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Manual for the New Strategy Against Female Genital Mutilation

- IP -

2nd Edition

1. Introduction

Following the 17th session of the *United Nations' Working Group on Indigenous Populations* held in Geneva (July 26-30, 1999), where the need for effective measures against female genital mutilation (FGM) was discussed, this manual is to support the efforts to overcome the problems with an entirely new approach. It has been realised that the fight against so-called "female circumcision" - which is a very cruel removal of the clitoris (clitordectomy), and, in many cases, of the *labiae* as well - apparently did not reach the envisaged goals.

It is estimated that this mutilation is carried out on more than two million girls annually. Their age at the time of the procedure varies, according to the tradition, from babies to grown-ups. We are facing a dilemma of cultural customs on the one hand and human rights aspects on the other. It seems to be the case that respecting one side automatically leads to neglecting the other.

Yet, intervention can be legitimated on medical and psychological grounds.

2. An example

In the Third World, it is the upper social classes who are the first to be europeanised. This usually means the loss of valuable culture and tradition; but in some ways, there could also be a positive outcome. In effect, attempts have been made there to abolish FGM. However, this had limited success, and it has become evident that even a legal ban - such as in Guinea, Niger, and Sudan - has been largely inefficacious.

The case of Egypt, where 97 % of the women are mutilated, clearly shows the constellation of the problem in a multi-factor setting. Clitorydectomy was so established that it was even carried out in hospitals. Due to the campaign against FGM, this procedure became officially prohibited in 1996.

But what happened then? Was this the end of FGM in Egypt?

Unfortunately, that was not the case. - As a result of the prohibition, the procedure was then carried out in barbershops and similar, non-official places. In effect, rusty razor blades led to an increase in complications, and due to the absence of anaesthesia, the tortures multiplied for the victims. Then, in 1997, the ban was lifted and public hospitals continued to mutilate the girls.

3. Cultural Factors

What do we learn from this? - Apparently, there are cultural factors which have been neglected:

- Tradition has proved to be very stable.
- There is a demand for having a ritual.
- Unless this demand is fulfilled, there is no solution to the problem.

From a eurocentric position, one could say - and this has actually been done - "We don't accept your tradition. Erase it and become like us". But we have seen where such ignorance has led us: the problem was not solved; indeed it has even become worse.

Cultural determinants are the major obstacles of effective intervention against FGM. Often, those concerned even want the procedure *themselves*. And in cases where mothers do not want to carry on the ritual on their daughters, the grandmothers enforce it with sly tricks.

A strategy in the fight against FGM can apparently only then be promising if it manages to overcome these self-maintaining cultural mechanisms. Efforts to ban FGM by law have failed, problems have become even worse. This suggests the need for a different strategy which takes the cultural system into account. The motivation for carrying out FGM is nourished by the thorough conviction that female maturity and coming of age are inevitably linked with such a ritual.

It also has to be considered that the women who carry out the mutilations professionally – often, these are the village midwives – don't want to lose their income and therefore strictly oppose any efforts of abolishing FGM.

4. The present situation

After fighting FGM for more than a decade, let us ascertain the current situation: success has been scarce. Even in cities, girls still are mutilated. As well as their mothers, they find themselves in an almost schizophrenic position - either, they have to break tradition entirely, or they have to surrender themselves to mutilation.

So, there are two necessities in the present situation:

- (a) there has to be a ritual;
- (b) mutilation must be stopped.

4.1 Looking for a solution

How can this situation, which at first sight looks contradictory, be solved? - Rites of passage can be found in any human society, they only vary in form. Therefore, to begin with, we must accept that there is a ritual at all. As we have experienced, this can hardly be changed. The chance is left to a variation in form. This apparently is the only promising strategy. But we must be cautious not to vary the procedure too much. If, for example, we suggested that the ritual be replaced by a mere celebration without genital surgery, we could expect a bad reception. Such a suggestion would also overlook the symbolic meaning of the ritual's actions. Going deeper into detail, we recognise:

- the ritual must concern the clitoris,
- some cutting has to take place,
- there must be some bleeding.

As long as we don't accept these traditional requirements, we won't be successful - this is what we have experienced so far. If we compare this situation to male circumcision, it is quite evident that it would also be considered as totally unacceptable and even ridiculous if someone were to suggest to only having a party without real circumcision.

Which choices do we have within the framework of the traditional requirements? - To answer this, it is useful to take a look at the variance of so-called "female circumcision". From place to place, from culture to culture, the extent of the procedure can be quite different. Apparently, the procedure was minimally invasive in the early Muslim setting. Present variations comprise

- a mild form only affecting the prepuce,
- clitoridectomy, i.e. removal of the gland or the entire clitoris,
- excision with the *labia minora*e also being removed,
- infibulation ("pharaonic circumcision") which even affects the *labia*e *maiora*e.

The rarely practised minimal operations which only remove the prepuce of the clitoris are as harmless as equivalent male circumcision.¹ But these are exceptions, and at the other end of the scale where the entire vulva is afflicted, the mutilation is extremely cruel. In some African cultures, the resulting wound is sewn or stitched with thorns in a very in sterile way. Victims of such a mutilation suffer life-long pain and severe infections which can lead to death.

However, only 2.5 % of so-called "female circumcisions" are being carried out in a relatively mild form, affecting only the prepuce or small parts of the clitoris. Looking at the other 97.5 %, this means that millions of women who are mutilated by severe forms of FGM are impaired physically as well as psychically - if they survive the mutilation at all. This harm urgently calls for intervention.

5. The new technique

In order to fulfil traditional requirements and yet not to mutilate, the following technique can be expected to be a solution to the problem.

Above the clitoris, there is the clitoral hood (*praeputium clitoridis*) with the gland (*glans clitoridis*) occasionally showing out of it (fig. 1). This hood is an equivalent to the foreskin of the male penis's gland.

The new technique is restricted to this foreskin of the clitoris, it does not remove anything, and it leaves the clitoris and labiae unharmed.

¹ With regard to the equivalent male operation, it has to be remembered that circumcision of the husband drastically reduces the wives' rate of cervical cancer.

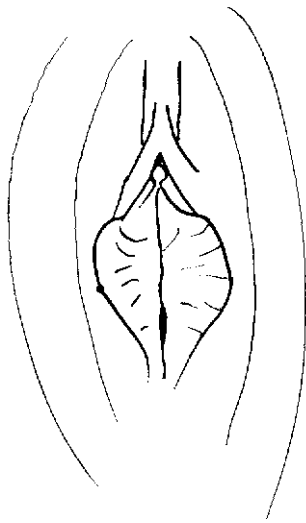


Figure 1: Schematic view of the female genital with clitoral hood (preaputium clitoridis), gland (glans clitoridis), inner lips (labiae minora), and outer lips (labiae maiora).

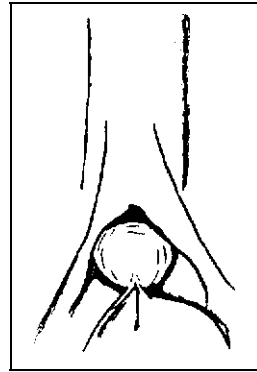


Figure 1a: Clitoris with hood.

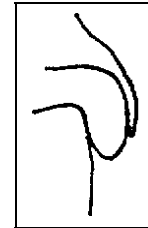
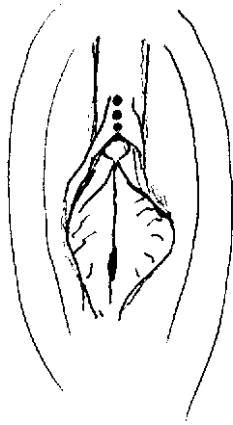


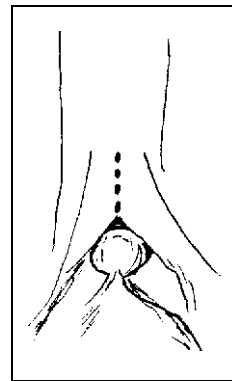
Figure 1b: Cross-section of Clitoris with hood (sagittal plane)

The incision is to be conducted vertically, only opening up the hood, thereby exposing the clitoral gland (fig. 2). In effect, this is neither a circumcision nor a clitoridectomy, but merely an *incisio praeputii* (incision of the foreskin). Nevertheless, it fulfils the basic traditional requirements of the ritual: there is genital surgery concerning the clitoral region, and there is blood. Incidentally, an equivalent procedure in which the male foreskin's upper side is just slit open can be found in South East Asia.²

² Tradition of the Mangyans on the island of Mindoro (Philippines)



*Figure 2: Alignment of the incision
(dotted line)*



*Figure 2a: Enlarged view of
the alignment of the incision
(dotted line)*

In cases where there is insistence that tradition strictly requires something to be cut off, only the prepuce should be removed, ensuring that the clitoris itself remains unharmed!

There is however another aspect to be mentioned: In many women, the clitoral hood turns out to be quite large, so that the clitoris is even obstructed: When sexually aroused, the clitoris swells and, like the male penis, stands up. But if the foreskin is large, the erected clitoris might then disappear behind it. Covered by the hood, the clitoris is less receptive to stimulation.

For those many women who are concerned by such predispositions, the new IP (*incisio praeputii*) method can even be seen as an advantage. Otherwise, they would not be able to fully enjoy clitoral stimulation during sexual intercourse due to the obstruction by a large hood. In effect,

the new method solves a little problem
instead of creating a big one.

5.1 Precautions

If available, a local anaesthetic (xylocaine) can be used. But anyway, IP is comparable to just a small injury of the skin. However, some points are very important:

- The incision should be carried out with a suitable, clean instrument (preferably with a sterile scalpel).
- Utmost caution is to be taken not to injure the clitoris itself which is directly underneath the hood!
- Immediately after the cut, the wound is to be disinfected. If no medical disinfectant is available, alcohol could do this service.
- Though healing can be expected within a few days (like for any other skin injury), fresh air and ventilation are to be ensured for the wound.³

As there is reason for hope that IP eventually will replace FGM, we cannot afford the risk of infections, especially not during the time of implementation. Those who are suspicious of IP and who thus would rather continue mutilation would use any complications as an argument against the new strategy.

³ In some places in African, recent modernisation - plastic roofing of the huts instead of traditional leaves - has brought about an increase of infections also in male circumcision during the boys' three days of retreat due to insufficient ventilation.

6. Strategical aspects

As we have learned, the mere prohibition of FGM has not been very successful. Therefore, the implementation of the new IP technique has to follow a different path:

- Instead of prohibiting the ritual, the professionals (these are often old women and in many cases midwives as well) who are used to carrying out the procedure, thus making their living, shall now be entitled by license - but they are required to carry it out in the NEW way.
- Instead of excluding them from the reformatory process, they shall be acknowledged and thus embraced to participate in it.

The lesson we have also learned is that if we try to achieve change while ignoring the traditional structures, we risk the mutilations being carried out secretly, "underground", and in non-official places.

Making it official means that we keep control over it.

The exact diplomacy is up to the local NGOs and activists. They are familiar with details of the respective cultural reality. It might be helpful if the professionals who are to carry out the ritual comply to the new technique *publicly* in order to bind them by word. Dissemination of the reform is bound to communicative strategies. For that reason, it could also be helpful to demonstrate the new technique in the villages with models of the vulva, or at least with drawings to clarify what is meant and to avoid misunderstanding. Of course, when translated into action, there needs to be some supervision. If possible, it may be beneficial to attend the reformed ritual itself.

In discussions with women who are insisting on their tradition, it has proved to be effective to tell them, "God has created the woman this way, because that is how He wanted her to be. And now, you destroy what God has created according to His will!" This argument can help to move these people at least not to have their daughters' (or even their own) clitorises destroyed.

Anyway, there is a need for control mechanisms:

- ⇒ It has to be ensured that the IP is carried out correctly without any injury to the clitoris itself.
- ⇒ The girls have to be checked more than once afterwards.

If the reform of the ritual is to succeed, it must be accepted as a full value replacement. In other words: the people concerned may not experience the change as a cultural loss. It has to be made clear - especially to the girls, but also to the other persons involved - that the new, minimally invasive method is a perfect rite of passage and that it achieves the desired initiation completely.

7. Prospects

Carried out officially, the reformed measure would, at least in towns, be shifted into the realm of medicine. Yet, it should be very clear that what is happening in Egypt (see above) is incompatible with medical ethics. Instead of mutilating girls in hospitals, physicians should act responsibly and take the opportunity to bring FGM to an end. If official institutions refuse to become involved at all, the mutilations are carried out underground, as we have seen. But if the demand for the ritual is recognised, reform would mean that instead of banning, there would be an offer to carry out the *reformed* measure officially in hospitals (which would also have a modelling effect on rural areas). As a result, this would mean an end to suffering from mutilation. Instead, there would be positive experiences -

- anaesthesia,
- drastic reduction of infections,
- no detriments, but rather a sexual improvement,
- and still, cultural identity.

In the long run, this might lead to a complete change in practice.

8. Feedback

In order to optimise this new approach in the fight against FGM, it is very desirable to disseminate it, to learn from experience, and to improve details. Therefore, you are welcome not only to copy and distribute this manual, as well as to translate it into other languages as required, but especially to gather data:

- about compliance;
- effectiveness of approaching people with the new idea;
- diplomacy;
- precision of surgery;
- conditions of healing;
- etc.

If you want to support this reform movement, please send all material (translations, data, photos etc.) to:

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Your contribution may then help to improve the next edition of the manual, and to optimise this strategy. Effectively, the aim is to prevent further cruelties.

With all the girls who are being mutilated each day in mind, there is no time to waste - act now!

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