



**End FGM**  
EUROPEAN NETWORK

**GAMS**

BELGIQUE - BELGIË



**GENITAL MUTILATION**  
**ADDRESSING COMMON**  
**MYTHS AND**  
**MISCONCEPTIONS**

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## INTRODUCTION

Female genital mutilation (FGM), also called female circumcision or female genital cutting, is a form of gender-based violence, perpetrated against women because they are female. Whilst the practice can elicit very strong feelings in people, it is also not very well understood by the general public. There are therefore many preconceived ideas about female genital mutilation, such as it being a practice affecting Sub-Saharan Muslim communities only. These ideas too often stigmatise affected communities, portraying them as “barbaric” and the women affected by the practice as passive victims. We wish to distance ourselves from this colonialist discourse and highlight the active resistance and role of the women affected by the practice.

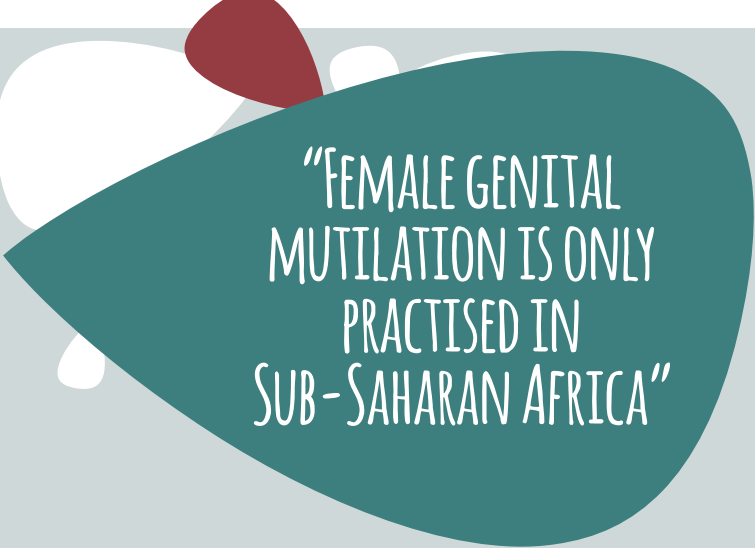
Through this publication, the Concerted Strategies for fighting female genital mutilation (CS-FGM), the Group for the Abolition of Female Sexual Mutilation (GAMS Belgium) and the End FGM European Network aim to address the preconceived ideas and stereotypes about “victims and perpetrators” of FGM. We have decided to deal with 13 different myths that we often hear in our work, be that from professional partners, discussions with the general public or when supporting women affected by the

practice. We would like to bring about a holistic conversation that considers that any analysis must take into account social norms affecting not only women's bodies, but those of children, men and intersex persons. It is also important to underline that the ideas in this text in no way reflect the experience of all women who have undergone FGM (or who have not undergone it), nor all affected communities.

This document is aimed at policy makers, professionals working with women who have undergone or are at risk of FGM, students and teachers wishing to discuss the issue as part of their curriculum, activists working on gender-based violence, public institutions or any other person interested in the issue. A better understanding of FGM is vital in providing quality services to those affected.

By addressing these misconceptions or myths and opening our minds, we can create an equal, inclusive and non-violent society.





## “FEMALE GENITAL MUTILATION IS ONLY PRACTISED IN SUB-SAHARAN AFRICA”

The idea that FGM is practised only in Africa has been around for a long time. However, studies over the last few decades have shown that FGM exists in several countries in Asia and the Middle East, such as India, Indonesia, Iran, Malaysia, Pakistan, Oman, Singapore, Sri Lanka and Yemen. It is practised by some Kurdish communities in Iraq or Syria and in indigenous communities in South America (such as the Embera in Colombia and Peru). It is also practised by migrant populations in Europe, Australia and North America. In 2019, it also came to light that FGM is being practiced by white Christian population in the United States.

Seeing FGM as an “African practice” presupposes that all African communities practise it. This is far from being the case. In some Sub-Saharan African countries, such as Madagascar, Botswana, the Democratic Republic of Congo, South Africa or Zambia, FGM is not practised or is only practised by some minority communities or migrant communities. Prevalence can vary vastly within the same country, depending on ethnic groups or regions.

Among the key reasons that FGM is presented as an “African problem” is that WHO and UNICEF publications often only include figures obtained through demographic and health studies (DHS<sup>1</sup>) or MICS (Multiple Indicator Cluster Surveys). In order to collect data on FGM, a country has to agree to add a specific

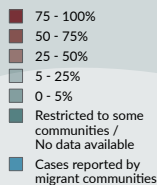
module on the issue – often considered as sensitive – to the DHS or equivalent questionnaire. However, many countries in Asia have not added this module. For this reason, there are no official, approved figures in those countries as there are in Africa. Publications which only include a map of Africa to show the prevalence of FGM thus show a truncated, fragmented image which distorts the reality of the practice.

Indonesia is a good example of this. Several activist organisations have been highlighting the practice of widespread, medicalised circumcision in Indonesia, but the authorities refused to introduce the FGM-specific module in their DHS. This has now been done and has allowed for the prevalence of the practice to become more visible (more than 50% of girls aged 0-14 have undergone FGM in Indonesia). These new figures raised the worldwide prevalence of FGM from 130 to 200 million girls and women (UNICEF 2016). In 2019, an estimated 4.1 million girls are at risk of being cut. In 25 countries where FGM is routinely practiced and data is available, an estimated 68 million girls will be cut between 2015 and 2030 unless concerted and accelerated action is taken (UNFPA 2019).

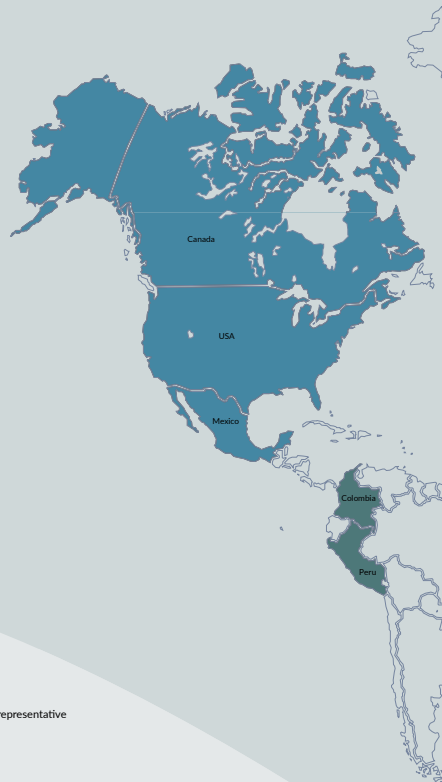
It is crucial, even if national and official data is not yet available, that research reports by non-governmental organisations are taken into consideration and mentioned in UNICEF, UNFPA and WHO reports and that they are included on a world map (and not a map of Africa), in order to show the scale of the problem.

An incomplete view of the regions in which FGM is practised can have consequences on social, medical and legal support available to those affected by the practice. Teams from organisations specialised on FGM have noted that asylum cases or partner organisations refer people from Sub-Saharan regions when in fact newly arrived migrant women in Europe, coming in particular from Iraq, Iran and Egypt, are rarely being put in touch with these organisations.

# FGM PREVALENCE



Source: UNICEF Global Database 2016, based on DHS, MICS and other nationally representative  
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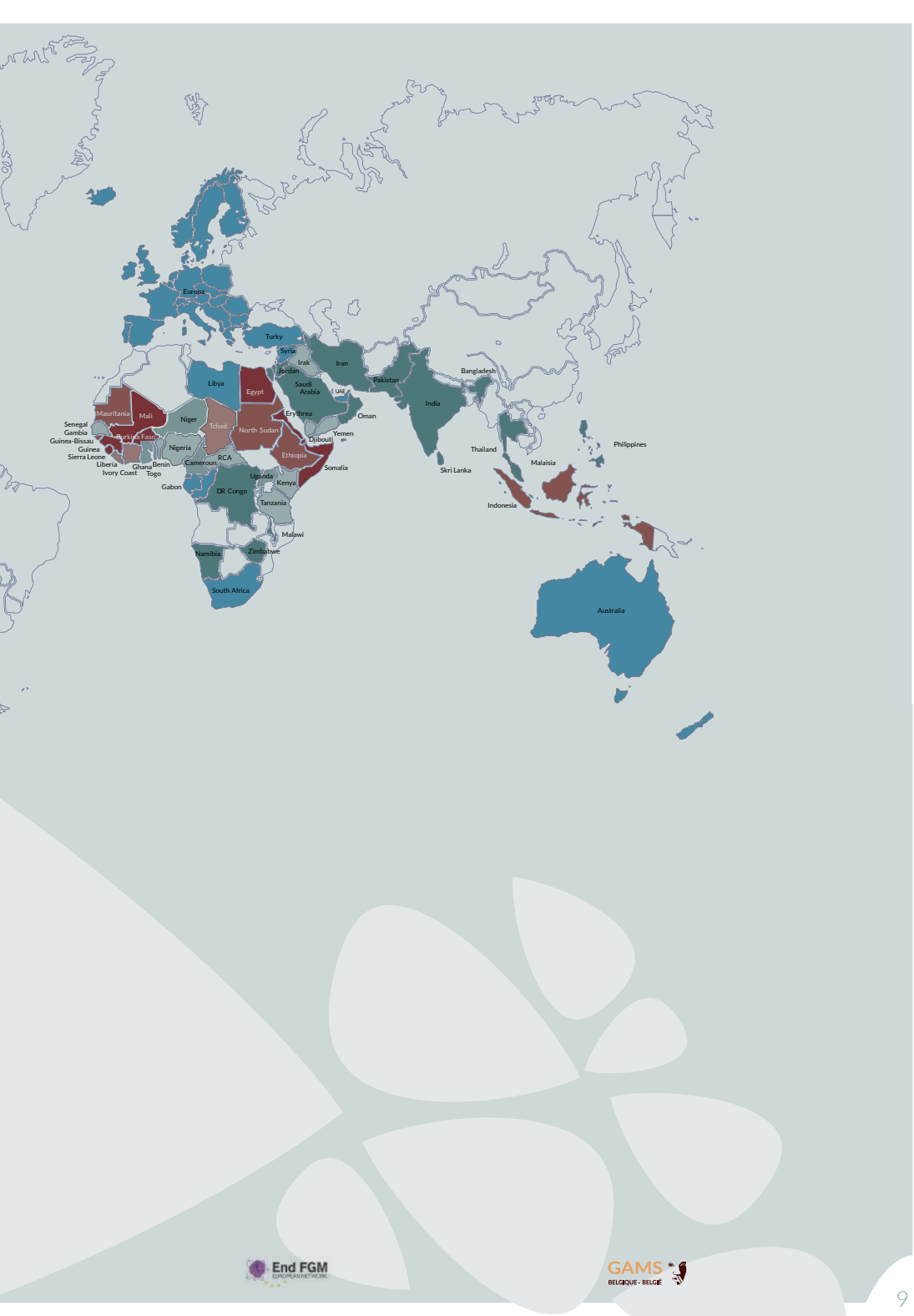


“In Spain, we work with the asylum centres to support women who are FGM survivors and those at risk of under-going the practise. The guides and information provided all focus on those coming from African countries. There is an information gap on the other regions and this means that women are not being supported.”

Asha Ismail,  
Founder, and President  
of Save a Girl Save a Generation

In addition, focusing FGM on Sub-Saharan Africa only can lead to generalisations about “black women” being considered as “victims” and “mutilated women”.







“IN EUROPE  
WE DON'T CIRCUMCISE  
WOMEN/GIRLS”

The idea that FGM is practised only in “developing” countries is accompanied by the idea that FGM is not a “Western” or European practice. However, throughout history, different types of FGM have been found in Europe and the United States. Until the end of the 19<sup>th</sup> century, clitoridectomy was practised in a medical context. Women were ‘cured’ by removing their clitoris ‘illnesses’ such as hysteria, nymphomania, homosexuality and masturbation. Once it had been proven that the practice had no positive effect on health, this form of FGM was banned in Europe.

All European Union (EU) member states criminalise FGM, either through specific provisions or through general provisions in their respective Criminal Codes. In almost all EU member states<sup>2</sup> FGM is an offence punishable even if committed abroad, through the application of the principle of extraterritoriality. Definitions of the offence and related penalties vary from country to country. It is worth noting that FGM is criminalised also in article 38 of the Council of Europe Convention on preventing and combatting violence against women and domestic violence (the so-called Istanbul Convention<sup>3</sup>), which is the first legally binding treaty recognising that FGM is a form of gender-based violence that exists also in Europe. To tackle this issue, in 2013 the European Commission has adopted an Action Plan on eliminating FGM in Europe and beyond<sup>4</sup>. However, despite the law prohibiting FGM

in all European countries, those living in Europe are affected by FGM.

Estimates based on census data from ten years ago, therefore quite outdated, indicate that over 500,000 women and girls are living in Europe with the lifelong consequences of FGM. However recent internal calculations by the End FGM European Network substantially increase this number up to almost a million. Census-based estimations are only partial, since they fail to account for second generation migrants or migrants in irregular situations and/or undocumented. On top of these, we must add also the number of women and girls coming to Europe every year to ask for asylum on grounds of being affected or at risk of FGM, which UNHCR<sup>5</sup> estimates to be at least 20,000 per year for the last five years. Finally, we must also consider the number of girls living in Europe who are at risk of being cut, so far estimated by EIGE<sup>6</sup> and other national sources to be around 170,000 in 13 EU countries. For instance, in Belgium, 8,600 girls are at risk of FGM<sup>7</sup>. This data relates only to the women and girls originating from countries outside of Europe where FGM is a “tradition”. The risk relates mainly to when they go back to this country (on holiday, for example).

In France, there have already been 29 recorded cases of FGM being practiced on French territory. A study conducted by the French Institute for Demographic Studies (INED) estimates that 28% of girls born in the 1980s in France with a mother who has undergone FGM had also been subjected to FGM, either in France or on a visit to their mother’s country of origin. This rate fell to 1% for those born in the 1990s, following some public court cases which took place in Paris during this period (Andro, Lesclingand and Pourette, 2009). The book “Exciseuse” (“The cutter”) by Natacha Henry and Linda Weil Curiel (2007) follows the story of Hawa Gréou, a cutter from Mali who carried out hundreds of mutilations in a private apartment in a Paris suburb, before being arrested and prosecuted.

“During a training session in Belgium for healthcare professionals, a participant approached me at the end to tell me she had been cut in London when she was seven years old. She lived in Paris and took the Eurostar with both her parents without being worried. Two years later, they did the same thing to her little sister. She was part from the Bohra community, an Indian Muslim community classified as a sectarian group in France”

Fabienne Richard, GAMS Belgium

In Belgium, specialised organisations have been in contact with doctors who have received requests from parents to practise FGM on their child. There are rumours that cutters have been active in Brussels, Verviers and Antwerp, but there has never been any tangible proof of this. Doctors have however raised cases of young girls born in Belgium and cut during a trip to a country of origin.

In March 2019, a Ugandan woman was convicted in the first case of FGM in the United Kingdom for having had her three-year-old daughter cut in her home in London in 2017.

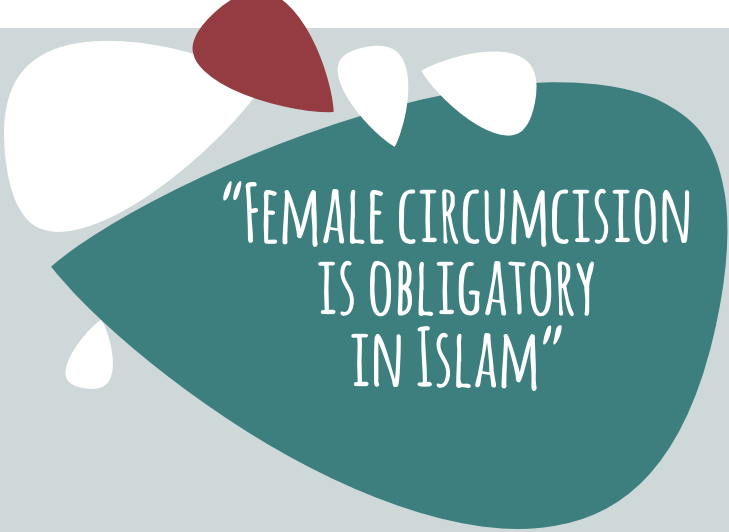
It is vital that everyone, be they a professional or a citizen, raise any risks or cases of FGM which they may witness, as this will potentially save hundreds of thousands of girls living on European territory. The aim of reporting is not necessarily to “punish” those involved in an FGM case, but above all to put in place mediation and awareness-raising in order to protect the girls.

For a comprehensive account of FGM court cases within the EU, it is worth mentioning



the existence of an interesting study<sup>8</sup> analysing 20 recent FGM cases, which was commissioned by the European Commission and that also assesses the evidence of transnational movements to have FGM performed, both within and outside the EU.





## "FEMALE CIRCUMCISION IS OBLIGATORY IN ISLAM"

Religion is one of the reasons most often raised in defence of FGM. The practise is often seen as a "Muslim practice". This can be explained by the fact that it is practised by different Muslim communities. Nevertheless, not all Muslim communities carry out FGM (for example, Morocco, Algeria and Tunisia do not), while several non-Muslim communities, Christian or animist, do so. This is the case in Burkina Faso and Sierra Leone, for example (see map of prevalence), where FGM is practised by both Christian and Muslim communities.

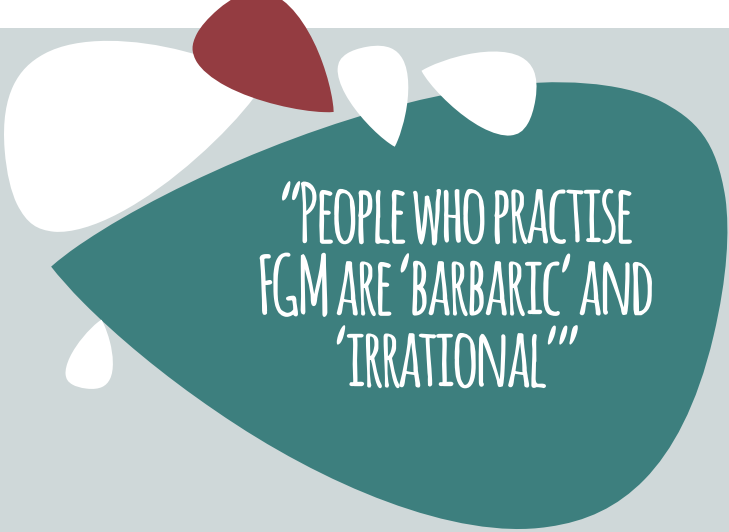
Although FGM is mentioned in certain sections of some religious texts, the practice is obligatory neither in Islam, nor in other religions. Some religious authorities oppose the practice, others encourage it or take a neutral position on the issue.

"FGM is a traditional practice which existed well before the arrival of monotheistic religions such as Islam. After people converted to these religions, certain traditions were integrated into religious practises and in the name of religion. Over time, we fused tradition and religion"

Omar Ba, historian

FGM is practised in a complex context of norms and beliefs. Depending on the country, ethnic group and time period, different arguments are used in favour of the practice: tradition, social cohesion, controlling women's sexuality, beauty, etc. Many combinations are possible. Although religion is sometimes included in this context, this element cannot on its own explain the existence or durability of the practice. There is a difference, however, between the African continent and Asia. In sub-Saharan Africa the practice precedes monotheistic religions and Muslims, Christians and Animists can be found among those who practise. In Asia, the practice began later and is seen as a religious obligation, in the same way as male circumcision - it is called "female Islamic circumcision" in Indonesia.

With the aim of ending FGM and offering support tailored to each person affected by the practice, a thorough understanding of its origins is vital. This allows the issue to be raised more easily and, above all, to correctly identify those affected. Practising a specific religion is not in itself an indication that someone practices FGM. Other more reliable factors can indicate if there is a risk of FGM: prevalence of the practice within the family, country and ethnicity of origin etc<sup>9</sup>.



“PEOPLE WHO PRACTISE  
FGM ARE ‘BARBARIC’ AND  
‘IRRATIONAL’”

This reasoning is simplistic and bordering on racial discrimination.

It is undeniably true that FGM has severe consequences on the physical and mental health of women in the short and long term (as well as being painful, it can also be fatal). Therefore, many people think parents of those who have undergone FGM are “bad parents” and that the family, the cutter and the community are “barbaric”. This is often the first reaction when faced with the reality of FGM:

How can a mother, who has undergone this practice and who knows how painful it is, subject her own daughter to the same thing? How can a cutter, who hears the cries, sees the pain that it causes, continue to practise her profession? How can a father who has lost his sister to complications following FGM continue to support the practice?

To understand the practice, we should remember that it is not carried out as an isolated action. FGM is part of a complex web of ritual and daily practices of constructed gender roles linked to feminine and masculine status. In some communities, circumcision is an obligatory ritual in order for a girl to be considered an adult woman, a full member of her community and a potential candidate for marriage. When FGM is the norm within a community, its members can face heavy social pressure. The reasons justifying



the practice are diverse and vary from one context to another: respecting tradition, protecting virginity and women's fidelity, religious obligation, etc. Some communities are convinced that FGM is hygienic and beneficial to health. These preconceived ideas can be explained by the vast lack of understanding of the clitoris (and in general female sexual organs) in many parts of the world, including Europe. The clitoris is seen as a source of "sexual promiscuity", something that might continue to grow if it is not cut, it can be seen as damaging for the baby etc. Added to this, is a lack of understanding and knowledge around the consequences of FGM.

When faced with this, subjecting your daughter to FGM cannot be seen as an irrational choice. When they accept to carry out FGM on their daughter, families wish to protect her against being stigmatised and socially excluded and to guarantee that her place in society will be respected. Standing out against the practice can, on the other hand, lead to persecution and violence; it is therefore this latter option which appears to be irrational.

**"We call a woman who has not undergone FGM 'bilakoro muso'. This means that even if she is a woman of a certain age, instead of being treated as an adult woman, she will be treated like a little girl..."**

A Malian man interviewed as part  
of a research conducted for [Men Speak Out Project](#)

Several researchers and activists believe that awareness-raising campaigns against FGM, ran by international institutions and organisations, are tainted with neo-colonialist vision. One of the arguments used by colonising states to justify colonisation was that they had to “bring civilisation to inferior races”. This idea was conveyed in Western anthropological narratives at the time. Colonised women were perceived as oppressed victims, powerless and voiceless, who had to be protected by their masculine partners and their customs (Janice Boddy, 2007). As a consequence, some international (and Western) campaigns around “traditional harmful practices” are, to this day, fed and strengthened by a hierarchical evolutionary idea according to which Western society is civilised and non-violent and all “other” societies are “barbaric”, “irrational” and “developing”.







## “FGM IS WOMEN’S BUSINESS”

FGM is generally perceived as “women’s business”. It is certainly true that those most affected are women, as they are the ones to undergo it and suffer its consequences. In addition, it is often - but not only - women who decide that a girl should be cut. Not only the mother, but also grandmothers, aunts, even friends and neighbours can be part of it. In many communities, it is mostly the women, traditional cutters or carers, who carry out the procedure. This is why, around the world, many initiatives to end FGM are focused on and target women.

However, FGM is a practice anchored in patriarchal tradition in general. As we have already seen, FGM is a strong social norm in practising communities. It is often an obligatory rite of passage for a girl to “become a woman”. This patriarchal practice is part of controlling women’s bodies and sexuality and is part of the spectrum of gender-based violence of which women are victims simply because they are women. In many affected communities, FGM aims to guarantee women’s “morality” (and therefore, that of society) by assuring they remain virgin until marriage and that they are faithful once they are married. Also, the social pressure which forces parents to subject their daughters to the practice is kept in place by the whole community, both men and women. On the one hand, men participate in perpetuating the practice as individuals, such as when a man refuses to marry a woman who has not been cut, or when a father funds his daughters to undergo FGM. On the other hand, men as a social group are the primary beneficiaries of a patriarchal system which guarantees their

social and economic power. Given the power they have in society, they undeniably have a role to play in maintaining or abandoning practices such as FGM.

Men are indirectly affected by the practice. Seeing the women and girls in their family suffer from FGM can have psychological consequences for them. Although men's sexual satisfaction often used to justify FGM is rarely questioned, the sexual consequences of FGM also affect men. Some have traumatising memories of their first sexual encounters with an infibulated woman, where the social pressure forces them to "open" their partner to prove their virility.

Men have a vital role to play in ending FGM. As members of their community, it is important that they clearly express their wish to end the practice and that they participate in the awareness-raising process. They have to be informed of the damaging consequences of the practice in order to be able to participate in abandoning it.

**"We know that men are hardly involved in FGM, but that they could play a role in putting an end to the practice. FGM is an extremely difficult topic to speak about across genders and even across different generations. Some husbands had never spoken to their wives about the practice. At FORWARD we work with women, men and young people, we support them through training and confidence building to speak out about FGM"**

Toks Okeniyi,  
Head of Programmes and Operations,  
FORWARD UK


Men's lack of knowledge on the issue can be explained by the significant taboos surrounding FGM. Because of this, women and men rarely talk about the subject. They do not know each other's opinion and continue to practise FGM, thinking that the other wishes it to continue. UNICEF's first report of FGM (2013) shows that in many countries, women underestimate to what extent men wish to abandon the practice. In Guinea, Sierra Leone and Chad, more men than women are against the practice.

**"A woman that I was supporting confided in me that she wanted to have her daughter cut. I asked her what her husband thought of this. She did not know, so she broached the subject with him. It was only then that she realised the father of the child was against FGM. The parents decided together not to subject their daughter to the practice. Without this conversation, the girl would have been very much at risk"**

A European child health professional

FGM is therefore not a women's business, but affects the whole community. To end the practice, it is important to raise awareness among all those affected.





"A WOMAN WHO HAS  
UNDERGONE FGM  
IS A VICTIM"

FGM has very different meanings when it comes to 'femininity', depending on cultural interpretation. For some practising communities, it is seen as essential to 'create' femininity and the status of an adult woman, whereas for others, it is seen as erasing femininity and the possibility of being considered a 'woman'.

Some authors believe that in the West, the clitoris has become the symbol of women's emancipation. Consequently, FGM is the symbol of women's oppression. Critics think that this is a Eurocentric and reductive vision of the reality of women affected by FGM. According to those critics, those in the West opposing FGM have a tendency to deny feminist movements in African countries, in particular the historical opposition to FGM. The anthropologist Rogaia Mustafa Abusharaf (2000) also gives the example of the tradition of strong women's rights movements in the Sudan and elsewhere in Africa, highlighting that African women are not "passive victims" who need to be "saved". Even if it is impossible to generalise the vision of "Africans" and "Europeans", Belgian specialised NGOs notice in their daily work that this vision of women who have undergone FGM as passive victims is very widespread. For example, the testimony of "victims" seem to attract the attention, in particular that of the media.



“At FSAN (Federation of Somali Associations of the Netherlands) we believe that to end FGM the charge must be led by survivors and individuals from impacted communities. We work with inspiring survivors and change makers (women, men and young people) from affected communities. However, when we are contacted by the media they rarely want to focus on the positive stories of these change makers. They are more interested in the personal experiences of violence”

Zahra Naleie,  
Programme manager,  
FSAN

Although it is obviously important to recognise FGM as a form of violence, being a victim should not be an identity. It is important to recognise women as agents of their own lives and to recognise the vast internal resources needed to reconstruct their life after a traumatic experience. Sometimes this reconstruction requires the help and support of professionals.

“The woman that you receive in your consultation room has undergone a mutilation. She is not a mutilated woman”

Annalisa d'Aguanno,  
Psychologist,  
GAMS Belgium

Victimisation can slow down resilience and psychological reconstruction. This reflection is relevant to other forms of gender-based violence, such as domestic violence or rape.



“WOMEN WHO HAVE  
UNDERGONE FGM  
EXPERIENCE NO SEXUAL  
PLEASURE”

FGM is an attack on women's external sexual organs. The practice can therefore have consequences on sexual health, such as pain during sexual intercourse, tears (linked to infibulation), and difficulties in feeling pleasure, or even the total absence of pleasure. One of the reasons for practising FGM is controlling women's sexuality.

But these facts can lead to incorrect ideas, such as the idea that cut women can never feel sexual pleasure or that women who are not cut only think about sex. People who are not affected by FGM and those originating from affected communities can both share these ideas.

“The most common stereotypes which I hear from my patients who have undergone FGM are on the one hand that “white women who are not cut” are “sex bombs” and that women who are cut think that they are not able to feel pleasure due to being cut”

Cendrine Vanderhoeven,  
Sexologist, CeMAViE<sup>10</sup>

Although women who have undergone FGM do experience sexual difficulties this is not true for all. Some women who have undergone FGM are happy with their sex life. Sexual problems can affect anyone, whether they have undergone FGM or not, and that includes men. The lived experience of sexuality can be influenced by many factors, in the present and in the future. Having undergone FGM can be a factor in experiencing pleasure, but it is not always the case. For women who suffer from sexual problems following FGM, psychological support, medical and sexological support (with or without a partner) can enable women to enjoy their sexuality.

Often, great importance is put on the absence or presence of the clitoris, the only human organ specifically designed for human pleasure. Although there are many different types of FGM (Types I to IV and many variations in each group), it should be noted that all women keep the majority of their clitoris intact. The clitoris is not only contained to the external and visible part, but measures between 8 to 12 centimetres long and extends into the body, around the vagina. During a clitoridectomy, only the external part of the clitoris is removed. Although sometimes difficult to attain, sensation in the clitoris is always possible. In addition, the clitoris plays an important role in women's sexuality, but we must not forget that the human body has other erogenous zones. In discovering all of her body, a woman can learn different ways to attain pleasure. Finally, not all types of FGM include the removal of the clitoris.

“Thinking about sexuality or wanting sexual touches or intimate relations can appear spontaneously for all women, whether they have undergone FGM or not. Sexual curiosity, being inquisitive about the body, looking at it, touching it, receiving caresses, is a healthy behaviour which we develop in childhood. Sexuality is part of being human and evolves; we learn about it throughout our lives. The presence or absence of a clitoris does not change this”

Céline Liurno,  
Psychologist and sexologist,  
Family Planning Centre FPS Solidaris  
Liege, Belgium





"WOMEN WHO HAVE  
UNDERGONE FGM MUST BE  
'REPAIRED'"


The consequences of FGM, both physical and sexual, can be treated using different methods. For example, FGM can lead to infections which have to be treated with antibiotics. An infibulation must be surgically opened to ease the flow of urine and menstruation, sexual intercourse and birth. The reversal of an infibulation can have positive effects on women's health and is (often) medically recommended.

The reconstruction of the clitoris is another matter, as it not only aims to treat some of the consequences of FGM, but also to 'repair' the body. It involves a surgical technique developed in France by Dr Pierre Foldès at the end of the 1980s. Reconstruction of the clitoris is now practised worldwide in several countries and using different surgical techniques. This intervention externalises and repositions the internal part of the clitoris and aims to reinstate its nerve function. The intervention "has been shown to be useful in cases in which the patient feels she needs to reinstate her bodily integrity" (CeMAViE). Surgery allows some women to find or enhance clitoral sensation, but it is not an obligatory path to attain a satisfying sexual life, nor a miracle solution for sexual problems. It is a relatively recent technique and the potential advantages are hotly debated in medical circles.

“I explain to women who want to have the operation that it can never be like before: we do not reconstruct the inner labia and the clitoris will not be the exact same. Sometimes they think that we are going to place a little speck between their legs and that everything will change, as though it were a button which we push to orgasm. But it doesn't work like that. Sexuality is all encompassing, women have to know their bodies to find pleasure and to guide their partners”

Cendrine Vanderhoeven,  
Sexologist, CeMAViE

Sexuality is not just a physical matter, but an emotional one too. This is why it is vital to tackle sexual problems from a multi-disciplinary angle. Not only medically by repairing the clitoris, but also through psychological and sexological support. In Europe, several countries offer multidisciplinary support and accompaniment for women living the lifelong consequences of FGM. For instance, in Belgium women who have undergone female genital mutilation have access to multidisciplinary support in two specialised centres, at CHU Saint Pierre in Brussels and the Ghent University Hospital. In France, there are also several centres that offer multidisciplinary services including reconstructive surgery for FGM survivors, such as La Maison des Femmes in Saint-Denis or the Women Safe – Institut de Santé Génésique in Saint-Germain-en-Laye. In Switzerland, the Geneva University Hospital also provides such interdisciplinary services for women who are FGM survivors.



## “COSMETIC SURGERY ON GENITALS HAS NOTHING TO DO WITH GENITAL MUTILATION”

We know that girls and women are exposed to numerous images of “what a woman should be”. Society’s norms and expectations include habits and behaviour, but different societies also have different expectations about the anatomy of genital organs, which do not always correspond to real/natural anatomy.

In order to be able to live up to these expectations, women and girls sometimes decide to subject themselves to cosmetic surgery to modify their genitals. These include labioplasty (reduction of outer or inner labia, clitoral-hood reduction), hymenoplasty (reconstruction of the hymen) which allows women to have a “second virginity”, as well as operations to narrow the opening of the vagina.

These forms of plastic surgery can be compared to FGM in different ways, as they are generally practised for non-medical reasons. Women themselves may ask for this cosmetic surgery, encouraged by the social pressure brought on by the image of the “ideal vulva” or the obligation to be a virgin before marriage, which can weigh heavily on women. These aesthetic reasons and societal pressure can play a role in choosing cosmetic surgery, as is the case for female genital mutilation. Surgical interventions on genitals can lead to complications such as bleeding, infection and pain.




The World Health Organisation (WHO) describes FGM as “all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons”. Cosmetic surgery can very easily fall into this category. The strategy of medicalising “traditional forms of FGM” comes up against strong resistance. Surgical interventions on the vulva for purely aesthetic reasons are legal and are becoming more commonplace in Europe. We could question why is the WHO remaining silent on the issue of labioplasty, whilst vehemently opposing female genital mutilation. Why are these practices acceptable in some contexts, but considered mutilation in other contexts?

We could go a step further and say that “FGM laws in European countries” on FGM are based on a double standard: can an adult woman or a surgeon be punished based on their ethnicity or the origin of the patient? Why do Western women have the freedom of individual choice, but women of other origins cannot consent to the same type of intervention? Can an adult woman from an FGM-practising region go through a medical intervention on her genitals for cosmetic reasons, in the same way that her neighbour can? Or would one be called plastic surgery and the other a form of genital mutilation?

“Female Genital Cosmetic Surgeries such as labiaplasty is becoming increasingly popular in Europe. There is some confusion that such surgery for non-medical reasons may or should, as per the WHO definition, be considered as a form of FGM. This raises questions of double standards applied for different communities. This is a complex issue and one that deserves urgent attention from feminist, psychological, clinical and ethical perspectives”

Fiona Coyle,  
Director, End FGM European Network





"IN WESTERN SOCIETIES  
WOMEN'S GENITALIA ARE  
TREATED WITH RESPECT"

Many women go through surgical interventions on their internal and/or external genitalia throughout their lives, often performed during pregnancy and childbirth. Healthcare professionals can decide to carry out these interventions, with or without the consent of the patient, provided they are medically justified. Perinatal statistics comparing European countries show that from country to country there are large differences in the number of interventions such as C-sections and episiotomies carried out; this opens a debate on to what extent are these procedures medically justified.

Patients and healthcare professionals are beginning to condemn what they see as obstetrical and gynaecological violence<sup>11</sup>. In the book "Le livre noir de la gynécologie" ("The black book of gynaecology", Dechalotte, 2017), women speak out about being mistreated by healthcare professionals in France. Mistreatment can occur before, during or after labour, in relation to assisted medical reproduction, after a miscarriage or during a simple check-up at the gynaecologist. Mistreatment includes: sexist or discriminatory comments, neglecting a patient's pain or complaining when they express it (as it counters the ideal of the "silent birth"), overlooking the wishes of the mother-to-be, vaginal or rectal touching without the patient's consent, rape, misinformation, disrespectful behaviour, refusal to provide contraception, unjustified hysterectomies, and unnecessary C-sections and episiotomies. It results in short and long-term physical and psychological sequelae for some women.

One of the criticised interventions is the episiotomy - a surgical cut made at the opening of the vagina during childbirth. Episiotomy prevents from serious vaginal tears during labour (laceration to the perineum - the area between the vagina and rectum) and protects the baby. However, complications following episiotomies have been documented since the late 1970s. Recent evidence-based medicine, as well as testimonies have shown that episiotomies can cause increased risk of faecal and urinal incontinence, decreased pelvic floor muscle strength, prolapse and sexual problems. Moreover, spontaneous tearing is often less painful, leads to less bleeding and heals more easily than episiotomies. There is no evidence that routine episiotomy reduces perineal/vaginal trauma or causes less harm to mother or child. Instead, a policy of selective episiotomy – i.e only when needed and not as a preventive measure – could result in 30% fewer women experiencing severe perineal/vaginal trauma.<sup>12</sup>

**“Episiotomies have a place in maternity care – and have the potential to save lives occasionally – but they should not be performed routinely”<sup>13</sup>**

Hannah Dahlen,  
Professor of Midwifery,  
Sydney (2015)

Since the 1990s, some authors have started drawing parallels between episiotomies and FGM. In the late 1990s, a debate article in the prestigious medical journal *The Lancet*, stressed the negative consequences of episiotomies (compared to natural tears) and the lack of evidence of supposed benefits. The author recalled the important role that the Journal played in combatting the practice of clitoridectomy in the UK in the 19th century and called for the Journal to “once more help turn support away from female genital mutilation, in this case its modern form—episiotomy” (Wagner, 1999).

Authors argue that episiotomies can be compared to FGM in several ways. It is part of a Western “birth ritual” which “marks the passage from the state of girl to that of mother in the flesh”, just like FGM. The consequences of FGM and episiotomies are also similar (severe pain, loss of self-esteem, pain during intercourse, lower libido, depression). Moreover, episiotomies can result in the section of the nerves of the inner parts of the clitoris.

Women who have suffered vaginal tears or an episiotomy, due to labour, frequently need stitching of the perinea. Recently, a second obstetrical abuse which can easily be compared to FGM has come to light: the “husband stitch”. This refers to a doctor making an extra stitch, when repairing vaginal tears or episiotomy, to tighten the vaginal opening and thus (supposedly) increase the sexual pleasure for a male partner. Women have testified of the negative consequences of this “husband stitch” on their sexuality and are calling for it to be abolished.





## “PRACTISING FGM IN A HOSPITAL REDUCES RISK”

Carrying out FGM in a hospital environment is sometimes considered to be a way of reducing the risk of infection and haemorrhaging and is called “medicalised FGM”. It is a ‘least worst option’ strategy. The practice of FGM is still very widespread in countries such as Guinea, Somalia and Egypt. In these countries, the norms surrounding the practice are so strong that a total abandonment in the near future seems impossible. In East Africa, infibulation (type III) is common and leads to serious consequences on the physical and mental health of women and girls. This is why for those who are pro-medicalisation, a new approach needs to be put in place where the first step would be to penalise the “worst” types of FGM, whilst allowing “lighter” forms such as “pricking” (small incision in the clitoris) to take place in a medical environment. In this way, risk could be reduced and could quickly improve the health and well-being of women, while slowly deconstructing the norms around the practice and in the long-term, convincing communities to end the practice.

However, for those opposed to FGM, any form of the practice should be considered of being a mutilation, a violation of human rights, a form of violence against women and an expression of inequality between men and women. “Minor forms” of FGM, as propagated by those who are pro-medicalisation, do not necessarily lead to lesser impact, because the consequences of FGM do not only depend on the type practised, but also on the expertise of the cutter, the level of hygiene, the age of the girl/woman, to what extent is the girl



resisting during the intervention, etc. This is why it is vital to hear each woman's testimony and not evaluate the consequences solely based on the type of FGM she has undergone. In addition, those against medicalisation believe that replacing one form of FGM for another will not necessarily lead to it being abandoned.

“In Guinea girls are cut by a health professional, often a midwife. One of these women reached out to us as she realised first-hand the harm that the cutting was causing. She started spreading awareness of the fact that a medicalised procedure still has negative consequences. Unfortunately, this woman was threatened and was no longer able to stay in Guinea. She now resides in France and we work with her to raise awareness on the consequences of all forms of FGM including medicalised FGM”

Sokhna Fall Ba,  
Project officer,  
Equilibres & Populations

Medicalisation does not resolve the problem of FGM being a type of child abuse and gender-based violence and does not put into question the reasons behind excision or infibulation, in particular the desire to control women's sexuality. Some also think that this makes raising awareness of the practice more difficult, as health professionals support it.

The lively debate surrounding medicalisation also brings into question other surgical interventions on the genital organs of children and adults, be they female or male. One of the arguments in favour of medicalisation is that "minor" FGM, such as incision of the clitoral hood, is no more serious than a male circumcision which is authorised and performed on baby boys in hospitals around the world. It is also true that some activists working to end FGM choose not to raise, or ignore, the issue of male circumcision. Others recognise that circumcision constitutes an attack on the integrity of children, which can have consequences on the health of men and boys.





## “MALE CIRCUMCISION AND FGM ARE COMPLETELY DIFFERENT / TOTALLY THE SAME”

When raising the issue of FGM, it is not unusual to also hear male circumcision being brought up. On one hand, some use circumcision to deny the existence of FGM as a form of gender-based violence. Others think the two practices are completely unrelated. This paper wishes to demonstrate that neither of these positions are correct.

Male circumcision, which involves cutting the foreskin, is mainly practised for religious reasons (in Judaism, Islam and Christian Orthodox Churches) or supposedly for hygienic reasons.

As in the case of FGM, circumcision is most often carried out without the consent of the child. In both cases, it is a violation of a child's bodily integrity. Most types of FGM, such as infibulation, removal of the clitoris and the labia, cannot be compared to circumcision in terms of the tissues cut and the health consequences. However, other practices such as the removal of the clitoral hood can be considered as being quite similar to circumcision.

Another parallel which can be drawn between male circumcision and FGM is that in certain communities where the two practices are common, they are part of a rite of passage into adulthood both for men and women. In many languages, especially African ones, the two practices have the same name. It is nevertheless vital to underline that in patriarchal societies, these practices construct hierarchical sexual identities; if FGM aims to make women more “docile” and to control their bodies and sexuality, circumcision builds men up to be “dominant” and “strong”.

“The danger with comparing circumcision and FGM is that we start to think of them as similar practices being as bad as each other. If we do this, we challenge the basis of FGM: male domination over women. It is vital to recall that even though both are bodily mutilations which can potentially be fatal, the systematic nature of the destructive consequences of FGM (both psychologically and physically) as well as its true function, even if rarely explicit, as the guarantor of society’s patriarchal organisation makes it impossible and, most importantly, dangerous to compare the two practices”

Lucie Goderniaux,  
Université des femmes

More and more people know that excision is not obligatory under Islam; yet some people use the religious argument to differentiate between FGM and male circumcision. Circumcision is often considered obligatory in both Jewish and Muslim religions. However, much like FGM, male circumcision is an ancient cultural practice which began before the arrival of monotheistic religions.

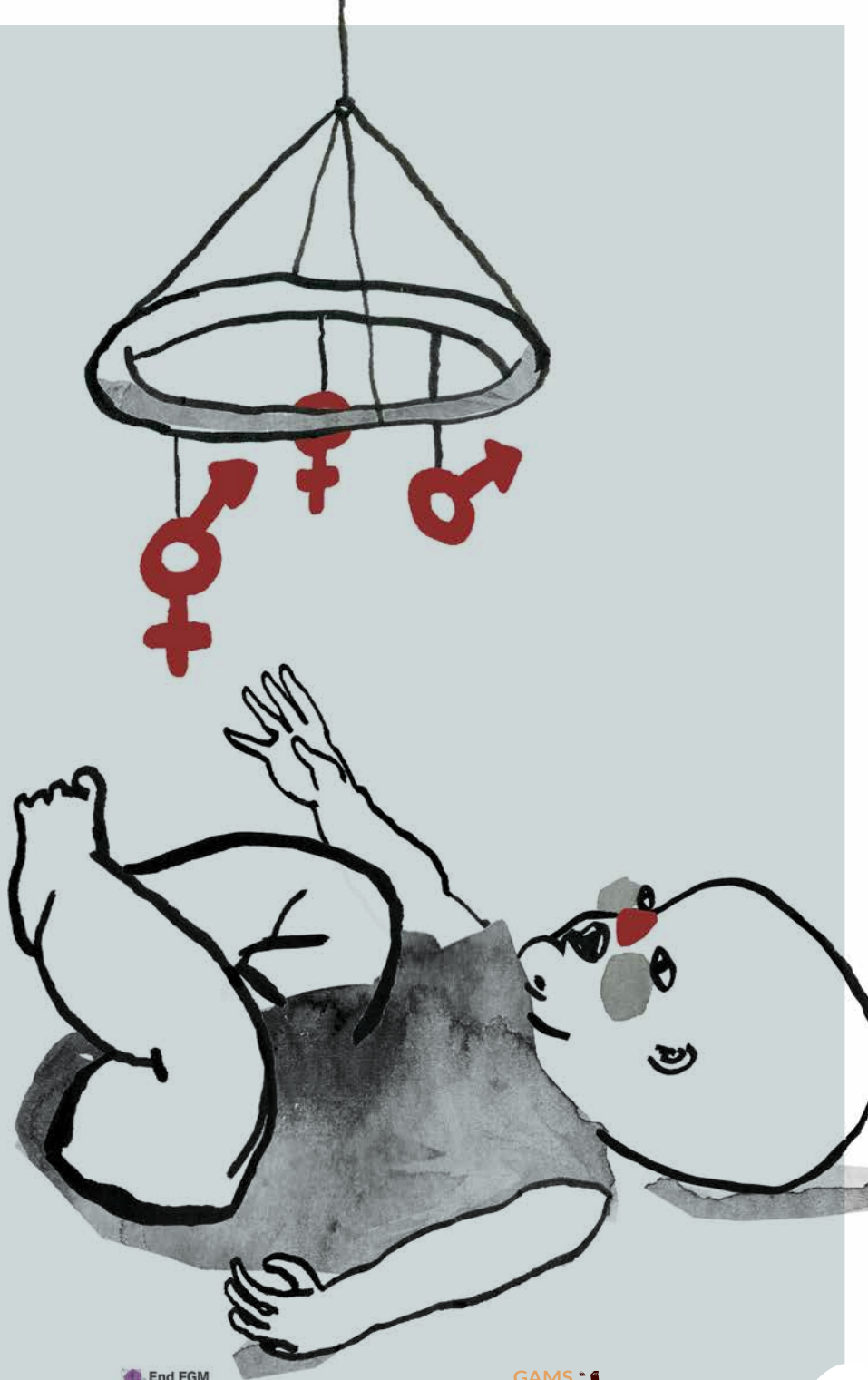
In some countries, it is also practised outside of a religious context for medical reasons. The potential benefits of circumcision on health are also used to justify the practice. Although some studies quote positive effects on the rate of HIV transmission and other sexually transmitted infections, others contradict this and highlight that only condoms effectively protect against sexually transmitted diseases. In addition, male circumcision is mostly carried out on children and babies who do not have sexual intercourse. The treatment of phimosis (when a narrow foreskin does not allow for it to be removed), is also used as an indicator for circumcision, even though some health professionals think that this condition is rare if the penis is not touched and that other solutions can be used to treat these rare cases. Circumcision can have health consequences, including haemorrhaging or even lead to death (CIRP, 2013).

Some NGOs, including “Droit au Corps” (Right to the Body), which brings together men who have had negative experiences with circumcision, condemns these practices on minors, who are not able to consent to the intervention. Their members believe that the lack of knowledge of anatomy and of the foreskin’s function in men’s sexuality and that of their partners is underestimated.

**“We believe that all forms of sexual mutilation on infants should end, whatever their gender and sex. Both excision and circumcision do not have any medical basis for intersex children. Cultural incoherence should be avoided for those who see the practice as a significant ritual, in particular as a rite of passage from child to adult”**

Member of the NGO Droit au Corps

The men in the NGO speak of painful and traumatising experiences of circumcision, whether it was carried for “medical” or religious reasons. Not opposing circumcisions carried out on adult men, could signal clear consent. Members of Droit au Corps testify to negative consequences on their sexuality and of less sensitivity of the penis following circumcision.





## "LAWS IN EUROPEAN COUNTRIES PROTECT ALL CHILDREN FROM GENITAL MUTILATION"

Another legal discrepancy arises between FGM and mutilation carried out on children born intersex. European countries have laws against female genital mutilation, supported by the position of the WHO.<sup>14</sup> Nevertheless, in the same states, intersex children may still be subjected to non-consensual surgical operations justified by so-called "sexual ambiguities".

The term "intersex" describes *"human beings whose biological sex cannot be classified as clearly male or female. An intersex person may have the biological attributes of both sexes or lack some of the biological attributes considered necessary to be defined as one or the other sex. Intersex is always congenital and can originate from genetic, chromosomal or hormonal variations. Environmental influences such as endocrine disruptors can also play a role in some intersex differences. The term is not applicable to situations where individuals deliberately alter their own anatomical characteristics"* (Organization Intersex International)<sup>15</sup>.

The general prevalence of intersex persons is estimated to be 1.7%<sup>16</sup>. This can include diversity in terms of anatomical sex (internal or external genital organs), the sex of the chromosomes or the sexual hormones.

In most European countries (and elsewhere in the world), when a child is born with genital organs considered to be ambiguous, doctors may carry out a series of tests (anatomical description, blood tests, urine tests) to "determine the sex" of the child. A sex reassignment operation is then carried out to align the chosen sex and the morphological sex of the child in at least 21 of the EU Member States (FRA, 2015). As the



baby is not in a position to give its consent, the parents are involved in the decision-making.<sup>17</sup> Critics note that parents often have very little understanding of what it means to be intersex beyond what they learn through the medical perspective. Under considerable stress and time pressure, they are faced with having to make a decision, without having been in touch with intersex organisations or intersex individuals. For other people, the intersex status may be determined at a later stage in life, during puberty or in adulthood.

Medical sex assignment generally requires a series of surgical interventions and hormone treatment, often for life. These interventions to “sexual normalisation”, known as Intersex Genital Mutilation, are condemned by intersex activists and researchers as most intersex people are in good health. These cosmetic interventions aim to make the child conform to sex and gender norms. The consequences are a sexual assignment which is often irreversible and can lead to sterility, pain and psychological suffering.

This is why the Organisation Intersex International Europe (OII Europe), which works for the rights of intersex people, calls for all hormonal and surgical interventions which are not vital to the survival of intersex children to be banned until they are old enough to give their clear consent. The EU Fundamental Rights Agency underlines that legal and medical professionals around the world must be trained on the rights of intersex people, in order to avoid “sexual normalisation” treatment on children not old enough to give their informed consent (FRA, 2015).

It is easy to see the parallels between the aim of “normalising” the sex/gender of intersex children and FGM practices as a rite of passage for a child to be considered a “woman” or a “man”. Mainstream opponents of FGM have been accused of cultural relativism, because they discount the rights of intersex people, concentrating solely on countries said to be developing. FGM in Africa and Asia is seen as misogynistic, whereas mutilation carried out in Western society is considered the result of “scientific medicine”. In reality, both FGM and mutilation carried out on intersex persons are linked to culture and are harmful practices aiming for gender conformity, whether consensual or not. There is a need for further analysis of laws in European countries which ban female genital mutilation in migrant communities, but which stays silent when it comes to interventions carried out on intersex children.



## CONCLUSION

This guide's objective was to break down several widespread ideas on FGM and to show that this practice has to be seen in a wider context of gender norms which persist in patriarchal societies.

In order for professionals to be able to tailor support to those affected, they must understand this practice, which is not contained to sub-Saharan Africa nor the preserve of Muslim communities.

The paper has tried to address misconceptions which stigmatise women and affected communities. The word “barbaric” is heard far too often when the subject of FGM is raised. In some communities, FGM has been practised for thousands of years, and is linked to very strong social norms. Therefore, women and girls who are not cut risk being rejected and stigmatised. In this context, subjecting your daughter to FGM can only be seen as a rational choice.

FGM is a form of gender-based violence, carried out on women simply because they are women. It is a result of a patriarchal society which guarantees that men hold primary power, to the detriment of women. It is therefore vital that men take responsibility in the fight against gender-based violence, including FGM. Due to a lack of communication between genders, in particular on sensitive issues such as FGM, awareness-raising is needed both for women and men.

Even though female genital mutilation has consequences on sexuality and on the mental and physical health of those affected, they must not be seen as passive “victims”, robbed of the power to act and denied sexual pleasure.

The clitoris was for a long time under-documented. A better knowledge of this organ allows us to understand that women who have undergone FGM, independently of the type of FGM they were subjected to, keep the majority of the organ dedicated to pleasure in their body. Reconstruction of the clitoris, sometimes hailed as a technique to “repair” women is possible for some, but is in no way to be considered a “miracle solution” nor obligatory. On the contrary, we call for a holistic approach, which includes not only medical support but also – and above all – social, sexual and psychological support for affected women.

We have seen that social norms weigh on women in all societies and are responsible not only for what is called female genital mutilation, but also for genital cosmetic surgery to which more and more women subject themselves in the name of body norms. This raises the question of how aesthetical interventions on women’s genitals can be justified, when the WHO defines female genital mutilation as all interventions practised for non-medical reasons and vehemently opposes medicalisation of FGM. Moreover, we have highlighted the critique against routine episiotomies during childbirth, prevalent in some hospitals in the ‘West’ even though research speaks against it.

Along the same line, the paper recommends further questioning and analysis of the laws which authorise hormonal and surgical interventions with no medical need on intersex children, unable to give their consent. These operations, much like FGM, aim to “normalise” the child so that they conform to gender norms. We also wish to invite NGOs and the public to reflect on circumcision, a practice which cannot be considered as “completely equal” nor “completely different” to FGM.

In conclusion, this guide has brought forward a critical and feminist analysis of various preconceived ideas linked to FGM. It has presented some issues to be reflected upon but does not give any pre-defined answers. It is up to each one of us, whether directly affected by FGM or not, to take the necessary steps to keep an open mind and not to hold on to false beliefs. We know that myths can have a negative impact on those directly affected by FGM, whether they are women who have undergone the practice, communities affected by it, a continent or a diaspora community linked to it. A better understanding of these issues is key for the work in favour of the abandonment of FGM and more generally for the human rights of all persons.

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# ACRONYMS

**CEMAViE** – Centre médical d'aide aux victimes de l'excision (Medical centre for care of victims of FGM)

**GAMS** – Groupe pour l'Abandon des Mutilations Sexuelles féminines (Group working for the abandonment of FGM, Belgium)

**FGM** – Female Genital Mutilation

**WHO** – World Health Organisation

**SC-MGF** – Stratégies Concertées de lutte contre les Mutilations Génitales Féminines (Concerted strategies on female genital mutilation, CS-FGM, a Belgian network for professionals and organisations involved in the work on prevention of FGM and protection of women and girls at risk)

**EU** – European Union

# GLOSSARY

This list is not exhaustive. Simplified definitions reflect their use in this guide.

**Clitoridectomy** – The removal of the whole or parts of the (external) clitoris and/or the prepuce of the clitoris (clitoral hood). Also known as Type I according to the WHO classification.

**Circumcision** – Removal of the whole or parts of the prepuce of the penis (foreskin)

**Defibulation / De-infibulation** – The practice of surgically cutting

open the sealed vaginal opening in a woman who has been infibulated

**Episiotomy** – A surgical incision of the perineum performed to widen the vaginal opening for the delivery of an infant, performed as the infant's head is crowning

**Female genital mutilation (FGM)** – The cutting or removal of some or all of the external female genitalia

**Gender** – Gender is a concept used in social sciences when referring to non-biological differences between men and women. Unlike sex, which refers to the biological differences between women and men, gender refers to the social, economic, political differences, etcetera. Gender is the object of studies in social sciences, Gender studies. The concept is used to demonstrate how inequalities between women and men are founded by social, cultural and economic factors.

**Hymenorrhaphy / Hymen reconstruction surgery** – a surgical aesthetical operation whose aim is to reconstruct the hymen in order to give the appearance of virginity.

**Hymen** – Membrane that surrounds or partially covers the external vaginal opening, separating the vulva from the vagina. The appearance of the hymen differs between individuals

**Myth** – A widely held but false belief or idea.

**Infibulation** – The removal of the inner and outer labia, and the suturing of the vulva, leaving a small hole for the passage of urine and menstrual fluid. Known as Type III female genital mutilation by the World Health Organization and as pharaonic circumcision in Africa.

**Intersex** – A person born with a combination of male and female biological characteristics, such as chromosomes or genitals, that can make doctors unable to assign their sex as distinctly male or female. Being intersex is a naturally occurring variation in humans, and isn't a medical problem.

**Nymphoplasty / Labioplasty** – Surgical interventions on the labia majora or minora of the vulva. Can involve the reduction or the increase of the size of the labia. Can also be used to repair the labia after a health problem or trauma.

**Patriarchy** – A system of society or government in which men hold the power and women are largely excluded from it. Most current societies are patriarchal meaning that men dominate the political sphere, the moral authority; social privilege and control of property

**Prevalence** – The specific proportion of a population found to be affected by a condition, at a specific time.

**Clitoral reconstruction of the clitoris** – A surgical technique aiming at creating a neo-clitoris by bringing the remains of the clitoris, under the scar tissue, to the surface.

**Gender-based violence** – All types of violence directed against a person because of that person's gender (including gender identity/expression) or as violence that affects persons of a specific gender disproportionately. Because of patriarchy, women and girls, of all ages and backgrounds, are most affected by gender-based violence. Therefore, the term “violence against women” is often used interchangeably. Gender based violence can be physical, sexual and/or psychological.

**Violence against women** – Understood as a violation of human rights and a form of discrimination against women and shall mean all acts of gender-based violence that result in, or are likely to result in, physical, sexual, psychological or economic harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life Female genital mutilation is a type of gender based violence against women.

# NOTES

1. These are studies carried out at national level with a representative sample of the population and repeated every 3 or 4 years, which provides an overview over several years.
2. Except for Bulgaria, Czech Republic and Luxembourg.
3. Available here: <https://www.coe.int/en/web/istanbul-convention/home>
4. Available here: <https://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:52013DC0833&from=EN>
5. See UNHCR, Too Much Pain Report, 2013 / 2014 / 2018.
6. See here: <https://eige.europa.eu/gender-based-violence/female-genital-mutilation>
7. "Medium level hypothesis" for 2016, Belgian prevalence study, Dubourg D. and Richard, F., 2018
8. See S. Johnsdotter and R. Mestre I Mestre, 2015, Female Genital Mutilation in Europe – An analysis of court cases, available here: <https://publications.europa.eu/en/publication-detail/-/publication/7ff7a7b-fc84-11e5-b713-01aa75ed71a1/language-en>
9. For more information on the indicators of risk, you can consult the flow chart and the risk scale: [www.strategiesconcertees-mgf.be/wp-content/uploads/MGF-tryptique\\_final\\_RTP.pdf](http://www.strategiesconcertees-mgf.be/wp-content/uploads/MGF-tryptique_final_RTP.pdf)
10. Medical pluridisciplinary center specialised in the care of women having undergone FGM, at the CHU St. Pierre hospital in Brussels, Belgium
11. While the term obstetrical and gynecological "violence" is preferred by some authors, to underline that the patient is a person in a vulnerable situation, the term "abuse" is used by others as it is seen as less violent for the professionals and a better way to sensitize them and incite them to care for their patients. Dechalotte, 2017
12. Today, some professional bodies recommend against the routine use of episiotomy. Nevertheless, studies have shown differences between hospitals and increasingly, between individual healthcare providers.
13. <http://theconversation.com/profiles/hannah-dahlen-6594> (Insérer ce lien pour la version en ligne do doc final, pas pour la version imprimée)
14. Currently, only Malta and, with certain nuances, Portugal prohibit harmful medical interventions on children born intersex. See ILGA Europe and OII Europe, 2018, Protecting Intersex People In Europe: A Toolkit For Law And Policymakers [https://oiiurope.org/wp-content/uploads/2019/05/Protecting\\_intersex\\_in\\_Europe\\_toolkit.pdf](https://oiiurope.org/wp-content/uploads/2019/05/Protecting_intersex_in_Europe_toolkit.pdf)
15. <https://oiiinternational.com/2533/welcome/>
16. <https://www.intersexequality.com/how-common-is-intersex-in-humans/>
17. Sometimes older persons who are unable to consent because of a mental or physical handicap are also subjected to these operations.

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