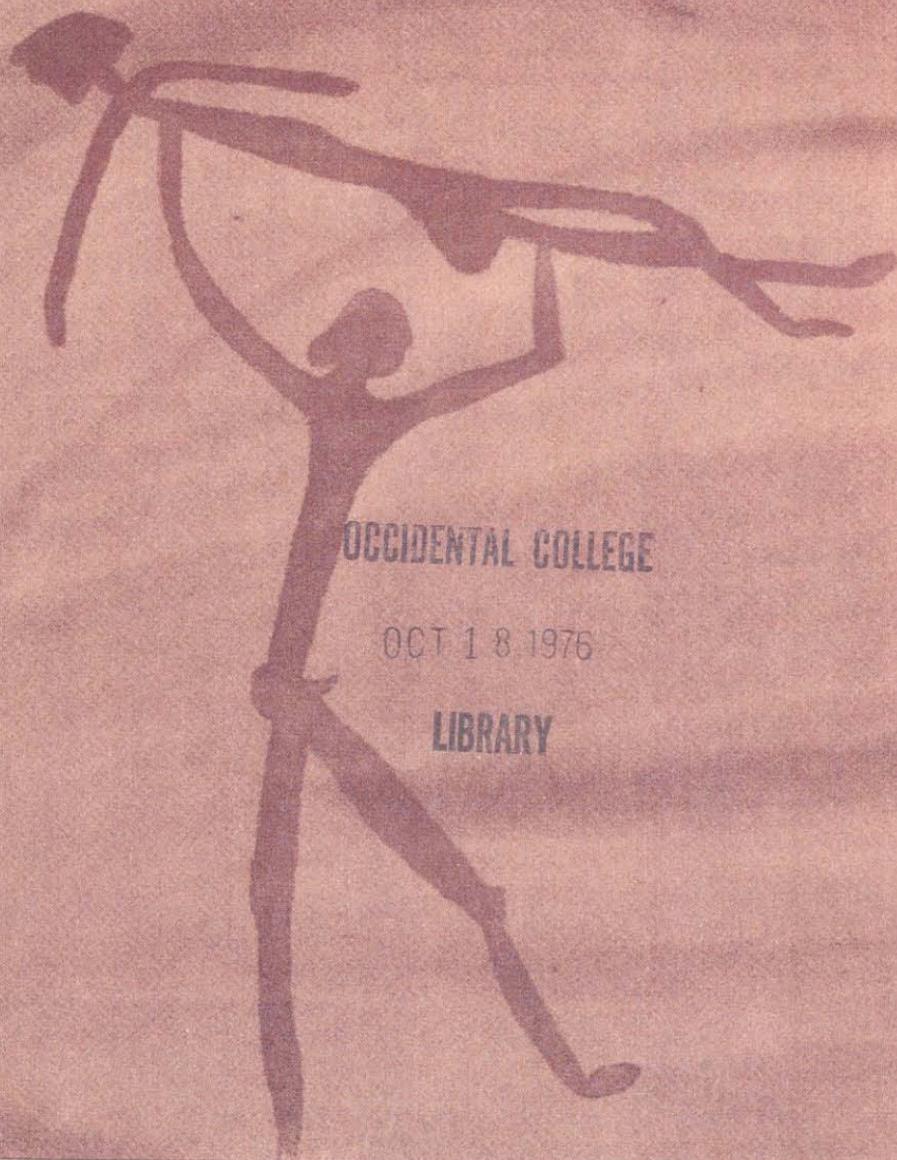


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Genital Mutilation of Women
in Africa

Fran P. Hosken

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Genital Mutilation of Women
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Cover Illustration: "Bushman" drawing by unknown male or female artist in a Namibian cave. From *The Hunter and his Art*, published by The Munger Africana Library.

INTRODUCTION

The International Women's Decade has already achieved some important and tangible goals in implementing the World Plan of Action agreed upon by the more than 140 United Nations countries. It has demonstrated that there is a direct relationship between the status and condition of women and a country's or region's development.

The United Nations, under the guidance of the U.N. International Women's Year Secretariat, has assembled an extraordinary quantity of first-rate research studies and reports of seminars and workshops on women in every culture and concerned with almost all aspects of women's lives.

THE SCOPE OF THE PROBLEM

One subject that critically affects the lives of millions of women in Africa was completely ignored: genital mutilation. Yet genital mutilation, or "operations based on customs" (the term used by the United Nations), was the subject of a resolution [680 BII (XXVI)] of the Status of Women Committee as early as 1958. The Economic and Social Council at that time invited the World Health Organization to undertake a study "of the persistence of customs which subject girls to ritual operations and of the measures adopted or planned to put an end to these practices."

The World Health Organization took the position that the operations in question were based on "social and cultural backgrounds," and therefore were outside its competence. WHO stated that it would supply medical information as part of any wider socioeconomic study undertaken [E/3592]. To date no such study has been made, nor has any further action been taken [see E.74 XIV, U.N. Action in the Field of Human Rights]. And the U.N. Status of

Women Committee documents show that the question of these operations was discussed at the U.N. Seminar on the Participation of Women in Public Life, which was held in 1960 in Addis Ababa for African participants. The summary of the debate on this subject is contained in paragraphs 60, 61, and 62 of the report of the seminar [ST/TAO/HR/9]. Subsequently, the Economic and Social Council drew the attention of the World Health Organization to this report and asked the agency whether it would undertake a study of the medical aspects of operations based on customs to which many women were still being subjected [Resolution 821 II (XXXII), July 19, 1961].

The paragraphs of the seminar report cited above state, among other things:

Par. 60. Many participants expressed strong concern at the continuance in certain parts of Africa of those customs and practices which led to the mutilation and scarification of the physical person, particularly the practice of female circumcision, a ritual operation performed on young girls. Two participants, one a medical practitioner and the other a practicing midwife, described in some detail the nature of this operation and its physical effects. It often caused severe hemorrhage and septicemia, resulting in some cases in death. By preventing generalized dilation at childbirth such operations not only intensified the difficulties of labour but also endangered the lives of both mother and child. In later life it could bring about a prolapse of the uterus, especially where women were compelled by circumstance to carry loads or to engage in heavy work.

Par. 61. In the course of the debate, reference was made to the reasons for the continuance of this custom, one participant expressing the view that it was often encouraged by men in the belief that it tended to prevent adultery, while another participant pointed out that it was often considered to have educative value because by undergoing this operation young girls learned the virtues of courage and endurance. The view was expressed that while it was the duty of all African women to further the development of African culture by supporting those rich and varied qualities which were of value not only to Africa but to the world, they should join in condemning those customs which were deleterious to health and indeed dangerous; for they led to backwardness, not to progress.

Par. 62. In discussing ways of overcoming this practice, one participant hoped that, in her own words, "The World Health Organization could show that this mutilation has no medical justification and that rather it is harmful to health and should be abolished forever." Apart from action at the international level, national legislation was needed; it was an effective instrument for doing away with this and other harmful customs.

Despite the fact that African women initiated the request, and that it was followed up by another ECOSOC resolution, WHO has done nothing to help African women, though recent medical publications show that genital mutilation continues to blight the life of millions of African women and severely damages large numbers of small children, the future mothers of Africa.

The extent to which genital mutilation continues to be practiced is not known. No health department of Africa collects such statistics, not even about the numbers of people involved in the practice, nor is any information available on how many girls die as an immediate result or how many women later succumb in childbirth.

Most health departments, by failing to collect information, either pretend that these operations don't exist or that they are not a health hazard, and thus perpetuate the secrecy that permits these damaging operations to continue unchecked. Yet the medical statistics collected in some large clinical studies -- for instance, in the Sudan where the problem of genital mutilation is recognized -- show an overwhelming number of health problems as a direct result of mutilation. In fact, all medical reports, including some quite recent ones, agree on the overwhelming health hazards, on the physical damage done to girls and women, and on the danger of such operations for their yet-unborn children.

Although WHO participated in the International Women's Year Conference in Mexico,¹ it continues to fail to recognize that genital mutilation is a medical and health problem of major proportions by failing to collect the pertinent information. UNICEF, though specifically charged with mother and child health, has never concerned itself with this issue that so greatly damages the health and well-being of both in large regions of Africa.

Extensive correspondence with the leadership of both WHO and UNICEF² shows that they claim they must be specifically asked to deal with this issue by the political leadership of the African countries where such practices continue. But the political leadership is almost everywhere all male. Nowhere are women able to speak out on what is not only a health issue but also a highly political one. Where they did speak out, as in the Seminar on the Participation of Women in Public Life, they were ignored. By failing to collect the critical information, both governments and international agencies protect themselves and perpetuate these damaging practices that have persisted for more than 2000 years.

According to what information I have been able to piece together, these practices will not "go away on their own," as some people claim. On the contrary. To the best of my knowledge these practices are being adopted into modern life in some countries, tacitly supported by some of the male political leadership, and are tolerated in practically all African countries.

An international feminist observer cannot help but wonder why the male African leadership does not speak out about the mutilation of women, a custom that was reinforced by Kenyatta in Kenya and is also supported by the African independence movement under his leadership and is documented in his book, Facing Mount Kenya.³ It clearly affects the status of women also in political affairs.

The first step if one is interested in dealing with a problem -- especially a problem concerned with health -- is to establish the critical parameters as to how many people are affected, who they are, where they live. The next question is why these damaging practices continue. Reports show that in some countries genital mutilation is now practiced, without any ritual significance, in modern hospitals and by trained medical doctors.

Anthropologists (mostly men) who have studied African traditions have done no service to women by utterly disregarding women's health while they attribute "cultural values" to such damaging traditions as excision and infibulation. It should be added that excision is not a necessary part of initiation rites, although Kenyatta has claimed that it is.⁴ As numerous African studies show, there are many initiation rites that are entirely beneficial and include neither excision nor circumcision nor any other "tests" that cause permanent physical damage. Moreover, those who have studied the Moslem religious literature on the point of female genital operations all agree that there is no "command" to perform these operations; on the contrary, deliberate damage to the physical person is prohibited.⁵

African women in the U.N. seminar mentioned above spoke out "condemning those customs which are deleterious to health and indeed dangerous." Why can't the anthropological literature distinguish between damaging and supportive customs, especially after unequivocal statements by the persons involved? Why don't those concerned with health hazards such as malaria, bilharzia, river blindness, and other diseases that threaten human life in Africa show equal concern with deliberately inflicted mutilation on helpless female children? This kind of damage is never discussed, though it represents a terrible health hazard that is entirely avoidable. Can Africa really afford to shut its eyes to the deliberate mutilation of large numbers of its female youth? In twenty-six African countries at least some of the population groups and tribes subject their female children to genital mutilation for a multitude of "reasons," many of which conflict and all of which are based on total ignorance concerning reproduction. Is it really in the interest of these population groups that such damaging myths are perpetuated under a cloak of silence and are praised as "culture" in the literature? I think not. The time has come to face the facts.

For three years I have systematically collected information on genital mutilation, and I have made two trips through Africa, the most recent one in 1973 (fifteen sub-Saharan countries and

twenty-five cities). My professional field is urban development and housing, and I am therefore concerned with modernization. On the first trip, investigating North African cities from Rabat to Cairo and Alexandria, I never heard of genital mutilation. One can still travel throughout Africa today as a journalist without learning the truth. In 1973, when I asked direct questions about this custom, the answer generally was, "these practices do not exist here," or "only a few people practice this in some remote rural areas," or "this practice has died out by now." None of this is usually true. What is true is that there is hardly any subject on which so much ignorance, or even deliberate misinformation, exists.

Genital mutilation continues in a wide area along the equator and north of it from the Red Sea Coast to the West Coast in a broad region that is inhabited by many different population groups under many different political jurisdictions. None of these independent countries have active programs against the mutilation of women.

The investigation of the ethnographic literature shows much detailed information on specific areas and peoples but does not provide an overview. Cross-cultural studies ignore the subject of genital mutilation. In the ethnographic literature, in fact, health does not seem to be of any concern to the ethnographers, and cultural practices are generally uncritically supported, without any mention of their sometimes terribly damaging effects -- mostly on women, but also on men.

THE MEDICAL REALITY

Two kinds of mutilation can be differentiated. One, excision, consists of removing the external genitalia, specifically the most sensitive organ, the clitoris; the other, infibulation, also closes the vulva and thus makes intercourse impossible. However, the medical literature indicates that at times after excision the vulva grow together spontaneously while the wound heals, thus producing, in effect, infibulation. This condition (mentioned in medical observations from Western Africa where infibulation is not practiced) requires repairs, since it obstructs the passage of urine and menstrual blood.

It is necessary to "open" infibulated women for intercourse, though cases are recorded in the medical literature where women have conceived through a pinhole opening. Frequently the new husband uses a knife on his bride, or the help of a midwife is solicited to make an incision in the often toughened scar. In either case intercourse takes place immediately and frequently to prevent the wound from closing again. Hospitals also record cases of women who have been severely damaged as the result of their "wedding nights" -- in Ethiopia and Somalia, for example.

Moreover, infibulated women cannot give birth normally. They must be cut open, or if no assistance is available, both mother and baby die. Childbirth mortality is predictably high. As more hospitals and maternity clinics are established and more women are persuaded to use them, the facts become known among health personnel, though they are concealed by government officials and international agencies. I have letters from officials of all kinds from many countries flatly asserting that "these practices do not exist in our country," despite the documentation by doctors working in hospitals. Of course, these practices have existed in some areas long before records of any kind have been kept. It would be interesting to compare the records of migrations, especially of Arab peoples, with the spread of the customs of excision and infibulation. Historical sources claim that excision is too widespread to have originated from any one area. However, many researchers state that infibulation originated in the area south of the Arabian peninsula and the Red Sea Coast, and that it was spread by Arab traders.

Both operations have been known in Egypt for a very long time, and it is stated that all the women of the generation born around 1920 were excised and that many of them were infibulated as well.⁶ Fibulation was, and possibly still is, being done by medical doctors for those who can afford such services for their children; the same is true in the Sudan -- "to prevent worse harm," it is said! In the Sudan, although actions are being taken to change the status of women, especially by education, no specific efforts are made to reduce the incidence of infibulation. The legislation passed in 1945, as a result of urging by the British, is generally ignored, and the majority of women are still excised and infibulated.

A thorough clinical study of genital mutilation by Dr. Abu el Futuh Shandall, covering more than 4000 women observed and recorded at the Khartoum hospital outpatient department, was published in the Sudan Medical Journal in 1967.⁷ The findings in his case histories on the devastating health results for girls and women are confirmed by other publications. Damage in excision operations depends on the skill (or lack of it) of the individual operator and on the environmental conditions, including sterile instruments, etc. Often an accidental slip or a movement by the victim may seal her fate, since some major blood vessels are in the genital area.

Kenya

Although excision often does not produce the difficulties at childbirth that the deliberate sewing or closing of the vulva does, nevertheless formation of scar tissue after excision frequently obstructs labor, especially with the first child, and results in great damage to both the mother and the baby, as a recent letter from a midwife in Kenya confirms:⁸

Circumcision in females is going on in the rural areas especially among those who are still strong believers of our traditions and cultural customs. It is still strongly carried out by the tribes like Kuria, Kisii, Masai, Suk, Nandi, Kipsigis and Kamba. Their reason for circumcising women is that if a girl is circumcised the sexual urge will decrease during puberty and therefore she cannot have sexual relationship with a man before marriage, since the sensitive organ is cut off. The circumcised girl when married does not practice extra-marital sexual relationship, thus keeps moral behavior in the society.

I would also like to point out that through my experience as a midwife working under the Ministry of Health recently I have seen some mothers, especially primagravida (women having children for the first time), having complications such as delay in second stage of labor because of the scar formed; the perineum cannot stretch to give room for the baby's head to be born. In this case an episiotomy has to be performed each time the woman gives birth, if not, there is a serious tear to both perineum and the muscles and this involves also the rectum. Sometimes these women end up with V.V.F. (vaginal vesicle fistula), which is very hard to repair if there is no experienced doctor. Also babies born of these women if premature normally die or have brain damage. Some babies are born dead because of delay in second stage if born at home without supervision of a qualified midwife. Haemorrhage is profuse in case of a tear on the scar and the scar always form haematoma when bruised and it is very painful.

An excision ceremony accompanying initiation is described in President Jomo Kenyatta's book, Facing Mount Kenya;⁹ the rite is typically romanticized. Dr. Kenyatta read anthropology in London and his book is based on his dissertation. However, as a man he was not allowed to attend this women-only rite, so his description is not firsthand. He claims that a steel axe (!) is used for the operation. He also states that only "the tip of the clitoris is cut off." That this also is quite untrue is documented by hospital records and confirmed also by the medical commission that signed the British prohibition against excision.

Dr. Leonard Bruce-Chwatt describes the doubly clever political use to which Kenyatta put his studies of anthropology in Britain.¹⁰ Kenyatta not only used the circumcision controversy to rally the people against the British, but he also insisted that genital mutilation of girls is an essential part of initiation and of African tribal life. Of course, many African tribes practice initiation rites without genital mutilation. Furthermore, the records show that the British opposed only the mutilation of girls but never opposed initiation rites.

It is ironic that in Kenyatta's lifetime the initiation rites of the Kikuyu -- the colorful traditions and ceremonies which he claimed to be so important for social coherence and stability -- have been all but abandoned; but my information

indicates that the damaging operations on young girls' genitalia continue as "private ceremonies" because men insist on them. Jomo Kenyatta says that "no Kikuyu would marry an uncircumcised girl." The rights of women in Kenya in actual practice as far as the majority of women are concerned have made little progress since Independence, with the exception of a tiny number of women in the modern sector who, except for Kenyatta's relatives, have limited political influence.

Somalia

In Somalia the government hospitals are now directly involved in infibulating little girls on a production-line basis. Dr. G. Pieters, who spent twenty-five years in surgical practice in Africa, including two years (1966-1968) in Mogadishu as a gynecologist, writes¹¹ [translation mine]:

Each Sunday the General Hospital in Mogadishu does about 15 circumcision operations on little boys and an equal number of infibulation operations on little girls. Two teams of male nurses work on a table on the boys and another team on the girls, one after the other in the main operating theater of the Hospital. The little girls, aged 4-8, are brought by their parents to the door of the surgical unit of the hospital and the parents wait outside.

Each little girl is taken into the large operating room and strapped on one of three tables in the gynaecological position with her legs apart by two male nurses dressed in surgical gowns with masks and gloves. They start by disinfecting the genital area of the child with mercurochrome. Local anesthetic, which is not sufficient, is given by four injections into the small lips and under the clitoris. The small lips are then clamped and cut off with surgical scissors; next the entire clitoris from top to bottom is excised. This is the nerve that must be taken out, the officiating male nurse explained to the doctor. The bleeding usually is not very profuse and wiped off with tampons. The two sides where the cuts were made are then brought together along the entire length of 2-3 centimeters, sutured with catgut and sewn together with silk, about 5-9 stitches. It is important, the operator explained, that only a tiny opening as small as a pencil point remains, the exact measurement depends on the operator....

After more local disinfection the little girl, who has frequently cried and screamed, is taken off the table and returned to the parents at the door, who pay about a dollar for the operation and go home with her. At certain times when infection seems more frequent, each child gets an injection of penicillin on 2 consecutive days. But there are rarely complications....

The entire female child population of Somalia is subjected to these operations in the towns. If the children are taken for

the traditional operations to their home villages, the infibulation is performed by neighbor women but, in contrast to the Sudan and elsewhere, without any celebration or rites. The above description of these village operations given by Dr. Pieters is that recorded by the sociologist Annie de Villeneuve,¹² since a man cannot be present at the operations which are performed at home and on all female children without exception throughout Somalia.

Dr. Pieters also relates that the wealthiest people in Somalia today hire surgeons to perform the operations with general anesthetic, though no foreign doctors are trusted to perform them. However, the opening of the bride is always left to the bridegroom or to his sisters or his aunts, who use "a little knife" to cut her open. This "little knife" is used on a woman time and again as she has to be cut open to allow delivery of a child. After each delivery a woman is re-infibulated, and after the baby is weaned the whole process starts again.

A description similar to that of Annie de Villeneuve is given, from eyewitness reports, in a book by Jacques Lantier¹³ [translation mine]:

Among the Somalis the initiation rites take place in the home among the women relatives, neighbors and friends. The father stays outside the door as a symbolic guard. The mother officiates, or her place is taken by an older woman. At each ceremony only one little girl is mutilated, but all girls without exception must undergo this operation before they are married. The ritual itself is not accompanied by any religious ceremony or medicinal preparations -- it is performed similar to castrating an animal.

The little girl sits down on a stool that is not even wiped and several women hold her down firmly. After separating her outer and inner lips (labia majora and labia minora) with her fingers, the old woman attaches them with large thorns onto the flesh of each thigh. With her kitchen knife the woman then pierces and slices open the hood of the clitoris and then begins to cut it out. While another woman wipes off the blood with a rag, the woman (or operator) digs with her fingernail a hole the length of the clitoris to detach and pull out that organ. The little girl screams in extreme pain, but no one pays the slightest attention.

The woman finishes this job by entirely pulling out the clitoris and then cuts it to the bone with the kitchen knife. Her helpers again wipe off the spurting blood with a rag. The woman then lifts up the skin that is left with her thumb and index finger to remove the remaining flesh. She then digs a deep hole amidst the gushing blood. The neighbor women who take part in the operation then plunge their fingers into the bloody hole to verify that every remnant of the clitoris is removed.

This operation is not always well managed, as the little girl struggles. It often happens that by the clumsy use of the knife or a poorly executed cut the bladder is pierced or

the rectum is cut open. If the little girl faints the mother blows pilipili (spice powder) into her nostrils to revive her.

But this is not the end of the torture. The most important phase of the ritual begins only now. After a short moment the woman takes the knife again and cuts off the inner lips (labia minora). The helper again wipes the blood with her rag. Then the mother with a swift motion begins to scrape off the skin from the inside of the large lips.

The woman conscientiously scrapes the flesh of the screaming child without the slightest concern for the extreme pain she inflicts. When the wound is large enough she adds some lengthwise cuts. The neighbor women carefully watch her "work" and when needed encourage her accomplishment.

The girl begins to howl once more. Sometimes in a spasm at this stage she bites off her tongue. The other women carefully watch the child to prevent such an accident. When her tongue flops out they throw spice powder on it which provokes an instant pulling back and the little girl opens her mouth to scream even harder.

With the abrasion of the skin completed according to the rules, the woman closes the bleeding large lips and fixes them one against another with long acacia thorns.

At this stage of the operation the child is spent and exhausted and generally stops crying but usually has convulsions. One then forces down her throat a concoction of plants.

The operator's chief concern is to achieve as narrow an opening as possible, just enough to allow the urine and the future menstrual flow to pass. A small splinter of wood is usually inserted to keep the wound from closing entirely. The honor of the operator depends on making this opening as small as possible, because among the Somalis the smaller this artificial passage is, the higher the value of the girl. (She is traded by her father, usually for goats, as soon as she starts menstruating, to a man willing to pay the price.)

Once the operation is finished, the mother washes the sex area of the girl and wipes her with a rag. Then the girl is freed and is ordered to get up. The neighbors then help to immobilize her thighs with ropes of goat skin. A solid bandage is then applied from the knees to the beltline of the girl, which is left in place for about 2 weeks. The girl must remain immobile stretched on a mat for the entire time while all the excrement evidently remains with her in the bandage.

After that the girl is released and the bandage is cleaned. Her sex organs are closed artificially and this is preserved until her marriage. Contrary to what one would assume, death is not a very frequent result of this operation. One does, of course, deplore the various complications which frequently leave the girls crippled and disabled for the rest of their lives.

At the HABITAT Conference (United Nations Conference on Human Settlements) in June 1976, I interviewed the leader of the Somali delegation, Mr. A. J. Abdille, who is in charge of organizing

the settlement of the largely still migratory population groups in the Somali Democratic Republic. Mr. Abdille told me that he had both his daughters infibulated, as of course his wife had been. I showed him Dr. Pieters' article and asked him about the use of the Government's hospitals for infibulation. He replied, "It is better that way." When I asked why the Revolutionary Government was not trying to change the custom instead, he said that it takes time, and remarked that his wife had learned to read recently. But learning to read is not a prerequisite for stopping genital mutilation. Once infibulation is institutionalized in hospitals, it will never be stopped. In his speech Mr. Abdille spoke about "abolition of harmful traditional beliefs such as tribalism," but not one word was said either at HABITAT or at the International Womens Year Conference in Mexico about the abolition by the Revolutionary Government of the harmful mutilation and infibulation of women.

Sudan

Dr. Futuh Shandall describes the results of excision and infibulation in the Sudan as follows:¹⁴

Besides the severe pain inflicted by this cruel operation, the psychological trauma on the girl is sometimes very severe in spite of the fact that she is brought up to look forward to the day of her circumcision (Tahour) as a unique day of pleasure and celebration in her honour....

Girls usually have no idea about the painful part of it because they are kept away from such scenes by their mothers until the day of their own circumcision....The immediate complications are shock, haemorrhage, retention of urine, injury to adjacent structures, infection and failure of the vulval wound to heal....

Out of the 3013 women of Group A who had Pharaonic Circumcision, 102 gave definite statements of having fainted and actually losing consciousness when circumcised without bleeding; 81 lost some blood that needed interference either by the midwife or doctor soon after the operation was completed; and 84 had a degree of haemorrhage which was sufficient to produce shock and need medical help. A total of 267 patients had either haemorrhage, shock or the combination (8.86%)....

Five girls had neurogenic shock (2.12%); 5 had haemorrhage needing interference (2.12%); and 3 had severe haemorrhage causing shock (1.27%), one needing transfusion. Two of the latter three were treated by the writer as emergencies. Both of them bled from the severed and carelessly ligated clitoral artery.

Retention of urine occurred in 10 percent of the cases, a third of whom needed catheterization, requiring removal of the sutures of the infibulation. That means that the child is sewn up again later.

It must be clear that in all the cases requiring medical attention the outcome, if such help is not available, is usually fatal. Only a tiny fraction of women in the Sudan have access to a hospital or to medical care. But a majority of the population groups living in the Sudan subject their girls to infibulation operations. To this should be added that the same immediate results of hemorrhage and infection exist everywhere in Africa where excision and clitoridectomy operations are practiced.

One wonders what the medical result of the operation is in most of Africa, since only a tiny minority of the population has access to hospitals. There are no statistics and no one knows how many children bleed to death as an immediate result of the operations or die from shock or perish later from infections, blood poisoning, and the like. This quite aside from the problems encountered in childbirth.

Asim Zaki Mustafa, a research assistant at the Department of Obstetrics and Gynaecology of the University of Khartoum, gives a list of complications of infibulation,¹⁵ which is summarized here.

Immediate Complications: Shock may be neurogenic, when analgesia is not given, or may follow haemorrhage. Haemorrhage, which can be fatal, may be primary, from the perineal branches of the external pudendal artery and the dorsal artery of the clitoris, or secondary, following infection of the wound. Circumcision by untrained persons on a struggling unanaesthetized girl may result in injuries to the urethra, bladder, vagina, perineum and anal canal. Bartholin's glands are often totally or partially excised, and trauma to or division of the duct may cause cyst formation. Fatal cases of tetanus and septicaemia have been reported. Urethritis, cystitis, and abscesses occur. Chronic pelvic infection may eventually follow. Retention of urine may be caused reflexly immediately after infibulation because of the fear of scalding the fresh wound. It may follow urethral strictures when the urethra is infected or injured [as reported by A. Worsley in the Journal of Obstetrics & Gynaecology 45 (1938): 686], or occlusion of the external urethral meatus by a skin flap. Anaemia may follow profuse bleeding. It may predispose to secondary infection by lowering the patient's resistance. It has been blamed for retarding the physical and mental development of some children [as reported by J. H. Sequeira in Lancet 2 (1931): 1054].

Later Gynaecological Complications: Implantation dermoids (tumors or cysts covered by skin) that are usually reported as rare are quite common in the Sudan as a result of the mutilations [as reported by H. M. Hathout in the Journal of Obstetrics & Gynaecology 70 (1963): 505]. Menorrhagia (excessive menstrual flow) may be caused indirectly by circumcision as a consequence of chronic pelvic infection. Dysmenorrhoea (painful and difficult menstruation) is due either to chronic pelvic infection or to obstruction of the

menstrual flow by a pinhole introitus. Painful coitus is another result. Cryptomenorrhoea (the retention of menstrual blood), caused by obstruction, may lead to hematocolpos or hematometra (an accumulation of menstrual blood). This has led strict parents to take severe disciplinary measures against innocent girls thought to be pregnant [see A. Z. Mustafa in El Hakim 9 (1969): 109]. Keloid formation (overgrowth of scar tissue) may occur, especially in patients of mixed Arab-Negro origin.

West Africa

Rites of central West African peoples are similar to those in East Africa. The girls of each village are excised together in a group and then must remain with the operator for some time in a special area. Often they work for the operator in her fields, and thus there is an economic incentive to continue the operations. In fact, everywhere the parents must pay something for the mutilation of their children, but they get the bride price upon marriage. Marriage cannot take place unless the girl has been excised.

In Nigeria, the most populous country of Africa, several of the largest population groups practice excision, and that usually means that all the females of each tribe have had the operation. Dr. Lawrence Longo¹⁶ relates his experience from clinical practice in Ife. Many specific Yoruba rites are observed to assure fertility. Circumcision (including on girls clitoridectomy and cutting away of the entire labia minora and majora) is carried out on boys and girls on the sixth day after birth. Occasionally, he reports, a hemorrhage results or infection or tetanus develops. One can but wonder how many six-day-old girl babies survive what amounts to a major operation, with its loss of blood and shock.

As in East Africa, hospitals are increasingly receiving badly damaged women, usually in the last stages of labor after all home remedies have failed and both mother and baby are beyond medical help. Dr. J. G. Taoko of Yalgado Hospital in Ougadougou, Upper Volta recently collaborated in an article published in Famille et Développement,¹⁷ which not only describes the damage done to girls and women in medical terms, but also describes some case histories in human terms. The medical results of the operations are summed up as "catastrophic." A "reader" column further confirms that genital mutilation is widespread, even among the educated and literate who responded to the article.

All the letters printed opposed genital mutilation, and several fatalities were reported. The magazine, which is published in Dakar, is distributed throughout the Francophone countries and deals with the problems faced by families and young people in straightforward ways. It gives important basic facts on health and family planning, and includes practical "how-to" information, with illustrations, about the many problems faced

especially by the younger generation, which is on the move. Neither in West Africa (according to Famille et Développement and other sources) nor in East Africa (according to a survey undertaken at the University of Nairobi¹⁸) are the facts pertaining to human reproduction known -- or readily available -- even among the literate, let alone taught in any schools.

EFFECTS ON FERTILITY

The medical literature also mentions that as much as 25 percent of infertility in women is the result of genital mutilation, often because of infections following the operation. Dr. Mark A. Belsey, Medical Officer in the Human Reproduction Unit of the World Health Organization, states in a report prepared for a meeting on infertility in Geneva in June 1975¹⁹ that

WHO is currently developing standardized research protocols for collaborative research on infertility and pregnancy wastage. Within the framework of this research it may be possible to estimate the frequency of female circumcision and infibulation procedures and to determine the effects of these procedures on fertility.

An extract from a background paper [HRP/SG/EPS75.4] for the Scientific Group on Epidemiology of Infertility states:²⁰

Certain rituals involving the genital organs may produce infection or injury that interferes with conception or increases the risk of pregnancy wastage. Such practices as female circumcision or infibulation are found throughout the world. Clitoridectomy performed under septic conditions may result in ascending infection in the genital tract. Infibulation, a far more radical procedure with very high immediate risk of haemorrhage and infection, may frequently result in severe scarring and near complete obliteration of the vaginal introitus. Coitus is difficult, painful and frequently associated with perineal trauma and infection risk. Unassisted delivery in the case of infibulation is nearly impossible, perineal damage the rule and potential injury to the infant not uncommon. Although the "so-called" Pharaonic Form was banned in the Sudan in 1946, to what extent it is still practiced there and in areas where it was not banned is not known. Mustafa (1966) claims that 20 to 25 percent of the cases of infertility in the Sudan are due to infibulation. Difficulties in delivery including prolonged labor, uterine inertia and severe perineal damage may increase the risk of perinatal mortality (Mustafa, 1966). In Meuwissen's study in Ghana (1966) marked vaginal changes were noted in 10.3 percent of 398 infertile women. These changes consist mainly of sclerous stenosis resulting from ritual circumcision and native treatments.

Unfortunately, the final paper of this meeting, published in January 1976, sheds no light on this problem.

Perhaps those who only see the damage that modernization has wrought in traditional cultures should take a second look at the medical reality of traditions before they blindly advocate opposition to change.

OUTLOOK AND CHANGE

In Ghana genital mutilation is practiced by the northern tribes, although it is "forbidden." However, according to the Honorable Mrs. Justice Jjagge, an influential Ghanaian, the Ghana National Council on Women and Development has listed circumcision as a subject for research.

In the Sudan, under the leadership of the Minister of Social Welfare, Dr. Fatima Abdul Mahmoud (a gynecologist trained in Moscow and London), some real changes are taking place with respect to the education of women. The newly established Sudanese Women's Union, which operates throughout the country, is actively pursuing the participation of women in every area of modern life. Dr. Mahmoud has written me that they are ready to support any investigation of circumcision, clitoridectomy, infibulation, and so on, by providing information, and that "a proposal has been made to establish a commission representing the concerned governmental and non-governmental bodies...."²¹

Conversations with African women who have political responsibility confirm their awareness and readiness for far-reaching change. Such change can only be beneficial for Africa, making available the vast unused, underused, or misused human resources and talents that African women represent. International support for change is greatly needed. The International Women's Year has effectively strengthened these activities, and it is hoped that the International Women's Decade will implement with international support the changes proposed during the year.

African male politicians do little to avail themselves of the abilities of women for development. Women in traditional Africa have been responsible for feeding and rearing their children and for growing most of the food that is consumed. As a result, they have enjoyed a certain amount of economic independence. This self-reliance has been taken away by modernization, especially in an urban environment.

Modernization -- that is, the importation of Western skills and Western machines from tractors to computers -- has been mostly for the use of men. By denying women equal access to education, and especially to technical training, women are kept in their

"traditional place," subservient to men, by economic dependence in the modern sector. Economic dependence is used to perpetuate genital mutilation, since marriage is the only career for women who do not have access to jobs and education, and excision or infibulation are demanded by men as a prerequisite for marriage. These practices are considered by men as the basis for a stable family life in large areas of Africa, especially where polygamy is practiced. Polygamy and genital mutilation frequently co-exist in the same population groups. The reluctance to change the condition of women is probably greater in Africa than elsewhere. Do men fear the power of African women? It is clear that the initiative must come from and be supported by men, because of the political power they hold.

Unless women are fully involved in development as equal partners with men, the future is bleak on a continent where famine is prevalent and where most of the food that people eat is still grown by women.²² The U.N. statistics produced for the International Women's Year show unequivocally that if development is to be achieved, women must be concerned in it -- because men are simply not able to produce enough for themselves and their dependents, once they move into a town. The move from rural to urban life is greater in Africa than in any other part of the world today, though the vast majority still live in rural areas. Food production is constantly decreasing in relation to population growth in most of Africa. The women who do most of the subsistence farming cannot increase production without better methods and modern tools. They are overburdened with hard and menial work and with constant childbearing, and they are given few opportunities to learn anything new. The more people move away from the land, the more food production will decrease, unless women are fully involved in modernization and education on an equal basis with men.

In much of Africa today women remain in the traditional environment, both physically and mentally, while men learn a new way of life, new skills, and a new kind of environment in which traditional women have no part. The gap between men and women grows as urbanization proceeds. These are the questions that must be raised with the male political leadership. If the quality of life is to be improved, the conditions of women must change.

A NOTE ABOUT THE AUTHOR

Franziska Porges Hosken completed her Matura with excellence in Vienna in 1938, received a B.A. from Smith College in 1940, and a Master of Architecture degree from the Harvard Graduate School of Design in 1944. She also did postgraduate work in city planning at the Massachusetts Institute of Technology from 1963 to 1966.

During World War II, Ms. Hosken was an ensign in the U.S. Coast Guard Reserve, assigned to communications intelligence.

She is bilingual in English and German, is fluent in French, and also speaks Spanish and Italian. She has traveled widely in Europe, Asia, and Latin America for many years. In 1973 she visited fifteen African countries in her roles as newspaper columnist, photographer, and urban consultant.

Ms. Hosken has published seven books, including The Functions of Cities (1972) and The Kathmandu Valley Towns (1974). She is the editor of WIN (Women's International Network) News and acts as international coordinator for WIN.

She has also served as an associate professor in the University Without Walls.

NOTES

1. See the "Statement" delivered at the International Women's Year Conference in Mexico by Dr. Tejada de Rivero, and the special issue of Health, the WHO publication.
2. See WIN (Women's International Network) News 1, no. 3 (1975); 1, no. 4 (1975); 2, no. 1 (1976); 2, no. 3 (1976).
3. Jomo Kenyatta, Facing Mount Kenya (New York: Vintage Books, 1965).
4. As reported in Leonard Bruce-Chwatt, "Female Circumcision and Politics," World Medicine 11 (January 14, 1976): 45.
5. A. Abu el Futuh Shandall, "Circumcision and Infibulation of Females: A General Consideration of the Problem and a Clinical Study of the Complications in Sudanese Women," Sudan Medical Journal 5, no. 178 (December 1967): 183-84.
6. Henny Harald Hansen, "Clitoridectomy: Female Circumcision in Egypt," Folk 14-15 (1972-73): 16.
7. Futuh Shandall, 184.
8. Letter in author's files, dated August 1975; name withheld to protect source.
9. Kenyatta, pp. 130-54.
10. Bruce-Chwatt, 45.
11. G. Pieters, "Gynaecologie au pays des femmes cousues," Acta Chirurgica Belgica 71 (May 1972): 173-93.
12. Annie de Villeneuve, "Étude sur une coutume Somalie: Les femmes cousues," Journal de la Société des Africanistes 6 (1937): 15-32.
13. Jacques Lantier, La cité magique et magie en Afrique Noire (Paris: Librairie A. Fayard, 1972), p. 277.
14. Futuh Shandall, 186.
15. A. Z. Mustafa, "Female Circumcision and Infibulation in the Sudan," Journal of Obstetrics & Gynaecology 73 (1966): 302-06.
16. Lawrence D. Longo, "Sociocultural Practices Relating to Obstetrics and Gynecology in a Community in West Africa," American Journal of Obstetrics and Gynecology 89 (1964): 470-75.

17. Famille et Développement, no. 2 (April 1975): 15.
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20. World Health Organization, Scientific Group on the Epidemiology of Infertility, Technical Report Series no. 582 (1975).
21. Letter to author, dated January 4, 1976.
22. Esther Boserup, Women's Role in Economic Development (London: George Allen and Unwin, 1970; New York: St. Martin's Press, 1970).

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the rectification of frontier -

We are going out to Egypt
in about a fortnight as I
am immensely interested in
the horrible and disgraceful
mismanagement of that
most unhappy country -

We have converted it into
an Oriental Ireland -

You will see an
article in the Times

SUPPLEMENT TO #36: Sir Samuel White Baker explored the Nile sources in 1861, discovering Lake Albert in 1864. In this 1884 letter, now in the Munger Africana Library, he describes fibulation of young girls as he observed it in East Africa.

1 Jan 84

Sanford Orleigh,
Abbot.

Dear Mr Walter Horn

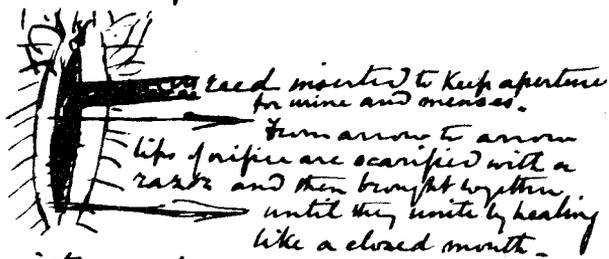
Many thanks for
your letter, and best wishes
for the new-born year -

I read your letter in the
Abyssini - I have always
advocated the policy of giving
a sea-port to that country -

You will see an article
in this month's Contemporary
Review which I was requested
to write, in which I suggest

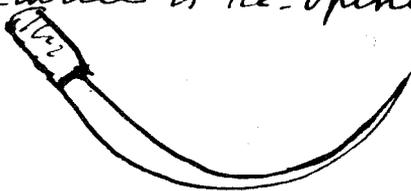
to day and I rejoice in
the fact that the leader
has boldly taken up the cause.

The allusion in Nile Tributaries
to an operation to ensure chastity
is a practical prevention



Connection with male organ becomes impossible.

On the night of marriage the
cicatrice is re-opened by an instrument



Point inserted, and one rip does it—

The girl is then led immediately to the

neck of her husband and thrust in, while
her bridesmaids (virgins with their lamps
trimmed) wait outside the door until
the husband appears and gives them a
bloody cloth as a proof of his wife's
virginity - -

I have not seen Mansfield
Parkinson for some years - He lost
his wife poor fellow, who left nine
daughters! -

William Fallin was a sad life.
In fact as we grow older the world
grows colder; our friends disappear
one by one -

Very sincerely yours

Samuel Baker

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