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Female Genital Cutting in Sudan

Female Genital Cutting (FGC), also known as female circumcision, or female genital mutilation, has been going on for a long time. This practice is defined as “all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons” (UNICEF 2017). There are many different types of FGC, the least extreme being type one, which involves partial or total removal of just the clitoris and/or prepuce (Gruenbaum 2006). The most extreme being Infibulation (type three) which is described as all external organs being cut off, covering the urethral opening, leaving a small hole for urine and menstrual blood, and sewing together the labia majora, which will have to be cut again before first sexual intercourse. (Bedri 2013). Sometimes, reinfibluation (making the hole smaller again) is practiced after a woman has given birth, divorced, or widowed in order to create the tight vaginal opening as a virgin (Almroth & Elmusharaf 2007). This practice happens in many countries among many cultures, but it is most prevalent in North and Eastern Africa, as well as the Middle East (UNICEF 2015).

One of the countries that has the highest prevalence of this issue is Sudan. According to many anthropologists, “Sudan is one of the countries with a seemingly constant prevalence of FGC, in spite of national legislation and local campaigns against the practice, FGC, mainly infibulation, is a highly institutionalized custom that is

integrated in Sudanese society" (Berggren, V., Musa Ahmed, Hernlund, Johansson, Habbani, & Edberg 2006). *The Lancet* estimates that the prevalence of Female genital cutting in Sudan is 89% (The Lancet 2010). The average age for a Sudanese girl to be cut is between four and eight, and infibulation, total removal of the clitoris, labia minora, and the vulva being sewn together is the most common type practiced (Hahn 2009). That number is extremely high, due to the fact that many parents want their daughters to be circumcised for various reasons. Many cultures perform female circumcision because they believe the practice will prevent promiscuity (thus insuring virginity and making the girl more eligible for marriage), increase fertility, make sex more pleasurable for her husband, and even the thought that it will make the girl "cleaner" and "more feminine" (Magied 2013). Some may even associate it with religious beliefs, although no major religious texts require it (UNICEF 2016). The most prevalent religion that practices FGC is Islam, although many Islamic leaders are starting to speak against it, as it is not mentioned in the Qur'an as a "duty of the faithful" (Hahn 2009). However, it is considered a cultural right of passage for many women and girls (GOV.UK 2011). Ellen Gruenbaun, who has studied FGC for 30 years, mostly in Sudan, says, "the exercise of cultural relativism helps us to see that it isn't parents' intent to mutilate their daughters but rather to give them proper, socially expected treatment" (Hahn 2009). Because it is such a deeply rooted tradition, many new mothers say they do it on the basis of immense pressure from their mothers and/or midwives (Berggren, V., Musa Ahmed, Hernlund, Johansson, Habbani, & Edberg 2006). Even though this practice is part of certain cultures, there are many risks involved, both emotionally and physically (15). Some of these medical complications include severe bleeding, fistulas, increased risk of

HIV/AIDS and Hepatitis B (from unclean tools used), vaginal infections, cysts, pain during sex, loss of sexual pleasure, severe scarring, urinary trouble, infertility, pelvic inflammatory disease, and sometimes even death (Bedri 2013). It also contributes to problems during childbirth and increased child mortality (The Lancet 2010). Nevertheless, it is a tough issue for medical professionals and anthropologists to address due to cultural differences. As Gruenbaum says, "knowing the harm that can result from genital cutting and recognizing the growing international consensus that the practices need to end, anthropologists have embraced a process of strengthening human rights and improving human health while offering the cultural analyses that could make the process more culturally sensitive, effective, and less disruptive to culturally valued institutions" (Hahn 2009) Anthropologists must take extra effort to be responsible and respectful when dealing with such issues.

There has been debate going on regarding the cultural context and the medical issues/ human rights issues associated with this practice. The fight to end FGC started quite some time ago, and it perhaps has taken so long to fight due to the fact that it involves completely changing social expectations (The Lancet 2010). Western women started becoming concerned with this long ago, "Female circumcision came to common attention in the West not in the wake of contemporary feminism's second surge, as some believe, but of its first (Hernlund & Shell-Duncan 2007). Many women in the west believe the practice to be "barbaric and unnecessary", just as they have done with African and other non-Western traditions for years. The tricky thing here is that while we must be respectful of traditions we cannot understand, this practice is a health and women's rights issue, and many people all over the world agree it must end. Is this ending culture or

helping end a harmful practice? The debate is very active, with people on both sides from the medical and anthropological communities, among other social justice and human rights advocates.

The World Health Organization (WHO) joined with United Nations Children Fund (UNICEF) and United Nations Population Fund (UNFPA) to make a statement against FGC in 1997 (WHO 2017). Since then these organizations have taken extensive efforts to end this practice. In May 2016, these three organizations collaborated once again to launch evidence based guidelines on the management of complications from FGC, and to insure the effectiveness of these guidelines, WHO is developing strategies for health workers to improve the knowledge about FGC and increase the skills to prevent FGC from taking place. There has been a slow decrease in the prevalence of FGC since the initial statement in 1997. (WHO 2017) This suggests that the efforts of WHO, UNICEF, and UNFPA have been somewhat successful. Some cultures find the West's extensive efforts to stop this practice distasteful and not culturally sensitive, thus creating more of an issue. In medical anthropologist Ellen Gruenbaum's book *The Female Circumcision Controversy,* she states that "Western outrage and Western efforts to stop genital mutilation often provoke a strong backlash from people in the countries where the practice is common, and the criticisms of outsiders are frequently simplistic and fail to appreciate the diversity of cultural contexts, the complex meanings and the conflicting responses to change" (Henriques 2010) It's difficult to develop a culturally sensitive anthropological approach to stopping FGC, and as successful as WHO's (and partners') efforts have been, they have failed to create an ideal strategy. In 2008, The World Health Assembly passed resolution WHA61.16, "on the elimination of FGM, emphasizing the

need for concerted action in all sectors - health, education, finance, justice and women's affairs (WHO 2017)." FGC is a very complex issue, which needs to be viewed and dealt with as such, and always with a cultural lens.

The term "medicalization" of FGC refers to when medical professionals perform the practice. WHO has taken a firm stand against medicalization of FGC since 1979 at the first International conference on FGC held in Khartoum, Sudan (WHO and partners 2017). This is a double-edged sword because yes, medicalization legitimized this practice contributing to the institutionalization of FGC and further giving people a reason to do it, however, medicalization is also a form of harm reduction. As Bettina Shell-Duncan, from the UW Department of Anthropology says, "As a harm reduction strategy, medicalization has the potential to improve health of women undergoing 'circumcision' via two avenues, 1) reducing risk of attendant medical complications by improving hygienic conditions, preventative medical measures, and/or skill level of the cutter, and 2) reducing the amount of cutting and presumable risk of complications" (Shell-Duncan 2001). I admire this statement because I am a firm believer in harm reduction. As of now, the WHO along with many other organizations hold a zero-tolerance policy on FGC, and do not seem willing to take intermediate steps to implement harm reduction. (Shell-Duncan 2001) This refusal to acknowledge the benefits of medicalization is not culturally sensitive or effective, just as absence-only sex education doesn't always prevent teen pregnancies from occurring. If FGC becomes illegal globally, it would still occur. However, it would occur in more unhygienic, risky situations (Bedri 2013). In order to really reduce the risks and mortality involved here, we must adapt to medicalization, community education, outreach, and culturally sensitive strategies. That way, if organizations acknowledge that

this practice is a cultural right of passage and develop relationships with the people practicing it, they can more effectively stop it in the long run. Shell-Duncan compares it to someone who is addicted to smoking cigarettes; the ultimate goal is to get them off of the substance completely, but they may need that middle step of nicotine patches or gum (Shell-Duncan 2001). Perhaps medicalization of FGC is like this, a step in the right direction, and a form of harm reduction.

Female genital cutting constitutes serious health and human rights violation; this is no longer a debate in the western medical health community. Perhaps my stance on this issue stems from looking through a western perspective. While many organizations admit that this is an issue and have even passed policies to end it, such as the WHA61.16, many do not put harm reduction “stepping stone” practices in place. Most people in Sudan who are open to the idea of change do not support the idea of complete abandonment of the practice, but seem to be open to modification and less harmful forms, such as type one or even less (Hahn 2009). Ultimately ending this practice is not simply a public health issue, but also a human rights issue to protect women and girls and give them ownership over their own bodies (Hahn 2009). If we are going to be successful in this goal in a culturally sensitive view while practicing cultural relativism, we must settle for harm reduction and modification, which may untimely lead to abandonment of the practice. As Ellen Guruenbaun says, “It will take a multipronged approach- one that includes health education, religious leadership, cultural leaders, media, and the arts - to accelerate change” (Hahn 2009). Because FGC involves so many aspects of identity, culture, and human rights, it will continue to take such a team to develop the very best way to deal with it, in a way that has the best interest of the women and girls at stake.

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