CHAPTER IV

FEMALE CIRCUMCISION

A. ANATOMICAL, HISTOLOGICAL, PHYSICAL, PSYCHOSOCIAL AND EPIDEMIOLOGICAL ASPECTS.

CIRCUMCISION AND INFIBULATION IN THE SUDAN

by

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PART I - General

Summary

Circumcision and infibulation constitute a community health problem and every effort should be made at community level to abolish these practices. Legislation abolishing pharoanic circumcision had little effect on minimizing this ritual and the legislation of 1946, although successful for a while, was soon forgotten both by the public and the legislators.

The problem persists until effective means of abolishing it are established and maintained. Sex education, together with the dangers of complication of pharaonic circumcision, should be taught to our children. Mothers should also be told of the dangers of this ritual and this can easily be done through women's organizations. Religious men should also help by explaining to the public the views of Islam towards pharaonic circumcision and its harmful effects.

It is hoped that pharaonic circumcision will soon be abolished.

Three types of circumcision are usually described:

1. Sunna circumcision

This consists of removal of the prepuce of the clitoris. The clitoris is preserved together with posterior larger parts of the labia minora.

2. Excision (or reduction)

Removal of prepuce and glans of clitoris together with the adjacent part or whole of labia minora without including the labia majora and without closure of the vulva. This is commonly practised in Egypt and is gradually replacing infibulation in the Sudan.

3. Infibulation

Excision plus infibulation. The second name for it is Pharaonic circumcision. It consists of removal of the whole clitoris, the labia minora and the medial part of the labia majora. The two sides of the vulva are brought together using silk or catgut. A small opening is allowed for urine and menstrual flow.

In spite of all the efforts towards abolition of this ritual it is still being practised even in towns. Gynaecological departments are still receiving young girls who have recently been circumcised with severe bleeding or fulminating infection and a number of young girls are admitted dying of tetanus. Retention of urine and injury to adjacent organs are also commonly seen; and the external urinary meatus has very often been completely excised during circumcision. The operator is usually an old woman, with no anatomical knowledge or surgical asepsis.

Delayed or remote complications include:

1. Scarring and keloid formation.
2. Vulval cysts and vulval abcesses
3. Recurrent urinary infection

4. Chronic pelvic infection. Most gynaecological problems relate to chronic pelvic infection and contribute to primary infertility.
5. Dysmenorrhea.
6. Tight circumcision resulting in cryptomenorrhea (retention of menstrual flow) and difficulty in marital consummation necessitating a surgical operation.

Several complications may be encountered during delivery. The tight introitus of pharaonic circumcision makes proper vaginal examination during labour very difficult and less informative.

The ritual of circumcision is strongly defended by the older generation of grandmothers and sometimes by the mothers themselves. The reason usually given to justify infibulation is that it preserves virginity by reducing the sensitive parts of the genitalia. Obliteration of the vaginal orifice is an added precaution. Uncircumcised girls may not be married and in Ethiopia in the sixteenth century, when missionaries tried to stop the practice of circumcision among their converts, the men refused to marry them. Circumcision was eventually allowed on the urgent advice of Rome.

Contrary to the belief that sexual desire is increased by circumcision, the author in a recent research proved that to be untrue. Histological specimens of tissue removed from circumcised girls showed abundance of nerve endings and touch organs (Pacinean corpuscles), while scar tissue removed from the circumcised vulva showed scarcity or complete absence of nerve endings.

A questionnaire among married circumcised women also showed a general reluctance towards sexual intercourse especially after repeated deliveries in which more trauma to the vulva had been inflicted through repeated episiotomy and repair.

PART II - The effect of the innervation of the vulva

SUMMARY

The normal vulva contains an abundance of nerve fibres, touch organs (Meissner and Merkile discs) and pressure organs (Pacini's corpuscles). The clitoris and labia minora are the most sensitive areas with an abundance of Pacini's corpuscles responsible for sexual arousal. Circumcision and infibulation destroy these nerve endings and especially the tactile organs, reducing the vulva to sheets of thick fibrous tissue with minimal innervation. These findings are from histological studies of specimens from female circumcisions.

INTRODUCTION

Several publications have appeared in the literature on circumcision and infibulation, including articles by Dewhurst (1964), Mustafa (1966) and Shandall (1967). However, nothing has so far been documented on the effect of this operation on the nerve supply of the vulva. In this paper the effect of circumcision on the nerve supply of the vulva is presented, together with discussion on delayed sexual arousal in circumcised females.

ANATOMICAL CONSIDERATIONS

Nerve supply of the vulva

The vulva and the adjacent areas of the thigh are mainly supplied by nerves arising from the lumbar and sacral plexuses. These are the iliohypogastric nerve ($T_{12}L_1$), ilioinguinal nerve (L_1), genitofemoral nerve (L_1-L_2) and the posterior femoral cutaneous nerve (S_1, S_2 and S_3).

In addition the mons veneris and labia majora are supplied by touch organs mainly concerned with tactile differentiation. These are the Meissner corpuscles, Merkel's tactile discs and peritrichial endings.

Pressure endings mainly concerned with sexual stimuli are found in the clitoris and labia minora and are known as Pacini's corpuscles and Dogiel-Krause corpuscles.

MATERIALS AND METHODS

1. Normal vulval tissue (clitoris, labia majora and labia minora) removed at circumcision from 13 female children aged 7-9 years, were examined histologically. These were preserved in 10% formol saline, blocked in paraffin, stained with haematoxylin and eosin and silver to demonstrate nerve endings.

2. Fibrous scar tissues of previously circumcised vulva removed at gynaecological repair operations from 10 women aged 25-35 years were also prepared for histological examination.

RESULTS

HISTOLOGY

Histological sections of normal vulval tissue showed abundance of nerve fibres under the skin of the labia minora. The nerve fibres stained black due to silver impregnation. Section of the clitoris showed Pacini's corpuscles with their whorling appearance of nerve fibres which also stained black.

HISTOPATHOLOGY

Histopathological section of old circumcision scar tissue showed in addition to inflammatory reactions in some sections, a few scattered nerve endings trapped in sheets of thick fibrous tissue. No Pacini's corpuscles were observed in any of the sections studied.

DISCUSSION

The effect of female circumcision and infibulation on sexual arousal has always been a matter for speculation. El Hakim (1979) reported that

it was thought that circumcision caused delayed sexual arousal in the female, but that there was no direct evidence. Indirect information has been obtained from opium addicts who claim that they resorted to the drug as a result of frustration from delayed sexual arousal in their circumcised wives. Baasher (1977) also reported on a survey carried out in Alexandria in which the respondents believed that circumcision caused delay in sexual satisfaction. Karim and Ammar (1965) however expressed a different view and concluded from their study of 651 circumcised females that though circumcision did not decrease sex desire it had a definite effect on orgasm.

The destruction of nerve and pressure endings, observed in the current work supported the concept of delayed sexual arousal since the nerve endings and especially Pacini's corpuscles were responsible for sexual arousal. The few nerve endings which were observed in histopathological section of old circumcision scar tissue were shown to be trapped in dense sheets of fibrous tissue, thus rendering these nerves functionless.

It was concluded from the direct data presented in the current work that delayed sexual arousal in the circumcised female was due to vulval nerve destruction.

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DAMAGE TO PHYSICAL HEALTH FROM PHARAONIC CIRCUMCISION (INFIBULATION) OF FEMALES
A REVIEW OF THE MEDICAL LITERATURE*

by

Dr Robert Cook

INTRODUCTION

Scope

This review covers only damage to physical health. It does not deal at all with psychiatric or social aspects.

TYPES OF CIRCUMCISION

It is important to distinguish as clearly as possible the main types of female circumcision. The classification of Shandall, followed also by Verzin, is adopted here. All are performed in childhood by traditional practitioners without anaesthetic (except in some well-to-do families in the case of Type I or modified Type II operations)

Type I - Circumcision proper. The circumferential excision of the clitoral prepuce, analogous to male circumcision. It is known in Muslim countries as the sunna circumcision. It is also sometimes practised in the United Stated to counter failure to attain orgasm on the part of the woman associated with redundancy or phimosis of the female prepuce (Rathmann, Wollman).

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As it has not been reported to have any adverse health consequences, this review is not concerned at all with this form of female circumcision.

Type II - Excision. Besides the excision of the prepuce, this involves the removal of the glans clitoridis or even of the clitoris itself, together with the adjacent parts of the labia minora, or even of the whole of the labia minora.

Type III - Infibulation also called Pharaonic circumcision. In this type the whole of the clitoris, whole of the labia minora, and at least the anterior two thirds and often the whole of the medial part of the labia majora are removed. The two sides of the vulva are then stitched together by silk or catgut sutures (in the Sudan) or by thorns (in Somalia), thus obliterating the vaginal introitus except for a very small opening posteriorly to allow exit of urine and mesntrual blood, complete occlusion of the introitus being prevented by the insertion of a small sliver fo wood, usually a match stick. The after-treatment described by Melly in Somalia and quoted below is confirmed as correct from personal experience by a Somali woman informant.

> "The legs are bound firmly together above and below the knee and at the ankles, and the child is kept in bed on a diet of camel's milk.
>
> "After three days she is allowed to get up and move about as much as she is able. Since her legs are still tied together, this is accomplished with the aid of a pole which the patient holds in front of her with both hands, progressing in small jumps. After seven days the wound is considered to be healed and the legs are released".

It is from this Type III, pharaonic circumcision or infibulation, that most of the adverse consequences to health result, and it is with this form of circumcision that this review is concerned.

For completeness, a Type IV is sometimes described even more drastic, known as introcision, enlargement of the vaginal orifice at puberty by tearing it downwards manually or splitting of the perineum with a stone knife. This is (or hopefully was) practised only by the Pitta-Patta tribe of Australian aborigines (Worsley) and need detain us no further .

GEOGRAPHICAL DISTRIBUTION

Two countries are mainly concerned, Sudan and Somalia.

Sudan. Formerly, in the 1940s and before, pharaonic circumcision was very common in those parts of the Sudan where circumcision was practised. (Circumcision of any kind is hardly practised in Southern Sudan. Aub Shamma et al.) For a detailed description of the distribution of the three types in Sudan the reader is referred to Shandall, p. 184. In spite of Types II and II being illegal since 1946, there is no doubt that pharaonic circumcision is still performed fairly widely in Northern Sudan, but likewise it is also clear that Type III (pharaonic circumcision) is gradually giving way to Type II (excision), and S. Modawi reports figures of a series showing that in 1960 Type III outnumbered Type II by some 6 to 1, whereas in 1970 Type II outnumbered Type III by almost 3 to 2.

The fact that the operation is illegal in Sudan makes it difficult to have more precise data. It can only be said that the incidence of pharaonic circumcision has apparently declined greatly from former near-universal levels but still remains substantial.

Somalia. Laycock reported in 1950. "Infibulation appears to be a universal practice in Somaliland" (i.e. now Northern Somalia), and there is no information to indicate that the present prevalence in Somalia is much less than universal. In Somalia, unlike Sudan, it has not been the subject of educational campaigns nor has it been made illegal.

Other countries. Pharaonic circumcision is also reported from Ethiopia among Somalis[10] and among Danakil, Harari and Galla (Huber) and in Eritrea (Type II, occasionally Type III (Shandall)). In Kenya Type II or Type II is practised in some areas. In Egypt Type I and Type II were formerly common, but for some decades have been steadily deminishing[15].

AGE AT WHICH CIRCUMCISION IS PERFORMED

Pharaonic circumcision is reported to be carried out in Sudan at ages after six[18], between five and 10 years (Shandall 1967) or five to eight years (Verzin 1975); and somewhat later in Somalia - after seven years of age[10] or between eight and 14 years[8]. In Ethiopia the DAnakil perform the operatioN as early as three years of age[5].

ADVERSE CONSEQUENCES TO PHYSICAL HEALTH

The consequences of pharaonic circumcision in terms of physical damage are likely to be greatly under-appreciated for the following reasons:

(a) In Sudan the operation is illegal, so that immediate consequences are likely to be concealed or medical aid sought only with recultance.
(b) In Sudan at least, pharaonic circumcision is declining in prevalence in cities and towns and so is performed more in remote communities where medical services are less accessible.
(c) Concerning as it does so intimate a part of the anatomy and physiology, the subject is one which may easily embarrass women to the extent that they seek medical assistance reluctantly and late, or prefer to go on suffering without relief.

IMMEDIATE COMPLICATIONS

Shock, resulting either or both from pain and fear and/or haemorrhage, is mentioned by most authors[5,6,8,9,11,15,16]. Even though the genitalia are still infantile[16] severe haemorrhage can result either from the dorsal artery of the clitoris or from the labial branches of the pudendal artery. Modawi reported six severe personal cases between 1955 and 1970. From questioning women Shandall concludes that the incidence of shock after pharaonic circumcision in the Khartoum area was formerly about eight or nine per cent, but has declined somewhat to about five per cent since the use of catgut or silk sutures and local analgesia has become more common. Huber reports also fatal secondary haemorrhage from the infected wound area.

Infection is reported also by many authors. The incidence was between seven and ten per cent in Shandall's series of histories, and fatal cases of tetanus are known to have occurred[5,11,15]. Hall reported an unusual complication, an outbreak of polyarthritis in a village in Kenya affecting five girls who had all been circumcised at the same ceremony. Verzin points out that the light bandaging together of the legs is likely to interfere with drainage of the wound and promotes the upward spread of infection to the vagina, uterus and adnexae[11]. Infection is also mentioned as a common complication.[9,12,18]. Verzin[16] and others mention also maduro-mycosis as a result of thorns being used to keep the remnants of the labia majora apposed.

Urine retention is naturally quite common in the first 48-72 hours after such trauma [5,9,12,16]. Its incidence in Shandall's series of histories was 10 per cent.

Damage to urethra or anus. The undeveloped state of the genitalia, the clandestine nature of the operation (Verzin) and the struggles of the little girl held forcibly in the lithotomy position make the ultimate extent of the operation dictated in many cases more by chance than design (Hathout). Damage to the urethra is mentioned by Pridie et al., Lenzi and Karim and Ammar; several cases are described by Worsley, one by Shandall and one by Huber which led to permanent incontinence. Shandall also reports on two cases of damage to the vaginal walls leading to total occlusion of the vaginal introitus and hence haematocolpos, which is also described by Laycock (two cases) and Hathout.

GYNAECOLOGICAL AND GENITO-URINARY COMPLICATIONS

The malformations resulting from pharaonic circumcision hinder gynaecological examination, e.g. bi-manual examination and the use of speculum[16].

Keloid formation is very common; Shandall believes keloids to be especially common after infection. They are not important in themselves, but they make surgery more difficult[9,11,16].

Implantation dermoid cysts are the commonest complications. They vary in size up to that of a football and they occasionally become infected, and present as abcesses[4,8,9,16]. Modawi saw eight cases of dermoid cysts in his series, six with abcesses, Siems (1958), quoted in Shandall, reported 124 cases among 3000 circumcised patients in Eastern Sudan, and Shandall reports 53 among 3820 patients, of which 51 were found among the 3013 cases of pharaonic circumcision and only two small ones among the 807 cases of Type I or Type II circumcision.

Chronic pelvic infection according to Shandall is three times commoner among women who have undergone pharaonic circumcision than in all other groups. It is mentioned also by Verzin and Modawi; and Laycock describes two cases of such severe chronic vaginitis as to lead to pseudo-elephantiasis of the vulval area.

Calculus formation, in the form of calcified deposits in the posterior fornix or under the bridge of skin which hides the urinary meatus after pharaonic circumcision, or elsewhere in the vagina, is described by many authors[5,9,11,14,15,16].

Dyspareunia and even apareunia, because of introital sdtenosis have been reported[2,5,9,14,15,16]. Funnel anus, anal fissures and occasionally incompetent and sphincter, all due to anal intercourse taking place in cases where vaingal intercourse is impossible, are reported by Verzin and Modawi. Huber also mentions vesico-vaginal and recto-vaginal fistulae either from defibulation performed at the time of marriage or from coital trauma.

Infertility. Through tight introitus, dyspareunia and chronic pelvic infection, pharaonic circumcision makes a significant contribution to infertility[6,15,16], although pregnancies do occur even in

instances where the degree of stenosis could not have permitted penile penetration. Lenzi describes four cases of infertility all associated with chronic salpingitis after pharaonic circumcision[9]. Pridie et al attribute between 20 and 25 per cent of all cases of infertility in Sudan to pharaonic circumcision[12].

Urinary tract infection. The bridge of skin which hides the urinary meatus after pharaonic circumcision results in a distorted stream and in the area being constantly wet. Washing cannot include the inner epithelial surface of this area of skin which thus remains irritated by urine and prone to bacterial infection[5,11,12,16]. Kothe et al[7] describe in detail a case of chronic recurrent cystopyelo-nephritis in a Sudanese woman aged 28 years. Shandall[15] reports that 28 per cent of patients with pharaonic circumcision had bacteriologically positive urine cultures, compared to eight per cent of women uncircumcised or with sunna circumcision. Symptoms of urinary tract infection occurred in sixteen per cent of women with pharaonic circumcision but in only four per cent of the others.

Increasing difficulty of micturition after many years, the result of progressive contraction of fibrous tissue, has also been reported[5,16,18].

OBSTETRIC COMPLICATIONS

Not only does pharaonic circumcision render examination in labour difficult, but also makes it difficult to perform catheterization[5,15,16].

Anterior episiotomy (performed in most cases, of course, by the untrained traditional birth attendant) is often necessary, in addition to the postero--lateral epiisiotomies often needed in primigravidae. If anterior episiotomy is not done the rigidity of the scar tissue forces the head back and leads to severe perineal lacerations[16]. Perineal tears are in any case common[4,11,15].

Among the consequences of the anterior episiotomies thus rendered necessary are:

- unnecessary blood loss[15]
- bladder and urethral fistulae[11,16]
- injury to the rectum and late uterine prolapse[8]
- local sepsis[8,12,16].

Delay in labour, prolonged second stage, uterine inertia and obstructed labour are all reported[5,8,11,12,16] and both Verzin and Modawi report vesico-vaginal and recto-vaginal fistulae resulting from obstructed labour which also must necessarily increase foetal loss and brain damage through anoxia.

As anterior episiotomy is always necessaary and infection is common, pharaonic circumcision is a significant contributor to puerperal sepsis. 40 out of 100 consecutive cases of puerperal sepsis reported by Shandall were due to infected anterior episiotomy alone.

SUMMARY

Pharaonic circumcision (infibulation) of females has been described in the foregoing pages. It is today mainly practised in Somalia, Sudan and parts of Ethiopia. From the medical literature cited in the references attached the following adverse consequences to physical health are described:

<u>Immediate</u>: shock due to pain and/or haemorrhage
infection of the wounds
urine retention
damage to urethra or anus
haematocolpos.

<u>Gynaecological and genito-urinary</u>:
keloid formation
implantation dermoid cysts, including abcesses

chronic pelvic infection
calculus formation
dyspareunia
infertility
urinary tract infection
difficulty of micturition

Obstetric: perineal lacerations
consequences of anterior episiotomy
including:
blood loss
injury to bladder, urethra or rectum
late uterine prolapse
puerperal sepsis
Delay in labour and its consequences:
vesico-vaginal, recto-vaginal fistulae
foetal loss
foetal brain damage

The sum total of suffering and disability consequent upon pharaonic circumcision is therefore very considerable, although it does not come to light in rural areas in particular as frequently as it would were medical care more easily available.

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REASONS FOR AND PURPOSES OF FEMALE CIRCUMCISION

by

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(original: FRENCH)

INTRODUCTION

Efforts have always been made to protect female chastity and to preserve virginity. Indeed, it is the search for virginity which generated the practice of infibulation or vaginal closure. This reason is often denied by the various peoples who practise this rite and many other motives have been mentioned. Female circumcision has in fact become an ancient tradition, a century-old custom, in many countries, and nobody really seems to know why it is practised. It is a custom which is intimately related to privacy, religion and superstition.

REASONS FOR CIRCUMCISION

The reasons and purposes most frequently cited by various authors are the following:

1. Prevention of sexual immorality

Excision of the most sensitive parts apparently aims at mitigating sexual desire in girls and women and making them less vulnerable to sexual temptations. Awareness of the concern for virginity is enough to realize the increasingly early age at which these operations are performed on girls in order to preserve their virginity until marriage.

It is obvious that removal of the clitoris, whether involving the labia or not, reduces sexual activity in females and diminishes the

pleasure which they can derive from intercourse; it can even cause frigidity. However, the physiology of such highly sensitive organs as clitoris and labia greatly excites curiosity. It is indeed false to pretend to prevent sexual immorality through female circumcision and infibulation, since prevention of sexual immorality, or protection of virginity, should be an ethical rather than a physical or physiological concern.

Abu-El-Futuh also expresses the view that sexual immorality cannot be prevented through pharaonic circumcision but rather through appropriate sexual and social education, as sexual ethics depend more on social conditions and the environment in which the girl's personality develops than on the amount of vulva excised. Abu-El-Futuh examined 200 prostitutes in the Sudan and found that 170 were circumcised according to the pharaonic method, 22 according to the so-called sunna type and eight only were not circumcised, thus giving the following ratio: 21 pharaonic circumcisions, three sunna circumcisions and one non-circumcised, while the proportions in the 4024 adult women he examined at the Clinic of Gynaecology/Obstetrics, General Hospital, Khartoum, were: 15 pharaonic circumcisions, four sunna and one non-circumcised as reported in "Clinical Study of the Complications of Female Circumcision observed in the Sudan". If infibulation did actually offer protection from sexual temptations, the ratio of infibulated females should be lower among prostitutes than among ordinary women. Thus, infibulation provides no protection; on the contrary, the vulvar skin diaphragm artificially constructed through infibulation can always be reconstructed without giving rise to any suspicion that it is not the original diaphragm.

According to Abu-El-Futuh, pharaonic circumcision could promote rather than prevent sexual immorality. In his opinion, Sudanese gynaecologists are sometimes asked by girls who had lost their virginity to have an operation for reconstruction. Such requests are usually refused.

Guirriec also reports that *restitutio ad integrum* is used in Somalia for dishonest purposes and some parous women undergo operation to pass as virgins.

2. *Personal hygiene*

Bantus in Kenya state that they practise female circumcision and infibulation to achieve greater cleanliness of the vulvar area.

Abu-El-Futuh considers that this may be true for the *sunna* circumcision as practised in the Sudan, where only the prepuce of the glans is excised. However, with the other types of circumcision, particularly infibulation, the resulting complications and discomfort will cause more misery than the formation of smegma between the prepuce and the glans clitoridis.

3. *Unwillingness of males to marry uncircumcised females*

This reason is sometimes cited, especially in Ethiopia where Catholic missionaries in the sixteenth century had prevented converts fron excising their daughters. As a result, males had refused to marry non-circumcised girls, as females in those areas were said to have enlarged genitalia and considered repugnant to males. Following investigations, the Church authorities were obliged to reinstate circumcision (see *History of Circumcision*, Zaborowski, 1894). A similar situation occurred in Kenya when the British authorities tried to stop female circumcision in that country (Sequeira, 1931).

There is therefore a genuine sociocultural problem, the solution of which depends on attitudinal change as well as on health care development in those regions. It should be pointed out, however, that in the Sudan, new generations definitely prefer to marry either girls circumcised according to the so-called *sunna* method and or non-circumcised girls (Abu-El-Futuh).

4. Prevention of enlargement of the clitoris and labia

In Ethiopia, congenital enlargement of the clitoris and labia is reported. Among the Bushmen in South Africa, enlargement of the labia minora would be acquired and due to manipulations they may reach up to 20 cms long giving the famous "apron" of the Hottentots. Such enlargement is an indication for circumcision among these populations. Abu-El-Futuh believes that when enlargement of the clitoris and labia is such that it becomes unaesthetic and uncomfortable, circumcision can be carried out and the operation should be performed by qualified medical personnel and under general anaesthesia.

It is worth mentioning here that this unaesthetic enlargement can be corrected by plastic surgery. Lattimer described an elegant technique of reduction and relocation of the enlarged clitoris preserving the glans as an alternative to amputation. This technique consists of the dissection of the base of the enlarged clitoris with skin cut-down; the crown of the glans clitoridis is them trimmed to appropriate size for the child's age and transfixed into the subcutaneous fatty tissue just above the urethra.

5. Improvement of fertility and prevention of maternal and infant mortality

Some tribes, particularly the Mandingo, Massaï and Swahili, believe that female circumcision improves fertility, maybe in a magic way, and prevents maternal and infant mortality; it is for these purposes that they practise this very ancient custom. However, infertility is among the numerous complications of the operation as it produces chronic genital infections. In addition, it is responsible for a large number of fatal complications for both mother and child.

6. Enhancement of husband's sexual pleasure

Many females believe that the narrowness of the vaginal orifice resulting from infibulation enhances the husband's pleasure and this is

the reason why they wish to maintain the practice and even insist on its being repeated after each delivery. Abu-El-Futuh tried to ascertain whether the narrowness of the vaginal orifice as a result of infibulation enhanced the husband's sexual pleasure. He questioned 300 husbands selected among polygamous males having both circumcised and non-circumcised wives. They were asked whether they experienced greater sexual pleasure with their infibulated wives. The results of the survey were as follows: 266 husbands emphatically stated that infibulation had no advantage over sunna circumcision. All responded that they preferred a non-circumcised wife or a wife circumcised according to the sunna method to an infibulated wife. Indeed, the former gave them enhanced pleasure, sharing with them sexual desire and intercourse, whereas the infibulated female apparently submitted to coitus, sometimes with suffering but never with pleasure. Ninety out of these 266 husbands stated that they never felt that their infibulated wives experienced orgasm; 60 others, out of the 300 said that they had their second wives because they were tired of "reopening" after each delivery. Only 30 out of 300 husbands indicated that intercourse with their infibulated wives gave them enhanced pleasure.

It can therefore be concluded that the narrowness of the vaginal orifice of infibulated females gives no special sexual pleasure.

7. To make the woman "feminine"

Certain psychoanalysts studying excision of the clitoris in some tribes claimed that the sole reason for this practice was that males regarded the clitoris as a small potential penis which should therefore be removed to make women truly feminine or "vaginal" for sexual intercouse. This theory is in conformity with the concept of the dual nature of female sexuality which Bruno Bettelheim (Les Blessures symboliques) postulates as early phallo-clitoral sexuality followed by a genito-vaginal sexuality. Bettelheim does not however accept this theory and states that it rests on very unstable psychological foundations and could not explain why the clitoris is removed.

8. Initiation of the girl into womanhood

Certain anthropologists think that the reason for female circumcision in some African tribes is to initiate the girl into a woman's life, irrespective of any religious belief. In Sierra Leone, for example, young girls of about 12 years of age are initiated into womanhood and during these ceremonies, and in the presence of the whole tribe, the girl is excised by a special midwife on the back of a river at full moon. The clitoris is removed to reduce sexual pleasure and to prevent promiscuity. The girl is then given a name and left alone, in total solitude, until a man asks her father for her marriage, usually around 15 years of age. The removed clitoris is buried near a tree or by a river. Female circumcision among these tribes thus forms part of the initiation rites.

9. Traditional factors

When members of a traditional community are asked why they follow the practice of circumcision, many females respond that they do so because it is the tradition. It seems, however, that it is not only adherence to tradition which contributes toward the maintenance of this practice, but also a deep psychological conditioning. Calling a female ghalfa (non-circumcised) is a very grave insult in the Sudan. Likewise, in Somalia, the worst insult is to accuse a woman of having an excessively wide vaginal orifice. Furthermore, Worsley points out that the adult Sudanese woman is proud of the scar of her tahur (circumcision) and calls it nafsi (myself), thus giving an aesthetic anatomical value to the practice, which the older women aim to perpetuate.

10. Religious reasons

It may be noted that the Skoptzis in Russia derive their authority for performing both male and female circumcision from Saint Matthew. However, female circumcision is mostly practised by Muslims in many

countries in the belief that it is a religious obligation. It should be noted however that the Koran does not mention male or female circumcision; it is believed by some that the Prophet Mohammed had recommended sunna as compulsory for boys and preferable for girls. In this connexion, Abu Dawood, quoting Om Atiya, reported that the Prophet of Islam had said to a woman who was circumcising a girl: "Circumcise, but do not cut deeply; it is enjoyable for the female and preferable for the male". The practice of infibulation, the removal of the clitoris and labia, is in actual fact condemned by Islam though Islam accepts the much simpler sunna circumcision. Therefore, it is clear that pharaonic circumcision or infibulation as practised in Muslim countries, such as Sudan and Somalia, is contrary to Islamic law.

11. Prevention of mania, nymphomania and onanism

Certain tribes say that circumcision prevents mania caused by excessive sexual desire which females experience before the operation, and it is to prevent this mania that the practice is continued. It is also worth mentioning that in the last century a London surgeon recommended and performed clitoridectomy and nymphectomy in cases of hysteria, erotomania and onanism in girls. This operation was rejected by both psychiatrists and surgeons as it was considered non-scientific.

Conclusion

In the light of this study and review of the various reasons for female circumcision, it can be concluded that none of these reasons would justify the continuation of this practice.

PSYCHO-SOCIAL ASPECTS OF FEMALE CIRCUMCISION

by

Dr Taha Baasher

An outline has been given of the historical perspective of female circumcision (FC), its psychological complications and the results of a preliminary study on community attitudes towards this custom[1]. In this paper, the psychosocial aspects will be further elaborated.

ORIGIN OF FEMALE CIRCUMCISION

On returning to his home country in 1767, Niebuhr, the German traveller who was the sole survivor of the first European scientific expedition to Arabia, Egypt and Syria, reported on the practice of female circumcision and stated thus:

> "In Oman, on the shores of the Persian Gulf, among the Christians of Abyssinia, and in Egypt among the Arabs and Copts this latter custom was prevalent."...
> "Much has been said concerning the origin of the custom, ... which seems, at first view, so absurd" and concluded that "out of cleanliness, and to render ablution easier ... the practice of circumcizing women has been first adopted."
>
> He further added that:
> "No law has appointed it ... it is usage, not a religious duty"[7].

To date, and over two centuries after Niebuhr's statement, female circumcision persists in several countries though considered absurd.

However, despite improved scientific means for investigation and more readily available information based on systematic research studies, convincing conclusions regarding the origin of this ritual, cannot be made. There are still many questions which remain unanswered.

- Where had this custom originated?
- How did it originate, and why?
- What are the factors which led to its persistence among certain communities and not in others?

It is possible to provide answers to some but not to all these questions. As evidence shows, female circumcision has been practised in one way or another in all continents of the world, old and new. However, there is no established historical evidence to indicate in which continent was this custom first practised; nor which type of operation was first performed. It is not possible, for example, to see the connexion between the practice of infibulation in the African continent and that of introcision in Australia.

Though there is a clear pictorial representation to demonstrate male circumcusion in Pharaonic Egypt as shown in the tomb of Ankmahor of the Sixth Dynasty (2340-2180 B.C.) at Saggara and in the Naga-Al-Deir stelae[8], there is no comparable historical evidence in the case of female circumcision. However, Herodotus, who visited Egypt in the middle of the fifth century B.C. and again Strabo, the Greek geographer, reported the practice of this custom in ancient Egypt, Ghalioungui seems to be right when he pointed out that the state of preservation of mummies does not permit firm conclusion as regards this practice[9].

It is interesting to note that Freud believed that circumcision came from Egypt. However, Philip, in <u>Freud and Religious Beliefs</u>[10], challenged this assumption and pointed out that "if Freud had fully examined his own authority (i.e. Herodotus), he would have found that there is a passage which states that the rite was practised by

Phoenicians, Hittites, Ethiopians, as well as by the Egyptians." Philip indicated that circumcision was a Kenite practice and that Moses derived it from there, and concluded that the source of circumcision in general and the origins of the Hebrew practice of circumcision are far more complex than Freud assumed.

To sum up, judging from available historical resources and anthropological findings, it is not possible to conclude whether there was one origin or several independent origins of female circumcision, and further research study is therefore needed in this respect.

THE PSYCHOLINGUISTICS OF FEMALE CIRCUMCISION

The study of the psychological aspects of language often gives meaningful insight into the human behaviour associated with names and social communication. In this respect the psycholinguistics of female circumcision seem interesting. Contrary to what has been reported in other cultures, the names commonly used in the Sudan to describe the female genetalia in general or the clitoris in particular are conspicuously limited. There are hardly any popular songs, similar to that of the Boy in the Boat, where the clitoris is metaphorically depicted in a Western culture[2] and which in a way indicates differences in social permissiveness and community tolerance regarding free communication of sexual love.

The name gamal (camel), for example, which is commonly used in central Sudan, seems to be derived from the protruding shape of the clitoris in the centre of the female genitalia, denoting its similarity to the hump of the camel. Similarly, in Egypt the clitoris is known as al bazr (protrusion) which also seems to describe the shape of this organ. It is also interesting to note that in classical Arabic the clitoris is known as the nawat, or the seed.

Etymologically, however, there is an important difference in literary Arabia between the terms for surgical operation of boys' and girls'

circumcision. For the male the operation is described as Khitan meaning cutting of the prepuce, and for the female khefadh indicating the process of reduction in the female genitalia which takes place[3].

The operator is classically known as the khatin for boys and the khafedha for girls. There is hardly any historical reference to the different types of operation. However, the type of circumcision which is obstetrically known as infibulation or Type III[4], and also called "pharaonic circumcision" has been commonly known under this name in the Sudan and not in Egypt. Conversely, in Egypt, this type of operation has been referred to as "Sudanese". Other types of operation, such as introcision, which is reported to be practised among some of the aborigenes in Australia[5], do not seem to have any name within the Middle East culture. Other features of the psycholinguistic aspect of female circumcision will be discussed under "psychosocial background".

Traditionally, female circumcision has been conceived as a symbol of purification and viewed as a way of cleanliness. In fact tahur, which is the generic name of circumcision, literally means purification, which again in a sense points to a religious background and gives it special sociocultural connotations. Inference of the same meaning can be made, when an uncircumcised girl is described as nigsa (unclean). This indicates the place of female circumcision in social life and reflects its subtle psycholinguistic usage. A woman, for example, may make a serious and solemn vow by saying "I would be uncircumcized if I do not do this or that ..." Again, among traditional societies where female circumcision is regularly practised, it is considered a degrading remark to address one as "the son of the uncircumcised". Hansen[6] refers to similar linguistic usage concerning female circumcision in rural Egypt and points out that the "son of an uncut mother", ibn el bazra, is a grave insult.

On the whole, under rapid socioeconomic changes, the psycholinguistic features of female circumcision in many urban communities remain as a cultural relic and should sooner or later disappear, as has been the case among certain social classes.

PSYCHOSOCIAL BACKGROUND OF FEMALE CIRCUMCISION

When dealing with the psychosocial background of this custom, several questions become pertinent. What social or psychological function does it serve? And what is the nature of motivational forces that make a mother willingly and faithfully subject her daughter to such a drastic operation, and undertake such a risk? Clearly the answers to these questions and others are intricately enmeshed in the cultural heritage and the social fabrics of traditional societies where the practice exists.

Whatever may be the meaning or motivation of female circumcision, it seems evident that the custom was first performed on the male and later practised on the female. Various views have been advanced to explain the psychological motives and social functions associated with this custom. These can be broadly grouped under three main headings, namely religious, psychosocial and medical.

(a) Female circumcision and religion

Within the context of magico-religious belief, it has often been suggested that the operation of circumcision and the giving of part of the genital organ can be interpretated as an offering of sacrifice to the deity presiding over fertility. Fertility cults are generally known and fairly common among preliterate and traditional communities. However, the practice of female circumcision which is observed in many parts of the world does not seem to be closely connected to a fertility cult. Moreover, there are a variety of magico-religious practices, including fertility rites and cults, which have been traditionally developed without resorting to extensive human hardship or mutilating surgical operations. Even if the operation has been originally practised in the female as a fertility rite, most likely it would have been symbolically applied and confined to partial clitoridectomy. Other reasons have therefore to be sought to explain female genital operations such as that of infibulation which results in radical changes in the genital organs.

On the other hand, reference has been made to Holy Writ to indicate the religious significance of circumcision. Sequeira[11], for example, while most likely referring to male circumcision, pointed out that there was considerable evidence in favour of a religious significance and quoted the reference in Holy Writ which stated that it was "an outward and visible sign of an inward and spiritual grace" (e.g. "circumcision of the heart"). In historical perspective Johnson[12], when referring to changes and modifications of the sexual tradition of the ancient Jews by the Christian Fathers, indicated that circumcision was no longer required and also indicated that Saint Paul said:

> "For in Jesus Christ neither circumcision availeth anything, nor uncircumcision, but faith which worketh by love."
> (Galatians, V, 6).

Among Muslim communities in Egypt and Sudan, for example, it is not uncommon to find that female circumcision has been traditionally practised under the pretext of adherence to religious principles. It is remarkable that this custom is no longer observed in leading Arab countries such as Saudi Arabia, the cradle of Islam and the centre of the Holy Lands. With such a wide diversity between Muslim communities, it is not surprising to come across conflicting views regarding the place of female circumcision in religious interpretation. Nonetheless, it is important to emphasize here that in the absence of any clear reference in the Holy Koran and in confirmed traditions (Hadith) of the Prophet Mohamed, leading Islamic theologians, such as Sheikh Shaltout[13] refuted the argument based on religious doctrine for the practice of female circumcision. Some of the confusion which may have arisen with regard to religious interpretation is probably due to generalization from male circumcision to the female. While there is a general consensus of opinion that circumcision was one of the commands, when the Lord made trial of the Prophet Abraham, there is no clear indication in the case of female circumcision. Even the often quoted saying of Prophet Mohamed to the traditional practitioner, Om Atteya, advising her to reduce but not to destroy, was challenged as

unreliable and unauthenticated. Nonetheless, some of the Muslim theologians advocated mild clitoridectomy and qualified their statement by describing female circumcision as a sign of "embellishment" or as being "preferable" and "commendable". The Mufti of the Sudan, Sheikh Ahmed El Taher, in reviewing the subject in 1946, clearly stated that the words "embellishment", "preferable" and "commendable" do not imply obligation[14].

As previously stated, there is no valid evidence of any indication by the Prophet Mohamed pertaining to female circumcision, yet partial clitoridectomy has been popularly known in some Islamic countries as the sunna type. Sunna means tradition and its theological inference, which can easily be discerned, has often been unwittingly emphasized. A girl, for example, may be considered "unclean" until she has undergone the Sunna (dakhalowha el sunna). The implications of such erroneous concepts and their psychological influence among the laity on enforcing adherence to this custom is generally great. The clear understanding of these inherent factors in the perpetuation of female circumcision should be helpful in developing an appropriate approach to deal with this traditional practice.

(b) Psychological factors and meaning

The ceremonies and rituals associated with female circumcision in the Sudan have been generally described by various scholars (Young, 1949; Barclay, 1964; Cederblad, 1968 and Hayes, 1975)[15,16,17,18] and the main characteristic features will be summarized as follows:

(i) The whole process is characteristically a woman's affair and the pattern of behaviour still follows centuries-old cultural practices. The family usually celebrates the occasion and female relatives and friends actively participate in the ceremony.

(ii) On the operation day, a Sudanese girl early in the morning is specially dressed in her best clothes, exceptionally adorned with

a new golden ring and bracelets and her palms and soles are carefully tinted with henna - a reddish herbal dye. Significantly, she is often referred to as the "bride", a clear indication of her coming of age and the future relation of the operation to marriage and the girl's expected sexual role.

(iii) A special feature of the ceremony is the jertik, with its special dress and rituals, which is traditionally designed to provide through magical means, protection against bleeding, evil eye and harmful spirits.

(iv) During the period of confinement following the operation, which naturally varies with the type of circumcision, special care is taken to feed the girl well and provide her with social and psychological support.

It is clear from the ceremony and rituals that female circumcision is deeply rooted in cultural traditions and ancient practices, which have resisted the wind of change. Consequently, its meaning and psychosocial implications seem fascinating and controversial. From what has already been stated it will be seen that the custom of female circumcision in the Sudan forms a psychosocial complex which draws from a constellation of religious beliefs, traditional practices and social values. These various elements have to be taken into consideration when explaining its meaning and theoretical background.

There is the tendency to explain such practices on the basis of initiation rites and as an endeavour to enforce the process of psychosocial development from puberty to adulthood. It is to be remembered, however, that the average age of the operation is now six or seven years. Pre-puberty and puberty operations may have been the norms of age in the past but they are now the exception. Socially for years after the operation, the child leads the same life as before and does not undertake new roles. One is, therefore, inclined to agree with

Kennedy[19] that the rituals may have effects on the social awareness of the child but "no obvious relationship to gaps or failures in the socialization process - such as are assumed in modern theories of Whiting[20], Cohen[21] and Young[22]."

From the community point of view, apart from its religious significance, female circumcision has been conceived to subserve specific purposes, mainly:

(a) to attenuate sexual desire;
(b) to preserve family customs and conform to social values; and
(c) to keep the genital organs clean and healthy.

It is a common belief that the clitoris is an essential focus of sexual desire and its excision is considered an important element in the control of sexual behaviour. The understanding of such beliefs has to be viewed within the context of moral values and community ethics. It is instructive to note that pre-marital and extra-marital relationships are regarded as a serious breach of the ethical code of Sudanese behaviour and that an unmarried girl is expected to lead a life of chastity and remain a virgin. It is possible that female circumcision has been traditionally practised to enforce these moral values and ethical standards. This is obviously one aspect of a whole range of activities in a complex system of socialization and conformity to community norms and traditional ways.

Although many families doubt the ethical role which female circumcision may play in the control of sexual desire, they readily perform the operation in order to confirm to the social milieu and spare their daughters the contempt which may be shown by the more conservative members of the community.

(c) <u>Female circumcision in medical practice</u>

Historically, excision of the clitoris and removal of its prepuce (female circumcision) have been known in medical practice for a variety of

psychological disorders and physical conditions. Huelsman[23] gave a detailed review of the literature and referred to the alleged benefits of declitorization during the first six decades of the nineteenth century and the later heated controversy regarding its merits and disadvantages in The Lancet - 1886 and 1967.

Though by the advent of the twentieth century clitoridectomy as a cure for masturbation and other psychiatric disorders such as "nymphomania", hysteria or epilepsy had almost disappeared, until very recently the operation was indicated for certain psychosexual problems, namely "lack of ability to have a climax"[24] and in the treatment of frigidity[25]. Clearly, the indication for such an operation is rather impressionistic and lacks scientific validation.

In conformity to social norms and community practice, the sunna type of female circumcision is still performed by medical practitioners in some countries[26]. There is no legal sanction against it and it is viewed as a progressive step compared with the radical operation of infibulation.

PSYCHIATRIC PROBLEMS ASSOCIATED WITH FEMALE CIRCUMCISION

The psychological sequelae to female circumcision may be seen as psychosexual disorders or frank psychiatric disturbances, and these will be generally discussed.

Psychosexual disorders

The sensitivity of the clitoris and the genitalia to sexual stimulation is generally established and the questions often raised are in connexion with the effects of female circumcision on female sexual desire and the attainment of orgasm.

While the clitoris and the genitalia in general are the main sexual receptors, sexual stimulation can be brought about by psychological

excitation or through other anatomical organs, mainly the breast and the rectum. Social and cultural factors have their influence too on sexuality and all these have to be taken into consideration when assessing the sequelae of female circumcision. Furthermore, research studies which have been carried out in this field are rather limited and no generalization should therefore be made in this respect.

Is psychoanalytic terms, circumcision has been viewed as a symbolic substitute for castration with certain influence on the Oedipus complex[27]. The explanation given by Anna Freud seems more plausible and reasonable. She stated that:

> "... any surgical interference with the child's body may serve as a focal point for the activation, reactivation, grouping and rationalization of ideas of being attacked, overwhelmed and/or castrated ..." and that "where the defence mechanism available at the time is strong enough to master these anxieties, all is well ..."[28]

There is no doubt that the child as a result of the operative interference of female circumcision is overwhelmed, subjected to excruciating pain and real suffering. Some of these physical and psychological reactions are mitigated by the social support and the special family care given to the child. However, the outcome of the operation and its effects on the mental state and well-being of the child in general depend on her psychological defences, personality formation, past experience, the preparatory phase, the way in which the operation has been performed and the ensuing complications which may take place.

In the absence of systematic prospective studies it is rather difficult to come to conclusive results with regard to specific effects of female circumcision on sexual practices such as masturbation. The conflicting findings in the literature can be generally seen if, for example, a comparison is drawn between the results obtained by Karim and Ammar[29] and those by Kinsey[30]. While Kinsey et al reported that 25%

of their female samples (5940) who were obviously non-circumcised masturbated, Karim and Ammar estimated that only 5% of the circumcised respondents (120) indulged in this practice. Due to the inherent difficulties in undertaking systematic research studies, such as failure of reporting, Karim and Ammar described their results on masturbation among circumcised girls as rather "doubtful".

Many assumptions have also been made regarding the effects of female circumcision on sexual desire which, as previously mentioned, can be affected by a variety of social, psychological and physiological factors. It is important to note that with regard to lack of sexual desire in the female, commonly referred to as frigidity, the rate of incidence, as reported in Western literature, may vary widely from 10% to 30% and more. Clearly, the variables here are so many and the criteria of investigation may not yield comparable results.

An important topic which has been given special attention in the past is the relationship between sexuality, female circumcision and the abuse of narcotic drugs, notably cannabis. It has been assumed that, because of less sexual desire and greater incidence of frigidity among circumcised females, there is more dependence on cannabis in order to increase male potency and compensate for sexual insensitivity. However, such an assumption has not been substantiated by any organized scientific study or clinical evidence. On the contrary, it has been observed that the abuse of cannabis may lead to sexual failure and impotence in the male. Probably what happens is that, under the effect of cannabis, in addition to the elation and change of mood, a certain disturbance in the sense of time takes place and this gives the feeling of a false prolongation in the time of coitus and in sexual vigour. In brief, as far as available evidence shows, there is no established correlation between the extent of cannabis abuse and the practice of female circumcision.

Surprisingly, female circumcision has been advocated in the treatment of frigidity[24] "with resulting cure of psychosomatic illness and

prevention of divorce"[25]. How many of the results obtained were due to new behavioural conditioning and suggestion is not clear and this has to be taken into consideration in the final assessment of the operation and the applied technique.

PSYCHIATRIC DISTURBANCES

Clinically, psychiatric disturbances associated with female circumcision have been observed to be either related to the inflicted psychological trauma or as a sequela to the physical complications of the operation, especially Type III (infibulation) with all its extensive surgical interference.

(a) Functional psychiatric manifestations

It is quite obvious that the mere notion of surgical interference in the highly sensitive genital organs constitutes a serious threat to the child and that the painful operation is a source of major physical as well as psychological trauma. The extent and nature of the immediate and remote psychiatric disturbances depend largely on the child's inner defences and the prevailing psychosocial environment. The functional psychiatric manifestations may take various clinical forms and behavioural reactions.

Even before the operation, the threat of "cutting" and the fear-provoking situation may disturb the mental state of the child to the degree of causing worry, anxiety, night terror, panic, etc. The case of the child with fearful dreams associated with the insect, praying mantis, commonly known in the Sudan as el tahora (the circumciser) is a vivid example in this respect. Once the underlying nature of the psychological trauma was discovered and the threat of the operation removed, the child soon recovered and showed no further abnormal behaviour.

In the mild form of simple removal of the prepuce of the clitoris, done under anaesthesia and within standard surgical conditions, and where

the child is psychologically well supported, no adverse emotional or behavioural reactions generally took place. This may not be so in the case of infibulation, with all its known hazards.

The child's reaction to the operation, confinement to bed and restriction of activities may take the form of various behavioural reactions, from that of restless, exaggerated singing, pressure of talk and a host of other symptoms.

It is therefore not uncommon that the family, as a precaution, uses various forms of traditional magico-religious practices, such as the <u>jertik</u>, amulets, fumigation, etc., with a view to preventing psychological complications which are traditionally attributed to the evil eye, <u>jinn</u> and other occult powers.

(b) <u>Organic psychiatric manifestations</u>

As a result of immediate physical complications of the operation, such as severe haemorrhage, surgical shock and retention of urine, as well as septicaemia and tetanus, organic psychiatric manifestations have been reported. The latter may be mild and appear as episodic behavioural disturbances, irritability, disturbed sleep and restlessness. In severe conditions this may develop into a fully-fledged toxic confusional state with all its clinical manifestations.

Whether these psychiatric complications, which take place during the formative years of the child, cause lasting and permanent damage to her is rather difficult to ascertain. Certainly, much depends on the severity of the condition and the management of the child during the period of her illness.

Apart from immediate physical complications which take place in childhood at the time of the operation, there are other serious conditions such as haematocolpos, dermoid cyst[31], vesical fistulae, etc[32], which

may develop later in adult life. These may lead to serious patho-physiological changes and a series of social and psychological problems. They may affect normal sexuality, interfere in marital relationships, lead to infertility or social incapacity. Reference has been made[1] to the patient with dermoid cyst which led to divorce and ended in psychotic excitement. Other psychiatric complications due to these physical conditions may present themselves as chronic irritability, anxiety, depressive episodes, conversion reactions or frank psychosis.

FEMALE CIRCUMCISION AND POLITICS

History tells us of the repeated attempts made strictly to prohibit the practice of female circumcision and the adverse consequences which took place. One of the early movements to oppose female circumcision was in Ethiopia, when in the sixteenth century the Roman Catholic mission prohibited the practice among its converts[33]. The result was a sociopolitical problem, for no one would marry the uncircumcised and the prohibition had to be lifted.

Sequeira in 1931 commented on the ensuing troubles in Kenya, following the movement to prohibit the practice, indicated the importance of making use of available information and hoped that "the guidance of experienced administrators may be able to influence the more enlightened natives with a view to the mitigation of the dangers of female circumcision even if the practice cannot be abolished". To date, in several countries, the situation does not appear much different. However, it is worthwhile to note the review of Bruce-Chwatt (1976)[34] on the opposition movement to female circumcision in Kenya in the early thirties and the medical, social, anthropolgical and political currents which it had created. The late Jomo Kenyatta's approach to the problem and his preference for "a gradual evolution to any drastic changes" is not only of great historical significance but also meaningful with regard to policy actions in matters highly emotionally-charged, deeply rooted in the social matrix, and intricately ingrained in the minds of traditional people. In this respect, it may be useful to restate what Kenyatta had written in 1938[35].

"The real argument was not in the defence of the surgical operation or its details but in the understanding of a very important fact in the tribal psychology of the Kikuyu - namely that this operation is still regarded as the very essence of an institution which has enormous educational, social, moral and religious implications quite apart from the operation itself. For the present, it is impossible for a member of the tribe to imagine an initiation without clitoridectomy. Therefore, the abolition of the surgical element in this custom means to the Kikuyu the abolition of the whole institution ...

"The abolition of irua (ritual operation) will destroy the tribal symbol which identifies the age-group and prevents the Kikuyu from perpetuating that spirit of collectivism and national solidarity which they have been able to maintain from time immemorial."

It seems interesting to compare the situation in Kenya in the early thirties with that in the Sudan in the early forties, when the British administration attempted to abolish female circumcision and a law to this effect was passed. The consequences and the adverse reactions which followed were not unlike those of Kenya. Immediately, the people strongly reacted against the newly-imposed measures and many families rushed to have their daughters circumcised, even at the hands of unskilled persons, and naturally several tragic cases were reported. Politically, the people interpreted the movement as a flagrant interference with their freedom, social customs and cultural beliefs. It was also inferred that the ruling administration was destroying regulating moral practices and leading the community into a state of sexual laxity. This had great political implications and culminated in mass demonstrations and open resistance. It can be clearly seen that the political interference was felt as a threat to national solidarity and to cultural and social order.

In the real life situation the legal regulations have never become a de facto law. In general, the circumcision law among traditional social groups was never accepted, either in concept or in practice, and remained

alien to the social system and cultural values. It has clearly been demonstrated that at certain times and in certain places customs have a stronger force than the law.

Indeed, all these historical events are important landmarks along the stormy road of female circumcision and call for concerted efforts in this field.

In recent years tremendous sociopolitical changes have taken place. Yet, the day when female circumcision will disappear from social life still looks distant. Hopefully, one would like to see collaborative efforts in this respect at all sociopolitical levels, with close coordination between religious, education and health institutions and community agencies in general.

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CLITORIS ENVY
A PSYCHODYNAMIC CONSTRUCT INSTRUMENTAL IN FEMALE CIRCUMCISION

by

Dr Mohammed Shaalan

In biological evolution we can witness the persistence of structures and functions that have outlived their usefulness as instruments of survival. The vermiform appendix is an example of one such organ. Its original function, as observed in some animals, concerned the digestion of cellulose, which is a major component in the food of vegetarian animals. As animals developed in the direction of carnivorous eating patterns, this function became superfluous. Yet the organ that was responsible for it persisted, albeit in rudimentary form, not only after its function ceased, but even when it had became a source of potential harm, namely in becoming liable to occlusion, infection and rupture that could kill the organism. In such situations, man, by evolving artificial means (medical and surgical interference) could consciously remove the redundant organ.

In cases where the organ had a more than physical biological function, namely a sociocultural one, we find interference taking on a traditional "surgical" ritual. An example of this is circumcision.

Circumcision is a social surgical ritual where a society condones or requires the removal of certain integumentary structures thought to be of major influence in sexual behaviour. The risk, even though small, to life and health involved in the operation gives reason to believe that it was otherwise thought worthwhile.

We cannot simply dismiss circumcision as an accidental occurrence of a redundant tradition. Its occurrence and persistence through the ages in so

many cultures make it necessary to search for a hypothesis upon which it might have been based. On the other hand its lack of ubiquity suggests the opposite, namely the disproof of that hypothesis is also possible. If circumcision was indeed based on the hypothesis that it performed a given function, the facts that: (a) it is not performed in some societies and (b) that in those societies where it persists it is on the decline, indicate that either it was found not to fulfil that function or that the function ceased to be necessary.

In this paper we shall try to discover the hypothesis on which this custom was based. Our inferences will be derived from observations in the clinical field, particularly with patients having sexual problems, as well as interview material gathered from a research project to study the matter[1]. We shall restrict our topic to female circumcision.

Female circumcision, though less widespread than its male counterpart, is nevertheless practised in many societies, amongst which is Egypt. It is more common among Muslims and is found more in the Nile Valley villages than in the cities and deserts. Though pharaonic in origin, it is associated with Islamic tradition (hadith) sunna, rather than direct ordainment. This is based on the Prophet's saying (not accepted by all theological authorities) advising against excess in the surgical removal of the part concerned.

The procedure aims at excision of the clitoris, and sometimes parts of the labia minora; exceptionally other parts, such as the labia majora, are abraded and sewn together (leaving a small opening for micturition); but this is restricted to the Nubian subcultures as well as Sudan. It is performed during prepubertal years.

[1]A research project supported by NIMH and carried out in Egypt by Karen Paige Ph.D. (Berkeley, Calif.) in collaboration with a team from the Dept of Neuropsychiatry, Faculty of Medicine, Al Azhar University.

The widespread belief surrounding the practice is that it is presumed to reduce sexual pleasure and excitability of the female. The alleged cautioning of the Prophet Mohammed against excess in the procedure (Liwaa-al-Islam, 1951) may seem to contradict this hypothesis; however, on the basis of the view that Islam is tolerant of sexual pleasure, the Prophet's caution to minimize excision (simply removing the prepuce rather than total clitoridectomy) seemed to favour enhancement of pleasure and excitability rather than its opposite. Nevertheless, this could support one probability, that the previous social trend was in favour of reducing sexual pleasure and excitability, and the Prophet's statement was designed to counteract this trend. It is worth noting the current virtual absence of circumcision in most Islamic countries; while in Egypt it is practically restricted to the Nile Valley, indicating its pharaonic rather than Islamic origin. A similar cautious approach when counteracting a strong social tradition is also evident in Islam's prohibition of alcohol. This, in turn, was associated with the decreased tendency to seek sexual pleasure which would increase the likelihood of premarital chastity and marital fidelity. While emphasizing such virtues for women, men were nevertheless exempt from strict adherence to them. The paradoxical situation was that the more men acknowledged their own uncontrollable desires, while simultaneously demanding chastity and fidelity in their own women kin (daughters, sisters, wives), the more they were protective of such virtues in their women. Circumcision would represent one such means of ensuring virtue in women. It is true that societies circumcised their boys too, even more commonly than girls, but such a practice was more associated with the function of enhancing pleasure rather than reducing it. Thus we arrive at a situation reflecting the relative attribution of values between men and women, where women were compensated for their presumed curtailment of pleasure by the virtues of chastity and fidelity, while men completed their punishment sentence in advance by the symbolic castration of circumcision in exchange for the condoning of a certain enjoyment of their "sins."

The physiological basis on which such a belief is based, is that the clitoris is a highly sensitive erotic organ, that is more or less

superficially located in the female genitalia, permitting relatively easy access to tactile stimulation. A woman may be much more easily aroused, excited and brought to orgasm by that organ than any other in her genitalia. Moreover, its function seems to be purely pleasurable and does not have any direct physiological utility.

Such a capacity seems to give an erotic advantage to women over men. For men no such stimulation leading to arousal, excitement and orgasm is possible without a concomitant physiological process in the form of ejaculation which does have a biological function. Thus a woman could presumably enjoy pleasure without having to fulfil any biological function (mothering). Ovulation is a more or less autonomous process which is minimally associated with sexual arousal, which is not the case in most animals; while a man, in order to attain such pleasure would almost invariably have to dispense with his ejaculation.

We might add to this that clitoral stimulation and excitement is possible within a condition of relative passivity on its part, where the activity would be the onus of the stimulating organ, be it the finger, tongue or phallus, belonging to the woman or her partner. For the man on the other hand, the equivalent process would necessitate a degree of activity most of which would fall within the domain of the motor component of his automatic (parasympathetic) nervous system. This namely is the development of an erection of the penis coupled with active thrusting movements, performed mostly by hips and waist. This second quality of sexual patterns of excitement, give another erotic advantage to women, in that they are more capable of voluntary sexual stimulation even in the absence of the autonomic component. Thus they can go through the motions of sexual activity, without being involved at the autonomic level. Thus a woman is more capable of infidelity by acceding to a man even though she might not be desiring him. By this same token she is more subject to rape, by permitting the possibility of sexual intercourse requiring the voluntary involvement of her male counterpart pitted solely against her voluntary passivity or even resistance.

Thus by virtue of her clitoral function woman possesses erotic advantages over man by having a greater capacity for the pursuit of purely erotic pleasure and the capacity to enjoy such a pleasure by simply acceding to a man's desire. Is it not possible here to observe the physiological basis of "clitoris envy" on the part of man towards woman, more deeply ingrained than its lately acknowledged counterpart, namely penis envy? Womb and breast envy have been described by psycho-analysts as having a basis in man's deep envy of woman's capacity for giving birth and nurturing. The fact that his very creation and survival were dependent on a woman (his mother) is one that is more deeply seated in any man's psychic make-up than his awareness of any additional advantages which have accrued to him through social customs and social organization, and that were a privilege of his maleness, that is, his possession of a penis. Yet even on the phallic-oedipal psycho-sexual development levels we might be ignoring that there, too, could be a source of envy, the reverse of what we are accustomed to think. No doubt the penis is larger and more visible than the clitoris, but the association of its pleasurable capabilities with its erectile state, which is not subject to voluntary control in the child or the adult, creates the basis of an envy of its female counterpart, the clitoris. For the latter is indeed capable of stimulation without, at least any manifest, motor requirements, (congestion, engorgement and "erection" of the clitoris, in addition to retraction of its hood, do indeed occur, but their lack of visibility and hence their display, obviates the need for having such motor complications as a sign of desire or excitement). Conversely, where excitement or arousal might be associated with punishment or guilt, the female would have the advantage of experiencing pleasure without displaying signs of it.

One could object to the attribution of psychic qualities to anatomical structures such as the penis or womb. If, however, one could regard the anatomic reference as a symbolic equivalent rather than a literal representation, the anatomic nomination could be excused. Thus, it is not the penis as an anatomic structure that is envied but rather what it might come to symbolize, be it essential male qualities or attributes of masculinity that have been acquired through social heritage.

Given these advantages that, though not openly acknowledged, could yet form the unconscious basis of men's envy of the clitoris, we can provide the psychodynamic basis of that custom in societies where man apparently makes the decisions. However, a psychodynamic basis is certainly not sufficient to explain the occurrence and maintenance of the practice as a ritual nor explain the fact that it is not practised in certain places and times.

Here we must refer back to the social value attributed to the practice, specifically in relation to chastity and fidelity, which neverthless would be related to the same psychodynamic basis. If women are envied because of their greater capacity for pleasure and hence for inchastity and infidelity, and the virtues concerned in turn have a function, then to maintain these virtues this capacity must be counteracted and balanced by some means or other. One means is the instillation and internalization of the necessity for such virtues. Another, a reflection of the unreliability of effect of the belief in such virtues, is by a physical structural intervention that might presumably reduce this capacity. Such intervention has in fact been the surgical removal of the organ thought to be responsible for such a capacity, namely the clitoris. Its removal was all the more feasible on account of its lack of direct usefulness in the process of reproduction. Loss of function was essentially psychological, not physiological (as regards the gross reproductive process). Thus an increased erotic capacity had to be controlled and balanced by a decreased desire which was further facilitated by the attempt to anatomico-physiologically reduce that capacity by circumcision. This would form the beginnings of a hypothesis on which circumcision was based: chastity and fidelity were desirable virtues (especially in women); the reduction of woman's capacity for erotic pleasure was conducive to chastity and fidelity. The curtailment of erotic pleasure secured the maintenance of such values; such curtailment was possible by means of removal of the clitoris.

We must further elucidate the origin of the value of chastity and fidelity, especially for women.

Reproduction is associated with sexuality at a more archaic level of awareness in women than in men. A woman knows in her anatomy that the organ associated with sexual intercourse, namely her vagina, is also the canal through which her offspring comes out. Likewise the breast that is used to suckle her infant is also a source of erotic pleasure. The clitoris (as well as the external genitalia) is associated with the reproductive function by contiguity at least. For the man, the association of the penis with reproduction is even more indirect than the clitoris. The contiguity of the penis to the vagina is temporary and functional in relation to intercourse.

As far as the offspring is concerned there is no doubt in a woman's mind of its being hers. This is not at all the case in the man. At best his assurance comes, if it does at all, in time, if and when he is able to detect physical resemblance between the offspring and himself. Here again is another source for the intimate relation between sexuality and reproduction in the case of woman as compared with man.

The immediate needs of the offspring were understandably best taken care of by the one that was most directly related to it, its mother. Yet a mother and offspring would have had a greater chance of survival if there was at least another human being who shared functions with them and assisted by procuring food and safety for them. For a man to continue to provide such needs it was necessary for him to be assured that the offspring was indeed his own and not any other man's. Such assurance could be provided if the woman displayed fidelity to him. It was best if he was assured that he was her first and last as well as her only man. Such an assurance could be given to the man by various circumstantial conditions. If his partner had a hymen on their first encounter indicating that he was the first man to penetrate her; if she could show evidence of relinquishing the pursuit of sexual pleasure for its own sake rather than for procreation by relinquishing her clitoris in circumcision; if she suppressed seductive behaviour and displayed her body minimally to other men; and probably other patterns of behaviour. In exchange for such fidelity on her part she would be assured of the surplus product of her male partner's labour. Indeed she could even relinquish her

reciprocal demand for fidelity on his part. Her primary concern is in the service of reproduction and her offspring and to that she could sacrifice her own needs for immediate pleasure, and leave that privilege to her male partner. Thereafter, she might envy him his penis, but originally he had envied her clitoris. Even where she might envy his promiscuity, originally he had feared her greater capacity for it. He might have managed to deny this fear, by splitting his object and projecting the feared part then reacting against it by contempt (hiding desire) in his institutionalization of prostitution. Prostitutes could embody what he envied and feared in women, but he could defend himself against the destructive effects of such fear and envy by changing the quality of his emotions into loathing and contempt. At the same time he allowed himself the expression of his desire with these symbols of his projected part. He could accept, allow and even require from say prostitutes, all the qualities that he feared and desired in his own woman. In return he might pay them a token from the surplus product of his labour but on no account would they be entitled to share or inherit ownership of his property.

In this way he could provide a safeguard that the desires of men like himself would not lead to their interfering in each other's property. Questions of offspring and inheritance would be agreed upon mutually. They would allow vent for their promiscuity through this segment of the population engaged in prostitution and who would be communally owned, so to speak and not interfere in matters of property and inheritance.

Thus to elaborate our hypothesis further: sexuality was associated with reproduction which required surplus male labour to provide for the offspring, and in exchange for female chastity and fidelity which would be considered a form of proprietorship, chastity and fidelity became desirable virtues especially in women. The reduction of woman's capacity for erotic pleasure was conducive to chastity and fidelity and the curtailment of such erotic pleasure secured the maintenance of such values; such curtailment made possible by the removal of the clitoris.

This could sum up the hypothesis which we believe could underlie the practice of circumcision.

It is possible by isolating the components of such a hypothesis to observe the role of each in maintaining or preventing the practice of circumcision. Thus we could observe the breakdown of the association between sexuality and reproduction with the advent of contraception. Sex thus came to be viewed more as recreational and relational rather than reproductive. Would the advent of contraception and the increased demand for non-reproductive sex be associated with diminution in the practice of circumcision?

Again, the prevalence of surplus production due to technological progress has given priority to the machine over the male labourer and a machine could, on the one hand be operated by either fewer men or relatively fewer men, by employing women. Thus surplus male labour was no more vital for reproduction. Would technological progress be associated with a diminution in circumcision? Furthermore, as female labour becomes possible and woman's primary function as a reproductive machine diminishes due to birth control and decreased infant mortality, she can obtain the produce of labour directly rather than in exchange for her chastity and fidelity.

Would the liberation of women be associated with less circumcision? The tendency towards more liberal sexual behaviour may have led to the realization that, after all, female circumcision was not crucial in curtailing erotic pleasure in women and even if it did, men too, in their sexual liberation demand greater erotic response in women. Would the rising incidence of sexual activity, especially among the non-prostitute female population, be associated with a decreasing belief in the effectiveness of circumcision as an antagonist to erotic pleasure?

The maintenance of the value of fidelity and chastity may have been observed to be independent either of female circumcision or of woman's capacity for erotic pleasure, Shandall (1967) found that prostitutes had a higher prevalence of infibulation although infibulated women in general

reported frigidity more often than non-infibulated women. Would such an observation be correlated with a decrease in the belief in the necessity for circumcision?

The removal of the clitoris has been observed to make no difference in woman's pursuit of erotic pleasure even of a clitoral stimulation type. In Egypt the practice of rubbing genitals without penetration is more common in unmarried couples than is full, penetrative intercourse and is generally referred to as "brushing". Would the rising incidence of "brushing", despite circumcision, decrease the belief in its effectiveness?

From our observations we can guess that the answers are almost unanimously against the belief in the value of circumcision. Yet the practice persists. It shows that there is a lag between the movement of a conviction from the premonitive phases, to the phase of open belief supported by ratiocination, to its implementation in practice. But with the rapid onset of change, technological advances in the induction of changes in the consciousness of people will become necessary in order to maintain some degree of harmony between necessity, thought and deed. Otherwise man may be trapped in a conflict between them.

The hypothesis and the fact

What we have heretofore attempted was the formulation of a hypothesis underlying the practice of female circumcision. In so far as this hypothesis was believed to be true, the phenomenon would have persisted, which was indeed the case in many areas as stated in the Hosken Report.

Yet the phenomenon on the one hand was not ubiquitous, and on the other its prevalence shows a decline.

We can therefore deduce that: either the practice of female circumcision was eventually discovered to have had no such function, and that it was merely a matter of inertia that kept the custom alive; such a situation is witnessed

in Egypt that the emphasis on the values which it was purportedly geared to have served, namely chastity and fidelity, has diminished; and this again is observable worldwide, including in Egypt.

In fact we have evidence from clinical impressions that both are true. Thus sexual desire does not seem to be any less in circumcized girls[1] than in those non-circumcised. The prevalence of pre-marital petting ("brushing") does not seem to correlate with circumcision[2]. Furthermore, neither sexual frigidity nor clitoral anhedonia (absence of pleasurable sensations at the site of the clitoris), seem to be related to an intact clitoris[3].

As for the values of chastity and fidelity, here again we find evidence of their decline again on the basis of clinical impressions. As the economic feasibility of marriage is declining, youths tend to seek outlets for their sexual needs or else resort to increasing their superego supports to help curb or repress their desires such as in excessive religious activity. With the increasing liberation of women and the easy access to contraceptives, however, the obstacle of lack of availability of partners is diminishing, favouring the former solution. Furthermore, economic necessity and increased mobility, on their part, in addition to rapid socioeconomic changes, add to the destabilization of the family unit, permitting more divorce and infidelity.

In the light of these observations we can state that circumcision is at best useless and has been discovered to have no value in promoting chastity or fidelity, which in any case are declining as values.

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[1]The case is different with infibulation (see Shandall, 1967).

[2]Large scale surveys would be needed to confirm such an impression.

[3]This might be explained on the basis of the findings of Teuber (quoted by Ziwar), 1979) that though in the intact limb the sensitivity increases toward the tip, amputation of that tip is generally followed by a heightened sensitivity at the stump of the amputation. Perhaps an analogous condition might be operation in the case of clitoridectomy.

Conclusions and recommendations

If we accept that circumcision is indeed based on a hypothesis that has ceased to be relevant for the present state of socioeconomic development, and that it is, at best, useless, if not outright harmful particularly in infibulation and that its maintenance is more a matter of inertia, so that it is merely a question of time before it disappears without any need for active intervention; the next question would be whether any action should be recommended.

As a consciously evolving organism that does not blindly wait for the biological laws of survival to assert themselves in time, it is indeed necessary for man to implement his predictions rather than passively wait for them to happen. Such implementation of any positive action, would be enhanced by his knowledge of the direction of evolution. In this case his activity would synchronize with the course of evolution rather than contradict it. This would doubly assure his success in implementation.

In this case there is a need to recommend action to counteract the practice of circumcision. The action recommended, moreover, must be tailored to the actual situation in question.

Thus, while many are losing faith in the value of circumcision, a certain amount of hesitation does indeed occur. A circumcised woman, never having had the chance to experience what it would be like to be uncircumcized, would be reluctant to believe that she had lost much. In her denial, she would assure herself of her intactness by allowing, openly or tacitly, her own or others' daughters to undergo the same procedure. She would justify her attitude through the belief that: "It preserves virtue by diminishing desire and I would like to protect my daughter from sin", or: "For me it was just a matter of tradition", implying that she had no temptation to sin, even though her daughter would have. At the same time she might herself be enjoying sex and would use denial and projection to ward off her guilt: "it is my daughter not me". To atone for her sin of enjoying sex she would punish her daughter.

In the light of this, any statement that circumcision is harmful would be resisted by such women in an attempt to assure themselves of their intactness, and to alleviate the guilt they would have for having circumcised or condoned the circumcision of their daughters or others'. What would be more appropriate is an approach that would focus on the uselessness of the practice, coupled with sexual enlightenment geared to minimize the guilt surrounding sexual desire and enjoyment.

Other targets to be aimed at, judging from the prevalent attitudes, could be as follows:

1. Circumcision does not necessarily diminish sexual desire, and even if and when it does this is not coupled with preservation of morality. As stated by Shandall (1967) prostitutes have a higher incidence of infibulation.

2. Circumcision is a pharaonic rather than an Islamic custom as shown by its virtual absence in most Arab countries while it is prevalent in many non-muslim African countries. (Hosken, 1978).

3. The clitoris is in no way uncosmetic and its absence or presence is hardly noticed by most men. What is more, its presence is not unhygienic.

4. Clitoral excitement is no displeasure to the man, on the contrary, along with other manifestations of excitement it is much more pleasing to him.

As far as areas where infibulation seems to be predominant, it might be wiser to follow the Sudanese example. Rather than attempt to eradicate the custom at one stroke, an Islamic-type gradualism should be attempted. First to enlighten the public as to the anti-Islamic nature of this practice, while offering them an opportunity to undergo a milder form of circumcision (preferably Type I) restricting the operation to removal of the prepuce. At a later time a requirement could be made that the practitioner, before embarking on the procedure, should caution his client about the uselessness and non-religious nature of the custom.

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FEMALE CIRCUMCISION IN THE WORLD TODAY: A GLOBAL REVIEW

by

Fran P. Hosken

The medical facts and physical damage from genital mutilations have been described by Shandall[1], Verzin[2] and Cook[3] in the medical literature. Shandall's clinical study on 3820 females, furthermore, provides some statistics on the incidence of the most frequent health problems resulting from the operations. However, neither primary fatalities mostly from haemorrhage, tetanus and infections, nor fatalities in childbirth due to obstructed labour, haemorrhage or infections have been generally recorded.

Based on extensive field work in African hospitals in 1977 and 1979, contacts with medical sources, search through the medical literature, and discussions at the Fifth Congress of the Obstetrical/Gynaecological Society of the Sudan in February 1977, it appears that mainly two types of operation are practised in Africa.

1. Excision or clitoridectomy, which may include the labia minora and parts or most of the external female genitalia (Type II - Verzin and Shandall's classification).

2. Infibulation or pharanoic circumcision Type III. A small opening "not larger than a kernel of corn" is created to allow the passage of urine and menstrual blood.[4]

In West Africa (Mali), the closure of the introitus is achieved by tying down the child and sometimes with the legs crossed. Sunna circumcision is less drastic and is described as the removal of the clitoral prepuce or a tiny skinfold.

A less damaging operation, an incision of the clitoris or skin about the clitoris or the partial removal of the clitoris, seems to be practised by Muslims in Indonesia and Malaysia.

There is evidence that less extensive forms of excision are also practised in the south of the Arabian Peninsula and along the Gulf.

At the present time the problem of female circumcision often referred to as genital mutilation in the popular press is most severe in Africa, the region comprising the Red Sea Coast and Kenya/Tanzania to the Atlantic shores and in areas in between, including all along the Gulf of Guinea.

Due to population growth and the failure to initiate any effective preventive measures, it is estimated that many females are still being subjected to genital mutilation. The secrecy surrounding these operations and the failure to seek help in cases of complications, even where appropriate assistance is available, have contributed to the failure to recognize the magnitude of the problem. Ignorance, confusion and myths about reproduction are widespread around the world, and especially prevalent in Africa and the Middle East.

There appears to be rather limited appreciation of the magnitude of the problem in the context of development among health care professionals in the modern sector.

The operation appears to enhance the incomes of both trained and traditional practitioners and birth attendants in some African and Middle Eastern countries. In the cities, the operation is sometimes performed on younger children, sometimes on newborn babies or girls under two years

of age. Although social and traditional rites are rapidly disappearing, the physical mutilations continue, except among a small minority of educated young people. In some communities the decisions are made, as in the past, by the male leaders of the family, who also pay for the operations.

METHODOLOGY

The information presented here is based on:

- published literature within the past 30 years;
- questionnaires and correspondence; and
- field investigations in Africa.

Questionnaires were sent to all health departments in the areas where genital mutilations have been reported, and to all adjoining countries, in French and English as appropriate. A more general questionnaire was used in Indonesia and Malaysia. The reports from the Arabian Peninsula were based on a field report, as well as published materials.

GENITAL MUTILATIONS OUTSIDE AFRICA

In the medical literature (Verzin, 1975; Shandall, 1967; Worsley, 1938[5], and others, several countries and population groups are cited as performing female circumcisions.

According to the data presented here, no medical evidence is available at the present time that these operations continue today outside Africa and the Arabian Peninsula, except for Indonesia and Malaysia. However, it is possible that sporadic instances of different types of genital operation may exist among remote population groups in isolated areas.

The following areas outside Africa were mentioned:

America

No medical case records have been found and the citation is based on unconfirmed tales of missionaries quoted in a German anthropological study of 1885 (Ploss: DAS WEIB). Brazil, Eastern Mexico and Peru were cited.

Europe

The report on the one isolated occurrence similarly dates back to the above study of 1885, which mentions the Skoptsi or circumcisers - a Russian sect who used circumcision to ensure perpetual virginity, and quoting St Matthew (xix.2) as their authority: "there be eunuchs that have made themselves eunuchs for the Kingdom of Heaven's sake"[6].

Australia

Introcision - or cutting into the perineum to enlarge the vagina as a puberty rite - has been reported in the past for some of the original inhabitants of Australia by anthropologists. The Australian Institute of Aboriginal Studies, as well as other first-hand sources in Australia, including obstetrical nurses in the area confirm that these practices died out more than 50 years ago.

Asia

Pakistan

No medical evidence of the practice has been found.

Indonesia

In contrast to Africa, the operations in Indonesia and Malaysia were introduced by Muslims in the eighth century and are not an indigenous practice as in Africa and the Middle East. They are said to be performed for religious reasons by devout Muslims.

Operations consist in cutting the prepuce of the clitoris and in some cases the clitoris itself. The operations are performed by the village midwives - dukun and by strict Muslims in Islamic hospitals.

The operations are performed in Java, but not on other islands. The girls subjected to the operations are usually six to seven years old, or even younger, sometimes newborn babies.

A study to document the facts was proposed by Dr Haji Ali Akbar of the Yarsi School of Medicine, Centre for Islamic Studies, Jakarta, Indonesia. No adverse effects on childbirth were recorded, and no menstrual difficulties. The effects on the sexuality of women are unknown, though the operations are said to be performed to "prevent hypersexuality of females".

The health problems resulting from infections, including tetanus, have not been adequately reported, though these operations are performed under unhygienic conditions by village women.

Malaysia

The operations are similar to the ones described in Indonesia, and are only practised by the ethnic Muslim Malays.

The operations are performed on girls aged seven days to nine years and on adult women who have officially converted to the Muslim faith.

The reasons are religious, though it is not obligatory. It is also stated that it is done to "lessen the sexual urge".

No detailed study has been made. However, a report of a study made in 1973 by the Ministry of Health, "A National Plan for the Operation of a Religious Circumcision Service among Muslim (male) Children" outlined plans to protect male children from infections due to the operations.

No such study was however proposed for female children, though they are similarly exposed to infections. The reason quoted was that female circumcision in Malaysia was not obligatory.

Arabian Peninsula

A recent field study of maternities, midwives and medical sources produced the following data.

United Arab Emirates

A report from a maternity centre in the Eastern part of the country states that all girls are excised at puberty (ablation of the clitoris).

Another practice that is recorded in the area of the Gulf is inserting salt into the vagina after delivery. The purpose is to restore the vagina to pre-childbirth condition, and make intercourse more pleasurable for the husband. Severe stenosis often resulted making normal delivery difficult.

Oman

Reports from maternities state that circumcision is practised in the same way as in the other Gulf states. The practice of putting salt into the vagina also continues.

Bahrain

Circumcision is rapidly decreasing, and consists in a cut made over the clitoris. Putting salt into the vagina is also practised traditionally.

Southern Yemen

Female circumcision is done in the area of the Hadramout Peninsula as documented by G. Pieters[7], and confirmed by Mrs Mehain Saleh, Maternal and Child Health Supervisor, Ministry of Health, Aden. She states that circumcision is done by traditional birth attendants often only seven days after birth.

AFRICA

Infibulation (Pharaonic circumcision)

Infibulation, in contrast to excision is usually performed on children between four and eight, and often younger, while excision in the past was a coming-of-age rite.

Somalia

Infibulation is practised on all girls of Somalia with few exceptions, mainly in the modern sector. All ethnic Somalis living in Ethiopia and Northern Kenya also practised infibulation.

Djibouti

The entire female population, with few exceptions, has been circumcised.

Southern Egypt

Nile Valley on Sudanese border (Nubia) is subject to circumcision.

Sudan

The majority of the female population of the Sudan is infibulated, that is, all the Muslim ethnic groups who live along the Nile Valley and

the Red Sea Coast. The non-Muslim ethnic groups of the Southern Sudan do not practise any kind of female circumcision. Infibulation is also practised in the Egyptian Nile Valley bordering the Sudan.

Eritrea/Ethiopia

Infibulation is practised all along the Red Sea Coast, in Eritrea and in the Harrar area (Ogaden) of Ethiopia, throughout Djibouti, as well as in Northern Kenya by the ethnic Somali population.

Northern Nigeria

Professor Agrégé S. Diarra, Chief of Obstetrics and Gynaecology at the Maternity Hospital of Treichville Hospital at Abidjan, stated in 1977 that infibulation was practised in Northern Nigeria amongst the Hansas.

Mali

Infibulation as well as excision, is practised in Mali, except for the northern area (Timbuctu).

According to the midwives in the Gabriel Touré Hospital in Bamako, the closing of the vulva is achieved not by sewing or by application of thorns, or by other mechanical means, or sticky pastes (gum arabic, sugar and egg), as in the Sudan or Somalia, but by tying the legs of the child togther in a crossed position, until the wound is healed. At times, the closure is complete, resulting in urinary retention and haematocolpos. Infibulation is reported to be decreasing.

Central Africa

Infibulation is said to be practised, as well as excision.

Infibulation by accident

Infibulation happens by accident also, in cases where excision is extensive, creating large wounded surfaces which adhere, closing most of the vaginal opening. In such cases, as in the case of intentional infibulation, delivery requires extensive cutting (double episiotomies). The obstruction also creates difficulties with intercourse in which case the husband returns the bride.

Excision

The removal of the clitoris, the labia minora, and sometimes all external genitalia is practised in parts of Kenya and Sierra Leone.

Excision is more commonly practised than infibulation. At the present time, excision is performed in a very broad area across the African continent, from east to west, parallel and mostly north of the Equator, in the most populous regions of Africa.

Some ethnic groups refuse and oppose excision as in the Luo tribe in Kenya, the second largest population group though they are surrounded by ethnic groups who have always subjected their female children to the operation.

CASE HISTORIES

The following reports are based on published medical documentation and two field investigations of East and West Africa in 1977 and 1979, visiting maternities, interviewing midwives, obstetricians, gynaecologists, and health workers.

Sudan

In the Sudan, infibulation (pharaonic circumcision) is extensively documented in two clinical studies, one by Dr Abu-El-Futuh Shandall of

3820 case histories, and another of 3000 women by Dr Osman Modawi[10]. Both studies confirm that pharaonic circumcision continues to be practised on a majority of female children.

At the Firth Obstetrical/Gynaecological Society Congress of the Sudan in 1977, the latest figures were presented, showing little change. Dr T. A. Baasher[11] gave a paper at the Congress on the "Psychological Aspects of Female Circumcision". He stated that: "it is now obvious that the rate of progress of combatting this practice is slow ... It is clear that a good "push" is needed before certain communities are finally convinced to give it up".

The Faculty of Medicine of the University of Khartoum in the Sudan is sponsoring a country-wide, WHO-assisted "Study of the Epidemiology of Female Circumcision" which is being directed by Dr Asma El Dareer[12]. The preliminary groundwork has been completed, and the province-by-province survey is under way. The objectives of the study as stated by Dr Dareer are:

- To find the magnitude of the problem and what type of circumcision is practised.
- To discover the religious and social background.
- To detect the health problems encountered.
- To find the best way to abolish this harmful, inhuman practice.

In the Sudan, the operations are more extensively documented than anywhere else in Africa or the Middle East; and the Government is making some effort to deal with the problem.

Egypt

In the Nile Valley, genital mutilation has been reported since recorded history (more than 2000 years). It is reported (Hansen, 1972[13]) that until the 1920s, practically every girl in Egypt was

circumcised. Infibulation also is quite recently reported from the Upper Nile Valley (Nubia) (Kennedy, 1970[14]). A consultation with Dr Roshdi Ammar in February 1977 of Ain Shams University Medical School confirmed these facts. He estimates that about one-third of the population still practises different forms of circumcision. (Karim and Ammar[15])

Family planning clinics report even higher percentages of women circumcised, including clinics in Cairo, which are frequented by many urban immigrants. The middle classes now prohibit the operating on their daughters. However, the operations continue to be performed by force without any rites, mostly by traditional midwives (dayas) on children too young to make any decisions.

Ethiopia

Excision called Girz in Amharic is universally practised by all population groups regardless of religion, except in Gojjam. On the highlands (Amharas), usually small babies nine to 40 days are excised; but in some areas, the operations are performed later and up to ten years. In Eritrea, and in the areas adjoining the Sudan and Somalia (Harrar), infibulation is the rule among the mainly Muslim population. According to a paediatrician at the Black Lion Hospital, Addis Ababa, damaged, bleeding children are often brought in. Besides heavy bleeding, fusion of the labia resulting in urinary retention, infection and tetanus are also reported.

The health department of Ethiopia warns parents against other types of mutilation such as removal of the uvula which is widely practised on small children.

Dr Alfonse Huber[16], who practised for many years in Ethiopia, states in a questionnaire that infibulation is practised in all Muslim areas (Donakil, Somali, Harrari). Excision is practised by other population groups, regardless of religion. He states that in his opinion "the

reason for the excision in this male-dominated society is the suppression and control of female sexuality" and that "infibulation is a crude method to demonstrate anatomical virginity when a bride is sold by her family. Female children from small babies to girls after puberty (before marriage) are operated on; the age depends on the tribe."

Another gynaecologist states that: "Infibulation is practised in some parts of Ethiopia by the Essas of the Harrar area and the Somalis in the Eastern region of the country. This is done to keep the virginity of the girl until marriage. Just before marriage, the vulva is partially cut open with a knife ... before delivery, the vulva is opened more ... some wives get the vulva stitched back after birth to narrow the entrance for the penis and thus increase male sexual enjoyment"[17].

Kenya

Most of the population groups of Kenya continue to practise excision in different forms, though this is generally denied. The only exception is the Luo, comprising 15% of the population[18].

Two surveys of secondary girls schools were made. One in 1975 in the Meru area east of Mt. Kenya showed that all students in the school were excised[19]. Another survey of a group of girls' schools in the Fort Hall Area (Central Province - Kikuyu), made in 1972, published in a thesis "The Kikuyu Female Circumcision Controversy"[20] revealed that more than half of the students were excised in an area which was in the centre of the above controversy 30 years before, and where the Church of Scotland intensively worked against excision. But in the adjoining area, up to 80% of the girls had been circumcised.

The late President Kenyatta, in his book Facing Mount Kenya, written at the London School of Economics where he studied anthropology under Bronislav Malinowsky, stated: "No Kikuyu would every think of marrying an uncircumcised girl"[21].

The political facts surrounding circumcision were further described by Dr Leonard Bruce-Chwatt[22]. Reliable sources state that of the Kalenjin group, the Tugen, Keyo, Marakwet, Sebei, practise female circumcision; but other sub-groups do not. In some cases, it depends on the village chief, who orders the circumcision, and determines the time for operation which also depends on the harvest. Circumcision does not take place every year, and usually only in years when the harvest is good, because circumcision is connected with feasting. In northern Kenya, in the territory adjoining Somalia, infibulation is practised.

A midwife from Kenya writes: "Circumcision in females is going on in the rural areas especially among those who are still strong believers in traditions and customs. It is still carried out by tribes like the Kuria, Kisii, Masai, Suk, Nandi, Kipsigis and Kamba. Their reason for circumcision is that it decreases the sexual urge; therefore, a girl does not have a sexual relationship with a man before marriage, since the sensitive organ is cut off. When married a woman does not practise extra-marital sex, and thus preserves moral behviour in the society"[23].

Somalia

In Somalia, almost the entire female population is infibulated, except for the younger generation of some families in the modern sector and the health-care field.

Under the guidance of the Somali Women's Democratic Organization (SWDO), a commission was organized including representatives of several ministries (health, education, justice, religion) to study the question and to organize a nationwide education campaign against pharaonic circumcision. This politically-supported initiative is presently being started with the objective of mobilizing all sections of the population to stop the mutilation of female children. The operations have been performed recently in urban areas on much younger children, often only three to four years old, while traditionally the age was six to eight.

Nigeria

Female circumcision is practised by some or most members of the three principal population groups, the Yoruba, the Ibo and the Hausa.

The Yoruba excise their baby girls on the sixth day, or shortly after birth (Longo)[24]. Excision is reported in the northern part of the country, among the Muslim Hausa[25], who also practise child marriage. The maternity of the City Hospital of Kano gets many cases of young girls, often under 12, with cuts in their vaginas (gishri or gishiri). It is reported by the midwives and doctors that these cuts are inflicted on the children in preparation for intercourse. Many girls are also brought to the hospital with lacerations of the vagina due to intercourse, as they are sold into marriage long before maturity.

Mali

Interviews with midwives at Gabriel Touré and Point G Hospitals showed that all population groups in Mali practise excision, and some also practise infibulation, except for the Songhai and the Moors (living in the area of Timbuctu). Nearly all of the women coming to the hospital maternities in Bakako have been excised according to the midwives.

The operations in rural areas continue as in the past to be performed by the blacksmiths' wives on girls 12 to 14 years old, occasionally after the first child.

In Bamako and in the towns, even younger children are excised, often newborn babies. The Hospital Gabriel Touré has a traditional excisor who operates on the babies. The babies are also operated on at home with attendant risk of infection.

A thesis by Assitan Diallo[26] provides the results of a survey in the Bamako area showing that the age of excision, which traditionally is a

puberty rite, has been reduced, and that most social customs have been abandoned in urban areas. Diallo states: "excision has become a caricature of the traditional rite". Only the operations continue. Even in Bamako, the capital, almost all female children continue to be circumcised.

Upper Volta

In Upper Volta, a meeting with Dr Joseph Kabore, Chief of Maternity of Yalgado Hospital, Ouagadougou, confirmed that excision is widely practised all over the country especially by the Mossi and more than 70% of the patients attending the hospital have been excised. Although infibulation is not intentional, frequently women come to the hospital unable to deliver their first child as the vagina is severely stenosed. Often a Caesarian is the only remedy. Where no assistance is available, both mother and baby may die. In the capital, the operations are done on much younger children than in rural areas, as the parents are afraid the girls will refuse.

Facial scarring and tribal marks have been prohibited by the Government as mutilation. Similarly, excision or genital mutilation should be forbidden, Dr Kabore suggests.

The women's organization, Femmes Voltaiques, also campaigned against circumcision; but their efforts resulted in such adverse reactions that they had to stop their campaign.

Senegal

From a meeting with Professor Carreia, Chief of Obstetrical/ Gynaelogical Services of Hôpital Dantec/Maternité and Madame N'Diaye Bineta, Deputy Chief, School of Midwives in March 1977[28]:

"Excision is practised in many areas of Senegal according to the midwives. But not in the Dakar area, where mostly Wolofs (35% of the

population) live and Serere (16.5%) - the two population groups who don't excise. It is practised in all other rural areas and all along the Senegal River, where the Toucouleur (9%) live. The Toucouleurs practise infibulation, they are a very traditional group. In the West, the Mandingo, the Soce (Casamas), the people from Mali, the Fulanis, as well as the Bambara also circumcise their girls.

About a quarter of the women who come to the maternity hospital in Dakar are excised. Circumcision of boys is now carried out in all hospitals with sterile instruments to prevent infection; but girls are operated on by the traditional old women, with any dirty tools and frequently infected. Professor Correia suggested that to effectively move against genital mutilation, it would have to be done by the Government on the political level, with the cooperation of the religious leaders. An information campaign would have to be organized including radio talks.

COST ANALYSIS

The human costs of the operations in terms of pain, partial or permanent disability cannot be measured and the young female children and women of Africa and the Middle East are most seriously affected.

There are four principal areas of cost involved:

1. The costs due to loss of life of female children and young women who are dying as the direct result of the operations. They represent an irretrievable loss to their families, communities and country.

2. The costs of making childbirth more hazardous. With more women seeking help in the hospitals, the costs of assistance are increasing for each government. Dr M. Warsame, the Director of the Benadir Hoospital in Somalia stated that the costs for repairing the damage done to girls and women as a result of these genital mutilations amounted to several hundred thousand Somali shillings in 1978.

3. The costs of work time lost due to illness, sometimes terminating in permanent disability, will have to be borne by the employer, the largest employer being the government.

4. If the operations are "modernized" and introduced into hospitals, the cost of performing genital operations on a large part of the female population, including the necessary drugs and care, will become astronomical.

These very real costs should be popularized because they are increasing due to population growth and modernization, and many more women are beginning to seek help from modern health care facilities.

From this accounting, it is obvious that any costs incurred now through mounting nationally and internationally supported local education and prevention campaigns against genital mutilations of females, will represent a very large net saving of the health care budget over the coming years. Such campaigns will greatly contribute to the health of each family and to the general welfare of the country.

CONCLUSION

Female circumcision has been practised for centuries, and with many serious complications. The present-day situation requires that it should be treated as a public health problem, and recognized as an impediment to development that can be prevented and eradicated.

The eradication of smallpox has recently succeeded, thanks to preventive measures. Vaccination, though requiring much effort and persuasion on the part of health authorities, has been accepted by people all over the world. Prevention and health education have made substantial advances also in tropical areas against malaria, measles, tetanus, typhoid and many childhood and communicable diseases. The prevention of unwanted pregnancies is an ongoing, worldwide campaign by family planning organizations with international support. The prevention

of man-made damage to female children should also become part of all health education, family planning, MCH (mother and child health) and preventive care programmes in Africa and the Middle East. Genital mutilation causes misery to the lives of millions of children and women. There is a clear case for prohibition.

The first step towards such a prevention campaign is the documentation, analysis and dissemination of information relating to female circumcision and its many serious complications and unhappy sequelae. Until the dangers to health became publicly known, the claim that "these practises no longer exist" and "circumcision only continues in a few isolated rural areas" cannot be refuted, and preventive measures will continue to be ignored.

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CHAPTER IV

FEMALE CIRCUMCISION

B. COUNTRY STUDIES ON FEMALE CIRCUMCISION

CIRCUMCISION OF GIRLS

by

Dr Nawal El Saadawi

The practice or circumcising girls is still common in a number of Islamic and Arab countries such as Egypt, the Sudan, Yemen and some of the Gulf countries.

The importance given to virginity and an intact hymen in these societies is the reason for which female circumcision still remains a very widespread practice, despite a growing tendency especially in urban Egypt, to discontinue the practice as something outmoded and harmful. Behind circumcision lies the belief that by removing parts of the external genital organs in girls, sexual desire is minimized. This permits a female who has reached puberty and adolescence to protect her virginity and therefore her honour, with greater ease. Chastity was imposed on the male attendants in the female harem by castration which turned them into inoffensive eunuchs. Similarly, female circumcision is meant to preserve the chastity of young girls by reducing their desire for sexual intercourse. Circumcision is most often performed on female children at the age of seven or eight, and by daya or indigenous midwives. Two women members of the family grasp the child's thighs and pull them apart to expose the external genital organs and to prevent her from struggling. The daya then cuts off the clitoris.

During the writer's period of service as a rural physician, she was called upon several times to treat complications arising from this primitive operation. The ignorant daya believed that effective circumcision necessitated a deep cut with the razor to ensure radical amputation of the clitoris, so that no part of the sexually sensitive organ would remain. Severe haemorrhage was therefore a common occurrence and sometimes led to loss of life. The dayas had no notion of asepsis, and as a result, infections

were common. Besides, the psychological shock of this cruel procedure left its imprint on the personality of the child and accompanied her into adolescence, through maturity. Sexual frigidity is one of the after-effects which is accentuated by other social and psychological factors influencing the personality and mental make-up of females in Arab societies. Girls are therefore exposed to a whole series of misfortunes as a result of outdated notions and values related to virginity which still remains the fundamental criterion of a girl's honour. In recent years, however, educated families are beginning to realize the harm that is done by the practice of female circumcision.

Nevertheless, a majority of families still impose on young female children the barbaric and cruel operation of circumcision. The research which the writer carried out on a sample of 160 Egyptian girls and women[1] showed that 97.5% of uneducated families still insist on maintaining the custom of female circumcision, but this percentage drops to 66.2% among educated families.

When the writer discussed the matter with these girls and women, most of them had no idea of the harm done by circumcision, and some of them even thought that it was good for the health and conducive to cleanliness and "purity". The operation in the common language of the people is termed the "cleansing" or "purifying" operation. Neither the uneducated nor the educated women realized the effect that amputation of the clitoris could have on them psychologically and sexually.

The dialogue that occurred between these women and the writer could be transcribed as follows:

- "Have you undergone circumcision?"
- "Yes".
- "How old were you at the time?"
- "I was a child, about seven or eight years old".
- "Do you remember the details of the operation?"
- "Of course. How could I possibly forget?"

- "Were you afraid?"
- "Very afraid. I hid on top of the cupboard, under the bed or in the neighbour's house, but they caught hold of me and I felt my body tremble in their hands."
- "Did you feel any pain?"
- "Very much so. It was like a burning flame and I screamed. My mother held my head so that I could not move it, my aunt caught hold of my right arm and my grandmother took charge of my left arm. Two strange women, whom I had not seen before tried to prevent me from moving my thighs by pushing them as far apart as possible. The daya sat between these two women holding a sharp razor in her hand, and cut off the clitoris. I was scared and suffered such great pain that I lost consciousness".
- "What happened after the operation?"
- "I had severe bodily pains and remained in bed for several days, unable to move. The pain in my external genital organs led to retention of urine. Every time I wanted to urinate the burning sensation was so unbearable that I could not pass water. The wound continued to bleed for some time and my mother used to change the dressing twice a day."
- "What did you feel on discovering that a small organ in your body had been removed?"
- "I did not know anything about the operation at the time, except that it was very simple, and that it was done to all girls for purposes of cleanliness, purity and the preservation of a good reputation. It was said that a girl who did not undergo this operation was liable to be talked about by people, her behaviour would become bad and she would start running after men, with the result that no one would want to marry her when she was ready for marriage. My grandmother told me that the operation had only consisted of the removal of a very small piece of flesh from between my thighs. and that the continued existence of this small piece of flesh would have made me unclean and impure, and would have caused the man whom I would marry to be repelled by me".
- "Did you believe what was said to you?"
- "Of course I did. I was happy the day I recovered from the effects of the operation and felt as though I was rid of something which had to be removed and I had become clean and pure."

Those were more or less the answers obtained from all those interviewed, whether educated or uneducated. One of them was a medical student preparing for her final examination, and the writer expected her answers to be different, but they were almost identical to the others. The discussion with her is transcribed:

- "You are going to be a medical doctor in a few weeks, so how can you believe that cutting off the clitoris from the body of a girl is a healthy procedure, or at least not harmful?"
- "This is what I was told by everyone. All the girls in my family have been circumcised. I have studied anatomy and medicine, yet I have never heard any of the professors who taught us explain that the clitoris had any function to fulfil in the body of a woman, neither have I read anything of the kind in the medical books I am studying".
- "That is true. To this day medical books to not consider the science of sex as a subject with which they should deal. The organs of a woman worthy of attention are considered to be only those directly related to reproduction, namely the vagina, the uterus and the ovaries. The clitoris however is an organ neglected by medicine, just as it is ignored and disdained by society".
- "I remember a student asking the professor one day about the clitoris. The professor went red in the face and retorted curtly that no one would ask him about this part of the female body during the examinations, since it was of no importance".

The writer's studies made her try to find out the effect of circumcision on girls and women, and to understand what results it had on their psychological and sexual life. The majority of the normal cases interviewed answered that the operation had no effect on them. It became clear that they were shy and timid and did not wish to communicate. But the writer was not daunted and would continue to question them closely about their sexual life before and after the circumcision. Once again, the following is a transcript of the dialogue that usually occurred:

- "Did you experience any change of feeling or of sexual desire after the operation?"
- "I was a child and therefore did not feel anything".
- "Did you not experience any sexual desire when you were a child?"
- "No, never. Do children experience sexual desire?"
- "Children feel pleasure when they touch their sexual organs, and some form of sexual play occurs between them, for example, during the game of bride and bridegroom usually practised under the bed. Have you never played this game with your friends as a child?"

At those words the young girl or woman would blush and appear rather confused. However, after the conversation had gone on for some time and an atmosphere of mutual confidence and understanding had been established, she would begin to recount her childhood memories. She would often refer to the pleasure she had felt when a man of the family permitted himself certain sexual caresses. Sometimes these caresses would be proferred by the domestic servant, the houseporter, the private teacher or the neighbour's son. A college student told the writer that her brother used to caress her sexual organs and that she experienced acute pleasure. However after undergoing circumcision she no longer had the same sensation of pleasure. A married woman admitted that during intercourse with her husband she had never experienced the slightest sexual enjoyment, and that her last memories of any form of pleasurable sensation went back twenty years, to the age of six, before she had undergone circumcision. A young girl said that she had been accustomed to practise masturbation but had given it up completely after removal of the clitoris at the age of ten.

The further these conversations went, and the more the writer delved into their lives, the more readily they opened themselves up and uncovered the secrets of childhood and adolescence - perhaps almost forgotten by them - or only vaguely remembered.

Being both a woman and a medical doctor the writer was able to obtain confessions from these women and girls which would have been almost impossible for a man to obtain. The Egyptian woman, accustomed to a very rigid and

severe upbringing built on a complete denial of any sexual life before marriage, adamantly refuses to admit that she has ever known, or experienced, anything related to sex before the first encounter with her husband. She is therefore ashamed to speak about such things with any man, even though he may be the doctor who is treating her.

The writer's discussions with some of the psychiatrists who had treated a certain number of the young girls and women in this sample led her to conclude that there were many aspects of the life of neurotic patients that remained unknown to psychiatrists. This was due either to the fact that the psychiatrist himself had not made the necessary effort to penetrate more deeply into the life of the woman patient or the patient herself actively refrained from divulging those things which her upbringing made her consider matters not to be discussed freely, especially with a man.

In fact the long and varied interchanges which the writer had over the years with the majority of practising psychiatrists in Egypt, her close association with a large number of her medical colleagues, the long periods spent working in health centres, general or specialized hospitals, and finally the four years spent as a member of the National Board of the Syndicate of Medical Professions, have all led her to the firm conclusion that the medical profession in our society is still incapable of understanding the fundamental problems with which sick people are burdened, whether they be men or women, but especially if they are women. The medical profession, like any other profession, is governed by the political, social and moral values which predominate in society and like other professions is one of the institutions which is utilized more often than not to protect these values and perpetuate them.

Men represent the vast majority in the medical profession, as in most professions. But apart from this, the mentality of women doctors differs little, if at all, from that of the men, and the writer has known quite a number of them who were even more rigid and backward in outlook than their male colleagues.

A rigid and backward attitude towards most problems, and in particular towards women and sex, predominates in the medical profession, and particularly within the precincts of the medical colleges in the universities.

Before undertaking her research study on "Women and Neurosis" at Ain Shams University, the writer had made a previous attempt to start it at the Kasr El Eini Medical College in the University of Cairo, but had been obliged to give up as a result of the numerous problems she encountered. The most important obstacle of all was the overpowering traditionalist mentality that characterized the professors responsible for her research work, and to whom the word "sex" could only be equated to the word "shame". "Respectable research" therefore could not possibly have sex as its subject, and one should under no circumstances think of penetrating into the areas even remotely related to it. One of the writer's medical colleagues in the research committee advised her not to refer at all to the question of sex in the title of her research paper, when she was obliged to transfer to Ain Shams University. This colleague warned the writer that any such reference would most probably lead to fundamental objections which would jeopardise her chances of going ahead with it. She had initially chosen to define her subject as "Problems that confront the sexual life of modern Egyptian women", but after prolonged negotiations she was obliged to delete the word "sexual" and replace it by "psychological" (psychic), thus making it possible to circumvent the sensitivities of the professors in Ain Shams Medical School and obtain their assent to go ahead with the research.

After the writer observed the very high percentage of women and girls who had been obliged to undergo circumcision, or who had been exposed to different forms of sexual violation or assault in their childhood, she started to look for research undertaken in these two areas, either in the medical colleges or in research institutes, but found nothing. Not a single medical doctor or researcher had ventured to do any work on these subjects, in view of the sensitive nature of the issues involved. This also explains why most of the research carried out in such institutions is of a formal and superficial nature, since its sole aim is to obtain a degree or a promotion. The path of

safety is often the one chosen and safety means carefully avoiding all controversial subjects. No one is therefore prepared to face difficulties with the responsible academic and scientific authorities, or to engage in any form of struggle against them, or their ideas. Nor is any one prepared to face up to those who lay down the norms of virtue, morals and religious behaviour in society. All the established leaderships in the area related to such matters suffer from a pronounced allergy towards the word "sex" and any of its implications especially if the word "sex" happens to be linked to the word "woman".

Nevertheless, the writer was fortunate enough to discover a small number of medical doctors who had the courage to be different, and to examine some of the problems related to the sexual life of women. One of the rare examples and the only research study carried out on the question of female circumcision in Egypt and its harmful effects was the joint effort of Dr Mahmoud Karim and Dr Rushdi Ammar, both from Ain Shams Medical College, published in 1965. It is in two parts, the first was published under the title "Female Circumcision and Sexual Desire", and the second "Complications of Female Circumcision". The conclusions arrived at as a result of this research study, which covered 651 women circumcised during childhood, may be summarized as follows:

1. Circumcision is an operation with harmful effects on the health of women, and is the cause of sexual shock to young girls. It reduces the capacity of a woman to reach the peak of her sexual pleasure (orgasm) and has a definite though lesser effect in reducing sexual desire.
2. Education helps to limit the extent to which female circumcision is practised, since educated parents have an increasing tendency to refuse the operation for their daughters. On the other hand, uneducated families still accept female circumcision in submission to prevailing tradition, or in the belief that removal of the clitoris reduces the sexual desire of the girl, and therefore helps to preserve her virginity and chastity after marriage.
3. There is no truth whatsoever in the idea that female circumcision helps in reducing the incidence of cancerous diseases of the external genital organs.
4. Female circumcision in all its forms and degrees, and in particular the fourth degree known as pharaonic or Sudanese excision, is accompanied by

immediate or delayed complications such as inflammations, haemorrhage, disturbances in the urinary passages, cysts or swellings that can obstruct the urinary flow or the vaginal opening etc.

5. Masturbation in circumcised girls is less frequent that was observed by Kinsey in uncircumcised girls.

The writer was able to exchange views with Dr Mahmoud Koraim during several meetings in Cairo and learnt that he had faced numerous difficulties while undertaking his research, and was the target of bitter criticism from some of his colleagues and from religious leaders who considered themselves the divinely appointed protectors of morality, and therefore required to shield their flock from such impious undertakings, which constituted a threat to established values and moral codes.

The findings of the writer's research study coincided with some of the conclusions arrived at by her two colleagues on a number of points. There is no longer any doubt that circumcision is the source of sexual and psychological shock to the girl, and leads to a varying degree of sexual frigidity. Education helps parents to realize that this operation is not beneficial, and should be avoided, but the writer has found that the traditional education given in our schools and universities, whose aim is simply some certificate or degree, rather than instilling useful knowledge and culture, is not very effective in combating the long-standing and established traditions that govern Egyptian society, and in particular those related to sex, virginity and chastity in girls, and chastity in women. These areas are strongly linked to moral and religious values that have dominated and operated in our society for hundreds of years.

Since circumcision in females aims primarily at ensuring virginity before marriage and chastity throughout, it is not to be expected that its practice will disappear easily from Egyptian society or within a short period of time. A growing number of educated families are, however, beginning to realize the harm that is done to females by this custom, and therefore seek to protect their daughters from this operation. Parallel to these changes, the

operation itself is no longer performed in the old primitive way, and the more radical degrees approaching, or involving excision, are dying out rapidly. Nowadays even in Upper Egypt and the Sudan, the operation is limited to the total, or more commonly the partial, amputation of the clitoris. Nevertheless, while undertaking her research, the writer was surprised to discover, contrary to what she had previously thought, that even in educated urban families, over 50% still considered circumcision as essential to ensure female virginity and chastity.

Many people think that female circumcision only started with the advent of Islam. But as a matter of fact it was well-known and widespread in some areas of the world before the Islamic era, including the Arabian peninsula. Mohamed the Prophet tried to oppose this custom since he considered it harmful to the sexual health of the woman. In one of his sayings, the advice reported as having been given by him to Om Attiah, a woman who did tattooings and circumcision, runs as follows: "If you circumcise take only a small part and refrain from cutting most of the clitoris off. The woman will have a bright and happy face, and is more welcome to her husband if her pleasure is complete".

This means that the circumcision of girls was not originally an Islamic custom, and was not restricted to monotheistic religions, but was practised in societies with widely varying religious backgrounds, in countries of the East and the West, and among peoples who believed in Christianity or in Islam, or were atheistic. Circumcision was known in Europe during the nineteenth century (Richer and Brown, 1866), in Egypt, the Sudan, Somaliland, Ethiopia, Kenya, Tanganyika, Ghana, Guinea and Nigeria. It was also practised in many Asian countries such as Ceylon and Indonesia, and in parts of Latin America. It is recorded as going back far into the past under the pharaonic kingdoms of Ancient Egypt, and Herodotus mentioned the existence of female circumcision seven hundred years before Christ was born. This is why the operation as practised in the Sudan is called pharaonic excision.

For many years the writer tried in vain to find relevant sociological or anthropological studies that would throw some light on the reasons for which

such a brutal operation is practised on females. However, she did discover other practices related to girls and female children which were even more savage. One of them was burying female children alive almost immediately after they were born, or even at a later stage. Other examples are the "chastity belt" or closing the aperture of the external organs with steel pins and a special iron lock. This last procedure is extremely primitive and is very much akin to Sudanese circumcision, where the clitoris, external lips and internal lips are completely excised, and the orifice of the genital organs closed with a flap of sheep's intestines leaving a very small opening barely sufficient to let the tip of the finger in, and to permit the menstrual and urinary flow. This opening is slit at the time of marriage and widened again when a child is born and then narrowed down after delivery. Complete closure of the aperture is also done on a woman who is divorced, so that she literally becomes a virgin once more and can have no sexual intercourse except in the eventuality of marriage, in which case the opening is restored.

In the face of all these strange and complicated procedures aimed at preventing sexual intercourse in women except if controlled by the husband, it is natural that we should ask ourselves why women in particular were subjected to such torture and cruel suppression. There seems to be no doubt that society as represented by its dominant classes and male structure realized, at a very early stage, that sexual desire in the female is very powerful, and that women unless controlled and subjugated by all sorts of measures will not submit themselves to the moral, social, legal and religious constraints with which they have been surrounded, and in particular the constraints related to monogamy. The patriarchal system, which came into being when society had reached a certain stage of development and which necessitated the imposition of one husband on the woman, whereas a man was left free to have several wives, would never have been possible or have been maintained to this day, without the whole range of cruel and ingenious devices that were used to keep her sexuality in check, and limit her sexual relations to only one man, who had to be her husband. This is the reason for the implacable enmity shown by society towards female sexuality, and the weapons used to resist and subjugate the turbulent force inherent in it. The slightest leniency manifested in

facing this "potential danger" meant that woman would break out of the prison bars behind which marriage has confined her, and step over the steely limits of a monogamous relationship to a forbidden intimacy with another man, which would inevitably lead to confusion in descendance and inheritance, since there was no guarantee that a strange man's child would not step into the waiting line of successors. Confusion between the children of the legitimate husband and the outside lover would mean the unavoidable collapse of the patriarchal family built around the name of the father alone.

History shows clearly that the father was keen on knowing who his real children were, solely for the purpose of handing down his landed property to them. The patriarchal family therefore came into existence mainly for economic reasons. It was necessary for society simultaneously to build up a system of moral asnd religious values, as well as a legal system capable of protecting and maintaining these economic interests. In the final analysis we can safely say that female circumcision, the chastity belt and other savage practices applied to women are basically the result of the economic interests that govern society. The continued existence of such practices in our society signifies that these economic interests are still operative. The thousands of dayas, nurses, paramedical staff and doctors who make money out of female circumcision naturally resist any change in the values and practices which are a source of gain to them. In the Sudan there is a veritable army of dayas who earn a livelihood out of the series of operations performed on women either to excise their external genital organs, or to alternately narrow and widen the outer aperture according to whether the woman is marrying, divorcing, remarrying or having a child.

Economic factors, and concomitantly political factors, are the basis upon which such customs as female circumcision have developed. It is important to understand the reasons for this tradition. Many people who are not able to distinguish between political and religious factors, conceal economic and political motives behind religious arguments in an attempt to hide the real forces that lie at the basis of what happens in society and in history. It has very often been proclaimed that Islam is at the root of female

circumcision, and is also responsible for the under-privileged and backward situation of women in Egypt and other Arab countries. Such a contention is not true. A story of Christianity shows that this religion is much more rigid and orthodox than Islam where women are concerned. Nevertheless, many countries were able to progress rapidly despite the predominance of Christianity as a religion. This progress was social, economic, scientific and also affected the life and position of women in society.

That is why the writer firmly believes that the reason for the lower status of women in our societies, and the lack of opportunities for progress afforded to them, are not due to Islam, but rather to certain economic and political forces, namely those of foreign imperialism operating mainly from the outside, and the reactionary classes operating from the inside. These two forces cooperate closely and are making a concerted attempt to misinterpret religion and to utilize it as an instrument of fear, oppression and exploitation.

Religion, if authentic in the principles it stands for, aims at truth, equality, justice, love and a healthy wholesome life for all people whether men or women. There can be no true religion that aims at disease, mutilation of the bodies of female children, and amputation of an essential part of their reproductive organs.

If religion comes from God, how can it order man to cut off an organ created by Him as long as that organ is not diseased or deformed? God does not create the organs of the body haphazardly. It is not possible that He should have created the clitoris in woman's body only in order that it be cut off at an early stage in life. This is a contradiction into which neither religion nor the Creator could possibly be involved. If God has created the clitoris as a sexually sensitive organ, whose sole function seems to be the procurement of sexual pleasure to the woman, it follows that He also considers such pleasure for women as normal and legitimate and therefore as an integral part of mental and physical health. The physical and mental health of women cannot be complete if they do not experience sexual pleasure.

There are still a large number of fathers and mothers afraid to leave the clitoris intact in the bodies of their daughters, and that often state that circumcision is a safeguard against the mistakes and deviations into which a girl may be led. This way of thinking is wrong and even dangerous, because what protects a boy or a girl from making mistakes is not the removal of a small piece of flesh from the body but awareness and understanding of the problems we face, and a worthwhile aim in life, an aim which gives life meaning and for the attainment of which we exert our mind and energies. The higher the level of consciousness to which we attain, the closer our aims draw to human motives and values, and the greater our desire to improve life, and its quality, rather than to indulge in the mere satisfaction of our senses and the experience of pleasure, even though these are an essential part of existence. The most liberated and free of girls is the one least preoccupied with sexual questions, since these no longer represent a problem. On the contrary, a free mind finds room for numerous interests and the many rich experiences of a cultured life. Girls who suffer sexual suppression, however, are greatly preoccupied with men and sex. And it is a common observation that an intelligent and cultured woman is much less engrossed in matters related to sex and to men than is the case with ordinary women, who have not got much else with which to fill their lives. Yet at the same time such a woman takes much more initiative to ensure that she will enjoy sex and experience pleasure, and acts with a greater degree of boldness than others. Once sexual satisfaction is attained she is able to turn herself fully to other important aspects of life.

In the life of liberated and intelligent women, sex does not occupy a disproportionate position but rather tends to maintain itself within normal limits. Ignorance, suppression, fear and all sorts of limitations exaggerate the role of sex in the life of girls and women, and cause it to swell out of all proportion and to end up by occupying the whole, or almost the whole of their lives.

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FEMALE CIRCUMCISION IN EGYPT: CURRENT RESEARCH AND SOCIAL IMPLICATIONS

by

Marie Bassili Assaad

INTRODUCTION

This paper is an attempt to provide a critical review of written and oral information on female circumcision in Egypt and to indicate areas where systematic study is needed to provide a fuller understanding of the problem. Such an understanding is necessary for defining possible methods of influencing opinion and disseminating knowledge on the effects of the practice of female circumcision upon women's health and self identity.

The subject of female circumcision, which has been buried in secrecy and taboo for many generations, is being finally brought into the open by feminists, health practitioners and social scientists concerned with the physical, psychological and moral well-being of women and girls. The genital mutilation of little girls has persisted for centuries because of insufficient knowledge and understanding; motivated by love and concern for their daughters' future, well-meaning women have perpetuated the custom and have inflicted much pain and suffering on their daughters out of a firm belief in the physical and moral benefits of this operation as the sure guarantee of marriage and consequent economic and social security. Since the custom has long been shrouded in mystery and taboo, it has not received serious attention from the educated and enlightened. Psychologists and gynaecologists have not included it among their many concerns for health and well-being, and many of the feminists who fought

successfully for women's political and social rights, believing that the practice of female circumcision was an insignificant and dying custom, did not include it in the list of causes for which they worked.

This paper is limited to an examination of the social implications of the practice and endeavours to answer some of the more obvious questions concerning female circumcision. The topics addressed in this paper are as follows:

1. Definition and extent of the practice and types of female circumcision popular in Egypt today: How widespread is the practice?

2. Origin of the practice, its meaning, Islamic views and legal status: Is female circumcision an Islamic injunction, or is it an African initiation rite that has been diffused to Egypt; or is it a Pharaonic survival? Was female circumcision forbidden by law or presidential decree as claimed in some literature? What is the present legal status of the practice?

3. Social interpretations of the practice within the Egyptian value system: how does the practice fit within the total value system? What is its meaning in relation to other beliefs and values - such as norms of female modesty, family honour and its relationship to female chastity and virginity, definition of male and female roles and segregation of the sexes? How does the practice serve as a guarantee for marriage and economic security?

4. Current research. The information treated in this paper includes a full review of the literature related to female circumcision in Egypt including legal and religious texts, four small-scale surveys on different population groups including a description of the writer's own research completed in 1979. Because of the nature of the subject matter, it is important to put the interpretation of the data in context. The views expressed here reflect the writer's personal experience as an Egyptian female participating in the culture and attempting, over a period of four

years, to compile literature and acquire an understanding of the subject; and as an Egyptian social scientist who has undertaken a pilot study to gain insights into the extent of the practice in Egypt, and discover whether women interviewed by women would be willing to answer questions and frankly express their views about their personal experiences.

In presenting these findings of the pilot study, the writer hopes that the information presented here will be useful to promote fuller discussion and initiate further research that could lay the foundation for action, and the commitment to eradicate the practice of female circumcision.

This pilot study was conducted on a sample of 54 women from the personnel and clients of a family planning centre in Cairo and with the following objectives:

a) to provide some evidence and support for the views expressed in this paper;

b) to test a set of questions that might serve as a basis for a more systematic study;

c) to acquire knowledge about the present extent of the practice and about the stated reasons, methods, locations and performers of female circumcision.

The study draws attention to the need to examine subjects from the viewpoint of those who are most directly involved. Since female circumcision is mainly a feminine concern, the study was designed to allow those who are the subjects and the objects of the practice to supply information and express their views. The questions were formulated to discover how much information could be collected by means of a structured interview schedule. This method was chosen to test the common opinion that if the practice of female circumcision existed in Egypt today, it would exist underground, and being a taboo subject, could not be studied through systematic research or structured interviews.

Four cases were selected from the total number of 54 interviews to provide some details about the types of answers received. These four cases were selected on the basis of age and religious affiliation - one older woman, one middle-aged woman, and two younger women - and best illustrate the following conclusions:

- both Christians and Muslims in Egypt practise female circumcision;
- the practice is perpetuated on the basis of custom and tradition and not on the basis of religious belief;
- the practice is not a meaningless cultural survival, but it fits within a total value system which promotes the segregation of the sexes, premarital chastity and virginity, and their close association with family honour or shame.

In conclusion, the paper suggests some guidelines for multi-faceted research which can deal with the cultural, psychological and social aspects of problems in formulating effective solutions. It also offers summaries and suggestions from other studies and makes its own suggestions on the need for further study and action.

In addition to the four studies mentioned already, there are two major programmes in progress. One is a large survey being conducted by Aim Shams University on a sample of 3000 cases comprising circumcised and uncircumcised, married and unmarried women and girls, as well as husbands and dayas. Dr Maher Mahran, assisted by Dr Sobhi Abuloz (professors of gynaecology), have presented the following papers which are currently in press.

1. "Complications of Female Circumcision", a hospital survey conducted from 1970 to 1975.

2. "Female Circumcision of Egypt", a paper delivered by Dr Maher Mahran to the Third International Congress on Sexology in Rome, October 1978.

The other programme, which is to be carried out by the Cairo Family Planning Association, has the following objectives:

Primary objective

Abolition, by legal and educational measures, of customary practices by means of which female children are mutilated through circumcision, practices detrimental to their health and to their psychological condition before and after marriage.

Specific objectives

1. To gain understanding of the historical, religious and sociological factors involved in female cicumcision.

2 To ascertain the ill effects of the practice of female circumcision on the health and psychological conditions of children, as well as its effect later on in their married lives.

1. Definition and extent of female circumcision in Egypt

Most writers seem to agree on the definition of female circumcision: excision or clitoridectomy which is called khafd meaning reducing in classical Arabic and is more popularly known by the term tahara or purification[1]; i.e. the partial or complete removal of the external female genitalia, varying from removal of the prepuce of the clitoris only to the full excision of the clitoris, the labia minora and the labia majora. The operation is usually performed between the ages of six and 10, before the girl reaches puberty. Types I and II, known as sunna circumcision, consisting of the removal of the tip or a part of the clitoris, with or without the removal of the libia minora, is commonly practised in Egypt. Types III and IV, known in Sudan as Pharaonic circumcision and in Egypt as Sudanese circumcision, consist of excision plus infibulation and are no longer practised in Egypt.

In spite of a lack of awareness among educated Egyptians concerning the prevalence of the practice of excision (types I and II), there are enough scattered data to support the opinion that most women in Egypt are circumcised. All studies testify to this fact[2]. Up-to-date information acquired from key informants such as gynaecologists in maternity and child health and family planning clinics, as well as the studies undertaken by Assaad, Baasher, Saadawy and Smith support the statement that sunna circumcision is still undergone by 70 to 90 percent of women and girls in Egypt. Only a privileged few are spared.

2. Origin, meaning, Islamic views and legal status of female circumcision

Origin of the practice

There are no clear records in which one might trace the origin of the practice of female circumcision in Egypt. It is difficult to ascertain whether it is originally an old African puberty rite that came to Egypt by diffusion, or whether it is a pharaonic survival that fitted within the cultural patterns of modern Egypt.

The few scattered references to the practice in pharaonic Egypt show that the subject is neither fully understood, nor well-researched[3]. However, there is sufficient evidence to help us conclude that there was some kind of female circumcision in Ancient Egypt, and that it was perhaps there that the custom originated.

Whatever the origin of female circumcision in Egypt, it does not conclusively originate in the Islamic tradition, contrary to popular beliefs. Both Muslims and Christians have circumcised their daughters since early times, and there is much evidence that the practice existed long before Christianity and Islam[4].

Meaning

Providing some explanation of the possible motives of female circumcision, Meinardus (1967) relates it to the pharaonic belief in the bisexuality of the gods. He writes:

> "Now, just as certain gods are believed to be bisexual, so every person is believed to be endowed with masculine and feminine "souls". These "souls" reveal their respective physiological characteristics in and through the procreative organs. Thus, the feminine "soul" of the man, so it is maintained, is located in the prepuce, whereas the masculine "soul" of the woman is situated in the clitoris. This means that as the young boy grows up and finally is admitted into the masculine society, he has to shed his feminine properties. This is accomplished by the removal of the prepuce, the feminine portion of his original bisexual state. The same is true with the young girl, who upon entering the feminine society, is delivered from her masculine properties by having her clitoris or her clitoris and labia excised. Only thus, being circumcised, can the girl claim to be fully a woman, and thus capable of the sexual life".

It is this mythological significance of female circumcision which also explains its importance with regard to the girl's virginity. The girl who is circumcised is declared ripe for sexual life, and to engage in sexual activity prior to circumcision is considered improper and immoral, since the girl has not entered the state of full womanhood which depends upon the partial or complete removal of her masculine organ, namely the clitoris.

According to Isis (1976), the same explanation is given in many places in Africa. Excision is practised to demarcate the sex of the person clearly, since it is believed that both the female and male sex exist in each person at birth. A boy is "female" by virtue of his foreskin, and a girl is male by her "clitoris". This view is also supported by Hansen (1972) who refers to the same explanation provided by Baumann (1955).

Islamic views

There is no mention of female circumcision in the Qur'an[6]. However, Islamic jurists have interpreted the often quoted hadith of Umm Attiya and others as favouring female circumcision insofar as the Prophet did not prohibit the practice, although he condemned total clitoridectomy.

Sheikh Ibrahim Mahrous, chairman of the Fatwa Committee of Al Azhar reviewing the teachings of the four Islamic schools, said in 1951[7]:

> "The Ash-Shafi's consider circumcision a duty for both males and females. The Malikites look upon it as an ordinance in men and an embellishment in women, while Hanbalites and the Hanafites describe it as sunna meaning tradition for men, and ennobling for women".

The eight eminent Muslim leaders interviewed by Lewa'a Al Islam in June 1951 referred to a number of sayings attributed to the Prophet and agreed that the milder form of female circumcision (Type I) is sunna for men and ennobling for women. The most frequently quoted of these sayings are the hadith concerning Umm Attiya who was excising a girl, and was told by the Prophet: "Reduce but do not destroy"*; the hadith related by Ahmad and El Beheky, confirming that "Circumcision is sunna for men and makrama (ennobling) for women", and the hadith of Abu Huraira who said[8]:

> "Islam is the religion of purity, and purity is accomplished by five deeds: circumcision, removal of pubic hairs, trimming of moustache, paring of nails and plucking of hairs from armpits."

To support this view, Fadilat Allam Bey Nassar, the Grand Mufti, quoted in 1951 the following fataw registered on 11 September 1950 in Dar El Ifta'a under number 180/63[9].

*This passage was quoted in Al Gomhouria, the Egyptian Arabic daily newspaper on Thursday 1 February 1979, p.7, as the answer given by members of the Fatwa committee on a question about female circumcision.

"Female circumcision is an Islamic practice mentioned in the tradition of the Prophet, and sanctioned by imams and jurists, in spite of their differences on whether it is a duty or a sunna. We support the practice as sunna and sanction it in view of its effect on attenuating the sexual desire in woman and directing it to the desirable moderation."

Legal status

Many educated people, including doctors living in Egypt today, believe that female circumcision is prohibited by law. This belief has been confirmed by several writers on the subject. Callender (1971) and Fakhouri (1972) simply mention that the government has officially banned the practice. Mustafa (1966), in attempting to confirm that female circumcision has been "unjustly attributed to Islam", mentions the fact that it is not practised in many Muslim countries, such as Saudi Arabia, Syria, Yemen, Iraq, Tunisia, Iran and Turkey and that it was recently abolished in Egypt. Goode (1970) affirms that Nasser passed a decree in April 1958 prohibiting the practice of clitoridectomy and punishing the offenders by fine or imprisonment. Although extensive efforts have been made to unearth this law and understand its implications, to date no one can confirm the existence of a law passed by parliament or a presidential decree.

However, Ministerial resolution no. 74 for the year 1959 was published in 24 June 1959 by the Minister of Public Health to establish a special committee to study and investigate the question of female circumcision in all its aspects - religious, health and social. This committee, consisting of seven male members, met on 6 July 1959 under the chairmanship of the Under-Secretary of the Ministry of Health and including the Grand Mufti, the Governor of Cairo, and five directors from the Ministry. After studying the question the following resolution was made:

"Circumcision as performed at present is physiologically and psychologically harmful for girls whether before or after marriage. Although Islamic jurists basing their arguments on verified ahadith (sayings of the Prophet), have differed on whether Khafd (reduction, meaning female circumcision) is a duty, a sunna or makrama (ennobling), yet they have all agreed that it is an Islamic ritual and Sharia law forbids total clitoridectomy. Therefore the committee sees the necessity to proceed with the Khafd operation in the following order:

1. It is absolutely forbidden for other than doctors to perform the operation.

2. For those who want circumcision, the operation should be partial and not total clitoridectomy, in accordance with by-laws to be formulated at a later stage.

This resolution was signed by both the Minister and the Under-secretary of the Ministry of Public Health.

3. Female circumcision and traditional values: A sociological interpretation

If we are to understand the strength of a belief in any culture, we have to examine its role within the social fabric. The purpose of this section is to understand the significance of female circumcision within Egyptian culture, and its place in the belief and value systems. As mentioned earlier, in spite of the fact that female circumcision did not originate with Islam, its strength lies in Islamic tradition. This is true not only because of the frequently repeated ahadith (sayings of the Prophet) in favour of sunna circumcision, but also because of the great value placed on female modesty and chastity in Islam. Although female circumcision, as explained above, is not mentioned in the Qur'an, premarital chastity and virginity are clearly mentioned[10]. Since it is generally recognized that Islam is an all-embracing religious code of

conduct in which many aspects of human relationships are regulated in meticulous detail, a religious value for female circumcision would have a strong hold on the members of the community[11]. It is an established fact that the modern and traditional sectors of Egyptian society regard a broken or damaged hymen (the symbol of virginity) before marriage as a matter of grave concern that still leads some of the more traditional rural families to kill their daughters. The physiological state of virginity is still considered the most precious possession of the unmarried woman. She, as well as members of her faily, will do anything to retain the impeccability of her hymen and protect it from any possible damage[12]. The government regulation on female circumcision states thus:

1. Female circumcision is forbidden in the Public Health Units for scientific and health reasons.

2. It is not permitted for certified <u>dayas</u> to perform any surgical operation including female circumcision.

Although this regulation may have had some role in abolishing Pharaonic circumcision, which is also forbidden by Islam, it may only have succeeded in pushing underground the popular practice of excision Types I and II. It is common knowledge that the uncertified <u>daya</u> or the barber are those who are have performed and continue to perform the operation. In view of the present situation, it might have been better to encourage the practice to come to the surface until the dangers of the operation were obvious, for this might have guaranteed good hygienic and medical conditions that would decrease complications such as haemorrhage and sepsis.

It is interesting to note that women who believe in female circumcision are not normally conscious of the religious or legal views on the subject. The main reason given by women is "the attenuation of sexual desire", thus protecting the woman against promiscuity, saving her from temptation, suspicion or disgrace, and preserving her chastity[13]. Another reason offered was "keeping the family custom" - a custom that is

based on the belief that woman is not fully woman unless her "ugly" external genitalia are removed; a custom that makes these women look down upon the uncircumcised woman and say to her, "you are like a man". The fact that her clitoris has not been removed prevents her from attaining the accepted status of full womanhood and marriage. This status is especially important in a segregated society where women's and men's roles are clearly delineated, where marriage is seen as an economic necessity, and where a woman derives her value from her family roles of wife and mother[14].

However, with the advance of knowledge and education, traditional concepts about woman's nature and her sexuality are ridiculed by the educated. Woman's view of herself and her belief in old custom changes in response to information, education, social and economic opportunities. The educated woman learns that her status may be derived from roles other than those of wife and mother. Other values are changing among the educated that may affect the practice of circumcision. The more educated the woman, the more informed she is about her true nature. The more active socially and economically she is, the more she condemns the practice of female circumcision. She sees its danger in terms of health hazards and looks upon it as unnecessary mutilation of innocent girls. Moreover, she increasingly defines her role in social change to include further understanding of the lives and needs of lower-income uneducated women. Educated women may with this consciousness finally provide the leadership that has been lacking in raising a public debate on the topic of female circumcision, by serving as role models and activists.

Even in the absence of social and economic change many uneducated women, given information, will question the validity of female circumcision. This questioning, and the educated woman's rejection of the practice, are based on new and emerging values such as respect for modern concepts of health and an enhanced definition of woman's identity and role. Moreover, in most cases, the memory of the operation is sufficiently traumatic that mere questioning by a trusted service-provider or a friend would receive positive response.

4. Current research

In addition to the pilot study undertaken by the writer, summaries of three other studies undertaken since 1977 are provided in this section to allow for comparison, and to provide a clearer understanding of the extent of the practice of female circumcision in Egypt.

1. El Mara'a Wal Sera'a El Nafsi (Woman and psychological conflict), Nawal Al Saadawy.

The study is based on the interviews conducted on a sample of 160 women from Cairo between the ages of 20 and 29, of whom 75 per cent were from the middle class and 70 per cent were married. 81.8 per cent of the sample were excised. Commenting on the reaction of the women interviewed Dr Al-Saadawy writes:

> "Most of the women with whom I discussed the operation did not realize the extent of its harm. They think it is performed for health reasons and for cleanliness and purification (tahara)".

2. Psychological aspects of female circumcision, T. A. Baasher, Regional Adviser on mental health, WHO Eastern Mediterranean Region.

Out of the 70 adult females between the ages of 18 and 55 interviewed in Alexandria in 1977, 70 per cent were excised, with a similar percentage among their older sisters, compared with 54 per cent among the younger sisters. 29 per cent of those circumcised were Sudanese and 19 per cent were Egyptians. 82.85 per cent were of the opinion that the practice of female circumcision should not continue, 11.4 per cent were in favour, and 5.7 per cent could not make up their minds. The majority of those who favoured the continuation of female circumcision were married housewives, over the age of 30, from low socioeconomic groups, and with no formal social background.

3. Female circumcision: A study of the knowledge and attitudes of nurses in Alexandria toward female circumcision, Eleanor Smith, Professor of Maternal and Child Health Nursing, Project Hope/Egypt.

63 per cent of the 135 nurses interviewed did not know about the possible types of the operation, and 32 per cent refused to answer the question about who usually performs such an operation. 76 per cent could not decide whether it was legel or illegal. 83 per cent believed that there were no disadvantages. 81 per cent reported that they knew no religious reasons for female circumcision. 67.4 per cent stated that they would not circumcise their daughters, while 29.2 per cent said that they would circumcise their daughters, either for aesthetic reasons (21%) or to decrease their sexual desire and protect them from delinquency (8.2%). The study showed positive correlations between age and education and the intention to circumcise daughters. Younger nurses were less inclined to circumcise their daughters than older ones. The lower the educational level, the more inclined the nurse was towards circumcision. It is also significant that 77 per cent of the nurses in the sample were themselves circumcised.

In view of the prevalence of the practice of female circumcision in Egypt and the lack of clear knowledge on the subject, this study supported the idea that two types of information should be included in the curricula of nursing schools to prepare nurses for their key role as health educators and women's counsellors. These two types of information comprised:

1. The practice of female circumcision, the function of the parts of the female genitalia that are removed, psychological effects, and religious and legal sanctions.

2. Human sexuality, the anatomy and physiology of female and male reproductive systems and marital relationships.

4. Preliminary enquiry regarding the practice of female circumcision, Marie Assaad, 1979.

Objectives of the study

1. To provide some evidence to test the interpretation of female circumcision described in the present paper.

2. To test a set of questions that may serve as a basis for more systematic study in the future.

3. To develop insight about the present extent of the practice and its perpetuation; how, where and by whom the operation is performed, and what are the stated reasons.

4. To learn about the practice from those who are most involved.

Sample selected

The sample consisted of all the women who within one week (four morning sessions) availed themselves of the services of a family planning centre in a low-socioeconomic housing area in Cairo. These comprised 54 Egyptians, of whom 52 were Muslim and two were Christian; all were married women within the age range 20 to 50 years; 66 per cent were between the ages of 25 and 39. 38 (70%) were illiterate or semi-literate and all had illiterate or semi-literate mothers.

Methodology

A structured interview schedule was administered by the social and paramedical staff of the centre. Consisting of 57 questions, this schedule was divided into five main parts:

1. Background data on the respondent and her parents.
2. Description of excision experience.

3. Marriage and sex experience
4. Daughter's excision.
5. Respondent's perception of other people's views on the practice of female circumcision.

Findings - extent of the practice

Of the 54 women interviewed, 49 (90.8%) were circumcised, and of these 23 (46.9%) have had their daughters circumcised, and 17 (34.7%) intended to do likewise. 43 (almost 94%) of the 46 respondents with sisters reported that their sisters were also circumcised.

Operators

on respondents

Dayas: (traditional midwives)	53 per cent (26)	of the	operations
Gypsies: (roaming fortune tellers)	16 per cent (8)	"	"
Barbers:	12 per cent (6)	"	"
Physicians:	12 per cent (6)	"	"
Trained nurses:	6 per cent (3)	"	"

on daughters: (total number circumcised: 39)

Dayas:	53.8 per cent (21)
Barbers:	30.7 per cent (12)
Physicians:	12.8 per cent (15)
Trained nurses:	2.5 per cent (1)

Type of operation

sunna

Reaction to the operation

1. Immediate complications: 87.7 per cent (or 43) of the circumcised respondents experienced fear, severe pain, bleeding, inflammation, and urinary disturbances; of these 60 per cent (or 26) remained inactive for a few days and the rest could not move about for more than one week.

2. Later complications: regarding the monthly period, most of the respondents were circumcised before puberty, hence could not report any effect upon their periods. Only one woman reported that she was circumcised after her monthly period and indicated that she had not perceived any difference between her periods before and after. Regarding sex, 93.8 per cent (46) of the circumcised respondents reported that they enjoyed sex and were happy with their husbands.

Attitudes towards the practice

Significantly, 81.6 per cent (40 out of 49) respondents indicated that they have already had, or intend to have, their daughters circumcised. The reasons given are arranged below in descending frequency:

1. Attenuation of sexual desire (13)
2. Family custom (7)
3. Hygienic purposes (3)

These same respondents gave similar reasons for their own circumcision with the difference that "family custom" predominated over "attenuation of sexual desire". The reasons are listed in the following order:

1. Family custom (20)
2. Attenuation of sexual desire (18)
3. Hygienic purposes (5)
4. To uphold the tradition of the Prophet (3)
5. Do not know why they are circumcised (3)

A similar pattern of responses emerged when the respondents were asked what they believed were other people's reasons for having their daughters circumcised.

Table 1

Respondents' perceptions of other people's views on female circumcision (N=54)

Persons	Support	Against	Don't know	Other views
Husbands	57.4% (31)	31.5% (17)	11.1% (6)	
Men in general	40.7% (22)	29.6% (16)	20.4% (11)	It depends on the man himself; some men like it, others don't 5.6% (3). It is not for the man to decide 3.7% (2).
Dayas	96.3% (52)	-	3.7% (2)	
Physicians	18.5% (10)	46.3% (25)	27.8% (5)	Not all physicians support FC 7.4% (4)
Religious leaders	33.3% (18)	13.0% (7)	53.7% (9)	
Government	7.4% (4)	38.9% (21)	53.7% (29)	

From these answers we learn the following lessons that may be useful for future action:

1. The *daya* plays an important role in perpetuating the practice and there is a need to pay special attention this category of person.
2. There is ambivalence in relation to other people's views, which necessitates wider dissemination of information.
3. The outlook of husbands and men in general is important and there is a need to investigate more fully how men perceive the practice of female circumcision.
4. 42 respondents (77.7 per cent) believed that people think of an uncircumcised woman as over-sexed and never satiated. The rest of the respondents either did not know other people's outlook or reported that an uncircumcised woman is accused of being like a man, with a "penis", i.e. highly sexed and insatiable.

Discussion

In spite of the limitation of this study in terms of sample size, training of interviewers, and data analysis, the results not only confirm

the findings of other studies (see Table 2), but give clear pictures of the extent of the practice and of how uneducated women in a lower income bracket perceive female circumcision. Supported by custom and fear of sexual expression, the practice seems to persist among this group of women, who insist on submitting their own daughters to the same fate. The study does not show any correlation between excision and sexual dissatisfaction and 94% of the excised respondents reported that they enjoyed sex. However, this result should be accepted with reservations, in view of the complex and intimate nature of the questions on sexual experience and the reticence of respondents on this subject.

CONCLUSIONS

We are persuaded that the practice of female circumcision will disappear with education and changing female roles when the status of women rises and women gain control over their own lives. However, given the findings outlined concerted efforts in the following areas would certainly assist the achievement of this desired end:

1. Multi-disciplinary action-research should be undertaken by psychologists, gynaecologists and social scientists - male and female - with the purpose of defining what information will be persuasive to men and women in eradicating the practice.

2. Health practitioners, social workers, nurses, family planning workers, feminists engaged in education and outreach programmes, and educated people in general should form the first audience of instruction. They should be informed about the practice, its extent, the reasons for its perpetuation, and the effect of traditional and unscientific beliefs of women about women's health and sexuality. It is important to engage this group first because of their potential for leadership roles.

3. People providing public health and other services should be given the informational tools required to conduct individualized group discussions within their ongoing programmes, whether in health units, family planning centres, maternity and child health centres, maternity units in hospitals, women's clubs, vocational training centres and youth clubs.

4. Change-agents need to be helped to be creative and imaginative in finding ways to convince the daya to work for and not against change. In view of the daya's influential role as a traditional midwife and leader, special effort must be exerted to involve her in these new concerns in relation to female circumcision as well as family planning. The daya must be cared for as a person, and guaranteed other sources of livelihood and importance.

5. Eleanor Smith's suggestions should be endorsed and followed up, particularly with regard to the training of nurses, by including information on the practice of female circumcision and female sexuality in their curricula.

6. Educational programmes in family planning centres and health services should begin now to experiment with the knowledge that is already available.

7. Ongoing evaluations of different approaches should be encouraged for their usefulness in establishing what is feasible and effective within service constraints.

Findings of the Four Studies

	Al-Saadawy	Baasher	Smith	Assaad
Size and Type of Sample	160 Average Middle Class, Cairo	70 Average Middle Class, Mainly Sudanese, Alexandria	135 Nurses Alexandria	54 Family Planning Clients, Poor Housing Area, Cairo
Percentage of Practice	81.8	70	77	90.8
Excised or intend to have Daughter Excised			29.2	81.6
Operators		Dayas 57% Physicians 18% Trained nurse, 18%	25% 35% 6.7%	53% 12% 6% Gypsies 16% Barbers 12%
Type of Operation		Pharaonic Sunna		Sunna
Complications		Fear, Severe Pain, Bleeding, Urinary Disturbances		Fear, Severe Pain, Bleeding, Urinary Disturbances

TABLE 2

	Al-Saadawy	Baasher	Smith	Assaad
Reasons to Support the Practice		Attenuation of Sexual Desire, Hygiene, Tradition, Family Customs	Attenuation of Sexual Desire, Hygiene, Tradition, Family Customs	Attenuation of Sexual Desire, Hygiene, Tradition, Family Customs
Reasons Against the Practice		Infringes on Human Rights, Disfigures, Disharmony in Marital Relation-ship, Physical Complications, Obstetrical, Psychological Complications, Does not Conform with Current Advances	Physical Complications Obstetrical, Psychological Complications	

TRADITIONAL PRACTICES AFFECTING THE HEALTH OF WOMAN
FEMALE CIRCUMCISION IN EGYPT

by

Dr A. S. El Din El Hakim

INTRODUCTION

However critical we may be of other aspects of social development in the modern world, we still feel that we can afford to be generous in acknowledging the brilliance of its achievements in the realm of science and technology.

We have accustomed ourselves to accept with resignation the fact that the products of human industrial enterprise are often ugly and frightening, and when we reflect upon the rewards of two centuries of development, we have little difficulty in excusing the occasionally unwanted consequences of our ingenious discovery and fertility in invention. Mistakes have been made, failures have occurred; nevertheless, the magnitude of our solid achievement sufficiently demonstrates that our progress has in the main been orderly and rational.

The previous paragraph may be needed to reach the point that, in our neurotic existence, woman, who constitutes half of society, who owns more stock than man, who spends 80 per cent of the money earned, must have her chance to participate effectively in society, especially in developing countries.

We must examine all the many factors of woman's impact on the world today - socially, economically, politically and morally - and reveal the problems she must face along with her new responsibilities.

Under the title "Traditional practices affecting the health of women and children" female circumcision is one of the topics.

This operation has been practised on a wide scale in the Egyptian community while its prevalence is decreasing due to many factors. One of the main factors is the interference of the health authorities by introducing regulations and legislation concerning female circumcision, after so many drastic complications have taken place.

As will be seen later, to understand the phenomenon, to approach and to become more capable of offering solutions, some relevant points should be discussed, thus:

1. The psycho-socioeconomic-cultural situation of woman in this society.
2. Sex taboos as regards woman.
3. Some psycho-pathological interpretations.
4. The meaning of the so-called "necessity" of female circumcision in this traditional practice and its probable complications.

1. Psycho-socioeconomic-cultural situation

We are increasingly speaking of women's rights, and not enough about their obligations.

The adolescent wishes to be popular, independent, "one of the crowd". "Everybody's doing it, why can't I?" Rushing to grow up, she patterns her behaviour on that of adult women, perhaps her mother who encourages her by not discouraging.

Unguided daughters are soon misguided by passionate love scenes of movies, the realism of television with the mistaken idea that all success in captivating a male, depends on kisses; all this physical contact is "love"; the true significance of love and sex has been obscured to such an extent that few people in our culture really understand what it is. Sex is equated with intercourse as a end in itself and love is confused with the same thing.

Frustrations, conflicting desires, emotional disorders of varying kinds and degrees are the foremost instigators of female offences - far greater than purely sexual motivations. In this connexion, psychiatrists and psychologists have pin-pointed the female "inability to meet demands of adult living", "a feeling of insecurity" and "weakness of will" as basic causes.

It is worth mentioning that a factor which reveals the lack of social stability is the increased divorce rate in this community.

Nowadays we find millions of wives proving their cooperative spirit in dealing with the man in their lives; millions more are nagging, pushing, needling, belittling, effeminizing their husbands through a cunning manipulation of the togetherness instrument.

In the area of subordination, most Egyptian women were financially dependent on their husbands, even with the increasing rate of women's employment. However, tracing the changing feminine role from ancient days through the suffrage movement to today's modern female, we must present a fascinating picture of the impact of women on the world, on society and on men.

12. Sex taboos

In Egyptian society, as well as that of many developing and religious nations, sex is considered as a matter of sin before marriage and even sometimes after marriage in certain circumstances.

Many prohibitions and restrictions have been set in order to control the sexual behaviour of women, aiming at the provision of a suitable family structure. Hence female virginity assumed its importance as an indicator of sexual relations and has been identified with the honour of the family. Clearly, circumcision of the female was thought of as a tradition to inhibit her sexual desire.

Sexual desire is a mutual affair; both sexes feel this need, both are impelled to satisfy it and both experience copulation as a consummatory act.

Now we can see man, in an attempt to hide his fears and suspicions as regards female virginity, harming her by resorting to the tradition of circumcision early in her childhood.

3. Psycho-pathological interpretation - illusion of clitoral orgasm

Most of this audience may be surprised by this illustration especially in this situation, when they think that our lasting aim is to condemn female circumcision, and may arrive at the question "if clitoral orgasm is truly an illusion, removal of the clitoris alone or with part of the labia minora or whatever the type of circumcision may be, why do you intend to save it, while it has no role in female gratification and sexual satisfaction?"

The answer will be clear when it is realized that the so-called feminisation of the male and the so-called masculinisation of the female is a healthy indication that everybody is becoming more human.

Masters and Johnson have exhaustively stated that something does take place in various parts of the body of the female before, during and after intercourse; they note and film and measure such phenomena as tumescence, detumescence, flushing, heartbeat, sweating, etc., most of which are paralleled by similar reactions in the male. Freud believed that clitoral orgasm was an expression of immaturity; woman must learn to progress or transfer from it to an allegedly deeper and more satisfying type of orgasm located in the vagina.

Bergler went further and stated that every woman who cannot or does not have vaginal orgasm is frigid. Feminist Eva Figer says "when modern woman discovered the orgasm, it was combined with modern birth control, perhaps the biggest single nail in the coffin of male dominance".

Nevertheless, sensory cells similar to those found in the glans penis are confined largely to the clitoris, with some located in the labia minora and lower vaginal muscles.

The vagina is homologous with the penile shaft and therefore cannot respond to sexual stimulation in the same way as the phallus. This widely held notion and the expectation of many women of rapid and climactic orgasm, similar to that of man, is probably incorrect. For satisfactory sexual relations, women must find themselves with a desirable partner, devoid of anxiety and guilt, and must then be provided with appropriate stimulation in order to achieve a slower and more enduring gratification.

Many women believe they are frigid due to misconceptions about feminine arousal.

4. The meaning of female circumcision

I shall try in psycho-pathological language to visualise what is behind this phenomenon in our culture.

It may have relation to the desired sex by parents and especially in rural areas where we find a woman dreads, not bearing another child as such, but that it might be a female. With his dominant status, to man the only symbol is "nobody can take her away from him".

It may be realized that female circumcision in traditional practice is actually an evolutionary regression. It is also a stigma added to the burden of females, stuck to her vagina, that always reminds her that she is inferior. It is a matter of degradation and humiliation to girls, the women of the future. We may be astonished when we know that circumcision is done by an indigenous midwife with the full approval of the mother, as if the most painful experience for mother becomes the most pleasurable to her when done to her daughter (identification with aggressor). Sex and reproduction become dissociated and split and the situation is: marriage for reproduction - a "woman" for pleasure.

MENTAL COMPLICATIONS

1. These consist of psychic trauma from the painful experience of the operation, especially if it is done without anaesthesia, or during post-operative complications. What the girl has been taught about this operation, either by the mother or by the traditional midwife, will be deeply rooted in her mind and will shape her cultural attitude. Most probably she is taught that it is done for cosmetic purposes etc.

2. The painful experience of circumcision may be reflected in the next experience of the girl's sexual life, viz: the removal of the hymen on the wedding day, the bride's day. Many cases involve horrible fears and expectations of severe pain from this experience - together with the traditional practice of removal of the hymen by the fingers of the midwife to obtain the proof of bleeding as a sign of virginity. The situation may lead to complete rejection of the husband, or to the sexual act which may be very painful. Some cases need psychiatric intervention.

3. After marriage sexual arousal may interfere with marital life. There are no direct data available regarding this complication. Indirect data have been collected from researchers on drug dependence, mainly opium, regarding the main causes of opium taking. Some cases give the idea that opium was taken to improve sexual potency which may be correlated with delayed arousal in the woman.

FEMALE CIRCUMCISION IN EGYPT

by

Dr Afaf Salem

INTRODUCTION

Female circumcision has been practised in Egypt throughout history. There are no available data to clarify the origin of the practice and the few references available only enable us to conclude that there was some kind of female circumcision in Ancient Egypt and that it was there that the practice originated. Both Muslims and Christians have circumcised their young girls since early times, maybe long before Christianity and Islam.

There is nothing in the Quran about female circumcision, and all the eminent Muslim leaders emphasize the fact that female circumcision is not included in the strict religious regulations that must be closely adhered to by all Muslims. Many of them have warned against total excision (Type 3), saying that "it is harmful and not accepted by Sharia (i.e. Islamic) law".

LEGAL ASPECTS

The serious complications resulting from female circumcision in Egypt have drawn the attention of health practitioners, social workers and public personalities who have asked for regulations regarding this operation.

In the Ministry of Health a special committee was organized in June 1959 to study and discuss the subject of female circumcision in all its aspects - religious, social, physical and mental. This committee included the Under-Secretary of the Ministry of Health as chairman and seven members,

namely Sheikh Hassan Maamoon, the Grand Mufti at the time, the Governor of Cairo, a social worker and four members representing the departments concerned in the Ministry of Health. In July 1959 this committee stated the following:

- Circumcision as practised at present has a harmful effect on the physical and mental health of females before and after marriage.
- Although Islamic jurists have differed on whether khefad (reduction) is a duty, a sunna (tradition) or makrama (ennobling), they have all agreed that it is an Islamic ritual and Sharia law forbids total clitoridectomy. The committee therefore stated that for those who desire circumcision the operation should be partial and not total and it is forbidden for any one other than a physician to perform female circumcision. A regulation was accordingly issued by the Ministry of Health in July 1959 which stated thus:

1. Female circumcision is an operation prohibited in all health units.
2. Only physicians can carry out circumcision for those who desire it.
3. Female circumcision should be partial and never total, to avoid harmful effects on the physical and mental health of women.
4. Licensed dayas are not allowed to carry out any surgical operation including female circumcision.

At that time there were schools for traditional birth attendants, dayas. They were granted a licence to be renewed every four years after one month's training; however, these schools were closed in 1962.

Present situation

As female circumcision is practised illegally and not registered in any way, very little information is available. According to observations on women aged between 14 and 40 years attending antenatal and postnatal clinics in urban MCH centres and rural health units, three types of circumcision are practised:

First type: The labia minora and the tip of the clitoris are removed. This is known as sunna circumcision and about 90 per cent of women are circumcised in this way in both urban and rural communities.

Second type: The labia minora and part of the clitoris are excised and this type is practised mostly in the rural areas.

Third type: Total removal of the clitoris and labia minora leading to pinhole vagina and fibrosis. This is mostly carried out in Upper Egypt and Nubia.

Complications

The following complications are reported from cases admitted to the hospitals of the Ministry of Health resulting from female circumcision carried out by dayas:

1. Haemorrhage immediately after the circumcision;
2. perineal tears resulting from the rigidity of the scar tissues and where anterior episiotomy has not been performed;
3. shock resulting from severe pain or haemorrhage;
4. infection of the wound;
5. mental complications.

Health education

After the issue of the regulation concerning female circumcision, it was necessary to add the subject of female circumcision to health education carried out in MCH centres and rural health units. This included anatomy of external genitalia, female sexuality, the practice of female circumcision and the harmful effects on both physical and mental health. This is carried out by person-to-person talks and group discussions during attendance of mothers at the MCH centres, with the objective of changing beliefs and introducing new ideas about circumcision in females.

Conclusion

In order to obtain more information on the practice of female circumcision in Egypt at the present time, it is recommended that the following preliminary surveys be carried out:

1. Girls aged 10-15 years should be reviewed to determine the incidence of the practice in both urban and rural areas and the type of circumcision carried out and to compare the results with the incidence before the issue of the regulation in 1959.
2. Surveys to show motives behind persistence amongst different cultures in practising female circumcision in spite of the prohibition by the Ministry of Health in 1959.

FEMALE CIRCUMCISION IN SOMALIA

by

Mrs Raqiya Haji Dualeh
Mrs Mariam Fara-Warsame

INTRODUCTION

Female circumcision may be considered as another form of female sexual oppression, which is the manipulation of women's sexuality in order to ensure their control, domination and exploitation. In specific terms it serves to harness women into a secondary, submissive role by giving them a negative concept of themselves. This oppression is so deeply rooted and so "personalized", that people often accept these attitudes as normal and innate, since it nearly always generates a sense of shame as the problems remain hidden.

Sexual oppression can take many forms, ranging from the subtle to the overt - female circumcision, chastity, rape, polygamy, sexual repression, motherhood, etc. are all used to define women and literally put them in their place.

The roots of women's sexual oppression can be said to exist in the family, the society, the state and religion. However, the manifestations of that oppression can take any number of forms and varying degrees of intensity. It is here, in the realm of practice, that these abstractions became harsh, concrete realities.

In the span of nine years, the Somali Revolution has achieved a great deal in all aspects of economic, social, cultural and political life of

the people. The revolutionary approach to the participation of women is one of its achievements. We have embarked on a difficult but progressive course and much has been achieved in a few years.

However, we still have to fight the struggle at the level of traditions, oppressions, prejudiced, out-moded concepts and ideologies of contempt for women, denial of their abilities, robbing them of confidence in themselves and other hangovers from the past. Thus we want to stress the belief in evolution; therefore some fact-finding is necessary in order to know the present and potential situation of women.

The Somali Revolution has emphasized the need to provide the basis to build a new generation free of traditional prejudices against women's rights, needs and responsibilities. Amongst our society, female circumcision is still widely practised. The majority of the population use infibulation or the pharaonic circumcision, the most drastic form which has been ably described by Mrs Edna Adan Ismail. Only a small minority of the old Hamar ethnic groups use the sunna type. Therefore, the Somali Women's Democratic Organization, with the help of the Revolutionary Government, wants to tackle such issues of oppression, exploitation and social ills. One of these ills is female circumcision and infibulation. We want to liberate our people from such impediments and protect our mothers and children. We believe it is the most cruel and abusive operation that could be performed on a human being; it constitutes destruction of the human being's physical nature, is offensive and humiliating. Millions of young girls who cannot speak for themselves are victims of this brutal practice.

It is a horrible ordeal and a sad experience for all those women who undergo this cruel operation. Also during marriage, it causes terrible and miserable suffering for women, because they have to undergo another operation in order to have intercourse. Many women face problems in childbirth as well as post-partum difficulties.

There is great danger to health in the practice, and its continuation is largely due to ignorance and illiteracy among the vast majority of women and their inability to determine other ways and means of establishing the virginity of girls. The practice has no religious basis. Sometimes there is not even a ritual involved and has only the most sadistic implications.

Cultural trends

Children are the centre of the life of the Somali family and maternity concerns not only the couple but all the family and even the whole community. Therefore, the whole collectivity feels and considers itself responsible or regarded as responsible for the children's purification as well as being responsible for their care, health, education, etc. Thus pressure for girls' circumcision is very high and regarded healthy and clean, just as uncircumcised boys are believed to be unclean. A non-circumcised girl is considered a disgrace to her whole family.

In Somalia, as in many other countries such as the Sudan and Egypt, circumcision is purposely done to keep girls "chaste". From an early age as 5 to 10 years, the girl undergoes the brutal operation to preserve chastity and subdue or diminish sexual response and prepare the girl for future married life.

Our society preserves and respects virginity before marriage and therefore does everything possible with this in view. All kinds of restrictions are put on the girl until she moves to her husband's home. A special feature of marriage in Somalia is the payment of dowry or bride price: however the marriage is meaningful only if the young wife is a virgin and implying infibulation. In that instance the groom and the rest of the relatives feel proud and happy. If the contrary is found, the bride is sent back to her family in disgrace. In view of the meaning and high regard attached to this operation, no family would dare try to

stop this traditional practice, because of fear of opposition from the older conservative generation and possibly from fanatical religious leaders.

Future trends

Abolition of this custom can only be accomplished through education, emancipation of women and raising the consciousness of both men and women. All medical researchers have shown that the brutal manner in which this operation is performed produces harmful effects on the victim's health, mental and physical. Several females die while those who survive have to endure considerable pain and agony; and also suffer unduly during childbirth. It is therefore a custom which is not compatible with the development of the nation.

Female circumcision is a barbaric act and it is necessary to eradicate it at the national level.

The alleged advantages in safeguarding virginity have no factual basis and like other countries promiscuity abounds amongst the modern generation. In spite of the fact that the majority of the people are convinced of the hardship and suffering associated with the horrid practice, nevertheless, few are prepared to denounce the custom publicly. Indeed, discussion of this subject is considered profane.

Legislation against this practice is essential, but judging from the Sudanese experience where the law prohibiting circumcision has existed for some 20 years, legislation does not seem to be effective. The only solution, therefore, lies in changing the attitudes of the people and increasing their awareness.

The strategy to combat this custom

The Somali Women's Organization, with the support of the Government, is launching a serious campaign in various forms against circumcision through the following activities:

1. Mobilization and consciousness-raising of women regarding the hazards of this practice.

2. Men must be involved in our campaign so that they play a more appropriate role as fathers and husbands.

3. Religious leaders to be approached to pronounce the true teachings of Islam in connexion with this practice and publicly denounce, in mosques and other religious gatherings, the various aspects of pharaonic circumcision which are not in confirmity with the Islamic religion.

4. It was realised that the emphasis of the circumcision campaign will be more realistic and effective through health education especially at secondary school level and in subjects like hygiene, biology, first aid and general education.

5. The topic should be included in the programmes of the IYC, MCH, Orientation Centres, seminars and political nationwide conferences of the Party and other social Organizations (women, workers and youth), regular meetings and university students' debates.

6. To obtain more reliable statistics to support further action, one of the campaign's strategies is to initiate a survey, preferably by medical personnel, since they possess first hand knowledge of the complications and deaths resulting from female circumcision.

7. The mass media should be actively engaged for educational purposes and people should be persuaded to accept the change. The Government should also take concrete steps to abolish this cruel operation.

The struggle against circumcision has culminated in the formation of a national committee coordinated by the Somali Women's Democratic Organization and composed of representatives of the various Ministries: Education, Health, Justice and Religious Affairs, Social Welfare, Information, Somali Women's Organization, Workers Union, Youth Organization, doctors, psychologists and members of the general public.

This Committee is now looking further into the arrangements of a nationwide campaign and has already started its activities.

We are confident that positive results will emanate from this campaign and will go a long way to eradicate the custom of circumcision in Somalia.

FEMALE CIRCUMCISION - PHYSICAL AND MENTAL COMPLICATIONS

by

Edna Adan Ismail

Female circumcision can be described as the partial or total excision of the female external genitalia and is classified in the following categories:

1. Mild sunna

The mildest form, also known as the "sunna", consists of the excision of the prepuce of the clitoris and in its mildest form may only consist of the pricking of the clitoris with a sharp instrument, such as a pin, and nothing more. This leaves very little or no damage and the child may never even be aware that this has ever been done to her when performed at birth. It leaves no adverse after effects on her later sexual or marital life.

2. Modified sunna

Partial or total excision of the body of the clitoris, and since the clitoris is composed of nerve and erectile tissues there may be a fair amount of nervous and tissue regrowth which may respond to later sexual stimulation. Research has shown that the partial or total lack of a clitoris does not necessarily mean the lack of an orgasm.

3. <u>Partial or total clitoridectomy</u>

This operation involves total or partial clitoridectomy with excision of the labia minora. In such cases the nerve tissues contained in the labia minora are also excised and there is less nervous stimulation felt. The resulting scar tissues may also extend to the vaginal orifice causing pain during intercourse and interfering with the proper dilatation of the vaginal orifice during childbirth, resulting in lacerations.

4. <u>Infibulation (pharaonic female circumcision)</u>

This is the most drastic and mutilating form which is commonly practised in Somalia. It consists of partial or total clitoridectomy, total excision of labia minora, excision of the inner walls of the labia majora down to the level of the lower end of the vagina, the suturing together or approximating the raw edges of the labia majora so that the opposite sides heal together virtually closing the vaginal orifice, but leaving a small opening for the passage of urine and menstrual flow.

In the first three forms no special after care is necessary other than stopping any bleeding; sometimes by cauterization of the wound or the application of herbs which act as haemostatics and also promote healing.

The operation is performed by a woman who earns her living through such operations and the subsequent opening up after marriage. She is usually the village midwife. Such women have no knowledge of asepsis or of anatomy and use no form of anaesthesia.

It may be done by paramedical personnel, and such people use local anaesthesia, sterile instruments and have some knowledge of asepsis. However, it has been found that because of the local anaesthesia, the child struggles less enabling more tissues to be excised.

The circumcision is done on young girls of between the ages of 5 and 8, either as individuals or in groups of girls who are either related or

neighbours. The girl is usually given a bath and her hair may be shaved off. She is then made to squat on a low stool and a strong woman sits behind pinning back her arms and her shoulders. Two more women hold one leg each so that her vulva is exposed and she is prevented from struggling. The "operator" sits in front of the child and with a razor blade or sharp knife excises the clitoris, the labia minora and the inner walls of the labia majora.

Using thorns which she has preselected and brought with her, she inserts on opposite sides, usually about 4 or 6 of them, half on each side, then winds a string or strip of cloth around the thorns to hold them in position rather like the way the hooks of boots are laced. She then sprinkles the wound with a powdered mixture containing sugar, gum and <u>malmal</u> which forms a glue that sticks to the cloth and blood forming a protective crust which also controls any haemorrhage. The child is then bound from the waist down to her toes and is carried out to lie on a mat.

<u>After care</u>

For the pharaonic type of circumcision more immediate treatment and after care is necessary. The child's diet consists of a low residue diet so that she will not have frequent bowel movements and her drinking is limited to about a few sips of water at a time. The passing of the first urine is awaited eagerly as this will show whether the urethral orifice has been blocked or not, and when the child is ready to urinate she is taken off the bedding and made to lie on her side on the bare floor and told to attempt to urinate: water may be poured nearby to stimulate micturition. During the first few days aromatic herbs and incense are burned below the child to fumigate her and help the healing process. On the seventh day the binder is removed from her thighs and legs, the crust of cloth, thorns and blood are moistened and the thorns removed. The binder is put back on her again but leaving the lower legs free so that with the help of a stick she can take short steps. On the 10th to 14th day all binders are removed and she can begin to take short steps or walk about without a stick.

Complications - physical

Complications are many, and can be classified in four stages.

1. Immediate: Shock from fear, pain and haemorrhage. Extensive lacerations may be sustained which may involve the vaginal orifice, the urethral meatus and sometimes the rectum. As the child struggles, cuts on her thighs and buttocks may be inflicted. Quite a few children are brought to hospital with uncontrollable haemorrhage and deep lacerations.

2. Within the first 10 days

(a) Sepsis ranks high in the list of complications and tetanus is not uncommon.

(b) Retention of urine is another common complication, due to the fact that the urethra is now covered with a flap of skin as well as the thorns and blood crust. Sometimes the small opening which was intended for the passage of urine closes up and may require reopening.

(c) Failure of the infibulation - sometimes the circumcision fails and the labia majora may not stick together calling for another attempt after a few weeks or months.

3. At the time of marriage. The husband may forcibly penetrate the barrier and cause lacerations which may involve the perineum and sometimes the rectum and even the urethra; again, infection of the new wound may occur.

4. At childbirth. The circumcision opening, which was opened to allow penetration on marriage, is no longer sufficient to allow for the birth of the child and therefore an upward opening is necessary as well as a lateral or bilateral episiotomy to widen the outlet. Once more infection may occur with unnecessary suffering during every childbirth.

5. Rectovaginal and vesico-vaginal fistulae are often seen.

6. Pelvic inflammation - because of the back flow and stagnation of urine and menstrual blood in the vagina and urethra, there is a constant threat of the entire uro-genital tract which may develop into chronic pelvic inflammation leading to dysmenorrhoea and infertility.

MENTAL COMPLICATIONS

These begin to affect the female child from an early age and remain with her throughout her life. Well before the child is circumcised she sees others who have been recently circumcised or hears tales of horror relating to the act of infibulation. Nor is it uncommon to frighten and threaten young girls with having their kintir (clitoris) cut off if they disobey their mothers or older relatives. At the same time, girls who themselves have been circumcised taunt others with insults and call them "unclean". It is in this frame of mind of mixed fear and sense of inferiority that the child reaches her turn for circumcision.

Many of the physical wounds will heal, and their pain and discomfort subside, whereas each stage of her older life will only add further to her mental injuries: the slow trickle of urine during micturition as opposed to the previous strong jet of her bladder - the onset of the menarche with its accompanying discomfort and odours - marriage, the opening up of the infibulation and the agony of intercourse - the birth of the first child and the knowledge that subsequent delivered are not going to be any easier on her scarred vulva. In spite of her attitude towards infibulation, she has to subject her daughters and granddaughters to the same ordeal.

Recent survey in Somalia

In 1978 and for the first time in Somalia, it was possible for three male medical students of the Faculty of Mogadishu to carry out a survey on the subject of infibulation for the purpose of a thesis.

The information obtained was based on the direct interview of 290 Somali females in the Region of Bendair and the information these 290 females gave totalled about 1130 females.

The direct interviews of the 290 women were carried out in hospitals, in homes and with university female students.

The following tables show the information gathered from these interviews. The persons interviewed comprised 35 percent housewives, 50 percent students, 15 percent civil servants and business women.

Table 1

Age distribution - direct interview

Age	Count	Percent	Age	Count	Percent
18-23	127	43%	41-45	13	5%
24-30	65	22%	46-50	6	2.5%
31-35	60	20%	over 50	4	1.5%
36-40	15	6%			
Total = 290 females					

Table 2

Educational background

	Level	Count	Percent
(1)	Illiterate	148	37%
(2)	Elementary	100	25%
(3)	Intermediate	30	8.3%
(4)	Secondary	100	25%
(5)	University	22	5.5%

Table 3

Educational background of husbands fathers and mothers

	Education	Husband	Father	Mother
(1)	Illiterate	18	123	234
(2)	Elementary	51	17	20
(3)	Intermediate	12	26	22
(4)	Secondary	12	89	4
(5)	University	15	35	10
	Total	108	290	290

Table 4

Types of circumcision

Direct interviews	Indirect information
Pharaonic type = 255 = 85.2%	984 = 87%
Clitoridectomy = 19 = 6.3%	48 = 4.2%
Sunna = 26 = 8.5%	100 = 8.8%
Total = 290	1132

Table 5

Where performed

Direct interviews		Indirect
At home	= 200 = 69%	762 = 67%
Outpatient clinic	60 = 21%[1]	51 = 5%
In hospital	30 = 10%	319 = 28%
Total	= 290	1132

Table 6

By whom performed

Direct		Indirect
Doctor	= 50 = 17%*	324 = 29%
Paramedical	90 = 31.5%[2]	105 = 9%
Non-medical	150 = 51.5%	703 = 51.5%

[1]The Ministry of Health forbids infibulation to be carried out in its hospitals and outpatient clinics. The mild sunna is permitted.

[2]Male nurses and dressers are known as "doctors". It is therefore likely that the term doctor referred to a male nurse while paramedical referred to a female such as a midwife.

Table 7

Age when performed

Direct		Indirect
Age	1- 24	3
	2- 9	3
	3- 35	7
	4- 83	20
	5-107	31
	6-265	45
	7-303	69
	8- 93	79
	9- 79	25
	10- 50	23
	11- 12	-
	12- 30	7
	13- 6	7
	14- -	2
	15- 6	2
	16- -	2

Table 8

Motives why performed

Direct			Indirect
Religious	200	69.5%	708 = 63%
Preservation virginity	58	= 20%	306 = 27%
Tradition	28	= 9.5%	89 = 8%
Hygienic reasons	4	= 1%	29 = 2%

Table 9

Complications

Direct		Indirect
Haemorrhage	- 53	- 199
Local infection	- 43	- 102
Urinary retention	- 12	- 49
General sepsis	- 4	- 29
Tetanus	- 0	- 18
Total	-112	- 397

Table 10

Penetration of 119 non-virgins among the 290 direct interviews

Natural	= 92	- (forceful penal penetration)
Instrumental	= 27	- (knife, razor, scissors)

Table 11

Hospitalizations - direct interviews

Reason	
Stranguria	- 38 cases
Clitoral and vulval cysts	- 36 (29 excisions)
Dysuria	- 19
Urinary retention	- 15
Total	108 out of 250

Table 12

Hospital records 7/77 to 7/78

	No of cases	Medium age	Operation
Vaginal stenosis	43	32	correction
Vulval cysts	36	27	excision
Clitoral cysts	22	25	excision
Vulval abcess	7	23	evacuation
Clitoral abcess	10	15	evacuation
Total	118	(resulting in 1967 hospital days)	

The above information clearly reveals the mutilating effects of the practice of female circumcision and urgent need for the abolition or modification of the operation.

It is rewarding to state that the writer was given the opportunity to discuss this subject in public for the first time on the occasion of the formation of the Democratic Women's Association in March 1977. The meeting was attended by about 500 persons and in the presence of the Minister of Health of the Somali Democratic Republic. The address was received with unexpected welcome and all present representing the women of all the 16 regions of the country, unanimously expressed their support for any steps to be taken for the abolition or modification of the barbaric practice of pharaonic circumcision.

COMMUNITY STUDY ON FEMALE CIRCUMCISION IN SOMALIA

1. Some epidemiological aspects

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Female circumcision is a common practice in some of the African countries. There have been reports on the subject over the last five decades following three descriptive papers in the scientific journals during the thirties. However, information on its epidemiology is scarce and there are few publications referring to the practice in Somalia. Otoo has described his findings in an unpublished report and the present publication, based on a community survey, describes observations on some aspects of epidemiology of female circumcision in Somalia.

MATERIAL AND METHODS

The investigations on epidemiology of female circumcision in Somalia were conducted in three representative samples of population of the country. One agricultural, one nomadic and three urban districts where socioeconomically and culturally different groups of people were residing, were randomly selected. In an agricultural district of Qorioli two

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villages of Abdi Ali and Haduman, in the predominantly nomadic district of Wanle Wen, two villages of Wamahen and Dudmai and in the capital, Mogadishu, three districts of Hodon, Hawlbadag and Karan, representing the upper, middle and lower socioeconomic strata of the urban population respectively, were selected for the study. The capital, Mogadishu and the districts of Qoriolio and Wanle Wen are located triangularly at a distance of 100 to 150 km from each other.

The local community was contacted for the survey, leaders were briefed and the people subsequently informed through their weekly meetings at Orientation Centres. The local community offered 16 volunteers to accompany public health nurse/midwives (PHNM) to houses and to introduce women and family heads. Each survey area was divided into 16 sectors, and an interviewer (PHNM) visited the first nine houses selected through cluster sampling in her sector, for the interview on the questionnaire, designed primarily for married women about 14 years of age. In the capital, those three districts were visited prior to the survey, by a team of experts which included a WHO statistician. A total of 187 urban and 175 rural women were interviewed.

The enquiry included questions on age, educational status, occupation and income of the couples, circumcisional status, information on performer of operation, type of instrument and anaesthesia used, circumcisional status of their daughters and age when circumcised. These women were physically examined in an MCH care centre by a gynaecologist. Shandall's classification was used to grade the circumcision:

Type I Circumcision proper (sunna): this is the circumferential excision of the clitoral prepuce.

Type II Excision: besides the prepuce, this involves the removal of the glans clitoridis or the clitoris itself, together with the adjacent parts of the labia minora, or the whole of the labia minora.

Type III Infibulation, also known as pharaonic circumcision: in this type, the whole of the labia minora, and at least the anterior two thirds, and often the whole of the medial part of the labia majora are removed. The two sides of the vulva are then stitched together, thus obliterating the vaginal introitus except for a very small opening posteriorly to allow the exit of urine and menstrual blood.

Type IV Introcision: at puberty, the vaginal orifice is enlarged by tearing it downwards manually, or splitting the perineum.

Information on health hazards, attitudes and practices is presented elsewhere.

OBSERVATIONS

Except for three out of a total of 562 women interviewed, 287 urban and 275 rural women had been circumcised. 65.6 per cent of them were 20-39 years of age, whereas four per cent were under 15 and 7.3 per cent were between 15 and 19 years of age. The illiteracy rate varied from 31.6 per cent in urban women to 68.4 per cent in rural women. 15.5 per cent of the total number of women had secondary, high school or university education, and all of them were from Mogadishu and belonged to the middle or high socioeconomic stratum. About one out of every third urban and seventh rural woman was economically active and gainfully employed. 17.3 per cent of the urban respondents were white collar workers, officers or professionals. The ratio of upper, middle and lower income groups was 1 : 1 : 2. 22.5 per cent of the rural respondants did not give information on their incomes. In urban localities 19.2 per cent of the circumcisions were performed by trained health personnel such as trained traditional birth attendants (TBAs), nurses or doctors. It was revealed to much surprise that 45.4 per cent of the women from the upper economic stratum were operated on by elderly women who were not even TBAs. None of the urban women in the upper or middle economic groups was operated on by

males, whereas 41.4 per cent of urban poor and 31.2 and 40.7 per cent of agricultural and nomadic village women were circumcised by males. In rural areas circumcisions were performed by untrained TBAs (47.3 per cent) or males (35.6 per cent) who were not trained. Only 4.3 per cent of the rural women had operations performed by trained TBAs or nurses. The nomadic population had limited access to TBAs, and 63.3 per cent of their circumcisions were performed by other women or barbers and 30 per cent by untrained TBAs.

Enquiries regarding unmarried daughters revealed that only 7.2 per cent of the girls under 15 years of age had not not been circumcised. Their mean age of circumcision was 7.2 years, 8.3 for the urban and 6.3 for the rural. None of the daughters of urban women were operated on before the age of five as compared with 13.5 per cent in the villages.

In the agricultural villages, the girls were operated on at the average age of six years, while in the nomadic population it was done by seven years.

In 94.7 per cent of the women, defloration was carried out without the aid of any sharp instrument at the time of first coitus. A razor blade was used in 8.7 per cent of urban and 1.8 per cent of rural women. None of these unsuccessful urban husbands used instruments themselves, but they enlisted the help of untrained TBAs or trained health personnel. It was only in one rural woman out of five that untrained TBAs incised the scar and in the remaining four, the husbands did that themselves.

Table I describes the physical examination of 255 women whose vaginal examination was done during the investigations. All the urban and nomadic women had the Type III operation, whereas in agricultural villages, 1.8 per cent had Type I, 24.3 per cent Type II and the rest, 73.9 per cent, the Type III circumcision.

The mean age of the circumcisers in the city and villages at the time of the investigation was 49.2 years and had on average, 14.2 years

experience. 25 per cent of the daughters of the operators had undergone Type II and 75 per cent Type III operations.

Half the number of performers were consulted frequently for restitching when husbands went away for long periods after delivery.

DISCUSSION

The present community-based study revealed that education, economic status, ethnicity or type of life such as nomadic, agricultural or skilled professional, had hardly any noticeable influence on the practice of female circumcision in Somalia. The practice is universal in urban as well as in nomadic populations within 150 kms of the capital. Not only 99.5 per cent of the women in the reproductive period of their lives were circumcised, but also 92.8 per cent of their unmarried daughters in the five to 15 year age group had undergone this ritual. It was easy for the mothers to recall their daughters' age at the time of circumcision. The average age of girls who were circumcised was seven years. None of the girls in the urban area was operated on under five years of age as compared with 13.5 per cent in the villages. Pharaonic circumcision is reported to be carried out in the Sudan between the ages of five and 10 years; in Ethiopia as early as three years and in Somaliland between eight and 14 years.

None of the women from the upper and middle economic groups in the present study was operated on by male circumcisers. One out of every fifth woman in the capital was circumcised by trained health personnel which may be due to easy accessibility and availability of such persons and health awareness of the people. In rural areas the TBAs and male traditional healers, who had no health training, carried out this task and in many instances those were the only persons available. In Somalia, approximately 70 000 - 75 000 out of 80 000 primary circumcisions are performed every year by untrained operators who have no knowledge of asepsis or haemostatics. 98.6 per cent of these operators were TBAs,

traditional healers or barbers. They were middle aged and performed approximately 17 operations in the city and 3-4 in the villages each month, which means that there are some 1200 - 1500 circumcisers in the country.

All the urban and nomadic women, and about 75 per cent of the women from agricultural villages had undergone Type III operations. It is worth noting that 24.3 per cent of the women from agricultural villages had Type II operations. Few women in villages had the Type I operation, which may be the result of an unsuccessful attempt to perform Type II. About 75 per cent of the circumcisers' daughters had undergone Type III operations, but 25 per cent had received Type II. Their attitudes are discussed elsewhere.

Secondary circumcision after delivery, or while the husband is away for long periods, is not infrequent in Somalia.

SUMMARY

A study was conducted in five districts - one each agricultural and nomadic, and three districts in the capital of Somalia representing different socioeconomic, cultural and ethnic groups to investigate epidemiological aspects of female circumcision. Approximately 99.5 per cent of 562 women who were interviewed and examined had undergone circumcision, and 92.8 per cent of their unmarried daughters aged between five and 15 years of age had been circumcised. The average age of their daughters at the time of circumcision was 7.2 years. Education, economic status, ethnic groups and type of life such as nomadic, agricultural or professional had no influence on the circumcisional status of these women. Based on the data it is estimated that every year in Somalia approximately 90 per cent of 80 000 circumcisions are performed by untrained traditional birth attendants, traditional healers, barbers and others from the community. Pharaonic circumcision is the commonest.

COMMUNITY STUDY ON FEMALE CIRCUMCISION IN SOMALIA

2. Immediate and late health hazards

The physical and psychological health hazards of female circumcision have been reported from Sudan, Egypt and Somalia. These observations are either on patients attending an out-patient clinic, or obtained through an enquiry from female medical and nursing students, nurses and the elite urban group of women, but the information is lacking on the physical hazards of the practice among women in a community. The incidence of deaths following circumcision is difficult to obtain as neither the circumciser nor the parents like to disclose this information. All the physical hazards are immediate or late consequences of an operation performed under rather crude conditions. The complications are more serious in pharaonic circumcision (Type III) than in sunna (Type I). Psychological complications are equally common but documentation is scanty.

Immediate complications such as shock, haemorrhage, retention of urine, local infection of the wound and ascending infection to the genito-urinary tract, accidental injury of urethra, anus or vagina are common. Fatal cases of tetanus and of maduromycosis and post-surgery epidemic arthritis have been reported.

Late complications include disfigurement and malformation of external genitalia, painful scar, keloids, implantation dermoid cyst, abcess, labial adhesions, haematocolpos, vesico-vaginal and urethro-vaginal fistulae, cystocele, and rectocele. Dysmenorrhorea, urinary tract infection, chronic pelvic inflammation, and coital difficulties such as dysparunia, aparunia, lack of orgasm and tight introitus, are common. Higher incidence of infertility in circumcised women than in non-circumcised has been observed and few women have developed vaginal and vulval calculi.

The incidence of psychological changes, such as diminished desire for coitus, lack of orgasm, depression psychosis in the circumcised women is significantly higher than those who are not. Their husbands also have psychological problems such as impotence and premature ejaculation, and development of addiction to drugs and hashish.

The hazards at the time of labour are due to the tough scar and its lacerations with profuse bleeding and possible injury to urethra and perineal tissues. Delayed labour has its complications.

The present study describes the incidence of health hazards in urban rural and nomadic communities in Somalia.

MATERIAL AND METHOD

These were the same as those adopted for the study on epidemiological aspects.

Many of the questions were, however, addressed to the married women above 14 years of age, and few to their husbands. The three districts in the city, were visited by a WHO statistician, and the organizers of the study prior to the survey, and a representative area having about 400 houses in each district was selected. In all, 287 urban and 275 rural women were interviewed. They were accompanied by the volunteers to a clinic or building offered by the community and utilized for the physical check-up of these women. Two gynaecologists, one medical officer, two PHNMs and two volunteers constituted the examination team. Examination of the genitalia was carried out by the gynaecologists. Internal pelvic examination was possible in 72 urban and 144 rural subjects. The interview was based on questions addressed to the women on their recall of experience of circumcision, complications during and after the operation, and of the first coitus, difficulty experienced during first labour and illness during the post-partum period. Complications at the time of and

following the circumcision of their daughters were also enquired into in detail. The women and their husbands were questioned regarding sexual behaviour.

Information was also collected on some epidemiological aspects, and, also on attitudes and practices of the women, their husbands, circumcisers, religious and local leaders, nurses and doctors on female circumcision. That is reported elsewhere. The classification of Shandall was used to grade circumcision.

OBSERVATIONS

99.5 per cent of the women examined were circumcised. All the urban and nomad women and 75 per cent of the women from agricultural villages had undergone Type III (pharaonic) circumcision. Ragged scars, the commonest finding, were detected in the rural women. Abnormalities other than ragged scars were observed in 19.4 and 8.3 per cent of the urban and rural woman. 12.5 per cent of the urban women had signs of pelvic inflammation predominantly salpingitis and 4.1 per cent had cystocele. Shandall, in his study, has reported signs of chronic pelvic inflammation in 13 per cent of the women attending outpatient clinics, who had undergone Type III circumcision. In the present study, none of the rural women had signs of chronic pelvic inflammation. In villages, the women had cystocele (2.1 per cent), keloid (0.7 per cent), infundibular dermoid cyst (0.7 per cent), fibrotic vaginal mass at the site of circumcision (0.7 per cent), episiotomy ragged scars (0.7 per cent), and other signs such as uterine prolapse, chronic cervicitis, vaginitis and vulval varicocity not necessarily related to the circumcision. If abnormalities such as ragged scars, episiotomy scar and keloid are excluded, the other abnormalities as a result of the circumcision were observed in 16.6 per cent of the urban and 3.5 per cent of the rural women. These complications are less frequent as compared with what are reported on the women attending clinics in the Sudan.

From the enquiry which was based on recall, it was gathered that varying from 24.0 to 73.1 per cent of the women encountered an extreme degree of pain, and 1.1 to 55.3 per cent were in a state of shock at the time of the operation. About 11.3 per cent to 50.9 per cent bled profusely. However, none were referred to the hospital nor to a doctor. Those who had local anaesthesia, 19.2 per cent of the urban women, experienced less pain and shock.

With reference to the post-operative, A higher number of rural women (66.4 per cent) experienced bleeding than their urban counterparts (43.1 per cent). 14.7 per cent of the urban and 6.6 per cent of the rural women could not pass urine until after 48 hours. One out of every fourth urban and sixth rural woman described symptoms and signs of infection following the operation. Shandall has reported that 10.1 per cent of the Sudanese women who had Type III circumcision had post-operative infection of the wound. In the present study 40.1 per cent of the daughters of the urban and 29.8 per cent of the rural women had some complication or other following the operation. None of their daughters died as a result of the operation.

29.6 per cent of the urban and 17.1 per cent of the rural women had painful menstruation. At the first coitus, pain was experienced by more than 75 per cent of the women. In four to five per cent, penetration was not possible; 20.1 - 39.8 per cent had bleeding, and 18.4 - 19.7 per cent later developed infection of the tear. Sterility was recorded in 2.4 per cent of the urban and 4.3 per cent of the rural women. The proportion of primary to secondary sterility was 2 : 1.

Surprisingly, none of the rural women experienced difficulty in the first labour, and delivery was normal. 19.2 per cent of the urban women had episiotomy at the time of labour, and 20.7 per cent were delivered by forceps. One third of the women had puerperial sepsis. The incidence was similar in urban and rural women. 48.2 per cent of the urban and 32.1 per cent of the rural husbands felt their wives were sexually "cold",

had no desire for coitus. About 7.0 to 7.5 per cent of the urban women from the upper and middle socioeconomic strata had persistent anxiety state which they attributed to the circumcision.

DISCUSSION

The time-old practice of female circumcision has a number of health hazards. The physical complications are of quite a serious nature even though the operations are performed by experienced circumcisers. In the present study, no information was revealed on deaths associated with the practice. None of the daughters, nor any of the sisters of the women who were interviewed, died due to haemorrhage, shock, infection or septicaemia. Presumably, the information was quite reliable and the people have not concealed anything from the interviewers. There are reports of girls being hospitalized and blood transfusions given and also of deaths from post-operative tetanus. The physical complications are very common in villages which indicates that the incisers are not as trained in the skill as their counterparts in the capital. The ragged scars are painful, and when torn, cause excessive bleeding and recurrent infection. It is worth investigating why 12.5 per cent of the women in Mogadishu had positive signs of chronic pelvic inflammation. Chances of infection are equally common in villages where techniques are not aseptic. However, Shandall, in his study in Sudan reported similar findings. In his series, infertility was 8.6 per cent perhaps due to pelvic inflammation. In the present series, infertility was 2.4 per cent among those urban women which is nearer to what otherwise might be prevalent in a community. As only three out of 562 women interviewed were not circumcised, there was no suitable control in the country. Women experienced painful first coitus which resulted in tear, bleeding and in some cases, infection. In four to five per cent, penetration was impossible and assistance had to be sought from a traditional birth attendant (TBA). These complications are not only physical injuries but also, psychosocially traumatic and damage caused by injury or failure to penetrate at the time of coitus causes long lasting psychological harm to the couple.

There were problems at the time of delivery and during the puerperium. An attempt to gather information on maternal and perinatal deaths proved difficult.

Half the number of husbands were not satisfied with the sexual behaviour of their wives. Only 7. to 7.5 per cent of the urban women from the upper or middle income groups mentioned their persistent state of anxiety which they attributed to circumcision. None of the villagers, nor the lower income group women responded adversely on this question.

It is certain that there are a number of serious physical as well as psychological health hazards of female circumcision. The sufferers are not only women, but also, their husbands. Young girls are equally disturbed before and after their operation. The psychological damage caused by the practice since early childhood of the girls leads to different personality formation of the woman.

Somalia has a polygamous society and divorce is quite frequent. It was not possible to examine the role of female circumcision on the rate of divorce and broken families and also its effect on polygamy.

SUMMARY

A community survey was conducted in villages of agricultural and nomadic districts and in three districts of the capital, Mogadishu, representing different ethnic, sociocultural and cultural groups to study the health hazards of female circumcision. In all, 562 women and their husbands were interviewed and 216 examined by gynaecologists. About 99.5 per cent of the women had been circumcised and the vast majority of them had undergone pharaonic operations. Many of these women had painful ragged scars, chronic pelvic inflammation and cystocele and few had keloid, infundibular dermoid cyst and fibrotic mass in connexion with the scar. Shock, haemorrhage and retention of urine and infection were common complications at the time of or after the operation. 40.8 per cent of the daughters of the urban and 19 per cent of the rural women had

some complications following circumcision. Menstruation was painful and 75 per cent of the women experienced severe pain at the time of first coitus and during the act, producing a tear, bleeding and, later infection of the wound. In the city where there was accessibility to a hospital, over 20 per cent of the women admitted for their first delivery required forceps application and an equal number of episiotomies was also performed. One third of the women developed puerperal sepsis following their first labour.

Approximately 50 per cent of husbands felt that their wives were sexually "cold". 7.0 to 7.5 per cent of the urban women from upper and middle economic strata suffered a state of persistent anxiety which they attributed to the circumcision.

COMMUNITY STUDY ON FEMALE CIRCUMCISION IN SOMALIA

3. Attitudes and practices

The practice of circumcising females has been prevalent for more than 25 centuries in some 40 countries, mostly in West and East Africa, as well as in some parts of the Southern Arabian Peninsula, where more than 74 million women have been circumcised. Nobody knows where, when and why this practice was started. Evidence shows that it was practised by Phoenicians, Hittites, Ethiopians and Egyptians. It is believed to have started as a means to protect the shepherd girls against likely male attacks while they were out unescorted with their grazing cattle. Many other reasons are offered by different people in those countries where the practice is widely prevalent. It is performed with a notion to prevent immorality. The female external genitalia are considered unclean and hence excised. Some give aesthetic reasons. These organs, particularly the clitoris, have been thought of as a "male" organ in a female body and a girl is not qualified for womanhood and marriage unless her "male" organ is removed.

It was believed that females have a greater sexual desire and that it can be curtailed by removal of the most sexually sensitive organs. Very often, the practice of female circumcision is linked with religion. But there is no reference to it in the Koran, and it was practised much earlier than Islam or Christianity. The views of several Egyptian muslim religious leaders registered in <u>fatwu</u> (religious edict) in Dar El Ifta are given as "female circumcision is an Islamic practice mentioned in the tradition of the Prophet and sanctioned by Imams and Juris. We support the practice as "sunna" (Type I) and sanction it in view of its effects on attenuating the sexual desire in women and directing it to the desirable moderation." Few other explanations and beliefs of the people on the subject have been identified.

The circumcisions are performed by untrained traditional birth attendants, traditional healers, priests and barbers. Involvement of health personnel in these operations is limited to urban areas. In the vast majority of cases, Type III and in some, Type II circumcisions are performed. In countries where the literacy rate of the people has increased, the present generation of girls is either subjected to Type I or to no circumcision at all. The physical and psychological hazards of public health importance affecting not only the women, but also their husbands, have been well documented. The social implications of the practice have been studied in Egypt. The present community study describes the beliefs, attitudes and practices on the subject in Somalia.

MATERIAL AND METHODS

A survey on the attitudes and practices on female circumcision was a part of the study on female circumcision in Somalia and conducted in three representative samples of population of the country as described in the study on epidemiological aspects. Attitudes were recorded by questioning the women and their husbands regarding their views on circumcision, whether their daughters had been circumcised and what type of circumcised wives the husbands preferred. The attitudes of 19 nurses, doctors, social workers and political leaders in the survey areas were also recorded. The women were examined by gynaecologists, as already described.

OBSERVATIONS

99.5 per cent of the 562 women had been circumcised, and Type III circumcision was the most common. The educational, economic status, ethnic group or pattern of life, whether nomadic or professional, had no significant influence on the circumcision rate. 92.8 per cent of their daughters above five years of age and under 15 years of age were circumcised. The mean age of circumcision of these girls was 7.2 years. The circumcised women encountered a number of physical and psychological hazards due to the operation. 80 per cent of the urban and

95.7 per cent of the rural women were operated on by untrained persons such as traditional birth attendants (TBAs), traditional healers and barbers. Defloration was done by either husbands or TBAs in 8.7 per cent of the urban and 1.8 per cent of the rural women before the first coitus. Reconstruction of the circumcision after delivery, or when the husbands went out for a long time, was not infrequent. The mean age of the performers was 49.2 years and they had about 14 years experience.

93.4 and 98.5 per cent of the urban and rural fathers, respectively were in favour of circumcision. One out of eight university trained urban fathers in the capital was against the practice. Higher income had some influence on the views: 11.7 per cent of the fathers from the higher income stratum as compared to 3.1 and 2.1 from middle and lower income groups were against the practice of circumcision. However, there was no difference in the percentage of their daughters who were circumcised.

Regarding the 210 husbands who were available for the interview, 49 per cent expressed preference for Type I circumcision (45.7 per cent) or no circumcision (3.3 per cent). The figures were not much different from villages as compared with those from the capital. 10.2 per cent of the urban husbands, 62.5 per cent of whom were from the poor economic group and 18.9 per cent of the rural husbands, favoured wives who had undergone Type III circumcision.

63.2 per cent of the doctors, nurses, social workers and political leaders interviewed, were against the practice of circumcision. Surprisingly, 44.5 per cent of the nurses were in favour of the practice. The reasons offered were that it is "traditional", "society believes in it", "religious" and "prevents promiscuity and prostitution".

In answer to the question "if circumcision is to be performed, which type would you prefer?" 26.3 per cent of 210 fathers were not in favour of circumcision at all, 52.7 per cent perferred Type I, 5.2 per cent Type

II and 15.8 per cent mentioned Type III. Those who were against the practice gave their reasons as (i) difficult first coitus, and (ii) difficult labour.

The attitudes and practices of the operators were enquired into. Half the circumcisers in the capital were using local anaesthesia and they were giving analgesic tablets after the operation. The considered haemorrhage, shock and retention of urine as frequent immediate complications. Those who were not using anaesthesia however desired its use. All of them said that they would like to apply some ointment for preventing infection and haemorrhage. 75 per cent of their daughters had undergone Type III and the rest Type II circumcision. However, 25 per cent said they would prefer Type I.

A typical ceremony of circumcision is briefly described. A family decides upon the date for circumcision in consultation with a circumciser. The latter prefers to carry out multiple operations generally, two or three in one day. Messengers are sent to invite the relatives, neighbours and friends. A hot season or post-harvest time is preferred, and the operation is performed in the morning unless the operator is otherwise preoccupied. The relatives arrive early in the morning, and those from a distance come one or two days earlier and stay with neighbours or the girl's parents. On the morning of the celebration day, the child is given a bath with soap and water. She sits on a stool 25 cm high and her legs and hands are tied together. Two persons hold the child and a third person stands at the back and holds her head. The eyes are bandaged with a new scarf which, later on, is given to the circumciser. A new cloth is put in front of the child to screen the operator from observers standing at the back of the child. The relatives and neighbours start singing and clapping in rhythm with drums beating, whilst the operator makes an incision. Nothing is applied locally as an antiseptic. The operator holds the clitoris with the index finger and thumb and applies sterile ash to get a good hold. With a small knife or razor she/he cuts from the top to the bottom. The clitoris is cut completely along with the skin and labia minora. The operator then catches both the labia and incises from above down, but does not incise

left and right separately. In Type I, only the prepuce is cut and the clitoris is punctured multiple times. In Type II, the clitoris, prepuce and labia minora are cut and, in Type III, the labia minora are also incised. Three to four thorns are used in villages, and threads in towns, to stitch the would of Type III operations. A matchstick is inserted to make a small opening. The stitches are removed on the fourth or fifth days. A beaten egg with gum and myrrh which is passed through smoke is applied to the wound. Some add sugar to the paste. The egg is supposed to promote healing and to reduce pain. Myrrh and smoke are considered as haemostatic and antiseptic. The wound is dressed with a cloth. The hands and legs are untied but both legs are retied together at the thighs, and the girl is put on a bed.

The relatives and friends help to slaughter a goat in preparation for the feast. The child is given milk with oil in villages, and cold tea or milk in a city. She is permitted to take only sips of water during the day. Her diet is restricted. The relatives and friends come to greet her and offer presents to her or her mother. The family presents money or a dress to the child and the feast starts at midday. The performer leaves after the operation and the operation fees range between $3 and $8 depending on the family's economic condition. In the villages, the payment is in kind, in the form of oil and maize.

The wound is exposed frequently to smoke, which is considered antiseptic. The child has to pass urine on the operation day. She is taken out or put on her side, or allowed to sit on a stool for the act. If she does not pass urine on the first day, then the circumciser is called, who removes any obstruction such as a blood clot, or clog or egg, myrrh or gum with a feather. If this procedure does not succeed, then water is poured onto the wound and the child is asked to drink water. The circumciser performs an operation if the child does not pass urine or refers the child to a hospital. A nurse or doctor is called in cases of excessive bleeding.

DISCUSSION

The findings from the study on some epidemiological aspects, physical and psychological hazards and attitudes and practices of female circumcision in Somalia are of great public health concern. The practice of circumcising girls about seven years of age is very common in the country and not much has changed during the last four decades, as evidenced from the observations on women in their forties, teenagers and information about the circumcisional status of their daughters. Neither educational or economic status has influenced its prevalence. The practice is equally common among the daughters of nomads who go out to graze their cattle, and in those of the white-collar city dwellers. Over 98 per cent of the population in Somalia is muslim and 99.5 per cent of the women who were examined had been circumcised. Hence, there was no possibility of comparing the observations with any control group. However, the study does indicate a favourable change in the attitude of the people, particularly the educated, the higher income group, the social workers and political leaders.

Female circumcision has a number of health hazards, many of which are life threatening at various stages of a woman's life, such as in the childhood period when the operation is performed, after marriage, at the time of the first coitus and first delivery. The cases who undergo re-infibulation after labour, risk developing complications during subsequent deliveries. Psychological hazards are equally common and important. The husbands do not necessarily benefit and their sex life is not satisfactory. There is evidence that the practice of circumcision adversely affects the social life, increases the divorce rate, and broken families. In Sudan, 20 per cent of the husbands married their second wives only because they could no longer endure the ordeal of perforating the progressively tightening circumcision scars of their first wives every time they had babies.

90 per cent of around 80 000 circumcisions performed in Somalia every year are by some 1200-1500 untrained persons. The present study has

shown that more than 90 per cent of fathers were in favour of circumcision due to various beliefs and social reasons. 45.7 per cent of husbands expressed a preference for a wife who had Type I circumcision, and only 10.2 per cent, Type III. In the Sudan, 88.7 per cent of husbands stated that Type III had no advantage whatsoever over Type I or no circumcision. 79 per cent of husbands interviewed in Somalia stated that if the practice had to continue, then it should be Type I or no circumcision. Many local leaders (62.3 per cent). such as social workers, political leaders and medical personnel were against the practice.

These findings on the attitude and practices on female circumcision in Somalia are of great importance in deciding the line of action to be taken. The physical and psychological health hazards of Types II and III are distressing. Even in nomadic areas, the people showed preference for Type I circumcision, and few for no circumcision at all.

The countries were alerted on the health problems by the WHO Director-General in 1976, when at the World Health Assembly, Dr Mahler stressed a need to "combat taboos, superstitions and practices that are detrimental to the health of women and children, such as female circumcision and infibulation." With the increasing awareness of the health hazards of the practice, politicians, policy-makers, educationists, professionals and religious leaders are making decisions to undertake some steps to combat this practice. In 1946, the Sudan passed legislation forbidding the practice, and midwives performing Type III circumcisions were imprisoned and fined. People reacted violently and the midwives continued to do it in secrecy, well protected by relatives who were in favour of it. The legislation rather forced the midwives and relatives to conceal any complications, resulting in higher morbidity and mortality. Gradually, this legislation became forgotten by the people and authorities alike. Circumcision of females continued, but Type III became rarer, not because of legislation, but because of more effective health education and attitudinal change. Recently, a national campaign for the abolition of all forms of female genital excisions has been

launched by the Society of Alpad Independent University College for Women in Sudan. The Chief Imam of Khartoum has instructed the preachers of 14 000 mosques to preach against the practice.

In Somalia, a National Committee on Female Circumcision has been formed recently. The committee has adopted the following strategies:

1. Legislation should be avoided at this stage and until sufficient public awareness has been created.

2. The "sunna" (Type I) circumcision should be encouraged in preference to other types, in order to prevent the hazards of more drastic infibulations.

3. Since the practice causes severe health hazards, it should be tackled in the same way as other health hazards.

4. Prevention and health education should be given due emphasis. Regular talks on the subjects to be arranged by health personnel for students of secondary schools, universities and technical institutions and also for people at orientation centres.

5. Religious leaders are to be oriented and convinced on the hazards of the practice, and they should point out to the parents that the practice has no valid religious bearing.

These strategies are realistic and necessary steps for the abolition of female circumcision. It is very clear that no method can change a population's practice of universal prevalence to the non-circumcision state in a short time and for years the practice will continue. Hence the training of circumcisers, how to perform the operation aseptically, minimizing the bleeding and other health hazards is of vital importance. They should be provided with antiseptic lotion and cream, analgesic tablets and local anesthetic agents. They should be persuaded to perform

only for Type I or no circumcision. It should be a slow process and these circumcisers, many of whom are TBAs and traditional healers, should be trained and involved in other health activities such as MCH care and primary health care. The health professionals at all levels should support and train these circumcisers. It is envisaged that the change from Type III to Type I circumcision will change the population behaviour and ultimately lead towards a future strategy of abolishing the practice.

SUMMARY

A community survey on attitudes and practices on female circumcision in Somalia was conducted in three representative samples of the population. 287 urban and 277 rural women and their 210 husbands were interviewed. Women were physically examined. The practice of female circumcision was universal and the vast majority of the women were operated upon by untrained persons. 95 per cent of the fathers were in favour of circumcision. The reasons offered by the interviewers for those in favour were "tradition", "societies' belief in it", "religious" and "prevention of promiscuity and prostitution". 49 per cent of the husbands expressed their preference for Type I circumcision or no circumcision of their wives. If circumcision had to be performed, then the fathers would prefer Type I (52.7 per cent). A typical circumcision ceremony in Somalia has been described, and findings on the attitudes and practices are discussed and strategies decided upon by the National Committee on Female Circumcision are endorsed and various suggestions included.

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SYMPOSIUM ON THE CHANGING STATUS OF SUDANESE WOMEN

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THE VIEWS OF SUDANESE GYNAECOLOGISTS, MIDWIVES AND COLLEGE STUDENTS ON FEMALE CIRCUMCISION

by

Dr Gasim Badri

INTRODUCTION

This paper shows the views of Sudanese gynaecologists, midwives and university students on female circumcision in the Sudan.

The practice of female circumcision (FC) in the Sudan is very old and widespread. The origin of the practice[1] is difficult to trace, but it is closely connected with the customs, traditions and religious beliefs of most of the peoples of the Sudan. In spite of the documental reports on the harmful effects of FC, it is still widely practised. The reasons for the continuation of the practice of FC are reviewed in this paper and based on the opinions of 3 groups; Sudanese gynaecologists, midwives and female college students. The Sudanese gynaecologists and midwives were mainly questioned on the physical consequences of FC while the college students were questioned about their attitudes towards FC.

HISTORY

Female circumcision has been widely practised in many parts of the world. It spread from Australia to Southern Europe and from East Africa to South America. The origin of the practice, however, is difficult to trace. In the Sudan[2] female circumcision goes back to antiquity and has been passed from one generation to the next. It not only became part of the tribal customs and traditions but was also associated with religion and is therefore deeply entrenched in society.

DEFINITION

Female circumcision is the popular term used to describe several forms of female genital mutilation. Medical authorities usually identify three types of the operation which differ in their severity of mutiliation. These are:

1. Clitoridectomy - this is the mildest form. It consists of the excision of the glans clitoris sometimes with a small portion of the clitoris itself. This operation is popularly known in the Sudan as sunna, and refers to the traditions (hadith) of the Prophet Mohammed, the implucation being that this type of female circumcision is recommended by Islam.

2. Excision - this is more severe than sunna. It involves the removal of the whole clitoris together with the upper part of the labia minora.

3. Infibulation - this is the most severe form of genital mutilation. It is popularly known in the Sudan as pharaonic circumcision. It involves the removal of the entire clitoris and labia minora as well as portions of the labia majora. The two sides of the vulva are then closed over the vagina except for a small opening (the size of the head of a matchstick) to allow for the passage of urine and later menstrual blood. Although this type of circumcision was prohibited in the Sudan in 1946, it is still widely practised (see Table 1).

The physical effects of female circumcision

Female circumcision, unlike male circumcision, has dire physical consequences. While male circumcision is approved by the medical profession and is widely practised as a hygienic procedure, female circumcision is of no such value. On the contrary, it is considered harmful. As one medical expert put it: "After so much thinking and deliberation I could not come up with a single benefit of FC, either from the medical point of view or from the humanitarian one".[3]

The harmful physical consequences of FC have already been reported by several investigators[4]. For this study, we developed a short questionnaire which was distributed to 68 Sudanese gynaecologists, in order to obtain their opinions regarding the following:

1. If there is any decrease in the practice of FC.

2. What type of FC is most common?

3. What are the consequences of "pharaonic" FC?

4. What are the consequences of sunna FC?

5. Whether he or she believes that FC should be abolished

6. If she/he believes it should be abolished, what are the best ways to achieve that?

7. If she/he has been active in any way in combating FC.

8. What are the reasons behind the continuation of the practice of FC?

43 gynaecologists responded to the questionnaire, from Khartoum, Port Sudan, Fasher, Dongola, Nyala, Damazin, Managil, Gedaref, El Nehud, Kadogli, Medani and El Obeid.

The majority of the respondents (37) believe that there is a slight decrease in the practice of FC. The remaining six believe that there is a moderate decrease.

29 of the respondents observe that infibulation is the most common form of FC. 10 believe that excision is the most prevalent one while only four think that clitoridectomy is the most common.

All respondents agreed upon the harmful consequences of FC. Although they pointed out that infibulation leads to more severe complications, they all agreed that any form of FC is bound to create many complications. 40 of the respondents mention that they personally know of cases where young girls lost their lives as a result of the operation. All respondents cited different complications such as infections, urinary complications, shock, tetanus, haemorrhage and retention cysts.

There are also later consequences of FC. All respondents indicated that in cases of infibulation cutting of the vulva is essential to make delivery possible, and that when married the infibulated woman will suffer greatly from sexual intercourse. In some cases medical help is sought to make penetration possible. Furthermore, the sexual act itself becomes less enjoyable and associated with pain rather than pleasure. 15 respondents mentioned that infertility may result, due to the infection that took place at the time of the operation. Two respondents stated that infertility may occur because of failure of the husband to achieve penetration. In some cases divorce may result as a consequence of the failure to achieve sexual intercourse. Several respondents mentioned that they found pelvic examinations difficult because of circumcision. They also believed that clitoridectomy and excision caused complications during childbirth but to a lesser extent than infibulation.

Regarding the abolition of FC all respondents were in full agreement. They all believed that it was a harmful and unnecessary practice and that an effort should be made to abolish it. All

respondents agreed to the need for wide publicity showing the dangers of FC and an effort to educate the public not only about these dangers but also about the erroneous belief that FC was required by religion. Eighteen of the respondents also favoured the introduction of laws prohibiting any form of FC. The other 25 gynaecologists believed that the introduction of laws in these matters would not be effective.

Although the medical opinion is unequivocally against FC and the dangers of FC are well-documented in medical literature, the operation of FC is still widely practised in the Sudan. Four reasons were advanced by the gynaecologists. These included the ignorance of the public, especially the mothers and grandmothers, regarding the immediate and later dangers of FC, and the lack of health education. FC is a public health hazard, yet there is very little effort on the part of the health authorities to highlight the many harmful effects. Religious reasons were mentioned and the widespread belief that FC is endorsed by Islam. That such a belief is utterly false is evident from the fact that in most Muslim countries, e.g. Pakistan, Iran, Saudi Arabia, Kuwait and Iraq, FC is unknown.

Social factors may be considerd as the main reason for the continuation of the practice of FC. Like any other social customs, the factors contributing to it are complex. One salient point is the belief that uncircumcised women are considered sexually promiscuous. So in order to guard against this belief and to preserve the chastity of the young woman, circumcision is performed.

Another factor is to ensure the virginity of the young woman at the time of marriage, hence the practice of infibulation. Two respondents however pointed out that infibulation may actually help some young women to engage in premarital sexual intercourse and prior to marriage the woman will be recircumcised to close the wide introitus, and the bridegroom will be led to believe that he has married a virgin.

A third social factor is that uncircumcised girls face derogation from their peers. They are referred to as *ghalfa* and *nigsa* (unclean). One school teacher related that she noted that one of her students (12 years old) had become suddenly despondent and was crying for no apparent reason. After making enquiries, she discovered that the girl had been derided by her classmates because she was uncircumcised.

A fourth social factor is the belief that men prefer women to be circumcised and hence an uncircumcised young woman will not find a husband.

Last but not least, FC is a purely female concern. Although in Sudanese society the man has the final word in matters concerning the affairs of his household, men have completely surrendered their authority to women regarding the circumcision of their daughters. Even when a father tries to intervene and prevent the circumcision of his daughter, often he is promptly told by his wife, his mother, or his mother-in-law that it is not his business, and usually the father is overruled.

All the gynaecologists who responded to the questionnaire pointed out that FC in all its forms was detrimental to the health of women and they clearly advocated abolition of this "unecessary barbaric practice". However, this belief is not shared by another important group of health personnel, namely the midwives. In a questionnaire answered by 40 midwives in Khartoum and Port Sudan, 10% of them expressed the view that FC of the sunna type should be continued. Like other women, these midwives maintained that FC was an established custom and a religious tradition which should be kept to ensure that girls did not go astray. Since the midwives are the persons who usually perform the operation, a great effort should be made to educate them and point out to them the errors of their assumptions. They should learn about the hazards of FC during their training.

Apart from seeking the opinions of professional health workers, the opinions of female college students were also sought. In a survey of 190

college students ranging in age from 19 to 41, with a model age of 23 years, and with 90% of them in their twenties, the students were asked the following questions:

1. Whether circumcised or not?
2. What type of circumcision?
3. What age at the time of circumcision?
4. Why was she circumcised?
5. Does she intend to circumcise her own daughters?
6. Does she think that her granddaughter will be circumcised?
7. Does she think that circumcision should be abolished?
8. What are the reasons for continuation of FC?

As Table 1 shows, 90% of the students were circumcised.

Table 1

Number of circumcised students

Circumcised	Uncircumcised
179	11

Of the 11 uncircumcised students, six were Muslims and five Copts. There were seven Copts among the circumcised students. These figures clearly indicated that there was no significant decline in the practice of FC.

Even more alarming was the prevalence of infibulation. As Table 2 shows, 60% of the students were infibulated, although infibulation has been prohibited by law since 1946.

Table 2

Type of circumcision

Infibulation (pharaonic)	Clitoridectomy (sunna)	Other
114	62	3

The majority of students attributed the reason for their excision to the fact that FC was a social custom deeply entrenched in Sudanese society.

It is heartening, however, to find out that the vast majority of the students declared that they were not going to circumcise their daughters. As Table 3 shows, 80% of them held this view.

Table 3

Are you going to circumcise your daughter?

Yes	No
38	152

It is interesting to note that 28 (70%) of the students who said that they intended to circumcise their daughters were themselves pharaonically circumcised. The other 10 students were sunna circumcised. The reason that all students gave for their intention to circumcise their daughters was that FC was a cultural heritage required by Islam. All of them expressed preference for the sunna type. Six students believed that it would be very difficult to abolish it and any such effort would be futile and disturb some people. Four students believed that the sunna type was a form of cleanliness and should be continued. Another four students gave sex as the reason for the belief that the sunna circumcision should

continue. They maintained that uncircumcised females were susceptible to sexual arousal and circumcision would help the young girls to control their sexual urge. One student claimed that there is medical evidence that sunna circumcision prevented some venereal diseases.

Finally, with regard to the reasons for the continuation of the practice of FC, the majority of the students (60%) advanced social reasons such as customs and traditions. They said that the mothers and grandmothers insisted on the operation as it was seen as part of the life cycle of women. The overwhelming majority of these college students (80%) were definitely against FC. Even those who wanted the practice of FC to continue wanted to see the milder form of clitoridectomy (the so-called sunna type). However, even among these highly educated young women there was a small minority who still believed that there were benefits in FC.

What is to be done?

Certain actions that could help in the efforts to abolish FC are now suggested.

It is evident that the majority of the public is unaware of the serious harmful consequences of FC. Therefore, an important first step would be to educate the public through all possible means and involving the health workers, educational authorities and religious leaders. Health authorities can help in these efforts by pointing out the dangers of FC. A detailed explanation of the dangers, both the immediate and the later complications, based on solid evidence, should be made available to the public. Pragmatic resolutions in professional meetings should also be passed.

The educational authorities can also help by disseminating the information about the harmful effects of FC in all schools and at all levels. The school has long been considered one of the most potent

agents of social change. Moreover, school teachers, especially in villages, are highly respected by the local community and they can be used to educate these people about the adverse effects of FC.

Thirdly, the role of the religious leaders in persuading the public to stop circumcising their daughters can hardly be overemphasized. By pointing out to the public that there is no religious basis for FC whatsoever, they will cause many parents to abandon the practice. Religious leaders can base their judgement on at least two things. Firstly, Sheikh Shaltool, the late head of El Azhar, decreed that there was no religious basis for FC. Secondly, in most Muslim countries such as Saudi Arabia, Kuwait, Iran, Pakistan and Tunisia, FC is virtually unknown.

This educational campaign should be carried out all over the country using all mass-media channels. It would be helpful to designate a week or so and call it, for example, "the week of combating FC". The practice of FC is a deeply-rooted custom in Sudanese society; and to combat it would require hard work, adequate planning and effective execution.

A law should be passed prohibiting FC in all its shapes and forms though many people hold the view that it is not advisable to combat social customs through legal actions, and some others believe that laws in these matters are very difficult if not impossible to enforce and therefore their introduction is useless. The present writer, however, is of the opinion that the passage of a law against FC will have many positive effects for the following reasons. Firstly, this will greatly reduce the number of infibulations. Since there is no existing law prohibiting FC as a whole, midwives perform infibulations under the guise of performing the legal sunna type. When there is no legal type at all, midwives will genuinely refrain from performing any such operation. There are many parents who do not want to circumcise their daughters but face great pressures from their relatives, especially the grandmothers. The wishes of such parents can be protected by the introduction of legislation

prohibiting FC. The passage of the law by itself may be used for educational purposes. Through discussion of the bill in Parliament the attention of the public will be drawn, and much debate in the newspapers, radio, television etc. will also be generated.

Apart from these three reasons FC has been shown to cause many physical disabilities to young girls and women and in some cases even led to death. It is unthinkable that such a practice should be allowed to continue. It is incumbent upon the Government to protect the lives and welfare of its citizens, and the passage of a law prohibiting FC has become mandatory.

Further, it is evident from the answers of some of the midwives to our questionnaire that they believe in the continuation of the sunna type and that they see no harm in it. This requires the Ministry of Health to put its own house in order. Midwives should be educated and shown the harmful consequences of FC. A person who is not herself convinced of an idea cannot convince others. If the motive of the midwives for advocating sunna circumcision is a financial one, as many people believe, then some financial help should be given to the midwives in lieu of the money they will lose on the prohibition of FC.

Lastly, as is clear from the answers of the college students, the majority of them (80%) do not intend to circumcise their daughters. However, these are highly educated women and one cannot assume that their views reflect those of the uneducated who constitute the majority of the Sudanese people. The good offices of the prominent citizens in village communities, such as the umda, or head of the tribe could be used to get such people to campaign against circumcision and actually refuse to circumcise their own daughters. Such an example would lead many people to follow suit.

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A STUDY ON PREVALENCE AND EPIDEMIOLOGY OF FEMALE CIRCUMCISION IN SUDAN TO-DATE

by

Dr Asma A. El Dareer

INTRODUCTION

In the Sudan and a few other developing countries, female circumcision is quite common. Over 90% of the female population in the northern part of Sudan is circumcised. The northern Sudan is inhabited by 75% of the total population of the country, who are Arabs and mainly Muslim. In the southern region some of the inhabitants are Christian and some Muslim, but most have their own tribal religions. Circumcision is not practised among these people except where they come in contact with the north, through marriage or geographical proximity.

The age at which the operation is performed is usually 4-8 years, but it is sometimes done as early as five months. Complications are quite common, especially with regard to childbirth. Consummation of marriage is always a difficult experience for both husband and wife, and unhappy marriage can easily result. Psychological disturbances are also reported.

Female circumcision was first discovered in ancient Egyptian mummies dating from 200 B.C. In the pre-Islamic era the custom was widespread in Egypt, Arabia and the Red Sea coasts.

Female circumcision in the Sudan was first seen as a social problem in the late thirties. It was widely discussed by British administrators and enlightened Sudanese. The majority of educated Sudanese felt it was the duty

of their generation to do away with the practice. The problem was openly discussed in the local press, educational institutes, social clubs and tribal gatherings. The leaders of society gave their full support to the movement. The religious leaders made clear to the public that any mutilating operation such as "pharaonic circumcision" was against the teaching of Islam. The Sudan Medical Service published a small pamphlet, containing a view of medical publications on female circumcision and their first-hand information and experience.

In 1946 the Legislative Assembly passed a law making pharaonic circumcision an offence punishable by fine and imprisonment. The sunna operation was considered legal. The immediate result of this law was that many children were circumcised at an earlier age, before the law could become operational.

However, the measure proved to be a failure, presumably due to the strong position of grandmothers in the family and to the fact that the majority of trained midwives had a vested interest in continuing the custom.

Pharaonic circumcision is still widespread in Sudan today, especially in rural areas. The situation is, however, slowly improving. The medical world and almost all educated families agree that pharaonic circumcision must disappear and many would like to see all forms disappear. No definite information is available about changes in practice and attitudes among people in Sudan. Therefore the need was felt for a nationwide survey on female circumcision.

OBJECTIVES

The objectives of the study are:

1. To determine the magnitude of the practice of female circumcision in the Sudan
2. To outline the social, religious and traditional attitudes towards the practice of female circumcision.

3. To identify the health problems encountered as a result of this practice.
4. To study the impact of socioeconomic factors on the practice.
5. To suggest the possible ways of dealing with this problem which can lead to abolishing female circumcision.

Before going into detail on the study, some notes on female circumcision in the Sudan are recorded.

TYPES OF CIRCUMCISION

1. Infibulation (pharaonic)

This consists of the removal of the whole clitoris, labia minora and the anterior two thirds of the labia majora. The two sides of the vulva are then brought together by stitching, obliterating the introitus leaving only a very small opening posteriorly for the passing of urine and menstrual blood. Sometimes the opening is measured by the thickness of a matchstick. In the past no stitches were used; the lower limbs were bound together for 40 days and a mixture of sticky substance put on the wound to promote fusion of the two sides.

In the past this type of circumcision was widely practised in the Sudan, and it is still performed in rural and some urban areas.

2. Sunna

This is the mildest type. It consists of the removal of the tip of the prepuce of the clitoris only. It is analogous to male circumcision. The word "sunna" connotes the following tradition or Hadith of the Prophet Mohammed. It is practised in Sudan by most educated people and religious families.

3. <u>Intermediate</u>

This is more drastic than the sunna and less severe than the pharaonic type. It consists of removal of the clitoris and parts or the whole of the labia minora. Sometimes slices of the labia majora are also removed and stitched. It was invented in the early fifties after the legislation of 1946, by a midwife called Hilbis. It is now practised in urban areas, mainly the Gezira and Khartoum, and is replacing the pharaonic type.

The Fallata tribe in the west and Rashyda in the east do not practise circumcision.

4. <u>Excision</u>

This consists of the removal of the entire clitoris together with adjacent parts of the labia minora, i.e. all external genitalia except the labia majora, without closure of the vulva. It is not practised in Sudan but in other African countries.

For comparison, the distribution of female circumcision in other parts of the world is presented.

<u>Sunna</u>: Sudan, Egypt and some tribes in the Yemen.

<u>Pharaonic</u>: Sudan, Somalia, Egypt, Ethiopia, Nigeria, Kenya and Mali.

<u>Intermediate</u>: Sudan and Egypt.

<u>Excision</u>: Kenya, Tanzania, Djibouti, Central African Republic, Nigeria, Upper Volta, Ivory Coast, Mali, Sierra Leone, Senegal, Ghana, Mauritania, Liberia, Togo, Benin, Chad and Niger.

This clearly shows that excision is widely practised in Africa.

Material and method

This is a major study designed to take place all over the Sudan, with the following centres; Khartoum, Medani, Kosti, Port Sudan, Dongola, El Fasher and Wau.

The sample will consist of 10 000 females and 5000 males, and by multi-stage random sampling with the household as a unit. For each sex, a separate questionnaire is designed.

The questionnaire consists of two sections, A and B. Section A is for all respondents, Section B for cooperative cases. The items on the questionnaire are: personal identification, social data, events accompanying circumcision, medical information, opinion on circumcision and a medical examination for those females who accept. The questionnaire is to be conducted by interviewers of both sexes.

So far, only part of Khartoum province and the whole of White Nile Province have been covered. This presentation is a preliminary report on this phase of the study. The questionnaire was conducted by medical students visiting houses and interviewing one female in every house.

Urban and rural areas were included and represented. Married and unmarried, different age groups and different tribes.

Results

75 per cent of respondents answered both sections of the questionnaire, with the exception of the physical examination which all of them refused.

The majority were in the age groups 15-24 years (37.5%) and 25-34 years (36%) as shown in table 1; table 2 shows their distribution by place of residence: 50 per cent live in urban and 50 per cent in rural areas.

Their levels of education and social status are shown in tables 3 and 4 respectively. Most of the subjects were uneducated (71%), 17 per cent were of elementary level and all mothers were illiterate. The education of fathers was elementary (68%), intermediate (25%), and their predominant occupation was farming (64%) followed by trade (31%). The main tribes were: Galeen (18%), Berti (17%), Shukria (15%), Baggara (4%) and Hose (3%). All were Muslim. Regarding the type of circumcision, the main one was pharaonic (84%), with intermediate (11%) and sunna (1%). The main problem was that they did not know exactly what was meant by each type, so they needed much explanation. The average age for circumcision was seven years, with the youngest two years and the eldest 11 years. 81% of cases were operated upon by midwives (traditional birth attendants) and the main instrument was a razor. A special razor known as "Moos El Shurafa" (razor of the honourable) was usually employed.

Indigenous midwives do not use anaesthesia, and the method of approximation in 38 per cent of cases is by binding the lower limbs together, and in 21 per cent by applying a mixture of egg and sugar.

Decircumcision consists of the cutting of the circumcision scar; it is done for almost all circumcised cases for each delivery, otherwise delivery would be very difficult. The decircumcision in itself may cause bleeding and infection, and needs to be closed again. Four per cent of decircumcisions were carried out for urine retention after circumcision and two per cent at menarche for difficulty in passing menstrual blood. 85 per cent of women interviewed had been afraid of the first sexual intercourse and in 92 per cent of these this was due to circumcision.

Of the 348 married females, 80 per cent underwent recircumcision mainly after delivery though not for each delivery. Most of such operations were carried out by midwives at home; only less than one per cent were done in hospital. The main reasons for recircumcision are that it is a custom and that the advice of mothers and grandmothers is followed. It is clear that the husband agrees with recircumcision otherwise he would not have paid the

fee. The most frequent complication is tight recircumcision. For all circumcised cases the mode of delivery was spontaneous, with anterior and/or posterio-lateral episiotomy.

The differences between the three types of circumcision are clear from the time required for healing; pharaonic takes up to 40 days, intermediate 7-15 days and sunna up to seven days. Also from the time taken for full penetration in marriage; the range in pharaonic was 2-12 weeks, intermediate 2-5 weeks and sunna or uncircumcised 3-7 days. In some cases of pharaonic or intermediate the husband found difficulties and sought help from the doctor or the midwife. Those who were shy used their finger or razors to re-establish the opening. The 81 per cent who agreed with circumcision gave their main reason as "religious requirements" (32%), and "good tradition" (28%) (Table 6). The range of educational level is insufficiently wide for comparison with reasons of approval. From these, 14 per cent wanted the sunna with "religious requirements" as a main reason; 44 per cent wanted the intermediate type with "less harmful than pharaonic" as a reason, while 42 per cent wanted pharaonic for reasons of "good tradition".

The 19 per cent who totally rejected circumcision gave reasons as "prohibited by religion", 50 per cent and "complications during marriage and labour", 22 per cent.

Almost all respondents who answered "no" suggested health education for stopping this practice. This in itself is an encouraging sign but would require a great deal of effort from the people concerned.

Discussion

The majority of women were pharaonically circumcised. The Hosa and Fallata tribes do not practise circumcision; in their answers they said that it was not the tradition of their tribes, and were completely ignorant of circumcision.

Those who practised the intermediate type followed the instructions and teachings of El Sayed Abdel Rahman El Mahdi, their religious and political leader, who prevented them from performing pharaonic circumcision. This is an example of the influence which may be exerted by some personalities. The majority of these subjects were from the Berti tribe.

Almost all cases denied any complications when asked direct questions, but when the complications were itemized they admitted them. In denying any complications, some women said that they remembered nothing about the events of the circumcision such as type, anaesthesia, instrument, time of healing; but when they came to the actual question of complication the immediate response was "none". Because of this attitude, the answers received were not altogether reliable.

Some cases reported complications like bleeding, fever, but related them to the fact that there had been no celebration of the occasion like henna, gertig, a situation called "kapsa".

When asked whether they discussed circumcision with others, few said they discussed it with the fathers, implying that the fathers had little role in the circumcision of their daughters. The impression was that the father preferred sunna but the mother had the type done which she preferred. Some respondents did not agree with circumcision at all, not even the sunna type, but when asked what they were planning for their daughters in the future their answers were that they wanted the pharaonic type, mainly to conform with the type being practised in society. Those who answered the questions related to sex hesitated and appeared shy. They considered the discussion of sex in public inappropriate. One case (classical pharaonic) admitted that she enjoyed sex only after she delivered, and some said they could not enjoy sex as an important organ was missing from their body.

Case reports

A. Repeated circumcision

1. One girl was circumcised at the age of five years (intermediate type). At the age of 11 years she was circumcised again because her mother discovered that the circumcision was not good. The poor girl suffered much from the second operation. She had bleeding, fever and tight circumcision so that she could not urinate and needed decircumcision.

2. A woman of 48 years, the daughter of a man working in the health services, and who had completed secondary school, was first sunna circumcised at the age of eight years according to her father's wish. At the age of 17 years, when she was engaged, her mother and grandmother took her without the knowledge of the father to a midwife who circumcised her pharaonically, because they thought that it was shameful for a girl to be married and not pharaonically circumcised. They told her father that she had a vulvar abcess. She suffered a great deal from this. They warned her not to tell her father, otherwise all of them would be imprisoned and there would be no marriage. At marriage she had tears and bleeding as she had a tight circumcision. Her husband consulted a physician who performed her decircumcision. In spite of all these events she underwent recircumcision after deliveries at home and in hospital. She did it because her mother refused to eat or drink until it was done.

She circumcised both her elder daughter (intermediate type) and the younger one (sunna). She advised her daughter to undergo recircumcision after the first delivery. Now she is convinced that there is no need for circumcusion and thinks the best way to stop it is through health education and strict law.

B. Tight circumcision

1. A woman of fity years had had as a child, a very tight circumcision. She could not even urinate. She remained like that for seven days. Then the

same operator (daya) came and made a small hole using a chicken feather. This gave some relief. The same problem appeared at the time of menarche. Again, she could not pass menstrual blood and needed decircumcision. In describing this, she said "sahmoha", i.e. opening of the circumcision scar, a very dark offensive blood came out. At the time of marriage consummation was not possible because of tightness until she was opened with a razor by an untrained midwife. In spite of all these troubles she underwent recircumcision after delivery because she thought it was shameful for her not to do so. Now she prefers the sunna type.

2. A woman of 58 years had classical pharaonic circumcision but it was so tight that she could not urinate. This continued for nine months until decircumcision was done with a razor. She delivered four times. After each delivery she underwent recircumcision because otherwise "the other women would laugh at her", although she was not convinced and her husband did not want it.

Strangely enough, she has two daughters whose father insisted on sunna circumcision, but the grandmother and mother took the girls at midnight to a midwife who did pharaonic circumcision. The elder one suffered from urine retention. The younger one was circumcised at the age of three and suffered from shock. Their father took the midwife to court and she was prohibited from practising.

C. Failure of sexual satisfaction

A woman of 50 years was pharaonically circumcised at the age of five. The opening was determined with a match stick. At the age of menarche she could not pass menstrual blood until decircumcised with a razor. A similar thing occurred at marriage. She underwent recircumcision after each of her 10 deliveries because she thought it was beautiful and also to please her husband. She did not enjoy her sexual life at all, never experienced satisfaction and suffered from dyspareunia. She is against circumcision because of complications during marriage and failure of sexual satisfaction.

Summary

In this paper a brief history of the problem has been given. Various types, together with the area where they are practised have been outlined and the scant effort made to abolish this harmful and useless practice which has survived for centuries, elucidated. Parts of the results of the epidemiological survey going on have been given. The salient points are that the majority of women are pharaonically circumcised. Most people do not want to stop circumcision totally, and prefer the less harmful sunna circumcision.

Table 1

Distribution of respondents by age

Age in years	No. of respondents	%
1. 1 - 15	1	0.25
2. 15 - 24	155	38.75
3. 25 - 34	146	36.50
4. 35 - 44	74	18.50
5. 45 - 54	15	3.75
6. 55 - 64	6	1.50
7. - 64	3	0.75

Table 2

Distribution of respondents by place of residence

Residence	No. of respondents	%
1. Urban	184	46
2. Urban slum	16	4
3. Village	200	50
4. Nomad	0	

Table 3

Distribution of respondents by level of education

	Education level	No. of respondents	%
1.	Illiterate	292	73
2.	Khalwa (home education)	0	0
3.	Elementary	70	17.5
4.	Intermediate	9	2.25
5.	Secondary	4	1
6.	Post-secondary	4	1
7.	I do not know	21	5.25

Table 4

Present marital status

	Marital status	No. of respondents	%
1.	Single	40	10
2.	Engaged	12	3
3.	Married	332	83
4.	Divorced	2	0.5
5.	Widowed	14	3.5

Table 5

Reasons for decircumcision

	Reasons	No. of respondents	%
1.	For urine retention (after circumcision)	16	4
2.	At menarche, for difficulty in passing menstrual blood	8	2
3.	At marriage, for difficulty in penetration	6	1.5
4.	For delivery	301	75.25

Table 6

Reasons for saying "yes" to circumcision

	Reason	No. of respondents	%
1.	Religious requirement	106	32
2.	Good tradition	89	28
3.	Cleanliness	23	8
4.	Increases chances for marriage	24	8
5.	Gives more pleasure to the husband	4	1.4
6.	It preserves virginity and prevents immorality	4	1.4
7.	It is less harmful than pharaonic	79	24
8.	Other, specify		

Table 7

Reasons for saying "no" to circumcision

	Reasons	No. of respondents	%
1.	It is prohibited by religion	39	50
2.	Might result in failure of sexual satisfaction	12	2.75
3.	Because of complications in marriage and labour	17	22
4.	Because of troubles experienced	4	5.5
5.	It is against human rights and women's dignity	8	11
6.	Other	6	8.75

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INTERIM REPORT ON STUDY OF EPIDEMIOLOGY OF FEMALE CIRCUMCISION IN THE SUDAN

by

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INTRODUCTION

This is a brief report on the study at present being carried out on "The Epidemiology of Female Circumcision in the Sudan". It represents a sample of work done in Khartoum, Northern Kordofan and Red Sea provinces. This was initiated at the request of Dr Cook, Regional Adviser, Maternal and Child Health, WHO Eastern Mediterranean Region. Because of logistic problems, it was agreed to take a sample of 10% from the whole sample carried out for both sexes, to give some idea of the realities of the problem.

The preparatory stage of this project started in 1977 with a preliminary pilot study in Khartoum urban and rural areas. A more detailed questionnaire was then designed. The real field work started in July 1978. Because of lack of interviewers the time allotted to field work was arranged for the vacation period, so that students would be able to participate in the research. In November 1978, the White Nile Province was covered; the result of this appeared in a paper presented at the WHO Seminar on Traditional Practices affecting the Health of Women and Children, which took place in Khartoum in February 1979.

To date, the following provinces have been covered: Red Sea, Northern Kordofan, Kassala and part of Khartoum Provinces. It is hoped that the remaining scheduled areas will be finished by the end of this year. They are as follows:

Khartoum	July 1980
El Fasher	April 1980
Dongola	May 1980
Wad Medani	June and November 1980
Wau	November 1980

Before summarizing the data obtained, some notes on the practice of female circumcision in the Sudan must be considered. It is a very ancient custom followed by Sudanese females, in Northern Sudan. Three different types exist in the Sudan. These are:

1. <u>Infibulation</u> (pharaonic)

This is the most common type in urban and rural areas. It consists of removal of the whole clitoris, the labia minora and the anterior two thirds of the labia majora. The two sides of the vulva are then brought together by stitching, obliterating the introitus leaving a small posterior opening for the passage of urine and menstrual blood. In the past no stitches were used; the lower limbs were bound together for 40 days and a mixture of sticky substance put on the wound to promote fusion of the two sides. The opening is measured by the thickness of a matchstick.

2. <u>Sunna</u>

This is the mildest type. It consists of removal of the tip of the prepuce of the clitoris only. It is analogous to male circumcision. The word "sunna" means following the tradition of the Prophet Mohammed. It is practised in Sudan by most educated people and religious families.

3. <u>Intermediate</u>

This is a practice between the sunna and pharaonic types, though it is closer to the pharaonic. It consists of removal of the clitoris and some parts of the labia minora or the whole of it. Sometimes slices of the labia majora are removed and stitched. It has various degrees, done according to request from the girl's relatives. It was invented in the early 1950s after the legislation of 1946 (which rendered pharaonic circumcision illegal), by a midwife called Hilbis. It is now practised in urban areas, mainly in the Gezira and Khartoum and is replacing the pharaonic type.

RESULTS

This report includes analysis of some data from the above three provinces, as well as an abstract of the paper entitled "Female Circumcision and its Consequences for Mother and Child", presented at the Yaoundé African Symposium on "The World of Work and the Protection of the Child".

The data regarding males include age, place of residence, education and opinion on circumcision. For females they include age, residence, education, type and age of circumcision, operator and opinion on circumcision. The results are as follows:

Tables (1-3) show the distribution of respondent by age, residence and level of education. For females the predominant age group is 25-34 years (37%) and 15-24 years (23%). The majority are from urban areas (75%). For males the commonest age group is 25-34 years (33.7%). The majority are from urban areas (57%). From table 4 the commonest type of circumcision appears to be pharaonic in all the three provinces. It reaches as much as 86%; in some places it is 100%, as found in rural areas. The table also shows that the practice of circumcision covers 100% of females, regardless of the type. It is clear that there is a very slight difference between the three provinces. There is no difference at all between different age groups or level of education. The only difference obtained concerns the age of circumcision: for Khartoum and Northern Kordofan the age range is 4-8 years, while in the Red Sea province it is usually between 7-40 days. This age obtains for the original inhabitants of the Red Sea area, while for those coming from the northern or central Sudan, the local traditional of circumcising daughters at the age of 4-8 years is retained.

Regarding the operator, the majority of subjects in the Khartoum area had been operated upon by a trained midwife, even in the case of the pharaonic type. The elder girls had been operated upon by traditional midwives. In Red Sea and North Kordofan, the traditional midwife is predominent and most cases are dealt with by her. With regard to the opinion of the population studies on the subject of female circumcision, the following data were obtained:

For females:

23.3% wanted the pharaonic type with "tradition" as the main reason.
32% wanted the intermediate type with "less harmful than pharaonic" as their reason.
22.7% wanted sunna with the reason of "religious requirement".
22% are totally against circumcision.

Thus the majority wanted the intermediate type. The younger generation is against circumcision.

For comparison, the opinion of males is as follows:

21.3% wanted the pharaonic type with "tradition" as their reason.
6.7% wanted the intermediate type with "less harmful than pharaonic" as a reason.
64% wanted sunna with "religious requirement" as their main reason.
6.7% are against circumcision totally.

Thus the majority is in favour of sunna circumcision, although they do not know exactly what is meant by "sunna".

There are various complications, some occurring immediately after operation and others later.

The most common immediate complications are haemorrhage, infection and urine retention.

One case of septicaemia died within two days. Another, which was a case of urine retention, was operated upon but unfortunately the wound became infected. Many cases who suffer complications are not reported, especially in the rural areas. This is due to the fact that the community or the family wish to protect the midwife.

The later consequences are those from which every female is liable to suffer. These complications include chronic pelvic infection, vulvar abcess, difficulties during marriage and labour.

Conclusion: female circumcision is widely practised in the Sudan, the predominant type being the pharaonic. There are different customs according to different areas. Complications and consequences are common and some cause serious impairment to health.

The people, whether in urban or rural areas, are seeking a change. It must be remembered that some even die as a result of this custom.

Table 1

Distribution of respondents by age

Age group	Khartoum		Red Sea		N. Kordofan		Total %	
	M%	F%	M%	F%	M%	F%	M%	F%
15-24 years	12	16	14	24	18	44	14.7	28
25-34 "	34	38	35	50	32	24	33.7	37.3
35-44 "	20	16	27	10	26	24	24.3	16.7
45-54 "	16	18	13	12	18	4	15.7	11.3
55-64 "	14	8	8	4	zero	2	7.3	4.7
-64 "	4	4	3	-	6	2	4.3	2

Table 2

Distribution of respondents by residence

Residence	Khartoum		Red Sea		N. Kordofan		Total %	
	M%	F%	M%	F%	M%	F%	M%	F%
Urban	60	96	55	70	58	60	57.7	75.7
Urban slum	14	4	20	22	zero	8	11.3	11.3
Village	26	-	13	zero	30	32	23	10.7
Nomad	-	-	12	8	12	-	8	2.7

Table 3

Distribution of respondents by education

Education	Khartoum		Red Sea		N. Kordofan		Total %	
	M%	F%	M%	F%	M%	F%	M%	F%
Illiterate	26	24	40	46	36	44	34	38
"Khalwa"[1]	26	2	20	10	16	2	20.7	4.7
Elementary	26	24	23	24	12	22	20.3	23.3
Intermediate	6	8	9	10	14	10	9.7	9.3
Secondary	2	36	6	6	22	12	10	18
Post-secondary	14	6	2	4	zero	8	5.3	6
Don't know	-	-	-	-	-	3	-	0.7

[1]Khalwa - education at home.

Table 4

Distribution by type of circumcision

Type	Khartoum %	Red Sea%	N. Kordofan%
Pharaonic	54	86	74
Intermediate	34	12	24
Sunna	6	2	zero
I do not know	6	-	2
Total	100	100	100

Table 5

Distribution by type of circumcision preferred by province

Type	Khartoum		Red Sea		N. Kordofan		Total %	
	M%	F%	M%	F%	M%	F%	M%	F%
No circumcision	4	26	4	12	12	20	6.7	19.3
Pharaonic	10	10	20	54	34	6	21.3	23.3
Intermediate	10	16	6	20	4	60	6.7	32
Sunna	76	44	70	12	46	12	64	22.7
All types	zero	4	zero	2	4	2	1.3	2.7

THE OBSTETRICAL AND GYNAECOLOGICAL ASPECTS OF FEMALE CIRCUMCISION IN THE SUDAN

by

Dr Suleiman Modawi

THE HISTORICAL REVIEW

Doctors in the Sudan, dealing with the large numbers of circumcised females in the population have had the opportunity to evaluate the effects of female circumcision as practised in different areas of the country.

In the early years of the Sudan Medical Service reports about circumcision appeared in the Medical Service annual reports; the Stack Research Laboratories report; the Sudan Notes and Records; the British Medical Journal and the Lancet. Among the early writers were Grillis, Squires, Hargan, Kirk, Bartholomew, Bloss and Abu Shamma. In 1945 the Medical Sub-Committee of the Governor General's Commission on Circumcision produced the first comprehensive report on the operation and its complications. The members of the committee were Dr Pridia, the Director of Medical Services, Dr Hovell, the gynaecologist; the late Dr Tigani El Mahi, the psychiatrist; Dr MacDonald, the Dean of the School of Medicine; Dr Ali Badri, Dr Halim and Dr Abu Shamma. Lectures on female circumcision to midwifery students were given by Miss Wold and Sitt Battoul M. Issa. Regular lectures on female circumcision were also started in 1966 for medical students. Among the early writers and lecturers were Dr Modawi, Dr Sandys, Dr Verzin, Dr Futuh and Dr Assam Zaki. Valuable contributions from other gynaecologists, registrars and general duty doctors also followed.

The operation

In a recent study Dr Salah Abu Bakr discussed the anatomical aspects of female circumcision, the tissues exposed to injuries and the effect of scarring on nerve destruction of the area. The following are the recognized types of the operation.

Type 1

The classical pharaonic circumcision or infibulation is also known in Egypt as the Sudanese circumcision. This operation aims at removing the clitoris and narrowing the introitus. With a sharp razor the clitoris is amputated and slices of the labia minora are removed. The damage done and tissues injured depend on the experience of the old midwife. The ends of the wounds are brought together by primitive means and there is rarely first intention healing. This operation is now illegal in the Sudan.

Type II

In the sunna circumcision or clitorectomy, the glans clitoris only is removed. This is the legal operation suggested as a substitute for Type I and recommended by gynaecologists for parents who insisted on having their daughters circumcised.

Type III

Re-infibulation or re-circumcision. This is sometimes done by midwives to close the patulous vagina after birth and also as a contraceptive measure.

Complications

For many years, the Sudanese have been performing the operation on their daughters who got happily married and produced children. In spite

of this fact, the reported complications of the operation occurred during all phases of life. Most of the early writers however exaggerated the complications in order to have the practice abolished.

Immediate and early complications

1. Shock

The amount of shock after the operation may be out of proportion to the amount of haemorrhage. Deaths due to primary shock are often not reported. The writer knows of such a death attributed to intravenous local anaesthesia.

2. Injury to adjacent parts e.g. urethra, rectum.

3. Haemorrhage

Primary haemorrhage may occur and the midwives may fail to control it by their primitive means. Such cases are usually not reported. In hospitals many cases of secondary haemorrhage were seen.

4. Infection

In the past, the operation was done under the most unhygienic conditions and infection may be localised to the area of the incision or may spread to adjacent cellular tissues. One case of gangrene of the vulva (NOMA) was seen in Khartoum in 1956. A girl of about nine years died in Khartoum Hospital of septicaemia the same year. A fatal case of tetanus occurred in Merowe Hospital in 1950. The extension of infection to the immature vaginal epithelium may cause vaginitis but the severest type usually follows the insertion of foreign bodies through the narrow opening. One case of vaginal calculus formed round a match stick was seen in 1957. Another case of vaginal calculus causing a vesicovaginal scar was discovered in the Stack Medical Research Laboratories.

Urinary complications

These are the most common complications seen in hospitals. Retention of urine may be due to reflex causes and to fear of passing urine through the scar tissue. More commonly it follows closure of the meatus by oedema, inflammatory exudates, granulation tissue or severe fibrosis. The retained urine in the vagina and later the bladder may become infected and the infection may spread upwards.

Complications before marriage

1. Retardation of growth in some girls, was attributed to circumcision, but most workers think that this was due to malnutrition and endemic diseases. Bartholomew reported a pelvic abnormality due to circumcision, but obstetricians think that the female pelvis in the Sudan conforms with standard types in their aetiology. Some workers have attributed delayed periods in some girls to circumcision.

2. Haematocolpos and vaginal stenosis

All such cases seen in the Sudan were due to closure of the introitus following circumcision.

3. Dysmenorrhoea

Some investigations showed that the incidence of this symptom was not increased among circumcised girls.

4. Keloid

Unsightly circumcision scars were generally seen in girls susceptible to keloid formation.

5. Elephantiasis of vulva

Two cases were seen in Bahr-El-Ghazal area in non-circumcised girls. The cause was filariasis.

6. Retention cyst

This complication was fairly common. The cause of this cyst was the inclusion of a small island of epithelium beneath the surface. Usually the cysts are small and grow slowly but may reach the size of a tennis ball. The contents were the characteristic sebaceous material and like sebaceous cysts elsewhere they were prone to infetion and abcess formation. Recurrence was common after incision, but marsupialization gives better results.

Complications after marriage

In cases of very narrow introitus the consummation of marriage was always difficult for both husband and wife. The opening in these cases barely admitted the tip of the finger and the scar tissue round the introitus was dense and dilated with difficulty. Wise couples take a course of slow gradual dilatations. Attempts at forceful penetration may cause rupture of the scar. In some areas instruments were used but most cases now come for repair in hospital.

Dyspareunia and vaginismus may be associated with a narrow introitus. Cases of rectal coitus were attributed to circumcision but those seen in the Sudan were among loose unmarried girls trying to preserve their circumcision intact. Signs of rectal coitus were noted in a girl with illegitimate pregnancy.

False vagina

In some women with tight introitus repeated pressure in the site of the opening may cause stretching and invagination of the skin and a false vaginal canal is formed. A woman complained of infertility and it turned

out that the husband was not aware of this false track and complained that his wife rejected his semen directly after ejaculation. In one case this false stretching was at the site of the urethra and its proximal part was included in the false canal.

Infertility was usually due to difficulty in penetration and sometimes dyspareunia. Cases usually conceived after a minor operation.

Chronic pelvic infections should be thoroughly investigated before attributing them to circumcision.

Effects on pregnancy and labour

Pregnancy could take place in the absence of penetration and cases have been seen in labour with a pin-hole introitus. If early abortion occurred in such cases the products of conception were retained in the vagina and severe infection followed.

In ante-natal clinics, it has been noticed that the percentage of vaginal discharge causing infection was high. No other complications directly attributable to pregnancy have been noticed.

During labour retention of urine was common and catheterization was sometimes difficult before opening the circumcision scar. Obstruction to labour due to scarring and stenosis of vagina has not been seen in the Sudan. The presenting part may be delayed by rigidity and scarring of the perineum and early anterior episiotomy and posterio-lateral episiotomy is essential. After labour the incisions are usually stitched but in cases with severe scarring the wound gapes and becomes infected. The incidence of puerperal infection is very high. This is the commonest cause of secondary infertility in the Sudan.

The psychological, social and other aspects of circumcision have not been discussed as they have been dealt with in other papers in this volume.

REFERENCES

1. Complete list of references will be found in Proceedings of the Fifth Congress of Obstetrics and Gynaecology, under "Changing Aspects of Circumcision" by S. Modawi (February 1977).

2. Recent Reference: "Abstract of the Proceedings of the Sixth Congress of Obstetrics and Gynaecology".

AHFAD UNIVERSITY COLLEGE FOR WOMEN
OMDURMAN, SUDAN
AFHAD SCHOOLS 75TH ANNIVERSITY

SYMPOSIUM ON THE CHANGING STATUS OF SUDANESE WOMEN

23 February - 1 March 1979

"FACTORS RELATED TO SUDANESE FAMILIES DECIDING AGAINST FEMALE CIRCUMCISION"

by

Dr G. Price

ABSTRACT

A preliminary report was given on a not yet completed research study designed to compare a group of uncircumcised Sudanese women and their families with a group of pharaonically circumcised Sudanese women and their families. The two groups are to be compared in terms of socioeconomic status, ties with the community and extended family, and equality and rights of women within the family. Information was also obtained concerning how the decision to circumcise or not to circumcise was made and by whom, how this decision has affected the respondent's life; what information concerning circumcision has reached the respondent through public channels; and the respondent's opinion as to how the practice of female circumcision can be combatted.

Interview data from 10 uncircumcised women and their mothers were reported therein. No comparative data from the pharaonically circumcised group were reported.

FACTORS RELATED TO SUDANESE FAMILIES DECIDING AGAINST FEMALE CIRCUMCISION

The circumcision of women is a long-standing practice in the Sudan and other parts of Africa and perhaps in parts of Asia, Australia and the Americas (David, 1977; Modawi, 1973). In the Sudan, the tradition appears to have its roots among the Red Sea tribes of the Eastern Sudan. The most severe type of infibulation is currently practised by the Beja, Hadandawa and Bani Amir tribes of the East, while a milder type of infibulation is reportedly practised by the Northern and Central tribes and by the Kababish of the Western Sudan (Modawi, 1973).

Four types

Female circumcision as practised in the Sudan is generally performed on girls between the ages of five and eight years (Modawi, 1973). The surgical details of the operation vary widely depending on the skill of the midwife or other person performing the operation, and the wishes of the parents. However, in the Sudan, the operation can be classified into four common forms (Cook, 1977; Clark and Diaz, 1977; Modawi, 1973).

Type I. The sunna circumcision consists of the excision of the glans clitoris with sometimes a small portion of the clitoris itself. This operation requires the skills and instruments of a trained surgeon.

Type II. The radical pharaonic circumcision aims at closing or narrowing the introitus. The clitoris is amputated and slices of the labia majora and labia minora are cut away. The amount of tissue removed and the damage done depends on the experience of the midwife. The wounds on the two sides are brought together by thorns and thread, or by catgut and/or tying the legs together for 40 days. A matchstick or similarly small object may be inserted into the wound to allow the development of a fistula for urination.

Type III. The modified pharaonic circumcision consists of excision of the clitoris with slices of the upper part of the labia minora. The wound is

then sutured with catgut. This operation was developed by a trained midwife - Shandall, 1967. The labia majora are preserved, leaving a narrowed introitus.

Type IV. Recircumcision or reinfibulation is performed for widows, divorcees and for women with Types II and III following childbirth.

Prevalence of the practice

No complete countrywide statistics concerning the practice of female circumcision are available for the Sudan. However, a preliminary report from a survey being carried out in the Northern Sudan by the University of Khartoum, Faculty of Medicine, was issued by Dareer in 1978. Based on a sample of 100 families interviewed in the Khartoum urban area and a village near Khartoum, the incidence of some form of female circumcision was 100 per cent. Furthermore, the legal sunna form was found in only four per cent of the 100 cases. Modawi (1973) reported that of 699 Northern Sudanese women seen in his private clinic in Khartoum during 1970, none was uncircumcised and only one per cent had the sunna form of circumcision.

Damage to physical health

The unsanitary conditions under which the three illegal types of the operation are often performed by untrained midwives, the lack of anaesthesia or asepsis and the destructive nature of the operation itself, lead to frequent and severe physical complications (Cook, 1977; Hosken, 1978; Modawi, 1973; Mustafa, 1966; Shandall, 1967). Pain, urinary retention, haemorrhage and shock sometimes leading to death, injuries to adjacent tissue such as the rectum and bladder, infection, septicaemia, tetanus, retention cysts, madura, vulva abcesses, infertility, severe vaginitis, painful menstruation and difficulty in passing menstrual blood have all been reported.

Difficulty in consummating marriage may lead to coital injuries. The opening to the vagina barely admits a finger and the scar tissue surrounding

the introitus is dense and rigid. Forcible penetration may cause ruptures of the scars, perineal tears, dyspareunia or formation of a false vagina (Cook, 1977; Modawi, 1973; Mustafa, 1966; Shandall, 1967).

Types II, III and IV also have adverse effects on the birth process. These include infections due to retention of spontaneous abortion, urine retention during labour, obstructed labour, and where decircumcision is not performed, severe tears with accompanying foetal brain damage.

Psychological complications

The emotional frustrations and disturbances surrounding the practice of female circumcision have been very little assessed. Sexual dysfunctions for the woman and resulting marital frustration are popularly reported but not frequently researched. Karim and Amman (1965) studied circumcised women in Egypt and concluded that female circumcision does not seem to decrease sexual desire, but definitely reduces female orgasmic ability. Shandall (1971) reported on 300 Sudanese husbands seen in his private practice who had two wives. All husbands had pharaonically circumcised first wives but 266 of the 300 had taken sunna circumcised or uncircumcised second wives. All 266 stated that they preferred the second wife sexually because there were fewer sexual difficulties and the husband and wife shared a more equal level of sexual desires and feelings.

The secrecy surrounding the practice and the limited availability of psychiatric services in the rural areas makes it likely that only extreme cases of psychological disturbances would be brought to the attention of a psychologist or psychiatrist. Baasher (1977) reported three cases of psychiatric complications related to female circumcision; anxiety state, reactive depression and psychotic excitement.

Attempts to combat female circumcision in the Sudan

In 1946 pharaonic circumcision (infibulation) was declared illegal in the Sudan and punishable by fine or imprisonment then up to seven years, now

reduced to five years. At that time a central committee was formed by the Governor-General's Council and many community leaders joined in a campaign against female circumcision. The issue was openly discussed in women's organizations, the press, educational institutes, social clubs and tribal gatherings. The Sudan Medical Service published and distributed a small, simple pamphlet describing female circumcision and its complications. In 1977 the 5th Congress of the Obstetrical and Gynaecological Society of the Sudan declared unanimously that all forms of female circumcision should be abolished. Religious leaders have published the opinion that forms of female circumcision other than the sunna are contrary to the teachings of Islam. With regard to the sunna form, attitudes vary according to religious sects. The Malaki and Hanafi sects consider the sunna desirable but not obligatory, while the Shafi consider the sunna a religious obligation (Clark and Diaz, 1978). Senior religious leaders, such as the Minister of Religious Affairs, have publicly spoken against pharaonic circumcision (Hosken, 1977).

Why then does the custom of circumcision, especially types II, III and IV, persist in the face of opposition from medical and religious authorities, threats of imprisonment, multiple and severe health complications, marital dissatisfaction and possible psychological trauma? No final answer is available but it is thought that many persons still see female circumcision as a religious obligation, and several writers have expressed the opinion that midwives have a vested financial interest in the continuation of the custom and grandmothers strongly encourage the practice as necessary for the protection of virginity, marriage and the dowry. The attenuation of female sexual desire, the preservation of custom and cleanliness have also been cited. Some have stated that the custom is related to the unequal status of women in society (Viva, 1978) and to the generally low level of education, economic power and trained health workers in the Sudan as a whole (Modawi 1973). Given female segregation and low levels of education among Sudanese women, anti-circumcision campaigns may not reach the persons who are the primary decision-makers regarding the practice.

The present research is a small-scale investigation into the possible relationship between circumcision of women, educational level, community ties

and the status of women within the family. The family's own perception of how they decided for or against circumcision and their views on how the practice can be most effectively combated are also examined.

Method

Subjects: Two groups of 15 subjects each were interviewed: Group 1, uncircumcised Sudanese women or girls, above the age of 12, and their mothers where possible; and Group 2, pharaonically circumcised Sudanese women or girls above the age of 12, and their mothers. Only native-born Sudanese were used as subjects though in some instances one parent from a tribe that customarily practises female circumcision were chosen as subjects. Only one daughter from each family was targeted, this being the eldest where possible.

Subjects were contacted through friends and Ahfad University College for Women students of the experimentor. This method of contact through friends was adopted because it was the only method possible for obtaining interviews with uncircumcised women. Those who have discontinued the practice or circumcision do not generally make this information publicly available or discuss it with strangers. Even when contacted through close friends and relatives, the mothers of two women who were not circumcised refused to be interviewed.

The 15 uncircumcised subjects were obtained first, then pharaonically circumcised females were matched for age and marital status, as the population of pharaonically circumcised women provides a larger number from which to choose.

Both groups of subjects were selected in a similar manner; however, the subjects were selected at random from the larger population of Sudanese women and from the urban population of the Three Towns area. The results of the two group comparisons can therefore be generalized to a very limited population, comprising the urban population and probably only the educated and middle or upper classes.

Procedure: Subjects were initially contacted and their participation requested by a mutual acquaintance and the experimenter. The person contacting the potential subject requested that the subject agree to an interview with the experimentor. Potential subjects were further informed that all information given would be confidential, that the purpose of the experiment was to learn about how families made the decision to circumcise or not to circumcise their daughter, and that the information would be presented at a World Health Organization conference and at an Ahfad UCW-sponsored symposium on the changing status of Sudanese women. These instructions were repeated at the time the experimentor initiated the interview in the subjects' homes. At the time of the interview subjects were also requested to provide only information about which they were certain and to report freely on lack of knowledge or reluctance to answer questions. Of the 10 uncircumcised subjects contacted all agreed to the interview; however, two mothers of these women refused to be interviewed. Reluctance to answer questions was encountered only with single women concerning questions about sex.

Materials: Two similar interview schedules were constructed, one for the uncircumcised group and the other for the pharaonically circumcised group. Areas of communality between the two interviews were: four questions concerning marital status, education, occupation, income and ethnic background of the family; four questions concerning ties with the community and extended family; 7-9 questions concerning the equality and rights of women within the family; eight questions concerning who in the family had been circumcised and how this decision was reached; six questions concerning the effects on the respondent's personal life whether pharaonically circumcised or uncircumcised; eight questions concerning why female circumcision was still practised in the Sudan, how it could be stopped, subjects' personal efforts to combat the practice, and anti-circumcision public campaigns which have reached them.

Questions on the interview schedule were used as a basis for collecting and scoring information and for giving a general, semi-structure to the

interview. Many open-ended questions were presented to the subject for spontaneous generation of answers and the interview was allowed to follow its natural course.

Results

Initially much difficulty was encountered in obtaining uncircumcised subjects; interviews with the matched group of pharaonically circumcised women were thus also delayed. By this time 10 uncircumcised girls and women had been interviewed. About half of the uncircumcised women volunteered to arrange an additional interview with an uncircumcised friend, so that a population of approximately 20 uncircumcised women would eventually be available for interviews. No difficulty was encountered in identifying a population of pharaonically circumcised women.

Results presented here are preliminary and incomplete. Interview data from 10 uncircumcised women and their families are reported. In examining this profile of uncircumcised women, it must be borne in mind that these 10 women are a highly biased sample who, given the method of their selection, necessarily represent a population more highly educated and economically well-off than the average Sudanese woman. Any conclusions about the uniqueness or similarities of these women must be made in comparison with the similarly biased sample of pharaonically circumcised women yet to be interviewed. The information presented here is intended to stimulate discussion about the ideas under investigation and how the investigation could be better conducted. When data collection is complete, the two groups of subjects will be compared statistically by correlation plus analysis of variance for items highly correlated with group membership.

Socioeconomic status and other population characteristics

All respondents were relatively young, well educated, mostly single and from high income and generally well educated families. Respondents' ages ranged from 16 to 29 with a mean age of 21. Seven were single, two married

and one divorced. The average respondent (70 per cent) is currently a student with some years of university education. All but one respondent had either completed a university or higher degree or had completed the maximum years of education appropriate to her age. All non-students were members of the labour force, 20 per cent in the health professions. The average income of employed respondents was LS.88 per month.

Education of mothers of the respondents ranged from five to 19 years with a mean of 8.1 years. Fathers' eduction ranged from 16 to 22 years with a mean of 17.7 years. 80 per cent of mothers were housewives, 20 per cent educators; 50 per cent of fathers were private businessmen, 30 per cent health professionals, 20 per cent senior administrators. Family incomes ranged from LS.200 monthly to 924 with an average of LS.457. The number of children in the nuclear family of origin ranged from two to nine averaging 5.4. Only one family had a non-native Sudanese parent (British mother) but 50 per cent had a non-Sudanese parent in the grandparents' generation or earlier. Of the "pure" Sudanese families, all but one parent was from a tribe of the Northern or Central Sudan, with one mother being from a tribe of the West (a tribe which practised infibulation). Thus none of the Red Sea tribes, which practise the most severe forms of infibulation, was represented. Respondents definitely represented an urban population: 65 per cent of families had resided in the Three Towns area all their lives or for not less than 15 years.

Community ties: Questions were devised in an effort to measure the strength of the respondent's ties with the community and extended family. Only two households included persons outside the nuclear family. Only one family had a grandparent living with them at the time of the interview. Mothers reported an average of 2.25 acquaintances or relatives whose opinions influenced the mothers' own opinions or behaviour, and daughters reported an average of 3.5. The number of hours per week generally spent socializing was reported as five by the average mother and 15.2 hours by the average daughter. This meaningful figure, especially for the daughters, included non-relations, a more meaningful measure would have been the number of hours spent socializing with close relatives.

Equality and rights of women: In all but one of the families girls were educated to a level equal to or greater than boys (commensurate with age). This did not hold true for their mothers, however. In all but one case, the mothers had received 3-16 fewer years of education than the father and 8.1 years less on the average.

In response to questions concerning the daughter's right to choose a husband, 60 per cent of families reported that daughters were given the right to find and select their own potential husband and then bring him for parental approval; 30 per cent reported that the family selected the potential husband but gave the daughter the right of refusal, and 10 per cent reported that the husband might be selected by either parents or daughters with the approval of both being necessary. No family would pursue a marriage against the daughter's wishes.

The giving of a dowry mahar by a man in payment for a wife was viewed as an index of female inequality. The majority of mothers and daughters, 60 per cent, reported that a dowry had not or would not be paid for their daughters and only 20 per cent felt sure that they would request a dowry.

The distribution of decision-making powers between husband and wife was investigated regarding money for household and major purchases, children for permissions, child care and education, and socializing by parents. On the average 77 per cent of decisions were taken by husband and wife jointly. Mothers tended to have more responsibility for daily household purchases and routine permissions for children, while fathers were more likely to have the final say on major purchases or radical requests for permission by children. It should be remembered that the fathers' opinions were not sought in this survey.

Where cooking and other household duties were shared by children, 33 per cent of families reported that brothers and sisters shared equally in these tasks and another 33 per cent reported that boys assumed less responsibility than girls but had some regular major household task.

Segregation of the sexes is infrequent in these families. All families reported that men and women regularly ate together though all reported occasions on which segregated eating occurred, especially when family elders were present. In 60 per cent of the parents and 66 per cent of the young married respondents, husband and wife regularly socialized together in mixed company.

Many of the above mentioned practices can also be viewed as deviations from tradition, unequal treatment of women being traditional in this society. Other deviations from tradition were noticed in many of these families: going outside the home without a tôb (a traditional garment worn by Sudanese women); girls attending the cinema; boys and girls attending social functions in mixed groups of peers or even in opposite sex couples was reported.

Since refusal to circumcise is a deviation from tradition, it may be correlated with other non-traditional practices.

The decision not to circumcise. In 78 per cent of the families, the decision not to circumcise the daughter was made by both parents, though both parents were opposed to circumcision in only 56 per cent of the families. In three families the father was opposed while the mother was not and vice-versa for one family. In one family the father made the decision and informed the wife, and vice versa for another family, while in the family with the English mother, the issue was never discussed. Three families reported that they were persuaded that female circumcision was an undesirable practice by a husband or father who was a doctor, and two families reported being persuaded by a relative who was an active member of the 40's campaign against female circumcision. Reasons stated for being opposed to female circumcision were: firstly, childbirth complications (listed by 67 per cent of families); secondly, hazards to the health of the girl or woman (56 per cent); problems regarding sexual relations in marriage (34 per cent); deprivation of sexual pleasure in women (34 per cent); pain (34 per cent); and 12 per cent had no reasons to offer. Although childbirth complications and health dangers were

more frequently cited as reasons for opposing female circumcision, when asked what single factor most influenced the decision against female circumcision, 57 per cent of mothers responded that it deprived women of sexual pleasure, as opposed to 29 per cent who cited complications of childbirth.

The attitude towards female circumcision of most respondents has probably been very little imparted by information received through public channels; 60 per cent of daughters and 50 per cent of mothers had heard no public announcements or discussions on female circumcision; 30 per cent of daughters had attended the same public lecture at the University of Khartoum Medical Faculty; 30 per cent of mothers had attended a discussion in a women's organization during the 50's and 10 per cent of mothers and daughters had viewed a single television programme on the subject.

Respondents believed there were no valid reasons for continuing the practice, and that others continued it out of the mistaken belief that it was necessary to preserve virginity and prevent immorality (50 per cent), by reducing female sexual arousal, to give sexual pleasure to the husbands (30 per cent), because it was traditional (20 per cent) or for religious reasons (20 per cent). It was suggested that the secrecy surrounding the practice and reluctance to discuss it contributed to its continuation.

Grandparents, especially grandmothers, are frequently cited as sources of pressure to circumcise girls. In 44 per cent of the cases the family was not living near a grandmother (of the uncircumcised girl) when the decision not to circumcise was made. One grandmother and one grandfather reportedly supported the decision not to circumcise, while four grandmothers expressed their opinion that the circumcision should be performed. In one case, the parents threatened legal actions against a grandmother they feared might interfere. In 20 per cent of the families, one grandmother was uncircumcised (foreign in both cases) and in another 20 per cent, one grandmother had the sunna circumcision. Thus it would seem that grandparents did not usually encourage dropping the tradition, and in 40 per cent of the cases urged that circumcision be practised.

Effects on their lives. All persons interviewed expressed very positive feelings about not being circumcised and all mothers and daughters continue to uphold the decision. None had encountered problems because of being uncircumcised other than teasing by friends, generally implying uncleanliness and hypersexuality. Only one respondent reported having ever felt worried over not being circumcised, and thereby being unclean and anticipating problems for her marriage and possible objectives by the in-laws. Others were certain that they would marry educated men who would approve of their not being circumcised. For the three women who had married, their husbands were reported to approve strongly of their being uncircumcised. Married women expressed the opinion that they found sexual relations with their husbands much more pleasurable than did their circumcised friends. Some circumcised friends had reported that sex for them was essentially a duty to the husband.

Uncircumcised women made positive statements about themselves such as "I am glad to have all my body and all my feelings", "I am normal", and with one exception, all appeared exceptionally poised, self-confident and mature. The only problem anticipated was social disapproval. Openness by families varied from the family in which the brothers were not told, to another in which the mother discussed her refusal to circumcise her daughter with each of her new classes of teacher trainees. Three to eight persons outside the nuclear family had been informed in 40 per cent of cases, 50 to 100 persons in another 40 per cent, 200 persons in one instance and 1000 in a third instance. However, in general, only close friends and members of the extended family were told of the daughter's condition. Approximately 45 per cent of respondents felt that the majority of people who knew about their being uncircumcised had mixed feeling of approval and disapproval; approximately a third felt that most people who knew approved, and about 22 per cent felt that most who knew disapproved.

How to combat the custom. Most uncircumcised women and their families have attempted to persuade only one or two other friends or relatives to discontinue the practice (60 per cent). This had been done through personal talks at home. One mother had also given a talk at a women's group and

another had helped to organize a campaign against female circumcision during the 50's, and continued her efforts at present through talks to classes of teacher-trainees. In order to persuade large numbers of other Sudanese to discontinue the practice, 90 per cent expressed the belief that a large-scale educational campaign should be conducted and aimed at women, men and children. Only 20 per cent spontaneously expressed the opinion that an improvement in the general status of women's rights and conditions would help to combat the practice; 30 per cent felt that the current legislation should be more strongly enforced, and 20 per cent felt that sex education was necessary to help parents understand that sexual arousal was also from the mind, not just in the body. That is, parents should be helped to understand that the best way to ensure the virginity of their daughters was through moral education, not through physical alteration of the sex organs.

Respondents believed that education campaigns should be conducted by the medical profession (60 per cent), the Government Ministries of Social Affairs and Health (40 per cent), women's organizations and other political organizations (30 per cent), families who have stopped circumcising their daughters, especially large influential families (40 per cent), and teachers (40 per cent). The means through which this campaign should be conducted included the new media, especially the radio and cinema which are more likely to reach the poor and the rural populations; by direct talks at home, especially by primary health care personnel and midwives, (45 per cent); and in state-provided schools (45 per cent), especially primary schools when girls were of an age to be circumcised.

When asked what would be the most persuasive argument against female circumcision, 45 per cent replied, "health hazards to the women or girl", 34 per cent cited complications for childbirth, 23 per cent sexual problems in marriage, 23 per cent said that it deprived women of sexual pleasure and 20 per cent stated that circumcision was not the best way to ensure virginity of daughters. Some respondents explained that the medical rather than the sexual problems created for women must be emphasized, because it was not socially acceptable for women to have a strong interest in sex.

Discussion

An analysis of the 10 uncircumcised women showed them to be better educated and from more highly educated and affluent families, who enjoyed more rights, freedom and power within their family, possibly having fewer ties with the extended family than the average Sudanese woman. No conclusions could be drawn regarding these factors and their uncircumcised status. The proper comparison group is not the average circumcised Sudanese woman, but rather circumcised Sudanese women selected from the same well-educated and financially secure population as these women. Until this select population of circumcised women has been interviewed, no conclusions can be made about the possible correlates of circumcision that are under investigation here.

However, useful information has been obtained concerning how these families made the decision not to circumcise their daughters, whether this decision has positively or negatively affected their lives and how these families believe female circumcision could best be combated.

Most families seem to have carried out the decision not to circumcise with very little support from either the extended family or the larger society. More often than not both parents were involved in and supported the decision. Mothers' support for the decision seemed to have most frequently been based on the belief that circumcision deprives women of sexual pleasure, with secondary consideration of dangers to health and childbirth complication. Grandmothers were generally in favour of circumcision, but nearly half of the families were living far away from the grandmother when the decision was taken. Three families had the precedent of an uncircumcised grandmother and half had at least one non-Sudanese parent, grandparent or great-grandparent. Very few mothers or daughters had been reached by anti-circumcision campaigns. It would seem likely that if this urban, high socioeconomic group has been so littled reached, the rural and the poorly educated may not have been reached at all by anti-circumcision campaigns.

All respondents were uniformly positive about not having been circumcised and the effect this had on their lives. Although none had received very much

social approval for this decision, neither the family who had told only three persons, nor the family that had told 1000, reported any severe social rejection. Ironically, the person who had been the least disclosing was also the only subject who reported personal worry and concern. Married women spoke very positively of the effects that not being circumcised had had on their marriages and sexual relationships with their husbands.

Very few families had made efforts to persuade others not to circumcise daughters and very few had been the recipient of public campaigns against circumcision. However, all were very much in favour of public anti-circumcision campaigns. Many felt that the secrecy surrounding the practice and the hesitation to discuss it helped to keep the practice alive. Respondents recommended that large-scale educational campaigns, aimed at all the population and emphasizing health and childbirth problems, be conducted by medical persons, women's organizations, government ministries, political organizations, families who had discontinued the practice, and teachers. The use of the mass media, especially radio and cinema, in order to reach the rural and uneducated, was emphasized, likewise the use of health visitors, midwives and mass campaigns. It was felt that both mothers and fathers needed to be reached if the practice were to be changed.

The difficulties experienced in obtaining a sample of uncircumcised women were probably evidence not only of the secrecy surrounding their status, but also of the size of the total population of uncircumcised women. If so few uncircumcised women are to be found among the urban and the socioeconimcally privileged, then it may be that very few or no uncircumcised women are to be found among the rural and the poorly educated. It seems unlikely that the practice of circumcision is rapidly dying out in the Sudan as has been claimed by more optimistic researchers (Modawi, 1967).

RECOMMENDATIONS

Female circumcision to date has focused primarily on documenting prevalence and physical complications and looking for the single cause of the practice. Certainly both documentation and looking for causes are important.

However, it seems unlikely that any one single factor, such as "the husband demands it" is responsible for the continuation of the practice. It seems more likely that the practice be determined in a multiple and complex manner and is related to the status of women in the society. In many societies, if a man requested female genital mutilation for his own sexual pleasure, he would be considered perverted. Such a request could probably be taken seriously only in a society where women had a much lower status than men.

Thus the implications for research are that sociocultural factors such as the roles and status of women in a society must be considered when examining the issue of female circumcision. And the implications for eradication of the practice are that it is likely to be a slow process since it is most likely related to changes in other sectors of the lives of women.

Before any large-scale campaign is mounted against female circumcision, further research must be conducted concerning the most persuasive arguments to be used and by whom. Is it really the case that men and women are ignorant of the health complications and sexual dysfunctions produced by the practice? Or, rather, the most important function an anti-circumcision campaign can serve is to give the public the support of medical authorities and other educated leaders in stopping the practice? Which is more important - the content of the message to provide knowledge which is lacking, or the status and authority of the bearer of the message and taking the issue out of the closet? If the content of the message were the most important element then perhaps a local health worker can serve to deliver it, but if the prestige of the bearer were the key element, then perhaps money is better invested in travelling campaigns by persons of high status or well-known public figures.

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FEMALE CIRCUMCISION IN UPPER VOLTA

by

Miss Alice Triendregeogon

INTRODUCTION

Upper Volta is located in the middle of West Africa and is bordered by Mali, Niger, Ghana, Ivory Coats, Togo and Bénin.

It has a population of about six and a half million people belonging to different ethnic groups. Among these are the Mossi who have a patriarchal cultural system, where women have a low social status. The Gourmantches are an ethnic group rather akin to the Mossi. The Penths (nomads), Gourounsi, Bissa, Senoufs, Bobo, Dagari, Lobi have a matriarchal system and the child belongs to the mother's family.

The country has about 30% Muslims, 20% Christians and the rest of the population has an animist religion.

All of these groups practise excision - clitoridectomy without infibulation. The Muslims do this for religious reasons and the other groups base their practice on tradition and custom. Usually the operation is performed when the girl is between 10 and 12 years and is considered highly significant. She is isolated for about four weeks and is taught about human sexuality, her role in life, the significance of prohibitions and how to conduct one's self in the community.

Excision of the clitoris is a mark of the attainment of adulthood and following this ritual, the girl becomes an adult and is considered fit for marriage.

Circumcised girls are proud of having undergone this operation and the uncircumcised ones are shunned and taunted with the result that some even develop an inferiority complex.

Some cultural customs are beginning to disappear, except excision which remains strongly practised, even though it is becoming more and more separated from its indications.

Excisions are practised in the cities as well as in the rural areas, by traditional midwives who use razor blades and knives and in very bad hygienic conditions. Many girls have been known to die of tetanus.

This situation drew the attention of the Voltaic Women's Organization who decided to campaign against female circumcision through the radio, every morning and in all the languages spoken in the country.

An investigation was first initiated amongst both the men and women regarding the practice of female circumcision.

Men

The Muslims stated that it was enshrined in their religion, whilst the non-Muslims and Christians claimed that it was a custom that must be retained and that it made a woman "clean" and promoted fertility. Several men claimed they would never cohabit with uncircumcised women and that such women were immoral and promiscuous.

Women

The women also claimed that tradition demanded circumcision, their mothers were circumcised so they must also follow otherwise they would not be "real" women and would not have husbands.

A non-excised woman could not have children.

In 1975 and based on the above statements, radio broadcasts were accordingly designed excluding any references to customs and religion and stressing mainly the immediate and remote complications and ill effects on health. The broacasts were made by a gynaecologist who also explained the unfounded beliefs regarding morality, sexuality and childbirth.

Parents were particularly urged not to have their daughters circumcised. The campaign was however short-lived and was discontinued on account of adverse reaction from many quarters. It appeared that all sections of the population preferred to continue with the practice of female circumcision. It is interesting to note that educated women, teachers, midwives and nurses were also amongst those who reacted against the campaign.

It is however hoped that with increasing health and general education it would be possible to revive the campaign against female circumcision shortly.