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FEMALE GENITAL MUTILATION

DECONSTRUCTING PRECONCEIVED IDEAS

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INTRODUCTION

Female genital mutilation (FGM), commonly referred to as "excision" or "cutting", is a part of gender violence to which women are subjected because they are women.1 Although FGM often generates strong feelings, it is also a subject on which the public is poorly informed. Consequently, there is a multitude of preconceived and stereotyped ideas around female genital mutilation, which is perceived as a practice that only concerns Sub-Saharan Muslim communities. These ideas stigmatise affected communities, presenting them as "barbaric", and the women affected by the practice are seen as passive victims. We want to distance ourselves from colonialist, guilt-inducing attitudes to highlight the active role and resistance of the women concerned.

With this publication, Concerted Strategies to fight against female genital mutilation (CS-FMG) and the Group for the abolition of female genital mutilation (GAMS Belgium want to deconstruct preconceived ideas and stereotypes about "victims and perpetrators" of female genital mutilation. Misunderstandings due to misconceptions and a lack of self-criticism are often an obstacle to appropriately guiding affected people. This brochure aims at raising everyone's awareness on this.

We decided to cover thirteen preconceived ideas that we often hear in our work, whether with professional partners, in discussions with the public or when we work with affected people. We also want to show that analysis must take account social norms affecting not just women's bodies, but also those of children, men, and intersex people. It is also important to stress that the ideas put forward in this text can in no way be generalised as applying to all cut (or non-cut) women, nor to all the affected communities. Lastly, this publication is intended for all the relevant actors in social work, education, civil society, institutions, politics, and all those committed to questioning socially constructed patriarchal roles.

The first version of this document was published in 2016. It had been designed for professionals supporting women who had suffered or were at risk of FGM; students and teachers covering this subject in their curriculum; activists working on the issue of gender-based violence and/or sexual and reproductive rights; public institutions and any other people interested in these issues. It is obvious that better understanding of female genital mutilation is crucial to provide quality support to affected women/survivors .

As part of the project entitled "Deconstruction of preconceived ideas about migrant women who have undergone FGM", funded by Equal Brussels in 2020, the brochure was revised thanks to input from numerous readers. We have paid particular attention to avoiding saviour-type writing, and made every effort possible to take a genuine anti-racist approach. This publication also contains a new chapter on obstetrical violence.

We are convinced that by deconstructing preconceived ideas and opening people's minds, it is possible to construct a fair, inclusive, non-racist and non-violent society.

"Female genital mutilation is only practised in Sub-Saharan Africa"

In 2016, UNICEF estimated that 200 million girls and women across the world underwent female genital mutilation. For a long time, it was thought that this practice was limited to Africa, more specifically to black Muslim communities in the continent. Yet, for several decades now, studies proved that this practice can also be found in several countries in Asia and the Middle East, such as India, Indonesia, Iran, Malaysia, Pakistan and Yemen. Female genital mutilation is also practised in Kurdish communities in Iraq and Syria, and in Indigenous communities in South America(such as the Emberá in Colombia). Moreover, the practice also exists in migrant populations from the above-mentioned countries. A recent report written by international NGOs points to the presence of female genital mutilation in more than 90 countries in the world and stresses the need to recognise FGM as a global problem (End FGM/C NETWORK, Equality Now, 2020).

The idea that FGM is an African practice reflects a neo-colonial vision3 of the African continent, which is often perceived as "a single country". This view ignores the diversity and cultural wealth of the African continent, such as ethnic and socio-economic multiculturalism. In addition, it implies that all African communities and countries practise FGM, whereas this is not the truth. In some Sub-Saharan African countries such as Madagascar, Botswana, Democratic Republic of Congo, South Africa and Zambia, genital

mutilation is either not practised or is practised only by certain minority or migrant communities. Furthermore, prevalence can vary greatly in a single country, according to ethnicities or regions.

The main explanation for female genital mutilation being presented as an "African problem" resides in the sources used by the World Health Organisation (WHO) and UNICEF for their publications. These organisations only take account of the figures obtained through Demographic and Health Surveys (DHS) and Multiple Indicator Cluster Surveys4 (MICS). Data on the practice of female genital mutilation is collected following agreement by the country to add a specific module on this subject, often considered "sensitive", in its questionnaire. Yet, as this has not been added in several Asian countries, it is impossible for these to obtain official, validated figures, as is the case for African countries. Publications including solely a map of Africa to represent FGM therefore give an inaccurate, partial image of reality.

To demonstrate the worldwide nature of the issue, it is important that UN and WHO reports take into account research conducted by non-state organisations, particularly when national and official data exist.

One example is Indonesia. Several activist organisations had detected the practice of widespread medical cutting in Indonesia, but at the time the authorities refused to introduce the specific FGM module in their demographic and health surveys. This was later included and made it possible to measure the scale of the practice (more than 50 % of girls aged 0 to 14 are cut in Indonesia). These new official figures saw worldwide prevalence of FGM rise from 130 to 200 million girls and excised women across the world (UNICEF, 2016).

Farzana Doctor, psychotherapist and writer, lives in Canada and her family belong to the Indian Bohra community, where FGM is considered a religious practice. 85 % of girls and women of her generation were subjected to type I or type IV FGM. FGM is taboo, a secret.

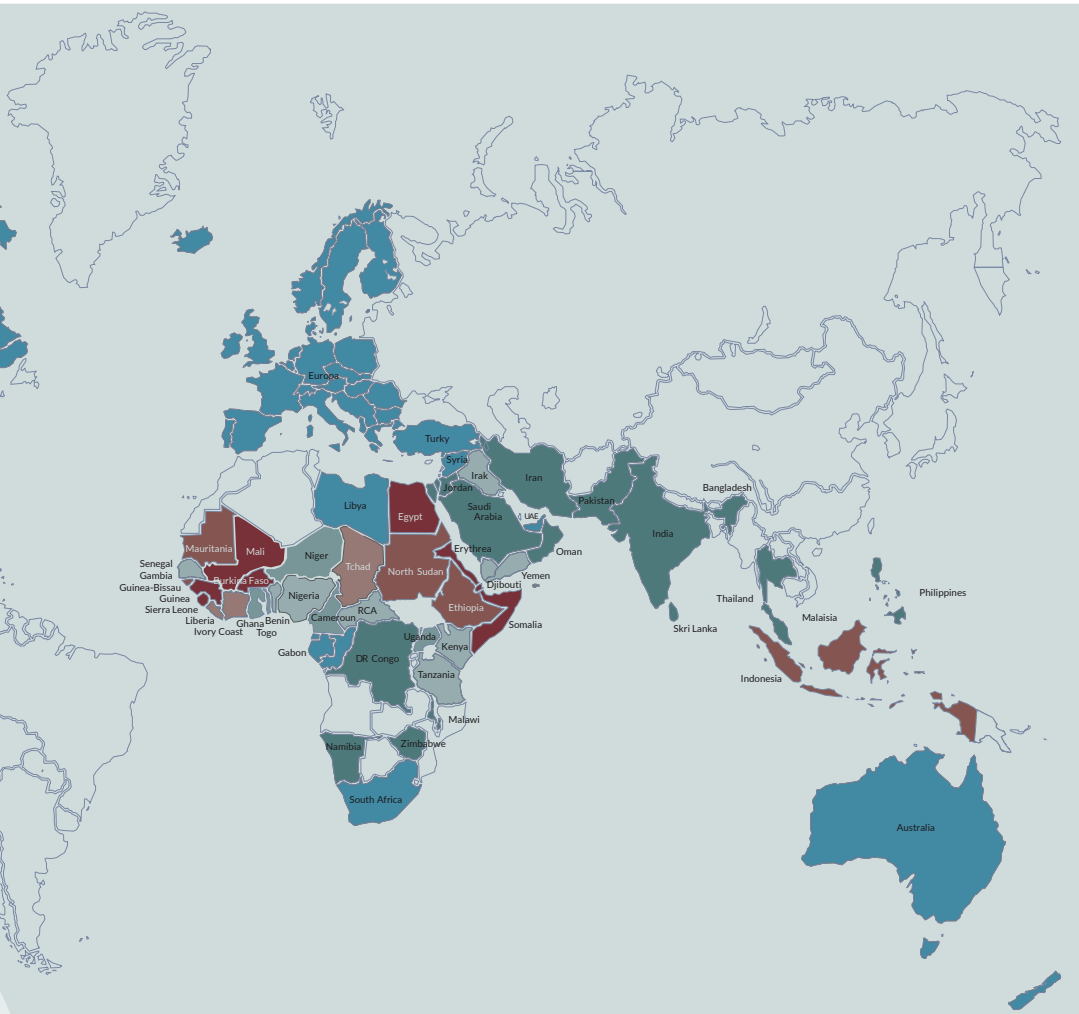
FGM PREVALENCE

- 75 - 100%
- 50 - 75%
- 25 - 50%
- 5 - 25%
- 0 - 5%
- Restricted to some communities / No data available
- Cases reported by migrant communities

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

"We don't talk about it: either in my family, or in public, and the Indian government is struggling to acknowledge that FGM is a problem in the country. When I was a child, on a visit to my family in India, a member of my family brought me to be cut without my parents knowing. My parents were against the practice. Before beginning therapeutic work, as an adult, I felt like I didn't fully believe in my own experience, in my feelings, as though I was not in full possession of a part of my body. In the beginning, it was very difficult for me to tell my story.""

Farzana Doctor



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An incomplete view of the regions where FGM is practised can have consequences on social, medical, and legal support provided to the affected women. Teams working in organisations specialised in fighting FGM remark that asylum bodies and partner associations refer a majority of people from Sub-Saharan regions to them, while other women, recently arrived from Iraq, Iran and Egypt in particular, are more rarely referred to them. Lack of access to professional help for women in need can have consequences on their health and, for women seeking asylum, on their asylum procedure.

Overall, the neo-colonial vision of FGM has an impact on the way black women's bodies are perceived. They will be considered and portrayed as "victims" and "excised/cut women" in a systematic manner, hence the subject will remain undiscussed

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

Oumar Diallo,
GAMS Belgium management Board member
and member of the Collectif mémoire coloniale
et lutte contre les discriminations*

*Collective for colonial memory and the combat against discriminations

"Women/girls are not cut in Europe"

In addition to the idea that female genital mutilation is only practised in countries referred to as "developing", there is the idea that FGM is not a European or "Western"5 practice. Yet, down through history, various forms of FGM have been observed and are practised in Europe and in the United States.

Until the mid-20th century, clitoridectomy and reduction or removal of the labia were practised for pseudo-medical reasons. By cutting women's clitorises (and intersex people's clitorises), the intention was to "cure" them of illnesses such as "hysteria", "nymphomania", homosexuality, and masturbation, or to "normalise" women whose genital organs were considered "hypertrophic". Such terms were used to describe "mental illnesses" and especially "excessive" sexual behaviour in women, in other words sexuality outside of marriage and/or non-heterosexual sexuality. These practices were carried out because medical professionals and society in general wanted to control and "re-feminise" women's bodies and sexual behaviour. (Whitehorn et al., 2002).

Furthermore, it is important to note that historically, 20th century European colonisers and scientists were aware that FGM was practised in certain African communities. According to French philosopher Elsa Dorlin, they considered the practice to be normal and necessary for African, i.e. black, women: FGM was a "preventive medicine" to avoid "deviant" behaviourin Africa, and a "curative treatment" in the West (Dorlin, E., 2006).

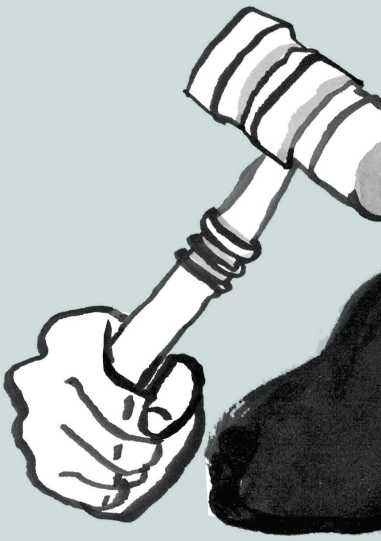
Today, Belgian law prohibits FGM of minors and adults, consenting or not. Article 409 of the Penal Code (2001) provides for three to five years in prison for "anyone having practised, facilitated or favoured any form of mutilation of the genital organs of a person of the female sex, or attempted to do so, with or without the consent of the latter". When the survivor is a minor, there is an aggravating circumstance.

Nevertheless, studies on prevalence estimate that 180,000 girls/women living in Europe are at risk of FGM. In Belgium, this figure rises to above 4,000 (End FGM EU, 2016). This data relates exclusively to girls/women from countries outside Europe where FGM is considered a "tradition". Young girls who live in Belgium and come from communities affected by FGM are mainly at risk when they return to the country of origin (during holidays for example). Currently, there is no proof that FGM, in its "traditional definition", is practised within the territory of Belgium.

On the contrary in France, more than thirty court cases have already referenced cutting being practised on the French territory. A study commissioned by the French Institute for Demographic Studies (INED) estimated that 28% of girls born in France in the 1980s with a mother who underwent FGM, had been cut either in French territory, or during a trip to the country of origin. It is estimated that this level decreased to 1 % for girls born in the 1990s, following public court cases that took place in Paris during the period (Andro, Lesclingand and Pourette, 2009). The book entitled Exciseuse by Natacha Henry and Linda Weil Curiel (2007) retraces the experience of Hawa Gréou, a Malian cutter who practised hundreds of cuttings in a private apartment in the Paris suburbs before being arrested and tried.

In Belgium, professor Els Leye's doctoral study (2008) demonstrated that, after childbirth, some Belgian gynaecologists had agreed to re-infibulate the genital organs of women who had been subjected to type III FGM in their country of origin. Furthermore, GAMS Belgium's experience in the field indicates that there is a possibility that cuttings also took place in Belgium. The association also

receives calls about risks of excision. It is important that any sign pointing to a risk of FGM (and any other form of gender-based violence) receive the necessary attention and that a contact be made with the specialised services if required. This makes it possible to protect girls living on the Belgian territory. However, issuing mass alerts could also lead to stigmatisation and discrimination against people who come from countries where FGM is practised. Authors have denounced this phenomenon in Sweden and the United Kingdom, where young girls of Somalian origin had been subjected to medical appointments without the consent of their parents. Such situations can have an impact on the wellbeing of the girls concerned. Also, because of their discriminatory nature, they can lead to tensions between law enforcement bodies, healthcare professionals and the affected communities (see also chapter 9: “Genital cosmetic surgery has nothing to do with genital mutilation”).



"FGM IS IMPOSED BY ISLAM"

Religious precepts are most often evoked in favour of the practice of FGM. As FGM is perpetrated by various Muslim communities, it is often perceived as a "Muslim practice". However, not all Muslim communities (such as those in Morocco, Tunisia, etc.) practise FGM, while many non-Muslim communities, such as Christians or animists, practise it. In Burkina Faso, and Sierra Leone, for example (see map of prevalence), FGM is practised by both Christian and Muslim communities. Nigeria, where FGM is mainly practised in the south of the country, is predominantly Christian.

FGM is an oral tradition and a social norm that is not mentioned in any religious text. It is important to recall that no religion imposes the practice of FGM, and certain religious authorities are deliberately opposed to it. This was the case on the 24th of November 2006 in Cairo, where the Grand Mufti of Egypt, Dr Ali Gomaa, signed a fatwa6 against FGM. Islamic scholars approved a declaration whereby the Egyptian *fatwa* is correct and must be respected (Pharos, 2016).

"Indeed, it is a traditional practice that existed well before the advent of monotheistic religions such as Islam. After that, people converted to these religions, some traditions were integrated into the religious practice and reproduced in the name of the religion. Over time, an amalgam was made between tradition and religion.""

Omar Ba, historian

However, other religious authorities encourage FGM or adopt a "neutral" position (according to their own terms). And because of a lack of knowledge and access to religious writings, many people believe that FGM is a religious obligation.

Maryam Sheikh, an academic from Somalia, explains that when she was growing up, she thought that all young Muslim girls were cut like her. It was when she went to university and met Muslim women from other countries that she realised the practice is not a religious obligation:

"I wondered why I had been forced to do something that was not compulsory in Islam. I am firmly convinced that it is easy to put an end to FGM in the Somalian community if we use the right formula – dissociate FGM from Islam and use the same Islam to change the scenarios and stories that keep FGM in place."

Maryam Sheikh,
feedback given as part of the
Community of Practice on FGM[7]

In any case, it could be argued that FGM is a form of gender-based violence, practised within a complex framework of patriarchal norms and beliefs, of social and family convictions and pressures. According to the country, the ethnic group and the period, various arguments are evoked in favour of the practice: tradition, social cohesion, control of women's sexuality, beauty, etc. Many combinations are possible. Although religion is often quoted in this context, this element alone cannot explain the existence or the durability of the practice. There is, however, a difference between the African and Asian continents. In Sub-Saharan Africa, the practice preceded monotheistic religions and the groups concerned can be Muslims, Christians, or animists. The same cannot be said of Asia, where the practice began later and is claimed to be a religious requirement, in the same way as male circumcision. In Indonesia, the phrasing "Islamic female circumcision" is used (Stop FGM Middle East).

To achieve abolition of FGM and ensure that care is accessible for all people confronted by the practice, it is important to have a good understanding of its origins. This makes it possible to talk about the subject without any stigmatisation, and to correctly identify the people concerned and affected. Belonging to a religious community does not necessarily indicate adherence to the practice of FGM. Other reliable factors can indicate whether there is a risk of FGM: prevalence of the practice in the family, the country, the ethnicity of origin, etc.8

"PEOPLE WHO PRACTISE FGM ARE "BARBARIANS", THEY ARE "IRRATIONAL" PEOPLE"

It is undeniable that FGM can have severe consequences on the physical and mental health of the people affected over the short and long term, even causing death. Therefore, many people believe that those who subject their daughters to this practice are "bad parents", and consider the family, the cutter and the community to be "barbarians". This is often the first reaction to the reality of FGM:

"How can a mother, who has been subjected to this practice and knows the pain it causes, condemn her own daughters to the same fate? How can a cutter, who hears the screams and sees the pain she is causing, continue to do her job? How can a father, who lost his sister through a complication related to excision, continue to support this practice?"

General reactions during GAMS Belgium activities

To avoid developing such attitudes, it is important to keep in mind that FGM is not an isolated practice exclusively related to the private family sphere. It is not just the responsibility of parents or female family members. Female genital mutilation is part of a complex set of daily ritual practices constructing male and female roles and sexual status. In some communities, FGM is a compulsory rite of passage for a girl to be considered as an adult woman, an integral member of her community and a potential candidate for marriage. Excision is a sign of belonging to a community and an honour for the family.

"A woman who is not cut is stigmatised in Mali. People call her *bilakoro mousso*: this means that even if you are a woman of a certain age, you will be treated like a little girl..."

A Malian man living in Belgium,
interviewed as part of a study conducted
by GAMS Belgium
(the *Men Speak out against FGM* project)

When FGM is the norm in a community, its members can be subjected to huge social pressure to perpetuate this practice and be rejected if they do not practise it. Placing oneself or being placed outside the group is not desirable for a person and certainly not for someone's own child. However, by accepting the cutting of their daughter, the family wants to protect her from stigmatisation and social exclusion, ensure her place in society and ensure respect for her. On the contrary, opposing the practice can lead to persecutions and violence. Based on this assumption, the idea of opposing it becomes irrational.

"Sometimes women, whose mothers are aware of the consequences of cutting, seek "compromises" between perpetuating the tradition and minimising the risks related to the cutting of their daughters. My mother, who belongs to this category, used to say: "I prefer the hospital than sending you (my sister and I) to the village, that way there'll be no complications." In a way, she was aware of the danger and preferred sparing us the possible risks, without stopping the perpetuation of this tradition."

Diariou Sow,
GAMS Belgium Management Board member

However, European political discourse on FGM also features declarations on the "barbaric" nature of specific forms of gender-based violence. It is based on a Eurocentric point of view, focusing only on good vs. bad. This dualist attitude can also be found in social media with hateful, racist messages addressed to communities that practise FGM.

"When the vocabulary used is violent and aggressive, it has disastrous consequences on the people targeted by these comments. Very often, these people feel humiliated, rejected, and misunderstood. This is a way of creating tensions and above all, of fuelling stereotypes. And this is what will subsequently be used by politicians and the media, and that will contribute to constructing and promoting hateful, racist discourses. All this to the detriment of the mental health and safety of the women and girls affected."

Isma Benboulerbah, Coordinator of Programmes,
End FGM European Network

Some researchers and activists estimate that awareness-raising campaigns against FGM, conducted by international organisations and institutions, are tainted by a neo- colonialist and racist vision. One of the arguments of colonialist States in favour of colonisation was that "civilisation had to be brought to inferior races". This idea of the white man's burden, (meaning "the white man's duty") was conveyed in the writings of western anthropologists of the time. Colonised women were perceived as oppressed, powerless, voiceless victims who needed to be protected from their male partners and their customs (Janice Boddy, 2007). It is crucial to distance oneself from this type of idea when dealing with FGM, as is the case with other racialised and racist violence against women.

There is evolutionist thinking hidden behind campaigns against "detrimental cultural practices", representing "western society" (as a whole) as civilised and non-violent. However, "other" societies are depicted as being "barbaric", "irrational" and "developing". Local activist initiatives to fight against FGM are still under-represented by the public (Van Raemdock, 2013).

During two webinars organised by GAMS Belgium in 2020 on the subject of "Feminism and antiracism: prospects for the fight against FGM in Belgium", the term white saviourism was used to analyse anti-FGM actions. This term designates white people who feel they must go and "save racialised people" and "help" racialised people without examining the culture or the real needs of the people concerned. A common example are young (or not so young) white Western people who go on humanitarian trips to "help Africa", often with no useful qualifications, and who post photos on social media showing themselves surrounded by "poor" racialised children.9 Webinars also made it possible to denounce the manner in which the subject of FGM is dealt with by some European NGOs involved: excessive use of survivors' accounts and images of young black girls, tearful interviews, lack of diversity in anti-FGM associations and insufficient inclusion of communities directly concerned by the issue. Lastly, speakers at the webinars noted that the fight against violence against women in general, and the fight against FGM are too often instrumentalised in anti-migrant political and Islamophobic discourse.

Il is crucial that all people involved in work on FGM understand and identify racist prejudices targeting the affected communities by FGM, to ensure they do not reproduce these, whether in their communication or their work in the field. Any action on female genital mutilation must consider the following points:

What are the needs of the group concerned? What role is given to the people directly involved? What are we saying about the localities in question? What are the power relationships at play? Who is missing in the action?

"Cutting is women's business"

FGM is usually perceived as "women's business". It is true that the practice primarily affects women because they are the ones who are subjected to it and who, consequently, suffer directly from complications. In addition, it is often

- but not only - women who decide that a girl must be cut. Not just the mother, but also grandmothers, aunts, or even female friends and neighbours have a say in it. In many communities, it is mainly women, traditional cutters or care workers, who carry out the intervention. Therefore, across the world, a lot of initiatives fighting against FGM are essentially targeted at women.

However, female genital mutilation is a practice rooted in a patriarchal societal construction. As explained previously, FGM is a strong social norm in affected communities and a compulsory rite marking the transition of a young girl into adulthood: when she becomes "a woman". This practice is part of the control exerted over women, their bodies and their sexuality, and is among the many acts of gender-based violence targeting them because they are women. In many affected communities, cutting aims to ensure women's "morals" and honour (and thereby, that of society as a whole), by ensuring their pre-marital virginity and their faithfulness after marriage. Cutting is an obligation for women to be able to get married; so social and community pressure drives parents to subject their daughters to this practice. On the one hand, men participate in perpetuating FGM as individuals when, for example, a man refuses to marry a woman

who has not been cut, or when a father participates in funding the cutting of his daughters. Racialised men do not have the same level of power as white men, and this idea implies that they have as much power, but that is not true.

On the other hand, men as a social group are the first beneficiaries of the patriarchal system ensuring they have social and economic power. Given the power they possess in society, they necessarily have a role to play in maintaining or abandoning practices such as FGM. It is therefore imperative that men question their privileges and take their responsibilities in the fight against this form of violence against women.

Furthermore, men are indirectly affected by the practice/ seeing the women and girls in their family suffer from FGM can have psychological consequences for them. In addition, while men's sexual satisfaction, which is sometimes put forward as a justification for FGM is rarely questioned, the sexual consequences of FGM also affect men. Some men have traumatic memories of the first sexual relations with a woman who has been infibulated, when social pressure obliges them to "open" their partner to prove their virility.

Men therefore have an important role to play in abolishing FGM. As members of their community, it is important that they speak out about their will to abolish the practice and that they participate in the awareness-raising process. Yet, men are often unaware of the amplitude of cutting. Therefore, they must be informed of the detrimental consequences of the practice in order to be able to participate in the process of abandoning it.

"In my family, all the girls are cut and I had never considered this as a detrimental practice generating complications that can be dangerous. It is when I began working for an NGO that was fighting against FGM that I became aware and realised there were problems related to the practice. When I was working on the Men Speak Out10 project, aiming to involve men in the work conducted against FGM, as the training progressed, men realised the extent of the problem. Today, they are determined to support women in their communities and fight against FGM."

Seydou Niang,
social worker and projects coordinator,
GAMS Belgium

Men's lack of knowledge on the issue can be explained by the significant taboo that persists around FGM. Because of this, men and women only rarely talk to each other about the subject. Therefore, they do not know what the other thinks and continue to practise FGM believing that this is what the other wants. The last UNICEF report on FGM (2013) shows that in several countries, women underestimate the number of men who want to abandon the practice. For example, in Guinea, Sierra Leone and Chad, more men than women are opposed to FGM.

Female genital mutilation is therefore not just women's business, it is the entire community's business. To put an end to the practice, everyone must take their responsibilities.

"A WOMAN WHO IS CUT IS A VICTIM"

FGM has very different meanings when it comes to "femininity", according to how one interprets it. For some affected communities, it is seen as essential for the "creation" femininity and the status of an adult woman; while for others, it is perceived as the very erasure of this same femininity and of the possibility of being considered as a "woman". Experiences also differ at the individual level.

Some authors think that in the West, the clitoris has become a symbol of women's emancipation. Consequently, FGM would be a symbol of the oppression of women. However, critics consider that this is a Eurocentric and reductive vision of the reality of those concerned. In addition, according to these critics, western opponents of FGM have tended to deny feminist movements in African countries, and particularly the historic opposition to FGM. Anthropologist Rogaia Mustafa Abusharaf (2000) gives the example of the tradition of women's rights movements in Sudan and elsewhere in Africa, recalling that African women are not "passive victims" who need to be "saved" (see also the discussion on the term "white saviour" in Chapter 4).

Specialised Belgian associations remark that in their daily work this vision of women who have been subjected to FGM s passive victims are indeed very widespread. Furthermore, the testimony of "victims" seems to have greater attraction for some public stakeholders, such as the media.

"GAMS Belgium is a mixed team of people from different cultures and different nationalities, who fight together against gender-based violence. But, in the media for example, black African colleagues are often portrayed as victims. We are expected to testify about our personal experience, about the violence we have suffered. Our role as activists and professionals in Belgium and in our countries of origin, is pushed into the background. It's not as attractive to the media."

Halimatou Barry,
coordinator of activities in Wallonia, GAMS Belgium

It is obviously important to recognise FGM as a form of violence, and having been a victim of it must not be seen as an identity. It is also important to recognise women as stakeholders in their own lives and to highlight their inner resources to rebuild themselves after this traumatic experience. Sometimes this personal reconstruction requires professional help and support.

"The woman you are receiving in your consultation was subjected to mutilation, but she is not a mutilated woman. However, for some people, it is important to go through a preliminary stage of recognising that they have been a victim, before being able to start the process of reconstruction."

Annalisa D'Aguanno, psychologist, GAMS Belgium

Victimisation can be an obstacle for psychological resilience and reconstruction. This reflection is also valid for other types of gender violence such as violence between partners or rape. And it is crucial to listen to the persons concerned and give them the choice of self-determination.

"WOMEN WHO ARE CUT DO NOT EXPERIENCE SEXUAL PLEASURE"

FGM is an attack on women's external sexual organs. The practice can therefore lead to consequences in terms of sexuality, such as pain during sexual intercourse, tearing (related to infibulation) and difficulties experiencing pleasure, or even a total absence of pleasure. One of the reasons cited for the practise of FGM is in fact to control women's sexuality.

Based on these realities, false preconceived ideas are formed, such as the idea that women who underwent FGM can never experience sexual pleasure or that women who are not cut only ever think of sex. Although sexual difficulties are possible, not all survivors women experience them. It is important to point out that some women who have been subjected to FGM are satisfied by their sex life. On the contrary, all people can encounter sexual troubles, whether they are a woman or not, cut or not. A person's experience of their sexuality is influenced by various factors, in the present and in the future. Having been subjected to FGM can be a factor with a negative consequence on sexuality, but this is not always the case. For women who suffer from sexual consequences, psychological, sexologist and/or medical support (alone or with the partner), can help to have a better experience of one's sexuality.

"As a survivor of FGM, it is important to recognise that this practice on girls' and women's bodies is the start of a long series of control over women's bodies and sexuality. The objective of the practice is to shut down women's sexual appetites and ensure they remain faithful to their husbands. However, it is the choice of partner and desire that create sexual emotion and enable fulfilling sexual relationships. FGM alone is not an obstacle to sexual pleasure, but the consequences of the act and its objective can dissociate us from our sexuality. The person who has been subjected to mutilation can become a passive participant in the sexual act. Which also leads to frustrations for the partner."

Diariou Sow,
GAMS Belgium Management Board member

Often, huge importance is attributed to the absence or presence of the clitoris, the only human organ specifically dedicated to sexual pleasure. Although there is a multitude of different forms of FGM (types I to IV and numerous variants within each group), it should be noted that all women retain a large part of their clitoris and that all FGM does not include removal of the clitoris. The clitoris is not just the outer, visible part, it measures between 8 and 12 cm and extends to the inside of the body, around the vagina. When clitoridectomy takes place, only the outer part is removed. Although sometimes difficult, sensations around the clitoris are therefore still possible. In addition, the clitoris plays an important role in the sexuality of those who have one, but it should not be forgotten that the human body contains other erogenous zones. By discovering the entirety of their body, everyone can learn different ways of experiencing pleasure. In fact, in every society, it is often through education/upbringing that girls and women learn to "hold themselves back", to not seek sexual relations, not take initiatives (Cf. victim blaming). Changing education is therefore an important stage to accessing one's sexuality.

"In my meetings with patients, those who are cut and those who are not, I realised that there are a lot of myths around FGM, and a lot of taboos around female genital anatomy and women's sexuality in general. There is the myth that women who are cut have little or no sexual responses. Yes, women who have been subjected to FGM can suffer from psychosexual complications, pain, etc. But these complications can be treated, and the clitoris is still there! Women are a lot more than just their genitalia, and sexual pleasure depends on numerous factors.

In addition to this there is the myth that women who are not cut are hypersexual. In many communities affected by FGM, the clitoris is seen as an organ that can grow like a penis and make girls hypersexual…"

Dr Jasmine Abdulcadir,
gynaecologist, Geneva Hospital, Switzerland12

Dr Abdulcadir (TedTalk, 2019) insists on the fact that myths and taboos around women's anatomy and sexuality don't only exist in communities practising FGM – they exist everywhere in the world. Including among healthcare professionals who are often too poorly trained in women's sexual anatomy and physiology. Even books on anatomy and medicine often do not correctly depict the clitoris.

Raising awareness on the anatomy of the genital organs and sexuality of women, whether they are excised or not, and educating all young people on the rights to a fulfilling love life, sexual life, and emotional life, is therefore of capital importance to ensure sexual rights and wellbeing for all people.

"WOMEN WHO ARE CUT MUST BE "REPAIRED""

Firstly, the term "repaired" implies that a woman who is cut is "incomplete", or "damaged", which can create a feeling of being different or inferior to women who have not been subjected to the practice. This attitude also tends to objectify female bodies. This is why we believe that precautions should be taken in using this term when speaking about a person: it is not the women who need to be "repaired" but where applicable the part of their body that was altered because of FGM.

The physical and psychosexual consequences of FGM can be dealt with thanks to various treatments. For example, FGM can lead to infections that must be treated with antibiotics. An infibulation can be surgically opened to facilitate the flow of urine and menstruation, sexual relations, and childbirth. When a person chooses after having been well informed and is further supported, this surgical intervention has very positive effects on mental and physical health.

Clitoral reconstruction is different, as it aims not only to treat some consequences of FGM but also to re-establish the part of the body that was altered by the mutilation. This intervention consists of exteriorising and repositioning the inner part of the clitoris and re-innerving it. The operation was demonstrated as being effective in "restoring the patient's physical integrity when the latter feels the need to do so" (CeMAViE). This is a relatively recent technique, the potential advantages of which are still subject to debate within the medical community. Although surgery enables some women to recover or

increase clitoral sensations, it is neither an imperative route to fulfilled sexuality, or a miracle solution to sexual troubles, because sexuality is not only physical, it is also emotional and a question of education (see chapter 7: "Excised women do not experience sexual pleasure").

As mentioned above, excision is not the only source of possible sexual discomfort for women who have been subjected to it. Many women also suffer other forms of gender-based violence, such as sexual violence, forced marriages or violence between partners. Furthermore, girls and women in general learn that they do not control their own sexuality and that the violence they experience can be easily put into perspective. The first stage for a survivor of FGM or other sexual violence to be able to get over the experience and recover is often the ability to talk about it. This is why we will constantly insist on the importance of approaching sexual problems from a multidisciplinary angle: not just medical (clitoral reparation), but also through psychological and sexologist support.

In Belgium, women who have been subjected to genital mutilation can have access to this multidisciplinary care in two specialised centres, one at Saint-Pierre University Hospital in Brussels (CeMAViE) and the other at UZ Gent (Ghent University Hospital).

"COSMETIC GENITAL SURGERY HAS NOTHING TO DO WITH GENITAL MUTILATION"

We know that girls and women are subjected to highly standardised images around femininity. Societal norms and expectations concern, for example, habits and behaviour, but different societies also have expectations concerning the anatomy of the genital organs, which do not always correspond to real/natural anatomy.

Yet, to adapt to these expectations, women and girls subject themselves to interventions such as cosmetic surgery to change their genitalia. The most common is labiaplasty (reduction of the outer lips or the inner lips13). Another practice is hymenoplasty (reconstruction of the hymen), which is supposed to enable women to have a "second virginity" (this practice is based on a myth about the hymen whereby it is possible to see if a woman is a "virgin", which is not the case), and operations to shrink the opening of the vagina.

These plastic surgeries can, to varying degrees, be compared to FGM, since they are generally practised for non-medical reasons. Although the request for cosmetic surgery is often made by women themselves, it is fuelled by social pressure generated by the distribution of images of the "ideal vulva" or the obligation for pre-marital virginity that weighs on women. These aesthetic reasons and societal pressure can therefore play a role in the practice of cosmetic surgery, as is the case for female genital mutilation. And surgical interventions on the genitalia can lead to complications such as bleeding, infections and pain.

A second parallel can be established: genital surgery can also lead to various complications. This is precisely why there is a high level of disunity within the medical community and activist organisations about the medicalisation of FGM as a strategy to "reduce risks" (see chapter 10). It is striking to observe that this strategy is increasingly condemned when it pertains to "the traditional form of FGM", whereas surgical correction of the lips, for example, is not discredited as often.

The World Health Organisation describes FGM as any intervention including partial or total ablation of a woman's outer genital organs or any other injury to the female genital organs, practised for non-medical reasons (WHO, 2008). A cosmetic intervention can easily be included in this definition. Yet, although the strategy for medicalisation of "traditional forms of FGM" is confronted by strong resistance, surgical interventions on the vulva for purely aesthetic reasons are legal and becoming more common in Europe. We can wonder why the WHO remains so silent about the increase in the number of labiaplasties, while it is firmly opposed to female genital mutilation. Why would such practices be acceptable for a white woman but considered as mutilation for racialised women?

We would go further and say that the Belgian law on FGM is based on a double standard: can the adult woman or the surgeon in question be punished based on the origin and skin colour of the patient? Do people think that a white, western woman has individual freedom of choice, while a black woman of African origin cannot consent to the same type of intervention? Will it be possible for an adult woman who comes from a region where FGM is practised, to obtain a medical intervention on her genitalia based on aesthetic reasons, just like her white neighbour will, or will it be considered as plastic surgery for the white woman and a slighter form of genital mutilation for the black woman?

"In Belgium, there is a hypocrisy around FGM in the sense that certain forms are tolerated and are not punished by law. For example, piercings, cosmetic genital surgery, etc. However, according to the WHO definition, one could consider these practices as forms of genital mutilation. By tolerating these practices, the protection of women and girls is endangered, because a girl could practise a type of mutilation in hospital or at a piercer's, for example. The law should protect against all types of FGM and should apply to all women, of all origins... Because if it does not, the law is racist."

A community relay person from GAMS Belgium, Flanders branch

Furthermore, Belgian law authorises cosmetic surgery on minors "with a sole view to personal satisfaction" because of distress felt by the minor (CODE, 2014), with parental consent.

This raises the question of the clarification of moral opinions and laws around genital plastic surgery and FGM, for adults and children.

"Practising excision in a hospital makes it possible to reduce risks"

Practising FGM in a hospital setting is considered, by some people, as a means to reduce the risks of infection and haemorrhages. This is considered to be the "less harmful strategy".

Partisans of medicalisation consider that efforts to abolish FGM, based on zero tolerance, have not yet yielded results everywhere. The practice remains very widespread in countries such as Guinea, Somalia, Egypt, etc. In these countries, the norm around the practice is so strong that total abolition in the near future seems impossible. In addition, in East Africa, infibulation (type III FGM) is common, and leads to serious consequences on physical and mental health. This is why, for those who say they are pro-medicalisation, it is necessary to implement a new approach, whereby the first stage would be to penalise the "worst" types of FGM while authorising the "gentlest" practices such as pricking (small incision of the clitoris), in medical settings. In this way, it would be possible to reduce risks, quickly improve women's health and wellbeing, start to deconstruct norms around the practice and, ultimately, convince communities to no longer practise at all.

Nevertheless, the approach in favour of medicalisation of FGM encounters very strong opposition. For its opponents, all forms of FGM must be considered as mutilation, violation of human rights, violence against women and an expression of inequality between men and women. The "minor forms" of FGM, promoted by the partisans of medicalisation, do not necessarily have a minor impact, as the

consequences of FGM do not depend solely on the type practised, but also on the expertise of the person carrying out the excision, the hygiene conditions, the age of the girl/woman, the degree of resistance from the girl during the intervention, etc. Furthermore, FGM leads to long-term complications and has psychological qui consequences that cannot be avoided by practising the intervention in a hospital. This is why it is all the more important to listen to each woman and not evaluate the consequences based on the type of FGM she was subjected to.

In addition, the opponents of medicalisation consider that replacing one FGM by another will not necessarily lead to their abandonment.

"In Guinea, where I work with a project raising awareness on FGM, I've heard testimonies given by women who have been excised twice. In this country, 30 % of girls under the age of 14 are excised by healthcare professionals, generally midwives. They cut less than traditional excisers, but the girls are subsequently excised a second time in their village, when they are controlled by aunts or grandmothers who consider that "it wasn't clean the first time"."

Jessica Tatout,
social worker at GAMS Belgium and
member of the Aniké association

L astly, medicalisation does not change the fact that excision is a violation of children's rights. Therefore, it does not question the reasons for excision/infibulation, and in particular the will to control girls' and women's sexuality. Some people also consider that this makes awareness-raising on these practices more difficult, because the medical community condones them.

This heated debate around medicalisation also raises questions about surgical interventions carried out on the genital organ of children and adults: women, men and intersex people (see chapters 12 "Circumcision and excision are completely different" and 13 "Belgian law protects all children from genital mutilation…").

"AN EPISIOTOMY IS NOT GENITAL MUTILATION, IT IS A MEDICALLY JUSTIFIED ACT"

During their life, many women undergo surgical operations on their inner and/or outer genital organs, which are often carried out before, during or after childbirth. Healthcare professionals can decide to carry out these interventions with or without the consent of the pregnant person, arguing that they are medically justified. Comparison of perinatal statistics in European countries demonstrates strong differences between countries in the use of interventions such as caesareans or episiotomies (EUROPERISTAT, 2013). Such an observation calls for debate on the extent to which these procedures can be presented as being medically justified.

Pregnant people and healthcare professionals are starting to condemn what they perceive as obstetrical and gynaecological violence.14 In the book entitled Le Livre Noir de la Gynécologie (Dechalotte, 2017), women testify about their bad treatment at the hands of healthcare professionals in France. This bad treatment takes place before, during or after childbirth, and is often linked to a medically assisted procreation procedure, to a miscarriage, or simply during a visit to the gynaecologist. It includes: sexist or discriminatory remarks, disregard for the patient's pain or recriminations when she speaks about it (in that they are out of kilter with the ideal of a "silent birth"), neglect of the future mother's desires, rectal or vaginal touching without the patient's consent, rape, misinformation, disrespectful attitudes, refusal to prescribe contraception, unjustified hysterectomies, unnecessary caesareans and episiotomies. The results are physical and psychological consequences in the short and long term for some women.

Among the interventions criticised, episiotomy – a surgical cut made to the opening of the vagina during labour – is often cited. Episiotomies are supposed to aim to prevent serious vaginal tearing during childbirth (laceration of the perineum – the area between the vagina and the rectum) and to protect the baby. Nevertheless, cases of complications following episiotomies documented since the end of the 1970s, and recent medical proof and testimonies, have highlighted the fact that this procedure can cause increased risk of urinary and faecal incontinence, a decrease in the strength of the pelvic muscles, prolapse and sexual problems. In addition, natural tearing is often less painful, causes less bleeding and heals more easily than an episiotomy. There is no proof that routine episiotomies decrease the traumatism to the vagina/perineum, or that they ensure less pain. A policy of selective episiotomy– practised only when necessary and not just as a preventive measure – would make it possible to reduce the number of women experiencing trauma to the vagina and perineum by 30 %.[15]

"As with every surgical intervention, if an episiotomy is justified, informed consent must always be asked for and obtained before it is practised."

Hanna Dahlen,
midwife and midwifery teacher,
Sydney (2015)

ince the 1990s, authors have been drawing parallels between episiotomies and genital mutilation. In 1999, an article published in the prestigious medical journal The Lancet, insists on the negative consequences of episiotomies (compared to natural tearing) and the lack of proof of their supposed benefits. The author recalls the major role played by the journal in the fight against the practice of clitoridectomy in the United Kingdom in the 19th century and exhorted The Lancet to "once more help turn support away from female genital mutilation, in this case in its modern form – episiotomy". (Wagner, 1999)

These authors argue that various points of comparison can be established between episiotomies and FGM. They are a part of the western "ritual of birth" that "marks the transition from girlhood to that of motherhood in the flesh", as is the case with FGM. The consequences of FGM and episiotomies are also similar: severe pain, loss of self-esteem, pain during sexual relations, decrease in libido, depression. In addition, episiotomies can lead to the nerves of the upper parts of the clitoris being sectioned (Dechalotte, 2017).

People having suffered vaginal tearing or an episiotomy during childbirth often have stitches in the perineum. Recently, a second obstetrical abuse, that can be easily likened to FGM, was highlighted: the husband stitch. This refers to an additional stitch made by a doctor when repairing vaginal tearing or an episiotomy, to re-tighten the opening of the vagina and thereby (supposedly) increase the sexual pleasure of male partners. Women have testified about the negative consequences of this practice on their sexuality and are calling for its abandonment (Mamabirth Blog, 2013 and Alonso, I, 2014).

"Circumcision and excision are completely different*"

When the issue of FGM is raised in training or actions for prevention, it is not rare that male circumcision is also spoken about. Some people seem to use circumcision to deny the reality of the gender violence that is female genital mutilation. At the same time, other people consider that the two practices are in no way related. This is in fact the predominant discourse conveyed by international organisations (UN, WHO) and by associations working to abolish FGM. We wish to demonstrate that the issue is not that simple and merits further reflection.

Circumcision, the cutting of the foreskin, is practiced mainly for religious reasons (Judaism, Islam) or for the supposed hygienic advantages (in the United States). As with excision, circumcision is an act that is most often carried out on the body of a child, without its consent. Circumcision can also lead to consequences on the health and sexuality of boys/men, and can even cause death. In both cases, there is an attack on the physical integrity of the child, which can have detrimental consequences. The majority of forms of female genital mutilation, such as infibulation, excision of the clitoris and labia, are not comparable to circumcision in terms of the tissue cut and consequences on health. However, other practices, such as solely removing the clitoral hood, can be considered as quite similar to circumcision. In no case can it be claimed that the equivalent of excision for men would be ablation of the entire penis, as is sometimes said.

*Note that End FGM EU does not have a position on male circumcision. This section represents the views of GAMS Belgium.

"Both male circumcision and excision are procedures that intentionally alter the genital organs of children who have no power of decision, for non-medical reasons."

Sara Johnsdotter, 2018

In some communities where both practices are common, they are part of the imperative transition to womanhood or manhood. In fact, in every community where FGM is common, circumcision is also practiced on boys. However, the opposite is not true. There are a lot more countries where circumcision of boys is practised compared to excision of girls. In several languages, in particular African languages, both practices also have the same name.

In an article published in 2020 in the journal Current Sexual Health Reports, Stéphanie Florquin and Fabienne Richard demonstrate, through concrete examples, that the issue of circumcision is not just theoretical for organisations working on FGM, such as GAMS Belgium, it also appears in their daily work:

"A woman came to GAMS Belgium because she did not agree with her husband about whether or not to circumcise their son. For the mother, who is opposed to the practice, it was a question of protecting the child from unjustified genital mutilation without consent."

"A man calls the organisation and tells us he was subjected to circumcision in childhood. He is still suffering from it today and asking us what we can do to support him."

Stéphanie Florquin and Fabienne Richard (2020)

As anti-FGM activists, Florquin and Richard (2020) believe that it is necessary to also question circumcision of boys, but remind us that it is not possible to consider the issue of excision and circumcision without taking account of structural inequalities between women and men. In their opinion, some authors who criticise anti-FGM discourse in the West do not take sufficient account of structural discrimination against women and the continuum of gender-based violence which are an integral part of women's lives in patriarchal societies.

Furthermore, in these patriarchal societies excision and circumcision practices construct gendered identities that are hierarchised: while excision aims to make women "better behaved" and control their body and their sexuality, circumcision on the contrary "builds" men who are "dominant" and "strong".

"The danger with likening circumcision and excision is that one could consider them as equivalent practices, each as restrictive as the other. This questions the very basis of excision: men's domination over women. I believe it is crucial to recall that although in both cases a potentially fatal bodily mutilation takes place, the systematic nature of the destructive consequences of excision (both psychologically and physically), and its real, although rarely explicit, purpose of ensuring patriarchal organisation of society, make any parallels between these two practices impossible and, above all, dangerous."

Lucie Goderniaux, Université des Femmes

Although increasing numbers of people know that excision is not required by Islam, some use the religious argument to make an absolute difference between excision and circumcision. In the Jewish and Muslim religions, the latter is generally seen as a religious obligation. However, as is the case with excision, circumcision is a very ancient cultural practice, dating much further back than the advent of monotheistic religions. Consequently, a supposed religious obligation alone cannot justify a practice that is contrary to the rights of children.

In some countries, circumcision is practised outside of a religious framework for medical purposes. The potential benefits of circumcision on health are also cited to justify this practice. While some studies focus on the positive effects on rates of transmission of HIV and other STDs (sexually transmitted diseases), others contradict this and highlight that condoms provide effective protection against sexually transmitted diseases. In addition, circumcision is most often practised on children or babies, who do not have sexual relations. Treatment of phimosis (where the foreskin cannot be stretched back past the glans of the penis) is also cited as a reason for circumcision, whereas some healthcare professionals consider that this pathology remains rare if a boy's penis is not unnecessarily tampered with and other treatment solutions exist when cases arise. Furthermore, circumcision can have consequences on health and lead to haemorrhages and even death.

Some associations, including Droit au corps, whose members include men with negative experiences of circumcision, denounce these practices on underage boys, who are incapable of consenting to the intervention. Members consider in particular that poor knowledge of anatomy and of the purpose of the foreskin in the sexuality of men and their partners is under evaluated.

"We believe it is necessary to fight against the sexual mutilation of all children, regardless of their gender or sex. Therefore against excision, circumcision and interventions that are not medically justified on intersex children. We must avoid cultural incoherence that consists, for example, of disparaging excision while valorising circumcision, for populations who consider them to have the same ritual signification, in particular the transition from the world of children to that of adults".

Member of the Droit au corps association

The men in the association talk about painful, traumatising experiences of circumcision, whether it was carried out for "medical" or religious reasons. The members of Droit au corps are not opposed to circumcisions practised on adult men who can give informed consent, they testify about the negative consequences on their sexuality, in particular less sensitivity of the glans following circumcision. In terms of impact on the body and consequences, it is striking that in the case of male circumcision, we immediately imagine "less invasive" procedures, carried out in the most sterile conditions, whereas we imagine that the most radical forms of FGM are generally practised in rural areas and with no anaesthetic. This vision can also be placed in a neo-colonial attitude, in which FGM is placed outside of its own context (other than plastic surgery, piercings) and male circumcision is presented as acceptable in the western context (Earp, 2014). However, male circumcision also takes place based on different types and can have substantial consequences on health. These include genital malformations, urological and sexual complaints, bleeding and sometimes even death (CIRP, 2013).[16]

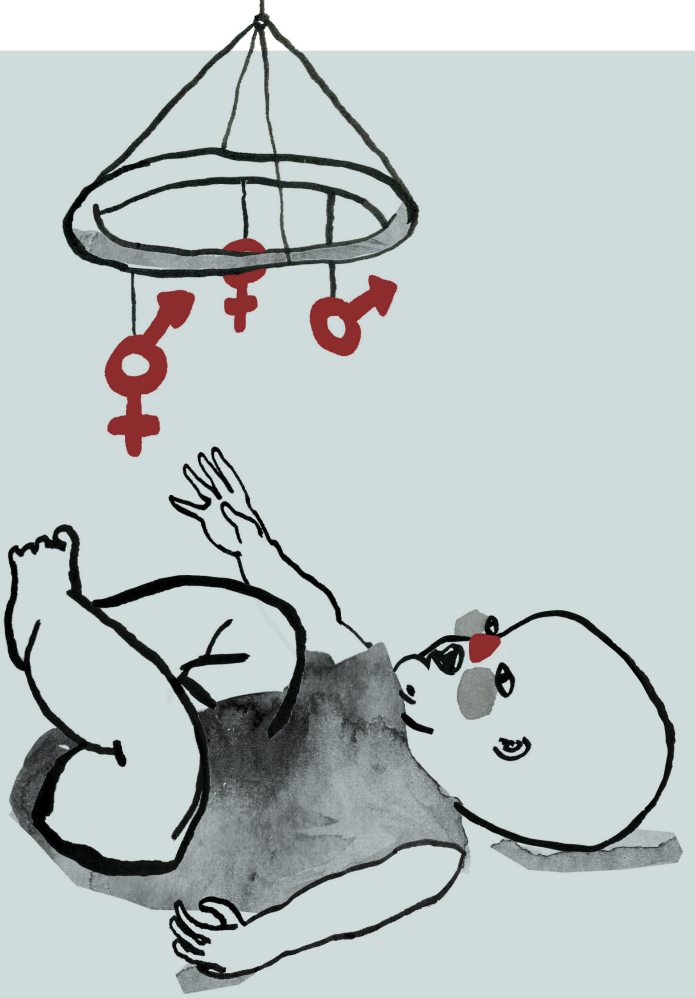
"BELGIAN LAW PROTECTS ALL CHILDREN FROM GENITAL MUTILATION..."

Another legislative incoherence is that between female genital mutilation and mutilation of children who are born intersex. European countries have laws against FGM that are supported by the position of the World Health Organisation. However, in these same States, intersex children can still be subjected to surgical operations justified by so-called "sexual ambiguity". The definition in Belgian law and that of the WHO only reject interventions on individuals of the female sex, but not those on intersex children (or on boys).

The term "intersex" describes a person whose biological sex cannot be clearly classified as male or female. An intersex person can have the biological attributes of both sexes or not have some biological attributes considered necessary for the definition of one sex or the other. Intersexuality is always congenital and can be generated by genetic, chromosomal or hormonal variations. Environmental influences such as endocrine disrupters can also play a role in some intersex differences. The term is not applicable in situations where individuals deliberately change their own anatomical characteristics (Organisation intersex international).

The general prevalence of intersex people is estimated to be 1.7 % of the population. This can include diversity in terms of anatomical sex (inner or outer genital organs), the sex of chromosomes or the sexual hormones.

In Belgium, as in the majority of European countries (and elsewhere in the world), when a child is born with genital organs considered to be ambiguous, doctors can conduct a series of tests (anatomical description, blood and urine tests) to "determine the gender" of the child. A gender



reassignment operation is subsequently carried out to align the gender chosen and the morphological sex of the child. This technique is used in at least 21 European Union member States (FRA, 2015). As infants are not capable of giving their consent, parents are involved in the decision. Critics point out that parents often have very poor knowledge of what the intersex condition means, apart from what they learn from the medical point of view. Finding themselves subjected to a stressful situation and pressure in terms of time, they are obliged to make a decision without having made contact with intersex organisations or people. In Belgium, parents have three months to make a decision about the sex of new-born children with a "gender ambiguity". If the person concerned later points out that a mistake has been made, they can submit a request to rectify their birth certificate to the courts. For other people, intersex status can be determined later in life, during puberty or in adulthood.

Medical gender assignation generally requires a series of medical surgeries and hormonal treatment that often needs to be taken for life. These "gender normalisation" interventions, also referred to as "intersex genital mutilation", are condemned by intersex activists and researchers. In the majority of cases they cannot be justified in terms of medical requirements as the majority of intersex people are in good health. These cosmetic interventions aim to make the child compliant with norms around sex and gender. The consequences are gender assignation that is often irreversible and can lead to infertility, severe pain and psychological suffering.

This is why Organisation Intersex international Europe (OII Europe) and Belgian associations Genres pluriels and Intersex Belgium, who work for the rights of intersex people, are calling for the prohibition of all non-vital hormonal and/or surgical interventions on intersex children until they are old enough to give their informed consent. The European for Fundamental Rights Agency highlights the importance of training professionals in the legal and healthcare spheres on the rights of intersex people in order to avoid "gender normalisation" interventions on children who are not old enough to give their informed consent (FRA, 2015).

It is easy to see the parallel between the objective of "normalising" the sex/gender of intersex children and the practices of FGM or circumcision as an imperative transition for a child to be considered a "woman" or a "man". Those opposed to mainstream FGM have been accused of cultural relativism because they ignore the rights of intersex people by focusing solely on countries referred to as developing countries (for example Ehreinreich, 2005). FGM in Africa and Asia is seen as a misogynous practice, while mutilation conducted in western societies is considered to be the result of "scientific medicine". In reality, both FGM and mutilation of intersex people are related to culture and are detrimental practices aimed at gender conformity, whether they are consented to or not.

"As with male circumcision, we observe that discussions on intersex genital mutilation are relatively rare in the "FGM sector", both at academic and association level [...]. Our meetings with children's rights professionals and healthcare professionals in Belgium point to a certain resistance to critical analysis of genital surgical interventions on intersex children. [...]

We believe that all professionals or academics who are committed to protecting the "genital integrity" of little girls at risk of being subjected to FGM, must also protest against surgical operations practised in Belgium with a view to "normalising" the genital organs of intersex children."

Stéphanie Florquin and Fabienne Richard,
in Critical Discussion on Female Genital Cutting/Mutilation
and Other Genital Alterations,
Current Sexual Health Reports, 2020

A more in-depth analysis of Belgian and European laws prohibiting female genital mutilation in migrant communities while remaining silent about medically unjustified interventions carried out on intersex children is necessary and urgent.

"There is a huge need for evidence-based research on the intersex condition. Unfortunately, this has not been started in Belgium. Political deciders must also be willing to invest in and encourage this type of research."

Wouter Vyvey, genital mutilation (intersex) expert

CONCLUSION

This guide aims to deconstruct a certain number of preconceived ideas about female genital mutilation and to demonstrate that these practices must be understood in the more global framework of gender norms that persist in our patriarchal societies.

In order for professionals to be able to provide services for all people concerned, it seems necessary to ensure good understanding of these practices, which are not limited to Sub-Saharan Africa or Muslim communities.

We have attempted to deconstruct ideas that stigmatise women and practising communities. Too often, we hear the word "barbaric" when the issue of female genital mutilation is raised. This type of terminology ignores the importance of social norms around FGM, which has been practised for thousands of years in many societies, and the manner in which women and girls who are not excised are treated. In this context, subjecting one's daughter to this act can only be seen as a rational choice. We believe it is necessary for everyone to look at their own norms and practices, and in particular for white people and/or people not affected by FGM to question the way they look at "Others".

FGM is gender violence, perpetrated against women because they are women, just like many other forms of violence. It is the product of a patriarchal society that ensures men hold the main power, to the detriment of women. However, in no case is it a criterion for a society to be considered as patriarchal, because FGM is not practised in the majority of patriarchal societies.

It seems essential to us that men take their responsibilities in the fight against gender violence, including FGM. Because of the lack of communication between men and women, in particular on intimate subjects such as FGM, it is necessary

to carry out awareness-raising among both women and men.

We have also seen that, even if female genital mutilation has consequences on the sexuality and mental and physical health of the women concerned, they must not be perceived as passive "victims", deprived of capacity for action and sexual pleasure. Better knowledge of the clitoris, which up to recently still remained very poorly known, enables us to better understand that excised women, regardless of the type of FGM, retain the majority of their body's organ dedicated to pleasure. Clitoral reconstruction, which is sometimes put forward as a technique to "repair" women, is a possibility for some but is by no means a miracle solution, or an obligation. On the contrary, we are advocating for a holistic response, including not just medical care but also (and above all) social, sexual and psychological care for the women concerned.

We also saw that the social norms weighing on women in all societies are responsible not just for what is commonly called female genital mutilation, but also obstetrical violence inflicted by the medical community, and cosmetic genital surgeries to which increasing numbers of women are willingly subjecting themselves. We have to wonder how these interventions on women's genitalia can be justified when the WHO defines genital mutilation as any intervention practised for non- therapeutic reasons and is firmly opposed to its medicalisation.

Similarly, we believe it is high time to question laws authorising hormonal and surgical interventions that are not medically necessary on intersex children who are incapable of giving their consent. Just like female genital mutilation, these operations aim to "normalise" children who must correspond to gender norms. We wish to invite associations and public authorities to think about circumcision, a practice that, like excision, is an intervention on the genital organ of a child who has no possibility to oppose it.

In conclusion, through this publication we have attempted to provide a feminist and anti-racist critical analysis of the various preconceived ideas relating to female genital mutilation. We have presented some elements of reflection, but we don't want it to stop here. Each person, whether directly concerned by the issue or not, must take the necessary critical distance to keep an open mind before adhering to false beliefs. Such beliefs can be damaging to the people directly concerned, whether they are women who have been subjected to FGM, affected communities, or an entire continent and its diaspora. It is through better overall understanding of the issue that the various stakeholders will be able to advance towards abolishing the practice of female genital mutilation.

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Acronyms

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

GAMS Belgique – Groupe pour l'abolition des mutilations sexuelles féminines (Group for the abolition of female genital mutilation)

FGM – Female Genital Mutilation

OMS – World Health Organisation

SC-MGF – Stratégies concertées de lutte contre les mutilations génitales féminines (Concerted strategies to fight against female genital mutilation)

Lexicon

The list is non-exhaustive. Definitions have been simplified and reflect use in this guide.

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

Clitoridectomy – type I female genital mutilation according to the WHO classification – is the partial or total ablation of the clitoris and/or the clitoral hood.

Circumcision – total or partial excision of the foreskin of the penis.

Defibulation - intervention consisting of sectioning the closure formed by the joining or sewing of the outer lips on the median line to open access to the outer orifice of the vagina.

Episiotomy - intervention consisting of cutting the perineum during childbirth, to facilitate the exit of the baby and avoid tearing.

Excision – type II female genital mutilation according to the WHO classification - concerns the partial or total ablation of the clitoris and the inner lips, with or without excision of the outer lips.

Gender - concept used in social science to designate non-biological differences between women and men. Contrary to sex, which refers to biological differences between women and men, gender refers to social, economic, demographic, political, etc., differences. Gender is the subject of a field of study in social science: gender studies. The concept of gender is frequently used to demonstrate that the inequalities between women and men are generated by social, cultural and economic factors.

Gender violence/gender-based violence – all forms of violence against a person because of that person's sex, gender or gender expression. Because of the hierarchical relations between women and men (patriarchy), the majority of gender violence is perpetrated by men against women: we refer to violence against women. The terms "violence against women" and "gender violence" are often used interchangeably. Gender violence also includes homophobic, transphobic and bi-phobic violence.

Hymenoplasty – intimate cosmetic surgical intervention on a woman, consisting of "repairing" the hymen.

Hymen – the membrane separating the vulva (outer part of the female sex) from the vagina (inner part of the female sex). The hymen has a different form in every person.

Infibulation – type III female genital mutilation according to the WHO classification – joining and sometimes sewing of the outer lips of the vulva, with or without ablation of the clitoris, leaving a small opening for the flow of urine and menstruation.

Intersex – concerns a person whose biological sex cannot be clearly classified as male or female. An intersex person can have the biological attributes of both genders or have some biological attributes considered necessary for the definition of one gender or the other

Nymphoplasty/labiaplasty - cosmetic surgical intervention on the outer lips and/or inner lips of the vulva. Can be a reduction or an augmentation of the size of the lips. It can also be used to repair lips damaged by illness or injury.

Patriarchy (patriarchal society) – a form of social and legal organisation based on possession of power by men to the detriment of women. The majority of current societies are patriarchal. Men dominate in political spheres, possess moral authority, enjoy social privilege and control of property.

Preconceived idea – a very widespread opinion considered to be correct. But often false, hence the need to dispel preconceived ideas. Preconceived ideas are so deeply integrated in culture that it is psychologically and sociologically very difficult to counter them. In Africa, people often refer to "beliefs".

Prevalence – number of people with a given affection , in a given population, at a given moment.

Reconstruction of the clitoris – surgical technique aimed at reconstructing a new clitoris by taking the stump of the clitoris from under the scar back to the surface.

Violence against women – physical, sexual, economic, and psychological violence against women. It can take place in a private setting (such as domestic violence) or in public (such as street harassment). Female genital mutilation is a form of gender-based violence against women.

End notes

1. In order to facilitate reading and demonstrate the importance of the role that assignation as a woman plays in the perpetuation of female genital mutilation, the word “women” will be used to designate all people (potentially concerned by) FGM. However, it should be stressed that all people concerned by FGM do not identify as “woman”, some are transgender men, non-binary people or intersex people. Transgender women are generally not concerned by FGM but can be concerned by other forms of genital mutilation such as intersex genital mutilation or circumcision.

2. Neo-colonial ideas that are based on a feeling of white people’s “western” superiority and on the idea that those who grew up in Europe (or in the United States) obviously had a better education, have more resources and are therefore capable and even obliged to “help” African (sub-Saharan) countries (Cf. a white man’s burden).

3. The term “neo-colonial” refers to a political and normative discourse that, like colonialism, is based on Eurocentrism, whereby the “western” perspective is considered to be a central departure point and a high moral standard. In neo-colonial discourse, violence against women is considered to be related to culture, leaving aside the specific sociocultural context.

4. These studies are conducted at national level among a representative sample of the population, and repeated every three or four years, which makes it possible to see a trend over several years.

5. We use the terms “development” and “western” in inverted commas to show that these expressions are not neutral because they convey the idea of a graded scale between countries, with some countries being more advanced, more developed (or more “civilised”). We do not adhere to such a vision of the world.

6. A *fatwa* is a legal opinion, an authoritative decision by an Islamic lawyer (mufti).

7. https: /copfgm.org/maryam-sheikh-abdis

8. For more information on risk indicators, see the triptych and the risk scale: www. strategiesconcertees- FGM.be/wp-content/uploads/FGM-tryptique_final_RTP.pdf

9. For more information: https: /www.moustique.be/24310/ white-saviors-qu-est-ce-que-le-complexe-du-sauveur-blanc et https: /metro.co.uk/2019/03/06/what-is-a-white-saviour-complex-8793979/

10. The Men Speak Out against FGM project aimed to involve migrant men in work on the prevention of FGM in three European countries (Belgium, United Kingdom, the Netherlands).

11. In the case of sexual violence, responsibility is often thrown back on the woman or girl subjected to the violence, by denouncing her behaviour or the way she is dressed.

12. [Video] Countering myths about FGM/C | Jasmine Abdulcadir | TEDxPlaceDesNationsWomen. https://www.youtube.com/ watch?v=0vI_4PZTkME

13. In the case of reduction of the inner lips, the term used is nymphoplasty.

14. While some authors prefer the term obstetrical and gynaecological “violence” to signify that a patient is in a vulnerable situation, the term “abuse” is used by others as it is perceived to be less violent for professionals and as a better means to raise their awareness and encourage them to be careful and look after their patients (Dechalotte, 2017).

15. Today, recommendations by professional bodies, in particular in the United States and the United Kingdom, are against routine practise of episiotomies. Nevertheless, studies have shown differences between hospitals and also, increasingly, individually between healthcare professionals.

16. Watson, L. (2014). "Unspeakable Mutilations: Circumcised Men Speak Out". Create Space, ISBN 978-1495266577. Et www. circumcisionharm.org

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