Female Genital Mutilation: Policies to Encourage Abandonment

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Introduction:

Female Genital Mutilation (FGM) also known as Female Genital Cutting (FGC) is a severe violation of girl’s and women’s human rights.

Waris Dirie – *Desert Flower* – “Female Mutilation has no cultural, no traditional and no religious aspect. It is a crime which seeks justice.”

FGM is practiced in many countries in Africa, the Middle East, and around the world. It is a barbaric practice that has no known religious significance and is incredibly harmful to children and women.

Health Consequences: Mental, physical and emotional.
History of Culture

Originated around 3000 BCE in Egypt.

Misconception that it is an Islamic tradition.

Performed by women in the villages with handmade tools.

Why this tradition continues.
Types of FGM - Classifications

FGM is classified into four main types as defined by the World Health Organization.

Type I: Clitoridectomy - Partial or total removal of the clitoris and/or the prepuce.

Type II: Excision - Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora.

Type III: Infibulation - Narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris.

Type IV or “Normal”: All other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, piercing, incising, scraping and cauterization.

(World Health Organization, Department of Reproductive Health and Research, 2008)
A. Normal

B. Type I

C. Type II

D. Type III
Incidence

The World Health Organization estimates between 100 and 140 million girls and women in the world have undergone FGM procedures, and 3 million girls are at risk every year.

Among countries with representative data, Egypt and Guinea have the highest prevalence of FGM on the African continent with 97% - 99% of ever married females stating they are circumcised. (Yount, 2002).

Other countries with extremely high prevalence are Mali at 92%, northern Sudan at 90% and Eritrea at 89%. Ethiopia, Burkina Faso and Mauritania follow with rates in the 70-80% range. (Unicef, 2005). More than likely due to caravan routes of trade.
Map of Incidence
Health Consequences

The removal of, or damage to, healthy, normal genital tissue interferes with the natural functioning of the body and causes several immediate and long-term health consequences.

Women who have undergone FGM suffer a higher rate of neonatal death compared with women who have not undergone the procedure.

Health consequences are not only physical but cause deep emotional scarring including impaired cognition, nightmares, panic attacks and post traumatic stress syndrome.

(World Health Organization, Department of Reproductive Health and Research, 2008)
Health Consequences

Immediate complications can include severe pain, shock, hemorrhage (bleeding), tetanus or sepsis (bacterial infection), urine retention, open sores in the genital region and injury to nearby genital tissue.

Long-term physical health consequences of FGM can include keloids, fistulas, cysts, infertility, persistent infections such as urinary or bladder and increased risk of childbirth complications including increased risk of death for both baby and mother.

In some extreme forms of Type III FGM, women must be opened and then reclosed after intercourse and childbirth. This is usually done with a knife or sharp piece of glass.
Why Choose Egypt?

FGM has been illegalized twice yet still continues.

Egypt abandonment programs with pt has tested multiple successful results.

Centre for Development and Population Activities (CEDPA) initiated:
• Positive Deviance Approach
• Toward New Horizons
• FGM-Free Village Model
Statement of Hypotheses

The higher level of education of the Respondent, the less likely she is to circumcise her daughter(s).

The higher level of education of the Respondent’s husband, the less likely she is to circumcise her daughter(s).

Urban Respondent is less likely to circumcise her daughter(s) than Rural Respondent.

Level at which the entire community is educated on the negative health consequences of the procedure and given alternate options for coming of age rituals or traditions, the more likely they will be to question the necessity of the procedure.
Data is from the Measure DHS – Department of Health Surveys’ website, which is funded through USAID (United States Agency of International Development).

Data was collected by the Ministry of Health and Population / El-Zanaty and Associates from March to June 2008 by surveying 16,527 Egyptian “ever married women” ages 15 – 49.

Of the 16,527 women surveyed, 15,605 admit to being circumcised, 918 say they are not and four are missing. (Demographic and Health Surveys)
Methods and Analysis

Unit of Analysis
   Respondent (Mother)

Dependent Variable:
   Intent to Circumcise Daughter

Independent Variables Include:
   Respondent Region
   Highest Level of Education of Respondent (mother)
   Highest Level of Education of Husband
   Percent of Wealth Index of Respondent
Methods and Analysis

![Egyptian Respondent's Average Age at Circumcision](image)

- 4 years old and under: 0%
- 5 to 8 years old: 20%
- 9 to 12 years old: 60%
- 13 to 16 years old: 5%
- 17 years and older: 5%
Methods and Analysis

- Phi = .295, p < .000
- Cramer’s V = .209, p < .000
- Chi = 690, p < .000

<table>
<thead>
<tr>
<th></th>
<th>Urban Governorates</th>
<th>Lower Egypt Urban</th>
<th>Lower Egypt Rural</th>
<th>Upper Egypt Urban</th>
<th>Upper Egypt Rural</th>
<th>Frontier Governorates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes % within Region</td>
<td>31.3%</td>
<td>30.1%</td>
<td>45.5%</td>
<td>43.5%</td>
<td>62.7%</td>
<td>42.5%</td>
</tr>
<tr>
<td>No % within Region</td>
<td>44.8%</td>
<td>44.6%</td>
<td>22.9%</td>
<td>34.7%</td>
<td>15.3%</td>
<td>39.5%</td>
</tr>
<tr>
<td>Don't know % within Region</td>
<td>23.9%</td>
<td>25.3%</td>
<td>31.6%</td>
<td>21.8%</td>
<td>22.0%</td>
<td>18.1%</td>
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</tbody>
</table>
Egyptian Regions
Methods and Analysis

Intent to Circumcise Daughter by Respondent's Highest Level of Education. Respondent (Mother) is Circumcised.

<table>
<thead>
<tr>
<th>Education Level</th>
<th>Yes</th>
<th>No</th>
<th>Don't Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-school/no education</td>
<td>60.5%</td>
<td>15.9%</td>
<td>23.7%</td>
</tr>
<tr>
<td>Primary</td>
<td>53.6%</td>
<td>22.8%</td>
<td>23.6%</td>
</tr>
<tr>
<td>Preparatory</td>
<td>49.3%</td>
<td>24.7%</td>
<td>26.0%</td>
</tr>
<tr>
<td>Secondary</td>
<td>38.7%</td>
<td>34.0%</td>
<td>27.3%</td>
</tr>
<tr>
<td>Upper intermediate</td>
<td>32.5%</td>
<td>44.0%</td>
<td>23.5%</td>
</tr>
<tr>
<td>University</td>
<td>21.6%</td>
<td>52.2%</td>
<td>26.2%</td>
</tr>
<tr>
<td>More than university</td>
<td>22.7%</td>
<td>63.6%</td>
<td>13.6%</td>
</tr>
</tbody>
</table>

Phi = .285, p < .000
Cramer's V = .202, p < .000
Chi Square = 643.9, p < .000
Methods and Analysis

Phi = .229, p < .000
Cramer’s V = .162, p < .000
Chi Square = 413.8, p < .000
Methods and Analysis

Intent to Circumcise Daughter Based on Percent of Wealth Index. Respondent is Circumcised.

<table>
<thead>
<tr>
<th>Category</th>
<th>Yes</th>
<th>No</th>
<th>Don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poorest</td>
<td>62.8%</td>
<td>13.6%</td>
<td>23.5%</td>
</tr>
<tr>
<td>Poorer</td>
<td>57.9%</td>
<td>16.4%</td>
<td>25.7%</td>
</tr>
<tr>
<td>Middle</td>
<td>48.2%</td>
<td>23.9%</td>
<td>27.9%</td>
</tr>
<tr>
<td>Richer</td>
<td>36.9%</td>
<td>36.4%</td>
<td>26.7%</td>
</tr>
<tr>
<td>Richest</td>
<td>23.3%</td>
<td>53.9%</td>
<td>22.8%</td>
</tr>
</tbody>
</table>

Phi = .346, p < .000
Cramer's V = .245, p < .000
Chi Square = 950.0 p < .000
Methods and Analysis

Phi = .273, p < .000
Cramer's V = .212, p < .000
Chi Square = 1488.5, p < .000
Abandonment of FGM will not be an easy task. However, my data shows that mothers are less likely to circumcise their daughters at a fairly high statistically significant level for:

Higher levels of education of both mother and father (both formal schooling and community education on awareness of the dangers of FGM).

By Region with mothers in urban areas less likely to circumcise their daughters than rural mothers.

Respondents with a higher wealth index.
Conclusion

• “We need to raise the status of women and children worldwide. FGM is no longer just a problem of third world countries. It has ‘reached the shores of the United States,’ and we can no longer say that we are not aware of this practice. The world has the tools and resources to end this form of torture and mutilation against women, and it must end today.” (Broussard, 2008)

• We must continue to fight female genital mutilation until every mother knows that she has the right to say “I will not circumcise my daughter.”
Questions?
Comments?