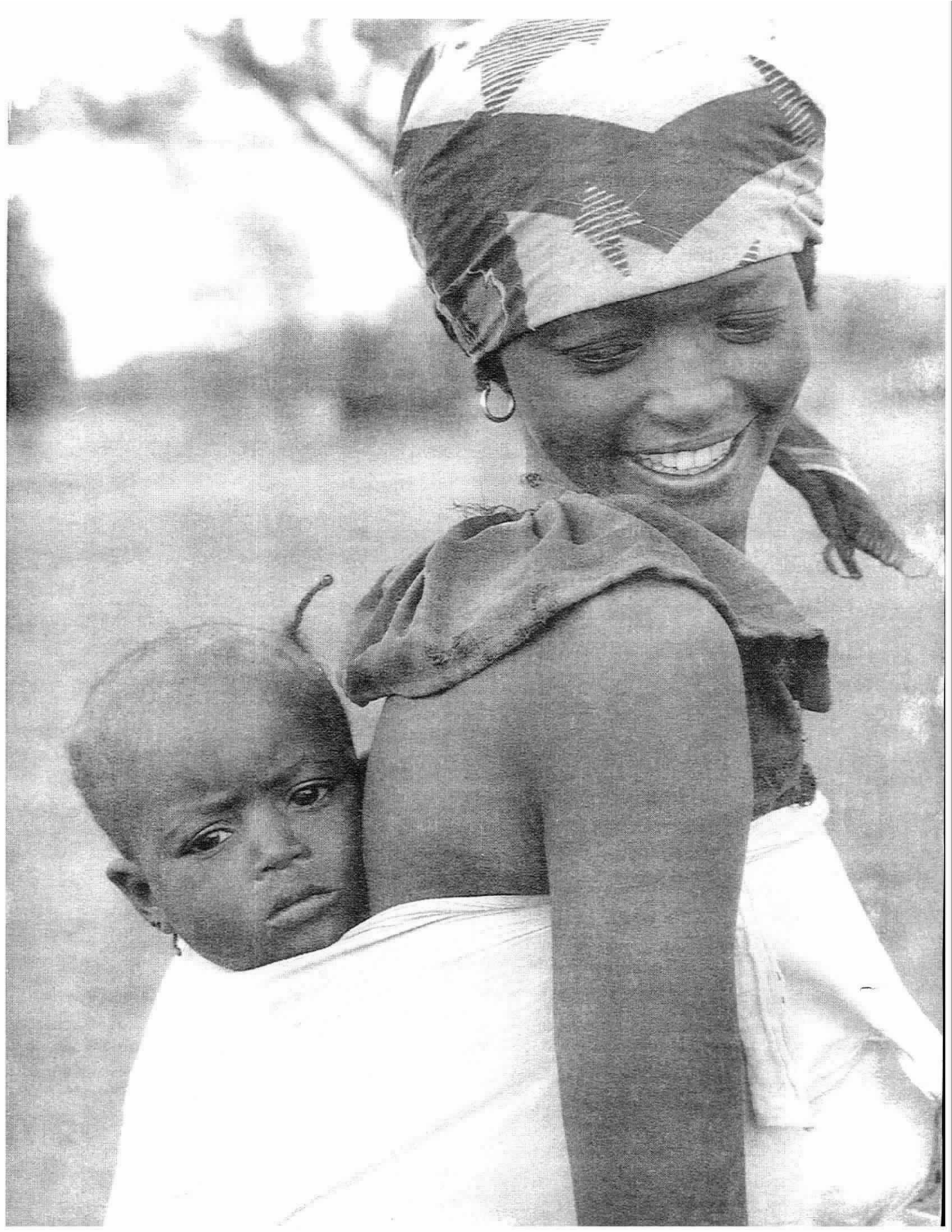

Introduction

Although female genital cutting has been the focus of international attention and disapproval in recent years, there has been little scientific research documenting the extent of its practice and support among women in Africa and elsewhere. Until the 1990s, Sudan was the only country with reliable large-scale survey data on the prevalence of genital cutting among women (Toubia, 1995; World Health Organization, 1996b). This report presents some of the first national level information on genital cutting, with the objective of fostering data-based discussion and decisionmaking among policymakers, program implementers, and other interested audiences. This analysis also aims at illuminating the challenges that remain ahead for those groups developing programs addressing genital cutting. Although international conference statements suggest widespread consensus against genital cutting, the survey findings often portray a more complicated reality of high prevalence levels and widespread support for these practices among women.

In this report, survey findings on genital cutting will be presented from the Central African Republic (CAR), Côte d'Ivoire, Egypt, Eritrea, Mali, northern Sudan, and Yemen.[1] These surveys were conducted between 1989 and 1996 by national organizations under the auspices of the Demographic and Health Surveys (DHS) Program.[2] The DHS Program is funded by the U.S. Agency for International Development.

Terminology

In this report, the term *female genital cutting* (FGC) (Eliah, 1996) is used to describe medically unnecessary procedures that involve the:

- Partial or complete removal of the clitoris (clitoridectomy);
- Removal of the clitoris and partial or complete removal of the labia minora (excision); and
- Partial or complete removal of any external genitalia, with stitching or narrowing of the vaginal opening (infibulation).

This classification is based on a typology of genital cutting procedures developed by the World Health Organization (World Health Organization, 1996a). The WHO typology also includes a fourth category, which covers an array of harmful procedures such as piercing, stretching or tightening of the female genitalia.

In surveying women about genital cutting, DHS uses locally recognized terms in a number of languages. Local terminology can vary considerably, depending upon region and ethnicity. Procedures involving genital cutting are known by many names, including (in English) sunna, intermediate, and pharaonic circumcision; clitoridectomy; excision; and infibulation.

Many organizations and governments, taking their lead from United Nations policy documents and conference statements, refer to all of these procedures as *female genital mutilation* (FGM).

[1] The data presented are from special tabulations of DHS data sets as well as the following DHS survey reports: (CAR) Ndamobissi et al., 1995; (Côte d'Ivoire) Sombo et al., 1995; (Egypt) El-Zanaty et al., 1996; (Eritrea) National Statistics Office and Macro International, 1997; (Mali) Coulibaly et al., 1996; (Northern Sudan) DOS and IRD, 1991; (Yemen) Central Statistical Organization et al., 1994.

[2] The 1991/1992 Yemen Demographic and Maternal and Child Health Survey was part of both the Demographic and Health Surveys (DHS) Program and the Pan Arab Project for Child Development (PAPCHILD).

FGM, while commonly used in the international arena, is not always accepted in the communities where these practices are widespread. Although the term "female circumcision" is still frequently used, few international or regional organizations currently use it. A number of researchers argue that because the term "circumcision" is used to describe a specific male procedure, which is less invasive, the term "female circumcision" obscures the more serious physical and psychological effects of genital cutting on women. Analogous operations for men would involve the partial or complete removal of the penis rather than just removal of the foreskin.

Why investigate genital cutting?

For years, the adverse effects of cutting on women have been documented by doctors, colonial administrators, social scientists, and activists. As early as the 1940s, a national movement against infibulation was underway in Sudan, with colonial law prohibiting its practice and professional Sudanese women raising public awareness of its risks (Gruenbaum, 1982). The attention granted female genital cutting among governments and donors, however, is a relatively recent phenomenon. Over the past 30 years, activists and medical professionals have successfully defined genital cutting as a reproductive health and human rights issue meriting international consideration. In Africa, for example, leaders that have recently spoken out against genital cutting include the presidents of Benin, Burkina Faso, Egypt, Kenya, and Senegal (Kiragu, 1995). American opposition to cutting has recently been formalized by federal legislation prohibiting its practice on minors and by USAID's expanded mandate to support eradication efforts internationally (RAINBO, 1997).

United Nations agencies, through conferences and policy statements, have raised public awareness and encouraged the eradication of genital cutting. These excerpts from the *Report of the International Conference on Population and Development* (UNFPA, 1994) urge governments to take action against genital cutting:

> 4.22. Governments are urged to prohibit female genital mutilation wherever it exists and to give vigorous support to efforts among non-governmental and community organizations and religious institutions to eliminate such practices; and
>
> 7.35. ...In a number of countries, harmful practices meant to control women's sexuality have led to great suffering. Among them is the practice of female genital mutilation, which is a violation of basic rights and a major lifelong risk to women's health.

The joint statement on female genital cutting prepared by the World Health Organization, UNICEF, and UNFPA (World Health Organization, 1996a) rejects these procedures based on health, human rights, gender equity, and economic grounds. This excerpt is from the preface:

> "Female genital mutilation (FGM)—sometimes locally referred to as 'female circumcision'—is a deeply rooted traditional practice that adversely affects the health of girls and women. It also reinforces the inequity suffered by girls and women in the communities where it is practised and must be addressed if their health, social, and economic development needs are to be met. The arguments against this practice are based upon universally recognized human rights standards, including the right to the highest attainable level of physical and mental health...It must be clearly and unambiguously stated that the practice is universally unacceptable because it is an infringement on the physical and psycho-sexual integrity of women and girls and it is a form of violence against them..."

When and why did genital cutting begin?

The earliest known writings on the subject suggest that female genital cutting has been practiced in Egypt for at least 2,000 years (Cloudsley, 1983). One Greek physician, writing in the sixth century, praised the Egyptian practice of genital "excision," explaining that unless the clitoris is cut, it will continue to grow and lead to inappropriate thoughts or behavior in young women (Abdalla, 1982). Most theories about the origins of genital cutting suggest that these procedures provided a means for families to safeguard the "value" of women, guaranteeing virginity before marriage and the creation of legitimate heirs during marriage. Some evidence also indicates that slave-traders acquired infibulated women or infibulated female slaves because these women—whose labor would be uninterrupted by childbearing—could be sold for higher prices (Cloudsley, 1983). Overall, no definitive evidence exists documenting exactly when or why genital cutting began.

Genital cutting occurs primarily in Africa. These practices have also been documented among African immigrant communities in a number of countries. As different researchers point out, however, genital cutting is not a practice historically restricted to Africa. As late as the 20th century, various Western physicians believed that a number of mental and physical "disorders" could be treated through the removal of women's external genitalia (Cloudsley, 1983; Van der Kwaak, 1992). In the 1800s, for instance, some doctors theorized that "hysteria" and "lesbianism" could be managed by modifying or removing female genitalia (Toubia, 1995).

Although often perceived to be a Muslim practice, genital cutting predates Islam in Africa. Additionally, genital cutting is not mandated as a religious requirement in the Qur'an. These practices have been documented among women of various faiths, including Christians, Jews, and followers of traditional religions (Toubia, 1995).

DHS Results

Across all seven surveys presented in this report, a total of 55,067 women and 1,114 men were interviewed on female genital cutting. In each country survey, interviewers queried respondents about genital cutting in the context of questions on health and well-being. A standard DHS survey features a series of "core" questions on living conditions, education, fertility, mortality, family planning, and maternal and child health. Each core questionnaire is modified to meet local needs, but retains enough standard elements to allow for comparative research between countries. DHS also has a number of modules on special subjects such as AIDS, maternal mortality, and female genital cutting. The module may be partly or wholly incorporated into a core questionnaire. The decision about whether to include questions on female genital cutting in a DHS survey is made jointly by the implementing institution of the host country (usually a government agency), USAID, and Macro International Inc.

The type of information collected on genital cutting varies. The most extensive data were collected in Egypt. Yemen has the least data on the subject, with only two questions in the Demographic and Maternal and Child Health Survey. A table summarizing the types of information collected from each country is included in Appendix B.