Kyoko Nakamura · Kaori Miyachi ·
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Female Genital Mutilation/ Cutting

Global Zero Tolerance Policy and Diverse Responses from African and Asian Local Communities

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Editors
Kyoko Nakamura
Faculty of Global and Regional Studies
Toyo University
Tokyo, Japan

Kaori Miyachi
Faculty of Education
Saga University
Saga, Japan

Yukio Miyawaki
Graduate School of Sustainable System Sciences
Osaka Metropolitan University
Osaka, Japan

Makiko Toda
Faculty of Contemporary Society
Kyoto Women's University
Kyoto, Japan

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Preface

This book originates from the Female Genital Mutilation/Cutting (FGM/C) Study Group launched by the editors in 2017. The members of the group are cultural anthropologists and political scientists, based in Japan, who study Africa from diverse perspectives, including gender, reproductive health rights, community development, life course, religion, and politics. The study was funded by several grants, including the Grant-in-Aid for Scientific Research (C), "Ethnographical Study on FC, FGM/C: Choices on Life Course and Social Status of African Women (FY2015–2018)" and the Grant-in-Aid for Scientific Research (S) "'African Potential' and Overcoming the Difficulties in the Modern World: Comprehensive Area Studies that will Provide a New Perspective for the Future of Humanity (FY 2016–2020)."

In the study group, each member has shared and discussed what they had learned in the field. At the 55th Annual Meeting of the Japan Association for African Studies held at Hokkaido University in May 2018, the group organized a forum, namely Female Genital Mutilation/Cutting and Diversity of Local Societies, to report the results of the discussion.

After this forum, the study group continued, with assistance from the Grant-in-Aid for Challenging Exploratory Research, "Interdisciplinary Research on Abolition of FGM: From 'Zero Tolerance' to 'Adaptive Governance.'" Members collected current local data through fieldwork and shared it with the study group to enrich the discussion.

The FGM/C Study Group has also actively engaged in discussions with invited international scholars who have interdisciplinary perspectives. In November 2017, it co-hosted a special seminar, "Gender Justice and Religion in Sub-Saharan Africa: The Case of Female Genital Mutilation" organized by the research project "Perspectives of Umesao Studies" at the Institute for Research in the Humanities, Kyoto University, Kyoto, Japan. In 2018, it organized the international workshop "Female Genital Mutilation in Malaysia" with the Center for Women's Studies at Osaka Prefecture University. In 2019, it organized the international workshop "Reconsidering FGM/C: Challenges from Medical and Anthropological Perspective" at Toyo University. Furthermore, in 2018, 2019, and 2020, members had the opportunity to

discuss FGM/C with Asian Studies scholars in a panel session at the Asia Pacific Conference hosted by Ritsumeikan Asia Pacific University.

These opportunities have allowed us to have interdisciplinary discussions with researchers from different countries and in various fields, many of whom have contributed to this book. They are Assoc. Prof. Getaneh Mehari (Addis Ababa University) who presents the case of the Somali Community in Ethiopia; Prof. Rogaia Mustafa Abusharaf (SFSQ, Georgetown University), a world pioneer in FGM/C research; Clinical Assoc. Prof. Nesrin Varol (University of Sydney) who shares the current situation in Australia from a medical viewpoint; Prof. Abdul Rashid (RCSI and UCD Malaysia Campus) who also presents the case from a medical viewpoint; and Prof. Yufu Iguchi (Ritsumeikan Asia Pacific University) who specializes in Malaysian studies.

Some results of the study group were first published in a Japanese book, *Global Discourse and Women's Bodies: Female Genital Mutilation/Cutting and Local Diversities in Africa*, by Koyo Shobo in 2021. It was made possible by a publication grant from Kyoto Women's University. We express our appreciation to Mr. Kiyoyasu Marui, Koyo Shobo, who supported the publishing and editing it and encouraged us to publish this book.

This book is the result of strengthening the Japanese book by reconsidering FGM/C from a broader interdisciplinary perspective, with comparative research on the FGM/C situation not only in Africa but also in Asia and Australia. We express our sincere gratitude to all of the researchers who discussed this issue in our study group and to all of those who provided financial support. We are also deeply grateful to Ms. Juno Kawakami, a senior editor at Springer, for her kind guidance and tireless support.

Although many strong FGM-elimination projects are currently underway, little is known about the realities of local societies and individuals. This book has the academic significance of portraying how the current situation of FGM/C is becoming increasingly diverse, politicized, and complex. Another feature of this book is that it considers the issue from a broad perspective, including the little-known practice of FGM/C in Asia, infant male circumcision as a potentially "neglected" sexual health and rights issue, and cases of African immigrant and refugee women who have migrated to Australia.

Finally, we express our deepest gratitude to all those who generously cooperated with our research on the extremely sensitive topic of FGM/C in the context of sexuality and politics. Without their trust, the research would not have been possible.

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Editors and Contributors

About the Editors

Kyoko Nakamura, Ph.D. is a professor of African area studies and cultural anthropology at Toyo University, Japan. She has been conducting research among pastoral communities in Kenya. Her research interests are age systems and life-course changes, women's social-status changes, tourism and culture, and body adornments and beads. Her major publications include "Life Story as a Tourism Commodity among the Kenyan 'Maasai,'" *Global-E* 12 12 (2019); "Local Recognition is Alienated from Global Discourse: Changes in Female Genital Mutilation/Cutting (FGM/C) in a Kenyan Pastoral Community," in T. Ochiai, M. Hirano-Nomoto, and D. E. Agbiboa, eds., People, Predicaments and Potentials in Africa (Bamenda: LANGAA Research and Publishing Common Interest Group, in collaboration with the Center for African Studies, Kyoto University, 2021).

Kaori Miyachi is a visiting researcher at Saga University, Japan, and an advanced social researcher certificated by the Japanese Association for Social Research. She studied at the graduate school of social anthropology at Tokyo Metropolitan University (MA and Ph.D. courses) in Japan and got MA in anthropology of development at University of Sussex in UK. She has conducted research on gender, aging, and reproductive health issues, mainly in Kenya and Japan, and has participated in several international programs in developing countries (NGOs, UN, and JICA). She has experiences of teaching at several universities, including Nagasaki University, Saga University, and Ritsumeikan Asia Pacific University. Her recent publications include "A Preparatory Study of Care for Elderly Women in Rural Kenya," *Arxiu d'Etnografia de Catalunya*, no. 22 (2021): 127–46.

Yukio Miyawaki, Ph.D. is a professor of area studies and cultural anthropology at the Graduate School of Sustainable System Sciences, Osaka Metropolitan University, Japan. He has been studying agro-pastoral societies in Ethiopia, focusing on their natural-resource utilization, historical memories, and the effects of agricultural

development projects on these societies. Recent publications are "The Interethnic Relationship Between the Hor and Ts'amako," in Echi Christina Gabbert and Sophia Thubauville, eds., *To Live with Others. Essays on Cultural Neighborhood in Southern Ethiopia* (Cologne: Rüdiger Köppe, 2010), and "Development of Community-Based Organization by Agro-Pastoral Women: A Case in Southwestern Ethiopia," Nilo-Ethiopian Studies 23 (2018): 1–22.

Makiko Toda, Ph.D. is a professor of comparative politics and international relations at Kyoto Women's University, Japan. She studies ethnic relations, political systems, and gender issues in Africa, especially in Nigeria, Kenya, and Rwanda. She earned an MA in West African Studies from Centre of West African Studies, University of Birmingham. She is the author of three books and many articles, including *Politics in Africa* (rev. ed., Tokyo: Ochanomizu Shobo, 2013; in Japanese); *Poverty, Conflict, and Gender: Comparative Politics for African Studies* (Kyoto: Koyo Shobo, 2015; in Japanese). She is the editor and co-editor of seven books, including *Understanding Global Society* (rev. ed., Kyoto: Koyo Shobo, 2019; in Japanese).

Contributors

Rogaia Mustafa Abusharaf SFSQ, Georgetown University, Doha, Qatar

Siti Nur Afiqah Unit of Research On Women and Gender, School of Social Sciences, Universiti Sains Malaysia, Penang, Malaysia

Manami Hayashi Research Fellow of Japan Society for the Promotion of Science/Osaka Metropolitan University, Osaka, Japan

Yuko Higashi Graduate School of Sustainable System Sciences, Osaka Metropolitan University, Osaka, Japan

Yufu Iguchi College of Asia Pacific Studies, Ritsumeikan Asia Pacific University, Oita, Japan

Getaneh Mehari Department of Social Anthropology, College of Social Sciences, Addis Ababa University, Addis Ababa, Ethiopia

Kaori Miyachi Faculty of Education, Saga University, Saga, Japan

Yukio Miyawaki Graduate School of Sustainable System Sciences, Osaka Metropolitan University, Osaka, Japan

Kyoko Nakamura Department of Regional Development Studies, Faculty of Global and Regional Studies, Toyo University, Tokyo, Japan

Abdul Rashid Department of Public Health Medicine, RCSI & UCD Malaysia Campus, Penang, Malaysia

Makiko Toda Faculty of Contemporary Society, Kyoto Women's University, Kyoto, Japan

Nesrin Varol Discipline of Obstetrics, Gynaecology and Neonatology, Sydney Medical School, University of Sydney, Sydney, Australia

Chapter 1
Introduction

Kyoko Nakamura

1.1 WHO Definition and Classification

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

K. Nakamura (✉)
Department of Regional Development Studies, Faculty of Global and Regional Studies, Toyo University, Tokyo, Japan
e-mail: nakamura064@toyo.jp

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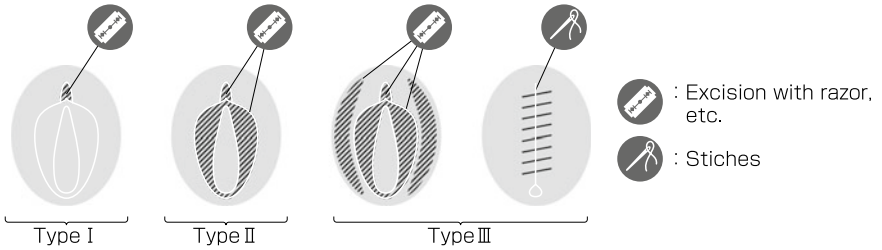

Fig. 1.1 Type I, II, III of the female genital mutilation/cutting (Grun 2015; modified by author)

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).

1.2 Terminology

There are numerous terms for "female circumcision" or "female genital mutilation" in English, such as female genital cutting, female genital mutilation/cutting, female genital surgery, female genital modification, and so on. The diversity of terminology indicates the complexity of the problems related to this procedure. The term used to describe the issue reflects the position or context in which the issue is being discussed. We need to pay attention to how the term is used to understand the politics and principles surrounding this issue.

In many societies which practice or have practiced this procedure, the same word is used for male and female circumcision (Abusharaf 2006; UNICEF 2013: 6–7). For example, the Arabic word *khtan*, Somali word *gudniinka*, Kikuyu word *irua*, Maasai word *emurata*, and Samburu word *muratare* are used for both male and female circumcision. Colonial missionaries and colonial governments also used the English word "circumcision." 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

[1] The subdivisions of the four typologies are defined as follows (WHO 2008). Type Ia, removal of the clitoral hood or prepuce only; Type Ib, removal of the clitoris with the prepuce. Type IIa, removal of the labia minora only; Type IIb, partial or total removal of the clitoris and the labia minora; Type IIc, partial or total removal of the clitoris, the labia minora, and the labia majora. Type IIIa: removal and apposition of the labia minora; Type IIIb: removal and apposition of the labia majora. The WHO (2018) also provides detailed illustrations showing the parts of the procedure.

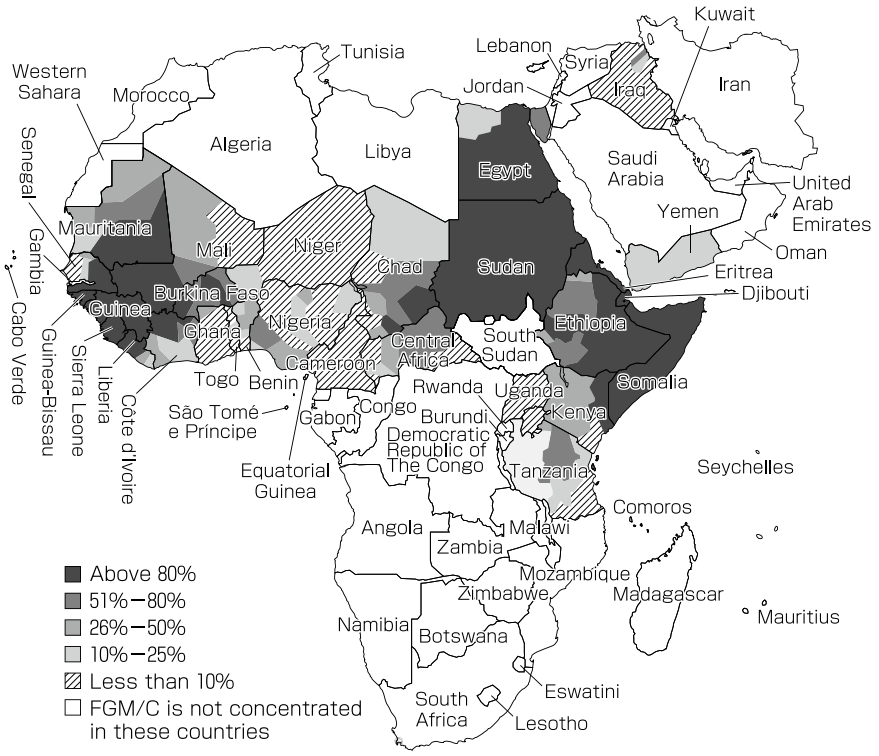

Fig. 1.2 Countries and their practice rates of female genital mutilation/cutting in Africa and the Middle East (%) (UNICEF 2013; modified by author)

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 [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).

In its 2013 report, UNICEF explained the background of its adoption of this hybrid terminology in view of the risk of "demonizing cultures under cover of condemning practices harmful to women and the girl child" (2013: 7). It noted that UNICEF

and the United Nations Population Fund (UNFPA) use the hybrid term in consideration for the significance of the term "mutilation" at the policy level, and, at the same time, to acknowledge that the practice is a violation of the rights of girls and women. As such, it recognizes the importance of employing respectful terminology when working with practicing communities (UNICEF 2013: 7). Subsequently, many individuals and organizations have begun to use the term "FGM/C." However, UN agencies often use the term "FGM" as a "tool" to advocate for the abolition of this practice. Since the UN General Assembly adopted a resolution to eradicate FGM in 2012, many individuals and organizations have begun to use the term again in the context of a stronger campaign for abolition. In the chapters of this book, each author has chosen the term that they think is most appropriate in their context. In this introduction, the hybrid term "FGM/C" is mainly used in consideration for both practicing community members and abolitionists.

1.3 The Abolition Movement and Politics and Economics in Western Societies

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

1.4 Enactment of Prohibition Laws and Local Reactions

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.

1.5 Zero Tolerance and the UN Ban on "Medicalization"

The focus of the early abolition movement against FGM/C was its health hazards. The WHO report on health hazards had a strong impact and moved people to support abolition. Gradually, UN agencies shifted their focus from "physical" and "medical" reasons to "human rights" and "ethics."

The WHO (2010) clearly stated that the "medicalization" of FGM would be detrimental to the elimination of it. Here, "medicalization" refers to operations conducted

Table 1.1 Countries with FGM/C prohibition laws and the years in which they were enacted (UNICEF 2013; modified by author)

Name of the country	Year of the enactment
Benin	2003
Burkina Faso	1996
Central African Republic	1966, 1996[a]
Chad	2003
Côte d'Ivoire	1998
Djibouti	1995, 2009[a]
Egypt	2008
Eritrea	2007
Ethiopia	2004
Ghana	1994, 2007[a]
Guinea	1965, 2000[a]
Guinea-Bissau	2011
Iraq (Kurdistan region)	2011
Kenya	2001, 2011[a]
Mauritania	2005
Niger	2003
Nigeria	1999–2006, 2015[b]
Senegal	1999
Somalia	2012
Sudan	2008–2009, 2020[b]
Togo	1998
Uganda	2010
United Republic of Tanzania	1998
Yemen	2001

[a]Later dates reflect amendments to the original law or new laws
[b]Expanded from some states to the whole country

by medical professionals.[2] For example, 38% of procedures in Egypt, 67% in Sudan, and 15% in Kenya are reported to be "medicalized" (Kimani and Shell-Duncan 2018: 26). 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

[2] In general, "medicalization" refers to the process by which a non-medical problem in society is gradually defined as a "disease" and becomes a target for prevention and treatment. However, with respect to FGM/C, medicalization is defined as the practice of FGM/C by health care providers in public or private health care institutions, homes, or any other place (WHO 2010: 2).

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 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). The chapters in this book provide examples to further this discussion.

1.6 Chapter Contents

In Chap. 2, Toda begins with an overview of the efforts and achievements thus far by the international and African communities with regard to the abolition of FGM/C. She then examines why "zero tolerance" has not been successful and points out the deep-rooted values of patriarchal societies in Africa. She explains the usefulness of the "positive-deviance approach," which involves finding a small number of successful cases and expanding the activities from within the community to the outside of the community. This approach is characterized by the fact that it is the insiders (and not outsiders) who facilitate change, unlike the top-down "zero tolerance" approach. Toda also raises the issue of "women living in a patriarchal society" and warns against the easy othering of this issue, using El Saadawi's term "victims of psychological and cultural clitoridectomy" (El Saadawi 2015).

In Chap. 3, Miyawaki takes the example of a small community in a peripheral Ethiopian district. He examines how the global idea of banning FGC was distorted as it reached the local grassroots community. The case clarifies how the straightforward enforcement of abolition can bring about conflicts. Miyawaki points out that FGC is embedded in societies not uniformly, but in various ways depending on each society. If the abolition of FGC is intended to empower women and to improve the social conditions in which they live, it is necessary to look for an approach that is localized for each society, particularly when FGC is accepted by inhabitants.

Chapter 4 is based on field research in a Somali community in Ethiopia. Mehari reveals the reality of the rapid transition from Type III (infibulation) to type I (sunna) in the region and the transformation of people's attitudes behind this transition. Local FGM intervention actors such as religious leaders, community leaders, health extension workers and schoolteachers play an important role in the transformation of people's consciousness. Their persuasion has led to widespread awareness of the health hazards of infibulation. Mehari especially points out the dual influence of

religious leaders who, while supporting the abandonment of infibulation, encourage sunna circumcision as a religious obligation.

In Chap. 5, Miyachi uses statistical data to discuss the changes surrounding female circumcision in the Gusii community in Kenya over the past two decades which have been a time of drastic change in the Gusii community—a society that was suddenly opened to the world through cell phones, the internet, migrant workers. However, Miyachi wonders why the campaign to abolish FGC has not been as successful as expected. People have become aware of the health risks of the procedure, but at the same time its significance as a rite of passage has been maintained. She also points out that a shift to medicalization had already occurred 20 years ago in the Gusii community, but the enactment of Kenya's prohibition law concealed the practice. She highlights the possibility that the zero tolerance approach has pushed the procedure underground, and because of that, girls' health may be at risk.

In Chap. 6, Nakamura raises awareness of the problem that members of the abolitionist movement may have an overly fixed view of the women of local communities where FGM/C is practiced, as "victims deprived of their autonomy." In order to break this stereotype, she describes the reaction of the local community to the abolition movement by incorporating the narratives of the locals as much as possible. This ethnographic description reveals that even within a single community with a common cultural background, the parties involved are diverse and flexible to change. She also mentions that community fragmentation and negative feelings emerge as a result of the very powerful top-down approach of the abolitionist movement.

In Chap. 7, Hayashi also reports on a Kenyan case, focusing on the Maasai women's grassroots abolition movement. She describes the typical programs of the abolition project, including the establishment of rescue centers and the implementation of alternative rites of passage (known as ARP) and examines their effectiveness.

Most of the FGM/C practice occurs in Africa and in the Middle East, but it is also prevalent among the Muslim communities in Southeast Asia, including Malaysia, Thailand, Singapore, Brunei, Philippines and Indonesia. However, there is scarcity of information related to its practice in this region. In Chap. 8, Rashid, Iguchi and Afiqah introduce the case of Malaysia. In Chap. 9 they discuss FGC in Malaysia from the aspect of medical control over the human body by using the theoretical framework of Michel Foucault's "medical gaze". They reveal that local people had initially thought that FGC functioned as a mark of religious identity, but they eventually came to adopt the same medical gaze as that of the European ideology of their colonizers. They point out Malaysian case provides an interesting example of a site of negotiation between the local traditional views of FGC based on custom or religion, and global discourses on FGC.

In Chap. 10, Varol discusses the importance of high-quality healthcare and expertise in FGM management in the context of Australia. Australia received 100,000 migrants and refugees from Sub-Saharan Africa between 2011 and 2019, many from countries with high FGM prevalence rates. Varol discusses the problems and ramifications faced by women with FGM in developed countries which lack the adequate expertise and referral pathways for issues relating to their FGM. She holds that

Australia can play a leading role in protecting these children and women. Further, she points out the commanding role migration plays as a catalyst for the abandonment of FGM, suggesting that, were developed countries to collaborate on research, training and prevention programs, they could make a significant contribution.

In Chap. 11, Higashi examines the lack of interrogation around the issue of male genital cutting. While global discourse has highlighted the injustices of FGM, it has, at the same time, remained largely silent on human rights with regard to medically unnecessary male genital cutting (male circumcision) in the absence of informed consent. Higashi asserts that this double standard should be addressed and argues for the protection of the rights of all infants and young children to grow to an age where they can make their own informed decisions. Pertinent parallels are drawn between male circumcision (without consent) and the rights infringements of sex-normalizing medical procedures employed on intersex infants and children.

In Chap. 12, in response to the editors' questions Abusharaf discusses the feminist movement in Sudan. After describing the feminist movement in Sudan in comparison to that in the West, she concludes that the international campaign can frame its efforts with the community activists who are aware of the local conditions and are working diligently to address elimination efforts.

None of the chapters in this book intends to give readers "the right answers" on how to understand and act on FGM. Rather, they attempt to present the diversity of local societies where FGM is practiced, the diversity of individuals within those societies, and the diversity of approaches to the problem, while being skeptical about the idea that there is one "right" answer. This is because each of the authors has witnessed in their fieldwork that the "zero tolerance" approach, which excludes diversity, has not worked well.

Using this book as a guide will enable readers to understand how the bodies of African women living in the same era are governed through the complex intertwining of politics, economics, society, culture, and religion. Readers will find themselves within the global discourse as they unravel a tangle of unexpected situations: conflicts of interest, the exercise of power and resistance, escape, concealment, bargaining, and the dichotomies that arise as the global discourse becomes increasingly powerful. I hope that this book will provide an opportunity for us to think about FGM/C not merely as a problem faced by distant "others" in Africa and Asia, but as one for all of us living in a global society.

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Kyoko Nakamura, Ph.D. is a professor of African area studies and cultural anthropology at Toyo University, Japan. She has been conducting research among pastoral communities in Kenya. Her research interests are age systems and life-course changes, women's social-status changes, tourism and culture, and body adornments and beads. Her major publications include "Life Story as a Tourism Commodity among the Kenyan 'Maasai,'" *Global-E* 12 12 (2019); "Local Recognition is Alienated from Global Discourse: Changes in Female Genital Mutilation/Cutting (FGM/C) in a Kenyan Pastoral Community," in T. Ochiai, M. Hirano-Nomoto and D. E. Agbiboa, eds., *People, Predicaments and Potentials in Africa* (Bamenda: LANGAA Research & Publishing Common Interest Group, in collaboration with the Center for African Studies, Kyoto University, 2021).

Chapter 2
Global Discourse and the Patriarchal Norms of FGM: Beyond the Zero Tolerance Policy

Makiko Toda

2.1 Introduction

This chapter considers effective ways to abolish female genital mutilation (FGM), sometimes called 'cutting'. As shown in Sect. 2.2, the international community has been trying to end this practice for over 60 years since 1952. Although FGM rates among African children under the age of 15 years have declined dramatically over the past two decades, FGM is still prevalent in some communities.

Before discussing the principal arguments, I briefly outline the concept of FGM in the context of cultural relativism and local diversity in Africa.

2.1.1 FGM and Cultural Relativism

In some situations, people who tolerate FGM give the following responses to any critique of its practice: 'Are you aware of its cultural relativism?' or 'Don't you think we, developed countries, must respect FGM as a part of African culture?'.

They, 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 has been principally practiced on girls under the age of 18, who do not understand the risks of FGM and are unable to

M. Toda (✉)
Faculty of Contemporary Society, Kyoto Women's University, Kyoto, Japan
e-mail: toda@kyoto-wu.ac.jp

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provide informed consent.[1] Regardless of the severity of its forms, FGM may cause psychological trauma stemming from pain, shock, and the use of physical force by those performing the procedure. Many women have described FGM—even type I, that is, clitoridectomy, or what may be called the Sunna style—as a traumatic event, which poses a sustained threat to their safety, even in adulthood.[2]

In areas where type III FGM (infibulation) is common, medical staff whom I interviewed are well aware of the problems it causes before and during pregnancy.[3] 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 societies in Africa, FGM has been used to make men masters of female sexual function, and historically, to reinforce the idea that wives are their husbands' property, as is typical of patriarchal societies. 'To counter deeply rooted gender-based discrimination that often results from patriarchal attitudes and related social norms'[4] is required to achieve Goal 5 of the Sustainable Development Goals (SDGs), that 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 it needs to dismiss the opinion of cultural relativists. Practices like FGM, Sati and foot binding etc., that kill or potentially kill women and girls, should not be termed 'culture'.

2.1.2 Local Diversity in Africa

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 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

[1] Therefore, this chapter does not discuss women over 18 years old who understand the risks of FGM, and consent to the practice. Chapter 10 shows the physical, psychological, and sexual complications caused by FGM.

[2] While many researchers point out that type II and type III FGM have negative effects on health and other aspects of well-being, little quantitative research has shown negative effects of type I FGM. Köbach et al. (2018) suggests that 'women who endured FGM I during their first year of life' show the psychological sequelae. Further, the narratives of women who have been cut compensate for the lack of the quantitative data on the negative effects of type I FGM. The narratives insist that even type I elicits severe psychological trauma. Reconstructive surgery after women have experienced FGM (Griffin and Jordal (eds) 2019) suggests severe psychological trauma.

[3] Time and place of the interview is not shown in this chapter to ensure the safety of interviewee.

[4] 'Achieving gender equality and the empowerment of women and girls will require more vigorous efforts, including legal frameworks, to counter deeply rooted gender-based discrimination that often results from patriarchal attitudes and related social norms' (United Nations Statistics Division 2021b).

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* (2014 KDHS; KNBS 2015), actively request FGM (see Chap. 5). While girls in the Somali community, where prevalence rates of FGM are the highest in Kenya (KNBS 2015: 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.

2.1.3 The Aim of This Chapter

As explained above, it is natural for the international community to adopt a zero tolerance policy towards FGM because of its potential to cause serious medical complications and its role in perpetuating patriarchal values. While the decrease in FGM rates and changes in its common forms are considered great achievements by the zero tolerance policy, FGM has not been completely abolished. Why do people continue to practice FGM? Further, is the zero tolerance policy effective in the abolishment of FGM? To answer these questions, this chapter focuses on three topics.

1. Zero tolerance policy in the international community.
2. Zero tolerance policy in Kenya, and FGM in the Somali community.
3. Ways of abolishing FGM beyond the zero tolerance approach.

[5] A former practitioner of FGM described the age at which FGM was carried out in a 2019 news article (Ryan 2019). UNFPA showed FGM is performed between the age of 5 and 8 (UNFPA 2010). The 2014 KDHS showed different ages (see Sect. 3.2).

2.2 Zero Tolerance Policy in the International Community

Why must we abolish all forms of FGM? As already mentioned, even mild FGM (type I) can cause psychological trauma, which can threaten safety in adulthood. Furthermore, FGM is the product of a patriarchal system, and thus an obstacle to achieving Goal 5 of the SDGs.

2.2.1 Efforts of the International Community

The international community has made significant efforts to abolish FGM (Table 2.1). The seminar on 'Harmful Traditional Practices Affecting the Health of Women and Children' was held in Khartoum, Sudan in 1979, where, in addition to the presentation by F. Hosken, reports of several countries practicing FGM (Egypt, Ethiopia, Kenya, Nigeria, Somalia, Sudan, and so on) were presented by other speakers showing the details of the zero tolerance policy. The discussion and recommendations back then were quite similar to the ones currently being held.

The seminar did not question all the traditional practices. In fact, one of the participants classified traditional practices into three categories: harmful, harmless, and useful. The recommendations of this seminar 'were proposed in support of useful practices and to abolish harmful ones. Special recommendations were made to correct harmful practices and to replace them with positive actions to promote better health'.

Given that FGM[6] was classified as a harmful practice, four recommendations were made in this seminar:

(i) Adoption of clear national policies to abolish female circumcision
(ii) Establishment of national commissions to coordinate and follow up the activities of the bodies involved, including, where appropriate, the enactment of legislation prohibiting female circumcision
(iii) Intensification of general education of the public, including health education at all levels, with special emphasis on the dangers and the undesirability of female circumcision
(iv) Intensification of education programmes for traditional birth attendants, midwives, healers, and other practitioners of traditional medicine, to demonstrate the harmful effects of female circumcision, with a view to enlisting their support along with general efforts to abolish this practice.

The seminar presented the reasons for carrying out FGM as follows:

- Initiation into 'adulthood'
- Proof of virginity before marriage
- Proof of virginity related to the payment of bride price
- To reduce sexual desire in the girl and to protect the young girl from promiscuity.

[6] In this seminar, the term 'female circumcision' was used instead of FGM.

Table 2.1 International, regional, and local efforts to end FGM (from 1952 to 2015, adoption of SDGs)

Year	Organiser	Main event/results
1952	UNCHR	UNCHR adopted a resolution (UNICEF 2005: vii)
1958	ECOSOC	ECOSOC invited WHO to study the persistence of customs subjecting girls to ritual operations[a] and to communicate the results of the study to the Commission on the Status of Women (ECOSOC 1958: 18)
1961	ECOSOC	ECOSOC invited WHO to study the medical aspects of operations based on customs[b] (ECOSOC 1961: 19)
1979	WHO	The first seminar on 'Harmful Traditional Practices affecting the health of Women and Children' was held in Khartoum, Sudan
1979	UNGA	The Convention on the Elimination of All Forms of Discrimination against Women was adopted
1984	IAC	The Inter-African Committee on Traditional Practices affecting the health of Women and Children (IAC) was created in Dakar, Senegal (IAC 2021)
1988	UNCHR	The Sub-Commission on Prevention of Discrimination and Protection of Minorities (now the Sub-Commission on the Promotion and Protection of Human Rights),[7] which was established by the Commission on Human Rights, appointed the Special Rapporteur on harmful traditional practices, Halima Embarek Warzazi, in 1988 (Warzazi 1989)
1989	UNGA	Convention on the Rights of the Child Article 24 3. States Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children
1990	CEDAW	Recommendations were adopted at the ninth session of CEDAW (1990)

(continued)

[7] The 'Sub-Commission on Prevention of Discrimination and Protection of Minorities' was renamed in 1999 (United Nations Human Rights Council 2020).

Table 2.1 (continued)

Year	Organiser	Main event/results
1993	WHO	The Forty-sixth World Health Assembly adopted resolution (World Health Assembly 1993)
1993	UNGA	'Declaration on the Elimination of Violence against Women' was adopted. In Article 2, FGM was admitted as violence against women (UNGA 1993)
1994	ICPD	The International Conference on Population and Development held at Cairo, Egypt, urged governments to put a stop to FGM (UNFPA 1995)
1994	UNCHR	The Special Rapporteur on violence against women, its causes and consequences, Radhika Coomaraswamy, was appointed by the Commission on Human Rights in 1994 (Coomaraswamy 1995)
1995	UN	The Fourth World Conference on Women held at Beijing, China, adopted the Beijing Declaration and the Platform for Action (UN 1996)
1996–2015	WHO	Regional Plan of Action to Accelerate the Elimination of Female Genital Mutilation in Africa covers a 20-year period (1996–2015) and consists of three phases (1996–1998, 1999–2006, 2007–2015). The goal is to accelerate the elimination of FGM to improve the health and quality of life of women and girls in countries in the Region[c] (WHO Regional Office for Africa 1997)
1997	WHO/UNFPA/UNICEF	Joint WHO/UNFPA/ UNICEF Statement for the elimination of FGM (updated in 2008) Around the same time, Resolutions and Decisions of UNGA, ECOSOC and Commission on Human Rights were adopted (UNGA 1999)
2001, 2003, 2005	UNGA	Resolution 56/128 of 19 December 2001, 58/156 of 22 December 2003, and 60/141 of 16 December 2005 (UNGA 2002, 2006)

(continued)

Table 2.1 (continued)

Year	Organiser	Main event/results
2003	AU	Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (the Maputo Protocol) Article V Elimination of Harmful Practices (b) 'Prohibition, through legislative measures backed by sanctions, of all forms of female genital mutilation, scarification, medicalisation, and para-medicalisation of female genital mutilation and all other practices in order to eradicate them' (AU 2003)
2007, 2008, 2010	Commission on the Status of Women	Resolution 51/2 of 9 March 2007, 52/2 of 7 March 2008, and 54/7 (Commission on the Status of Women 2010)
2008	OHCHR et al.	Eliminating Female Genital Mutilation: An interagency statement—OHCHR, UNAIDS, UNDP, UNECA, UNESCO, UNFPA, UNHCR, UNICEF, UNIFEM, WHO (2008)
2009	European Parliament	European Parliament resolution of 24 March 2009 on combating female genital mutilation in the EU (European Parliament 2009)
2011	AU	Assembly of the Union Seventeenth Ordinary Session at Malabo, Equatorial Guinea adopted the 'Decision on the Support of a Draft Resolution at the Sixty sixth Ordinary session of the General Assembly of the United Nations to Ban Female Genital Mutilation in the world' (AU 2011)

(continued)

With regard to religion, a speaker from Egypt mentioned that FGM was practiced by both Muslims and Christians, and that 'there is no religious basis for the practice'. It only fits into 'the people's value system about virginity and family honour'.

This seminar presented the problems of FGM as follows:

- FGM is 'performed on female children, mostly at an age too young to be able to make any decisions on their own'. The operations are performed at a younger age because parents are afraid their daughters will refuse to submit to them when they are able to decide for themselves.

Table 2.1 (continued)

Year	Organiser	Main event/results
2012	UNGA	The resolution, 'Intensifying global efforts for the elimination of female genital mutilations', was adopted The General Assembly, 2. *Calls upon* States to enhance awareness-raising and formal, non-formal education and training in order to promote the direct engagement of girls and boys, women and men and to ensure that all key actors, Government officials, including law enforcement and judicial personnel, immigration officials, health-care providers, community and religious leaders, teachers, employers, media professionals and those directly working with girls, as well as parents, families and communities, work to eliminate attitudes and harmful practices, in particular all forms of female genital mutilations, that negatively affect girls; 4. *Urges* states to condemn all harmful practices that affect women and girls, in particular female genital mutilations, whether committed within or outside a medial institution, and to take all necessary measures, including enacting and enforcing legislation, to prohibit female genital mutilations and protect women and girls from this form of violence, and to end impunity; 21. *Calls upon* States, the United Nations system, civil society, and all stakeholders to continue to observe 6 February as the International Day of Zero Tolerance for Female Genital Mutilation and to use the day to enhance awareness-raising campaigns and to take concrete actions against female genital mutilations (UNGA 2013)
2013, 2015	UNGA	Resolution 68/146 of 18 December 2013, 70/138 of 17 December 2015 (UNGA 2014, 2016)

(continued)

Table 2.1 (continued)

Year	Organiser	Main event/results
2015	UNGA	UNGA unanimously adopted the resolution, 'Transforming our world: the 2030 Agenda for Sustainable Development' Goal 5. Achieve gender equality and empower all women and girls 5.3 Eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation (UNGA 2015)

[a]WHO (1959) showed its position at that time as follows:
'Noting resolution 680 B II (XXVI) of the Economic and Social Council inviting the World Health Organization to undertake a study of the persistence of customs which subject girls to ritual operations and of the measures adopted or planned for putting a stop to such practices;
Believing that the ritual operations in question are based on social and cultural backgrounds, the study of which is outside the competence of the World Health Organization; and
Noting that the only contribution of the World Health Organization would consist in giving information of a general nature on the medical effects of the practice in question [...]'
[b]WHO (1962) showed its position at that time as follows:
'BELIEVES that a study of the medical aspects of this subject could not be undertaken in isolation but must be related to the cultural and socio-economic background of the countries concerned [...]'
[c]The goal of the Regional Plan of Action is 'to accelerate the elimination of female genital mutilation in order to improve the health and quality of life of women and girls in countries in the Region'
'The overall objectives of the Regional Plan of Action are:
(a) to reduce the proportion of girls and women aged 1–20 years who have undergone any type of genital mutilation in countries where intervention programmes for the elimination of the practice have been implemented' (WHO Regional Office for Africa 1997: 12)
'To achieve these objectives, the following specific targets are set:
(i) The proportion of females in the age group 1–20 years undergoing female genital mutilation to be reduced by 40% by the year 2015' (WHO Regional Office for Africa 1997: 13)

- FGM incurs a heavy cost (mentioned by Hosken):

  1. The costs due to loss of life
  2. The costs incurred by making childbirth more hazardous
  3. Costs of work time lost, health insurance, and social security
  4. Costs of operations performed in hospitals.

- FGM also leaves psychological scars on the woman. When women perceive themselves as victims of outdated customs and male prejudice, this results in negative attitudes about themselves.

This seminar also presented the measures against FGM as follows:

- Legislation prohibiting FGM
- Abolishing FGM through education given that health education seems to be the most effective method to stop the practice

- Education for the practitioners of FGM (like the *daya* in Egypt), and a guarantee for the practitioners' other sources of livelihood
- Health practitioners, social workers, nurses, family planning workers, feminists engaged in education and outreach programmes, and educated people in general should form the first audience of instruction. They should be informed about the practice, the extent, and the reasons of its perpetuation, and how traditional and erroneous beliefs of women and women's health and sexuality can be modified. It is important to engage this group first because of their prospective leadership roles.[8] (WHO Regional Office for the Eastern Mediterranean 1979).

The policy against FGM has not changed much since the early days. Readers can find the same discussions and recommendations as those mentioned above in the documents. Although many African countries have anti-FGM laws and anti-FGM programmes, not much has been achieved yet in the promotion of secondary and higher education, higher prevalence of health education, and the reduction of patriarchal values.

2.2.2 Universal Declaration of Human Rights

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 'to counter deeply rooted gender-based discrimination that often results from patriarchal attitudes and related social norms'.

[8] This proposal is related to the 'positive deviance approach' discussed in Sect. 4.

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.

2.2.4 Changes in Africa

The prevalence of FGM in Africa is shown in Chapter 1 (see Fig. 2). As mentioned, there, not all ethnic groups in Africa follow this tradition. Some groups with the tradition of FGM have already decided to abolish it, while others continue to practice it despite the zero tolerance policy of their governments and the international community.

According to the news in November 2018, FGM rates among African children under 15 years of age have shown a 'huge and significant decline' over the past two decades ("Mixed messages on FGM" 2018). In East Africa, the prevalence decreased from 71.4% in 1995 to 8.0% in 2016. In North Africa, it decreased from 57.7% in 1990 to 14.1% in 2015. In West Africa, it decreased from 73.6% in 1996 to 25.4% in 2017 (Kandala et al. 2018).

As shown in Table 2.1, one of the targets of the 'Regional Plan of Action to Accelerate the Elimination of Female Genital Mutilation in Africa (1996–2015)' is for 'the proportion of females in the age group 1–20 years undergoing female genital mutilation to be reduced by 40% by the year 2015'. For those under 15 years of age, this target can be said to have been achieved.

While the efforts of the international community and local NGOs have paid off as we receive this good news for children under 15 years, researchers should highlight the fact that the zero tolerance policy has not succeeded in abolishing FGM completely.

2.3 Zero Tolerance Policy in Kenya and FGM in the Somali Community

2.3.1 Zero Tolerance Policy in Kenya

This section outlines the zero tolerance policy in Kenya. UNFPA-UNICEF stated that the 'Government of Kenya recognizes that FGM/C is a fundamental violation of the rights of women and girls. Decrees and bans against FGM/C were issued in 1982, 1989, 1998 and 2001' (UNFPA-UNICEF 2013).

The Children Act of 2001 prohibits FGM[9] and other harmful practices[10] that 'negatively affect the child's life, health, social welfare, dignity or physical or psychological development' (Article 14), and imposes a penalty of 'imprisonment not exceeding twelve months', or 'a fine not exceeding fifty thousand shillings or to both such imprisonment and fine' (Article 20) (Republic of Kenya 2001, revised 2012).

The Constitution of Kenya 2010 also guarantees women and children the right to life (Article 26), the right to equality and freedom from discrimination (Article 27), the right to dignity (Article 28), and the right to freedom and security of the person (Article 29). Article 44 prevents any person from compelling 'another person to perform, observe, or undergo any cultural practice or rite' while Article 53 guarantees every child the right to be protected from 'harmful cultural practices' (Republic of Kenya 2010).

Since 2011, the law 'Prohibition of Female Genital Mutilation Act' prohibits FGM from being performed on women of any age. 'A person, including a person undergoing a course of training while under supervision by a medical practitioner or midwife with a view to becoming a medical practitioner or midwife, who performs female genital mutilation on another person commits an offence'. If the person above 'causes the death of another, that person shall, on conviction, be liable to imprisonment for life' (Article 19). 'A person who commits an offence under this Act is liable, on conviction, to imprisonment for a term of not less than 3 years, or to a fine of not less than two hundred thousand shillings, or both' (Article 29) (Republic of Kenya 2011).

2.3.2 FGM in the Somali Community

I now explain why Somali people in Kenya continue to practice FGM, and illustrate the efforts of local people to abolish FGM. More than 40 ethnic groups comprise Kenya's population, with the Somali accounting for 5.8% of the country's population (2019 est.). Most Kenyans are Christians (85.5%, 2019 est.) (CIA 2021), but most Somalis are traditional pastoralists and Muslims who follow the Shafi'i school (Abdullahi 2017: 132). According to the 2014 KDHS, the FGM prevalence rate in Kenya is 21%, but among the ethnic groups that practice FGM in Kenya, the Somali women showed the highest prevalence rates at 93.6% (KNBS 2015: 333).

Percentage distribution of Somali women aged 15–49 years who underwent FGM by type of FGM:

Type I: 1.4%

[9] Children Act, 2001, uses the term 'female circumcision'.

[10] 'Definition: harmful traditional practices should be defined as widely as possible and include FGM/C, early and forced marriage, crimes committed in the name of honour, dowry-related violence, and son preference' (ActionAid UK, Gender and Development Network, Womankind, International Planned Parenthood Federation, Orchid Project 2013).

Type II: 64.6%
Type III (infibulation): 32.3%
Do not know/missing: 1.6% (KNBS 2015: 333).

Percentage distribution of Somali women aged 15–49 years who underwent FGM by age:

Under 5 years old: 5.2% (including women who reported having FGM during infancy but did not provide a specific age)
5–9 years old: 72.7%
10–14 years old: 18.9%
over 15 years old: 0.2%
Do not know/ missing: 2.9% (KNBS 2015: 335).

The 2014 KDHS also shows the percentage of girls aged 0–14 years who underwent FGM according to age and mother's background. In total, 36% of girls whose mothers are Somali underwent FGM. Of them, 1.5% were younger than 5 years; 40.0%, 5–9 years; and 76.4%, 10–14 years (KNBS 2015: 337). These figures show that even after the Children's Act of 2001 which prohibits FGM for children under 18 years, most Somali girls have still undergone FGM. Somali girls in Kenya are generally cut when they are between 6 and 9 years old. These girls are too young to understand and consent to the risk of FGM.

The effects of FGM are as follows:

- Excessive bleeding
- Infection (including HIV/AIDS)
- Mental trauma
- Delay in delivery causes the child and/or mother to die.

Type III FGM especially causes strong pain because menstrual blood is unable to flow out, and it prevents girls or women from going to school or work. FGM is a big obstacle to women's and girls' empowerment.

2.3.2.1 Reasons for Practicing FGM

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.

Somali people also practice FGM because of peer pressure. According to the 2014 KDHS, about 82.7% of women and 87.0% of men (15–49 years old) feel that FGM is required by the community (KNBS 2015: 341).

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).

Among the four Sunni schools, only the Shafi'i school considers the practice obligatory for women. The Somali people mainly adhere to the Shafi'i school, which was historically introduced through its connection with Yemen Islamic education centres.

Most people who live in remote areas do not know which school they belong to, and simply follow the preachings of religious leaders. Thus, people will change their mindset only if the religious leaders change their interpretation. As shown in Sect. 2.3, because regional and national meetings of Muslim religious leaders have been held to discuss FGM (UNFPA 2010), some changes can be found in the Somali community.

In conclusion, I summarise what the educated Somali told me during interviews:

- FGM is harmful for women.
- FGM has nothing to do with Islam.
- Recently, the type of FGM has changed from type III to type I in town, because a local NGO founded by local Somali women has persuaded local religious leaders not to accept type III and to abolish FGM.

2.3.2.2 Change of Common FGM Forms

The efforts of local people to abolish FGM should be emphasised. Many women's groups have made efforts to abolish FGM in this area. For more than 20 years, an NGO which was founded by local Somali women has tried to persuade local religious leaders not to accept type III and to abolish FGM. As a result, several effects were observed:

Firstly, the prevalence of FGM has decreased. A small survey by researchers in 2018 showed that FGM prevalence among Somalis in Garissa, the former capital of North-Eastern Province, dropped to 62.5%. They insisted that the reason for this drop is partly the high awareness of the anti-FGM law (Derow et al. 2021).

Secondly, local NGOs have achieved a change in the common form of FGM. According to the 2014 KDHS, among girls under 15 years of age with Somali

mothers, the prevalence of type I or II is 88%, and that of type III is 11% (KNBS 2015: 338). Currently, most Somali young girls have only gone through type I or II FGM.

Although this is a great improvement, it must be realised that many women have described even type I FGM as a traumatic childhood event, therefore, more efforts to abolish even type I FGM need to be undertaken.

2.3.2.3 The Negative Effect of Anti-FGM Law on Somali Women's Health

Kenya outlawed FGM in 2011. The zero tolerance policy of the Kenyan government had a negative effect on many women in the Somali community. A married woman who lives in the capital, Nairobi, said the following:

> Our Somali community don't go to government hospitals to give birth due to their conditions (FGM/C). They go to private facilities because in government facility, the health personnel will be shocked and even say this one has been cut.
>
> Married woman, IDI, Eastleigh (Kimani et al. 2020: 7)

The anti-FGM law and the zero tolerance policy discouraged Somali pregnant women who were cut when they were young from seeing non-Somali medical doctors at public hospitals and clinics. Such women are thus deprived of their rights to healthcare services. This situation is an obstacle to achieving Goal 3 of the SDGs, which aims to 'reduce the global maternal mortality ratio' (UNGA 2015).

2.4 Ways of Abolishing FGM—Beyond the Zero Tolerance Approach

2.4.1 The Role of Religious Leaders

Kenya outlawed FGM in 2011 and adopted the zero tolerance policy, but Somali people have continued the practice. Why could the anti-FGM law not completely abolish FGM in this area? Can it be said that the zero tolerance policy will be effective in abolishing the practice completely?

To abolish FGM, researchers and activists need to consider how to change people's mindset. According to the 2014 KDHS, 81.2% of Somali women and 79.8% of Somali men (aged 15–49 years) believe that FGM should continue (KNBS 2015: 343). In this area, religious leaders have a strong influence on the behaviour of ordinary people. According to a report by UNFPA (2010), several regional and national meetings with Muslim religious leaders and scholars had taken place over the years due to the efforts of local NGOs, and after they were made to understand the medical harm caused by type III (infibulation), scholars took a stronger stand against FGM.

This report anticipated future problems that would arise because religious leaders and scholars had not yet reached a firm consensus on abolishing all forms of FGM, and because some leaders did allow for less severe cutting of the clitoris, or light pricking to draw blood (UNFPA 2010).

Approximately 10 years have passed since the publication of this report. Religious leaders' attitudes have changed people's mindset, and parents tend to choose type I/II for their daughters in this area.

Recently a renowned Islamic scholar in Garissa claimed that FGM 'is purely a cultural practice sneaked into religion to attract a larger audience' (Wangeci 2017). Although it is expected that religious leaders will agree on abolishing FGM completely in the near future, it will take a little time. Until then, the 'positive deviance' approach will be more effective than the zero tolerance policy in changing people's mindset.

2.4.2 Positive Deviance Approach

The positive deviance approach is 'a methodology that focuses on individuals who have 'deviated' from conventional societal expectations and explored—though perhaps not openly—successful alternatives to cultural norms, beliefs or perceptions in their communities' (Masterson and Swanson 2000: 13).

International NGOs including the 'Centre for Development and Population Activities' and local NGOs in Egypt showed that this 'positive deviance approach' had succeeded in changing people's mindset in Egypt, where 97% of all women were cut at that time. Local NGOs identified the remaining 3% of women who were not cut as positive deviants. In fact, the fathers, mothers, and husbands of these women were also labelled as positive deviants. This project (1998–2000) not only built the capacity of individuals and local organisations, but also provided the foundation for ongoing community-based exploration, reaffirming the important development principles of sustainability and ownership. The positive deviance approach also showed that positive role models for FGM abandonment already exist within communities and that these role models can take on important positions as advocates and strategists to end FGM (Masterson and Swanson 2000).

UNFPA (2010) mentioned an excellent point. Some 'parents of the younger girls are avoiding the cut altogether. Although the most recent DHS data only register a drop in prevalence of 1.5% (97.5 in 2008/2009 compared to 99% 5 years earlier), Zeinab[11] pointed out that that includes all girls and women aged 15–49 years, and does not highlight changes occurring in the youngest generation'. This means that we can find positive deviants in the Somali community as well.

The zero tolerance policy being conducted by the United Nations and African governments will not achieve success without first persuading local people not to

[11] Zeinab Abdi Ahmed was an UNICEF Kenya Child Protection Specialist who led the Joint UNFPA/UNICEF Programme on Female Genital Mutilation/Cutting in the province.

practice FGM. While religious leaders have great power to change people's mindset, positive deviants also play an important role as positive role models against FGM in the community.

As mentioned before, according to the 2014 KDHS, 82.7% of women and 87.0% of men (15–49 years old) believe that FGM is required in the community (KNBS 2015: 341), while 82.3% of Somali women and 83.4% of Somali men believe that their religion requires FGM (KNBS 2015: 340). This means that at least 10% of the Somali can be expected to be positive deviants in FGM abandonment. The positive deviance approach may provide an excellent tool for the advocacy of FGM abandonment in the Somali community.

2.5 Conclusion

While the decrease in FGM rates and changes in the common types of FGM are considered great achievements by the zero tolerance policy, FGM has not yet been completely abolished. Why do people continue FGM? Is the zero tolerance policy effective in abolishing FGM? To answer these questions, this chapter focused on three topics.

1. Zero tolerance policy in the international community
2. Zero tolerance policy in Kenya, and FGM in the Somali community
3. Ways of abolishing FGM beyond the zero tolerance approach.

It was shown that the zero tolerance policy and anti-FGM law alone could not change the patriarchal mindset expecting girls to be cut. To abolish FGM completely, the positive deviance approach appears more effective than the zero tolerance policy. I hope to work with local NGOs using this approach to change people's mindset in order to abolish FGM.

In addition to abolishing patriarchal values, eradicating poverty is crucial in the abolishment of FGM. Currently, the father of a girl who is not excised will not be paid the bride-price in full. In other words, to keep their status as masters of the house, to feed their families and prepare the bride-price for their sons' brides, fathers in poverty accept FGM. Without eradicating poverty, FGM will not be abolished.

Nawal El Saadawi argued in her book, *The Hidden Face of Eve: Women in the Arab World*,

> I disagree with those women in America and Europe who concentrate on issues such as female circumcision and depict them as proof of the unusual and barbaric oppression to which women are exposed only in African or Arab countries. I oppose all attempts to deal with such problems in isolation, or to sever their links with the general economic and social pressures to which women everywhere are exposed, and with the oppression which is the daily bread fed to the female sex in developed and developing countries, in both of which a patriarchal class system still prevails. Women in Europe and America may not be exposed to surgical removal of the clitoris. Nevertheless, they are victims of cultural and psychological clitoridectomy. (El Saadawi 2015: XLVI–XLVII)

Although El Saadawi did not mention Japan above, I argue that Japanese women are also 'victims of cultural and psychological clitoridectomy'. Japan is also a patriarchal society, and many Japanese women, especially in rural areas, still feel like they are treated as the property of their husbands' families. In fact, many Japanese still use the word 'master' to mention their own or other women's husbands, suggesting that married women belong to the husband's family in Japanese society.[12]

As the case of Japan shows, it is difficult to change patriarchal beliefs. Although the situation in Japan and in Africa are completely different, both of them maintain the machine of a patriarchal society and it may require time to dismantle it, but it is surely attainable.

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Makiko Toda, Ph.D. is a professor of comparative politics and international relations at Kyoto Women's University, Japan. She studies ethnic relations, political systems and gender issues in Africa, especially in Nigeria, Kenya and Rwanda. She earned an MA in West African Studies from Centre of West African Studies, University of Birmingham. She is the author of three books and many articles, including *Politics in Africa* (rev. ed., Tokyo: Ochanomizu Shobo, 2013; in Japanese); *Poverty, Conflict, and Gender: Comparative Politics for African Studies* (Kyoto: Koyo Shobo, 2015; in Japanese). She is the editor and co-editor of seven books, including *Understanding Global Society* (rev. ed., Kyoto: Koyo Shobo, 2019; in Japanese).

Chapter 3
What Has Become of FGC After Strict Eradication Campaigns?: Female Genital Cutting and Its Eradication Activities Among the Yellow Bull in Ethiopia

Yukio Miyawaki

3.1 Introduction

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, 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.[1] The WHO and UNICEF declared a

[1] In 2003, the Inter-African Committee on Traditional Practices (IAC) declared a policy on FGC of "zero tolerance". Recognition of this trend led UN organizations to change their policy and reclassify FGC from a "health problem" to a "human rights violation" (Boyle 2002; Shell-Duncan 2008).

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Y. Miyawaki (✉)
Graduate School of Sustainable System Sciences, Osaka Metropolitan University, Osaka, Japan
e-mail: yukio@omu.ac.jp

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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.[2] If the problem is considered to be the patriarchal character of the culture and social system of which FGC is a part, it is difficult to distinguish it from genital cosmetic surgery, which is done to enhance sex appeal in Western societies. The WHO tries to ban all types of FGC, including the cutting of the prepuce of the clitoris, yet they justify their tolerance for male circumcision on the pretext that it protects against HIV, although the validity of this claim is still in dispute (cf. Shell-Duncan 2008).

According to a recent UNICEF report, the rate of FGC in Africa is declining (UNICEF 2020). However, the process of abolition is not straightforward. Ideas of abolition have been modified and interpreted differently according to the local setting. For example, in one community in Mali, FGM was abolished, not because awareness of human rights and women's health had spread among inhabitants, but because local leaders wanted to display their political hegemony through running an NGO for FGM abolishment, and circumcisers had accepted the economic compensation given to them. Although the ideas appeared to have been accepted, they have been distorted and have not reached the local communities (cf. Gosselin 2000). When the ban was enforced, FGC may well have been practiced illegally (Boyden 2012; Pells and Robinson 2014). If those who enforce the ban are not supported by the inhabitants, the inhabitants may well show open resistance (cf. Thomas 2003). The enforcement of "zero tolerance" seems to have caused much confusion.

In this chapter, I examine what the strict banning of FGC brought about when it reached a grassroots community, and how stakeholders negotiated with each other over their "culture" according to their social position. I focus on one agro-pastoral

[2] Although FGC is often said to be done on small children, in some societies girls over the age of 15 undergo FGC (Central Statistical Agency 2017: 322). Girls of the Yellow Bull, to whom I refer in this chapter, undergo FGC at the age of approximately 20.

society in Ethiopia, which I call the Yellow Bull, where FGC continues despite strong pressure from the local government to abolish it. Why do people continue FGC? How do stakeholders see FGC? How has political power been wielded during negotiations? I attempt to answer these questions by describing the cultural background of the Yellow Bull and the practice of FGC abolition among them.

3.2 FGC in Ethiopia

3.2.1 General View of FGC in Ethiopia

Before investigating the case of the Yellow Bull, I review the overall situation concerning FGC in Ethiopia. Although FGC has been banned by criminal law, it is still prevalent in Ethiopia. According to UNICEF, 65% of women in Ethiopia have undergone FGC (UNICEF 2020). The type of FGC, percentage of women who have had FGC, and age at which the procedure is performed, vary according to area and ethnic group. The percentage of women[3] who have undergone FGC among those aged 15–49 is higher in the east of the country. The regions with the highest prevalence are Somali, at 98.5%, and then Afar, at 91.2%. The regions with moderate prevalence are Oromia at 75.6% and Amhara at 61.7%. The lowest prevalence is in Tigray, at 24.2%. In western and southwestern Ethiopia, there is a mosaic of ethnic groups in which those who practice this custom and those who do not are mingled (Central Statistical Agency 2017).

The type of FGC varies according to ethnicity. Somali and Afar mostly practice infibulation, the Amhara practice clitoridectomy, and for the Oromo excision is common. The age at which girls typically undergo FGC also differs. Among Afar, Amhara, and Tigray, cutting is done from one to two weeks after birth, while for the Somali the practice typically occurs at approximately eight years. Some of the Oromo groups practice it before marriage (UNICEF 2020). Overall, the practice of FGC has been declining this decade, but at a rate that differs according to ethnic group. Among the Tigray, FGC has been disappearing rapidly, but among Somali and Afar, it is still widely practiced.

Studies on FGC in Ethiopia until the 1990s were relatively few compared to those in other African countries. However, some substantial researches have been conducted since the 2000s. Though lacking detailed ethnographic information on communities, since most of them are quantitative, the existing studies do show some general tendencies concerning FGC practice.

[3] The estimated rates of prevalence of FGC in Ethiopia vary according to researchers. Robera et al. (2020) estimates prevalence of FGC in Ethiopia as 77.28% based on meta-analysis of 19 studies carried out in Ethiopia between 2001 and 2017.

3.2.2 FGC in Ethiopia Based on DHS

Some studies concerning FGC were conducted using data collected by the DHS (Demographic and Health Survey) in 2016 and 2005 in Ethiopia.

According to a study by Ayenew et al. (2021) based on DHS 2016, prevalence of FGC in Ethiopia is 66.9%. The respondents who were in the age group of 20–34 and 34–49 were more likely to be circumcised as compared to the age group of 15–19. Religion was an important factor for FGC. Being a Muslim, rather than an Orthodox Christian, increased the odds of circumcision by 2.17 times. Residence was another important factor. Women living in rural areas were 2.12 times more likely to have had FGC as compared to those living in urban areas. Having a primary-educated husband decreased the likelihood of FGC by 49% as compared to having a husband with no education. Wealth index was another variable that was negatively associated with female genital cutting. Women of the middle and rich wealth index category were 44–45% less likely to have had FGC compared to poor women.

Dawit et al. (2021) showed the attitude towards FGC among Ethiopian women based on DHS 2016 with multiple logistic regression analysis. Their research indicated that women with at least a secondary education were above four times more likely to agree with the termination of the practice. On the contrary, women who were circumcised, had Muslim faith, no formal education, or were poor, were less likely to support the discontinuation of FGC.

The study conducted by Zenebe (2010), which used the database of DHS 2005, and analyzed the attitude toward FGC of 12,689 women aged 15–49, showed similar results. He added that those aware of the need to avoid HIV were 0.6 times less likely to support the continuation of FGM compared to their counterparts.

3.2.3 FGC in Amhara Region

3.2.3.1 DHS Data Analysis[4]

The DHS data from 2005 were used to analyze the FGC status of 1942 women aged 15–49 years who resided in the Amhara region (Rahlenbeck and Wubegzier 2009). The majority of those women (68.6%) replied that they had undergone FGC, and the rate declined from 77% in women aged 45–59, to 59% in those aged 15–24 years. Half of the respondents (54%) disapproved of the continuation of FGC. Of particular interest is that the researchers measured the difference in the respondents' opinions on the continuation of FGC through a score on self-empowerment as well as degree of education. The self-empowerment score was assessed through sets of questions measuring the degree to which a woman is able to make decisions on her own sexuality and her response to domestic violence inflicted by her husband.

[4] Analysis on FGM in regional populations based on DHS 2016 had not been found till the end of 2021 when this chapter was written.

Respondents who scored high on empowerment indices had a 1.5 times increase in the odds of favoring discontinuation compared to women who scored low. Women who had attended school had a four times increase in the odds of disapproving of the practice compared to those who never did.

3.2.3.2 East Gojjam

Andalem (2013) conducted research in the East Gojjam zone in the Amhara region in 2013 on 730 women aged 15–49 years who had daughters less than five years old. Most women were Amhara and Orthodox Christians. Most of the respondents (77.7%) had undergone FGC, and 62.7% of their daughters had been circumcised. Most of the circumcised daughters (95.9%) had been circumcised under one year of age. Most were circumcised by traditional circumcisers. More than half of the respondents (61.5%) supported the continuation of FGC. The reasons for continuation were, "tradition/custom," "to give birth," "to increase happiness during sex," "to increase community's acceptance," "to get husband easily" among others.

Women's age, educational level, previous circumcision, and health education were significantly associated with FGC practice. Women in the 18–24 age range were less likely to have undergone FGC compared to those in the 34–49 range. Women who had not attended school were 5.43 times more likely to have undergone FGC than those who had formal education. Respondents who had undergone FGC were 3.45 times more likely to circumcise their daughters compared to those who had not undergone FGC.

3.2.4 FGC in Harari Region

This research was carried out in the city of Harar in Harari region on women of the Adere, the Oromo, and the Amhara, who inhabited the city (Missailidis and Gebre-Medhin 2000). Eight women from each group (24 total) were interviewed. They were aged between 20 and 60 years.

The women of all groups believed that the reason they practiced FGC was to reduce and control female sexuality. They considered virginity to be a prerequisite for marriage and believed it was impossible to maintain virginity and chastity without FGC. The Muslim Adere and the Oromo regarded FGC as an act of religious importance, and the Christian Amhara saw it as a cultural custom. The Adere and Oromo practiced infibulation on four-year-olds to puberty, and the Amhara practiced excision on the eighth day of birth.

Although FGC was prevalent in this area, Muslim leaders had already participated in anti-FGM campaigns, and infibulation had been declining. People became free to marry a person of their own choice, thus FGC became less important for marital reasons.

3.2.5 FGC in Somali Region

3.2.5.1 Somali Refugees in Somali Region

Getnet and Wakgari (2009) carried out research in three refugee camps in the Somali region on 492 refugees, 246 Somali women and 246 Somali men in 2004. The researchers investigated not only the FGC status of interviewees but also that of their female children aged 1–12 years. They also interviewed circumcisers.

Almost half (42.4%) of their female children had undergone FGC. However, as they got older, the rate of the children having been circumcised increased, and 98% of them had undergone FGC among children aged 11–12. The researchers inferred that Somali girls generally undergo FGC at the age of 7–8 years. The most prevalent type of FGC was clitoridectomy (63.9%), and this form was more common in younger girls.

The operation was performed using traditional female circumcisers. The average age of the circumcisers was 45 years, and 73% of them were illiterate. The forms of FGC practiced by them included clitoral cutting (11.5%), vaginal stitching (42.3%), and clitoral cutting and stitching (46.2%). However, most of them (96.2%) replied, at the time of the interview, that they preferred to perform milder clitoral cutting.

Most of the parents replied that they intended to have their children undergo FGC, and the intention among the women to circumcise the girls was higher (91.1%) than that reported by men (75.2%).

The results of logistic regression showed that the practice of FGC was significantly associated with the age of the parents and their involvement in anti-FGM interventions. The practice of FGC was more common among younger parents, and less among parents who had participated in one of the anti-FGM activities. The practice of FGC was widespread among Somali refugees, and there was considerable support for the continuation of the practice. However, the form of FGC has been changing to milder clitoral cutting. Anti-FGM intervention was negatively associated with the practice and the intention to circumcise daughters.

3.2.5.2 Jijiga City

Muktar et al. (2013) conducted research in 2012 in Jijiga, the capital city of the Somali region, involving 323 women aged 15–49 years. Most of them were Somali (71%) and Muslims (84%). Since they inhabited the city, most of them were well-educated. Of these, 41.5% had finished 12th grade.[5]

Most respondents (90%) had undergone FGC, and the age of their circumcision was between 6–14 years. Infibulation is the most common form of FGC. Mothers (67.4%) trained traditional birth attendants (53%), and village women (47%) were decision makers for this practice.

[5] In Ethiopia, primary education is offered for eight years and is compulsory between ages 7 and 12. Four years of secondary education, comprising two two-year cycles, follow.

Most respondents (91.3%) had heard about the ill effects of FGC, and 29.5% of them had received information about the harmful effects of the practice from radio and TV. More than half of them (63.4%) did not support the continuation of FGC, but 67% of them wanted to have their daughters undergo FGM. Among those who wanted exposure of their daughters to FGC, however, most (83%) wanted to have them undergo FGC in the mildest form (cutting prepuce).

The reasons for practicing FGC were "tradition" (85%), "religious requirement" (47%), "to protect virginity" (76%), "to be accepted bride" (85%), "to decrease sexual drive" (55.2%) and "to be admitted into women's group" (55.2%).

In this area, there was a trend away from the severe form (infibulation) to a milder form (cutting prepuce). Though most of the respondents had a negative attitude toward FGC, they wanted FGC to continue and to be practiced on their daughters. The researchers inferred that this inconsistency was due to inadequate knowledge about reproductive health among the women involved in this study.

3.2.6 Oromia Region

3.2.6.1 East Hararge

This research was conducted in the East Hararge zone in the Oromia region in 2008 on 848 women aged 15–49 years (Wondimu et al. 2012). Most of them were Oromos (96%), Muslims (95%), and illiterate (84%).

Most of the respondents (92.3%) replied that they had undergone FGC, had experienced difficulty in delivery (41.3%) and in their first sexual intercourse (30.6%); 38.5% replied that FGC continued. The types of FGC claimed to be practiced in this area were clitoridectomy (78.9%), cutting of clitoris and labia (35.2%), clitoris, labia, and surrounding parts (23.5%), cutting of clitoris, labia, surrounding part, and stitching (10.4%).

The reasons given for practicing FGC were to reduce "female hyperactivity" in sexual practice (60.3%) and to prevent females from early initiation into sex before marriage (25.1%). The results of logistic regression analysis showed that women living in rural areas were less likely to be circumcised than women living in urban areas. The ownership of a radio, indicating a higher socio-economic status, seemed to be associated with a lower risk of women or their daughters being circumcised.

3.2.6.2 Bale

Daniel et al. (2015) conducted research in 2014 at the Bale zone in the Oromia region on 634 women aged 15–49 years. Most of them were Oromo (83%), and 13% were Amhara. More than half (59%) were Muslims, 37% were Orthodox Christians, and 4% were Protestants. The majority (73%) supported the discontinuation of FGC. The reasons for performing FGC were "religious requirement," "safeguarding virginity," and "maintaining culture."

Factors associated with the intention to continue FGC were place of residence, educational level, and circumcision status. The odds of intention to continue FGM were about six times higher among rural residents compared to their urban counterparts. Those who were illiterate were about eight times more likely to continue FGC than those who attended secondary level education and above. Circumcised respondents were nearly three times more likely to intend supporting a continuation of FGC than uncircumcised respondents.

3.2.7 FGC in Transition

Quantitative studies conducted since the 2000s show that FGC in Ethiopia is in transition. Some studies report that the number of women who have undergone FGC is declining (Rahlenbeck and Wubegzier 2009; Abebe et al. 2009), while others report that the type of FGC has changed to milder forms such as clitoridectomy or cutting prepuce (Missailidis and Gebre-Medhin 2000; Getnet and Wakgari 2009; Muktar et al. 2013). Most studies emphasize that many women support discontinuation of FGC (Abebe et al. 2009; Muktar et al. 2013; Daniel et al. 2015).

The factors that are considered to affect the attitude toward FGC are age, education level, experience of FGC (Rahlenbeck and Wubegzier 2009; Andalem 2013; Daniel et al. 2015), and location of residence (Abebe et al. 2009; Wondimu et al. 2012; Daniel et al. 2015). Some studies indicate that anti-FGM campaigns affect women's attitudes (Missailidis and Gebre-Medhin 2000; Zenebe 2010; Andalem 2013; Daniel et al. 2015).

Although these studies indicate some general tendencies concerning FGC in Ethiopia, how local inhabitants in grassroots communities have interpreted anti-FGM campaigns, reconsidered the meaning of their customs, and reacted to those campaigns have not been described. In the next section, I will show how those campaigns reached grassroots society by examining the case of FGC abolition in the Yellow Bull based on a detailed ethnographic survey.

3.3 Forced Abolition and Resistance of Women: FGC Among the Yellow Bull

3.3.1 Historical Background of the Yellow Bull

The Yellow Bull are agro-pastoralists who live in the peripheral district of Ethiopia.[6] Their preferred type of FGC has shifted in the last decade from excision (type II) to

[6] Yellow Bull is a pseudonym which refers to one ethnic group in Ethiopia. I use the pseudonym so as not to jeopardize the personal lives of my informants due to the contents of this chapter.

clitoridectomy (type I). An NGO that carried out a development project in 2006 tried to persuade them to abolish FGC, then the local government banned it. The Yellow Bull declared that they had stopped FGC and held a big ceremony celebrating its abandonment. However, they continued practicing it. They persistently resisted the local government's strict enforcement of the FGC ban. The case of the Yellow Bull shows what happens when the abolition process is enforced without regard for local conditions. Before examining the process of FGC abolition, I will briefly discuss the social and historical background of the Yellow Bull.

The Yellow Bull depend on flood retreat cultivation and livestock herding. Their society consists of two territorial sections, with each section consisting of two regional groups, each with its own chief and age organization.[7] The elders of the age organizations wield considerable power, and play an important role in the administration of regional groups, such as distributing flood plains, arranging marriages, and reconciling warring ethnic groups.

Although the Yellow Bull lived as an independent agro-pastoral group until the end of the nineteenth century, the invasion of the Ethiopian empire destroyed their autonomy. Since then, they have been ruled by the Ethiopian state. Under the Ethiopian Empire, the mediators, known as *chika shum*, mediated between the empire and the local people, and wielded power over the inhabitants. The mediators imitated the culture of the highlanders. The Yellow Bull felt antipathy toward the ruling highlanders and tried to maintain their ethnic identity by preserving their traditions.

After the empire was dismantled by the Derg military junta in 1974, peasant associations were organized in rural societies. The Yellow Bull, too, were organized into a peasant association, and some of their men began to participate in local administrative politics. After the Ethiopian People's Revolutionary Democratic Front (EPRDF) purged the Derg in 1991, and Ethiopia became a federal state based on ethnicity, local administrative offices were occupied by staff that came from the dominant ethnic groups of the area. Some young, educated, Yellow Bull men entered office. However, most of the uneducated Yellow Bull disliked them, since they considered the officials to be similar to the "disgusting" highlanders.

Resistance against the rule of the Ethiopian state by maintaining patriarchal traditions has thus formed the cornerstone of the Yellow Bull culture. Their resistance to the abolition of FGC should be understood in this historical context.

[7] The age organization is the most important social arrangement of the Yellow Bull. They organize age sets for every eight years, and boys and girls of each territorial section enter a new age set after they reach puberty. They have their own leaders in their age set, and form strong ties among their peers.

3.3.2 FGC of the Yellow Bull

In their language, the Yellow Bull refer to FGC as "tying knees." Women who have undergone FGC have their knees tied together until their scars heal. Women of the Yellow Bull marry at the age of approximately 20. The marriage ceremony continues for five days, and FGC is performed on the last day of the ceremony.

On the morning of the day, women who have married into the lineage of the bride gather in the bride's house to join the procedure. The circumcisers of the Yellow Bull are female, and they are said to have special circumcision skills. In the evening, at home, the bride takes off her clothes and sits astride a long wooden tub made of a log which has been cut in half and hollowed out. The circumciser cuts the bride's external genitalia with a small knife. Until the first years of the twenty-first century, they cut all parts of the external genitalia. At that time, the women who participated in the ceremony watched the procedure to check that all parts of the external genitalia were removed. Starting around 2010, however, the type of FGC practiced gradually shifted to clitoridectomy. After cutting, the bride, wrapped in a sheet of white cloth, is laid on a cowhide.

When a circumcision is performed, the groom comes to the house. He wears special ornaments typically worn by the killer of an enemy. The brothers of the bride demand that the groom provides nulliparous cows as bridewealth. With these cows, the bride is said to "be bought" by the groom.

After the negotiation of bridewealth, friends of the groom bring the bride, who has undergone FGC, to the groom's house. She drinks a cup of liquid, called "poison" in their language, and becomes a member of the groom's family. She has her knees tied and stays there to heal the wound by exposing it to smoke from burning wood. After several months, the married couple build a new house and are acknowledged as an independent household. They have the right to plot on a flood plain which is assigned by the elders of the settlement.

3.3.3 Patriarchy and the Politics of Interpretation: Ritual Meanings of FGC Among the Yellow Bull

3.3.3.1 Transition of Women's Status

When asked why they undergo FGC, the Yellow Bull most commonly answer that it is their tradition and that it makes girls clean and turns them into adult women. If a woman has not undergone FGC, her child is considered to be polluted, and the child cannot enter their age organization. The child and her/his mother would then be expelled from the Yellow Bull into neighboring ethnic groups.

The reason children of women who have not undergone FGC are considered "polluted" is that the Yellow Bull associates FGC with the transition of the status

of a woman through marriage. Through FGC, a woman's belonging is considered to change from her father's clan to her husband's clan.

The transition of a woman's belonging is very important for both the woman and her husband. The most important priority for men of the Yellow Bull is to have offspring and having male children, in particular, is regarded as very important. If men have male children, they have heirs to the cattle they inherited from their fathers. If men marry, they gain a woman who will give birth to their offspring, and for the woman to undergo FGC means that the children she gives birth to are his descendants, even if they are not the biological father. A woman who gives birth to a child but who has not undergone FGC does not belong to the clan of the man who would be her spouse, and consequently, the child does not belong to any clan. Thus, the child is regarded as polluted and expelled from the Yellow Bull.

The Yellow Bull members explain the meaning of FGC as the transition of a woman's status in several ways. One of the elders explained it as follows: "It is that the husband owns his wife's ghost." Significantly, when she dies, she is buried in the cemetery of her husband's clan. Her belonging changes irreversibly. One of the women said that FGC was like cutting the ears of cattle. The men of the Yellow Bull own many cattle, and as a mark of ownership, each man makes his own specific cutting-mark cut on both ears of his cattle. These accounts emphasize how FGC marks the irreversible transition of a woman's belonging.

FGC is also important for women. For a woman to marry, she becomes an adult. Through the generation set of her husband, she is incorporated into the generation system of the Yellow Bull.[8] If she occupies a higher position in the generation system, she can wield strong power by presiding over the marriage ceremonies of the settlement.

3.3.3.2 Ethnic Identity and FGC

For women of the Yellow Bull, FGC is considered not only a sign of adulthood but also a mark of their ethnic identity. There are four ethnic groups living in the areas adjacent to the Yellow Bull. Of these, the Yellow Bull intermarry with only two ethnic groups. These groups practice FGC. The Yellow Bull considers the cattle and women of these groups to be fertile. However, the Yellow Bull avoid marrying into the other two ethnic groups who do not practice FGC. The Yellow Bull say that if their men own those groups' cattle, drought will result. Likewise, they say that if their men marry those groups' women, infertility will result.

Such beliefs are also reflected in the women's view of their ethnic identities. Women of the Yellow Bull deride those whose genitals are considered insufficiently

[8] The generation system, which is different from the age organization, is another important organization to which all the Yellow Bull belong. A Yellow Bull enters a generation set (which is different from that of age organization) below the generation set of his or her father. The members of the higher generation sets play an important role in the rituals of marriage. Since marriage is the foundation of the Yellow Bull's kinship system, those who belong to the upper generation sets are considered to have strong power.

cut, saying they are like women of those groups who do not practice FGC. Women of those groups are said to have infertile "hot blood," unlike women of the Yellow Bull, who have undergone FGC and are considered fertile. This contrast gives Yellow Bull women pride in their ethnicity and constitutes part of their ethnic identity.

3.3.3.3 Death and Rebirth, Murder and Plunder

The meaning of FGC as a mark of the transition of women's status is known to all the Yellow Bull. However, the following interpretation of FGC was mentioned only by the elders who were familiar with some special rituals. According to them, for a bride to undergo FGC in her parents' house represents her death. After FGC, she is wrapped with a sheet of white cloth, which is also used to wrap the body of the dead at a funeral. Then, the bride is brought to the groom's house and drinks a cup of liquid called "poison." Significantly, a newborn male baby is also fed this liquid; with this ritual, the baby is regarded as belonging to the clan where he was born. Thus, for a bride to drink this liquid after she has entered the groom's house suggests that she is reborn there and now belongs to the groom's clan.

This symbolism recalls another ritual practiced by the community. The Yellow Bull believe that killing enemies belonging to certain ethnic groups brings fertility to the killers. Through the blood of killed enemies, the killer is blessed with a good harvest, plenty of milk from his cattle, many children, and a long life. However, if he wants to have the power of fertility, he must behave according to certain regulations and carry out specific rituals. First, he must ask a friend who accompanies him on the battlefield to cut off and bring the penis of a dead enemy. Then he must "buy" that organ from his friend in exchange for calves. In his settlement, the killer wears special ornaments and demonstrates that he has killed the enemy.

In the settlement, a third person can "buy" the power of fertility from the killer in exchange for calves, through a ritual called "putting on the ornaments." In this ritual, the man who wants to "buy" the power of fertility behaves as if he were a killer, and the killer behaves as if he were an enemy about to be killed. The man then snatches the penis of the killed enemy from the killer.

The elders say that these rituals and marriage rituals have common features. Firstly, the leading actor in both rituals wears a "special ornament of the killer." At the marriage ritual, the groom wears "special ornaments" when he comes to the bride's house after she has had her genitalia cut. This suggests that FGC is enacted as a symbolic murder. The bride is killed like an enemy by the groom. Secondly, the object of exchange is "bought" with calves. During the ritual of killing, the penis of the killed enemy is "bought," just as in the ritual of marriage, the bride who has undergone FGC is "bought."

Thirdly, in both rituals, buyers and sellers have similar relationships. After marriage, the groom and the brothers of the bride enter a special relationship, and the members of their lineages cannot intermarry until their grandchildren's generation. Similarly, the killer of the enemy and his friend—the one who bought the penis—enter a special relationship, and the members of their lineages are prohibited from

intermarriage forever. Referring to these similarities, the elders agree that marriage and killing enemies have common characteristics.

The concepts underpinning these rituals of marriage and killing enemies, seem to show how the patriarchy of the Yellow Bull has been established. It gives men the active role of gaining and exchanging the object (the bride or the blood of the enemy) that has the power of fertility, and which comes from outside their locality (their clan or ethnic group). It assigns to women the passive role of being acquired and exchanged. It asserts that even the fertility of women is ensured and enhanced by men. In this regard, FGC is not only a mark of the transition of a woman's status, but a ritual that emphasizes women's subordinate gender identity, in which they come of age by being symbolically killed and exchanged by men.

Thus, for the Yellow Bull, the FGC has multi-layered meanings. Abolitionists like the WHO believe that FGC is based solely on the patriarchal oppression of women. The multi-layered meanings of the FGC of the Yellow Bull seem to square with this assertion. How, then, do women of the Yellow Bull themselves regard FGC and its relation to patriarchal oppression?

3.3.4 Interpretation of FGC and Resistance of Women

3.3.4.1 Patriarchy and Resistance of Women

Women of the Yellow Bull say that FGC is an important tradition that has been handed down from their grandmothers. Since FGC is painful, they are nervous before the procedure. However, after FGC, they feel proud to become an adult woman of the Yellow Bull and feel they can establish themselves in their community.

From a feminist point of view, this system, in which women belong to the kinship of their husbands through marital exchange, and engage in the reproduction of their community, is typically patriarchal (Rubin 1975). Women's gender identity is molded in such a system, and it functions as a part of it, meaning that FGC is embedded in patriarchy as a symbol of women's subordinate status. If this is true, then the women of the Yellow Bull are "prisoners of convention" who are imprinted with a false consciousness to preserve male domination.

If they are "prisoners of convention" who uncritically accept a male-dominated social system, then they would be subordinate to men in all the situations of their everyday life. However, the way they cope with male dominance in everyday life is much more complex. Women of the Yellow Bull have resisted male dominance in many ways. They frequently outwit the husbands whom they were forced to marry and meet their former lovers with the help of their female friends. Recently, girls have often resisted forced marriage by soliciting intervention by police stationed in a nearby town.

Resistance sometimes becomes more systematic. One example is spirit possession. The notion of spirit possession began in the Yellow Bull in the 1960s and rapidly spread among them. Those who were "possessed" by spirits organized cults

that imitated the age organization of the Yellow Bull. The dominant members of those cults wielded power almost equivalent to that of the elders of the traditional age organization. Most of the cult members were women. They were able to gain freedom for their activities on the pretext of participating in a séance. When they had any trouble with their husbands, they even took power from their husbands in their households in cooperation with the members of their cults.

Another case is the Women's Association. The association was organized in the mid-1990s, when the money economy gradually spread among the Yellow Bull. Their customs prohibited women from owning livestock, which is the most important property. Women needed to ask their husbands for permission to sell small livestock in the weekly market to earn money, which was necessary, for instance, to bring sick children to the nearby clinic. By utilizing the NGO's micro-finance project, the women who joined the association bought commodities such as salt and coffee at cheaper prices from the merchants outside the Yellow Bull and sold them at a weekly market. The members were able to earn profits through sales. Men criticized the association at first, saying that women should not own property. However, they finally admitted that the association was successful, and some of them even asked the women to let them join.

The Yellow Bull is a typical patriarchal society. Men monopolize the rights of their property. A woman is exchanged for bridewealth through marriage, and then transitions from the clan of her father to her husband's clan. A woman must obey her father before marriage and obey her husband after she marries. However, women have regarded such situations critically and have never passed the chance to achieve self-determination. In that case, why do they support FGC, which seems central to the patriarchy of the Yellow Bull?

3.3.4.2 FGC and Women's Domain

As I was talking with some women of the Yellow Bull, one of the aged women said with a sarcastic smile, "Men do not know that women who gather at the marriage ceremony say that today is the day of mourning for the bride." According to this woman, women of the Yellow Bull recognize that the ritual symbols of the marriage ceremony suggest that FGC is a symbolic murder of the bride by the groom. However, she interpreted the ritual quite differently. Male elders interpret FGC as an opportunity for the groom to release the bride's power to reproduce. Thus, in their view, men's superiority as a catalyst to enhance women's fertility is justified. On the other hand, the woman ridiculed men who tried to give symbolic meaning to dressing up as killers in order to justify men's superiority. She insinuated that FGC itself was performed in the bride's house only by women, and that men could not interfere.

Men are never able to interfere with FGC, and the way FGC is performed is determined by women. Women do not accept the symbolic interpretations that men try to demonstrate by dressing as killers outside the house. The place where FGC is done is considered an autonomous and independent place where they engrave the mark of their identity by themselves. Women of the Yellow Bull have their own age

organization constituted from four age sets, and through the age set they belong to, they have their own age peers with whom they maintain strong ties even after they are married. The age sets are organized into a hierarchical age organization which forms the social basis of women's solidarity in the Yellow Bull and a means of resisting interference by men. For women of the Yellow Bull, FGC has thus become the mark of their identity and secured communality, and is embedded into the solid age organization.

Though there was a discrepancy between the way women and men interpreted its symbolism, FGC itself was not problematic until the first decade of the twenty-first century when the situation changed. The ban on FGC intensified in Ethiopia, and men's intervention in FGC became apparent among the Yellow Bull.

3.4 Abolition of FGC in the Yellow Bull

3.4.1 FGM Abolition Campaign Among the Yellow Bull

The situation concerning FGC in the Yellow Bull changed in 1999 when a girl bled to death after FGC. People said that she drank too much alcohol before the procedure, to ease the pain. The circumciser was caught by the police and jailed for six months. Before then, people did not worry about the risks of FGC or local government interventions. This incident made them recognize that FGC could become a pretext for the government to intervene in their customary practices.

As the abolition campaign spread into the district, it began to influence local politics.[9] For example, in 2003, a young official of the Yellow Bull was expelled from the administrative office of the district for performing FGC on his bride when he married. However, it was performed in the bride's house by her female relatives

[9] The abolition of FGC in Ethiopia was attempted for the first time by the National Committee on Traditional Practices of Ethiopia (NCTPE) in 1987. The NCTPE changed its name to "Ye Ethiopia Goji Limadawi Dirgitoch Aswogaj Mahiber" (EGLDAM) in 2004, and then to "Organization for the Development of Women and Children in Ethiopia" (ODWACE) in 2009. ODWACE ceased attempts at FGC abolition shortly after the Charities and Societies Proclamation No. 621/2009, which regulated NGOs concerned with human-rights activities, came into force in 2009.

The federal constitution of 1997 prohibited the physical and mental oppression of women in general. It was a criminal law revised in 2004 that decreed, "Whoever circumcises a woman of any age is punishable with simple imprisonment for not less than three months, or fine not less than five hundred birr." It went on to say that "whoever infibulates the genitalia of a woman is punishable with rigorous imprisonment from three years to five years, that where injury to body or health has resulted due to the act […] the punishment shall be rigorous imprisonment from five years to ten years" (Proclamation No. 414/2004).

In tandem with strengthening the law in 2009, the Ethiopian government started campaigns of FGC abolition through the media, schools, and gatherings in local communities. The government had hastened to expand the network of health extension workers in provinces, and the abolition of FGC was incorporated in this policy (Boyden et al. 2012). Additionally, many local NGOs addressed this issue in local communities with the assistance of international NGOs

according to custom, and he could not prevent it. He was said to have been entrapped by his rivals in the office.

At about that time, in one of the territorial areas of the Yellow Bull, the chair of the ward (*kebele*) attempted to entrap his political rival by utilizing FGC. The chair threatened his rival, saying that he would report the circumciser to the authorities if the rival let his sister undergo FGC at her marriage ceremony, which was being planned at the time. The circumciser yielded to the threat and cut just a little bit of the bride's genitalia. However, the relatives of the bride and groom got angry, criticized this circumcision, and the rival of the chair faced a difficult predicament. Thus, FGC was used as a tool for political sabotage.

In 2006, one NGO launched a campaign to abolish FGC among the Yellow Bull. The campaign was led by a staff member of the NGO who came from the Yellow Bull. He gathered the elders, youth, chairmen of *kebele*, and health extension workers, and organized workshops where participants discussed the "harmful traditions" that hindered the development of the Yellow Bull.

First, they tackled the problem of HIV infection. The members of the NGO taught the participants how the virus spread and explained that extramarital sexual relations, which were not uncommon among the Yellow Bull, accelerated the rate of infection. After two years of such informational sessions, the participants were said to have recognized the risk of HIV infection and started to refrain from extramarital relations. Until then, during the off-season of agriculture, when marriage ceremonies were held, circumcisers used the same knife when cutting the genitals of all the brides. However, after the campaign, they started using a new razor for each FGC.

The NGO also tackled the custom of the abandonment of the first newborn twin, the taboo against using ox plows and gathering honey, and finally FGC. Although the campaign for the first three taboos was well accepted, opposition to the FGC ban was very strong. The NGO explained the health problems that FGC caused girls, but the participants did not agree to a complete ban on the practice. Despite their resistance to a ban, however, the number of patients who underwent clitoridectomy gradually increased. The NGO's efforts continued until 2013, when the ceremony of FGC abandonment was held at the Yellow Bull.

Meanwhile, the local government's regulations against FGC became stricter. In 2010, the local government gathered educated Yellow Bull men in the town near the administration office. The lecturers dispatched from the provincial capital taught the risks of FGC and told them to organize a committee to abolish "harmful traditions." Although the committee was organized, the members did not initiate any major activities because they knew that abolition was quite difficult. However, as pressure from the state increased, the officials who worked in the local government made every effort to make the committee more functional. They established the posts of chair and secretary of the committee and assigned members to these posts.

3.4.2 Failure of Abolition

By order of the local government, a man was nominated as the chair. After initially refusing, he was persuaded to accept the position. He was the first man among the Yellow Bull who had been educated and had been attempting to reform their "traditions." He was already opposed to FGC because of the health issues. He had many acquaintances among elderly women and participated in the activities of the Women's Association. He tried to persuade some elderly women in the association, but they disagreed. They insisted that the FGC was a tradition, and they wanted to continue it. After some discussions they arrived at a compromise. The women decided to stop excision in favor of clitoridectomy. They did so because the NGO had launched a campaign about FGC health problems, and awareness of health problems and HIV infection had spread among them. Furthermore, having observed the brides who, based on the NGO's warnings, had undergone clitoridectomy instead of excision, they recognized that the clitoridectomy wound healed much faster than that of excision.

The man developed a strategy to satisfy local governments. The Yellow Bull would tell the government they had abandoned FGC, while in practice, the lighter type of FGC would continue. The man energetically organized meetings of women in each territorial section, each age set, and each clan, and gradually got them to reach a consensus. Once a consensus was reached, he convinced the male elders and prepared a ceremony for "the abandonment of FGC."

In 2013, a big feast to celebrate the abandonment of FGC was held in one of the territorial sections of the Yellow Bull. The officials of the local government, NGO members, and the elders gathered. Oxen were slaughtered, and meat was served to the participants. The chiefs were recognized as persons of merit for their role in the abandonment of the FGC. The NGO funded this ceremony and bought oxen and small livestock for the feast. Ornaments and clothes were bought for the chiefs who won awards. Although it was officially declared that the Yellow Bull abandoned all FGC, they continued practicing the lighter type of FGC. This strategy, however, did not last long.

At that time, the Yellow Bull sometimes brought women who had birth problems to the clinic of a town near the office of the local government. While examining the patients, medical staff of the clinic noticed that women of the Yellow Bull were still undergoing FGC. Furthermore, two women of the Yellow Bull died during childbirth at the clinic, and on receiving reports of those incidents, the local government insisted those deaths were caused by FGC and resumed strictly enforcing the FGC ban among the Yellow Bull.

Women of the Yellow Bull considered this to be unjust, since their FGC had changed from excision to clitoridectomy. According to one of the women, their view was as follows: "Since long ago, women have sometimes died in childbirth. Cows may die, and goats may die when they give birth. The government ascribes the mother's death to circumcision. Even wild animals die when they give birth, but they do not undergo circumcision." However, their opinions were not considered.

The elders of the Yellow Bull also tried to resist the government's policy. Their strategy was to evade enforcement. They postponed marriage ceremonies among the Yellow Bull for eight months so that FGC at the ceremony would not become an issue. They planned to resume ceremonies if pressure from the government eased.

However, this strategy failed because of the government's hardline stance. In 2014, the government dispatched policemen to the Yellow Bull, apprehended the elders, and put them in jail. The elders of the northern territorial section surrendered to the government immediately and promised to resume marriage ceremonies. The government dispatched health extension workers guarded by policemen and allowed them to check the genitals of the brides.

The surrender of the elderly and subsequent government measures generated antipathy and anger among the people. The unmarried girls who had not undergone FGC were angriest. All unmarried girls disappeared from the settlement of the Yellow Bull. They planned to flee across borders to neighboring states. They were angry because they felt that the entire process was determined by men, including the elders and officials of the Yellow Bull. They thought that they themselves should make decisions on this matter. The girls who fled from the settlements were persuaded to return, but a girl who had just married, and who was suspected of being the leader of this exodus, was accused of having undergone FGC, and was caught and sentenced to three months' imprisonment. She was jailed for being cut, not for cutting.

In 2014, marriage ceremonies resumed, and health extension workers checked the genitalia of the brides to ensure that they had not undergone FGC. However, the youth in the southern territorial section were infuriated. When health extension workers and policemen approached their settlements, the youth held them off at gunpoint. The government detained some women of the southern territorial section in retaliation, but the youth attacked the jail and released them. The youth of the northern territorial section, who were agitated by the southern youth, also vowed to resist the government. The government then relented.

3.4.3 Stakeholders and Politics of FGC

The case of the Yellow Bull shows how strict abolition campaigns can bring about twisted results as they reached the grassroots, and the attitudes of stakeholders concerned with the abolition of FGC varied according to their social positions.

For women of the Yellow Bull, FGC was an important symbol of their gender and ethnic identity. They believed that they themselves should decide on matters concerning FGC. Women learned of the health problems caused by FGC and gradually accepted clitoridectomy, the lighter type of FGC. However, they strongly opposed a complete ban.

The man appointed as chair of the abolition committee attempted to bridge the gap between the government and the Yellow Bull women. Though he had once supported the abolition of FGC, he accepted the opinion of the women and came up with a scheme that he considered to be a compromise. FGC was not an issue of

tradition for him, but an issue of health and the gender identity of women. However, his strategy failed because of the government's strict stance.

Those who opposed the ban most stubbornly were the youth in the southern territorial section. There were two factors that made them reluctant to go along with the ban.

One is the distance from the state power. Ever since the Yellow Bull was ruled by the state, the government-backed mediators who ruled the Yellow Bull came from the northern territorial section. The southern territorial section was deprived of the chance to produce such mediators. Since they had been alienated from state power, they were deeply resentful of state rule. The government ban on FGC was considered another interference in their tradition by the "disgusting" highlanders.

The other factor was the ceremony of the age organization. At the time, the transition ceremony of the generation set, which is performed once every 30 years, was approaching. Once the transition was complete, the youth would become elders expected to lead each territorial section. They believed that if important traditions such as FGC were abolished around the time of their transition ceremony, it would bring shame to the name of their generation set. Thus, they feared the government's abolition of FGC would damage their own ethnic and gender identities as guardians of their tradition.

The elders of the northern section feared that there would be severe consequences if they resolutely opposed the government. Some of them admonished resisters to obey the government by referring to the invasion of the Ethiopian Empire and the subsequent massacre that occurred 100 years ago. Instead of open resistance, they attempted a strategy of postponement which was the "weapon of the weak" they resorted to when the government imposed unreasonable demands on them. However, this time, government officials were also from the Yellow Bull and saw through their strategy. Confronted with the government's strict measures, the elderly chose to surrender rather than engage in all-out resistance.

Officials from the Yellow Bull were also caught between resistance from the people and the orders from their superiors. Since they knew the situation of the Yellow Bull very well, they recognized that completely abolishing FGM would take a long time. Nevertheless, they took strict measures to try to abolish the practice because the pressure from provincial officials was very strong. The Yellow Bull is a small ethnic group with no officials above the district. Thus, it was difficult for them to defy the orders of their superiors. For officials of the Yellow Bull, arguing back against a direct order was very difficult. If they did not obey the order, they would be accused of colluding in illegal practices. They could not help but proceed with the policy.

3.5 Conclusion

The case of the Yellow Bull shows how strict abolition campaigns for zero tolerance can bring about twisted results when reaching grassroots society. The straightforward enforcement of abolition resulted in multiple conflicts, as described above.

The abolition discourses of the WHO face many difficulties which seem to stem from the way in which the WHO conceptualizes FGC. First, the definition of FGC is quite abstract and detached from the historical and social contexts in which it is practiced, and where practice is quite varied. Second, it lacks a comparative perspective with other risks and values found in actual communities.

FGC is embedded in societies not uniformly, but in various ways, depending on the society. If the abolition of FGC is intended to empower women and to improve the social conditions in which they live, it is necessary to first investigate what kind of conditions they live in, and what kinds of customs and deeds they value. Instead of strict measures of zero tolerance, it is necessary to look for an approach that is localized to each society, particularly when FGC is accepted by inhabitants. Such an approach would incorporate all the stances local stakeholders take on FGC and would attempt to find the best compromise. Such an approach may seem moderate, but it would be accepted by them, and would be a first step toward stopping this practice.

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Yukio Miyawaki, Ph.D. is a professor of area studies and cultural anthropology at the Graduate School of Sustainable System Sciences, Osaka Metropolitan University, Japan. He has been studying agro-pastoral societies in Ethiopia, focusing on their natural-resource utilization, historical memories, and the effects of agricultural development projects on these societies. Recent publications are "The Interethnic Relationship between the Hor and Ts'amako," in Echi Christina Gabbert and Sophia Thubauville, eds., *To Live with Others. Essays on Cultural Neighborhood in Southern Ethiopia* (Cologne: Rüdiger Köppe, 2010) and "Development of Community-Based Organization by Agro-Pastoral Women: A Case in Southwestern Ethiopia," *Nilo-Ethiopian Studies* 23 (2018): 1–22.

Chapter 4
Ending Female Genital Mutilation: Progress and Challenges in the Somali Region, Ethiopia

Getaneh Mehari

4.1 Introduction

Female genital mutilation (FGM) is defined as a practice that embraces "all procedures involving partial or total removal of the external female genitalia or injury to the female genital organs for non-medical reasons" (WHO 2014). FGM involves practices such as cutting, piercing, removing, and sewing the external parts of female genitalia (Muteshi et al. 2016). It is classified into the following four broad types: Clitoridectomy (Type I), a partial or total removal of the clitoris; Excision (Type II), a partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora; Infibulation (Type III), narrowing of the vaginal opening through the creation of a covering seal; and other (Type IV) which refers to all other harmful procedures to the female genitalia for non-medical purposes (WHO 2014).

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).

Different types of FGM are practiced in Ethiopia. According to the demographic and health survey of Ethiopia, the overwhelming majority of women in the 15–49 age group, 73%, have undergone excision, while 7% have experienced infibulation and the remaining 3% have undergone clitoridectomy. Somali, Afar, and Harari are

G. Mehari (✉)
Department of Social Anthropology, College of Social Sciences, Addis Ababa University, Addis Ababa, Ethiopia
e-mail: getanehmeh@gmail.com

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the three regions where infibulation is widely practiced. The age of girls having undergone FGM also varies across regions. FGM is performed shortly after birth in the Amhara, Tigray and Afar regions as well as in northern parts of Oromia. In southern Ethiopia, it is practiced when girls are approaching the age of marriage as it is practiced mostly as a rite of passage in preparation for marriage. In most cases, it is performed by traditional practitioners in Ethiopia (CSA and ICF 2016).

Female genital mutilation is practiced in 27 countries in Africa. The prevalence of FGM among women aged 15–49 years is very high in some African countries, for example, it is 98% in Somalia, 93% in Djibouti, 91% in Egypt, 89% in Eritrea, and 88% in Sudan. In Nigeria, Kenya, and Senegal, on the other hand, its prevalence is relatively low (27%, 27% and 26%, respectively). In Ethiopia its prevalence is lower than in countries such as Somalia but higher than in Kenya and Senegal. Around 74% of girls and women in the 15–49 years age category are circumcised in Ethiopia (UNICEF 2013). According to the sources, FGM has declined from 80% in 2005 to 65% in 2016 and has been declining even more among girls under 15 years (CSA and ORC Macro 2006; CSA and ICF 2016). The prevalence varies considerably from region to region within Ethiopia. It is very high in regions such as Somali region (99%), Afar (91%), Harai (82%), and Oromia (76%) and lower in Gambela (33%) and Tigray (24%). According to sources, the practice is declining in some regions unlike the Somali region where it has remained at 99% (CSA and ICF 2016) (see Fig. 4.1 which is based on the findings of the 2016 Ethiopian Demographic and Health Survey).

Several studies conducted among Somali communities not only in Ethiopia, but also in Kenya and Somalia, show that changes towards abandonment of the practice

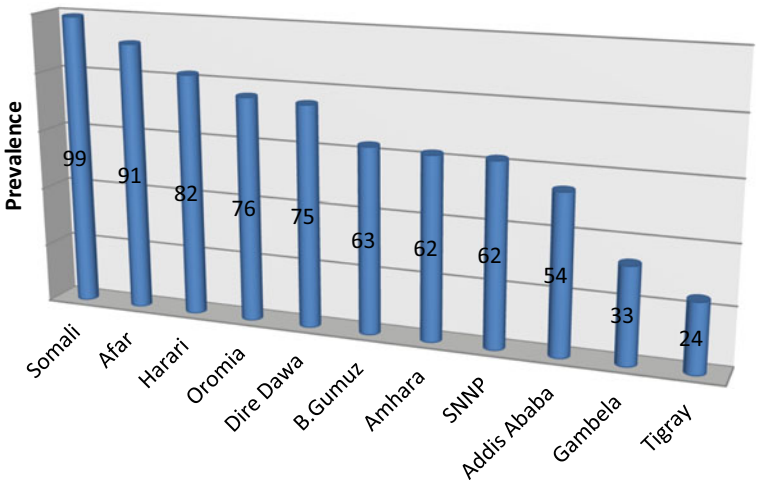

Fig. 4.1 Prevalence of FGM among women aged 15–49 years in Ethiopia by region (CSA and ICF 2016)

are minimal, with only slight shifts to the less severe form of FGM (Sunna circumcision) and more medicalization of the practice (e.g., Mehari et al. 2020; Kipchumba et al. 2019; Powell and Yussuf 2018; Smith et al. 2016; Vestbostad and Astrid 2014).

4.2 Objectives and Methods

4.2.1 Objectives

Despite continuous efforts, the major challenges hindering the abandonment of FGM after decades of interventions are not adequately explained. This chapter examines these challenges, relying on data collected from a rural community (community Q), and a town (Town B) in the Somali region. It aims to assess efforts and interventions aimed at eliminating FGM; examine achievements in fostering the abandonment of the practice, and explore specific challenges that hinder such efforts.

4.2.2 Methods and Sources of Data

Primary and secondary data were gathered from various different sources. Secondary data were gathered from sources such as country profiles, documents in government offices (including women's affairs offices), documents of NGOs working on women and children, journal articles, books, official survey reports and other online sources. A desk review (Mehari et al. 2018) accomplished as a prelude to an FGM research project was also used as a source. The latter compiled information on FGM norms, practices and interventions intended to eliminate FGM in the Ethiopian context.

Much of the qualitative data was gathered in 2019 for a research project entitled "Exploring and tracing changes in FGM: Shifting norms and practices in Ethiopia." The data was collected through multiple methods: in-depth interviews, key informant interviews, and focus group discussions.[1] The field work was conducted in April and early May of 2019 in two research sites located in Oromia regional state and Somali regional state. This chapter relies on qualitative data gathered from two sites in the Somali region: *kebele*/community Q (rural community) and town B.

Qualitative field data was collected from different categories of participants in order to capture diverse views and voices. Twenty four participants were involved in individual interviews (in-depth interviews and key informant interviews): village elders (2), leader of women's groups (1), religious leader (1), government official (1), healthcare workers (2), FGM program implementers (2), mothers of girls (5), fathers of girls (5), and girls aged 15–17 (5). Another twenty eight community members participated in four focus group discussions. The focus group discussions involved

[1] The research project was funded by Population Council and led by the author (Principal Investigator of the project) of this chapter.

four categories of participants: younger women (aged 18–35), older women (40+ years old), younger men (18–35) and older men (40+ years old).

4.2.3 Study Sites and People

Ethiopia is a land-locked country located in the Horn of Africa. It has the second largest population in the African continent. According to projection based on the United Nations data, its population has reached 120 million in 2022 (World Population Review 2022). Ethiopia shares boundaries with six countries: Sudan, and South Sudan in the west, Eritrea in the north, Djibouti and Somalia in the east, Kenya in the south. The political map of the country comprises 9 regional states[2] (Tigray, Afar, Amhara, Oromia, Somali, Benishangul-Gumuz, Gambela, Harari and Southern Nations, Nationalities and Peoples' Regional States/SNNPRS) and two city administrations (Addis Ababa and Dire Dawa). The current administrative structure of Ethiopia has five levels: the Federal State, Regional States, Zones, Districts (known as *woreda*), and *kebeles* (the lowest administrative units in the country).

The Somali region, from which data for this study was gathered, is the second largest regional state in Ethiopia. More than 95% of the region's population are ethnic Somali and adherents of Islam. The Somali of Ethiopia share the same ethnic and religious identities with the Somali of the neighbouring countries: Djibouti, Somalia, and Kenya. The total population of the Somali region was estimated to be 5,748,998 in 2017 (CSA 2013). The Somali share a common language, a belief in a common ancestry, and religion (Islam). Islam plays a central role in the modern Somali identity (Adugna 2004). The major source of livelihoods for most of the Somali population is nomadic pastoralism characterized by herding livestock (camels, goats, and flocks of sheep) and agro-pastoralism, which mixes livestock herding and crop farming.

4.3 Analysis of Findings

4.3.1 Interventions: Agents and Strategies

Various agents have been engaged in FGM interventions in the Somali region. Government institutions and offices such as women's affairs offices, health bureaus, healthcare institutions, and schools have been the major actors in the implementation of FGM programs. Other actors include local NGOs, United Nations organizations (e.g., UNICEF) and other international NGOs (e.g., Save the Children). Religious leaders and community leaders have also played a central role.

[2] Two regional states (Sidama Region and South Western Peoples Region) are added after the 2018 political changes in Ethiopia.

Health extension workers (HEWs) are involved, for example, in disseminating information related to FGM and educating women at the grassroots level. Healthcare workers serving at health care facilities (clinics, health centres, and hospitals) have been engaged in teaching about the health consequences of FGM and providing clinical services. School teachers also play an important role in establishing girls/FGM clubs and informing girls about the negative implications of FGM. The health education of schoolgirls has furthermore had a reverberating effect on other members of the community, mainly the parents of those girls who gained FGM-related knowledge from school clubs. Actors implementing FGM programs have employed diverse approaches to accelerate the abandonment of the practice. They have used the health approach to enhance awareness of the health implications of FGM. Religious and legal approaches have also been used to accelerate the abandonment of the practice.

4.3.2 Ending Female Genital Mutilation/Cutting: Progress and Challenges

With reference to the data collected from community Q and town B in the Somali region, this section explores both the progress and the challenges related to efforts aimed at ending FGM. It reports on public awareness in the community, cultural motives for continuing the practice and discusses how some of the obstacles revolve around the double meaning and ambiguities in how FGM is defined and what it constitutes. The double standards of some religious leaders who exploit this ambiguity are also discussed.

4.3.2.1 Changes in FGM-Related Awareness

Progress observed in the Somali study setting was mainly limited to an increased awareness related to the health risks and negative impacts of infibulation, locally known as Gudnika Faronika. Most of the community members participating in the study showed awareness of the health problems associated with Gudnika Faronika, such as bleeding, infections, severe pain during sex and complication during child delivery. Despite this public awareness, there was some confusion around what constitutes FGM. Many equated the abandonment of FGM with the abandonment of Gudnika Faronika. Shifting from infibulation to the less severe form of the practice (known as Sunna) was commonly regarded as abandonment of FGM. This misunderstanding was widely observed among different categories of participants including health extension workers. The following short excerpt quoted from one of them clearly demonstrates this reality:

> The culture of Gudnika Faronika has extremely affected women of our community. That is, women have many reproductive health problems and these problems are caused by Gudnika Faronika. Therefore, I advise women to abandon Gudnika Faronika and shift towards the Sunna type.

Advising community members to practise the Sunna circumcision is widely observed in the Somali study setting. Besides HEWs, other change agents (e.g., FGM program implementers, women's representatives at the grassroots level) advise community members to shift to the Sunna type as a means of abandoning infibulation. The following quotation from a representative of women's affairs section at the grassroots level is revealing. As women's affairs offices are the leading government actors implementing and coordinating anti-FGM interventions, the woman was expected to support efforts aimed at eliminating all forms of FGM. Instead, in addition to encouraging community members to practise the Sunna cutting, she revealed her intention to let her daughters undergo the Sunna circumcision.

> Now how can we stop female circumcision? We are not ready to abandon it. I have six daughters and I am not ready to leave them uncut. I prefer the Sunna type for my younger daughters. I have already circumcised two daughters … They have undergone Gudnika Faronika. Then I am planning to let the remaining four daughters undergo the Sunna cut … Now I don't want to let my girls undergo Gudnika Faronika. I prefer the Sunna type and I think it is easy and my four girls will not suffer. (*Kebele* women's affairs representative, late 50s)

These examples show how contested the meanings are around FGM and it is one of the major obstacles to eliminating all types of FGM. Most of the study participants considered FGM and Gudnika Faronika (infibulation) as synonymous. This conflation of FGM with infibulation leads to the suggestion that the Sunna type does not constitute FGM. Thus local discourses relating to the abandonment of FGM do not refer to the Sunna type, which is regarded as a mere mild and symbolic cutting of the clitoris intended to purify girls. This is one of the main obstacles to achieving the ambitious global target of "zero tolerance to FGM" and "ending FGM by 2030."

In addition to hindering the abandonment of the practice, the association between FGM and Gudnika Faronika has implications for the enforcement of the anti-FGM law. The Ethiopian Criminal Code (FDRE 2005) criminalizes all forms of FGM regardless of their severity and level of health related risks. Despite this, however, the local understanding of the law is confined to Gudnika Faronika/infibulation. Accordingly, practicing Gudnika Faronika is understood as violation of the law and subject to legal sanctions. Once again, the Sunna cut is removed from local discourses related to anti-FGM law. This misunderstanding leads to a widely held assumption that Gudnika Faronika is illegal but that Sunna cutting is not. This view resonates in what a Somali FGM program implementer boldly noted: "…the pharaonic version is officially banned and the Sunna version is not officially prohibited." This not only contradicts the articles of the criminal law but also has implications for the enforcement of the anti-FGM law.

4.3.2.2 Marriageability, Purity and Virginity

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. This assertion implies that the Sunna cut does not contradict Islamic teachings. The following excerpt portrays this view in clear terms.

> Today we understand that Gudnika Faronika is in contradiction with Islamic teachings and recognize its health problems. It is also considered as a sign of backwardness. Therefore, we are inclining toward the Sunna type and Sunna is becoming a sign of civilization. Today we are well aware of the negative impacts of Gudnika Faronika. (Father of girls, 48)

4.3.2.5 Role of Religion and Religious Leaders

The major findings of the study, as mentioned in the previous sections, demonstrate the huge role of religion and religious leaders in constructing and deconstructing meanings related to FGM, denouncing one type of FGM and depicting the other type as a religious requirement. The role of religion and religious leaders will be examined in the following section as it deserves further discussion.

According to study findings, the two types of FGM, Gudnika Faronika and Sunna, are portrayed in local discourses in different ways. Gudnika Faronika is considered as a pre-Islamic practice that contradicts the Islamic teachings and the Sunna cut as mild practice aimed at purifying girls. The following quote from a program implementer

reveals the role of religious leaders in constructing meanings of FGM in the context of the study area.

> Religious leaders are involved in informing community members who are sometimes confused … Sheiks support the Sunna cut, arguing that the pharaonic type contradicts with Islam. However, ignoring the teachings of religious leaders, community members practice Gudnika Faronika declaring [pretending] that they are practicing the Sunna type. Religious leaders supported the Sunna type because they said that it is written in the religious Hadiiz. But no one is sure about it. (FGM program implementer)

As depicted above, the involvement of religious leaders in FGM-related discourses and practices in the Somali setting has a dual face. First, religious leaders support the abandonment of Gudnika Faronika (infibulation) depicting it as a pre-Islamic practice. Second, they encourage the Sunna circumcision as a religious obligation. This shows the contentious position of religious leaders in FGM discourses. Their ambivalent attitudes have exacerbated the problems facing FGM abandonment projects. The program implementer quoted above added the following words when asked about the major challenges of anti-FGM interventions in the region: "The major challenge is that religious leaders support the *Sunna* form of circumcision."

Findings generated from the field data show the influence of religion and religious leaders on the effectiveness of FGM interventions. Religious discourses and definitions related to FGM play an important role in this regard. The following quote from a key informant from an international NGO working on women and child issues in the Somali region reveals the reality.

> We work in collaboration with clan leaders and religious leaders who have a good image in the community. Then, we implement the project activities through clan leaders and religious leaders and they are mostly involved during awareness creation programs. That is, during awareness creation programs elders [clan and religious leaders] inform their community members about the negative impacts of FGM. They tell the community that FGM is a non-religious practice and practicing FGM [pharaonic type/infibulation] to circumcise girls is unethical. (FGM program implementer)

The quotation also depicts how FGM is equated with the pharaonic type and other forms like the Sunna cutting are not targeted in the elimination project. The following long quotation from another key informant engaged in the implementation of anti-FGM programs further elaborates the influence of religious leaders in denouncing Gudnika Faronika by resorting to historical and religious accounts.

> Religious leaders are recognized as the most influential social actors and key agents that can accelerate the abandonment of FGM … Religious leaders associated the practice [Gudnika Faronika] with the devil's act of circumcising girls. They teach the history [alleged origin] of Gudnika Faronika associating it with the practices of the rulers of ancient Egypt named Pharaon. The Pharaon claimed that he was "God" and much hated in the Islamic teachings… Religious leaders played a great role in informing people that FGM is not a religious obligation in Islamic teachings and it is totally against Islam. They are involved in campaigning against the negative impacts of FGM and most of the time they teach people during public gathering at mosques and during public meetings, and holidays. I can say that religious leaders play positive role in the process of abandoning FGM. (Young woman, FGM program implementer)

This excerpt provides an insider's point of view as the informant is a member of the Somali ethnic group and a follower of Islam. It also provides an insightful account of the reality on the ground as reflected by an educated Somali young woman who was working for an international NGO implementing interventions intended to foster the abandonment of FGM. The long quotation below also reflects the views of the same key informant on issues such as the shift from the pharaonic type to Sunna circumcision, the role of religious leaders in denouncing the pharaonic type and supporting the Sunna cutting, and the overall trends of abandonment and continuation of FGM in the study area. The key informant said the following when asked this question: Is there a shift of FGM from pharaonic type to Sunna type?

> This is a great question as it is locally believed that Sunna [circumcision] is allowed in our religion [Islam]. … It is said that Sunna is the type of female circumcision allowed among Muslims. Sunna is only cutting small slice of the clitoris. Therefore, Sunna is allowed in our religion. However, some NGOs do not tolerate even the Sunna type which is practiced and accepted by many people of the region …Look our project program is titled 'No Girl or Woman Shall Undergo FGM: Cementing Change towards Zero Tolerance to FGM'. That zero tolerance means… not touching the genital parts of a girl and it also rejects the Sunna type, which many religious leaders are recommending to be practiced. There is also clear misunderstanding between NGOs and the wider community members. There is great confusion over what local people regarding [sic] appropriate and what NGOs are looking for.

The above excerpt provides an insight into misunderstandings between FGM program implementers and community members (including religious leaders) on basic issues such as the meanings and abandonment of FGM. The field data clearly reveal that organizations engaged in anti-FGM campaigns failed to foster the abandonment of all forms of FGM. This is mainly because religious leaders' portrayal of the Sunna cutting as a religious obligation has been widely accepted in the study area. Recognizing the influential role of religious leaders, NGOs have attempted to convince them to condemn all forms of FGM. The young Somali woman quoted above said the following about the effort of her organization and the challenges it encountered.

> We have requested many influential religious leaders to come together and denounce all forms of FGM. However, some religious leaders got into a heated argument over the issue, denouncing all forms of female circumcision. Then, strong arguments, debates for and against female circumcisions divided the religious leaders and this further increased the confusions over the question of abandoning FGM. Then, it totally become difficult to officially denounce the Sunna practice and now the project implementers are forced to accept the reality on the ground that people offered a strong resistance to the idea of stopping the Sunna cutting. Now the campaign targets the Pharaonic version not the Sunna version. In a nutshell, the Pharaonic version is officially banned and the Sunna version is not officially banned.

These excerpts reveal the arguments and counter arguments around this issue. The association between FGM and Islamic teachings remains controversial and the notion of denouncing all types of the practice (including the Sunna type) is contested. Though religious leaders tend to denounce the pharaonic type, they are not ready to support the abandonment of the Sunna circumcision. It seems that the pro-Sunna

position of religious leaders is behind the strong resistance to the complete abandonment of FGM, which has forced actors implementing FGM programs to retreat from the total abandonment approach to the abandonment of infibulation.

4.4 General Discussion

Government agencies, domestic and international organizations have been implementing FGM interventions in the study sites of the Somali region, Ethiopia. The widely employed intervention methods include the health risk and religious approaches. Despite this, however, changes in FGM-related norms and practices were limited to a growing public awareness related to the health implications of infibulation, locally known as Gudnika Faronika. Emphasizing infibulation, the health approach excluded the Sunna cutting from efforts to eliminate all forms of FGM. Similarly, according to other studies in Somaliland, though the health approach enhanced people's awareness of the health risks of infibulation, it undermined the harms of the Sunna circumcision, which is considered as a mild cutting of clitoris without significant health implications (Kipchumba et al. 2019; Lunde and Sagbakken 2014; Vestbostad and Astrid 2014). The religious approach has been widely used in FGM intervention in the Somali region of Ethiopia. The influence of religious leaders on FGM has been mixed. While encouraging the abandonment of infibulation by depicting it as a pre-Islamic practice that contradicts Islamic teachings, most have supported the continuation of FGM by portraying the Sunna circumcision as a religious obligation. The dual role of religious leaders in hindering the abandonment of FGM was also observed by other researchers (Kipchumba et al. 2019; Powell and Yussuf 2018; Lunde and Sagbakken 2014). Researchers have also noted the shift towards the Sunna circumcision rather than total abandonment of the practice in Somalia and Somaliland (Powell and Yussuf 2018; Smith et al. 2016; Vestbostad and Astrid 2014). Furthermore, studies in Ethiopia observed this same shift in Somali, Afar and Harari regions (Mehari et al. 2020; Spadacini and Nichols 1998), partly as a form of resistance to total abandonment of the practice (NCA 2011).

This does not mean that the associations between FGM and notions of purity versus impurity are limited to the context of Islam (e.g., Umeh et al. 2021; Mehari 2014, 2016; Terefe 2012). Umeh and associates (2021) point out a close association between FGM and the physical cleanliness of women in the socio-cultural context of Nigeria. People will practice FGM on a dead woman (if found uncut upon her death) to purify the body before the burial ceremony (probably to protect humans and other beings, and the land, from pollution). FGM is also practiced immediately before birth of a child if the mother is found uncut, to protect the child from touching the clitoris (to safeguard the child from pollution) as the clitoris is deemed unclean and polluting. Although the authors noted the connection between FGM and beliefs in purity/impurity, they did not explain the relationship between these beliefs and indigenous religions. According to ethnographic findings, in some African cultures FGM-related notions of purity, impurity, and pollution and taboos associated with

them are so embedded in indigenous religions that they continue influencing human collective behaviour (Mehari 2016; Terefe 2012).

The influence of taboos in sustaining FGM norms and practices has been observed in the Gamo (e.g., Mehari 2014, 2016) and Arsi Oromo (Terefe 2012) cultural settings in Ethiopia. Local concepts such as *qetsera gome* (taboos related to FGM) and *tuna* (the state of impurity) are good examples in the Gamo cultural setting. Among FGM-practicing Gamo communities, uncut girls/women are not only regarded as *tuna*, but also as having a potential to pollute others; for instance, when men have sex with them. According to the Gamo belief system, impurity related to FGM is contagious; for example, a man who had sex with an uncut woman would pollute a cut (purified) woman if he sleeps with her before cleansing himself with rituals. This belief in purity and pollution is embedded in the indigenous belief system in the Gamo highlands where Christianity is a universal religion. Although these findings are limited to few cultural settings, they throw light on the role of indigenous religions in supporting FGM norms and practices in African contexts. Hence, one can argue that the roots of FGM-related notions of purity and impurity in predominantly Muslim societies (e.g., the Somali) could be in pre-Islam indigenous belief systems; and these beliefs could have been intermingled with Islamic teachings that support the Sunna circumcision. The claims that Gudnika Faronika is pre-Islamic may well have elements of truth.

The association between FGM and collective religious/ethnic identity also plays an important role in sustaining the practice in the context of the Somali region of Ethiopia. "Uncircumcised woman is not considered as a Somali and a Muslim," a widely observed assertion of study participants, is a good example that demonstrates the role of FGM as a collective identity marker. Sanctions against uncut girls/women (including humiliating songs, insulting words, social and religious exclusion) serve the purpose of protecting these collective identities. The function of FGM as a symbol of collective identity is yet another challenge that hinders the abandonment of the practice in the Somali region. Findings in other African countries support this argument. In Egypt, where FGM is widely practiced, the prevalence of FGM has been declining at a higher rate among Coptic Christians compared to slow changes among Muslims. The prevalence of the practice among Muslims remained more stable mainly because FGM is considered as a symbol of collective identity (Blaydes and Platas 2020; Hayford and Trinitapoli 2011). FGM also serves as a symbol of collective identity (Mehari 2016; Coyne and Coyne 2014; Wagner 2011) and a socio-cultural boundary between FGM-practicing and FGM-free communities living in close proximity (Mehari 2016, 2014). Analysing cross-sectional data from 13 African countries, Wagner (2011) noted that the function of FGM as a symbol of ethnic identity is a main factor in the continuation of the practice. This argument is more relevant to the Ethiopian setting where regional boundaries follow ethnic lines and the country's politics is dominated by competing ethnic (in some cases religious) identities.

4.5 Conclusion

The mottoes of the global FGM campaigns, including "Zero Tolerance for FGM" and "Ending FGM by 2030," are intended to eradicate all forms of the practice. Actors implementing FGM programs in the Somali region are informed by these and other global catchwords. For example, "No girl or woman shall undergo FGM: Cementing change towards zero tolerance for FGM" is a motto of an NGO running FGM programs in the region. Despite the rhetoric and ambitious plans, there is a huge gap between what program implementing agencies aspire towards and the realities on the ground. The absence of a common understanding on the very meaning of "FGM" hinders the success of FGM campaigns. For program-implementing organizations, "FGM" embraces all forms of female genital mutilation; similarly, "abandonment" implies stopping all types of FGM. According to the widely observed local misunderstanding, however, "FGM" implies Gudnika Faronika (infibulation) and "abandonment" refers to both abandoning infibulation and shifting to the Sunna type of FGM.

These misunderstandings are aggravated by the double standards of religious narratives that depict the pharaonic type (infibulation) as contrary to Islamic teachings and portray the Sunna type as a religious obligation. The pro-Sunna narratives influence not only ordinary people but also local change agents (e.g., health extension workers, program implementers) who share common ethnic (Somali) and religious (Islam) identities. As a result, many of them uphold the pro-Sunna narratives and appreciate the shift to the Sunna type as a big achievement. The local reality, including an extraordinary resistance against the abandonment of all forms of FGM, has forced program-implementing organizations to shift from the "total abandonment model" to pragmatic approaches so as to accelerate the abandonment of infibulation. Overall, FGM interventions failed to foster changes towards total abandonment of the practice: infibulation is still widely practiced with slight shifts to the Sunna cutting. It will be difficult to achieve grand plans such as "Ending FGM by 2030" and "No girl or woman shall undergo FGM" without missing global targets unless local and global actors critically evaluate FGM interventions dominated by Western/global perspectives, identify their limitations, and craft locally appropriate intervention models.

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Getaneh Mehari, Ph.D. is an associate professor of social anthropology at the College of Social Sciences, Addis Ababa University, Ethiopia. He is interested in gender, legal pluralism and food security. He has been conducting research among the Gamo and Dorze in southwestern Ethiopia. Recent publications are "Cursed or Blessed? Female Genital Cutting in the Gamo Cultural Landscape, South Western Ethiopia," *Ahfad Journal* 33, 1 (2016); "Exploring Changes in Female Genital Mutilation/Cutting: Shifting Norms and Practices among Communities in Fafan and West Arsi Zones, Ethiopia," with A. Molla, A. Mamo, and D. Matanda, in *Evidence to End FGM/C: Research to Help Girls and Women Thrive* (New YorkPopulation Council, 2020).

Chapter 5
Transformation and Continuation: FGC Among the Gusii People in Western Kenya

Kaori Miyachi

Kenya has a long history of attempts to stop this practice. The challenge started at the beginning of the twentieth century with the activities of the Scottish missionaries and the colonial government among the local people, e.g., the Meru and the Kikuyu people (Hetherington 1998; Thomas 1996, 1998, 2003). The controversy regarding FC has persisted for more than one century. Recently, legal frameworks such as the Children Act (2001) and the Prohibition of Female Genital Mutilation Act in 2011 (Republic of Kenya 2012) provided for public engagement and advocacy to accelerate the eradication of this practice (Kimani and Obianwu 2020). However, even after illegalisation, the prevalence is still high among some ethnic groups such as the Gusii (Kisii)[1] people of western Kenya.

In this study, the main purpose is to focus on changes regarding FGC among the Gusii. Throughout the research (conducted by the author in 1998 and 1999–2000)[2] it was observed that there has been a growing trend to medicalize FC, reduce the involvement of cutting and bleeding, and diminish the rituals. Yet in spite of the efforts to abolish it for decades, it maintains a high prevalence. I would like to examine the reasons for its continuation with reference to current research about the Gusii.

[1] "Gusii" is used as the ethnic group name in this paper. In their local language (in *Ekegusii*), the name of the group is *Abagusii* (Singular form: *Omogusii).* Geographically, the area name is Kisii i.e., Kisii County (previously Kisii District).

[2] The author carried out the anthropological research in 1998 and then 1999–2000 for several months in some of the rural communities of Kisii Town, Kisii County. Research involved in-depth interviews with 5 nurses, 6 traditional circumcisers, 9 pairs of girls with their mothers as participant observers. There were 22 cases in December 1999. Interviews were also conducted with officers working actively for the eradication of FGM in Kisii Town, and members of a self-help group working to change the situation of gender inequality (including FC) in rural areas (more detailed information in Miyachi 2004, 2014, 2021).

K. Miyachi (✉)
Faculty of Education, Saga University, Saga, Japan
e-mail: kmiyachi@cc.saga-u.ac.jp

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5.1 Introduction

In the typology of FGM, there are three main types: Type I (clitoridectomy), Type II (excision), Type III (infibulation or pharaonic circumcision), and Type IV which is used to describe all other harmful procedures to the female genitalia in the absence of medical necessity (WHO 2010). In Kenya, several types exist. Kenya's FC eradication movement has a long history of more than one hundred years. It began at the beginning of the twentieth century with the Scottish missionaries and the colonial government (Thomas 1996, 1998, 2003; Natsoulas 1998; Robertson 1996; Adima 2020). In the 1950s, the issue became controversial under the colonial situation. The practice was considered as strongly connected with the ethnic identity of the Kikuyu people (Kenyatta 1962). In the 1970s, global attention increased and anti-FGM campaigns became widespread. Influenced by the wave of anti-FGM activity, President Daniel Arap Moi announced the presidential ban prohibiting the practice on girls. (*Nairobi Times*, "Moi Condemns Girls 'Circumcision"' July 27, 1982). The global wave promoted eradication programmes in Kenya in the 1990s and finally, it was totally criminalized in 2011 by the Prohibition of Female Genital Mutilation Act (Republic of Kenya 2012).

Kenya is recognized as a success story for eradication. However, as UNICEF has recently shown, the practice is not abolished yet (UNICEF 2021). To comprehend the continuity of the practice in this study, we will consider it from a long-term and anthropological perspective. Reference will be made to previous ethnographies of the 1940s and 1970s (Mayer 1953; Matsuzono 1991, and others) and research done during the 1990s (Gwako 1993, 1995; Miyachi 2004, 2014) as well as more recent research into the Gusii (Van et al. 2021; Matanda et al. 2021). This historical view, covering several decades of one ethnic group, will help to comprehend local people's perspectives in more depth.

5.2 Changes of FC/FGC in KDHS

In the reports of the Kenya Demographic and Health Survey (KDHS) published by the Kenyan National Bureau of Statistics (KNBS), the issue of "female circumcision" was first included in the report of 1998 (Chapter 12: Female Circumcision). The topic was covered as "gender violence" in 2003 (Chapter 15: Gender Violence), 2008–2009 (Chapter 16: Gender-based Violence), and then it was described as "female genital cutting" in the report of 2014 (Chapter 18: Female Genital Cutting).[3] The KDHS covers several issues, and interestingly includes data according to ethnic group. Figure 5.1 shows the prevalence of the practice drawn from surveys conducted in 1998, 2003, 2008–2009, and 2014, in the different areas (which correspond to ethnic

[3] The KDHS report of 1993 dealt with "Circumcision" in only two lines regarding HIV/AIDS infection (KNBS 1994, p. 127).

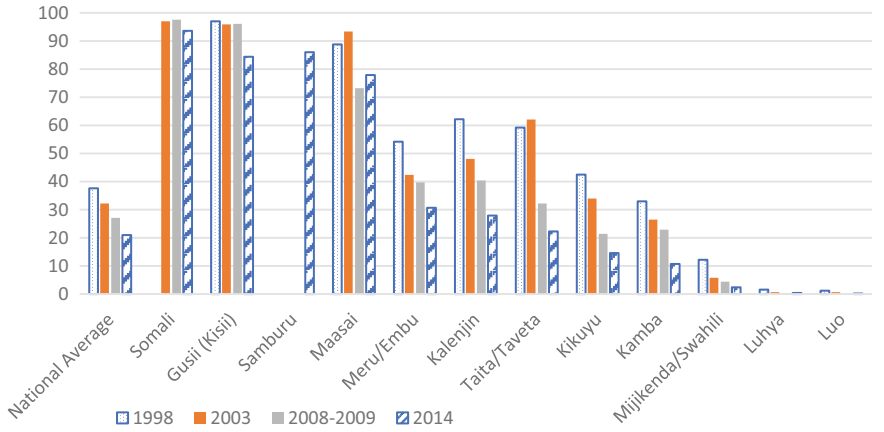

Fig. 5.1 Percentages of FC/FGC prevalence by Ethnic Group. *Source* The original data from the KDHS of 1998, 2003, 2008–2009, and 2014. Because of the limited research in some areas in 1998, 2003, 2008–2009, the data of some ethnic groups were not included (KNBS 1999, 2004, 2010, 2015; Kandala et al. 2017, 2019)

groups). The national average revealed a gradual decline from 37.6% in 1998 to 21% in 2014 (KNBS 1999, 2015).

Figure 5.1 illustrates the diversity of practice among the ethnic groups. In the Luo people, an ethnic group living in the adjacent area of the Gusii, the percentage was quite low because they do not have a tradition of circumcision for girls or boys. The comparison with levels in the Gusii community highlights the importance of circumcision to the Gusii. One must note also the decline among the Kikuyu and the Meru people. Historically, these people have been the ones who have been most vehement in their opposition to the anti-FC movement (Robertson 1996; Thomas 1996, 1998, 2003). The Kikuyu people's practice dropped sharply (1998: 42.5%; 2003: 34.0%; 2008–2009: 21.4%; 2014: 14.6%), and the Meru's also decreased. Ethnic groups showing high prevalence besides the Gusii include the Somali, the Samburu, and the Maasai. The prevalence in the Gusii is the second highest (84%) in the 2014 report (KNBS 2015, p. 333).

The data suggests no correlation between the practice of FGC and the Muslim religion. While most of the Gusii people are Christians, practice is highly prevalent. On the other hand, of the women of the Mijikenda/Swahili people, mainly Muslims, there were 83% who had not heard about FGC (and they comprised only 2.4% of the total prevalence). Yet, there was high prevalence (94%) and performance (often of Type III) in the Somali, who are predominantly Muslim.

Types of operation have been changing too. Among some ethnic groups, there are changes from Type III to Type II. In the case of the Gusii, cutting the genital part has decreased, thus changing from Type II to Type I or even to Type IV by the definition of WHO. Differences also occur in the same family, such as cutting styles differing among sisters in the same home (Nakamura 2021).

5.3 FGC as a Tradition Among the Gusii People

The Gusii people are Bantu-speaking and live in an area of western Kenya with a high-altitude and moderate rainfall all year round. With fertile soil and a moderate tropical climate, it is one of the most agriculturally active regions in the country. Most people are farmers, and in Kisii, they produce maize, a staple food, and many varieties of vegetables and fruits, as well as tea, coffee, and pyrethrum (Republic of Kenya 1996). In addition to these agricultural products, soapstone-carving, the folk-art industry, is also prevalent. With regard to religion, most people are Christians, belonging to Seventh Day Adventists (SDA), the Lutherans, and the Catholics. Muslim people are few in this area.

FGC has been conducted as a tradition for a long time among the Gusii people. It has been described as a rite of passage, an important ritual for girls and boys (Mayer 1953; LeVine 1979; LeVine et al. 1994; Matsuzono 1981, 1984, 1991; Silberschmidt 1992, 1999; Raikes 1994; Wangila 2007). Because of the high prevalence of the practice among them, the Gusii have received a lot of attention from researchers (Njue and Askew 2004; Kandala et al. 2017, 2019; Ouko 2014; Kimani et al. 2020).

5.3.1 As a Rite of Passage

Circumcision is called *okwaroka* in the Gusii language (*Ekegusii*), meaning "leaving the nest." As an important rite of passage for girls and boys (Mayer 1953; LeVine 1979; Matsuzono 1982; Matsuzono 1984, 1991). This sequence of events involves mainly three processes: preparation, operation, and seclusion.

Preparation starts a few years before the operation. Children must be ready mentally and convince their parents that they are brave enough to endure the pain during cutting. (The circumcision site is considered defiled by crying; a purification ritual then has to be performed to clean the place and the stones for sitting on.) Children are circumcised at their own request with their parent's permission. Parents also need to prepare for the cost of payment to the operator and the cost of the celebration.

According to an ethnography of the Gusii, circumcision activities in the 1970s were performed near the river early in the morning (Matsuzono 1991; Gwako 1993, 1995). The girls were escorted by elder women to the place, where the girls' bodies were dipped in the cold river to make them cold enough not to feel pain in the pubic area. The operations were done by the traditional circumcisers, *omosari*. Usually, these were female farmers who performed the operation only during the circumcision season. The circumciser sprinkled ashes on the girl, grabbed the clitoris, and cut it off with a knife in a deft move that took only a few seconds. In those days, circumcisers cut the labia minor and tip of the clitoris with a blade (Matsuzono 1991).

After the operation, the girls spent a few hours there until the bleeding stopped before returning to their homes. The grandmothers and elder relatives escorted them while singing songs and performing dances. At home, the girls entered a specific

place, such as the grandmother's kitchen hut, to spend a seclusion period. That time was an important part of the rite of passage, as the girls were taught by the elders how to behave well as Gusii women. It also provided healing time for the scars. They were not allowed to go out, not even with their parents; only with caregivers, such as their grandmothers and sisters. The children in the same seclusion hut were, nevertheless, quite happy because they were relieved of various tasks. After the seclusion, about one month in "old days," the celebration ceremony was held. It gave great honour to both the children and other family members, especially mothers and grandmothers.

5.3.2 Reasons for the Practice

There are several reasons given for performing these practices. In the case of the Gusii, many were mentioned,[4] but here, I would like to focus on two, namely, life stages and gender.

5.3.2.1 Life Stages

There are several life stages in Gusii culture, each based on a life event such as circumcision, marriage, and childbirth. In their language, an infant girl is called *ekengwerere* or *omwana*. An uncircumcised girl is called *egesagaane*. After circumcision, a girl is called *omoiseke* and a married woman is called *omosubaati*. Grandmothers are called *omongina* (Table 5.1). These stages, circumcision, marriage, and childbirth, are considered a necessary part of progression into adulthood, and once achieved it is taken for granted that one would then have children and grandchildren. In the Gusii language, there is the word *amasikani*, which means "respect." The community considers it important in daily life to show respect to older persons (Matsuzono 1991, p. 100). The term *omongina* is the most respectful term for women.

A girl is only considered a full-fledged member of her family and society once she has gone through marriage, childbirth, and the birth of grandchildren. In this patrilineal society, a woman moves into the husband's residence from a different area, after which childbirth and her children's circumcision confirm her new position in the society.

[4] In the research in 1999–2000, several different reasons were mentioned. Girls at primary school mentioned peer pressure; they did not want to be called *egesagaane* (an uncircumcised girl). Adolescent girls believed it as necessary for marriage. Mothers mentioned it was also necessary to control girls' sexuality (Miyachi 2014).

Table 5.1 Gusii life stages

Female	Male
Infant (*ekengwerere*)	Infant (*ekengwerere*)
Uncircumcised girl (*egesagaane*)	Uncircumcised boy (*omoisia*)
Circumcised girl (*omoiseke*)	Circumcised boy (*omomura*)
Married woman (*omosubaati*)	Male elder (*omogaaka*)
Female elder (*omongina*)	

LeVine et al. (1994: 81)

5.3.2.2 Gender Perspectives

Gender perspective is an important factor. Before the rituals of circumcision, children of both genders are considered asexual beings. They are not subjected to much regulation regarding the gendered division of labour and behavioural norms. However, after circumcision, girls undergo a status transformation to "females" (Matsuzono 1984: 29) and gain "femininity" (Silberschmidt 1999: 64). Circumcision also provides women with a kind of "power" that allows them to sublimate their feelings of subordination, frustration, and hostility toward men (Silberschmidt 1999: 72). For example, older women's obscene songs and lewd and suggestive dances are considered unacceptable in Gusii communities with their strict gender norms. However, during the circumcision ceremony, unusual acts, teasing attitudes, and songs are allowed. The ceremony is a special occasion for women. In this way, traditional circumcision elevates the life stage from childhood to adulthood and brings with it the consolidation of gender identity.

5.4 Medicalization and Changes of FGC from 1980s Until 2000

As Fig. 5.1 shows, FGC has continued as a custom. However, the style of operation has been changing since the 1980s (Matsuzono 1991; Gwako 1995). This section focuses on the growing medicalization of FGC since the 1980s, and other changes noted in my research in 1999–2000.

5.4.1 Medicalization Since the 1980s

Until the early 1980s, the operation was almost always performed by a traditional circumciser, *omosari*. (Matsuzono 1991, pp. 136–137). Then, because of concern

about infectious diseases, such as HIV/AIDS, medicalization became widespread among the Gusii. Usually, a medicalized operation refers to hygienic surgery performed by doctors or nurses trained in Western medicine and has been considered less harmful to the female body (Shell-Duncan 2001: 1021). Parents, mainly mothers, became concerned about health risks, thus they preferred nurses with a modern method who operated with less cutting and less bleeding. These nurses had studied western medicine in nursing schools (Gwako 1993, 1995; Njue and Askew 2004; Miyachi 2004, 2014).

Interviews during my research with the primary school students in 2000 showed that among 70 girls, 68 of them had been circumcised (Miyachi 2004, 2014). 54.4% (37 girls) were operated on at home, 35.3% (24 girls) at the local private clinics, and 10.3% (7 girls) at hospitals. Among the 68 circumcised girls, 7 were operated on by traditional circumcisers, and the rest by female nurses.

Interviews with *omosari* confirmed the medicalization of the practice. According to them, mothers preferred the nurses with their modern method, thus many *omosari* went out of business. *Omosari* were originally farmers and earned only pocket money from the operation. In the interviews, they showed understanding of this "medicalization wave".

The nurses in the interviews mentioned that they became aware of the presidential ban from the radio and newspapers. Some of them attended the anti-FGM seminars. Nevertheless, they still performed it because they thought if they rejected the request, mothers would take girls to *omosari* which may cause health problems. The nurses also mentioned that if someone was arrested, they would cease practicing it.

5.4.2 The Places of the Operation

From the research, it was obvious that the medicalized style was common among the Gusii even in rural areas. There were mainly three places to have an operation: at the home, at the clinic, or at the hospital.

5.4.2.1 Operation at the Home

In December 1999, there were nurses visiting girls' houses for operations. At that time, the presidential ban was also widely recognized in rural communities, but operations continued. These home visits occurred at night, because during the day the nurses worked at clinics, but also to hide the operation from neighbours.

I would like to describe one case here. The nurse arrived at the house and was welcomed by family members. They were devoted Christians and the nurse and the girl's mother belonged to the same church. After prayer, the nurse warned the

grandmother and other family members not to make any sounds of joy or celebration.[5] The nurses were very cautious for fear of being arrested. After the prayer, the family members and the nurse went outside and then started preparation. The family members took small chairs from the kitchen for the nurse and the girl to sit on. She put a sheet on the ground and took out her instruments, such as forceps, a clean and new surgical knife, and cotton dressing to stop the bleeding. She also put on surgical rubber gloves to protect both the girl and herself against blood infections. The girl sat on the chair after taking off her underwear and the grandmother held the girl from behind to prevent her from closing her legs. The nurse did not use anaesthesia, because the cutting part was very small, she explained, and the girl was more afraid of the injection than the operation. After cutting the tip of the foreskin (no cutting of labia minor), the nurse put the cotton dressing on the girl's genital parts. Two sisters, around six and ten years old, were operated on. The surgery itself took a few minutes and neither of them cried. After the operation, the girls were able to stand and walk to the seclusion place, in this case, the grandmother's kitchen hut in the compound. They spent one week together in the same hut. The other cases of operations at home were the same. Sometimes cousins were also included so that the girls could spend their seclusion time together.

5.4.2.2 Operation at the Clinic

The operation at the clinic was similar to the one at the home. The small medical facilities in the rural areas are called "clinic," which are private and run by nurses. "Clinic" offers basic medical services, medicines, and family planning methods like injections and pills.

The girl visited a clinic nearby escorted by the mother (though mothers do not attend the operation, as a matter of tradition). On arrival, the girl followed the nurse's instructions. She lay on a bed and her operation was quickly performed using anaesthesia. The nurse asked the girl to open her legs and made a small cut. There was almost no bleeding. A few minutes later, she put the underwear back on with the gauze. After the operation, the girl was able to walk home escorted by the mother. The mother was not at the operation scene but waited at the clinic, and then paid the nurse before they left. I visited the girl one week later, after her seclusion period. She said she had no pain at all at that time and felt happy.

[5] Traditionally, when their grandchildren were circumcised, the grandmothers would congratulate them and make a loud, high-pitched celebratory noise, '*Alili–li–li*!' They would also start singing vulgar songs (Miyachi 2004, 2014). In most cases, the celebration was small, except in the case of the twins, when it was customary to have a large feast.

5.4.2.3 Operation at the Hospital

In my research in 1999–2000, there were a few hospitals in Kisii providing for male circumcision only. Female circumcisions at the hospital were not common there because of the Presidential Ban, and in the case of FGC, the operator is required to be a female, as was the case here. In the interviews with one father, a widower, he explained that there was no female family member to take care of his girl in the compound, so he chose the hospital where he could also ask for one week of post-operative care for the child. Traditionally the father is not allowed to be at the operation or to see his daughter during the seclusion period. According to him, it cost a lot of money for one week of hospitalization.

5.4.3 People's Reactions

There are several issues to clarify here, about girls' behaviours, changing cutting styles, and changing rituals.

5.4.3.1 Girls Behaviour

In December 1999, according to participant observers in the research, the girls after the seclusion period were happy. They were proud of themselves for completing the process, withstanding the pain, and had no more worries about being teased for being "uncircumcised girls." In addition, they could look forward to Christmas presents and a special meal to celebrate Christmas day. And of course, parents and other family members were all honoured. Peer pressure was strong in rural areas, as almost all members practice FGC. Furthermore, at that time, anti-FGM activities were few and only visible in Kisii town. In rural areas in 2000, with no internet, no available radio for girls and mothers, information around FGM was limited.

5.4.3.2 Changing Cutting Styles

Cutting styles and cutting parts were also changing. Previously, the old type involved cutting the labia minor and part of the clitoris (Type II). This changed to cutting a part of the clitoris (Type I), or to pricking and nicking the clitoris (Type IV).

The nurses, operators of the cutting, decided how much to cut the genital part, and tried to minimise it. Operations were performed hygienically. Unlike the old procedure, the nurses simply made an incision and let out a few drops of blood. The important point here was not the kind of operation, but that the fact of cutting itself was considered most important.

How was the reaction of grandmothers to these changes? One of the grandmothers told me that "current cutting is nothing, too small, little blood." The grandmothers

seemed a bit unhappy with the smaller operation, which was different from what they had experienced. But they understood the changes and followed the mother's decision. The mothers, on the other hand, tended to choose a nurse for their daughters through acquaintances in church or some other social network, based on the nurse's reputation. Some common comments were, "I heard that *that* nurse doesn't cut off too much." or "I don't have to worry because she doesn't make girls bleed much."

The fee for the operation was between 100 and 200 Kenyan Shillings (approximately US $1–2). This was not a large amount of money for nurses, and not so expensive for the parents. But in some cases, the parents could not afford to pay in cash, so the nurses received agricultural products as payment. As their main source of income was from hospitals and clinics the nurses did not need the extra cash. In 2000, they mentioned that they would stop operating as soon as the presidential ban led to someone's arrest.

5.4.3.3 Changing Style of Celebration

At the time of the research in 1999–2000, the celebratory feasts were becoming less frequent. There were two main reasons for this: the Presidential Ban and the economic burden for parents. Firstly, the ban impacted nurses who performed the circumcisions; they were afraid of being arrested so they asked families to celebrate quietly. The second reason was that children's education was becoming expensive, so parents did not have enough money to provide food and drinks for as many guests as before. After the seclusion period, most parents had small celebrations. They shared food like *mandazi* (deep-fried buns) and soda, only within the family, that is, without inviting other relatives and neighbours.

The operations took place in December when schools closed for the long year-end vacation so that children could celebrate Christmas with their families after the seclusion period. Circumcision itself was not mentioned explicitly in connection with Christianity, but it was a joyful time for the family as they could celebrate both Christmas and the end of the process of the ritual.

5.4.3.4 Other Changes

Regarding the age of circumcision, earlier ethnographies in the 1940s show it was performed at approximately 15–16 years, in time for the marriage of adolescent girls (Mayer 1953). The age of circumcision tended to decrease every year (Matsuzono 1991; Gwako 1993, 1995), and research in 1999–2000 showed it was performed on girls around 6–10 years old. There were several reasons for this, one of which was based on the parents' request. Some parents mentioned they preferred the girls' operation to occur before the occasion of meeting a boy at school. Parents were worried about girls' sexual behaviour and early pregnancies. Nurses mentioned that younger girls, e.g., under 6 years old, did not have fear. Older girls, on hearing several

stories from other girls at school or from friends, became fearful and nervous, so some nurses felt the operation was easier for little girls who did not yet feel fear.

5.5 How Have People's Attitudes Changed?

There have been many changes in the daily life of people in rural areas. Now there are mobile phones, electricity, internet, TV, and other media which were not in common use in 2000. People's lifestyles have changed. There has been an increase in education, and work in urban areas and even abroad; thus local people are more aware of the global attention to FGM. Intermarriage with different ethnic groups, which do not practice it, is also more common. These social changes affect the perceived importance of the ritual. The situation surrounding the FGM Act and anti-FGM activities and the changing attitudes towards it will be further examined in this section.

5.5.1 Anti-FGM Activities

5.5.1.1 Activities in 2000

In the research of 2000, the Presidential Ban was widely known to nurses and community people. It had led to greater medicalization, a shift of style from Type II to Type I and Type IV, and a decrease in celebratory activities. There was also increased awareness of how other ethnic groups, such as the Somali people practiced FGC, i.e., that they practiced the more severe Type III, called infibulation. Mothers in Kisii disapproved of this, knowing that it causes severe blood loss and long-term physical problems, and believed the operation style in the Gusii was not as harmful and had no negative effects on girls' bodies.

There were a few anti-FGM activists in Kisii at that time. There were several nationwide organisations, such as MYWO (Maendeleo Ya Wanawake Organization), and FPAK (Family Planning Association of Kenya, currently named "Family Health Options Kenya"). The international organization PATH (The Program for Appropriate Technology in Health) also offered information about the negative aspects of FGM. When I interviewed the project staff in Kisii Town, the respondent said, "I am a Gusii myself, so I know that this circumcision is important for people. If we try to promote the anti-FGM activities strongly, it will cause people's opposition, and other projects will not be successful. That's why we don't do much against it" (Miyachi 2004: 124).

5.5.1.2 Recent Anti-FGM Activities

Since then, owing to its high prevalence in Kisii, there have been various activist groups against FGM in the area. Religious organisations included the Adventist Relief Agency (ADRA), Action Aid, Julie K, Lutheran Outreach, Christian Children's Fund (CCF), SDA, and WAFNET. Some international medical organisations, such as ATFC, Vivid Communication, CWS, AMREF, World Relief, MARLIN, PATH, Mosocho, and RWAIDO, have also been active (Evelia et al. 2007, p. 10). Since 2008, UNICEF and UNFPA have also contributed to providing programmes for eradication nationwide (UNICEF 2021).

Such activities have included announcements and health talks at churches and community gatherings (*baraza*), outreach to the community and religious leaders, and education for girls focusing on empowerment and reproductive health. "Alternative Rites of Passage" (ARPs) have been promoted by international and national organizations as a substitute for traditional rites of passage. In ARP, instead of cutting genital parts, the girls attend seminars on reproductive health and participate in empowerment programs (UNICEF 2021; Hayashi 2017; Buttia 2016). These activities have been implemented nationwide. UN agencies, such as UNICEF and UNFPA, also sponsor activities. When I visited briefly in 2018, schoolteachers told me that they have also begun to offer education on FGM through DVDs and textbooks. Recently, there have been news reports concerning arrests of parents and those who have performed FGM.

5.5.2 What About the Reaction to Anti-FGM Activities

5.5.2.1 The Community Survey

I would like to refer here to one survey which was conducted in a rural community in Kisii (Okemwa et al. 2014). It included 373 respondents (aged 15 years and above) and employed questionnaires, focus group discussions, and key informant interviews. One of the interesting points of the survey was about men's behaviour. When men were interviewed about the anti-FGM activities, 55% responded, "I would not marry a woman who is not circumcised." Furthermore, women in leadership positions (teachers and nurses) were also seen to support their daughters' operations. The results demonstrated that it was still considered important as a rite of passage in that community. The rate of practice was 99% in the community. While 93% of the population knew about anti-FGM activities, people did not support them. Reasons cited were negative images surrounding such activities, including "loss of respect for parents," "daughters leaving the house," and "girls dressing immodestly" (Okemwa et al. 2014). These results differ from the nationwide research, KDHS of 2014, yet it is possible to comprehend this contradiction. Even if they understood the bad effects of the operation, behaviour change was quite another challenge.

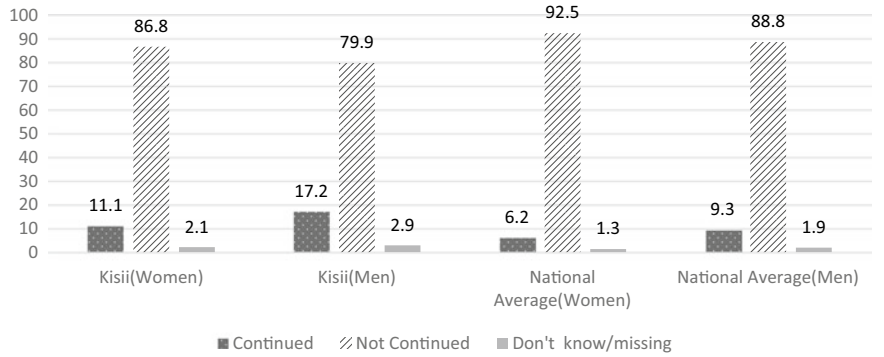

Fig. 5.2 Continue and not continue the practice. *Source* The original data from the KDHS 2014 (KNBS 2015)

5.5.2.2 Men's Attitude

One of the keys to the successful eradication of FGM is male involvement. However, fathers and other males are rather reluctant to be involved in female matters, including circumcision. Fathers say it is a women's issue. The KDHS of 2014 included male participants in the research (KNBS 2015). A question about their attitude towards continuation was included.

As Fig. 5.2 illustrates that most men and women believed that the practice should be discontinued. However, broken down by gender, and ethnic group, a slightly higher percentage of males than females responded that the practice should continue. It was also shown that among the women in Kisii (Gusii people), the preference for continuation (11.1%) was higher than the national average (6.2%).

5.5.3 No More FGC?

During my brief visit in 2018, there were drastic changes. The nurses, key informants of the research in 2000, were no longer performing operations. Some of them had totally retired as nurses. Some said they did not perform it because they were afraid of being arrested. But they mentioned also that others were doing it, instead of them, secretly. In 2000, even though some operations and celebrations were practiced in private, they were happy to talk about it. Now, because of the law, people have become silent. I also visited the mothers and fathers of the girls and the teachers at school. All they mentioned was that "it is not good practice, and we should stop it." It was rather surprising, because the mothers were insisting on its continuation in 2000, but had changed their attitudes by 2018. They said they had learned more about it at seminars, community gatherings, and churches.

Recent research on Gusii mothers shows that FGC has become more individual-based and secret (Van et al. 2021). However, its prevalence has decreased. Van et al. (2021) reveals that FGC prevalence in the youngest Kisii birth cohort has fallen considerably in comparison to the oldest cohort of Kisii women, born between 1960 and 1969, for which it was almost 100% (Van et al. 2021: 2). Recent research with mothers (asked about their daughters' situations) revealed that cutting in the younger generation has almost halved (Van et al. 2021, p. 8).

5.6 Conclusion

There have been so many attempts to eradicate FGC in Kisii. The enactment of the anti-FGM law in 2011 has greatly influenced the community. Campaigns by internal and international organisations have been conducted on TV, radio, and in newspapers. People's awareness has increased. Teachers and students have also been educated on the effects. Community members have gained information from attending local meetings, and churches also offer information. However, obtaining information is not enough to achieve abolition. Genital cutting for both girls and boys is a health risk and people are aware of it. Yet it is still recognized as a rite of passage, one that affirms the identity of being a Gusii. The pain caused by circumcision is considered an important part of the process of becoming an adult.

Because of the FGM Act, and under the circumstances of COVID-19, it is difficult to examine the current situation. Under the strict Act, there are concerns about it becoming underground and being performed on even younger girls in Kenya (UNICEF 2021). According to one report, operations seem to have been secretly performed by retired nurses on younger girls in the age group of four to six years old (Komba et al. 2020). Additionally, if there are any health problems after the operation, they cannot go to the hospital, because parents and medical personnel are afraid of getting involved. As such, the zero tolerance approach may drive the practice underground, which puts girls' health at further risk.

Thus far, the global strategy against FGM has been a "zero tolerance" approach, which is simple, powerful, and widely spread. In terms of eradication of FGM, however, alternative strategies should be formulated based on each cultural and social context. There was an innovative activity, run by a self-help women's group in Kisii, which dealt not only with FC but also with other gender issues, like women's inheritance, women's marriage, and domestic violence (Miyachi 2004, 2014). The group found a way to persuade local mothers not to perform FC on their daughters. In addition, they supported income-generation activities for local women. One woman in the group said, "My daughter may be teased for not being circumcised, but one day someone has to break this bad chain of events." They visited houses trying to persuade mothers and grandmothers. This type of local approach was unique and different from those on the national and international levels. This is a grassroots but comprehensive approach, which seemed much more effective among the community people.

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Kaori Miyachi is a visiting researcher at Saga University, Japan, and an advanced social researcher certificated by the Japanese Association for Social Research. She studied at the graduate school of social anthropology at Tokyo Metropolitan University (MA and Ph.D. courses) in Japan and got MA in anthropology of development at University of Sussex in UK. She has conducted research on gender, aging, and reproductive health issues, mainly in Kenya and Japan, and has participated in several international programs in developing countries (NGOs, UN, and JICA). She has experiences of teaching at several universities, including Nagasaki University, Saga University, and Ritsumeikan Asia Pacific University. Her recent publications include "A Preparatory Study of Care for Elderly Women in Rural Kenya," *Arxiu d'Etnografia de Catalunya,* no. 22 (2021): 127–46.

Chapter 6
An Ethnography of Diversity and Flexibility Around Female Circumcision and Female Genital Mutilation/Cutting: A Case of a Local Community Response to the Abolition Movement in Kenya

Kyoko Nakamura

6.1 Introduction

In January 2018, a Kenya female doctor, Dr. Tatu Kamau, opined that FGM/C should be legalized and that the FGM/C ban was unconstitutional. In Kenya, the Children Act of 2001 banned the practice of circumcision for girls under the age of 18 (Republic of Kenya 2012a, b). Later, in 2011, the Prohibition of Female Genital Mutilation Act came into force, which imposes severe penalties on women who have undergone the procedure, regardless of age, on their parents and on circumcisers or doctors who perform the procedure (Republic of Kenya 2012a, b [2011]). Dr. Kamau agreed that girls who are not yet capable of making various decisions have to be protected in their decision-making and should not be forced to do things they may not be prepared for, and that the Children's Act should continue to protect the girl child. However, she then made a powerful speech in front of TV news cameras about the rights of adult women. She said, "I have noticed many women are making decisions later on in life, and they are being harassed and jailed. Once you reach adulthood, there should be no reason why you cannot make that decision. If a woman can decide to smoke, to join the army, and do all sorts of things that might bring them harm or injury, then even the right to make the decision of female circumcision should be available to them. Once the decision is made, they should not be denied access to the best medical care." Dr. Kamau is an experienced physician and has held several important positions at the Ministry of Health. She continued, "I am threatened if Parliament can decide what I should do and what I should not do. If Parliament can abolish a culture or try to

K. Nakamura (✉)
Department of Regional Development Studies, Faculty of Global and Regional Studies, Toyo University, Tokyo, Japan
e-mail: nakamura064@toyo.jp

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abolish a culture, tomorrow it will be a religion, tomorrow it will be something else" (KTN News 2018, Kenya; Hodal 2018).

Dr. Kamau's arguments were very clear and had a great impact on people in the local community where I was conducting field research. Since the enactment of the FGM ban, people were reluctant to speak out on the topic of female genital mutilation/cutting (hereinafter as FGM/C)[1] but Dr. Kamau's statement was a representation of their unspoken thoughts. Many people said, "she said what I wanted to say" or, "she is telling the truth." Some among the elders began to insist that their culture should be protected. On the other hand, those who had been involved in the abolition project lamented, "After all our efforts, we have just begun to see signs of change, and then she interfered to ruin it. What, on earth, is the point? It's a shame."

There were also many who felt that Dr. Kamau's public statements were in the interest of protecting her own business. For if the ban on the procedure was lifted, medicalization would surely advance, and doctors would be able to perform the procedure with impunity. "This is a great opportunity for doctors," many said. However, others counteracted this view, saying that those who were calling for abolition were also doing it for commercial purposes, and that it was a profitable business opportunity. The funds attracted by the keyword "ANTI-FGM" are enormous. It is distributed to people in various ways through "projects." "Who would kill a cow that produces milk?"; this was the most cynical opinion. Directly or indirectly, people benefit from the milk being squeezed out of the abolition project. It is only worthwhile if it is kept "alive" and if FGM/C were allowed, there would be no milk.[2]

While there may be no right or wrong opinions, they all have a point, thus highlighting the complexity of the issue. One thing we should not forget is that there are still many people directly involved in this issue, who remain silent. They do not speak English, a strong communicative language, nor have the forums and tools to speak out. How and with whom can people who promote abolition empathize, without hearing their voices?

The anti-FGM/C movement, led by Western countries, has spawned abolitionist movements and prohibition laws in countries which have that practice. However, little information about the responses of local communities to this top-down approach of abolition exists besides a few reports from NGOs and other organizations working in the field (e.g., Mohamud et al. 2006). Many of us who live outside of societies that have the practice do not have any idea of the reality of what it feels like to experience FGM/C. As mentioned above, since the enactment of the Prohibition Act in 2011, which made FGM/C severely punishable, talking openly about it has become taboo, with the risk of fines, and even imprisonment. Even anthropologists who have lived

[1] In this chapter I primarily use the term FGM/C, which was created as a hybrid term that takes into account both community parties and abolitionists (UNICEF 2013: 7, Introduction of this volume). I also use "circumcision" or "female circumcision" when it is in the context of local rites of passage.

[2] In the face of criticism and opposition, Dr. Kamau continued her challenge and never wavered in her fight for legalization of FGM/C, but in 2021, her case was dismissed by the High Court of Kenya. The Court ruled that the practice of FGM/C violates a woman's right to health, human dignity and in instances when it results in death, the right to life, adding that the practice also undermines international human rights standards (African Union 2021).

in these societies for a long time might find it extremely difficult to openly ask or talk about this issue. The gap is increasing between the global abolitionist movement and local societies that try to interpret the movement and deal with it. This discrepancy shows in the current situation where abolition has not been able to penetrate local societies despite the rapid growth of the abolition movement.

It seems that the views of those who support the abolition movement are too stereotypical when they regard women as "victims deprived of their autonomy." It may be because the practice of FGM/C appears outrageous in light of the abolition supporters' common sense and values.

Using Tanzania's Maasai society as a case study, Hodgson (2017) points out that development practitioners familiar with local societies consider the anti-FGM/C movement a low priority compared to other problems that need to be addressed (e.g., increasing impoverishment and political marginalization of their communities). Nevertheless, Western donors and activists of FGM/C abolition projects and African elites have continued to assume that they can speak for (rather than listen to) rural, poorly educated women. She points out that these Westerners and African elites regard local women like the Maasai as the cultural "other" (Hodgson 2017: 98–99, 114–121).

Miyawaki (2007), having accumulated ethnographic accounts of peripheral societies in Ethiopia, points out that in societies with strong patriarchal control, many of the practices known as FGM/C are closely related to controlling women's sexuality and their ability to reproduce, and these practices have detrimental effects on women's health. Miyawaki then emphasizes the importance of understanding the various forms of FGM/C, the cultural and social meanings assigned to them and the importance of understanding the various forms of patriarchy that lie behind them. He also argues that each society has its own historical and cultural background where various powers intersect, and that we should clarify what choice each person involved is making from his/her respective standpoint (Miyawaki 2007: 278–280).

This chapter takes as a case study one society in Kenya that strongly maintains FGM/C (indicated anonymously as "Community R"). It will depict this issue from the people's perspective as much as possible. Through ethnographic descriptions that make the most of the narratives of the people involved, I will clarify how people living within the local society perceive and react to the anti-FGM/C movement, and what kind of changes occur in local society in relation to FC or FGM/C. In particular, through the description of people's reactions to the recent abolition movement, this chapter will demonstrate that even within a single community with a common cultural background, the people involved have diverse values and make diverse choices. Then, I will specifically discuss the efficacy and limitations of the fixed and powerful prescriptions promoted by the international community, in its "zero tolerance" approach to FGM/C.

Now that the United Nations has made the eradication of FGM/C a strong goal and nations are enacting laws to prohibit it, it has become highly politicized to talk and write about this topic. In my ethnographic work as an anthropologist, I have asked myself whether I am qualified to speak on behalf of these communities and have felt anxious that my writings may be detrimental to some people. At the same time, I

have been fascinated by the way of life of these people who do not have the power to speak out, who suffer from being tossed around by global discourse, but who, on the other hand, can take advantage of it in a clever way, and I have had a strong desire to describe the reality of their lives. I had been torn between these conflicting feelings, but I decided to write this chapter out of a strong desire to change the anti-FGM movement for the better, since it is clearly at a standstill and confusing to the local people.

6.2 The Undergrounding of FGM/C

In Kenya after the Children Act of 2001 came into force, projects aimed at the abolition of FGM/C by various international NGOs became more evident. In Community R a number of community-based organizations (CBOs) have been formed by members of the local community to carry out development activities, usually in collaboration with international NGOs. The activities related to FGM/C are mainly awareness-raising programs (or "seminars" as people call them), held on various scales and in various places, such as churches, schools, NGO offices, and even under the trees outside. Most of the seminar participants are paid a "sitting allowance" so many people are willing to attend. The content of the education mostly stresses the health hazards of the procedure, using pictures and illustrations. These activities firmly established a perception among the local community that the government and *wazungu*[3] consider female circumcision undesirable, but they did little to change people's attitudes in Community R. It was obvious to almost everyone that girls would still undergo the procedure before marriage.[4]

However, the prohibition of the FGM Act of 2011 specifically affected people's behavior. It banned the practice and instituted strict punishments for offenders (i.e., imprisonment for a term of not less than three years, a fine of not less than 200,000 Kenyan shillings, or both). Kenya's new constitution, adopted in 2010, led to a number of local government-led reforms supplemented with efforts by chiefs and political leaders of local communities, all of whom were expected to play a role in the abolition movement. Rumors circulated of arrests by the police for violating the prohibition law and being forced to pay hefty fines. People suddenly began to change their attitudes.

In and around the town where the police and NGO offices are located, people started having their daughters undergo FGM/C in secret at distant relatives' places and returning as if nothing had happened. Eventually, even in the homesteads far away from the town, measures to avoid being arrested spread rapidly, such as slightly shifting the schedule of the wedding ceremony, and holding the procedure in the middle of the night instead of early morning. People began to refrain from celebratory

[3] A Kiswahili word meaning "white people.".

[4] The age of marriage for women in Community R was around 16–20 years old, but has become higher as schooling has become more widespread among women.

songs and even from gathering to drink *chai* (milk tea) which is an essential aspect of any kind of community gathering. This situation can be described as the concealment and undergrounding of FGM/C.

6.3 Local Intermediate Option, "*Kati-Kati*"

Parallel with the progression of people's confusion, one significant change was quietly occurring. Under the indirect influence of the anti-FGM/C movement, a significant change in practice emerged: the diversification of operating styles. In addition to the conventional circumcising style, that is, total removal of the clitoris and labia minora (WHO Type II), a totally new style called *kati-kati* was created locally. At the same time, the *suna* (*sunna*) style (WHO Type I) was also introduced. *Kati-kati* is a Kiswahili word meaning "in the middle" or "in between." This word is used to refer to cutting in the middle of the clitoris. The style known as *suna* involves the removal of only the skin of the clitoris. In Islamic areas, the term *Sunna* refers to the traditions and practices that Muslims should follow. Community R define *suna* as a style in which the appearance once the wound has healed does not show that circumcision has occurred.

Ms. M is an experienced female circumciser who has been working for almost 30 years in highland area B. She explained to me how she learned the *kati-kati* style.

> In 2003 I was invited to participate in a training program. The group consisted of two female circumcisers, including me, and two traditional birth attendants (TBAs). The program had continued for seven days, and we were provided with accommodation, meals and money. We were seated like students in school, and one of our teachers was a woman from our community. Although her father was from a different ethnic group, she could speak our language, while the other teachers were nurses from different ethnic groups of Kenya.
>
> The most impressive thing they said was, "You are not bad at all. You are just doing your work to earn a living. However, since the Kenyan government now forbids us to circumcise a girl, you should stop it. If you are called to perform the operation, first you should refuse to do it. If they insist that you do it, please give them the option of *the suna* style. If they do not accept this, you will cut in the middle, not in the usual way (cutting off the entire clitoris). If people still insist on the usual style, you should charge 2000 Kenyan shillings for it."
>
> At that time, we usually charged from 300 to 500 Kenyan shillings for one operation, and I was surprised that they told me to charge as much as 2,000 Kenyan shillings. I did not raise my charges after the training program because I was afraid that people would never avail of my services if I charged so much. I also did not change my style immediately, but it was the first time I knew the new style. (interviewed in 2013)

The new method or procedure was proposed to the circumcisers as a compromise measure by the development project staff and the medical professionals of the local society. The circumciser did not adopt it immediately, but gradually changed and started to offer a less mutilating style of operation. Ms. M continued:

> Nowadays whenever I am called upon to perform an operation, I ask both the parents and daughters which style they would like, the usual one, *kati-kati* or *suna*. Now I prefer *kati-kati* because the amount of blood flow is somewhat less than with the usual style. I perform *kati-kati* unless parents and girls strongly insist on total removal.
>
> I know that in town, many people prefer *kati-kati*, while other ethnic groups prefer *suna*. Even in this community, Christians prefer *suna*. In the homestead, many parents still want the usual style, but some educated girls prefer *kati-kati*. If a girl is going to the lowland area to marry, I always cut it completely, wherever she lives. If she goes to the lowlands, there is no need to give them the options. Lowland people do not approve of new circumcision styles.
>
> There was one time when my services were availed of, and I was ordered by the girl's father to just pretend to do the operation and cut nothing. (interviewed in 2013)

Her statement shows that the people in the community gradually began to change, even before the law of 2011 was imposed. There have been compromises made between the global abolition movement and the local desire to maintain the practice, which has resulted in a clear intermediate option.

6.4 Diversification of Operation Styles and People's Identity

Community R is divided into two categories: a relatively cool highland and a dry, hot lowland. The ecological differences between these areas are reflected in their economic and social differences. Highlanders, in addition to keeping animals, sometimes cultivate crops, while lowlanders maintain a nomadic way of life, living in simple temporary huts, and depending heavily on livestock products. In the highlands, people live more "developed" lives than in the lowlands. In terms of education, a higher percentage of highland children were enrolled in primary schools. People of Community R draw a distinction between highlanders and lowlanders when they consider the choices available for the operation. This can be seen in the following quote from Ms. P, who lives in a homestead in the highlands and attended three years of primary school, as she explained her experience in choosing the style of operation.

> Before my operation, the circumciser asked my mother and me what style we wanted. As I was a highland girl who had been informed about *suna* and *kati-kati*,[5] I knew that *suna* had no meaning, and therefore I did not want it. I did not want *kati-kati* either because I heard that the bleeding would not stop easily. Therefore, I selected the usual style. My parents said, "Please remove it completely." I also said to her, "Remove completely!". (interviewed in 2013)

I asked Ms. P, "The bleeding by *kati-kati* will not stop easily?" She replied, "I know now that this was incorrect. I have observed many operations on many girls, and now I see that *kati-kati* is good. Bleeding by *kati-kati* is neither too much nor too little. Now I like *kati-kati*. I will recommend *kati-kati* for my sisters and daughters."

[5] Ms. P was 17 years old at the time of the procedure.

I asked her, "Do you regret that you did not select *kati-kati*?" She replied, "Not at all! I like my style!".

Ms. P's statement shows that the anti-FGM/C movements have allowed people to change their attitudes, but they have not simply followed the prescriptions given by others. People have made self-directed decisions associated with their social identities. Individual girls ask themselves, "Which style is the most suitable for me?".

Mr. L provided the following comments. Mr. L had no formal education and married his first wife in 1999. At that time, there were no options for the operation. He gave his comments from a husband's point of view.

> Now everyone knows that in our community, we have three styles of female circumcision, the usual one, *kati-kati*, and *suna.* We are highland males of age set M[6] (30–45 years old at the time of the interview). For now, we can accept the *kati-kati* style, but we are not yet ready to accept *suna* as circumcision. We think it will bring bad luck. People of the next generation might accept it. (interviewed in 2013)

Mr. L showed the flexibility of the males of age set M, who were the youngest group of elders at the time of the interview, and he accepted the new style. He also foresaw that males of the next generation might have different ideas. It is clear that people are ready to change their attitudes and respect others' choices. A few years after the interview, Mr. L married his second wife, and her style was *kati-kati.* In 2018, his first daughter was circumcised, and she selected *kati-kati.* He said that he and his first wife discussed their first daughter's style and gave her advice, enabling her to select it. It is very rare for a husband to talk with his wife on this matter. Males of his age are usually very reluctant to speak up on this matter because it is considered a woman's issue so traditionally males should not intervene. When he talked to me in 2018, there were several of his peers (of age set M) listening. None of them had ever talked with their wives regarding this matter, and they did not even know their wives' choices. One of them said to me, "We usually do not want to know about this matter at all! If my daughter goes through it and becomes an adult woman of 'good smell' I do not care about the style!" Women of "good smell" means women who are blessed and have gained auspicious status.

By 2015, *kati-kati* had become a popular selection among secondary school girls in the highland area of Community R. Ms. P said:

> The other day (August 2015), four girls in this area were circumcised on the same day. Two of them selected the usual style because they are "girls of beads" (uneducated girls), and the others selected *kati-kati*, because they were secondary school students. Girls at the secondary school like *kati-kati.* (interviewed in 2015)

The *kati-kati* style has become popular among educated girls because it represents their identity of being educated and "modern women" who are aware of the world outside the community, while still respecting their culture. Ms. T was circumcised when she was a first-year secondary school student in 2018. Her words are typical of this new identity:

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[6] Community R has an age system. All males of the society are divided into several groups according to age. These groups are called "age sets".

> On the day of my circumcision, the circumciser asked me and my mother "Which style do you want?" and my mother answered, "Please do it in the *kati-kati* style." I did not talk about the style with my mother before, but I knew that I would opt for the *kati-kati* because here in highland area most educated girls select the *kati-kati*, and I thought it would be natural and suitable for me. We (secondary school girls) do not have to discuss the styles with our parents because we find the person (whom we marry) who will approve of our style by ourselves. (interviewed in 2018)

Her words also indicate that she selected the style of operation on her own initiative and was proud of her decision. She also showed a desire to select her spouse by herself, which is a new trend in Community R. Her younger sister, a 15-year-old primary school student, was circumcised on the same day, and also selected *kati-kati*. Sometimes even sisters of the same mother select different options, although girls of the same educational background in the same area tend to select the same style. Ms. T said she did not talk with her sister about her choice, but she guessed that her sister might follow her choice.

When selecting from the options available for operating styles, choices can be said to differ according to three dichotomies. The first is place of residence, that is, town versus homestead. Typically, town people earn wages and wear Western-style clothes. Homestead people live with their livestock and wear beaded necklaces and waistcloths. The second dichotomy is educated versus uneducated. Because schools have banned the wearing of beads, educated women usually wear Western-style clothes, while uneducated women often wear beads. The third dichotomy is highlander versus lowlander. Highland people are more "modern," while lowland people are "traditional." Lowland people are very proud that they have maintained their culture and they usually do not accept *kati-kati* as a circumcision option.

At both international and national levels, the movement to abolish FGM/C involves medical, health, and human rights issues. However, local people pay almost no attention to the dominant discourse when they select a circumcision option. The importance and meaning of this practice differ in international and national contexts. Discussions among the local people about the health aspects of circumcision, such as bleeding, are based on personal experiences. The local people do not view choices about circumcision as involving decisions between right or wrong, good or bad, healthy or unhealthy and safe or unsafe, but rather as a way to express their position to the "Western modernized world" or to express their own identities in the context of their tradition.

Local attitudes toward FC or FGM/C have started to change among members of Community R. New cutting styles, which are less mutilating than the traditional style, have been created through negotiations between those individuals who believe this practice is mandatory and NGO or CBO personnel who are attempting to abolish the practice. At the same time, circumcisers play an important role as intermediaries in the process.

6.5 Controversial Consequences of the Powerful and Inflexible Zero Tolerance Policy

In this section, I will discuss how the Prohibition Act of FGM, with its severe penalties, has affected the community. As mentioned above, after the law, the practice went underground and there were no more celebrations for "female circumcision." The option of refusing to be circumcised has also emerged, though in very rare cases.

I mentioned the following statement by circumciser M: "Only once was I called for the operation and ordered by a girl's father to just pretend to do the operation and cut nothing." When I heard this, I probed the girl's identity. Both her father and mother were university graduates; her father worked for an international NGO, and her mother was from a different ethnic group. After her "pretend circumcision," she went to study at a university outside Kenya, married a British man, and still lives outside the country. In other words, she is a woman with strongly Westernized values, living in a world disconnected from the local community. Women with higher education levels who refused the procedure have existed even prior to the enactment of the Prohibition Law.

However, Ms. S, who will be introduced next, is a woman with an average level of education at the time of the survey, having completed only eight years of primary school. Ms. S (21 years old at the time of the interview) was the first woman I met in Community R with an average educational background who had given birth without having been circumcised. In 2015, she was residing in a lowland town, and by the next time we met, in 2018, she had moved to a lowland homestead. However, the fact that her father was a pastor of a Christian church and that she herself was even more devout than her father, as evidenced by her words, is a major characteristic that sets her apart from others.

> Ms. S: I gave birth to my first daughter in 2014 without being circumcised. I know that female circumcisions are bad. In the Bible, there is a description of male circumcision, but there is no description of female circumcision. This means that God intended circumcision only for men. Female circumcision is a making of human beings, not of God. Therefore, it is unnecessary. My husband, who is from the same ethnic group as me, asked me to be circumcised, because his parents could not accept me as his wife without being circumcised, but I refused.
>
> Author: As long as you continue to refuse to be circumcised, do you think you can be formally married to your husband?
>
> Ms. S: I cannot marry him. I mean I cannot be a wife within my ethnic group. However, I can just get married in Church and go to the government office to submit the marriage document. I will be a "Kenyan wife". (interviewed in 2015)

Ms. S had two older sisters of the same mother who also lived in a lowland town. One of her sisters, Ms. J, listened to Ms. S and I while she made us a cup of tea. Ms. J was an unmarried mother who was circumcised with *kati-kati* in 2008 and had given birth to two children. Ms. J said to me, "As my sister told you, here in our community, it would be almost impossible to be formally married without being circumcised. I also advised her to cut just a very small part, but she refused it. Now, I think this is

her wish. Now that even the government supports it, no one can force her to do it. I also support her."

Three years later, in 2018, I met Ms. S again. She was carrying another child and remained uncircumcised and formally unmarried. She cheerfully said to me, "Life goes on just like when we met before!" Ms. S's case is exceptional, as I know of only two other women who gave birth without being circumcised and remained in the community, but both of them chose to be circumcised afterwards. Nevertheless, there are cases and the law can work to support and protect women who wish to refuse the operation.

A certain number of women rejected circumcision and later reconsidered. This is often related to the fact that various abolition projects provide strong support for rejection, sometimes with significant assistance, such as financial aid for higher education. Other uncircumcised women who had children were no longer living in the community as they married men of other ethnic groups (so I could only hear about them through others).

Until now, the importance of female circumcision in the value system of the local community has been maintained, and Ms. S is quite exceptional. However, Ms. S's case shows that for women like her, who have a strong will to reject it, the prohibition law may serve to support their choice.

There is a broader negative impact that the Prohibition Act of FGM has had on the community at large. In some parts of the community, the mutual trust of the people has been weakened because local chiefs have been ordered by national government to be strict in their enforcement of this law. Furthermore, some NGOs have provided chiefs with incentives such as mobile phones and credit so that they support the anti-FGM projects. These chiefs then "hire" community health volunteer workers or other members of the community to spy for them in the area. Rumors of planned circumcisions are reported to the chiefs who then call the police. Some NGOs pay the chiefs according to the number of girls they "save." In most cases, chiefs themselves would like their daughters to be circumcised and thus require the people of their areas to conceal the ceremony completely. This trend of subterfuge has deprived people of the opportunity to openly discuss matters.

Another unexpected consequence has been that seeking medical assistance or treatment for the operation became very difficult after the strict law. Before the law, in addition to the traditional circumcisers, some medical doctors or nurses also conducted the operation, but once cases began to be reported to the police they became too afraid to get involved. In homestead operations, the medical staff in nearby clinics may refuse to attend to the girl, even if the bleeding will not stop. People have also become afraid of seeking help from a doctor following the operation because they might be reported to the police. The enactment of the ban has thus increased the risk of the health hazards of the procedure, as the law reflects the WHO's view that the medicalization of FGM/C is detrimental to the elimination of this practice (WHO 2010: 7–10).

In short, the abolition projects developed and the severe legal penalties are currently undermining people's peaceful lives. As a result, people's attitudes toward the abolition project have begun to shift from "indifference" to "alarm" to "disgust."

There is clearly an "anti-anti-FGM/C" sentiment emerging in the community, and I want to sound the alarm on this.

6.6 Conclusion

In this chapter, I have attempted to describe the real faces of the people in local communities who have maintained FGM/C as a practice. It is evident that the people involved are very diverse. Lesorogol (2008) points out that school enrollment has had a significant impact on the knowledge, abilities, values, and behaviors of women in Kenyan pastoral society, causing a division between educated and uneducated women as if they were from "different ethnic groups." In my own research in Community R, the division between school-educated and non-school-educated women around the 1990s and the 2000s was clear. School-educated women, known as "girls of school," made the choice to be circumcised before marriage and often entered into love marriages or became unmarried mothers, while uneducated women, known as "girls of beads," wore large, beaded necklaces, enjoyed love affairs with unmarried young men, and, once married, were circumcised and married off to strange men chosen by their fathers. In those days, the decision to go to school was not common for girls and made with a firm resolve. Parents sent their daughters to school based on their willingness to learn, and the majority of these girls did not drop out easily. The "girls of beads" lived "traditionally" while the "girls of school" distanced themselves from the former. However, with the rapid social changes, an increasing number of daughters are receiving school education, and in the 2010s and beyond, the education level of women has become more diverse. Nowadays, it makes little sense to divide women into two categories based on whether they have attended school or not. In other words, the attitude of women towards "tradition" is not simply dichotomized by whether they are educated or not, but has become a gradation of shades, based on various combinations of multiple indicators, such as whether they live in the lowlands or the highlands, whether they are in pastoralism or wage labor, whether they attend a church or not, and what level of education and work their parents had.

The diversification of operation "styles" occurred under these circumstances, and women used this as an expression of their identity and increased their pride in themselves by choosing what suited them from among the options. People also respected and acknowledged the choices of others who were different from theirs. In addition, they did not consider their choices to be absolute, and they were flexible to change. Many explained the importance of FGM/C by saying, "Now *we still think* that this (FGM/C) is something that we have to maintain." Their diverse and flexible attitudes contrast with the increasingly rigid global abolitionist movement.

Many proponents of the international humanitarian principles of "zero tolerance" and "leave no one behind" see communities with FGM/C practice as homogeneous groups lacking in diversity, and this perception has led to a strong policy of trying to solve the problem with a single prescription. As clarified in this chapter, this fixed perception has created a discrepancy between the global and the local, and

this approach does not allow one to evaluate the changes that are being proactively created by the people themselves in moderating the practice. In addition, there is the danger of creating a negative "anti-anti FGM/C" sentiment among those who resist the strong anti-FGM/C movement, and of hardening the attitudes of people, which should rather remain flexible and diverse.

The various cultures and norms that have been maintained in local communities are constantly being reshaped by individuals who are trying to find a new identity in a rapidly changing society. Even though they live in the same community at the same time—even sisters born to the same parents, for example—they may each make different choices based on the trajectory of their lives. As third parties, our attitude toward FGM/C should be to realize that there are as many different approaches as there are diverse individuals, and that these approaches are constantly changing over time. It might be the most effective way to promote the anti-FGM/C movement, though it seems a long way off.

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Kyoko Nakamura Ph.D., is a professor of African area studies and cultural anthropology at Toyo University, Japan. She has been conducting research among pastoral communities in Kenya. Her research interests are age systems and life-course changes, women's social-status changes, tourism and culture, and body adornments and beads. Her major publications include "Life Story as a Tourism Commodity among the Kenyan 'Maasai,"' *Global-E* 12 12 (2019); "Local Recognition is Alienated from Global Discourse: Changes in Female Genital Mutilation/Cutting (FGM/C) in a Kenyan Pastoral Community," in T. Ochiai, M. Hirano-Nomoto and D. E. Agbiboa, eds., *People, Predicaments and Potentials in Africa* (Bamenda: LANGAA Research & Publishing Common Interest Group, in collaboration with the Center for African Studies, Kyoto University, 2021).

Chapter 7
Research Note on a Grassroots Movement to Eradicate Female Genital Mutilation/Cutting Among Kenyan Maasai

Manami Hayashi

7.1 FGM/C Among Maasai Girls

The Maasai are pastoralists who live in northern Tanzania and western Kenya. In Maasai culture, boys and girls undergo "circumcision," called *emurata* in Maa, as rites of passage into adulthood when they reach about 15 years of age. In Kenya, *emurata* of girls, which institutions such as the United Nations call female genital mutilation/cutting (FGM/C), is strictly forbidden by the 2011 "Prohibition of Female Genital Mutilation Act." However, FGM/C is still prevalent among the Maasai despite many eradication programs.

The author studied the eradication of FGM/C between January 2013 and September 2019 in a Maasai community in western Kenya (Hayashi 2021). This paper focuses on the activities of an organization called "Osotua" (a pseudonym for privacy) that was established by a Maasai woman in the 1990s to eradicate FGM/C.

7.2 CBO Activities on Anti-FGM/C

Osotua is a community-based organization (CBO) that has five major aims: to protect girls, provide reconciliation programs, organize alternative rites of passage (ARPs), conduct enlightenment activities, and generate income for retired circumcisers.

Osotua's first project was the establishment of a rescue center for girls who have escaped from traditional harmful practices, such as FGM/C and early marriage. Osotua has a broad network and works with cooperating chiefs, pastors, and teachers in the community. These individuals keep in touch with the Osotua staff and report

M. Hayashi (✉)
Research Fellow of Japan Society for the Promotion of Science/Osaka Metropolitan University, Osaka, Japan
e-mail: hayashi.m.manami@gmail.com

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FGM/C or early marriage by mobile phone. The rescue center provides accommodation, food, clothing, and education for these girls and provides them with support until they complete their secondary school education.

As a second initiative, Osotua organizes reconciliation programs for the parents, so that they do not enforce FGM/C or early marriage of girls. The CBO suggests that the parents allow education for the girls until the end of secondary school. Once they have completed this education, Osotua holds reconciliation meetings to reunite the girls with their parents.

As a third initiative, the CBO has organized an ARP program. As recommended by the Anti-FGM Board of the Kenyan Government, the ARP provides training for girls enabling them to enter womanhood without cutting their genital parts, and is considered an effective program for eradicating FGM/C. The Osotua ARP consists of a 4-day empowerment program for girls. In the program, Osotua staff provide information about the reproductive health and rights (RH/R) of girls. On the fifth day, they have a graduation ceremony and invite the girls' parents, relatives, and local people to congratulate the girls on their coming-of-age experience without FGM/C (Hayashi 2017).

Osotua's fourth program is the organization of enlightenment activities to eradicate repressive customs such as FGM/C and early marriage. Osotua gives seminars on the adverse effects of FGM/C and information on RH/R.

The fifth element involves organizing income-generating activities for retired circumcisers who have lost their jobs due to the anti-FGM Act. One such example would be preparing 100 acres of land for retired circumcisers to produce cash crops.

7.3 Reactions of the Girl, Her Mother, and a Neighbor

Osotua has been working enthusiastically to eradicate FGM/C, and this section covers local people's reactions. In 2016 the author interviewed a girl who attended the ARP in 2015, as well as her mother and a neighboring women who has a little girl. All of the interviewees' names are pseudonyms for privacy.

- **The girl's case**

  Ann was 12 years old, the fourth of six children and the second daughter. She was in fifth grade at primary school. Her older sister dropped out of primary school and got married after undergoing FGM/C, but Ann wanted to continue her secondary education. She joined the ARP in 2015 on her mother's advice. She enjoyed the program and made some female friends there. She liked the venue, a private school built with support from an international NGO. The school had high-quality facilities and accommodation, attractive to Maasai girls because remote villages lack teachers and classroom equipment. She wrote the workshop lessons in her notebook and brought them back to her village. Some friends from the same village also participated in the program. She talked about FGM/C with her friends in the village and they also opposed it. She insisted to her parents that she would

not undergo FGM/C. She hoped to finish primary school and go on to secondary school. She said that she wanted to become a professor.

- **The mother's case**

  Ann's mother June was 37 years old. She had four sons and two daughters, and ran a small business that sold milk. She had never gone to school but was a pious Christian who prayed every day. June said that she did not want her daughters to undergo the cruel type of FGM/C (type II) or early marriage. She also mentioned past financial hardship and appreciated Osotua for providing fees for girls' education and for empowering Maasai women.

  In 2015 June had encouraged her daughter Ann to join the Osotua ARP program and she, June, participated in the graduation ceremony. Ann had enjoyed the program and said she wanted to be admitted to the school. After the ceremony, Ann insisted that she would not accept FGM/C. She was given the Osotua hotline number so that she could call the CBO whenever she felt she was being forced into FGM/C. June noted that the hotline had an impact on her daughter and on herself.

  > Did you know the girls were given the Osotua hotline number? My daughter told me that she remembered the number perfectly. When something happens that she does not like, she pretends to call to Osotua in front of me. All I can do is just to watch her calling in surprise. Therefore, we, as parents, fear our daughters, because we cannot do anything wrong.

  June also mentioned other Maasai women's opinions about Osotua. She said that Maasai women, who prefer traditional culture, do not stop FGM/C because "they keep girls in an inferior position." June also said that some local Maasai women did not think well of Osotua, saying that the CBO is too "progressive." According to June, many village women were not convinced because the Osotua representative who was against FGM/C was herself circumcised. When the ARP was announced in 2015, one of June's neighbors did not support her daughter's participation. June stated that "the Osotua philosophy had not entered her body."

- **The little girl's mother's case**

  Nancy is 27 years old and was married in 2009. She is June's neighbor and has a 4-year-old daughter. She raises vegetables as a cash crop. Although Nancy had never gone to school, she was eager for her daughter to be educated and sent her to the preschool in town. Nancy went to church every Sunday where she received information about the ARP. She was interested in the CBO program that teaches girls not to undergo FGM/C, and she attended the ceremony. She knew that some of her neighbors' daughters insisted that they would refuse FGM/C. She said that the girls' parents would accept the daughters' will, because their daughters knew the Osotua hotline number. These days, parents fear that their daughters will call the hotline. I asked Nancy about her daughter's FGM/C, and she answered that she would respect her daughter's wishes.

  > I would not have undergone *emurata* (circumcision), if I knew that *emurata* had no benefit. I decided to undergo *emurata* because all my older sisters and peers had. My

daughter might also say that she wants to undergo *emurata* like her friends. In this case, I would support her. I would prepare her *emurata* in secret at midnight.

This study has several findings. First, the girl who wished to undergo secondary education was attracted by the high-quality schools supported by the CBO, because their remote village has few teachers or facilities. ARP events give girls the opportunity to have a better education. Another interesting finding is how the hotline plays an important role as a warning to parents not to force their daughters to undergo FGM/C. Finally, the network for protecting girls is important and the hotline and network of cooperators in Osotua provide alternative options for Maasai girls.

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Manami Hayashi is a Research Fellow of Japan Society for the Promotion of Science/Osaka Metropolitan University, Japan; she received her Ph.D. in language and culture at Osaka University. Over the past decade, she has conducted fieldwork in the Maasai pastoral society in East Africa. Her doctoral dissertation investigates how female rites of passage of Maasai have transformed vis-à-vis globalization. She has written a book chapter and papers about grassroots movements to eradicate female genital mutilation in Kenya, including "The State of Female Genital Mutilation among Kenyan Maasai: The View from a Community-Based Organisation in Maa Pastoral Society," in *Senri Ethnological Reports* 143 (Osaka: National Museum of Ethnology, 2017).

Chapter 8
Female Genital Cutting in Asia: The Case of Malaysia

Abdul Rashid, Yufu Iguchi, and Siti Nur Afiqah

8.1 Introduction

This chapter is based on research conducted by the authors among the Malay Women Muslim communities (Rashid & Iguchi 2019) and Muslim doctors (Rashid et al. 2020). A mixed-method (qualitative and quantitative) study was conducted among Malay Muslim women aged 18 years and older in the rural areas of Kedah and Penang, two states located in the Northern region of Peninsular Malaysia; and among Muslim medical practitioners registered as members in two major medical associations in Malaysia. In total 605 Malay Muslim women data and 366 Muslim doctors' data were used for analysis. The qualitative component of the study included face-to-face interviews using semi-structured interview guides and using snowball sampling method until data saturation was achieved. Eight traditional midwives, known as Mak Bidans in Malay, practice or had practiced FGC and 24 doctors who had experience performing FGC were interviewed in depth. Focus group discussions were also conducted with seven participants each from two groups of women (aged 18–45 and more than 45 years old) and one group of adult married men. In-depth interviews were held with two Muftis (religious scholars or jurists qualified to issue Islamic legal opinions). No focus group discussion was held with the doctors. This study was ethically conducted and all the participants provided a written informed consent. The research only commenced after receiving the ethical approval from Ritsumeikan Asia Pacific University Research Ethics Committee.

A. Rashid (✉)
Department of Public Health Medicine, RCSI & UCD Malaysia Campus, Penang, Malaysia
e-mail: rashid@rcsiucd.edu.my

Y. Iguchi
College of Asia Pacific Studies, Ritsumeikan Asia Pacific University, Oita, Japan

S. N. Afiqah
Unit of Research On Women and Gender, School of Social Sciences, Universiti Sains Malaysia, Penang, Malaysia

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8.2 Background

Female Genital Mutilation (FGM) or Female Genital Cutting (FGC) involves the partial or total removal or any other injury to the female genitalia for non-medical reasons and it is categorised into four broad types (UNICEF 2013, 2014; WHO 2010).

Type I: known as clitoridectomy which is the partial or total removal of the clitoris and or the prepuce.
Type II: partial or total removal of the clitoris and labia minora with or without the excision of the labia majora.
Type III: the narrowing of the vaginal orifice by cutting and bringing together the labia minora and or the labia majora to create a type of seal with or without excision of the clitoris. When the cut edges of the labia are stitched together, it is referred to as infibulation.
Type IV: all other "harmful" procedures to the female genitalia for non-medical purposes, which include pricking, piercing, incising, scraping and cauterization to draw blood, but no removal of tissue and no permanent alteration of the external genitalia.

To eradicate the practice, the United Nations (UN) as part of its zero-tolerance policy to any forms of non-therapeutic cutting, have adopted the term Female Genital Mutilation (Newland 2006). Although the adoption of the terminology is based on the good intention to stop the practice, the term is considered derogatory by some communities and does not help with the eradication of the practice (Bagnol and Mariano 2008). Many researchers and people involved with the eradication of the practice are unhappy with the terminology because, for a myriad of reasons, it over-simplifies and fails to reflect the full extent of the varied types of practice conducted by different communities in different parts of the world. The practice has been described as violent by many, but really it is an act which is conducted by misguided parents who consider it their parental responsibility and have no intention to inflict harm on their children (Newland 2006; Wander 2017; WHO 2010). There are many different alternate terminologies proposed instead of Female Genital Mutilation. These include Female Genital Surgeries, Female Genital Operations, Female Genital Alterations, Female Circumcision and of course Female Genital Cutting (Arora and Jacobs 2016; Obermeyer and Reynolds 1999; Walley 1997). However, in Malaysia, Indonesia and Thailand the practice is more commonly referred to as Khitan, or Sunat, which is taken from the Arabic word *sunnah* (Putranti 2008; Rashid and Iguchi 2019). The authors of this chapter feel the term Female Genital Mutilation is culturally insensitive and does not aptly describe the practice in Malaysia as the type of cutting which is conducted in this region does not result in any form of mutilation. For the purposes of this chapter the authors will rather use the term Female Genital Cutting (FGC). There are also reports that the term FGM is an impediment to the goal of eradicating this practice (Bagnol and Mariano 2008). In Malaysia, the community and the traditional practitioners, as well as the doctors, consider FGM as reported in

Africa as a foreign practice, something completely different that has no relation nor bears any resemblance to what is practiced in Malaysia. This sentiment emboldens resistance to the eradication of the practice.

8.3 Prevalence

Worldwide, millions of girls have been cut and millions more will be cut each year (UNFPA 2018; UNICEF 2013, 2014). The practice is most prevalent in Africa and in the Middle East, but it is also prevalent among the Muslim communities in South East Asia including Malaysia, Thailand, Singapore, Brunei, Philippines and Indonesia. While there is an abundance of information available concerning the practice in Africa and in the Middle East there is little information concerning the practice in South East Asia (Clarence-Smith 2008; Marranci 2015; Putranti and Kebijakan 2003; Rashid and Iguchi 2019). There are only a handful of published studies on FGC in Malaysia and no official data relating to its practice. From the studies that have been conducted, the prevalence of FGC is about 99% in the Muslim community (Ab. Rahman et al. 1999; Rashid and Iguchi 2019; Rashid et al. 2009). In Indonesia FGC is reported to range from 43 to 95% (Putranti and Kebijakan 2003). There is no official data for Singapore and Thailand (Clarence-Smith 2008; Marranci 2015) but it is believed that most Muslims in these countries practice FGC. The practice of FGC has been prevalent in the Muslim community especially the Malay Muslim community in Malaysia for centuries. Although largely considered a religious practice, culture has also been commonly cited as a reason. FGC in Malaysia is not openly discussed or planned as is done for male circumcision; however, it is sanctioned by the community elders.

8.4 Malaysia

Malaysia is located in Southeast Asia and has a population of about 32 million, of whom 23.3% are 0–14 years old, 70.0% between 15 and 64 years old and 6.7% are above 65. The ratio of male to female is 106:100. Islam is the most professed religion with 61.3% of the population being Muslims, most of whom are Malays (Malaysia 2020). Islam falls under the jurisdiction of each state, and the Sultan of each state is the head of all Islamic matters and Malay customs. Each state can issue a *fatwa*, a non-binding religious edict. Except for the national *fatwa* and the *fatwa* from the state of Kelantan (on the east coast of peninsular Malaysia) in which state FGC is considered *wajib* or mandatory, all other states in the country are silent concerning FGC. *Fatwas* have become something of an academic matter rather than a legal practical issue. (The usual and most common access to the *fatwas* for the common folks are during the Friday prayer sermons which in Malaysia are not attended by

women.) By comparison, in Singapore the Islamic department endorses FGC and the religious experts there believe that FGC is mandatory (Marranci 2015).

8.4.1 History of Malay and Islam in Malaysia

The Malays make up the majority of the Muslim population in Malaysia. Historically, it is hypothesised that the Malay race originated in the Yunnan province of China and then settled in the wetlands of South East Asia. Others speculate they originate from Borneo (Halimi 2008). Most likely the Malays are an eclectic mix of people who settled in the South East Asia region because of its strategic location for trade and its fertile land which made it optimal for farming. The "Indians" from present day India used to travel to the northern parts of peninsular Malaysia for trade and along with it introduced their religion, culture and even food. Traders, and much later missionaries, introduced Hinduism and Buddhism to the population (Halimi 2008; Sivanantham and Suberamaniam 2014). The spread of Hinduism, Buddhism and later Islam were most likely not as a result of organized missionary movements but rather due to the economic standing of these merchants which attracted the local population. Even today, there is still a strong influence of Sanskrit in the Malay language. Many archaeological sites are still being discovered today showing Hindu and Buddhist relics in peninsular Malaysia, especially in the northern region which boasts of the first Malay sultanate. Similarly, Islam was introduced to the region by the Muslim traders and probably only much later by missionaries from India and the Arabian Peninsula. The traders/missionaries probably introduced to the natives the brand of Islam which they practiced, the sects and schools of thought and probably other influences from their own personal beliefs or cultures. There is conflict of opinion as to who was the first Sultan to convert to Islam but irrespective of who was the first Sultan to convert, the masses did not adopt Islam but rather historians believe the conversion of the population was much slower and not coerced.

8.4.2 FGC in Malaysia

In Malaysia, the practice of FGC is categorised as type IV which involves nicking the tip of the clitoris and/or teasing out a piece of the tissue from the prepuce of the clitoris (Ab. Rahman et al. 1999; Rashid et al. 2009). The practice of FGC has been commonly associated with patriarchy, but interestingly in Malaysia men have very little or no role in the practice. The mothers, grandmothers and the aunties are the ones involved. At most, the men are tasked to drive the mother and daughter to the location where the FGC will be conducted. No discussions are held with the father nor is he consulted, which is not to say that the fathers are unaware or opposed to the practice. Just like the mothers, they too believe that the practice is obligatory in Islam (Rashid and Iguchi 2019; Rashid et al. 2009).

8.4.2.1 A Traditional Practice

FGC in Malaysia was and is predominantly conducted by traditional practitioners who have no medical training, and is performed without any anaesthesia and sterilization (Momoh 2010; UNICEF 2013).

Malaya, now Malaysia, was colonized by the British for almost 200 years. The colonials were interested in the abundance of natural resources available in the occupied territory. Initially the interest was in the spices but later included tin and rubber. Although there were hospitals and clinics, they were mainly for the colonials and their families and for the workforce, so that the supply chain was not disrupted due to sickness and death. Most of the populace were left to seek traditional health services which were provided by either the shamans or the traditional birth attendants called the *bidan*. Besides the shamans and the *bidans* who were important health care providers, Imams, who were religious leaders, would double up as health educationists especially for "problems" of the soul. This was achieved mainly by supplications. Even today Imams along with *ustaz* (male religious teachers) and *ustazahs* (female religious teachers) are important sources of reference for religious issues and wield tremendous influence on the villagers on religious matters and practices.

Bidans were important health providers especially for the rural folks, particularly in matters related to childbirth. They were also essential in the practice of FGC. However, this changed after independence. With a better more modern health care system, especially for mothers and children, maternal and child mortality decreased. Currently, all births are attended by trained health personnel, making the jobs of *bidan* redundant.

It is not certain how the *bidans* got involved with the practice of FGC but it's safe to postulate that because *bidans* were easily accessible, and had traditionally been consulted on issues related to female wellbeing and the birth of babies, it seems natural that they took up FGC. The *bidans* would traditionally massage both the mother and child using herbs and recite specific verses from the Koran. This practice of massaging is still considered important especially in the Malay Muslim community. The traditional *bidans* have no formal training and most of their practice is learned from their parents or other family members.

A retired *bidan* from a remote village had this to say:

> My aunty taught me…my family has a history of Mak Bidans, we are all Mak Bidans even my aunty…I followed her, she would take me around and teach me and how to recite prayers, read the right recitations…I was a village *bidan*, in the old days everyone gave birth at home…when they have labour pains, the family members came to fetch me, all I do is wait. My aunty also taught me to do *sunat*. I watched and then when I did, she supervised. I have siblings but they were not interested in learning, they didn't want, they said no, not even massage.

Most *bidans* still practice their art not because of money but rather for altruistic reasons. However as mentioned earlier, the *bidans* are a dying breed and not many are interested in plying the trade. Most young women would prefer to find more "glamorous" employment in the city with higher paying jobs that come with benefits.

Hence, very few are interested in learning the trade from the older *bidans*. Although the older women of the community still prefer for a *bidan* to conduct the FGC, mostly because of the association of the practice with religion and culture, *bidans* are now difficult to come by. Even the *bidans* themselves are resigned to this fate but most have no issues with doctors performing FGC. However, they do emphasize that the practice should be done by a Muslim doctor who will able to recite a prayer before the procedure.

A 77-year-old practicing *bidan*:

> …there is no other *bidan* around this village, they have all died, of old age…it will disappear…no one wants to learn, no young people want to learn…maybe they are shy, not interested…I am willing to teach. Nowadays everyone goes to doctors…it's okay, the *bidans* are all old, the only ones left, are old, all are old, no replacements, no more.

There is no financial incentive for the *bidans* to practice FGC. Being part of the society they live in, the *bidans* share the same beliefs, which is motivation enough to continue with FGC. For the *bidans*, the main source of income is post-natal care which includes massage and use of herbs etc. They consider the practice as part of their social and religious responsibilities and do not set a fee. Rather the parents pay as much as they like as a token of charity which may range from Ringgit Malaysia (RM)1 to RM 20 (1USD = RM4).

FGC is commonly conducted on girls from the age of 0 to 15 years old in South East Asia (Merli 2008; Putranti 2008). There are no cultural or religious reasons for this. In Indonesia and in Thailand, girls undergo FGC more commonly in the first 40 days of life (Feillard and Marcoes 1998; Putranti 2008; Putranti and Kebijakan 2003). In Singapore, FGC is commonly conducted on children as young as one or two months of age (Marranci 2015). In Malaysia, the median age of girls undergoing FGC is six years old. A younger age is preferred by the *bidans* because it is easier to restrain the child. The *bidans* also reason that when done on younger children it prevents embarrassing the girl and they also claim it helps with wound healing (Rashid and Iguchi 2019; Rashid et al. 2009). Although traditionally FGC is conducted on young girls, because the practice is related to religion there are reports of FGC being done on women who convert to Islam. Some Muslim clerics and family members of the spouse insist that, irrespective of age, a woman who marries a Muslim man must undergo FGC. However, there is no directive from the Muslim authorities in the country for this practice. Even a Mufti (a Muslim legal expert who acts as an advisor to the sultan on Islamic matters and is authorized to issue a *fatwa*) who was interviewed by the authors was against this practice emphasizing that this is not a requirement.

The most common type of FGC conducted in Malaysia is type IV. The *bidans* most commonly nick the tip or the tissue overlying the clitoris and may remove a very small bit of the tissue. The common instruments used by the *bidans* include razor blades, scissors and penknife, but other instruments including nail clippers have also reportedly been used. Razor blades are now preferred because they are easily available and cheap. In most instances the razor is used once and then discarded. Interestingly, the *bidans* insist on a drop of blood for the fulfilment of the practice. The type of cutting and the instrument are not important; the emphasis is on a drop

of blood, which one *bidan* specified must be as big as a mosquito. There are reports of parents getting their children to undergo the procedure twice because there was no blood in the first instance. However, no one is able to explain why this requirement is mandatory and what this belief is based upon. The tissue over the clitoris is either cut, nicked, pricked or scraped but *no* part of the clitoris is ever cut or removed. No sterilization, gloves, sedation or anaesthesia is used. But the *bidan* will usually wash her hands with soap and water before and after the procedure. She will usually recite a prayer and supplications are made for the wellbeing of the child. She will then open the vagina using her fingers and the cut or nick is then done. Once a drop of blood is seen, a piece of cotton is applied. The procedure is done either in the *bidan*'s home or in the home of the clients.

A 70-year-old *bidan* who still practices FGC

> Sometimes they (parents) come, sometimes I go to their house, but mostly they come to my house. I read Bismilliah (in the name of Allah) and Niat (intention) that we are doing it because of Islam, just like when I help deliver a child. I wash the area using a cotton with clean water…it's just a small thing like the comb of a chicken, if we can't find it, we take the tissue a bit…tease off using a very small knife…I use a razor blade, the edge of the blade….I tie the end of the blade with cloth to prevent cutting myself…I just tease the skin outside only…its *sunnah* to have some blood…otherwise difficult… it has to bleed a bit, it's a requirement…I put a bit of cotton over the bleeding area. Sometimes I throw away the blade but sometimes I reuse it…I also do on adults…usually at home…same as doing for children…sometimes they cry because they are scared, it's the blade (that scares them), hahaha (laughs). The skin of the adult is harder, in children its soft, adult have tough skin.

8.4.2.2 Medicalization

Internationally, health campaigns have highlighted the dangers and risks of FGC being conducted by traditional "cutters" thus driving the practice from traditional practitioners to health care professionals. In the past 30 years, Malaysia has transitioned from a mostly rural population to an urban one. Modern health care is now ubiquitous and the level of education among the population is high and access to information easy. Health clinics, both private and public, are available almost everywhere. With modern medicine easily accessible and affordable and an increase in awareness of the importance of hygiene and infections, more parents are turning to doctors to perform FGC on their children, hence the trend toward medicalization of FGC in Malaysia (Rashid and Iguchi 2019; Rashid et al. 2009).

A 45-year-old mother:

> I prefer doctors, female doctors …they do it so fast, sometimes the girls may not even cry and if she does, its only for a short while. The doctor uses a small scissors and removes a very small piece of the tissue…Nowadays everyone prefers the doctors, it's difficult to find *bidans*, can't find them and not every *bidan* can *sunat*, some only massage…the old ones can't see properly anymore hahaha (laughs). Those days we preferred *bidans* but now, hmm, but it's okay the doctors have better medicine, if something happens…and doctors nowadays know how to recite prayers and bismillah…and clean, the cleanliness is guaranteed, and they don't recycle the blades.

Medicalization is defined by the World Health Organization (WHO) as the "situation in which FGC is practiced by any category of health care providers, whether in a public or private clinic, at home or elsewhere" (UNFPA 2018; WHO 2010). The prevalence of FGC carried out by health care workers is 18% but the rates reported actually range between 1 and 74%. In Malaysia, the prevalence of medicalization is reported as 20.5%, but the community's self-reported medicalization rate ranges from 28 to 39% (Rashid and Iguchi 2019; Rashid et al. 2009). In Malaysia, besides doctors, no other health care providers have been reported to practice FGC (Rashid et al. 2020).

There are several issues related to doctors conducting FGC. A major issue is that the involvement of doctors creates an impression that the practice is a health necessity and thus legitimizes it in the eyes of the population. (El-Gibaly et al. 2019; Foldes and Martz 2015; Johansen 2011; Kimani and Shell-Duncan 2018; Pearce and Bewley 2014; UNFPA 2018). Doctors in Malaysia, as in most other countries, are not trained to perform FGC. The parents assume that the doctors are experts and are trained to do FGC and hence are unlikely to harm their children. The reasons cited by the doctors in Malaysia for practicing FGC include that it is a harmless cultural procedure and they do not see any harm in fulfilling the wishes of the parents. Another important reason cited is harm reduction. This is discussed later. But monetary reasons, which are commonly mentioned in reports elsewhere in the world as an important motivator for the practice by doctors, is not an incentive for doctors in Malaysia.

Only Muslim doctors have been reported to practice FGC. Most of the doctors who practice FGC are older and are not working with the Ministry of Health. Because the doctors themselves are from the same community, they have similar religious, social and cultural motivations as those who request their services (being Sunni Muslim and followers of the Shafi'i sect). Some of the doctors have themselves undergone the practice and see no reason to abandon it (El-Gibaly et al. 2019; Rashid et al. 2020; UNFPA 2018).

There is no official training on FGC in the medical curriculum. The doctors have learned the art from their seniors who themselves have not undergone any formal training. Most of the doctors have learned the art from the *bidans*, by observation and by talking to them on how to perform it. The doctors supplement their knowledge by reading books, watching videos online and asking religious figures. They then adapt and modify according to what suits them best.

A 53-year-old doctor:

> …actually, I learned from a senior doctor, and I also learned from this village *bidan*. I did some reading from the internet…I asked the *ustaz*, what is female circumcision and it's stand in our religion. He explained about the *madhab*,* and that we are madhab shafi'i and it is *wajib*…must perform female circumcision. And then according to this kitab written by Abdullah Nasir Ulwan, it mentions how it's supposed to be done, when it's supposed to be done and what are the things that we are looking for.
>
> *discussed in detail later.

The doctors, just like the *bidans*, do not practice FGC for money. They charge on average about RM31. This is a paltry sum hence unlikely to be a motivator for the

practice. Just like the *bidans*, they are part of the community with the same beliefs, and perform FGC because they consider it part of their societal responsibility.

Doctors in general perform FGC on girls aged from 7 to 12 months of age, with most preferring children between the ages of 4 and 6 months. Again, the most common reason given is because the child is easy to restrain. In general, most doctors do not perform FGC on adults.

All the FGC performed by doctors is done in their clinics. Most doctors get verbal consent from the parents and some of the doctors verbally ask the parents if the child has any bleeding disorders. Most doctors conduct type IV FGC by either nicking or cutting off a small piece of the tissue, sometimes with the use of local anaesthesia. A minute drop of blood is mentioned by the doctors too. This is not surprising considering most learned the art from the *bidans*. But some doctors claim that the parents are the ones who insist on seeing the drop of blood to ensure that the procedure is properly done. Essential medical supplies such as flavin, povidone, hibitane, saline, gauze, cotton, paracetamol, antibiotic creams and anaesthetic creams are often used. Instruments commonly used for "cutting" include needles, surgical blades, scalpels and curved scissors. Antibiotics are almost never used due to the minimal cut inflicted. In most cases the prepuce of the clitoris is scraped, pricked, incised or cut, after reciting some verses which vary between the practitioners, and supplications for the wellbeing of the child. This is done even by doctors who don't believe that the practice is related to religion.

A 37-year-old doctor:

> First, I examine the baby, I ask how old the baby is, because usually I don't do if more than six months old. If the baby is older than that (age) I will ask them to go to another centre, maybe they are more experienced…so for me I only do on a less than six months old baby and if the baby has no fever and is healthy. I put the baby on the couch then I open the private area and clean with alcohol swab only for around one or two minutes. I don't use any anaesthesia because it is a simple procedure. I use a needle, clean needle, a single use needle, then find the clitoris…I only prick, very superficial prick above the clitoris. I make sure 5 cent blood (size), I mean, I estimate the blood stain on the cotton around 5 cents, it is more than enough…I check to make sure there is no injury to the urethra, as a doctor I know the anatomy. After that, I compress the area using a cotton dipped in flavin and tell the mother to remove the cotton at home and if there is still bleeding, if it is just a small oozing, keep pressing, that's it.

Alarmingly, there are a few who cut a portion of the clitoris, transitioning the practice from type IV to type I, that is, from a minimal practice to that of mutilation.

8.4.2.3 Reasons

Many reasons have been cited for the practice, including religion, culture, fertility and even cleanliness. Some in the community believe that the type of FGC practiced in Malaysia helps to clean the parts over the clitoris and eventually leads to improved vaginal health and prevention of sexually transmittable infections. This belief of course has no scientific basis or logical reasoning but is something which has been

shared over the years by generations. Although health benefits have been mentioned, overwhelmingly the practice of FGC is tied to religion and, to some extent, culture. In Malaysia, like in other South East Asian countries where FGC is practiced, the main reason cited for the practice is Islam (Clarence-Smith 2008; Rashid et al. 2009). Worth noting is that there are reports of small communities of Hindus, Catholics and Buddhists in Indonesia who practice FGC but this is mainly for cultural rather than religious reasons (Putranti 2008; Putranti and Kebijakan 2003).

Islam

FGC predates Islam but most of the practice of FGC is prevalent in Islamic countries although it is not exclusively practiced by Muslims. Not all Islamic countries report the practice of FGC because it is dependent mainly on the type of *madhab* which the community follows. In Malaysia, FGC is solely practiced by the Muslim community especially the Malay Muslim community.

This chapter is related to the practice of FGC in Malaysia but because Islam is the primary motivator for FGC in Malaysia, it is important to understand the religion of Islam. It would be amiss if there is no introduction to Islam in this chapter, but the authors are cognizant it would take more than a chapter, if not a book to discuss Islam. The discussion provided here is brief and should suffice for a basic understanding of this chapter. Islam is a monotheistic religion which is based upon the teachings of the Koran which were revealed to the Prophet Mohammad [Peace be Upon Him (PBUH)]. There are almost two billion followers of Islam and it is fast expanding. The two largest denominations currently in Islam are the Sunnah Wal Jamaah, or Sunni, for short, and Shia. Most of the Muslim community in Malaysia are followers of the Sunni sect from the Shafi'i school of jurisprudence. There are four major schools of jurisprudence or *madhabs* in the Sunni sect. The four major *madhabs* are based on the teachings of the four revered Imams. Imam Hanifah is the founder of the first of the four *madhabs* and has the greatest number of followers. Others are Imam Malik, Imam Muhammad Ibn Idriss Ash-Shafi'i better known as the Imam Shafi'i who was the student of Imam Malik, and the last founder of the main four *madhabs,* Imam Ahmad Ibn Hanbal. It is said that it is because of Imam Shafi'i that the collection of sound and authenticated *hadiths* were collected (Bewley and Rifai 2013). Although most Muslim scholars believe that there are little or inconsequential differences between the *madhabs*, there are differences of opinion or *khilaf* on some issues. Different parts of the world have different *madhabs* which would predominate depending of course on the ancient day traders and preachers who introduced Islam there. In Malaysia, Thailand, Indonesia, Brunei, Philippines and Singapore, the Shafi'i school of jurisprudence dominates. Concerning FGC, there are differences of opinion with regard to the Islamic law and guidance. The Hanafi teachings do not consider FGC as *sunnah* whereas the Maliki and the Hanbali schools consider FGC as a recommended practice. However, the Shafi'i school considers the practice as mandatory.

The Koran is the revelation from Allah, Subhana Wa Ta'ala (SWT) (meaning the most glorified, the most high), and as such it is indisputable. *Hadiths,* on the other

hand are texts which are considered important in Islam. Some *hadiths* were documented during the time of the prophet Mohammad (PBUH) but most were collected after his passing. *Hadiths* or traditions are the words, actions and the silent approval of the Prophet Mohammad (PBUH) and his closest companions. *Hadiths* have been collected by the Islamic scholars using a meticulous scientific process based on the transmission called *Isnad*. The *hadiths* are classified into broad categories which include *Sahih* or authentic, *Hassan* or good, and *Daif* or weak. *Sunnah*, which is often interchanged with *hadith*, actually refers to the acts of the prophet Mohammad (PBUH) while *hadith* refers to the narration of words, deeds or tacit approval of the prophet Mohammad (PBUH) which is transmitted from person to person. There is no mention of FGC in the Koran. There are some *hadiths* from which proponents of FGC commonly quote but on the other hand those who do not consider the practice as mandatory claim that these *hadiths* are *Daif* or weak. This opinion is also shared by a local Mufti who was interviewed by the authors.

Most people in the Nusantara, a Malay realm which encompasses south of Thailand, Malaysia, Singapore, Indonesia and Brunei, either believe FGC is *wajib* (mandatory) or at the very least it is *sunnah* i.e., it is encouraged but is not mandatory. There are however people in the community who believe that FGC is just a custom and has no relation to religion. In Indonesia, a large proportion of the Muslim population believe the practice is *wajib*. In Malaysia, most of the Malay Muslim community too consider the practice as *wajib* and some believe that those who have not undergone the procedure are not Muslims (Rashid and Iguchi 2019; Rashid et al. 2020). Although nothing is mentioned concerning FGC in the Koran, there are people in the community, *bidans* and even religious teachers, who falsely claim that there are verses in the Koran which mention the obligation of the practice in girls and women.

According to a young woman from a village in northern Malaysia:

> According to the Islamic religion, it is *wajib* in Islam, all Muslims must do, irrespective of whether they are male or female…must do…can't say cannot do, or its okay not to do, cannot be like that, it's *wajib*, must do…from the viewpoint of prayers, it is not acceptable.

A Muslim woman's identity, Muslimah, is often associated with FGC. Just as for the Muslim man wearing a beard and a skull cap reflects his identity as a Muslim man, a woman's identity includes wearing a hijab to reflect her identity as a Muslim woman. Although most will never use FGC as a marker of being a Muslim woman, there are people in the community who do. But there are many Muslim women and men, *bidans* and religious leaders, who are very clear in stating that just because a person has not undergone FGC does not make them any less a Muslim than others.

Muslims in this region consider it their responsibility as good Muslim parents to ensure that their daughters/granddaughters are accepted into mosques and that their prayers are accepted and not rejected because of being unclean (Feillard and Marcoes 1998; Newland 2006; Putranti 2008; UNICEF 2013). Some Muslims who practice FGC in Malaysia feel that FGC is *wajib*. They are of the opinion that without FGC the girl/woman is not a Muslim; the vagina will be dirty resulting in her prayers not being accepted. It is this religious concern for their children that makes parents insist their daughters/granddaughters undergo FGC. They consider it a parental responsibility,

not a violent or an oppressive act (Newland 2006). This would suggest that the practice is taken so seriously in the community that they would take notice of the persons who are not cut and ostracise their parents and families. But in reality, FGC is not spoken of. Some younger women are not even aware of whether they have undergone FGC because they were not informed of this by their parents. FGC is a topic which is neither spoken of nor discussed on just any occasion, not because of shame but rather because the community considers it a very private issue. One gentleman who was interviewed by the authors even commented that he does not know if his wife had undergone FGC and it would be embarrassing to ask her about this. The persons who have not been cut are not ostracised nor are their families isolated. Neither they nor their family members will have any issues in getting married. This is in sharp contrast with the reports from Africa where the girl and even the family members are shunned by the community and the daughters are not considered marriage worthy (Molleman and Franse 2009). In contrast to what is reported in Africa where even those who don't believe in the practice succumb to the pressure of society (Kaplan et al. 2013), because FGC is practiced in such a quiet manner in Malaysia and no one discusses it, societal pressure does not occur. But it is a common and accepted belief in the community that all the women undergo the procedure. During the author's discussions with Muslim women in rural areas, they expressed shock that there are Muslim women in Malaysia who have not undergone FGC. They believe that all Muslim women in the world undergo the exact same type of procedure as that in Malaysia. This belief strengthens their resolve that the practice is ubiquitous among the Muslim communities and hence what they are doing is right and is in accordance with the teachings of Islam.

The doctors who practice FGC on the other hand are more aware, and know that FGC is not *wajib* but rather believe it is *sunnah*. They are more knowledgeable concerning the jurisprudence of the different sects in relation to FGC and most are aware of the *fatwas* issued concerning FGC. They are also aware that there are no health benefits or health justifications for the practice, but they practice it because they believe it is recommended in their religion.

A 58-year-old male general practitioner:

> …first of all being a Muslim, I believe it is a religious obligation. I don't know if it's *wajib.* I am not a religious person to say it is *wajib* or not. But I believe in my religion and we have to do it. Because there are certain things you cannot see, you cannot understand…you just follow.

The *bidans* and the Muslims in the community are quick to disassociate what is done in Malaysia with that in Africa and the Middle East and they are quick to condemn the latter. They consider it a very different practice, unrelated to religion.

Culture and Ritual

Culture is another commonly cited reason for the practice not only in Malaysia but also around the region. In the case of male circumcision, the practice is commonly discussed in the community. Male circumcision is done in groups in the villages, and even in the cities it is conducted along with the siblings and other family members in

a festive environment, and a feast is usually held afterwards. However, in the case of FGC, it occurs without any festivities and in most cases, the matter is not discussed outside the immediate family. FGC, when practiced by the *bidans*, has an element of ritual. Rituals include having betel leaves and areca nut placed on a plate and the parents then "offer alms" on this plate. The fee for the practice is not discussed in advance and it is commonly up to the parents to pay the fee which is referred to as alms. A special meal made from yellow rice is made for the occasion for immediate family members. These rituals are fast disappearing but some of the elderly women in the villages insist on them.

Doctors too believe that FGC is a cultural practice and not a religious obligation. Some will tell this to the parents but if the parents insist on wanting to proceed, the doctors usually oblige. After all, they share the same cultural beliefs with the community. There are no rituals when FGC is conducted in doctors' clinics.

Libido

Another common reason cited for the practice of FGC is to control the libido of girls. The women in the community believe that girls who do not undergo the practice will end up being "wild" and have a high sexual drive which may result in them becoming promiscuous. They believe FGC is able to reduce the sexual drive of women and keep them chaste. Interestingly, there are older women in the community who rationalize that removing the layer of tissue over the clitoris will enhance the sensitivity and hence increase the sexual pleasure of women (Rashid and Iguchi 2019; Rashid et al. 2009). Some doctors too have such beliefs. They rationalize that removing the tissue over the clitoris increases sensitivity leading to greater pleasure during intercourse. Others in the community believe that besides libido, girls who do not undergo FGC will end up being stubborn and have bad attitudes.

Harm Reduction

The doctors in Malaysia who practice FGC cite harm reduction as a reason for the practice. They worry that if not done in a sterilized environment, the parents will take their children to the *bidans* who may inadvertently inflict harm on the girls. This view is even shared by some doctors in the west (Doucet et al. 2017; Serour 2013; Johansen 2011). Although harm reduction as a strategy in reducing the extreme forms of the practice has been shown to be effective in places where the more serious forms of FGC are practiced (Bedri et al. 2018; Pearce and Bewley 2014), this justification is flawed in the case of Malaysia where the practice is minimal in comparison. Rather, it legitimizes this irreversible practice which, moreover, is being done on children who are not able to provide consent (Berggren et al. 2004; Johansen et al. 2013; Kimani and Shell-Duncan 2018; Pearce and Bewley 2014; Shell-Duncan 2001; WHO 2010).

8.4.2.4 Health Effects of FGC

There are many reported health effects of FGC, most if not all related to type I, II and III. These include bleeding, infections, urinary problems, reproductive problems

including infertility and labour problems, adhesions and obstructions. In addition to the physical side effects, there are also mental health issues (Muteshi et al. 2016; Obermeyer and Reynolds 1999). The possibility of health risks related to FGC is associated not only with the type but also the skills of the practitioner and the instruments used. (Khaja et al. 2010). However, studies conducted in Malaysia, Indonesia and Singapore have not reported any evidence of injury to the clitoris or the labia; there were no signs of excised tissues nor was any loss of libido reported (Ab. Rahman et al. 1999; Marranci 2015; Newland 2006; Rashid et al. 2009). Similarly, there have been no reported complications from FGC performed by *bidans* or doctors in Malaysia (Rashid and Iguchi 2019; Rashid et al. 2020). On the contrary, some women in the community believe that FGC has health benefits related to hygiene. This of course has no scientific basis. It is crucial to mention, however, that the authors noted blood stains and rust on the tools used by the traditional practitioners which can potentially pose a risk of cross infection.

8.4.2.5 Law

WHO considers FGC a traditional practice that endangers the health of girls and women and hence has recommended it be made illegal by member countries. The UN has adopted a resolution for a global effort to end FGC. By law, most international communities treat FGC as a violation of the human rights of children and consider it a harmful practice. The international medical fraternity describes the procedure as harmful both physically and mentally. Gender rights activists view it as detrimental to women's health and a sign of deep gender inequality (Obermeyer and Reynolds 1999). But enacting a law does not necessarily correspond with a decline of the practice in local communities. This is especially true when the people in the community are not informed of the reasons for the law, their concerns are not addressed and their participation is not included in the programme. It is reported that in some countries in Africa, laws have been enacted to make the practice illegal but in spite of this FGC is still prevalent in communities. In Malaysia, there is no specific law that prohibits FGC. The Malaysian Medical Council is silent on the practice by doctors and most doctors who practice FGC consider the silence as a tacit approval. Most doctors are unaware of the stand taken by the UN bodies and the World Medical Association concerning the practice.

8.5 Conclusion

The number of *bidans* have decreased tremendously and are now a dying breed but this has not reduced the enthusiasm for FGC in the Muslim community. There is now a transition of FGC from a traditional-style practice towards medicalization. As it stands presently, the practice is unlikely to decrease, let alone stop, as the Muslim community considers the practice an integral part of their religion, and mandatory.

The doctors who practice FGC are of the opinion that the practice must continue since they feel it is a religious obligation and a harmless procedure. It is imperative that the practice of FGC is stopped, as advocated by the international community, but stigmatizing and criminalizing the practice without taking into consideration the sensitivity and the complexity of the issue will only result in distrust and confrontation. It is pertinent to understand and respect the community's beliefs and culture and not assume that what works in other parts of the world will work here as well. There is no one solution that fits all; it's like trying to insert a round peg into a square hole. The community and religious leaders must be engaged in open and frank discussions and adopt programmes to gradually but surely stop the practice. Doctors, on the other hand, must stop the practice. They are not trained to perform FGC and must cease conducting it. The Malaysian Medical Council must ban outright the practice among the doctors. Researchers and academics from different backgrounds must work together rather than in silos and there must be intelligent discourse among them rather than confrontations. Only then can there be a reasonable expectation of the complete elimination of the practice in Malaysia.

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Abdul Rashid (Prof. Dr.) is head of the Department of Public Health Medicine at the RCSI & UCD Malaysia Campus in Penang, Malaysia. He has been studying Female Genital Cutting (FGC) among the Muslim communities in Malaysia and in Southeast Asia. His area of research interest is marginalised populations' social, health, and well-being. He has more than 95 peer-reviewed publications and has published several books to date, including "Medicalization of Female Genital Cutting in Malaysia: A Mixed-Methods Study," with Yufu Iguchi and Siti Nur Afiqah, *PLOS Med.* 17, 10 (2020), and "Use of Hormones among Trans Women in the West Coast of Peninsular Malaysia: A Mixed-Methods Study," with Siti Nur Afiqah and Yufu Iguchi, in *Transgender Health* (2021).

Yufu Iguchi Ph.D., is a professor of gender studies, cultural studies, and area studies at the College of Asia Pacific Studies, Ritsumeikan Asia Pacific University. She has conducted research on female genital cutting in Malaysia and Southeast Asian countries from the viewpoint of sexuality and the female body. Her recent publications include "Female Genital Cutting in Malaysia: A Mixed-Methods Study," with Abdul Rashid, in *BMJ Open* 9, 4 (2019), and "Female Genital Mutilation in Malaysia from the Viewpoint of Sexuality and the Female Body," with Abdul Rashid, in *Tonan Ajia Kenkyu* [*Southeast Asian Studies*] 57, 2 (2020).

Siti Nur Afiqah is a Ph.D. candidate at the Unit for Research on Women and Gender, School of Social Sciences, Universiti Sains Malaysia. She holds an MA degree in linguistics and English Language studies from the Universiti Sains Malaysia and is currently an RCSI & UCD Malaysia Campus administrative executive. Her research interests are gender issues among marginalized populations and her Ph.D. research focuses on female genital cutting among immigrants. She is also actively involved in other studies of the transgender and indigenous communities of peninsular Malaysia.

Chapter 9
Female Genital Cutting and the "Medical Gaze" in Southeast Asia

Yufu Iguchi, Abdul Rashid, and Siti Nur Afiqah

9.1 Introduction

This article argues female genital cutting (FGC) in Southeast Asia from the viewpoint of the increasing global medical control over the female body.[1] It questions modern medicine's involvement in women's health issues and the influence it has on the public health policies enforced by legislators. In this study, we focus on the medicalization of FGC in Southeast Asia as manifestation of the modern medicine system. Our study does not assume that modern medicine necessarily stands for progress and civilization. Rather, we question the aspect of its control in defining and governing the human body and the unquestioned premise that medicine can legally "harm" the human body. We aim to reveal the complexity of FGC issues in the light of the above concerns. Needless to say, the authors do not promote the medicalization of FGC and a "milder" form of FGC. Rather, we aim to question and problematize acts that harm and control the female body.

There are different terms to refer to FGC, for instance, female circumcision, female genital mutilation, female genital cutting, female genital surgery, female

[1] This is the part of KAKEN research, "Sexuality and nationalism: Politics of discourses of female genital mutilation in Malaysia" [15K01936], Grant-in-Aid for Scientific Research [C] and "The female body in post-colonies: 'Female genital mutilation' in Southeast Asia and Africa" [19H04390], Grant-in- Aid for Scientific Research [B] Japan Society for the Promotion of Science [JSPS].

Y. Iguchi (✉)
College of Asia Pacific Studies, Ritsumeikan Asia Pacific University, Oita, Japan
e-mail: yufuig@apu.ac.jp

A. Rashid
Department of Public Health Medicine, RCSI & UCD Malaysia Campus, Penang, Malaysia

S. N. Afiqah
Unit of Research On Women and Gender, School of Social Sciences, Universiti Sains Malaysia, Penang, Malaysia

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genital operation, and female genital alteration. We choose to use FGC in this article for the following two reasons. First, the term FGC covers both the practices performed in Africa and Asia that harm the female genitals as well as its practice in Southeast Asia where the genitals are not mutilated. Merli describes the practice in southern Thailand, saying "a very small piece of skin, no larger than a grain of rice, was removed (in others the skin was only pricked or scratched for the same purpose)" (Merli 2008: 279). Isa et al. described one process as follows: "the method used [in Malaysia]—nicking with a small knife, drawing a drop of blood—leaves no physical damage and does not lead to complications" (Isa et al. 1999: 141–142). Secondly we choose the term to counter a specific aspect of the rhetoric of Southeast Asian discourse around FGC. That is, many religious leaders in Southeast Asian countries call the local practice "female circumcision" (using a translation of the English term) to differentiate it from the African practice. They call the African practice "FGM" and agree that it violates women's human rights. Yet, they urge for the legitimization of the local practice because they believe that the procedure follows Islam and is different from "FGM." (Iguchi and Rashid 2020: 175). (Other terms such as female genital mutilation, female circumcision, and female genital operation are used in this article only in direct and indirect quotations from literature.)

While previous scholars have problematized the issue of FGC in terms of a dichotomy between preserving tradition or protecting human rights[2] we, in contrast, have situated the issue in the context of the increasing global medical control over the female body, contending that arguments for either stopping or encouraging FGC have both led to increasing medical intervention in women's bodies. Specifically, we sought to answer the following questions: what are the processes of medical control over women's bodies through FGC in Southeast Asia? Is FGC being actively promoted or is it an unconscious practice? Using a cultural studies methodology of text analysis, we examined various discourses on FGC in Southeast Asia, including interview results from our own research projects, in an attempt to answer these questions.[3]

Our report is divided into three sections: first, a review of the theoretical discussions on modern medicine and its relation to the female body, Second, an overview of FGC in various parts of Southeast Asia. Third, an examination of how FGC has promoted medical control over the female body in Southeast Asia.

9.2 Theoretical Background

The theoretical framework of our discussion is based on the ideas of Michel Foucault's and those influenced by him. Foucault held that the development of

[2] For the debate, please refer to Boddy (2007: 2–3) and Iguchi and Rashid (2020: 170–172).

[3] We have conducted research projects on FGC since 2016. The first project was conducted in rural northern Malaysia (2016–2017). The second project focused on the medicalization of FGC in Malaysia (2018–2019) and the third was conducted in Southeast Asia (2019–present).

modern medicine did not reflect progress and civilization, but rather it restructured the concept of the human body and offered a system to control the human body according to a binary opposition between health and disease (Foucault [1963] 1994).

In his *History of Sexuality* (*Histoire de la Sexualité*), Foucault ([1976] 1990) argued for two concepts of the human body as forms of biopower: an anatomo-politics of the human body centered on the body as a machine, and a bio-politics of the population focused on the species body.

> In concrete terms, starting in the seventeenth century, this power over life evolved in two basic forms; these forms were not antithetical, however; they constituted rather two poles of development linked together by a whole intermediary cluster of relations. One of these poles – the first to be formed, it seems – centered on the body as a machine: its disciplining, the optimization of its usefulness and its docility, its integration into systems of efficient and economic controls, all this was ensured by the procedures of power that characterized the disciplines: an anatomo-politics of the human body. The second, formed somewhat later, focused on the species body, the body imbued with the mechanics of life and serving as the basis of the biological processes: propagation, births and mortality, the level of health, life expectancy and longevity, with all the conditions that can cause these to vary. Their supervision was effected through an entire series of interventions and regulatory controls: a bio-politics of the population. (Foucault [1976] 1990: 139)

In short, modern medicine views the human body as a machine at the individual level and functions as a bio-politics at the population level by medically controlling and intervening with not only patients but also healthy people (Mima 2015: 134).

It is the moral concept of the "model man" or the *healthy man* that modern medicine utilizes to control individual human bodies and populations. Foucault's *Naissance de la Clinique* [*The Birth of the Clinic*] (1963) questions the idea of progress and civilization in modern medicine and argues that modern medicine has generated the moral concept of the healthy man.

> Medicine must no longer be confined to a body of techniques for curing ills and of the knowledge that they require; it will also embrace a knowledge of healthy man, that is, a study of *non-sick man* and a definition of the model man. In the ordering of human existence it assumes a normative posture, which authorizes it not only to distribute advice as to healthy life, but also to dictate the standards for physical and moral relations of the individual and of the society in which he lives. (Foucault [1963] 1994: 34)

By interlinking with state governments, modern medicine provides those in power with systems to control the human body according to this binary opposition of health and disease (Foucault 1994: 35).

One can trace the history of colonial and postcolonial medical control over the female body in terms of this moral concept of the "model man." Under European colonialism from the end of the nineteenth to the early twentieth century, systems expanded to non-Western colonies (Arnold 1993; Headrick 1981; Manderson 1996). Colonial governments used public health systems to govern their residents according to this binary opposition of health and disease. Referring to Edward Said's *Orientalism*, Lenore Manderson observed that European thought's binarism of "them/us, inferior/superior, lower/upper and ruled/ruler" underpinned colonial discourses (Manderson 1996: xiv). In other words, the colonies and their residents were seen as signifying "illness" (Wakimura 2002).

Until the eighteenth century women's and men's bodies had been observed as similar (Laqueur 1990). However, at the end of the eighteenth century, with the development of modern medicine, a new model formed that stressed the differences between women's and men's bodies. Under the model, modern medicine implicitly observed the female body as "illness" because it has organs such as the womb and the ovary that are different from the male body's (Ogino 2002: 157–163). This is also why obstetrics and gynecology were established as clinical departments that were especially for women.

Ogino further argues that modern medicine has implicitly controlled women by controlling their wombs and ovaries in the sense not only of the control of the organs' function but also of the moral control of women. In this process, discourses of women's identity were constructed centered on women's sexual organs (Ogino 2002: 192). Foucault calls the same process (reducing women's existence to sex) *hystérisation* of women (Foucault 1990: 104).

That the colonized female population came to signify women as illness had a double meaning: women were ill in contrast to European women at the level of colonialism and in contrast to colonial men at the level of gender. Specifically, colonial medicine redefined the female body with respect to reproductive health, and as objects of colonial state control (Manderson 1996).

Undoubtedly, colonial governments saw the practice of FGC as a symbol of illness in colonies. According to Boddy, stopping "female circumcision" for the sake of infant mortality and maternal health was a project to "civilize" women in colonial Sudan (Boddy 2007). In short, eradicating the practice aimed to create healthy men and women who could contribute to the colonial economy by creating productive/reproductive labor. Today, governments and international NGOs have carried out projects to stop FGC. Iguchi and Rashid have analyzed postcolonial FGC controversies engendered by the opposition between concepts of universal humanism and cultural relativism and argued that the medical gaze has provided an unquestioned premise for both of these camps (Iguchi and Rashid 2019).[4]

In Southeast Asia, medical control over the female body and women's sexuality has been promoted since the nineteenth century under colonial rule. However, colonial governments in Southeast Asia, unlike those in Africa, did not pay much attention to the practice of FGC.[5] Our chief question is: what is the situation today? Do Southeast Asian countries see FGC as an issue of women's health, sexuality, and human rights, or is it still an unconscious local practice?

[4] The medical gaze observes the female body, especially the female sexual organ, and investigates it as an object of anatomy.

[5] We found no previous research on the issue. Feillard and Marcoes showed that the Dutch government noticed the practice of "female circumcision" in the mid-nineteenth century; they gave no description of whether or not the government took political intervention (Feillard and Marcoes 1998: 339).

9.3 FGC in Southeast Asia

WHO and UN agencies define female genital mutilation (FGM) as "partial or total removal of the female external genitalia or other injury to the female genital organs for non-medical reasons" and consider it "a harmful practice and a violation of the human rights of girls and women" (WHO 2011: 1–2). "FGM" is currently practiced in 33 countries in Africa and in some countries in Asia and the Middle East (UNFPA 2022). It is estimated that 200 million women worldwide have undergone "FGM", and that 4 million girls are at risk of mutilation each year (UNFPA 2022).

FGC is popular among Muslim women in Southeast Asia. In Southeast Asia, the practice of FGC relates to Islam, while in Africa it predates Islam. Not all Muslim communities perform FGC. There are four schools of thought in Sunna Islam, *Hanafi*, *Hanbali*, *Maliki*, and *Shafi'i*, and only the *Shafi'i* school regards "female circumcision" as compulsory [*wajib*] (Rashid et al. 2009: 5).[6] Researchers believed that FGC was introduced to Southeast Asia with the advent of *Shafi'i* Islam in pre-modern times (Clarence-Smith 2008; Feillard and Marcoes 1998). There are academic articles on the practice of FGC in Indonesia (Budiharsana et al. 2003; Clarence-Smith 2008; Feillard and Marcoes 1998; Newland 2006; Putranti 2008; Susilastuti et al. 2017), in Malaysia (Ainslie 2015; Isa et al. 1999; Iguchi and Rashid 2020; Rashid and Iguchi 2019; Rashid et al. 2009, 2020; Salleha et al. 2017), in southern Thailand (Merli 2008, 2010), and in Singapore (Marranci 2015) but none on the practice in Brunei, southern Philippines, or the Muslim communities in Vietnam and Cambodia, although the practice is reported there. Additionally, there have been more studies on FGC in Indonesia than in other Southeast Asian countries.

Indonesia's Basic Health Research (*Riset Kesehatan Dasar*, *Riskedas*) includes information on FGC (Susilastuti et al. 2017: 6). Feillard and Marcoes trace the history of FGC in the country to the Dutch colonial period finding that the oldest record of the practice of FGC in Indonesia is found in *Description Historique du Royaume de Macacar* by the French writer, Nicolas Gervaise in 1688 (Feillard and Marcoes 1998: 338). Scholars have conducted multiple studies across Indonesia, for instance, in Padang, Padang Pariaman, Serang, Sumenep, Kutai Kartanegara, Gorontalo, Makassar, and Bone (Budiharsana et al. 2003); West Java (Newland 2006); and Yogyakarta and Madura (Putranti 2008). Susilastuti et al. conducted surveys in the seven areas with the highest prevalence of FGC: Gorontalo, Bangka Belitung, Banten, West Java, Rian, South Kalimantan, and West Sulawesi (Susilastuti et al. 2017).

According to Indonesia's Basic Health Research 2013, 51% of women in the country had been circumcised at that time and in most cases traditional practitioners had performed the practice. Most women had undergone the practice between age one and five (Susilastuti et al. 2017: 6). Clarence-Smith observed that FGC became more popular and widespread with the Islamic revivalism that started in the 1970s (Clarence-Smith 2008: 20), and Susilastuti et al. later observed that "Muslims who

[6] They distinguish female circumcision from the practice in Africa.

did not carry out FGM/C on their daughters were then encouraged to adopt the practice" (Susilastuti et al. 2017: 3).

Furthermore the increasing medicalization of FGC in Indonesia encouraged the spread of the practice: "Clinics now offer the service of ear piercing (*tindik*), vaccination, and child delivery in one package…The coupling of circumcision with ear piercing for girls is increasingly taken for granted to the point that the term *sunat* is sometimes used for ear piercing" (Feillard and Marcoes 1998: 356).

The Indonesian government takes an ambivalent attitude toward FGC. In 2006, the Ministry of Health (MOH) "issued a regulation prohibiting all forms of female genital cutting to be performed by medical professionals" (Susilastuti et al. 2017: 4) but in 2010 it "overturned an existing ban on the practice under pressure from Indonesia's largest Muslim cleric body, the *Majelis Ulema*" (Patel and Roy 2016: 6). The *Majelis Ulema* issued a *fatwa* in 2008 "stating that the prohibition of FGM/C was against the Islamic law" (Susilastuti et al. 2017: 4).

As a result of a compromise, the MOH introduced guidelines on how to perform FGM/C based on the *fatwa*; the guidelines allowed medical professionals to perform the procedure, causing disputes among medical professionals and human rights groups that raised concerns about the medicalization of FGC (Patel and Roy 2016: 6). In 2014, the Indonesian government revoked the 2010 law, stating that FGC lacked medical urgency; however, critics contended that "this 2014 regulation [was] a step backwards rather than forward because it still allows for the practice of FGC to be continued without any State intervention and facilitation" (Patel and Roy 2016: 6).

It is often said that FGC in Indonesia is largely symbolic, with no injury. However, Susilastuti et al. showed that only 1.2% of practitioners performed the "symbolic" act with no injury and 33.2% of women had undergone type 1, partial, or total removal of the clitoris and/or the prepuce (Susilastuti et al. 2017: 69, 117). It is not clear, however, whether the respondents in that study had adequate anatomical knowledge of the female genitalia to answer the questions adequately.

The Malaysian government has no official statistics on FGC, and there are only seven academic articles on the practice in Malaysia even though the practice is very common among Malay women (Ainslie 2015; Iguchi and Rashid 2020; Isa et al. 1999; Rashid and Iguchi 2019; Rashid et al. 2009, 2020; Salleha et al. 2017).[7] In a recent study in rural northern Malaysia by Rashid and Iguchi, 99.3% of respondents had undergone FGC (Rashid and Iguchi 2019: 1, 4).[8]

According to Isa et al., the procedure involves nicking the skin of the clitoris with a small knife, resulting in only a drop of blood (Isa et al. 1999: 141–2). In a survey of medical doctors, Rashid et al. found that "most doctors used instruments to nick (29.3%) and prick the prepuce of the clitoris (25.3%)" (Rashid et al. 2020: 9). The method used in Malaysia can be categorized as WHO's type four (Rashid et al. 2020).

[7] The *Hosken Report* (Hosken 1993) mentions Malaysia. Authors of anthropological works such as Lederman (1983) and Peletzs (1996) partly address FGC in Malaysia.

[8] Other researchers show similarly high prevalences (Isa et al. 1999: 139; Rashid et al. 2009: 3; Salleha et al. 2017: 137).

In one recent study, 87.6% of respondents believed that FGC was compulsory in Islam, and nearly all, (99.3%), wanted to continue the practice in the future (Rashid and Iguchi 2019: 4). There were contradictory findings in Malaysia concerning FGC and sexual desire. Some study survey respondents thought that the reason for FGC was to control women's libidos (Isa et al. 1999; Rashid and Iguchi 2019; Salleha et al. 2017), but others believed the practiced increased the libido (Rashid et al. 2009).

Rashid et al. reported a current trend of medicalization of FGC in Malaysia evident in quantitative data and interviews with medical doctors who had performed FGC (Rashid et al. 2020). For example, although fewer FGCs are being performed by traditional midwives (*bidans*), more are being conducted in clinics in rural Malaysia (Rashid and Iguchi 2019: 4; Rashid et al. 2009: 3). However, as in Indonesia, the Malaysian government shows an ambivalent attitude toward the practice of FGC. The UN reported that Malaysia had "taken effective and legal measures to prohibit the practice of female genital mutilation and raised awareness of its prohibition" (UN 2003: 199). However, the Department of Islam Development Malaysia (*Jabatan Kemajuan Islam Malaysia* [JAKIM]) issued a *fatwa* in 2009 to say that "female circumcision" in Malaysia is legal from the Islamic point of view (JAKIM 2009).

In February 2018, several delegates from Muslim countries to the 69th Committee on the Elimination of Discrimination against Women strongly criticized Malaysia for allowing FGC,[9] but in November 2018, Malaysia's UN delegates asserted that "female circumcision" was Malaysia's cultural obligation at the Universal Periodic Review of the United Nations Human Rights Council. Critics considered this a self-justification, and National Human Rights Commission Malaysia accused the delegates of making an "unconvincing and misleading" statement.[10] The then Deputy Prime Minister Datuk Seri Dr. Wan Azizah Wan Ismail affirmed the government's standpoint that "female circumcision" in Malaysia was unlike that practiced in African countries.[11] Again, the Southeast Asian rhetoric came into play. Wan Azizah carefully chose the term "female circumcision" for referring to the Malaysian practice to differentiate it from the African "FGM".

FGC is popular among Muslim women in Malaysia and is embedded deeply in their daily lives. Most of them had not recognized it as an issue of dispute until the debates between Malaysia's UN delegates and National Human Rights Commission Malaysia.

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[9] "Malaysia urged to abolish female genital mutilation." *Star Online* (2018 February 22) https://www.thestar.com.my/news/nation/2018/02/22/malaysia-urged-to-abolish-female-genital-mutilation/ (accessed November 13, 2019).

[10] Suhakam calls out DPM's ministry for "misleading" response to UN on female circumcision. *Malay Mail* (2018 November 14). https://www.malaymail.com/s/1693213/suhakam-calls-out-dpms-ministry-for-misleading-response-to-un-on-female-cir?utm_source=izooto&utm_medium=push_notification&utm_campaign=browser_push&utm_content=&utm_term = (accessed November 13, 2019).

[11] DPM maintains that female circumcision is part of Malaysian culture. *Star Online* (2018, Nov 15) https://www.thestar.com.my/news/nation/2018/11/15/dpm-maintains-that-female-genital-mutilation-is-part-of-msian-culture/#EBrip245lmrmoeBh.99 (accessed November 13, 2019).

In southern Thailand, Malay-speaking Muslims are the majority. "Among the Thai-and Malay-speaking Muslims living in southern Thailand, the traditional midwife performs a mild form of female genital cutting (FGC) on baby girls" (Merli 2008: 32). Merli conducted research in the Satun Province in Thailand bordering the Malaysian state of Perlis, and focused on the multiplicity of local discourses regarding female and male circumcision: "People have different views of the practice: men question the cutting, considering it both un-Islamic and un-modern, whereas women generally support it" (Merli 2008: 32). In Satun, "female circumcision" is markedly gender-segregated and is not medicalized, whereas male circumcision has become medicalized and is publicly displayed. In Singapore, meanwhile, Marranci observed that women performed female genital operation as a mark of their Malay Muslim identity. Marranci indicates that the government was silent about the practice because a ban could have been construed as an attack on the already-threatened Malay identity (Marranci 2015: 288).

9.4 FGC Through the Medical Gaze

The WHO and other international organizations often argue that "FGM" is performed to suppress women's sexual desire (WHO 2022). However, we here focus on the problem of dominance and control in the act of seeing the female body as an object of medical science. In other words, the question here is whether the female body is seen by the medical gaze, that is, in terms of the two forms of biopower in the Foucauldian sense: the anatomo-politics of the human body centered on the body as a machine and the bio-politics of the population focused on the species body (Foucault [1976] 1990: 139).

We discuss Southeast Asian discourses of FGC through the medical gaze from three viewpoints. The first is medical FGC intervention by the state. The crucial question here is whether the state public health department intervenes in FGC and, if so, how state intervention can be evaluated from perspectives such as religion and culture. The second viewpoint we address is the medicalization of FGC and whether it constitutes medical intervention in the female body, and the third is the meaning of FGC for the local people. Is it a traditional practice, the meaning of which has been constructed outside of the modern framework, or has it been restructured in the processes of modernization and medicalization?

As stated earlier, medical control of the female body began in colonial times in Southeast Asia. Scholars, writers, and administrators at the time described FGC practices in colonial Indonesia (Feillard and Marcoes 1998) yet there is no record that colonial governments or public health departments attempted to stop the practice of FGC.

In contemporary Indonesia, the MOH has national statistical data on FGC (Susilastuti et al. 2017: 6) and recognizes the practice in its public health policy, but the government takes an ambiguous attitude toward the practice. In contrast, other Southeast Asian countries do not have official statistics on FGC. The government

of Singapore situates the issue of FGC within ethnic politics and seemingly tries to avoid interventions (Marranci 2015).

Despite the absence of official data, FGC is a popular practice in Malaysia. The Malaysian government does not address it as a public health matter but recognizes the practice from a religious viewpoint. In 2009, JAKIM issued a *fatwa* to say that "female circumcision" is compulsory in Islam.

> The Fatwa Committee National Council of Islamic Religious Affairs Malaysia held on 21st–23rd April 2009 has discussed on rulings on female genital mutilation. The Committee has decided that female circumcision is part of Islamic teachings and it should be observed by Muslims. (JAKIM 2009)

This is a state intervention in FGC, seemingly on the grounds of religion, but we argue that it is nonetheless a medical intervention because the logic of the 2009 *fatwa* derives its terms from the anatomo-politics of the human body centered on the body as a machine. Iguchi and Rashid might call it the anatomical gaze, under which the human body is recognized as an assembly of different parts (Iguchi and Rashid 2020: 180). The 2009 *fatwa* provides anatomical details of the differences between "female circumcision" as an Islamic obligation, and "FGM" as banned by the WHO. After explaining the WHO's four types of "FGM", the resolution argues that a part of the skin in the upper part of the female genital is cut in Malaysian "female circumcision."[12] Clearly the religious discourse co-opts medical terminology to justify and explain the resolution's legitimacy.

International organizations such as the WHO oppose the practice of FGC by medical practitioners and health care providers because it is harmful and has no medical value (WHO 2011: 1–2). The WHO defines medicalization of "FGM" as a "situation in which FGM is practiced by any category of healthcare provider, whether in a public or private clinic, at home or elsewhere" (WHO 2010: 2). To the WHO, FGC is not medicine at all, and any interventions should be aimed at abolishing the practice (Shell-Duncan and Hernlund 2000: 109).

How can one see this process of medicalization of FGM from the Foucauldian viewpoint? According to Rashid et al., the Malaysian government is silent on medical practitioners' performing FGC, and "the Malaysian Medical Council (MMC) has not stated its official stand on the practice of FGC among doctors" (Rashid et al. 2020: 5). Furthermore, 20.5% of the Muslim doctors in their survey practiced FGC and most had only received unofficial training from their colleagues (Rashid et al. 2020: 8–10). Nearly two thirds, 60%, believed that FGC was legal in Malaysia (Rashid et al. 2020: 13). Most of those who performed the practice obtained consent first, and some asked whether patients had infectious diseases, bleeding disorders, or other ailments (Rashid et al. 2020: 9–11). Most of the doctors performed WHO type 4, nicking or pricking the prepuce of the clitoris, and most used local anesthesia (Rashid et al. 2020: 9). After the procedure, more than half applied antiseptic, and nearly all said that they had never encountered any complications (Rashid et al. 2020: 8–9).

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[12] "*Di dalam Islam para fuqaha' sepakat mendefinisikan berkhatan untuk perempuan adalah merujuk kepada pemotongan sebahagian kulit pada bahagian atas faraj bagi perempuan*" (JAKIM 2009).

We think it is clear that FGC as practiced by doctors in Malaysia is a "medical" procedure even though the WHO does not allow the practice. In a survey conducted by Rashid et al., 63.9% believed that medical doctors should be the ones to conduct FGC in the future, citing the medical arguments of fewer complications and better hygiene, safety, and expertise (Rashid et al. 2020: 15). These doctors clearly viewed the practice of FGC under the medical gaze in the Foucauldian sense. Therefore, the acts of both medicalizing FGC and stopping the practice promote medical control over the female body.

The question remains as to the local peoples' perceptions and interpretations of the practice of FGC. In modern times, medical science and knowledge regarding the human body have converged with public government policy to promote governmental control over the female body. We examined the extent of this process through the discursive formation of FGC.

Newland's study on West Java showed that "female circumcision" was an unconscious practice for the local people. Referring to Pierre Bourdieu's concept of *habitus*, Newland described the practice as "unproblematized" (Newland 2006: 397). The meaning of the practice has been constructed outside of the modern framework. Newland found that female circumcision in West Java was performed as one of a series of birth rituals, and that "circumcision inscribe[d] the major distinction between Muslim and heathens" (Newland 2006: 396–397). In Newland's study, the local people did not consider the practice of FGC through the medical gaze.

Similarly, when we conducted research in the rural areas of northern Malaysia in 2016, villagers told us that all Muslim sects in the world perform the same practice as they do; they did not know that the international community problematized FGC. As in West Java, the local people in northern Malaysia thought that circumcision was a mark of Muslim identity. A village woman said,

> *Dia [sunat] adalah salah satu tanda-tanda nak tentukan bahawa kita seorang Islam. Untuk bezakan antara yang bukan Islam dengan Islam. Dengan cara kita bersunat.* [*Sunat* is one of the marks by which we can differentiate Muslims from non-Muslims. Therefore, we practice circumcision.][13]

However, although female circumcision was an unproblematized practice for the local people in northern Malaysia, they did not create their own autonomous cultural sphere on the subject. Medical terminologies and viewpoints gradually came to pervade the local people's ideas and consciousness. According to Rashid and Iguchi, female respondents generally preferred that medical practitioners perform FGC because of hygiene: "More younger respondents were in [*sic*] the opinion that doctors should conduct FGC as compared with older respondents who preferred traditional midwives" (Rashid and Iguchi 2019: 4). This shows a gradual transformation of the people's ideas regarding FGC. Rather than situating the human body in cultural and religious frameworks, increasing numbers of people came to view it from a medical aspect.

[13] The interview was conducted in 2016.

Merli's study in southern Thailand reflected a process of negotiation between the global and local discourses on FGC (Merli 2008). Merli found that the local women in Satun did not consider that medical practitioners might perform FGC.

> One of the reasons women in Satun do not consider the medicalisation of the female *sunat* possible is the experience they have of the routine medical interventions on female genitalia during childbirth, which they find inexplicable and harmful. Where medical authorities have monopolised women's bodies in the context of human reproduction, the *bidan* and other Muslim women guard their authority and autonomy to perform a slight cut which perpetuates their ethnic and religious identities. (Merli 2008: 39)

Ogino has explained that the female body became a male-centric society's target of control in the nineteenth century when male doctors began to confront the process of child delivery, which had traditionally been attended by female midwives (Ogino 2002:157–163). Ogino's analysis appears to be one-way, whereas Merli studied local women who were resistant to medical control and were attempting to maintain their autonomy over their bodies in the face of attempts at medical control as evidenced in the above quotation. The process of medical control is not one-way but is always a process of contestation and negotiation.

9.5 Conclusion

In this article, we examined discourses on FGC in Southeast Asia, analyzed them with regard to the increasing medical control over women's bodies, and identified three points. The first was the state's use of FGC to medically control the female body. Distinct state medical control over FGC does not appear to exist in Southeast Asia, although the government of Indonesia does partly intervene in the practice from a public health perspective. Yet the interesting part is that from the Foucauldian viewpoint, the religious resolution has incorporated the medical gaze to consolidate its stance.

The second point we identified was the ambivalent nature of medicine. Modern medicine was formed on the assumptions of progress and civilization, but Foucault questioned these assumptions and argued that modern medicine embraced the moral concept of the model man; through that concept, modern medicine has controlled populations using the medical gaze (Foucault 1994). Indeed, to the extent of objectifying the female genitalia, medical practitioners are sharing the same medical gaze whether they are promoting FGC or attempting to stop it. Either way, they are implicitly contributing to medical control over the female body.

The third point we explored was whether local people themselves had internalized the medical gaze around FGC and considered the practice as a medical one, and we found that the answer was not simple. Local people initially thought that FGC marked religious identity, but they increasingly came to view it through the medical gaze as did the European colonists. In this sense, Southeast Asia presents as a complex site of negotiation and contestation between the local and global discourses on FGC.

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Yufu Iguchi Ph.D., is a professor of gender studies, cultural studies, and area studies at the College of Asia Pacific Studies, Ritsumeikan Asia Pacific University. She has conducted research on female genital cutting in Malaysia and Southeast Asian countries from the viewpoint of sexuality and the female body. Her recent publications include "Female Genital Cutting in Malaysia: A Mixed-Methods Study," with Abdul Rashid, in *BMJ Open* 9, 4 (2019), and "Female Genital Mutilation in Malaysia from the Viewpoint of Sexuality and the Female Body," with Abdul Rashid, in *Tonan Ajia Kenkyu* [*Southeast Asian Studies*] 57, 2 (2020).

Abdul Rashid (Prof. Dr.) is head of the Department of Public Health Medicine at the RCSI & UCD Malaysia Campus in Penang, Malaysia. He has been studying Female Genital Cutting (FGC) among the Muslim communities in Malaysia and in Southeast Asia. His area of research interest is marginalised populations' social, health, and well-being. He has more than 95 peer-reviewed publications and has published several books to date, including "Medicalization of Female Genital Cutting in Malaysia: A Mixed-Methods Study," with Yufu Iguchi and Siti Nur Afiqah, *PLOS Med.* 17, 10 (2020), and "Use of Hormones among Trans Women in the West Coast of Peninsular Malaysia: A Mixed-Methods Study," with Siti Nur Afiqah and Yufu Iguchi, in *Transgender Health* (2021).

Siti Nur Afiqah is a Ph.D. candidate at the Unit for Research on Women and Gender, School of Social Sciences, Universiti Sains Malaysia. She holds an MA degree in linguistics and English Language studies from the Universiti Sains Malaysia and is currently an RCSI & UCD Malaysia Campus administrative executive. Her research interests are gender issues among marginalized populations and her Ph.D. research focuses on female genital cutting among immigrants. She is also actively involved in other studies of the transgender and indigenous communities of peninsular Malaysia.

Chapter 10
Healthcare Provision for Refugees and Immigrant Women with FGM Living in Australia

Nesrin Varol

10.1 Introduction

It is estimated that more than 200 million girls and women alive today have been subjected to female genital mutilation (FGM) in the world, mainly in 31 countries across three continents, with more than half living in Egypt, Ethiopia and Indonesia (UNICEF 2021). There is evidence from small-scale research studies that the practice also occurs in communities in 20 countries in Eastern Europe, Latin America, the Middle East, and South-eastern Asia, as well as North America, Australia and New Zealand (Cappa et al. 2019).

As a result of migration, FGM has become a transnational public health, human rights, and gender injustice issue. FGM violates many human rights, including the human right of the child, the human right to life, the human right to be free of torture or cruel, inhumane or degrading treatment, the human right to equality and non-discrimination on the basis of gender, the human right to a standard of living adequate for the health and well-being of a person and her family. No religion condones or mandates it. FGM has deeply entrenched sociocultural roots, the main propagators being social obligation and pressure for families to conform, marriageability for economic security or survival, and fear of exclusion from resources and opportunities as young women (Darkenoo 1994; UNICEF 2005). FGM is closely linked to child marriage, as girls may be taken from school after the cutting to be married. FGM is ultimately a symptom of poverty and gender inequality. It is important to remember that these women were children when the cutting was done to them; they did not have any say in it; they were not able to consent. It is hence the dignity of these women and girls which we must foremost protect and respect on our path to helping communities abandon this practice.

N. Varol (✉)
Discipline of Obstetrics, Gynaecology and Neonatology, Sydney Medical School, University of Sydney, Sydney, Australia
e-mail: nesrin.varol@sydney.edu.au

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The physical and psychological suffering for many of these children and women can be enormous, often lifelong and irreversible. A World Health Organization (WHO) study estimated that 2.8 million 15 year-old girls in six African countries would lose about 130,000 years of life due to obstetric complications from FGM. It is estimated that up to I$ 5.82 (international [purchasing power] dollars adjusted for the cost of living in each country) are required to fund prevention programs for the more severe FGM types. These costs would be offset by the economic saving of preventing and managing obstetric complications from FGM (Bishai et al. 2010).

Male partners of women with FGM experience physical and psychological complications as well (Almroth et al. 2001). A Sudanese study of men married to women with FGM most notably revealed that they felt responsible for their wives' pain and suffering and experienced their continuing suffering as their own (Almroth et al. 2001). In contrast to the social norms and expectations, most of the young men in the study stated they would have preferred to be married to uncut women (Almroth et al. 2001). Men are critically part of the solution towards abandonment of FGM.

Analogous to FGM was the practice of foot binding that originated in Imperial China from the tenth century until the establishment of the People's Republic of China in 1949. It had similar sociocultural underpinnings, determining status and controlling women's sexuality, and was eventually abandoned, with advocacy by men having played a crucial role (Broadwin 2020).

Global efforts for the abandonment of FGM over the last three decades have significantly reduced the prevalence of this practice, especially with the contribution of the UNFPA-UNICEF Joint Programme on the Elimination of FGM (UNFPA and UNICEF 2021). Today, girls are one third less likely to have undergone the cutting, especially those aged 15–19. More women, girls, as well as men, are opposed to the practice than in the past, and more men and women understand the health complications (UNFPA and UNICEF 2021; Gele et al. 2013b). In countries with data on FGM prevalence, 63% of men and 67% of women want the practice to end (UNICEF 2016). However, due to population growth, if FGM continues to be performed at the current rate in countries of prevalence, the WHO predicts 68 million girls and women will have been subjected to this practice by 2030 (WHO 2020).

The WHO's modelling predicts an annual global economic cost of USD 1.4 billion if all the health complications of FGM were to be treated (WHO 2020). This translates to 10–30% of a country's annual health budget. If FGM were to be abandoned, the savings in health costs would be more than 60% by 2050. However, the reality is that as the practice continues and more children are being cut, the costs will double over the same time period (WHO 2020).

Australia is home to more than 83,000 women and girls with FGM who were born in African countries and the Middle East (Australian Bureau of Statistics 2011). There are more than 140,000 people with ancestry from these regions living in Australia, comprising about 1.5% of the total population (Australian Bureau of Statistics 2011). We do not have information on women and girls with FGM from Asian countries, such as Indonesia, where FGM is also prevalent. The Royal Hospital for Women in Melbourne alone reports caring for 600–700 women with FGM per year (Bourke 2010). Women who have been subjected to FGM as children in their country of

origin require specialised healthcare to treat and prevent further complications and suffering.

This chapter explores what is known about the burden of complications from FGM in Australia, the scope of healthcare provision for these women and what kind of evidence-based policy responses are needed to strengthen health, community, and legislative systems to provide optimal care and to help communities abandon this harmful practice.

10.2 Burden of Complication of FGM in Australia

In countries where FGM is prevalent, girls are usually subjected to FGM between infancy and age 15 (WHO 2008). The WHO describes four types of FGM (WHO 2022). Type III, also known as infibulation, is the most severe with various degrees of cutting and removing of the external genitalia and then suturing the vaginal opening to create a seal, which allows a slow release of menstrual blood and urine only.

Girls may die from infection and/or haemorrhage or experience a long list of well-known acute and chronic physical, psychological, and sexual complications, as outlined in Table 10.1. (Almroth et al. 2005; Elnashar and Abdelhady 2007; Matanda et al. 2019; Sarayloo et al. 2019; Talle 2007; WHO 2008).

Whilst sub-Saharan Africa continues to have some of the world's highest maternal and infant mortality rates, FGM causes the additional deaths of ten to 20 babies per

Table 10.1 Complications of FGM

Immediate complications	Long term complications
Death	Vulval abscess, ulcer, cyst, neuroma, keloid scar
Haemorrhage	Vaginal obstruction with haematocolpos, haematometra, dysmenorrhoea
Infection (HIV, hepatitis, other organisms, wound, septicaemia)	Apareunia, dyspareunia, vaginismus
Shock from haemorrhage or sepsis	Sexual dysfunction, anorgasmia
Acute severe pain	Relationship problems
Psychological trauma	Urinary incontinence, urinary tract obstruction, urinary tract infection, voiding difficulties
Fracture of bones or dislocation of joints from force of being held down	Pelvic inflammatory disease
Acute urinary retention	Chronic vulval and/or pelvic pain
Damage to urethra, anus, rectum and/or perineum	Vesicovaginal or rectovaginal fistula
	Post-traumatic stress disorder
	Depression, anxiety
	Infertility

1000 births (UNFPA 2009). The WHO initiated a landmark collaborative prospective study of 30,000 women across 28 obstetric centres in six African countries. The study centres varied from isolated rural healthcare centres to tertiary teaching hospitals in capital cities. It revealed that obstetric complications increased with the severity of FGM type. FGM type III was associated with a 30% higher caesarean section and 70% postpartum haemorrhage risk compared to women without FGM. Perinatal mortality rate was 15%, 32% and 55% higher for women with type I, II and III, respectively. Moreover, newborns of mothers with FGM type III were 66% more likely to require resuscitation (Banks et al. 2006, June 3).

There is limited data on the burden of disease and complications from FGM in Australia. There is only one study on maternal and neonatal outcomes of women with FGM. This retrospective study at a metropolitan Australian hospital analysed data on women with and without FGM who gave birth over a seven-year period (Varol et al. 2016). This hospital is a multicultural centre of excellence for the provision of maternity and neonatal care services for women with low-risk births, of which there are approximately 1500 per year. At the time the hospital's patients spoke 17 languages and more than two thirds had a non-English speaking background. It was one of only three hospitals in Australia that had established a specialised FGM clinic with obstetricians and midwives trained to follow the guidelines for optimal maternity care of women with FGM by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists. The clinic had counselling, psychological and translation services. The maternity care involved establishing a clear plan for antenatal care, labour and birth for each woman. The benefits of de-infibulation were explained, and the procedure was offered preferably in the second trimester, so that vaginal examinations could be performed as normal during labour. De-infibulation was also done during labour (Varol et al. 2016).

Importantly, this hospital provided training on FGM for obstetricians, midwives, general practitioners, and nurses specialising in reproductive health. The curriculum covered the sociocultural underpinnings of FGM, cultural competence, identification of FGM types, de-infibulation surgical competence, recognition of FGM complications, and legal framework around this practice. It also conducted education sessions for migrant women and their partners on FGM (Varol et al. 2016).

The prevalence of FGM in women who gave birth at this hospital was 2–3%. The measured maternal and neonatal outcomes were caesarean section, instrumental birth, episiotomy, genital tract trauma, postpartum haemorrhage of more than 500 mls, low birth weight, admission to special care nursery, and stillbirth. Women with FGM had similar obstetric outcomes to women without FGM, except for a significantly higher risk of first and second perineal tears and of caesarean sections. The former was more common with FGM type III. It was noted that none of the caesarean sections, however, had FGM indications (Varol et al. 2016).

The authors of the Australian study (Varol et al. 2016) showed that their results were in keeping with those of other high-income countries. Provision of high-quality obstetric care with expertise in FGM seems to be able to minimise obstetric complications (Abdelshahid and Campbell 2015; Amusan and Asekun-Olarinmoye 2006; Essen et al. 2005; Wuest et al. 2009). Having the skill to perform de-infibulation is a

very important aspect of care for these women. The reason for emergency caesarean sections in a study in Switzerland was that vaginal examinations were not able to be performed in labour for women with FGM type III who had not been de-infibulated (Wuest et al. 2009). A study from Saudi Arabia showed no difference in obstetric and neonatal outcomes. All their patients underwent de-infibulation at vaginal delivery, and there were no FGM indications for their caesarean sections (Brown et al. 2010). Similarly, studies from the United Kingdom and Sweden supported the benefit of de-infibulation with regard to caesarean sections. The latter also showed that de-infibulation was associated with lower risk of prolonged labour (Essen et al. 2005; Hernandez 2007).

In contrast to the findings of the Australian study and in keeping with the WHO study in the six African countries (Banks et al. 2006, June 3), obstetric complications are reported to be higher in African countries as well as hospitals in high-income countries that do not have high-quality obstetric care and/or specialised FGM knowledge (Frega et al. 2013; Herral et al. 2004; Johnson et al. 2005; Small et al. 2008; Vangen et al. 2002).

Cultural factors and poor cultural competence, as well as language barriers, adversely affect health outcomes as shown by studies of Somali-born women receiving care in high-income countries compared to locally-born women (Herral et al. 2004; Johnson et al. 2005; Small et al. 2008; Vangen et al. 2002). A meta-analysis in six countries revealed that these women were more likely to labour without analgesia or epidural and to undergo a caesarean section (Small et al. 2008) despite their aversion to this operation (Brown et al. 2010; Hernandez 2007; Vangen et al. 2002).

The Australian study also evaluated data collection and accuracy in identifying the correct type of FGM diagnosis by their midwives, by comparing two databases, i.e., one used by all midwives and doctors and one by the midwives that specialised in FGM (Varol et al. 2016). Through formalised training and education by the Clinical Midwife Consultant and an obstetrician, data collection increased from only 14 to 90% over the six years. Accuracy was low at 35%. The Australian study highlights the importance of integrating a specialised FGM unit in hospitals that care for women with FGM and fostering training and education of their midwives and doctors to provide the best care for women with FGM.

10.3 Knowledge and Training of Health Care Workers

FGM and its associated complications are generally not the primary concern of women who migrated to Australia. They have multiple and complex immediate challenges that need to be acknowledged and addressed. These women usually come from countries where they experienced war or conflict, poverty, malnutrition, health issues, lack of access to education and healthcare (Women's Refugee Commission 2009). Many refugees and migrants experience significant obstacles to finding healthcare services and affordable accommodation, due to language barriers, limited education

and finances, loneliness and isolation from lack of social support, as well as domestic violence (Comas-Diaz and Jansen 1995; Dona and Berry 1999; NSW Government Department of Health 2018). A community-based participatory study of 619 women in Australia and New Zealand confirmed these findings; these women's main concern was not that they had undergone FGM but the financial difficulties of resettlement, discrimination and social integration of their children, and their families remaining in conflicted countries (Guerin et al. 2006). All these factors make the usual work of healthcare providers more challenging, requiring cultural competence, knowledge and training in the management of FGM complications, and established referral pathways to other community and health specialists. For example, perinatal outcomes of refugee and migrant women from low- to middle-income countries, especially from African countries, have been reported to be poorer (Belihu et al. 2016; Gibson-Helm et al. 2014). Cultural competence is a very important aspect of healthcare to be included in curricula in nursing and medical institutions and their governing colleges. It delivers better healthcare as it is respectful of and responsive to health and cultural beliefs as well as the language needs of patients (Beach et al. 2005; Truong et al. 2014).

10.3.1 Doctors

A systematic review of doctors' experiences and needs concerning the care of women with FGM, evaluated data derived from ten studies from Australia, New Zealand, United States, Belgium, UK, Sweden, Egypt, and Sudan (Dawson et al. 2015a). The UK study identified gaps in knowledge on the type of FGM (Zaidi et al. 2007) and the importance of identifying women with FGM as high risk for obstetric complications on the first antenatal visit. Moreover, a caesarean section was considered the best delivery method if vaginal examination was not possible (Zaidi et al. 2007). Another UK study identified lack of knowledge on the prevalence of psychological complications and half of the doctors expressed concern about how to access referral pathways to specialist services (Purchase et al. 2013). A third of them did not know about antenatal de-infibulation and a fifth were not aware that FGM was illegal (Purchase et al. 2013). Only 1% of Flemish gynaecologists were aware of hospital guidelines or information on FGM, and more than half expressed the need for access to technical guidelines on the medical management of women with FGM (Leye et al. 2008). Clinical guidelines and education on FGM led by professionals with experience in this area were also requested by Swedish doctors (Tamaddon et al. 2006).

An audit of two hospitals in Western Australia had a prevalence of pregnant women with FGM of 0.3 and 2.2% (Shukralla and McGurgan 2020). Documented compliance with the hospital's FGM Clinical Guideline was found to be poor. Documentation of discussions between patients and healthcare workers on the maternal complications of FGM was non-existent in one hospital, and 18% at the other site. The authors postulated that this was most likely due to the lack of confidence in

their knowledge on FGM (Shukralla and McGurgan 2020). Similarly, a survey of Australian child health specialists showed that 10% (n = 50) acknowledged they had cared for a child with FGM but only a minority had clinical experience or formal education in this field (Sureshkumar et al. 2016).

10.3.2 Midwives

With regard to the experience of midwives caring for women with FGM, there was one study which evaluated data from focus group discussions of 48 midwives in three Australian urban hospitals (Dawson et al. 2015a, b, c). Many midwives lacked the surgical skills of de-infibulation and had little confidence in their knowledge of FGM types and data collection. Moreover, they expressed fear of having to care for these women due to a lack of experience. Other issues were: difficulty in establishing rapport with their patients, lack of availability of interpreters and misunderstanding of cultural values.

A review of the global experience of midwives involved in the care of women of FGM (Dawson et al. 2015b, c) showed similar results to the one on doctors (Dawson et al. 2015a). Ten papers were included in this review, with eight being from high-income countries. The review again identified a lack of technical knowledge and training opportunities and limited cultural competency. Midwives expressed their need for professional education and training, a working environment supported by guidelines, responsive policy, and community education (Dawson et al. 2015b, c).

Two studies of midwives from Sudan and Somaliland reported a different problem (Berggren et al. 2004; Isman et al. 2013). While acknowledging its illegality some of them still performed FGM, as well as re-infibulation after childbirth (either in hospital, the woman's house or their own home). The main reasons were to supplement their low salaries and pressure from the community. Midwives in the Sudanese study said they were not afraid of prosecution as the law was rarely enforced (Berggren et al. 2004). Some midwives disliked carrying out re-infibulation but performed it anyway, and maintained that the women would otherwise have it done by someone else without the same experience and skill they had (Berggren et al. 2004). Somaliland midwives were confident in counselling women regarding FGM as they had experienced it themselves. They felt their work was honourable, beneficial to women, and that they were supported by their community (Berggren et al. 2004). Midwives reported challenges in convincing families to abandon FGM and expressed the need for community education and health promotion as well as providing midwives with alternative employment (Isman et al. 2013).

10.3.3 Women with FGM as Healthcare Recipients

It is essential to hear the voices of women as recipients of care when we are designing and implementing maternity services for them. Otherwise these may be inappropriate

for their needs and/or the women may not use them. A very insightful Australian study from Western Sydney involved in-depth interviews and focus group discussions involving 23 migrant and refugee women with a history of FGM who had given birth in Australia within ten years or were pregnant at the time of the study (Turkmani et al. 2020). These women appreciated their meaningful involvement in the care design and delivery, and regarded the time taken to build trust between healthcare provider and recipient as a crucial factor. Overall, they appreciated the high standard of maternity care they received in Australia. They mentioned respectful care, a feeling of safety, receiving required information, access to skilled healthcare providers, being able to have a care plan and family support, and the midwifery continuity care (Turkmani et al. 2020).

Most women described feeling embarrassed and uncomfortable with their bodies after de-infibulation and wished re-infibulation had been done (Turkmani et al. 2020). One can postulate that there may not have been adequate antenatal counselling and explanation regarding FGM, its complications, the benefits of de-infibulation, and the appearance and function of the vulva after de-infibulation. Receiving knowledge through words, diagrams and photos would be empowering and perhaps have allowed them to appreciate the changes to their bodies. This may be inferred from these quotes from two women in the study:

> "Sometimes they don't even talk about FGM with us and just write everything down and say all is good without giving us the details. I think it is mostly because they don't know anything about FGM, and they just look at you and they have no idea."
>
> "If these midwives and doctors know where to cut (de-infibulation), how to cut and when to cut it will be so helpful for us and for them because we will not have a problem and they will be relaxed and confident in what they do. Now, as soon as they see us, they are shaking … Oh my God. They can get advice from doctors and midwives who worked in our country and have real experience of treatment of women with FGM." (Turkmani et al. 2020)

For these women, developing trust was directly associated with the healthcare provider's competence in FGM. A show of surprise or shock at their FGM made the women feel anxious and lose confidence that they would receive the appropriate care. They wished to be treated the same as women without FGM but with a tailored approach to appropriately manage the implications of their FGM (Turkmani et al. 2020).

The women were motivated to be involved in the decision-making regarding their care but struggled with the language barrier and lack of health literacy. Sometimes they were bypassed and husbands and mothers-in-law were consulted instead. Many requested psychological services, as pregnancy and birth bring up traumas of the past related to the FGM (Turkmani et al. 2020).

There was a belief that FGM may be continuing in their communities, even in Australia. The women emphasized the importance of community- and school-based interventions with media and education campaigns, involving not only women but also men and young people. The women believed that men are a crucial part of the abandonment process. However, they emphasized the challenge of this, as they believed men supported the cultural obligation and gave licence for the practice to continue. They maintained men lacked knowledge on the health complications of

FGM and would not be interested in supporting change (Turkmani et al. 2020). A quote from one of the participants underlined the importance of finding ways to include men in the conversation:

> "At the moment, most of the trainings are for women. We need men to talk to men so we can engage them otherwise you cannot force them to sit in a class. You need to train more men to open up and talk about this issue with other men in the community and engage them at the same level as women. Men are still looking at it as a good thing." (Turkmani et al. 2020)

Women explained that the cultural taboo around FGM made it difficult to discuss it even with male members of one's family. They suggested facilitating workshops in the community in Australia to foster an environment where men and women can receive education on this issue and debate it amongst themselves (Turkmani et al. 2020).

10.4 Men and FGM

A systematic review of the role of men in the abandonment of FGM (Varol et al. 2015) supported the pertinent comments regarding men by the women in the Australian study (Turkmani et al. 2020). It included 25 studies from 15 countries, i.e., Egypt, Yemen, Oman, Nigeria, North Sudan, Senegal, Guinea, Somalia, Gambia, Sierra Leone, Ghana, USA, Norway, Sweden and Spain. Somali men in Oslo acknowledged that it continued due to social pressure and obligation (Gele et al. 2012). Fathers in Egypt believed uncut women to be promiscuous (Abdelshahid and Campbell 2015), and men in Guinea considered FGM important in preventing premarital sex in women (Gage and Van Rossem 2006). In a study of 993 men in Gambia 72% did not know FGM had negative health consequences (Kaplan et al. 2013). Men complained about the effect of FGM on their marital sexual relationships and found the lack of sexual response in their wives disturbing or inconvenient (Abdelshahid and Campbell 2015; Fahmy et al. 2010). Almost all 99 men and Christian and Muslim religious leaders, acknowledged a women's equal right to enjoy sex (Fahmy et al. 2010). However, despite this belief and their relationship problems, some men remained staunch supporters of FGM due to their fear of loss of control over their sexual relationship (Fahmy et al. 2010) and their wives' fidelity (Abdelshahid and Campbell 2015).

On the other hand, the systematic review also revealed that many men want the practice to end but feel unable to voice their concerns. In some countries, i.e., Guinea, Sierra Leone and Chad, more men than women want FGM to end (UNICEF 2013, July). The women in the Australian study recommended enabling conversation between men and women (Turkmani et al. 2020). This is supported by DHS data that there may be limited dialogue on FGM between the genders and that many women and men did not know the opinion of the opposite sex regarding FGM (UNICEF 2013, July). Communication would allow a debate on the validity of this practice in a culturally sensitive way (Varol et al. 2015). A family planning study showed just

how essential communication is for change (Shattuck et al. 2011). Teaching men communication skills to discuss contraception with their partners not only increased contraception use but also improved spousal relationships (Shattuck et al. 2011).

The women in the Australian study maintained that sustainable change needed to start within the family (Turkmani et al. 2020). Similarly, the systematic review (Varol et al. 2015) showed that men also believed that change should come from within the community rather than be imposed by government or non-government organizations (Gele et al. 2013a). Support for abandonment of FGM by men was directly related to level of education, higher socio-economic class and urban living (Varol et al. 2015). Each additional year of schooling significantly increased the odds of supporting abandonment of the practice (Gage and Van Rossem 2006). Education is the most crucial factor in helping communities end FGM. Studies have shown that men do want to be involved in health promotion programs addressing the welfare of families, and respond positively to them (Baylies and Bujra 2000; Drennan 1998). Generally, involvement of men in reproductive health services places men in secondary roles only as supporters for the benefit of women (Kululanga et al. 2012; Sternberg and Hubley 2004). The systematic review suggested the possibility of the provision of reproductive health services specific to men where a man-to-man strategy would facilitate discussion and management of their private and sensitive health and personal issues (Varol et al. 2015).

Migration to countries where FGM is not prevalent seems to be a catalyst for change (Varol et al. 2015). The systematic review cited three studies examining attitudes of men from Somalia living in Norway (Gele et al. 2012) and the USA (Johnson-Agbakwu et al. 2014), and men from Ethiopia and Eritrea living in Sweden (Johnsdotter et al. 2009). It was found that men had very good knowledge of the complications of FGM and almost all of them strongly rejected this practice (Gele et al. 2012; Johnsdotter et al. 2009; Johnson-Agbakwu et al. 2014). They found it had neither meaning within their cultural framework, nor a religious mandate (Gele et al. 2012; Johnsdotter et al. 2009). This supports the view that social obligation and pressure are the most prominent propagating factors of FGM. When people move to another country away from their community and extended families, not only is social pressure for conformity relieved, but the benefits and positive reinforcements are also removed (Varol et al. 2015). As an example, uncut Somali girls in Norway were more likely to attract boyfriends and get married as compared to girls who had undergone FGM (Gele et al. 2012). Even moving to another country within Africa where FGM remained prevalent was associated with anti-FGM attitudes. Eighty-nine percent of Somali male refugees in Ethiopia welcomed the usefulness of interventions to abandon this practice (Mitike and Deressa 2009). These findings support the belief by women and men (Gele et al. 2013a; Turkmani et al. 2020) that, in the absence of migration, change needs to come from within the communities, as the need to conform overrides any other outside intervention and influence.

10.5 Policy Responses in Australia

Between 2011 and 2019, Australia received about 100,000 migrants and refugees from Sub-Saharan Africa (Australian Bureau of Statistics 2019, November). Some of these countries have FGM prevalence rates of between 74 and 98% (UNICEF 2013, July). Whilst it is inaccurate to extrapolate prevalence of FGM data from country of birth, there would be a significant number of women and girls who would have FGM and hence require healthcare in Australia that is specific to their needs. The Australian study on obstetric outcome showed that 2–3% of all women delivering their babies at a metropolitan hospital had FGM and that with high-quality obstetric care and specialised FGM expertise, the outcome was similar for them compared to women without FGM (Varol et al. 2016). There are only three hospitals in Australia with FGM clinics, i.e., in Sydney, Melbourne and Perth. There are other hospitals in Victoria within which the Reproductive Rights Program provides education and training for healthcare providers and support for women affected by FGM (Multicultural Centre for Women's Health). Moreover, the New South Wales Ministry of Health has developed clinical guidelines for maternity care of women with FGM (NSW Government Department of Health Kids and Families 2014, September).

There is no other data on the prevalence of FGM in Australia on which to base policy development and resource allocations. Information on the prevalence of FGM and maternal and neonatal complications can be included in the National Perinatal Data Collection of the Australian Institute of Health and Welfare. This would also be a prerequisite for monitoring and evaluating health and community intervention programs. Accurate data collection and the ability to ask about and discuss FGM with women requires an improvement in current education and training programs for doctors, midwives and nurses (Dawson et al. 2015a, b, c). We need to incorporate teaching on FGM in curricula of under- and postgraduate medical, midwifery and nursing colleges (Varol et al. 2017). Furthermore, to improve the healthcare for these women and reduce healthcare costs for the government, there is a need to establish other FGM clinics in hospitals where women with FGM present for maternity care (Varol et al. 2017). These clinics need to be holistic with gynaecological, urological, paediatric, psychological, social work and interpreter services (Varol et al. 2017). We also need to establish a directory with easily accessible referral pathways for clinicians and other government and non-government community services involved in the care of women with FGM (Varol et al. 2017).

Programs aimed at multiple levels of intervention have been shown to be effective in the abandonment of FGM (Varol et al. 2017). The largest decline globally has been in Kenya and Burkina Faso with a combination of legal and community education responses (Rahman and Toubia 2000; Shell-Duncan et al. 2013; UNICEF 2013, July). In Australia, FGM was first made illegal in New South Wales in 1994 and the other states and territories soon followed. Penalties vary for performing or helping to perform FGM, ranging from seven to 21 years imprisonment (Australian Government Attorney General's Department 2013). Three cases of successful prosecution have been seen in Australia to date, which sent strong messages to people. It also

allowed members of a particular community to speak out about FGM and sparked an international campaign to end it (Tavawalla 2016). Legislation and prosecution are most effective within a framework of community culturally-affirming interventions (Costello et al. 2013). The legal profession in Australia, like in the European Union, has limited tools for education and training in this practice (European Institute for Gender Equality 2013). As with the needs of healthcare workers, training should include a multidisciplinary national program for child protection professionals to understand the sociocultural underpinnings, to identify children at risk of FGM, and access pathways for appropriate referral (Varol et al. 2017).

The Australian Government has been addressing violence against women in a National Plan, focusing on domestic and family violence, prevention and intervention programs involving women, men and communities, provision of support services for women, and research and evaluation programs to inform policy (Australian Government Department of Social Services 2011). This Plan also addresses other national reforms on children, settlement services for refugee and migrant women, human trafficking and slavery, disability and homelessness. It has been suggested that all professionals involved in the care of women with FGM and protection of girls from FGM, form a network of experts within this National Plan to coordinate research, training and intervention programs, and inform policy (Varol et al. 2017).

10.6 Conclusion

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 refugee-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, 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.

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Nesrin Varol is a gynaecological surgeon and clinical associate professor at the University of Sydney, Australia. Nesrin's Ph.D. on FGM focuses on improving the healthcare of women and girls with FGM in Australia and the role of men in the abandonment of this practice. Nesrin was involved in establishing the Africa Coordinating Centre for Abandonment of FGM/C at the University of Nairobi, Kenya, in 2012. Her recent publications include "Evidence-based Policy Responses to Strengthen Health, Community and Legislative Systems to Care for Women with Female Genital Mutilation in Australia," with J. Hall, K. Black, S. Turkmani, and A. Dawson, *Reproductive Health* 14 (2017): 63.

Chapter 11
Autonomy, Bodily Integrity and Male Genital Cutting

Yuko Higashi

11.1 Introduction

In 2019, the 3rd International Experts Meeting on female genital mutilation/cutting (FGM/C) was held in Brussels, Belgium, and was attended by interdisciplinary experts from all five regions of the world. Concerns about widespread inaccuracies, inconsistencies, double standards, and Western cultural bias in the prevailing discourses on the genital cutting of children were shared and discussed. Unlike FGM/C and other forms of genital cutting of children (e.g., genital "normalizing" surgery of intersex children), male genital cutting, namely male circumcision, has been relatively unchallenged and rarely (if ever) discussed by major bodies advocating for human rights. This chapter is inspired by a call for a more coherent sex- and gender-inclusive approach to the debate on genital cutting, that recognizes the special vulnerability of children and young people, regardless of the race, religion, or immigration status of their parents, to medically unnecessary genital cutting; and the moral importance of bodily integrity, respect for bodily/sexual boundaries, and a free, full, and informed consent (The Brussels Collaboration on Bodily Integrity 2019: 24). No one, certainly no child, including infant males and young boys, should be left behind.

11.2 From Reproductive Health to Sexual Rights

The human rights discourse related to sexuality has increased dramatically since the mid-1990s. The 1994 International Conference on Population and Development

Y. Higashi (✉)
Graduate School of Sustainable System Sciences, Osaka Metropolitan University, Osaka, Japan
e-mail: higashi@omu.ac.jp

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(ICPD) in Cairo, the largest intergovernmental conference on population and development ever held at that time, was a historic turning point. According to Correa and Howe (2007), it was the first time the term "sexual rights" appeared in negotiations among representatives of the governments participating in the conference. The conference covered numerous controversial issues, but the outcome document, the Cairo Programme of Action (United Nations 1994), failed to include the term "sexual rights" or any references to homosexuality in the final text. Nevertheless, the fact that the concept was explored was a significant milestone and led to the understanding that Chap. 7 ("Reproductive Rights and Health") pertains to more than just reproductive health rights.

The following year, the Fourth World Conference on Women (FWCW) was held in Beijing, where the term sexual rights was explored again. The concept was elaborated and reflected upon in the outcome document (United Nations 1995) as:

> The human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence. Equal relationships between women and men in matters of sexual relations and reproduction, including full respect for the integrity of the person, require mutual respect, consent and shared responsibility for sexual behaviour and its consequences.

These two conferences were arguably major steps forward in terms of women's rights, and indeed the rights of all regardless of age, sex and gender, health-related conditions, and sexual orientation, gender identity and expression and sex characteristics (SOGIESC). The chronological advancement of rights, with acknowledgement of its oversimplification, was laid out by Lottes (2013), who modified the original timeline of progression presented by Ruth Dixon Muller: Human Rights → Women's Rights → Reproductive Rights → Women's Sexual Rights → Sexual Rights for All.

Various lists of sexual rights have been issued by experts and international organizations (see HERA 1998; IPPF 2008; Kirkendall 1976; WAS 1999, 2014; WGNRR 1996; WHO 2006), with a significant overlap in content. A revised version of the *Declaration of Sexual Rights* issued by the World Association for Sexual Health (WAS), formerly known as the World Association for Sexology, provides the most comprehensive list of sexual rights in terms of age, gender, and SOGIESC. It has been revised for clear alignment with human rights and supports numerous human rights treaties and consensus statements (WAS 2014; see appendix).

The focus of this chapter is the child's right to autonomy and bodily integrity, which is a critical component of sexual rights. Autonomy is characterized as the ability to make informed decisions (self-determination) and be treated as the principal actor and decision-maker in matters regarding one's own sexuality and reproduction (personhood). A frequently cited definition of bodily integrity, by Martha Nussbaum, is as follows: "being able to move freely from place to place; being able to be secure against violent assault, including sexual assault; having opportunities for sexual satisfaction and for choice in matters of reproduction" (Nussbaum 2007: 23). WAS (2014) emphasized the right to autonomy and bodily integrity in relation to sexuality thusly:

> Everyone has the right to control and decide freely on matters related to their sexuality and their body. This includes the choice of sexual behaviors, practices, partners, and relationships with due regard to the rights of others. Free and informed decision making requires free and informed consent prior to any sexually-related testing, interventions, therapies, surgeries, or research.

An example of the violation of this right is forced, coercive, or otherwise involuntary sterilization. In 2014, the World Health Organization (WHO) and other UN agencies, such as the Office of the High Commissioner for Human Rights (OHCHR), UN Women, Joint United Nations Programme on HIV/AIDS (UNAIDS), United Nations Development Programme (UNDP), United Nations Population Fund (UNFPA), and United Nations Children's Fund (UNICEF) issued an interagency statement calling for the elimination of forced, coercive, or otherwise involuntary sterilization (WHO 2014). This document recognized the disproportionate use of sterilization and other forms of deconversion among certain populations, including persons living with HIV, persons with disabilities, indigenous peoples and ethnic minorities, and trans and gender diverse (TGD) and intersex persons. It clearly stated that any form of involuntary, coercive or forced sterilization violates ethical principles, including respect for autonomy and bodily integrity, beneficence, and non-maleficence. The statement strongly condemns violations of those human rights guaranteed by various national and international instruments, including the right to privacy, reproductive rights, and the right to be free from discrimination, torture and cruel, inhumane, or degrading treatment or punishment. This document is a critical reminder of the famous slogan "My Body, My Choice" according to which no-one, including parents and spouses, leaders of communities and clans, professionals, or the state, has the right to decide what an individual does with their own body.

In addition to sterilization, body (genital) modification has been used as a medical intervention for TGD people and intersex infants[1] in many countries. According to Japan's Act on Special Cases in Handling Gender for People with Gender Identity Disorder (Law No. 111 of 2003; Effective Jul. 16, 2004), as of April 2022, a person who wishes to change their gender on *Koseki*, the official family registry, must fulfill the following conditions: diagnosed with gender identity disorder by two independent medical professionals; aged 20 years or older; not currently married; not the parent of a minor; does not have gonads/functioning gonads; and endowed with genitalia that closely resemble those of another gender. Even if a TGD person desires to undergo gender affirmation surgery, these prerequisites undermine their ability to give free, full, and informed consent.[2]

With regard to intersex persons, sex-normalizing procedures, among others, have been performed on the genitalia and/or reproductive organs of infants and children

[1] The prevalence of intersex conditions is estimated to be between 0.05% and 1.7% in the general population (Fausto-Sterling 2000; Blackless et al. 2000). Some intersex conditions do not fall under the medical diagnosis of disorders of sexual development (DSD), a group of approximately 60 conditions in which chromosomal sex is inconsistent with phenotypic sex, or in which the phenotype is not classifiable as either male or female (Sax 2002).

[2] There has been a global trend toward new gender recognition laws that do not have medical interventions as prerequisites, and toward the reformation of existing laws (see ILGA World 2020).

with little consideration of their views and rights. The aim of such medical interventions is to "correct" perceived ambiguities, including by making the genital phenotype appear more stereotypically male or female (Beh and Diamond 2000; GIRES 2006). This has been the standard protocol since the 1960s, when gender identity clinics were first established in the United States (US), since then it has been widely accepted in other countries where surgical interventions are available (Colapinto 2000; Kessler 1998). The underlying rationale is that the body must strictly conform to one gender; thus, atypical sex characteristics (external genitalia in this case) are viewed as both a medical problem and psychosocial emergency that impede the healthy development of the child; therefore, according to this view, there is a need for correction through surgical, hormonal, or other medical treatments, and sometimes via psychological means, as that is in the best interests of the child. It should be emphasized that it should be acceptable for any individual, regardless of their intersex status, to decide themselves to undergo such medical interventions if it is based on free and informed decision-making; in any other circumstance, the principle of "respect for autonomy and bodily integrity, self-determination, and human dignity" (WHO 2014: 7)is violated. Thus, if a person is too young to give free, full, and informed consent, it is unethical to expect or demand any type of irreversible intervention be considered or conducted.

11.3 Medically Unnecessary Genital Cutting

11.3.1 Terminology

Communication theory tells us that language has the power to manifest change. Referring to medical interventions for intersex infants and children as "so-called sex-normalizing or other procedures" (WHO 2014: 7), together with the use of similar language in global human rights campaigns on diverse SOGIESC (e.g., UN Free and Equal campaign), shows that efforts have been made to de-medicalize diverse sex characteristics and highlights that such irreversible early interventions are harmful (Human Rights Watch 2017; OHCHR 2019; UN 2016; WHO 2014).[3]

This chapter uses the term "genital cutting" regardless of gender, sex, and cultural, religious, and health-related factors, to acknowledge that terms are inherently culturally bound and evolve over time. The author recognizes the dilemma shared by researchers and human rights advocates regarding which terms to use to avoid the

[3] The UN *Free & Equal* campaign did not include intersex issues in their global campaign, stating that: "If transgender people are often overlooked, intersex people have been nearly invisible, at least until recently. This is reflected in the acronyms used. Until a few years ago, the official UN acronym was LGBT. The 'I' was added after consultations with intersex people, though not all intersex activists were in favor of being associated with the LGBT community" (Trithart 2021:11–12).

Using the term "intersex", as in LGBTI in human rights campaigns, is a conscious political choice. The adoption of this term instead of "people with a disorder of sexual development (DSD)" represents the "de-medicalization" of diverse sex characteristics.

stigmatization of certain practices, especially those that are culturally and religiously motivated (see Chap. 6). The significance of the use of the term "genital cutting" in this chapter is related to the political justification and context underlying the replacement of "female circumcision" with "FGM".

The WHO, along with other major bodies behind anti-FGM campaigns, explained that replacement of the term "female circumcision" was done to establish "a clear linguistic distinction from male circumcision and emphasize the gravity and harm of the act. Use of the word 'mutilation' reinforces the fact that the practice is a violation of girls' and women's rights" (WHO 2008: 22). Thus, some even consider the use of the term "female genital cutting" (FGC) for girls and women to be problematic, because "[This term] draws a parallel with male circumcision and, as a result, creates confusion between these two distinct practices" (WHO 2008: 22). Although they never clearly state that male genital cutting, i.e., male circumcision, is not harmful, the inference is that it can be viewed as considerably less invasive and debilitating, and the negative psychological and emotional consequences are thus ignored. This is partly designed to mitigate conflict with Judaism and Islam (Iguchi and Rashid 2019).

Positive values are promoted in relation to the act of male circumcision, whether it is performed in a ceremonial, cultural, or religious context, or even in a health-related (propylic) context, but this obfuscates the issue of un-consenting, non-therapeutic surgical interventions for male infants and young boys. Thus, ethical issues surrounding male genital cutting remain unchallenged and undiscussed at the global scale, where permanent removal of the foreskin is viewed as less harmful than a needle prick to the clitoral hood, as performed in Malaysia, Indonesia, and some other countries (see Taher 2017; Iguchi and Rashid 2019) which falls under the definition of FGM. The term genital cutting is thus used in this chapter to draw attention to the double standards and inaccuracies in global human rights discourse regarding these practices.

11.3.2 Circumcision

Circumcision may predate recorded human history (Cox and Morris 2012; El-Gohary 2015). Although there is little proof beyond anecdotal evidence, it is believed that circumcision as a rite of passage during puberty was practiced as long ago as 1000 B.C. Herodotus' *The Histories* cites the Egyptians as the earliest people to practice circumcision, and ancient Egyptian reliefs representing rites of passage have been uncovered, along with the mummies of circumcised youth and adults (Waszak 1978; Morimoto 1989; Dunsmuir and Gordon 1999; WHO and UNAIDS 2007).

The term "circumcision" is derived from the Latin words *circum* (meaning "around") and *caedere* (meaning "to cut"), which refers to the partial or total removal of the sleeve of skin and mucosal tissue that covers the glans of the penis, known as the foreskin. Genital cutting and modification have been performed for faith-based, perceived health-related, sociocultural, and cosmetic reasons, along with other

perceived personal benefits. Sara Johnsdotter, a medical anthropologist from Sweden, notes that the "rationales for the circumcision of boys and girls vary with local context, but genital modifications are often performed with similar motives irrespective of gender" (Johnsdotter 2018: 22). It has been suggested that in many societies "female circumcision" was introduced in imitation of the male rite, i.e., female circumcision may be practiced within a culture or clan where male circumcision is practiced, but not in one where it is not (Cohen 1997: 562).

11.3.3 Genital Cutting for "Health Benefits"

With advances in surgery, male genital cutting was introduced into some previously non-circumcising cultures for both health-related and social reasons; male genital cutting became increasingly popular in English-speaking industrialized countries toward the end of the nineteenth century (Dunsmuir and Gordon 1999). The perceived health benefits at that time included prevention of a range of "unwanted" conditions and "undesirable" behaviors, including masturbation, syphilis, nocturnal incontinence, and the enhancement of sexual pleasure. Male genital cutting also became widely practiced in North America, New Zealand, and Europe due to these perceived benefits (WHO and UNAIDS 2007).

Male genital cutting is one of the most common surgical procedures conducted today. As of 2007, the WHO estimates that approximately 30% of boys and men aged 15 years and older worldwide have been circumcised. Around two thirds (69%) are Muslim (mainly living in Asia, the Middle East and North Africa), 0.8% are Jewish, and 13% are non-Muslim and non-Jewish men living in the US (WHO and UNAIDS 2007: 7). A more recent study based on data from 237 countries estimates that the global prevalence of circumcision ranges from 37 to 39%, with approximately half of all procedures being performed for religious and cultural reasons (Morris et al. 2016).

Although male genital cutting gained in popularity in English-speaking countries and Europe during the mid-1800s, the US is the only country where infant male genital cutting, namely neonatal male circumcision (NMC), has been routinely practiced to date. The prevalence rose to about 80% in the 1960s and remains high, at 76–92%, compared to Central and South America (<20%) (Nelson et al. 2005). The American Academy of Pediatrics (AAP) did stop endorsing routine NMC in 1971, but that had little impact on the popularity of the practice. This high prevalence of NMC explains why an estimated 13% of circumcised males in the world are non-Muslim and non-Jewish men living in the US.

It should be noted that the AAP has never banned NMC, but have rather supported the parents' decision based on the advantages and disadvantages of NMC indicated by "scientific evidence." The 2012 Technical Report on male circumcision concluded that the health benefits of newborn male circumcision outweigh the risks according to current evidence (AAP 2012).

Interestingly, the high prevalence of male circumcision in the US has greatly influenced South Korea, which is the only country with an exceptionally high prevalence of circumcision in East Asia despite body modification being rare due to the strong Confucian and Buddhist tradition.[4] One community-based survey found that the prevalence was more than 90% in some age groups (Pang and Kim 2002), while another community-based survey found that 78.0% of randomly sampled men aged 20 years were circumcised, predominantly during their elementary school years, while 11.5% wished to be circumcised later. This high prevalence was believed to be associated with their close relationship and direct contact with the US military, particularly throughout the Korean War (Kim et al. 2012; Ku et al. 2003).

In addition to previously advertised health benefits (e.g., penile hygiene and the prevention of cancers and infections) male circumcision has been touted as "a highly cost-effective intervention for preventing HIV acquisition," especially in African countries where HIV infection through heterosexual vaginal intercourse is prevalent (WHO and UNAIDS 2016: 2). A contemporary voluntary medical male circumcision (VMMC) campaign has reached new territories through its promotion in sub-Saharan Africa, where it is called "VMMC2021"; the goal is to achieve a 90% circumcision rate among males aged 10–29 years by 2021. The VMMC campaign is also referenced in the widely used *International Technical Guidance on Sexuality Education* (UNESCO 2018). This invaluable publication, co-published by the United Nations Educational, Scientific and Cultural Organization (UNESCO), UNAIDS, UNFPA, UNICEF, UN Women and WHO, promotes comprehensive sex education worldwide. The importance of the VMMC campaign is mentioned in the "Understanding, recognizing, and reducing the risk of STIs (sexually transmitted infections), including HIV for children older than 12 years old" program, and is referenced together with pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) (UNESCO 2018: 79).

11.3.4 A New Trend

There has been an increasing trend toward the promotion of "intactivism", which advocates for the eradication of routine NMC. The AAP's position statement has been criticized by non-US-based physicians and representatives of general medical associations and societies for pediatrics, pediatric surgery, and pediatric urology in northern Europe. They argued that "the possible protection against urinary tract infections in infant boys…can easily be treated with antibiotics without tissue loss. The other claimed health benefits, including protection against HIV/AIDS, genital herpes,

[4] For example, circumcision has always been extremely rare in Japan, where it is generally referred to as "phimosis surgery" or "foreskin cutting". The most recent community-based study reported that, among 4126 male respondents (aged >18 years) recruited online, only 4% reported being circumcised (Onuki and Higashi 2019). Male genital cutting in Japan is practiced largely at beauty and aesthetic clinics, typically as a means to regain control of the body and enhance self-confidence (Castro-Vázquez 2012). The prevalence of NMC remains unknown.

genital warts, and penile cancer, are questionable, weak, and likely to have little public health relevance in a Western context, and they do not represent compelling reasons for surgery before boys are old enough to decide for themselves" (Frisch et al. 2013: 796). The Nordic Ombudsmen for Children and Pediatric Experts issued the following joint statement: "Circumcision, performed without a medical indication, on a person who is incapable of giving consent, violates fundamental medical-ethical principles, not least because the procedure is irreversible, painful, and may cause serious complications. There are no health-related reasons for circumcising young boys in the Nordic countries. Circumstances that may make circumcision advantageous for adult men are of little relevance to young boys in the Nordic countries, and on these matters the boys will have the opportunity to decide for themselves when they reach the age and maturity required to give consent" (Lindboe et al. 2013). The Child Rights International Network and Council of Europe also issued their position statements, which articulate that the autonomy and bodily integrity of all children should be protected regardless of gender or intersex condition (CRIN 2013; Council of Europe 2013).

The ripples of this advocacy movement are slowly but surely progressing, even though male genital cutting has not been profiled as a human rights violation to the same extent as FGM/C at a global level. The Brussels Collaboration on Bodily Integrity (2019) summarized the shared features of different forms of un-consenting, medically unnecessary genital cutting as follows: an invasive surgical procedure that results in permanent physical alteration of a body part; medically unnecessary; overwhelmingly performed on minors, including infants or children without free, full, and informed consent; and performed in accordance with norms, beliefs, or values that may not be the child's own, and which the child may not adopt when of age (see Fig. 11.1).

As of April 2022, the major bodies leading human rights campaigns, namely the UN, Amnesty International, and Human Rights Watch, along with other agencies specializing in the protection of children's rights (such as UNICEF and UNESCO) and major sexual and reproductive health and rights (SRHR) advocacy groups, such as the International Planned Parenthood Federation (IPPF) and WAS, have not stated

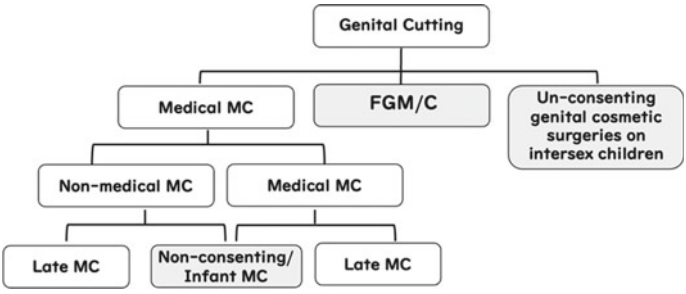

Fig. 11.1 Different forms of genital cutting and male circumcision

that involuntary nontherapeutic genital cutting is a violation of human rights regardless of gender. Again, it seems inaccurate to describe the pricking and piercing of female body parts as a more invasive practice than partial or total removal of the foreskin, as performed on boys within the same communities without their consent and with no therapeutic merit; nevertheless, the latter has somehow been tolerated. Why is this the case?

11.4 A Conflict of Issues

One reason for this tolerance could be a conflict of issues. Charli Carpenter, a professor in the Department of Political Science and Legal Studies at the University of Massachusetts-Amherst specializing in international law and human security, analyzed why some issues get neglected by the "elite gatekeepers" of global human rights campaigns (Carpenter 2014). In the case of male circumcision, some critical challenges faced by "intactivists" were cited (e.g., child rights vs. religious or cultural rights, failure to recognize the vulnerable victim and guilty perpetrator, competition between the two genders associated with gender-mainstreaming, and the global promotion of VMMC). Building on Carpenter's work, the complexities and challenges can be summarized as follows:

(1) Despite the longstanding medical debate surrounding VMMC and the criticism of campaigns such as VMMC2021 in eastern and southern Africa on grounds of perceived racism, stereotypes, and Western neocolonialism (Fish et al. 2020), global promotion of male circumcision is intensifying. This type of campaign can be easily misconstrued as encouraging routine NMC or other types of medically unnecessary genital cutting in childhood. The current author's concern extends to the insufficient emphasis on the autonomy and bodily integrity of boys and young men, even in an inarguably valuable document such as *International Technical Guidance on Sexuality Education* (UNESCO 2018). This document refers to genital cutting/male circumcision only in the context of VMMC. However, it does highlight the importance of learning about values, rights, and culture, and sets a goal for learners (aged $\geq$15 years) of being able to "analyze local and/or national laws and policies concerning child, early, and forced marriage (CEFM), FGM/C, non-consensual surgical interventions on intersex children, forced sterilization, age of consent, gender equality, sexual orientation, gender identity, abortion, rape, sexual abuse, sex trafficking; and people's access to sexual and reproductive health services and reproductive rights" (UNESCO 2018: 47). It seems peculiar that male circumcision is missing from such a comprehensive list.

Sexual health, as defined by the WHO, is "a state of physical, emotional, mental, and social well-being in relation to sexuality, and is not merely the absence of disease, dysfunction, or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the

possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination, and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected, and fulfilled" (WHO 2006). Children (and parents who may be considering having their children circumcised) have the right to learn more about the foreskin and its protective, sexual, sensory, mechanical, and immunological functions. The foreskin is elastic, double-layered, and comprised of skin, mucosa, specialized nerves, blood vessels, and muscle fibers; it protects the glans of the penis, keeping it moist and sensitive, provides lubrication that enhances pleasure during sexual activity, and has specialized immunological components. As with any medical procedure circumcision has potential risks, including not only immediate and post-operative damage (e.g., excessive bleeding and accidental amputation of the glans), but also long-term psychosocial damage (e.g., diminished sexual pleasure, and negative body and self-image). Awareness of peer and social pressure regarding how the penis should appear must be also discussed to enable free, full, and informed consent.

(2) While children are not considered to have absolute autonomy, their autonomy tends to be negated entirely in debates regarding children's rights versus religious, cultural and parental rights. These debates thus remain contentious and highly polarized. Analysis of both the scale and impact of female and male circumcision exposes a clear double standard within a male-controlled system that legitimizes and justifies acts of violence against, and repression and stigmatization of girls and women. In contrast, male circumcision is normalized as a relatively safe, harmless and common practice.

(3) Gender mainstreaming has created competition. As Carpenter notes, "the gender equity argument through reference to FGM linked circumcision not to children's human rights but to health and to gender—two issue clusters where the strong ethical argument about children's rights held far less sway" (Carpenter 2014: 145). The fixed position of the vulnerable victim makes the pain, scarring, suffering, and other psychosocial complications experienced by girls and women even more profound and intergenerational, while infant males and young boys are automatically assumed to face little or no social or psychological stigma as the result of circumcision. Ilsa Lottes, an American Sociologist, draws attention to the inclusive nature of sexual rights by using the phrase "human rights related to sexuality", where "the term sexual rights is sometimes narrowly interpreted in terms of reproductive rights and abortion, women's rights, or the rights of LGBT individuals" (Lottes 2013: 383).

(4) In relation to parents' rights, definitions of the obviously vulnerable victim and obviously guilty perpetrator are missing from the male genital mutilation debate. Parents are considered to make decisions regarding NMC in the best interests of their child, rather than engaging in an abusive act. However, studies of parental decisions about elective NMC indicate that whether the father is circumcised influences the decision to perform NMC on the son. It should be noted that families in which the father was circumcised were overwhelmingly more likely to view NMC as a safe procedure for all boys; in fact, only families in which the

father was not circumcised stated that NMC was unsafe (Rediger and Muller 2013; Ku et al. 2003).

This children's rights versus parents' rights debate parallels the intersex rights movement. During the 1990s, US-based intersex rights advocates began to openly and explicitly argue against medically unnecessary surgeries performed on un-consenting intersex children. The beliefs/recommendations of these advocates were as follows: intersexuality is primarily a problem of stigma and trauma, not gender; the child is the patient, not the parents; professional mental health care is essential; honest, complete disclosure represents good medicine; and all children should be assigned as male or female, without un-consenting "normalizing" surgery (Chase 2003).

According to a 2015 European Union Agency for Fundamental Rights (FRA) report on the fundamental rights of intersex people in the European Union, "normalizing" surgery is carried out on intersex children in at least 21 member states, in 8 of which "a legal representative can consent to sex 'normalizing' medical interventions independently of the child's ability to decide" (FRA 2015). This situation mirrors that occurring globally, where such medical intervention is widely available. However, conventional norms, beliefs, and values holding that a child's body must conform to a strict gender binary code have been challenged and discussed (such that views are slowly changing), with the goal of ensuring autonomy and bodily integrity (which is considered to be in the best interests of the child). The *Free and Equal* global public awareness/human rights campaign was concerned with SOGIESC (OHCHR 2019). Other notable agencies, such as the Human Rights Watch and Amnesty International, have also condemned such surgical intervention as "harmful", and have called on governments and parents to wait until a child is old enough to make a free, full, and informed consent (Amnesty International 2013; Human Rights Watch 2017; OHCHR 2019; WHO 2014). Current worldwide efforts to raise awareness about intersex issues are a good example of how an unnoticed, "neglected" issue can achieve international prominence.

11.5 Conclusion: Leave No One Behind

As stated in the Introduction, "no one should be left behind." This is the central tenet of the transformative, aspirational Sustainable Development Goals (SDGs) outlined in the 2030 Agenda for Sustainable Development (which set out a 15-year plan to achieve the goals). It represents the commitment made by all UN Member States to work towards eradicating poverty, discrimination and exclusion, and to reduce inequalities that render people vulnerable, particularly children. Goal 5.3., pertaining to gender equality, is to "Eliminate all harmful practices, such as child, early, and forced marriage and female genital mutilation" (United Nations 2015: 18).

There is growing public interest in FGM/C eradication campaigns that highlight its severe negative impact on girls and women. These campaigns frame FGM/C as a global human rights and reproductive health issue. Coalitions promoting intactivism,

i.e., the eradication of NMC and any other form of involuntary male genital cutting, share these same common goals and aspirations. The concept of gender is not, and should not be, restricted to cisgender and/or heterosexual girls and women.

Autonomy and bodily integrity should be protected through approaches based on human rights, empowerment and capabilities, regardless of race, immigration status, assigned sex, experienced gender, sex characteristics, or sexual orientation. The importance of free, full, and informed consent requires us to delay surgery until the individuals involved are old enough to make their own decisions.

Appendix: Declaration of Sexual Rights

In recognition that sexual rights are essential for the achievement of the highest attainable sexual health, the World Association for Sexual Health:

States that sexual rights are grounded in universal human rights that are already recognized in international and regional human rights documents, in national constitutions and laws, human rights standards, and principles, and in scientific knowledge related to human sexuality and sexual health.

Reaffirms that sexuality is a central aspect of being human throughout life, encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy, and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviors, practices, roles, and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, legal, historical, religious, and spiritual factors.

Recognizes that sexuality is a source of pleasure and wellbeing and contributes to overall fulfillment and satisfaction.

Reaffirms that sexual health is a state of physical, emotional, mental, and social wellbeing in relation to sexuality, and not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination, and violence.

Reaffirms that sexual health cannot be defined, understood, or made operational without a broad understanding of sexuality.

Reaffirms that for sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected, and fulfilled.

Recognizes that sexual rights are based on the inherent freedom, dignity, and equality of all human beings and include a commitment to protection from harm.

States that equality and non-discrimination are foundational to all human rights protection and promotion, and include the prohibition of any distinction, exclusion, or restriction on the basis of race, ethnicity, color, sex, language, religion, political, or other opinion, national or social origin, property, birth or other status, including disability, age, nationality, marital and family status, sexual orientation and gender identity, health status, place of residence, or economic and social situation.

Recognizes that persons' sexual orientations, gender identities, gender expressions, and bodily diversities require human rights protection.

Recognizes that all types of violence, harassment, discrimination, exclusion, and stigmatization are violations of human rights, and impact the wellbeing of individuals, families, and communities.

Affirms that the obligations to respect, protect, and fulfill human rights apply to all sexual rights and freedoms.

Affirms that sexual rights protect all people's rights to fulfill and express their sexuality and enjoy sexual health, with due regard for the rights of others.

Sexual rights are human rights pertaining to sexuality:

1. The right to equality and non-discrimination

   Everyone is entitled to enjoy all sexual rights set forth in this Declaration without distinction of any kind such as race, ethnicity, color, sex, language, religion, political or other opinion, national or social origin, place of residence, property, birth, disability, age, nationality, marital and family status, sexual orientation, gender identity and expression, health status, economic and social situation, or other status.
2. The right to life, liberty, and security of the person

   Everyone has the right to life, liberty, and security that cannot be arbitrarily threatened, limited, or taken away for reasons related to sexuality. These include: sexual orientation, consensual sexual behavior and practices, gender identity and expression, or the access to or provision of services related to sexual and reproductive health.
3. The right to autonomy and bodily integrity

   Everyone has the right to control and decide freely on matters related to their sexuality and their body. This includes the choice of sexual behaviors, practices, partners, and relationships with due regard to the rights of others. Free and informed decision making requires free and informed consent prior to any sexually-related testing, intervention, therapy, surgery, or research.
4. The right to be free from torture and cruel, inhuman, or degrading treatment or punishment

   Everyone shall be free from torture and cruel, inhuman, or degrading treatment or punishment related to sexuality, including harmful traditional practices; forced sterilization, contraception, or abortion; and other forms of torture, cruel, inhuman, or degrading treatment perpetrated for reasons related to someone's

sex, gender, sexual orientation, gender identity and expression, and bodily diversity.

5. The right to be free from all forms of violence and coercion

   Everyone shall be free from sexuality related violence and coercion, including: rape, sexual abuse, sexual harassment, bullying, sexual exploitation and slavery, trafficking for purposes of sexual exploitation, virginity testing, and violence committed because of real or perceived sexual practices, sexual orientation, gender identity and expression, and bodily diversity.

6. The right to privacy

   Everyone has the right to privacy related to sexuality, their sexual life, and choices regarding their own body and consensual sexual relations and practices without arbitrary interference and intrusion. This includes the right to control the disclosure of sexuality-related personal information to others.

7. The right to the highest attainable standard of health, including sexual health, with the possibility of pleasurable, satisfying, and safe sexual experiences

   Everyone has the right to the highest attainable level of health and wellbeing in relation to sexuality, including the possibility of pleasurable, satisfying, and safe sexual experiences. This requires the availability, accessibility, acceptability of quality health services, and access to the conditions that influence and determine health, including sexual health.

8. The right to enjoy the benefits of scientific progress and its application

   Everyone has the right to enjoy the benefits of scientific progress and its applications in relation to sexuality and sexual health.

9. The right to information

   Everyone shall have access to scientifically accurate and understandable information related to sexuality, sexual health, and sexual rights through diverse sources. Such information should not be arbitrarily censored, withheld, or intentionally misrepresented.

10. The right to education and the right to comprehensive sexuality education

    Everyone has the right to education and comprehensive sexuality education. Comprehensive sexuality education must be age appropriate, scientifically accurate, culturally competent, and grounded in human rights, gender equality, and a positive approach to sexuality and pleasure.

11. The right to enter, form, and dissolve marriage and other similar types of relationships based on equality and full and free consent

    Everyone has the right to choose whether or not to marry and to enter freely and with full and free consent into marriage, partnership or other similar relationships. All persons are entitled to equal rights when entering into, during, and at the dissolution of marriage, partnerships, and other similar relationships, without discrimination and exclusion of any kind. This right includes equal entitlements to social welfare and other benefits regardless of the form of such relationships.

12. The right to decide whether to have children, the number and spacing of children, and to have the information and the means to do so

Everyone has the right to decide whether to have children and the number and spacing of children. To exercise this right requires access to the conditions that influence and determine health and wellbeing, including sexual and reproductive health services related to pregnancy, contraception, fertility, pregnancy termination, and adoption.

13. The right to the freedom of thought, opinion, and expression
    Everyone has the right to freedom of thought, opinion, and expression regarding sexuality and has the right to express their own sexuality through, for example, appearance, communication, and behavior, with due respect to the rights of others.
14. The right to freedom of association and peaceful assembly
    Everyone has the right to peacefully organize, associate, assemble, demonstrate, and advocate including about sexuality, sexual health, and sexual rights.
15. The right to participation in public and political life
    Everyone is entitled to an environment that enables active, free, and meaningful participation in and contribution to the civil, economic, social, cultural, political, and other aspects of human life at local, national, regional, and international levels. In particular, all persons are entitled to participate in the development and implementation of policies that determine their welfare, including their sexuality and sexual health.
16. The right to access to justice, remedies, and redress
    Everyone has the right to access justice, remedies, and redress for violations of their sexual rights. This requires effective, adequate, accessible, and appropriate educative, legislative, judicial, and other measures. Remedies include redress through restitution, compensation, rehabilitation, satisfaction, and guarantee of non-repetition.

The World Association for Sexual Health (WAS) is a multidisciplinary, worldwide group of scientific societies, NGOs, and professionals in the field of human sexuality, which promotes sexual health throughout the lifespan and through the world by developing, promoting, and supporting sexology and sexual rights for all. The WAS accomplishes this by advocacy actions, networking, facilitating the exchange of information, ideas, and experiences and advancing scientifically based sexuality research, sexuality education and clinical sexology, with a trans-disciplinary approach. The WAS Declaration of Sexual Rights was originally proclaimed at the 13th World Congress of Sexology in Valencia, Spain, in 1997 and then, in 1999, a revision was approved in Hong Kong by the WAS General Assembly and then reaffirmed in the WAS Declaration: Sexual Health for the Millennium (2008). This revised declaration was approved by the WAS Advisory Council in March, 2014.

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Yuko Higashi, Ph.D. is a sexologist and professor of social work and gender studies at Osaka Metropolitan University. Her work has been centered around sexual health and rights, especially autonomy and bodily integrity. She has served on the Advisory Committee and the Sexual Rights Committee of the World Association for Sexual Health and the Advisory Committee of Asia-Oceania Federation of Sexology. She has also been involved with Trans-Net Japan, Sexuality Education and Empowerment, Japanese Association for Sex Education, Japan Society of Sexual Science, and other Japanese organizations. Her recent publications include "Medically Unnecessary Genital Cutting and the Rights of the Child," *American Journal of Bioethics* 19, 10 (2019): 17–28.

Chapter 12
Notes on the History of Feminist Activism in Sudan: Editors' Interview with Prof. Rogaia Mustafa Abusharaf

Rogaia Mustafa Abusharaf

12.1 African Academics Are at the Forefront of Illuminating the Cultural Underpinnings of This Practice

Editors—As a Sudanese woman who studied and taught at an American university, you will be very aware of the differences and discrepancies between the perspectives of Africa and the West on the issue of FGM/C. From your point of view, how has the academic research on FGM/C been going so far?

Prof. Abusharaf—I must start by saying that academic research is critical and more so for those involved in human rights activism and social policy-making in any arena of state and society dynamics. Since the practice of FGM/FC continues to attract the attention of scholars from a vast array of disciplines, I believe that there is an excellent opportunity for concerned academics to dispel some of the preconceived notions about Africa and its peoples. There are already damaging perceptions that African women suffer from. And specifically, when it comes to cutting, African women are seen as irrational and primitive. In many African societies today, there are impressive efforts to end harmful practices. Therefore, we notice more than ever before, the increased awareness of the importance of engaging the communities in which FGM/FC is practiced. There is also a rising recognition of the importance of listening to people's voices either about the continuity or the change experienced vis-à-vis FGM/FC.

Prof. Rogaia Mustafa Abusharaf is a prominent pioneer in FGM/C research. The editors of this volume, Nakamura, Miyachi, Miyawaki and Toda and other contributors had an opportunity to discuss this issue for the first time with her at a workshop in Japan in 2017. Since then we have been deepening our discussion on this topic. This section covers the questions posed to Prof. Abusharaf and her responses.

R. M. Abusharaf (✉)
SFSQ, Georgetown University, Doha, Qatar
e-mail: rma57@georgetown.edu

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Academic researchers also made a huge difference in the ways in which they approached this subject. There is a significant acknowledgement of the significance of the language used to describe this long-established tradition. Elsewhere, I emphasized the point about the term "mutilation," and the ways in which it othered African women, not only the supporters of the practice but also its opponents. Any meaningful discussion dealing with this practice should heed the significance of terminology. Attention to language is vital to understanding the political and ideological debates that surround this thorny subject. Anthropologists in particular have always used female circumcision or cutting rather than mutilation to acknowledge the views of the people who adhere to this practice as a rite of passage. The usage of the word mutilation has been extremely alienating as it is a value-laden term that has no resonance with African communities' understanding of the ritual.

African academics are at the forefront of illuminating the cultural underpinnings of this practice. They are by no means supportive of the cutting but rather invested in a nuanced approach guided by a great sensitivity to the local contexts. Scholars like Leslie Obiora, Asma Abdel Halim, Asha Mahmoud, Fuambai Ahmadu, Hamid Albashir and Shahira Ahmad are among those who called for the recognition of the practice's symbolic significance in a life-cycle's transition. Their work is critical for crafting any appropriate remedy deemed well-informed and keen on change. For example, it is becoming common knowledge that where it is practiced, female circumcision is passionately perpetuated and closely safeguarded; it is regarded as an essential coming-of-age ritual that ensures chastity, promotes cleanliness and fertility, and enhances the beauty of a woman's body. In Arabic the colloquial word for circumcision, *tahara,* means "to purify." Elsewhere, a New York based human rights organization, RAINBOW under the able leadership of Dr. Nahid Toubia, who is a fervent activist of women's rights throughout Africa, published a list on the terminology used to describe the practice. I share them here because none of the words actually translates into "mutilation." The practice is known as bolokoli, khifad, qodiin, irua, bondo, kuruna, and kene-kene. Let me turn to the importance of these terms and their local associations so that we can get a clearer picture as to why the recent recognition of language is so important.

In some societies the experience of this rite of passage includes secret ceremonies and instruction in cooking, crafts, childcare and the use of herbs. After circumcision adolescent girls suddenly become marriageable, and they are allowed to wear jewelry and womanly garments that advertise their charms. Among the Masai of Kenya and Tanzania, girls undergo the operation publicly; then the cutting becomes a test of bravery and a proof that they will be able to endure the pain of childbirth. Circumcision gives girls status in their communities. By complying, they also please their parents who can arrange a marriage and gain a high bridal price for a circumcised daughter.

The consequences of not undergoing the ritual are equally powerful: teasing, disrespect and ostracism. Among the Sabiny people of Uganda, an uncircumcised woman who marries into the community is always lowest in the pecking order of village women, and she is not allowed to perform the public duties of a wife, such as serving elders. Uncut women are called girls, whatever their age, and they are

forbidden to speak at community gatherings. The social pressures are so intense that uncircumcised wives often opt for the operation as adults. Girls, too, can be driven to desperation. Genital cutting is often so closely associated with virginity that a girl who is spared the ordeal by enlightened parents is generally assumed to be promiscuous, a man-chaser. Such beliefs may seem absurd to outsiders. Because of these symbolic considerations, the women themselves are more often than not the primary agents for the continuity of the practice.

Here we must look at the state of the activism on the continent. I think that African human rights activists are painfully aware of women's agency in upholding this tradition. No one is calling Africans by disparaging adjectives or calling them "prisoners of ritual" as the American Hanny Lightfoot-Klein called women in the title of her book. There is also another important development that we are seeing today with respect to the current scholarship and activism. For example, there is a shift away from the emphasis on male oppression as an explanation of this ritual's continuation.

Some Western feminist representational discourses on female "circumcision" as a signifier for sexual oppression have come under considerable criticism for their ethnocentrism and reductionism. Let me be more specific here and just use *The Hosken Report*, as an example throughout. Fran Hosken's report is not an exception to the West's condescension. Like a myriad of similar reports, it is filled with negative statements about the African societies in question. The report attempts to discuss "circumcision" as a symbol of universal male dominance. However, when I convened a gathering of African activists in Bellagio Study Center, I was extremely impressed about the efforts that illuminated the important role of women as the ultimate brokers in the change we have seen in Ghana, Sudan, Egypt, and Kenya, among other places. They also shared powerful lessons about the critical role of religion in challenging the idea about the practice as a religious edict. We learned that in Egypt, Sudan, Senegal and Mali, religious leaders, both Muslim and Christian, who may otherwise espouse conservative views on gender, worked very closely to challenge the practice and to deploy their authority in service of the women's rights campaigns in their countries. We rarely hear about these important approaches.

12.2 Western Feminist Representations and Negative Images of Africa and Africans

Editors—You offer a critical examination of Western feminist representations. What do you think are the problems they have faced?

Prof. Abusharaf—I have to stress at the outset that my misgivings about the representations of the practice by white feminists is not a defense of the practice by any means on my part. Make no mistake: I believe that this practice must end if women are to enjoy the most basic human rights. It goes without saying that I am very supportive of the right to health, the right of the child and the right to bodily

integrity. Therefore, my reservations about Western feminists (of course not all of them) who addressed this practice are based on the moral judgement they exude. I agree with anthropologist Richard Shweder who wrote powerfully against the ideas about African mothers as bad mothers who put their girls in harm's way. Therefore, it does little good for a Westerner, or even an African-born woman such as myself, to condemn the practice unilaterally.

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. Let me elaborate a little. Varying and conflicting paradigms have generated controversy and increased polarization between some Western feminists and Africans who view their interventions and protestations as inherently paternalistic and as another incidence of veiled racism.

Many commentators have concerned themselves with the question of why women who undergo an ostensibly harmful procedure tend to venerate their own mutilation. Since Hosken's report is widely cited, often uncritically, by the most sophisticated scholars, I will return to it. The report describes the practice as a vehicle for the sexual mutilation of females and contends that the operation has been practiced by male-dominated tribal societies of Africa and the Middle East for centuries. She describes the types of "circumcision" women endure and discusses whether they are able to experience orgasm. Hosken and others who have gathered information on the subject have tended to oversimplify the complex tapestry of values that account for its resilience among a wide range of societies. She argues that Western intervention is imperative "because the myth about the importance of cultural tradition must be laid to rest, considering that development—the introduction of Western technology and living patterns—is the goal of every country where the operations are practiced today."

By overemphasizing the effects of female circumcision on sexual pleasure, she has distanced herself from the socioeconomic contexts of broader violations of women's rights. Her report not only lacks a comprehensive view on the subject but also is noticeably impressionistic. The emphasis on lack of sexual gratification due to "circumcision" may be wrong-headed. A number of circumcised women I interviewed in a northern Sudanese town near Khartoum North said: "Do people think that because we are circumcised, we do not experience pleasure? We have very rewarding relationships and good experiences in our sex lives." This is a big problem, the inability to recognize the historical and existential realities of African societies makes her work not only ethnocentric and partial but also conveniently unconcerned with the specificity of women's experience. Instead, her intervention has focused on the universality of female oppression by patriarchal authority throughout the world. The assumption of a "universal sisterhood" falls short of understanding how multiple factors like class, religion, race, and sexuality converge to produce a diversity of experiences

that determines the extent to which sexism will be an oppressive force in the lives of women across the globe.

In another publication, "Female Genital Mutilation and Human Rights" (1981) Hosken emphasized bodily integrity as a paramount idea. This is not in dispute; yes, bodily integrity is supreme in any discussion of women's rights as human rights. Ever since the UN Fourth World Conference of Women's Platform of Action (1995) affirmed that women's rights are human rights, this concept has raised complex issues regarding the applicability of universal laws to local sociocultural settings. According to one Nigerian scholar (as reported by Rebecca Cook), such human rights discourses may not be productive in Africa, where the severity of socioeconomic problems faced by women in countries undergoing structural adjustment and grinding poverty are devastating. In many societies in which cultural expressions are often seen as deliberate acts of violence, as dominance and transgression against women, such rights discourse is perceived as an ethnocentric commentary on cultural difference. I have no doubt there are campaigns that have well-meaning intentions. However, I will not retreat from my view that the views perpetuated on this problem have succeeded in foregrounding negative images of Africa and Africans.

12.3 Feminist Movement in Sudan

Editors—How has the feminist movement in Sudan developed? Could you begin by telling us about its history?

Prof. Abusharaf—As with feminist movements throughout the Third World, the history of Sudanese feminism is intricately connected to that of the nationalist anti-colonial resistance and has, throughout, mirrored the broader political complexities. Women's rights activists yearned for a truly transformative politics. From its inception, the politics of the women's movement in the Sudan depended on multiple alliances, recognizing and drawing upon the broader identity of women as wives, mothers, workers, and citizens. That, however, does not in any way make it "less feminist," for there is no doubt that "women's issues" and gender have played a pivotal role in shaping oppositional consciousness and in affirming the inalienable rights of Sudanese women within the household and beyond.

Recently, I have shared some background about the Sudanese women's movement in Foresight Africa, a publication of the Brookings Institution in Washington D.C. I tried to locate women's rights activists in the Sudan at the forefront of the revolution under way in the country. Maybe a brief background can help address your question. When the first Sudanese woman to be admitted in Kitchener Medical School, the formidable Dr. Khalda Zahir Soror Al-Sadat, and her schoolteacher friend, Fatima Talib, got together one afternoon in Omdurman, they felt it important to reach out to others in their neighborhood to establish a Sudanese woman's union to agitate for the rights of women under British colonialism (1898–1956).

Under colonial domination, women's lives were adversely affected by the colonial pursuit of economic policies, which fundamentally changed their traditional

roles without providing alternatives. The oppressive British policies against Sudanese people in general and women in particular generated multiple forms of resistance. At the level of the family, social conservatism and male favoritism added a conspicuous dimension to the movement of liberating society and its most disadvantaged members: the women. They brought to light the complex relationship between Sudanese women and the institutional state structure as a vital component of her vision of agitating for women's rights. The extent to which colonialism, militarism (after independence), and patriarchy have all collaborated in the subordination of women and their relegation to the status of second-class citizens, was examined and elaborated upon. Their idea gathered momentum as evidenced in an impressive gathering at the home of their compatriot Aziza Makki Osman Azraq.

The effort came to fruition in 1952 with the founding of the Sudanese Women's Union. Far from being an elitist, urban-based effort, the Union succeeded in including women of all regional, religious, ethnic, and socioeconomic backgrounds throughout the country. Along with significant milestones achieved since then, such as the adoption of equal pay for equal work in 1953, the Union focused on a plethora of discriminatory practices often rationalized as revered traditions. They ended "Obedience Laws," which forced a woman to return to her abusive partner and relinquish every right or entitlement due to her as a human being. These monumental struggles, however, were not without adversaries who mounted unjustified criticisms of the Union as foreign innovations that had no roots in Sudanese customs and traditions. One of the main objectives was focused on strengthening women's position in society. SWU initiated adult literacy classes and emphasized education as a primary feminist goal.

According to Kashif (1994), between 1952 and 1959, thirty-four night-schools were established throughout the country, with the largest enrolment by residents of Omdurman in Khartoum, and in many regions such as Singa, Kassala, Fashir, Wadi Halfa, and Juba. In addition to declaring its intention of obliterating illiteracy among women, the union listed other goals for a strategy for women's liberation. Foremost among these is the liberation of women from oppressive practices within the household and on a societal level. In this regard it aimed at ameliorating prevailing social injustices and securing women's self-representation, political participation, literacy, legal rights, equal pay for equal work, childcare and better terms of employment, including maternal leave. When I interviewed Dr. Khalda Zahir in Khartoum about the union's approach to female circumcision, she averred:

> If our movement had focused on eradicating female circumcision when it started, people could have been very suspicious of our motives. That is why we tried to address fundamental questions and issues such as poverty, illiteracy, and exploitation in and outside the home and employment. Circumcision is a symptom, not a cause of women's subordination.

Dr. Zahir's point is validated by the facts on the ground. Studies have shown that the more educated women are, the less willing they are to have their daughters circumcised. I have no doubt that when African women have taken their rightful places in the various spheres of life, when they have gained social equality, political power, economic opportunities, and access to education and health care, genital

mutilation will end. To understand genital cutting as a practice that touches female sexuality, it is necessary to understand specific institutionalized ideologies. Those ideologies represent a plethora of complex notions of culture, ritual, male dominance and female authority over younger generations, social behavior, and economic power. From this vantage point it becomes obvious that female genital cutting should be squarely situated within the contexts of women's political and economic status and sex roles within the family and society.

Editors—What is the essential difference between the Sudanese feminist movement and the Western feminist movement?

Prof. Abusharaf—Unlike feminist movements in the West, in Sudan women's emancipation was hardly equated with sexual liberation. Instead, the broader conceptualization of women's issues taken by the Sudanese feminist movement differs fundamentally and constitutively from that of feminists in the Western world. This in turn raises a fundamental question: just how important is politics to the Sudanese feminist agenda?

SWU's ultimate goal is achieving equality between men and women within the society and the family. The deep conviction of women's equality held by SWU activists manifested itself in attempts to ensure women's participation in public life on equitable terms. Securing women's right to vote in 1956 attested to this effort. With regard to the sphere of family, SWU succeeded in 1969 in changing existing family law, including ending the so-called obedience law. An Act was issued, also in 1969, providing women with the rights to be consulted before marriage, to initiate divorce, and to secure custody of their children. Other aims included the provision of health care, affordable housing, safe drinking water, and the protection of children through the prevention of child labor.

Editors—Can you be more specific about what the feminist movement in Sudan, specifically the SWU, has accomplished?

Prof. Abusharaf—In an interview I conducted with Fatima Ahmed Ibrahim, she indicated the following to me: In addition, the group succeeded in 1955 in creating Sudan's first woman's magazine, *Sawt el Maraa* (Woman's Voice), which attempted to explain the real issues behind female oppression and clarify the position of Islam on women's status in general and on female "circumcision" in particular. This publication helped Sudanese women to express their concerns. Advocating a general transformative change does not mean sweeping female circumcision under the rug. Indeed, evidence of the efforts of SWU to end the practice can be found in *Our Harvest in Twenty Years*.

It can be argued that SWU women were cognizant of the implications of genital cutting, through which women and men are indoctrinated into feminine and masculine roles and subsequently into specific societal responsibilities. Under such circumstances, the female body not only emerges as a battlefield, but practices of female excision or the obligatory physical recognition of virginity are both carried out with the sole objective of preserving cultural values and traditions. With this in mind, the SWU made its position unmistakable: that efforts for the obliteration of female "circumcision" have to be initiated by Sudanese women themselves. Only when we talk about social change that recognizes the existential realities of women can we

talk about eradication of harmful practices. Any efforts that overlook historical and political contexts can only produce what David Harvey has termed "a well-meaning pseudo-science".

The SWU unyieldingly attempts to empower women to devise strategies addressing the complexities of their everyday life, by challenging hereditary forms of power. Resisting patriarchal institutions, military oppression, and class oppression must take precedence over striving for sexual freedoms. Were it not for the painstaking efforts of the SWU, the impact of state policies could have further deepened the exploitation and oppression of Sudanese women.

12.4 International Campaigns Should Collaborate with Community Activists

Editors—Currently, there is an intense international campaign for a zero tolerance policy, but it has not yielded tangible results in many countries. What do you see as the challenges facing the movement to end FGM/C?

Prof. Abusharaf—International efforts to end genital mutilation began in 1979, when the World Health Organization published statements against it. Then, after a gathering of African women's organizations in Dakar, Senegal, in 1984, the Inter-African Committee Against Traditional Practices Affecting the Health of Women and Children was formed; since then, affiliates in twenty-three African countries have been working to end the practice. In 1994 the International Conference on Population and Development in Cairo adopted the first international document to specifically address female genital mutilation, calling it a "basic rights violation" that should be prohibited.

A variety of projects have aimed to end genital cutting:

Alternative initiation rituals: In 1996 in the Meru district of Kenya, twenty-five mother daughter pairs took part in a six-day training session, during which they were told about the health effects of circumcision and coached on how to defend against being cut. The session culminated in a celebration in which the girls' received gifts and "books of wisdom" prepared by their parents.

Employment for midwives: In several African countries, programs have aimed at finding other ways for midwives, and traditional healers to make a living. A soap factory set up near Umbada. Sudan, with help from Oxfam and UNICEF, is one example.

Health education: Many African governments have launched public-information campaigns. In Burkina Faso, for instance, a national committee has held awareness meetings and distributed teaching materials. A documentary film, ("My daughter will not be excised"), has been shown on national television. And in Sierra Leone,

health workers found that when it was explained to women that genital surgery had caused their physical ailments, they were more willing to leave their daughters uncut.

So far, the success of such pilot projects remains uncertain. The available statistics are disheartening: in Egypt, Eritrea and Mali the percentages of women circumcised remain the same among young and old. Attitudes, however, do seem to be shifting. In Eritrea men and women under twenty-five are much more likely than people in their forties to think the tradition should be abandoned. And in recent years in Burkina Faso, parents who are opposed to circumcision but who fear the wrath of aunts or grandmothers have been known to stage fake operations.

I think the Zero Tolerance campaign has also picked up momentum as I can see from newsletters issued by different local and regional activists. I think it is a great step. I cannot but agree and support any effort to end the needless suffering. I hope for greater material support for community activists to help further their efforts. The Sudan right now is in a devastated economic and political situation. Moving from one spot to the next is a daily challenge. Still, there is room for coordination with the growing number of non-governmental organizations. In my view the international campaign can frame its efforts with these community activists who are aware of the local conditions and are working diligently to address elimination efforts. These include the Babikir Bedri Scientific Association for Women's Studies, the National Committee on Harmful Traditional Practices, the Assembly of Sudanese Muslim Women, and the most recent Sudanese organization to take up this issue, the Mutawinat, among others who I am confident will cooperate to end harmful practices to the best of their ability.

Editors—Thank you very much, Prof. Abusharaf. It was a very valuable talk for us as we try to find concrete ways to improve the FGM/C abolition movement in all the regions facing difficulties at the moment.

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Rogaia Mustafa Abusharaf is a professor of anthropology at SFSQ-Georgetown University in Qatar. She writes on culture and politics, anthropology of gender, human rights, migration and diaspora issues in Sudan, the Gulf, the United States, Canada, and Liverpool in the United Kingdom. She edited *Female Circumcision: Multicultural Perspectives* (Philadelphia: University of Pennsylvania Press, 2009) and is the author of *Wanderings: Sudanese Migrants and Exiles in North America* (Ithaca, NY: Cornell University Press, 2002), *Transforming Displaced Women in Sudan: Politics and the Body in a Squatter Settlement* (Chicago: University of Chicago Press, 2009), and *Darfur Allegory* (Chicago: University of Chicago Press, 2021).

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