

The Case Against the Medicalization of Female Genital Mutilation

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Les mutilations génitales sont socialement et psychologiquement nocives pour les femmes. Plutôt que de les abolir, les pro-mutilatrices préfèrent médicaliser ces pratiques afin de les faire accepter légalement. Cet article réitère l'impact négatif des mutilations sur la santé des femmes et leur bien-être et examine les implications socio-économiques de cette médicalisation.

Contrary to claims by some scholars that “woman” as a category was non-existent in pre-colonial African societies (Oyewumi), historical analyses of their practices and traditions indicate otherwise. The “otherness” of woman relative to men in pre-colonial Africa is reflected still today in women’s location in traditional and religious practices. The continued practice of female genital mutilation (FGM), which emerged in Egypt and spread across the continent some two thousand years ago (Nour; Bonvillain) is among the most harmful of these traditions.

Movement activities against FGM date back to the seventeenth-century (Dorkenoo). Since then, these activities have been somewhat successful in creating awareness, both within and beyond domestic borders, of the negative socioeconomic and psychological impacts of FGM, but the process has been fraught with difficulties and the goal of eliminating FGM is yet to be realized. One of the many

obstacles facing activism against female genital mutilation today is its medicalization, which legalizes the practice and permits medical doctors to perform the procedure. This article reiterates the negative impact of FGM on women’s health and well-being and examines the socioeconomic implications of its medicalization.

The Case Against Female Genital Mutilation

Scholars and activists have for sometime now pointed out that FGM is medically, socially and psychologically harmful to women (Dorkenoo; Baashar,; Toubia; WHO 1996a; Amnesty International; Thomas 1998). It has been argued that the use of the term “female circumcision” to refer to the removal or incision of female genital organs is either a misnomer (Bettelheim) or a euphemism (Dorkenoo; Shell-Duncan and Herblund). Thus, concerns about the health hazards of this tradition generated the current, widespread use of an alternative terminology: “female genital mutilation.” In medical terms, “[a]ny definitive and irremediable removal of a healthy organ is a mutilation” (Zwang cited in Dorkenoo). According to Zwang, the external female organ “is genetically programmed and is identically reproduced in all the embryos and in all

racés...” and when normal, “there is absolutely no reason, medical, moral, or aesthetic, to suppress all or any part of these exterior genital organs.”

Female genital mutilation is generally categorized into four types, according to the parts removed or the procedure used (Walker and Parmar; Dorkenoo; WHO 2000). The first type, “circumcision” or “clitoridectomy” involves the removal of the prepuce or hood of the clitoris. The second type, “excision,” involves the partial or total removal of the clitoris and all or part of the labia minora. The third type is “infibulation.” In this procedure, the clitoris, labia minora and “at least the anterior two-thirds and often the whole of the medial part of the labia majora” (Dorkenoo 5) are partially or completely removed. The two sides of the vulva are then joined together with either adhesive substances such as eggs, sugar or acacia tar, or stitched together with thorns or silk. Flesh from the labia majora may be scraped off to enhance this process. A small passage for menstruation and urination is usually allowed. The victim’s legs are then bound together and made immobile for 40 days to allow scar tissue formation (“Female Genital Mutilation: Inter-African Committee Conference on Harmful Traditional Practices”). The fourth type, “intermediate infibulation,” entails different forms of mutilation that are

followed with different degrees of stitching. The clitoris will either be removed before stitching or left intact while the labia minora are removed.

The instruments used are rarely sterilized. Special knives and razor blades are commonly used but this varies among cultures. Some Malian tribes, for example, use saw-toothed knives while fingernails have been

Law Council; Morris; WHO 2000).

Although 90 per cent of women who experienced FGM claim not to enjoy sex, some accept the practice "... because they think sexual enjoyment is a masculine right only, and they must do everything possible to please and satisfy their husbands" (Winter 157). The research finding that some victims of the FGM believe sexual pleasure is the restricted

and Leunita Auko Muruli found that women in Northern Kenya who experience FGM are recognized as the female heads of their new households and are assigned livestock, this kind of vertical mobility is not true for many other groups of women who are affected by FGM. In Ghana, for instance, FGM affects primarily Muslim women from Upper East, Upper West and Northern Regions (Amnesty International) where poverty rates are highest (WHO 2000). They constitute approximately 15 to 30 per cent of the female population (WHO 2000; Dorkenoo; Hosken). An estimated 75 per cent of them reside in those regions (WHO 2000) while the remaining 25 per cent are migrants living in the coastal and forest areas of the southern sectors of Ghana. Wherever they reside, these women are usually very poor. Improvement in their socio-economic conditions is not a function of their genital mutilation. Further, objectification of women's bodies remains constant even in cases where their socio-economic positions are elevated. The rights of children who are not mature and knowledgeable to give consent to the mutilation of their genitalia are also abused (Nour).

The impact of the pervasiveness of these justifications is reflected in some women's relentless defense of the practice and arguments for the preservation of tradition (Walker and Parmar). Once socialized to perceive FGM as a necessary condition for women's initiation into adulthood (Patrick), mothers feel obligated to subject their daughters to FGM to ensure they remain "pure" for marriage (see "Female Genital Mutilation in Nigeria"; "Female Genital Mutilation"; Mandara).

When pitted against the impact of FGM on women's health and well-being, and the suffering victims endure, female genital mutilation does not merit any justification. Many women have lost their lives due to FGM-related complications and excessive loss of blood ("Progress Report: Women's International Net-

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used to remove the clitoris of baby girls in some parts of the Gambia (Dorkenoo). Those performing the procedure will pass their fingers through the wounds to evaluate their own work. Relations of the victim may do the same to ascertain the satisfactoriness of the operation. Sometimes, the nails of those performing the procedure are extremely filthy, as Alice Walker observed in a mass mutilation process in the Gambia (cited in Walker and Parmar). The victims do not receive anesthesia prior to the operation. Their two hands are usually held down.

Patriarchal Justifications for FGM and the Impact on Women's Health and Well-Being

The higher prevalence of female genital mutilation in rural areas, where women have limited access to economic resources and reproductive rights (Dorkenoo; Assan), attests to the effectiveness of pervasive, yet unsubstantiated patriarchal justifications for FGM. These "justifications" primarily defend male dominance over women and the subjugation of women as objects for men's sexual gratification. Others defend the practice as a religious obligation (Dorkenoo and Elworthy; Family

right of men (hence the need to remove women's clitoris) (RACOG 1997) has been questioned by "anti-mutilationists" who argue that "incorporation of female genital cutting procedures in the biomedical healthcare system institutionalizes the custom and counteracts efforts to eliminate the practice of female circumcision" (Shell-Duncan, Obiero and Muruli 111).

Some FGM advocates argue that it improves the health conditions of circumcised women. This is, however, unfounded (Dorkenoo and Elworthy 1994; Mandara, Mackie). Indeed, in a recent study, Mairo Usman Mandara discovered in interviews with medical doctors in Nigeria that 80 per cent of them did not believe in any medical benefits to women of female "circumcision" or female genital mutilation.

Others justify the practice by arguing it protects a woman's virginity, and reduces her sexual urges, thus boosting a woman's level of marriageability (WHO 1996b; Dorkenoo and Elworthy; Family Law Council; Morris). Yet, a woman's economic "worth" after FGM is hardly enhanced, nor does it place them at par, socio-politically, with men! While researchers, Bettina Shell-Duncan, Walter Obungu Obiero,

work Grassroots Campaigns to Stop FGM"; Shell-Duncan and Hernlund; Jones, Smith, Kieke and Wilcox; Center for Reproductive Rights). Mutilated women find it difficult to get pregnant and, when they do, they stand a higher risk of miscarriage (Balk). Complications during pregnancies, child defects, and the high incidence of child and maternal mortality that result from genital mutilations have been well documented ("Female Genital Mutilation in Nigeria"; Shell-Duncan and Hernlund; Mandara). Efua Dorkenoo recalls when as a student-obstetrician in the UK, a chance encounter with a pregnant victim of FGM ignited her academic interest in the subject. The pregnant woman had undergone a radical form of infibulation and had sustained a mass scar tissue around her genitalia. The opening left was not big enough for delivery. "This threw the midwives and obstetricians into panic" (2) because they were not familiar with this tradition and had never been trained or equipped with the necessary skills to handle it.

I. M. Thomas also recounts her frequent encounter with gynecological complications associated with FGM. These complications include haematodolpos, acute or chronic urinary infections with retention of urine, painful menstruation, painful intercourse, inability to consummate marriage, and obstructed labour with impacted head at the perineum. A research study among Ugandan women who had been mutilated indicates that 76 per cent of them suffered chronic sexually transmitted infections (STIs), hemorrhage, and "sustained tears after every birth," all of which make them more susceptible to HIV and other forms of sexually transmitted diseases ("Female Genital Mutilation").

Evidence also exists to support assertions that FGM has a psychological impact (Baashar; Toubia; WHO 1996a). Girls may experience disturbances in sleep patterns, mood, and cognitive responses. Such difficulties extend into adulthood with "feelings

of incompleteness, loss of self-esteem, depression, chronic anxiety, phobia, panic or even psychotic disorders" (Patrick: 17). Other reports identify attitude toward sexual relations as a possible parameter for measuring this psychological effect in FGM victims. According to Thomas, women who have experienced genital mutilations stand a higher risk of painful sexual intercourse and frigidity. Research

when Christian missionaries called for its ban in some parts of Africa (Dorkenoo). The British colonial administration, in a joint effort with some Sudanese professionals and religious bodies, also made additional attempts to ban the practice in the 1940s (Dorkenoo). Scholars delineate some of the factors that impeded early activism against FGM as the lack of proximity to reference groups,

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conducted in the Sudan indicated that 91 per cent of newly-married women had negative experiences in their sexual life, and 82 per cent indicated negative attitudes toward sexual intercourse with their husbands ("Female Genital Mutilation in Nigeria"). According to this same report, 72 per cent of the male respondents complained about their wives' negative attitudes to sex because of acute health complications that resulted from FGM. This creates another problem for the women. Cultures practicing the FGM generally abhor women who refuse to undergo the procedure (Female Genital Mutilation in Nigeria). However, husbands of women who have experienced FGM usually resort to sexual promiscuity with "uncircumcised" women (Female Genital Mutilation in Nigeria). As Thomas suggests, genitally mutilated women suffer the additional indirect consequence of male infidelity and its associated higher risk of STIs.

Is Patriarchy Prevailing Through Medicalized FGM?

Patriarchal ideologies thwart the fight against this harmful practice. As stated earlier, the fight against FGM began in the seventeenth century

the level of intensity of patriarchal values, resource accessibility, observation of cultural relativism, and the group's perception of movement efforts by external agencies (Buechler; McAdam) as some of the factors that impeded early activism against FGM. The fight continues today.

Literature abounds on current efforts by local and international non-governmental and governmental organizations to secure women against female genital mutilation ("Progress Report: Women's International Network Grassroots Campaigns to Stop FGM"; Shell-Duncan and Hernlund; Thomas 2000). These efforts have been burdened with problems such as those indicated above. But the most recent obstacle is the medicalization of FGM that will allow physicians to legally perform FGM or "defibulation" (the opening of the tightly stitched vulva) in hospitals (Nour). While legalizing defibulation might be seen as a step forward, anti-mutilation activists vehemently oppose the legalization of FGM in hospitals (Shell-Duncan, Obiero and Muruli). Medicalizing FGM not only nullifies earlier struggles by concealing the general, and fallacious, rationale behind the practice, it also denies the negative social, physical and psychological impact

on the lives of women.

While laws prohibiting FGM exist in most industrialized nations (Center for Reproductive Rights), FGM is practiced in Europe and North America among immigrant communities whose cultures of origin favour the procedure although no reliable statistics are available (Center for Reproductive Rights; Dorkenoo; "Austria: Conference of Prevention and Elimination of FGM"; Jones *et al.*; Shell-Duncan and Hernlund; Patrick). The practice has been medicalized in the United States where the procedure can be performed legally on a woman who is at least 19 years old and who gives informed consent (Nour). In Canada however, article 268 of the *Canadian Criminal Code* defines female genital mutilation as an aggravated assault and thus outlaws excision, infibulation or mutilation of the female genitalia (Inter-Parliamentary Union; Amnesty International; Female Genital Cutting and Education and Networking Project). In addition, provincial organizations such as the FGM Prevention Task Force in Ontario have initiated other steps to further assist in the protection of immigrant women and children from FGM (Ontario Human Rights Commission). The Task Force is an inter-organizational initiative mandated by the Minister Responsible for Women's Issues to develop and recommend strategies and policies that would provide support to women and girls who have experienced FGM. Furthermore, the College of Physicians and Surgeons of Ontario has advised its members not to perform the procedure on women and children (College of Physicians and Surgeons of Ontario).

While some might argue that medicalizing FGM ensures that the procedure would be performed under controlled, sterile conditions, in poor rural regions where the incidence of FGM is highest, medicalized FGM would remain inaccessible to many victims. The poor would continue to resort to the use of hazardous

traditional instruments, jeopardizing women and girls' health while subjecting them to the patriarchal ideologies embedded in the practice. Shell-Duncan *et al.* call on scholars to assess the role that medicalization plays in anti-FGM efforts. While legalizing FGM could be seen as a step forward—at the very least helping to reduce health hazards among the victims—women's poor economic status make the potential benefits remarkably remote and its harmful effects on women's and girls' well-being would in no way be diminished.

Conclusion

Anti-FGM activists have been successful, to some extent, in creating awareness across the globe of its existence and hazards. While this has increased interest in research and campaigns against the practice, there is much more that needs to be done. From a constructionist perspective, the movement against FGM requires an understanding of the meanings that the victims attach to their collective actions. The use of traditional birth attendants and parents who pledge to abandon the procedure as local reference groups in anti-FGM campaigns is thus indispensable. It is against such groups that individuals evaluate or compare themselves. Comparisons with reference groups could cause the relatively less privileged to either initiate or embrace change (McAdam; Buechler). They bridge the academic and cultural gap between foreign activists and potential victims. The literature indicates this approach has been successful in some West African villages (Mackie). However, this strategy would be even more effective if high-ranking native scholars, rather than obscuring pre-colonial patriarchal relationships, participated in this fight. The victims might find it easier to relate to local scholars or activists. Such scholars also stand a better chance of communicating with the victims than foreigners, defying Charles Louis

Montesquieu's (Levine) commendation of the foreigner as being better positioned to understand actors and their actions. Rather than denying evidence of the pre-colonial African woman's position as an "objectified other," or denigrating western efforts to help eliminate FGM, it is time that women in general oppose its practice by any means.

Mairo Usman Mandara conducted research on 250 Nigerian doctors to examine their attitudes toward and views on "female genital cutting" (FGC), as she preferred to call it. Findings showed that 20 per cent of the respondents supported the practice. These supporters argued that if the tradition could not be abolished then women were better off with a medicalized FGC. Nevertheless, the same research showed that 80 per cent of the doctors interviewed declared that "performing the procedure could be equated to a malpractice" because women do not derive any benefits from "circumcision" (105). Yet, some of the respondents in Mandara's research considered the fight against FGM trivial because "...hundreds and thousands of men, women and children are dying of malnutrition, communicable diseases, malaria..." (104). According to these respondents, international NGOs' campaigns against this practice are a waste of limited resources. Medicalization of FGM does not invalidate the problems of women's disadvantaged positions. Even if FGM is permitted in hospitals, it is certain that resources will not be sacrificed on disadvantaged poor women for such procedures. But, if an estimated majority of medical doctors in a country where the incidence of female genital mutilation is considered high believe it is "malpractice" to medicalize the procedure (Mandara),¹ then the least that we can do as scholars is to reject FGM in its entirety and focus on promoting the advancement of women's socio-economic status and improving their overall physical and psychological health and well-being.

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