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FEMALE GENITAL MUTILATION: A GROTESQUE FORM OF VIOLENCE AGAINST WOMEN

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Abstract

Female Genital Mutilation is internationally recognised as a violation of the human rights of the girls and women, reflecting deep rooted inequality between the sexes. Since FGM is almost carried out on minors, it is also violation of the human rights of the children. Female Circumcision according to WHO, includes procedures that involve partial or total removal of the external female gentalia or injury to them for non- medical reasons. A recent UNICEF report study states that more than 130 million girls are at risk of being cut before their 15th birthday if the current trend continues. Most survivors are from African Countries, but it is also practiced in India, Pakistan, Indonesia, Malaysia and some countries in Middle East. A major motivation is that the practice is believed to ensure the girl conforms to the key social norms related to sexual restraint, feminity, respectability and maturity. Reasons for carrying out the practice range from ethnic and tribal cultures, family relations, tribal connections, class, economic and social circumstances and education etc.The present study explores this practice with an overview upon the societal and extra cultural factors prevalent and facilitating such practice with psychological grave consequences on the victims. The study is based on secondary data findings and research and uses a compressive sociological analysis based on dialectical perspectives.

Keywords: *Genital Mutilation, Circumcision, Dialectical, Femininity, Sociological, Human Rights*

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INTRODUCTION:

Brutal, criminal, regressive….Mere adjectives cannot sum up what girls aged six and seven go through in the name of religion and tradition. Female Genital Mutilation in India is like Vagina monologue, barely audible and rarely heard. It is high time it became a dialogue![1]

Female Genital Mutilation is an age old practice which dates back to several hundreds of years ago. According to Okeke, Anyaehie&Ezenyeaku (2012), FGM is widely recognised as

[1]Thomas Mini .P; "The Cut and Hurt", http://www.the week.In/the week/cover/female-genital-mutilation-in, November 09, 2014.

a violation of human rights, which is deeply rooted in cultural beliefs and perceptions over decades and generations with no easy task for change. This practice is defined by World Health Organisation (WHO) (2010) as, "all procedures that involve partial or total injury to the female genital organs for non- medical reasons". Female genital mutilation (FGM) or female circumcision, according to the World Health Organisation, includes procedures that involve partial or total removal of the external female genitalia, or injury to the female genital organs for non-medical reasons. A recent UNICEF report states that more than 130 million girls and women alive today have undergone FGM in 29 countries where the practice is prevalent. As many as 30 million girls are at risk of being cut before their 15^{th} birthday if the current trend continues. Most survivors are from African countries, but FGM is also practised in India, Pakistan, Indonesia, Malaysia and some countries in the Middle East.

Historical Perspectives:

Kouba&Mausher (1985) states that though the exact date of female genital circumcision and when female genital mutilation started is not very clear, existing documents and Greek historians and geographers, such as Herodotus (425-23 AD) show that female circumcision happened in Ancient Egypt and the time of the Pharaohs. Consequently, Egypt is considered as the source country of female circumcision. Female Circumcision has prevailed during the years of 1400 B.C to 2000 B.C in Egypt (Drumma, 2010), apparently it was done in religious ceremonies and rites (Ahmadi, 2013). According to existing evidences, the Egyptians are considered as the pioneers of this tradition although female circumcision has also moved to other regions of the world – especially Africa. Momoh (2005) states that female circumcision was present a long time ago and among other nations of the world including the Romans who in order to avoid their female slaves from pregnancy, installed some rings on the two sides of the outer lips of the uterus. The procedure, according to AID (2013 b), is carried out at a variety of ages, ranging from shortly after birth to sometime during the first pregnancy. It most commonly occurs between the ages of 0 to 15 years and the age is decreasing in some countries. The practice has been linked in some countries with rites of passage for women. FGM is usually performed by traditional practitioners using a sharp object such as knife, razor or broken glass.

According to Wikipedia (2014), FGM is practiced in Africa, the Middle East, Indonesia & Malaysia as well by some migrants in Europe, United States and Australia. It is also seen in some populations of South Asia namely –Afghanistan (EWIC, 2005) , Maldives (HRW,2012); Malaysia (Rahman,Isa, Shuib, Shukri and Oshman, 1998). The highest known prevalence rates are in 30 African countries, in band that stretches from Senegal in west

Africa to Ethiopia in the north to Tanzania in the South. According to AID (2013b) , countries with high prevalence rates (> 85 %) are for example : Somalia, Egypt and Mali. Low prevalence rates (< 30%) are found in Senegal, Central African Republic and Nigeria). As a result of immigration, FGM has also spread to Ethiopia, Australia and the Unites States with some families having their daughters undergo the procedure while on vacation overseas. As Western Governments become more aware of FGM, legislation has come into effect in western Countries to make the practice a Criminal Offence. In 2006, Khalid Adem became the first man in the US to be persecuted for mutilating his daughter by cutting off her Clitoris with a scissors (Gulf News 2012). According to Ahmadi (2013), a female genital mutilation is presently carried out in vast regions of the African Continent and Some Asian Countries of the sub Sahara, such as the countries located in the famous region of Horu Africa (Sudan, Somalia, Eritrea, Ethiopia and Djibouti). It is obvious that some countries of the West Africa (Niger, Nigeria, Togo, Benin, Ghana, Mali, Senegal, Cote d'ivoririe (Ivory Coast), Cameron, Burkina Faso, Mauritania, Liberia, Sierra Leone, Guinea – Bissau and Equatorial Guinea have the highest percentage of FGM around the world.[2]

Both women and men can be complicit in reinforcing gender norms and practices that support violence against women. FGM also differs from most often forms of violence against women in that, in practicing communities, it is done routinely on almost all girls, usually minors and is promoted as a highly valued cultural practice and social norm.

There are population based data on FGM prevalence from all African Countries in which the practice has been documented. Estimates suggest that:

1. 100-140 million girls and women are at risk of FGM each year; and
2. In the 28 countries from which national prevalence data exists (27 in Africa and Yemen), more than 101 million girls aged 10 years and older are living with effects of FGM.
3. FGM is known to be practiced in 27 countries in Asia and the Middle East; immigrants from these countries wherever they live, including in Australia, Canada, Europe, New Zealand and the USA; and
4. A few population groups in Central and South America

   In the 28 countries in Africa and the Middle East for which data are available, national prevalence among women aged 15 years and older ranges from 0.6% (Uganda, 2006) to 97.9% (Somalia, 2006). There are some regional patterns in FGM prevalence. According

[2]Ofor, Marian Onomerhie, Ofle, Nididi Mercy; " Female Genital Mutilation: The Place of Culture and the debilitating Effects on the Dignity of the Female Gender", European Scientific Journal, May 2015 edition, Vol. 2 No. 14 .

to demographic Health Surveys done during 1989-2002, within north –eastern Africa (Egypt, Eritrea, Ethiopia and Northern Sudan), prevalence was estimated at 80-97%, while in eastern Africa (Kenya and the United Republic of Tanzania) it was estimated to be 18-38 %. However, prevalence can vary strikingly between different ethnic groups within a single country. FGM has been documented in several countries outside Africa but national prevalence data are not available. An estimated 90% of FGM cases involve Clitoridectomy or excision and around 10% involve infibulations, which has the most severe negative consequences.

Types of FGM:

Type 1 – Clitoridectomy : partial or total removal of the clitoris (a small, sensitive and erectile part of the female genitals) and (or in very rare cases only, the prepuce, the fold of skin surrounding the clitoris).

Type 2- Excision: partial or total removal of the Clitoris and the labia minora, with or without excision of the labia majors (the labia are the 'lips' that surround the vagina

Type 3- Infibulation : narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the inner, outer, labia with or without removal of the clitoris.

Type 4- Other: all other harmful procedures to the Female Genitalia for non- medical purposes that is, pricking, piercing, incision, scrapping and cauterizing the genital area.

FGM differs from most forms of violence against girls and women in that women are not only the victims but also involved in perpetration. A girl's female relatives are normally responsible for arranging FGM, which, in turn, is usually performed by traditional female excisers. FGM is also increasingly being done by male and female health care providers.

Female Genital Mutilation is internationally recognised as a violation of the human rights of girls and women, reflecting deep rooted inequality between the sexes. Since FGM is almost always carried out on minors, it is also a violation of the rights of children.

FGM, which has been outlawed in many countries as a serious violation of human rights, is still prevalent among the Dawoodi Bohra Community in India. An educated and affluent group of people, DawoodiBohras are a sub-sect of ismaili Shias. India has a rough estimate of 5 lakh Bohras – around half of the 10 lakh strong Bohra community in the world – spread across Maharashtra, Gujarat and Rajasthan. Around 90 percent of Bohri women still undergo the archaic ritual. Survivors of FGM, also known as 'Khatna' among Bohris, often compare it to rape. For Johari, who belongs to the same community, the response to the trauma has been more of outright anger. She says the intention has

been to moderate pleasure. "That is what the Bohris have been told for years", she says. "Cutting is done with the objective of subduing a girl's sexual urges. Basically, the belief is that if you get your daughter's circumcision done, she will not have premarital or extra marital affairs. In India, Khatna used to be carried out by traditional practitioners with no medical training. Khatna is generally done at the age of six or seven – the age when a girl is 'old enough to remember what she went through and young enough not to question it", says PriyaGoswami, Director of A Pinch of Skin, a documentary on genital cutting that won special mention at the 60th National Film Awards. She remarked that FGM was practised by Bohras settled abroad, too. "There are a lot of expatriate Bohras, settled in developed countries, who get their daughters to fly back to India to undergo genital cutting", She further remarked. On further investigations undertaken by 'The week', it was found that genital cutting is also done in premier multispecialty hospitals in metro cities. A woman married to a Bohri is expected to undergo circumcision in order to be considered a Bohri. "There won't be blood loss or pain. Only a pinch of the clitoris is removed, that too, under anaesthesia. The person has to be in the hospital for 4-6 hours only", says the gynaecologist from one of the multispecialty Bohra hospitals in Mumbai. The procedure costs Rs 15,000. Cutting is usually done on Tuesdays, Thursdays and Fridays.Khatna can be performed only after a sanction from the religious head.

Unlike male circumcision, Khatna is a hush-hush affair. Bohris don't talk about it. Some of the men in the community don't even know that this practice exists. But there is a consensus among them on whether to continue the practice. Older women do not question the practice; for them, it lies in the zone of unquestioning belief. Some are for the practice and ensure that even their maid's daughter get it done; others don't believe in the practice but lack courage to speak against it. There are mothers who haven't got it done on their daughters, but lie about it for the fear of being ostracised. Those who choose not to comply with the patriarchal directives have strong reasons to do so. Genital cutting can have several health implications. Complications can be immediate such as shock, bleeding and infection. Sometimes it can also lead to death. It can also cause sexual dysfunction, infertility, urinary problems, vaginal tears during coitus and delivery. At times, bleeding can be profuse, leading to morbidity and mortality. FGM victims often complain that they don't feel attracted to men the way their peers do. Some of the women are worried about how much effect Khatna will have on their sexual life since it is easier to reach orgasm if she had not undergone khatna. Clitoris stimulation is what makes a woman sexually excited. Khatna limits one's sexual pleasures. Dr. Prakash Kothari,

sexologist and founder advisor to the World Association for Sexology, partly agrees with other protagonists of the awareness campaigns against Khatna and believes that in females, clitoris is the most reliable orgasm trigger. Most of the women require sexual stimulation of the clitoris to have orgasm". Examining cases from Africa the doctor further laments that it leads to psychological trauma of the victims but the desire level and orgasmic capacity were not hampered at all. The arousal sensations were very much there. Female sexuality is dependent on the hormones produced by the ovaries, which are deep inside. Whatever on gets done externally will not have an impact on your desire level. The Bohra community is witnessing currently, a silent movement.

Mama Efua(Efua Dorkenoo), the mother of the global campaign against female genital mutilation eventually died of cancer on October 18, fighting for three decades against FGM. Originally from Ghana, Dorkenoo came to England in the 1960's, where she started working as a nurse. It was here that she met a woman in labour, who had undergone infibulations. And there began a long battle against this gruesome practice. In 1983, Dorkenoo founded the Foundation for Women's Health Research and Development. She has also worked with the World Health Organisation and was associated with several other organisations. Her work was instrumental in the passing of the Prohibition of Female Circumcision Act, 1985, in Britain….. "Of course, prevention must be central, but prosecution is the flip side of the same coin. Because in many cases if a parent or guardian feels they can get away with it, they will". In 1994, Dorkenoo received the Order of the British Empire and came out with a book, "Cutting the Rose: Female Genital Mutilation: The Practice and its Prevention". [3]

Consequences of FGM:

Health Consequences: FGM has no health benefits. It involves removing and damaging healthy and normal female genital tissue and interferes with the natural functions of girls and women's bodies. Traditional excisers use a variety of tools to perform FGM, including razor blades and knives and do not usually use anaesthetic. An estimated 18% of all FGM is done by health care providers who use surgical scissors and anaesthetic. All forms of FGM can cause immediate bleeding and pain and are associated with risk of infection with the extent of the cutting.

[3]Ibid, "The Cut and the Hurt", The Week

Table:1 Immediate & Long Term Health Consequences of Female Genital Mutilation

Immediate Health Risks	Longer Term Health Risks
Severe Pain	Need for Surgery
Shock	Urinary and Menstrual problem
Haemorrhage (excessive bleeding)	Painful sexual intercourse & poor quality of sexual life
Sepsis	Infertility
Infections	Chronic pain
Unintended Labia Fusion	Infections (Cysts, abscesses and genital ulcers, chronic pelvic infections, urinary tract infections
Death	Keloids that is excessive scar tissues & Increased risk of Cervical cancer
Psychological consequences	Reproductive tract infections
Difficulty in passing urine	Psychological consequences like fear of sexual intercourse, post traumatic stress disorder, anxiety, depression
Known Obstetric Complications	Conditions Often Considered to be associated with FGM
Caesarean section	HIV (in the short term)
Postpatrum Haemorrhage	Obsteric fistula
Extended Maternal hospital stay	Incontinence
Still birth or early neo natal death	
Infant resuscitation	

Research into health effects of FGM has progressed in recent years. A WHO led study of more than 28000 pregnant women in 6 African countries found that those who had undergone FGM had a significantly higher risk of child birth complications such as caesarean section and post partum haemorrhage, than those without FGM. In addition the death rate for babies during and immediately after birth was higher for mothers with FGM than those without.[4]They are 1.5 times more likely to experience pain during sexual intercourse, have significantly less sexual satisfaction and are twice as likely to report a lack of sexual desire.

Social Consequences:

Amongst the factors that encourage families to circumcise their daughters is the family's concern about the girl's inability to marry if she is not circumscribed. La Barbera, (2010) states that an important part of this goes back to the recognition of women who are not circumscribed as indecent which has resulted in the fact that African women do strongly support the action of FGM in spite of the pain and agony and consider it so vital for their daughter's future especially for their marriage. Some indigenous Africans believethat circumcised girls might control their sexual desires accordingly after maturity and it

[4]Ahmadi, Amir B.A (2013), "An analytical Approach to Female Genital Mutilation in West Africa", International Journal of Women's Research, Vol. 3, No.1.Spring 2013, pp- 37-56.

protects them from sins and faults, while a great number of Africans also believe that women, who have not gone through circumcision in their childhood, face multiple physical problems at birth(La Barbera 2010). It is further believed that uncircumcised women have lower fertility power compared to circumcised women and are not able to control their sexual desires (Ahmadi 2013). On the other hand, in the majority of West African countries, female circumcision represents their purity and innocence (Erlich, 1986). Virginity in a lot of African countries is valued as a pre requisite fro marriage and equated to female honour. FGM infibulations in particular, is defended in this context as it is assumed to reduce a woman's sexual desire and lessen temptation to have extra marital sex therapy preserving a girl's virginity (AID, 2013 e). Apart from this amongst the gender based factors, FGM is often deemed necessarily in order for a girl to be considered a s complete woman, and the practice marks the divergence of the sexes in terms of their roles in life and marriage. The removal of clitoris and labia – viewed by some as the 'male parts' of a woman's body – is thought to enhance the girl's femininity, often synonymous with docility and obedience (AID, 2013 e).

High Risk Factors for FGM:

The most common risk factor for either undergoing FGM or focussing a girl to undergo the procedure are cultural, religious and social; these influences include:

1) Social pressure to conform with peers
2) The perception of FGM as necessary to raise a girl properly and prepare her for adulthood and marriage
3) The assumption that FGM reduces women's sexual desire, and thereby preserves pre marital virginity and prevents promiscuity
4) The association of FGM with ideas of cleanliness (Hygienic, aesthetic and moral); including the belief that, left uncut, the clitoris would grow excessively
5) Women's belief, in some rare cases, that FGM improves male sexual pleasure and virility and in even rarer cases, that FGM facilitates childbirth by improving a women's ability to tolerate the pain of childbirth through the pain of FGM
6) The belief that FGM is supported or mandated by religion or that it facilitates living up to religious expectations of sexual constraint.
7) The notion that FGM is an important cultural tradition that should not be questioned or stopped especially not by people from outside the community.
8) Young age is a key risk factor for undergoing FGM, with most procedures carried out on girls aged between infancy and 15 years.

9) Research also suggests that if a mother has more education, her daughter is less likely to undergo FGM. Notably, this protective effect of education has also been seen in other forms of violence against women. Research in Kenya has shown that secondary education is associated with a four fold increase in disapproval of FGM.

FGM as a Human Rights Violation:

According to Wikipedia (2014), Sudan was the first country to outlaw FGM in 1946, under the British, although there is currently no law forbidding it. The Togolese government in 1998 voted unanimously to outlaw the practice of FGM (US Deptt; 2001). Penalties ranging from a prison term of two months to ten years and a fine of 100,000 francs to one million francs (approx. US $ 160 to 1,600) are approved by the law. A person who had knowledge that the procedure was going to take place and failed to inform public authorities can be punished with one month to one year imprisonment or a fine of from 20,000 to 50,000 francs (approx. US $ 32 to 800). In July 2003, at its second Summit, The African Union adopted the Maputo Protocol promoting women's rights and calling for an end to FGM. The agreement came into force in November 2005, and by December 2008; 25 member countries had benefitted it (US Deptt, 2001). Togo ratified the Maputo Protocol in 2005 (Wikipedia 2014); and as of 2013, 18 African Countries have outlawed FGM/Cutting practice, including Benin, Burkina, Faso, Central African Republican, Chad, Cote d'Ivoire, Djibouti, Egypt, Ghana, Guinea, Kenya, Niger, Nigeria, Senegal, Somalia, Sudan, Tanzania, Togo and Uganda (Lazuta, 2013;FRS,2013).

Legal Repercussions: The Global view

Legal sanctions against FGM are the most common type of intervention at the national and international levels, but there is strong evidence that laws alone are not enough. Nevertheless, legislation creates an enabling environment for intervention at the local level, as illustrated in Ghana and Senegal. A study in the European Union found that effective implementation of laws related to FGM is associated with better knowledge including how to deal with an at risk girl, and attitudes among health care providers who are in contact with these populations.

In Uganda, anyone convicted of carrying out FGM is subject to 10 years in prison. If the life of the patient is lost during the operation, a life sentence is recommended (BBC News, 2009). Uganda signed the Maputo Protocol in 2003 but has not ratified it (UG Pulse 2008). In early July 2009, President Yomen Museveni stated that a law would be passed prohibiting the practice, with alternative livelihoods found for its practitioners (The New Vision, 2007).

In Nigeria, of the six largest ethnic groups, the Yoruba, Hausa, Fulani, Ibo, Ijaw and Kanimi, only the Fulani do not practice any form of female genital mutilation (Online News 2005).

Reasons for the increase have been attributed amongst others to the definition of FGM used, which included Type 4 FGM's. In small parts of Nigeria, the vagina walls are cut in new born girls or other traditional practitioners performed, such as the angora and gishiri cuts- which fall under Type 4 FGM Classification of the World Health Organisation (FGECD, 2011). Presenting Federal Law blaming the practice of FGM in Nigeria, although Nigeria ratified the Maputo Protocol in 2005. Perpetrators of these dastardly acts usually dare any law enforcement agent to arrest them as they go about carrying out their 'business'. These laws are being mocked by excisers who conduct FGMs, and they dare any law enforcement agent to arrest them (UN, 2009). On Jan 26th ,2015 BBC News reported the jailing of an Egyptian medical Doctor charged with manslaughter performing female genital mutilation operation on teenage girls.

Few interventions aimed at preventing FGM have undergone high quality and systematic evaluation; thus much more rigorous research is needed. A systematic review of Berg and Denison (2012) found that there was little evidence of the effectiveness of interventions to prevent FGM. The review highlights that the factors related to the continuation or discontinuation of the practice were tradition, religion and concern with reducing women's sexual desire. Conversely, health complications and lack of sexual satisfaction did not favour support of the practice.Researchers and practitioners recommend that preventive interventions include elements of community dialogue ; understanding of the importance of local rewards and punishments and a method for coordinating change among social groups that includes men and women from multiple generations within the community and related communities.Research underscores the importance of working with communities, long term investment and a focus on human rights as understood in the local context, to support collective change. A systematic review of interventions to prevent FGM, however, concluded that rights based messages showed variable results. A strong message from reviews and studies is that multicomponent interventions that combine an array of approaches are more effective than those focussed on single targets. Single issue campaigns, that is policies aimed only at persuading excisers or health care providers to change their practices, have not been successful in eliminating FGM. Similarly, single target campaigns focussed on health messages have not resulted in widespread abandonment of FGM. The components of a comprehensive, rights based strategy might include approaches focussed on reducing gender discrimination, improving social justice and supporting human rights, community development and empowerment and literacy among women and girls.

Conclusive Remarks:

The eventual, total eradication of FGM in the countries that practice it especially in the West African Sub region and Sub Sahara Africa as a whole is still much of a mirage. The enactment of appropriate laws and enforcement of sanctions may go a long way in helping to reduce the prevalence of this menace, but it will not completely eradicate it. Creation of awareness as to the obvious dangers of emanating from the practice will, in the long run, help in curbing the excesses of parents and traditionalists who obviously do

not want to do away with this barbaric custom which, from all evidence does no good but harm to the physical and psychological dignity of the female gender.