



# Seven Things to Know about Female Genital Surgeries in Africa

BY THE PUBLIC POLICY ADVISORY NETWORK ON FEMALE GENITAL  
SURGERIES IN AFRICA

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Western media coverage of female genital modifications in Africa has been hyperbolic and one-sided, presenting them uniformly as mutilation and ignoring the cultural complexities that underlie these practices. Even if we ultimately decide that female genital modifications should be abandoned, the debate around them should be grounded in a better account of the facts.

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Starting in the early 1980s, media coverage of customary African genital surgeries for females has been problematic and overly reliant on sources from within a global activist and advocacy movement opposed to the practice, variously described as female genital mutilation, female genital cutting, or female circumcision. Here, we use the more neutral expression female genital surgery. In their passion to end the practice, antimutilation advocacy organizations often make claims about female genital surgeries in Africa that are inaccurate or overgeneralized or that don't apply to most cases.

The aim of this article—which we offer as a public policy advisory statement from a group of concerned

research scholars, physicians, and policy experts—is not to take a collective stance on the practice of genital surgeries for either females or males. Our main aim is to express our concern about the media coverage of female genital surgeries in Africa, to call for greater accuracy in cultural representations of little-known others, and to strive for evenhandedness and high standards of reason and evidence in any future public policy debates. In effect, the statement is an invitation to actually have that debate, with all sides of the story fairly represented.

Some of the signatories of this policy statement support efforts to promote voluntary abandonment of all practices of genital surgery on children. Other signatories wish to allow parents to continue to circumcise males, but not females. Still other signatories seek to preserve the right of parents to carry forward their religious and cultural traditions and

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conceptions of a normal body and appropriate gender development and to continue to surgically modify the genitals of both girls and boys under conditions that are not harmful. Others believe that children's rights include their rights not to have surgical changes made to their bodies before they are old enough to decide for themselves. But whatever our ethical ideals, whatever policies we might personally promote, whatever programs we have tried to implement,

we believe that any genuine public policy debate should be grounded in the best available evidence and begins with fact checking.

The dominant tone and substance of mainstream media representations of female genital surgeries in Africa is illustrated by a 1995 opinion piece by A.M. Rosenthal, the former editor and columnist at the *New York Times*:

Here is a dream for Americans, worthy of their country and what

they would like it to be. The dream is that the U.S. could bring about the end of a system of torture that has crippled 100 million people now living upon this earth and every year takes at least two million more into an existence of suffering, deprivation and disease. . . . The torture is female genital mutilation. This is what it usually includes: the partial or total excision of the clitoris and all or parts of the labia minora and labia

## The Public Policy Advisory Network on Female Genital Surgeries in Africa

The Public Policy Advisory Network on Female Genital Surgeries in Africa is an informal group that includes medical researchers, anthropologists, physicians, legal scholars, geographical area specialists, and feminists who have expert knowledge about female genital surgeries in Africa and are concerned about the accuracy, objectivity, fairness, and balance of current media representations of the practice. "Seven Things to Know about Female Genital Surgeries in Africa" is published as a collective statement with the support and endorsement of the network. Portions of the text were initially drafted by Lucrezia Catania, Ellen Gruenbaum, and Richard A. Shweder with significant revisions from Fuambai Sia Ahmadu and Bettina Shell-Duncan, and then finalized in the light of editorial suggestions from the entire network. For more information about the network, contact Fuambai Ahmadu.

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majora, plus the sewing or pinning together of both sides of the vulva, by catgut or thorns, and the obliteration of the vaginal entrance except for a tiny passage. The male equivalent would be the removal of the penis. . . . The purpose is to insure virginity and destroy sexual pleasure. It is a form of male control, perhaps the ultimate except for murder.<sup>1</sup>

Mainstream news reports on the topic have mostly followed suit, reporting as established facts claims about the disastrous health consequences of female genital surgeries (including the attenuation of female sexual capacity). Feature articles have deplored the custom, quoting (for example) African antimutilation activists who declare that female genital surgery is “the most widespread and deadly of all violence victimizing women and girls in Africa”<sup>2</sup> and painting the now-familiar portrait of African female genital surgeries as savage, horrifying, harmful, misogynist, abusive, and socially unjust—“A Rite of Torture for Girls.”<sup>3</sup>

It is noteworthy that Rosenthal credited three antimutilation advocacy groups, including the organization that publishes *The Hosken Report*, a document that popularized the expression “female genital mutilation” and was widely distributed to opinion-makers and journalists in the 1980s and 1990s.<sup>4</sup> The advocacy literature characteristically features lists of short- and long-term medical complications all said to be caused by female genital surgery, including blood loss, septic shock, acute infection, reduction of the sex drive, elimination of the capacity for orgasm, menstrual problems, incontinence, sterility, child-bearing difficulties (including maternal mortality), and death at an

early age. Over the past three decades or so, the standard mainstream media narrative has recapitulated and popularized many of those claims, often without independent fact checking or a critical and balanced assessment of the evidence.

For example, looking ahead to a point we will make later, Rosenthal’s description of what a typical female genital surgery in Africa “usually includes” (namely, “the sewing or pinning together of both sides of the vulva, by catgut or thorns, and the

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obliteration of the vaginal entrance except for a tiny passage”) is not factually correct, since infibulations amount to approximately 10 percent of cases across the continent, according to a 2007 estimate generated by P. Stanley Yoder and Shane Khan.<sup>5</sup> That 10 percent includes surgeries using medical suture techniques and conducted under hygienic conditions in clinics or hospitals. Nevertheless, the image inscribed by Rosenthal has become the prototype of an African female genital surgery in the minds of many people.

#### **A Primer on Female Genital Surgery**

Customary *male* genital surgery, such as neonatal male circumcision, is a familiar practice in the United States, and approximately 30 percent of all males in the world have had their genitals surgically modified in some way, often (as in Turkey,

South Korea, and many countries in Africa) during their preadolescent or adolescent years.<sup>6</sup> Customary female genital surgery is far less familiar in the United States, and also less prevalent globally, although it is practiced in many East and West African countries, among particular ethnic groups in other regions of Africa, and in some parts of Southeast Asia (for example, Malaysia) and the Middle East.<sup>7</sup> Nationally representative survey data on female genital surgery are available for twenty-eight African countries.

In some countries, the prevalence among women aged fifteen to forty-nine is very high (over 80 percent). These include estimates from Djibouti (93 percent), Egypt (91 percent), Eritrea (89 percent), Guinea (96 percent), Mali (85 percent), Sierra Leone (91 percent), Somalia (98 percent), and northern Sudan (89 percent).

As with customary forms of male genital surgery, the female age for genital modification varies considerably, ranging from infancy to late adolescence. The meanings and motives associated with the practice vary as well and are not necessarily shared by every ethnic group. Nevertheless, concerns about carrying forward one’s traditions and being included in them are commonplace. Many women who have had genital surgeries view the procedure as a cosmetic beautification, moral enhancement, or dignifying improvement of the appearance of the human body. This is true of both male and female genital modifications in African cultures. Within the aesthetic terms of these body ideals, cosmetically unmodified genitals in both men and women are perceived and experienced as distasteful, unclean, excessively fleshy, malodorous, and somewhat ugly to behold and touch. The enhancement of gender identity is also frequently a

significant feature of genital surgery, from the point of view of insiders who support the practice. In the case of male genital surgeries, the aim is to enhance male gender identity by removing bodily signs of femininity (the foreskin is perceived as a fleshy, vagina-like female element on the male body). In the case of female genital surgeries, the aim is often to enhance female gender identity by removing bodily signs of masculinity (the visible part of the clitoris is perceived as a protruding, penis-like masculine element on the female body).

The style and degree of surgery also vary. A type I female genital surgery, as classified by the World Health Organization, is restricted to procedures involving reduction of either the clitoral hood (the prepuce) or the external or protruding elements of clitoral tissue, or both. Type II involves partial or complete labial reductions and partial or complete reductions of the external or protruding elements of clitoral tissue. Approximately 90 percent of all female genital surgeries in Africa are either type I or type II.<sup>8</sup> The remaining 10 percent of cases, classified as type III, are those in which the operation is concluded by shielding and narrowing the vaginal opening with stitches or other techniques of sealing, which forms a smooth surface of joined tissue that is opened at the time of first sexual intercourse. This “infibulation” or “sealing” procedure occurs largely in the Northeast of Africa and among certain Fula and other ethnic groups across the Sahara belt. In all other regional and ethnic settings, type I and type II surgeries are most common, and they are the main focus of this public policy statement.

Focusing, then, primarily (although not exclusively) on the 90 percent, it is our hope that some basic fact checking and a more thoroughgoing representation of the voices of research scholars will change the character of the media discussion of female genital surgeries. We also believe that far greater attention should

be paid to the perspectives of African women who value the practice and describe it accordingly (for example, as genital beautification or genital cleansing). In what follows, we hope to supply the public with accurate information about the practice of genital surgery in Africa and move the coverage of the topic from an overheated, ideologically charged, and one-sided story about “mutilation,” morbidity, and patriarchal oppression to a real, evidence-based policy debate governed by the standards of critical reason and fact checking. To that end, we have all agreed to be signatories of this advisory statement despite differences in our views of the appropriate public policy response to the practice. The first part lists seven facts about female genital surgeries in Africa that we believe to be true based on the best research available on the topic.

Many of the facts enumerated below may seem astonishing. Several counter the familiar and widely circulated horror-inducing representations promoted by antimutilation advocacy organizations and uncritically recapitulated by the media in the United States, Canada, Europe, and elsewhere. The second part of the statement traces a few policy implications and invites a more balanced public policy conversation.

### **Seven Things to Know about Female Genital Surgeries in Africa**

*1. Research by gynecologists and others has demonstrated that a high percentage of women who have had genital surgery have rich sexual lives, including desire, arousal, orgasm, and satisfaction, and their frequency of sexual activity is not reduced.<sup>9</sup>* This is true of the 10 percent (type III) as well as the 90 percent (types I and II). One probable explanation for this fact is that most female erectile tissue and its structure is located beneath the surface of a woman’s vulva. Surgical reductions of external tissues per se do not prevent sexual

responsiveness or orgasm. It is noteworthy that cosmetic surgeons who perform reductions of the clitoris and the clitoral hood in the United States, Europe, and Canada recount that there is usually no long-term reduction in sexual sensation, which is consistent with the findings of research on African women.

Both of these findings fit with the broader emerging scientific understanding of sexuality as a complex interaction of mental processes, relational dynamics, and neurophysiological and biochemical mechanisms. It should also be emphasized that cases of sexual dysfunction and pain during sex have been reported both by women who have undergone female genital surgery and by those who have not. Further research is required to understand the physical and psychological impact, if any, of various types of genital surgeries, the influence of sociocultural context, and the extent to which sexual sensation and function may be affected, particularly in cases of type III.

*2. The widely publicized and sensationalized reproductive health and medical complications associated with female genital surgeries in Africa are infrequent events and represent the exception rather than the rule.<sup>10</sup>* Reviews of the medical and demographic literature and direct comparisons of matched samples of “uncut” and “cut” (primarily type II) African women suggest that, from a public health point of view, the vast majority of genital surgeries in Africa are safe, even with current procedures and under current conditions. According to some medical experts, with a proper input of medical resources, the potential for harm can be reasonably managed. The exceptions, where and when they occur, are usually the result of inadequate surgical conditions, hygiene, or malpractice, as well as relative deficiencies in the general health care system in Africa. Significantly, reviews of the medical literature indicate that most of the widely publicized claims about high morbidity or mortality and negative

reproductive health consequences of female genital surgeries do not stand up to critical scientific analysis. In countries in Africa where morbidities (infertility, stillbirths, menstrual problems, damage to the perineum) are relatively high compared to North American or European standards, those morbidity levels are just as high for “uncut” women.<sup>11</sup> In Western countries, some medical experts who treat affected African women suggest that instances of morbidity may be related more to miscommunication, fear, distrust, delays in seeking care, and avoiding medical and surgical interventions than to surgical genital modification per se.<sup>12</sup>

*3. Female genital surgeries in Africa are viewed by many insiders as aesthetic enhancements of the body and are not judged to be “mutilations.”*<sup>13</sup> From the perspective of those who value these surgeries, they are associated with a positive aesthetic ideal aimed at making the genitals more attractive—“smooth and clean.” The surgeries also serve to enhance gender identity from the point of view of many insiders. These aesthetic and gender identity norms are in flux and are variable even among mainstream populations in Europe and North America. The globalization of images of women’s bodies has increasingly popularized the ideal of a smooth and clean genital look that is reminiscent of the aesthetic standards associated with genital surgeries in East and West Africa. As an index of this recent trend, although the number of operations performed each year is quite small, type I and type II genital surgeries (described as clitoroplexy, clitoral reduction, and labiaplasty by cosmetic surgeons) are gaining in popularity in North America and Europe in what is now one of the fastest growing forms of cosmetic surgery in those regions of the world.<sup>14</sup>

*4. Customary genital surgeries are not restricted to females.* In almost all societies where there are customary female genital surgeries, there are also customary male genital surgeries, at similar ages and for parallel reasons. In other words, there are few societies in the world, if any, in which female but not male genital surgeries are customary. As a broad generalization, it seems fair to say that societies for whom genital surgeries are normal and routine are not singling out females as targets of punishment,

**Female genital surgeries worldwide should be addressed in a larger context of discussions of health promotion, parental and children’s rights, religious and cultural freedom, gender parity, debates on permissible cosmetic alterations of the body, and female empowerment issues.**

sexual deprivation, or humiliation. The frequency with which overheated, rhetorically loaded, and inappropriate analogies are invoked in the antimutilation literature (“female castration,” “sexual blinding of women,” and so on) is both a measure of the need for more balanced critical thinking and open debate about this topic and one of the reasons we are publishing this public policy advisory statement.

*5. The empirical association between patriarchy and genital surgeries is not well established.* The vast majority of the world’s societies can be described as patriarchal, and most either do not modify the genitals of either sex or modify the genitals of males only. There are almost no patriarchal societies with customary genital surgeries for females only. Across human societies there is a broad range of cultural attitudes concerning female sexuality—from societies that press for temperance, restraint, and the control of sexuality to those that

are more permissive and encouraging of sexual adventures and experimentation—but these differences do not correlate strongly with the presence or absence of female genital surgeries. In some societies where genital surgeries are customary for females and males (for example, in Northeast Africa), chastity and virginity are highly valued, and type III surgeries involving infibulation may be expressive of these values, but those chastity and virginity concerns are neither distinctive nor characteristic of all societies

for whom genital surgeries are customary. Indeed, female genital surgeries are not customary in the vast majority of the world’s most sexually restrictive societies.

*6. Female genital surgery in Africa is typically controlled and managed by women.* Similarly, male genital surgery is usually controlled and managed

by men. Although both men and women play roles in perpetuating and supporting the genital modification customs of their cultures, female genital surgery should not be blamed on men or on patriarchy. Demographic and health survey data reveal that when compared with men, an equal or higher proportion of women favor the continuation of female genital surgeries. A more thoughtful analysis is needed: those who want to ensure that women have a say in the conduct of their lives should support women in their quest for choices about their own bodies and traditions. Ironically, the effect of some antimutilation campaigns in Africa is to weaken female power centers within society and bring women’s bodies and lives under the hegemonic control and management of local male religious or political leaders. We see it as preferable that any changes that may be made are led by the women of these societies themselves.

7. *The findings of the WHO Study Group on Female Genital Mutilation and Obstetric Outcome*<sup>15</sup> is the subject of criticism that has not been adequately publicized. The reported evidence does not support sensational media claims about female genital surgery as a cause of perinatal and maternal mortality during birth. The WHO study was published in the prestigious medical journal *Lancet* in 2006 and received widespread and rather sensationalized coverage by the media. A story in the *New York Times* began as follows: “The first large medical study of female genital cutting has found that the procedure has deadly consequences when the women give birth, raising by more than 50 percent the likelihood that the woman or her baby will die.”<sup>16</sup>

A careful reading of the WHO study reveals that the results are very complex. There were no statistically significant differences in reproductive health between those who had a type I genital surgery and those who had no surgery. The perinatal death rate for the women in the sample who had a type III surgery was, in fact, lower (193 infant deaths out of 6,595 births) than for those who had no surgery at all (296 infant deaths out of 7,171 births) and became statistically significant only through nontransparent statistical adjustment of the data. After statistical adjustments, there was no significant difference in risk of maternal mortality when comparing “uncut” women with the sample of women with type I and type III genital surgeries. “Infibulated” women did not have higher maternal mortality than “uncut” women, although women with type II surgeries did. Maternal death was not a frequent event. The absolute raw numbers for maternal deaths were as follows: out of 28,393 deliveries, fifty-four women died before discharge: nine had no female genital surgeries, fifteen had type I, twenty-three had type II, and seven had type III. The study collected data on women across six nations but did

not display the within-nation results so that one could determine if the results replicated well. There was no direct control for the quality of health care available for “cut” versus “uncut” women. Although it is understandable that a hospital-based study could not offer a sample that would represent the whole population, a dispassionate assessment of the WHO study group findings might well conclude that the results of the study have been sensationalized and misrepresented. The reported findings suggest that female genital surgeries are less hazardous than cigarette smoking as a risk factor for pregnancy.<sup>17</sup>

It should also be pointed out that the WHO study was not the first large medical study of female genital cutting. A high-quality Medical Research Council study of the reproductive health of over one thousand “cut” and “uncut” women in the Gambia published in 2001 suggested that many of the reproductive morbidities publicized by antimutilation activists were equally prevalent among “uncut” women.<sup>18</sup> That study received no media attention.

## Policy Implications

*1. Better fact checking and better representation of the voices of scholars and the perspectives and experiences of African women who value female genital surgery are likely to change the character of the discussion.* For nearly three decades, there has been an uncritical relationship between the media and antimutilation advocacy groups. In the face of horrifying and sensational claims about African parents “mutilating” their daughters and damaging their sexual pleasure and reproductive capacities, there has been surprisingly little journalistic exploration of alternative views or consultation with experts who can assess current evidence.

We recommend that journalists, activists, and policy-makers cease using violent and preemptive rhetoric. We recommend a more balanced

discussion of the topic in the press and in public policy forums. Female genital surgeries worldwide should be addressed in a larger context of discussions of health promotion, parental and children’s rights, religious and cultural freedom, gender parity, debates on permissible cosmetic alterations of the body, and female empowerment issues.

The voices of African women who support female and male genital modification for their children and themselves have not been adequately represented in the media or in public policy forums. These parents are neither monsters nor fools: like parents everywhere, they want to do the right thing for their children and are concerned about their children’s health. Nor are they necessarily uneducated or ignorant or helpless prisoners of an insufferably dangerous tradition that they themselves would like to escape, if only they could find a way out. Many highly educated women in Africa embrace the practice and do so without negative health consequences. For the sake of a balanced discussion, it will be necessary to create a context where women can express their support for the practices without being attacked. African women who live outside Africa but who grew up in regions of Africa where genital surgeries are routine and have a positive connotation should be included in a more respectful and productive discourse that creates a supportive or protective context against stigmatization, fear, or humiliation. Some medical practitioners have suggested that the horror-inducing media coverage of the topic over the past three decades can have a psychological impact on a woman’s genital self-image upon immigration to countries where female genital surgery is condemned, thereby inducing an “acquired sexual dysfunction.”<sup>19</sup>

*2. It should be acknowledged that female genital surgeries are not unique to African women.* Surgical practices that reduce or alter the external genitalia of women include

## Further Reading

Some of the publications cited in the endnotes provide a core reading list for readers wanting more information about female genital surgeries. Other relevant publications are listed here.

1. J. Abdulcadir et al., "Care of Women with Female Genital Mutilation/Cutting," *Swiss Medical Weekly* 140 (2011): w13137.
2. R. Abusharaf, "Virtuous Cuts: Female Genital Mutilation in an African Ontology," *Differences: A Journal of Feminist Cultural Studies* 12 (2001): 112-40.
3. K. Bell, "Genital Cutting and Western Discourses on Sexuality," *Medical Anthropology Quarterly* 19, no. 2 (2005): 125-48.
4. J. Boddy, *Civilizing Women: British Crusades in Colonial Sudan* (Princeton, N.J.: Princeton University Press, 2007).
5. J. Boddy, "Violence Embodied? Circumcision, Gender Politics, and Cultural Aesthetics," in *Rethinking Violence Against Women*, ed. R.E. Dobash and R.P. Dobash (Thousand Oaks, Calif.: Sage, 1996).
6. J. Boddy, "Womb as Oasis: The Symbolic Context of Pharaonic Circumcision in Rural Northern Sudan," *American Ethnologist* 9 (1982): 682-98.
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9. C. Fernandez-Romano, "The Banning of Female Circumcision: Cultural Imperialism or a Triumph for Women's Rights?" *Temple International and Comparative Law Journal* 13 (1999): 137-61.
10. M. Johnson, "Becoming a Muslim, Becoming a Person: Female 'Circumcision,' Religious Identity, and Personhood in Guinea-Bissau," in *Female "Circumcision" in Africa: Culture, Controversy and Change*, ed. B. Shell-Duncan and Y. Hernlund (Boulder, Colo.: Lynne Rienner, 2000), 215-34.
11. S. Johnsdotter, "Projected Cultural Histories of the Cutting of Female Genitalia: A Poor Reflection in the Mirror," *History and Anthropology* 23, no. 1 (2012): 91-114.
12. S. Johnsdotter and B. Essen, "Gender and Ethnicity: The Politics of Genital Modifications," *Reproductive Health Matters* 18, no. 35 (2010): 29-37.
13. C. Kratz, "Circumcision, Pluralism, and Dilemmas of Cultural Relativism," in *Applying Anthropology: An Introductory Reader*, 9th ed., ed. A. Podelfsky, P.J. Brown, and S. Lacey (New York: McGraw Hill, 2008), 269-80.
14. C. Kratz, "Seeking Asylum, Debating Values and Setting Precedents in the 1990s: The Cases of Kassindja and Abankwah in the United States," in *Transcultural Bodies: Female Genital Cutting in Global Context*, ed. Y. Hernlund and B. Shell-Duncan (New Brunswick, N.J.: Rutgers University Press, 2007), 167-201.
15. C. Kratz, "Female Circumcision in Africa," in *Africana: The Encyclopedia of the African and African American Experience*, 2nd ed., ed. K.A. Appiah and H.L. Gates, Jr., (New York: Oxford University Press, 2004).
16. M. Malmstrom, "Just Like Couscous: Gender, Agency and the Politics of Female Circumcision in Cairo," doctoral thesis, University of Gothenburg, Sweden, 2009, <http://gupea.ub.gu.se/dspace/handle/2077/20269>.
17. M. McKinley, "Cultural Culprits," *Berkeley Journal of Gender, Law and Justice* 24 (2009): 91-164.
18. W. Njambi, "'One Vagina To Go': Eve Ensler's Universal Vagina and Its Implications for African Women," *Australian Feminist Studies* 24, no. 60 (2009): 167-80.
19. W. Njambi, "Rescuing African Women and Girls from Female Genital Practices: A Benevolent and Civilizing Mission," in *Burden or Benefit? Imperial Legacies of Benevolence*, ed. H. Gilbert and C. Tiffin (Indianapolis: Indiana University Press, 2008).
20. M. Parker, "Rethinking Female Circumcision," *Africa* 65 (1995): 506-524.
21. B. Shell-Duncan and Y. Hernlund, "Female 'Circumcision' in Africa: Dimensions of the Problem and the Debates," in *Female "Circumcision" in Africa*, ed. Shell-Duncan and Hernlund, 1-40.
22. R.A. Shweder, "What about 'Female Genital Mutilation'? And Why Understanding Culture Matters in the First Place," in *Engaging Cultural Differences*, ed. R. Shweder, M. Minow, and H. Markus (New York: Russell Sage Foundation Press, 2003), 216-51.
23. R.A. Shweder, "When Cultures Collide Whose Rights? Which Tradition of Values? A Critique of the Global Anti-FGM Campaign," in *Global Justice and the Bulwarks of Localism: Human Rights in Context*, ed. C.L. Eisgruber and A. Sajo (Leiden, the Netherlands, and Boston, Mass.: Martinus Nijhoff, 2005), 181-99.
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26. C.J. Walley, "Searching for 'Voices': Feminism, Anthropology, and the Global Debate over Female Genital Operations," *Cultural Anthropology* 12 (1997): 405-38.
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a wide range of behaviors, from the genital modification rites of passage celebrated by some African women to genital piercings on college campuses to cosmetic labia or clitoral reductions and vaginal rejuvenations requested by some Western women, to ritual practices and excisions among particular ethnic groups in Malaysia, the Middle East, India, and South America. Global health policies have singled out African female genital surgeries as “mutilation” and have targeted these for global eradication while largely ignoring similar cultural, religious, and aesthetic surgical practices involving female (and male) genitalia in other parts of the world. This has led to further stigmatization and prejudicial treatment of affected African women in clinics and hospitals on the continent, as well as those in the Western diaspora. A more forthright and critical discussion of this focus is called for.

**3. *There are medical advocates worldwide seeking to promote public health by broadening the legal scope for safe, hospital-based genital surgeries for females.*** Parental and religious rights advocates who argue for such choices claim moral and legal parity with the practice of neonatal male genital surgery and with other legally available body modification procedures (breast implants, sex change operations, and cosmetic surgeries for “normalizing” the appearance of Down syndrome children). They should be given a voice in public policy forums. Advocates of such approaches should be encouraged to articulate their proposals and defend them with reference to relevant legal, ethical, and cosmetic medical norms. A more respectful and less ethnocentric discourse is needed—one that breaks with the old schemes for demonizing and criminalizing others, provides the scientific and ethical basis for a better informed discussion, and more effectively contributes to social and cultural change.

**4. *“Zero tolerance” slogans of the type promoted by antimutilation advocacy groups are counterproductive***

***to balanced critical discussion and do not help the process of change.*** Such slogans tend to limit debate and imply that those who disagree are bad people. Such slogans do not promote the thoughtful, respectful dialogue that is essential to cross-cultural understanding and to encouraging those who are considering change. Indeed, criminalization, although it may be well-intended, often serves to drive a practice underground (as has happened at times with abortion), making it less accessible to the public health measures and the open dialogue that could improve health and promote the possibility of change.

**5. *Adult women should be free to choose what makes them happy with their own bodies.*** Legislation and regulations in countries that criminalize female genital surgeries for adult women should be reexamined. In effect, they treat women from African backgrounds in a discriminatory way by denying their autonomy. If an adult woman wants to undergo cosmetic surgery to reduce the size of her labia or clitoris in accordance with her aesthetic and cultural ideals, she should be free to do so. Similarly, those who believe such surgeries to be unnecessary or harmful should be free to present their information and argue their case. Some feminists in the West have argued that such procedures as breast implants, liposuction, and cosmetic genital surgeries exploit women and pressure them to conform to a cultural ideal of feminine beauty. This, in turn, may create a desire for cosmetic surgical procedures, which are never entirely free of risk. Others argue that a woman has the right to decide herself whether to have cosmetic surgery. But these debates have respected that individuals are in fact choosing for themselves.

**6. *Studies of genital surgeries for males or females should be multidisciplinary, and there should be support for a network linking researchers and advocates who have diverse points of view about the topic.*** Experts should deepen their knowledge of variations in practices in the countries where

genital surgeries are considered normal and routine. Research should include dimensions of variation in different age groups, social classes, generations, and religions and should study change over time.

**7. *Women and girls who have undergone genital surgery as children and who are living in countries where female genital surgery is not practiced or is illegal should not be subjected to social messages that stigmatize them, teach them to expect sexual dysfunction, or make them fear sexual relationships.*** In particular, we question the discourse that creates negative expectations about sexuality among women and girls who have had genital surgeries during childhood in their countries of origin (including girls who are adopted from practicing societies in Southeast Asia, Africa, and other parts of the world) but who are now living in Europe and North America. The horrifying, stigmatizing, and frequently erroneous or hyperbolic messages of the media, some activists, and well-meaning health educators and doctors may provoke what could be called “psychological mutilation”: being told that one is mutilated or is a victim of mutilation and that one should expect no sexual pleasure can compromise the development of a normal and healthy psychosexual life. To help women avoid these social messages, they should be allowed to choose knowledgeable caregivers and counselors who are comfortable treating them.

Our aim in this policy statement is not to take a collective stance or arrive at a moral judgment about the practice of genital surgeries for either females or males. Our hope is that this essay might serve as an invitation to recognize that there actually are many sides to this story, to sound a call for greater accuracy and genuine fact checking in media representations of other cultures, and to place the provocative topic of female genital surgeries in a forum where critical reason, free inquiry, and debate in the pursuit of accurate and relevant bioethical information are highly valued.

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