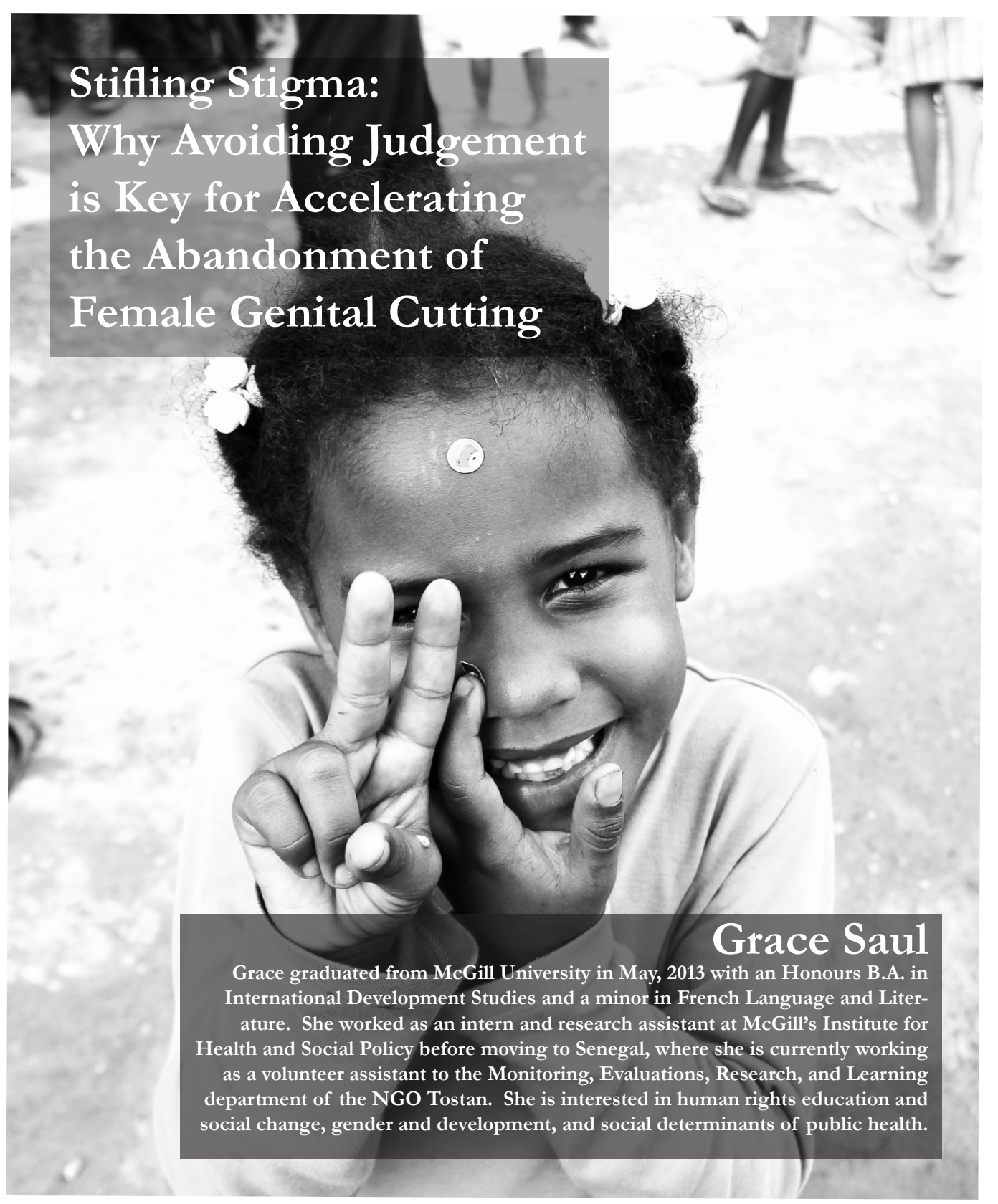

Stifling Stigma: Why Avoiding Judgement is Key for Accelerating the Abandonment of Female Genital Cutting

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When discussed in the global North and West, the issue of Female Genital Cutting (FGC) often sparks visceral reactions of fear, disgust, anger, and dejection. Among the most common responses is an expressed inability to comprehend *why* the practice is performed and *how* it continues to be a reality for millions of women throughout the developing world. Since the mid-20th century, health workers, feminists, national governments, and international organizations have singled out FGC for intervention, strongly condemning the practice for the troubling health consequences it presents and for its role in the continued underdevelopment of women (Herlund & Shell-Duncan, 2007). The practice is now considered by all influential global agencies and political actors to be strictly counter-normative (Herlund, & Shell-Duncan, 2007; Cook, 2008). The United Nations officially denounces the practice of "Female Genital Mutilation" as a violation of Human Rights and as a form of Violence Against Women (Herlund & Shell-Duncan, 2007). This assimilation of FGC into the dominant international Human Rights framework has helped increase global awareness of the issue (Cook, 2008; Gruenbaum, 2005). However, it has not necessarily contributed to a more meaningful understanding of the role FGC plays in practicing communities or of the social dynamics that preserve the tradition (Herlund & Shell-Duncan, 2008; Herlund & Shell-Duncan, 2006). Consequently, increased awareness has largely failed to translate into meaningful strategies for accelerating the abandonment of the practice (Shell-Duncan, 2008). Too often, communities practicing FGC have interpreted the fierce condemnation of the practice and its portrayal as being purely oppressive to women as yet another form of Western aggression. Accordingly, the proliferation of anti-FGC rhetoric has in large part served only to obscure the true complexity of the issue and to complicate efforts to protect the health and human rights of the girls and women concerned.

The international community's vigorous condemnation of "Female Genital Mutilation" based on moral grounds, along with a commonly perpetuated characterization of communities that practice FGC as oppressive and violent towards women, disregards the intricacy of the cultural values and norms preserving the tradition (Kanywani, 2002). In effect, such perversion thwarts efforts to end the practice, as communities respond to the perceived attack on their cultural rights with resistance and defensiveness (Henlund &Shell-Duncan, 2007; Shell-Duncan, 2008). Using the term "mutilation" to describe FGC instantly implies that the bodies of women who have experienced the practice are disfigured, deformed, or otherwise flawed by Western standards. This judgment serves to solidify an 'us' v. 'them' dichotomy between communities that practice FGC and those that do not (Lien & Schultz, 2013). As the rhetoric of 'right' versus 'wrong' and of 'civilization' versus 'barbarity' is all too familiar in the developing world context, the anti-FGC movement has often been seen as a continuation of "the colonialist effort to interpret indigenous African culture and thereby dominate it" (Okome, 1999, p. 4). This perceived imperialist assault has galvanized some practicing communities to advocate FGC more adamantly in defense of their traditions and 'cultural identity' (Herlund &Shell-Duncan, 2007; Shell-Duncan, 2008).

The portrayal of FGC solely as a barbaric and forceful means of ensuring male domi-

nation over women's bodies and societal roles overlooks the deeply entrenched social norms that maintain the practice. While it is true that control of female sexuality and ensuring marriageability are commonly cited reasons for FGC, these alone do not suffice in explaining the continuation of the tradition (Herlund & Shell-Duncan, 2007) Members of practicing communities often cite religion, hygiene, moral and physical purification, protection against sexually transmitted diseases, and the promotion of fertility, maternal health and child survival as reasons for FGC (WHO Interagency Statement, 2008). The practice is additionally considered to be an important means of enhancing social cohesion and female solidarity, and as such, is preserved by an extremely powerful convention of female pressure (Herlund & Shell-Duncan, 2007; Kanywani, 2002). Indeed, it is often the women in practicing communities who advocate the practice most adamantly, emphasizing its role in upholding cultural values including religious piety, tradition, health and fertility, and requiring it for moving up the adult female hierarchy (Prazak & Coffman, 2007). The fact that many members of practicing communities consider FGC to be exclusively a 'women's affair' complicates essentialist depictions of the practice as a symptom of the pervasive misogyny within 'primitive' societies (Caldwell, Orubuloye, & Cadwell, 2000).

Herlund and Shell-Duncan (2007) argue, convincingly, that only a few individuals in practicing communities are deeply engaged with the reasons behind FGC, while the majority chooses to follow the practice primarily out of fear of the very real discriminatory treatment and social sanctions they will face if they depart from the social norm. In practicing communities, girls and women who are uncut are considered to be abnormal and even revolting, while their parents are regarded as neglectful and cruel. The women face severe social consequences and may be entirely ostracized from their community (Prazak & Coffman, 2007; Cook, 2008). Research engaging focus groups in The Gambia found that even among groups of children, uncut peers were insulted as '*solema*' and excluded from social groups and activities (Herlund & Shell-Duncan, 2007). In light of the social necessity of the practice, the decision to have one's daughter cut is thus made out of love for the child and the desire for her to be included as a full member of the community (Shell-Duncan, 2008). This decision is typically the product of contemplation of the various reasons behind FGC, but more importantly, of the influence of personal experiences and the social pressure exerted by proximate social actors (Herlund & Shell-Duncan, 2007). Painting a simplistic image of barbarism and misogyny around FGC does little to stimulate meaningful discussion about the reasoning behind the decision to cut young women.

This failure to deeply engage with the reasons why the practice is retained is in large part why despite significant successes in increasing awareness of associated health risks and persuading national governments to pass legislation against the practice, global pressure to eliminate FGC has not resulted in large-scale behavior change (Herlund & Shell-Duncan, 2007; Prazak & Coffman, 2007; Caldwell et al., 2000). Strictly health-based approaches, which dominated the anti-FGC movement for much of the 20th century, presumed that if people were truly aware of the health risks presented by the practice, they would act 'rationally' and choose to abandon it (Prazak &Coffman, 2007; Caldwell et al., 2000). Early interventions focused,

therefore, on educating populations about the adverse short- and long-term effects of FGC on women's health (Prazak &Coffman, 2007). What this approach failed to appreciate, however, was that people in communities practicing FGC are often well aware of many of the potential health consequences posed by FGC, yet judge the risk to be worth taking, given the cultural and social importance of the practice (Prazak & Coffman, 2007; Kanywani, 2002).

Labeling this as "irrational" obscures the complexity of the social contexts in which such difficult decisions are made, placing the blame on individuals while ignoring the pervasive influence of the community. When women from ethnic groups that do not practice FGC marry into practicing groups, for example, not only are they excluded from community decision-making and serious discussions among adult women. They also oftentimes possess limited authority to oppose the cutting of their own daughters. They are additionally forbidden from attending the FGC ceremony or visiting their daughters in seclusion. Where FGC is a prerequisite for group inclusion and full social rights, the prevailing pressure placed on the individual is evident. Women in such situations have sometimes elected to undergo FGC against their own tradition, even after having already had several children (Herlund & Shell-Duncan, 2007). Thus, in this context, awareness of health risks notwithstanding, the decision to practice FGC can indeed be considered rational.

Furthermore, anti-FGC campaigns have often drawn their information about the health consequences of FGC from case studies of infibulation: the most extreme yet least-practiced form of FGC wherein the clitoris, labia minor and often the entire medial part of the labia majora are removed and the two sides of the vulva are sutured together, leaving only a small opening for the passage of urine and menstrual blood (Shell-Duncan, 2008; Kanywani, 2002). The complications present in these cases are often inconsistent with the experiences of women in communities practicing less severe forms of FGC. The information presented as representative of the general health risks associated with FGC is then perceived to be highly exaggerated, and thus the credibility of anti-FGC campaigns is undermine (Kanywani, 2002). These unintended consequences experienced by well-meaning anti-FCG campaigns further demonstrate the importance of contextualizing the debate surrounding FGC and of placing the real-life medical and social experiences of women and girls at the center of the conversation.

Efforts to accelerate the abandonment of FGC must recognize that on issues so intimately linked to tradition and cultural values, meaningful change can only come through enhancing the capabilities of communities to engage in discussion about how to build community consensus around norms that protect the rights of women and children (Herlund & Shell-Duncan, 2007; Shell-Duncan, 2008). While it is essential that communities become fully aware of the true health risks associated with FGC, outside actors must always be considerate of socio-traditional contexts and take care not to tread on the cultural rights and autonomy of the women in these communities, many of whom do not identify FGC as the most pressing issue limiting their social advancement. In isolating FGC from its full context, one runs the risk of overlooking other critical, cross-cutting development issues, many of which are gendered (Prazak &Coffman, 2007).

Aggressive rhetoric that stigmatizes wom-

en who have undergone FGC, denounces the 'backwardness' and 'barbarity' of their communities, and fails to consider the intricate motivations driving decision-making, reduces the depth of the problem and serves only to provoke defensive reactions and to limit opportunities for positive change through empowerment. The international community's reductive condemnation of 'Female Genital Mutilation' falsely dichotomizes 'pro-' and 'anti-FGC' camps, neglecting the fact that often times, multiple and seemingly contradictory reasons for the practice coexist within the same communities, families, and even individuals. In reality, culture is not static, and neither is the practice of FGC (Herlund & Shell-Duncan, 2007). As Gruenbaum (2005) aptly states, "cultural values can be anchors that reinforce tradition, but they can also be the source of ideas for rethinking and challenging cultural practices." Within practicing communities, FGC is a tradition whose meaning is continuously reinterpreted in light of changing social circumstances (Herlund & Shell-Duncan, 2007). It is for this reason that efforts aiming to accelerate the abandonment of FGC must avoid sensationalism, and focus instead on providing communities with the tools they require to critically examine the social needs that Female Genital Cutting fulfills for them. Only then will communities be able to engage in a constructive conversation about possible alternative ways of upholding cultural values whilst bringing about the positive changes they wish to see in the future.

References

1. Caldwell, John C., I.O. Orubuloye & Pat Caldwell (2000). Female Genital Mutilation: Conditions of Decline. *Population Research and Policy Review*, 19(3), 233-254.
2. Cook, Rebecca J. (2008). Ethical Concerns in Female Genital Cutting/Les préoccupations éthiques par rapport à l'incision génitale féminine. *African Journal of Reproductive Health/ La Revue Africaine de la Santé* 12(1), 7-16.
3. Easton, Pater, Karen Monkman & Rebecca Miles (2003). Social Policy from the Bottom up: Abandoning FGC in Sub-Saharan Africa. *Development in Practice* 13(5), 445-458.
4. Gruenbaum, Ellen (2005). Socio-cultural dynamics of female genital cutting: Research findings, gaps, and directions. *Culture, Health & Sexuality* 7(5), 429-441.
5. Hernlund, Ylva & Bettina Shell-Duncan (2007). Contingency, Context and Change: Negotiating Female Genital Cutting in The Gambia and Senegal. *Africa Today* 53(4), 43-57.
6. Kanywani, Maroushka F. (2002). *Talking Taboo: Representations of Female Genital Mutilation (FGM) in Feminist Debates, Human Rights Discourse & the Media.* (Masters dissertation). McGill University.
7. Lien, Inger-Lise & Jon-Hakon Schultz (2013). Internalizing Knowledge and Changing Attitudes to Female Genital Cutting/Mutilation. *Obstetrics and Gynecology International* Vol 2013, 1-10.
8. Prazak, Miroslava & Jennifer Coffman (2007). Anthropological Perspectives on Female Genital Cutting: Embodying Tradition, Violence, and Social Resilience. *Africa Today* 53(4), v-xi.
9. Shell-Duncan, Bettina (2008). From Health to Human Rights: Female Genital Cutting and the Politics of Intervention. *American Anthropologist* 110(2), 225-236.
10. Shell-Duncan, Bettina & Yiva Herniund (2006). Are There "Stages of Change" in the Practice of Female Genital Cutting?: Qualitative Research Findings from Senegal and The Gambia. *African Journal of Reproductive Health/La Revue Africaine de la Santé* 10(2), 57-71.
11. World Health Organization Interagency Statement: OHCHR, UNAIDS, UNDP, UNECA, UNESCO, UNFPA, UNHCR, UNICEF, UNIFEM, WHO (2008). *Eliminating Female Genital Mutilation.* WHO Library Cataloguing-in-Publication Data. retrieved 10 Aug. 2013 from http://www.un.org/womenwatch/daw/csw/csw52/statements_missions/Interagency_Statement_on_Eliminating_FGM.pdf