Report

Female genital mutilation of women in West Africa

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SAMMENDRAG

Kjønnslemlestelse av kvinner er et sammensatt og kontroversielt tema. Den kulturelle variasjonen i Vest-Afrika bidrar til å gjøre forholdene sammensatte, gjennom interaksjon og konflikt mellom syn på tradisjon og modernitet i stadig endring. Flere faktorer påvirker foreldre eller foresatte når de skal beslutte om en jente eller ung kvinne skal utsettes for kjønnslemlestelse eller ikke. Dette gjelder både private, interne vurderinger, religiøs tro, hvilket syn som er utbredt både i lokalmiljøet og i en større sammenheng, og sosioøkonomisk bakgrunn. Personer med noe de skal ha sagt om saken er ikke avgrenset til en jente/ung kvinnes foreldre eller nærmeste foresatte. Særlig der hvor det er konflikt rundt beslutningen kan mange bli involvert – både på initiativ fra den ene eller begge parter i konflikten, og fordi de selv tar initiativ til å forsøke å overtale den ene eller den andre parten.

SUMMARY

Female genital mutilation is a complex and controversial issue. The cultural variation in West Africa contributes to this complexity, through the interaction and conflict between changing perceptions of tradition and modernity. A number of factors may influence decisions made by parents or guardians on whether to have girls and young women be subjected to FGM or not: both private, internal considerations, religious beliefs, views on the issue in the local community as well as on a larger scale and socioeconomic background. People with a say in the matter are not limited to a girl/young woman’s parents or closest guardians. Especially where there is conflict around the decision, many may be involved – both on the initiative of one or both of the parties to the conflict, or because they choose to try to persuade one or the other party on their own initiative.

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1. INTRODUCTION

This report concerns the subject of female genital mutilation (FGM) in West Africa. The region is defined here as the countries Benin, Burkina Faso, Cabo Verde, Cameroon, the Central-African Republic, Chad, Côte d'Ivoire, Equatorial Guinea, Gabon, the Gambia, Ghana, Guinea, Guinea-Bissau, Liberia, Mali, Mauretania, Niger, Nigeria, São Tomé & Príncipe, Senegal, Sierra Leone and Togo.

When discussing controversial issues, it is not uncommon to find disagreement around terms and terminology – that the terminology applied signal the position of the author on the subject in question.[1] This is clearly also the case for this report. We have chosen to use the term *female genital mutilation* (FGM) in line with Norwegian legislation and government policy. This is also the term employed by the World Health Organisation, as well as by international human rights organisations. The term *female circumcision* is also widespread, not least among people who themselves practice FGM and who do not see this practice as uniformly negative. We will not use this term here, as it could give the impression that we hold a neutral view of the phenomenon. Forces working against the phenomenon in societies where it is widespread often use the term *female genital cutting*, because they want to avoid judgmental connotations of the term FGM.

This report intends to provide a general background of several important aspects of the phenomenon in a West African context – a region where the variation regarding the practice of FGM is considerable.

Landinfo is preparing reports on those countries in the region that are important with regards to immigration from West Africa to Norway.

2. WHAT IS FEMALE GENITAL MUTILATION?

This chapter describes practical and general aspects of female genital mutilation: Types of FGM, when FGM is performed, who performs FGM and how widespread is the practice. We will return to another fundamental aspect – *why* female genital mutilation is practiced in different areas – in part 3.2.

2.1 TYPES OF FEMALE GENITAL MUTILATION

In 1997, the World Health Organization (WHO) defined a classification of four categories of FGM. According to information from UNICEF (UNICEF 2005, p. 2), this classification is under reconsideration. The new version introduces a fifth category, adding to instead of altering the original four-fold categorization. The definitions for categories I to IV are based on the WHO fact sheet from 2000 (WHO 2000), whereas the definition of type V follows UNICEF 2005:

[1] See Shell-Duncan & Hernlund 2000, especially pages 1-3. However, the question of terminology is important for the discussion in the entire chapter.

I. Clitoridectomy: partial or total removal of the clitoris (a small, sensitive and erectile part of the female genitals) and, rarely, the prepuce (the fold of skin surrounding the clitoris) as well.

II. Excision: partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (the labia are "the lips" that surround the vagina).

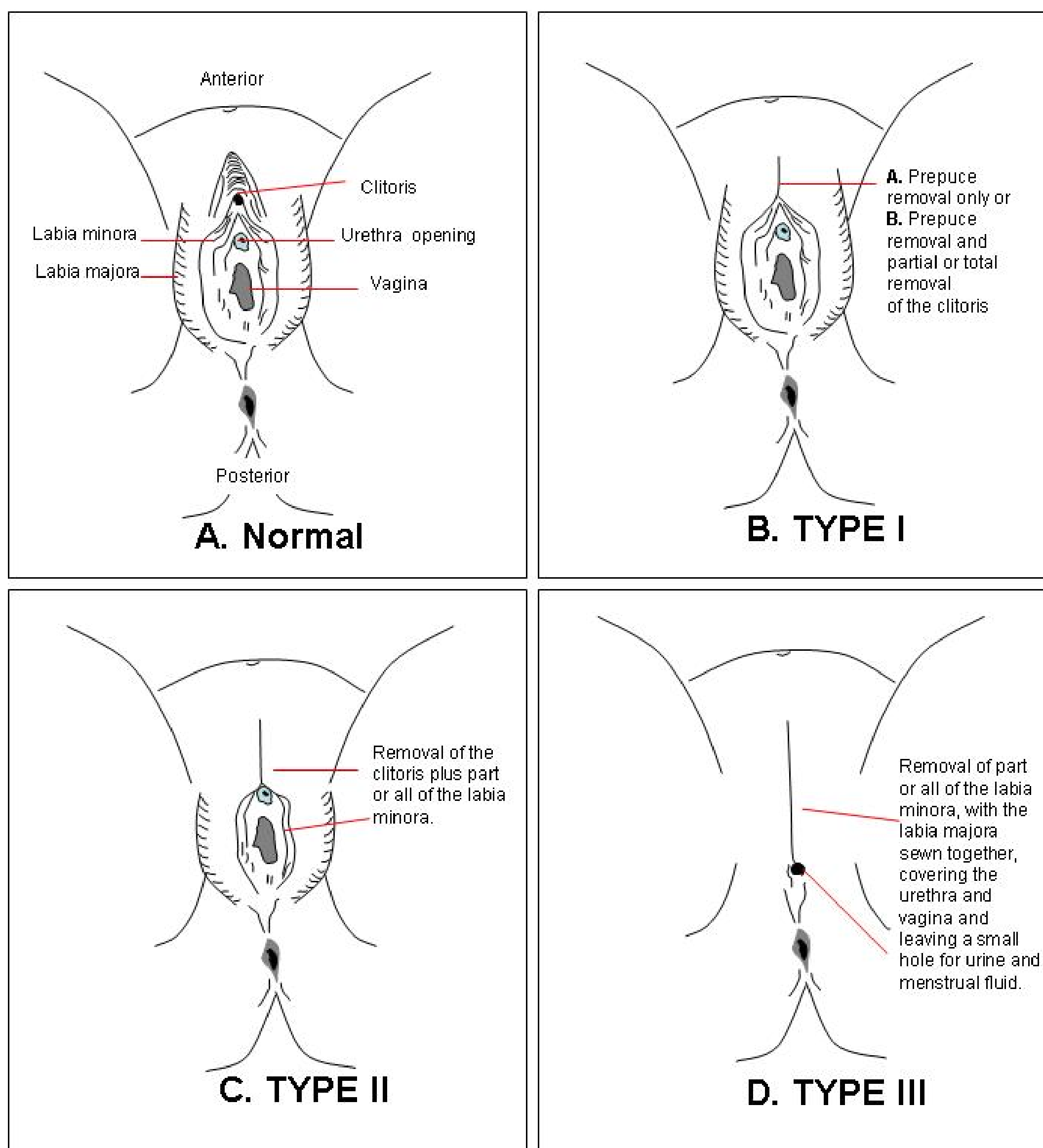
III. Infibulation: narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the inner, and sometimes outer, labia, with or without removal of the clitoris. Resealing the vaginal opening after birth is called *reinfibulation*.

IV. Other: all other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterising the genital area. Examples include cauterising or burning all or parts of the clitoris and surrounding areas; scraping around the vaginal opening (socalled *angurya*-cuts); cuts inside the vagina (*gishiri*-cuts); inserting acidic substances or herbs in the vagina to induce bleeding in order for the vaginal opening to contract; as well as any other procedure that creates lasting changes or harm to the genitals.

V. Symbolic practices: nicking or pricking of the clitoris to release a few drops of blood, where the intention is symbolic rather than to create lasting changes to the genitals.

The difference between type I and II is not altogether clear. Certain FGM procedures can be difficult to categorise as either type I or type II (cf. Shell-Duncan & Hernlund 2000, p. 3-7).

FGM types I through III:[2]



There is considerable variation concerning FGM type IV, as this definition includes a wide variety of procedures leaving very different marks on or damages to the genitals. Type V, on the other hand, leaves few or no visible marks on the genitals.

2.2 WHEN IS FGM PERFORMED?

FGM is closely associated with tradition, and in many cases the procedures are performed in association with different kinds of *rites de passage* – often during puberty. There is, however, large variation when it comes to *when* FGM is performed – from when a newborn girl is a few days old, during childhood, when entering adulthood, or on adult women (i.e. before marriage).

[2] The illustration is taken from the Wikipedia article on FGM, and is available at http://en.wikipedia.org/wiki/Image:FGC_Types.jpg [retrieved on 02.12.2008]. The illustration is in the public domain.

The traditions related to FGM are changing, and from several places there are reports of girls being subjected to FGM at lower ages than what used to be the norm. One reason can be to avoid alerting activists working against FGM in the given community; another that younger girls have fewer possibilities to protest and resist FGM than older girls (cf. IRIN 2005, p. 7-8, 25).

2.3 WHO PERFORMS FGM?

FGM is often performed by persons with a traditional role as circumcisers in the community. They are usually middle aged or elderly women, i.e. traditional healers or midwives, but can also be of another profession (like barbers). In some cases, men perform FGM, but usually it is women who perform the operation.

Traditionally, health practitioners have only rarely been involved in performing FGM, but there are examples of nurses practising FGM in certain areas.[3] Some activists regard this as a positive development, and argue that FGM is less problematic when performed under anesthesia and hygienic conditions, compared to FGM done with homemade tools and under unhygienic conditions. WHO rejects this position, as its opposition to the phenomenon is based on principles: FGM is never acceptable. (See Shell-Duncan & Hernlund 2000, p. 31-32 for further discussion of this subject.)

2.4 PREVALENCE OF FGM

It is very difficult to give exact information on the prevalence of FGM in different communities. As the practice of FGM is impossible to separate from attitudes concerning sexuality, the subject is taboo in many societies. The rituals performed in connection with FGM are often meant to be kept secret from outsiders, the whole subject is a very sensitive and private one, it is highly symbolic and its performance (or lack of such) has large consequences for the girls and women in question, as well as their families and relatives. In many societies, battling against the practice has also contributed to making the subject more controversial. In those communities where the subject is discussed openly, it often happens in general terms, without reference to whether individual women themselves have been through FGM or not.

Available statistics on the prevalence of FGM is only very rarely based on larger health surveys including large and/or representative population groups. Most existing estimates are based on surveys of fairly small groups of women, and it is usually problematic to generalise these findings apply them as valid for larger groups, or, for that matter, the entire population of a country. This is especially true in societies where there is large variation in the practice of FGM between or within different social groups.

Estimates of FGM prevalence in different areas and within different groups may also be contradictory when comparing different surveys and estimates. We refer to Shell-Duncan & Herlund 2000, p. 7-13 for a detailed discussion of the phenomenon of contradictory estimates, and to their comment on how many who write on this subject base their estimates on data which are difficult to verify.

[3] Where health practitioners perform FGM, there are reports that they at times perform less severe operations than what is common among more traditional practitioners; sometimes purely symbolic ”nicking” as described for type V in part 2.1 above.

2.4.1 The prevalence of the different types of FGM

Local traditions usually dictate what type of FGM is performed in different communities. WHO estimates that close to 80 % of all cases of FGM on a world basis can be categorised as type II, whereas around 15 % are of type III – the remaining cases are either type I or type IV (or type V).

All types of FGM are performed in West Africa, however there are indications that type III is less prevalent in this area compared to the Horn of Africa.[4]

2.4.2 FGM, tradition and belonging to social groups

FGM is a practice with a very long history in Africa, but there is considerable variation to the practice – regarding the type, when FGM is performed, who performs FGM and the kind of arguments used to justify it. These conditions are closely related to local culture and traditions in the communities where FGM is performed.

FGM is inseparably connected to questions of sexuality and reproduction, and the attitudes a community holds toward the practice of FGM relate to general views on controlling sexuality and reproduction. The traditional views regarding FGM will generally be common to a certain group of people in a community (though not necessarily all members of the group), because the practice of FGM is usually connected to people belonging to a certain social group. This collective identity as a social group may in some cases include an entire community, like in the case of a small village, but in other communities it need not include more than a set of people defining themselves as belonging to a certain group.

Such a group identity may be defined as ethnic, but it is important to stress at this point that it may also be defined on the basis of religion, family ties, clan ties, caste, socioeconomic level, level of education and one or several of a number of other criteria. Although traditions concerning the practice of FGM are usually connected to the collective identity of a certain group, it must be kept in mind that very few people can be defined as members of a single social group only. Most people belong to several different social groups – groups that may differ in social practices and traditions, or that have changing attitudes to certain traditions or practices according to context and changing conditions.

Attitudes toward the practice of FGM in West Africa are as complex as the societies in the region – and this is a part of the world with extraordinary cultural variation. There hardly exists any community in West Africa, even in remote rural areas, which is not multi-ethnic, multi-religious and socially differentiated on several levels.

Traditions for the practice of FGM may be one of the central criteria for defining group identity – i.e. where the members of a given group define themselves as belonging to a community which practices a certain type of FGM on its female members at a certain age, where the practice is performed by a certain category of people, where the practice is justified with a set of arguments, etc. On the other hand, the practice of FGM can be generally similar in a larger geographical area inhabited

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[4] According to Shell-Duncan & Hernlund (2000, p. 9), in West Africa FGM type III is only prevalent in parts of Mali and a small area in northern Nigeria.

by a number of different communities who define themselves as distinct from each other based on entirely different criteria than precisely how and when FGM is performed.

2.4.2.1 West Africa – one of the most culturally diverse regions in the world

West Africa is a very culturally complex region. A vast number of different languages are spoken, stemming from one of three large, unrelated language groups in the area (the Afro-Asiatic, the Nilo-Saharic and Niger-Congo). Only in Nigeria, covering an area barely the combined size of France and Spain, some 500 languages are spoken.[5] The cultural diversity between different groups both within and between these language groups is considerable. For several hundred years, West Africa has also experienced large migrations over great distances – migrations that only increased during and after colonial times.

The consequence of this is an unusually large cultural diversity between a plethora of different ethnic groups. Other socioeconomic factors like educational level, migration, contact with other social groups, etc., also contribute to diversification *within* different groups and an even more complex picture.

3. CHANGING TRADITIONS

Cultural traditions are far from static and undergo constant changes throughout the world. Traditions concerning FGM are no exception. The large societal upheavals in West Africa following centuries of migration, the introduction of Islam (during the Middle Ages) and Christianity (mainly during colonial times), colonialism, decolonialism, globalisation and migration to the West and North have all had a huge impact on culture and traditions. Outside cultural influences have been significant, with "imported" impulses, values and concepts – especially from Europe, but also from the Middle East. These impulses are often associated with modernity, whereas African ideas are associated with tradition. As is the case elsewhere in the world, traditions in West Africa are often seen to be considerably more static and unchangeable in principle than what they are in practice.

3.1 INTERACTION AND CONFLICT BETWEEN TRADITION AND MODERNITY

Put very simple, the interaction between tradition and modernity is often presented as a contradiction in terms – a question of either the one or the other, as the two presumably cannot possibly be combined. Furthermore, modernity is associated with the present and the future, whereas tradition is associated with the past and – only reluctantly – the present. Many consider it inevitable that modernity will make tradition obsolete, regardless of whether they think this development is positive or not.

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[5] See Gordon 2005. A number of these languages are closely related, and could be defined as dialect clusters of larger languages. But despite this, the language variation in West Africa is enormous compared to the situation in Europe.

However, few people can be considered completely modern or traditional in their principles and actions. Most people live a combination of the modern and the traditional, though not necessarily simultaneously and with regards to the same aspects of life. In a Norwegian context, an individual may well both consult her/his family doctor, practice traditional medicine and see a non-certified new age “healer” for a given illness[6] – even though modern medicine is usually considered to diametrically opposed to “old wives’ tales” and new age “healing”. Parallel to this, an urban West African with higher education may well want her children to participate in coming of age rituals in their ancestral village. These choices between modernity and tradition – constantly made by us all – may often involve FGM in a West African context. And like with other such choices, the result depends on a large number of factors.

3.2 CONDITIONS THAT CONTRIBUTE TOWARD THE CONTINUED PRACTICE OF FGM

FGM is generally perceived as a traditional phenomenon, and arguments that justify FGM are often associated with conservative values and a focus on tradition as a social adhesive – practices that are important in themselves.[7] Still, an intention to follow tradition is only rarely considered self-evident or inevitable in today’s modern African societies. Most people are conscious that there are numerous choices, and are influenced by different conditions. Thus several factors may influence the decision of a girl’s parents or guardians on whether to subject her to FGM or not.

3.2.1 Tradition

3.2.1.1 Views on female sexuality, reproduction, the female body and aesthetics

Attitudes towards sexuality as something that must be controlled and held back – particularly in regards of female sexuality – are crucial for favourable views on FGM. The belief that women who are not subjected to FGM will grow abnormally large reproductive organs is widespread, and so are preconceptions that female reproductive organs that are not cut or removed will be in the way during childbirth and/or that contact with them may be harmful to the child. Another common notion is that women who are not subjected to FGM are less fertile than “cut” women. Even more common is the perception that women who are not subjected to FGM will be unable to control their sexual urges.

However, such misconceptions are now regressing in many areas, as people living in communities where FGM is not universally practiced are unable to observe clear differences in behaviour between women who have been subjected to some form of FGM and those who have not. This also leads to a more widespread knowledge that women not subjected to FGM do not grow abnormally large reproductive organs, or, for that matter, that they are not more subject to birth complications than other women (quite the opposite, in fact).

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[6] This illness could be anything from a common cold to cancer.

[7] However, there are examples of communities where the practice of FGM is fairly recent. See Leonard 2000 for one such example.

Even so, many keep maintaining that women who have been subjected to FGM behave more properly than other women. The argument that women who are not subjected to FGM develop abnormally large reproductive organs is being replaced by the argument that the reproductive organs of women who are not cut are ugly and repulsive.

3.2.1.2 Worries that young women not subjected to FGM will be unable to find a husband

Another important argument that contributes to the continued practice of FGM is guardians' worries that young women who are not cut will have difficulties getting married. In communities where a large majority practices FGM, being one of the few considered "unclean" is tantamount to stigmatisation. This may then lead to problems for women being accepted as potential wives to men from communities where it is unusual for women not to have been subjected to some type of FGM.

3.2.1.3 Collective identity

In collectively oriented societies like the African ones, personal identity is often intrinsically linked to group identity, and membership in a group or community is generally more important than individual life projects. In many communities, having gone through FGM is a crucial factor when defining women as members of a particular social group. Especially in communities where the large majority of women have been subjected to FGM, being among the few who have not may lead to social ostracisation.

The consequence of this may both be pressure from adults in a girl's or young woman's community, but also considerable peer pressure.

3.2.1.4 Association with rites of passage

Some communities in West Africa practice FGM in association with rites of passage marking the transformation from childhood to adulthood. It is very difficult to opt out of certain aspects of such rites. This makes it extremely hard for a girl or her guardians to resist her being subjected to FGM, without opting out of the whole process of rite of passage. Not having gone through the rite of passage with one's peers, may lead to a young woman being stigmatised as a non-adult in her community.[8]

3.2.1.5 Resisting declining social norms associated with modernity through "return to tradition"

Modernity is often associated with positive concepts like development, social mobility and prestige. But at the same time, modernity is also blamed by many for a general decline in social norms, the unpredictability of life and increasing social differences – in Africa, as in the rest of the world.

Values and behaviour associated with modernity may therefore be characterised as "un-African" and out of sync with African realities, followed by appeals to a "return to tradition" presented as a way of resisting declining social norms. Young women's behaviour is often used as examples of general social decline and backsliding.

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[8] In many areas, the sense of community with the peers with whom one went through a rite of passage is a bond almost as important as family ties. Ostracisation from such a community may imply social catastrophe in regions where such networks constitute the only social security that exists.

Appeals for a return to tradition will therefore often focus on controlling the sexual activities of young women, and may lead to people arguing that the practice of FGM is necessary to control young women.

3.2.1.6 Copying other groups' traditions in order to secure entry and acceptance

In cases where a woman who belongs to a community that does not practice FGM marries a man from a community that does, her future in-laws may demand that she undergoes FGM in accordance with the traditions of her future husband's community, before they are allowed to marry. (This, however, is not inevitable.)

The practice of FGM may spread between communities because of such demands. Shell-Duncan & Hernlund provides several examples of groups who have started to practice FGM in order for their women to gain acceptance as potential wives in other groups that have practiced FGM for a long time (2000, p. 35-6).

3.2.2 Religion

FGM has long, often very long, traditions in West Africa. It has been practiced since long before the penetration of Islam and Christianity in the region. The interaction between different religious concepts in West African societies also influences the practice of FGM.

3.2.2.1 Traditional religion

Attitudes and concepts linked to FGM are associated with local religions and largely predate Islam and Christianity. This, however, does not only affect non-Muslim or non-Christian West Africans. Synchretic religious practice where people mix forms of Islam or Christianity with rites and rituals from local religion(s) is very common. Thus many West Africans consider it important to continue the tradition of FGM founded in local religion, even when this contradicts Islamic or Christian theology and practice in congregations they belong to.

3.2.2.2 Islam

In some Muslim communities in West Africa, it is a common misconception that FGM is sanctioned by Islam. Arguments for this position either stem from a lack of knowledge about Islam (see Johnson 2000), or are founded on a controversial saying attributed to the prophet Muhammad.[9] This saying is, however, universally rejected by leading Muslim religious scholars, both within *sunni*- and *shi'a*-Islam.

3.2.2.3 Christianity

We are not aware of any examples from West Africa of claims that the Bible sanctions the practice of FGM.

[9] So-called *hadith*, sayings of the prophet Muhammad and his contemporary followers, is an important source of jurisprudence in Islam. This saying is also commonly used as an argument for FGM among Muslims in the Horn of Africa, the Sudan and Egypt.

3.3 CONDITIONS THAT CONTRIBUTE TOWARD THE REJECTION OF FGM

Because FGM is generally associated with tradition, the work against FGM is often linked to concepts of (progressive) development and modernity. In many communities it is common that people and social groups who identify with progress and modernity stress FGM as one of traditional practices with an exceptionally negative symbolic value. These people and groups have considerable influence in African societies, but there are also large groups who are deeply sceptical with regards to projects and developments associated with modernity. Modernity is not seen as entirely positive, but is also associated with negative social changes – such as alienation, declining importance of family ties and responsibilities, colonialism, neocolonialism, declining social norms and increasing social differences.

At the same time it is imperative to emphasise that although the conditions presented below have a positive influence contributing towards a decline in the practice of FGM, they never function as any sort of "guarantee" against FGM – alone or in combination. When parents and others with responsibility or influence on the upbringing of girls and young women make the decision on whether they should be subjected to FGM or not, they often end up in a classic situation of cross-pressure, where they have to take a number of factors into consideration. Even though the aspects outlined below often influence a girl's guardians to avoid subjecting her to FGM or to perform a less extensive type, it is not given that they are the determining factors.

3.3.1 Legislation making FGM illegal

FGM is illegal in several countries in West Africa. Rahman & Toubia (2001) and US State Department (2001a and 2001b) include detailed information as of 2001. The UN-run news agency IRIN News (see http://www.irinnews.org) follows the development in this field closely, and is a good source of information regarding the introduction and implementation of new legislation against FGM.[10]

3.3.2 Information and consciousness-building

We find projects on FGM information and consciousness-building in most West African countries. Such projects are run by both state authorities and NGOs – both local and international ones, and often in cooperation with Western donor countries. Some information work is also done by religious organisations and congregations.

Amongst a number of aspects, information campaigns focus on the harmful consequences of FGM, the lack of religious sanctions for FGM, on groups and public authorities working against FGM and on awareness-building concerning legislation making FGM illegal in the different countries.

Several methods are used to reach the target groups, especially mass media (radio and television in particular), poster campaigns, popular meetings and information efforts in schools and congregations. In order to reach populations with a low level

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[10] Amnesty International provides some information on FGM in its annual reports, but it seems the e-newsletter on work against FGM has been suspended (the last edition seems to be Amnesty 2004). Human Rights Watch also provides only limited information on FGM, with the exception of the subject being mentioned in annual reports and sporadic other reports.

of education and knowledge, the information is often presented verbally, and preferably in local languages and dialects, or varieties of former colonial languages that are used by large segments of the population.

It is hard to measure what effect such information efforts actually have, and what methods are more efficient than others:

> *To date, […] no consensus exists on the most appropriate approach to the elimination of female genital cutting.* (Shell-Duncan & Hernlund 2000, p. 25)

Information and consciousness-building efforts may also have other, unintended effects, namely that raised consciousness among teenage girls regarding their personal rights leads to FGM being practiced at a considerably earlier age – when girls neither are in a position to resist or aware that they have a right to do so (see IRIN 2005, p. 13).

3.3.3 Activism

In addition to information efforts, many groups – both state authorities, local NGOs and international aid organisations – work as activists in order to influence communities on a local level to put a stop to the practice of FGM.

One of the focus areas of such activists is to attempt to influence the traditional practitioners of FGM to stop this practice, a project which can turn out to be a complicated balancing act. For such projects to succeed, the traditional practitioners must both be given an opportunity to leave the practice with their honour intact, and be provided with alternative sources of income (see Gosselin 2000 for a description of such a project in Mali).

Other projects focus on changes in attitudes on a village level, where the aim is to achieve collective change affecting the whole community. Such collective change, where everyone in a village agrees to stop practising FGM simultaneously, achieves avoidance of potential stigmatisation of girls who are not subjected to FGM. When a whole community changes its practice, individuals are not obliged to be pioneers at the local level.

Projects like these often focus on the rural population, as people in rural areas live in more homogenous village communities that are more sheltered from modernising influences than the urban population.

Activists' efforts against FGM are hindered by a general distrust of modernity and the perceived attacks made by "modern city-folk" on traditions and conventional wisdom. Such distrust is widespread in the countryside, but also on different socio-economic levels in urban areas, where what is perceived as declining social norms and a lack of focus on traditional values is regarded with worry. In order to avoid that anti-FGM activism is seen as simply yet another modernising project, many activists stress that they do not intend to abolish traditions and rituals. They emphasise that a change of content in the rituals may actually strengthen them, even though the aspect of FGM is removed. Hernlund (2000) describes attempts to revise and revive puberty rites of passage for Gambian girls, but where the practice of FGM is rejected.

3.3.4 Social background and mobility

Tradition is closely associated with ethnic identity, but it is important to emphasise that although ethnicity is an important aspect of daily life for Africans in a way that is rather less common in Western Europe, there are important social differences *within* ethnic groups. These social differences may influence the attitudes regarding FGM. The researchers Bettina Shell-Duncan and Ylva Hernlund have pointed out that the practice of FGM in many places has turned into an important criteria in the differentiation between socioeconomic classes *within* different ethnic groups (2000, p. 7). In communities where a particular type of FGM is associated with a social class with high prestige and esteem, other social classes may adopt the practice of this type of FGM in order to climb socially to the same socio-economic level.

There is a tendency that FGM is less widespread among the higher social classes in West Africa, especially among the affluent and rich, or that these classes practice less drastic types of FGM. However, privileged West Africans are also concerned with the high prestige of positions of traditional leadership, posts where the holders are expected to be role models in the practice of local traditions – including FGM. Thus it is in no way given that the high social position of a girl's family protects her from being subjected to FGM, even though there is a tendency that girls and young women from such backgrounds are less in the danger zone than their peers from poorer family backgrounds.

3.3.5 Educational level

Many studies clearly show that FGM is less widespread among women with some education than among others, and this is particularly evident for women with higher education. This shows that parents and guardians who make their girls' education a priority, also subject them to FGM to a lesser extend than others. Researchers have also found a clear tendency in a number of studies that there is a clear correlation between the educational level of parents and guardians, especially of mothers, and lower incidences of FGM.

There are probably several reasons why higher educational levels act as a counterbalance to the practice of FGM. Education is often associated with more positive aspects of progress and modernity, and African schools often disseminate strong scepticism towards local traditions in general, as such traditions are seen as incompatible with modern life. Schools are also often the arena for information efforts and awareness-building addressing girls and young women, with the express aim of freeing them from a traditional role and mindset, and of making them conscious of their individual rights – both in general, and concerning FGM.

3.3.6 Urbanisation

Urbanisation is a strong social process in West Africa, as elsewhere in the world. This urbanisation is primarily characterised by large migration from rural areas to cities, but processes where rural areas are reclassified as urban or semi-urban are also important (like when the large cities expand and envelop villages, and when villages expand and become local urban centres).

West African migrants who have left the countryside and moved to the cities, generally stay in close touch with their villages of origin.[11] For many, the village remains "home" – even after several generations. Keeping frequent contact with relatives is generally a high priority. One of the main reasons for this is that the family in the village of origin remains the most important social security net people have access to, under living conditions most West Africans experience as considerably more unpredictable and financially insecure than we are used to in our part of the world. In times of crisis, which are depressingly recurrent for most West Africans, it is primarily relatives "back home" whom people are able to rely on – both for financial assistance and refuge. On the other hand, successful urban migrants have a responsibility for assisting their relatives in the village, and to help relatives visiting in the city or wishing to migrate there themselves.

A direct consequence of this is that West Africans generally keep in close touch with their area of origin, not least when it comes to marking important rites of passage like birth, the transition from childhood to adulthood, marriage and death. On such occasions, there is a strong focus on traditions, and urban migrants are expected to demontrate that they have not lost grip on how traditions and rituals are practiced. The dependence urban migrants feel concerning their relatives in the village therefore often make them less free to break with traditions associated with village life than they may wish to be. At the same time, this communication obviously goes in both directions, and contributes to influence attitudes in the countryside through new ideas and impulses from an outside world that comes gradually closer. This complex interaction is highly relevant for the attitudes to and practice of FGM.

3.3.7 Religion

Religion is often associated with tradition, not the least in our part of the world. Here it is crucial to emphasise that religion may also be associated with progress and modernity. This is especially common in societies like the West African ones, where religious conversion or a marked change in religious practice within a religion often implies a symbolic break with tradition.

Both Christian and Muslim communities in the region run missionary activities targeting groups and individuals who practice African religions, and partly targeting each other (i.e. Christian mission targeting Muslims and vice versa). Home missionary efforts are even more important both within Christian and Muslim communities, targeting people who practice more syncretistic versions of Christianity and Islam (i.e. people who mix Christianity or Islam with local African rites and religious views).

3.3.7.1 Christianity

Christianity was introduced in West Africa through European missionary efforts targeting the local population, but these missionary activities saw very little success before mid to late 19th century. The change came when conversion to Christianity

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[11] Only 5-10 years ago, people mainly stayed in touch through journeys home, letters sent with relatives and friends going back home, or through unreliable mail services. During the last decade, the explosive growth in mobile phone networks and internet access in the region has made it considerably easier for people to maintain frequent contact with family, relatives and friends in their areas of origin and elsewhere.

was linked to the establishment of missionary schools with the express aim of creating a Christian, Westernised local elite (Kirby 1994, p. 59). Conversion could lead to social advantages, or became otherwise advantageous. Christianity came with the colonial powers and was associated with European cultural influences, preconceptions of modernity and the ideology of progress from the very start. As a result of this, Christian congregations in West Africa generally condemn anything associated with "pagan" pre-Christian traditions and religious views.[12] This concerns the religious practice of non-Christians, but there is also strong condemnation of the widespread syncretism practiced in the region –Christians who follow local traditions and practice religious rites not part of Christian doctrine.

Within churches that have been established in the region for generations, like the Catholic church, the Anglican church, the Methodist church and others, almost all local religious rites and traditions have been rejected as paganism and idolatry. Since the arrival of Christian missionaries around four centuries ago, the Church has been associated with a "civilising project" with very negative attitudes towards aspects and expressions of local culture and religious practice difficult to combine with Christian doctrines. This development has continued even after West Africans assumed control of the local Church organisations from decolonialisation started in the late 1950s until our days.[13]

Pentecostal churches experience explosive growth all over the world, and West Africa is no exception. One of the many reasons why these churches experience enormous expansion in West Africa may be that they to a lesser extent than more established churches reject the existence of occult forces. This is not to say that these churches are any less condemning towards such forces, it is rather a question of accepting such forces as part of a Christian universe – although as deeds attributed to the Devil. Thus traditional religious practice is not rejected as irrelevant superstition, but condemned as worship of demonic forces.

In this regard, churches and congregations can be important actors in the work against the practice of FGM on a local level, with much influence over the individual members of the congregations. This, however, requires that the subject of FGM is addressed from the pulpit during service, or in other church meetings.

3.3.7.2 Islam

Islam is an imported religion in West Africa, though with very long roots – especially in the savannah belt south of the Sahara from the Sudan in the east to Senegal in the west. Islam has been established here for centuries, and this religion is not associated with explicitly external cultural influences in the same way as Christianity is.

After decolonialisation and through globalisation West Africa (like other non-Arab Muslim societies), has been exposed to new influences from Islamic religious

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[12] There are certain exceptions, in the form of local religions which fuse Christian doctrines with local pre-Christian traditions and religious views. However, these congregations are rarely recognised as Christian by established Christian churches, and in cases not even by the followers themselves.

[13] Parallel with a tendency to secularisation in these churches' original core areas in Europe and North American, African church leader have achieved large influence in the last few decades. This is especially clear within the Anglican/Episcopalian church, where particularly Nigerian bishops have become very influential.

centres.[14] One result of this is that West African Muslims in our time are exposed to a larger number of alternative ways of practicing Islam than they were in the past – ways that are often very different from each other. At one end of the scale we find a traditional West African practice of Islam, greatly influenced by Moroccan Sufi brotherhoods, local pre-Islamic culture and syncretism. At the other, we find a Middle Eastern Islam strongly inspired by Islamism (the Egyptian Muslim Brothers, etc.) which often strongly condemns Sufi Islam and syncretistic practice, and which is associated with an urban modernity looking more to Arab world views and ideals than to Western ones.

Varieties of traditional Muslim practice with long roots in West Africa have often incorporated pre-Islamic practice of FGM. There are several examples of FGM being justified as an Islamic practice – in some places as a near requirement for a woman to be able to define herself as a Muslim (see Johnson 2000 for a description of the situation in Guinea-Bissau).

On the other hand there are numerous examples of West African Muslims oriented towards Islamist tendencies from the Middle East and North Africa who argue against FGM and what is considered an un-Islamic practice that should be rejected. Their most important argument is that neither the Qur'an nor other universally acclaimed sources of Islamic jurisprudence (collections of *hadith*s) explicitly sanction FGM or support the practice. (The Qur'an mentions neither male circumcision nor FGM at all.) The Norwegian Muslim religious historian Anne Sofie Roald (2003) points out that shi'a-Islam since early times has had a clear prohibition against FGM, based on a *hadith* text. Within sunni-Islam, the phenomenon must be regarded as illegal today, based on knowledge of how the practice of FGM harms women's health and contravenes women's religiously defined right to sexual pleasure.

During a conference with a focus on FGM held in Cairo in May 2003 under the direction of *Dar al-Ifta*,[15] the participating Muslim religious thinkers emphasised that FGM contravenes the Islamic principle of the integrity of the body, and that it must be considered an abomination against God's creation. Both the rector of the al-Azhar University (the most important religious university in the entire Islamic world), Muhammad Sayyid Tantawi, and Egypt's Grand Mufti[16] Ali Gum'a attended the conference. They are among the most important religious thinkers within sunni-Islam.

The following verses of the Qur'an are often used to support this view. The most relevant parts are underlined:

> *Allah it is Who appointed for you the earth for a dwelling-place and the sky for a canopy, <u>and fashioned you and perfected your shapes</u>, and hath*

[14] As recently as 20-40 years ago only senior religious scholars and important businessmen were travelling to Arab countries and were in a position to bring home impulses from that region, apart from the tiny minority with the means to finance a pilgrimage to Mecca. Today many West Africans, especially Muslims, study in Arab countries like Morocco and Egypt (both religious and secular studies), many go as work migrant to the Arab Gulf, and more people have the means to travel on a pilgrimage to Mecca.

[15] The public Egyptian body responsible for issuing *fatwa*s, i.e. legal interpretations of Islamic jurisprudence.

[16] A *mufti* is someone who is in a position to issue *fatwa*s.

provided you with good things. Such is Allah, your Lord. Then blessed be Allah, the Lord of the Worlds! (The Qur'an 40:64)

Such as remember Allah, standing, sitting, and reclining, and consider the creation of the heavens and the earth, (and say): Our Lord! Thou createdst not this in vain. Glory be to thee! Preserve us from the doom of Fire. (The Qur'an 3:191)

Spend your wealth for the cause of Allah, and be not cast by your own hands to ruin; and do good. Lo! Allah loveth the beneficent. (The Qur'an 2:195)

Despite the clearly negative position concerning FGM taken by leading Muslim religious thinkers, it is still far from universally known among Muslims in West Africa. As a consequence, it will be long before Islam is used to justify FGM (cf. part 3.2.2.2). There are also examples of communities where a focus on Islam has made obsolete the rituals surrounding the FGM, but where the actual FGM continues to be practiced (see Hernlund 2000 for a description of the situation in the Gambia).

3.3.7.3 Traditional religion

Traditional religion and religious practice is emphasised in many communities as justification for practicing FGM, accordingly it is difficult to use traditional religion as an argument against FGM. However, large-scale migration moves West African societies in a direction where people are exposed to different ethnic and social groups. This is especially the case in urban areas. Consequentially, migrants are also exposed to groups with different traditions and practices. Influence from groups and communities that focus on following tradition, but who do not practice FGM, may contribute to other groups realising that it is perfectly possible for women to lead lives in accordance with tradition and conservative social values, without being subjected to FGM.[17]

3.4 FGM AS AN ISSUE THAT CONCERNS THE EXTENDED FAMILY

FGM is associated with traditions shared by communities, and the practice of FGM has social consequences for a number of people apart from girls and young women. Physically, the operation involves the girls themselves, as well as the people performing the operation and those who assist them. However, these people are not necessarily involved in making the decision to perform FGM. The parents of a girl or young woman are important, maybe especially her mother, but there are others who traditionally have a say in the decision. Grandparents, aunts and uncles (especially older siblings of both parents) have a lot of influence, but more distant relatives may also be involved in the decision. It is extremely rare that the upbringing of children is perceived as something that only concerns the children's parents.

At this point, we need to underline that a considerable number of West African children grow up with other people than their biological parents, compared to what is common in Western Europe. The share of children living with other people than their biological parents varies from region to region and between different social groups,

[17] Note that this influence may go in more than one direction. There are examples where groups who have not practiced FGM traditionally adopt the practice through influence from groups with high prestige in an area where they have recently migrated. South Sudanese migrants in North Sudan constitute one such example.

but estimates indicate that it concerns some 10 to 30 % of all children in several West African countries (Isiugo-Abanihe 1985, p. 61-63). Children often live with relatives, and traditionally they hold obligations and rights both towards their foster parents and their biological parents. Children may live with foster parents for shorter periods of time, or most of their childhood. Under such conditions, both foster parents and biological parents (as well as other relatives, as mentioned above) have influence over important life decisions made on behalf of the child.

In addition to the fact that more people than a girl/young woman's parents and/or guardians are involved and influential concerning decisions regarding her upbringing, these decisions may also have social consequences for others than the girl/young woman herself. Whether a young woman has been subjected to FGM or not affects her social status, but also that of her relatives.[18] Thus the interest other family members have in influencing this decision increases, and it is relatively easy for them to justify why they should be heard in the decision making process – to the extent that they have to explain why.

We have only been able to find very few scientific studies focusing on what kind of influence other relatives than a girl's parents/guardians have on the decision on whether to subject her to FGM. However, in a study from Nigeria, the reason "the grandparents expect it" comes far down on the list of arguments parents cite as having influenced their decision to subject their daughters to FGM (see Orubuloye, Caldwell & Caldwell 2000, p. 81, table 4.2:

Why do you and your husband want your daughters to be "circumcised"?	Rural (n=298) %	Urban (n=738) %
Tradition, culture, social conformity	90	65
Prevents death at birth	2	4
Reduces sexuality and promiscuity	2	6
Grandparents expect it	4	2
Don't want "circumcision"	2	23

[18] This is of course also the case with other decisions concerning the upbringing of children, i.e. whether a child is sent to school or not, giving some children priority over others when resources are scarce, etc.

In the same study, mothers who had chosen not to have FGM performed on their daughters were asked about the reactions from their own relatives, as well as from their in-laws (from Orubuloye, Caldwell & Caldwell 2000, p. 88, table 4.8):

Attitude of mothers' relatives	Distribution (n=52) %
In favor of the decision not to "circumcise"	45
Against the decision	16
Relatives don't know about the decision	23
Respondent doesn't know or care about her relatives' attitudes on these matters	13
No response	3
Attitude of her husband's relatives	
In favor of the decision not to "circumcise"	50
Against the decision	20
Relatives don't know about the decision	19
Respondent doesn't know or care about her in-laws' attitudes on these matters	10
No response	1

In an article concerning this subject in a Gambian context, there is information that it happens occasionally that girls are subjected to FGM against their own will as well as their mothers' (Hernlund 2000, p. 243). Such cases are also known elsewhere in the region.

Finally it is extremely difficult to state who will have the last word in cases where there are differences of opinion around the question of whether to subject girls and young women to FGM – the girls/young women themselves, their parents, other guardians or members of the extended family. This will depend on a number of factors – both decided by local cultural patterns and purely individual circumstances that are very difficult to predict. From the Nigerian study quoted above, it can seem that the parents/guardians usually have the final say, but this is clearly a subject which has received very little focus in the scientific literature on FGM.

4. POSSIBILITIES FOR PROTECTION AGAINST FGM

Conflicts of interest around FGM usually (though not always) take one of the two following forms:

- Parents/guardians wish to subject a daughter to FGM, against her will.[19]
- Parents/guardians wish to abstain from subjecting a daughter to FGM, but meet pressure from other relatives who wish the girl to be subjected to FGM.

Most conflicts between girls/young women and their parents/guardians will end with the girls having to submit and let themselves be subjected to FGM. This is closely related with girls' and young women's relatively limited autonomy in most West African societies, compared to what is common in i.e. Western European societies. The social risk connected to acting against the will of close relatives can be considerable, as most depend on them in their daily lives. One consequence of this is that compromises or the weaker party in a relationship accommodating the stronger is the most common result when there is conflict. Standing alone, with limited or no support from family and relatives, is usually considered worse than accommodating them or even submitting completely, against one's own personal wishes.

In situations where parents/guardians wish not to have their daughters subjected to FGM, but where other relatives may try to intervene and overrule their decision, the circumstances are more complex. As mentioned above in part 3.4, it is not given who will have the last word – parents/guardians or other relatives, and the result is far from certain.

In cases of conflict around the question on whether a girl/young women should be subjected to FGM or not, those in favour of FGM will often justify their position with arguments as described in part 3.2, whereas those who are against FGM will probably present arguments as described in part 3.3. In addition to discussions among the concerned, both parties will also be able to involve others to try to tip the scales in their favour. This part of the report will focus on what other persons and institutions that those opposing FGM can turn to for moral and practical support.

4.1 TRADITIONAL CONFLICT SOLVING MECHANISMS

When conflicts erupt within the family in West Africa, it is generally unusual to involve outsiders – especially representatives of public authorities, as most people are deeply distrustful of them. At the same time, most West Africans have a considerably wider circle of people they trust on different levels than what is

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[19] Cases where daughters wish to have FGM performed, against the will of their parents/guardians, do exist, see Leonard 2000. Such cases seem to be rare, and conflicts of this type will not be discussed here.

common in Western Europe, and members of this large circle can be asked for assistance when people need support in internal family conflicts.[20]

This circle consists of family members and relatives (even relatives so distant that many in Europe would probably not even be aware they were related to them), but also friends, neighbours, colleagues, religious leaders, figures of authority in the local community, etc. A "private family matter" is generally not something only involving parents and siblings; it can be discussed with a large number of other people – even when the subject is as sensitive as FGM.

However, as FGM concerns sexuality and gender roles, some women will hesitate to involve men, even men they have close ties to. In the same way, many men will resist attempts to involve them in the discussion of what they regard as a subject that mainly concerns women, even when they are actively asked to become involved.

4.1.1 Involving family members in discussions and mediation

In different situations of conflict between family members, the most common strategy is to attempt to build alliances with others within the family who see the question mainly like oneself, but who also carry weight and have authority within the family. Relative age and gender is important in this respect, but also educational level, social standing, personality and special ties within the family will influence who will be appealed to for assistance.

West African families, including nuclear families, are usually considerably larger than what is the case in Western Europe (as the birth rate per woman is still generally higher than what is common in Europe). Accordingly, most West Africans have more siblings than Europeans, as well as more aunts, uncles, cousins, great aunts, great uncles, etc. As mentioned above, people also maintain everyday contact with a considerably wider family circle than what is common in Europe.

Families of this size show considerable internal social variation – concerning social standing, financial situation, educational level and religious views. As a result of this, there is usually also a large spectre of views within an extended family, and most people will have access to relatives they trust and who they can turn to for assistance in different kinds of crisis situations. Of course, this is the case for both parties in a conflict situation, who will both try to mobilise the support of family members for their cause. In cases where no party is able to convince the other, the elders in the family will often make the final decision – either a compromise solution[21] or a solution favouring one of the parties.

4.1.2 Involving traditional authority figures

In some cases, people who are directly involved in the conflict, their allies and/or family members with considerable authority may choose to involve traditional authority figures for advice, assistance with mediation or to make a decision. Such

[20] In societies with widespread poverty, and where there has never been a state-run social security system making any large difference, it remains crucial to establish and maintain reciprocally obliging social ties with people one can turn to in times of need.

[21] In the case of FGM, a possible compromise solution may be that FGM is performed, but of a less extensive type than what was originally intended.

traditional authority figures may be clan leaders, people holding other kinds of traditional leadership positions and practitioners of traditional medicine.

We would like to emphasise that although people with authority deriving from their legitimacy as guardians of traditional values could be expected to generally uphold traditions, including FGM, regardless of circumstances, they may be very pragmatic when they see that upholding certain traditions creates large conflicts and problems in the local community. It is therefore not set in stone that traditional authorities will always recommend that FGM be performed.

4.1.3 Village and clan councils

Especially in rural areas, deadlocked conflicts between family members may be subject to a more formalised mechanism for solving conflicts. In many rural communities in West Africa, there are structures where deep, complicated conflicts are addressed in different kinds of councils. People appointed to sit on such councils are often elders held in high esteem and whose faculties of judgment is generally trusted by people in the community. Often they will try to reach some kind of consensual resolution. Compromise solutions are common in cases being heard before councils of this kind.

4.1.4 Turning to a social network outside the family circle

In today's urbanised West Africa, people's social networks outside the family circle increase in importance, and it is common to mobilise such relations in order to persuade an opponent in a family conflict – especially among people living in cities. This, however, depends on the person in question being trusted by more people in the family than just the one(s) appealing to him/her for help – otherwise it will be easier for the opponent(s) to dismiss the person as an outsider.

There are virtually no limits to what kinds of people may be brought into the dispute this way, but they must be people with weight and authority. They could be colleagues or work superiors, contacts from civil society or prominent members of one's congregation, to mention a few examples.

4.1.5 Religious authorities

In addition to prominent members from one's own congregation, religious leaders – that is priests, imams, deacons, board chairmen, etc. – are people who may be mobilised for support in family conflicts. Such people will rarely be seen as outsiders. Religious leaders are in general people who command great respect and authority in West African societies.

4.2 PUBLIC AUTHORITIES

Most West Africans are deeply distrustful of public authorities in general, including the police and the courts. To the extent that people do involve representatives of the public authorities in family conflicts, it is most often because they have close personal ties to the individual and want to draw on the authority the person derives from a general position of power, and only rarely solely because of his/her formal role per se.

Thus, if i.e. a judge becomes involved because one of the parties in a family conflict appeals to him/her for support, it is probably because s/he is someone with considerable prestige, authority and influence in general (which is meant to "rub off" on the one who has asked for help), and not because of his/her professional legal background.

4.2.1 Enforcement of legislation prohibiting FGM

Legislation prohibiting FGM is only rarely enforced in the West African countries that have introduced it. One important reason is that it would imply prosecution of a huge number of people (see Economist 1999). According to Shell-Duncan & Hernlund, "Formal legislation has proven […] to be a poor instrument of cultural change" (2000, p. 33), and in their opinion, a legal ban can be directly counterproductive (2000, p. 34).

4.2.2 Public authorities acting as *ombudsmen*

In several West African countries we find state-supported human rights commissions and similar public authorities that are mandated to act as *ombudsmen* for the general public. Several such bodies offer help with arbitration and legal assistance to people who turn to them for help.

During a discussion with a representative from Landinfo, the staff at the National Human Rights Commission in Nigeria stated that legislation prohibiting FGM is symbolically important as an expression of progressive values. They also maintained that a legal ban may work as an extra deterrent when the commission mediates in cases where young women resist being subjected to FGM, even though it is common knowledge that the ban rarely or never leads to prosecution of people responsible for subjecting girls and young women to FGM.

Generally, such public bodies have scarce resources, even in countries that are relatively wealthy for the region (like Nigeria and Côte d'Ivoire). Many people are unaware of the possibility that they can turn to these commissions for help, and even when people do know of the possibility, the general distrust of public authorities and reluctance to involve people to which one has no personal ties in private family matters results in them being involved in relatively few cases. There is also reason to believe that most people who would appeal to such a commission for help would be well educated people from higher social strata.

4.3 NGOs

Organisations working for women's and children's rights in general, and against FGM in particular, could be expected to inspire larger trust with most people than public authorities. However, representatives of such organisations may be dismissed as outsiders if they involve themselves in family conflicts on behalf of a young woman or her parents/guardians in order to resist pressure to undergo FGM.

In the cases where people do contact such organisations, they can often provide both help with mediation and legal assistance. However, most such organisations have limited resources, something which has consequences for the help they are able to provide in different cases – especially to people who live far away from the capital or other large cities.

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