AMERICAN ACADEMY OF CLINICAL SEXOLOGISTS

A CLINICAL GUIDE FOR HEALTH PRACTITIONERS TO INTERACT IN A CULTURALLY SENSITIVE MANNER WITH PATIENTS WHO HAVE UNDERGONE FEMALE GENITAL MUTILATION

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DISSERTATION APPROVAL

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The final copies have been examined by the Dissertation Committee and the signatures which appear here verify the fact that any necessary changes have been incorporated and the dissertation is now given the final approval with reference to content, form and mechanical accuracy.

The dissertation is therefore accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy.

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To Mr. Sabroso,

Thank you for your endless support, love, and patience. I adore you!

They suffered, they cried… Why do we need to make it worse? This work is dedicated to all the girls and women who suffer, very often in silence, the personal violation, and pain of female genital mutilation and to those committed to their care and the relief of their suffering.

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ABBREVIATIONS

CDC	Centers for Disease Control and Prevention
ESARO	Eastern and Southern Africa Research Activities
FGC	Female Genital Cutting
FGM	Female Genital Mutilation
IAC	The Inter-African Committee in Traditional Practices Affecting the Health of Women and Children
PID	Pelvic Inflammatory Disease
RAINBO	Research Action and Information Network for the Bodily Integrity of Women
UN	United Nations
UNCHR	United Nations Commission on Human Rights
UNICEF	United Nations Children's Fund
WHO	World Health Organization

ABSTRACT

FGM is the traditional custom of ritually cutting the genitalia of women and girls, this practice persists primarily in Africa and among certain communities in the Middle East and Asia. It is one of the many harmful traditional practices that affect girls and women around the world.

Due to recent immigration patterns, providers of women's health care, and in particular obstetrician-gynecologists, have increasingly encountered patients who have undergone female genital mutilation.

It is common for women seeking medical care to be subjected to feelings of intimidation, humiliation, and exposure due to the lack of experience, cultural sensitivity, and understanding from our health care system.

This research serves as a clinical guide for health practitioners on how to interact in a culturally sensitive manner with patients who undergone FGM. This guide will facilitate the clinical encounter and promote effective communication with these patients. It will furnish health care providers with an informational background in the social and cultural meanings of FGM; provide information on culturally sensitive counseling, education, and outreach and inform about legal concerns in the United States and the legal risk involved in caring for genitally mutilated women, including requirements for reporting to authorities and counseling the patient about the law. The special concerns of adolescents and children will also be addressed.

INTRODUCTION

> “The little girl, entirely nude is immobilized in the sitting position on a low stool by at least three women. One of them has her arms tightly around the little girl's chest, two others hold the child's thighs apart by force, in order to open wide the vulva. The child's arms are tied behind her back and immobilized by two other women guests.... Then the old woman takes her razor and excises the clitoris. The infibulation follows: the operator cuts with her razor from top to bottom of the small lip and then scrapes the flesh from the inside of the large lip. This nymphectomy and scraping are repeated on the other side of the vulva.
>
> The little girl howls and writhes in pain, although strongly held down. The operator wipes the blood from the wound and the mother, as well as the guests "verify" the work sometimes putting their fingers in... The opening left for the urine and menstruation blood is minuscule. Then the operator applies a paste and ensures the adhesion of the large lips by means of an acacia thorn, which pierces one lip and passes into the other. She sticks in three or four in this manner down the vulva ... Paste is again put on the wound. However, both applications are not sufficient to ensure the coalescence of the large lips; so the little girl is then tied up from her pelvis to her feet: strips of material rolled up into a rope immobilize her legs entirely. Exhausted, the little girl is then dressed and put on a bed.” (Dorkenoo, 1994 4)

Female genital mutilation refers to the culturally determined practice of ritually cutting off female's external genitals.

FGM covers a range of procedures, but in the great majority of cases it involves the excision of the clitoris and the labia minora. At its most extreme, the procedure entails the excision of almost all the external genitalia and the stitching up of the vulva to leave only a tiny opening. Whatever form it takes, it is a grave threat to their health.

The procedure was legally practiced by doctors in the United States until 1996 as a procedure to prevent masturbation, as a cure of many mental disorders, and as a means of controlling female sexuality. It is still common in many developing countries, some at rates

exceeding 95%.[1]

It is estimated that 130 million girls and women have undergone FGM. Approximately 2 million are subjected to this practice each year worldwide.[2]

The great majority of affected women live in sub-Saharan Africa, but the practice is also known in parts of the Middle East and Asia.

Today, women with FGM are increasingly found in Europe, Australia, New Zealand, Canada and the United States of America, largely as a result of migration from countries where FGM is a cultural tradition.[3]

According to the Centers for Disease Control and Prevention (CDC), an estimated 168,000 women and girls in the United States had either undergone FGM or were at risk for FGM in 1990. Of these, 48,000 were girls younger than 18 years old.[4]

Because of recent immigration patterns, providers of women's health care, and in particular obstetrician-gynecologists, have increasingly encountered patients who have undergone female genital mutilation.

For most obstetrician-gynecologists and other medical and mental health care providers, female genital mutilation is an unfamiliar and foreign cultural practice that evokes visceral responses and/or curiosity. As a result, most patients, to avoid being subjected to judgmental reactions, do not pursue even cursory treatment. It is common for women seeking medical care to be subjected to feelings of intimidation, humiliation, and exposure.[5]

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[1]Hanny Lightfoot-Klein, *Secret wounds* (New York: Harrington Park Press, 2002), 23.

[2]Nahid Toubia, *Caring for women with circumcision: a technical manual for health care providers* (New York: Research, Action and Information Network for the Bodily Integrity of Women (RAINBO), 1999), 12.

[3]Ibid.

[4]ACOG, *Slide-lecture kit, Female Circumcision/Female Genital Mutilation: Clinical Management of Circumcised Women* (Washington, D.C., 1999).

[5]Hanny Lightfoot-Klein, Interview by the author, telephone interview, Miami, FL. 23 January 2007.

> "Women have reported that one of the most traumatic experiences they have had was during a pelvic examination by a health provider unfamiliar with the practice, they were found to be excised; and when the health provider called in the rest of the staff to look at her mutilated genitals." (WHO, 2000)

It is incumbent upon the medical and mental health community to develop an understanding of this practice in order to provide optimal and compassionate health care, examinations, and interventions to affected women.

The complications of FGM – physical, psychological, and sexual – require skilled and sensitive management by health care workers, yet FGM is rarely mentioned, let alone covered in detail, in the training curricula of sexologists, gynecologists, nurses, midwives and other health professionals. This research is committed to filling these gaps in professional education by producing a range of training materials to build the capacity of health personnel to provide quality care for women who undergone FGM.

These materials are dedicated to all the girls and women who suffer, very often in silence, the personal violation, and pain of FGM and to those committed to their care and the relief of their suffering.

The Chapter 1 looks at female genital mutilation as a practice, including the terminology, definition, the history, culture, and prevalence.

The Chapter 2 describes the types of mutilation with their specific procedures and reasons.

The Chapter 3 contains a description of the effects of FGM. It includes the physical, psychological/psychosocial, and sexual aspects. Some cultural variables affecting the moral assessment of the practice is also discussed in this chapter, to bring the awareness of the harmful role of culturally biased assessment and diagnosis to the patient's treatment.

The Chapter 4 describes US laws on FGM and its legal risks. It discusses defibulation and re-infibulation issues; and how to counsel the patient on the law.

Chapter 5 presents the cross-cultural competence in health care.

Chapter 6 presents techniques and considerations for providing quality and sensitive health care to woman and girls with FGM complications.

The Chapter 7 provides counseling guidelines for nurses, midwives, mental health care providers and other medical professionals who work with this population.

Chapter 8 concludes the research.

CHAPTER 1

FEMALE GENITAL MUTILATION: UNDERSTANDING THE PRACTICE

Terminology

Female genital mutilation is a term used to describe a spectrum of surgical excisions of the female genitalia, for cultural or other non-therapeutic reasons. There have been many debates about the terminology used to describe this practice. In some cases, the term female circumcision is used as opposed to female genital mutilation. There has been much misinformation perpetuated through the use of different terms but what is absolutely clear that in medical terms what is described in this chapter is mutilation rather that the softer concept of circumcision. Gerard Zwang, author of Mutilation Sexualles Feminines, defines this point noting that:

> "Any definitive and irremediable removal of a healthy organ is a mutilation. The female external genital constitutes the vulva, which comprises the labia majora, the labia minora, or nymphae, and the clitoris is covered by its prepuce, in front of vestibule to the urinary meatus and the vaginal orifice. Their constitution in female humans is genetically programmed and is identically reproduced in all the embryos and in all races. The vulva is an integral part of the natural inheritance of humanity. When normal, there is absolutely no reason, medical, moral, or aesthetic, to suppress all or any part of exterior genital organs." (Dorkenoo, 1994 4)

The use of the word *mutilation* reinforces the idea that this practice is a violation of the human rights of girls and women, and thereby helps promote national and international advocacy towards its abandonment. At the community level, however, the term can be problematic. Local languages generally use the less judgmental *cutting* to describe the practice; parents

understandably resent the suggestion that they are mutilating their daughters. In this spirit, in 1999, the UN called for tact and patience regarding activities in this area and drew attention to the risk of *demonizing* certain cultures, religions and communities. As a result, the term *cutting* has increasingly come to be used to avoid alienating communities.[6]

In this dissertation, the term *mutilation* was chosen following the medical terminology.

The cultures and the prevalence

There are substantial bodies of evidence that support the fact that wide variations of mutilations are performed on the normal female vulva in many different countries.[7]

In order to best understand FGM, it is imperative to take into the account the cultural background and complexities of the social systems where this practice is performed. Awa Thiam, the noted Senegalese writer and activist, maintains that female genital mutilation in a variety of forms is practiced in the Middle Eastern countries such as Yemen, Saudi Arabia, Iraq, Jordan, Syria, the United Arab Emirates, and Oman, and in more than twenty countries in Africa. It is also practiced among Muslim populations in Indonesia, Malaysia, and Melanesia.[8]

The practice is not solely confined to the Eastern Hemisphere of the globe. FGM is also practiced in North America, Latin America and in some countries in Europe. In the United States, FGM was practiced from the 1890s to the 1930s as a cure for masturbation and as a means of controlling female sexuality.[9]

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[6]Dorkenoo, *Cutting the Rose: Female Genital Mutilation: The Practice and its Prevention*, 1994. 4.

[7]Ibid., 5.

[8]Ibid., 461.

[9]Hanny Lightfoot-Klein, *Secret wounds* (New York: Harrington Park Press, 2002), 20.

The first publicized case of FGM in the United States dates back to 1986 in Atlanta, Georgia. A nurse was charged with child abuse for severing the clitoris of her two-year-old niece.[10] Today, in the United States, FGM is performed among some immigrant populations who seek to maintain their culture in a foreign land. The Center for Disease Control has estimated that the primary locations with populations at risk for female genital mutilation include 12 states: New York, California, Texas, New Jersey, Maryland, Florida, Illinois, Georgia, Virginia, Pennsylvania, Ohio, Massachusetts, and the District of Columbia.[11]

FGM is performed also in Canada. Recently, several doctors in the Toronto area, where a large Somali community resides, have reported to the College of Physicians and Surgeon of Ontario that they have been approached by patients to have the procedure performed. There are no specific laws in Canada that state that female genital mutilation is illegal. In April 1994, Justice Minister Allan Rock announced that legislation on FGM would not be introduced because the procedure is already banned under the Criminal Code. Regardless, the College of Physicians and Surgeons in Ontario, British Columbia and Alberta have felt the specific need to ban female genital mutilation after receiving inquiries from doctors who were approached by their patients to have the procedure performed. [12]

The practice has also been traced in Eastern Mexico, Peru and Brazil. It has been reported that an Amerindian tribe known as the Conibos, in north-eastern Peru, perform circumcision in the following way:

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[10]Ramsey Meserak, *Cruel Traditions* (n.p., 1992), http://www.forwardusa.ore/CruelTrad. html. FORWARD USA, 2

[11]Posterski, Don, ed. Female Circumcision in Canada - Context Research to Make Religion Relevant. January 1995. 5.

[12]Ibid.

> "As soon as a girl has attained maturity, a feast is arranged, in which mashato, an intoxicating drink brewed from manioc roots, plays a large part. The girl is made insensibly drunk and then subjected to the operation. An old woman, in the presence of a roaring tribe, performs it with a bamboo knife while the girl lies stretched out on three posts. She cuts around the hymen from the introitus vaginae, severs the hymen from the labia, at the same time exposing the clitoris. Then she paints the bleeding parts with medical herbs and after a while introduces into the vagina a slightly moistened penis made from clay which conforms exactly in size and in shape to that of the betrothed." (Abdalla, 1982 73)

It seems that from the descriptions, the vagina is forcibly opened to ensure easier penetration for the penis. In most cases the clitoris is not removed, nor are the girls sewn up to ensure virginity, but the intention to secure domination of women's sexuality is clear.

In Europe, FGM is also known to be practiced among some immigrant groups in such countries as England, France, Germany Norway and Sweden. Women in Sweden have recently been shocked by accounts of mutilations performed in Swedish hospitals on daughters of certain immigrants. In France, women from Mali and Senegal are reported to bring an excisor to France once a year to operate on their daughters in their apartments. In the last decade, reports appeared in the British press that excision for non-medical reasons had been performed in a London private clinic.[13]

In Germany, before 1995, the subject of FGM was largely unknown. One reason was that the issue was specifically excluded from the work of major aid organizations because they did not want to interfere with the culture, religion, and traditions of other nations. This view is slowly changing.

Whether at UNICEF, Terre des Femmes, or Amnesty International, female genital mutilation is becoming an increasingly important issue. Even though it was being practiced

[13]Elworthy, Scilla. Female Circumcision, Excision, and Infibulation: The Fact and Proposals for Change, London: Minority Rights Group, 1992. 6.

among immigrant populations in Germany, the human rights violation of female genital mutilation became known to a large part of the German population for the first time in 1995, as a result of media reports of the World Conference on Women in Beijing. [14]

[14]Dennison, George C. et al. Sexual Mutilations a Human Tragedy. New York: Plenum Press. 1987 George C. n.p., 1987. 159.

CHAPTER 2

TYPES OF FGM

The World Health Organization (WHO) groups FGM into four categories.

1. Type I, clitoridectomy, involves removing the prepuce with or without excision of part or all of the clitoris.

2. Type II excision, removes the prepuce and clitoris together with partial or total excision of the labia minora.

3. Type III, infibulation, removes part or all of the external genitalia and stitches/narrows the vaginal opening. (In northwestern Nigeria infibulation is often performed after a clitoridectomy).

4. Type IV, unclassified, includes all other procedures such as pricking, piercing, or incising of the clitoris and/or labia; stretching 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 or herbs into the vagina to cause bleeding or for the purpose of tightening or narrowing it; and any other procedure that falls under the definition given above. [15]

In Islamic culture, Type I is also called Sunna, (*tradition*) meaning following the tradition of the prophet Mohammed. It is thought to be the type recommended by Islam.[16] It consists of removing only the tip of the prepuce of the clitoris, and is therefore, analogous to male

[15]World Health Organization, "Female Genital Mutilation," in *Fact Sheet no 241* (Geneva, June 2000, n.d.).

[16]El Dareer, and Asma, *Women Why Do You Weep? Circumcision and its Consequences* (London: Zed Books, 1982) 2.

circumcision. In some tribes this is accomplished by applying a heated piece of stone or pearl to the prepuce of the clitoris and burning it away.[17] In Arabic Type II, clitoridectomy or excision, is called khafd (*reduction* in Arabic); and Type III or infibulation, is also known as *pharaonic circumcision* because it was thought to be practiced in Egypt during the Pharaoh dynasties (2850—525 B.C.)[18]

The Inter-African Committee on Traditional Practices Affecting the Health of Women and Children (IAC) adds that pharaonic circumcision is also called Sudanese circumcision. IAC adds defibulation and re-infibulation as types of FGM. Defibulation is performed to allow intercourse or on a mother who is giving birth to enlarge the passage. According to IAC, the *gishiri* cut is performed when labor is prolonged. The traditional birth attendant cuts soft tissues with a knife to enlarge the vaginal orifice. The *angurya* cut is performed on infants to remove the hymen loop. This procedure is based on the belief that if the loop is not removed, it will continue to grow and seal the vaginal opening. Normally, the loop disappears a few weeks after birth. Re-infibulation is performed on women who have lost their infibulation. Young mothers after delivery or wives during a long absence from their husbands are re-infibulated.[19]

Infibulation/Pharaonic circumcision is the most extreme form of FGM, which causes the most damage to girls and women in the immediate and long term. It accounts for approximately 15 percent of all procedures. Infibulation involves the cutting of the clitoris, labia minora, labia majora and the prepuce. The two sides of the vulva are stitched together with silk or catgut

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[17]Ibid., 2.

[18]Edvige Bilotti, *The Practice of Female Genital Mutilation* [book on-line] (Milano, Italy: Mediterranea Media, 1996); available from http://www.medmedia.org/review/numero3/en/art2.htm; Internet.

[19]Inter-African Commitee on Traditional Practices Affecting the Health of Women and Children, *Report on the Regional Seminar on Traditional Prectices Affecting the Health of Women and Children in Africa* (Geneva: African Committee, Inter, 1990).

sutures, or thorns. A small opening is left for the passage of urine and menstrual blood. The girl's legs are bound together from hip to ankle and she is kept immobilized for forty days to permit the formation of scar tissue over the wound. In some communities, there is no stitching. To facilitate healing, the raw edges of the wound are brought together by adhesive substances such as eggs, sugar, or acacia tar and the girl is kept immobile. In rare cases, animal excreta are placed on the wound. Some tribes in Western Sudan have placed animal excreta on the wound. [20]

The procedure of female genital mutilation is carried out with various types of sharp instruments. Special knives, which are used amongst some tribes in Mali; kitchen knives; razor blades known as *Moos el Surfa*; broken glass; scissors, and on rare occasions, sharp stones have been reported to have been used in eastern Sudan. Burning or cauterization is practiced in some parts of Ethiopia. Fingernails have also been used in The Gambia to pluck out the clitoris of young female babies. [21]

These instruments are rarely sterilized before the operation is performed. As a result, much unintended damage is caused. Also, anesthetics and antiseptics are rarely used in the process. Only on very few occasions is the operation performed in a medical clinic; then a scalpel used and anesthesia administered.[22] Once the external genitals are removed, mixtures made of herbs; local porridge, ashes and animal dung are rubbed into the wound to stop the bleeding.

In the majority of the countries where it is practiced, female genital mutilations are performed in the villages by women in the roles that are traditionally ascribed: local midwifes,

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[20]Dorkenoo, *Cutting the Rose: Female Genital Mutilation: The Practice and its Prevention*, 1994. 5.

[21]Ibid., 8.

[22]Slack, Allison. *Female Circumcision* (Human Rights Quarterly, Volume 10 Number 4. November: 1988), 442.

known as *Daya* in Egypt and Sudan, or by elderly women known as *Gadda* in Somalia. Most men are seldom present during the operation. In Mali, Senegal, and Gambia, it is traditionally performed by a woman of the blacksmith's caste gifted with knowledge of the occult. In The Gambia they are referred to as *ngansingbas*.[23]

In northern Nigeria and Egypt, barbers also carry out the task, but usually, it is performed by a woman, rarely by the mother. Today, in urban areas, female genital mutilation is performed in hospitals or in private by Western trained doctors, nurses, and midwives. [24]

The World Health Organization took a stance on the medicalization of FGM, in 1982. It issued a statement condemning the procedure being performed by medical health professionals under any circumstances. In 1993, in the United Kingdom, a doctor was struck off the medical register for misconduct for agreeing to perform female genital mutilation. [25]

The age at which girls are mutilated varies both geographically and ethnically. The mutilations are performed on newborns in tribes in Mauritania, Nigeria, and Ethiopia and among the nomads in Sudan. It is commonly performed on pre-pubescent girls; on women on their wedding night in Kenya and Tanzania; on widows in the Darasa ethnic group in Ethiopia; and on women who have had their first child. FGM is so deeply rooted that in some cases if a non-mutilated woman dies, relatives may insist on performing the procedure before burial. [26]

Most experts maintain that the age at which FGM takes place is falling, indicating a weakening of the link to initiation into adulthood. To illustrate this point, some refugees seeking

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[23]Dorkenoo, *Cutting the Rose: Female Genital Mutilation: The Practice and its Prevention*, 1994. 9.

[24]Ibid.

[25]Ibid., 10.

[26]Ibid., 12.

asylum in North America and Europe have mutilated girls at a younger age than customary, before leaving, so as to overcome legislative pressures against FGM in their new countries. In Australia in 1993, two sisters, both under the age of three, were found infibulated. FGM is also practiced at an early age so as to avoid resistance by older girls.

Aminata Diop, a 23 year-old woman from Mali, fled her village to avoid being genitally mutilated and eventually sought asylum in France. While Aminata Diop was fortunate enough to escape being genitally mutilated, a twenty-two year-old woman who presently resides in Ohio, actually underwent the procedure. In an interview this young woman goes on to describe her experience stating:

> "The experience was just that, an experience. They call it a ceremony but I still don't see it as that. I was coming in from in the pool and going to take a shower. As I walked into the bathroom, I started to take a shower when my grandmother caught me off guard and walked behind me. Before I knew what was happening, my hands were tied behind my back. Now at this time I was told that I was going to become a woman. I knew what was going to happen next because my mom always told me a little about this when I was six or seven. Before I knew it, I was asked to lay on my back.
>
> My father, who stood behind me, spread my legs apart and pulled them back to the side. Next I felt a deadly cutting from what I heard that took two to four minutes. I don't remember screaming for the pain was too sharp to do anything. The next part freaked me out the most. My grandmother who was doing the cutting called my father to come look. He rubbed his finger through it. All I remember was seeing blood on his right arm. When he pulled it up, my legs were pulled back and then they wiped and cleaned the area off with rubbing alcohol I think. Then my grandmother started sewing it up from the top only leaving a quarter at inch at most. I don't remember anything until the next day when I woke up in my bed. My arms were still tied but now my legs were free. Later my grandmother came in and told me that my mother would be proud. My mother was shocked. She did not want this to happen because it happened to her. She could not have done anything because she was out of town."[27]

[27]Melisa Wright, *Rites vs. Rites: The case of Female Genital Mutilation.* (Canada: Arcadia University, 1996), 22.

According to Professor Patroba Ondiek, Ph.D., Program Coordinator for Save the Children of Tarime, (Sachita) Tarime, who has worked extensively with FGM and after he has traveled in countries that performed Type III. He concludes that, "Type III is the most terrible," and says it is done in Somalia, Mali, Nigeria, and Ethiopia. He observes, "This is too much. I do not know what they want this lady to do. Why did they do that? It's only for urine, that's all they have left." Rachel Carnegie, Consultant, United Nations Children's Fund (UNICEF) Eastern and Southern Africa Research Activities (ESARO), explained the suffering when Type III is performed:

> "Sometimes the girl's legs are bound together for several weeks so that she cannot move, to allow the wound to close if the vulva does not heal properly or the opening is thought to be too big, the girl may be operated on again. Later in life, the woman may need to be cut again in order to have sexual intercourse. When it comes to childbirth, she will need to be cut to allow the baby out." (Skaine, 2005 10)

One of the studies by the UNIEF and ESARO reported in 1999 highlights the relationship between types of FGM and the likelihood of associated complications such as obstructed labor. The study surveyed 21 clinics in rural Burkina Faso and four rural and four urban clinics in Mali. Ninety-three percent of the women in Burkina Faso and 94 percent in Mali had undergone cutting. In Burkina Faso about half had had a clitoridectomy, and in Mali about three-fourths had undergone excision. About five percent of both samples had undergone infibulation. Those women who were infibulated were almost two-and-a-half times more likely to have complications than those women who had excision or clitoridectomy. [28]

[28]Skaine, Rosemarie. *Female genital mutilation: legal, cultural, and medical issues* (Jefferson, N.C.: McFarland, 2005), 10.

Difference Between Male and Female Genital Mutilation

In examining the procedures of female genital mutilation, the most frequent question that arises is what is the difference between female and male circumcision? The practice of female genital mutilation, which many Westerners regard as barbaric and irrational, has its parallels throughout history in secular male circumcision as practiced in North America and Europe.

The first difference found in these two sexual mutilations is the fact that unlike FGM, male circumcision is usually performed in hospitals on the second or third day after birth, by trained physicians before the mother and infant are discharged from the hospital. FGM on the other hand, is usually performed by local persons who are not trained. [29]

Male circumcision remains an acceptable practice in North America, and parts of Europe because it is thought to have hygienic benefits and it is considered minor surgery with no long-lasting physical and/or psychological effects. However, FGM, in many cases, goes far beyond this.

Excision and infibulation both involve the removal of the skin, flesh, and nerves responsible for genital stimulation, to refer to them as *circumcision* invites an inaccurate comparison to male circumcision[30]. As Hosken remarks:

> "While the male operation removes a small piece of skin that has few nerves, the female operation correctly called excision, removes the entire organ of the clitoris, and frequently, adjacent structure, often damaging arteries, the urethra, the perineum, and even the rectum."

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[29]Dorkenoo, *Cutting the rose: female genital mutilation: the practice and its prevention*, 12.

[30]Hosken, Fran P., *Stop female genital mutilation: women speak: facts and actions* (Lexington, Mass.: Women's International Network News, 1995), 1.

Hosken, in fact, suggests that if excision and infibulation are the female equivalent of a genital operation performed on males, it is not circumcision but castration. [31] But this is not entirely accurate either, for although the vulva and clitoris may be the physiological equivalents to the penis, castration implies the removal of one or more of the reproductive organs (for a woman: the ovaries. uterus and vagina) while, for a genitally mutilated woman, these are all left intact. This is not to imply that the consequences of the female form of excision are not more serious than the male form. On the contrary, by forcibly preventing the loss of virginity of an unmarried woman and by permanently altering her sexuality to make it purely reproductive, excision and infibulation are psychological as well as physical manipulations. FGM is an attempt to control a woman's sexual identity and to model a woman's purity, duty or nobility on her ability to procreate (ovulate, be penetrated, and give birth). Female genital manipulations are potentially reprehensible. [32] The effects of FGM will be explored in the subsequent chapter.

Rites and Reasons

FGM have different functions and meanings including the control over female sexuality and the maintenance of patriarchy. As much as some cultures feel compelled to create universal laws to eradicate it, we must first understand its importance and the degree to which this practice is embedded in the cultural context in which it occurs. Female Genital Mutilation is

[31]Hosken, Fran P., *Stop female genital mutilation: women speak : facts and actions* (Lexington, Mass.: Women's International Network News, 1995), 1.

[32]Kate Bouleware-Miller, *Female Circumcision: Challenges to the Practice as a Human Rights Violation.* (n.p.: Harvard Women's Law Journal. Volume 8, 1985), 172-4.

practiced in mainly traditional patrilineal, closed societies where women possess limited rights and are assigned a subordinate role under male control.[33]

> "Patriarchy is based upon the principle of the dominance of the father over the mother with respect to the parentage of the children and by the extension, the primacy of the male in human society which implies the subordination of the female." (Dorkenoo, 1994 35)

Women are defined in terms of their own patrilineage and that of their husbands. Polygamy is common in many of these cultures and women have little or no right to ownership and inheritance, while being relegated to authority of their fathers, brothers and husbands. As a result of the traditional patrilineal society assigning women a subordinate role, women feel unable to oppose community dictates, even when these affect them adversely. Women championing many of the cultural practices adopted by their communities do not realize that some of the practices they promote were designed to subjugate them and more importantly, to control their sexuality while at the same time maintaining male chauvinistic attitudes in respect to marital and sexual relations. [34]

The consequence of this is that in the mid 1980s when most women in Africa have voting rights and can influence political decisions against practices that affect their health, they continue to uphold the dictates and mores of the communities in which they live. They seem to regard traditional beliefs as inviolable.[35] It is only among the educated in the urban areas that women are becoming aware, from outside sources, that other opinions exist. Once they become more knowledgeable about this practice in terms of the effects and consequences of FGM, a sense of

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[33]Efua Dorkenoo, *Cutting the Rose: Female Genital Mutilation: The Practice and its Prevention* (London, UK: Minority Rights Group, 1994), 34.

[34]Olayinka Koso-Thomas, *Circumcision of Women: a Strategy for Eradication* (Atlantic Highlands, N.J., USA: Zed Books, 1987), 1.

[35]Ibid.

outrage is noticed. This is where they encounter repressed rage, the rejection of the feminine role that was assigned to them in their communities, and the rejection of sexuality. It is at this point that a woman must grapple with the realization that she has been not only a non-consenting victim, but also an uninformed and un-consulted one.[36]

Also, the practice of FGM is closely linked to virginity, chastity, and fidelity, which are considered pre-requisites for marriage in FGM practicing societies. Thus, it has been documented that women, because of this, undergo FGM in order to be eligible for marriage. This is because, within these communities, marriage and motherhood are the only attainable status for young women and marriage provides women with a path to social and economic survival and advancement. A bride price can not be obtained if the girl has not been genitally mutilated and is not pure. A woman's status is increased in marriage, especially as the bearer of sons for the purposes for inheritance. In recent times, however, African feminists have started to question the bride price as human rights issue and have called for its abolition. [37]

If the girl is found not to be genitally mutilated and not a virgin, the husband to be has the right to reject her and to reject the marriage. A young Somali woman describes what commonly occurs on the day of the wedding:

> "Women from the groom's family visit and examine the bride. They check to ensure that infibulation has been done and that she is a virgin. The genital area should be as smooth as the palm of one's hand. To make intercourse easier, the vulva may be cut open slightly. Otherwise, the groom widens the opening with his penis which is painful for the bride and the groom. On the wedding night, a cloth is placed under the bride's genital area. After intercourse, the cloth is displayed to the members of the groom family as proof of the bride's virginity. Having too large an opening can be grounds for divorce. If the groom refers to the sexual experience as 'falling into a ditch' he may annul the marriage the next day" (Dorkenoo, 1994 48)

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[36]Ibid.

[37]Dorkenoo, *Cutting the Rose: Female Genital Mutilation: The Practice and its Prevention*, 1994. 35.

Many men adhere to this belief. In the movie, Fire eyes[38] many of the men interviewed maintained that they did not wish to marry an uncircumcised woman which accentuates a woman's active support of this practice. As long as women derive economic security and survival from their roles as wives and mothers, they will continue to defend this practice. In this context FGM is viewed as a license to marry.

In rural Africa, illiteracy perpetuates the continuance of this practice, thus compounding their powerlessness. The majority of women in these societies lack education and training. As a result, many women must rely on the interpretations and words of men in processing and understanding the information they receive. Those who have a vested interest in maintaining the status quo have relied on the ignorance of women to allow certain religious convictions and interpretations to be accepted without question. Women are rarely asked for their opinion, and their contribution to society is hardly acknowledged, except when women in these societies threaten the status quo. [39]

Common to cultures that practice FGM is the importance placed on the family unit and the protection of the family honor. Despite various regional and cultural differences, the family form, which is the most common, is the extended family system where several generations of the family live together. This usually includes the patriarch, the father, who is the head of the family, and is revered. The extended family has close ties and members are very supportive of each

[38]This powerful film is the first to present an African viewpoint on a culturally explosive issue. Somali filmmaker Soraya Mire knows firsthand about the traditional African practice of female genital mutilation. At thirteen, she was subjected to it and spent the next twenty years recovering physically and emotionally from its cruel legacy. In this video, several women who have been subjected to this rite of passage voice varying points of view on perpetuating the practice. Testimony Corn doctors detail the various forms of female circumcision and the horrendous ob/gyn problems that result. Date: 1994, Color, 60 minutes, Filmmakers Library)

[39]Slack, Allison. *Female Circumcision*. November: Volume 10 Number 4. Human Rights Quarterly, 1988. 446.

other. The extended family serves as the social security for all members of the family. When discussing the relationship of FGM and the family, the concept of family honor must be included. The concept of family honor prevails strongly in the Middle East, northern Sudan, Djibouti, Egypt, and the Horn of Africa.[40]

Family honor is maintained by conforming to specific norms of behavior. When an individual deviates from these norms, the family, not the individual is shamed. Family honor depends on the behavior of the woman. Women who do not adhere to the codes of behavior of the family, not only threaten the reputation of the family but they also put their own life at risk. Once a woman's honor is lost, it cannot be restored. In Muslim society, men are economically, morally and legally responsible for the women of their kinship. Since Muslim men are supported by religious and legal systems in their responsibilities to women, the authority to impose upon women whatever sanctions they deem necessary to protect the reputation of the family. [41]

Economics is another reason cited for the continuation of FGM in these societies. In many communities, women's access to land and to economic resources is through the male members of their family and husbands. This implies that they are unable to directly inherit land or be in control of major resources especially outside midwifery and the safe of small craft items. FGM is seen as an irreplaceable source of revenue for excisor, who are mainly women. In some societies in which FGM is strongly embedded in the culture, the role of circumciser is the highest possible status obtainable by women. An excisor who receives money for her services contributes to the village economy. One can see that women who rely on FGM as a source of income will promote and perpetuate the practice.[42]

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[40]Dorkenoo, *Cutting the Rose: Female Genital Mutilation: The Practice and its Prevention*, 1994. 47.

[41]Ibid., 48.

[42]Ibid.

The current economic aspect of FGM and excision is a modem development resulting from the advent of cash into traditional subsistence economies. The role of an excisor varies within different ethnic groups that practiced FGM. In Somalia, excisors are not respected, while in West Africa, they wield considerable power and have considerable status within traditional power structures. These communities regard attacks on these excisors as an attack on the respected older women in the community. [43]

Paradoxically, excisors are gatekeepers of traditional power bases for women called *secret societies* in West Africa. However, it may be difficult to understand how a power base for women could condone mutilation. It is easier to view this as a space for women within a wider male dominated society. Some anthropologists have interpreted this as a remnant of matriarchy. The evidence given is that when certain age groups undergo this procedure together, bonding and sisterhood develops which can last a lifetime.[44]

The practice of FGM in most societies is viewed in a functional aspect. It is surrounded by various ceremonies, celebrations and coming of age rituals. An excerpt from a young girl who has been circumcised:

> "I remember that day all too vividly. I was dressed up in my finest clothing and jewelry and paraded through the streets where singing, dancing, heavy drinking, and gifts from family and friends were presented to me to celebrate my newly attained womanhood status." (Koso-Thomas, 1987 27)

In communities where it is performed on girls in the same age groups, specific periods of the year are designated for the execution of FGM. In the Sudan, the time of year when FGM is practiced occurs usually after the harvest. Thus, it has become a focus for communities coming together to celebrate and reinforce their identity, giving a comprehensive element to the practice

[43]Dorkenoo, *Cutting the Rose: Female Genital Mutilation: The Practice and its Prevention*, 1994. 48.

[44]Ibid., 48-49.

of FGM. Today, however, many of the elaborate celebrations surrounding FGM have disappeared. This is due to the fact that girls are being circumcised too young to celebrate a rite of passage. Yet, despite the diminished nature of elaborate celebrations surrounding FGM, this practice still remains a common cultural tradition in many African societies. To avoid creating a social vacuum in these communities, campaigns for eradication will have to seek an alternative focus for celebration in the communities.[45]

The justifications of FGM are at first glance bewildering, at times conflicting, and always at odd with biological fact. This section of the chapter examines these justifications in detail because they are believed with such tenacity. The question that comes to mind then is why are they believed? Justifications for the practice of female genital mutilation can be categorized under five headings. These include: psychosexual, religious, sociological, hygiene/aesthetics and the need to maintain tradition that has been with these cultures for thousands of years. [46]

Psychosexual

Within the communities that practice FGM, there exists the widely held belief that women have an extensive sexual appetite and thereby need their sexuality controlled. The main reason given for the control of sexuality is to discourage promiscuity by reducing a woman's sensitivity and desire for sexual intercourse. In Islamic countries, there seems to be an implicit belief that a woman's sexuality is irresponsible and wanton and therefore must be controlled by men.[47] This is a contrast to male circumcision, which is in no way an attempt to inhibit or stifle

[45]Ibid.

[46]Ibid., 23-24.

[47]Slack, Allison. *Female Circumcision*. November: Volume 10 Number 4. Human Rights Quarterly, 1988. 445.

sexual pleasure, performance, ability, or desire. The control of a woman's sexuality is not a new concept. In ancient Roman times, rings were forced through a girl's labia and closed by wire or padlocks. Later the West incorporated chastity belts to control women's sexuality. In the same vein, clitoridectomy and ovariotomy were common solutions to women's perceived behavioral problems such as masturbation, obsessive eating, attempted suicide, hysteria and dysmenorhea.[48] Infibulation, which is the severest form of FGM, is mainly performed to secure a bride's virginity. According to a Somalian woman, it is the most effective means to keep a girl's virginity intact and as noted earlier, virginity is viewed in Africa as a prerequisite for marriage. A tightly sewn vagina reassures a woman's husband that he is the only man to have intercourse with her. In polygamous societies, FGM is beneficial to men. Men with several wives might find it impossible to satisfy the needs of all of their wives. Female Genital Mutilation diminishes a wife's pleasure and desire thus lessening the demands placed upon men to perform.[49]

Another dimension of the psychosexual dimension has to do with the beliefs surrounding FGM. These beliefs or myths run very deep and may appear to us Westerners as irrational and a sign of ignorance of biological, medical, and religious facts. African beliefs surrounding FGM have been dismissed as mere superstitions, whereas deeper analysis points to a complex set of ideas which underpin a social system. The following are few examples of such beliefs. The Bambara and Dogon tribes of Mali believe that: “When human beings first arrive in the world, they are both male and female and possess twin souls. The boy's female soul is in the prepuce or

[48]Dorkenoo, *Cutting the Rose: Female Genital Mutilation: The Practice and its Prevention*, 1994. 34.

[49]Scilla McLean, and Stella Graham, *Female Circumcision, Excision and Infibulation* (n.p.: The Minority Rights Group Report no. 47, 1985).

foreskin, the female element in the genitals, and the girls male's soul is in the clitoris the male element."[50]

According to the myth, adolescents can not be admitted into the adult world until they have been rid of the physical characteristics of the opposite sex. Hence the justification of male and female circumcision.

The Bambara also believe that the clitoris is poisonous and will kill a man if his penis comes into contact with it during intercourse. Similarly, the Mossi of Burkina Faso, believe that if a baby's head comes into contact with the clitoris during childbirth, it could cause the death of a baby. In some areas, notably Ethiopia and the Ivory Coast, people believe that if the female genitals are not excised, they will grow and dangle between the legs like a man's testicles and will grow to be the size of a penis.[51] Oliyinka Koso-Thomas points out that it is often argued that genital mutilation maintains good health in a woman. Evidence is often quoted of girls who were always sick, but after being mutilated became healthy. When circumcised women do fall ill, it is believed to be caused by supernatural causes. Moreover, genital mutilation is often been credited with healing powers. It is claimed to have cured women suffering from melancholia, nymphomania, hysteria, insanity and epilepsy as well as kleptomania. [52]

The psychosexual justification has some flaws. Any attempt to justify FGM on the basis of controlling the sexuality of girls and the perseverance of virginity is irrational. According to an interview conducted by Allison Slack of a Sudanese woman explained that her sexual

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[50]Hanny Lightfoot-Klein, *Prisoners of Ritual: an Odyssey into Female Genital Circumcision in Africa* (New York: Harrington Park Press, 1989), 38.

[51]Slack, Allison. *Female Circumcision*. November: Volume 10 Number 4. Human Rights Quarterly, 1988, 447.

[52]Hanny Lightfoot-Klein, *Prisoners of Ritual: an Odyssey into Female Genital Circumcision in Africa* (New York: Harrington Park Press, 1989) 39.

sensation and response had been substantially reduced due to her infibulation. She notes that "With the *Pharonic* (Infibulation), you can not really feel your man."[53]

A study of 200 prostitutes in the Sudan found that 170 of the women examined had been infibulated.[54]

A common justification for FGM is that it would guarantee a bride's virginity before marriage. In reality, it is possible to open a woman with a knife anytime and to be re-infibulated at any time. In many countries, circumcised women after giving birth have themselves re-infibulated so as to maintain the attraction of their husbands. It is also possible for an unmarried girl to have sexual intercourse and be re-infibulated. In this case, the loss of virginity would be hidden and her honor, as well as her family's, would be protected. [55]

The suggestion that death could occur during delivery if the baby's head touches the clitoris and that a man could die if his penis comes into contact with a non-mutilated women is false. So much evidence exists of normal, healthy delivery of babies from non-mutilated women and too much evidence that men who have had sexual intercourse with non-mutilated women are still alive, that no reasonable person who has knowledge of such evidence could accept this argument. Of the 300 men interviewed by Koso-Thomas in Sierra Leone area, 266 confessed that they enjoyed sexual intercourse more with non-mutilated women than with genially mutilated women. [56]

An examination of the belief that a mutilated woman is better equipped to maintain good health reveals some irrational elements. In practice, mutilated women rarely complain of their

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[53]Slack, *Female Circumcision*, 456.

[54]McLean and Graham, *Female Circumcision, Excision and Infibulation*, 45.

[55]Koso-Thomas, *Circumcision of Women: a Strategy for Eradication*, 11.

[56]Ibid.

ailments. Yet, the defenders of FGM seem to compare illnesses between non-mutilated and mutilated women. The problem with this argument is that there is such a substantial majority of genitally mutilated women in these communities that to find a greater number of ailments amongst the non-mutilated women would be virtually impossible. [57]

Religion

Excision and infibulation are practiced by followers of a number of religions including Islam. In Africa, FGM is performed by Christians including Catholics and Protestants. [58]

No evidence exists that supports FGM in the various religious texts; however, the practice of FGM has been interpreted to the people in FGM practicing communities. A number of studies reveal that the most common responses given for the justification of FGM involved the adherence to religion.[59] In some parts of Africa, the importance of being circumcised is emphasized by Islamic male religious leaders who reinforce genital operations by telling people they are demanded by the Koran, and have religious significance.[60]

Islam is the only religion that has incorporated this practice into its religious doctrine even though FGM is not mentioned in the Koran. It is carried out by some Muslim communities who are of the belief that it is demanded by the Islamic faith. The Muslim population of the Sudan provides a case in point. Communities in the Sudan are largely ignorant of the precepts of their own religion, and that Pharaonic type of FGM is to be included in the Koran demands. Islam's stem emphasis on chastity and its general suppression of sexuality have provided a fertile

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[57]Ibid.

[58]Dorkenoo, *Cutting the Rose: Female Genital Mutilation: The Practice and its Prevention*, 1994. 36.

[59]Slack, *Female Circumcision*, 446.

[60]Ibid.

ground for FGM. The Koran notes that “virginity is still considered the most precious possession of the unmarried woman.”[61]

According to Keba Kobt M.D., from Cairo, Egypt the Muslim believes on FGM comes from a misinterpretation of the Koran:

> “There is no mention of it in the Koran, and only a brief mention in the authentic hadiths, which states: A woman used to perform circumcision in Medina. The Prophet said to her: 'Do not cut severely, as that is better for a woman and more desirable for a husband.' But because of this still debated hadz'th, some scholars of the Shari school of Islam, found mostly in East Africa, consider female circumcision obligatory.” [62]

In Christianity, FGM is not mentioned in the Bible, but it is still practiced by Christians of all denominations. In the 17” Century Ethiopia, Roman Catholic missionaries attempted to discourage FGM, but found out that the number of converts quickly diminished. In Kenya in the 1920s, it has been documented that while the Scottish Presbyterian Church and Anglican Church were trying to stop FGM, the Roman Catholic Church did not dismiss it in efforts to avoid losing converts. In Kenya, the Protestant missionaries' attempts to stop FGM met with resistance and it became a political issue. The late President Jomo Kenyatta of Kenya, wrote in “Facing Mount Kenya” that no proper Kikuyu (Kenyan Tribe), would dream of marrying a non-mutilated girl. His successor, President Arap Moi abandoned this practice in Kenya in 1982. However, the most active Christian church in Africa campaigning against FGM is the Coptic Orthodox Church in Egypt. Furthermore, FGM does not have a strong religious basis in either Islam or Christianity. It is a fact that 80 percent of those in the Islamic world do not practice FGM, especially in Saudi

[61]Ibid.

[62]Keba Kobt, *Interview by the author, live interview* (Fort Lauderdale, Florida, November 11th, 2007, n.d.).

Arabia and Iran.[63] The religious argument is given by chauvinistic religious leaders who endorse the subjugation of women and has relied on the ignorance of their followers. Since many of the women in the communities that practice FGM are illiterate they have to rely on the interpretations of others, hence the misconception. [64]

> "It is important to note that neither the Bible nor the Koran subscribe to the practice of FGM, although it is frequently carried out by communities – especially Muslim communities – in the genuine belief that it is part of their religion." [65]

Sociological

Many scholars explain the practice in terms of the initiation rites of development into adulthood. In many areas, an elaborate celebration surrounds the event. Ceremonies are rich in symbolism and include songs, dance, and chants intended to teach the young girl her duties and the desirable characteristics of a good wife and mother. The event is rich in ritual with special convalescent huts for the girls attended by the instructors. In these huts the girls are isolated from the family and society until they emerge healed, as marriageable women, or in the case of very young girls, with gifts of clothing and food. [66] However, some aspects of the initiation rites are weakening. Assilan Diallo in her thesis entitled *"L 'Excision en milieu Bambara"* discovered in her research in ritual rites in Mali that these ceremonies have disappeared. She notes that the

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[63]Hanny Lightfoot-Klein, *Prisoners of Ritual: an Odyssey into Female Genital Circumcision in Africa* (New York: Harrington Park Press, 1989) 41.

[64]Ibid.

[65]World Health Organization, "Student's Manual," in *Female Genital Mutilation: Integrating the Prevention and the Management of the Health Complications into the Curricula of Nursing and Midwifery* (Geneva, 1998), 24.

[66]Dorkenoo, *Cutting the Rose: Female Genital Mutilation: The Practice and its Prevention*, 1994. 39.

traditional songs are no longer taught to the girls, and not one of her respondents received any instructions concerned with the initiation into adulthood.[67]

Also, FGM is weakening as an initiation rite because the cost of maintaining training programs is too expensive for most parents to afford. African women are beginning to question the content of what used to be initiation rites. They believe that it is in these initiation rites that the patriarchal ideology is strengthened thorough songs, speeches, and actions throughout the term in the initiation chamber. As long as the ceremonial aspect of female circumcision continues to decline, and girls continue to be circumcised at a younger age, the defense of FGM as a puberty rite loses its validity.[68]

Hygiene/Aesthetics

It is a measure of pride amongst many African women to be clean. In some countries such as Egypt, the Sudan, Somalia and Ethiopia, the female genitals are considered to be dirty due to the secretions produced by the clitoris; furthermore, the labia majora and minora are thought to be foul smelling and unhygienic leaving the female body unclean. In communities that require women to cleanse their genitals with soap and water after micturition, it is thought that the hands used to wash the genital area may become contaminated in food and water. Hence, the removal of the genital organs is used to promote cleanliness.[69] In Egypt an unexcised girl is called *nigsa* which means unclean. Thus, the genital body hairs are removed to attain a smooth and, therefore, clean body. The same sentiment exists in Somalia and Sudan where the aim of

[67]Assilan Diallo, *L'Excision en Mileu Bambara* (Bamako, Mali: Ecole Normale Superieure, 1984), 20.

[68]Dorkenoo, *Cutting the Rose: Female Genital Mutilation: The Practice and its Prevention*, 1994. 39.

[69]Koso-Thomas, *Circumcision of Women: a Strategy for Eradication*, 7.

FGM is to produce a smooth skin surface. Most women in these countries believe that the removal of genital hairs made them cleaner.[70]

This argument is comparatively justified with male circumcision. Since the prepuce or the foreskin is primarily removed for aesthetic reasons, it is believed that the clitoris, which is homologous to the penis, should be removed for the same reason. Men in some cultures consider uncircumcised female genitalia unpleasant to the sight and touch. This view is common amongst the Temnes, Madingos, Limbas and the Lokkos of Sierra Leone. A flat, smooth area of skin, without the fleshy encumbrances appears to these groups to be more pleasing to the sight and touch.[71]

Yet in practice, female genital mutilation has the opposite effect for the promotion of hygiene. Upon circumcision, urine and menstrual blood can not escape naturally thus increasing the discomfort, odor, and infection. There is no evidence that the clitoris produces a hormone or any other substance that emits an odor offensive enough to warrant its removal or the entire area around it. Similarly there are a number of glands in the body that produce offensive odors such as the sweat glands under the armpits. These odors can be eliminated when cleansed on a regular basis.[72]

Tradition

The dominant justification for the practice of FGM is the importance of tradition. In a questionnaire survey given in five rural communities in Nigeria, 280 men, and women were asked about their experiences with the practice and why the practice still exists. Amongst the

[70]Dorkenoo, *Cutting the Rose: Female Genital Mutilation: The Practice and its Prevention*, 1994, 40.

[71]Koso-Thomas, *Circumcision of Women: a Strategy for Eradication*, 7.

[72]Ibid.

different reasons cited, the dominant one had to do with tradition and the maintenance of tradition.[73] One reason why tradition was the prevalent answer has to do with the fact that traditions are firmly woven into the social fabric. Nayra Atiya interviewed five Egyptian women who spoke of female genital mutilation with a strong sense of compliance with tradition.

> "It is true that God created us this way, but when we woke up to ourselves, we found this custom handed down to us from our grandfathers and theirs from those of whom we are not even aware and those we no longer know. We emerged into this world and found this habit already existed. It's just so. My people do this, and so I must do like they do." (Slack, 1988 449)

The strength of tradition in FGM practicing societies has served as a power that helps to bind the community together and provide a source of cultural identity that is an important factor in rural communities. A study of the FGM in Somalia found that for the Somali woman, the excissory practice is an important factor in cultural identification even today.[74]

The concept of tradition as a means of support of FGM, have been argued from a standpoint that this is a practice which is deeply embedded in the FGM practicing communities and is sewn in the complex cultural system. Thus, it is believed that to eliminate this practice would be to impose Western cultural values on societies subject to political or economic domination thus disturbing the delicate cultural balance. FGM serves as a rite of passage and the abolition of such a practice could result in the abolition of an entire institution.

The power of traditional adherence to cultural practices can be seen in Western cultures as well. Male circumcision clearly illustrates this point. Many Westerners especially in the United States, have their sons circumcised ignoring the fact that the practice is unnecessary. This phenomenon shows a need to maintain tradition. The following quote emphasizes this point:

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[73]Slack, Allison. *Female Circumcision*. November: Volume 10 Number 4. Human Rights Quarterly, 1988, 448.

[74]Ibid., 449.

"when approved by a certain culture, ritual can become standardized, repetitive, and prescribed. That is, cultural rules command that the ritual be performed.[75]

In arguing that it is an inherent right to preserve tradition, many people belonging to cultures that still genitally mutilate women, maintain that it is their right of cultural self-determination to continue this tradition. In their view, they believe that it is wrong for outsiders to make ethical judgments about behavior in cultures other than their own. In defense of FGM, in Kenya, it is believed that: “it is unintelligent to discuss the emotional attitudes of either side, or to take sides in the question without understanding the reasons why the educated intelligent Gikuyu (prominent tribe in Kenya) still cling to this practice”.[76] These communities believe that the argument of cultural self- determination rejects Western liberal concepts of human rights and support non-Western ideas and beliefs. Jomo Kenyatta sums up this belief by noting that:

> "The overwhelming majority of the local people in Kenya, believe that it is the secret aim of those who attack this centuries old custom to disintegrate their social order and thereby hasten their Europeanization.” (Lewis, 1995 1-55)

The other side of the argument, human rights Universalists maintains that the fundamental human rights standards must apply across cultural and national boundaries in order to have force and meaning. Universalists argue that the international community has an obligation to protest human rights violations where ever they are perpetuated. [77] This belief provides the foundation of the international human rights system.

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[75]Ibid.

[76]Ibid., 463.

[77]Hope Lewis, “Harvard Human Rights Journal,” in *Between Irua and Female Genital Mutilation: Feminist Human Rights Discourse and Cultural Divide* (Cambridge, Massachusetts, 1995), 1-55.

From the Universalist human rights perspective, the primary ethical basis of universal concern about FGM is that it involves the infliction of great physical pain for women and children. This concern prompts the question of whether a society has the right to execute a tradition simply for the sake of tradition, even when it is dangerous or fatal. This question has raised many contradictions.[78]

In trying to reconcile the debate between universalism and cultural relativism, it would be remiss not to mention how other non-western cultures would perceive and judge western culture. One might ask if the West engages in any activity that is comparable to female genital mutilation. Of course, there are examples of comparable practices. Such comparisons are alterations to women's bodies for cosmetic purposes. How can we as Westerners condemn non-western societies that practice FGM, when we ourselves work hard to achieve the ideal of the perfect body and face by removing ribs to appear thinner, breast augmentation with saline substances to make breasts appear larger and noses to appear smaller? How would it be if Western women were told that their actions are barbaric or immoral or prohibited by law to undergo such operations? This argument can be refuted by maintaining that western women have a choice of whether they want their bodies augmented or put their health at risk in attempts to become thinner. When both sides of the argument are presented, it must be noted that the Western world is not without imperfections. This leads to the question of, at what point a practice should be considered dangerous enough to be a violation of human rights justifying external influence.[79]

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[78]Ibid.

[79]Ibid., 31-32.

While it is hypocritical to pass judgement on another culture, the tragic circumstances and effects of female genital mutilation cannot be ignored. Female Genital Mutilation severely affects the health and welfare of women who undergo this procedure.

The effects are so numerous that they have been utilized as arguments against the practice.

CHAPTER 3

THE EFFECTS OF FEMALE GENITAL MUTILATION

There are many effects of FGM, but they are mainly categorized into health or physical, psychological and sexual. The health effects are the most severe.

This is due to the fact that the women who have undergone the most severe forms of FGM are most likely to suffer from health complications for the rest of their lives. The severity of the problem depends upon the skill and eyesight of the excisor, the type of mutilation performed, the hygienic conditions under which the operation is performed and the health and co-operation of the child at the time of the genital mutilation.[80] Dr. Mark Belsey of the Division of Family Health, World Health Organization, Geneva, remarked in a 1993 documentary interview that "there is no single practice which has such dramatic negative effects on health in the broadest sense as female genital mutilation." [81]

Genital mutilation is commonly performed when girls are young and uninformed and is often preceded by acts of deception, intimidation, coercion, and violence by parents, relatives, and friends that the girl has trusted. Girls are generally conscious when the painful operation is undertaken as no anesthetic or other medication is used. They have to be physically restrained

[80]Koso-Thomas, *Circumcision of Women: a Strategy for Eradication*, 25.

[81]Dorkenoo, *Cutting the Rose: Female Genital Mutilation: The Practice and its Prevention*, 1994, 13.

because they struggle. In some instances they are forced to watch the mutilation of other girls, this can lead to psychological and psychosocial problems.[82]

Physical Aspect

Generally the health or physical problems related to FGM are divided into mainly two categories, immediate and long-term.[83]

I. Immediate

Severe pain due to the operation being performed with crude instruments and with out anesthetic. In medical settings where local anesthetic is available, it is difficult to administer it as the clitoris is a highly vascular organ with a dense concentration of nerve endings. Multiple painful injections are requires to anesthetize the area completely.[84]

Hemorrhage is the most common and unavoidable immediate complication. Amputation of the clitoris involves cutting across the high-pressure clitoral artery, which results in severe bleeding. Sudden blood loss has caused *hemorrhagic shock*, and in some cases, *neurogenic shock* where severe pain and massive loss of blood can be fatal. Hemorrhage can also result in long-term anemia. Other immediate complications include urinary infection, which can be contracted via two means. Infection could be caused by the unhygienic conditions, contamination of the

[82]World Health Organization, "Student's Manual," in *Female Genital Mutilation: Integrating the Prevention and the Managementof the Health Complications into the Curricula of nursing and Midwifery* (Geneva, 1998), 30.

[83]Ibid., 28.

[84]Ibid.

wound with urine/feces and the use of unsterilized instruments or crude tools. Infection can also be contracted by the traditional medicines used for healing the wound.

Many girls also experience *urinary infection* as a result of urine retention for hours or days. Urinary retention is caused because many genitally mutilated girls and women are afraid to pass urine on the raw wound.[85]

The practice of binding the patient's legs together after an infibulation may aggravate an *infection* by preventing the drainage of the wound. Thus, the infection may spread internally to the uterus, fallopian tubes and ovaries causing *chronic pelvic infection and infertility*. In a report on *Pelvic Inflammatory Disease (PID)* is one of the persistent clinical problems that face Sudanese gynecologists. It is reported that one-third of women reporting to gynecology clinics in Sudan, suffer from PID.[86] Infection may also include tetanus, which is usually fatal due to the use of unsterilized instruments. *Injury to the adjacent tissue of urethra, vagina, perineum, and rectum* can result from the use of those instruments, or because the operator is ignorant of the anatomy and physiology of the female external genitalia, has poor eyesight or a careless technique, or may be operating in poor light. Such injury is especially likely if the girl is struggling because of pain and fear.

Fracture or dislocation. Occasionally a girl's clavicle, femur, or humerous bones are fractured or dislocation of the hip joint can occur if heavy pressure is applied to restrain the struggling girl during the operation. It is common for several adults to hold a girl down during the mutilation.[87]

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[85]Hamid Rushwan, *Etiologic Factors in Pelvic Inflammatory Disease in Sudanese Women* (Khartoum: American Journal of Obstetrics and Gynecology, 1980), 138: 877-879.

[86]Ibid., 138: 877-879.

[87]World Health Organization, *Female Genital Mutilation: Integrating the Prevention and the Management of the Health Complications into the Curricula of Nursing and Midwifery*, 29.

D*elay in the healing of the wound*, which results from infection, anemia, and malnutrition. Other intermediate effects include *pelvic infection*, which is caused by an infection of the uterus and vagina. The most common form of intermediate complications is the formation of *dermatoid cysts* in the line of the scar. The vaginal duct's mucus secretion accumulates forming cysts, which later become infected and form *abscesses on the vulva*. The formation of *keyloids* is yet another disfiguring complication that not only leads to the production of excess connective tissue in the scar, but also it causes anxiety, shame and fear in women who think that their genitals are growing in monstrous shapes.[88]

II. Long Term Complications

Long term complications are associated with infibulation more than with clitoridectomy alone because of interference with the drainage of urine and menstrual blood. Long-term complications include *hematocolopos* in which the menstrual blood accumulates over many months in the vagina and uterus; infertility and recurrent urinary tract infection. A common bodily function like urinating can be a time consuming and painful experience for women. A woman who has been infibulated can take anywhere between fifteen and thirty minutes to empty her bladder. [89]

Clitoral neuroma. A painful neuroma can develop as a result of the clitoral nerve being trapped in a stitch or in the scar tissue of the healed wound, leading to hypersensitivity and dyspareunia.

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[88]Toubia, Nahid. Female Genital Mutilation: an Overview. Geneva, World Health Organization. September 29, 1998 article, 712.

[89]Ibid., 713.

Fistulae (holes or false passages) between the bladder and the vagina (vesico-vaginal) or between the rectum and vagina (recto-vaginal), can develop as a result of injury to the soft tissues during mutilation, opening up infibulation or re-suturing an infibulation, sexual intercourse or obstructed labor. Urinary or fecal incontinence can be lifelong and have serious social consequences.

Dyspareunia (painful sexual intercourse). This is a consequence of many of female genital mutilation because of scarring, the reduced vaginal opening, and complications such as infections. Vaginal penetration may be difficult or even impossible and re-cutting may be necessary. Vaginismus may result from injury to the vulval area and repeated vigorous sexual intercourse; the vaginal opening closes by reflex action, causing considerable pain and soreness.[90]

The most common long-term consequences are *problems in pregnancy and childbirth*. In the event of a miscarriage, the fetus may be retained in the uterus or the birth canal. Difficulties in performing an examination during labor can lead to incorrect monitoring of the stage of labor and fetal presentation. Tough scar tissue, which forms after genital mutilation, prevents dilation of the birth canal, and result in obstructed labor. Obstructed labor is hazardous and health consequences may be fatal for mother and baby. The mother will suffer lacerations and formation of the fistulas, as well as severe blood loss. The baby may suffer from neonatal brain damage or death as a result of the pressure of the baby's head on the posterior wall of the urinary bladder and the anterior wall of the rectum during prolonged labor.

[90]World Health Organization, *Female Genital Mutilation: Integrating the Prevention and the Management of the Health Complications into the Curricula of Nursing and Midwifery*, 30.

Deinfibualtion is necessary in order to allow the passage of the baby. Re-infibulation is often demanded by the husband and the woman concerned. Repetition of de-infibulation and re-infibulation weakens scar tissue.[91]

A recent phenomenon that concerns gynecologists of women who were infibulated is the *transmission of HIV and the exposure of AIDS*. The United Nations Development Program identified this as a health risk. The risk of HIV transmission may be increased for women who have undergone the procedure of FGM due to scar tissue, and the small vaginal opening prone to laceration during sexual intercourse or as a result of anal intercourse due to inability to penetrate the vagina. HIV may also be transmitted when groups of children are simultaneously mutilated with the same instrument.[92]

Psychological and Psychosocial effects

Genitally mutilated women also suffer from psychological problems. In contrast to the numerous studies and case reports on the physical effects of FGM, little scientific research is available on the sexual and psychological effects of FGM. It is evident that severe pain can result in deep psychological wounds, leaving painful memories and emotional scars. Nahid Toubia, maintains that during her clinical experience in Sudan many infibulated women have a syndrome of chronic anxiety and depression arising from worry over the state of their genitals, intractable

[91]Toubia, Nahid. Female Genital Mutilation: an Overview. Geneva, World Health Organization. September 29, 1998 article, 713.

[92]World Health Organization, *Female Genital Mutilation: Integrating the Prevention and the Management of the Health Complications into the Curricula of Nursing and Midwifery*, 17-19.

dysmenorrhea, and the fear of infertility. Her observations also confirm that many women feel a sense of a loss of trust and confidence in those that are caregivers, especially their mother.[93]

For some girls, as mentioned before, mutilation is an occasion marked by fear, submission, inhibition, and the suppression of feelings. The experience is a vivid *landmark* in their mental development, the memory of which never leaves them. Some women have sometimes reported that they suffer pain during sexual intercourse and menstruation that is almost as bad as the initial experience of genital mutilation. They suffer in silence. In Sudan an official day off from work every month is given to women to deal with the menstrual problems.[94]

Women and girls are ready to express the humiliation and fear that have become part of their lives as a result of enduring genital mutilation. Others find it difficult or impossible to talk about their personal experience, but their obvious anxiety and sometimes tearfulness reflect the depth of their emotional pain.

Girls may suffer fear of betrayal; bitterness and anger at being subjected to such an ordeal, even if the receive support from their families immediately after the procedure. This may cause a crisis of confidence and trust in family and friends and that may have long term implications. It may affect the relationship between the girl and her parents, and may also affect her ability to form intimate relationships in the future, even perhaps with her own children.[95]

For some girls and women, the experience of genital mutilation and its effect on them psychologically are comparable to the experience of rape.[96]

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[93]Toubia, Nahid. Female Genital Mutilation: an Overview. Geneva, World Health Organization. September 29, 1998. Article, 713.

[94]World Health Organization, *Female Genital Mutilation: Integrating the Prevention and the Management of the Health Complications into the Curricula of Nursing and Midwifery*, 31.

[95]Ibid.

[96]Ibid.

The experience of genital mutilation has been associated with a range of mental and psychosomatic disorders. For example, girls have reported disturbances in their eating and sleeping habits, and in mood and cognition. Symptoms include sleeplessness, nightmares, loss of appetite, weight loss or excessive weight gain, as well as panic attacks, difficulties in concentration and learning, and other symptoms of post-traumatic stress. As they grow older, women may develop feelings of incompleteness, loss of self-esteem, depression, chronic anxiety, phobias, panic, or even psychotic disorders. Many women suffer in silence, unable to express their pain and fear.[97]

Girls who have not been excised may be socially stigmatized, rejected by their communities, and unable to marry locally, which may also cause psychological trauma.[98]

Psychosexual

Some reports maintain that women fear the act of sex, experience pain from sex and receive little or no physical pleasure during sex. An interview with a young 22-year-old girl who was circumcised at age 14 adds light to this point. She noted that:

> "I am afraid to enter in a relationship with a guy because I don't want to scare him away and I don't know if he would understand." (Dorkenoo, 1994 26)

Another story of Amina from Somalia deep sexual effect goes deeper than this. She notes that:

[97]Ibid.

[98]Ibid.

> "I was eight when it happened. I still feel hurt and aggrieved about it like there is something missing and I am not a real girl ... My aunt, her sister, my mother and some neighbors held me down... and they didn't give me any anesthetic" (Dorkenoo, 1994 26)

Amina confides that she is now 28 and is still grieving about what happened to her. She finds it difficult to keep a fulfilling relationship because of pain and inability to feel any sensation during intercourse. Most of the time she has intercourse, she feels used and she goes into severe depression. [99] Many women traumatized by FGM have no acceptable means of expressing their feelings and fears due to social taboos and the fear of being branded as promiscuous or as prostitutes. They also suffer in silence especially over sexual health problems. Nahid Toubia observed amongst the female patients in the outpatient department of the gynecology clinic in Sudan:

> "Thousands of women present themselves with vague complaints all metaphorically linked to their pelvises, which really mean their genitals since they are socially too shy to speak of their genitals. They complain of symptoms of anxiety and depression, loss of sleep, backache and many other complaints uttered in sad monotonous voices. When I probe them a little, the flood of their pain and anxiety over their genitals, their sexual lives, their fertility and all other physical and psychological complications of their circumcision is unbearable. These women are holding back a silent scream, so strong that if uttered it would shake the earth. Instead, it is held back depleting their energy and draining their confidence in their abilities. Meanwhile the medical establishment treats them as malingers and a burden on the health system and resources."

The psychological effects of female circumcision among immigrants differ from those where the practice is prevalent. Genitally mutilated women living in societies where the procedure is not generally performed may have serious problems in developing in their sexual identity. If this is not resolved, health professionals may be called in to deal with such problems.[100]

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[99] Dorkenoo, *Cutting the Rose: Female Genital Mutilation: The Practice and its Prevention*, 1994. 26.

[100] Toubia, Nahid. Female Genital Mutilation: an Overview. Geneva, World Health Organization. September 29, 1998. Article, 715.

Some Cultural Variables Affecting a Moral Assessment of Female Genital Mutilation

Frigidity anxiety and depression have been listed by Koso-Thomas among the adverse effects of FGM [101], effects that she attributes to a circumcised women's fear of sexual activity or even of just being touched. But other reports contradict these findings. However, the relationship between FGM and psychological trauma is not that easily verifiable and it is difficult to establish a static correlation.

To begin with, some reports cast doubt on the observation that a woman's sexual drive and pleasure are permanently frustrated by FGM. For instance, it has been suggested that if FGM is performed early enough, a girl may compensate the loss of her clitoris and labia by developing greater sensitivity in other erogenous zones, transferring her sexual responsiveness to these areas[102]. The pituitary gland that regulates sexual drive is certainly left intact in the brain. Furthermore, a genitally mutilated woman may not know any other sexual experience with which to compare her own; or she may place other values above sexual satisfaction, such as spiritual purity, physical chastity, or emotional security.[103]

Lightfoot-Klein interviewed many Sudanese women who, even after having undergone the most drastic form of FGM (infibulation) nevertheless reported full emotional and sexual satisfaction with their husbands. This is supported by some, but not all, of her colleagues'

[101]Koso-Thomas, *Circumcision of Women: a Strategy for Eradication*, 27.

[102]Hanny Lightfoot-Klein, *Prisoners of Ritual: an Odyssey into Female Genital Circumcision in Africa* (New York: Harrington Park Press, 1989) 87-88.

[103]Gruenbaum, Ellen. Nuer women in southern Sudan: health, reproduction, and work. Working papers / Women in International Development, ed. 215. East Lansing, Mich.: Michigan State University, 1993. 167

findings on the same issue.[104] Lightfoot-Klein attributes the discrepancies to the interviewer's own cultural and psychological biases, or their lack of insight into others. For example, where indifference to sex has been reported among, say, Sudanese women, she suggests that the interviewee might have been saying what was culturally appropriate: in Sudanese culture, a woman is expected to act completely passively as a sexual partner and must express her need for sex through ritual activities, such as taking a smoke-bath that perfumes her body and living quarters with the smell of sandalwood, rather than by verbally asserting her own desire.[105] To attribute the alleged sexual indifference to a loss of libido or sexual feeling might therefore be an inference of the interviewer.

Critics of FGM may sacrifice empirical observation to what they consider to be more urgent: making a political statement. Fran Hosken[106] and Alice Walker (film maker and author of Warrior Marks) have both been criticized for having portrayed FGM in a way that is either too ethnocentric or too superficial to allow an in-depth analysis of how women are affected by it. Although Hosken accomplished some ground-breaking research on the topic of FGM her information was gathered from the statements of foreign diplomats or other spokespersons, usually men, rather than from women, and although Walker wrote a book where she recounts her cinematographic exploration of the subject, her film has been criticized for sensationalizing FGM. By contrast Lightfoot-Klein [107] and Brooks,[108] having spent several years living within the

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[104]Passmore-Sandenon, Lilian. Against the Mutilation of Women: The Struggle Against Unnecessary Suffering. Brill Academic Pub (1981). 42

[105]Lightfoot-Klein, *Prisoners of Ritual: an Odyssey into Female Genital Circumcision in Africa*, 90.

[106]Hosken, Fran P. The Hosken Report: Genital and Sexual Mutilation of Females, 2d enl. ed. WIN news. Lexington, Mass.: Women's International Network News, 1979.

[107]Lightfoot-Klein, *Prisoners of Ritual: an Odyssey into Female Genital Circumcision in Africa*, 90.

[108]Geraldine Brooks, *Nine Parts of Desire: the Hidden World of Islamic Women* (New York: Anchor Books, 1995).

culture, clearly developed intimate relationships with the women they were studying. Because of problems relative to disclosure on the topic of FGM, close interpersonal relationships are practically a prerequisite to good information gathering.

Still, it may be argued that although a more intimate or *sensitive* approach may be the preferred means by which to acquire and interpret women's own perceptions of their sexuality after FGM, medical facts should also be allowed to speak for themselves. The problem is that there is no way to isolate women's sexual experience in order to gain access to less subjective data about the degree of their sexual arousal and responsiveness, except perhaps by hooking them up to electrodes during sexual intercourse Master's and Johnson's style. However, this is a method that the sexually demure women of mutilating cultures are unlikely to agree to use.[109] It is also a method that gauges nervous and glandular, rather than cognitive or emotional responses, and it certainly does not gauge satisfaction, which is a broad qualification for which the testimony of women, when gained in confidence and accompanied by evidence to adequately support an interpretation of this testimony, should at least partially suffice.

Lightfoot-Klein is herself convinced that women who have no external genitalia can still have intense sexual experiences, including orgasm; she even cites studies by Master and Johnson, Money, Ogden, Otto and Verkauf that confirm that orgasm can be elicited without clitoral or vaginal stimulation [110]. Surely, when a woman has an infection or suffers pain as a result of sexual activity, she will not be able to enjoy her sexuality fully, if at all; but in the case of a healthy genitally mutilated woman, it is not necessary, according to Lightfoot-Klein, assume that sexual fulfillment is absent from her life. For her part, Lightfoot-Klein concludes that:

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[109]Lightfoot-Klein, *Secret wounds*, 77.

[110]Lightfoot-Klein, *Prisoners of ritual: an odyssey into female genital circumcision in Africa*, 83-87.

> "in my own study it was quite clear that an impressive number of women gave the appearance of being lusty, sexually fulfilled women, in addition to the statements that they made [...and...] exhibited a relaxed body posture, smiled and laughed readily and heartily, asked questions and in general gave evidence of enjoying the exchange of information." (Lightfoot-Klein, 1989 84)

In order to access detailed and meaningful information, the anthropologist, sociologist or doctor investigating women's attitudes toward their sexuality in a foreign culture must somehow *enter* that culture. If she has not lived there or cannot adopt some of the cultural norms that would enable her to penetrate a culture (e.g. by wearing a veil), she must use her intelligence and imagination in order to both gain access to usually closed circles of contacts, and learn how to communicate with circumcised women, and eventually be taken into their confidence on the sensitive manner of their sexuality.

Gunning suggests that the outsider can take certain steps toward, not overcoming her own cultural centrism, but acquiring a clearer picture of her own boundaries in relation to someone else's. She suggests a three-pronged approach to the other: recognizing interconnectedness by looking at your own and the other's historical contexts, taking an *in-depth look* at how the other sees herself within it, and searching for analogues of cultural practices that you challenge from within your own context[111]. Gunning's world-traveling methodology adopts and applies a certain form of cultural relativism that, she believes, allows her to evaluate FGM more objectively than if she were simply approaching the practice as an outsider; she conducts a point-by-point analysis of the advantages of this methodology over other more traditional approaches. The main weakness of her own approach, however, is that it appears to be inspired and justified by the author's own sentimentality, she practically makes a moral conversion a prerequisite to engaging

[111]Sandra Gunning, Tera W. Hunter, and Michele Mitchell, *Dialogues of Dispersal: Gender, Sexuality and African Diasporas*, Gender and history (Malden, MA: Blackwell Publishing, 1992). 205

in her world-traveling methodology, as though one could modify contempt for certain values by sheer will-power, through invoking respect or by attempting to metaphorically speak a foreign discourse, she even makes playfulness a condition for successfully archiving authentic cross-cultural understanding [112]. In fact, some doubts has emerged by the community if Gunning has raised or explicitly solved the epistemological questions that are important to defining and communicating the scope and limits of her approach to this issue.

[112]Ibid., 703.

CHAPTER 4

THE LAW AND FEMALE GENITAL MUTILATION

For immigrants and refugees the social and economic context that compelled parents to genitally mutilate their daughters no longer exists and the only lasting reason for the practice is to preserve cultural identity. In a modern legal system that seeks to protect the rights of each individual, *culture* is no longer acceptable as a justification for violating the bodily integrity of a child by removing a healthy part of her body or performing any other ritual that may be detrimental to her mental or physical health. Prompted by activists from both the northern countries and Africa, the international community including the World Health Organization and the UN Commission on Human Rights, began to condemn the practice of FGM as a violation of internationally recognized human rights. At the national level, laws have been passed criminalizing the practice in countries receiving African immigrants such as, Australia, Norway, Sweden, an the United Kingdom, as well as some African countries such as Ghana (1994), Burkina Faso (1996), Ivory Coast, Togo and Senegal (1998). In Egypt a ministerial decree issued in 1997 prohibits the practice and makes it punishable under existing laws of grievous bodily injury.[113]

[113]Toubia, Nahid. *Caring for Women with Circumcision: a technical manual for health care providers.* New York: Research, Action and Information Network for the Bodily Integrity of Women (RAINBO), 1999. 67.

Legal Status in the US

A federal law criminalizing FGM was passed in 1996 and became effective in April 1997. This law provides that performing FGM in the United States on a girl under age 18 is a felony punishable by fines or up to 5 years imprisonment. The statute provides that "whoever knowingly circumcises, excises, or infibulates the whole or any part of the labia majora or labia minora or clitoris of another person" under 18 is guilty under the statute. The statute exempts a surgical operation that is "necessary to the health of the person on whom it is performed, and is performed by a person licensed in the place of its performance as a medical practitioner." The law specifically exempts cultural beliefs or practices as a defense.

The law clearly penalizes those who perform the surgery, whether they are medically trained or not. Moreover, general principles of criminal law could extend liability to a parent, guardian, or other person (an *accomplice* or *accessory*) who consents to, assists in arranging, or is otherwise involved in the procedure.

Under well-established legal principles, American criminal laws do not extend beyond the territorial boundaries of the United States. Thus, FGM performed in other countries are not punishable under U.S. law. Moreover, federal law does not apply to procedures performed on women over age 18. Thus, adult women could consent to FGM as they would other elective, non-medically indicated surgical procedures such as cosmetic surgery. This would include consent to reinfibulation.[114]

State Laws

As of December 1998, ten states enacted criminal laws on FGM. These are California, Delaware, Illinois, Maryland, Minnesota, New York, North Dakota, Rhode Island, Tennessee

[114]Ibid., 67-68.

and Wisconsin. These were enacted prior to and after the federal law's passage. Several additional states have introduced legislation on FGM, though these bills have not yet passed. Other state legislatures may choose to address the issue in the future as well. [115]

Most state laws take an approach similar to the federal law in criminalizing FGM. Some state laws on FGM including Illinois, Minnesota, Rhode Island and Tennessee, prohibit performance of the procedure generally, without specifying an age limit. These laws thus leave open the possibility of criminalization of surgery performed on women above the age of consent. Other state laws such as California and Delaware explicitly criminalize the conduct of parents or guardians who *permit* or *allow* FGM to be performed.[116]

In states where laws on FGM exist in addition to the federal law, both state and federal law enforcement authorities could bring criminal charges against individuals for violations. In addition, in states where no specific legislation related to FGM has been passed, existing statutes related to child abuse/child protection; assault and battery; and/or the unlawful practice of medicine may also result in a health care provider or parent being found legally liable for his or her involvement in FGM. It is worth noting that the American Medical Association specifically condemned the practice and supported the enactment of legislation to criminalize the practice in the United States. For the latest information on whether a state has a specific law on FGM or a general law that may apply, consult with legal advisers. [117]

A health care provider should also be aware of the following issues regarding applicable laws:

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[115]Ibid., 68.

[116]Ibid.

[117]Ibid.

Legal Risks of Caring for Genitally Mutilated Girls and Women

While performing FGM is illegal in the United States, caring for women who are already genitally mutilated is not illegal. In fact, refusing to care for genitally mutilated women could result in severely damaging their willingness to avail themselves of health care services. Health care providers presented with such women have a unique opportunity to positively impact these women's lives by being open to treating the complications these women suffer, if any. Of course, denying medical treatment and thereby providing inadequate care may carry malpractice risks that do not exist if appropriate care is provided.[118]

Defibulation

Defibulation, or opening up the tightly sewn vulva of a woman with Type III FGM, is not illegal and is medically encouraged as long as it is performed with the informed consent of the woman without any form of coercion. In cases where FGM has already occurred and defibulation is not necessitated by a medical emergency, such as during childbirth, a clinician who performs defibulation on a girl under the age of consent without her parents' or guardian's permission may risk sanctions under state law applicable to a health care provider's failure to obtain required consent. Consult a local legal counsel for further details on the law- in your state.[119]

Re-infibulation

Re-infibulation, or closing the vulva of a woman with Type III FGM after defibulation had been performed to facilitate delivery of a child, is not illegal under existing law in most

[118]Ibid.

[119]Ibid.

states if the woman is over 18. However, while the criminal statutes on FGM do not explicitly address re-infibulation, it is likely that law enforcement and judicial personnel would interpret them to prohibit a person from performing this procedure on a girl under age 18. While it is not clear whether reinfibulation constitutes part of pregnancy-related medical treatment, it is worth noting that in the case of pregnant women under 18, the law in most states considers them *exempted minors*, that is, their pregnancy has rendered them legally competent to make decisions regarding their medical care without parental consent.[120]

Experience shows that informative and respectful counseling against reinfibulation removes the conflict between the women's cultural orientation towards re-infibulation and the physician/nurses' orientation against the procedure. Most women agree not to reinfibulate once the potential health risks are explained to them. Clearly, avoiding legal measures and judicial intervention is always desirable. If the woman insists on reinfibulation despite adequate counseling, it is then left to the physician to consider whether to follow her request or abstain from performing the procedure on the basis of professional and ethical consciousness. [121]

Reporting to the Authorities

In most states, the fact that FGM is a criminal offense probably does not itself create an affirmative duty on the part of health care providers to report it in adults. However, most state laws do require physicians and other health care providers to report child abuse and suspicion of future imminent harm to the child. Thus, health care providers should review applicable state laws related to their duty to report suspected instances of child abuse and consider whether and how FGM is encompassed in state legislation governing child abuse/protection. Given the

[120]Ibid.

[121]Ibid., 69.

cultural complexities involved, particularly the fact that parents intend to benefit, not harm, their daughters, and that the risk of future harm after FGM is performed is usually nonexistent, reporting a procedure that has already occurred may not be warranted. However, if there are other uncircumcised daughters in the family or if the health care provider learns of an intended, but not yet executed, FGM (to take place either in the U.S. or abroad), reporting may be warranted or required under state law to protect the child.[122]

It is worth reemphasizing that parents are not liable under the criminal statutes on FGM if the procedure occurred outside the territorial jurisdiction of the U.S. Extreme caution is necessary when dealing with recent refugees and immigrants, many of whom genitally mutilate their daughters just before they come to the U.S. For those who are known to have resided in the U.S. for a longer period, the procedure may have been performed during a visit abroad. This action does not violate federal or state criminal statutes. However, if a health care provider learns that a parent intends to take the child out of the U.S. for the procedure, reporting may be warranted under state child abuse/protection laws.[123]

If the clinician is presented with a fresh wound complication in a young girl, it is advisable for that individual and/or the social worker to assist the family to understand the legal situation in the U.S. and counsel them against the practice. As discussed above, whether there is a duty to report the FGM will depend upon whether state law mandates reporting crimes generally and/or child abuse, assuming FGM falls under that definition, even in circumstances when no future harm to the child is likely.[124]

It is important to keep in mind that recently arrived refugees and immigrants often have

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[122]Ibid., 70.

[123]Ibid.

[124]Ibid.

few financial resources to spend on defending themselves. An unjustified reporting can be extremely detrimental to the well being of the whole family.[125]

In all cases it would be appropriate to refer the case to the social worker or the community outreach worker for further counseling of the family against FGM of this girl or her sisters. It is strongly advised that health facilities at the national regional or local level devise protocols on how to handle child reporting and protection issues.[126]

Counseling the Patient on the Law

It is possible that the patient may not have heard of the law against FGM in the United States. It is the professional obligation of the physician to take the opportunity of the clinical encounter to inform the woman and her family about the law. This is best not done as the first part of the clinical exchange and time should be allowed for the woman to develop a degree of trust and appreciation for the care she is given before the law is mentioned. Experience shows that people respond better to concern for their well-being than to threats of punishment.

The passage of laws that criminalize a practice that is largely confined to new immigrants and refugees, coupled with the use of terminology favored by some rights advocates, such as *mutilation* and *barbarism* have already angered many individuals. Those in immigrant communities who come from countries where FGM is performed feel unjustly targeted in their new country. It is prudent to use great care in how you approach the subject because you may have to deal with anger not caused by your own words or actions.[127]

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[125]Ibid.

[126]Ibid., 46.

[127]Ibid., 71.

CHAPTER 5

CROSS-CULTURAL COMPETENCE IN HEALTH CARE

Cultural competence in health care has been defined as:

> "The ability of individuals and systems to respond respectfully and effectively to people of all cultures, in a manner that affirms the worth and preserves the dignity of individuals, families, and communities." (Refugee Health Program; Minneapolis, Minnesota 1996)[128]

The migration experience

Arrival in a new country brings many problems of adjustment, language, finding a place to live and a job. The perception that the country you are moving to is concerned about FGM and there are laws about it, and reports in the media can be embarrassing, humiliating and confusing for young women whose experience is that it is an important and accepted practice and not something for public discussion.

Women who have practiced this in isolated parts of the world can find it difficult to understand and accept the negative reaction to it. This can make them feel alienated and not accepted.

Some women may have pressure from their community to continue the practice, while their own knowledge and understanding tells them not to.

Both men and women may be distressed by the questioning and rejection of beliefs that have been important to them. Young women who reject their parents' values about this may face

[128]Refugee Health Assessment: A Guide for Health Care Clinicians - Massachusetts Department of Public Health - Bureau of Communicable Disease Control - Refugee and Immigrant Health Program page 27.

communication difficulties and stresses within their families if their parents believe that the young woman will be unable to lead a normal life unless she has FGM.

Support and understanding, without blame, are very important for women, parents and communities in this situation.[129]

The personal emotions and feelings of health care professionals can play an important role. Some health care providers are reluctant to address the subject out of respect for, or ignorance of, different cultures. Feelings of powerlessness (FGM procedures are irreversible) or anger (cutting genitals is alien to Western practice) may all hamper adequate care for women with FGM[130]. Moreover, a qualitative study among a limited number of midwives in three hospitals and two antenatal clinics in Sweden revealed that both obstetric and psychosocial care for women with FGM may be suboptimal, due to communication difficulties among midwives, circumcised women, and their families.[131]

A lack of technical guidance for caring for women with FGM hampers the provision of optimal care[132]. A similar study in Canada found that Somali women perceived a lack of knowledge and ability by health care professionals to care appropriately for women with FGM during birth[133]. The Swedish study among midwives revealed that the absence of guidelines on what to do in case of a specific request for reinfibulation after delivery forces midwives to refer to the law. They preferred to have supportive guidelines advising them what they could do

[129]Nienhuis, G., & Haaijer, I. Ignorance of female circumcision may hamper adequate care. In Werkgroep Interculturele Verpeging (Ed.), Intercultureel Verplegen. Utrecht: De Tijdstroom. 1995

[130]Ibid.

[131]Widmark, & B. M. Ahlberg (2002). A study of Swedish midwives' encounters with infibulated African women in Sweden. Midwifery, 18, 113–125

[132]Widmark (n.p., 2002).

[133]Chalmers, B., & Hashi, K. O. (2000). 432 Somali women's birth experiences in Canada after earlier female genital mutilation. Birth, 27, 227–234.

however, rather than a law instructing them on what they could not do.[134]

A lack of knowledge about the health care expectations and needs of affected communities is another issue in delivering appropriate care. In the Netherlands, a small study among Somali women revealed that obstetric care is insufficiently focused on their expectations and needs, and education about obstetric procedures in the Netherlands toward Somali women is necessary.[135] In addition to deficiencies within existing health services, the lack of operational coherence among health and social services, other agencies (such as education, judiciary, police, immigration officials), policymakers and grassroots organizations, further hamper adequate care for those affected by FGM. Powell and colleagues (2004) argue that services develop their own codes of practice in isolation from the multiple other agencies and that the care for women with FGM must be provided collaboratively as part of an integrated approach if it is to be effective.[136]

[134]Widmark, & B. M. Ahlberg (2002). A study of Swedish midwives' encounters with infibulated African women in Sweden. Midwifery, 18, 113–125

[135]Nienhuis, G. (1998). Somali women tell: It's like you have to do the delivery here by yourself. Tijdschrift voor Verloskundigen.

[136]Powell, R. A., Leye, E., Jayakody, A., Mwangi-Powell, F. N., & Morison, L. (2004). Female genital mutilation, asylum seekers, and refugees: The need for an integrated European Union agenda. Health Policy, 70, 151–162..

CHAPTER 6

TECHNIQUES AND CONSIDERATIONS FOR THE QUALITY AND SENSITIVE HEALTH CARE OF WOMEN AND GIRLS WITH FGM COMPLICATIONS

This chapter is intended to prepare health practitioners who, for the first time, may be encountering conditions in woman that result from FGM. Women who come from the cultures where FGM is practiced have immigrated to the United States and live throughout the country.

It is very important for the medical and mental health care providers to be able to identify and to manage the physical, psychosocial, and sexual complications that are consequences of female genital mutilation.

Adolescent Refugee Girls and Young Women often have unique needs. During the examination, providers should be considerate of refugees' cultural and religious beliefs and accommodate them as possible. For example, an Islamic woman may not wish to be examined by a male physician. If using interpreters, bear in mind that the gender of the interpreter should similarly be considered, such that those of opposite gender from the patient may need to stand behind a curtain or screen, and that in some instances the patient may not wish to speak freely in front of an interpreter of different gender. [137]

[137]Refugee Health Assessment: A Guide for Health Care Clinicians - Massachusetts Department of Public Health - Bureau of Communicable Disease Control - Refugee and Immigrant Health Program page 27.

Basics for Successful Communication

Successful medical treatment of women with FGM is predicated on successful communication. Perhaps as with no other clinical situation is there a greater need for the health care provider to be culturally aware and attuned to the social and psychological circumstances of the patient. This section of the chapter is designed to help the medical and mental health care professionals acquire the communication skills necessary to achieve a successful medical outcome in this special patient population. Ultimately, providers must make their own assessments of the community they are serving and develop their own rapport with patients. [138]

The health care provider has the opportunity to educate patients by providing accurate information, and positive reproductive health care experiences. Physicians, mental health providers, nurses, and midwifes are in a unique position to influence genitally mutilated women's perceptions of themselves, their bodies and their decision to seek future health care. Some women may seek no more than standard OB/GYN services, while others may have special needs related to their mutilation, such as family planning information and appropriate birth control methods.[139]

Effective communication is contingent on a two-way dialogue between provider and patient. The provider's own beliefs, values, and culture will influence the patient-provider interaction, and will affect interpretation of a woman's verbal and non-verbal signals. It is imperative that the provider remains nonjudgmental regardless of his or her personal beliefs and tries to find means to dialogue that facilitate the exchange of information on an equal basis.[140]

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[138]Toubia, Nahid. *Caring for Women with Circumcision: a technical manual for health care providers.* New York: Research, Action and Information Network for the Bodily Integrity of Women (RAINBO), 1999. 51.

[139]Ibid.

[140]Ibid.

The following are general guidelines to help you establish successful communication with genitally mutilated women and their families:

Use the right terminology

This dissertation is not the appropriate place to explore the political debates that surround different terms such as female circumcision, genital cutting, and genital mutilation. Your purposes as a health and/or mental health care provider are better served by using language that will be most comfortable to your patients. [141]

Start by remembering not to use *genital mutilation* with patients. The majority of women prefer the term *circumcision* when speaking in English. They may be offended when they are referred to as *mutilated* or when their parents or culture are referred to as *mutilators*.

In many cases women may not be familiar with the terminology in English and the best way to refer to the procedure is to use the word in her own language. Please refer to the appendices for a list of commonly used terms from various ethnic groups and languages. Even when you have used *circumcision* as a way of introducing the subject take the opportunity to ask the woman what term she prefers to use and enter it in the patient's records for future reference.[142]

Establish the basic facts

Given the private and sensitive nature of the practice, most women do not want information about their mutilation to be public knowledge. It is therefore inappropriate to have a question on FGM included in the history-taking form if it will be filled by a receptionist or other non-medical staff.

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[141]Ibid., 52.

[142]Ibid.

In order to determine if a woman may be genitally mutilated, the appropriate approach would be to have a nurse or physician trained around this issue should be able to judge if and when to ask a woman about their genital mutilation. The question should be part of the clinician's routine history-taking, posed in the same casual tone, and not asked in isolation. If a gynecological examination is to be conducted during the visit the question may be posed just prior to asking her to lie on the examination table. For example, the clinician may say, "Before I examine you, is there anything special I need to be aware of like any previous surgery in the area or circumcision?" [143]

Usually it is not useful to ask the patient about the type of FGM she has unless there is a particular reason why she may know. In general, women are not familiar with the official classifications and may never have had the opportunity to view their genitals or hear a description of non-mutilated genitalia. To document the extent of her genital mutilation, it is best to wait for a physical examination when you can view and classify the circumcision according to standard WHO classification (see chapter 2) and enter it appropriately in the notes.[144]

Secure privacy and confidentiality for the client.

Once it is established that the woman is genitally mutilated, the information, and the subsequent clinical examination should be handled with professionalism and discretion. Avoid whispering and gazing amongst the staff expressing pity or exhibiting patronizing attitudes. The nurse or physician should convey to the patient that s/he is comfortable dealing with her

[143]Ibid.

[144]Ibid.

condition. It is neither appropriate nor productive to display any feelings of horror or disapproval to the woman. Staff who have been educated and trained beforehand are best prepared to handle the patient, and will be less likely to react inappropriately. The patient should be made to feel confident that she is in safe hands, will not be judged and will not be made an object of curiosity or put on display. The most traumatizing experience women have reported is when a woman's genital mutilation was first discovered during a pelvic examination by a health care provider unfamiliar with the practice who then called in the rest of the staff to look at her *mutilated* genitals. [145]

> "The feeling of vulnerability and shame I felt lying on my back naked with my legs open and being reduced to a curious spectacle on public display is something I will never forget. It is worse than what I remember of the circumcision." (Toubia, 1999 53)

Regardless of any educational justification, a woman must not be viewed or examined by any staff other than the attending physician and nurse unless she consents to be part of a teaching session. The clinician should emphasize that care is not conditional on the woman's consent to an educational session. Also, unless she requires it or translation necessitates it, no other person should be present at the time of examination or during further questioning about her circumcision. It is of utmost importance that the patient's right to privacy and confidentiality is rigorously protected. The fact that she may be unfamiliar with Western health systems, speak a different language, and have an unusual condition is no excuse to violate her rights.[146]

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[145]Ibid, 53.

[146]Toubia, Nahid. *Caring for Women with Circumcision: a technical manual for health care providers.* New York: Research, Action, and Information Network for the Bodily Integrity of Women (RAINBO), 1999. 53.

Do not stereotype your patient

In the United States, it is still common for individuals to be referred to as Africans or from the Middle East, obscuring a wide variety of social, cultural, religious, and individual differences. For example, individuals from the same region, or even country, may be Christian, Muslim or belong to a local religion. Within each religion and culture there are social variations which affect an individual's behavior and choices. The way a woman chooses to dress should not be used as a license for anyone to define who she is. The common stereotype of Muslim women - veiled, passive, and submissive - will not fit all Muslim women; and a woman dressed in traditional dress such as the boubou common to West Africans may be a housewife, a University lecturer, or a street vendor.[147]

When addressing women or referring to them, it is a matter of respect to address them by name or refer to them, for example, according to the color of their clothing such as "the lady wearing the pink silk dress" rather than using such potentially discriminatory and objectifying terms as "that black woman" or "that African woman."[148]

Set the right tone of interaction

When a patient walks into a health care facility, she will immediately get a sense whether she is welcome. Pictures or posters in the waiting areas that reflect the patient's ethnicity or their culture will help set them at ease. If you routinely serve a particular community, you may want to learn a few greeting words from the language of the patients. It is a simple gesture that acknowledges their culture and shows that you are willing to make an effort.[149]

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[147]Ibid., 53-54.

[148]Ibid.

[149]Ibid., 54.

A warm greeting is an expectation in most African and Middle Eastern cultures and will help determine the success of any subsequent conversation. In America *Hello* is considered to be sufficient. For many Africans the greeting may involve not only the initial salutation but also a number of cordial inquiries about family. Such a greeting on the part of the physician or nurse may encourage patients to talk about what is happening in their communities. Good eye contact and a smile will reassure the patient that you treat her as an individual.[150]

Support the woman's decision-making process

While in the U.S. and other Western cultures, women are expected to advocate for and make decisions regarding their own health, in many African cultures a woman's decision-making process is expected to involve the family. You will need to assess when a woman wants to make individual decisions or involve others. To support a woman's right to make her own decision you must provide the space for her to express her needs. If she chooses to involve her husband or family members you should also be supportive of that process.[151]

Understand her health care behavior and practices

In many African societies physicians and nurses are held in very high esteem and thought to be very knowledgeable. They may be expected to diagnose the ailment and prescribe treatment without lengthy questioning. The patient may be reluctant to answer extensive history taking so it is important to explain to her the significance of such information. Some women may never have had a pelvic examination and may be reluctant to expose their genitals so you must explain in advance what you will be doing. Some patients may come seeking a tangible treatment

[150]Ibid.

[151]Ibid.

such as a pill or an injection and may need longer explanation why such treatment is not necessary.[152]

Traditional medicine plays an important role in the health seeking behavior of many African women. To most modern health care providers the use of traditional medicine is still considered a sign of ignorance. While it is true that many traditional healing methods may be harmful, others may be beneficial or inconsequential. Some African immigrants still defer to traditional medicine in the form of herbal teas and washes, scarification, cauterization, and bloodletting as home remedies or as prescribed by traditional healers. Some women may use herbs to prepare the birth canal. In addition, the belief in *the evil eye* is widespread among African immigrants. To protect oneself, a person may wear anklets, belts made of beads, or shells to ward off dangerous spirits. Some individuals choose a fluctuating balance between the use of traditional and modern healing systems. It is important to respect the patient's beliefs and to work with her to discourage her use of potentially harmful home remedies, particularly those which may cause drug interaction, while endorsing those which may give her physical or psychological comfort.[153]

Give appropriate and well-timed information

When giving information, the provider should recognize that whatever is said and how it is said will influence the outcome of the treatment. To ensure the communication of adequate information the physician or nurse should:

• Make sure to speak slowly and clearly and use simple but accurate terms.

• Use pictures and diagrams as much as possible for women with low literacy.

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[152]Ibid.

[153]Ibid.

• Do nor overwhelm the patient with too much new information during the first visit; select the most important information and postpone the rest for follow-up visits.

• In urban settings or situations where the patient may not return for subsequent care, give out adequate written information.

• Ask whether she understood the most vital information necessary for her to make a decision or to follow a course of treatment and ask the patient to repeat the most important points. Give her adequate time, and encourage her to ask questions.[154]

When taking history or asking other questions you may want to observe the following:

• Give the woman ample time to respond to questions.

• Do nor interrupt her or presuppose her answers.

• Do not force her to repeat things in medical terms, or in popular American English.

• Repeat back to the patient your understanding of what she has said. [155]

Barriers to Successful Communication

Language

Immigrant and refugee women identify language as one of the major barriers to seeking health care. Providing adequate interpretation is one of the requirements of the Minority Health Act of the United States. Larger hospitals and groups of clinics often consolidate their resources and create interpreter banks. Whenever possible a well trained medical interpreter should be made available to the patient. The use of family interpreters should be avoided when there are

[154]Ibid., 55.

[155]Ibid.

other options, even if one is voluntarily provided. [156]

When dealing with sensitive issues of reproductive health and sexuality (including FGM) the personal characteristics of the professional interpreter become exceedingly important. Professional interpreters are usually trained on issues of patient confidentiality. However, a woman's perception of the interpreter and their role may impact the exchange. A woman may not feel comfortable discussing issues related to her genitals with a professional male interpreter from her own ethnic back ground or from her community, or she may nor want to reveal sexual or marital problems to a stranger who is not a physician. In general, with regard to reproductive health, women tend to express a preference for female interpreters even when they are indifferent to the gender of the health care provider. [157]

While professional interpreters may be available for some languages and in areas serving larger populations, it may sometimes be difficult to provide interpretation services if the patient's language is less common, or the population served is very small. To combat this problem, some providers use call-in interpretation services such as national dial-in language lines, but the services cannot provide every language, or the costs may be prohibitive to some institutions. Though these may be useful, they are not an adequate substitute for face-to-face interpretation. When neither of the above is available, it is often unavoidable that the patient provides her own interpreter. Always choose an adult family member as an interpreter and avoid using children. Using children as interpreters imposes the unfair burden of taking responsibility for an adult, and inappropriately exposes the youngsters to intimate information about their elders. [158]

When the interpreter is a family member, three main problems can arise:

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[156]Ibid.

[157]Ibid., 56.

[158]Ibid.

1) When a child, spouse, or other family member interprets, the imbalance of power between family members may interfere with adequate care and decision making, and may keep women from being frank with the provider;

2) S/he is not trained in objective translation;

3) S/he usually does not know scientific terms and is unaware of confidentiality issues.[159]

If appropriate interpreters are not readily available, clinicians should do their best with what is available. Most important is to be aware of the possible dynamics involved in the three-way exchange and try to overcome them. The golden rule is to always look at and talk to the woman directly and not to her interpreter. Meanwhile take other measures to improve the situation in future visits. For example, if the interpreter is a relative, try to find an independent interpreter for the following visit. If the interpreter is a child avoid discussing very sensitive issues at the first encounter and inquire if she can bring an adult (preferably female) interpreter for the next visit. A long-term solution may be possible by identifying women from within the community who can be trained to become patient advocates and interpreters.[160]

Patient and/or provider modesty

Many women who come from African countries where FGM is prevalent may have had a social upbringing which emphasized social and physical modesty. Some women consider it vulgar to discuss their genitals, and would not be comfortable talking about their sexuality, or sexual behavior.[161]

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[159]Ibid.

[160]Ibid.

[161]Ibid., 57.

> "In societies where FGM is practiced, it may not be surprising that the discussion of sexuality and reproductive issues is rather taboo, which is why women can have dermoid cysts the size of a tennis ball at their infibulation scar, yet say nothing to family and friends."[162] (El Dareer, Asma 1982)

The clinician should welcome the patient's guidance in discussing such matters by telling her that though women are biologically the same everywhere their cultural practices differ. Ask such questions as "How do women feel about... in your culture?" which may open up the conversation in a less personalized way.[163]

Clinicians should assess their own beliefs and values regarding such private issues, and recognize that his/her own sense of modesty may contribute to any unease sensed when approaching subjects of reproductive health. With appropriate training in sexual counseling, and gentle probing into the patient's own comfort level during the clinical encounter, the clinician should be able to build trust over time to overcome this universal obstacle.[164]

Perceptional differences

One of the least recognized difficulties of communication between patient and provider is the difference in knowledge and perceptions regarding bodily functions and therefore what constitutes appropriate health care. The patient comes from a cultural context that assigns bodily functions based on knowledge that is not derived from biomedical science. Health care providers are trained in Western style biomedicine sometimes mixed with their own cultural perceptions.[165]

One incident that illustrates this is a dialogue that occurred between OB/GYN staff (nurse-midwives and physicians) in a European setting and a group of refugee women they

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[162]El Dareer, Asma, *Women Why Do You Weep? Circumcision and its Consequences*, 4.

[163]Toubia, *Caring for women with circumcision: a technical manual for health care providers*, 57.

[164]Ibid.

[165]Ibid.

served. The refugee women were infibulated, and complained that they were not given adequate support during their labor and were instructed to keep pushing. The providers explained that they followed their usual procedure and gave uterine contractors (oxytocin) whenever necessary and routinely performed defibulation to facilitate the second stage of labor. On further probing it was clarified that the practice in the women's community involves another woman sitting behind her encircling her with her arms for support as she is pushing. Since they were not receiving such physical support, the women thought their bodies were *tearing inside* because they were infibulated. They were unaware that since they are defibulated there is no further risk of tearing and that their *inside* is not affected by the infibulation. This example demonstrates two very different perceptions and approaches to solutions. The medical doctors were clear about the physiological and anatomical facts and used biomedical solutions of defibulation and uterine contractors to facilitate labor. The women were protesting the lack of combined physical and emotional support necessary to address their perception of their abnormal bodies with an embrace that also protected them from the memories of their initial trauma.[166]

How does one resolve this difference between medical and cultural perceptions? First take the time to explain what exactly was cut when she was genitally mutilated and what you are doing to minimize the effect on her labor. When necessary, show her simple diagrams of normal and infibulated anatomy, the physiology of labor and how, for the purposes of delivery their genital mutilation could be reversed with defibulation. Second, look into the possibility of allowing a female friend or relative to attend labor to give the customary support. With care listening, the problems can be identified and solutions found.[167]

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[166]Ibid.

[167]Ibid. 58

Physician-Patient-Family power dynamics

When interacting with a patient from another culture there are at least two belief systems which must be dealt with: the clinician's and the patient's. If the woman is accompanied by her husband, mother-in-law or male relative her own opinions and needs may become secondary to theirs. Negotiating the gender and power dynamics between the woman and her family and between the clinician and the woman within a comfort zone of both sets of beliefs is a formidable task. Women's needs and choices will fall at opposite ends of the spectrum and anywhere in between. Some will not deal with a health care provider without the presence of a male relative and may defer decisions to him. In this case, the clinician must respect her comfort level and include others in her decision-making while constantly referring to her for her opinion. Another woman may welcome the chance to ask questions and make independent choices for herself. This woman may appreciate a private session without family members. In recognizing, respecting and working within these dynamics, the clinician should be able to tailor care so as to not create conflict between a woman and her family.[168]

The provider's sex

One of the most commonly perceived barriers to communication is that women from non-Western countries prefer a female health care provider, particularly for reproductive health care. This is not universally true. Many women who come from societies where social modesty is important have expressed no preference for the sex of the health care provider, and believe in the neutrality of the physician. Some may even express more confidence in the wisdom and knowledge of male physicians. This may be explained by the fact that in their own countries

[168]Ibid.

most physicians are men. On the other hand those who have experienced female physicians often prefer them for their reproductive health care. Female nurses, midwives, and interpreters are always preferred and are often seen as allies or confidantes. Most genitally mutilated women prefer a health care provider from their own or neighboring culture, particularly if the individual can speak their language. In practice, most genitally mutilated women are attracted to particular clinics or individual health care providers on the recommendation of other women because of the providers' sensitivity and compassion regardless of race, sex, or nationality.[169]

Beyond the clinical session

Counseling

In many African societies the concept of health encompasses both the physical and psychological, each reinforcing the other. When a patient seeks the help of a healer, she is most likely prompted by physical symptoms. However, in the traditional healing practices of most African cultures, a healer does not simply dispense herbs or prescribe treatment; she or he also provides counseling to the patients. In addition to discussing the presenting physical symptoms, the treatment may include discussions of the patient's life such as daily activities, past and present events. Hence, when treatment is prescribed, the healer has not only dealt with the physical aspects of the problem, but has also helped alleviate the patient's fears, worries, or concerns. In some cases, the healer even acts as a mediator between couples or family members, still in the context of treating the patient. The patient is therefore able to discuss her emotional or psychological problems without the social stigma often attached to mental illness.[170]

For many Africans, specialized counseling or mental health services, as may be practiced

[169]Ibid.

[170]Ibid., 61.

in the West, may seem alien or strange, particularly when the mental and physical are treated separately. In many African countries psychology as a science has not gained much attention in medical facilities; the few specialists in the field only have time to deal with extremely debilitating mental illnesses.

Consequently, little has been known of the everyday psychological effects of FGM on a girl or a woman and even less about possible approaches to provide counseling on FGM. Most women may consider counseling as strange, or even a waste of their time.[171]

Do all genitally mutilated women need counseling?

The definitive answer is no. Not all women who have been genitally mutilated want or need counseling. Many genitally mutilated women are very well adjusted and enjoy a healthy emotional and sexual life. On the other hand, many women who may benefit from counseling are not provided such an option, or may not know of the services that are available to them.

Assessing the client's need for counseling

In the clinical situation, the health care provider is advised to assess the client's needs without imposing personal values and beliefs on the client. To do so, the clinician may:

• Provide written information (a leaflet) about the availability and possible benefits of counseling, while leaving it up to the patient to request such services.

• Mention existing support services. Avoid labeling it *counseling service* and based on the client's responsiveness, the clinician may either make the referral, or stop at letting her know that more information would be made available upon her request.[172]

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[171]Ibid.

[172]Ibid.

However, it is extremely important to remember that the provider must not make assumptions based on personal values and beliefs in assessing the woman's needs. The clinician should avoid suggesting that a woman *must be angry or suffering*. It would be inappropriate to even suggest solutions to problems that may not exist to begin with. By so doing, the patient would most likely feel judged and mistreated, and may not return to the health facility.[173]

When should genitally mutilated women be referred for counseling?

There are cases whereby the clinician should strongly recommend, or refer a genitally mutilated woman to counseling.

1. When a circumcised woman expresses enthusiasm for counseling or requests a referral.

2. When the clinician is convinced that counseling is necessary for a favorable outcome of the treatment. For example, an infibulated pregnant woman who may be anxious about defibulation may need counseling, (including counseling against re-infibulation) since she may be experiencing flash backs of her FGM. Counseling is also necessary when the clinician suspects that total relief of the presenting symptoms will not be achieved with surgical or medical intervention alone and some therapeutic counseling maybe necessary.

3. When the presenting symptoms are primarily psychological or sexual in nature.

Where can genitally mutilated women receive counseling?

As the patient-provider relationship develops, the genitally mutilated woman may request or be clearly in need of counseling services. There are three main barriers to providing this service for women:

1. Lack of mental health professionals who are familiar with cross-cultural issues.

[173]Ibid., 62.

2. Lack of knowledge of the practice of FGM and its possible effect on women.

3 Reluctance by most genitally mutilated women to speak to foreign counselors.

Institutions and health practitioners who service a large population of genitally mutilated women may want to invest in gaining knowledge and experience in this area by hiring an individual who specializes in outreach and counseling for women who have been genitally mutilated. Look for an opportunity to recruit a qualified woman from the community (for example someone with a nursing or social work degree) and provide her with training in counseling. She will add valuable cultural knowledge to your services. [174]

Creating a counseling or support group for genitally mutilated women is another possibility. The supportive presence of others with a similar experience may help reduce the woman's suspicion and anxiety towards counseling. Such a group will, in turn, increase knowledge and awareness of the psychological needs and feelings of those who have to live with FGM. The group facilitator must bear in mind the diversity within the African immigrant community, particularly among genitally mutilated women, in terms of culture, language, education, age, and marital status and how that may affect the group dynamic. It may be advisable to start support and counseling groups with individuals with similar characteristics to encourage openness and avoid conflict. [175]

Other institutions and professionals who may encounter genitally mutilated women less frequently may want to be prepared by researching if other health care institutions offer counseling for genitally mutilated women. Moreover, although community based organizations servicing populations of African immigrants may not provide counseling on FGM specifically,

[174]Ibid.

[175]Ibid., 62-63.

they may be extremely helpful in locating practicing counselors or therapists from within the community who are familiar with the subject. They may also want to introduce FGM to their existing support groups.[176]

Special Concerns of Children and Adolescents

Most likely, the genital mutilation of a child is discovered accidentally during a routine check-up or treatment of a common childhood illness. The mutilated genitals of a child may, understandably, evoke much stronger feelings from the medical staff than the same in an adult. It is important to remember this ritual was not done as violence or as a deliberate act to hurt the child. It is a culturally normalized procedure that is deeply believed to be in the interest of the child. The parents who Westerners may perceive as cruel or abusive might have gone to great trouble and financial sacrifice to provide what they believe is their daughter's right to this ritual. They are more likely to be loving rather than abusive parents. It is important that the family is treated with respect and their right to privacy ensured. Harsh and confrontational exchanges would not be beneficial for the child nor for the reputation of the health facility.[177]

Adolescent girls who have been genitally mutilated and are living in host countries may or may not be experiencing problems particularly related to FGM. Although there are no studies on the experience of genitally mutilated adolescents growing up in the West, there is enough anecdotal evidence that their concerns about FGM are very much intertwined with other concerns common to all adolescents regarding sexuality, body image, attractiveness, identity, belonging, and conforming with peers. Girls may have gone through the ritual at a young age in the home country; they may have clear memories of it, or may have vague or no memory of it at

[176]Ibid. 63.

[177]Ibid. 47-48.

all, particularly if it was never discussed in the family. Girls who were not aware that they had been circumcised may find out while examining themselves, or they may suspect that they had been genitally mutilated because of information they heard in the media or from peers. The most important thing to remember is that these young women are not dissimilar to all other teens and they requite at least the same services. [178]

A health care practitioner may become aware that a girl has undergone FGM in the context of a totally unrelated matter. For example, in the course of contraceptive counseling with the school nurse or counselor, the young woman may mention that she is genitally mutilated. In such an encounter, it is advisable to gently probe the subject and let the young woman know that she should feel comfortable talking about it if she desired. It is important to note, however, that one must not conclude from the single fact that a girl has undergone FGM that she is necessarily experiencing related emotional and psychological problems. For many women, FGM is a part of a culture they subscribe to and accept and may not be troubled by it. Health care professionals must be extremely careful not to make these young women feel that they are viewed and treated as *abnormal*. Most adolescents are more comfortable *fitting in* with the rest of their peers than *standing out* if they do not reveal any FGM related problems, treating them as *different* or *abnormal* will most likely inhibit them from expressing their concerns, and may add to their load of worries and anxieties shared by most adolescents. Alternatively, an adolescent girl may indeed be experiencing difficulties related to FGM. If an adolescent girl was sexually active or considering becoming so, she may be very confused about how she may be different from her non-genitally mutilated friends. She may present her problem to the school nurse or counselor, or seek advice from a physician. While there can be some physical problems that need attending to, the majority of adolescents will need sensitive and appropriate counseling. Peer support groups

[178]Ibid.

for adolescent girls who have undergone FGM may be ideal mechanisms in that they provide the atmosphere of shared experience necessary for reaching out, addressing and resolving adolescent issues.[179]

The greatest dilemma for these young women is that they fall between the values and demands of two different cultures. Part of them relates to their parents who accepted FGM at least at some point in their lives but who are also likely to have traditional values which discourage sex outside of marriage. Another part may be attracted to the culture that surrounds them, which not only rejects FGM but is also saturated with messages that push young people to be sexually active regardless of marriage. The resulting communication gap is often devastating to the family, particularly to the daughters. Immigrant and refugee service providers and youth counselors need to pay much more attention to this problem and find means of facilitating dialogue between adolescents and their parents to reduce family tensions. Counselors, who are culturally competent to deal with adolescents from minority backgrounds must be identified, trained and encouraged to develop and share their skills with other professionals.[180]

Young women who have been infibulated may want to seek defibulation. The health care provider must pay extra attention to issues of confidentiality in these cases to protect the adolescents' privacy and safety. It is important to be aware of the possible legal and professional repercussions of providing such services to a minor without parental consent. The balance between protecting the privacy of the girl and abiding by applicable legal requirements may be a very delicate one and health facilities may want to give extra thought as to how they handle such situations.[181]

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[179]Ibid.

[180]Ibid., 48.

[181]Ibid., 48-49. Appendix I – For Legal information and questions: Center for Reproductive Law and Policy.

Reproductive Health Education

Many women do not have access to reproductive and sexual health information and may not have seen a diagram of the reproductive organs, or normal female genitals. Many genitally mutilated women may not have an understanding of the type of FGM they have. Providing such information within the limited time available at the clinical session is almost impossible.[182]

Educational Workshops

Hospitals and clinics that service communities with large numbers of genitally mutilated women may consider conducting group education sessions on reproductive anatomy and physiology, general reproductive health information such as contraception and prevention of sexually transmitted disease and types of FGM performed on women. Such sessions could be incorporated into pre-natal care services, school and women's health clinics, maternal and infant care programs and other venues where groups of women may gather. Because in some cultures women may shy away from publicly discussing reproductive health aspects, it would be advisable during outreach to refer to it in a more comprehensive title such as *Women's Health*.[183]

Development of Educational Material

The preparation of simple and clear material in print that can be available in waiting rooms and postnatal wards could also add to the information available to women. As much as possible this material should be made available in English and other languages of the populations served such as French, Arabic, Somali, Amharic, and Swahili.

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[182]Ibid., 62.

[183]Ibid., 63.

Because of the complex cultural variables involved in receiving and processing information, it is extremely important that providers engaging in the production of educational materials consult with professionals and institutions who may lend their expertise in assessing how this information should be presented to the target population. Anecdotal evidence has shown repeatedly that when educational materials were produced in the absence of cultural context, the women were not able to relate to or process the information.[184] The contribution of community based organizations, research centers, resource persons and professionals from the communities will greatly determine how well the educational materials may be received by the women. [185]

Outreach

Since only a fraction of genitally mutilated women actually come in contact with health services, some health programs, social services, and refugee resettlement agencies may consider incorporating FGM information and educational efforts in their work. The first step to take is to sensitize the program or service staff to the needs of circumcised women and identify the barriers women may face in accessing services and information.[186]

Hospitals and health care providers may consider engaging in partnerships with community-based organizations and other service providers for African immigrants in order to reach a wider population than the fraction that voluntarily seeks health care. Such partnerships could involve projects such as the training of health care provider staff on cultural sensitivity by the community based organizations and/or work shops for immigrant women on select aspects of health and the health care system of the host country. A hospital or other health care provider

[184]D Woolard, and E Richard, *Female Circumcision: An Emerging Concern in College Health Care* (n.p.: FACH, 3/1/1997), 45, 230-32.

[185]Ibid.

[186]Ibid., 64.

may collaborate by sponsoring an event organized by a community based organization, such as community health fairs targeting African immigrant women.[187]

Institutions and agencies with the resources to provide training for community health educators may also want to invest in recruiting women from the community. Experience shows that the most successful outreach staff is those who are part of the community since women respond to them faster than to outsiders. In addition, setting up such a program will provide employment opportunities for immigrant women who are usually motivated to serve their own community.[188]

Access

Given that the majority of genitally mutilated women are first generation refugees and immigrants, they all face numerous barriers to accessing health care. As mentioned in the beginning of the chapter, language is one of the well identified barriers to accessing of health care services. Hospitals and clinics serving large numbers of patients with a particular language should consider recruiting and training patient companions and translators from within the community, particularly other women. Resources should be made available to employ or remunerate these individuals rather than rely on the use of their time as volunteers. [189]

In Europe, Canada, and Australia where health care is a universal right to all who are legally residing in the country, there are no financial barriers to accessing the health care system. However, cultural and communication barriers still operate in limiting genitally mutilated women from accessing health care.

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[187]Ibid.

[188]Ibid.

[189]Ibid.

In the United States, access to health care is generally limited by insurance coverage or one's ability to pay, and most recently by a person's immigration status. With the cuts in social benefits to legal immigrants, many of whom have low income, it is important to consider ways to facilitate low cost and subsidized care for genitally mutilated women. Health care providers and institutions can help in overcoming this barrier by identifying existing public services that are available, including *not-for- profit*, private and charity clinics that provide services on a sliding fee scale, and then making the information widely available.[190]

Moreover, in the U.S., lack of transportation to health care facilities is another barrier to accessing services. Since the private car is the major mode of transport in most locations with the exception of a few major cities, immigrant and refugee women are handicapped since most do not know how to drive nor have the linguistic skills to obtain a driver's license. Facilitating transportation for women may be another consideration when attempting to improve access to health care.

A final barrier to access experienced by many immigrant and refugee women is the lack of childcare at home. Hospitals and clinics may consider incorporating childcare centers in their services as part of facilitating access to care for women.[191]

How to Respond to a Request for FGM

Some health care providers will be faced with a request from a newly delivered mother or a family to *circumcise* their daughter. This has been a dilemma reported by nurses in post-natal wards in the U.S. when they refuse to circumcise the baby girl but agree to or even offer FGM for a baby boy. This creates confusion in the mind of the mother regarding the health and legal

[190]Ibid., 64-65.

[191]Ibid., 65.

systems in America. The most important thing to do is to not react harshly or in a dismissive manner, but to use this opportunity to educate the family and help protect the child.[192]

The physician's first response should be something like this:

"*I understand that female circumcision is commonly performed in your culture and has been an old tradition. Recently there have been many studies and information from African countries to show that this practice is harmful to girls and women. Because of that the United States (or other Western country) government and the United Nations decided that female circumcision must be made illegal. As a health care provider in the United States I will be breaking the law if I perform this procedure and can be put in jail. You should also know that if you get it done by someone else both you and the circumciser will be subject to imprisonment and possibly deportation. Circumcision for boys is not thought to be harmful as is circumcision for girls and therefore is not illegal in America."*[193]

The following general rules can help guide the health care provider's conversation with the parents.

- It is important to speak in a way that shows that you under stand where the family comes from and that you will not condemn or judge them for asking you.
- Take this opportunity to inform them of some of the harmful effects of FGM on the girl's physical and mental health, her adjustment to a new society and later her sexuality, including within marriage. Do not recite the physical complications common in Africa since they are unlikely to happen in an American (or Western)

[192]Ibid., 46-47.

[193]Ibid.

hospital or clinic and cannot be used as the justification for refusing their request.

- If the parents mention sending the child to their country of origin to be circumcised, remind them that they are putting their daughter through tremendous and unnecessary physical risk. Bring to their attention that they should think of what their daughter will feel growing up in the new country feeling so different and possibly ashamed when her friends at school learn about her circumcision. Also bring it to their attention that they may still be persecuted under child protection laws or may be made to pay civil damages to the girl or organizations working against FGM in the future under a civil suit.
- Remind them that adherence to culture or preservation of virginity cannot be forced by circumcision and they are better off spending more time understanding their daughter's experience growing up in the West and talking to her about the parts of their culture she should be proud of.
- If you have no time for counseling, make sure you refer the parents to a counselor (a nurse or social worker) who is familiar with the subject. On one hand, it may not be necessary to create alarm if the family can be convinced through counseling in your clinic. On the other hand, if there is reason to be concerned that the child may be at risk, it is advisable, and may be your legal duty, to alert social services so that the agency can keep in close touch with the family and take action to protect the child if necessary.
- Please note (and remind them) that FGM is not a requirement of any religion, though it may be interpreted to be so by different individuals or local religious leaders.[194]

[194]Ibid., 47.

Provide them with brochures on the health, religious and legal aspects of FGM if you have them and any other information on local community organizations working against the practice.[195]

[195]Ibid., 47-48.

CHAPTER 7

CULTURALLY SENSITIVE COUNSELING GUIDELINES FOR NURSES, MIDWIVES AND MENTAL HEALTH CARE PROVIDERS

WHO defines counseling as "helping someone to explore a problem so that they cope more effectively."[196] As mentioned previously, there is a need for nurses, midwives, and mental health providers to be trained in providing culturally sensitive counseling to genitally mutilated women because it is an important element in the management of FGM complications. Counseling of a girl or woman with FGM complications must be strictly confidential.

The aim of counseling is to help a client, a couple, or a family come to terms with, or to solve a problem they have.[197] The problem may be one identified by the patient, or may be an issue identified by the health care provider that he/she believes negatively affects the woman's health and well being.

Counseling may occur during the doctor's office visit with a nurse or midwife or in an office of a mental health care provider as a result of a referral.

During counseling sessions it is important to build a trusting relationship with clients, so that they feel safe in discussing their concerns with you as the counselor.

The following guidelines are quoted, taken from the World Health Organization, Female Genital Mutilation: Integrating the Prevention and the Management of the Health Complications into the Curricula of nursing and Midwifery; certain omissions were made due to incompatibility

[196]World Health Organization, *Female Genital Mutilation: Integrating the Prevention and the Managementof the Health Complications into the Curricula of nursing and Midwifery*, 71.

[197]Ibid., 64.

with United Sates laws and procedures.

Important factors for achieving this are:

- Privacy and confidentiality – make sure that counseling is carried out in a room where nobody can come in without permission, and where the discussion cannot be overheard by other people.
- Patience – the mental health care provider should be relaxed and not pressed for time.
- A carefully considered seating plan – counselor and client should be on the same level, and seated close to each other, with no barriers between them so that the counselor can lean towards the client to demonstrate attentiveness and support during the discussion.
- Eye contact – it is important to look at the client directly and to observe her carefully so that you become aware of her mannerisms and body language (body cues), as these may tell a different story from her words. The provider should not look her straight in the eye all the time, but observe the whole person and her actions.
- Attentive listening – observe the client's tone of voice as well as what she is saying as this may tell you more than her words. You should allow the client to do most of the talking, but try to paraphrase what she has said from time to time to check that you understand her correctly.
- Showing concern (empathizing) – try to put yourself in the client's position and show that you care.
- Appropriate facial expressions – you should be aware of your facial expression

and ensure it is appropriate to what is being said. Smile when you greet the client, but if she cried during the session your facial expression should show sympathy and concern.

- Respect – you should always show respect for your clients as dignified human beings with their own religious and cultural beliefs.
- A non-judgmental attitude – it is very important for you not to be judgmental. Counselors need to be aware of their own biases and prejudices so that they do not interfere with the counseling process.[198]

Using counseling skills

Preparation for counseling session

- Welcome the client (and her partner/husband if appropriate) and invite her to sit down.
- Greet her and introduce yourself in the culturally appropriate manner.
- Ask client her name and ask if you can help her with anything.
- Let the client talk and encourage her by nodding or saying “ah” from time to time.
- Give client information about the services available in your clinic or ward or centre and the staff who will care for her.
- Let client explain her concerns; be patient as she may find it hard to express her experiences and feelings.
- Listen carefully and observe non-verbal cues (e.g. body language; tone of voice) to enhance the understanding of the client’s situation.

[198]Ibid.

- Paraphrase the client's information from time to time to check that you have heard her correctly and avoid misunderstanding.
- Show concern throughout the session by being attentive and making eye contact from time to time.
- Empathize with client when she is describing a disturbing experience, which may make her weep.
- Explain to client how you can help If the purpose of counseling is to raise with the client the need for opening up her infibulated vulva after type III FGM, give her detailed information about the procedure, and advise her that her genitalia will be changed by the operation. Give her information about her after care.
- If counseling is for psychosocial or sexual problems, ask questions as appropriate to draw out as much information from the client as possible about her problems. Advise her that there are various ways of conducting sexual relationships; teach her appropriate techniques by which both she and her partner may be aroused. If she expresses a wish for her partner to be involved in the discussion, draw him into the counseling session also. It is known that FGM does not necessarily lead to inability of a woman to achieve orgasm or enjoy sex. Therefore sexual problems may be due to fear of pain, rather than to any physical malfunction. However, if sexual intercourse is not possible as a result of infibulation or extensive scarring the issue of opening up the tight introitus should be addressed during counseling.[199]
- Assist the client, and her partner where appropriate, to make an informed decision on the steps to be taken to solve the problem.

[199]Ibid., 65.

- Assist them to act on their decision by giving advice on how to proceed.
- Give client an appointment for another counseling or follow-up session to prepare for the next step.[200]

Please note:

> "A client's problem may not be resolved in a single counseling session. Several sessions may be required for her to resolve a relationship problem and reach optimal psychological well-being. You should be prepared to spend as much time as is necessary for this process." (World Health Organization, 1998 65)

Psychosocial Counseling

Psychosocial refers to the psychological and social aspects of human experience – i.e. how a person feels about her or his relationships with others in society. FGM can affect self-confidence and self-esteem and cause problems in relationships: these would mostly be classified as psychosocial or sexual problems.[201]

Psychosocial and sexual problems are identified by interviewing clients using interpersonal communication, observation and listening skills. It is not easy for a client to talk about a sexual problem as it is a sensitive issue. Moreover, in areas where FGM is practiced, sex is taboo – something which is not talked about. Therefore, a woman will rarely speak directly about a psychosocial problem, but will tend to present with some physical complaint. It is essential for the health care professional to pick up non-verbal cues of psychosocial problems, by observing body language and listening carefully to the tone of voice, which may give more meaning to what the client is saying and feeling. Sometimes a client may just cry, which tells a

[200]Ibid.

[201]Ibid., 66.

lot about how distressed she is. She should be given comfort and a shoulder to cry on.[202]

Identifying psychosocial and sexual problems

The procedure for identifying psychosocial and sexual problems

- Make it clear with body language and the way you are sitting that you are ready to listen to her concerns, and that she should feel free to share anything she wishes with you. Encourage her to talk using facilitation skills such as eye contact, nodding your head, saying *ah, ah*, and listening attentively while also observing non-verbal cues.[203]
- When the client has opened up to you, ask her about her eating and sleeping patterns. Ask about menstrual patterns and sexual relationships in a very tactful manner, as these questions may embarrass the client and result in communication breakdown.
- Use *open-ended* questions – i.e. questions that require more than a simple *yes* or *no* answer, and thus offer the client the chance to explain things in some detail.
- Use observation skills continuously to pick up nonverbal cues, and tell the client what you have observed to give her the chance to tell you more about the situation.
- Listen carefully and empathetically (showing concern).

[202]Ibid., 67.

[203]Ibid.

- Use all your senses to try to understand the client's world. It may not be easy the first time you meet her, but arrange for subsequent visits to explore more.
- Support the client throughout the interview to give her psychological strength.
- Assess the client's intellectual status – that is her ability to understand information and comprehend a situation.[204]

> "Each girl or women should be treated as a unique individual with unique needs and problems. Counseling and care should be tailored to individual needs and problems, not carried out according to a formula devised for some imagined, stereotypical client." (World Health Organization 1998, 67)

- Record your findings and share these with clients wherever appropriate.

Management of girls or women with psychosocial and sexual problems associated with FGM

In some instances girls and women from FGM practicing communities to visit a clinic complaining of a wide variety of physical problems for which no sign can be found when they are examined. Their complaints are, in fact, *psychosomatic* – that is, they are psychological problems which the client experiences, or disguises, as physical discomfort. Anxiety about their genitals or about sexual relationships may manifest themselves in psychosomatic symptoms. Often the girl or woman is unaware that her symptoms are based on psychological anxieties. But in some cases the woman is aware of the fact that the symptoms she is presenting are not the real cause of her problems, but she is too shy to discuss them directly and attends the clinic hoping the health care provider will be able to read between the lines.[205]

[204]Ibid.

[205]Ibid., 68.

Key elements in managing psychosocial and sexual complications

The key elements in managing psychosocial and sexual complications are:

- Identification of the problem by interviewing the client (history taking).
- Counseling to help her identify the real problem and accept it (girls should be referred for specialized counseling).
- Referral of clients who are severely disturbed for more specialized care.

> "Counseling is the principle tool used in managing psychosocial and sexual problem. Counseling of a girl or woman should be strictly confidential. If the client has a partner, he should be counseled separately if necessary, until the right moment arrives for them to be counseled as a couple. The aim of counseling is to help a client, a couple, or a family come to terms with, or solves a problem they have." (World Health Organization, 1998 68)

Managing psychosocial problems

Psychosocial problems include: chronic anxiety, and feelings of fear, humiliation, betrayal, stress, loss of self- esteem, depression, phobias, and panic attacks.

These may manifest as psychosomatic symptoms such as nightmares, sleeping and eating disorders, disturbances of mood and cognition, loss of appetite, excessive weight loss or gain, and negative body image.[206]

The procedure for managing such symptoms is as follows:

- Assess client to identify the exact problem (take a detailed history).
- Counsel client, and partner where appropriate
- If the client has type III FGM, counsel her as to the need for opening up. (defibulation)

[206]Ibid., 66.

- If she has other types of FGM, counsel her until she is relieved of her symptoms.
- If symptoms are severe, refer client for further management by the health care provider.

Managing sexual problems

Painful intercourse (dyspareunia).

The procedure for managing this condition is as follows:

- Interview client to identify the real problem.
- Assess client to identify the type of FGM.
- If opening up the introitus is indicated, and anxieties about the procedure are the main problem, counsel the client and her husband/partner about the need for the procedure and its benefits. Explore the patient's expectations and fears.
- Where opening up is not indicated, encourage foreplay to stimulate maximum arousal, and the use of lubricating jelly.
- Follow-up client to monitor progress.
- Counsel the client and her husband about the importance of discussing sexual matters.
- Invite them to come back whenever they have problems.
- Advice the couple of the changes to expect as a result of opening up operation – e.g. changes with urine flow and with sexual intercourse.[207]

Other sexual problems

An example is failure or difficulty in penetration by husband/partner. The procedure for managing such problems is as follows:

[207]Ibid., 70.

- Assess the type of FGM.
- Interview the client to find out what the problem is.
- Counsel the client and her husband/partner together.
- Refer the couple to a health care provider to open up of introitus.
- Record FGM type and complications presented.[208]

Documentation of FGM

Referral is necessary when a client presents with a problem that is beyond the competence of the care provider. However, referral is not a simple matter, it is a skill. If clients are not well informed about where to go and why referral is necessary, the process may fail and the patient remains untreated. The health and the mental health care provider must know what services are available and which ones are appropriate for the different conditions.[209]

> "Referral is a skill. If the client is not well informed about the reasons for the referral she may refuse to go. Besides, FGM is a sensitive issue; for a client who has developed confidence and trust in a particular health care provider, transfer to another place where she will meet new people may be daunting."

Procedure for referral of clients

- Inform the client sensitively that she has a problem which needs further management.
- Give her the facts and reasons for referral.
- Check that she has understood what you have said.
- Involve others, such as her husband/partner, who will accompany her to the

[208]Ibid.

[209]Ibid., 71.

referral facility.

- Give them detailed information about what to expect and what to do at the referral point.
- Give the referral letter to the client or her attendants and give detailed instructions about whom to hand it on to at the referral point.
- Ask client to return for follow-up and monitoring of progress after she has received specialist treatment at the higher level facility.
- Ask client to repeat the important information she has been given, to check that she has understood.
- Wish her good luck and tell her you will see her when she comes back from the referral point.[210]

[210]Ibid.

CHAPTER 8

CONCLUSION

Ideally, adequate care for women with FGM should focus not only on appropriate clinical care, but also should include culturally sensitive professional counseling. Because affected communities can be deterred from contact with health care services that are unable to give appropriate and sensitive treatment.

Health care professionals need to be informed of how to deal with the provision of counseling services concerning deinfibulation, reversal operations, caesarean sections, and prevention of FGM in newborn girls, and guidance on successful communication strategies. Ethical issues, such as reinfibulation, need to be discussed at a national level, and health care providers need clear guidelines on these issues.

Health care practitioners needs to efficiently refer the patient when they do not have the adequate skills or time to give appropriate care for a woman with health problems due to FGM, or where to report or refer a girl at risk.

Last but not least, training must included in their curricula of medical students, mental health care professionals, nurses, and midwives. Training should take into account various levels: clinical care, the prevention of FGM; counseling, communication and attitudes (e.g., open communication skills), and ethical issues. It is recommended that in order to establish these guidelines, all agencies working in the field of FGM be interlinked at the national level.

This research is intended to benefit all women and girls who seek medial care by providing clear culturally sensitive guidelines to the health care field and stressing the

importance of the adoption of a non-judgmental posture to make women and girls feel safe and cared for.

APPENDIX I

For information on local community groups and community education material contact:	RAINBO African Immigrant Program 915 Broadway, Suite 1109 New York, NY 10010 Tel: (212) 477-3318 Fax: (212) 477-4154 Email: rainbq@aol.com http://www.rainbo.org
For legal information and questions contact:	Center for Reproductive Law and Policy (CRLP) International Program 120 Wall Street New York, NY 10005 Tel: (212) 514-5534 Fax: (212) 514-5538 http://www.crlp.org

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