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# Female genital mutilation: an overview

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**Female genital mutilation: an overview**

The literature on female genital mutilation (also known as female circumcision) within a feminist theoretical context is discussed. Issues of culture, politics and religion in the literature will be examined in relation to feminist thought and the paper will also assess the effects of female genital mutilation on women's health and status within developing societies. Parallels with other similar practices in developed and developing countries will be drawn and policy strategies discussed.

## INTRODUCTION

Female genital mutilation (FGM), sometimes referred to as female circumcision, has been referred to in the nursing and medical journals. The articles have been largely descriptive, focusing on the procedure and its health consequences (for example, Black & Debelle 1995 and Thompson 1989). This paper examines the broader issues surrounding the practice and gives perspective on the social, religious and cultural effects of FGM. The paper also examines political and feminist interpretations and draws parallels with western medical practices. Initiatives to eradicate FGM or minimize the negative consequences are also described.

### Definition and varieties of female genital mutilation

Commonly in the literature, FGM is divided into categories or types. Morgan & Steinem (1983) suggest three types of circumcision; firstly, Sunna (meaning traditional) circumcision which involves removal of the prepuce and/or tip of the clitoris; secondly, clitoridectomy (which may or may not include excision of the labia minora); and, thirdly, infibulation (from the Latin *fibula* meaning 'clasp') which generally leaves only a tiny aperture for the release of urine and menstrual blood. Infibulation is sometimes referred to a pharaonic or Sudanese circumcision.

However, the organization FORWARD (Foundation for Women's Health Research and Development) (1992) has suggested that female genital mutilation be defined as 'Removal of, or injury to, any part of the female genital organ'. Perhaps for reasons of debate this broader definition is often more useful because the degree of cutting and sewing varies as individually as the operator who performs the operation and the girl or woman on whom the operation is carried out.

### Geographical spread of female genital mutilation

The exact number of female genital mutilations worldwide is unknown. Estimates for Africa, where FGM is most common, range from 30 million (Brisset 1979) to 80 million (Hosken 1982) to 100 million (Gleviczky 1980, Hosken 1993). A list of countries involved is reproduced in Table 1, derived from the findings of Dorkenoo (1994) and Hosken (1993).

## THE PROCEDURE AND ITS PRACTITIONERS

Ninety-five per cent of female genital mutilation is performed on girls from a day old to 16 years of age (Royal College of Nursing 1994). In some countries such as the Gambia, girls are circumcised in groups which comprise of 50 to 100 girls at a time. In others such as Egypt it is a private family matter and girls are circumcised individually (El Saadawi 1980, Bhatia 1994). The cutting is carried out mainly by women, often midwives, except in Egypt where the male barbers carry out the task. In Mali, Senegal and the Gambia, FGM is traditionally carried out by a woman from the blacksmiths clan, in Egypt and the Sudan by *dayas* (traditional birth attendants), and in Somalia excisors are from the Midgan clan (Dorkenoo 1994). These women are given high status and derive their income from their practice.

**Table 1** Geographical spread of female genital mutilation

| | |
|---|---|
| *Africa and the Middle East* | |
| Mauritania | |
| Mali | |
| Senegal | |
| Gambia | |
| Guinea | |
| Guinea Bissan | |
| Sierra Leone | |
| Liberia | |
| Ivory Coast | |
| Burkino Faso | |
| Ghana | Circumscison and excision widespread in some groups |
| Togo | |
| Benin | |
| Niger | |
| Nigeria | |
| Cameroon | |
| Chad | |
| Central African Republic | |
| Egypt | |
| Ethiopia | |
| Uganda | |
| Kenya | |
| Tanzania | |
| Sudan | |
| Somalia | |
| Parts of Mali | Areas where most women are infibulated |
| Parts of Nigeria | |
| Eritrea | |
| Dzibouti | |
| Parts of Sudan | |
| Malawi | |
| Parts of Israel | |
| Yemen | |
| Oman | Some cases reported |
| Qatar | |
| Bahrain | |
| United Arab Emirates | |
| Border areas of Saudi Arabia | |
| *Latin America* | |
| Mexico | Clitoridectomy reported to be practised by some indigenous groups |
| Colombia | |
| Peru | |
| Brazil | |
| *India and the Far East* | |
| Some areas of India and Pakistan inhabited by Bohra Muslims | Circumcision practised by some groups |
| Some areas of Malaysia | |
| Some areas of Indonesia | |
| *North America, Australia and Western Europe* | |
| Canada | |
| United States of America | Circumcision, excision and infibulation practised by some African immigrant population groups |
| Australia | |
| England | |
| France | |
| Germany | |
| Sweden | |
| Norway | |
| Denmark | |
| Italy | |

(Derived from the findings of Dorkenoo (1994) and Hosken (1993).)

The girl is stripped naked and laid flat on a bed or the floor or sometimes made to sit on a low stool. She is restrained by a number of other women, who are often female relatives. The cutting is carried out by means of razors, razor blades, scissors, knives (occasionally blessed by the clergy, Ghadially 1991) and, more rarely, pieces of glass. Depending on the degree of scraping, the little girl may be tied from her pelvis to feet to immobilize her legs and promote healing. Further paste may be applied, the girl is then undressed and put to bed. The procedure lasts 15–20 minutes depending on the struggles of the girl, the degree of mutilation and the skill of the excisor (McLean 1980). Analgesia is not traditionally given although, in recent years, some midwives in urban areas of Africa use a local anaesthetic.

## Consequences of female genital mutilation

Koso-Thomas (1987) found that 85% of all women undergoing circumcision in Sierra Leone were likely to be affected by some condition requiring medical attention at some time during their life. Medical problems include a slow shuffling gait, difficulty with urination, urinary tract infections, HIV infection, infertility, depression and various other psychological disturbances (Baasher 1982), frigidity and other difficulties related to sexual intercourse and childbirth (El Saadawi 1980, Lightfoot-Klein 1989, Dorkenoo 1994).

If, for example, a girl is infibulated too tightly the aperture may spontaneously close and require re-opening. Even if it is open the commencement of menstruation may cause difficulties if the pinhole size opening does not allow release of menstrual blood. Marriage may often involve further cutting. In many areas, for example Sudan, Egypt and Kenya, the groom is expected to penetrate the bride on the wedding night. To achieve this he will sometimes tear the bride (causing injury to himself also) or will cut her open with 'a little knife' often left for the purpose (Daly


 

1991). Repeated intercourse is then required to keep the wound from closing.

Childbirth requires still more cutting to permit the birth of the child; even so, perineal tears and prolonged labour are common, causing fetal distress, anoxia and death (Cook 1979, cited in Lightfoot-Klein 1989 p. 59). Maternal mortality is also high. Although other factors must be taken into account, it is notable that maternal mortality is much higher in countries with a high incidence of pharaonic circumcision. Following childbirth, re-infibulation or 're-circumcision' often takes place (Lightfoot-Klein 1989). This cycle of cutting open and sewing closed is repeated with each birth, creating increased scarring and decreased elasticity in the perineal and vaginal area.

### *Taboo*

Because of the taboo regarding the operations, the physical and mental consequences of mutilation are often attributed to other causes or denied altogether. Gevins (1987), for example, quotes a circumcised woman who disparages her daughter for speaking of the health consequences of FGM. 'She said "you didn't die, I didn't die. How many people can you cite who have died?" "Well, I don't know, but I do know that people have infection and leaking!" "But", she said, "people who haven't been circumcised have that — even white women have that!" '

Conversely, it is often believed that the effects of circumcision are health-promoting. Walker & Parmar (1993) note that; 'rarely do the women connect the medical problems of many excised women with the excision itself. Often the women are genuinely shocked to learn these medical facts'. This allows women to focus on the positive benefits of FGM such as initiation into womanhood (Kéré & Tapsoba 1994) whilst avoiding painful focus on the negative effects of FGM.

Ghadially (1991) also reports the assertions of an excisor that the wound heals in a day or two and that complaints are rare. Perhaps because of the secrecy in which many circumcisions are carried out, the illegality of the procedure in some countries, and the stigma attached, malevolent side-effects and consequences of operations are under reported. El Dareer (1983) suggests that 84·5% of cases needing medical intervention were unreported.

## REASONS GIVEN FOR CIRCUMCISION OF FEMALES

Koso-Thomas (1987) interviewed 400 women at family planning centres, hospitals and nursing homes in Sierra Leone, 369 of whom had been circumcised, and asked why women submit to circumcision. The results are given in Table 2.

Table 2 Reasons given for circumsion of females

| | |
|---|---|
| Tradition | 257 |
| Societal acceptance | 105 |
| Religion | 51 |
| Increasing chances to marry | 12 |
| Preservation of virginity | 11 |
| Female hygiene | 10 |
| Prevention of promiscuity | 6 |
| Enhancement of fertility | 3 |
| To please husband | 2 |
| To maintain health | 1 |

### Cultural and social pressures

Although the origins of FGM are only speculated on in the literature, there are suggestions that it has existed for at least 5000 years (DeMeo 1982). Other practices, which were arguably less harmful such as facial scarification, have not spread geographically to the same extent, and have, particularly in recent times, waned in popularity. This does not seem to have happened with FGM. The literature would suggest there is a combination of other factors which may account for its prolonged and widespread practice.

Savané (1984) describes how university-educated women occupying administrative posts are still victims of traditional models of behaviour. She suggests that they are pulled by two worlds — the traditional and modern. They want the liberation which is represented by westernization but they also need the traditional structures and roles which offer psychological security. In some societies, circumcision is not only positively reinforced by the perceived social rewards but also negatively reinforced (Kéré & Tapsoba 1994).

Within certain groups the uncircumcised woman is ostracized, regarded as unmarriageable or a prostitute and her children will also be stigmatized. For example, in some parts of Africa the greatest insult is to be referred to as 'son of an uncircumcised woman' (Lightfoot-Klein 1989).

### Religion

Religion is often stated as a reason for FGM. However, the practice predates all the major religions which practise the operation. FGM is often associated with Islam (Brooks 1995). Yet, circumcision of females is not carried out in Saudi Arabia which is the locus of Islam. The Koran does not condone the circumcision of women and the *hadith* or anecdotal traditions about the prophet's life and sayings would seem to indicate that Mohammed extolled women's sexuality and their right to sexual pleasure. Furthermore, Mohammed's own wives and daughters were not circumcised (Brooks 1995).

However, since 1949 there have been two fatwas

(opinions of religions scholars which are morally obligatory for the believer) issued opposing giving up excision. The most recent was by the present Great Sheikh of Al Azhar in January 1981 (Aldeeb Abu-Sahlieh 1981, cited in Dorkenoo 1994). Brooks (1995) also points out that some Christians and Animists also practice FGM, as do some Fallasha, an ancient Jewish sect living in the Ethiopian highlands, and a Russian Coptic Christian sect (Davis 1985). I conclude that, while religion is given as a reason for circumcision, religious scriptures show little evidence of female circumcision as a religious obligation. However, several authors suggest that religion is used to legitimize FGM as a means of female social control (El Saadawi 1980, Lightfoot-Klein 1989, Brooks 1995).

## Marriageability and social relations

Marriageability and social relations are also given as reasons for FGM. In Kenya, for example, President Kenyatta (1938), in his book *Facing Mount Kenya*, stated categorically that no Kikuyu man would consider marrying an uncircumcised woman. Infibulation in particular is considered beneficial in increasing a girl's marriageability in some societies and a tightly sewn infibulation is said to increase a man's sexual pleasure. However, when Shandall (1967), cited in Dorkenoo (1994) surveyed 300 Sudanese husbands who had one infibulated wife and one noninfibulated wife, 266 of the husbands stated categorically that they preferred nonexcised or Sunna-circumcised women sexually.

El Saadawi (1980) suggests that the above rationales do not explain FGM's inception and continuance. She further suggests that female circumcision (and also the use of chastity belts, or the closing of the external organs with steel pins or iron tacks) was aimed at controlling female sexuality and, in turn, causing women to be more submissive to moral, social, legal and religious constraints, especially the constraints of monogamy. Only by restricting the female could a man be sure his wife's children were also his own. El Saadawi also suggests that men were not alone in promoting FGM to protect their economies. The thousands of *dayas*, nurses, paramedical staff, doctors, midwives and lay women who make their living from circumcisions and the effects of circumcisions are not only making a living from the practice but also derive status within the community because of their actions.

The radical feminist Mary Daly (1991, 1994) offers another suggestion that female genital mutilation is only one of a number of phallocentric and gynocidal practices developed to transfer power to the male and preserve the female strictly for their own pleasure and reproductive purposes. Daly draws parallels between Indian *suttee* (or widow-burning), Chinese footbinding, African genital mutilation, European witch-burning and, finally, American gynaecology. Daly links these practices by identification of what she describes as 'the sado-ritual syndrome'.

The sado-ritual syndrome has a pattern of seven parts; firstly, an obsession with purity; secondly a total erasure of responsibility for the atrocities performed; thirdly, gynocidal ritual practices having an inherent tendency to catch on and spread; forthly, women being used as scapegoats and 'token torturers'; fifthly, compulsive orderliness, obsessive repetitiveness and fixation upon minute details which divert attention from the horror; sixthly, behaviour which at other times and places is unacceptable becoming acceptable and even normative as a consequence of conditioning throughout the ritual atrocity. Finally, there is legitimation of the ritual by the rituals of 'objective' scholarship despite appearances of disapproval (Daly 1991).

Applied to FGM the references to purity and purification have already been mentioned. The circumcised woman's perpetual pain (or the imminent threat of this) is an important condition for their perpetual purity, 'for pain preoccupies minds, emotions, imaginations, sensations, prohibiting presence of self' (Daly 1991). Erasure of male responsibility is present by virtue of male absence at the execution of the mutilation (except in Egypt or where the patient is anaesthetized and unaware of the male presence).

As already mentioned, the practice has spread geographically, mainly because of immigration. Women, midwives, nurses, excisors or female relatives are utilized as the 'token torturers' carrying out the operation and therefore, on occasion, scapegoated by outsiders and the law, even though they are not the main beneficiaries or perpetrators of the practice. The highly ritualized ceremonies which often accompany the procedure are common in most practising groups. These ceremonies are sometimes religious and often associated with rites of passage or premarital rites. However, as Daly points out, because the age at which girls are mutilated varies from several weeks to 15 years, the ritual would appear to have little to do with physiological development or social maturity. The ritual has become normalized and is defended as a traditional and cultural rite in many societies, as will be discussed below. Finally, she cites several examples of scholarship which have detracted from the mutilating effects of FGM, and instead suggested misleading rationales (Daly 1991).

While, Daly's analysis might be considered radical even by some feminists themselves, her descriptions of FGM as violent acts not unrelated to other violent acts against women are by no means unique. El-Bushra & Piza Lopez (1993) cites FGM as an example of 'gender violence' comparable with rape, domestic violence, child abuse, female feticide and infanticide. Caputi & Russell (1992) also suggests that there is a continuum of 'anti female terror' which ranges from verbal abuse and mutilations of beautification to FGM, torture and femicide (woman killing). It would appear that, in the literature, examination of the rational and the social and cultural interpretations differ from the


 

merely descriptive to the more highly critical analysis of the practice, depending on the perspective taken.

## CULTURAL, POLITICAL AND COLONIAL INTERPRETATIONS

In Kenya during the early part of the twentieth century, missionaries set up schools and churches in the attempt to christianize the country. Sodomy, dancing, polygamy and female genital mutilations were condemned by the churches because of the sexual overtones. In 1937 a Scottish Presbyterian minister called the Rev. William Arthur MD threatened to excommunicate any of his congregation who refused to sign a pledge stating that they would not circumcise their daughters. He did this because of a strong belief that FGM was medically harmful.

However, at this time a strong nationalist movement, under the Kikuyu Central Association (KCA) led by Jomo Kenyatta, became suspicious of the Rev. Arthur's motives and called for the withdrawal of children from schools and churches. The Kikuku refused to sign the pledge against FGM and the dispute between the KCA and the missionaries dissolved into a bitter political struggle. This was demonstrated by the circumcision and strangling of a German missionary named Hulda Stumpt in 1930. The fact that Stumpt had been circumcised was suppressed by the British colonial press who realized that the missionaries, in touching this custom, had unwittingly threatened British colonial authority. FGM had become a political weapon against the British, turning many Kenyans towards nationalism. FGM, which had been waning in popularity before 1930, was to become popular again after 1930 (Anton 1995).

Dr Helen Dadet, a lecturer at the University of Nairobi, suggests that; 'By saying that you don't want girls circumcised, now you are getting too close to what holds society together. You are getting too close to what makes a Kikuyu woman feel that she's a full woman. You are touching on people's sense of values, sense of identity, sense of well-being and if you play with what makes somebody feel like somebody you are inviting aggression.' (Anton 1995).

### Neo-colonialism perceptions

Just as well-intentioned intervention in Kenya was perceived as a colonialist threat to indigenous culture, so the intervention of modern-day westerners to eradicate FGM has also been perceived as neo-colonialist or even racist (Davis 1985). Assitan Diallo of Mali, interviewed by Gevins (1987), explains that it is easy to see that something is wrong with a system when you are outside it, and warns that westerners must beware of causing a backlash by threatening people's culture. She continues: 'We have been colonised by this Western World and we have, let's say, something against them. That means we don't want them to overwhelm our lives anymore'.

Angela Davis (1985), speaking as an African-American woman, finds herself sensitive to the underlying racism which she says characterizes western emphasis on issues such as FGM. Davis feels this is particularly evident in sensationalist reporting which is insensitive to the dignity of the very women they want to save. Rana Kabbani, speaking to Brooks, criticizes western misconceptions, particularly of Muslim women; 'Western ignorance is often inseparable from a patronising view that insists on seeing us as helpless victims, while hardly distinguishing between the very different cultures we come from' (Brooks 1995).

Morgan & Steinem (1983) suggest that while the situation is complicated by the suspicion of many African and Arab governments that western interest is motivated by racist or neo-colonialist desires to eradicate indigenous cultures, these governments are representations of patriarchal authority who consider 'as central to their freedom and power the right to decide what is done with "their" women'. This suggests that 'culture' affects women, 'politics' affects men. This allows human rights organizations and politicians to ignore practice which is in fact a human rights issue. Gallagher (1993) suggests that this is a major obstacle causing difficulties in dealing with FGM because, 'the international community remains wary of defining as a violation, any practice or phenomena [*sic*] which is not attributable directly or indirectly to the state. In other words human rights entitlements are held against the state. Unfortunately for women this excludes the vast range of indignities to which they may be subject in the 'private' sphere by family, spouse or community'.

### Debates and differences amongst women

If division in relation to culture and politics is clear from the literature, perhaps even more clearly divided are the views of women in relation to FGM. Differences occur mainly along the lines of black/white and western/Arab and African cultures. An example of dispute along these lines is related by Walker & Parmar (1993), following a BBC 1 television programme on FGM in which Nigerian writer, Buchi Emecheta, who lives in England made some comments in defence of female genital mutilation. This inspired Poline Nyaga, a local government councillor, to ask the British government to legalize FGM as 'a right, especially for some African families who want to carry on this tradition whilst living in the United Kingdom'. This resulted in an angry picket of Brent Council in London by members of FORWARD and a statement from Alice Walker in which she described herself as 'saddened beyond measure that an African woman has embraced the torture of African children' (Walker & Parmar 1993).

Walker (1992) herself says she is keenly aware of the debate which erupted during the 1985 United Nations

Decade for Women Conference in Nairobi, Kenya. African women at this conference had reacted angrily when western feminists raised the subject of FGM, and suggested that western feminists 'stop groping about in our panties' (Walker & Parmar 1993). The focus by western feminists on FGM also ignores other forms of oppression and human rights abuse such as poverty, the effects of war, employment discrimination, illiteracy, inadequate health care and personal status law (Davis 1985).

## WESTERN MEDICINE AND FEMALE GENITAL SURGERY

Morgan & Steinem (1983) report how, in nineteenth-century London, Dr Isaac Baker Brown justified scissoring off the clitoris of his patients as a cure for insomnia, sterility and 'unhappy marriages'. In the United States of America, training was offered by the Orifical Surgery Society in clitoridectomy and infibulation 'because of the vast amount of sickness and suffering which could be saved the gentler sex' (quoted in Morgan & Steinem 1983). Clitoridectomies were approved of and were practised well into the twentieth century and endorsed by practitioners such as 'the father of gynaecology' J. Marion Sims (Daly 1991). Oöphorectomy, or female castration, was also widespread from 1880 to 1900 as a cure for psychological disorders. The last castration for a psychological disorder took place in 1946 (Barker-Benfield 1976) and the last known clitoridectomy took place in Kentucky, USA, in 1953 on a girl aged 12 years (Spare Rib editorial in Rowe 1982).

The practice of physical clitoridectomy for psychiatric disorders waned as psychological clitoridectomy became popular through Freudian psychoanalysis. Freud (1963), cited in Walker & Parmar (1993 p. 110), decreed that the 'vaginal' orgasm was a mark of maturity and the clitoral orgasm must be 'eliminated' as a 'necessary pre-condition for the development of femininity'. This propaganda had negative effects on the psyche and the sexuality of millions of women in North America and Europe (Dorkenoo 1994).

Although clitoridectomy and oöphorectomy fell into disuse, other mutilating surgeries have been and continue to be practised on women in both the USA (Daly 1991) and the UK (Wright 1994). These include unnecessary hysterectomies, Caesarean sections and episiotomies.

Davis (1985) also notes that, while western women recoil in horror at the effects of FGM, they rarely admit that they are also appalled by the lengths to which some women in the USA will go in order to alter their bodies surgically 'in accordance with male supremacist standards of beauty'. Nawal El Saadawi (quoted in Rowe 1982), speaking on psychological clitoridectomy of women in the west, suggested: 'sometimes you think you are free, but still you are not free ... how many Western women do not even know that they have a clitoris?'

### Legislation and medicalization

Legislation now exists in several western and African countries outlawing FGM (United Nations 1991). Some of these countries include Kenya, Norway, Denmark, Sweden, Switzerland and the United Kingdom. However, because of the secrecy which surrounds the practice of FGM, and the reluctance of governments to intervene, the legislation is often less effective than legislation against other forms of child abuse.

In France during 1993, Linda Weil-Curiel, a lawyer who has campaigned against FGM, brought parents of Gambian extraction to court after they had paid 30 dollars to have their 1-month-old daughter excised. However, the parents refused to name the excisor who continued to practise in Paris for some time afterwards (Walker & Parmar 1993). The following year, a 46-year-old circumcisior was brought to court and found guilty of 'voluntary blows and injuries leading to mutilations' on young children. She received only a 1-year suspended prison sentence after the president of the Paris Criminal Court directed the jury to be lenient because there was no criminal intent (Dorozynski 1994).

In 1993, a Harley Street gynaecologist was 'struck off' the medical register by the British General Medical Council after he had offered to carry out an illegal female circumcision on a *Sunday Times* journalist posing as a client. However, Dr Faroogue Haydor Siddigue did not face criminal charges even though the Prohibition of Female Circumcision Act (1985) made FGM an offence (Dyer 1993).

Legislation in Africa has been even less successful. For example, in Kenya, President Daniel Arap Moi banned the practice of FGM after 14 excised girls had died. However, Hosken (1993) estimates that 50% of girls continue to be circumcised. Legislation may actually have harmful effects if the practice is pushed underground because parents may avoid seeking necessary medical treatment if they risk prosecution. Furthermore, there is no existing legislation (except in the UK where Section 8 of the Children's Act 1989 can be invoked) to prohibit removal of children to other countries where FGM is legal (Trevelyan 1992).

Some governments and sections of the medical establishment have instead suggested that the practice be medicalized. In Egypt during the 1994 United Nations Cairo Conference on population, one leading Islamic cleric asked the 3000 delegates, 'What's all the fuss about? We are only talking about a tiny and useless piece of skin' (quoted in Bhatia 1994). The outcry worldwide forced the Egyptian president Mubarak to agree to push through legislation banning the operation. However, within months, Egypt had done a U-turn on the issue and Dr Ali Abdul Fatah Omaar, the health minister, declared, 'We have no plans to ban this operation by introducing legislation, but we are looking at ways for it to be carried out by qualified doctors


 

and under proper medical supervision' (quoted in Kandela 1995).

Calls for the medicalization of FGM have come from within the UK (Boulton 1993) and the European parliament (Dorkenoo 1994) even though the World Medical Association and the World Health Organization have condemned the participation of physicians in such practices (Richards 1993). Feminists have also condemned the medicalization of FGM as institutionalization of FGM which is unlikely to reduce the number or severity of circumcisions carried out worldwide (Dorkenoo 1994).

## OTHER INITIATIVES AND ACTION AGAINST FGM

In 1958 the Economic and Social Council of the United Nations (UN) invited the World Health Organization (WHO) to study customs which subject girls to ritual operations and to suggest measures for stopping such practices, but the 12th WHO assembly in 1959, rejected the report (Tomasevski 1993 p. 86). Nothing happened for nearly 20 years until 1979 when the WHO provided an opportunity for discussion, in its seminar on 'Traditional Practices Affecting the Health of Women and Children'. This seminar condemned female circumcision as a health hazard and constituted the first step towards formulating a policy against FGM (Tomasevski 1993). Progress was not enhanced by the UN Conference on women held in July 1990, which failed to condemn FGM in case it appeared that industrial nations were imposing their values on the Third World (News report in the *Boston Globe*, 1 August 1980, cited in Daly 1994). However, nongovernment organizations (NGOs), such as the Arab Lawyers Union, International Alliance of Women, International Council for Women, League of Red Cross and Red Crescent Societies and Soroptimist International, formed a working group to coordinate their action against FGM in 1977. In 1981, NGOs raised traditional practices as a human rights problem before the working group on slavery which decided to disseminate the information received and seek additional data.

Ten years later the commission delivered to the Economic and Social Council a detailed report on FGM (Gallagher 1993). Progress in the area was not to come early, as a report from the UN special rapporteur in Djibouti wrote, 'The team was made to understand that the issue of human rights and traditional practices was not considered a priority ... No law has been decreed against female circumcision since the experience of other countries regarding legislation on this issue resulted in failure' (Warzazi 1991). Gallagher (1993) suggests that it is doubtful whether the work of the UN human rights system has had a great impact on the incidence or severity of FGM. She instead recognizes the work of NGOs who have played a crucial role in the fight against FGM and concludes that 'without the impetus from these concerned groups, the international human rights community would have maintained a comfortable distance from such difficult, culturally and politically sensitive issues'.

Dorkenoo (1994) chronicles the efforts of NGOs such as the NGO Working Group on Traditional Practices Affecting the Health of Women and Children, The Inter-African Committee on Traditional Practices Affecting the Health of Women and Children, Minority Rights Group and Foundation for Women's Health Research and Development (FORWARD International), and also notes the efforts of individuals, for example, the research and writing of Hosken (1981, 1982, 1993), Thiam (1980), Abdella (1982), Koso-Thomas (1987), Walker & Parmar (1993) and Walker (1992). Dorkenoo (1994) also painstakingly relates the present status and current initiatives taking place in 23 countries in Africa as well as the western world initiatives.

## IMPLICATIONS

FGM is not mentioned in the well-known obstetric and paediatric textbooks, leading one author to suggest a 'conspiracy of silence' amongst the medical profession (Black & Debelle 1995). The Royal College of Nursing has, however, published an excellent pamphlet outlining the practice of FGM and suggesting that nurses, midwives and health visitors must,

> assume their role as advocates in order to increase professional and public awareness, develop communication and networking links with the relevant local communities, work with colleagues to develop local policies for responding to individual cases, recognise the sensibility and complexity of issues related to FGM, report suspected cases to their managers, the family's GP and the social services department and work at all times in partnership with colleagues from appropriate statutory and voluntary agencies and, where possible, with members of the family.
>
> (Royal College of Nursing 1994).

Specific advice is also given in the publication to nurses, midwives and health visitors working in education and management.

### Pregnancy

Special care is required for women during pregnancy and childbirth but to date only one centre in Britain caters for the needs of genitaly mutilated women. Northwick Park Hospital, Middlesex, England, set up a specialist antenatal clinic finded by the Department of Health, England, in September 1993. Although it accepts referrals from outside the area there continues to be a need for increased awareness and education for nurses and midwives who may encounter FGM in other geographical areas (Eaton 1993). The education of nurses, midwives and health visitors in

relation to FGM requires knowledge of not just its medical consequences but, as this paper demonstrates, of the complex cultural, social and political meanings of FGM within practising communities.

## CONCLUSIONS

This paper has reviewed the literature on female genital mutilation, which is sometimes euphemistically referred to as female circumcision. A description of the procedure, its effects and the reasons given for the continuance of FGM has been outlined. Although the literature is mainly comprised of anecdotal evidence, interviews and firsthand accounts of FGM, there have been several large-scale studies of FGM and its effects (Hosken 1981, 1982, 1993, Lightfoot-Klein 1989) which have been discussed.

Discussion of wider political, cultural, religious and feminist debates have been outlined, with reference to the trends and historical settings described in the current literature. Finally, current thinking by legislators and the medical establishment is reviewed in relation to strategies for the eradication of FGM.

The estimates for girls at risk of genital mutilation of 6000 per day in Africa and 2000 per annum in Britain are staggering (Dorkenoo 1994). Yet the past 30 years have seen relatively little political will or legislative initiative dealing effectively with FGM. However, strategies of informing, educating and supporting men and women are likely to have greater success in decreasing the numbers of circumcisions globally.

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