Facts About

Female Genital Mutilation

(or **FGM** / **Female Circumcision** / **Female Cutting**)

Developed by the Networklearning Team

with thanks to Dr Comfort Momoh MBE for information and advice

networklearning.org

Published by Stichting Networklearning, June 2014

Contents

…What my grandmother called
the three feminine sorrows;
She said "the day of circumcision,
the wedding night and the births of a baby
are the triple feminine sorrows";
as the birth bursts, I cry for help;
when the battered flesh tears;
No mercy, "push!" They say.
"It is only feminine pain!"

– Dahabo Ali Muse

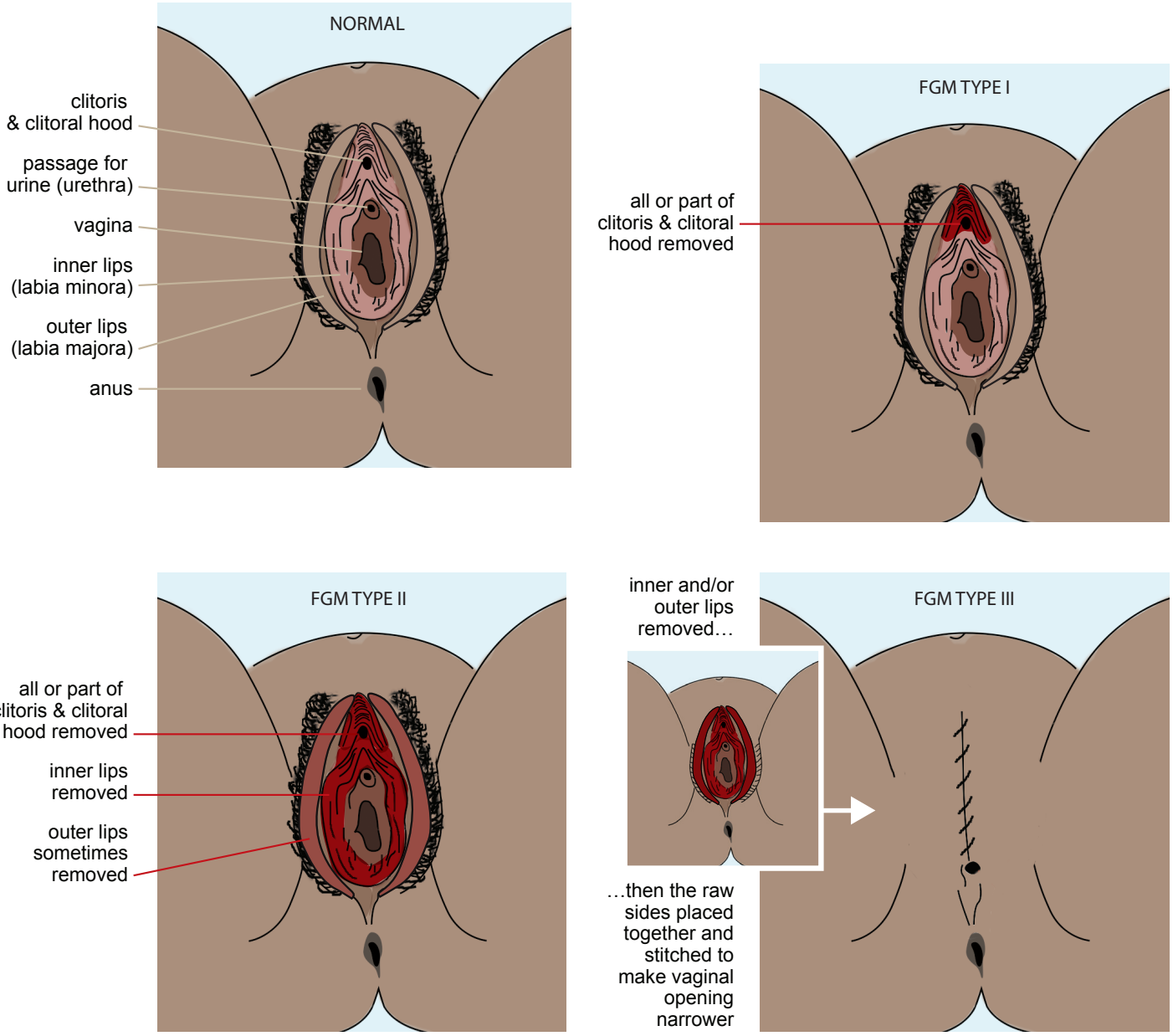
1 What is FGM?

Female Genital Mutilation is a procedure in which a sharp instrument is used to cut or otherwise damage the external genitals of girls.

How much damage is done?

FGM is categorised into types by those who study the problem:

- In **FGM type I** the clitoris is removed;
- In **FGM type II** the clitoris and inner lips are removed.
- **FGM type III** involves even more severe removal and reconstruction. This form of mutilation is also called 'infibulation'. See illustration.
- There is also an **FGM type IV** category, which covers various procedures in different cultures where girls' genitalia are modified by scratching, scraping, stretching etc.

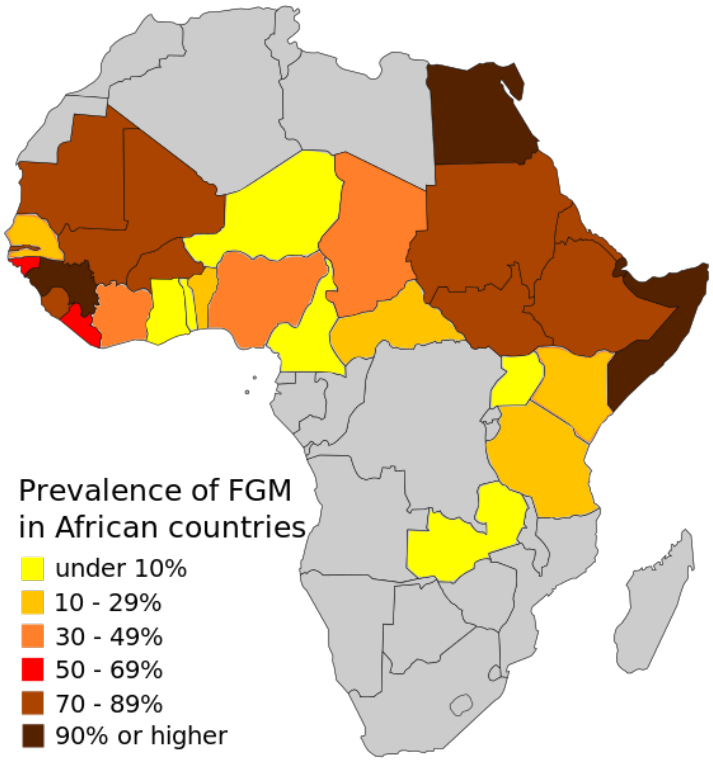


2 Where and when girls are at risk

2.1 Geographical spread of FGM

Just counting the 29 countries in Africa and Middle East where FGM is most common, there are more than 125 million girls and women who have been mutilated. **(ref 1)**

- In **West Africa** – countries such as Mali, Burkina Fasu and Senegal – FGM types I and II are the most common. It is often difficult to distinguish between the two, though, because women rarely have sufficient knowledge of anatomy to know what type of procedure took place. And neither do the cutters: a village practitioner in Sierra Leone said "I cut what I find in the middle of the vagina". Type III FGM (infibulation) is rarely found in West Africa. **(ref 2)**



- In **East Africa**, countries with the highest percentage of women subjected to FGM include Sudan, Somalia and Egypt – usually the more severe Type III (infibulation). **(ref 2)**
- In the **Middle East** it is emerging that FGM is more common than was thought – for example it is found in Oman and Saudi Arabia, as well as in Yemen. In one province of Yemen, among one ethnic group, over 80% of females were found to have undergone FGM. **(ref 3)**
- In **Asia**, FGM is prevalent in countries including Indonesia and Iraqi Kurdistan. A country's overall rates may be affected by high or low rates within one or two ethnic groups. As in Africa, groups have their own traditions concerning the severity of the procedure used.
- FGM is a **global** problem. 3 million girls are cut every year across the world and nearly every country has a population of women at risk. For example, FGM is illegal in the UK – nevertheless it is estimated 22,000 girls living there are at risk. **(ref 4)**

2.2 Age of girls subject to FGM

FGM is performed on girls at different ages depending on the ethnic group.

- In some, including groups in Yemen, girls are cut within two weeks of birth, usually at home. In some countries, such as Egypt, this pattern seems to be a response to the practice becoming illegal: the procedure is less visible.
- In other cultures the operation is carried out on girls mostly under the age of five (e.g. in Eritrea and Nigeria).
- In yet other regions the girls are older and FGM is part of a larger initiation into the

ethnic group. These girls are cut before they begin to menstruate. This is usually around age 13 to 15 and marks the traditional age when marriages are arranged; this is also the age when boys are initiated into their ethnic group.

2.3 FGM Rituals

Sometimes FGM is carried out on a group of 20 girls or more. It can be a full ceremony, usually organized by mothers and grandmothers and part of a wider ritual which marks the girls' full entry into the adult female group.

If the event is for carrying out **FGM type III**, the girls may be physically bound or sat upon to keep them still while they are being cut. The wound is cleaned with cloth or mosses. Then the cut surfaces of the outer lips (labia majora) are put together and sewn up, leaving a gap for urine and menstrual blood. The two cut lips will bond to form a tough central scar. The girls may have to lie still for a few weeks to allow the wounds to heal.

The cutter is often a local traditional midwife or another older, respected female. Sometimes it is a male traditional barber.

Increasingly, western-trained health workers are involved, for example in Egypt, Sudan and Kenya. In some studies over half the girls were given local anaesthetics – reflecting an increasing medicalisation of the FGM procedure.

3 The effects of FGM

3.1 Dangers from the procedure

FGM, especially when done in rural, unhygienic conditions, brings a high risk of physical problems such as heavy bleeding or infection. The girl may go into shock. Death rates from FGM procedures are unreported.

The use of unsterilized knives on groups of girls may lead to the spread of infections – both bacterial (such as tetanus) and viral (such as HIV, as one girl may be carrying the infection from birth).

> One ceremony in Uganda, described by a nurse in 2007, involved thirty girls being cut, all with the same unsterilized knife.

3.2 Psychological damage

The girls remain at risk of going into shock as they recover; a very painful procedure has being carried out on one of the most sensitive areas of their bodies – performed by trusted female relations and neighbours.

As the girls grow older, they may develop feelings of incompleteness; they may lose self-esteem; they may become depressed or anxious, develop unreasonable fears, have panic attacks and even psychotic disorders.

Many suffer in silence, unable to express their pain and fear. They know that what they are experiencing is "normal" for women in their culture. But this "normal" mind-set generates huge tension along with the pain, fear and ignorance.

3.3 Lifelong physical problems

As the body heals, it forms scar tissue at the site of the cuts. Unlike normal tissue, scar

tissue is not designed to stretch. As it forms it also starts to build attachments to other tissue and this can create blockages. Female genitals need to stretch: to let out blood, urine and babies – and to enfold a penis. Because scar tissue does not stretch, it tears instead and can develop holes ('fistulas') between the vagina and the urethra, or between the vagina and the rectum. So these holes for the passage of urine and faeces may leak long-term. A woman can be left with a smelly, uncontrollable condition – one which may make her an outcast for life.

Urination and menstruation

The girls pass urine and their menstrual flow when monthly periods begin. But the normal route for these liquids may now be smaller. It may also be scarred and partially blocked. It is more difficult to keep the whole area clean. Infection is a continual risk.

Marriage and sexual relations

The new husband of a girl with Type III FGM may face difficulties in penetrating his wife, due to the original procedure and any later damage. Remember those cut outer lips which were put together to bond and form a tough central scar? The husband may need to take a knife to the bedroom. With it he can cut the thread that has sewn up his wife. He may then also have to cut her scarred flesh before intercourse can take place.

3.4 Childbirth risks

A newborn's head is far bigger than a penis. And, as noted, scar tissue is not designed to stretch. The same cutting of scar tissue, done to allow those first sexual relations, may have to be repeated in order to make childbearing possible.

Afterwards the woman will need repairs again. She or her husband may request re-infibulation – for her exterior genitals to be returned to their previous FGM III state. If this is done, the same problems will repeat themselves during future sexual relations and childbirths. Caesarians are more likely to be needed. Since in some of these cultures large families are still seen as desirable, the whole process may be repeated nine or ten times in the woman's lifetime.

> People from the Somali communities are less likely to want re-infibulation; people from the Sudanese culture frequently want it.

Complications

One common complication of FGM is that the baby's head gets stuck in the birth canal. The mother is also at risk of heavy bleeding. These and other complications can lead to her death.

Deaths in childbirth

The more women with FGM in a community, the higher the rate of deaths in childbirth. And the difference between low and high is large:

- In the UK, maternal mortality rate (MMR) statistics show that only one mother dies for every 8,000 childbirths.
- In Malawi, a poor African country where FGM is not much practiced, one mother dies for every 217 childbirths.
- In Somalia, with extreme and almost universal FGM type III, one woman dies in childbirth for every 100 women giving birth.

Example: where too many women die in childbirth

One of the authors spent a month in north-eastern Africa. She worked with five local colleagues on a project proposal. Three of them had lost their mothers when they were under the age of six. One had also lost a stepmother (if a mother dies, the extended family quickly arranges a replacement). These colleagues all said that the cause of death was childbirth. But they did not remember much about their mothers: "She was… just a woman".

Four of the five colleagues grew up in the bush living with the women and the animals. As babies they would have been weaned early, at about six weeks. Local nursing mothers said that their breast milk was of poor quality: "We are only women. Of course our milk is rubbish". Fathers were away on the coast earning money, remote and admired. But at about the age of ten my colleagues were sent to live with their fathers to get an education. As adults, their fathers were very important to them – and difficult to please. So were the clan elders, the 'Super-fathers'. A lot of project time was spent in meetings negotiating with fathers and elders. Women were not allowed in, except for one TBA who was the sister of the Governor; she was allowed a say – but from the doorway. She told the author that in her small village in the previous month there had been three deaths in childbirth.

The risk to babies

FGM increases the chances of babies dying in various ways. A WHO study followed nearly 30,000 women in six countries. The risk of death for the babies was

- 15% higher for FGM type I
- 32% higher for FGM type II
- 55% higher for FGM type III

Of the babies born alive, 25% had a low birth weight or a serious infection, putting them at further risk.

4 Why does FGM happen?

If a behaviour is difficult to understand, it may help to ask not only who it affects – but who benefits from it. Clearly it is a procedure that physically damages one gender and not the other. What are the payoffs for those who seek to perpetuate FGM?

Many motivations may never be mentioned. But overall, where FGM is performed, the controlling role of males is reinforced: they want assurance that new babies will be the children of their official fathers; that property will be correctly passed on – even though part of the price paid for this is that sexual pleasure within the marriage is made difficult or, with FGM III, practically impossible.

Reasons used to justify the practice of FGM

#1 Sexual fidelity – by removing the clitoris, it is hoped that the sexual feelings of the female are reduced. It is assumed that by making her less sensitive sexually there is less chance of her being unfaithful. FGM is thought to keep her "pure" for her husband and

his family. Extreme forms of FGM make sexual penetration of the woman difficult. It is said that this lessens the chances of wives being physically "unfaithful", and that girls are less likely to be raped when away from their family in the bush, looking after the animals.

#2 Marriage – in communities where FGM is normal, a young man and his family will not accept a bride who has not been cut. So the parents of a girl, by getting her cut, make it possible for her to be married. It is a "normal" part of their loving care for her.

#3 Money – almost always a powerful motivator. Raising a girl costs money. If her marriage brings a 'bride price' this money comes back to her family.

The demand for FGM also ensures an income for those performing the procedure. If a big percentage of a TBA's income comes from FGM, she will have a big investment in keeping the practice going.

#4 Community belonging – Girls who have not gone through FGM may be socially stigmatised, rejected by their communities, and unable to marry locally. This can cause psychological trauma. In this situation, FGM seems the best way to build a sense of belonging. FGM marks a girl as part of her cultural group.

During the recent wars in Liberia, Sierra Leone and Somalia, people were dislocated, raped, had their limbs amputated, houses burnt and worse. As refugees and IDPs, they became almost invisible, belonging nowhere. Now that peace has returned, various ethnic groups are holding initiation ceremonies in increasing numbers. These enable people to feel that they belong to their own specific group. And FGM is usually part of the ceremony for girls, with boys also being initiated. In these countries, a higher number of women and girls want FGM to continue. As one urban, educated woman said: "I'm proud of it. I'll do it to my girls as it was done to me. I don't want to be stopped. For Muslims, it's a must. We're ready to face any problems it causes because it's our culture."

#5 Religion – the highest proportions of females with FGM are found in Islamic communities; but it is also found in Christian and Animist cultures. Neither Christian nor Islamic mainstream leaders see the practice as part of correct religious behaviour.

Some religions see male circumcision as essential, as an irreversible mark of commitment to their group. But FGM is different. As part of a large campaign in the North East Province of Kenya, Sheikh Abdullahii Gudow put it like this:

"Many Imams have studied this issue thoroughly, and they agree: Islam calls for the circumcision of men, but not for women. God created you in the perfect shape, and those who say the clitoris is not supposed to be there – are you questioning the wisdom of God's creation?"

5 Bringing About Change

5.1 Understanding current Knowledge, Attitudes & Practice

— What do people know about FGM and its effects?

— What do they think their religion says on the matter?

— What do women think is believed and wanted by their partners and the people in their community?

Ideas about FGM are often a tangled ball of truths, half-truths and nonsense. Opinions, facts and falsehoods exist in the same place but contradict each other. But there are some trends. Those who tend to favour FGM are more likely to be:

- older women
- males
- people from the poorest countries
- people with no education

In fact females overestimate the number of men who want to keep the practice. Men often know very little about the reality of FGM because until recently it was 'women's business'. And husbands and wives usually do not know the opinion held by the other.

5.2 The role of doctors, nurses and medicalisation

Educational programmes on FGM are often targeted towards Traditional Birth Attendants (TBAs) because they have usually been the cutters. Some TBAs are encouraged to make minimal scratches on the clitoris in the hopes that the procedure becomes a token only, and, in time, FGM disappears.

But more and more FGM is done by professionally trained health workers, nurses and doctors. The families see them as safer and more hygienic than the untrained traditional workers. People who live in countries where FGM is illegal take their daughters on holiday to one of the many countries where it is legal – and the clinics take credit cards.

There are principles involved here. Doctors and nurses need to remember that one foundation of their work is "First do no Harm". And second: never do damage to a healthy organ.

The response to FGM by professionals has to be, always, "No". And the move towards legal, enforced sanctions everywhere needs stepping up.

However, doctors with surgical skills are needed when it comes to childbirth involving an infibulated woman. These women are at risk of pain and death – they need the best care possible.

> In **Kenya**, FGM is illegal. But the country includes a million Somalis who practice an extreme form of FGM.
>
> Everywhere in the country, the practice is fast being medicalised – increasingly it is done by trained doctors and nurses who carry it out (illegally) in the homes of the girls' families. And the girls are younger than before – nowadays, mostly under four.
>
> Nevertheless, overall, there is a decrease in FGM numbers in Kenya: girls aged 15 to 19 are three times less likely to have suffered FGM than women aged 45 to 49.

Another problem of principle comes up after delivery. The birth mother and/or husband may request that she be re-stitched to return her to her prebirth infibulated condition. And this procedure may then be repeated over and over during her reproductive years. Doctors and nurses faced with this request may not be equipped with the information, training and support they need to make good decisions. Often they just don't know what to say or how to persuade. So they agree to re-infibulation. In this way, another part of the problem is being medicalised.

Example: Medicalisation that is well-considered

In the UK people have realised that there are quite a lot of refugees from countries where FGM is practiced – and some appropriate strategies to help survivors have begun to develop.

Since any hospital has numerous and changing staff on duty, they need to do a lot of training, so that everyone is familiar with other cultures and attitudes and the need for respect and understanding. So there are now eight specialist **African Well Women's Clinics** which have acquired the expertise and knowledge of what is needed. Each clinic is staffed by a full-time midwife trained in Public Health and the care of women with FGM, along with a female back-up consultant and good female translators.

The Clinics can do the following:

- Give advice, counselling, education and training
- Carry out surgical de-infibulation at non-crisis times on pregnant and non-pregnant women
- Repair fistulas
- Restore sensibility to a FGM clitoris

Example: A positive side – restoring sensibility to the clitoris

This is an area where a few dedicated professionals are working. Some women wish to experience the sexuality of their own bodies, including pleasure and orgasms. And couples often see shared sexual satisfaction as a way of strengthening the bonds of their partnership.

Sometimes a woman with a cut clitoris can still experience orgasm if her partner uses stimulation and takes time. And some women want to undergo repair to improve this capability. A clitoris is like a plant stem with a long root: the visible part may be cut off but the root is still there and responding to stimulus. The flesh around the clitoris can be surgically cut back to expose the remaining root and restore sensibility.

But it is a delicate and difficult operation which only a few surgeons do.

5.3 The key change agents

Who should be doing what?

Law makers and enforcers…

In many countries FGM is illegal. This includes all North countries (Europe, USA etc.) In Africa the picture is muddled. For example in Liberia, Sierra Leone and Somalia there are no laws against FGM. In Somalia it would be almost impossible to enforce laws without the cooperation of clan elders. Wherever there is the passing of a law against FGM, enforcing it and achieving a first conviction is of enormous importance. **(ref 5)**

Traditional and religious leaders…

Highly respected individuals can be powerful agents of change. They have the ability to influence decisions within families and to build consensus within communities. They can therefore play a critical role in the abandonment of FGM.

Parents and grandparents…

Different cultures invest family members with different powers. Often fathers decide on work for their sons while grandmothers control child rearing, FGM and marriage arrangements. Sometimes one strong individual changes the normal pattern. If educational inputs are developed for village level, the project should understand who has a position of power and can really change things. Grandmothers, for example, need help in understanding the danger posed by FGM to their own lineage: that it risks their daughters and daughters-in-law dying – together with the babies, their own grandchildren.

Human Rights Agencies…

FGM is a Human Rights issue – the procedure has no physical benefits and uses physical force on young girls who are not old enough to give consent. Nowadays, people are slowly beginning to accept the importance of *everybody* having Human Rights – including four-month-old babies.

5.4 What role can your NGO play?

As the reader of this booklet you may be involved in activities related to FGM. If you work for an NGO and have any say in its activities, you might want to consider the following:

- The staff of any NGO worth its salt should know about FGM in its district or region. You might want each staff member to be well informed, know their own mind on the issue and – if they want to see FGM disappear – be able to discuss and debate the issues. So, to make this happen, what needs to happen in your NGO?
- You could consider whether in your district or region, enough is known about FGM (Knowledge, Attitudes and Practice) in the main ethnic groups. Is some field research needed – and could your NGO do this?
- You could look at current NGO activities and projects and see whether they provide a chance to spread information and motivation on the FGM issue.
- You could ask whether the Health Workers in your region are dealing with various problems around FGM.
  — Are they receiving training in the skills they need to handle these problems well?

— Are their actions contributing to the ending of FGM?
— What is needed to make them effective?

Good Luck with whatever activities you start against FGM!

Example: Action against FGM in Senegal

Action at government level: in 1999 Senegal passed laws specifically aimed at FGM but like many countries did not take measures to enforce them – until in 2006 it came out that an eighteen-month-old girl had been cut. The parents, grandmother and cutter all went on trial and received prison sentences.

Religious and media reactions: For most people it was a big shock. In response came demonstrations and speeches defending FGM by local religious leaders. But the issue was also discussed through media such as radio debates. In 2010, a joint fatwah condemning FGM was passed by the religious leaders in Mauritania – leaders of the same ethnic and religious group as the people of north Senegal.

Action at NGO/village level: a Senegalese NGO called Tostan works in villages where FGM is practiced. They have to be invited in before they start work in the village. They form two study groups, one with about thirty adults and another with about thirty adolescents – mostly women but not all. The groups meet about three times a week for three years. Each student undertakes to pass on what they learn to someone who is also likely to pass it on.

In the first year they study issues such as Human Rights, health, democracy and problem-solving. In the second year they learn skills in literacy and using cell phones. In the third year they study micro-finance and develop project proposals. Good proposals are submitted for financing.

FGM inevitably comes into focus via the issue of Human Rights and also as a threat to health. The need to oppose FGM may then develop as a project proposal. One village mobilised its people to stop FGM. However this led to a big ruckus as marriages were not only taking place within that one village but within a group of thirteen villages. So education and mobilisation had to start again in all thirteen villages.

The NGO claims that over four thousand villages now say they have stopped FGM and 77% have actually done so.

> **Note:** this project treated FGM as only one of several issues including illiteracy and lack of jobs. It seems to have had more resources than most development projects. Usually it is not possible to get funding for three years of preparatory work, or to get access to microcredit and mobile phones. Good projects often need good resources if they are to succeed.

6 References & further reading

References

1. Statistics – who.int/reproductivehealth/topics/fgm/overview/en
2. Tradition and Rights: Female Genital Cutting in West Africa Plan International – plan-international.org/files/global/publications/protection/femalecutting.pdf
3. FGM in the Middle East – stopfgmmiddleeast.wordpress.com/countries/yemen/
4. "UK's legislation regarding female genital mutilation and the implementation of the law in the UK" (Kwateng-kluvitse A., 2004). It is estimated that in the UK 22,000 girls are at risk of undergoing FGM and 279,500 women have already undergone it. The campaigning organisation Daughters of Eve are raising awareness and trying to stop it – dofeve.org
5. Laws – warisdirie.files.wordpress.com/2010/11/prevalence-of-fgm-and-laws1.pdf

Further Reading – General

"Female Genital Mutilation" (ed. Momoh Comfort) has a wide range of articles and authors. This book would greatly help any clinic in the North wishing to start effective work around FGM with a medical/HR focus. Also available online at Google Books: http://books.google.nl/books?id=dVjlP0RfVAMC&printsec=frontcover#v=onepage&q&f=false

Wikipedia references are not always kept accurate over time, however the following seems to be kept accurate, up-to-date and well referenced: http://en.wikipedia.org/wiki/Female_genital_mutilation.

Get informed about how to fight medicalisation – "Global Strategy to Stop Health-Care Providers from Performing FGM" (PDF, also available in Arabic): https://www.unfpa.org/public/home/publications/pid/7922

Further Reading for Health Personnel

"Female Genital Mutilation: Integrating the Prevention and the Management of the Health Complications into the curricula of nursing and midwifery" (PDF, also in French).

- A Student's Manual: http://www.who.int/reproductivehealth/publications/fgm/RHR_01_17/en/
- A Teacher's Guide: http://www.who.int/reproductivehealth/publications/fgm/RHR_01_16/en/