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Cultural Relativism: Perspectives on Somali Female Circumcision in Mombasa

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Cultural Relativism:
Perspectives on Somali Female Circumcision in Mombasa

Whitney Harkness

Fall Semester 2011
Kenya: Islam and Swahili Cultural Identity

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Abstract

A harsh economy, tense politics, and culture clash have created a difficult environment for Somali refugees flooding into Kenya. This climate is perfectly captured by various groups' perspectives on female circumcision practices in the Somali community. The following study looks at Somali circumcision and its roll in their culture as well as how their culture has been influenced by living in Mombasa. Also, it will examine how social and political biases play a large part in how other groups, such as NGOs, the Swahili and the Barawa view Somali female circumcision. Finally it will evaluate the roll that circumcision plays in the Somali community and whether or not it should remain a protected cultural rite, or if the government is right in banning the practice through recent legislation. This study holds significance in its analysis of the situation and its attempt to view female circumcision without cultural bias, something that is very rarely done in dealing with cultural rites such as these.

Introduction

Female genital mutilation, cutting, or circumcision has been practiced for centuries in 28 different African countries, including Kenya and Somalia (FIDA 1). Between 100 and 140 million girls have undergone female circumcision and approximately two million girls are added to that total every year, or about 6,000 girls a day (Askew 1). The practice is a very important coming of age ritual, a prerequisite for marriage, and fulfills values of aesthetics in many different cultures. Although universally many women undergo this procedure, the types and severity of circumcision vary greatly from one culture to another, as does the prevalence and societal role of the cut.

In Somalia, female circumcision is essentially universal. It is a very important part of the culture for both women and men, and is engrained into their religious and social structure. On Kenya's coast, however, female circumcision does not have such a positive and pronounced cultural role. Kenyans are not the most welcoming of Somalis in the first place and the relationship between them has not been helped by the recent outbreak of war between the Kenyan military and Al-Shabbab terrorist forces in Somalia. With recent anti-female circumcision legislation, practicing this ritual and holding onto their culture becomes harder each day for Somali refugees. This study will examine not only the importance of female circumcision in Somali culture, but will also show how cultural, political, and social biases influence the movement against female circumcision.

Definition of Terms

For the purposes of this paper I will use the term *female circumcision* or FC as describing procedures done to women for non-medical purposes that involve either partial or total removal

of the external female genitalia for cultural, religious, or other non-therapeutic reasons. The term, *female circumcision*, is used by the Somali community and to avoid cultural bias it is the phrase I will use. Activist groups, non-governmental organizations (NGOs), the World Health Organization and the United Nations use the term *female genital mutilation*, or FGM, instead. They substitute “mutilation” for “circumcision” to reinforce “the idea that this practice is a violation of the human rights of girls and women, and thereby helps promote national and internal advocacy towards its abandonment” (FIDA 5). There has been much debate on the other side about the use of “mutilation” as it implies that western bodies are “normal” and circumcised women are “mutilated” and somehow wrong (African Women Are Free to Chose). Because of this sentiment I will use the language used by the community itself, and only refer to it as FGM when representing an opposing viewpoint or quoting a source. It is important to note, however, that my use of the term “circumcision” is not intended to draw a connection between female and male circumcision, as I could write another 40 pages on that debate alone. Female and male circumcision are holistically different procedures done for different reasons, under different contexts, and have very different outcomes for women and men.¹ This paper strives to find the truth about female circumcision and how people feel about it, so I will try to use as neutral as possible language.

There are four defined types of female circumcision. The first type (Type I), also known as *Sunna circumcision* in some communities, involves removal of the prepuce with or without partial or total excision of the clitoris. Type II circumcision involves excision of the whole

¹ This is a point to which many NGOs argue that FGM should be used instead, or FGC (Female Genital Cutting). I’m not going to even get into the debate about female vs. male circumcision as it is a very controversial point and frankly I do not have the time or space in this paper to even touch on that subject. There is plentiful information on the debate, however, so interested readers could easily search the internet and find more information on this topic if they so desire. It is an important point, however something I cannot tackle in addition to the research presented in this paper during the course of a three week period.

clitoris with partial or total removal of the labia minora (FIDA 1). The third type (Type III), also known as *infibulation*, is the most commonly practiced form of circumcision among the Somali. The circumciser cuts and removes all or part of the clitoris and labia minora and then scrapes the labia majora to create raw surfaces. The labia majora is then stitched together so that the scar tissue forms a cover over the vagina. Thorns or stitches are used to hold together the two sides together and the legs may be bound preventing movement for up to 40 days. Only a small opening is left to allow urine and menstrual fluids to exit, and often this is created after the fact with a small twig or straw (Askew 1). Type IV female circumcision encompasses everything that does not fall under one of the first three varieties, including pricking, piercing or incising the clitoris or labia, stretching, cauterization by burning, scraping of tissue, cutting, introduction of corrosive substances to cause bleeding or narrowing the vaginal canal, or any other non-medical and non-therapeutic operation or procedure intended to prohibit sexual intercourse or promote virginity in the woman, or for any other cultural belief (FIDA 1).²

Circumcision in Somalia

Infibulation, or Type III circumcision, is believed to have begun in Egypt and spread into the Sudan and Somalia from there (FIDA 6). Oral tales of the practice claim the practice was started and spread by Egyptian traders who came into Northern Somalia (Askew 7). It was thought “to have been started by a legendary woman ruler in Northern Somalia, Arawelo, who was known to castrate men and sew up women to suppress their sexual desire as a form of punishment. It is not clear, however, how such an oppressive act would be adopted and converted into a strongly celebrated cultural practice” (Askew 7). Today it is the form preferred by Somalis

² For diagrams to better visualize and understand Type I, II, and III circumcision, please refer to the first page of the third appendix, “Supplementary Diagrams,” included at the end of this paper.

and is widespread throughout the community, however Type II cutting is also present to a lesser degree (Askew 1).

Female circumcision itself plays a large part in many African societies, and Somalia is no exception to this. It is important to note, however, that female circumcision for the Somalis differs greatly from many other African cultures. First of all, the type of circumcision practiced is the most severe in Africa due to the huge amount of tissue removed. Second, the actual circumcision is not accompanied by ceremonies or celebrations. Girls around the same age may be cut together at one girl's home, however girls are never cut in public in the community. While sometimes tea parties are arranged to offer prayers for the girls, there are no other cultural events which mark the cut (Askew 13). It is instead a necessary part of being a part of the culture and not a marker of age or role in the community, and is performed at any age.

For Somalis, infibulation is an essential part of a girl's identity, usually done before the age of ten so that the woman is eligible to marry young (Askew 12). The day before the wedding the girls are checked physically to make sure that their vaginas are still intact and stitched, and this is considered to be proof of virginity (Askew 8). Most men will reject women if they have not undergone the cut as then they are unsure if they are virgin and pure (LandInfo 14). After the wedding night, like in Swahili tradition, the bedclothes are checked for blood from breaking the seal and the mother is rewarded for raising her daughter right if indeed the infibulation was good and secure (Askew 8).

Most girls undergo the procedure between the ages of five and eight within Somalia and during holidays from school, making December the most popular month for the cut (LandInfo

13). At the circumcision there are four women present, two to hold each of the girl's legs apart, one to hold the head and hands, and the practitioner. According to one practitioner,

“We first cut the clitoris from its base, then the sides, the black feather like part which comes down is cut up to its bottom and the sides which does not have the black feather is scratched with a bent blade on both sides and virtually remove everything between the legs and the edges are brought together and then smeared with a paste locally called *malma*³. These days we stitch, but [for a] long time we used acacia thorns for stitching” (qtd in Askew 13).

This method of infibulation is very similar to how the practice is done in the Sudan, one of the few other regions that practice Type III circumcision (as this type only makes up around 15% of total female circumcision in the world [Askew 1]).

Female circumcision, contrary to what many western human rights organizations may think, seems to be a primarily female-dominated and supported ritual. The decision to circumcise a girl comes from the mother and grandmother of a girl, who are considered her guardians and have all the responsibility of raising her (Askew 12). Traditionally women are the practitioners, or *guddaay*, and supporters of this rite, not men (LandInfo 13). The majority of circumcisions are performed in the girl's home, although it is also performed at another person's home, the practitioner's home, or occasionally health care facilities (Askew 13). These days there is an increasing number of medical professionals involved in performing the cut, using more hygienic conditions and local analgesia (LandInfo 13). Although the father must give consent on the final decision, he traditionally respects the opinion and choices of the wife as to when and where the

³ Malmal is a paste made from mixing egg white with white flour and is used to arrest the bleeding and stick the cut tissues together (Askew 13).

girl will be cut (Askew 12).⁴ Thus it seems the cut is preserved not by a patriarchal sexist society but by the society of women who perpetuate this tradition.

Legislation and Reception

Female circumcision is regarded in the international community very differently than within places like Somalia. Since 1979, the World Health Organization has identified FC as a threat to women. It is widely considered a violation of basic human rights of both women and children by not only the WHO but also the International Conference on Population and Development and the Fourth World Conference on Women in 1995. It is seen as a violation of the rights of the child, freedom from torture, and rights to health and bodily integrity (FIDA 2). The international community further rejects this practice as it does carry with it a number of health risks, such as “physical and psychological trauma, sterility⁵, damage to the urethra and anus, tetanus, child and maternal mortality⁶ and more recently HIV infection” (FIDA 2). In addition, the forceable physical suppression of a woman’s sexual pleasure and freedom is foreign and offensive to many western-based NGOs (AWA-FC).

NGOs have taken a number of different initiatives towards stopping female circumcision. The most common initiatives against female circumcision are alternative rite of passage ceremonies (ARP) and inter-generational dialogues (IGD). ARPs usually consist of educational seminars for large groups of girls in a particular community in which they learn about health and sexual well being, as well as about reproduction and motherhood and simultaneously encourages

⁴ This is a dynamic that will be further explored later in the paper.

⁵ Sterility as a side effect usually comes not from the procedure itself but from complications of the procedure, including frequent urinary tract infections due to a bruised urethra and obstructed opening for menstrual fluids which in turn infect the larger area and can cause poly-cystic ovarian syndrome and infertility (FIDA 2).

⁶ These complications are discussed at further length later in the paper as a result of my field research.

them to take pride in their bodies and health. IGDs, on the other hand, aim at educating parents and elders in specific communities to keep them from circumcising their daughters, nieces, and granddaughters while encouraging open conversation about experiences with the practice. Other popular methods of interference are creating safe haven houses for girls where they can be “rescued” from the practice, religious dialogue conferences throughout the Muslim districts of Kenya, community and personal education, and legislation (FIDA 3). There are a large number of NGOs active in Kenya fighting FC or FGM through these means, including Maendeleo ya Wanawake Organisation (MYWO), People’s Council and the Federation of Women Lawyers Kenya (FIDA).

Many tribes within Kenya have practiced circumcision for years. The highest prevalence rates are among the Somali refugees (97%), Kisii (96%), Kuria (96%) and Maasai (93%) (Supra-regional Project 1). Overall, according to the 2003 KDHS survey, 32% of all Kenyan women between the ages of 15 and 49 are circumcised, with a prevalence of 25% among girls 20-24 years and 20% among 15-19 year old girls (Center for Reproductive Health). Although these numbers are trending downwards, it is nevertheless a big issue in the North Eastern province, where percentages are still very high at 99% (FIDA 10). The most cited reasons for practicing FC are, “the need to observe customs and traditions, the attempt to improve the marriage prospects of women, the wish to curb women’s sexual desire and the need to mark the passage from childhood to womanhood” (Supra-regional Project 1). Most circumcisions are done by traditional practitioners, however there is a growing medicalization of the practice as more and more girls go to nurses, doctors, and midwives to perform the circumcision in a more sterile and less painful way (Supra-regional Project 1).

Setting

At present, Kenya is engaged in a war against Al-Shabbab, the militant quasi-Islamic terrorist organization that has taken much of Somalia hostage. Because of the presence of Al-Shabbab, many Somalis have escaped violence and destruction by moving to refugee camps throughout the North East Province of Kenya. This outbreak of war is not the beginning of the influx of Somalis into Kenya. Over the last few hundred years, southern Somalia has been plagued by “hostile takeover and exploitation of the south’s arable land and labour by outsiders” (Eno 1). Due to political oppression, many Somali minority groups have migrated into Kenya starting as early as 20 years ago, creating a growing and ever-present Somali presence in Kenya (Eno 1). The state of chaos that the nation of Somalia has now seemingly fallen into is a result of poorly written property laws and discrimination against these groups in the South that have a long history of agricultural cultivation and peace, such as the Barawa (Eno 5-7). Yet with the increasingly harsh conditions of Somalia thousands of Somali refugees have flooded into Kenya over the last 20 years, the majority coming in more recent memory (Fatma 11/5). With Al-Shabbab now affecting Kenyan tourism due to kidnappings along the border, many Kenyans have come to associate Somalis with the terrorists and treat them harshly (Muna, 11/10).

These refugees have mostly remained along the border of Kenya, living in the North East Province. However, many have flocked to bigger towns such as Nairobi and Mombasa creating small pocket Somali communities, causing tension with the local populations due to their cut-throat business sense, seemingly violent nature, and cultural practices, female circumcision being often cited as the most “violent” and offense in particular to the Muslims of Mombasa (Mama Aisha 11/12). Further, the overwhelming feeling that all Somalis are somehow related to Al-

Shabbab causes huge tension between Kenyans and Somalis, due to the fact that not only is Kenya at war against that group but also because Al-Shabbab is seemingly responsible for the worsened economy. Somali female circumcision in particular continues to be a breaking point between health care providers and the Somali population, not only due to language and cultural barriers but also because of long-standing opinions on the matter.

Many countries throughout the world, due to urging by non-governmental and human rights organizations, have developed legislation banning or limiting the practice of all three types of female circumcision. Kenya is no exception as many ethnic groups in the country have a long tradition of circumcising their women. In accordance with international views on FC, the Kenyan government has ratified a number of international conventions including the recommendations of the Fourth World Conference on Women (1995), the Convention on the Rights of the Child (1990), the African Charter on the Rights and Welfare of the Child (1990), and the Protocol on the Rights of Women in Africa, or the “Maputo Protocol” (2003) (Supra-regional Project 2). In November 1999 the government began its National Plan for Action for the Elimination of FGM⁷ through the Ministry of Health, a movement which aimed to reduce the proportion of girls affected by FC over the next 20 years and is still active today (Supra-regional Project 2). Finally, the government enacted the first influential piece of legislation, the Children’s Act, in 2001. This act, “describes girls who are likely to be forced into circumcision as children in need of special care and protection” (Supra-regional Project 2). The initial incentive for this anti-FC movement came not from the Kenyan government but from NGOs such as the infamous Maendeleo ya

⁷ This plan has four main parts: 1) Establish national and district mechanisms for the coordination of FGM programs, 2) Establish multi-sectoral collaboration to ensure relevant intervention in key development programs, 3) Map and coordinate new and ongoing FGM interventions, 4) Invest in human resource and organizational capacity-building, and 5) Establish pro-active mechanisms for resource mobilization for FGM elimination programs (Supra-regional Project 2). Whether or not the government has actually followed through on this plan for action is a whole other debate, one which I will touch on later in my discussion/analysis section.

Wanawake Organisation (MYWO) and the Programme for Appropriate Technology in Health (PATH) project (Supra-regional Project 2).⁸

While these laws have made major strides towards stopping female circumcision altogether in Kenya and rates of FC have continued to decline, there nevertheless are numerous loopholes and limitations in these pieces of legislation. Because of this the Kenyan government recently passed a new piece of legislation, the Prohibition of Female Genital Mutilation Bill, 2010, which outlaws, “offence of female genital mutilation, aiding and abetting female genital mutilation, procuring a person to perform female genital mutilation, use of premises to perform female genital mutilation, possession of tools or equipment, [and] failure to report commission of offence” (Kenya Women Parliamentary Association).⁹ The chairperson of the KWPA Hon. Linah Jebii Kilimo, MP, has stated on this legislation, “This bill is a landslide victory for many crusaders for FGM/C abandonment and once enacted into law will provide a legal framework for punishing the perpetrators of this outdated and harmful practice” (KWPA). The bill was backed not only by the KWPA but also by the Minister for Gender, Children and Social Development and many NGOs active in Kenya. While leaders in the anti-FGM movement celebrate finally having strong criminalization for practitioners and supporters of female circumcision, they also recognize that “all these legal frameworks have gaps as it relates to seeking legal redress...even

⁸ This program in particular came into conjunction with the Kenyan Ministry of Health in June 2000, however it started earlier in the 1990’s on a more localized level by introducing alternative rites of passage and education initiatives. The goals of this project are “to increase within the communities the knowledge of the harmful nature of FGM (its medical and social consequences) and of the fact that it is a violation of human rights, to change the attitude of community members and to implement an accepted practice as an alternative to FGM, to identify and support innovative approaches, and to work through district representatives of the relevant ministries and civil society bodies to integrate the elimination of FGM into development plans” (Supra-regional Project 2). This project centered in Trans Mara, Kajiado, Tharaka, and Kuria districts and among the Somali community in Dadaab Refugee camp. The program mostly implemented alternative rites of passage within the communities as well as education of the community, forums, and community dedications (Supra-national Project 2).

⁹ For the full text of the bill, please refer to the second appendix at the end of this paper, “Important Documents.”

though it offers protection for persons, there are loopholes that still make young girls vulnerable,” as said the Honorable Fred Kapondi, Member of Parliament and the mover of the bill (Kenya Women Parliamentary Association). While this law is groundbreaking in its criminalization of the practice, it nevertheless has limitations in execution as that is up to citizens and public servants, such as the police and health care providers.

Methodology

For this study I centered my research in Old Town, Mombasa. Although Somali refugees and immigrants can be found throughout the city, the largest pockets are in town surrounding Biashara street and the marketplaces. Many of my interviews took place in the Somali textile market between Biashara and the old spice market. This market is predominantly made up of Somali and Barawa merchants, many of whom have immigrated to Kenya in the last two to three years. Although I spoke with many people in the market, only eight merchants were willing to admit to coming from Somali and talk to me about their lives and experiences. In addition to this, I spoke with one representative from FIDA Mombasa, one health-care provider from Bomu Hospital, one midwife, and one patient at Mewa Hospital. I also befriended a Barawa woman and interviewed her extensively as well as her brother, mother, sister, and three of her Somali friends. Of my 24 interviewees, six were male and the rest female.

In traveling around the city and talking to Kenyans about my project, I received a number of unsolicited opinions on the Somali and their culture that I never anticipated receiving. Almost every day someone new would volunteer their own perspective on the subject, resulting in a total of five very important informal interviews as well as a slew of comments from uncountable other sources that came to form a seemingly homogeneous mindset about the Somalis. Of the most important of these interviews, three were with men and two with women, all of whom were Swahili Kenyans. The project in whole is thus a reflection of opinions expressed in 22 informal and two formal interviews.

Due to the highly person nature of these interviews and the very heated subject matter, all names have been omitted from the text with the exception of the two formal interviews with

representatives from Bomu Hospital and FIDA Kenya, as they both verbally consented to being cited in my paper. Some small details have been omitted so as not to disclose too much information on the identities of many of these women and men as well, but the core of knowledge remains intact.

With most of my interviewees, I began the conversation by asking how long they had been in Kenya, what they thought about living in Mombasa versus their home towns, and if they found the culture to be different. With Swahili interviewees, I asked them if they knew anything about the Somali population and let them talk from there. The vast majority of useful information came not from my questions, but by sitting back and just letting them talk.

Discussion and Analysis

The situation between the Swahili and Somali is tense at best. The issue of how Somalis circumcise their women comes up frequently and is often cited as an example of how harsh these people can be. In my research, this topic was often brought up instead of being instigated by my questions. The way in which both the Swahili and Barawa view Somali female circumcision is revealing of their view on the Somali as a people due to socio-economic factors.

The Barawa, or Brava, people are a tribe originating from Yemen, however today the tribe consists of a mix of pure arab, Somali, and other ethnic origins. They are agriculturalists who live on the arable land of Southern Somalia and due to their fertile position have been invaded and discriminated against by the ethnic Somalis of the north. Because of this, the Barawa began immigrating to the more pleasant and hospitable lands of Kenya (Abu Bakr 11/11). Although things are much more pleasant than growing up in Somalia in the midst of civil war, times are nevertheless getting more and more difficult. The culture in particular is hard to adjust to as is learning Kiswahili, as most Barawa only speak Kibarawa and perhaps Kisomali. The majority of Barawa have thus chosen to live in Mombasa due to the huge population of Muslims - Islam, in the words of one interviewee, is “the great unifier. It is all one culture, it is Islam” (Abu Bakr 11/11).

The Barawa in Kenya nevertheless have extreme difficulties living alongside the recent Somali refugees, as they are as different as the Kikuyu to the Luo. They believe the Somali are “violent” and “bad people” (Salama 11/11). The Barawas that I spoke to were very clear that they were *not* Somali, especially when I asked if they were from Somalia and how long they had been here; “I am a Barawa, which is not Somali. I have been in Mombasa for 20 years and been doing

business here. They [Somalis] are not like us, they make us seem bad” (Abdul 11/10). The Somalis likewise have to stick together as many of them have never learned neither English nor Swahili. They find the culture of Mombasa overwhelmingly different from cities like Mogadishu and Kismayu.

On the other hand, the Barawa and Somali do have a lot in common. The Swahili I spoke with refer to both groups as being equally dislikable and similar. Both communities have a strong need to stick together to make it through the tough economic times in a country which is growing more and more hostile towards anyone from Somalia. Like the Somali, the Barawa people also practice female circumcision and believe it is a requirement of Islam, however they practice Type I circumcision in which they only prick the clitoral hood, creating very little blood and minimal side effects later in life. They believe the Somali “do it harshly” and cause unnecessarily large amounts of blood and pain (Salama 11/11). Their version, on the other hand, is “good” and they want “to get very little blood, little pain” (Salama 11/11). The Somali, conversely, believe that the Barawa do not circumcise properly and thus are doing their women a disservice. Both groups, however, are well educated about the practices of the other. The Barawa similarly do not have any rituals or special ceremonies that accompany the circumcision.

In my experience, Barawa and Somali women seem to have very similar personalities - they are very quiet and conservative in the street, very often wearing a conservative, flowing, plain bui bui with ninja and large hijab, but when they enter the household they become very loud, joking, and outspoken. Though Swahili women also demonstrate these characteristics, in my experience they are more free and joke in front of men and in the streets, whereas Somali and Barawa women become immediately reserved when coming into contact with men or exiting the

home. Swahili women have also noticed and remarked on this difference, claiming that Somali women will never say anything to their husbands - their husbands' word is the law and they will not counter it with their own wants or desires (Mama Aisha 11/12).

Swahili people have a very similar opinion of the way in which Somalis circumcise their women. One woman remarked that it was "violent" and emblematic of the ways in which women are powerless to their men (Mama Aisha 11/23). In addition to finding female circumcision repulsive, the overwhelming number of Swahili interviewees expressed disdain towards the Somali, calling them "violent" and "bad people," even going so far as to say that they are all in Al-Shabbab and harming the Kenyan people (Ameena 11/6). One woman believed that the women wear large bui bui so that they can conceal knives and other weapons and fight at any minute (Christine 11/11). Part of this perception is due to the economic hardships and Somali's cut-throat approach to business (Abdul 11/10). Somalis dominate textile markets, like the ones around Biashara street, they pedal goods and very aggressively change money on almost every street corner. Whether or not they are actually prospering in the downturned economy, the Swahili and Barawa individuals I spoke with all believed that the Somali were very well off, and one Somali man even admitted it to me himself (Hassan 11/15). This feeling that the Somali are very well off financially has clearly created some resentment towards them, which filters over into disdain for the aspects of Somali culture that are different from Swahili or Barawa culture.

Despite recent Kenyan legislation and NGO's work, Somalis still perpetuate female circumcision as an important part of their culture and heritage, as well as their religious beliefs. The reasons for continuing to practice circumcision in the community are fairly predictable and universal: "a cultural tradition that brings honor for the family and girl, a means for controlling

female sexuality, a perceived requirement of Islam, a necessary condition for marriage, and genital beauty and cleanliness,” with tradition, prevention of immorality and preservation of virginity being the most common defenses (Askew 7). One Somali shopkeeper who had grown up in Europe and now lives in Kenya told me that being circumcised gave her a sense of her heritage despite being raised abroad, as it connected her to her mother and grandmother, as well as the Somali women she met in her travels (Muna 11/10). Many Somali girls living in Europe and the US even travel all the way back to Kenya on their winter holiday to have the procedure done, thus connecting them to their heritage and allowing for an opportunity to meet family that still lives in the region (Mama Aisha 11/23).

Circumcision plays a large part in the suppression of the female libido. They believe that, “If the girls are not circumcised, [they] will bring shame to [their] mother and also to [their] relatives. A lady whose daughter is not circumcised is pointed [at] by others” (qtd in Askew 8). These girls are open and cannot be controlled nor verified as virgin, and thus are dishonorable. As one traditional practitioner said, an uncircumcised woman “will start chasing men because of her uncontrollable sexual urge, excessive sexual desire, she will be very vulnerable, she has no security and [will] subsequently [be] disgraced. Circumcised girls will not go for another man because her husband will trust her” (qtd in Askew 8). Men can divorce their wives if they are not cut, and men do not want to marry an “open,” or uncircumcised women as she will always need to be with a man; “a woman who is open cannot be without a man...it makes a woman complete” (Abu Bakr 11/11). Men can divorce their wives if they find them not to be infibulated as then there is no “proof” of virginity. Somali men want their women to be indifferent towards sex and marriage so that they do not have to worry about pleasing her. One man told me about

how after he married his uncircumcised wife, a Mijikenda woman, she was crazy and always wanted him and he could not live like that so they divorced (Abu Bakr 11/11).

For the Swahili, however, woman's enjoyment of marriage is a key aspect of life. One remarked that it made a woman "not enjoy being married" and a woman has a right to sexual pleasure according to the Quran (Mama Aisha 11/23). Another woman told me that the way Somalis circumcise just keeps a woman from being fulfilled and that marriage should be fun, but for them it is all work all the time and there is no enjoyment (Luna 11/25).

For Somali women, circumcision is not a violation of Islam and a woman's right to pleasure, but instead it is seen as a requirement of Islam. Non-circumcised women are afraid to be thought of as non-believers by their husbands and neighbors. However, the debate as to whether or not it's *sunna*, or recommended practice by the prophet. One midwife remarked, "They say it is sunna but then I say, show me where it is written and they cannot...I have read just as much as them if not more and I have never seen it written that it is required of Islam" (Mama Aisha 11/23). Many religious leaders agree that there is no basis for the continuation of female circumcision and yet the practice continues as does the myth that it is indeed a Muslim practice. In fact, the reason the Barawa practice the small degree of circumcision that they do is that they believe the Prophet Mohammed has instructed them to do it and they are fulfilling the minimum requirement (Salama 11/11).

Further, female circumcision forms a sense of camaraderie among women in the community. As one mother said, "I was cut so I must cut her [my daughter] so that she feels what I felt" (qtd in Askew 8). One woman told me that she had family, friends, and neighbors who all did it, so that it was no big deal and something that everyone underwent (Salama 11/11).

Likewise peer pressure is a large factor in influencing the girls themselves to want to be circumcised as their peers refer to them as “outcasts” (Askew 8). All women, either Barawa or Somali, continue to be cut even living in Kenya because it is such an important part of the culture and tradition (Salama 11/11). Girls are also often cut in groups as large as 14-16, adding more sense of sisterhood to the procedure (Mama Aisha 11/23).

Another reason for circumcision comes from the importance of children in Somali culture. Men want to have many wives so that they may multiply, as it is written in many holy texts such as the bible and Quaran. Thus most Somali men have at least two, if not three or four, wives. Somali women try to have at least one child every year, often becoming pregnant just a month-three months after giving birth. A woman’s role in marriage is therefore not to enjoy sex and want to have it for pleasure, but to simply have as many children by one man as they can (Mama Aisha 11/12). Further, the wife will remain faithful to the husband because she does not desire to have sex for any other purpose than having children; “if she [the wife] stays with the husband she is okay, and if she stays without it is okay, she does not feel like she is missing something” (Askew 9). Uncircumcised women are also seen as unclean, as in Islam it is forbidden to buy meat slaughtered by an uncircumcised man or woman, and the external genitalia is thought to attract and keep dirt (Askew 10).

Many studies have been conducted on female circumcision, however many of these studies are based on graphic images of worst-case scenarios for the few women that come forward to talk about their negative experiences. Very few studies have actually been carried out examining exactly how these women feel about circumcision. Further, the kinds of measurable medical complications depend on the type of circumcision practiced, and many studies do not

take this into account. In examination of Somali infibulation, many studies do not account for potential confounding factors like poverty levels and motherhood services when comparing mortality rates of cut and uncut women.¹⁰ Further there is hardly any evidence for the impact of circumcision negatively affecting a woman's sex drive. The only evidence supporting this theory is that for infibulated women sex is more painful and difficult due to the narrowed vagina opening (Askew 3). While sex is uncomfortable for these women, sexual desires come from the mind, not the genitalia, and thus these women still feel urges but cannot be satisfied as easily as uncut women.

The complications arising from infibulation are further complicated by the types of facilities Somali women frequent. Hospitals in the North Eastern Province have not enough staff or training to help Somali women when they are in labor and have complications, which are very common among these women (Askew 18). When the circumcision is being done a number of medical risks are raised. A girl is usually cut using a razor blade or knife, but when girls are cut together in a group often the same blade is used for all of the girls, raising the risk of blood-borne illness transmission and infection. Moreover, traditional practitioners do not wear gloves nor do they usually have the girl bathe or clean the genitalia prior to the procedure. When the procedure is medicalized, however, the instruments are often sterile and the area cleansed before it is cut (Christine 11/15). After the circumcision, the girl's legs are bound for seven days to immobilize the girl and hasten healing. After untying the girl, she is made to sit on a hole dug in the house filled with hot charcoal and medicinal herbs to dry the wound and minimize infection by

¹⁰ From a recent study on Somali FC in Kenya, it was found that among the Somali in Garissa (North East Province) maternal mortality was at a rate of 17/1000 versus 0.56/1000 among women in Nairobi or 0.45/1000 in Machakos. It seems that this huge difference in mortality rate could be chalked up to the fact that women in the latter areas are rarely or less severely cut than Somali women, but also these areas have much better access for safe motherhood services and hygienic conditions (Askew 3).

cauterizing it (Askew 13). The girls circumcised in less hygienic conditions will often come to hospitals and clinics with septicemia, anemia, and other related infections and illnesses, sometimes even resulting in death of the girl (Mama Aisha 11/23).

Following the healing of the area, there are sometimes more complications and additional procedures. Often women must undergo a second procedure when they are married so that the opening is wide enough for sexual intercourse (de-infibulation). It is preferred for the male sexual organ to do this through sexual intercourse after the wedding, however if the scar is too tough and this is impossible then the husband's mother will arrange for the girl's mother to come and cut the vagina using a knife, razor blade, or scissors, or occasionally the man will bring sharp instruments with him to do it himself. Sometimes the couple will go secretly to midwives or other doctors as well to have this procedure carried out, which many Swahili doctors will do for these women so the man does not appear weak to his family (Mama Aisha 11/23). Also, re-infibulation is sometimes requested by the women following childbirth so as to create a more virgin-like appearance and increase sexual pleasure for the husband, however some women do not desire this operation so as to allow for easier childbirth in the future and lessen the pain of vaginal intercourse. Many Swahili midwives, however, refuse to execute this procedure due to their disagreement with infibulation in the first place and so as to decrease further complications during periods and urination (Mama Aisha 11/23).

During labor in particular, however, it becomes necessary to do a severe and large episiotomy, otherwise the vagina altogether may tear. Because the vagina reforms into solid scar tissue following infibulation, the vaginal walls and membranes cannot stretch as they naturally do on an uncircumcised woman, so that the only way to get the baby's head out of the small,

quarter-sized hole is to make one large lateral and vertical incision to the perineum.¹¹ This incision is required every time a Somali woman gives birth, which can be as many as 16 times in her life. In Western countries, however, doctors opt out of natural childbirth in favor of simply performing a caesarian section so as to prevent obstructed labour and prevent Somali women from having more than three/four children (Mama Aisha 11/23).¹²

Throughout a woman's life there are yet even more complications which seem to stem directly from being infibulated. Some women report pain throughout their lives due to circumcision, such as painful urination and menstruation, coitus, and childbirth. Because of the very small opening created, often menstrual blood is blocked from fully leaving the vaginal canal, thus flowing back and causing problems for the woman. Similarly urine is trapped in this way and can cause very frequent urinary tract infections. Injury to the urethra during the procedure can also result in permanent fibrosis, cysts, and other painful and hard to treat conditions. Women know about the sexual complications of their circumcision and roughly $\frac{3}{4}$ of the girls interviewed in the Askew study reported being afraid of marriage - only 5% said they were happily awaiting their wedding night. Further, 72% of the study's women reported "pain and bleeding during penetration" (16). Once married, 73% of the women reported fear of sexual penetration, psychological trauma, depression, and/or lack of sexual satisfaction or desire (Askew 16). Of the women that I spoke with, none spoke fondly of being married or of their husbands if they had been wed, and each unmarried girl said that she would like to put off getting

¹¹ Refer to the diagram on the first page of the third appendix, "Supplementary Diagrams" for a rough outline of what an episiotomy on an infibulated vagina works. Explained and illustrated for me by Mama Aisha, 11/12.

¹² When a Caesarian, or "C" section occurs, the doctor cuts through the abdominal muscles to access the uterus and extract the infant surgically. Because this cuts through muscle, a c-section can only be performed 3-4 times on a woman, so the surgeon will tie the mother's fallopian tubes making her sterile after her third or fourth delivery. It was suggested that this is not only to prevent complications but also to limit population growth in the Somali community abroad (Mama Aisha 11/23).

married in favor of staying independent and avoiding being tied down to a man. Though no one admitted to their circumcision and fears of sex being a part of this, it did seem to be a common theme that women believe once they are married they are an object and property of their husbands and that their lives stop being about their needs and instead revolve around their husbands. In the modern world that we live in today, it is becoming easier and easier for women to stay independent of men and postpone marriage as long as possible, as well as insist on having fewer children.¹³ However some women still feel pressure to submit to their husbands for fear of divorce or their taking multiple wives (Salama 11/11). Thus infibulation seems to be a good deterrent for sexual misconduct in women, however it does come with some glaring complications and downsides.

Somalis do not see female circumcision as a human rights violation, but rather a requirement of their religion. The international community, on the other hand, sees FC as a human rights violation because at no point in the process is the girl's consent sought (Askew 20). Prior to the passing of the newest legislation, for those health care providers who circumcise medically, the majority (84%) knew that the practice is illegal but only one third knew that it is criminalized in Kenya through the Children's Act, and very few health providers know about the Ministry of Health (MOH)'s National Plan for Action for the Elimination of FGC (Askew 20). For those Somali living in Mombasa, however, there is definitely an awareness of the legality of female circumcision.

¹³ This new female tendency to embrace family planning and tell the husband not to have so many children is limited and somewhat ineffective, as the rate of polygamy in the community continues to rise and Somali men do not believe in family planning. Among older women in particular however this dynamic of equality and the woman's opinion does not seem to exist, whereas this phenomenon is mostly seen in younger couples (Salama 11/16).

Mombasa Somalis are well aware that the Swahili do not practice circumcision and that they look down on the practice, and they also know that it is now illegal and criminalized. Despite this, they continue to cut their women because of the huge pressure put on women by men as women must be infibulated to be married. Women will even go to Swahili midwives and doctors to ask them to circumcise their girls. One midwife I spoke with reported having Somali women come to her on a regular basis to ask for her circumcision services, and despite rejecting them each and every time they continue to come and try to coerce her with good money into infibulating their daughters during the December holiday. She even reported a truck full of 16 girls showing up at her doorstep one night asking to be circumcised for 500 shillings a piece (Mama Aisha 11/23). Though they know it is illegal, they still feel strongly compelled to do it, and thus seek to perform the task through any means possible.

The biggest drawback and challenge to reaching this community is the language and educational barrier. Since many Somalis do not speak English nor Kiswahili, they must have everything translated for them. At a clinic in Mombasa I witnessed a doctor telling a Somali woman that her son was underweight and she needed to breast-feed by explaining in Kiswahili to the mother's aunt who then translated into Somali. Although health care providers will say everything they can and attempt to lecture as much as possible, only so much of the information is sure to be translated and conveyed.

Further, many of these women are not well educated due to the poor educational structures in Somalia and the chaos of moving to a new country and attempting to adapt and learn new languages and cultures. Even beyond circumcision, many of these women do not understand that they should not feed their babies porridge and solid food at 6 months old, nor do

they understand the importance of breast-feeding not only for the nutritional and immune system benefits but also because of the connection it fosters between child and mother (Mama Aisha 11/12). Despite NGOs and health care providers best efforts, Somali women stay firmly committed to their ways and tradition and a huge amount of education and experience is required before behavior changes.

Whether or not the type of circumcision practiced has changed is a matter of some debate currently. Since coming to Kenya, the Askew study concluded that the severity of circumcision has declined from cutting everything to leaving some parts and/or leaving the opening larger or not stitching at all (Askew 11). Further, the medicalization of the practice has led to less painful circumcision and fewer immediate complications from use of local analgesia and hygienic conditions. However, one midwife found in her dealings with the Somali that each and every single one was circumcised, and only 1/20 had Type II, less severe circumcisions (Mama Aisha 11/23). Yet NGO's efforts in other communities and regions of Kenya have proven more successful (Mama Aisha 11/23). Part of this stems from the lack of NGO involvement with the Somali community itself.

There are a number of NGOs that are currently working in Kenya to eliminate the practice of female circumcision, however there are very few actually working with the Somali population. Part of this comes from the nature of the Somali population in Kenya - many Somalis are refugees and thus not permanent inhabitants of Kenya. Due to cultural-conflict between the two different groups many Kenyan resources, services, and NGOs do not attempt to work with this group in favor of devoting their energies towards "real Kenyans" (Christine 11/15). The other reason this is the case is because of the nature of NGOs doing work with women in

Mombasa. Organizations such as FIDA do work on a voluntary basis - that is to say that FIDA helps women when they come in to the office with a problem, or self-report. Within the Somali community, however, the practice of female circumcision is believed to be good and done at an age young enough that very few women would seek help to avoid undergoing the cut or report the circumcision of another girl (Susan Lewa 11/23). The few organizations that have done work with the Somali population, such as the Population Council, focus on the refugee camps and in larger cities such as Garissa that are comprised of primarily Somalis. In places like Mombasa there is in fact very little being done to stop FC, as it is done so far under the surface and education initiatives are being done on a much smaller, 1-on-1 basis.

The greatest limitation and challenge in executing their goals with the Somali community to these NGOs comes from their own perceptions about how women themselves feel about circumcision due to their own cultural biases. Many Somalis and health workers believe strongly that the movement to encourage abandonment of FC is “driven by western influences, with an aim of forcing the Somalis to forsake their traditional culture and become absorbed into a westernized culture” (Askew 21). Following a statement by the Sierra Leone Association of Journalists bashing a certain tribe of women for their circumcision practices, AWA-FC issued a very important and controversial statement defending female circumcision and calling out the bias of many western groups. The AWA-FC, interestingly enough, was started by a number of black Americans who had spent time in Africa, studied female circumcision rituals, and dedicated themselves to defending the act. AWA-FC summarizes many pro-FC arguments and asks questions of NGOs previously untouched throughout all of Africa:

“Through political pressure from first world countries on whose aid they continue to depend as well as internal political expediency, several African countries have

introduced anti-FGM legislation over against the full knowledge, participation and desires of the majority of affected women... While we respect and do not support the coercion of the minority to uphold a tradition they find offensive, we certainly will not allow the minority to impose their will and worldview on the majority of women who are circumcised and their prerogatives as parents to make this decision for their children... Free to Choose will not accept attempts to delegitimize the positive experiences of most circumcised women and any attempts to deny African women, circumcised or not, our rights to self-determination... to give up a practice that is culturally meaningful to many African women... our western feminist sisters who pretend they do not have a stake in seeing their own uncircumcised bodies as 'normal', 'healthy', and 'whole' and therefore morally superior to our own supposedly 'mutilated' African bodies" (Statement by African Women Are Free to Choose).

This statement sums up the thoughts of many women in the Somali community who find value in being circumcised as their status as such makes up a large part of their ethnic identity. Whether or not circumcision is a good practice is still up in the air, however there are groups in support of it that constantly fight against Western practices and biases.

Not many NGOs have actually stopped and asked themselves whether or not FC is a good practice. Because of the negative side effects, it is assumed to be okay. In conversations with Kenyans and NGOs, whenever I asked the question, "why is female circumcision bad?" my response was usually something to the effect of, "It is bad for the woman because it mutilates her, it ruins her sexuality, and it is barbaric." Some of the things that we do to our bodies, however, can be seen as equally barbaric. One Somali woman equated female circumcision with a procedure common among American women following childbirth which similarly reshapes the vagina and adds an extra stitch to tighten everything up again (Rukia 11/17). It is incredibly possible and it seems to be the truth that very few people have actually considered FC from the Somali perspective, as NGOs and government officials just look at the negative "side effects" and assume this is the case and thus it must be stopped.

Conclusion

Female circumcision is incredibly important for many different African cultures, but for the Somali especially it is a key part of a woman's identity and affects her for the rest of her life. In my interviews and research I strove to understand why the Somali practice circumcision and why other groups believe it is wrong. Ultimately, infibulation is practiced so that mothers can be sure that their daughters remain pure and chaste, and so that new husbands can know that their wives are exclusively theirs. Unfortunately it does carry with it a number of very negative side effects and social stigmas.

Female circumcision, specifically infibulation, is a dangerous procedure. When done by a traditional practitioner who often does not know to wear gloves or disinfect the area, illness, infection and permanent damage are very real risks. Medicalization of the procedure has helped to alleviate these dangers, however the circumcision still creates problems for women for the rest of their lives. I am sure that there are some infibulated women out there who had very positive experiences and have never had any sort of complication due to the cut. However, research and my conversations with health care providers show that more often than not, this is not the case.

It is therefore very important to take into consideration the positive benefits of infibulation, namely, creating a sense of camaraderie and preserving a community's values. In going into this project I strove to keep as clear a mind as possible about a procedure my Western upbringing has taught me is grotesque, inhumane, and inherently wrong. The decision to start circumcising girls does come from a fairly logical place, however in my opinion the risks outweigh the benefits.

Barawa and Swahili women present a very nice context for how Somali women enforce essentially the same cultural and religious ideals. All three groups of these are Muslim, and thus have very similar values and pursuits as a community. Despite being uncircumcised, Swahili women remain chaste until marriage. And although they disagree with the theological perspective, Swahilis still have a strong sense of community and chose not to circumcise their women in favor of raising their daughters and allowing them to make their own decisions, not limiting them or keeping them in line by performing a risky procedure.

The dilemma I see with Somali female circumcision is that it stems from another aspect of Somali culture - the urge to have so many children. My recommendations for the future would be to change the culture at its core. Having so many children puts considerable economic strain on a family and as such I would recommend that Somali families have fewer children, 2-4 per family so as to increase the health of the mother and child, give the mother time to breast feed and pay attention to the baby as she should, educate her children, and save money. If children were able to have more 1-on-1 attention in the home from their parents, they would have a stronger educational and moral foundation and thus would not need to be circumcised so as to keep their faith close and morals tight.

Further, if Somalis truly believe that circumcision must happen to be properly Islamic, I would recommend reducing to Type II, if not Type I circumcision as the Barawa practice. These methods limit the number of future complications and allow for easier childbirth and unobstructed menstrual flow. With medicalized, sanitary practice, these methods do not remove a woman's entire ability to have an orgasm or enjoy sex. The evidence has shown that infibulation does not limit a woman's desire to have sex but rather makes it less enjoyable, and thus the way

Somali circumcision is not a good way of controlling these women. It should be a woman's choice that ensures her virginity and her moral character should ultimately be judged, not how tightly sewn shut her body is.

For organizations working towards eliminating the practice, I think a more holistic and thoughtful approach is needed. NGOs should work to understand why these women practice female circumcision so that they can help women to be healthier and safer. By approaching an incredibly important cultural act as wrong and calling it "mutilation" will not encourage these women to even listen to what NGOs are saying. If these organizations really want to reach out to the population, they need to get on their level and educate not from a position of power but on the same level. Further, this community is not one that will reach out for help on this issue, as no one (or very few people) finds female circumcision wrong. Further, this community is in great need of maternal health care. If you educate the mother and help her, the child will follow. It is my opinion that by educating Somali women about nutrition and health, then the practice will slowly begin to be abandoned or lessened in its severity. At the very least, I would recommend increasing the amount of medical resources for this population as they are struggling greatly to make ends meet and disease and infection does not help with this.

Recommendations and Limitations

This project was very limited. First, I was limited by time. I wish I could come back and have a much larger project examining the whole population, but one month was not enough time to talk to everyone and get a good idea of the entire situation. Although I do feel that I got a wealth of information out of this project, I only skimmed the surface of this issue. Second, I wish I could have completed this project in Garissa, the hub of Somali refugees in the North Eastern Province, however with the current political climate being what it is I doubt SIT would have allowed me that chance. Likewise going to Nairobi for the ISP period was a less-than-appealing prospect, so I conducted my research in Mombasa where the cultural climate is very compelling but also has fewer Somalis than the previous two cities. This decision ultimately was a good one as it colored my research in a whole different light, as religious differences were eliminated from contributing factors.

Third, finding Somali people to talk to was very difficult. This was in part due to the color of my skin and my nationality. Somalis do not like Americans as they feel that we are behind the current war and downfall of their country, and they assume that if they tell me that they are Somali I am either a CIA or an FBI agent coming to get them. Further, many Somalis in Mombasa are here somewhat illegally as refugees and thus are fearful of anyone knowing what they are. With great tension between the Somalis and Kenyans my original topic of examining the cultural significance of FC took a back-seat to my research on why these groups don't get along. Unfortunately I had to understand the history of Somali/Swahili confrontation before I could understand what life is like for the Somalis and how living in Mombasa has affected them

and their culture. This took more time and ultimately disallowed from me speaking with many women about female circumcision.

If I were to make recommendations for anyone intending to study anything to do with Somali culture, I would recommend that they find a friend in the community quickly. I found one about 2 weeks into the ISP and wish I had met her sooner. She opened me up to me a wealth of interviews. Somalis are very hard to talk to just by finding them and asking if they are Somali and will answer few questions due to their hesitancies about Americans, but if you have a friend they are much more open and willing to talk. Further, I wish that this project could have been completed in the North Eastern province, however that is something I do not foresee SIT allowing for the next few years.

Staying in Mombasa, though it had its disadvantages, also has a thriving Muslim culture and a huge expanse of knowledge on the topic. It is harder to find information on this topic on the coast, but it may be worthwhile to look at how Islam plays a role in justifying and continuing female circumcision. If I would have had more time, I would definitely have wanted to speak with a few Muslim leaders and scholars to discuss the debate from a theological perspective. Likewise, it would be interesting to have more extensive conversations and focus group discussions with Somali women, however these were few and far to come by.

For future projects having anything to do regarding medical procedures or health, I recommend speaking with health care providers in the provincial hospital as well as small clinics as they do not require a lot of the formalities that bigger hospitals like MEWA and Bomu ask for before they will say anything. The most useful person I talked to was a midwife who ran her own small clinic, and the least helpful was the human resource manager at MEWA hospital (the

conversation was very surface due to the sensitive nature of the subject and his reluctance to say something which could get the hospital into trouble).

It was also quite difficult to be sure that people were telling me the truth. Not many people were willing to talk about their personal experiences but instead wanted to speak in generalities about the whole population. Those who did offer me their own experiences seemed as if they could have had an agenda and spoke with me for reasons I could not quite make out. My findings are a reflection of what these groups are willing to say to a young, white woman from America, as opposed to a true representation of the situation on the ground. I strove to eliminate these limitations as much as possible by gathering information from people I knew or met through friends in Kenya, however that likewise limited by ability to get a good sample group. Despite these limitations, I believe the above research paints a fairly acute picture of the situation on the ground, how these groups interact, and how their cultural biases affect their perceptions of a long-standing Somali custom.

Appendices

List of Terms and Abbreviations

Al-Shabbab	a militant quasi-islamic terrorist organization present in southern Somalia and along the border of Kenya
AWA-FC	African Women Are Free to Choose; An organization created to defend female circumcision and the rights of women to chose how their own bodies should look.
Barawa/Brava	a tribe of agriculturalists inhabiting southern Somalia
Children's Act	a piece of legislation enacted in Kenya in 2001 which outlawed female circumcision for children as a violation of human rights
episiotomy	a procedure done during childbirth by a doctor or midwife when the vagina is not stretched wide enough to allow for the baby to exit. Types and sizes of incisions vary - see figure below for infibulated episiotomy diagram. Episiotomy is done to prevent the vagina from tearing on its own, usually being more painful, ragged, and large then when preemptively done medically.
FGC	female genital cutting; usually used interchangeable for FGM
FGM	female genital mutilation; the term for female circumcision used by many NGOs and health organizations
FIDA	Federación Internacional de Abogadas; International NGO fighting for women's rights. In Kenya, it is known a the Federation of Women Lawyers Kenya and has offices in Garissa, Mombasa, and Nairobi.
Guddaay	a traditional Somali female circumciser
hadith	a book accompanying the Quaran in the Islamic faith that details the life of the Prophet Mohammed and his teachings
NGO	Non-Governmental Organization; an organization ranging in size from very local or international that is not associated or funded by any government in particular. Many international not-for-profit human rights organizations would fit into this category

Quaran	the holy book of Islam
Sunna	a type of circumcision referring to anything from very light pricking of the clitoris to total excision of the clitoris and labia minora and vulva. The word “sunna” means following in the Prophet’s (Mohammed’s) teachings, however there is no clear evidence that the prophet endorsed such a practice, however many practitioners use this term in justifying the establishment of female circumcision in a community.
Type I Circumcision	circumcision in which the prepuce is removed with or without partial or total excision of the clitoris
Type II Circumcision	excision of the entire clitoris with partial or total removal of the labia minora
Type III Circumcision	Also known as <i>infibulation</i> , removing all or part of the clitoris and labia minora, cutting or scraping the labia major, and stitching the labia majora together leaving only a small opening at the bottom for urine and menstrual blood to flow through
WHO	The World Health Organization; An international non-governmental organization that defines international standards of health care and medical practice.

Important Documents

Bill for introduction into the National Assembly:-
The Prohibition of Female Genital Mutilation Bill, 2010...
...1609

THE PROHIBITION OF FEMALE GENITAL MUTILATION BILL, 2010 ARRANGEMENT OF CLAUSES

Clause

PART I-PRELIMINARY

1. Short title
2. Interpretation

PART II-OFFENCES

3. Offence of female genital mutilation.
4. Aiding and abetting female genital mutilation.
5. Procuring a person to perform genital female mutilation in another country.
6. Use of premises to perform female genital mutilation.
7. Possession of tools or equipment.
8. Failure to report commission of offence.

PART III-MISCELLANEOUS

9. Entry into premises.
10. Measures by Government.
11. Extra-territorial jurisdiction.
12. Penalty for offences.

THE PROHIBITION OF FEMALE GENITAL MUTILATION BILL, 2010

A bill for

AN ACT of Parliament to prohibit the practice of female genital mutilation, to safeguard against violation of a person's mental or physical integrity through the practice of female genital mutilation and for connected purposes

ENACTED by the Parliament of Kenya, as follows:

PART I-PRELIMINARY

Short title

1. This Act may be cited as the Prohibition of Female Genital Mutilation Act, 2010.

Interpretation

2. In this Act, unless the context otherwise requires... "female genital mutilation" comprises all procedures involving partial or total removal of the female genitalia or other injury to the female genital organs, or any harmful procedure to the female genitalia, for non-medical reasons, and includes:-
 - a) Clitoridectomy, which is the partial or total removal of the clitoris or the prepuce;
 - b) Excision, which is the partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora;
 - c) Infibulations, which is the narrowing of the vaginal orifice with the creation of a covering seal by cutting and appositioning

the labia minora or the labia majora, with or without excision of the clitoris,

But does not include a sexual reassignment procedure or a medical procedure that has a genuine therapeutic purpose;

"lawful enforcement officer" includes a police officer, a member of the provincial administration, a children's officer, a probation officer, a gender and social development officer, a gender and social development officer and a cultural officer; and

"Sexual reassignment procedure" means any surgical procedure that is performed for the purposes of altering (whether wholly or partly) the genital appearance of a person to the genital appearance (as nearly as practicable) of a person of the opposite sex.

PART II-OFFENCES

3. (1) A person who performs female genital mutilation on another person commits an offence.

(2) If in the process of committing an offence under subsection (1) a person causes the death of another, that person shall, on conviction, be liable to imprisonment for life.

(3) No offence under subsection (1) is committed by an approved person who performs:-

- a) A surgical operation on another person which is necessary for that other person's physical or mental health; or
- b) A surgical operation on another person who is in any stage of labour or has just given birth, for purposes connected with the labour or birth.

(4) The following are, for purposes of this Act, approved persons:-

- a) In relation to an operation falling within paragraph (a) of subsection (3), a medical practitioner;
- b) In relation to an operation falling within paragraph (b) of subsection (3), a medical practitioner, a registered midwife or a person undergoing a course of training with a view of becoming a medical practitioner or midwife.

(5) In determining, for purposes of subsection (3) (a), whether or not any surgical procedure is performed on any person for the benefit of that person's physical or mental health, a person's culture, religion or other custom or practice shall be on no effect.

(6) It is no defence to a charge under this section that the person on whom the act involving female genital mutilation was performed consented to that act, or that the person charged believed that such consent had been

given.

(7) In this section:-

"medical practitioner" means a person registered as such under the Medical Practitioners and Dentists Act;

"midwife" means a person registered as such under the Nurses Act.

Aiding and abetting female genital mutilation.

4. A person who aids, abets, counsels or procures -
 - d) a person to commit an offence under section 3; or
 - e) another person to perform female genital mutilation on that other person, commits an offence.

Procuring a person to perform genital female mutilation in another country.

5. A person commits an offence if the person takes another person from Kenya to another country, or arranges for another person to be brought into Kenya from another country, with the intention of having that other person subjected to female genital mutilation.

Use of premises to perform female genital mutilation

6. A person who knowingly allows any premises, for which that person is in control of, or responsible for, to be used for purposes of performing female genital mutilation commits an offence.

Possession of tools or equipment.

7. A person who is found in possession of a tool or equipment for a purpose connected with the performance of female genital mutilation commits an offence.

Failure to report commission of offence.

8. A person commits an offence if the person, being aware that an offence of genital mutilation has been, is in the process of being, or intends to be, committed, fails to report accordingly to a law enforcement officer.

PART III - MISCELLANEOUS.

Entry into premises.

9. A law enforcement officer may, without a warrant, enter any premises for the purpose of ascertaining whether there is or has been, on or in connection with such premises any contravention of this Act.

Measures by Government.

10. The Government shall take necessary steps within its available resources to:-
 - a) protect women and girls from female genital mutilation;
 - b) provide support services to victims of female genital mutilation; and
 - c) undertake public education and

sensitize the people of Kenya on the dangers and adverse effects of female genital mutilation.

Extra-territorial jurisdiction.

11. (1) A person who, while being a citizen of, or permanently residing in, Kenya, commits an act outside Kenya which act would constitute an offence under section 3 had it been committed in Kenya, is guilty of such an offence under this Act.

(2) A person may not be convicted of an offence contemplated in subsection (1) if such a person has been acquitted or convicted in the country where that offence was committed.

Penalty for offences

12. A person who commits an offence under this Act is liable, on conviction, to imprisonment for a term of not less than three years but not more than seven years, or to a fine of not less than one hundred thousand shillings but not more than five hundred thousand shillings, or both.

MEMORANDUM OF OBJECTS AND REASONS

The principal object of this Bill is to provide a legislative framework for addressing the issue of female genital mutilation. The Bill seeks to prohibit the practice of female genital mutilation and all its manifestations.

PART I provides for preliminary matters

PART II contains provisions on offences relating to various aspects of female genital mutilation. In particular, clause 3 makes it an offence for a person to perform female genital mutilation to another person, while clause 4 outlaws aiding and abetting of female genital mutilation. This part also makes it an offence for a person's premises to be used in the performance of female genital mutilation, and also for a person to possess tools or equipment for performing that act. Clause 8 makes it an offence for a person to fail to report the commission of the offence of female genital mutilation to the law enforcement officers.

Part III contains miscellaneous provisions. Clause 9 empowers a law enforcement officer to enter into any premises without warrant in order to ascertain whether there has been violation of the provisions of the Bill. Clause 10 requires the Government to put in place some measures aimed at bringing to an end the practice of female genital mutilation. Clause 12 sets out the general penalty for various offences provided for in the Bill.

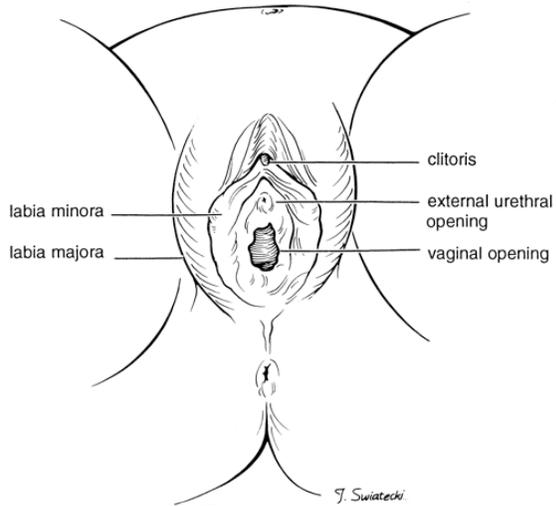
The enactment of this Bill shall not occasion additional expenditure of public funds

Dated the 7th December, 2010

FRED C. KAPONDI,

Member of Parliament.

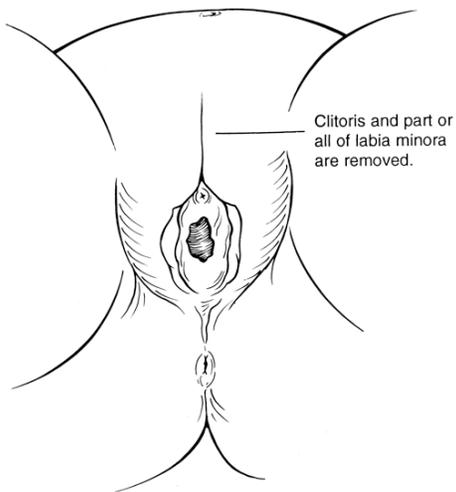
Supplementary Diagrams



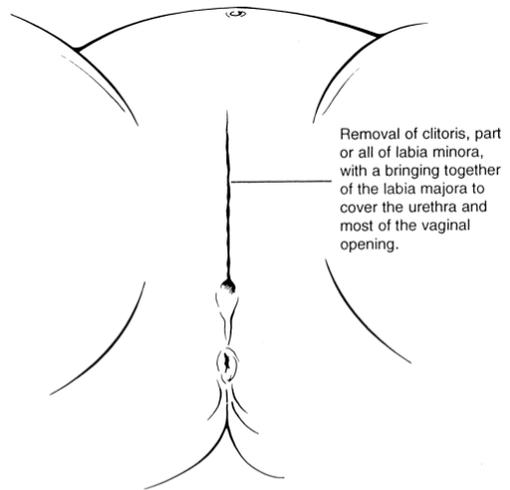
Normal female genital anatomy. [\[1\]](#)
[\(from American Academy of Pediatrics, PEDIATRICS Vol. 102 No. 1 Jul 1998, pp. 153-156\)](#)



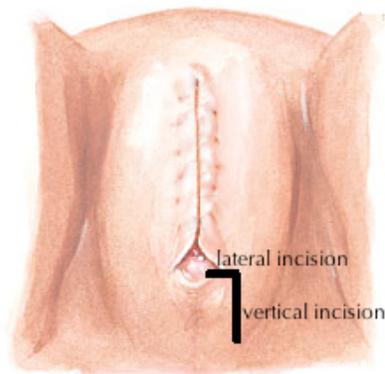
Type I female genital mutilation. [\[1\]](#)
[from American Academy of Pediatrics, PEDIATRICS Vol. 102 No. 1 Jul 1998, pp. 153-156;](#)



Type II female genital mutilation. [\[1\]](#)
[from American Academy of Pediatrics, PEDIATRICS Vol. 102 No. 1 Jul 1998, pp. 153-156;](#)

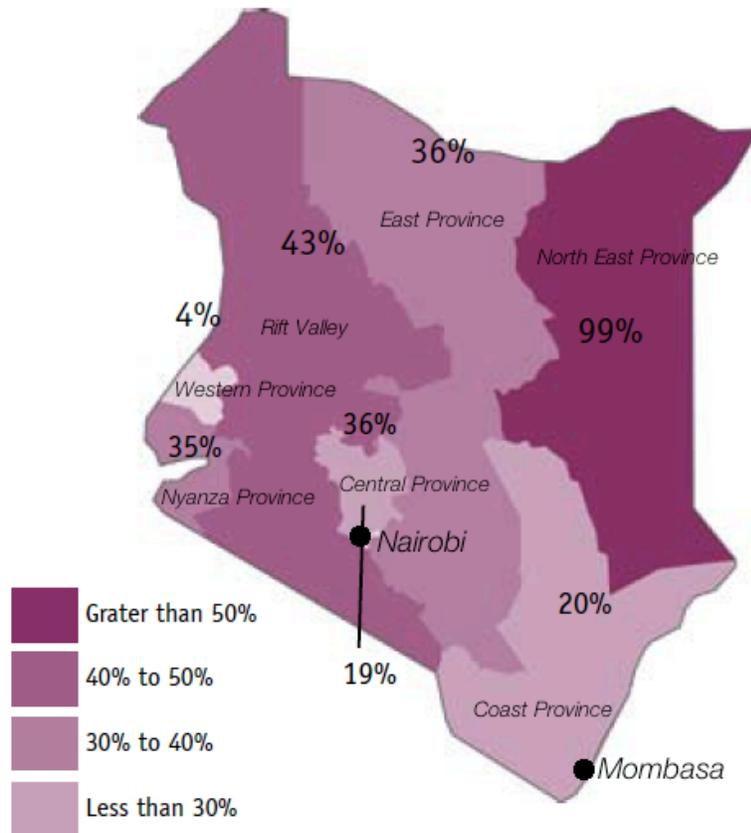


Type III female genital mutilation. [\[1\]](#)
[American Academy of Pediatrics, PEDIATRICS Vol. 102 No. 1 Jul 1998, pp. 153-156;](#)



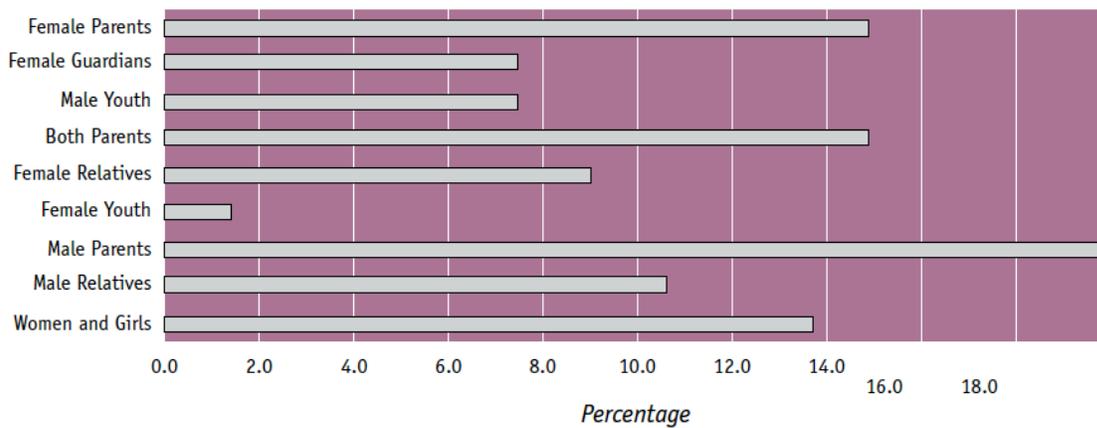
Infibulated vagina with episiotomy incisions

Female Circumcision by Province



Source: Kenya Demographic and Health Survey (KDHS), 2003.

Table 2: Perpetrators of FGM



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Abu Bakr, Barawa man. Interview with Whitney Harkness. Personal Interview. Mombasa, November 11, 2011.

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All names above have been changed to protect subjects' identities, except the starred ()*