Female Genital Cutting

Knowledge and Intervention in Egypt

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Introduction

In its most extreme form, female genital cutting (FGC) removes a woman's clitoris and severely narrows the vaginal opening to the size of a dime. However, in its most minor form, a woman's clitoris is scratched or minimally excised resulting in little permanent damage. Between 100 and 140 million women have undergone some form of FGC worldwide and this number is expected to increase by a projected number of two million every year.[1] Doctors, lobbyists, journalists, NGOs and other interest groups in their discussion of FGC demand complete eradication of the practice due to its observable short-term and long-term health implications. Often, demands for complete eradication are coupled with the criticism of FGC as a practice which oppresses women. Internationally, any compromise, including harm-reduction policies, is condemned by the media and by western audiences. The most prominent of such policies is institutionalization in hospitals and medicalization, the education of doctors about FGC.

While it sounds unprecedented to the western audience, FGC is an important tradition of women in Egypt. The purpose of this paper is to explore the gaps within current published knowledge regarding FGC. I will argue that those who advocate absolute eradication of FGC often do so without the strong support of peer-reviewed literature or research, but instead from a platform of moral outrage.

The prevalence of FGC can be explained by its important cultural purpose. FGC is often seen as a rite of passage—done to gain honor, continue tradition and avoid social exclusion.[2] In this paper I will refer to the practice as female genital cutting (FGC) instead of using the more prevalent terms female genital mutilation (FGM) or female circumcision. FGM, which suggests violent disfiguration, is a term often used by groups fighting for its eradication.[3] The discourse surrounding FGC in western countries suggests that it is the ultimate tool of oppression, forced upon women by men. Advocacy groups tend to ignore the fact that women are often approving of FGC; these are attitudes that I will explore later in this paper.[4] While one could make the argument that this practice undeniably qualifies as mutilation, this framing is problematic because it alienates women by stripping females of agency and ignoring female endorsement. Additionally, the term female circumcision has also been criticized as a misnomer since it likens female and male circumcision, although they are physically different procedures; FGC alters or removes an important sex organ while male circumcision removes foreskin.[5] Anthropologist Christine Walley summarizes the issue in this way: "existing usages are deeply embedded in the 'either/or' perspective characteristic of discussions of female genital operations, with *circumcision* signaling relativistic tolerance and *mutilation* implying moral outrage."[6] Whenever possible, I will refer to this practice as female genital cutting (FGC) because of its neutral connotation.

I will begin by describing the World Health Organization's definition of FGC. This definition will be followed by a discussion of attitudes concerning FGC among Egyptian women in 1995, before any major legislation or advocacy against FGC was enacted, and then attitudes in 2008, after major legislation was passed. I will then discuss the variations in the practice of FGC, the physical health implications of type I and type II FGC and the disease burden and cost associated with FGC, pointing out the assumptions in existing literature and the lack of research and knowledge in each of these sections. There are serious discrepancies between available data and the dominant claims made in favor of eradication, and these discrepancies could have serious implications for the future of FGC policy. I will then discuss official Egyptian legislation in response to advocacy work and international pressures regarding FGC. There is poor evidence to support the push for the complete eradication of FGC and rather, this position may be developed against a background of moral outrage. I will conclude by discussing concrete areas where more research can be done and will put forth reasons why medicalization should be discussed as a practical possibility. Given the polar discourse surrounding FGC, understanding and responding to the practice requires a multidisciplinary lens, one that takes into attitudes of women and men, health-related consequences and economic burdens. Hopefully, by discussing what is known and not known, we can explore these gaps of knowledge and approach FGC objectively, with the ultimate goal of lessening or eliminating its health and economic burden in the best, most effective way possible.

The World Health Organization (WHO) definition of female genital mutilation/cutting

The WHO's definition and classification of "female genital mutilation" has been used widely in almost every publication about this practice since its publication. In a Joint Declaration published by the WHO, the United Nations Children's Fund (UNICEF) and the United Nations Population Fund (UNFPA) in 1997, female genital mutilation was defined to include all procedures that involved the total or partial removal of female genitalia or any injury to female genital organs without medical reason. This document officially classified the different severities of "mutilation": type I is the partial or total removal of the clitoris; type II is the total removal of the clitoris and the partial or total cutting of the labia minora; type III is the partial or total removal of the external genitalia and the stitching or narrowing of the vaginal opening (also known as infibulation); type IV includes all other unclassified damage done to female genitalia, including but not limited to scraping, pricking, burning or introduction of corrosive substances into the vagina.[7]

Attitudes of Egyptian women in 1995

Culturally, FGC extends beyond the physical, emotional or psychological harm it causes. FGC is seen as not only a procedure, but also as a rite of passage in many communities, marking a girl's coming of age or the beginning of her womanhood.[8,9] Marriage, future economic stability and social acceptance can be contingent on this practice.[10-13] Richard Shweder, a cultural anthropologist at the University of Chicago, argues from his experience in Kenya that this procedure is seen as a test of courage, encouraged by mothers and maintained by the community of women. After the procedure is completed there is a celebration, marking a girl's maturation into a young woman, allowing her to join the ranks of older generations of women.[10]

The Egypt Demographic and Health Survey (EDHS) first

collected information on FGC in 1995. Since this survey uses the term female circumcision, I will refer to FGC as female circumcision when using data from the Egyptian Demographic and Health Surveys. The survey found that 97% of female respondents had been circumcised: by age, prevalence rates are 98.1% among women ages 15-19 and 96.8% among women ages 45-49 in 1995. 81.6% of participating women claimed that they wanted the practice to continue, while only 13% claimed that they wanted it to end, with not much difference between age groups and only a small difference between urban and rural residents (91.2% of rural residents supported the practice, while only 70.3% of urban residents showed support). Of the group of women who wanted the practice to continue, approximately 60% said it was a good tradition, 40% attributed the practice to cleanliness and 30% said it was religious duty.[14]

Attitudes of Egyptian women in 2008

Between 1995 and 2008, there has been rapid change in attitudes among Egyptian women towards FGC. The Egyptian government banned the procedure in 2000, but the 2008 EDHS found that the practice is still prevalent: 91.1% of female respondents overall (out of the 5,540 surveyed) between the ages of 15 and 49 had been circumcised. However, only 54% of women in 2008 argued that this practice should be continued (compared to 82% in 1995), and these attitudes differed significantly based on age-group; only 34% of women ages 15-19 believed this practice should continue, while 69% of women ages 40-44 supported the practice. The percentage of women who believed men supported the practice also dropped significantly from 61% in 2000, the earliest survey to ask this question, to 49%.[4,33] When asked about reasons for supporting the practice, 50% of women in 2008 still thought it was a religious duty, 45% of women thought that husbands preferred this practice, 34% of women thought the practice could prevent adultery and only 6% of women recognized that this practice makes childbirth difficult. The reduction and regulation of a woman's sexual desire through the clitoris was still a prevalent justification for FGC in some rural and slum areas.[2]

> In this intermediary stage, we must remember that alienation and victimization of men and women complicit in FGC, especially on the foundation of inconclusive research, can compromise the sustainability of any intervention.

The numbers reported by the EDHS suggest that significant changes are occurring in the nation. The prevalence of FGC among younger cohorts of women is lower: 80.7% of women ages 15 to 19 have had this procedure, compared to 96.0% of women ages 45 to 49. However, it is unclear to what extent these differences could be attributed to specific interventions, legislation or different methods of survey administration.

Significant variations in the practice of FGC

Though the WHO has defined and classified types of FGC, almost all aspects of the practice differ drastically by region.[8,12] There is high variation in the severity of cutting, the age at which the procedure is performed, the person who performs the procedure, the instrument used for the cutting, whether it is done privately (in the home) or in a hospital and how the wound is cared for afterwards.

To illustrate this point, I will compare the urban areas of Upper Egypt and the rural areas of Upper Egypt. The urban areas can be characterized by higher levels of education, higher standards of living and higher levels of urbanization: 48.3% of men and 40.7% of women have completed or achieved more than a secondary level of education, 96.1% of respondents had a television, 60.0% owned their own satellite dish, and only 4.2% of households had agricultural land. In the rural parts of Upper Egypt, only 26.4 % of men and 14.8% of women have completed or achieved more than secondary level of education, 87.5% of households had a television but only 35.4% owned their own satellite dish, and 25.3% of households had agricultural land.

Comparing these two regions, the prevalence rate of FGC in the rural parts of Upper Egypt is 95.6%, but the prevalence rate in urban areas was 86.2%. While the median age of circumcision is around 10 years for all regions of Egypt, only 36.8% of women in rural Upper Egypt underwent the procedure at that age, compared to 42.3% of women living in urban areas. Unsurprisingly, this survey also recorded that a higher percentage of women living in urban areas received the procedure by medical personnel, while a higher percentage of women in rural areas got the procedure done by *dayas*, or traditional birth attendants. The conditions of the procedure, whether it was in the hospital or by *dayas*, can be telling of other characteristics, like the tools that were used to perform the cutting, the hygienic conditions of the procedure and the aftercare.[4]

Apart from data collected from the EDHS, very few broad qualitative studies addressing the variations of the procedure have been conducted. Sayed *et al.* conducted a survey of 819 households in 1996, representative of 1,732 girls under the age of 20 in a village near but not within Assuit, an Upper Egyptian urban center. This study is not generalizable to Egypt nationally since this study was done only in one village in Upper Egypt. Sayed *et al.* found that 62.3% of girls in that village had undergone type I cutting, and the parents of 36.3% of girls planned for their daughters to undergo type I cutting in the future. In this study, 80% of girls were circumcised between five to eight years of age, 90% of girls reported no complications with the procedure, 97.5% of girls had this procedure done by a *daya* and 80% of girls had the procedure done with razors. From this research, type I cutting is observed to be the prevalent procedure in this area and it is usually done at a young age by dayas in villages in Upper Egypt. Since routines for FGC depend heavily on geographical location and socioeconomic context, more research like that of Sayed *et al.* needs be done for a national picture of FGC. These studies are useful to make rough generalizations about specific areas of similar composition, and they can be instructive to use as a starting point for future research. The context of the cutting procedure is important and, as I will subsequently describe, there is insufficient research to describe how physical consequences differ based on which method is used. This lack of knowledge is an obstacle to the formation of any broad claim or intervention about harm-reduction or eradication of FGC.

Type I and type II FGC and the physical implications

The prevalence of each type of FGC is unclear, but it is generally accepted that type I and type II procedures are the most common in Egypt, while type III and type IV circumcisions, which are common in countries like Sudan, Somalia or Djibouti, are rare in Egypt for reasons that are not clear.[15-17] As previously mentioned, FGC may present both short-term and long-term health problems, depending on the type of cutting. Once a girl is cut, there is an immediate risk of shock, infection, profuse bleeding, hemorrhage, sepsis and tetanus. Infection can halt healing, promote keloid scar formation and lead to acute urinary retention.[13] Some of these health conditions including sepsis and tetanus are caused by the lack of sterile tools or lack of awareness about proper hygienic practices, which are often amplified by unsterile conditions.[13,18]

Possible long-term health conditions include problems with urination, sexual dysfunction, anemia, infertility, problems with menstruation, frequent cysts, obstetric complications and a higher

risk of contracting HIV.[7,19] However, these conditions do not occur in every case of FGC, and studies that seek to document this causal relationship are often unsound.[11] For example, in a study done by El-Defrawi *et al.*, 250 women were randomly selected from Maternal and Childhood centers to participate in a questionnaire about the psychological aspects of their sexual impulse and behavior (psychosexual activity). Of these women, 80% were circumcised and these women had disproportionally more problems with dysmenorrhea, vaginal dryness, lack of sexual desire, being less satisfied with sex and having difficulty reaching orgasm. This study is a good indication that sexual dysfunction can exist among circumcised women. However, this study is not representative of the general circumcised population because the participants were already patients in these centers for psychosexual problems.[20]

There is no evidence that all women who have undergone FGC suffer from all or any of these complications; instead, the noted prevalence of each specific health consequence differs throughout the literature and the ramifications of circumcision vary for each individual.[11] The undocumented nature of these health consequences is a critical gap in knowledge and will be explored later in this paper.

The disease burden and cost associated with FGC

More research is necessary to understand the cost of FGC and why or how women experience different physical consequences.[11,13,21] According to an extensive review of literature done by Obermeyer, there have been no published attempts to establish overall the economic and physical burden associated with FGC.[11]

In one of the few studies documenting the cost of this practice, Bishai *et al* extrapolates obstetric costs from a large study done by the WHO in which 28,393 women were followed to determine adverse outcomes from admission before labor or early in labor.[22,23] Bishai *et al* uses frequency, relative risk and cost of health consequences for each type of FGC to create a statistical model to approximate overall costs. Using this model, the researchers found that a total medical cost of $3.7 million in purchasing power parity (an international standard that is used by economists to compare across different countries) was incurred for the 53 million women in Burkina Faso, Ghana, Kenya, Nigeria, Senegal and Sudan. Egypt was not one of the six countries analyzed using this statistical model, but these results provide a rough approximation of the burden Egypt may face. The study estimates that in the next year, approximately 2.8 million 15-year-old girls undergoing the procedure worldwide would lose approximately 130,000 years of life, collectively. This study is specifically concerned with obstetric costs and focuses heavily on type III cutting, but it allows us to extrapolate the significant monetary burden of FGC. By using the statistical model to estimate the cost of type I and type II cutting given multiple different constraints, Bishai *et al.* reveals that type I and type II cutting procedures lead to higher costs, more years of life lost, or both, 77% and 85% of the time, respectively.[22] Unfortunately, equivalent studies have not been published for Egypt or for type I and type II cutting specifically.

Since this study does not measure psychological damage, other medical complications immediately after the initial procedure or hospitalizations due to recurring infections or pain, it underestimates the actual societal cost of FGC. Different women experience different degrees of pain or handicap, but since variations of FGC have not been well researched, the disease burden and economic cost cannot be easily characterized or measured.

Characterizing the insufficient data informing the discourse about FGC

In an extensive review of literature on female genital surgeries that support "facts" about FGC, Carla Obermeyer discovered that many surveys were not generalizable to all women who had undergone the procedure; often these studies were biased or contextual. Of the 435 articles that appeared when "female circumcision" and "female genital mutilation" were searched as of April 1996, Obermeyer concluded that only 17 articles and eight surveys sought to estimate prevalence of FGC and only eight articles systematically assessed the complications of FGC. The surveys contained various flaws: they lacked information about the method of data collection, had high percentages of non-response to questionnaires or had biased sample selection. The difficulty of proving causation exists even in countries with well-established infrastructure and with issues that are not controversial. Egypt does not have the necessary infrastructure in rural areas, and this type of research is ethnically and methodologically controversial because FGC is a sensitive issue. To avoid these obstacles, data measuring health outcomes are usually collected by asking women to report the complications they have experienced. However, this can be inaccurate due to the possibility of selection bias, and women are often unable to accurately determine the cause of pain. Obermeyer concludes that the base of knowledge that is usually used to draw conclusions about FGC is flawed and limited. As a result, barriers to collecting comprehensive research have driven a disproportional allocation of resources towards "intervention studies" without "scientific inquiry."[11]

In a recent systematic review of published sources between 1997 and 2005, Obermeyer explores the claim that FGC is associated with certain health consequences. Through this review, she found that there are statistically higher risks for anemia (prevalence of 81%), swelling in the vaginal area (prevalence range between 2% and 50%), chronic pelvic infections (prevalence of 22%), caesarean section (prevalence of 51%), perineal tears (62%), prolonged labor of over 24 hours (40%) and pain when urinating (58-64%). Though these percentages are high, ranges are wide and there is insufficient evidence to prove definite infertility or increased mortality of the mother or infant. There is also inconclusive evidence regarding urinary symptoms and mixed evidence on obstetric and gynecological complications. Additionally, there is insufficient data to prove a causal relationship between FGC and any of these health consequences.[24] The lack of reliable data in this area of research is a gap in knowledge requiring urgent attention.

Egyptian legislation and advocacy with regards to FGC

Before the 1990s, conservative and Islamic institutions used religious and moral conduct to argue for the traditional, religious and cultural value of FGC.[25,26] This was important because the Egyptian constitution maintained that Shari'a (Islamic) law should be the main source of legislation in the nation (Lombardi 2006). However, FGC actually predates Islam, indicated by evidence of type III circumcision, also known as Pharaonic circumcision, among mummies of ancient Egypt.[27] The association of FGC to religion is unclear.

The debate about the virtue of FGC started in the 1950s, but the 1994 International Conference on Population and Development (ICPD) is considered to be the turning point.[25,26,28] During this conference, an Egyptian task force, made up of Egyptian NGOs and activists took a solid stance against *all* practices of FGC. In 1997, the Court of Cassation (Egypt's highest appeal court) upheld a decree that banned FGC by all people, including all medical practitioners, in response to international pressures to ban FGC.[29] Whether this decree was issued for reasons of health or physical wellbeing is unclear; it is perceived that this decision was made to appease advocates and lobbyists who upheld any genital mutilation as a violation of human rights. This emphasis opposed medicalization: anything less than eradication was unjustified.[25] In 2007 and 2008, the practice was criminalized and loopholes to the previous decree were closed. Grand Mufti Ali Gomma, Egypt's current highest ranking official of religious law, issued a *fatwa*, absolutely condemning the practice on a religious level.[30-32] However, laws against this practice do not seem to be seriously enforced; these procedures, especially in rural areas, are difficult to monitor. Local beliefs and traditions supporting FGC are still prevalent as of 2008, making enforcement even more difficult.[33]

The complete eradication of "female genital mutilation"

The WHO recently published another interagency statement in 2008 with UNAIDS, UNFPA, UNICEF and other international organizations condemning "female genital mutilation" as a manifestation of "deep[ly]-rooted inequality between the sexes…an extreme form of discrimination against women… a violation of the rights of the child" and other violations of human rights.[23] This statement is written in the same tone as the initial joint declaration published in

1997, which frames "female genital mutilation" as a problem that needs to be completely eliminated through enforcing legislation, working with youth organizations and educating women's groups about the dangers of the practice.[7] In both these statements, the medicalization of "female genital mutilation" was prohibited on the basis that there are still serious risks associated with even a medical procedure. Medicalization was seen as a threat because it would legitimate and institutionalize this form of "mutilation."[7,23]

Since FGC is a practice that inflicts extraneous harm and presents a burden to health care systems, some scholars argue the ultimate goal should be eradication.[34] Whether or not eradication is the goal, there has not been adequate research to conclusively identify the most effective method of responding to FGC. There is insufficient data quantifying the harm medicalization might cause, which means there is insufficient data to argue that medicalization is not a viable interim solution.[11] Acting from a position of moral outrage and arguing for complete eradication without considering realistic interim solutions will compromise any end goal, whether it is eradication or harm-reduction.[13,34,35]

The medicalization of FGC as a viable alternative

The addition of the harm-reduction approach to the services that doctors are educated about and that hospitals provide, is often framed in opposition to complete eradication, but this is not necessarily true.[34] Using Obermeyer's work, Bettina Shell-Duncan argues that medicalization could reduce physical risk by improving hygienic conditions, reducing the amount of cutting and by serving as an interim solution while other interventions are conducted to eradicate the practice. This could serve many purposes: the procedure could be done in sanitary conditions, professionals could monitor the procedure and researchers would have the time and means to study FGC in a medical setting. Furthermore, given the changing attitudes among Egyptian women in coming years, this procedure may become a choice for women in the future, at which point, they can choose to have this procedure done in a safe place. As a compromise, a harm-reduction approach through medicalization would allow for a wide scope of services that will offer safer solutions in the process of change.[13]

In some contexts, complete eradication of FGC is unheard of, given its social importance. In 2000, Shell-Duncan published a study surveying 920 Rendille women, a group inhabiting the Kaisut Desert of northern Kenya, across five communities in the Marsabit District. In this community, FCG is critical to the women. One woman claimed that, for the Rendille women, "circumcision is the only thing that separates us from animals." Shell-Duncan describes the ceremony that accompanies the excision during the marriage ceremony and overall involvement of the community; there is no question of how precious this ceremony is to the Rendille people. While this example might not be representative of FGC generally, any attempt to completely eradicate FGC would have social implications within communities. As discussed above, 54% of women in Egypt in 2008 still believe that this tradition should continue (this percentage represents 62.3% of women in rural areas and 42.7% of women in urban areas). While the ultimate goal is to eradicate FGC, there are effective, concrete intermediate steps that could be taken in light of the cultural significance of this practice to reduce harm: sterile razors, anti-tetanus injections and prophylactic antibiotics are associated with a nearly 70% lower risk of immediate complications.[13]

There are opponents to this view: for example, C. Nana Derby argues that medicalization of FGC "…not only nullifies earlier struggles by concealing the general, fallacious rationale behind the practice, it also denies the negative social, physical and psychological impact on the lives of women."[36] However, many of the physical and psychological surveys Derby cites were conducted more than two decades ago or they are not generalizable to *all* women who could benefit from medicalizing FGC. These surveys often suffer from selection bias by representing only specific groups of women.

To be fair to the opponents, there is also a lack of research proving the potential positive effects of medicalization. However, the claim that medicalization opposes eradication is unmerited. Given its value to women who may not be concerned about its negative social, physical or psychological impact, like the women of the Rendille community, medicalization must be discussed as a viable option. As Richard Shweder argued when writing about FGC, we must "save any powerful conclusive feelings for the end of the argument, rather than have them color or short-circuit all objective analysis."[10]

The future of FGC research and intervention

As I have demonstrated in this paper, there are many gaps in knowledge remaining in the field of FGC today. First, FGC operates in many different cultural contexts within Egypt, and there are significant variations in the way it is conducted. While there is a good approximation of what FGC looks like on a national level due to the work of the EDHS, there is no holistic information about characteristics of FGC. Consequently, there is not enough research detailing how different variations of FGC affect the severity of health complications. Factors like hygiene, practice or aftercare vary significantly depending on whether the procedure is being done in rural or urban areas, in the hospital or at home, by a traditional birth attendant or a doctor. While research in this domain is difficult, researchers should think about ways to investigate important characteristics like the setting in which the procedure is done, what is used for the cutting, how sterile the environment usually is, whether it is done privately or publicly and how the wound is cared for afterwards.

While I have described the possible consequences of FGC, definitive data on the physical implications solely due to FGC is lacking because these factors are not controlled for when arguing causality.

In addition to causality, the psychological and psychosexual implications of FGC are not well understood. The consequences of FGC might be tied to other factors that could be eliminated through medicalization. El-Defrawi *et al,* in the study above, showed correlation between psychological and psychosexual implications among women using services from Maternal and Childhood centers. Nonetheless, generalizable research that shows these consequences impact all women who have undergone FGC needs to be done.

Not only is the field ill-informed about the physical health consequences, but also there has been little research detailing the exact health burden or economic cost of this tradition. In looking for articles that address this topic, I was unable to find anything specific to Egypt or type I and type II cutting. This type of research can further inform the debate of the future of FGC and whether, economically, suggestions of eradication or medicalization are financially viable and advantageous.

Finally, attitudes among women are changing, but researchers are unsure of the cause of this change. There is a plethora of possibilities: advocacy, education, legislation, media or acculturation. If the impetus is pinpointed, legislators could use this information to effectively discourage FGC.

In light of all these gaps in knowledge, the first critical step is to conduct more research in Egypt and in other countries in which FGC is a common practice. The consequences of FGC for a woman's health, controlling for variations of method, need to be researched further in order for any definitive claims to be made concerning the future of FGC. This way, all parties may have an informed dialogue about how much damage FGC causes and how best to achieve a situation in which women are as safe and healthy as possible. In addition to improving health outcomes, this research should be used to influence legislative decisions. In this intermediary stage, we must remember that alienation and victimization of men and women complicit in FGC, especially on the foundation of inconclusive research, can compromise the sustainability of any intervention. Because FGC is a tradition that is still important to many women, cultural awareness and sensitivity should always be at the forefront of our minds. Community involvement and consent is absolutely necessary to ensure an intervention's success, especially with regards to a practice as fundamental and deeply embedded as FGC. While intervention is done to prevent the most harmful practices and methods, efforts to be culturally competent should lay the groundwork for the final resolution, a resolution that is well informed and celebrated by all parties.

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