Women in Muslim Societies

DIVERSITY WITHIN UNITY

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When Modernity Confronts Traditional Practices: Female Genital Cutting in Northeast Africa

Noor J. Kassamali

Female genital cutting (FGC)[1] is a complex and controversial issue. It is a provocative subject that has caused emotionally charged debate, both in the West and in some of the developing nations where this practice is prevalent. This debate is a relatively recent phenomenon, for up until a decade or two ago there was very little awareness of this issue in the West. It was brought to the fore at an international level by the combined delegation of East and West African women, of which I was a part, in Copenhagen in 1980 at the nongovernmental organizations (NGOs) forum at the United Nations Mid-Decade Conference for Women. The very concept of excising a woman or girl's genitalia is repugnant to most of us, both in the West and the developing world. Although there can be no doubt that our efforts should lead to the eradication of this practice, this can only occur when the myths and misconceptions that surround it are understood and dispelled. Only then can appropriate strategies that are more likely to succeed be formulated.

Current discussion and critique of FGC encompasses not only cultural relativism, cultural hegemony, and feminism but also the rights of women and children and their right to healthy development. It has been discussed as a form of child abuse;[2] as an infringement of basic human rights, that is, as gender-based violence; and in terms of gender dynamics, as a deliberate attempt to curtail the sexuality of women in some patriarchal societies.[3] According to 1997 United Nations (UN) estimates, approximately 130 million women and girls worldwide are affected. This may be a conservative number since accurate statistics are difficult to document. The countries in which this practice is prevalent do not often have the means to gather meaningful data for several reasons, including the presence of largely rural populations and the disincentive to disclose the prevalence of a practice that is officially illegal. This custom is reportedly practiced in twenty African countries and is also found in the southern parts of the Arabian peninsula, namely Oman and Yemen. It has also been reported in Indonesia;

Malaysia; the Bohra sect of the Indian subcontinent; in parts of South America, namely Brazil and Peru; in the aboriginal peoples of Australia; and even in a Russian Christian sect known as the Skopti.[4]

Despite its widespread distribution and practice by geographically and ethnically diverse groups, the custom has in the last two decades been associated with Islam, both by the lay media and some academicians.[5] Is FGC an Islamic custom? If so, what are some of the religious sources that discuss this practice? What is the role of the primarily male, Muslim clerics in this debate? And of what relevance is the practice of this custom to the current discussion on the status of Muslim women? Such questions are indeed germane to the discussion of this topic, but an even more basic issue looms: the alleged association of Islam with FGC is regarded as an established fact in the Western media, which thrives on stereotyping Islam in the most negative light. Here, FGC is often portrayed as a violent custom whose aim is to subjugate women and girls. Such a depiction perpetuates the stereotype of Islam as a violent faith and of Muslim women as subjugated and submissive.[6]

In this chapter I attempt to clarify some of the issues surrounding the practice of FGC and its alleged association with Islam in particular. Given the widespread diversity of the practice of this ritual, the major focus here will be limited to northeast Africa because it is there that the most severe form, infibulation, is to be found, and it is also there that the incidence of this practice is the highest in the world. As it will become clear, my perspective on this subject is grounded in my East African upbringing and my subsequent medical training.

Female genital cutting encompasses several types of procedures, which may be broadly classified into the categories of clitoridectomies and infibulations. The former consists of the excision of the clitoris or the labia minora or both, whereas the latter is much more extensive and consists of the excision of the clitoris, labia minora and majora, and the radical narrowing of the vagina. There are thus five or six different variations of FGC depending on locale, ethnicity, socioeconomic status, and education levels. The medical consequences of this procedure, which are well documented in the literature, are significant and are all uniformly devastating. Since a significant majority of these procedures are performed by unskilled and medically untrained women, there may be profound long-term effects on a woman's subsequent health and mental well-being, aside from the initial pain and trauma of the procedure because of the lack of anesthesia and aseptic techniques. Given its negative effects, why has this custom persisted in these cultures over several centuries?

THE ORIGINS OF FGC

Understanding why a custom has survived is not tantamount to condoning it. On the contrary, a clear understanding of why such a deleterious practice has persisted may be the key to its eventual eradication. Although its tenacity cannot be used as a justification for its existence, it also cannot be ignored.

The practice of FGC dates back to antiquity, and although various theories have been advanced, its origins remain obscure.[7] Several sources attest that this custom first arose in the Nile valley in ancient Egypt. The historian Herodotus reported the practice in Egypt in the fifth century B.C.E. but noted that the Romans, Phoenicians, and Ethiopians also practiced it. In his travels to Upper Egypt in 25 B.C.E., the Greek geographer Strabo described the practice among the Egyptians. Some sources suggest that evidence from mummies of an even earlier period reveals circumcision, but this claim is difficult to substantiate because of their state of preservation. From its origins in the Nile valley, female circumcision spread to adjacent lands via the trade routes. Pietro Bembos's account, published posthumously in the 1550s, documents the spread of this practice. Later, several eighteenth-century travelers reported similar findings.

Initially the type of circumcision varied with class. Clitoridectomy was probably a premarital rite of the upper classes, whereas infibulation was more common in enslaved women. Infibulated women, mainly from Sudan and Nubia, fetched a higher price on the market because buyers assumed that they were less likely to get pregnant.[8]

The custom of female genital cutting, therefore, did not originate with Islam but predates it by at least 2,500 years. The custom continued in the Nile valley even with the Muslim conquest of Egypt in 642 C.E. Over the centuries, Islamic elements were appropriated into the custom. Nevertheless, the custom is not found among most Muslims, whether they belong to the majority Sunni or the minority Shi'a denominations. Notably, FGC is unknown in Saudi Arabia, the cradle of Islam. The practice is also absent in Iran, the country with the largest Shi'a Muslim population. Claims for the "Islamicity" of this practice need to be examined very closely. Although practicing Muslims are fairly uniform in their acknowledgment of the five basic pillars (*arkan*), there is substantial diversity of practices rooted in local traditions. Thus we have, in essence, many local "Islams." It is quite evident, then, that FGC is a local tradition and not a universal Islamic practice. The practice is confined to countries within the Nile basin or under its influence and in West Africa.

JUSTIFICATIONS FOR FGC

In 1985, the Working Group on Traditional Practices Affecting the Health of Women and Children reported that the three major reasons cited for the continuation of female circumcision were tradition, religion, and the diminution of women's sexual sensitivity.[9] More recently, a joint survey done in Cairo by the Department of Obstetrics and Gynaecology at Zagazig

University and the Department of Community, Environmental, and Occupational Health at Ain Shams University in 1991 substantiates these findings. Sixteen hundred Cairene women were interviewed about the practice of FGC. According to the results of this survey, the most frequently cited motivations for FGC were tradition (32.9 percent), religion (28.6 percent), hygiene (18.3 percent), and diminution of libido (6.6 percent).[10] The entrenchment of tradition is also evident in the significant resistance encountered by sixteenth-century Roman Catholic missionaries proselytizing in Ethiopia to their attempts to abolish this practice. They had to appeal to the Pope for special dispensation to permit the continuation of the procedure. Mzee Jomo Kenyatta, the founding president of Kenya, also turned to tradition when he urged the Gikuyu women to have FGC as a means to oppose the British colonial authorities and adhere to their cultural customs. His argument was based on the premise that the colonial power wished to eradicate this custom in order to annihilate the Gikuyu's traditional practices. Kenyatta, an anthropologist, has written an elaborate account of this practice called *irua* and the justifications for its continuation.[11] It is interesting to note that the Gikuyu, who are Christian, have this custom, whereas the Muslim population of the Kenyan coast does not.

Muslim groups that practice this custom often cite religious justifications and may precede the ceremony with a prayer or recitation of verses from the Qur'an. Yet religion is not a determining factor. In Egypt, where this practice is deeply entrenched, both Muslims and Christians practice FGC. Esther Hicks's hypothesis that "the geographic area penetrated by Islam coincides with the general distribution of infibulation, and all populations known to practice infibulation are (to one degree or other) of the Islamic faith" is erroneous not only in the case of the Gikuyu (which she acknowledges) but also in the case of the various West African tribes.[12]

The final frequently cited reason for the continuation of this practice is the diminution of a woman's sexuality. This often enrages most of the groups in the West dealing with FGC. However, efforts to control women's sexuality are not limited to Africa and the less developed world. In the mid-nineteenth to early twentieth centuries, clitoridectomies and oophorectomies (removal of the ovaries) were advocated and practiced in the United States and England as cures for female masturbation, hysteria, and insanity.[13] As recently as 1936, L. Emmett Holt's text *Diseases of Infancy and Childhood* recommended removal of the clitoris as a treatment for masturbation.[14] These practices died out in the West as education levels rose and as the medical justification for these procedures became untenable. Therefore, surgical repression of a woman's sexuality is not unique to Africa and was an acceptable practice in the West just sixty years ago.

FGC AND ISLAM

Lawrence Cutner hypothesizes that "there seems to be an implicit cultural belief in Islamic countries that a woman's sexuality is irresponsible and wanton and therefore must be controlled by men." He argues that "in the Muslim culture the use of female circumcision has much to do with the social value system that honors the preservation of the female's virginity."[15] FGC, therefore, must have seemed like an adequate means to control the sexuality of women, analogous to the iron chastity belts used in twelfth-century Europe. Unfortunately, Cutner's hypothesis is echoed by many men, both the ulema (Muslim clerics) and laypeople in the countries where this practice is prevalent. The critique of this practice by female Muslim scholars is based precisely on these grounds, namely, that some ulema (who are primarily men) sanction FGC as being Sunna, or in the tradition of the Prophet, because the procedures diminish a woman's sexual desire. This is not to imply that there is unanimity among the ulema. The debate regarding FGC among them is rife with disagreements and contradictory opinions. In October 1994, the mufti of Egypt, Shaykh Muhammad Sayyid Tantawi, publicly declared that the Qur'an does not have any stipulations regarding FGC. He went on to assert that the hadith (reported sayings) attributed to the Prophet were unreliable and that there was no evidence to suggest that the Prophet had ordered his own daughters to undergo any type of FGC. He went on to state that "a young girl's modesty does not stem from 'circumcision' but rather from a good religious and moral education."[16] However, within days, Shaykh Gad al-Haq Ali of al-Azhar issued a *fatwa* (religious ruling) that "female circumcision is a part of the legal body of Islam and is a laudable practice that does honor to the women." Subsequently a lawsuit was filed against the imam of al-Azhar by the Egyptian Organization of Human Rights for the damage caused by this fatwa.[17] Marie Assad states that many Islamic jurists believe that "female circumcision is an Islamic tradition mentioned in the tradition of the Prophet and sanctioned by the Imams (religious leaders) and jurists, in spite of their differences on whether it is a duty of Sunna; they support the practice and sanction it in view of its effect on attenuating the sexual desire of women and directing it to the desirable moderation."[18]

In my view, the position of these religious leaders is not only contrary to the Prophet's teaching but also the Qur'an. Muslim women not only have the right to sexual satisfaction within the context of a marriage but also can initiate sexual intercourse (Sura 4:1). An account from the Prophet states that he granted divorce to a woman whose husband was sexually impotent.[19] This right to sexual gratification within marriage is recognized even by uneducated, rural women.[20] In Islam (in contrast to Christianity), sexual intercourse does not have the stigma of sin; within the

context of a marriage, it is even considered to be a meritorious act. Hitherto, the predominantly male religious elite has had the privilege of interpreting the Qur'an and the hadith, primarily because literacy was confined to a privileged few. Some religious leaders have thus managed to claim Islamic authenticity for a custom that is local and, in my view, violates the spirit of the Prophet's teachings about the position of women in Islam.

The Qur'an, which contains numerous prescriptions for everyday issues, is conspicuously silent on the practice of female or male circumcision. There is some doubt whether female circumcision was practiced in pre-Islamic Arabia. If it was prevalent in pre-Islamic Arabia, one would expect a somewhat fuller discussion of this subject, similar to the ones on sexual intercourse (Sura 2:187, 23:10), menstruation (Sura 2:228, 65:4), or breast-feeding and weaning (Sura 2:233, 31:14) in the Qur'an or the hadith and the commentaries of early Muslim scholars. Dr. Said al-Naggar, an Egyptian scholar of the history of the life of the Prophet Muhammad, has not found a single reference on circumcision in his studies.[21] The practice of male circumcision, however, which is universal in Islam, is legitimized by the Qur'anic verse that recommends adherence to the practices of Abraham: "Follow, then, the community of Abraham, a man of pure faith, who was not a polytheist" (Sura 3:95). Although the Qur'an does not mention any specific practices, Abraham's account of his covenant with the Lord and the ritual of male circumcision are acknowledged and accepted by all Muslims.[22] Hence, only the male rite of circumcision, which is thought to originate from Abraham, is documented in the hadith. The Muslim position on this subject was best articulated by Dr. Hassan Hathout when he was at the Faculty of Medicine at the University of Kuwait: "It is incorrect to assert that female circumcision is sunna in Islam. Only male circumcision is sunna in Islam, a tradition taken from the Prophet Abraham which remained and is still performed in Judaism."[23]

How, then, is female circumcision justified by the Muslim groups who sanction it? The justification rests on one oft-quoted hadith of the Prophet to Umm Attiya, a woman of Medina who reportedly circumcised women. The Prophet is alleged to have said, "Reduce but do not destroy; this is enjoyable to the woman and is preferable to the man." Another version of the same hadith reads "Do not go in deep. It is more illuminating to the face and more enjoyable to the husband." This hadith (or its many variations) is not found in Muhammad al-Bukhari, whose collection of the hadith is regarded by most Muslims as the most extensive and the most authentic. It is doubtful whether this hadith, given its several versions, is authentic, This is also a view held by a number of Muslim scholars and clerics.[24] Haifaa Jawad asserts that in the absence of a Qur'anic reference, the hadith is too tenuous and the custom cannot, on this basis, be considered Islamic.[25] Similarly, Imam Deen Warith Mohammed reiterates that the "practice has no Qur'anic base and has no support in Sunnah."[26] Even if

the hadith is authentic, it clearly suggests, as many commentators have realized, an attempt by the Prophet to ameliorate the custom; it explicitly says that excision should be minimized because it disrupts both male and female sexual pleasure. Certainly, infibulation and clitoridectomy would go against the supposed prophetic injunction.

Many commentators have sought to answer the questions: What then are the conditions that make female circumcision acceptable to the Muslims who practice it? What "Islamic" sanctions do they cite in order to justify it? In the nineteenth century, Richard Burton suggested that the origins of this practice lay in a domestic dispute in Abraham's household. According to his account, it was Sarah who, in a fit of jealousy, cut off Hagar's clitoris while she lay asleep. (Hagar is generally referred to as "the mother of all Muslims" because the mythic origin of the Arabs is traced through her son Ishmael to Abraham.) God then ordered both Sarah and Abraham to circumcise themselves.[27] This hypothesis is implausible, for, if it were true, the custom would have been perpetuated on both Jewish and Muslim men and women. Barbara Stowasser, in her recent book, has revived the Abrahamic connection and suggests that the religious legitimization of female circumcision may have occurred with Hagar.[28] According to Stowasser, the account of Sarah's jealousy of Hagar prompted the patriarch Abraham to order Hagar "to pierce her ears and have herself circumcised." Hence, Hagar, despite her Egyptian origins, was not circumcised prior to joining Abraham's household. Stowasser therefore concludes that female circumcision was introduced into pre-Islamic Arabia by Hagar. Yet even if one accepts the myth of the Abrahamic origin of the Arabs, one needs to bear in mind that the place where Hagar and Ishmael sought refuge was an area near present day Mecca in Saudi Arabia. The memory of Hagar's attempt to find water for her son by running back and forth between the hills of Marwa and Safa is commemorated to this day during the hajj. If Abraham's admonition to Hagar regarding circumcision was the origin of the practice in certain Muslim populations, then we should surely expect to find it being practiced in this region, but it is not reported.

As increasing numbers of Muslim women gain access to both secular and Qur'anic education, male-dominated interpretations of the Qur'an and the hadith will be increasingly challenged. According to Mernissi, the original Qur'anic revelation regarding the *hijab* or veil has been interpreted out of context.[29] In the case of the veil, the only specific recommendation in the Qur'an, for both men and women, is to dress modestly. However, the veil, which has its origins in the Byzantine empire, was appropriated because it fit very well with the patriarchal system. Similarly, the Qur'an emphasizes chastity for both the sexes. Therefore the religious leaders' espousing the claim that female circumcision is necessary to curtail women's sexual desire while turning a blind eye to male sexual desire is hypocritical.

As Nawal el Saadawi states succinctly, "female circumcision, like the veil, is a political issue rather than a religious one."[30] Both the veil and female circumcision were accepted and considered to be "Islamic" by certain Muslim groups because the former facilitates the segregation and seclusion of women and the latter ensures virginity by discouraging promiscuity (since infibulation severely narrows the vagina to only allow urination and menstrual flow, penetration during intercourse is very painful).

However, from a medical perspective, circumcision does not ensure virginity. Medically, it is far more difficult to reconstruct the vaginal hymeneal tissue than it is to recircumcise a sexually active woman. The procedure called *adla,* or tightening (also sometimes referred to as *adlat al-rujal* or "recircumcision for man"), is common because it simulates virginity (the vaginal introitus is narrowed, presumably to increase a man's pleasure). Many postpartum women undergo this procedure, as do divorced and widowed women prior to remarriage. Clearly then, the mere narrowing of the vaginal introitus does not guarantee virginity, nor does it discourage promiscuity.

The argument that FGC discourages promiscuity can, in fact, be used against the very premise that it is supposed to protect, as illustrated by O. Koso-Thomas's study in Sierra Leone.[31] She interviewed fifty women who had been sexually active prior to their circumcision and found that most of them had been unable to achieve the level of sexual satisfaction that they had experienced prior to circumcision. This led some to search for a sexually compatible partner, and in the process, many of these women lost their husbands and homes. Ironically, then, the very procedure that is believed to curb promiscuous behavior led to the opposite effect. Another study done among the Ibos of Nigeria reveals that the incidence of premarital coitus is increasing at an equal rate in circumcised and noncircumcised women. U. Megafu speculates that it is probably the influence of Westernization rather than circumcisional status that plays a major role in this change in sexual behavior. The same author reports that clitoridectomy did not diminish a woman's libido, contrary to the widespread belief that excision of the genitalia will suppress a woman's sexual desire.[32] This is only partially true because, in spite of painful intercourse as a result of circumcision, some Sudanese women did report the ability to achieve orgasm.[33] Similarly, a survey of Egyptian women reported that female circumcision did not decrease the women's libido, but it did affect their orgasmic ability.[34] Female circumcision neither curtails desire nor ensures chastity, yet the practice continues.

FGC AND PATRIARCHAL SOCIETIES

The peoples who perpetuate this custom have a number of traits in common: they live in patrilineal, nomadic pastoral, or agro-pastoral societies

in which women have very limited influence. Women are initially economically dependent on their fathers and, after marriage, on their husbands. To challenge such an entrenched custom, a woman would risk ostracism and even expulsion from the group; thus, she would need to be economically independent.

In patrilineal societies, family honor is closely associated with the (sexual) behavior of the womenfolk. FGC, therefore, may have seemed a logical way to prevent women from having premarital sex. There is also the widespread belief that FGC guarantees virginity. FGC would then seem to be an appropriate measure to control women's sexual behavior. There is also tremendous societal pressure on the men to marry circumcised women only, and often the "proof of penetrating the bride" is publicly verified by the family matriarch's displaying a bloodied bedsheet. Some men may experience considerable anxiety because intercourse is usually painful, and sometimes, because penetration is impossible, the woman is again cut open manually with a knife or blade. In a study done in Sudan, difficulty of penetration was reported in 66 of the 231 women interviewed.[35] In another study from Sudan, A. A. Shandall studied 300 males who had two wives each, one infibulated and the other clitoridectomized or intact. The men unanimously preferred the latter because they could share sexual gratification with them.[36] In spite of this, not enough men have spoken up to oppose this custom. Unfortunately, in many of these rural, patrilineal societies, much of the decisionmaking power rests with the men, and unless the men can be persuaded about the futility of this custom, it will continue to persist.

In addition, men in patrilineal societies want to be certain that their children are indeed fathered by themselves and are not the progeny of their wives' extramarital lovers. Paternity is a major issue for these groups because of their inheritance laws. Prolonged male absenteeism is another feature of these pastoral groups. In this case, FGC is like the chastity belts used in the West when the males were away from their homes for extended periods of time.

However, even in patriarchal societies, the role of women themselves in perpetuating traditional customs, be they harmful or benign, cannot be underestimated. Women are generally considered to be the custodians of tradition in most cultures. In the case of FGC, it is the women who make the necessary arrangements for this rite, which is most detrimental to their health and well-being. Regardless of the explanations offered for the continuation of this practice, it seems paradoxical that women sanction its perpetuation. Their low social status and their need for a larger community identity over individual survival may explain why this practice has persisted. In the agro-pastoral, patrilineal societies where an individual woman has virtually no authority, the practice may serve as a "collective social identity."

SOCIOECONOMIC FACTORS AND FGC

FGC is clearly more prevalent among rural peoples, who tend to be poorer and less educated, than among urban groups. Statistics vary, from 50–70 percent of women in urban areas having been circumcised to 95 percent in the rural areas of Egypt.[37] Urban areas offer greater economic opportunities for women, leading to a decreased dependency on males and therefore a decreased incentive, for themselves or their daughters, to undergo FGC. Also, as women's level of education increases and they gain more economic independence, these practices decline (see Table 3.1). The lower prevalence of FGC—50 percent in urban Egypt compared to 100 percent in Somalia and 90 percent in Sudan, Ethiopia, and Eritrea—can generally be attributed to the higher levels of education and economic stability attained by the Egyptian women. Maternal and infant mortality rates are also higher in these countries because of a number of different obstetric complications that occur in women who have undergone FGC. The figures from Ethiopia and Eritrea may not be reflective of the current situation because there were significant changes during and after the civil war.[38]

FGC AND THE INTERNATIONAL DEBATE

The first discussion of FGC at an international level took place at the NGO forum at the United Nations Mid-Decade Conference for Women. The confrontational interaction between African and Western women revealed a disjunction between the priorities of these two groups as well as between their approaches to the eradication of this custom. The Western women, for

Table 3.1 Female Circumcision, Literacy, and Maternal and Infant Mortality in Selected Countries

	Percentage of Females Circumcised	Percentage of Female Literacy	Female Life Expectancy (male = 100)	Maternal Mortality (per 10,000 births)	Infant Mortality (per 1,000 births)
Somalia	100	6.0	109.1	1,100	215
Sudan	90	15.0	104.0	660	104
Ethiopia and Eritrea	90	46.7	106.8	N.A.	130
Kenya	60	49.0	106.9	170	68
Egypt	50	30.0	105.1	320	61
Nigeria	50	31.0	106.0	800	101
Mauritania	25	N.A.	108.9	N.A.	122
Tanzania	10	31.4	107.7	340	102

Source: Adapted from Minority Rights Group in Dorkenoo and Elworthy, *Female Genital Mutilation*, 22.

the most part, did not exhibit the level of cultural sensitivity conducive to meaningful dialogue. The African women wanted female circumcision to be discussed within the context of the socioeconomic conditions that allow for its perpetuation, not as a sexually repressive practice. Unfortunately, nearly two decades later, very little progress has been attained, which is due in part to differences in the analytical framework of these two groups.

Western analysis is dominated by two divergent approaches. Some anthropologists, not surprisingly, adopt a culturally relativist position and discuss female circumcision within the framework of gender identity and as a rite of passage. This would be a compelling thesis if female circumcision were performed only at puberty. However, this is clearly not the case. There is considerable variation in the age when circumcision occurs, both geographically and ethnically. In some parts of Mali, Mauritania, Nigeria, and Ethiopia, female babies are circumcised right after birth. Given that girls in some tribes, such as the Bambaras of Mali, are circumcised when they are infants, the gender identity framework is of questionable validity. These infants have not had the opportunity to interact with the world at large as members of the female gender. In most parts of Africa, male and female infants are treated equally; the differentiation of roles is not emphasized until puberty.

Viewing female circumcision as a rite of passage into adulthood is equally suspect. In some tribes of Kenya and Tanzania, the women are circumcised just prior to marriage or on their wedding night, whereas in other tribes such as the Gikuyu, it is clearly a prepubertal rite of passage. In some parts of Nigeria, women are not circumcised until they are about to deliver their first child because some tribes believe that the clitoris may actually harm the child as it traverses the birth canal, and it is therefore excised.[39]

Anthropological studies may, nonetheless, be useful in designing strategies for the eradication of female circumcision. Detailed ethnographies can allow for the understanding of this practice within its larger setting. This information can then be useful in devising eradication strategies that are group-specific and culturally sensitive. Fieldwork can also identify the various social forces at play and how they perpetuate this custom. All cultures are dynamic; they respond to external forces and appropriate other customs, cuisines, and vocabulary from those with whom they come into contact. Migration, for example, is already playing a small but serendipitous role in the eradication of female circumcision. Small numbers of Sudanese and Egyptians who have migrated to Saudi Arabia, the Gulf States, and other Muslim countries for economic reasons elect not to circumcise their daughters because they recognize that female circumcision is not integral to their identity as Muslims. Such knowledge may prove to be a powerful disincentive for those who have previously used religious justifications for the practice. The influence that Saudi Arabia exerts in the religious practices on the rest of the Muslim world should not be underestimated.

Another approach advocated by some Western feminists has been vehemently opposed by the Africans. This approach is considered to be too myopic because it focuses exclusively on sexuality and the sexual oppression of women. Much of their efforts are directed at the elimination of the practice without trying to understand why the practice exists or if it serves any function in the indigenous societies. Western critics of this approach have recognized that the

> resurgence of campaigns to abolish female circumcision is in part an outgrowth of the general concern about women's health and also of Western feminists' concerns with female sexuality. While the former has generated an objective, analytical contribution to an understanding of health implications of female circumcision, the latter has in some instances sensationalized the issue by taking it out of general context of underdevelopment and the oppression of women in under-developed societies.[40]

The efforts of the U.S. writer and more recently, filmmaker, Alice Walker are a case in point.[41] Although well intentioned, her efforts cannot belie a bias for the agenda of Western feminists. Walker has thrust herself into the midst of this debate, and her actions have been criticized. Many of the African women involved in the fight for eradication feel Westerners have no understanding of the cultural nuances.

Regarding Walker's film *Warrior Marks*, Salem Merkuria, a filmmaker, and Seble Dawit, an Ethiopian human rights lawyer, say, "we do not believe that force changes traditional habits and practices. Superior Western attitudes do not enhance dialogue or equal exchange of ideas. FGM does not exist in a vacuum but as part of a social fabric." Nahid Toubia, a Sudanese woman surgeon and adviser to the Population Council, had an even stronger reaction: "*Warrior Marks* is a portrayal by an outsider. . . . I, Alice Walker, save the beautiful children who are being tortured by their own people. It's like saying Harlem women are giving their children AIDS because they don't love them."[42]

Wilkista Onsando of Maendeleo ya Wanawake, the premier women's organization of Kenya, states: "Let the indigenous people fight it according to their own traditions. It will die faster than if others tell us what to do."[43] This has been a recurrent plea from African women to Western agencies: do not dictate to us, but help us eradicate this practice in a manner that is effective in Africa. In 1979, Atawaif Osman, then the director of the College of Nursing, Ministry of Education in Khartoum, Sudan, who has devoted almost her entire life to this issue, declared: "Ultimately, it is a Sudanese problem, a problem of which we are aware and which must be solved by us. In every discussion with Sudanese, the importance of greater literacy is emphasized, especially educational opportunities for women."[44] This view is shared by a majority of women from the many

different countries. Many African women, including myself, feel there is an excess of sensational journalism regarding this issue and not enough support for ongoing grassroots efforts to eradicate this practice at the local level. The practice of FGC must be seen within the perspective of the tremendous economic hardships and other urgent health problems that exist in these countries. To focus solely on FGC would be counterproductive. Unless the issues of dire poverty, hunger, illiteracy, and unhygienic conditions are addressed and there are simultaneous efforts to advance the status of women through economic and educational means, the impact will be marginal.

There are two factors that will influence the pace of this transformation. First, the changes will occur at a rate that is acceptable to people involved in this process, which may not be the rate desired by outsiders; nonetheless, change will not occur any faster if there is coercion. Second, in attempting to eradicate such a deeply embedded practice, recommending alternative customs is necessary. An example of this would be to substitute a ritual of just nicking the clitoris or labia without excising any tissue. The ideal goal would be total eradication, but perhaps nicking would be a step toward this, recognizing that as more women have access to education and economic independence, that this practice, too, will fall into disfavor. This interim strategy has been advocated by some as a means to gradually phase out the practice.[45] However, the mere consideration of this view at a Seattle hospital serving a sizable Somali immigrant population created considerable controversy.[46] Many Somali and other African women who have undergone FGC and currently reside in the United States may be more receptive to performing only a ritual nicking of the clitoris on their daughters. The Somali women questioned in Seattle stated that this would satisfy their belief system. The transition from infibulation to no procedure is so drastic that few will be comfortable with it.

Symbolic nicking could also be advocated as a substitute procedure in Africa, which would maintain the tradition and the ceremony associated with it to a certain extent and would not jeopardize the health of the individuals involved. Such a transition phase would last, perhaps, one to two generations. Concurrent improvement in the level of education and economic status of the women over this period will eventually lead to a decline in FGC. The three UN agencies currently supporting a global ban against FGC are now cognizant of the fact that it may take three generations to eradicate this practice.[47] A long-term focus on the issue with concomitant change in the position of women and other underlying social factors, although slow, may be the most reliable method. Such slow change is evident in the decline of FGC in Sudan from 96 percent to 89 percent over the past decade. Even more encouraging is the recent trend toward the less severe (sunna, or clitoridectomy type 1) form, rather than infibulation.[48]

FGC AND LEGISLATIVE EFFORTS IN NORTHEAST AFRICA

In northeast Africa, female circumcision is practiced by animists, Muslims, Copts, Catholics, Protestants, and the Falashas (Ethiopian Jews). The most severe forms of FGC are practiced. Yet there are many contradictions. Here we find some of the more innovative approaches to eradication and, in Sudan, the longest history of legislative efforts to eradicate the custom, yet more than 90 percent of the women are circumcised in the most severe form. The initial campaigns in the Sudan to eradicate this practice were introduced by the British governor-general in 1943. This had little effect, so three years later, legislation making infibulation illegal was passed, which was done primarily to discourage the extensive procedure of infibulation in favor of clitoridectomy. The unanticipated consequences of this act were devastating. Many parents, fearing that the practice was about to be outlawed, rushed to have their daughters circumcised prior to the legislation going into effect, which resulted in a significant number of medical complications and deaths. The experience clearly demonstrates the complexity of eradication. Any approach to eradication must not only be multidisciplinary but also culturally sensitive. Previous legislation has been ineffective because it has been perceived as being introduced under Western coercion; legislation enacted in consultation with some of the women's organizations in the respective countries may fare better. It may not propose the drastic changes that some of us in the West desire, but it may be more acceptable to the indigenous peoples and therefore have a greater probability of success.

The eradication effort in Egypt did not fare any better. This custom, which is locally referred to as *khitan*, is deeply ingrained in the Egyptian milieu. After all, it is there that this practice is supposed to have originated. A resolution was passed in 1959 by the People's Assembly stipulating that partial clitoridectomy could be performed only under medical supervision. Thirty-five years later, this issue was still not resolved. In 1994, Ali Abdel-Fattah, minister of health, issued a decree to the effect that the procedure could only be performed by physicians at public hospitals; a significant reversal in the Egyptian government's policy.[49] A number of NGOs successfully filed suit against the minister for reversing the long-standing ban.[50] In the past few decades, as opportunities for Egyptian women have increased, there has occurred a decline in the practice by some of the more educated and affluent segments of the society.

Initially, like Egypt, Somalia started its eradication campaign by encouraging partial clitoridectomy, rather than infibulation, under medical supervision with use of anesthesia and antibiotics (today, all forms of female circumcision are banned). The Somali campaign was innovative because its message focused on the four premises associated with the practice: "it was not healthy, not clean, not Islamic and it did not even guarantee virginity."[51] In Somalia, the impetus to eradicate came from within: it was strongly advocated by the Somali Women's Democratic Organization. The measures advocated included the need for an educational effort throughout the country to present medical facts and reexamine traditional attitudes; cooperation with community leaders (religious leaders, doctors, etc.) to combat this practice; and use of mass media to encourage change and to establish a different relationship between the sexes. Eventually, one of the women leading this campaign and the author of *Sisters in Affliction: Circumcision and Infibulation of Women in Africa*, Raqiya Abdullah, became the deputy minister for health in 1983. The current status of the effort is uncertain because of the political instability after the overthrow of Siad Barre.[52]

The Ethiopian civil war, which ended in 1991, provided a unique opportunity to combat FGC. The Eritrean Peoples Liberation Front maintained the position of forbidding forced marriages and FGC and encouraged a significant number of young women to join its forces. This change in ideology and attitude regarding women's roles resulted in a permanent change in that society. Subsequently, once the civil war was over, these practices were no longer considered to be of any value and were eliminated.

Legislative efforts thus have had limited, if any, success in the eradication of female circumcision in northeast Africa. This is not to state that legislation is ineffectual, but we should be cognizant of its limited impact in the African milieu.

FGC AND LEGISLATIVE EFFORTS IN THE WEST

The recent influx of economic and political refugees from the different African countries to Europe and North America has brought the FGC debate to the West. Several countries have enacted legislation to ban this custom, such as Sweden (1982) and England (1985), and others such as Belgium, France, and the Netherlands have prosecuted the parents and practitioners who circumcise girls. In the United States, then Representative Patricia Schroeder and the Congressional Women's Caucus introduced a bill, with support from the American Medical Association, which made FGC illegal for girls under 18 years of age.[53] The bill also recommended that the Department of Health and Human Services fund programs to educate the immigrant communities that practice this custom about its deleterious effect on the health of the women and its legal ramifications. Representative Schroeder advocated that FGC be treated as a form of child abuse. Whether the legislative ban will be more successful in the West remains to be seen. The possibility that it will drive the practice underground cannot be discounted, nor can the parallel with unsafe abortions be dismissed. There is some anecdotal evidence that those immigrants practicing

FGC may be taking their daughters back to their countries of origin to have the procedures. To ensure compliance with the law, FGC would have to be a "reportable" condition that requires all medical personnel to notify police or social workers. The American Medical Association is currently lobbying state health departments and the Centers for Disease Control to make FGC a reportable condition (in the United States, there exist mandatory requirements for reporting of all cases of child abuse, with penalties for not doing so).[54] Such a step would also make life easier for those immigrants who are opposed to FGC and would provide them with a reasonable justification for avoiding it, that is, that the country of current residence forbids this procedure.

STRATEGIES FOR ERADICATION

Eradication attempts must be cognizant of the views of women affected by FGC as well as those who defend and perpetuate it. Unless we unravel and understand the several threads in the social fabric within which this practice exists, our probability of success in eradication will be fairly small. The role of legislation at both the national and international level, directed at the countries where the practice is prevalent, has been marginal. More often than not, legislative efforts have been viewed as neocolonialist or imperialist in inspiration. Experience has shown that attempts to outlaw the practice in isolation from its complex sociocultural milieu have only resulted in the exacerbation of practice. It is also essential that if legislation is to be enacted, cultural sensitivities must be respected. For example, to refer to the practice as a form of child abuse in Africa would only meet with resistance. Although it is true that it causes pain and a myriad of other problems, no mother subjects her child to this procedure with the clear intent of causing harm. Labeling the practice as child abuse is judgmental and rooted in cultural hegemonism. It reveals ignorance and a lack of understanding of the complexities of this debate. Such rhetoric ultimately impedes the process of transformation.

Recent efforts by international agencies such as the International Monetary Fund (IMF) and the World Bank to link economic aid programs with a national commitment to eradicate this custom, as in the case of Burkina Faso, have not been in existence long enough to assess their impact. It is possible that such external pressures applied to governments, particularly if these measures have been requested by some groups within that country, will be successful.[55] Many women's groups in Africa support such a strategy and find it preferable to the argument that FGC is child abuse and a violation of human rights.[56] However, such a strategy may be viewed as coercive, with economic aid as a reward for compliance.

In my view, if FGC were to be presented as a violation of the right to good health and be included under the broad umbrella of immunization

and nutrition efforts, the chances for the eradication of FGC would be increased. This would be a persuasive argument because Article 15 of the UN's Universal Declaration of Human Rights states, "Everyone has the right to a standard of living adequate for the health and well-being of himself" and "Motherhood and childhood are entitled to special care and assistance." Similar articles are included in the Banjul Charter on Human and Peoples Rights, which was unanimously adopted by the Assembly of Heads of State and Government of the Organization of African Unity (OAU) and has been ratified by most of the African nations. Eradication attempts within this framework can then be represented as enforcement of African concerns. Most recently, three UN agencies, the United Nations Children's Fund (UNICEF), the United Nations Development Programme (UNDP), and the World Health Organization (WHO), will direct a joint, multidisciplinary plan to educate about and ultimately eradicate this practice.[57] These agencies will publicize the deleterious consequences of FGC and will target medical personnel, traditional healers, religious leaders, politicians, and at the local level, village elders and other leaders.

A number of African women, including Marie Assad, Asma El Dareer, and Edna Ismail, and the United Nations Working Group on Traditional Practices Affecting the Health of Women and Children have also recommended a multidisciplinary approach that includes education, health and family planning services, and vocational training programs designed for women. Both men and women need to be educated because in most parts of Africa, marriage is still vital to a woman's social status and survival. Unless the men in these cultures are sensitized to marrying uncircumcised women, these women will be ostracized and considered "unmarriageable." Men must be made to understand that these procedures do not ensure a woman's virginity and have a deleterious affect on fertility. The most compelling data regarding infertility come from Sudan. Approximately 20–25 percent of infertility in Sudan is secondary to chronic pelvic and tubal infections, a direct consequence of infibulation.[58]

In many of these societies, it is a stigma to be barren. It is therefore ironic that a practice that is supposed to enhance the fertility of women actually renders them sterile. Childbearing and motherhood are the primary functions afforded to women in these patriarchal cultures. Those unable to conceive are often considered to be deviant, and barren women will often seek to be labeled as *mazurin*, or possessed by spirits, to have their childlessness legitimized.[59] Infertility as a consequence of FGC should be emphasized in all the educational campaigns. This would be in keeping with the sentiment expressed in the Banjul Charter regarding the right of every woman and child to healthy development.

Many of the studies have focused on the medical complications from FGC, but the demographic consequences of this practice have not yet been adequately addressed. High infant and child mortality is a consequence of FGC. Somalia has the fourth-highest infant mortality rate in the world, and

we may seek additional insight there. Omar Mohamud's study of female circumcision and its demographic consequences is the first to demonstrate these findings.[60] The two results of this study were that infant mortality is higher with infibulation and that there is an excess of female child mortality; both of these events can be related to FGC. Women who have been infibulated experience very prolonged and difficult labor because of the inelastic scar tissue resulting from the procedure. According to UNICEF and data from the Somali Ministry of Planning, Somali women routinely reduce their food intake in the third trimester of their pregnancy to prevent the baby from gaining weight. Although this facilitates their labor, it leads to infants of low birth weight in whom the mortality is extremely high. The prolonged labor also results in fetal hypoxia and stillbirths, and the lack of the protective labia predisposes them to increased infections, which are associated with premature labor. An excess of female child mortality was also noted in the 5- to 15-year-old age interval, which corresponds with the age when FGC is performed. One may then postulate that high female child mortality occurs in all countries that practice FGC. Gender-specific child mortality data should be utilized to facilitate the eradication effort, both by the respective governments and Western donor nations.

Women who perform circumcisions not only need to be educated about the subsequent health hazards but also must be retrained for other skills. Several studies have documented the position of authority and the social status enjoyed by these women in their societies.[61] The procedures also provide a significant source of income. It is therefore unlikely that these women will relinquish their status and income without adequate compensation. The model of a community health worker, generally a woman, has been successful in many developing countries. These women, who also at times function as traditional birth attendants, can conceivably have their roles broadened to include performing basic first aid, monitoring the growth of children, and encouraging immunizations and family planning. Ensuring an alternative means of earning their livelihood will be paramount in gaining their cooperation in efforts toward the eradication of FGC. Government subsidies in the form of training and direct remuneration (which may be more lucrative) may entice at least some of these women to abandon their profession. Western aid agencies can play a pivotal role here in funding some of these programs and ensuring their continued operation until the custom has declined substantially.

CONCLUSION

The complexity of the issue of FGC demands not only an understanding of the custom within the societies that practice it but also a willingness to compromise with these societies. FGC has been the norm for several hundred if not several thousand years. The West has stepped into this milieu only in the last century and initially with a judgmental and colonial attitude; such attitudes are surprisingly prevalent even today. A review of the nomenclature is illustrative: "female circumcision," which is the collective term for both clitoridectomy and infibulation, was abandoned by feminists for the more graphic and subjective "female genital mutilation." This term has now fallen into disfavor, and such nonjudgmental terms as "female genital cutting" or "female genital operations" are the preferred terminology. Perhaps this subtle change in nomenclature is associated with a change in the attitude of individuals involved in this debate. It is now recognized by both Western and non-Western institutions that the progress in this arena will be gradual. The previous approach toward eradication of FGC was analogous to the medical model for the eradication of smallpox—namely, we must eradicate the "disease"—and this had very limited success. The "social problem" approach has not fared any better. Condemnation of the practice by international and local organizations failed to discourage the abandonment of the custom, for it is difficult to abolish a practice that is not perceived as being harmful either to the individual or the society. A gradual transformation of the practice and the sociocultural environment in which it exists seems the most feasible eradication strategy.

Slow change may not be consistent with the goals of many Western agencies that advocate immediate eradication. But given the limited effect of earlier strategies, there is an urgent need to identify interventions that are most likely to succeed in the cultures that practice FGC. A multidisciplinary approach that promotes awareness about the health consequences (high maternal and infant mortality, infertility, and increased genitourinary problems) and increases education and economic opportunities for women is more likely to be effective. International agencies such as IMF and World Bank can be instrumental in the implementation of programs based on this approach.

Finally, religious and charismatic leaders who reflect the diverse religious, ethnic, and cultural backgrounds of the countries in which FGC is practiced can play a substantial role. One example is Shaykh Abdel Ghaffar Mansour from al-Azhar University, the oldest institution of religious and secular learning in the Islamic world. At the UN population conference held in Cairo he stated that FGC should be discontinued in the name of humanity.[62] Such leadership must convince the ulema who do not subscribe to this view of the facts that these practices are not the norm in Saudi Arabia and are not mentioned in the scriptures. Leaders should not hesitate to declare a jihad on this practice, which causes bodily and psychic trauma to half of their population. Finally, the entire society needs to understand that premarital chastity is not a physical but a moral issue and

that life-threatening, at times fatal procedures performed under unhygienic conditions do not curb promiscuity or ensure virginity.

NOTES

1. As an African, I prefer the term "female genital cutting" (FGC) to the term "female genital mutilation" (FGM) because I find FGM to be derogatory and culture laden. The term "female circumcision" is too euphemistic for the extensive procedure that is often the norm in northeast Africa. "Female genital operations" (FGOs) has also been used, but as a physician, I feel that this is a misnomer because it implies a surgical quality that is clearly not present in a majority of the procedures.

2. Patricia Schroeder, "Female Genital Mutilation—A Form of Child Abuse," *New England Journal of Medicine*, 331, no. 11 (1994), 739–740; Kay Boulware-Miller, "Female Circumcision: Challenges to the Practice as a Human Rights Violation," *Harvard Women's Law Journal* 8 (1985), 170.

3. Lawrence P. Cutner, "Female Genital Mutilation," *Obstetrical and Gynecological Survey* 40 (1985), 438.

4. Ibid.

5. Esther K. Hicks, *Infibulation: Female Genital Mutilation in Islamic Northeastern Africa*, revised and expanded edition (New Brunswick, NJ: Transaction Publishers, 1996).

6. Sue Armstrong, "Female Circumcision: Fighting a Cruel Tradition," *New Scientist*, February 2, 1991; Dina Ezzat, "A Savage Surgery," *The Middle East*, January 1994; "Genital Mutilation: Stop the Butchering," *The Arizona Republic*, April 4, 1994; David Kaplan, "Is It Torture or Tradition?" *Newsweek*, December 20, 1993.

7. Hanny Lightfoot-Klein, *Prisoners of Ritual* (London: Haworth Press, 1989), 27.

8. I. R. Sami, "Female Circumcision with Special Reference to the Sudan," *Annals of Tropical Pediatrics*, 6 (1986), 100.

9. Report issued by joint WHO/FIGO Task Force, *European Journal of Obstetrics and Gynecology and Reproductive Biology* 45 (1992), 153–154.

10. "Female Genital Mutilation in Egypt," *Huqooq Al Insaan* (April 1995), 15.

11. Jomo Kenyatta, *Facing Mount Kenya* (London: Vintage, 1965), 125–148.

12. Hicks, *Infibulation*, 27.

13. G. J. Barker-Benfield, *The Horrors of the Half-Known Life: Male Attitudes Towards Women and Sexuality in Nineteenth Century America* (New York: Harper and Row, 1976), cited in Alison Slack, "Female Circumcision: A Critical Appraisal," *Human Rights Quarterly*, 10 (1988), 437–486.

14. V. Bullough and B. Bullough, *Sin, Sickness and Sanity: A History of Sexual Attitudes* (New York: New American Library, 1977), cited in Hanny Lightfoot-Klein, *Prisoners and Ritual* (London: Haworth, 1989), 180.

15. Cutner, "Female Genital Mutilation," 438.

16. "Female Genital Mutilation in Egypt," 15.

17. "Lawsuit Against the Grand Imam of Al Azhar," *Huqooq Al Insaan* (April 1995), 13.

18. Marie B. Assad, "Female Circumcision in Egypt: Social Implications, Current Research, and Prospects for Change," *Studies in Family Planning*, 11 (1980).

19. Fazlur Rahman, *Health and Medicine in the Islamic Tradition* (New York: Crossroad Publishing, 1989), 121.

20. Soheir A. Morsy, "Sex Differences and Folk Illness in an Egyptian Village," in *Women in the Muslim World*, ed. Lois Beck and Nikki Keddie (Cambridge: Harvard University Press, 1980), 611.

21. Ezzat, "Savage Surgery," 36.

22. Yahya Cohen, "Circumcision: Myth, Ritual, Operation," *Medical Journal of Malaysia*, 39 (1985), 213.

23. Efua Dorkenoo and Scilla Elworthy, *Female Genital Mutilation: Proposals for Change* (London: Minority Rights Group, 1992), 75.

24. The text of this hadith, in Ibn Dawud, *Kitab al-Adab*, Bab 45, hadith no. 4587, is "Sulayman b. al-Rahman al-Dimashqi and 'Abd al-Wahhab b. 'Abd al-Rahim al-Ashja'i told us: Marwan told us: Muhammad b. Hasan told us: 'Abd al-Wahhab al-Kufi said, from 'Abd al-Malik b. 'Umayr, from Umm 'Atiyya al-Ansari that a woman used to circumcise in Madina and the Prophet said to her: Do not be too vigorous as this is more enjoyable for the woman and more desirable to the husband. Ibn Dawud said: it is transmitted from 'Ubayd al-Allah b. 'Amr from 'Abd al-Malik with the same meaning and his (own) *isnad*. Ibn Dawud said: it is not a sound Hadith and it has been transmitted as *mursal* (missing the companion in the *isnad*). Ibn Dawud said: Muhammad b. Hasan is unknown and this Hadith is weak." I thank Whitney Bodman for this reference.

25. Haifaa Jawad, "Female Circumcision: Cultural Necessity or Religious Obligation?" *The American Journal of Islamic Social Sciences*, 11 (1994), 598.

26. Zakiyyah Muhammad, quoting Imam Warith Deen Muhammad in "Female Circumcision, or Let Us 'Purify' Women," *Islam in America* (fall 1994), 36.

27. Sir Richard Burton, *Personal Narrative of a Pilgrimage to Al-Madinah and Meccah* (New York: Dover Publications, 1964), vol. 2:19.

28. Barbara Stowasser, *Women in the Qur'an: Traditions and Interpretation* (New York: Oxford University Press, 1994), 147.

29. Fatima Mernissi, *The Veil and the Male Elite: A Feminist Interpretation of Women's Rights in Islam*, trans. Mary J. Lakeland (Reading, MA: Addison-Wesley, 1991), 85.

30. Nawal El Saadawi, cited in George Graham's article, "Pledge over Female Mutilation: World Bank and IMF Win Commitment by Burkina Faso," *Financial Times*, April 22, 1994.

31. O. Koso-Thomas, *The Circumcision of Women: A Strategy for Eradication* (London: Zed Books, 1987).

32. U. Megafu, "Female Ritual Circumcision in Africa: An Investigation of the Presumed Benefits Among Ibos of Nigeria," *East African Medical Journal* 40 (1983), 11.

33. Lightfoot-Klein, *Prisoners of Ritual*, 347.

34. M. Karim and R. Ammar, *Female Circumcision and Sexual Desire* (Cairo: Ain Shams University Press, 1985), cited in Hanny Lightfoot-Klein, *Prisoners of Ritual* (London: Haworth, 1989), 41.

35. Asma El Dareer, "Complications of Female Circumcision in the Sudan," *Tropical Doctor*, 13 (1983), 133.

36. A. A. Shandall, cited in Lightfoot-Klein, *Prisoners of Ritual*, 97.

37. "Female Genital Mutilation in Egypt," *Huqooq Al Insaan*, 4.

38. Figures for this table are from Dorkenoo and Elworthy, *Female Genital Mutilation*, 22.

39. Robert A. Myers, F. I. Omorodion, A. E. Isenabemhe, and G. I. Akenzua, "Circumcision: Its Nature and Practice Among Some Ethnic Groups in Southern Nigeria," *Social Science Medicine*, 21 (1985), 584.

40. B. Giorgis, *Female Circumcision in Africa* (U.S. Economic Commission for Africa, African Training and Research Center for Women, Addis Ababa, Ethiopia, 1981), 7, quoted in Esther K. Hicks, *Infibulation: Female Genital Mutilation in Islamic Northeastern Africa,* revised and expanded edition (New Brunswick, NJ: Transaction Publishers, 1996), 193.

41. Alice Walker, *Possessing the Secret of Joy* (Pocket Star Books, 1993); A. Walker and P. Parmar, *Warrior Marks: Female Genital Mutilation and the Sexual Binding of Women* (New York: Harcourt Brace, 1992).

42. David Kaplan, "Is It Torture or Tradition?" 124.

43. Ibid.

44. Dorkenoo and Elworthy, *Female Genital Mutilation*, 29.

45. Some commentators have drawn an analogy between slavery and FGC, arguing that just as slavery was a reprehensible practice and it would have been outrageous to suggest an alternative to its outright abolition, such an approach should also be rejected for FGC. This analogy is inapplicable here because slavery subjugates one group to another against their will, which is not the case for FGC. These procedures are uniformly carried out by women, regardless of the diversity of the groups that they occur in, with the consent, approval, and participation of the mothers of the female children.

46. Carol M. Ostrom, "Doctors at Seattle Hospital Consider Circumcising Muslim Girls," *News and Observer* (Raleigh, NC), September 29, 1996, 30A.

47. "Three UN Agencies Call for an End to Female Genital Cutting," *Boston Globe*, April 10, 1997, A29.

48. Celia W. Dugger, "Genital Cutting Embraced as a Rite of Passage in Some Cultures," *News and Observer* (Raleigh, NC), October 6, 1996, 21A.

49. "Female Genital Mutilation in Egypt," *Huqooq Al Insaan*, 15.

50. "Egypt Again Restricts Female Circumcisions," *News and Observer*, December 30, 1995, 11A. The remarks of Hassan al-Kallah, undersecretary of health, are pertinent: "People misunderstood us. They thought we are supporting the operation which is not true. We are against it, but we could not change the traditions of the society overnight. We are being attacked by people who did not understand Egyptian culture."

51. Dorkenoo and Elworthy, *Female Genital Mutilation*, 31.

52. Ibid.

53. Patricia Schroeder, "Female Genital Mutilation."

54. Christina Kent, "AMA Efforts Advance Ban on Female Circumcision: Culturally Sensitive Public Education Urged," *American Medical News*, October 28, 1996, 40.

55. The threat of the withdrawal of U.S. aid is thought to be a primary reason for the Egyptian government's reversal of allowing FGC to be performed in government hospitals ("Egypt Again Restricts Female Circumcisions," *News and Observer*).

56. There have been several attempts to view FGC as a violation of human rights in general and children's rights in particular. Even Efua Dorkenoo, the most outspoken African opponent of FGC, recognizes FGC does not neatly fit into the category of torture. It happens at home, is condoned by the family and community, and is culturally accepted. In a human rights context, it cannot be viewed as torture by authorities in power but only as citizen upon citizen abuse. See Efua Dorkenoo, *Cutting the Rose: Female Genital Mutilation, The Practice and Its Prevention* (London: Minority Rights Group, 1994), 70, quoted in Esther K. Hicks, *Infibulation: Female Genital Mutilation in Islamic Northeastern Africa,* revised and expanded edition (New Brunswick, NJ: Transaction Publishers, 1996), 3.

57. "Three UN Agencies," *Boston Globe*, A29.

58. *WHO Chronicle*, 40 (1986), 32.

59. Soheir A. Morsy, "Sex Differences," 602.

60. Omar A. Mohamud, "Female Circumcision and Child Mortality in Urban Somalia," *Genus* 47 (1991), 203–222.

61. Pamela Constantinides, cited in Slack, "Female Circumcision: A Critical Appraisal," 442.

62. Shaykh Abdel Ghaffar Mansour, cited in Barbara Crossette, "In Cairo, Please to Stop Maiming Girls," *New York Times*, September 11, 1994.