

Female genital mutilation in Djibouti

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Abstract

The practice of female genital mutilation (we will use the latest definition adopted by WHO/UNFP: female genital mutilation/cutting or FGM/C) is still widespread in 28 African countries. The World Health Organisation (WHO) estimates that more than two million females undergo some form of genital mutilation every year.

Its negative health impact and its ethical and human rights aspects have been discussed and attempts to eliminate it have been the objectives of several meetings promoted by national and international organisations thanks to an increased awareness related to FGM/C in those countries practicing it and also, maybe due to the number of Africans migrating to industrialized countries.

We review the present situation in Djibouti, a small country in the Horn of Africa, where 98 % of the female population has suffered different forms of FGM/C.

Keywords: female genital mutilation/cutting, Djibouti

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Introduction

FGM/C is prevalent in many parts of the world. It has been estimated that at present 120-140 million females in the African continent have been mutilated¹.

The Republic of Djibouti has a surface of 23 000 sq km and a population estimated at 864 000 inhabitants, 75 % of them living in the capital. In 1977 the country gained its independence from France and although small in size and with almost no natural resources, it has gained, due to its location, an important geostrategical role and is now the site of French and United States military bases.

In spite of recent government efforts, its health indicators remain poor. Life expectancy: 58/62 years (male/female); probability of dying before reaching the age of 5: 94 per 1000 live births; maternal death rate: 730 per 100 000 live births and lifetime maternal risk of dying: 1 in 19 (for comparison, in Spain: 1 in 17 400); among the “extremely poor” females 9 % die in childbirth and a large proportion of these deaths has been linked to peripartum haemorrhaging and this to FGM/C^{2,3}.

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Historical background and justification

Female excision was already mentioned in antiquity being “the habit of Egyptians to excise future husbands and wives”⁴ and has been detected in ancient mummies⁵. In Greece FGM/C was recorded in a papyrus from 163 B.C⁶. and Soranos from Ephesus in the third century, considered the father of obstetrics and gynaecology, described the technique of female excision. Several Arab sources have documented the practice of FGM/C in the pre-Islamic era. Female circumcision was also practised in Europe and North America by the medical profession as late as the nineteenth century as a treatment for a wide variety of conditions, including masturbation⁷⁻¹⁰.

The reasons justifying such procedure vary but mostly have to do with “a good tradition” and “religious demand”⁵. More specifically they are closely related to the lower status of women in those societies practising it and the marked asymmetry of gender relations^{11,12}. They could be divided into five groups:

Hygienic and aesthetic. The external female genitalia are considered dirty and “unsightly” and should be flat, rigid and dry;

Sociological. Identification with the cultural traditions, as a rite of passage of girls into womanhood, and for the maintenance of social cohesion;

Psychological. Reduction of sensitive tissue and thus to curb sexual pleasure in order to maintain chastity

and virginity, to guarantee women's fidelity, and even to increase males sexual pleasure;
Myths and false beliefs. To enhance fertility and promote child survival; and
Religious. FGM/C has been practiced in a range of communities with different religions: Christian, Muslim and animist. Muslim communities often have the false belief that FGM/C is related to teachings of the Islamic law.

Classification and consequences

The World Health Organization classifies FGM/C into four categories¹³:

Type I. Excision of the prepuce with partial/total excision of the clitoris (known in several areas as Sunna);

Type II. Excision of the prepuce and clitoris with partial/total excision of the labia minora;

Type III. Partial/total excision of the external genitalia and stitching the vaginal opening with its consequent narrowing (also known as infibulation or pharaonic form); and

Type IV. Includes several types of genital manipulation: pricking, piercing, incising and stretching the clitoris or labia; burning the clitoris; scraping the tissue surrounding the vagina; introduction into the vagina of corrosive substances or of herbs.

We must remark though that there is significant confusion about these categories and that self reported forms of FGM/C are not always accurate as was shown in a study from Khartoum¹⁴. An author with a vast experience in Sudan has proposed a simpler classification into two categories grouping type I with type II and type III with type IV¹⁵.

The consequences of FGM/C can be severe and are related to the anatomical extent of the mutilation¹⁶. In a hospital-based study in Sudan, primary infertility was linked to FGM/C and associated with the anatomical extent of the mutilation¹⁷. In a large prospective study of pregnant women conducted in six African countries it was shown that those having suffered FGM/C were more likely to have adverse obstetric outcomes³. Other consequences of FGM/C include cysts and abscesses, urinary tract infections and incontinence, keloids, vesico-vaginal and recto-vaginal fistulae, dyspareunia and sexual dysfunction, neonatal complications, and menstrual and urinary difficulties. To these physical problems we must add the psychological complications following FGM/C which is usually performed in very young girls¹⁵.

In settings where this practice cannot be abandoned at present, its medicalization (its performance in health centres) could constitute a transitory way of reducing its harmful effects¹⁸ but a risk exists that institutionalising the procedure will give it a "good name"^{1,19}. Moreover, little impact has been shown in countries such as Egypt that have adopted this strategy²⁰.

International actions and agreements

Over the past two decades FGM/C has gained increasing recognition as a human and health rights issue among professional health associations, governments and the international community. Several outstanding agreements have been reached:

- The Universal Declaration of Human Rights (1948).
- The Convention on the Elimination of All Forms of Discrimination against Women (1979).
- The Convention on the Rights of the Child (1990).
- The Vienna Declaration and the Programme of Action of the World Conference on Human Rights (1993).
- The Declaration on Violence against Women (1993).
- The Inter-African Committee against Traditional Practices Harmful to Women's and Children's Health (Addis Ababa, 1994).
- The Platform for Action of the Fourth World Conference on Women (1995).
- The African Protocol on Rights of Women (2005).

The meeting held in Addis Ababa passed a resolution targeting the "total eradication of FGM/C by the year 2000"⁶. As a result, at least 17 African countries have adopted specific laws banning FGM/C¹. We must consider though that the agreements reached in those meetings, almost universally signed and adopted by the participating governments, very often are not enforced or are even forgotten once at home.

The situation in Djibouti

The consequences of this practice are evidenced by the high maternal death rate suffered in Djibouti and Somalia (> 700 per 100 000 live births) where FGM/C is almost universal when compared to other nearby countries with a similar health and midwifery care but where FGM/C is much less common (Kenya and Tanzania: < 500 per 100 000 live births). Not only FGM/C is a widespread practice but the most mutilating forms are the most prevalent. A study by the Ministry of Health indicated that 93 % of women between 14 and 45 years of age had suffered mutilations of types II or III²¹.

Specific studies on the distribution of FGM/C have never been conducted but it is known that Issas have a higher prevalence of the type III form which is performed among girls 7-12-years-old while Afars usually adopt types I and II forms and undertake the operation at a much younger age. FGM/C is usually performed by traditional practitioners and traditional birth attendants (TBA) or, sometimes, by an old member of the family.

In a book compiling several interviews Erlich concluded that the motivation for the continuation of this practice was very complex. It must be noted that less than 10 % of the women interviewed agreed to answer⁹. Reasons such as aesthetic, tradition and religion were mentioned, and to a lesser degree other reasons such as controlling women's sexuality. Males were reluctant to discuss this issue but, in general, supported the practice.

Several campaigns have been launched in Djibouti with the support of international organizations but for different reasons most of them have had little significant impact. The "Union National des Femmes Djiboutiennes" implemented a campaign during the 80s (financed by UNICEF) to change public attitudes favoring the lighter form of FGM/C. The campaign failed because the means of communication were not adequate and because the message of adopting the Sunna form (type I) instead of the Pharaonic form (type III) was misinterpreted as Sunna in Djibouti corresponds to type III. In 1990 under international pressure a National Committee to Fight Harmful Traditional Practices was created. In 1995 the National Assembly declared illegal and punishable the practice of FGM/C but the article of the National Penal Code related to this issue has never been applied up to present. In 1997 the Ministry of Health assisted with the United Nation Fund for Population (UNFP) promoted the "Project to Fight Female Circumcision" within a larger frame of "restoring the dignity and respect of women" and "to raise the condition of women within society". The project suffered from the very beginning by the lack of enthusiasm shown by the higher political authorities and for being underfunded. Multiple surveys and forty information and health education initiatives have been conducted. Most of these activities were poorly designed and not field tested; often the numbers of subjects were too small and not very representative.

Nevertheless they demonstrated that FGM/C was almost universal among women in Djibouti (98.8 %) and that 68 % of them had been subjected

to type III mutilation. A survey amongst teen-agers showed that more than half of the females accepted the practice as reasonable. A study on the perception of FGM/C among TBAs and women showed that the main reasons for the continuation of this practice were tradition/culture (34 %), religion (30 %), revenue (15 %) and family pressure (11 %). Most TBAs agreed on the need to discontinue type III mutilation but did not want to stop FGM/C in all forms. One third of the women would submit their daughters to type III excision. A study conducted in 2002 in the maternity wards of the capital on the association of FGM/C and obstetrical and neonatal complications showed again the high prevalence of FGM/C, mostly of type II (30 %) and type III (63 %). A need for episiotomy, rectocele and cystocele and other obstetrical complications was linked to the degree of mutilation as was the neonatal death rate. This study is important as it constitutes one of the few and last direct observational study conducted²¹.

The practice of FGM/C in medical institutions as a temporary measure to reduce its deleterious effects is out of the questions as Djibouti is one of the 17 African countries selected to implement the UNFPA/UNICEF Joint Programme to accelerate the abandonment of FGM/C. The First Lady herself launched it in 2008 with the presence of the President of the National Assembly and several Ministers and with the full support of the United States Ambassador.

Efforts to eradicate FGM/C have not been, so far, very successful; Djibouti is a very good example of this failure. What are the reasons for this?

It is fundamental to consider that this practice is deeply rooted into some societies and has been "legitimized" and given different meanings and roles by its members. In those societies FGM/C constitutes an initiation ceremony and a right to passage into "womanhood" with all the sexual aspects that it entails.¹ Therefore, it is paradoxical but not surprising that the subjects suffering it also create its demand otherwise they will not "belong" into their community and will be ostracized and rejected. Thus, unless the demand is quenched this practice will not disappear. Communities practicing FGM/C are characterized by the significant asymmetry of its gender relations^{11,15}. This gap will not be filled overnight as it entails a change in the power structure: until women gain more power a change will not take place; this will be an arduous

and slow process. No matter how much external pressure is applied, no matter how many laws are issued making the practise of FGM/C illegal it will continue to be performed²².

Conclusions

The decision to abandon this practice will come from the communities as a whole and not from the individuals. This decision will be a collective choice that can be accelerated by women's education (and also of males) and health workers, reinforced by deliberations with local and national leaders and women's organisations and addressed in a wider context (cultural identity, reproductive health, sexually transmitted infections, polygamy, child marriage, etc.).

Hopefully, when this collective choice will be made FGM/C will become history as it has occurred with other harmful practices such as the European chastity belts, the Chinese foot-binding or the African slave trade.

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