Female Genital Mutilation/Cutting: Global Zero Tolerance Policy and Diverse Responses from African and Asian Local Communities by Kyoko Nakamura, Kaori Miyachi, Yukio Miyawaki, Makiko Toda Quotes

The World Health Organization (WHO) defines female genital mutilation and classifies the operation types as follows (WHO, UNICEF, and UNFPA 1997; UNICEF 2013) (Fig. 1.1): Female genital mutilation comprises all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for cultural or other non-therapeutic reasons. Type I: Excision of the prepuce, with or without excision of part or all of the clitoris Type II: Excision of the clitoris with partial or total excision of the labia minora Type III: Excision of part or all of the external genitalia and stitching/narrowing of the vaginal opening (infibulation) Type IV: Unclassified: includes pricking, piercing, or incision of the clitoris and/or labia; cauterization by burning of the clitoris and surrounding tissue; scraping of tissue surrounding the vaginal orifice (angurya cuts) or cutting of the vagina (gishiri cuts); introduction of corrosive substances of herbs into the vagina to cause bleeding or for the purposes of tightening or narrowing it; and any other procedure that falls under the definition of female genital mutilation provided above. A wide variety of procedures fall under the term, “female genital mutilation.” They range from procedures which involve a minor incision at the tip of the clitoris to those that excise all of the external genitalia and stitch the vaginal opening. The WHO (2008) subdivided these types in their 2008 paper.1 This procedure is mainly practiced in Africa. According to UNICEF (2013) more than 125 million girls and women alive today have undergone some form of FGM/C in a swath of 29 countries across Africa and the Middle East (Fig. 1.2). FGM/C has also been observed in Asian countries such as Indonesia and Malaysia (Iguchi and Rashid 2020). In recent years, this practice has become apparent in immigrant communities in Europe and the United States (Macklin 2006; Hernlund and Shell-Duncan 2007).[1]

The term "female genital mutilation" appeared in the context of the abolitionist movement initiated by Western countries. In 1979, Fran Hosken, a renowned American social activist, started to use the term "female genital mutilation," claiming that "circumcision" does not express the difference between male and female circumcision and thus causes confusion. She used the term to alert the world to the violent nature of the practice and called for its abolition (Hosken 1994

[1] 1-2

[1979]). The term was popularized in the international abolitionist movement of the 1980s. In 1991, the WHO urged UN agencies to adopt the term; the UN agencies agreed, and the use of the term quickly expanded (WHO 2008: 22). However, the word "mutilation" has strong negative connotations that could be injurious to the dignity of the person undergoing the procedure. Thus, many individuals and organizations have not adopted this term. These individuals and organizations use the term "female genital cutting" (FGC) which includes the more objective and moderate term "cutting" in place of "mutilation." In 1999, UNICEF and other UN agencies reviewed the use of "mutilation" and subsequently introduced the hybrid term "female genital mutilation/cutting" (FGM/C).[2]

Attempts by Western societies to abolish FGM/C were first observed as early as the colonial period. For example, in Kenya, missionaries of the Protestant Church began efforts to stop the practice in 1906 (Thomas 2003: 22). Owing to the pressure exercised by the colonial government and missionaries to abolish the practice, FGM/C became an instrument of opposition to the colonial government by the end of the 1950s, especially for those living in central Kenya where resistance to the colonial government was fierce (Thomas 2003: 79–102; Matsuda 2009: 271–273). The women in this region even showed their resistance by circumcising themselves. The issue was extremely tricky for the new Kenyan government to address once it gained independence because it could potentially divide the populace and make it difficult for the government to achieve national unity (Thomas 2003: 179). With the rise of feminism in the West, female circumcision in Africa was “discovered” at the end of the 1970s, and the movement to abolish it gained momentum. At the Second World Conference on Women in 1980, Fran Hosken brought forward the issue of female circumcision, a gesture strongly opposed by the African women who participated in the conference. In the 1980s, the WHO, UNICEF, and other UN agencies joined the abolition movement. In the 1990s, many international organizations, including international NGOs, began to develop projects in various parts of Africa to promote abolition. The United States enacted the Anti-FGM Act in 1996, requiring nations to implement initiatives to abolish FGM/C as a condition for receiving international aid (Center for Reproductive Rights 2004), thus linking the abolition of FGM/C with conditions for aid from the World Bank and the International Monetary Fund. This meant that African countries hoping to receive economic support from the international community felt forced to work toward the elimination of FGM/C within their nations. Later, in 2012, the UN declared in a General Assembly resolution that it would step up its efforts to eradicate FGM/C. Since 2015, the number of projects aimed at

[2] 2-3

eliminating FGM/C have skyrocketed in line with the Sustainable Development Goals (SDGs) which call for its eradication.[3]

The first step taken by African countries to abolish FGM/C was the enactment of prohibition laws, which proceeded rapidly during the 1990s and the 2000s. Of the 29 countries in Africa and the Middle East where FGM/C is practiced, 24 have enacted prohibition laws as of 2020 (UNICEF 2013) (see Table 1.1). This book deals with three cases in Kenya (Chapters 5, 6 and 7) where the Children Act of 2001 explicitly prohibits "circumcision" for girls under 18 (Republic of Kenya 2012), and the Prohibition of Female Genital Mutilation Act (FGM Act) delivers harsh punishment and fines (Republic of Kenya 2012 [2011]). The rapid progress in enacting legislation to ban FGM/C is highly commendable, as it has contributed to a dramatic decrease in the practice of FGM/C. The legislation provided an opportunity to reexamine the procedure's necessity to those who would typically perform it unquestioningly and provided a strong justification for refusal to those who sought to escape it. However, there was simultaneously a negative reaction to its abolition through the coercive force of state laws. Those who wished to continue this practice began to practice it in secret owing to their fear of fines and imprisonment (Chapters 5 and 6). In Somalia, where the procedure symbolizes virginity, there was a reported increase of young marriages before sexual maturity– –an alternative way to demonstrate the purity of the girl at the time of marriage (World Vision 2014: 12; Pell and Robinson 2014). Community fragmentation also occurred in Kenya (Chapter 6), and the women in Ethiopia displayed fierce resistance to anti-FGM/C legislation (Chapter 2). It thus became clear that the development of prohibition laws could not be the goal of the abolition movement. There are women who actively want to practice FGM/C. For them, the ban has created a situation in which they are deprived of their freedom over their own bodies by the state. We need to pay attention to the complexities of the situation.[4]

Despite the fact that medicalization would undoubtedly reduce the risk of health problems, UN agencies are attempting to curb it. This is because the operation may be perceived as safe if a medical professional performs it. Additionally, given the respect and influence that medical professionals wield in the community, their participation in this practice may further discourage people from seeking its abolition (Kimani and Shell-Duncan 2018: 29; WHO 2010: 9). Medical professionals have become reluctant to perform FGM/C because those who perform the operation are also subject to punishment as per the prohibition laws that have been enacted in various countries. UN agencies have clearly stated that this practice violates women's human rights and

[3] 4-5
[4] 5

should be eradicated, even if it is not a health risk. This position is symbolized by their “zero tolerance” slogan. The slogan refers to their strong determination to forbid a single exception to be made in the campaign for abolition. This implies not tolerating any type of FGM/C procedure, not even a very minor one such as pricking the clitoris/labia with a needle. Ironically, if an international consensus that FGM/C is a human rights violation against women is formed and the pursuit of “zero tolerance” intensifies, the mitigation of the health hazards of FGM/C may well be neglected (Kimani and Shell-Duncan 2018: 30–31).[5]

In some situations, people who tolerate FGM give responses to critiques of its practice such as, 'Are you aware of its cultural relativism?' or 'Don't you think we, developed countries, must respect FGM as a part of African culture?' These cultural relativists do not seem to be aware that FGM is a violation of children's and women's rights due to its potential to cause serious medical complications. There is no reason a practice that can kill women and girls should be termed 'culture'. The biggest problem with FGM is that it is primarily practiced on girls under the age of 18, who do not understand the risks of FGM and cannot provide informed consent. Regardless of its severity, FGM may cause psychological trauma from pain, shock, and the use of physical force by those performing the procedure. Many women describe FGM, even type I, or clitoridectomy, also called the Sunna style, as a traumatic event, posing a sustained threat to their safety, even in adulthood. In areas where type III FGM (infibulation) is common, medical staff I interviewed are well aware of the problems it causes before and during pregnancy. Why, then, do people in these areas continue to practice FGM if it can rob women of their lives? A female medical staff member said, 'FGM is just a tool for men to control women'. In many African societies, FGM has been used to make men masters of female sexual function and historically to reinforce the idea that wives are their husbands' property, typical of patriarchal societies. 'To counter deeply rooted gender-based discrimination that often results from patriarchal attitudes and related social norms' is required to achieve Goal 5 of the Sustainable Development Goals (SDGs), which is to achieve gender equality and empower all women and girls. The international community thus needs to abolish FGM, a tool to maintain patriarchal values, and dismiss the opinions of cultural relativists. Practices like FGM, Sati, and foot binding, that kill or potentially kill women and girls, should not be termed 'culture'.[6]

When researchers talk about FGM in Africa, local diversity should be emphasised. In Africa, there are thousands of ethnic groups in 54 countries (55 if we include the Sahrawi Arab Democratic

[5] 6-7
[6] 42-43

Republic in the Western Sahara). Not all ethnic groups follow the tradition of FGM. Of those that do, some have abolished their tradition of cutting and others have changed the common forms of FGM, while others, still, have continued practicing it. In many places where FGM prevails, local people have already decided on whether to abolish it, and whether to change the common form of FGM, as revealed in this book. Even if FGM is a part of African culture, cultural values are not immutable and do generally change over time. Nowadays, many community leaders in Africa do understand the risk of FGM. As shown in Sect. 2.1, FGM rates among African children under 15 years of age have declined dramatically over the past two decades. Furthermore, as seen in Sect. 2.2 and other chapters in this book, in some places the severe forms of practice are decreasing, and new, harmless substitutions have been introduced for the younger generations in Africa. While girls in some communities are excised without their consent due to their young age, girls in the Gusii community, where prevalence rates are the third highest in Kenya according to the Kenya Demographic and Health Survey 2014 (2014KDHS; KNBS 2015), actively request FGM (see Chap.5).While girls in the Somali community, where prevalence rates of FGM are the highest in Kenya (KNBS2015:333–334), are generally cut when they are between the ages of 6 and 9,5 girls in community A (see Chap. 6) are excised before their marriage. Community A also practices different forms of FGM. The traditional style of FGM followed by community A is type II. However, type I (the Sunna style) and the kati-kati style have been recently introduced. Therefore, girls can choose between three styles. Kati-kati is a Kiswahili word that means 'in the middle' and refers to the cutting in the middle of the clitoris. The kati-kati style is now the most popular among secondary school girls. People who regard FGM as a culture that should be maintained, ought to understand the local diversity in Africa, considering that many families have taken the decision to refrain from cutting their girls, and many communities have modified their practice of FGM from severe to milder forms.[7]

The international community considers FGM to be a violation of children's and women's rights. Universalists claim that FGM violates the fundamental universal human rights under the Universal Declaration of Human Rights (UDHR) (UNFPA 2014), which is regarded as the customary international law that binds all nations as follows: The right to be free from discrimination (Article 2) The right to life (Article 3) The right to physical integrity (Article 1) The right to health (Article 25) The right not to be subjected to torture or degrading treatment or punishment (Article 5). Article 26 (right to education) can also be included because type III FGM can retain menstruation, cause strong pain, and prevent girls from going to school (Sect. 2.2). 2.2.3 SDGs As mentioned, to achieve Goal 5 of SDGs (achieve gender equality and empower all women and girls), it is required

[7] 14-15

'to counter deeply rooted gender-based discrimination that often results from patriarchal attitudes and related social norms'. Target 5.3 of Goal 5 of the SDGs aims to 'eliminate all harmful practices', including FGM (United Nations Statistics Division 2021a). SDGs have been adopted by all 193 United Nations member states. Nawal El Saadawi, an Egyptian feminist, psychiatrist, author, and campaigner against FGM, pointed out that FGM is the product of a patriarchal system (El Saadawi 2015) and indeed African women whom I have met have confirmed that it is a tool for men to control women. As such, the international community needs to abolish it.[8]

FGM is extremely harmful to wives and daughters. Why do Somali people still practice it? Generally, FGM is practiced for a variety of reasons in Africa. In some places it is believed that girls must be cut to control their libido. In others, there is a perception that intact girls are dirty or ugly, that the clitoris could kill their husband during intercourse or kill their first-born child at birth, or that FGM is proof that they can endure the pain of childbirth and so on. FGM is also regarded as a rite of passage into adulthood (see Chapters 5, 6 and 7). The most common reason the Somali continue practicing FGM is for proof of girls' virginity. Traditionally, girls are forced to marry at around 14 years old by their fathers and FGM is seen as a prerequisite for marriage because Somali men view it as proof of virginity. There are other reasons for poor families to continue this practice, such as bride-price, exchange of bride with livestock, money and so on, all of which are deeply rooted in patriarchal values. With regards to the bride-price, the father of a girl who is not excised will not be paid the bride-price in full. Poor families need the bride-price for daughters not only to maintain their daily lives but also to pay the bride-price for their sons' brides… Another reason is their religious beliefs. While some Somalis, who were educated and spoke English, told me that FGM had nothing to do with Islam, most Somali who live in remote areas still believe that FGM is required by Islam. According to the 2014 KDHS, 82.3% of Somali women and 83.4% of Somali men believe that their religion requires FGM (KNBS 2015: 340).[9]

Female genital cutting (FGC) refers to various controversial practices involving modifications of female genitalia. Cultural anthropologists have identified this practice as "female circumcision," and many regard it as a rite of passage, the function of which is to protect women's chastity and maintain the integrity of patrilineal lineages (Hayes 1974). Activists concerned with abolishing this practice regard it as a tool of men's domination over women's sexuality and call it "female genital mutilation" (FGM). This term implies that the practice irreparably damages women's bodies. They have also criticized the anthropologists who describe FGC as a rite of passage,

[8] 22-23
[9] 25-26

accusing them of participation in covering up patriarchal rule (cf. Hosken 1993). This argument has developed into a controversy between relativism and universalism among scholars and activists. While scholars and activists have argued over their ethical stances on FGC, international organizations such as the WHO and UNICEF have pushed for FGC abolition since the late 1970s. At first these UN organizations regarded FGC as a health issue for women. However, in the 1990s, the UN changed its stance and defined FGC as a "human rights violation" against women. The WHO and UNICEF declared a policy on FGC of "zero tolerance," including "medicalized" FGC, and called for its abolition in African states where it was practiced. Between the late 1990s and 2010, various African states criminalized FGC (Boyle 2002). The abolition of FGC may have been intended to empower women and to improve the social conditions in which they live. However, the WHO policy seems to have suffered from difficulties and contradictions. The practices defined as FGM by the WHO range widely, from pricking genitalia to infibulation, and from cutting genitalia without any anesthesia by traditional circumcisers, to excision with anesthesia in sanitary medical facilities. It is unlikely that these different types of FGCs cause similar health problems. The human rights discourse, which asserts that FGC is practiced to oppress women in patriarchal societies, does not readily fit all the cases that are called "FGM." In most societies where FGC is practiced, it is done by women, many of whom willingly perform the procedure. Thus it is oversimplifying to suggest that FGC is done to oppress women. In many societies, FGC is commonly practiced with culture-based consent so it is unreasonable to compare it to torture, which is inflicted on unwilling victims. FGC is said to violate the rights of children who are made to undergo this practice by their parents. However, in many societies, parents have their children undergo this practice out of concern for their children's welfare.[10]

FGM is considered as a violation of the rights of girls and women and a violation of their bodily/physical integrity (WHO 2014). This is a central issue in FGM discourses (Abusharaf 1995; Ramos and Boyle 2000; Amado 2004). In some African cultures it is similarly seen as an abuse of the God-given integrity of girls' and women's bodies (Mehari 2016). FGM negatively affects the well-being of girls and women. Its health implications include severe bleeding, infections, infertility, risk of complications during childbirth, and risks of new-born deaths. The negative implications of infibulation are more severe as it involves stitching and re-opening (de-infibulation) during marriage and childbirth (WHO 2014).[11]

[10] 35-36
[11] 57

The study findings indicate that local views on perceived benefits of FGM play an important role in sustaining the practice. Marriageability and purity were the most frequently mentioned advantages of FGM in the Somali study sites. Study participants reported that uncut girls cannot find a husband in the Somali cultural setting. A schoolgirl described the relationship between FGM and marriageability in the Somali context as follows: "uncircumcised girls are disregarded and no one will marry them." Uncircumcised girls are subjected to gossip and insulting words such as "buryo qab", which roughly means girl with long clitoris. The girl further reported that uncircumcised girls "are stigmatized and can't freely interact with community members. It will be very difficult for uncircumcised girls to live in our kebele." (Kebele refers to the smallest administrative level in Ethiopia). Some participants of the study described the benefits of FGM, especially focusing on Gudnika Faronika (infibulation). According to their views, infibulation plays an important role in enhancing the social value of girls and the prestige of their families and husbands. A health extension worker from the Somali study site magnified the relationship between FGM, purity, and virginity. She stated that Gudnika Faronika increases girls' marriageability by maintaining their virginity and purity. She claimed that a "woman undergone circumcision [meaning Gudnika Faronika] and remained sealed is highly valued and marrying to such a lady is seen as a prestige both for the man marrying her and the girl's family." Most of the study participants, including women and girls, claimed that virginity and purity are essential to enhance marriageability of girls in the Somali context. The girl must be both halal (pure/clean) and a virgin to get married with respect and dignity. Study participants reported that the virginity of girls would be checked prior to marriage and those found unsealed would be subject to mistreatment including rejection by the bridegroom and his family: Girls who do not undergo Gudnika Faronika are viewed as morally weak and uncontrolled and thus a dishonor towards the family reputation …those who miss the mark of pre-marriage virginity check may face social isolation, become unqualified for marriage, and in some cases, ignored by their own family. In addition to marriage denial, girls who don't undergo circumcision would face insulting songs. (Woman, community leader, mid-50s). The notion of purity is a highly emphasized issue among Somali study participants. Infibulation, especially, is considered as a means of both preserving girls' virginity and a process of purifying them. The notion of purity/cleanness echoed by study participants was expressed in religious terms such as halal as opposed to haram (spiritual impurity), as shown in the following quotation: Most mothers say Gudnika Faronika is good for making girls clean and keeping them virgin until marriage. Therefore, the practice is highly favored as culturally right as it upholds girl's virginity… If a girl undergoes Gudnika Faronika [infibulation] she is considered as halalen or clean. If a girl remains uncircumcised, she would be

considered as haram or unclean and she will be isolated from the community. (Girl, 16) This quote shows that views of FGM-related purity and impurity are closely associated with Islamic notions such as halalen and haram, and reveals why perceptions of Gudnika Faronika and the Sunna cutting differ. According to the study findings, Gudnika Faronika has two perceived benefits: it purifies girls and preserves girls' virginity by prohibiting vaginal sex (as it partially seals the female genitalia). On the other hand, although it serves the purpose of purifying girls, the Sunna cutting does not preserve girls' virginity (as it does not prevent vaginal sex). Somali communities cherish the value of virginity above all and thus prefer Gudnika Faronika which fosters purity, in their eyes, and protects virginity of girls and it is these two qualities together which enhance the social status and marriageability of girls. 4.3.2.3 Total Abandonment or Shifting to Sunna Cutting? The association of Sunna circumcision with religious obligation (purity of girls) is one of the chief obstacles to the total abandonment of FGM. The strong resistance to the total abandonment of FGM observed in the study sites has forced NGOs to shift from the "total abandonment" model to the abandonment only of infibulation. This is because actors implementing anti-FGM programs are left with these options: (1) insisting on the total abandonment of FGM that requires direct confrontation in the face of a very strong resistance from the local community; or (2) crafting pragmatic intervention models that involve toning down the targets of FGM intervention, i.e., tolerating the Sunna cut, and exclusively focusing on the abandonment of infibulation. For some program implementers this shifting from infibulation to Sunna cut is an acceptable compromise and represents an intermediate success because it minimizes the health risks associated with infibulation and could pave the way for the total abandonment of the practice in the future. A key informant working for an international NGO running FGM programs in the study zone shared the above view. It is imperative to note that the key informant was an educated young woman with years of work experience in implementing interventions aimed at eliminating FGM. She said the following when asked her view on shifting to the less severe type of FGM: Yes, I can say it [the shift to the Sunna cutting] is good. When I compare the Sunna type with the pharaonic type [infibulation], the Sunna type has less effect, less harm than the pharaonic type and I think Sunna is the best [option]. That is, the Sunna type is just cutting little slices from the clitoris and it is much simpler than the pharaonic type. I think the Sunna type has no harm and it is much safer than the pharaonic type. Therefore, as I am religious person, I can't prohibit what is not prohibited in my religion [Islam]. (Young woman, FGM program implementer) The above excerpt shows the level of awareness of FGM and the role of religion and religious leaders in sustaining FGM by encouraging the shift from infibulation to the Sunna cutting. The other challenge to the total abandonment of FGM observed in the Somali study setting was the tendency to exaggerate the advantages of the Sunna cutting as compared with infibulation. 4.3.2.4 Romanticizing Sunna Cut Girls Romanticizing Sunna cut girls is another development that hinders the abandonment of

FGM. “Sunna cut girls are sweet” is one of the widely observed expressions in the study area. Some men use the phrase “sweet girls” to refer to Sunna-cut girls. The message behind “sweet girls” is that Sunna cut girls/women are good for sexual satisfaction of men/husbands as compared to infibulated girls/women. The following quotation provides more information on the dominant view that magnifies the benefits of the Sunna cut such as avoiding pain and health risks and enhancing sexual pleasure and quality of life. A Somali man in his late 40s said the following about the Sunna cut. Many women are suffering from a lot of complications related to Gudnika Faronika [infibulation]. The Sunna cut has benefits …Girls [who have undergone the Sunna type] do not face health complications and men will have good sex and women will give birth without health complications. The other benefit of the Sunna type is, during sexual intercourse, women will satisfy their husbands and they will also lead a happy life. (Father of girls, 48) The phrase “lucky girls” is another powerful expression that signifies the benefits of the Sunna circumcision. It portrays that Sunna cut girls are lucky compared to infibulated girls, as the “lucky girls” do not experience the suffering and pain associated with infibulation. Study participants, including girls, reflected this view. The following short excerpt is quoted from a Somali girl interviewed for this study: “I was told that the Sunna cut is too simple since girls did not cry like those girls who were experiencing Gudnika Faronika [infibulation]. Girls who undergo the Sunna cut are very lucky.” The romanticizing of the Sunna type also involves appreciating it as a sign of modernity. Study participants portrayed the Sunna circumcision as not only less severe and healthier to girls. They also associate it with urban culture and civilization. Gudnika Faronika, on the other hand, is labelled as a sign of backwardness and the practice of rural communities. In terms of religion, Gudnika Faronika is portrayed as a pre-Islamic practice that contradicts Islamic teachings.[12]

Girls and women will continue to be subjected to FGM in the world as long as there is systematic gender inequality, a lack of empowerment and voices of women, poverty, the need to conform to customs concerning marriageability for economic survival, and lack of access to education for girls and women, preventing them from being able to earn their own living. FGM is a global concern due to migration and refuge-seekers from countries of conflict and war. It is a moral, health and human rights imperative to protect children from this trauma by addressing the underlying causes. Migration to countries such as Australia where FGM is not prevalent, provides a catalyst for change within communities, as underlying propagators are no longer present. Australia has world-class legal, health and education systems which we can leverage, in consultation with affected women, men and their families, to form a national network of experts to develop, implement and evaluate national policy and guidelines on healthcare provision,

[12] 62-65

protection of girls, and prevention of FGM. This may be placed within the broader program which already addresses gender-based violence. We are more likely to see the end of FGM if there is global collaboration on research, training, and prevention programs.[13]

We must learn from history: when the colonial European powers tried to abolish the surgery in the first half of this century, local people rejected the interference and clung even more fiercely to their traditions. This is what we have learned from Lynn Thomas' work on the resistance with which these efforts were met. Without an understanding of indigenous cultures, and without a deep commitment from within those cultures to end the cutting, eradication efforts imposed from the outside are bound to fail.[14]

[13] 152
[14] 182