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Grassroots activists and movements against female genital mutilation and cutting bridged with political alliances: agency power and the potential to bring about change

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GRASSROOTS ACTIVISTS AND MOVEMENTS AGAINST FEMALE GENITAL MUTILATION AND CUTTING BRIDGED WITH POLITICAL ALLIANCES: AGENCY POWER AND THE POTENTIAL TO BRING ABOUT CHANGE

By

Aisha Kearney

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Grassroots Activists and Movements Against Female Genital Mutilation and Cutting

Bridged with Political Alliances: Agency, Power and the Potential to Bring About Change

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Grassroots Activists and Movements Against Female Genital Mutilation and Cutting Bridged with Political Alliances: Agency, Power and the Potential to Bring About Change

Abstract

In this thesis I highlight grassroots activists and social movements/mobilization against FGM/C throughout some of the regions where it’s concentrated, and consider the political alliances that have aided these activists and their movements towards declines in the prevalence of the practice. I consider the recent outlawing of the practice in the Gambia (last year) which was strongly motivated by grassroots activists originally from the Gambia and the transnational political alliances they were able to form. I examine activists and movements in Senegal, paying particular attention to the approach of NGO TOSTAN. I also highlight long standing histories of grassroots activism against FGM/C in Kenya, a country which has seen large scale declines in the practice over the last several decades. In addition to highlighting areas that are witnessing declines in FGM/C, I consider Somalia where FGM/C has not been outlawed, and declines are not evident but public outreach against FGM/C is being engaged in within a context of providing maternal, infant and child health care. I emphasize the agency indigenous or “native” women show in challenging “traditional” “cultural” practices they themselves were subjected to at a young (nonconsensual) age. I propose the need for continued political, social and (in some cases) religious support in their endeavors, alliances outside of individual agency to challenge dominant power structures and traditional sociocultural customs.

My research questions are 1) Is the prevalence of FGM/C based on these women being victims of patriarchal and patrilineal male power structures that need to be updated and modified, or are these women already exercising agency and power in perpetuating the continuation of this practice? 2) Are larger structural and power dynamics worth closer analysis, for example, can access to education, gainful employment, financial security outside of marriage and changes in property and inheritance laws, change the perceived necessity of the practice? 3) Are grassroots activists against the practice being ignored and silenced under the guise of maintaining the appearance of distinct cultural homogeneity and otherness from Western neocolonial powers? 4) How can women from and/or based in the West legitimately form alliances with grassroots activists and involve themselves in global issues of women’s human rights, and not come across as patronizing and ethnocentric? 5) What is the potential for declines and modifications of these practices once laws outlawing them are put in place? Using current data on laws against FGM/C, and the prevalence of FGM/C within certain sociocultural power dynamics, I emphasize the initiative grassroots activists and movements show in combating these practices and explore the potential for continued declines in prevalence, along with changes in attitudes towards women and their bodies that have justified its existence to date.
Introduction

In this thesis, in order to accurately portray the various activists I am highlighting, I use the terms they have come to embrace and use in their struggle against the perpetuation of various forms of culturally sanctioned female genital operations. The two terms embraced by these activists are Female Genital Mutilation and/or Female Genital Cutting, so those are the terms I utilize as well. FGM/C is a catch-all term for numerous forms of nonmedical surgical procedures mainly performed on prepubescent girls to remove, alter dramatically or reduce female genitalia.

An estimated 200 million women and girls alive today have been subjected to FGM/C (UNICEF 2016), concentrated in 29 African countries, and practiced to some extent in countries such as Yemen, Oman and Indonesia (Finke 2006:13). As many as 3 million girls undergo FGM/C each year (Finke 2006:13). Currently as many as 30 million girls are at risk of being cut before they turn 15 (UNICEF 2016). There are four major forms of FGM/C, with the most severe form being specifically termed infibulation and the least severe form being specifically termed clitoridectomy in medical literature. These various procedures are practiced in many different cultures, among various ethnic groups, but are most prevalent on the African continent throughout portions of East, Northeast, Central and West Africa,

FGM is practiced across a wide range of cultures and it is likely that the practice arose independently amongst different peoples, aided by Egyptian slave raids from Sudan for concubines and maids traded through the Red Sea to the Persian Gulf (Lightfoot-Klein 1983, Mackie 1996, from 28 Too Many Report 2015:12).

This quote alludes to the likelihood that FGM/C in Northeast Africa was historically carried out on women and girls in response to them being captured and enslaved from Sudan and brought to Egypt and the Middle East. There are reports that FGM/C may have been practiced to obtain higher prices for enslaved females from Somalia in the 1600’s and practiced in Egypt during the
1700’s to prevent pregnancy in enslaved females (by possibly reducing instances of rape) (28 Too Many Report 2015:12). While in regions of Northeast Africa, such as Somalia, Sudan and Djibouti, infibulation is the most common procedure, in many other cultures, in West Africa for instance, less extensive procedures of excision and clitoridectomy are more commonly performed. Before going further, I will explain what is entailed for the four major types of FGM/C recognized (classified by the World Health Organization).

The least extensive type of FGM/C is Type I, termed clitoridectomy in medical literature, and is the “only one that can be construed as analogous to male circumcision” (Shell-Duncan and Hernlund 2000:4). It involves the partial or whole removal of the clitoris, along with the clitoral prepuce. It is sometimes referred to as sunna circumcision, reflecting its association with being an Islamic practice, despite there being no actual reference to female circumcision in the Quran (which does ordain male circumcision as a health precaution). Type II is often referred to as excision and is thought to be the most commonly practiced form of FGM/C as it reportedly “constitutes up to 80% of all female genital mutilation practiced” (Dorkenoo 1999:88). It involves complete removal the clitoris, labia minora, and most or all of the labia majora. According to researchers Type I can grade into Type II so “attempts to differentiate the two types in survey research have proven to be difficult, and commonly the two become collapsed into a single category” (Shell-Duncan and Hernlund 2000:4).

The most radical form of the various procedures is Type III, known as infibulation, or pharaonic circumcision, thought to have ancient origins dating as far back as the time of Ancient Egypt, and later considered to be a practice of some ancient Romans reported to have fastened a “fibula, or clasp, through the labia majora to prevent women from having extramarital sex” (Dualeh 1982:10, from Shell-Duncan and Hernlund 2000:4). This form is said to be “widespread
in Somalia, northern Sudan and Djibouti”, but is reportedly practiced in some parts of Ethiopia, Eritrea, northern Kenya, and in small parts of Mali and northern Nigeria (Dorkenoo 1999:88). An estimated 20% of women and (more commonly) girls are subjected to this most severe form of FGM/C each year (Finke 2006:14). The later term suggests the origins of the practice are from Ancient Egypt, yet in Egypt the procedure is referred to as “Sudanese circumcision” (Shell-Duncan and Hernlund 2000:4). This “ancient” procedure involves the removal of the clitoris, labia minora, and most or all of the labia majora. The instruments used to perform this operation can vary,

Any sharp cutting instrument such as a knife, broken glass, razor blade will do, or the operator may have somehow acquired medical instruments like a scalpel, forceps or scissors. The instruments may be new or may have already been used for other purposes and/or on other persons. Sterilization is seldom known nor performed by these traditional operators (Edna Adan Maternity Hospital online 2016).

The cut edges are then stitched together to cover the urethra and vaginal opening, leaving a small opening the size of a matchstick for the passage of urine and menstrual blood. A small stick is often inserted to maintain the opening, and the legs of the girl are bound together for a week, supposedly to promote healing. During this time the prepubescent girl is unable to eat and has to lie on her side for the passage of urine.

The suture that remains after the procedure must be opened (de-infibulation) often with a knife or other sharp instrument for the act of intercourse once the girl is married and eventually for child birth, so that the woman or girl enters an endless cycle of being cut open (de-infibulation) and sewn back up (re-infibulation) for her entire sexual and reproductive life. Thus this procedure, most commonly performed without anesthesia on prepubescent girls, must repeatedly be amended throughout the course of their lives.
Type IV of FGM/C refers to various other forms of non-medical vaginal surgeries. In Sudan there is a variation known as matsawat or “intermediate circumcision” performed by a small minority of the population. It entails a similar amount of cutting as infibulation (Type III), but is followed by the stitching together of the anterior two-thirds (rather than all) of the outer labia, leaving a larger opening. This procedure is thought to have evolved as a compromise by those who carried out infibulation surgeries reacting to the 1946 ban on infibulation in Sudan (Shell-Duncan and Hernlund 2000:4-5).

Among certain ethnic groups in West Africa, including some Fulani and Mandinka, another modified form of infibulation, known as vaginal “sealing” is practiced, although not with the same frequency as other operations in the region. This version involves excision and the subsequent “sealing of the vagina, not by stitching but by allowing blood to coagulate to form what amounts to an artificial hymen” (Shell-Duncan and Hernlund 2000:5). Other variations of FGM/C include hymenectomy; zur-zur cuts of the cervix and gishiri cuts, which involve the cutting of the vaginal wall. Justifications for these so called hymenctomies include to “remedy obstructed labor” and to “facilitate sexual penetration in communities where child marriage is widely practiced” (Harvard Law Review 1993:1947, from Shell-Duncan and Hernlund 2000:5).

In addition to the mentioned practices, there are reports of “symbolic circumcision”, which can involve “nicking the clitoris with a sharp instrument to cause bleeding but no permanent alteration of the external genitalia” (Shell-Duncan and Hernlund 2000:5). “Symbolic circumcision” is said to occur to some extent in Indonesia and Malaysia, as well as in various other regions of the world including Africa and the Middle East.
There are various reasons or justifications given for the various surgeries. They can range from aesthetic and proposed health or hygienic reasons to supposed religious and/or cultural traditions which equate female circumcision (Type I, clitoridectomy) with being analogous to male circumcision. Other often cited justifications, especially for infibulation (Type III) and vaginal “sealing” is that it’s an act of “purification” necessary to assure girls maintain their virginity and desirability for marriage, promote chastity and “control” a female’s sex drive.

It has been noted by Gerry Mackie that “A group may perform it at infancy, before puberty, at puberty, with or without initiation rites, upon contracting marriage, in the seventh month of the first pregnancy, after the birth of the first child” (Duncan and Hernlund 2000:3). Although the regions and cultures where FGM/C is prevalent vary, these operations tend to be practiced within cultures with patriarchal and patrilineal structures. While the age of these operations range, they are most commonly performed on prepubescent girls. These various practices also tend to be viewed as a painful “rite of passage” a girl must bravely undergo if she is to become a woman and withstand the pain of childbirth, considered an important duty and affirmation of womanhood. A number of ethnic groups believe that the clitoris is a “dangerous” male part of the body that must be removed,

They believe, for instance, that during birth the baby will die if it touches the mother’s clitoris. Thus the circumcisers are proud to do their (religious) duty and join in the process of increasing the girl’s eligibility for marriage (and raising the bride price) (Finke 2006:13). FGM/C is often closely linked to a woman or girl’s marriaigability, and a family’s ability to secure bride-wealth (also called bride price). Girls that have undergone these operations are commonly viewed as having become women and deemed eligible or “fit” for marriage and subsequent childbearing expectations.

**Rejection of Universalist versus Cultural Relativist Debate**
The just mentioned procedures under the umbrella of FGM/C have been hotly debated internationally for several decades. Anthropologists have long studied cultures where FGM/C is practiced. Some have criticized those who have promoted the eradication of all forms of the procedure. Such criticisms include that those against the practice come from Western society and fail to adopt an emic or insider perspective; that they are from neocolonial nation states, and inherently or willfully lacking the cultural perspective, context and sensitivity needed to understand or appreciate why the practice continues to exist (Ahmadu 1995:45, Breitung 1996:66, from Shell-Duncan and Hernlund 2000:2,26, Boddy in Hernlund and Shell-Duncan 2007, Ahmadu 2015). Criticisms may also maintain that these various academics, politicians, legal scholars, women and human rights activists, among others, do not have a right to tell people how to live, what to do with their bodies, or their children’s bodies for that matter and that people affected by this practice should “argue this one out for themselves” (Schepker-Hughes 1991:26, from Shell-Duncan and Hernlund 2000:2).

Ellen Gruenbaum has argued that other issues of economic development are more pertinent and that FGM/C has served as a “smokescreen” or distraction from them (Greenbaum 1982, from Gruenbaum 1996:456). She has also argued for the cultural and historical context of FGM/C in Sudan to be considered (Gruenbaum 1996, 2001), but has more recently wrote an article focusing on activism against FGM/C in which she advocates for culturally sensitive and contextualized engagement with local grassroots activists (Gruenbaum 2005), as well as another article stressing that the socio-cultural dynamics involved in the perpetuation of FGM/C be well understood if the practice is to be effectively challenged (Gruenbaum 2005). I agree with Gruenbaum’s more recent analysis based off of her ethnographic studies in Sudan and engagement with activists, as well as UNICEF (UNICEF 2013).
I consider issues of development in tandem with challenging practices of FGM/C, using the arguments of activists themselves, and factoring larger power dynamics that not only perpetuate practices of FGM/C, but more broadly enable the second class status of women and girls. I consider how FGM/C is interrelated to a lack of opportunities for women and girls and how a lack of opportunities is a major impediment to development across Africa. Although I foreground the perspectives and methods of activists and movements against FGM/C, I also analyze larger power dynamics which activists and women and girls in general, must overcome. I recognize a need to present this point of view of the practice and the interrelated power dynamics involved because of a reintroduction of cultural relativists arguments, and counterproductive debates between relativist and universalist stances. There has been a reluctance to continue to support anti-FGM/C movements, sometimes because of relativist viewpoints, but also because of concerns over funding such movements.

Africa is not the only place where cultural relativist positions have made anthropologists reluctant to engage “foreign” and grassroots movements for women’s rights due to combination of reasons, notably including a fear of appearing patronizing and ethnocentric. A similar reluctance can be found in Latin and Mesoamerica and other regions throughout the world. Activist anthropologist Shannon Speed makes note of this reluctance to engage women’s rights campaigns and movements in Mexico, but further points out that (indigenous) women from within Mexico are capable of having their own frameworks, arguments and motivations for campaigning for their rights, whether they appear to share similarities with what’s considered more “Western” notions of individual rights or whether they are driven by an emphasis on collective rights,
But indigenous women, rather than accepting the designation of individual rights-bearer in need of protection… against the illiberal collective, have instead constructed a distinct position…which articulates both the collective and the individual aspects of their experience into their social struggle on various terrains…Drawing in part on the arguments of indigenous women...some recent writings have argued that culture is continually changing and that indigenous groups are capable of both defending their culture and transforming it from within (toward better gender equality). This position rejects the dichotomy between relativism and women’s rights and interrogates the definition of culture that underlies both the relativism and universalism stances [Speed 2008:125].

I see this rejection of both relativist and universalist positions translatable and already evident in African women’s positions and struggles for women’s human rights, as well as their strategic engagement with political alliances which may be transnationally based or from within their local communities.

FGM/C is a controversial and politicized topic that frankly is impossible to ignore. Beyond hearing about it in the news media (sometimes sensationally), it is a topic that is normally brought up in my studies, with articles and debates on the practices often being part of the curriculum. Debates on the topic have generally been between universalist and cultural relativist positions. As a student of anthropology, I have felt compelled to take a somewhat cultural relativist position, but still make my opposition to FGM/C on human rights, health and wellbeing grounds clear. I have no intention of avoiding the human rights of women and girls on the continent of Africa (on the issue of FGM/C or another), the birthplace of humankind, because it might appear ethnocentric and patronizing coming from someone in a Western country. I do not fit neatly into two opposing stereotypical dichotomies of a privileged Western white middle class woman ethnocentrically and patronizingly condemning FGM/C and the cultures where they are prevalent versus an underprivileged, black African woman complacent in her own ancient and perpetual cycles of oppression. As an African American woman, like many people, my cultural allegiances are complex. My perspective on this issue is also complex and rarely expressed.
Alice Walker, a celebrated and inspiring African American novelist has engaged this topic, but has been criticized for portraying FGM/C in a generic African culture, and thus not understanding or appreciating the cultural complexities and context involved in the various forms of the practices (Gruenbaum 1996:456). I seek to not only consider cultural context, but additionally the historical, economic and social contexts in which women and girls subjected to FGM/C live, elaborating on larger power dynamics within our increasingly transcultural and transnational world, where cultural is not static (and never has been), but fluid.

I grew up in NY where I’m from, but also grew up attending my father’s (an Imam) Mosque (Masjid) with “sisters” from many of the countries where FGM/C is commonly practiced. I’ve had friendships with girls, boys, women and men from these exotically viewed places. My fiancé is from the Gambia. My older sister’s husband is from Mali. I don’t consider people I’ve grown up with (around) to be study subjects from exotic or distant places. I view them as people living in a globalizing, transnational and transcultural world, trying to survive, shaping fluid identities while retaining some form of cultural and national ties to their various homelands.

I am against practices of FGM/C, but understand the cultural sensitivity, respect and patience needed in enabling women (and girls) to define themselves and work towards their own notions of human rights (just as is done on various other human rights issues). It is in the spirit of activists and social movements for women’s reproductive, health and human rights, which inevitably include social mobilization against FGM/C that I write this analysis. It is also in the spirit and tradition of activist anthropologists and their commitment to social movements in various regions of the world that I position myself. Changing practices that are portrayed as cultural hallmarks in the countries where they are practiced and in the West, is not easy, especially after recent eras of Western colonialism and neocolonial relations that persist. It is my
belief that women, whether they call themselves feminists or not, should support the plight of women globally by showing solidarity with other women in a universal plight for women’s human rights and the condition of womanhood. Realizing that not all concepts of women’s rights or even human rights are universally the same, I prefer to focus on what can be agreed upon and understood between the various modern cultures.

There is a need for women to be able to make decisions for themselves, and that is why in this paper I emphasize grassroots activists, social mobilization and movements against FGM/C and the systemic and communal power structures they must overcome to bring about a sustained decline in the practice. From an anthropological point of view, I acknowledge the legitimacy of movements against what has been considered a “harmful traditional practice”, having the initiative and support of women from within the cultures where it takes place. I am highlighting some of the many grassroots movements and additionally pointing out the lack of access to education, literacy, gainful employment, financial security and ultimately power, women and girls disproportionately face in many of the cultures where these practices are prevalent.

The Gambia

FGM has no health benefits yet has serious, immediate and long-term physical and psychological health consequences, which can be severe, including post-traumatic stress disorder, depression, anxiety and reduced desire or sexual satisfaction. Babies born to women who have experienced FGM suffer higher rates of neonatal death, and mothers can experience obstetric complications and fistula. In The Gambia, there is strong in-country evidence of medical complications caused directly by FGM [28 Too Many Report 2015:5].

Nobody can do it here, except the ngangsimba…There is a female dispenser who actually circumcised girls and I went there and told them “Look, this is a customary practice”…female circumcision should be secretive. It is exclusively the area of the ngangsimbas’ –Elder Mandinka Man (Shell-Duncan et al. 2010, from 28 Too Many Report 2015:31).

Ngangsimba is a Mandinka word referring to the female head of the women’s community in Mandinka villages. Ngangsimbas hold significant authority and there have been instances
where they have limited discussion in communities around FGM. Ngangsinbas are responsible for performing FGM. (Loveday 2010, from 28 Too Many Report 2015:31).

In the Gambia FGM/C has traditionally been carried out on girls in a context of initiation rituals that teach and socially condition girls to withstand pain, preferably in silence during the ritual and later in life as dutiful and obedient wives. The pain girls are socially conditioned to withstand in such initiation rituals may include activities that range from painful hair braiding to FGM/C. Among the Mandinka (the most prevalent ethnic group within Gambia) the three main virtues of female behavior valued in society and traditionally indoctrinated during initiation rights (nyaaka) are respect (horomo), secrecy (suture), and endurance (sabati) (28 Too Many Report 2015: 22). Pain is to be accepted in silence, without complaint. This brave but subjugated acceptance of pain, lived in secrecy, carried in silence with endurance and strength, may include FGM/C and other forms of violence against women and girls, as will be explored ahead.

FGM/C Is Banned in Gambia

At the recent Youth Summit, 100 young activists were taught by a leading Islamic scholar, Hama Jaiteh, that FGM is not an Islamic practice and were encouraged to spread the word in their communities. They were told that Islam was being used to ‘shield an evil intention [that is] harmful to a person’s development’. Young women stood up and urged others not to be afraid to challenge practices such as FGM. This summit has been followed in January 2015 with the launch of a media campaign, supported by The Girl Generation. The aim of the campaign is to raise awareness of the effects of FGM and influence those with authority to help end FGM [28 Too Many Report 2015:6].

On November 23, 2015, Gambian President Yahya Jammeh made the step of banning FGM/C after years of defending it as a traditional cultural practice. He pointed out the health consequences that can occur with the practice, that it was not a practice that originates in Islam (Jammeh has also recently renamed the Gambia, The Islamic Republic of Gambia), and said that it had no place in the 21st century. What accounts for this apparent change in opinion? FGM/C is widespread in Gambia. In The Gambia, an estimated 75% of women and girls age 15-49 have
been subjected to it with 12% being subjected to “vaginal sealing”, a localized version of infibulation (Type III) and 99% having the operation done by “traditional practitioners”, not a healthcare professional (UNICEF 2016). Of those, more than half (55%) underwent the operation before the age of 5 (UNICEF 2016).

I’m not assuming president Jammeh did not have a change of heart and opinion on the matter, but I am going to acknowledge the influence and pressure grassroots activists who campaigned against the practice within Gambia had (long term President Jammeh is also up for re-election as I submit this thesis; the opposition includes anti-FGM/C activist and Executive Director of NGO GAMCOTRAP, Dr. Isatou Touray). Young women challenged the cultural and social status quo and brought other young Gambians together to learn social media and campaigning skills. Young women were able to join forces with transnational organizations and agencies, network through social media and gain international attention to what they identified as a culturally sanctioned, but harmful and debilitating practice they had experienced and wanted to see eradicated for future generations.

**Fahma Mohammed, Jaha Dukareh, Isatou Jeng, Dr. Isatou Touray**

In February of 2014, a Gambian youth movement joined a Guardian led *Global Multimedia Campaign To End FGM*, when 17 year old Fahma Mohammed led international campaigns against the practice and urged the former UK education secretary, Michael Gove to write all schools in Britain warning that girls attending schools there, born to families from the main 29 FGM/C practicing countries were at risk (UNICEF now estimates there are 30 main FGM/C practicing countries, UNICEF 2016 ). Mohammed started a petition on Change.org which led to
more than 250,000 signatures in its first 21 days, and is publicly backed by UN Secretary General, Ban Ki-moon. Gove met with Mohammed and agreed to write to all schools.

This campaign inspired Jaha Dukareh, at the time residing in the US, but originally from the Gambia, to start a similar petition also on Change.org, calling for a new prevalence study into FGM/C. Dukureh then met with government officials in Washington D.C. to advise what steps to take next, before deciding on returning to the Gambia to launch her Guardian backed Global Media Campaign as part of a new generation of youth who want to end the practice. After joining forces with the Guardian based in the USA, as well as the United Nations and returning to the Gambia after 10 years in the United States in 2014 to lead a campaign among Gambian youth and young women age 15-25, Dukureh finally received a phone call from President Jammeh in November of 2015, 10 minutes before he made the announcement to make FGM/C illegal. It was a surprise for her after years of campaigning.

She’d led a campaign empowering youth, with events like *The Generation That Will End FGM*, co-funded by The Guardian and Equality Now in Banjul, for a series of workshops that discussed openly the health impacts of FGM/C, which reportedly can include infections, hemorrhage, infertility, the spread of H.I.V. (by the spread of blood from one person to another when using unsterilized cutting instruments on multiple persons) and complications during childbirth, including mother and infant death. Her workshops also provided information on how to start a social media campaign. Dukerah explains her focus on reaching the youth, who make up 60% of the population,

The focus on youth is because they are the future parents and they have a better chance at ending FGM in a generation,…We want them to know that the strongest tool they have is their own voices. We want them to come out of the conference believing they can actually change FGM within a generation (The Guardian 2014).
As someone of the Fulani ethnic group, Dukureh knows all too well how it feels to not have a say in what happens to her own body. As a young girl she was subjected to the most severe form of the procedure practiced in the Gambia, a localized version of infibulation or vaginal “sealing”.

Now with her initiative and advisement, Guardian backed media campaigns including radio campaigns (for people who do not have access to other forms of media), have been launched to get the message out to people in all corners of the country, from rural villages to urban cities. In addition to Gambia, The Guardian backed Global Media Campaign has been utilized in many other countries where FGM/C is practiced, working with grassroots activists in countries like Kenya, Nigeria, Sierra Leone and Uganda, in an effort to break the silence on the harm this traditional practice causes for the millions of women and girls living with it.

Isatou Jeng is another survivor turned activist against FGM/C from Gambia and organizing from within Gambia. Like many of the Gambian women I encountered on my trip there (who proudly wore traditional attire in contrast with the Gambian men who often opted for more Western imported clothing and associations), Jeng is very proud of her Gambian, and by extension her “African” heritage. She is always looking for ways to embrace her heritage.

I was born and raised in Africa, so both culture and tradition are dear to my heart. I’ve always taken pride in admiring the rich cultural wealth that expands the continent and have found endless excuses to celebrate my own African identity. However, I do not believe all we rejoice in is worth celebrating. Female genital mutilation/cutting (FGM/C) is a long standing tradition that continues to violate the reproductive health and sexual rights of women and girls throughout Africa and worldwide [Isatou Jeng 2016]. Although Jeng is proud of her heritage (and of course she should be), there are some aspects of her culture which she no longer wishes to embrace. FGM/C and the effects of it can be considered a “cultural” or “traditional” aspect of her culture that she is against and actively campaigns against, mobilizing others in her community and beyond.
Jeng like many other former girls, had no say in the decision process surrounding her operation. Her operation was carried out on her while she was a six month old baby. When she asks her mother about why the operation was carried out, her mother often refers to a local saying “to cleanse you in order to be accepted in society and to protect your virginity” (Isatou Jeng 2016). Jeng loves her mother, has forgiven her and believes her mother was attempting to look out for her best interests when she allowed her daughter to be cut, but this “justification” as well as religious ones are unsettling to her, “What unsettles me most is that she uses religion to justify the practice. To this day I struggle to comprehend her argument because I believe that God created us to be perfect” (Isatou Jeng 2016).

I wish I was Solima

The term solima in Gambia is a traditional term used to refer to an uncut woman. It often holds “extremely offensive connotations”, but Jeng actually uses it as a campaign slogan in an “attempt to make people think about the true meaning of the word.” Jeng has been persistent and relentless in speaking out against FGM/C whether around her mother and immediate family or among wider audiences.

From a young age I was persistent in voicing my views against the practice, making it clear to my family that campaigning to end FGM/C is what I am destined to pursue with the utmost commitment and dedication. As always, it was my mother who stood strong by my side encouraging my work to promote and protect the human rights of women and girls. Her unwavering support has not always come easy, over the years she has struggled to witness the new generation of girls, especially those in her bloodline, remain uncut, but she has supported their statuses and soothed their cries at being called solima [Isatou Jeng 2016].

Jeng understands that in order to begin to eradicate FGM/C, engaging and respectful dialogue is needed between mothers and daughters, school boys and girls, religious and community leaders, village elders and the youth, grandparents and parents, brides and grooms.
I am attempting to demystify the misconceptions surrounding FGM/C, but witnessing your community hold onto a tradition you have worked so hard to diffuse can be a serious setback. It is important to remember that this is a challenging journey, but I am always optimistic that the future looks bright. Every 6th February we celebrate Zero Tolerance Day to end FGM/C which measures our universal progress in ending the practice, highlighting what still needs to be done [Isatou Jeng 2016].

Although this December upon us will mark a year since FGM/C was banned in Gambia (December 2015), the practice is far from being eliminated there, and that is the case in many of the countries where laws against FGM/C are on the books. Jeng knows well the opposition against such laws and campaigns like hers.

Just days after the law’s enactment devastating news of girls being cut in community backyards made my heart heavy. However we cannot let this news defeat us; it only makes us stronger and more committed to our global goal of ending FGM/C worldwide. In order to end the practice we need collective commitment from all stakeholders to help people understand the negative consequences of the practice and that FGM/C can never be justified [Isatou Jeng 2016].

The Impact of GAMCOTRAP and Activists

When people are informed and empowered they demand their rights and take informed decisions guided by knowledge and belief that the best interest of the child, [and the] health and wellbeing of women is paramount (Dr Isatou Touray, Activist and Executive Director of GAMCOTRAP, from 28 Too Many Report 2015:7).

What I know today, if I had known that before, I would never have circumcised any woman. We have caused lots of suffering to our women…what I know today, if my grandparents knew that, they would not have circumcised anyone. Ignorance was the problem- Aja Babung Sidibeh, former FGM/C practitioner or “cutter” (28 Too Many Report 2015:5).

The Gambia Committee on Traditional Practices Affecting the Health of Women and Children (GAMCOTRAP) operates as a Non-Governmental Organization (NGO) co-founded and directed by Gambian activist Dr. Isatou Touray and based in the Gambia. This NGO has engaged women and girls there on issues of health and women’s rights conducting “Dropping the Knife” ceremonies since 2007. These ceremonies along with engaging in productive dialogue with communities feature dozens of former “cutters” or FGM/C practitioners vowing to abandon
the practice. It has been reported that 564 communities in the Upper, Central and Lower River Regions have participated in these “Dropping the Knife” ceremonies. Due to the recent work of activists, their campaigns and social movements, along with NGO’s and other actors against FGM/C, the prevalence is reported to have dropped from 78.6% in 2005/2006 to current estimates at 74.9% (28 Too Many Report 2015:7,10). It is quite feasible that with the continuation of these credible and inspiring movements and campaigns, along with the current outlawing of the practices by President Jammeh as of December of 2015, last year, that FGM/C will continue to be abandoned in community after community.

The Sentiment Feels Personal

As much as this topic might seem to be abstract for someone such as myself who was not subjected to FGM/C and has not done ethnographic studies in any of the countries where it is prevalent, it still manages to be somewhat more personal for me, as I have travelled to the Gambia. I did not travel to Gambia as a student observer of the practice, but as an African American woman with a fiancé from there, as well as a mother of a daughter. My decision to travel there was not only influenced by my interests in meeting my fiancé’s family, but was also motivated by an interests in the African Diaspora I am a part of (not the current one), who wanted to see one of the places on the motherland where enslaved Africans were captured and forcibly brought to the Americas during the trans-Atlantic slave trade.

I appreciated my short trip there (two week plane ticket), meeting my fiancé’s mother in the village, whom I addressed as “mom” (his father had passed away years prior), as well as other family and friends. I enjoyed seeing various sites in Serrekunda, such as markets, the police station (where a friend of my fiancé’s worked), Mosques, restaurants, the spirit and sense of
community among the people, as well as the beach and club scene in Senegambia where European women and men tourists frequented, often looking for exotic sexual encounters with local young men and women (although male prostitutes appeared to be more numerous and socially accepted than females). Young men in particular sought to please European tourist women sexually based on their ability to pay them. My fiancé told me that the young African women at the clubs were Nigerian because Gambian women did not go to clubs, as if it wasn’t part of the behavior of a proper Gambian lady, which struck me as somewhat odd, but I usually didn’t go to clubs either (and only went once during my trip). I tried to convince myself that maybe they likewise just didn’t want to go to clubs, but the difference between the standards of expected “behavior” of native Gambian women and European women with money and resources (including the ability to freely traverse and tour the world) remained striking.

I enjoyed going to Banjul, seeing the picturesque Mosques and a Church, and viewing president Jammeh’s home (from outside the gates, with a careful distance from a few armed guards). Men and women often approached me speaking various African languages. When I was addressed in English they called my sister, and I appreciated that. Yet I became disturbed when I went to a museum and saw an exhibit about the practice of FGM/C or “circumcision”. It said the practice was traditional for a majority of the ethnic groups in Gambia (including the Mandinka, the majority ethnic group to which my fiancé belongs) before a girl could be married to her fiancé. A beaded necklace the young bride was traditionally given for her wedding was displayed and my fiancé (who had asked for his mother’s blessing in seeking to marry me) smiled, and proudly told me how a young woman would be bestowed with such a fine necklace, but failed to mention the practice of FGM/C being described. Near the beaded necklace was a “devil mask” the person performing the surgery was supposed to wear to scare away evil spirits
and apparently frighten the young female, as it frightened me. My fiancé seemed oblivious, but I found the exhibit disturbing.

Although it certainly wasn’t my first time hearing about FGM/C, I hadn’t realized how prevalent the practices remained throughout Africa (namely in the country I was visiting). Later after we left, I asked him about the practice, and could sense I was touching on a subject that was rarely casually discussed, but we’ve had a number of conversations about it since then. They’ve gone from him initially seeming not to know what I was asking about, to him saying he knew what I was referring to but that it was a cultural practice he was not familiar with because it’s a woman’s matter, to him saying he disagrees with the practice and that it is not actually an Islamic practice (he is Muslim).

I became aware during my trip to the Gambia that I was among a minority of women there who had not been subjected to FGM/C; that it was forced upon young women and (more commonly) girls and that it was often a prerequisite for marriage. These marriage pre-requisites, carried out to “control”, “subdue” or prevent the full development of a women’s sexual functioning, can and do give “the impression that women are owned chattel who should only be used for male satisfaction and whose own personal pleasure does not matter” (Daffeh et al. 1999:25, from Hernlund and Shell-Duncan 2007:31).

**Senegal**

The rationale for the TOSTAN strategy as a model for changing behavior concerning FGM/C has been explained by reference to social convention theory. Briefly, this theory suggests that FGM/C is considered to be such an integral part of the social expectations of appropriate parental behavior in preparing girls for adulthood and marriage, that not practicing it is perceived as bringing more harm than benefit to a family, even when parents know that the practice is harmful physically and psychologically. The stigmatization, social isolation, and difficulty in finding marriage partners for uncut daughters can be powerful reasons for families to continue to conform to this custom. The TOSTAN approach which includes
education, community dialogue and debate, and public declaration, enabled several families to question and decline to participate in this social convention [Diop and Askew 2009:309].

Some men from all villages except one dropped out of the program; indeed in one village, all nine men who had said they would participate did not. According to an informant in this village, “the people thought the program was coming to fight against the traditional culture that had come down from their forefathers and especially to fight against the principles of Islam and the purification of the woman [Diop and Askew 2009:312].

There have been many grassroots activists and movements against FGM/C in Senegal. One notable activist from Senegal is Khadidiatou Ko’ita, formerly a victim of the practice who allowed three of her daughters to be subjected to it because it was expected as part of her “traditional” culture and social responsibility, but has since dedicated her life to banning it. She published a book called Blood Stains: A Child of Africa Reclaims Her Human Rights, which detailed the cycle of oppression she experienced in her life ever since being forced to undergo the practice at the age of 7 in order for her to be married off “pure” at an age when “other girls enter the 6th grade” (Khadidiatou Koïta 2012:19). For many former young girls like Ko’ita, the cycle of oppression does not end with their early experience of FGM/C, it may be followed by adolescent marriage to a polygamous husband who controls the family’s finances, a husband with the right to physically beat and have sex with his young wife when he chooses.

For many women subjected to FGM/C, their so called sexual satisfaction is supposed to be tied to their husbands’ ability to reach orgasm, not theirs. I am not here to vouch for every woman’s sexual experience, or to debate the purpose of the clitoris (most medical professionals identify it as being central to a woman’s main erogenous zone and important, if not essential for reaching orgasm). What I don’t think there’s any mystery or reasonable debate over is the fact that there is an expectation that sexual intercourse for an infibulated woman (Type III and variations of Type IV such as vaginal “sealing”), who literally has to be cut open with a knife for
sex acts, is not expected to be pleasant or enjoyable, but painful for her. This sex act for her also must serve a purpose in that it must result in her becoming pregnant and bearing children for her husband’s patrilineage. Her family may receive bride-wealth money (or other valued currency such as cattle) and the girl is usually unable to finish grade school after being married off. It is common for girls to drop out of school, often illiterate, and unable to be gainfully employed outside of her husband’s control for the remainder of their lives.

Ko’ita herself dropped out of school after the 7th grade, but has overcome many odds and found success as a tailor, accountant and activist against FGM/C. She has campaigned to ban the practice in Senegal, and in Europe. It’s poignant examples of real women trying to balance allegiances to tradition, culture and social pressure with their desire to not allow their daughters to be cut, that makes me support approaching this issue from an educational, social and political framework rather than a legal one entirely focused on banning and criminalizing the practice.

The Approach of TOSTAN

In every social movement, people from within the local communities with an intimate understanding of how to approach these movements add crucial insight to anthropologists or other professionals often more abstract knowledge and approach. Even if an anthropologist has spent a great deal of time doing ethnographic research, local activists, indigenous to the region and affected by the practice (whether because of being subjected to it themselves, or knowing family and friends affected by it), would find greater appreciation in being incorporated in campaigns against it. It’s a matter of respect, but also practicality, as Senegalese activist and sociologist, Awa Thiam pointed out,

It is possible for us to work together; It’s clear that African women need to take the initiative, but Western women have the means to help us…our fight can’t be modeled on Western feminism, but solidarity with other women is essential (Awa Thiam 1978, from Spadacini and Nichols 1998:3).
With a commitment of incorporating the input of local and indigenous women, and being aware of the additional social hardships women face, a more practical approach can be used and to greater affect, as Molly Melching of Illinois found with her TOSTAN (meaning breakthrough in Wolof) NGO program in Senegal, founded in 1988. Initially she set out to address health care, education and employment concerns but incorporated an emphasis on empowerment and human rights. She found that local women were interested in discussing their views on FGM/C as an impediment to their health and overall wellbeing as well as a violation of their human rights. Melching found that being careful not to outright condemn the practice, but talk openly about the harmful health effects it can cause by engaging in open and supportive, culturally informed dialogue has been transformative.

TOSTAN first started operating within 20 villages in Kolda, a region in Senegal that comprises mostly of Soninke, Mandinka and Fulani ethnic groups, and thus differs from the majority Wolof ethnic group in Senegal. Throughout the country and particularly in this region, women and girls are at a strong disadvantage. For example only 23% of girls reach secondary school compared with 77% of boys; the average age of first marriage for females is 17 compared with 25 for males and one out of four females is married before the age of 15 (Diop and Askew 2009:308). The fertility rate in this region has consistently been high at 7 children born per woman, significantly higher than the overall country rate of 4.36 children born per woman (UNICEF 2016). The Maternal Mortality Rate (MMR) has also been much higher than the national average (Diop and Askew 2009:308).

Although the TOSTAN agenda was not specifically to combat FGM/C, dialogue on the topic became one of the aspects of empowering women and girls by discussing health, hygiene and human rights. In 1997 a historic event took place,
Declaration in Malicounda Bambara to end FGM/C. Village women who had participated in TOSTAN’s activities and had learned about human rights and the health consequences of FGM/C decided that they wanted to end the practice and initiated a series of public discussions to extend and reinforce acceptance of that goal throughout their villages; these discussions led to the Malicounda public declaration [TOSTAN 1999, from Diop and Askew 2009:308].

TOSTAN’s approach was inspired and informed by local traditions and knowledge, and put to use by actors and leaders within their villages and communities. Holistic and community based approaches to ending FGM/C utilized by TOSTAN include women and girls being encouraged to “adopt a friend/relative” (Ndeye Dikke’) to share information learned in class with, public discussions and social mobilization such as public FGM/C abandonment declarations (also known as “Dropping the Knife” ceremonies), theater and radio broadcasts (Diop and Askew 2009). With the agency “local” women have shown in seeking to abandon FGM/C within an NGO that has sought to empower women by educating, providing healthcare and hygiene workshops as well as human rights discussions in an open and culturally informed, relevant atmosphere in which local women and girls, and in some cases men, engaged with the broader community and publicly denounced FGM/C, FGM/C has been outlawed in Senegal since 1999. Women in thousands of villages across the country have vowed not to allow their daughters to be cut and continue to do so.

Today in Senegal around 25% of women and girls age 15-49 have been subjected to FGM/C with continued declines in prevalence (UNICEF 2016). Of those who practice it, some ethnic groups such as the Mandinka, Fulani, and Soninke are traditionally and culturally more attached to the practice than others, such as the Wolof who comprise a majority of the Senegalese population at 38.7% and the Serer, who make up 15% of the population (UNICEF 2016).

**Kenya: A Long History of Grassroots Activism**
Women fought and are fighting at the household level to control their fertility, their businesses, their mobility, the conditions of their marriages, and their crops. Most important, they have contested the terrain of their bodies and their labor by organizing collectively (Robertson 1996:617).

In an insightful article about the history of activism against FGM/C in Kenya, Claire Robertson not only details the long standing history of grassroots activism against the practice, she also points out the financial pressures women face to continue the practice. Rather than ignore or make light of larger structural conditions, Robertson takes into consideration the economic hardships women face as the result of colonialism, in addition to laws that don’t grant women the amount of property and inheritance men receive, despite women being the main agriculturalists who provide the bulk of the crops consumed in the country. Robertson takes issue with the lack of acknowledgement of the efforts of these grassroots activists, or a total lack of understanding of power dynamics people in the West often have concerning African women and girls, and the tendency to stereotype Kenyan and other African women as exotic others.

The hard work and solidarity of working-class central Kenyan women are exemplary survival strategies in the face of increasing hardship. They deserve the recognition, admiration, and sympathetic solidarity of other women on an egalitarian basis rather than a condescending reemphasis on "otherness" that paradoxically sacralizes the very "tradition" such women are intimately involved in changing. But in the furor over female genital mutilation (FGM), hard-won knowledge regarding cross-cultural understanding is being ignored or undermined in the United States by once again demonizing women in non-Western cultures, especially African women [Robertson 1996:615].

In Kenya, like in a number of other parts of Africa where FGM/C exists, people are often socially and politically organized into age groups. In order to pass from one age group to another, girls are expected to undergo FGM/C and boys are often also expected to undergo circumcision. Among the Kikuyu and Kamba ethnic groups in Kenya, these surgeries have traditionally been viewed as a necessary “rite of passage” youth undergo in order to be viewed as
a mature man or woman and join the brotherhood and sisterhood of fellow inducted who underwent the procedures at the same time.

Although among the Kikuyu and Kamba, girls generally were subjected to the procedure between the age of 10 and 15 (or the first appearance of breasts), while males underwent the procedure from age 16-18, it signified a passage from childhood into adulthood, as members of “opposite sexes” became accepted by society (Robertson 1996:621). People who have passed from one age group to another are more respected and yield more power. Although older men often yield more power than women, older women have been able to achieve elevated status by undergoing the required rites of passage as they age, so that older women who have undergone FGM/C, have married, produced and raised their own children, et cetera, had authority over younger women. Likewise older males who have been circumcised and acquired wives and their labor (women’s labor often serves the purposes and profits of males) had authority over younger males, whether they were related or not, in what can be considered a gerontocratic system. Traditionally village elders often formed councils which made many local decisions regarding what happens in the village, whether they complied with national laws or not.

The old form of Kikuyu women's organization centered around their age-sets (Kikuyu = mariika) and a solidarity induced by their common initiation ritual. Part of this ritual was genital mutilation in the form of clitoridectomy, which could vary from a minor nick to complete removal of the clitoris and some of the labia. Clitoridectomy was also part of Kamba female initiation rites, but their age-sets seem to have been somewhat less defined [Robertson 1996:620].

Although there are variations to this gerontocratic system, there are some commonalities across many cultures in Africa where FGM/C is practiced. The degree of power older women have compared to men also varies, but they almost universally have more power than younger women and girls. The result is that girls tend to have the least power, and are the most vulnerable
members of society. Although there may be benefits to this gerontocratic system in which elderly are treated as older and wiser and worthy of increased respect, this kind of organization appears to have a large role in the perpetuation of FGM/C, because the elderly can be reluctant to change and abandon tradition. Today many Kenyans are embracing a more democratic organization of equals, while still respecting their elders, which Robertson notes can be more empowering for younger generations and promote more democratic organization. “The shift from gerontocratic female organization to more democratic organizations of equals could serve as a model for breaking the hardening shell of oligarchy in contemporary Kenya” (Robertson 1996: 617).

Despite the common narrative that activists against FGM/C are entirely based in the West with no appreciation of other cultures or understanding of the exotic other, there have been grassroots activists against the practice in Kenya for at least the past century with movements against it being taken up notably, collectively by women’s labor rights groups.

From the 1920s to 1990 women's collective efforts moved from a more specific form of patriarchally sanctioned organization concerned with controlling sexuality and fertility to a more class-based women's solidarity involved with promoting women's economic activities, as part of an overall shift within Kenyan society linked to class formation (Robertson 1996: 617).

This practice, once associated with a designated girls rite of passage into womanhood, sisterhood and some relative gains in power, is increasingly being viewed as a rite of passage that controls and confines women in relation to men. Women in an effort to gain control over their labor have also found reason to gain control over their bodies.

Families have begun to place greater value in sending their daughters to school, rather than marrying them off to secure bride-wealth. As the capable women and girls that they are, they are
proving their inherent value as females in their families, families who no longer see marrying
their daughters off as the best ‘return on investment’ after raising them. Young girls are also
realizing their potential and the need for more opportunities for the betterment of their lives and
the potential of Kenya as a nation. A basic education means literacy, access to higher education,
access to jobs, access to travel, and being able to navigate oneself in the world. It means
knowing the law, and realizing that FGM/C has been banned and has been falsely promoted as
being part of the religion of Islam. It means being able to rebound after divorce in good health
and support oneself and one’s family. FGM/C is part of this broader picture of opportunity.

Central Kenyan women have been making increasingly successful efforts to stop FGM,
efforts emanating from changes within their cultures that amply illustrate strengths that U.S.
women might well emulate in seeking to better their own status. Moreover, some of these
changes are the result of processes such as class formation connected to the impoverishment
of much of the Kenyan population and so in some ways have ambivalent implications for the
status of working-class women [Robertson 1996:616].

Critics of campaigns against FGM/C based in the West usually point out cases of historical
opposition from Kenyan groups fighting colonial powers against what has been seen as Western
interventionist tactics and condemnation of indigenous cultures and traditional practices,
including FGM/C. I think some opposition is understandable, especially in the context of
resisting colonial and neocolonial domination. After all, formerly British colonists were coming
into Kenya and other African regions to exploit the resources and control the populations, all
while holding themselves as culturally, physically and morally superior. Western and
neocolonial nations have an undeniable and relatively recent history.

Despite attempts by activists such as Dorkenoo to portray it (FGM/C) as a global issue, as a
cultural norm, it is fundamentally an African phenomenon (Fitzpatrick 1994:542). Therefore
in the international human rights discourse, this issue seems to pit the West qua International
Community against Africa, a situation which, considering the continued economic
exploitation of the African continent and the history of missionaries' and colonialists' efforts
at eradicating female circumcision, readily leads to accusations of Western imperialism. As Rhoda E. Howard observes, “in the present world economic situation, in which many African economies continue to spiral downward, culture can be seen as the last bastion of national pride. When all else in gone, culture can be preserved” (1995:111) [Gosselin 2000:45].

A number of Kenyans and Africans in other countries have responded to what can be viewed as ethnocentric condemnation and intervention, by wanting to embrace “traditions” that can be viewed as distinct or opposed to Western ones. Unfortunately in a context of symbolically “resisting” colonial and neocolonial influence, practices of FGM/C may increase.

Despite FGM/C often being defended as an ancient, culturally sanctioned practice that certain homogenous African cultures (and/or countries) want to continue, women and girls often see themselves as benefitting from abandoning some “harmful traditional practices” (as is the phrase used in many grassroots movements against FGM/C) from the past and controlling not only their bodies, but their labor and wealth as Robertson notes.

Before colonialism the local Kikuyu and Kamba speaking peoples participated in a mixed economy of pastoralist (more goats than cows) and horticultural elements. Animals were used for bride-wealth in a system in which polygyny allowed men to maximize the amount of land cultivated by women for the men's patrilineages and, therefore, their wealth (Robertson 1996: 619).

In the West and around the world, women have and continue to fight for representation, for economic, civic, social and reproductive rights. This struggle is well known in Kenya. In reality the struggle for women’s rights and the status of womanhood faces particular challenges in Kenya (and other African countries where FGM/C is practiced) deriving from the recent era of colonialism, neocolonialism, as well as existent patriarchal and gerontocratic power structures. This reality makes supporting activists and building momentum against FGM/C and other issues that repress women and girls in Africa, all the more important.

**ECAW in Kenya Today**
Although activism has a long history in Kenya, today activism has become more visible, and has incorporated support from men and women alike. ECAW is a vital NGO in Kenya that combats FGM/C through community engagement and education. The important work this organization does can be found online at orchidproject.org. Men and women, young and elderly all work and volunteer for ECAW in numerous faculties, notably including as paralegals. They are often indigenous Kenyan’s who work for little or no pay to host community events and programs that discuss FGM/C openly and inform the communities of the harmful effects the operations can have. Often they find younger Kenyans are more receptive to ending the practice, while village elders may be more reluctant to change, but can still be engaged in productive dialogue. “Cutters” may actually use the money they earn performing FGM/C to pay village elderly, who in response remain loyal supporters of the practice of FGM/C (Orchid Project 2016). It’s economic power dynamics like these, in addition to culture and “tradition” that ECAW members understand, and are thus better equipped to challenge. ECAW, like many other grassroots organizations is made up of grassroots activists who work on the front lines to combat FGM/C year-round, involving themselves in girl’s empowerment programs, and often seeking out religious support from local respected pastors and imams.

The Impact of Movements and Activism in Kenya

Declines in Kenya (as well as nearby Tanzania) have been dramatic, dropping by as much as two-thirds over the past few decades (UNICEF 2016). Today around 21% of women and girls 15-49 have been subjected to FGM/C in Kenya, with continued declines in prevalence, and a decline among surveyed women and girls 15-49 who think the practice should continue (UNICEF 2016). In Kenya and Tanzania women aged 45-49 are three times more likely to have been cut than girls aged 15-19 (UNICEF 2013).
Infibulation and Edna Adan Ismail’s Health Based Movement Against It

Infibulation and reinfibulation after childbirth create and recreate virginity, which is highly prized in a bride. In recent years this custom has even spread as a result of women’s economic dependence on men and marriage (Robertson 1996:622).

Infibulation (Type III) is not the most common type of FGM/C practiced, but it is the most common in certain Northeast and Horn of Africa counties, such as Sudan, Somalia and Djibouti. In areas where infibulation is practiced, there tends to be an emphasis placed on women not being sexually active that is even stronger than in places where the less invasive operations are common, “A comment I have heard is that you can’t leave your girl open: it is like leaving the door to your house open when you sleep, for anyone to enter” (Edna Adan Ismail 2013).

Whereas men are accepted as sexually active beings, women are not. Rather they are expected to only be sexually responsive to the desires of their husband. Having a clitoris, which is seen as similar to having a penis (by the ability of both a clitoris and a penis to become erect in response to sexual pleasure), makes women too similar to men rather than opposite. A girl that undergoes infibulation is viewed as pure and marriageable: a true woman. Girls are expected to develop into women by being socially and physically conditioned to only have sex for the purposes of satisfying a husband’s sexual desire, becoming pregnant and bearing children. A study in Sudan noted this procedure is done not only to “render a girl marriageable”, but is seen as “a necessary condition of becoming a woman, of being enabled to use her one great gift, fertility” (Boddy 1982:683, from Shell-Duncan and Hernlund 2000:21).

Edna Adan Ismail (former foreign minister of Somaliland, a politically unrecognized part of Somalia) is among the most well known and internationally influential activist against infibulation. She has publicly explained her objection to the practice (and FGM/C in general) on health and religious grounds since 1976, including in the Half the Sky (2011) documentary.
Ismail underwent the procedure at the age of eight at the request of her mother and grandmother, and without her father’s (a medical doctor who was away traveling at the time) knowledge,

I believe that for my mother and for others it is seen as a way to purify the daughter...a kind of chastity belt...Women from the community are invited to witness the cutting...A sheep is slaughtered, and there is a day of celebration (Edna Adan Ismail 2013).

Although the community celebrated this event, it upset her father, and instilled in her a sense that it was unjust. Ismail grew up to become a trained nurse, midwife, and outspoken diplomat against FGM/C who returned to Hargeisa, Somaliland after fleeing during the civil war. She’d spent years working for women’s health, including getting FGM/C banned in Djibouti, before returning to open the Edna Adan Maternity and Teaching Hospital with her UN pension and international funds (Georgetown University online 2016).

Although infibulation has not been banned and continues to be almost universal in Somalia as a whole, at a prevalence rate of 98%, there is a greater willingness to discuss the topic openly, which is actually an encouraging development if you consider that this is a topic which is perpetuated impart because people have been unable or unwilling to discuss it. Reduction in maternal and infant mortality rates is also evident in Somalia as a whole and particularly in Somaliland, where Ismail’s maternity hospital is located. Her ability to speak and relate to the local community while also being an international diplomat who was able to acquire international funds and the support of people in the international community is an example of the ‘multiple hats’ activists sometimes have to wear.

The agency of Mrs. Ismail, along with her own resources and relative position of power within Somalia (as diplomat and medical professional) met with the international funds and support she’s received, have enabled her to build a maternity hospital, otherwise a far off goal in a region dealing with poverty, drought and instability. Her hospital works to reduce mortality
rates of women, infants and young children in tandem with informing the public of the harms of infibulation. She campaigns against FGM/C utilizing an online media presence with links to other websites, such as The Orchid Project. She is a mentor for the young women she trains at her hospital in an unrecognized part of Somalia, within a country that maintains among the strictest patriarchal laws and customs in the world. Despite many obstacles, she continues to be an inspiration and voice against FGM/C around the globe.

Many of the challenges Somalis as a whole face can be traced to recent eras of colonialism, the more recent civil war, instability, poverty and natural disasters like drought, but the practice of infibulation is an unnecessary and harmful procedure that greatly reduces a women’s quality of life, and even threatens her and her child’s chances of surviving childbirth. Infibulation is not only unnecessary, it is also painful, obstructive, debilitating and objectifying.

Although the ones who instigate the procedure being done are many and can include both a girl’s and her prospective suitor’s parents, as well as her prospective suitor, and others, the procedure is usually carried out by a traditional “cutter”, an older, often an elderly women who is paid to perform the operation. This “cutter” is usually able to acquire a relatively high paid salary, in some cases making more money than a trained nurse. It is easy to look at the fact that women are the main persons who carry out infibulations on young girls, and view women as the main instigators of the practice, and that may be the case in a number of situations. But this general assessment and conclusion is often reached by a number of observers who fail to consider the larger structural power dynamics or even the obvious fact that in a Muslim and socially conservative country, where men and women are often segregated, having a male perform such a surgery on females would be considered inappropriate, even taboo, just as
Traditional Birth Attendants (TBA) and midwives in Somalia and most other FGM/C practicing countries are also female, not male.

FGM/C like childbirth is considered a women’s matter that women must undergo, but often is in the directed interests of males. In Somalia, male’s authority over females is far reaching and includes total control over their bodies and reproductive rights, as well as control over the household income. Being a strict patriarchal and patrilineal society, Somali citizenship is only determined by the citizenship of the father (CIA World Fact Book 2016). Women seek the permission of males on most matters, which may range from working and going outside the home, to opting for a c-section during childbirth (Half the Sky 2012), often a recommended procedure when vaginal delivery is blocked due to the practice of infibulation, leaving a scarred, sealed and less elastic vaginal opening. It is the men who expect to marry an infibulated virgin, who through the course of the marriage decide when there will be sexual intercourse. Their authority over their wives is given further weight by local religious customs and interpretations of Islam (although FGM/C is not an Islamic practice and it is not confined to those that identify themselves as Muslim), as well as the relatives of the groom and the bride, with the brides relatives often being paid bride-wealth monies for allowing their daughter to marry.

This most extreme version of FGM/C, dominant in Somalia, entails a lifelong cycle of pain and objectification, starting from being forcibly infibulated without anesthesia as a prepubescent girl, to being taken out of school in order to be married off and become a capable bearer of children for a husband’s patrilineage, to potentially being divorced if determined unable to bear children, a matter complicated by having a sewn-up womb. Wives unable to bear children are likely to be divorced by their husbands. As harsh as this may sound, poverty, a lack of education
and opportunity exacerbate the disadvantages women and girls face, leaving them and their families dependent upon bride-wealth money and the mercy of a husband, or men general.

In sum, although women may appear to be perpetrators of FGM/C who may exercise relative forms of power by allowing FGM/C to be perpetrated against their daughters, may frown upon “unclean” women and girls and a minority may earn money as “cutters”, it is worthwhile to consider larger structures of power that repress women and girls and constrain their agency and potential opposition to FGM/C, especially considering the young age that the various operations most commonly take place and interrelated structural power dynamics that have yet to be addressed or even adequately acknowledged.

A Closer Analysis of Agency and Power

In all cultures, the shaping of the relationships among human beings and the establishment of socio-cultural norms is bound up with the exercise of power. The body is a symbol of reified power relationships, because the social connections within a society also find expression in corporeal images. Control over people’s bodies is thus, concomitantly, an expression of the social control being exercised within a society. FGM is best understood not as an isolated phenomenon but rather as the tip of the iceberg of asymmetrical gender relations [Finke 2006: 14].

In probably the most common usage “agency” can be virtually synonymous with the forms of power people have at their disposal, their ability to act on their own behalf, influence other people and events, and maintain some kind of control over their own lives…It is this-an agency of projects-that the less powerful seek to nourish and protect by creating or protecting sites, literally or metaphorically, “on the margins of power” [Ortner 2006:143-144].

The economic disparity and lack of opportunity women in particular face in the global South is interrelated to FGM/C and acceptance of repression and violence against women. There are various expressions of violence against women around the world, and Africa is not free from them. Africa is undoubtedly diverse. There are some matriarchal and matrilineal cultures and there are many patriarchal and patrilineal ones. Often there are both matriarchal and patriarchal or matrilineal and patrilineal cultures within the same nation state, and fluid variations exist as
well (as there are in the modern United States where families are now more bilineal instead of patrilineal). But what is found in the countries where FGM/C is historically and currently prevalent are pretty compelling data on adult female literacy rates compared to men, women and girls age of (first) marriage compared to men (women in FGM/C practicing countries are often married young in order to guarantee virginity and to polygamous husbands 10 or more years older according to UNICEF 2016), attitudes on violence against women, gainful employment opportunities for women compared to men, as well as property inheritance rates for women compared to men.

The patriarchal and patrilineal power structures that are dominant in the various FGM/C practicing countries, have the combined impact of marginalizing women and girls and making them dependent on men, their choices and their interests. The agency of women and girls is constrained and often viewed as a threat to male power.

**Literacy, Access to Public Education, and Gainful Employment**

Social factors including gender, ethnicity (“race”), and socioeconomic status may each play a role in rendering individuals and groups vulnerable to extreme human suffering. But in some settings these factors by themselves have limited explanatory power. Rather, simultaneous consideration of various social “axes” is imperative in efforts to discern a political economy of brutality…Amartya Sen reminds us of the need to move beyond “the cold” and often inarticulate statistics of low incomes” to look at the various ways in which agency---what he terms the “capabilities of each person”---is constrained [Farmer 2005:42-43].

If we look at the labor force participation rate in many FGM/C practicing countries by sex, the data is striking. In Somalia which currently has the highest rate of FGM/C in the world at 98% and has not been banned, data on the adult female labor force participation rate is 37.2%, compared with an adult male labor force participation rate of 75.5%, making adult males twice as likely to be gainfully employed as adult females (UN country profile: Somalia 2013). The primary-secondary school gross enrolment rate is 13.8 per 100 females and 25.8 per 100 males,
making boys around twice as likely to be enrolled in primary through secondary school as girls. Females are about half as likely to be enrolled in school as children, and are half as likely to be gainfully employed as adults (UN country profile: Somalia 2013). Meanwhile the child (age 5-14) labor (unpaid) rate is high, estimated at 49% (2016 CIA World Factbook 2006 est.).

Literacy rates and access to education are also challenges in many other FGM/C practicing countries, and many African countries in general. In Guinea, where the FGM/C rate is the second highest in the world at 97%, the overall adult literacy rate for the country is only 30.4%. For men it’s 38.1% and for women it’s 22.8%. Males spend ten years in school, while females spend 8 years (2016 CIA World Factbook 2014 est.). Only 11% of students in higher education are women and only 2-3% of women use birth control (Merry 2006:93). The average “woman” is married by the age of 16, and women are responsible for 80% of subsistence agricultural work, despite being less likely to be gainfully employed than men (Merry 2006:94). Although the overall rate of (gainful) employment is low, the child (age 5-14) labor (unpaid) rate is at 25% (2016 CIA World Factbook 2003 est.). In Mali, another country where the FGM/C rate is high at 89% (the 5th highest in the world), the adult literacy rate for the entire population is low at 38.7%, but especially lower for females. Whereas it’s 48.2% for men, it’s only 29.2% for women. Males spend 9 years in school while females spend 7 years. The child labor rate for Mali is 36% (2016 CIA World Factbook 2010 est.), but overall adult gainful employment is low.

Considering Gambia, Senegal and Kenya, where FGM/C rates are at about 75%, 25% and 21% respectively, there are also differences between adult males and females literacy rates and access to gainful employment. In Gambia, the current adult literacy rate is at just 55%, with 63.9% of men being literate and 47.6% of women being literate (2016 CIA World Factbook 2015 est.). Although in Gambia both males and females attend school for 9 years, that does not
necessarily mean they have equal attendance access on a day to day basis. The child labor rate in Gambia is 25% (2016 CIA World Factbook 2006 est.) but the overall adult gainful employment rate is low. In Senegal the overall literacy rate is just 57.7% with 69.7% of men being literate and just 46.6% of females being literate. Likewise in Senegal (as in Gambia), although both males and females attend school for the same time-span of 8 years, that does not necessarily mean they have equal access to school attendance on a day to day basis. The child labor rate is 22%. While adult and youth unemployment is high overall, youth 15-24 are more than twice as likely to be gainfully employed if they are male (2016 CIA World Factbook 2011 est.)

In Kenya, where the prevalence of FGM/C has fallen by two-thirds in the past several decades, literacy rates are relatively high for both adult males and females. Both male and female populations spend 11 years in primary through tertiary schooling (2016 CIA World Factbook 2009 est.). The overall adult literacy rate is 78%, with 81.1% of men being literate and 74.9% of women being literate (2016 CIA World Factbook 2015 est.).

In all FGM/C practicing countries, fertility rates range from a relative low average in Kenya of 3.14 children born per woman to 6.62 births per woman in Niger. The figure for Niger is actually the current highest in Africa and the world. Both countries have a relatively low prevalence rate of FGM/C of 21% and 2% respectively (UNICEF 2016). Four of the top five highest fertility rates in the world are in FGM/C practicing countries with Mali and Somalia (both countries with high FGM/C prevalence rates of 89% and 98% respectively) coming in at third and fourth place respectively (UNICEF 2016). In fact 28 of the 30 countries with the highest world fertility rates are all in Africa (including many FGM/C practicing countries). The only two non-African countries are Afghanistan and Timor-Leste, ranking at 10th and 15th place respectively (CIA World Factbook 2016 est.).
Economic Dynamics and the Feminization of Poverty

Another dimension of the power dynamics that women from FGM/C practicing countries face that is often overlooked, are the economic dynamics in which these women live. As was stated, in many FGM/C practicing countries and throughout African countries where FGM/C is not prevalent as well, there are cultural and historical customs of a groom’s family offering to pay bride-wealth in the form of a locally valued currency. In pastoral societies traditionally common in Kenya among the Kikuyu and Kamba, and among some Fulani in West Africa, this may take the form of cattle, while in a more agricultural society, such as the Mandinka in West Africa, this may take the form of harvest goods and/or money, just to name a few of the kinds of possible valued currency. In addition to her parents, a bride may also receive jewelry, sometimes in the form of a necklace. A bride’s parents would be offered such currency as a way of saying thanks for giving their blessing in their daughter’s marriage and in a number of cases to compensate for their daughters inability to care for her own parents and family because she would be expected to care for her groom, his parents and family after marriage.

Although this is not a criticism of a bride-wealth system versus a dowry system, one of the conditions of this bride-wealth system within a patriarchal culture/society is often that the bride is not only expected to serve the groom and his family, but also that her body (and all it can produce) is for all practical purposes rendered the property of her husband and his family, which in a traditional patrilineal society, would be considered her new family, and lineage would be traced from the groom to the male offspring their union produces. The wife is often expected to enter the marriage as a virgin (especially in cases where infibulation or vaginal sealing is practiced), is expected to submit to sex on her husband’s terms, is commonly expected to produce numerous children for her husband’s patrilineage, and is unable to initiate a divorce.
In countries where FGM/C is prevalent, women continue to face acute forms of poverty due to being located in the Global South, often in recent former European colonies, and dealing with neocolonial international relations (including structural adjustment programs, and multinational corporations based elsewhere) combined with local property and inheritance laws that may only allow for women and girls to receive half the inheritance men receive, if that. Justifications for women receiving less inheritance than men can be religious (In Islam women traditionally receive half the inheritance of men in many cases), social or regarded as more practical, considering women’s often marginalized status within and outside the home. A more in depth look and example of the economic disadvantages women face compared to men can be found in Pat Caplan’s ethnographic study of men and women’s economic and labor relations in Kenya, and the effect it has on raising boys and girls (1989).

In many FGM/C practicing countries, unequal property and inheritance rights reinforces the feminization of poverty and marginalization of women and girls. This feminization of poverty manifests itself in extreme forms among women and girls in many FGM/C practicing countries and among women throughout the Global South, including a majority of African countries.

Views on Wife Beating

The practice has been, for example, to ask whether women are more passive or use different language than men, rather than asking whether women are more often observed in relationships in which they are relatively powerless in structural terms and are responding strategically to that structural condition (Sprague 1997:93).

Although some Islamic states insist that women and men are not equal, it is nevertheless possible within this religious tradition to critique violence against women…Similarly, some conservative Christian groups in the United States emphasize the inequality of man and woman in marriage while stressing the duty of husbands to honor their wives (Merry 2006: 77).
When women and girls, as well as men and boys (all within the age of 15-49) were surveyed around the globe, a relatively high percentage of them in FGM/C practicing countries expressed views tolerant of violence against women in a range of circumstances. Respondents were asked if they believed a husband beating his wife is acceptable for at least one of the following, if the wife burns food, argues with him, goes out without telling him, neglects the children or refuses sexual relations.

In Gambia 33% of men responded that a husband was justified in beating his wife under such circumstances, with more rural and poor Gambian men answering yes than urban and wealthier Gambian men (41% rural vs. 28% urban and 43% poorest vs. 24% wealthiest). Gambian women answered yes at higher rates than men with 58% saying a husband is justified in beating a wife in such circumstances, including higher rates among rural and poorer Gambian women (73% rural vs. 47% urban and 69% poorest vs. 38% of wealthiest). In Senegal 27% of men answered yes to the same questions on accepting wife beating, again with significantly higher rates among rural (39%) and poorest men (46%) compared to urban (19%) and wealthiest (14%) men. Senegalese women answered at a rate of 57%, including higher rates among rural (70%) and poorest (82%) women compared with urban (46%) and wealthiest (39%) women.

In Kenya, 44% of men answered yes with modestly higher rates among rural (47%) and poorest (54%) men vs. urban (36%) and wealthiest (36%) men. Kenyan women answered yes at a rate of 53% with higher percentages of rural and poorer women answering yes at rates of 59% and 67% respectively. Unfortunately data on Somali men is not known and there is limited data on Somali women, but as many as 76% of Somali women within limited regions are reported to have found it acceptable for men to be violent towards a wife if she upsets him for the before mentioned reasons (UNICEF 2015).
These percentages on acceptance of violence against women in the countries I am covering where campaigns against FGM/C have been gaining momentum and support are actually relatively lower than in many other countries in Africa, including the top 5 FGM/C practicing ones. For example in Guinea, a country which currently has the second highest FGM/C prevalence rate in the world after Somalia, at 97%, despite being banned since 1965 (UNICEF 2015), where being called “uncircumcised” is still a grave insult, equating a woman as “the lowest of the low” (Finke 2006:15), 92% of women and girls (15-49) surveyed think a husband is justified in beating his wife (UNICEF 2015), while 66% of men and boys are reported to think a husband is justified. This rate in Guinea is the highest reported by women in the world, with Afghanistan coming in second place with 90% of surveyed women there in agreement that a man is justified in beating his wife, if she burns food, argues with him, goes out without telling him, neglects the children or refuses sexual relations.

In Sierra Leone, a country which currently has the fourth highest FGM/C rate in the world at 90% (UNICEF 2016), 63% of women and girls (15-49) answered yes with slightly higher rates among rural (67%) and poorest (70%) women, while 34% of men and boys answered yes, with rural and poorest men answering yes at a somewhat higher rate of 38% and 40% respectively. There is no current data available on Djibouti, a country with the third highest FGM/C prevalence rate at 93%. In Mali, where the current FGM/C prevalence rate is the 5th highest in the world at 89% (UNICEF 2016), 87% of women and girls (15-49) accept violence against a wife and there is no data on men and boys available.

The survey data is quantitative, not qualitative, so I cannot provide much insight on the reasons why the answers were given. One cannot ignore that in every case, women were more likely to express acceptance of violence against women (against a wife) in the form of being beat
for upsetting a husband. There may be numerous reasons why such a large portion of women accept violence against themselves. For example literacy rates among women in many African countries, including FGM/C practicing countries (especially in Somalia and Guinea) are significantly low and women are less educated than men. Women are also married at young ages and may be rendered dependent upon the mercy of their husband socially and economically.

In a context where women and girls are conditioned to be socially and economically dependent upon a husband from an early age, who are taught that the greatest aspiration they can have for themselves is to serve and obey a husband; that their bodies belong to that husband, to be used at his discretion (an arrangement that might be finalized through the exchange of bride-wealth from a groom to a bride’s family); In a context where girls are taught that they must learn to accept pain as a rite of passage into womanhood so that they can be prepared to bear children, it may begin to become more apparent why women admit to accepting violence against themselves at higher rates than those reported by men. FGM/C is just one of many forms of violence they have been socialized to accept.

**Mortality Rates**

FGM is always traumatic. Immediate complications can include severe pain, shock, hemorrhage (bleeding), tetanus or sepsis (bacterial infection), urine retention, open sores in the genital region and injury to nearby genital tissue. Long-term consequences can include recurrent bladder and urinary tract infections, cysts, infertility, an increased risk of childbirth complications and newborn deaths, and the need for later surgeries. For example, a woman with Type III infibulation needs to be cut open later to allow for sexual intercourse and childbirth [WHO 2013, from 28 Too Many Report 2015:13].

Female Genital Mutilation (FGM), also known as Female Circumcision (FC), or Female Genital Cutting (FGC), is a universal practice that results in many health-related and life threatening complications. It also has other physical and psychological effects that do great harm to the wellbeing of women and children who have had it performed on them. In the countries where most or a large number of women have been mutilated, the medical complications that result from these practices place a heavy burden on the health services of these countries [Edna Adan Maternity Hospital online 2016].
In Gambia the maternal mortality rate (MMR) is currently high at an estimated 706 deaths per 100,000 live births (2016 CIA World Factbook 2015 est.). This figure is actually a major reduction from a rate of 1,050 deaths per live births in 1990 (UNICEF 2016). Somalia also has a high MMR of 732 deaths per 100,000 live births, meaning one out of 12 women die from pregnancy related causes. This is high but significantly down from a rate of 1,210 in 1990 (UNICEF 2016). Like in many African countries, access to health services in Somalia is low and the infant mortality rate (IMR) is 79 per 1,000 live births (UNICEF 2010-2015 est.), while the child under five mortality rate (U5MR) is 137 deaths per 1,000 live births, making it the third highest in the world (UNICEF 2016). The IMR in Sierra Leone was reported at 117 per 1,000 live births (UNICEF 2012 est.). The child under five mortality rate was reported at 120 per 1,000 live births, the fifth highest in the world (UNICEF 2015 est.), but a major decline from 1990 when it was 257 per 1,000 live births (UNICEF 2016), during this time fertility rates in Sierra Leone also significantly declined and currently stands at 4.76 children born per woman (CIA World Factbook 2016 est.). In Mali, Guinea and Djibouti, the U5MR stands at 115, 94 and 65 respectively (UNICEF 2015 est.).

In Sierra Leone where the current FGM/C rate is 90%, the current MMR is estimated at a staggering 1,360 deaths per 100,000 women (2016 CIA World Factbook 2015 est.), thus 1 in 8 women risk dying from pregnancy or childbirth. To put these numbers in context, Italy has a MMR of 4 deaths per 100,000 live births; Greece and Finland both have rates of 3 maternal deaths per 100,000 live births, while countries like Syria and Iraq, in the midst of war still manage to have far lower maternal death rates at 68 and 50 per 100,000 live births respectively (2016 CIA World Factbook 2015 est.).
FGM/C is not necessarily the sole cause of such outrageous statistics, obviously poverty, disease and a lack of healthcare services plays a significant role. Yet I am in vigorous agreement with Edna Adan Ismail and numerous others that FGM/C places a heavy burden on the limited healthcare facilities, professionals and resources of impoverished countries, and their ability to care for the women within these countries. Ninety nine percent of maternal deaths occur in “developing” countries, including a majority of African ones (WHO 2016). Women within these countries who are expected to undergo FGM/C and produce children as an affirmation of their womanhood, are along with their young children often the casualties of prioritizing what limited resources will be invested in, and who’s lives will be salvaged at local and national levels. They are casualties (intended or not) of structural violence at local, national and international levels (impart because of the peripheral and impoverished status of many of the countries they live in).

A Holistic Approach to Reducing and Ending FGM/C

Female genital mutilation reinforces the inequities suffered by women in the communities where it is practiced and must be addressed if the health, social and economic development needs of women are to be met (Dorkenoo 1999:87).

The various activists and movements mentioned share in common a holistic approach to challenging practices of FGM/C. They have focused on healthcare, reducing maternal and infant mortality rates, on reproductive, sexual and human rights; on educating and reaching out to communities, door to door and with media campaigns which target women and girls, as well as men and boys. They have been receptive and engaging with transnational support networks, have sought support from religious and community leaders and have shown women and girls within FGM/C practicing countries respect and cooperation while helping to empower their lives.

Poverty, lack of education and opportunities, as well as a desire for capital are driving forces in the perpetuation of FGM/C. Being a “cutter” is still a profitable enterprise, at times more
profitable than going to school to become a nurse or midwife. Cutters are in demand by men seeking virginal wives. They are in demand by parents and grandparents looking to marry their daughters off with a good reputation in the community and receive bride-wealth money for the family, whom otherwise may be living in abject poverty. It’s about economics, politics and social pressures, in addition to culture and tradition.

Because FGM/C is often interpreted as a religiously mandated procedure, it is vital that religious leaders be engaged and encouraged to send a clear and consistent message that the practice has no place in Islam or any of the other main religions observed in FGM/C practicing countries. There is evidence that some Mandinka families who have migrated to Europe and/or made the Islamic pilgrimage of Hajj are beginning to realize that FGM/C is not a religiously mandated procedure and are either beginning to use other justifications for its practice (such as cultural ones), or starting to abandon it for religious and identity reasons, as Islam plays a strong role in cultural identity for many Mandinkas and other ethnic groups that practice FGM/C (Hernlund and Shell-Duncan 2007:208). Religious leaders have great influence in many FGM/C practicing countries and that influence should be taken advantage of when possible. Considering that the Islamic faith is held in high regard and travel to Mecca for Hajj (if one is able) is one of the five pillars of Islam, learning that FGM/C is not considered an Islamic practice of the sunnah (and especially known to not be mentioned in the Quran), has significant potential that is often overlooked in FGM/C campaigns which take root in the West.

Although women usually carry out the procedure on women and girls, these operations are ultimately done to satisfy the requirements of potential male suitors, and secure marriage prospects, so an approach that does not address the views men have towards women and the demands they place on them within society, is destined to be inadequate. Societal weaknesses
have to be addressed and communities should be invested in with time and money. Africa boasts many countries with the world’s youngest populations, including FGM/C practicing ones, which is one reason why many of the activists that have started campaigns designed to reach out to youth specifically, may be able to continue to inspire change for their future. Laws banning FGM/C are symbolically and often substantively helpful, but monitoring the effects of the laws, as well as addressing local pressures to continue FGM/C perpetuation is also key to the laws impact and relevancy in local communities.

FGM/C may not be an easy subject for women, especially women who have undergone the procedure to talk about. It may feel embarrassing, even demeaning to have one of the main subjects in the battle for women’s human rights to be centered around operations that happened to the most private part of one’s body, usually at an age when there was no actual understanding of the reasons for or implications of the procedure, but the fact that FGM/C is usually carried out in secrecy and people are discouraged from voicing opposition to it, is precisely why it continues to be perpetuated. Breaking the silence may not change the fact that some 200 million women and girls have already been subjected to FGM/C, but it can change the outlook for future generations who are able to challenge practices and traditions that they previously were not able to question. Women and girls of today, some of whom have been subjected to FGM/C, and some who have not, all have a chance to challenge traditional practices that are harmful, and designed to confine them as the potential property of men. They may be realizing that these practices that may at one time have increased their chances of marriage (still an important aspiration for many), are no longer reliable ways of guaranteeing a husband due to modern globalization and the transnational and transcultural relationships that come with it.

Conclusion
Women's movements have reshaped the world's democracies, demanding that governments and citizens pay attention to "women's issues" such as pay equity, violence, feminization of poverty, reproductive rights, and representation. But women's movements, like many contemporary social movements, are increasingly divided along lines of race, sexuality, ethnicity, and class. When such division obstructs cooperation, women lose their most effective advocates in the public sphere. With a renewed assault on women's reproductive rights, economic security, and freedom from violence in the United States and around the world, women need effective sources of policy influence more than ever. It is critical, then, that movements overcome these divisions and improve their influence on policy and society. But can they? [Weldon 2006:55].

The transnational movement against gender violence… mobilizes people not only across differences of race, class, and sexuality but also across differences of language, national context, level of development, and the like. Though initially hobbled by internal division, activists have united over two decades, successfully promoting a number of international agreements. Violence against women has by no means been eliminated, but activists have succeeded in dramatically increasing the awareness of and resources devoted to combating violence against women around the globe [Weldon 2006:55].

In this thesis, a limited number of activists and countries were highlighted. I’ve focused on the Senegambia region because of significant developments in both the Gambia and Senegal recently. Activists and social movements in this region continue to show potential and may serve as models for other regions in Africa and beyond. I’ve looked at continuing developments in Kenya, one of the countries that have seen large scale declines in FGM/C over the past several decades, as part of another region where campaigns and movements may serve as paradigms for how to combat FGM/C when translatable and applicable. I’ve considered Somalia, where the most extreme form of FGM//C is most common and still widespread, considering the well publicized efforts of activist and medical professional Edna Adan Ismail who educates and trains young women at her maternity hospital and combats FGM/C within a context of providing maternal, infant and young child care in a country plagued by high rates of mortality for those populations.

Throughout this paper, I have addressed five key research questions using a combination of activist’s points of view, strategies for challenging FGM/C through dialogue, educating the
public and empowerment of women and girls, as well as changing attitudes towards FGM/C in the general population and figures on declines. I’ve considered the approach of TOSTAN, an NGO founded by “Westerner” Molly Melching of Illinois for an example of how Western women can legitimately and credibly engage grassroots dialogue and movements for women’s rights, on the subject of FGM/C or another, regarding health, wellbeing, human rights and empowerment. I’ve looked at structural power dynamics, such as access to education and gainful employment, religious and communal influence, the legacy of colonialism. I’ve raised the issues of property and inheritance rights and bride-wealth marriage customs within patrilineal and patriarchal cultures/societies suffering from modern high rates of poverty and how they can often be interrelated to the perpetuation of FGM/C. I’ve considered an overall acceptance of violence against women and considered some maternal, infant and child under 5 mortality rates in the current top 5 (prevalence rate) FGM/C practicing countries in addition to the main ones I’m covering.

My conclusion is that there is promise in these movements and real potential for continued prevalence declines and modifications of FGM/C. Reduced prevalence rates are evident across Africa with large scale declines in countries such as Kenya, Tanzania, Nigeria, Liberia, Burkina Faso, among others and more incremental declines in countries like Egypt and Sudan. Declines in the Gambia and Senegal have recently become evident as well. Over the past decade, there have also been declines in the number of women and girls who think the practice should continue. These changes owe substantial credit to grassroots activists and social mobilization campaigns, NGO’s like GAMCOTRAP, TOSTAN, ECAW and the international organizations and political allies these various actors or “agents” have strategically formed.
What all of these activists, campaigns, social movements and organizations share in common, beyond a commitment to women’s rights, are culturally relevant social mobilization initiatives which often also utilize media, many of them having an online and radio presence. Despite their cultural and social differences, these various actors are utilizing media to mobilize their campaigns and gain broader support networks, something social activists around the world are having to learn to do. The work of these various actors and their movements is enabled to reach wider audiences with media campaigns despite limited access to many forms of media in a number of FGM/C practicing countries. Activism against FGM/C which utilizes radio as a way of reaching the most people (see Spadacini and Nichols 1998, Finke 2006 for examples on using media in anti-FGM/C campaigns in Ethiopia) has begun to find success throughout Africa.

Grassroots activists who have fought hard to challenge conditions which repress women and girls are often either ignored as fringe elements that fail to thoroughly condemn their cultures for practicing FGM/C or are treated as emotionally charged dissidents that should go back to their “culture”. But where would women in the West be today if they never challenged the status quo that kept them in the house as the property of their husbands? And where would so called Western white women of today be without the likes of Harriet Tubman, Sojourner Truth, Frances Watkins Harper and other African American women who fought for both African American and women’s rights because they did not have the luxury of picking battles? Undoubtedly systemic discrimination in the United States still exists. Likewise as colonial history has it, these women, largely of color, mainly in Africa, do not have the luxury of opting to fight for women’s rights one day and their rights as colored people from a marginalized part of the world the next.

FGM/C is still an important issue facing women and girls. Activists who campaign against FGM/C realize the “multiple hats” they have to wear in forming and supporting grassroots
movements on the ground and bridging political alliances locally, nationally and internationally through diplomatic channels like the UN, WHO, African Union, through governments, NGOs, religious institutions and leaders and by utilizing multi-media campaigns. Anthropologists may be able to aid them in bridging cross cultural dialogue, respect and cooperation in their quest to challenge “traditional” sociocultural power structures and retain narrative and substantive control over their at times, distinct frameworks (from the West) for women’s human rights. Activists, campaigns and social movements may at times seek financial and resource oriented support from the West, often as a consequence of living with the effects of recent eras of colonialism, current structural adjustment programs and poverty, but this should not equate a lack of agency and cultural expertise in combating FGM/C on the part of “local” and transnational activists.

Women subjected to FGM/C face many challenges, challenges women globally face, but which may take on a more acute form due to the intersection of their gender, class (also related to living in and deriving from the global South), ethnicity and race. Many of them are fighting for their economic, civic, reproductive, health and in some cases, their sexual rights. In sum, they are fighting for their human rights as women and girls. The movement against FGM/C is part of both local and global movements for women’s rights. Women and girls are feeling empowered to end FGM/C, and women, girls, and their male allies, whether they be from within cultures where FGM/C is commonly practiced or whether they are in the West, can support activists and movements against the practice with dialogue and cooperation, in addition to funding and investment. The agency of these various activists met with resources and opportunities has enormous potential because agency met with resources and opportunities has been shown to enable women and girls to feel empowered and act empowered, transcending culture, race, social class and borders.
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