Using HIV/AIDS Education as a Model for Female Genital Cutting Education: Respecting Culture While Educating Communities

Farley Moore*

ABSTRACT

While the prevalence of FGC is still quite high, there have been human rights movements and ideological shifts away from the practice. Many countries have recently passed laws that prohibit FGC, even if it takes place in other jurisdictions. Since legislation was passed that makes FGC illegal in most countries where it is still routinely practiced, these women have also been pushed to the fringes of society. FGC may be practiced under worse conditions, where infection is more likely. Where it is illegal, after the procedure, the woman is less likely to seek medical help because of fear. The people performing FGC will also be more likely to keep the girl or woman from seeking medical attention in the case of an emergency to avoid consequences for themselves.

Keywords: FGC, FGM, cultural respect, oppression, feminism, autonomy, global health, human rights

INTRODUCTION

Female genital cutting (FGC), referred to by many global health organizations as female genital mutilation (FGM), has been practiced for centuries, mostly in Africa, Malaysia, and Indonesia.[1] FGC is a term that encompasses multiple acts, including removal of the clitoris, removal of the labia minora, narrowing of the vaginal opening, and pricking, piercing, or cauterization. Justifications for FGC include maintaining sexual propriety, safety for women and children, and solidifying cultural identity.[2] While the prevalence of FGC is still quite high, there have been human rights movements and ideological shifts away from the practice. Many countries have recently passed laws that prohibit FGC, even if it takes place in other jurisdictions. In 31 countries for which prevalence data is available, 30 years ago, one in two women between the ages of 15 and 19 had undergone some form of FGC; today that number is about one in three, or 34 percent.[3] However, a review of the current laws related to FGC show that legislating against FGC pushes it into secrecy. As FGC is

* Farley Moore, MS Candidate Columbia University

so closely tied to cultural identity, education about FGC, and the context of cultural female oppression may be more useful than laws in limiting the practice of nonconsensual FGC.

I. Background: Weaknesses of Legislation as an approach to end nonconsensual FGC

Most women that undergo FGC live in rural areas and lack a traditional education.[4] Since legislation was passed that makes FGC illegal in most countries where it is still routinely practiced, these women have also been pushed to the fringes of society. FGC may be practiced under worse conditions, where infection is more likely.[5] Where it is illegal, after the procedure, the woman is less likely to seek medical help because of fear. The people performing FGC will also be more likely to keep the girl or woman from seeking medical attention in the case of an emergency to avoid consequences for themselves. These conditions come together to create serious social justice concerns. One study in Iran found that, "…less educated mothers and mothers living in rural areas had more positive attitudes towards FGM and feel more social pressure to allow FGM."[6] There are many social justice issues that need to be addressed in these communities in order to end forced FGC while tolerating women's autonomous decisions to undergo consensual FGC. Legislation is not the best way to end the practice.

As of 2019, 60 countries had adopted laws against FGC, including 24 African countries.[7] The penalties for violating these laws range from imprisonment to fines, but some countries do not enforce punishments. For example, in Kenya, only 74 individuals were prosecuted in the two years since the law against FGC was passed there. In contrast, Burkina Faso successfully convicted 241 people in one year.[8] Leaving the fate of FGC to legislation will not be enough. More needs to be done to protect underage girls from suffering forced FGC in the immediate future. I argue that those who view FGC through a Western lens should not presume to force our views on other people. The effects of legislation, whom it will impact, and what consequences may arise need to be examined in cultural context. Education is not as forceful as legislation is. While education without legislation making FGC illegal leaves room for women to make the choice to undergo FGC, the culture should be educated to meet the human rights approach. As no one from an outside culture is in the position to mandate people's consensual cultural actions, education is a better tool to discourage the practice. Legislation demands compliance and forces a complete abandonment of a way of life. If compliance is forced through legislation, a cultural gap is left in which women could suffer consequences ranging from being unmarriageable to becoming a social outcast.[9] I do agree with the stance that FGC should be approached as a practice that is harmful and dangerous to women, but attempting to force its end without education would only cause another kind of harm for these women. FGC should come to a more natural end through education as communities shift their cultural beliefs to align with what they learn about the painful practice.

Cultural pressures and lack of education may prohibit even a consenting adult woman from making an autonomous choice to undergo FGC. Education should inform both the women and the community about the coercive forces that could convince women to make choices against their best interest. Once education has been delivered and risks explained, I assert there is nothing else an outsider can ethically do to prevent a woman from making the decision to undergo FGC. A similar choice that we are more familiar with is making a living organ donation to a family member. Doctors can educate the donor on the risks and explain the pressure they may feel from the family to donate, but can never know if the decision was solely the choice of the donor or if there was familial or cultural pressure. Using legislation to prevent an adult woman from undergoing FGC voluntarily is another way of limiting her autonomy.

Another issue with legislation is the lack of input from the community. People that participate in FGC are not likely to have a voice in government, and therefore do not have any say in guiding the legislation.[10] When

these groups feel that they have been left out of the decision-making process they are less likely to follow the regulations.

II. Education as a Means of Reducing FGC and Eliminating Nonconsensual FGC

A parallel of the legislation versus education debate surrounding FGC focuses on the spread of HIV in countries that have criminalized homosexual behavior. There is strong evidence from multiple quantitative studies[11] that shows an increase in HIV transmission in countries that criminalize homosexual behavior. A study in the Caribbean commissioned by UNAIDS discovered that, "the HIV prevalence among men who have sex with men (MSM) rose from 1 in 15 in countries where homosexuality is not criminalised to 1 in 4 in countries where it is criminalised".[12] As MSM communities were criminalized, it became more difficult to seek health care, and concerns of stigma heightened. As expected, creating legislation against MSM only pushed it further underground, leading to greater transmission of HIV. Legislating FGC poses a similar risk. While in some countries, such as Cote d'Ivoire, Nigeria, Ethiopia, and Kenya legislation against FGC has resulted in reduction of the practice, in others, including Chad and Sierra Leone, the practice has actually increased.[13] Legislation of MSM is inherently different than FGC because MSM is entered into for mutual satisfaction and the participants are not coerced into the act by cultural oppression like those participating in FGC. Pain and risk are necessary results of FGC. FGC is less likely to be voluntary than MSM. However, legislating both behaviors leads people engaging in the acts to the fringe of society where they may fail to seek medical attention. In both cases, education would mean that people willingly participating would be counseled to take greater precautions, leading to more safety overall.

Criminalization can also serve to prevent concurrent methods from being as useful. "Experts have repeatedly concluded that, rather than slowing the spread of HIV, the criminalisation of homosexuality seriously impedes the effectiveness of measures designed to reverse the HIV pandemic."[14] If homosexual behavior is illegal, then doing public health outreach would not work because no one would want to admit that they engage in illegal behavior. Likewise, once you have made FGC illegal, doing community outreach and education would be less effective. Going into a community that participates in FGC, educating the people about risks, and then still encouraging women to make their own choices would effectively be condoning illegal behavior.

School based HIV/AIDS education has become a proven intervention strategy in limiting transmission. Without school-based education about HIV/AIDS, "… there would have been no turning back the epidemic among injection drug users in European capital cities; and the 20-30% declines in new infections recently reported in no less than 22 countries in sub-Saharan Africa…"[15] HIV education in schools includes information on condom use, drug injection, how to prevent HIV transmission, seeking testing, getting counseling after infection, and how to manage infection.[16] Education provides many more avenues for people at risk for HIV. The legislation of homosexual behavior does not even address risks, such as transmission by intravenous drug use, but serves to prevent people from seeking resources out of fear of being punished under the law. There are numerous gaps in legislation that can be covered by education.

III. Community-Based Education

One of the most important issues with using legislation instead of education is the lack of community input. Instead of having Western organizations come into communities that practice FGC, community members should have the tools to implement the education themselves. The tools may include doing small training programs for individuals interested in becoming educators or providing materials about best practices. It is important that the Western organizations do not write the material themselves. Community members are

the only ones who know the nuances of their culture, and how best to approach the topic of changing a time-honored tradition. The materials should cover the risks of FGC, and address women's autonomy. Providing framework and assistance when asked should be the extent of Western interference in these cultures. This model resembles the facilitator model that has been used in Egypt.[17]

Much of the research done using the facilitator model is aimed at the complete eradication of FGC, however this work does not include eradication research because, while that is a secondary goal of education, the immediate goal is promoting safe practices and eliminating child and nonconsensual FGC.

In addition to using facilitators from the community, it would also be beneficial to include general community education unrelated to FGC. There is a complex set of social justice issues that underlies FGC. They must be addressed at the community level. "…I[i]lliteracy, gender inequality, and low socio-economic development…" [18] contribute to a lack of autonomy and informed consent. Individuals inside these communities want to be advocates and learn how to influence lasting change, as seen in the Egypt study on facilitators.

CONCLUSION

While I believe that education is the best approach to stopping FGC, there are still ethical issues that need to be addressed. For example, education takes time, and in that time many more girls and women may be forced to undergo some form of FGC. It is my hope that with education, the legislation making FGC illegal will become unnecessary as women learn about the dangers of the procedure and as cultural norms shift to empower women. The legal issue with FGC should be limited to its use on minors and non-consenting adults. If an adult woman who is educated about both the procedure and the context of oppression still wants to undergo FGC, then I believe she should be able to, and that it should be beyond the scope of her country's government to control her actions. Where there is true autonomy, Westerners should not interfere by imposing restrictive laws on the voluntary choices of people who operate with different cultural norms.

[1] Lightfoot-Klein, H. (1991). Prisoners of Ritual: Some Contemporary Developments in the History of Female Genital Mutilation. Retrieved from http://www.fgmnetwork.org/articles/prisonersofritual.htm

[2] Llamas, J. (2017, April). Female Circumcision: The History, the Current Prevalence and the Approach to a Patient. Retrieved from https://med.virginia.edu/family-medicine/wp-content/uploads/sites/285/2017/01/Llamas-Paper.pdf

[3] UNICEF. (2020, February). Female genital mutilation (FGM). Retrieved from https://data.unicef.org/topic/child-protection/female-genital-mu

[4] Besera, Ghenet, and Amira Roess. "The Relationship between Female Genital Cutting and Women's Autonomy in Eritrea." *International Journal of Gynecology & Obstetrics* 126, no. 3 (2014): 235–39. https://doi.org/10.1016/j.ijgo.2014.03.038.

[5] Monahan, Kathleen. "Cultural Beliefs, Human Rights Violations, and Female Genital Cutting." *Journal of Immigrant & Refugee Studies* 5, no. 3 (2007): 21–35. https://doi.org/10.1300/j500v05n03_02.

[6] Pashaei, Tahereh, Koen Ponnet, Maryam Moeeni, Maryam Khazaee-pool, and Fereshteh Majlessi. "Daughters at Risk of Female Genital Mutilation: Examining the Determinants of Mothers' Intentions to Allow Their Daughters to Undergo Female Genital Mutilation," March 31, 2016. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4816284/.

[7] Nabaneh, Satang, and Adamson S. Muula. "Female Genital Mutilation/Cutting in Africa: A Complex Legal and Ethical Landscape." *International Journal of Gynecology & Obstetrics* 145, no. 2 (2019): 253–57. https://doi.org/10.1002/ijgo.12792.

[8] Ibid., 254.

[9] Kathleen Monahan DSW, LCSW, BCD (2007) Cultural Beliefs, Human Rights Violations, and Female Genital Cutting, Journal of Immigrant & Refugee Studies, 5:3, 21-35. https://doi.org/10.1300/J500v05n03_02

[10] Ibid., 256.

[11] Laverack, P. (2015). *Criminalising Homosexuality and Public Health: Adverse Impacts on the Prevention and Treatment of Hiv and Aids*. Human Dignity Trust. Retrieved from https://www.humandignitytrust.org/wp-content/uploads/resources/5.-Criminalisation-Public-Health-and-HIV.pdf

[12] Ibid., 6.

[13] Nabaneh, Satang, and Adamson S. Muula. "Female Genital Mutilation/Cutting in Africa: A Complex Legal and Ethical Landscape."

[14] Ibid., 5.

[15] Aggleton, Peter, Ekua Yankah, and Mary Crewe. "Education and HIV/AIDS—30 Years On." *AIDS Education and Prevention* 23, no. 6 (2011): 495–507. https://doi.org/10.1521/aeap.2011.23.6.495.

[16] Centers for Disease Control. (1998, January 29). Guidelines for Effective School Health Education To Prevent the Spread of AIDS. Retrieved from https://www.cdc.gov/mmwr/preview/mmwrhtml/00001751.htm

[17] Abdel-Tawab, Nahla, and Sahar Hegazi. Rep. *Critical Analysis of Interventions against FGC in Egypt*. Washington D.C.: Population Council, 2000. https://knowledgecommons.popcouncil.org/cgi/viewcontent.cgi?article=1028&context=departments_sbsr-rh.

[18] Abdel-Tawab, Nahla, and Sahar Hegazi. Rep. *Critical Analysis of Interventions against FGC in Egypt*. Washington D.C.: Population Council, 2000.