Cultural Beliefs, Human Rights Violations, and Female Genital Cutting: Complication at the Crossroad of Progress

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ABSTRACT. Female genital cutting (FGC) or as it is sometimes erroneously called, female circumcision, has been performed on over 173 million girls worldwide. Yearly, there are at least 2-3 million girls who experience this procedure. The physical, psychological and long-term health-care effects are only recently being recognized. Health care practitioners and social workers need to understand and address the complex and multi-dynamic cultural issues as well as the healthcare dilemmas for these women. Community networking, education, assistance in accessing the medical system, and reducing language barriers are interventions that should be delivered with cultural sensitivity and an understanding of the long term outcomes on health. doi:10.1300/J500v05n03_02 [Article copies available for a fee from The Haworth Document Delivery Service: 1-800-HAWORTH. E-mail address: <docdelivery@haworthpress.com> Website: <http://www.HaworthPress.com> © 2007 by The Haworth Press, Inc. All rights reserved.]

KEYWORDS. Female genital cutting, female genital mutilation, female circumcision, violence

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INTRODUCTION

Female genital cutting (FGC), which has also been called female circumcision, is a procedure that has existed for over 2,000 years and is practiced worldwide in many different cultures for a variety of reasons. It is defined as the “medically unnecessary modification of female genitals” (Council on Scientific Affairs, 1995).

Indeed, although the term genital mutilation is medically correct and the term used by the World Health Organization (1993) there are those that consider the term insulting and pejorative (preferring the term circumcision) indicating that outside cultures do not understand the relevance of the custom but would seek to eradicate it nevertheless.

Clearly, there has been a struggle to identify the procedure without causing insult to traditional societies that advocate its use, while not minimizing its impact. Obermeyer and Reynolds (1999) use the term female genital surgeries while Yount (2002) uses the term female genital cutting, which can indicate any one of the types of FGC, and the term employed in this article.

The procedure involves excising the female genitalia and, depending on the type of procedure performed and how it is conducted, can result in hemorrhage, septicemia, long-term menstrual difficulties, difficulty with birth, injury to the newborn during the birthing process, bladder and urinary difficulty, and sexuality problems and, in some cases, death (Kelly, Hillard, & Adams, 2005; Nour, 2004; Nour, Michels, & Bryant, 2006). Mental health difficulties such as anxiety disorders and Post-Traumatic Stress Disorder are now being noted (Behrendt & Moritz, 2005). Toubia (1994) has identified FGC as the anatomical equivalent to the amputation of the penis. Infibulation or phanoric cutting is identified with more severe health outcomes (Larson & Yan, 2000; Obermeyer, 1999) while the sunnah procedure, is thought to have less severe health outcomes and is currently the most common (Yount, 2002).

Critics of the strong rhetoric regarding the negative health outcomes of FGC point out that there is not enough existing data to support negative health outcomes including the impact on sexuality (Obermeyer & Reynolds, 1999; Yount, 2002). Existing studies on health outcomes are derived from self-report and case studies and large population samples are hampered by methodological and ethical constraints (Obermeyer, 1999; Yount, 2002). It is important to note that since the inception of zero tolerance toward FGC (Newland, 2006), worldwide there has been a slow but steady decrease in the most severe type (infibulation) of FGC.
(Gruenbaum, 2005; Yount, 1999) while at the same time some countries, e.g., Egypt, have medicalized the procedure (Gruenbaum, 2005). Breitung (1996) identifies the attention of western governments toward the problem “. . . in large part to increased immigration from Middle Eastern and African countries and the resulting presence of immigrants who desire to continue the practice in the West” (p. 1). According to Eyega and Conneely (1997) “. . . from 1990 to 1994, more than 53,000 African women immigrated to the United States, more than 80% of them from FGC-practicing countries” (p. 175). Worldwide, it is estimated that 13 million people have left their country to seek asylum from war, conflict or human rights violations (Momoh, 2004). This influx of immigrants who believe in and perform traditional practices that run contrary to the host country’s value system creates what Breitung (1998) calls “. . . debate on the issue of universal values and cultural relativism . . .” (p. 1).

**Magnitude of the Problem**

Currently, there are over 173,000,000 women and girls who have experienced female genital cutting. At a minimum two million girls are “at-risk” for FGC (Center for Reproductive Rights, 2004; WHO, 2000) while others believe between four and five million procedures are performed annually on female infants and girls (Ntiri, 1993; Ziv, 1996). While many countries have outlawed the procedure, it has remained as an important traditional practice and in rural areas it is difficult to enforce the cessation.

**The Practice of FGC**

There are different types of female genital cutting, which can range from a slight nick of the clitoris to the removal of all genitalia (Hayford, 2005). The most common fall into four categories: Type I, Clitoridectomy, is the least severe of female genital mutilation and involves excising the hood of the clitoris, also referred to as “Sunna Circumcision” by practitioners of the procedure. Type II, is an Excision, in which the clitoris and part of the labia minora are removed. Type III, Infibulation, or pharaonic, is the most extreme form of the procedures in which the clitoris, the labia minora, and much of the labia majora are removed. Type IV includes introcision, e.g., (gishri cuts) of the clitoris (Nwajei & Otiono, 2003; WHO, 2000).
Depending on the geographical area in which the procedure is carried out, running water or sanitary conditions may be limited and negatively impact carrying out this procedure. Additionally, there may only be local anesthesia, or none at all and the child may experience excruciating pain. Moreover, the procedure is usually conducted by a layperson with limited knowledge of the need for a sterile environment, anatomy and surgical technique (Toubia, 1994).

FGC is practiced by a variety of religions including Muslim, Christian, and indigenous African religions. It is practiced in 28 African countries, Malaysia, Yemen, India, The Sudan, Egypt and there are some reports that the practice occurs in Korea (Center for Reproductive Rights, 2004; WHO, 2000). Additionally, some countries may have a high proportion of the practice of infibulation while another country may have a high proportion of excision (Center for Reproductive Rights, 2004).

It should be noted however, that an influx of immigrants to countries where FGC was previously unknown, means that populations will, naturally, bring their customs, rituals and traditional values with them. Many countries have responded by instituting laws, making the practice of FGC illegal. Australia, Belgium, Canada, England, France, Sweden, The Netherlands, New Zealand and the United States have enacted legislation making it a criminal offense to practice the procedure. These offenses are usually prosecuted under child abuse laws (Center for Reproductive Rights, 2004).

Religion, Culture, or Both

There has long been debate about whether FGC is a religious practice, a facet of patriarchy or merely a custom that has descended through the centuries. Although FGC occurs in many Muslim countries it is more of a traditional practice than a religious one (Gruenbaum, 2005; Olenick, 1998). While the Holy Koran makes several instructive references regarding the least damaging circumcision, these references have little to do with the way the practice is interpreted and carried out today. Additionally, there are those who believe that these passages have little credibility or authenticity (Abu-Sahlieh, 1994; El-Saadawi, 1980). Baba Lee, an Islamic scholar, states,

Some Islamic scholars are trying to make a link between Islam and female circumcision, which is wrong. It’s a tradition that had been
practiced long before Islam came to this continent. It has nothing to do with Islam. It is not mentioned in the Holy Koran; it is not mentioned in any hadith. So it cannot be stated as a sunna or as a faridah. A sunna is a practice based on the prophet’s words or deeds, and faridah means an obligation. (Walker & Parmar, p. 325)

The primary underpinning of the custom of FGC is the maintenance and promotion of chastity and preventing promiscuity within the culture (Center for Reproductive Rights, 2004). Indeed, many of the countries that have traditional beliefs in FGC consider an “uncircumcised woman” to be unsuitable for marriage. Additionally, a dowry is higher if the girl is a virgin at the time of marriage and FGC ensures her virginity.

There are some cultures that believe that the female genitalia are un-clean and therefore the practice is necessary for hygiene. Other myths and customs surrounding female genitalia have fostered and indeed, bolster the practice of FGC. These include ideas that the clitoris emits a poison that will harm the penis. It is interesting to note that the Arabic word for FGM is Tahara meaning “to purify” (Lax, p. 407). Other beliefs include the notion that if not removed, the clitoris will continue to grow and will be a “penislike” organ between a woman’s legs (Abusharaf, 1997; Lax, 2000).

Underscoring all of these beliefs and the practice however, is the notion that FGC will control female desire and fidelity before and during marriage by physically removing genitalia that control sexual behavior (Bergen, 1999; WHO, 2000).

**Human Rights Violations and FGC**

Many international and national organizations that deal with women’s health and human rights have called attention to the practice of FGC and the long-term destructive consequences of the procedure. The World Health Organization (WHO), UNICEF, the World Bank, USAID, and the World Health Assembly have all expressed that FGC should be eradicated and their willingness to support efforts in this endeavor. The International Federation of Gynecology and Obstetrics as well as the American College of Obstetricians and Gynecologists and the Council on Scientific Affairs of the American Medical Association strongly recommended that the practice be stopped (Columbia Public Health Magazine, 1995, p. 1).
In 1976, WHO Director General Halfan Mahler, M.D., called for the elimination of “. . . practices that are detrimental to the health of women and children, such as female circumcision and infibulation” (Rushwan, 1990). The United Nations has called the practice of FGC inhumane, and has declared it one of the most serious health and human rights violations facing women worldwide. The American Academy of Pediatrics (1999) opposes all forms of female genital cutting and recommends that “. . . all members actively seek to dissuade families from carrying out FGM” (p. 4). In March 2004, Amnesty International launched a global campaign to eradicate not only violence toward women but specifically female genital cutting. It is noteworthy that in 1997 the Inter-African Committee on Traditional Practices Affecting the Health of Women and Children (IAC) issued the Addis Ababa Declaration that, “. . . called on African governments to adopt clear policies and concrete measures aimed at eradicating or drastically reducing FGM by the year 2005” (Amnesty International, Female Genital Mutilation, Strategies for Change, 1998).

In 1959, over 45 years ago, the United Nations General Assembly developed the Declaration of the Rights of the Child (DRC) which provided that children worldwide should be free of torture and degrading practices and should have a basic right to health. Particularly pertinent to FGC are Principles 2 and 9 of the DRC. Principle 2 states that children, “. . . shall enjoy special protection” . . . “to develop physically, mentally, morally, spiritually and socially in a healthy and normal manner and in conditions of freedom and dignity” (U.N., Breitung, p. 9). Principle 9 states that children should be protected from “. . . all forms of neglect, cruelty and exploitation” (Breitung, p. 9).

The Women’s International Network (1997) has compiled information from the preliminary report of 1995 from the UN Special Rapporteur, international conferences and reports from governments around the world, which presents a changing and encouraging stance about traditional practices toward girls and women. As mentioned, several countries have criminalized the practice. New Zealand’s legislation states, “medical and surgical procedures may NOT be performed for reasons of culture, religion, custom or practice” (New Zealand Crimes Act, 1996 amendment). Other countries such as Sierra Leone, Somalia, Kenya, Nigeria and Senegal continue the practice with several countries forming secret societies that strive to continue the practice.
**Why Do Cultures Continue to Practice FGC?**

Discussion of eradication of FGC is viewed by many as “cultural imperialism” that dismisses FGC as a necessary and valuable ritual that binds the individual child to the community, while promoting and stabilizing the norms and values of the society (Newland, 2006). When addressing social change, the role of women in these societies must be examined insofar as the definition of femininity and marriageability. Feminist theory posits that patriarchal control over women and their sexuality, and ultimately their lack of access to resources helps to perpetuate FGC (Amado, 2003; Hayford, 2005; Yount, 2002) yet women themselves control the rituals regarding the decision to perform FGC on their daughters. So why does FGC continue? One supposition is that marriage provides safety, security, and resources for women and FGC is a prerequisite. Secondly, several researchers have cited a stable relationship between the increase of female education with the decrease of FGC, and ultimately, a woman’s decision to have FGC performed on her daughter (Boyle, Heger, McMorris, and Gomez, 2002; Gruenbaum, 2005; Hayford, 2005; Yount, 2002). Thirdly, women’s ideas of feminine appeal and peer pressure (Hayford, 2005) surrounding community norms and righteous behavior (FGC being the sign of righteousness) must also be addressed before social change can begin to emerge.

Indeed, there are those parents who feel that their daughter will not be “normal” and socially acceptable and therefore marriageable if they do not have FGC performed and thus, they are not fulfilling their role as good parents. This is why the attempts at enforcement through the use of Principles 2 and 9 of the DRC are doomed to failure: Parents who allow FGC do not believe that it is harmful, rather they are ensuring a safe and dignified place in society for their daughters by following cultural norms. Additionally, they believe that individuals outside of the culture are dictating changes in their customs, which, at the very least is insulting to them, and at the very worst, seeks to annihilate their cultural norms and values.

**Eradication: What Works and What Does Not?**

While there have been major worldwide endeavors at eradicating FGC through legislation, legislation alone will not abolish the practice. Those who oppose the practice recognize that criminalizing the behavior and attempting to extinguish it through punishment such as prison and/or deportation is an essential first step. However, because of the un-
intended consequences of the legislation, it is not sufficient. While criminalization removes the practice from being something that is sanctioned by law, “true believers” are driven underground, leading individuals to conduct the practice in clandestine and secretive ways. If the procedure is conducted secretly, there is risk, even in developed countries, that the victim will undergo unsafe surgery.

Another unfortunate consequence is that girls and young women who have had FGC performed would be reluctant to seek medical care because FGC would be noted during medical examination and reported. The fear is that the community, midwives and/or their family would be in danger of prison and possibly deportation.

The legal differences between the developed countries and countries in which FGC is practiced openly have led to the involvement of the United States court system in a variety of ways. On the one hand some individuals and families have sought asylum and attempted to avert deportation because of the fear that return to their country will lead to FGC being performed on their child. On the other hand the following account from a Child Protective Service supervisor reveals an opposite situation.

We had a father who was an Ambassador from an African country and his daughter turned twelve. The child learned that she would be sent back home to have the procedure performed and she did not want it. She went to the school authorities who promptly called CPS. We went to court to have this blocked and the court found in favor of the father. We tried to stall the father as long as we could but to no avail.

Several approaches have brought the problem of FGC into the limelight thus creating a new atmosphere that ensures that eradication is becoming a reality. Federal U.S. legislation brought a national focus to the problem requiring anyone applying for a Visa or entering the U.S. to be informed about the health difficulties of FGC as well as the legal ramifications. Sixteen U.S. states have adopted criminal legislation to end FGC. Federal legislation also included an approach to ensure compliance by exacting a financial penalty. The Center for Reproductive Rights (2004), in a briefing paper states, “. . . U.S. executive directors of international financial institutions, such as the World Bank, were required by federal law to oppose non-humanitarian loans to countries that have not undertaken educational measures designed to prevent FGM” (p. 3).
There has been a proliferation of education programs geared at educating women and thus empowering them to make decisions about their bodies. These programs do not address the problem of FGC alone but issues such as hygiene, peer pressure, sexuality and nutrition.

**Eradication in Countries Where FGC Is a Traditional Practice**

As mentioned, the IAC has adopted policies and measures at eradicating FGC, yet there are still populations that hold to the traditional practice as an important and valued way of life. These groups view accounts of FGC as sensationalized portrayals, thereby polarizing groups that have discrepant values and ideals (Manderson, 2004). Needless to say, these populations will view eradication of FGC as attempts to undermine their traditional value system and cultural identification and has evoked the current backlash regarding eradication efforts (Gruenbaum, 2005; James & Robertson, 2002).

Several projects have been conducted that have been successful in decreasing the incidence of FGC while also attempting to help the host culture develop an understanding of how harmful the practice is. TOSTAN (“breakthrough”) is a project funded by UNICEF and developed by an American social worker, Mollie Melching. The 18-month program was devised in Senegal after years of study with the emphasis on hygiene, body awareness and functionality and human rights, using storytelling, proverbs and discussion (Easton, Monkman, & Miles, 2003; Tostan, 1999). FGC was never mentioned until the second year of the project and it was not in the context of eradication.

Other similar projects such as the Coptic Evangelical Organization for Social Services in Egypt, have had success in decreasing FGC in this way. Another significant program is the Godparent Association Inc. program, a United States organization that, through monetary support and letter writing, provides volunteers who serve as “godparents” to young girls at risk for genital mutilation. The Bafrow Health Education Component has conducted home visits in over 30 villages in Banjul, Gambia to promote awareness of well being, as well as the “My Baby Tree Project” designed to help parents and children understand the nature of care taking and well being. Research, Action & Information Network for Bodily Integrity of Women (RAINBO) is an organization that assists female immigrant populations in accessing medical care, learning more about their rights and ultimately stopping FGC.

The philosophy for each of these programs is that eradicating FGC cannot just be legislated or mandated but rather must come from within
the culture itself and indeed the culture must see the need for the change. That vision most often comes from increased knowledge about basic bodily function, physical outcome after FGC and what changing traditional values will mean.

Eradication in Host Countries Where FGC Is Illegal

Many countries have acted on making the traditional practice of FGC illegal in their country because of the assumption that the thousands of immigrants flowing into the country will continue the traditional practice. In 1982 Sweden made FGC illegal responding to the fact that they had 10,000 female immigrants from Ethiopia, Eritrea and Somalia living in their urban cities who, while seeking asylum from their countries because of racial and civil strife, still practiced FGC.

Like Sweden, most industrial countries that have large immigrant populations have learned that criminalizing the practice, although essential, will not be enough. As mentioned before, criminalizing alone will drive those strongly favoring it underground.

In the United States, FGC eradication can be increasingly successful if legislation is coupled with education. Immigration and Customs Enforcement, under the auspices of the Department of Homeland Security must provide all aliens issued U.S. visas with information on the harmful effects and legal ramifications of FGC (Center for Reproductive Law and Policy, 1997; Center for Reproductive Rights, 2005). FGC laws currently call for community education but healthcare providers and social workers will also need to be educated regarding this problem and how to address the complex cultural issues related to it (Kelly, Hillard, & Adams, 2005).

The response to FGM must be multi-faceted to address these complex dynamics. This response, at a minimum, should include:

- Training of all health care providers, e.g., doctors, nurses, midwives, family physicians, pediatricians, social workers, and family counselors in understanding the different procedures of FGC, the variety from culture to culture, and the long-term consequences. Moreover, cultural sensitivity must be developed so that these providers can assist the woman and her family with her physical and psychological needs.
- Training of social workers, public health nurses, healthcare providers and police who come in contact with girls who would be considered to be at high risk for the practice.
• Standards of practice that address the special care needs of women who have been genitally cut. Nursing and medical schools have begun to incorporate information about the practice within curricula, but this needs to be more institutionalized.
• Community education of immigrant populations regarding female health that includes the reproductive system, childbirth and family planning.
• Ensuring that women who have been genitally cut receive medical and psychological assistance by trained providers.
• If a practitioner uses an interpreter he/she must maintain eye contact with the patient. Avoid using an interpreter where a “culture clash” might exist with the patient.
• Practitioners need to be aware of and familiar with current community networks that will assist in working with immigrant women to address the fear of deportation, the medical system, and provide peer/cultural support.
• Practitioners need to maintain currency with the voluminous amount of material on the Internet and current publications regarding FGC.

What Can Social Workers Do?

While social workers can assist in developing legislation and community education and awareness programs that address the issues of FGC, they must also work with and educate health care professionals who will interact with women who have experienced the traditional practice. Health care providers’ reactions during the initial examination are generally one of shock and dismay and this may induce fear and shame for the woman. Word of this kind of reaction may flow through the cultural community and women may then avoid the health care professional fearing this kind of experience. Health care providers must be prepared for what the genital area will look like after it has been cut so that they can reduce embarrassment and awkwardness in the situation.

Social workers can assist by helping prepare health care workers for the initial examination by providing training, information, and guidance. It is imperative that social workers be able to provide therapeutic intervention for women who have experienced FGC and assist them in working through many of the psychosexual issues that they experience.
CONCLUSION

FGC is a serious worldwide health problem for millions of girls and women. Health problems can range from mild depression and low sexual self-esteem to serious physical and mental health problems.

Those who believe in FGC state that it is cultural imperialism and cultural ethnocentrism to demand that this practice be halted and find their cultural norms, values and beliefs threatened by outsiders. PropONENTS of eradication believe that this practice violates the basic and essential human rights of children.

Legislation, to prevent FGC has created unintended consequences such as driving the practice underground or making women and families reluctant to seek healthcare because of fear of punishment or deportation. Child abuse laws have also been another way of stopping the practice but this also can create problems with healthcare for children. There have been reports of children who have experienced FGC being taken away from families and put in foster care, demonstrating for the rest of the observing community the dire consequences that may exist in continuing a cultural tradition and subsequently, that at all costs, the practice should remain secret.

The intrinsic question becomes: How do we (as outsiders) contribute to the eradication of a tradition that we believe is medically mutilating (or can cause death) and is a clear violation of human rights, while the identified culture wants to preserve the practice because it is fundamental to their sense of community and cultural identity?

In a study on women’s health in Ethiopia, Berhane, Gossaye, Emmelin, and Hogberg (2001) observe the difficult process of surrendering (painful) traditional customs and values for new belief systems. The authors’ state:

A very important observation in this study was that if the reasons/causes for maintaining the traditional practices can be replaced by alternative modern approaches, traditional practices could be easier to abolish or modify. For example, though the nail-extraction procedure in itself is a very painful procedure and prone to complications, it was intended to make the bride more beautiful for her wedding. But, since the intended purpose was easily satisfied by the introduction of nail polish, which is actually seen as more colorful and attractive, the practice was being abolished. On the other hand, female circumcision, which is believed to be part of a woman’s cultural heritage and sign of eligibility for
marriage was a harder practice to change. It demands a radical shift in societal attitudes and influential groups such as elders before substantial changes can be seen. (p. 17)

The most successful endeavors at eradication thus far have been projects that work directly with practicing/immigrant groups to provide them with information on which to base informed decisions such as the Research, Action, and Information Network for the Bodily Integrity of Women (RAINBO) and the Foundation for Women’s Health, Research and Development (FORWARD). Both of these groups conduct research, educate and work with traditional groups in raising consciousness regarding FGC. They also provide literature and training to healthcare professionals. While the projects have the underlying motivation that they want FGC to stop, they are also hopeful that it will end as a result of women’s new knowledge and decision-making power, and not through forced ideology. At the very least, healthcare professionals need to understand the physical and psychological difficulties that result from FGC and the complex dynamics involved in the cultural belief that perpetuates the practice.

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