as a mother and wife and will provide women a better chance for higher education, careers, and more autonomous and self-determining lives. Gruenbaum agrees that, “The oppression or subordination of women, their poverty, and their restricted opportunities are a more fundamental issue to address if we wish to understand people’s willingness to continue to participate in these practices and the obstacles that reformers must face” (Gruenbaum 2001:47). Similarly, Woldemicael asserts that, “increased levels of girls’ education, higher household economic status or employment, urbanization, and exposures to mass media are considered important factors to abandoning traditional practices” (Woldemicael 2009:4). Increased education and economic status provide women with the tools to challenge and eliminate FGC.

7. Legislation should be implemented at both a cultural and national level. On a cultural level, midwives should take an oath not to circumcise girls in order to fulfill the medical mantra to “do no harm.” In the Midwifery School in Sudan, if any trained midwife violates the rule, she will have her equipment box taken away and be recalled for two months of additional training and renewal of the oath. If there is a second offense, she will not be allowed to practice again (Gruenbaum 2005:102). On a national level, FGC has already been and should continue to be made illegal in FGC-practicing countries. Additionally, the legislation needs to be as well enforced as possible to prevent a resistive increase in the practice.

8. Alternative rites of passage that represent the same cultural significance as FGC may be introduced. Where FGC represents a transition from girlhood to womanhood, theater performances, interpretive dances, gift-giving ceremonies, songs, and educational workshops can be used to make this distinction for a girl within a society. Mgbako suggests that alternative rites of passages ceremonies should include several activities such as communal feasting, traditional singing and dancing, gift giving to the girls passing through ritual, declaration by the girls that they have not been and will not undergo FGC, and declarations by fathers, mothers, and community leaders of their commitment to support the abandonment of the practice (Mgbako 2010:133).

In the following sections, I will combine all of these key factors into a comprehensive and holistic eradication plan.

Phase 1: Cultural Sensitivity and Permission

Phase 1 of the eradication strategy highlights the importance of cultural sensitivity and gaining permission from a society before entering into it with a controversial agenda. The organization seeking entrance into a society should first gain permission from community leaders to conduct educational workshops on health, human rights, education and women's empowerment. The topic of female genital cutting should not be mentioned when gaining permission for these educational workshops and the "discourse of oppression" should be avoided at all times. Advocates should recognize the cultural importance of traditions and rituals and eliminate reproachful language, as with the example of using the terminology of "female genital cutting/circumcision" over "mutilation."

Phase 2: Identifying "Positive Deviants" and Organizing Workshops

After gaining the permission to hold educational workshops within the community, the organization should conduct ethnographic research to determine what Mgbako calls "Positive Deviants." Positive Deviants are "members of the community who have either decided not to undergo FGC or, alternatively, have decided to abandon FGC and are willing to become advocates within their own communities to convince others to do the same" (Mgbako 2010:128). Such community members have an insider's point of view and the ability to communicate their views on health, human rights, education, and empowerment within their community. Furthermore, "Positive Deviants" can be men or women, but should also include religious authorities (to debunk the religious myths of FGC), midwives or other medical professionals (to talk about the health consequences of

FGC) and community leaders that have the respect and trust of their community members.

After Positive Deviants are identified, both the advocates from the anti-FGC organization and the advocates from within the society should organize educational workshops and open dialogues. For example, one week a female-only workshop may be held to discuss social roles, health disparities, economic opportunities, and women's health concerns (reproductive issues, etc.). In the beginning, gender segregation will aid in creating a trusting environment that allows for the discussion of taboo subjects. While female Positive Deviants should facilitate the discussion, medical and other (female) professionals should be available to answer questions concerning health, economics, education, etc.

According to Mgbako, in the most successful anti-FGC projects that involve the use of community education workshops, the workshop organizers do not explicitly raise the issue of FGC. Instead, the organizers have found that without fail (although sometimes with the help of leading questions) workshop participants will bring up the topic of FGC on their own, after an environment of trust and safety has been established within the workshop (Mgbako 2010:127). Eventually, it is assumed that the topic of female genital cutting will be brought up when discussing women's health and reproductive rites. According to research by Toubia, the subject of female circumcision "is not taboo," but rather "it is *painful*" and when women feel they are in a safe environment, they are "desperate to talk about it" (Gruenbaum 2001:16).

Then, during another week a male-only workshop should be conducted to discuss similar topics, while similarly allowing for an environment of honesty, trust, and privacy. Male Positive Deviants, community leaders, and religious scholars may guide the conversations to discuss community health, human rights, improvements in education, the economy, and religion. Finally, educational workshops should be held where both men and women meet together. These educational workshops and conversations may prompt discussions about improvements in sanitation, water quality, health, gender roles, education, among other things, and will foster an environment and desire for a community-wide and insider-driven force for positive social change.

Phase 3: Alternative Rites of Passage and Positive Outcomes

Once an environment of trust and open dialogue has been established within an FGC-practicing society, and the topic of FGC has been discussed, acceptable alternative rites of passages can be debated and implemented within a society. Because FGC remains mostly in the female sphere of society, women in particular should be involved in the discussion of alternative rites of passage that still symbolize a transition from girlhood to womanhood, or whatever cultural significance FGC holds within that specific society. As discussed previously, alternative rites of passages could include communal feasting, traditional singing and dancing, gift giving to the girls passing through ritual, declaration by the girls that they have not been and will not undergo FGC, and declarations by fathers, mothers, and community leaders of their commitment to support the abandonment of the practice. For their participation in the educational workshops, “Positive Deviants” should be rewarded with highly desired good, such as special tools, food or clothing. The positive reinforcement and reward for the Positive Deviants’

participation would most likely encourage others to act as conversation leaders and advocates for health, human rights, and education within societies with the promise of rewards. It is important that “Positive Deviants” remain in the society as educated and respected leaders and fulfill traditional roles. Over time, these influential roles may be passed down from parent to child. In doing so, the cycle of change will be continued from generation to generation.

Chapter 10: Conclusion

While some anthropologists, feminists, and social scientists, argue that FGC is a legitimate rite of passage that is deeply embedded in the cultures that practice it, as we have seen, FGC cannot be justified by many of the offered cultural reasons. FGC is performed on girls of a wide age range, and is often performed at infancy with no anesthesia. Therefore, in many societies that practice FGC at infancy, the claim that FGC is a legitimate rite of passage from girlhood to womanhood cannot be made. Furthermore, the cutting of genitalia at infancy does not indicate that a girl is marriageable at that age.

Seventy percent of FGC practitioners assert that religion is the primary rationalization for FGC, yet the most respected and educated religious scholars and authorities argue that FGC has no religious justifications. FGC is not practiced universally among any religion and there are no religious texts to support the practice. Unlike male circumcision, that represents a religious covenant with God and portrays a deeply embedded identity, FGC has no such cultural significance. By debunking the belief of FGC as a religious duty well known worldwide, the prevalence and rate of FGC will be significantly reduced.

In FGC-practicing societies, “circumcision” and infibulation in particular are believed to reduce female sexual desire, prevent promiscuous behavior by making sexual intercourse less appealing and “guarantee” virginity of females upon marriages. Through covert techniques such as secret marriages strictly for sexual pleasure and medical procedures to redo infibulations, the premiums and morality and purity are undermined and virginity upon marriage is no longer “guaranteed.” The accepted cultural belief that men are

expected to engage in premarital sexual behavior provides insight into the gender imbalance and oppressive attitudes towards women found in FGC-practicing cultures. Also, the circumcision status of a woman is believed to play a significant role in her marriageability. However, whether or not a woman is circumcised is rarely discussed when arranging marriages and thus, does not affect a woman's ability to get married, have children, and receive economic security.

In many FGC-practicing communities, FGC is believed to be beneficial and healthy. However, Chapter 6 clearly demonstrates that that is not the case. The list of physical, psychological, sexual, and reproductive health ramifications of FGC is almost endless. Removal of the clitoris does not prevent deaths during childbirth nor does the clitoris grow to the size of a penis if left uncut. The severity of and risks associated with FGC are the main reason that FGC is a violation of basic human rights.

On the other hand, it is often asserted the female genital cutting and male circumcision are both genital mutilation. This is like claiming that ear piercing and penilectomies are equally as harmful to bodily integrity and health. Unlike female genital cutting, male circumcision is adequately justified as a legitimate religious rite of passage and is a significant factor in Jewish and Muslim identity. Moreover, scientific studies have expanded on the wide range of health benefits of male circumcision that are not associated with FGC. In the case of religion, male circumcision is a legitimate rite of passage. In terms of health, male circumcision may prevent certain infections and cancers and may increase sexual pleasure. Female genital cutting possesses none of these health benefits.

When approaching female genital cutting as a threat to human rights, it is important to remain culturally sensitive, but in this case, not culturally relativistic. Successful advocacy campaigns recognize the cultural significance of FGC and focus on women's empowerment, alternative rites of passage, education, health, and improved standards of living for all members of the community. It is important to not approach the topic of FGC with blameful language and to avoid a "discourse of oppression" as much as possible. The eradication of FGC is not hopeless and can be achieved through the combined efforts of human rights groups and advocacy campaigns that deal with FGC in a culturally sensitive way.

As this thesis has demonstrated, female genital cutting is, indeed, *mutilation*. The practice removes healthy organs and tissue from innocent girls and with it eliminates their human rights to bodily integrity and wholeness, sexual pleasure, and a lifetime without pain or suffering from the physical, psychological, reproductive, and sexual ramifications. No matter the severity of the type of FGC, all forms deny girls and women these basic human rights and cannot be justified by religious, cultural, or medical reasons.

References Cited

- Abu-Sahlieh, Sami A. Aldeeb
2005 Islamic Law and the Issue of Male and Female Circumcision. *Third World Legal Studies* 13(4):73-101.
- Abusharaf, Rogaia Mustafa
2006 *Female Circumcision: Multicultural Perspectives*. Philadelphia: University of Pennsylvania Press.
- Ahmadu, Fuambai
2007 "Ain't I A Woman Too!": Challenging Myths of Sexual Dysfunction in Circumcised Women. *In Transcultural Bodies: Female Genital Cutting in Global Context*. Ylva K. Hernlund and Bettina K. Shell-Duncan, eds. Rutgers, NJ: Rutgers University Press. pp. 278-310.
- Althaus, Frances A.
1997 Female Circumcision: Rite of Passage or Violation of Rights? *International Family Planning Perspectives* 23(3):130-133.
- Baloch, Shahla, with Meharunnissa Khaskheli, Imdad A. Khushk and Aneela Sheeba
2008 Frequency of Second Stage Intervention and its Outcome in Relation With Instrumental Vaginal Delivery Versus Caesarean Section. *Journal of Ayub Medical College* 20(1):87-90.
- Behrendt, Alice
2005 Posttraumatic Stress Disorder and Memory Problems After Female Genital Mutilation. *The American Journal of Psychiatry* 162(5):1000-1002.
- Bodman, Herbert L. and Nayereh Tohidi
1998 *Women in Muslim Societies: Diversity Within Unity*. Boulder, CO: Lynne Rienner Publishers, Inc.
- Caldwell, John C, I. O. Orubuloye, and Pat Caldwell
2000 Female Genital Mutilation: Conditions of Decline. *Population Research and Policy Review* 19(3): 233-254.
- Circumcision in Law
2000 Landmark case: suit against a "successful," parentally-consented infant circumcision. <http://www.circumstitions.com/Law.html> (accessed April 10, 2012)
- Darby, Robert, and J. Steven Svoboda
2007 A Rose by Any Other Name? *Medical Anthropology Quarterly* 21(3): 301-323.

- Dorkenoo, Efua
1996 Cutting the Rose: Female Genital Mutilation: The Practice and its Prevention. London: Minority Rights Group.
- Dunsmuir, W.D. and E. M. Gordon
1999 The history of circumcision. *BJU International* 83(1):1-12
- Einstein, Gillian
2008 From Body to Brain: Considering the Neurobiological Effects of Female Genital Cutting. *Perspectives in Biology and Medicine* 51(1):84-97.
- Elnashar, A.
2007 The impact of female genital cutting on health of newly married women. *International Journal of Gynecology and Obstetrics* 97:238-244.
- Esere, M. O.
2007 A Cross-Ethnic Study of the Attitude of Married Women in Nigeria Towards Female Genital Mutilation. *African Journal for the Psychological Study of Social Issues* 10(1):114-125.
- Epstein, David
2001 Medical Complications of Female Genital Mutilation. *Journal of American College Health* 49(6):275-280.
- Gruenbaum, Ellen
2001 *The Female Circumcision Controversy: An Anthropological Perspective*. Philadelphia: University of Pennsylvania Press.
- Gruenbaum, Ellen
2005 Feminist Activism for the Abolition of FGC in Sudan. *Journal of Middle East Women's Studies* 1(2):89-111. Print.
- Gruenbaum, Ellen.
2006 Sexuality Issues in the Movement to Abolish Female Genital Cutting in Sudan. *Medical Anthropology Quarterly* 20(1):121-138.
- Gülen, M. Fethullah
2010 *Questions and Answers About Islam Vol. 2*. New Jersey: Tughra Books.
- Hayes, Rose Oldfield
1975 Female Genital Mutilation, Fertility Control, Women's Roles, and the Patrilineage in Modern Sudan: A Functional Analysis. *American Ethnologist* 2(4):617-633.

- Hernlund, Ylva, and Bettina Shell-Duncan
2007 Contingency, Context, and Change: Negotiating Female Genital Cutting in the Gambia and Senegal. *Africa Today* 53(4):43-57.
- Hicks, Ester K.
1993 *Infibulation: Female Mutilation in Islamic Northeastern Africa*. New Brunswick, NJ: Transaction.
- Hoenig, Sidney B.
1963 Circumcision: The Covenant of Abraham. *The Jewish Quarterly Review* 53(4):322-334.
- Huelsman, B. R.
1976 An Anthropological View of Clitoral and Other Female Genital Mutilations. In *The Clitoris*. T. P. Lowry and T. Snyder Lowry, eds. St Louis, MO: Warren H. Green Inc. pp 111–161.
- Iweulmor, Juliet
2005 Preserving a Woman's Genitalia: An Analysis of Female Circumcision/Female Genital Mutilation in Africa.
http://forms.gradsch.psu.edu/diversity/mcnair/mcnair_jrn12005/files/27_iweulmor.pdf (accessed April 10, 2012)
- Joint United Nations Programme on HIV/AIDS, and World Health Organization
2007 Male circumcision: Global trends and determinants of prevalence, safety, and acceptability.
http://whqlibdoc.who.int/publications/2007/9789241596169_eng.pdf
(accessed April 10, 2012)
- Kaplan, Adriana, with Suiberto Hechavarría, Miguel Martín and Isabelle Bohoure
2011 Health consequences of female genital mutilation/cutting in the Gambia, evidence into action. *Reproductive Health* 8(26):1-6.
- Kassamali, Noor J.
1998 When Modernity Confronts Traditional Practices: Female Genital Cutting in Northeast Africa. In *Women in Muslim Societies: Diversity Within Unity*. H. L. Bodman and N. Tohidi, eds. London: Lynne Rienner Publishers. pp. 39-61.
- Kristof, Nicholas D. and Sheryl WuDunn
2009 *Half The Sky: Turning Oppression into Opportunity for Women Worldwide*. New York: Random House, Inc.
- Mgbako, Chi, with Meghna Saxena, Anna Cave, Nasim Farjad, and Helen Shin
2010 Penetrating the Silence in Sierra Leone: A Blueprint for the Eradication of Female Genital Mutilation. *Harvard Human Rights Journal* 23:111-140.

- Moses, Stephen, with Robert C. Bailey and Allan R. Ronald
1998 Male circumcision: assessment of health benefits and risks. *Sexually Transmitted infections* 74(5):368-73.
- Nour, Nawal M.
2008 Female Genital Cutting: A Persisting Practice. *Reviews in Gynecology and Obstetrics* 1(3):135-139.
- Obermeyer, Carla Makhoulouf
1999 Female Genital Surgeries: The Known, the Unknown, and the Unknowable. *Medical Anthropology Quarterly* 13(1):79-106.
- Popenoe, Rebecca
1999 Islam and the Body: Female Fattening Among Arabs in Niger. https://openaccess.leidenuniv.nl/bitstream/handle/1887/17336/ISIM_4_Islam_and_the_Body-Female_Fattening_among_Arabs_in_Niger.pdf?sequence=1 (accessed April 10, 2012):
- Prazak, Miroslava.
2007 Introducing Alternative Rites of Passage. *Africa Today* 53(4):19-40.
- Prazak, Miroslava, and Jennifer E. Coffman
2007 Anthropological Perspectives on Female Genital Cutting: Embodying Tradition, Violence, and Social Resilience.” *Africa Today* 53(4):v-xi.
- Raouf, Sanaria A, with Teresa Ball, Alison Hughes, Roger Holder, and Spyros Papaioannou
2001 Obstetric and neonatal outcomes for women with reversed and non-reversed type III female genital mutilation. *International Journal of Gynecology and Obstetrics* 113:141-143.
- Scheper-Hughes, Nancy
1991 Virgin Territory: The Male Discovery of the Clitoris. *Medical Anthropology Quarterly* 5:25-28.
- Sembene, Ousmane
2004 *Moolaadé*. 124 min. New York: New Yorker Films.
- Shaik, Sa'diyya
2003 Family Planning, Contraception, and Abortion in Islam: Undertaking *Khilafah*. In *Sacred Rights: The Case for Contraception and Abortion in World Religions*. D. Maguire, ed. Oxford: Oxford University Press. pp. 105-128.
- Shulman, Rabbi Moshe
A Guide to Brit Milah/Bris Milah. <http://www.milah.net/> (accessed April 10, 2012)

- Slack, Allison T.
1988 Female Circumcision: A Critical Appraisal. *Humans Rights Quarterly* 10(4):437-486.
- Smith, Courtney
2001 Who Defines “Mutilation”? Challenging Imperialism in the Discourse of Female Genital Cutting. *Feminist Formations* 23(1):25-46.
- Stedman’s Medical Dictionary (26th Edition)
1995 Baltimore: Williams & Wilkins.
- The Nemours Foundation
2012 What is the Apgar Score?
http://kidshealth.org/parent/pregnancy_center/q_a/apgar.html (accessed April 10, 2012)
- Tobian, Aaron A. R, and Ronald H. Gray
2011 The Medical Benefits of Male Circumcision. *The Journal of the American Medical Association* 306(13):1479-1480.
- United Nations Department of Public Information
1996 Women and Violence. <http://www.un.org/rights/dpi1772e.htm> (accessed April 10, 2012)
- United Nations Population Fund
2004 Female Genital Mutilation/Cutting in Somalia.
http://siteresources.worldbank.org/INTSOMALIA/Data%20and%20Reference/20316684/FGM_Final_Report.pdf (accessed April 10, 2012):17
- Utz-Billing, I.
2008 Female genital mutilation: an injury, physical and mental harm. *Journal of Psychosomatic Obstetrics and Gynecology* 29(4):225-229.
- Woldemicael, Gebremariam
2009 Female Genital Cutting in Contemporary Eritrea: Determinants, Future Prospects, and Strategies for Eradication. *Eastern Africa Social Science Research Review* 25(2):1-29.
- World Health Organization
2012 Female genital mutilation.
<http://www.who.int/mediacentre/factsheets/fs241/en/> (accessed April 10, 2012)
- Yount, Kathryn M.
2004 Symbolic Gender Politics, Religious Group Identity, and the Decline in Female Genital Cutting in Minya, Egypt. *Social Forces* 82(3):1063-1090.

Author's Biography

Morgan Haley Brockington was born in Portland, Maine on May 23, 1990 and grew up in Saco, Maine. Morgan studies Anthropology and Pre-Medical Studies in the Honors College. She was a Sophomore Eagles and is an All Maine Woman. Morgan is also a University Singer and an Emergency Medical Technician with the University Volunteer Ambulance Corps. Morgan is a member of Phi Beta Kappa and the National Society for College Scholars.

Upon graduation, Morgan will take a gap year to work in Emergency Medical Services or a medically related research setting and apply to graduate programs. In the future, Morgan plans to continue on to receive a Masters in Medical Anthropology and Cross-Cultural Medicine focusing on immigrant and women's health and a medical degree specializing in Emergency Medicine or Infectious Disease. She hopes to one day combine her love for anthropology and medicine to increase cross-cultural competency in the United States and abroad by working with the World Health Organization or Doctors Without Borders.