Complexity of Female Genital Mutilation/Cutting

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Abstract

The problem of Female Genital Mutilation/Cutting (FGM/C) continues unabated despite a declining trend in its overall prevalence rate. This article examines the complexity of FGM/C in Kenya and the ethical issues and social work values surrounding the practice. It argues that the practice should be abolished because it violates fundamental human rights, social work values and ethical principles.

Keywords: social work values, ethical principles, human rights, medical ethics, ethical relativism, psychosexual

1. Introductory Background

The World Health Organization (WHO) defines female genital mutilation/cutting (FGM/C) as "all procedures involving partial or total removal of the female external genitalia or other injury to the female genital organs for non-medical reasons" (WHO, 2008, p. 1). The age at which FGM/C is performed varies with local traditions and circumstances. In most cases, it is carried out on girls between the ages of 0 and 15 years. However, adult women are also occasionally subjected to the procedure. Debate on the practice of FGM has been a source of controversy since the late 1970s because it touches on some of the fundamental human rights and social work values. It permeates the cultural, legal, social, political, economic, religious and medical spheres. Efforts to eliminate the practice are increasing, hence, arousing public debate. While many programs to address FGM/C have focused mainly on the health risks of the practice, it is important to include the ethical and social work values dimensions in the debate in order to deal with it in a holistic way (UNICEF, 2013).

FGM/C has no known health benefits (WHO, 2008). On the contrary, it is known to be physically and psychologically harmful to girls and women. Along with causing severe pain and trauma, the removal of (or damage to) healthy normal genital tissue interferes with the natural functioning of the body. Immediate and long-term health consequences of FGM/C include severe bleeding, infections, retention of urine, and potential complications during childbirth that can lead to maternal and new-born deaths later in life. The practice is against social work values committed to the primary importance of the individual in society. Social workers attempt to change aspects of the society that create or contribute to people's problems (Morales et al., 2011).

The World Health Organization (WHO) estimates between 100 and 140 million girls and women in the world are estimated to have undergone such procedures, and 3 million girls and women are estimated to be at risk of undergoing the procedures every year (WHO, 2008; Oloo et al., 2011; UNICEF, 2013). FGM/C is most prevalent in the western, eastern, and northeastern regions of Africa; some parts of Asia and the Middle East; and among certain immigrant communities in North America and Europe (WHO, 2008). Research shows that the practice of FGM/C is concentrated in 29 countries, 27 of which are in Africa, with prevalence of between 1% and 98% (UNICEF, 2013). The most frequent type of FGM/C that occurs throughout Africa involves the

removal of the entire clitoris (clitoridectomy), usually with the labia minora, and in some instances, the labia majora (Elsayed et al., 2011). Proponents of the practice rely on sexual control of women, religion, tradition and cultural myths to defend the practice (Burson, 2007).

Although there is little information as to the origins of the practice of female genital mutilation/cutting (FGM/C), the most radical form of the practice has been traced to ancient Egypt, through the examination of Egyptian mummies. The practice has occurred for nearly 2,500 years, and began prior to the development of either Islam or Christianity (Burson, 2007).

2. Evolution of the Concept of FGM/C

The term "female genital mutilation/cutting" (FGM/C) became popular from the late 1990s. Since the late 1970s, the term female genital mutilation (FGM) gained growing support. According to WHO (2008), the word "mutilation" establishes a clear linguistic distinction from male circumcision and emphasizes the gravity and harm of the act. In addition, the word "mutilation" reinforces the fact that the practice is a violation of girls' and women's rights, and thereby helps to promote national and international advocacy for its abandonment. The term FGM was adopted in 1990 by the Inter-African Committee on Traditional Practices Affecting the Health of Women and Children in Addis Ababa, Ethiopia (UNICEF, 2013; WHO, 2008).

The term FGM has been considered derogatory to what has been considered an age-old practice in many communities thereby estranging practicing communities and perhaps hindering the process of social change for the elimination of the practice (WHO, 2008). In the late 1990s, the terms "female genital cutting" and "female genital mutilation/cutting" were increasingly used among researchers and various international development agencies. To describe the practice in a more culturally sensitive way, the United Nations Children's Fund (UNICEF) and the United Nations Population Fund (UNFPA) recommended the use of a hybrid term, "female genital mutilation/cutting" (FGM/C). This was meant to capture the significance of the term "mutilation" at the policy level and highlight that the practice is a violation of the rights of girls and women. At the same time, it recognized the importance of employing respectful terminology when working with practicing communities (UNICEF, 2013, p. 7; WHO, 2008).

3. Forms of FGM/C

A classification of female genital mutilation was first drawn up at a technical consultation in 1995 (WHO, 1996). According to WHO, an agreed classification is useful for purposes such as research on the consequences of different forms of female genital mutilation, estimates of prevalence and trends in change, gynecological examination and management of health consequences, and for legal cases. A common typology can ensure the comparability of data sets. Nevertheless, classification naturally entails simplification and hence cannot reflect the vast variations in actual practice. The WHO has classified four broad types of FGM/C: clitoridectomy, excision, infibulation and unclassified/symbolic circumcision (Van Der Kwaak, 1992; WHO, 2008; UNICEF, 2013).

3.1 Type I (clitoridectomy)

Type I involves partial or total removal of the clitoris and/or the prepuce. In medical literature this form of FGM/C is also referred to as "clitoridectomy." A number of practicing communities also refer to it as *sunna*, which is Arabic for "tradition" or "duty."

3.2 Type II (excision)

Type II involves partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora. The WHO definition recognizes that although this form of cutting is more extensive than Type I, there is considerable variability in the form or degree of cutting. This type of cutting is often referred to as "excision."

3.3 Type III (infibulation)

Type III involves narrowing of the vaginal orifice by cutting and bringing together the labia minora and/or the labia majora to create a type of seal, with or without excision of the clitoris. In most instances, the cut edges of the labia are stitched together, which is referred to as 'infibulation'. The adhesion of the labia results in near complete covering of the urethra and the vaginal orifice, which must be reopened for sexual intercourse and childbirth, a procedure known as "defibulation." In some instances, this is followed by "reinfibulation."

3.4 Type IV (unclassified/symbolic circumcision)

Type IV includes all other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, piercing, incising, scraping and cauterization. Pricking or nicking involves cutting to draw blood, but no removal of tissue and no permanent alteration of the external genitalia. This is sometimes called "symbolic circumcision," and some communities have described it as a traditional form of FGM/C. Although symbolic circumcision is still highly controversial, it has been proposed as an alternative to more severe forms of cutting in both African and other countries where FGM/C is performed.

Although the type of FMG/C varies from culture to culture and country to country, about 85% of genital cuttings worldwide involve type I (clitoridectomy), with type III (infibulation) accounting for about 15% (Lane & Rubinstein, 1996). All types carry health risks, but the risks are substantially higher for those who have undergone the more extreme form of FGM/C, type III (Oloo et al., 2011).

4. FGM/C in Kenya

FGM/C in Kenya mostly involves partial or total removal of the external female genitalia or other injury to the female organs for cultural or other non-therapeutic reasons. The practice is widely condemned as harmful because it poses a potentially great risk to the health and well-being of the women and girls who are subjected to it. It is also generally recognized as a violation of girl's and women's rights (KNBS, 2010).

The practice is entrenched in an elaborate ritual of initiation into womanhood (UNFPA & UNICEF, 2013). For instance, among the *Maasai*, the ritual of FGM/C begins with the girl getting rid of all her childhood possessions and clothing. She undergoes ritual shaving and washing, and then sits in a dark hut before a female circumciser, surrounded by her family. A special curved blade cuts away the girl's clitoris and labia minora without any anesthesia. The only concession to the girl's pain is that she may cry out without disgrace (Beckwith & Fisher, 1999).

The most prevalent types of FGM/C in Kenya are types I (clitoridectomy) and II (excision). Most women who have undergone FGM/C had their genitalia cut, with some flesh removed (UNICEF 2013). According to the 2008–09 Kenya Demographic Health Surveys (KDHS), the vast majority of women, 83%, say that they had some flesh removed, which usually includes removal of the clitoris, while 2% say they were nicked with no flesh removed. Thirteen percent of women say they had type III (infibulation), the most invasive form of the procedure in which the labia are removed and sewn closed (KNBS, 2010).

Most cases of FGM/C are performed by traditional practitioners at home using blade or razor and without anesthetic (UNICEF 2013). The vast majority of women had the operation performed by a traditional practitioner (78%), and only 20% were circumcised by health professionals. The mean age at which the procedure is performed ranges from about 9 to 16 years among various ethnic groups: the *Somali* (9), *Kisii* (10), *Embu* (13), *Maasai* (14), *Kikuyu* (14), *Meru* (15), *Kalenjin* (16), and *Kamba* (16) (UNICEF, 2013).

4.1 Prevalence

Despite efforts to eliminate the practice, prevalence of FGM/C in Kenya remains relatively high. According to the Kenya Demographic and

Health Surveys (KDHS) 2008-09, on average, 27% of females aged 15–49 years had undergone FGM/C in 2008-09, a decline from 32% in 2003 and 38% in 1998 (Kenya National Bureau of Statistics, 2010). Although these statistics show a declining trend in its overall prevalence rate, some communities in Kenya continue with the practice unabated. The prevalence of the practice varies among ethnic groups (UNFPA & UNICEF, 2013). FGM/C has declined substantially in some ethnic groups, such as the Kikuyu and Kalenjin, whereas in others, such as the *Kisii* and *Somali*, it remains nearly universal. The practice is now quite rare among the *Kamba* (10%), *Kalenjin* (8%) and *Kikuyu* (4%), and has almost disappeared entirely among the *Meru* (less than 2%) (UNICEF, 2013).

FGM/C is traditionally practiced in 29 ethnic communities living in Kenya (UNFPA & UNICEF, 2013). Kenya has significant regional variations in FGM/C. The prevalence ranges from 0.8% in the west to over 97% in the northeast of Kenya. Ethnicity appears to be the most determining influence over FGM/C in Kenya. With regard to ethnicity, the prevalence has remained highest among the Somali (97%), *Kisii* (96%), *Kuria* (96%) and the *Maasai* (73%), relatively low among the *Kikuyu*, *Kamba* and *Turkana*, and rarely practiced among the *Luo* and *Luhya* (less than 1%). These regional differences are reflective of the diverse ethnic communities, as well as the type of FGM/C performed and the underlying reasons for practicing it (KNBS, 2010; Oloo et al., 2011; UNICEF, 2013).

Different ethnic groups also practice different types of circumcision. For instance, the *Kisii* and *Kikuyu* ethnic groups practice type I (clitoridectomy), the Maasai and Meru practice type II (excision), and the *Somali*, *Borana*, *Rendille* and *Samburu* practice the more severe form of type III (infibulation). There is evidence that among the *Kisii*, there is an increasing trend towards nicking the skin around the clitoris (type IV) (Njue and Askew, 2004; KNBS, 2010; 28 Too Many, 2013). While social work values respect and appreciates individual and group differences, it does not condone practices that cause harm to an individual.

There is also a relationship between FGM/C and other factors like religion, level of education, location, and household wealth. According to the KDHS 2008-09, the percentage of Muslim women who undergo the practice is about double (44.4%) that of Christian women (17.7%) (KNBS, 2010; 28 Too Many, 2013). There is a strong relationship between level of education and FGM/C status. Fifty-four percent of women without any formal education report that they undergo the procedure compared with only 19% of those with at least some secondary education. Women's support for the continuation of FGM/C is disaggregated by their level of education. Support for the practice declines progressively with increased levels of education. Compared to men with secondary or higher education, men with no education are more likely to support the continuation of FGM/C (Oloo et al. 2011; UNICEF, 2013).

The KDHS 2008–09 also indicates that rural women are more likely to undergo FGM/C than urban women. A higher percentage of rural women (31%) than urban women (17%) have undergone the procedure. In addition, urban women are more likely than rural women to have the procedure performed by a health professional (Oloo et al., 2011; UNICEF, 2013; KNBS, 2010; UNFPA & UNICEF, 2013).

Finally, data also indicates that the percentage of women who undergoes the procedure declines steadily as their wealth increases (UNFPA & UNICEF, 2013). Modernization theory posits that improvements in economic status, particularly for women, will have broad social effects, including a decline in FGM/C. If economic development serves to reduce the demand for FGM/C, one would expect to see a lower prevalence among daughters of women from wealthier households (UNICEF, 2013).

5. The Complexity of FGM/C

Social workers should understand the complexity of FGM/C in order to address the practice that is contrary to social work values. Social work practice is founded on a strong knowledge base as

the underpinning for doing and the willingness to transmit knowledge and skills to others (Morales, et al., 2011). What are the perceived benefits of FGM/C and the reasons why both women and men in some communities believe it should continue? The reasons why some communities in Kenya continue the practice of FGM/C are deeply rooted in their traditional culture, driven by a complex combination of psychosexual and social reasons, specific to each context (Muteshi and Sass, 2005). Communities that practice FGM/C in Kenya report a variety of reasons for continuing with it including social acceptance, preservation of virginity, better marriage prospects, cleanliness/hygiene, more sexual pleasure for the man; and religious necessity/approval (UNICEF, 2013). Justifications for the perpetuation of the practice pose a challenge in the fight against FGM/C, and, in part, explain the resistance to ending FGM/G in some communities.

FGM/C is situated in social customs. Strong adherence to tradition makes the eradication of FGM/C among the practicing communities such a difficult task for those seeking to end the practice. Perhaps the most important justification for FGM/C is that because it is an age-old practiced tradition, its adherents simply consider it normal (Lane & Rubinstein, 1996). Most communities practicing FGM/C in Kenya regard it as a ritual of transition to womanhood. Among the Marakwet, Embu, Kalenjin, Maasai, Meru and Kikuyu, FGM/C is considered a necessary rite of passage for a girl to become a woman. It is often done as part of a ritual of initiation into womanhood (28 Too Many, 2013). These communities also view FGM/C as a fundamental symbol of ethnic identity used to distinguish them from neighboring non-FGM/C communities (Njue and Askew, 2004; UNFPA & UNICEF, 2013).).

The most commonly reported reason for FGM/C is gaining social acceptance (UNICEF, 2013). In the 2008-09 Kenya Demographic Health Surveys (KDHS), 24% of women who underwent FGM/C cited social acceptance as the most important reason for its justification (Oloo et al., 2011). Pressure from the communities where FGM/C is practiced forces even some adult and married women to go for the cut voluntarily so as to gain acceptance and avoid ridicule. Some communities cannot tolerate women who have not undergone FGM/C. For instance, in December 2013, pressure from the *Marakwet* community forced seven women aged between 24 and 28 to willingly undergo FGM/C in order to avoid ridicule and to be able to participate at some community ceremonies (KTN News Kenya, 2013).

FGM/C is often motivated by beliefs about what is considered suitable sexual behavior in a particular community. The justification for FGM/C in such case appears to be grounded in the social desire in terminating or reducing feelings of sexual arousal in women so that they will be much less likely to engage in pre-marital sexual relationship or adultery (Elsayed et al., 2011). The *Kisii* and the *Somali*, for instance, believe that FGM/C ensures and preserves virginity, marital faithfulness and prevents promiscuity. They say "when you cut a girl, you know she will remain pure until she gets married, and that after marriage, she will be faithful." They believe that infibulation provides physical evidence of virginity, and the removal of clitoris and labia minora reduces a woman's sexual response (Lane & Rubinstein, 1996).

FGM/C is also associated with sexuality and the beautiful appearance of the female body; uncut genitalia can be considered unclean or too masculine (28 Too Many, 2013). If a girl is not cut, it is believed that her clitoris will grow long like a penis and thus the removal of this potentially masculine organ makes a girl more completely female (Lane & Rubinstein, 1996). In addition, FGM/C is meant to give more sexual pleasure for the man – the infibulated vaginal opening is believed to offer greater friction for the husband during sexual intercourse (Lane & Rubinstein, 1996). These are highly valued, for example, in the Somali community where infibulation is used to enforce these values (MOH, 2004). For these communities, an uncut girl is considered to be sexually promiscuous. In the 2008-09 KDHS, 16% of women who

underwent FGM/C believe that it preserves virginity until marriage (Oloo et al., 2011).

There is a strong link between FGM/C and marriageability as many men in practicing communities continue to reject women who are uncut. It is thought to increase a woman's marriage prospect and with the ability to attract a higher bride price, especially among the *Meru*, *Massai* and *Samburu* communities (Chege et al., 2001). In the 2008-09 KDHS, 9% of women who underwent FGM/C believe that it increases marriage prospects (Oloo et al., 2011).

FGM/C is sometimes performed by some communities as a religious obligation. According to an Islamic Religious Leader, "The religious influence is huge. In most Muslim communities in Kenya, having a law on FGM/C or talking about the negative health effects of FGM/C will have no effect at all as long as people believe that it is their religious duty to circumcise their girls" (UNFPA & UNICEF, 2013:26).

Among Kenyan Muslims practicing FGM/C, in particular, the *Somali* community, the practice is regarded as a religious requirement and obligation (Lane & Rubinstein, 1996; MOH, 2004). The *Somalis* who practice near universal FGM/C (98%) believe it is required by Islam. The *Somali*, *Borona* and *Orma*, for instance, believe that FGM/C constitutes an Islamic requirement. However, in the 2008-09 KDHS, only 7% of women who experienced FGM/C felt that it is required by their religion. Many studies show that the practice precedes both Christianity and Islam (Lane & Rubinstein, 1996; Burson, 2007; 28 Too Many, 2013). According to most Islamic scholars, while the removal of the foreskin is considered a religious requirement for all Muslim children, removal of the prepuce is not deemed necessary for female children (Lane & Rubinstein, 1996). The practice is not mentioned at all in the Koran. Nevertheless, many Muslims often consider FGM/C to be founded on Islam. According to some scholars of the *Hadith* (the sayings and actions of the Prophet Mohammad), the prophet is reported to have said, "When you perform excision do not exhaust [do not remove the clitoris completely], for this is good for women and liked by husbands" (Lane & Rubinstein, 1996:34). Proponents of this view base their opinion largely on the custom and beliefs about the need to control female sexuality, rather than on the authority of the Koran or Hadith (Lane & Rubinstein, 1996).

However, not all Islamic groups practice FGM/C, and many non-Islamic groups do. Followers of all three monotheistic religions – Christianity, Judaism and Islam—"have at times practiced FGM/C and consider their practices sanctioned, or at least not prohibited, by God." Despite the fact that FGM/C predates the birth of Islam and Christianity and is not mandated by religious scriptures, the belief that it is a religious requirement contributes to the continuation of the practice in a number of settings (UNICEF, 2013).

Finally, there are cultural myths associated with the practice of FGM/C. Examples of myths that are used to inflict fear in the girls and motivate them to face the knife include the following (Kallestein, 2009):

- If you are not cut, then your clitoris will grow very long and they will sweep the ground;
- If you are not cut, then you will remain a kid;
- If you are not cut, then you will not get married;
- If you are not cut, then your first born child will not survive;
- If you are not cut, then you will not receive blessings from the ancestors.

6. Current Trends in the Practice of FGM/C in Kenya

Numerous studies have described recent changes in how and when the practice is performed, including a tendency for FGM/C to be carried out at younger ages and by medical personnel. Since 2001, there has been a marked trend towards girls undergoing FGM/C much younger, with many girls under 10 years of age. This appears to be in order to cut them before they might refuse

and also in response to the illegality of FGM/C. Consequently many girls are dying as their families are too scared to take them to hospital for fear of being arrested (KNBS, 2010; Oloo et al., 2011).

With the establishment of legislation and declining acceptability, parents tend to handle the practice in a less visible and more private manner or perform FGM/C in less radical forms. For example, carrying out the procedure in the absence of elaborate ritual celebration, use of medical instruments, antibiotics and/or anesthetics by traditional practitioners, cutting less flesh to reduce severity of the procedure and symbolic pricking or nicking of the clitoris mainly carried out by medical professional (KNBS, 2010; 28 Too Many, 2013).

As long as there is social support for the continuation of FGM/C, parents will look for ways to decrease harm to their daughters by having FGM/C carried out by medical personnel. The medicalization of FGM/C has grown in Kenya in recent years. Despite being illegal this means that the procedure takes place in a hospital or clinic and is done by medical professionals using surgical instruments and anesthetics (KNBS, 2010; Oloo et al., 2011; 28 Too Many, 2013). Research shows that since the illegalization of FGM/C in Kenya, the percentage of girls who had the procedure performed by health-care personnel increased nonetheless, rising from 34% in 1998 to 41% in 2008-2009 (UNICEF, 2013).

7. Fighting FGM/C in Kenya

To deal with the problem of FGM/C in a holistic way requires a combined approach including strengthening social work values. Simply illegalizing the practice does not effectively address the problem. Kenya has a long history of efforts to encourage the elimination of FGM/C, dating back to the 1930s'unsuccessful efforts by the colonial administration and Christian missionaries opposed to the practice (Lane & Rubinstein, 1996).

Efforts to eliminate FGM/C have been strengthen by the United Nations General Assembly adoption of the resolution *Intensifying global efforts for the elimination of female genital mutilations* on December 20th, 2012. This resolution urges "states to pursue a comprehensive, culturally sensitive, systematic approach that incorporates a social perspective and is based on human rights and gender-equality principles" (UNICEF, 2013:3).

Key players involved in the fight against FGM/C in Kenya include government actors, particularly the Ministry of Health; non-governmental organizations; UN organizations, in particular UNICEF and UNFPA, and other development partners such as the WHO, the World Bank, the media, and key figures like members of parliament, religious groups and officials have also made public pronouncements against the practice (Oloo et al., 2011; UNICEF, 2013; UNFPA & UNICEF, 2013). The mass media has increased its coverage of the practice on a wide range of issues including children and women's rights, consequences of FGM/C, as well as ways in which individuals and communities can fight the practice (WHO, 2008).

8. Approaches in the Fight Against FGM/C

Diverse approaches have been used by different agencies at local and national level with varying degree of success to encourage the elimination of FGM/C in Kenya. These include health risk/harmful traditional practice approach, legal approach, faith-based approach, promotion of girl's education, and the alternative rite of passage approach. These approaches use a variety of behavior change channels. Some use traditional communications strategies such as poems and folklore, community education, advocacy, youth participation, research, integrated strategies, educational materials and counseling of survivors (Population Council, 2007; Oloo, et al., 2011). These approaches should be accompanied by social works values which put emphasis on achieving social justice and giving priority to the most vulnerable members of the society, i.e., those most likely to experience problems in their social interactions due to age, gender, race or ethnicity,

sexual orientation, or other characteristics (Morales, 2011). `

8.1 Health Risk/Harmful Traditional Practice Approach

Strategies that include education about the negative consequences of FGM/C have been the most frequently used in Kenya and globally for the eradication of FGM/C. Research has shown that this approach in itself is not sufficient to eradicate the practice and can have the negative consequences of encouraging the medicalization of the FGM/C (28 Too Many, 2013).

8.2 Legal Approach

Programs to address FGM/C initially focused on associated health risks. However, the practice was re-conceptualized as a human rights violation at the 1993 World Conference on Human Rights in Vienna. National legislation was subsequently established in many countries to prohibit the practice and to step up action against it (UNICEF, 2013). The Government of Kenya recognizes that FGM/C is a fundamental violation of the rights of girls and women. The government issued decrees and bans against FGM/C in 1982, 1989, 1998 and 2001. The Children's Act of 2001 prohibits FGM/C and other harmful practices that "negatively affect" children under 18 years old, imposing a penalty of twelve months of imprisonment and/or a fine. However, since the Act only applied to children and was not widely publicized by the government, its impact was limited (UNFPA & UNICEF, 2013:7). The Children's Act has been strengthened by the Prohibition of Female Genital Mutilation Act 2011 which criminalizes all forms of FGM/C performed on anyone, regardless of age, aiding FGM/C, taking someone abroad for FGM/C and stigmatizing women who have not undergone FGM/C.

Although legislation theoretically offers protection for girls and women and a deterrent to families and circumcisers, it can be difficult to enforce and does not in itself change beliefs and behavior (Population Council, 2007). It is most effective when accompanied by awareness raising and community dialogue. However, mere awareness of the problems associated with FGM/C can lead to despair if it is not combined with action that empowers the people to bring about social change. If anti-FGM/C laws are introduced before society has changed its attitudes and beliefs or is not accompanied by the requisite social support, it may drive the practice underground, encourage people to cross the border to undergo it in a neighboring country, and prevent people seeking medical treatment for health complications (Population Council, 2007; 28 Too Many).

8.3 Faith-based Approach

A religious-oriented approach tries to demonstrate that FGM/C is not compatible with the religion of a community and thereby lead to a change of attitude and behavior. This has been used among both Muslim and Christian communities. Taking a religion-based approach in such communities may be a more successful technique than traditional strategies. Although FGM/C is practiced in some communities in the belief that it is a religious requirement, research shows that the practice pre-dates Islam and Christianity (28 Too Many, 2013).

8.4 Empowerment of Girls and Women

There is a strong relationship between education and FGM/C. Every authentic response to FGM/C should start out from education. It is of utmost importance that the education system in itself responds to the problem in a visionary and dynamic way – partly in order to equip individuals to deal with the problem successfully, but more importantly so as to equip them to wrong-foot the problem. This approach involves promotion of girl's education to oppose FGM/C and supporting girls escaping from early marriage and FGM/C. There is a strong link between FGM/C and early marriage among some ethnic groups such as the *Maasai*. Girls are cut prior to getting married and often drop out of school following being cut. This approach encourages the girls to remain in

education and in some cases encourages them to speak out against FGM/C (28 Too Many, 2013).

8.5 The Alternative Rites of Passage (ARP) Approach

The alternative rites of passage (ARP) approach reinforces the traditional positive values but without FGM/C (WHO, 2008). It maintains the celebration of the passage of a girl to womanhood, thus respecting the culture and tradition, without the act of genital cutting. In ARP ceremonies, girls are educated about their role as women in society and receive more relevant instruction such as lessons about reproductive health and the importance of formal education. ARP is often suggested as an intervention offering a culturally-sensitive approach, leading to the long term abandonment of FGM/C (Oloo et al. 2011).

Despite the aforementioned approaches, the practice of FGM/C continues. Survey data from before and after the adoption of these measures in Kenya show that the percentage of girls who had the procedure performed by health-care personnel increased nonetheless rising from 34% in 1998 to 41% in 2008–09. This suggests that as long as there is social support for the continuation of FGM/C, parents will look for ways to decrease harm to their daughters by having FGM/C carried out by medical personnel (UNICEF, 2013). Nevertheless, the previous approaches should be strengthened by social work values to comprehensively address the problem of FGM/C and consequently eliminate the practice.

9. Ethics and FGM/C

In dealing with social problems, one cannot avoid making some ethical considerations guided by social work values. The process of debate and analysis of ethical perspectives and social work values in FGM/C can generate "the kind of thoughtful judgment that is always more valuable than simplistic conclusions reached without the benefits of careful, sustained reflection and discourse" (Reamer, 1991:13). However, some critiques argue that ethical norms are not applicable in dealing with issues like FGM/C. They contend that though thinkers have applied ethics to these problems for many years, they have failed to achieve definitive, indisputable outcomes. Cheryl Noble, for instance, asserts that "Applied Ethics is of limited value because ethicists too often get caught up in the analysis of abstractions that are far removed from pressing real world problems" (Reamer, 1991:10).

10. Arguments against FGM/C

Why should FGM/C be abolished? First, it is considered as an important problem, from both public health and ethical aspects in the countries where it still exists. It violates the essential principles of medical ethics, human rights and social work values. Therefore, "no intelligent effort at improvement can be made until the nature and source of the unsatisfactory aspects of the situation are clarified" (Sheffield, 2011:28).

10.1 No-benefit Argument

The main ethical drawback of FGM/C is that it is a senseless practice which provides no direct benefit to girls on whom it is performed. It has no known health benefits (WHO, 2008). On the contrary, it inflicts undue harm on the little girls (who are the primary victims) and women, and it violates the fundamental ethical principles of bodily integrity, autonomy and self-determination, without the full informed consent of most of the victim. Undefined medical indications for FGM/C and possible risks to females make it ethically unacceptable (Elsayed et al., 2011). According to UNICEF (2013), 59% of girls and women who have undergone FGM/C in Kenya do not see any benefit associated with the practice.

10.2 Health Risks Argument

The risk factors in FGM/C include bleeding, often severe enough to cause death, infection, particularly due to poor sanitary conditions; risk of HIV transmission due to sharing of knives; and complications during childbirth, often leading to stillbirths (WHO, 2008; UNICEF, 2013). Research

has shown that there is an association between FGM/C and the risk of HIV/AIDS (Kinuthia, 2010; WHO, 2008). FGM/C can be a risk factor in the transmission of HIV. First, the cutting is often performed using non-sterile instruments, which can bring women into contact with infected blood. Second, studies reveal a higher rate of genital herpes among women subjected to FGM/C. This can increase the risk of HIV infection since genital herpes is known to facilitate transmission of HIV. Finally, injuries during sexual intercourse are one of the medium-term complications of FGM/C and depend on the extent of the mutilation. In the case of Type III FGM (infibulation) or where scarring seriously narrows the vagina, sexual intercourse can result in injuries and bleeding, which in turn increase the risk of infection (WHO, 2008).

10.3 Human Rights Argument

FGM/C is recognized as a harmful practice that contravenes several basic rights of girls and women. Article 25 of the Universal Declaration of Human Rights states that "everyone has the right to a standard of living adequate for health and well-being…" This article has been used to argue that FGM/C violates the right to health and bodily integrity (UNICEF, 2013). Oloo et al. (2011:7) argues that regardless of the reasons for its practice, FGM is harmful and violates the rights and dignity of women and girls, the rights to health, security and physical integrity of the person, the right to be free from torture and degrading treatment, and the right to life when the procedure results in death." FGM/C has been widely recognized as a harmful practice and was specifically condemned in the 2003 African Union Protocol to the Africa Charter on Human Rights on the Rights of Women (Article 5, Elimination of Harmful Practices), which states:

> States parties shall prohibit and condemn all harmful practice which negatively affect the human rights of women and which are contrary to recognized international standards. States parties shall take all necessary legislative and other measures to eliminate such practices, including: […] all forms of female genital mutilation, scarification, medicalization and paramedicalization of female genital mutilation and all other practices in order to eradicate them. (Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa , 2003; Oloo et al., 2011:8).

In addition, FGM/C violates the Convention on the Rights of the Child (CRC). In 1989, the UN General Assembly adopts the Convention on the Rights of the Child (CRC), which includes provisions to protect children against harmful practices (UNICEF, 2013).

The principle of respect for fundamental human rights can help define the obligations of practitioners engaged in FGM/C. According to the principle of respect for fundamental rights, every person has an obligation to recognize and respect fundamental rights such as the rights to life and to physical security. These are rights that no person or institution is morally permitted to violate (Boatright 1997). We cannot speak about human rights in a society that cannot protect its girls where FGM/C becomes a normal practice (Elsayed et al., 2011).

10.4 Human Dignity Argument

FGM/C is often assumed to be a manifestation of patriarchal control over women (UNICEF, 2013). When FGM/C is performed under the pretext of more sexual pleasure for the man; girls and women end up being treated merely as objects. This undermines their inherent human dignity and goes contrary to Kant's "kingdom of ends." By this, Kant means that we must never treat people for our own selfish ends, but rather as ends in themselves as possible members of the "kingdom of ends" (Kant, 1981:438; Pacho, 2013).

10.5 Human Freedom Argument

In some communities, FGM/C is often associated with early and forced marriage ranging from 10 and 15 years with most girls marrying men many times their age. After the procedure, a girl is considered a woman and hence mature and ripe for marriage. The parents decide for the girl on whom to marry and whom not to marry. This may not be the best, or most reasonable, or most favorable to the girl's fulfillment and meaning in life (Stevenson, 1987). The practice, therefore, promotes infringement of the girl's freedom of choice since she is expected to comply with the decision and existing norms in the community without compromise.

10.6 Gender-based Violence Argument

FGM/C is linked to gender-based violence. The 1993 Vienna World Conference on Human Rights classified FGM/C as a form of violence against women (VAW). Therefore ending FGM/C contributes to the larger issues of ending violence against children and women (UNICEF, 2013).

10.7 Medical Ethics Argument

FGM/C violates the principles of medical ethics. Medical ethics refers to the application of principles of ethics into medicine and medical practices (Beauchamp and Childress, 2001). The essential principles of medical ethics include respect for autonomy, beneficence (doing good), non-maleficence (no harm or evil) and justice. Medical ethics is at the heart of the FGM/C discourse primarily because the FGM/C is considered as a medical/surgical intervention performed by some doctors and other medical workers, for example, midwives who are the most frequent medical workers performing genital cutting (Burson, 2007).

The ethical dilemma with performing FGM/C comes from the deeply held social and religious beliefs about the practice and the moral beliefs that are used by the people who support and continue the practice. In this case, if the medical professional performs FGM/C, he/she does not need any reasoning for his/her action. On the other hand refusal may be considered as a resistance or violation to social norms (morality) which is a very serious insult to cultural identity. Violating social tradition is considered as disrespect in their society. The medical professional may lose his/her credibility and respect as a community-oriented health worker. Alternatively, performing medically meaningless and harmful procedures by medical professionals is not only unethical; but it is equally illegal and an obvious violation of the principle of non-maleficence (Elsayed et al., 2011).

Furthermore, most FGM/C is done by midwives, nurse midwives as well as village midwives (birth attendants) that are not trained or qualified to perform surgical interventions. They may not be aware or able to treat immediate complications when they occur such as bleeding and/or shock. So they carry out others' job which is by all means unethical and also illegal. It is unethical because they inflict unnecessary harm and hazard on little girls for nothing, which otherwise, could be preventable. The principles of beneficence and nonmaleficence are violated (Elsayed et al., 2011).

The principle of negative harm can help define the obligations of medical practitioners engaged in FGM/C. The principle of negative harm holds that medical practitioners have an obligation not to add to the suffering of people they deal with. Consequently, they should at least adhere to four obligations: (1) not to inflict evil or harm; (2) actively to prevent evil or harm; (3) actively to eradicate evil; and (4) to promote the good (Boatright, 1997).

10.8 Informed Consent Argument

As a surgical intervention, FGM/C requires obtaining prior informed consent from the person on whom the surgery will be performed. Informed consent is a procedure that should be assigned without any questions or counter arguments. It is justified to show respect for autonomy, to ensure justice, and to minimize risk (Bottrell et al., 2000). Informed consent is usually obtained from a competent person i.e. an adult person with a sound

mind. In the case of children, informed consent is sought from their parents or any other legal guardian. This is the practice in daily scheduled medical and health care. The only exception is permissible in emergency situations where urgent interventions are to be performed. FGM/C is neither a medical emergency nor is it important from a medical point of view. In the case of FGM/C, informed consent is usually not sought. Nevertheless, medical professionals are often asked to perform FGM/C by the mother (sometimes by other family members), not for herself; but for another person – her little daughter. Here, the mother is acting as a proxy decision-maker. The proxy decision-maker does not have the right to make her values and perspectives; instead she must do what is in the best interest of her little incompetent daughter. In addition, she does not have the right to make her values and perspectives to harm any other person, even if this person is her own child. FGM/C is an irreversible and senseless intervention, so it can be postponed until these little girls reach eighteen, the age of legal responsibility in many countries. Then, they will be able to make an autonomous decision pertaining to their own bodies (Elsayed et al., 2011).

10.9 Psychosexual Argument

The justification for FGM/C sometimes appears to be grounded in the social desire in terminating or reducing feelings of sexual arousal in women so that they will be much less likely to engage in pre-marital sexual relationship or adultery (Elsayed et al., 2011). Physical effects of the type I of FGM/C (clitoridectomy) include reduced sexual desire in women. There is strongly held belief in communities where FGM/C is practiced that FGM/C improves moral behavior of women by reducing their sexual arousal. They also believe that FGM/C preserves girls' chastity. The supporters are not aware (or do not want to be aware) that sexual arousal is regulated by a complex hormonal mechanism and directed by the nervous system. On the other hand, human behavior is based on reasoning and the individual personal value system not physical features. So both, behavior improvement and sexual control of women through FGM/C are ethically not accepted. Why reduce their sexual activity and want them to get married and take their social responsibility as wives and mothers at the same time? FGM/C hinders the women's right to maintain both their social role and normal and healthy sexual life. Yet, they have the absolute right to enjoy their sexual life and it is the society's duty to protect this right. We cannot speak about human rights in a society that cannot protect its girls where FGM/C becomes a normal practice (Elsayed et al., 2011).

11. Ethical Relativism and FGM/C

Ethical relativism is the theory that right and wrong is determined by what one's society says is right and wrong. Thus "what is right in one place may be wrong in another, because the only criterion for distinguishing right from wrong – and so the only ethical standard for judging an action – is the moral system of the society in which the act occurs" (Shaw and Vincent, 2001: 11). Ethical relativism embraces the notion that groups and individuals hold different sets of values that must be respected (Lane & Rubinstein, 1996). For the ethical relativist there is no absolute ethical standard independent of cultural context—the requirements of morality are all relative to society. Due to the diversity of human values and the multiplicity of moral codes, the only criterion for moral judgment rests with what particular cultures and societies determine to be right and wrong. If ethical relativism is correct, there can be no common framework for resolving moral disputes or for reaching agreement on ethical matters among members of different societies.

Many ethicists reject the theory of ethical relativism. Shaw and Vincent (2001) identify a number of problems. First, disagreements in ethical matters do not imply that all options are correct. Second, ethical relativism undermines any moral criticism of the practices of other cultures so long as their behavior conforms to their own standards. Third, ethical relativism undermines ethical progress, since for the relativist there can be no

such thing – although morality may change it cannot get better or worse. Finally, ethical relativism undermines any critical evaluation of one's own moral principles and practices.

The problem with ethical relativism in relation to the fight against FGM/C is that from a relativist's point of view, it makes no sense for people to criticize the practice of FGM/C accepted by a particular community, because whatever the community takes to be right is right in its context. However, a relativist should recognize that there is no good reason for claiming that "majority rule" on moral issues is automatically right. The belief that it is automatically right has unacceptable consequences. Furthermore, the practice calls for universal or common norms for evaluating particular practices that undermine human dignity and freedom (Shaw and Vincent, 2001). Human rights, for instance, constitute universal criteria for evaluating particular cultures and practices, with particular reference to human dignity and freedoms. Thus, human rights approach can help overcome the problem of ethical relativism in dealing with FGM/C. Social work values can also reinforce this approach with its commitment to social justice and the economic, physical, and mental well-being of all in society.

12. Conclusion

Female genital mutilation/cutting (FGM/C) is internationally recognized as a violation of human rights and social work values. Although progress has been made leading to a declining trend in some communities in Kenya and elsewhere, efforts still needs to be strengthened to comprehensively address the problem and consequently eliminate the practice. FGM/C has no known health benefits. On the contrary, it inflicts undue harm on the little girls and women, and it violates the fundamental ethical principles of bodily integrity, autonomy and self-determination without the full informed consent of the victim. Ethical inquiry and social work values are relevant in addressing FGM/C in Kenya since they enhance our understanding of moral issues associated with the practice and how to deal with it. Dealing with the practice in Kenyan diverse cultures requires a well-informed and ethically balanced judgment. From the moral point of view, while dealing with FGM/C, issues pertaining to human dignity, rights and freedoms, social work values as well as future implications must always be taken into account. Consequently, an appropriate moral response to FGM/C largely depends on clear understanding and application of ethical principles and social work values.

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