

Female Circumcision/ Female Genital Mutilation

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The ritual cutting of parts of a girl's genitals, often termed female circumcision (FC) or female genital mutilation (FGM), once practised in different parts of the world is now only common in Africa. Twenty-eight African countries are confirmed to have some form of the ritual as described in the World Health Organisation's classification, and the total number of women and girls affected is estimated at about 100 to 130 million with an annual increase of about two million. The prevalence rates vary widely between countries (5 percent in Zaire and over 90 percent in Sudan), and tend to follow tribal and ethnic, rather than national affiliation. Within a country or a social group it is known to cross religious, income, and, in some places, educational boundaries. In the past it was performed by specialized circumcisers, traditional healers, birth attendants, and barbers. More recently, modern health practitioners such as trained nurses, midwives, and doctors are increasingly involved in providing the service.

Despite its clear health ramifications the involvement of the African medical and research community in the issue has been hesitant and patchy. Documentation of prevalence was primarily undertaken by advocacy groups who lacked the research training that would produce reliable data. In 1979 the Faculty of Medicine in Khartoum undertook the first specialized national survey on FC. This was followed by inclusion of FC related

questions in the Sudan Fertility Survey (1980) and the Sudan Demographic and Health Survey (1989–90). Starting in 1993 the Demographic and Health Survey (DHS III) introduced a module on FC/FGM which has now been adapted and applied in seven countries.

Sudan has also provided the majority of clinical studies documenting the physical complications of the practice, followed by Nigeria and Somalia. Given that both Sudan and Somalia have a high prevalence of the severest form (infibulation), emphasis was made on the most extreme physical complications and minor attention was given to the psychological, sexual, and social consequences of the practice. Recently there has been more discussion of the issues from the point of view of medical ethics, and the involvement of health professionals at the international level, but no clear policy positions or regulations from African medical and nursing associations at regional and national levels.

On the other hand, activism by women groups, both African and international, have made FC/FGM one of the more prominent issues of women's and children's rights, particularly within the United Nations system. This has resulted in unequivocal condemnation of the practice and strong recommendations for actions to stop it in the declarations of two recent world conferences: the International Conference on Population and Development (Cairo 1994) and the World Con-

ference on Women (Beijing 1995). These documents were approved and signed, without reservation, by the governments of all the countries where the practice is common.

The violation of the medical code of ethics of "do no harm" may be easier to illicit since FC/FGM involves the removal or irreversible damage of the sexual organs of a girl for no health benefit and in the name of culture and tradition. This was the reason behind the recent decree (1997) by the minister of health in Egypt to consider the practice of FC by registered nurses and physicians a criminal act, punishable by existing laws against bodily injury.

There are strong arguments and good reasons why FC/FGM must be considered a violation of the human rights of the girl child to her bodily integrity, but the call for immediate laws to punish it proponents is more controversial and complex. First, there is the lack of violent intent by the family, who undertake the practice primarily to "normalize" the daughter to her culture, and their lack of knowledge about its adverse effects. Second, there is the widespread nature of the practice which could make legal measure impractical and may result in serious adverse effects on the community. Thirdly, the belief in the practice is deep and protected by layers of superstitions, erroneous religious beliefs, and gender power structures that must be peeled and eroded before a law can become effective. In the absence of policies and programmes to bring about social change and a wider community involvement, passing a criminal law may only drive the practice underground.

Ghana, where the practice is known amongst minority tribes living in the North, was the first post-independence African country to pass a law to criminalize FC/FGM in 1994. While studies to document the base line information on prevalence and health consequences are necessary, it is equally important to study the impact of passing the law on the community and its effect on their future behaviour. In Burkina Faso, where no survey data are available but the estimated prevalence of FC/FGM is over 70 percent nationally, the government has been supporting a nationwide campaign against the practice for over ten years, which

culminated in the passing of a criminal law in 1996. The effect of the campaign as well as the criminal law, has yet to be studied.

Non-legal measures against the practice have been in place for over a decade in many countries. These range from campaigns which disseminate information on the health consequences of the practice, alternative skill training, and education of circumcisers, and more recently, the introduction of alternative rituals. While these programmes vary in design, the focus of their target audience, their use of conventional educational techniques (such as lectures and speeches) and non-conventional methods (such as theatre, song, and radio messages), they share one thing in common: there has been little systematic study or evaluation of their effectiveness.

Since FC/FGM is not a disease, but a human practice based on beliefs and social structures, efforts to stop it must focus research less on clinical models to document its complications, or epidemiological models of disease eradication, and more on exploring and studying the process of social change. The impact of factors such as economics, education, and urbanisation as well specific programmes targeted against the practice on individual, family, and community behaviour is at the centre of the questions to be answered by the scientific community in the future.

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