No Words Can Express
Two Voices on Female Genital Mutilation

by Kowser Omer Hashi and Joan Silver

Cet article discutte des mutilations génitales féminines et leurs effets sur les Somaliennes qui vivent au Canada. Afin que ces femmes obtiennent les soins qu'elles nécessitent et que les futures générations de Somaliennes n'aient pas à subir ces mutilations, les auteures insistent sur l'importance de l'éducation. L'une des auteures, elle même Somalienne, partage ses sentiments sur les mutilations génitales.

Once you go through it, you don't talk about the pain to young girls.

Kowser Omer Hashi's voice will appear throughout this article in italics.

Only women who have gone through it and survived could understand what it feels like. No words can express.

Throughout Canada women and children live in the shadow of violence all the time. We have heard about rape, child abuse, sexual assault, pornography, and sexual harassment. Now we must add female genital mutilation (FGM) to our list.

Female genital mutilation is also commonly known as female circumcision. It is an extreme example of how societies around the world attempt to suppress women's sexuality, maintain their subjugation, and control their reproductive functions.

Approximately 60,000 Somali refugees have entered Canada and, of these, approximately half would be women. If they are eight years of age or older, you can be certain they have been genitally mutilated.

It is violence against women and a lifetime of health hazards, but people who practice it don't see it that way. It is a form of girl child abuse, but mothers misunderstand religion and think it is a requirement.

What is female genital mutilation? The Foundation For Women's Health Research and Development (FORWARD) in London, England has identified three different types of this procedure.

- Circumcision: This is the mildest type of procedure and is performed only on a small proportion of the millions of women concerned. In this procedure, the hood of the clitoris is cut.
- Excision: In this procedure the clitoris is cut and all or a part of the labia minora.
- Infibulation: This procedure involves cutting the clitoris, the labia minora and at least the anterior two thirds and often the whole of the medial part of the labia majora. The two sides of the vulva are then sutured or otherwise closed in some manner thus obliterating the vaginal area except for a small opening for the purpose of allowing for the passage of urine or menstrual blood. The final opening is the size of a corn kernel.

With rare exceptions, infibulation is practiced on 100 per cent of women in Somalia. If people tell you this is not so, it is because they want to protect the secret of the tradition or perhaps they don't want you to know that they have been circumcised.

In rural areas, crude instruments such as dull kitchen knives, rusty razor blades, or shards of unwashed glass are used. Stitching may be done with silk, catgut or with thorns. Girls may have their legs bound together for up to forty days to allow scar tissue to form over the wound. Anesthetics are usually not used and conditions are often not hygienic.

Little girls often put pressure on their mothers to have the procedure done, not knowing of the pain. Girls are not allowed to witness the procedure. They often hear how when they are infibulated, that they will be getting special gifts and will be like beautiful little queens. I kept putting pressure on my mother and wanted to get this special gift. Now I know why my mother was trying to put it off for a short period of time. But once you go through it, you don't talk about the pain to young girls. It seems a very powerful form of brainwashing is done during the procedure. All I could think of was how I would be a little queen!

In Somalia, all girls without exception are infibulated as it is a requirement for marriage. Since marriage is a must for Somali women, the practice continues today.

In Somalia, the entire subject of sex is taboo. Neither children nor adults discuss sex and sex education in schools is unheard of.

In Canada, health and sex education classes begin at the elementary level. By the time students are at the secondary level, topics such as AIDS, sexual intercourse, venereal disease, and human sexuality are commonplace. For the female Somali students these topics are not only new but totally taboo. Furthermore, any diagrams of the female form used in class do not match the anatomy of female Somali students.

The practice of infibulation ensures the sexual oppression of women. A woman's role is to provide sexual pleasure to her husband and to bear his children. If you talk to Somali men and women they will tell you that infibulation is performed to eliminate female sexual pleasure, decrease the risk of nymphomania, and to assure virginity prior to marriage. As large labia are considered an ob-

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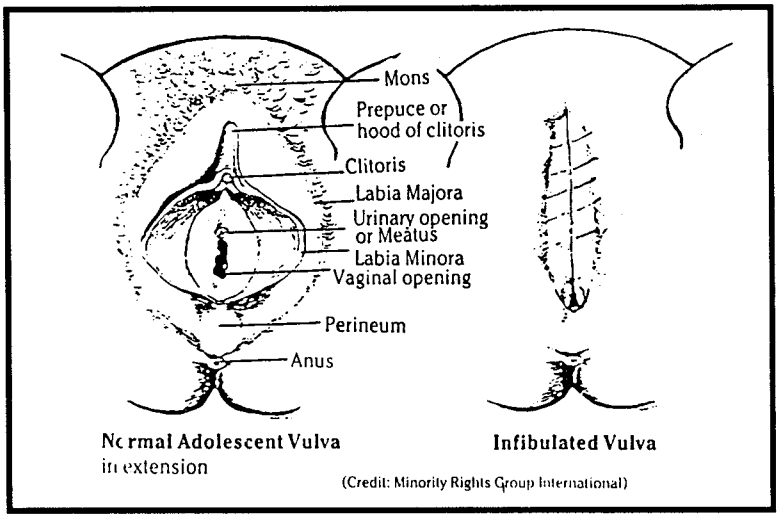
struction to sexual intercourse they are eliminated to increase male pleasure. Infibulation removes every possibility for women's sexual pleasure and assures the faithfulness of women to their husbands. Somalis also believe it facilitates cleanliness because removing the labia provides a smooth surface.

At last my wish came to reality. My mother found a traditional midwife, who can see clearly, had access to anesthesia, catgut, painkiller, and clean needles. The operator and her team came one early morning carrying a midwifery kit donated by the World Health Organization to midwives for births. I was dressed in a pretty new dress and had a light breakfast. I nearly got scared and ran to hide under the bed, but the women pulled me out and took me to the room that was prepared for the special occasion. The door was closed and I was pinned down to the floor. The women told me that to cry or scream was unheard of for a girl. One woman covered my eyes and I was completely immobile. The operator injected me with the needles but I can even feel right now how horrible it was. I accepted it as a way of our life and that cannot be changed.



In the Somali community, women have had an essential part of their being, their creativity, removed and are assigned a devalued and inferior place. They do not have the capacity to define themselves. They do not have access to resources and they do not participate in decisions that affect their day to day living. Infibulating the women reinforces their passivity and dependence as men exert their rights to authority and continued control.

FGM is not seen [by Somalis] as a form of violence against women and girl children; rather it is seen as a sense of belonging to the community. We also believe in our culture that if you discontinue a cultural practice, you pay the consequences, and that Allah (God) will punish you. So many women feel they will be cursed if they speak up against female genital mutilation.

Somali women are kept isolated and, for the most part, are much less educated than the men. They believe the mutilation of their genitals is necessary. They believe in the myths that are designed to justify and continue the practice. They believe no Somali man will marry them if they are not infibulated. They believe men are entitled to infibulated women. A sixteen year old student understood clearly why she was infibulated. She told me, "Men no like big hole." It would be a family disgrace and just cause for an annulment or divorce if a man married a woman with a "big hole."

When women get pregnant, they are worried about having baby girls, knowing of the man-made pain that will rob her of her happiness and innocent childhood. The new baby girl comes into a cruel world that is not welcoming her a as a full citizen or human.

What about the mutilated women who become disabled from the infibulation? Some become sterile and are un-marriageable. What about all the other mutilated women who find sex painful and receive no pleasure from it? What about the women who have a lifetime of medical problems from this violation to their body? What about the women who die in childbirth because of this act? What about the children who die in childbirth because of complications brought about from the mutilation?

There are many serious health effects which result from the practice of female genital mutilation—immediate, long term, and effects on marriage and childbirth. At the time of the procedure and immediately after, a girl can experience shock, infection, tetanus, blood poisoning, injury to adjoining organs, hemorrhage, and urine retention. In the long term, she can develop cysts at the site of the infibulation, acute chronic PID [pelvic inflammatory disease]. dysmenorrhea [painful menstruation] from backed-up menstrual flow, chronic urinary tract infections, abscesses in the vulva, and infertility from the scarring and infections. First night of marriage is very painful. If the woman becomes pregnant, she may have a delayed or obstructed labour, she may have serious tears of the perineum, and the baby may have difficulty when coming out, especially if the physician or midwife is not familiar with working with women who have had FGM.

In Somalia, all women are infibulated. While they are in Somalia, they are "all in the same boat" and no one looks at them askance. In Canada, not only do they have to deal with the myriad of medical problems and pain from urinary problems, menstruation, sex and childbirth, but female infibulation is not a socially accepted practice. In addition to the medical problems they already have, a host of new ones will be added.

My own experience of working with other African women in the United States made me realize how little doctors in North America know about how to deliver the babies of African women; too many did Cesarean sections when they were not necessary. That's why I began to consult with health care professionals about providing for the special needs of genitally mutilated women. When I delivered my baby in a hospital in Toronto, it was cold and lonely and I missed having women around me. Here, the nurse only comes in once in a

while, but she was monitoring me from the nurses station. Technology has replaced the human care and touch of nursing and midwifery that I knew at home.

A Somali woman tried to explain FGM to me. She said that a Somalian woman experiences three sorrows in her life. The first sorrow is when she is infibulated. The second sorrow is her wedding night. The third sorrow is the day she gives birth.

For the first time these women will learn that what was done to them was unnecessary and will bring them a lifetime of pain and medical problems. They will learn that female genital mutilation is against the law. They will learn that FGM has nothing to do with their Muslim religion for 95 per cent of Muslims around the world do not infibulate their women.

At Kipling Collegiate in Etobicoke, Ontario, we have begun to address the needs of our female Somali students. In the fall of 1993, Kowser Omer Hashi, a qualified nurse, midwife, and reprodcutive health counselor came into the school when the Somali girls were scheduled to have their sex and health education classes. Kowser met with the Somali girls and addressed the same topics that were being covered by the health teacher with the other students. She brought in visuals and other items such as an artificial penis, and various birth control devices. Her expertise with the Somali culture and language facilitated the process. The girls responded favourably to her classes and insisted that they continue even after the health program was completed. We have made arrangements for these sessions with Kower to continue during the lunch hour one day a week.

An all day session at the school for the female Somali students was conducted in English and Somali. The school invited Somali women to speak about general health issues, human sexuality, venereal disease and FGM . At the end of this day the students had an opportunity to share their concerns and give input as to where we can go from here.

The Somali students need to have opportunities to discuss and understand what happened to them and why. Involving supportive and respected female members of their culture is essential. Co-operatively, we can ensure that the students become more knowledgeable about the health problems they are likely to experience. We can provide them with resources within the community to help them address their needs in relation to this issue. Throughout this process the students will also be made aware of the legal and moral ramifications of continuing this practice in Canada.

FGM is not a black women's issue, it is a human rights issue. We need every woman to support us without passing judgement and work with us to eradicate this human tragedy.

Hopefully, the next generation of Somali girls will grow with love, guidance, and strong Somali values that will encourage them to make healthy choices in an informed, positive way about their own sexuality. Hopefully, these girls will become mothers of daughters who will not experience female genital mutilation.

Kowser Omer Hashi is a Somali nurse and midwife who lives in Toronto where she works as a reproductive health counsellor at the Birth Control and VD Information Centre. As an FGM consultant, she provides pre/post-partum assistance as well as labour support to women who have been genitally mutilated. She sits on the advisory boards of various women's community projects and is a member of the Ontario FGM Prevention Task Force.

Joan Silver is a teacher who has worked with Somali students for the last three years at Kipling Collegiate in Toronto. She has learned a great deal about female genital mutilation from her Somali students.

References

Hedley, Rodney and Efua Dorkenoo. Child Protection and Female Genital Mutilation Advice for Health, Education and Social Work Professionals. London, England: FORWARD Ltd.

KAILI GLENNON

I am afraid. We are
walking and walking and I
do not know if this
line will ever end.
This is a line of hatred,
a line that is being held up
by whips, guns,
and anger. I am so
tired and hungry. I scream
out for help. I receive
nothing but a whip
on my back, but it does
not hurt my back. It
hurts in my heart, because
my dream has been
shattered. A dream that
we will all be equal....
someday.

Kaili Glennon lives in Toronto. She is thirteen years old.

Facts About Female Genital Mutilation

Throughout history, an estimated 80 to 114 million girls and women have undergone FGM. The practice is widespread in 27 African countries, seven Middle-Eastern countries as well as parts of Malaysia, India, and Indonesia. However, as famine and wars scatter people around the globe, FGM is rapidly becoming an issue in North America, Europe, and Australia.

Common Justifications for FGM

- ritual initiation into "womanhood"
- religious requirement
- ensure chastity
- prevent nymphomania
- reduce female sexuality and prevent masturbation
- improve aesthetic appearance of vulva
- increase male sexual pleasure
- ensure marriageability
- increase fertility
- improve hygiene
- avoid family "disgrace"

Ages when FGM is performed

Country	*Age*
Ethiopia	8th day after birth
Somalia	3–4 years (sunnia/excision)
	4–10 years (infibulation)
Egypt	3–8 years
Sudan	5–8 years (infibulation)
Kenya	14 and up
Mali	shortly after marriage

Health Consequences of FGM

A) Complications during or shortly after the procedure:

- shock due to pain and bleeding
- hemorrhage
- urine retention
- tetanus
- infection and failure of wound to heal
- septicemia (blood poisoning)
- injury or trauma to adjoining organs
- possible transmission of HIV and other viral infections through unsterilized instruments

B) Long-term complications:

- scarring and keloid formation
- vulval dermiod cysts and vulval abscesses
- acute or chronic pelvic inflammatory disease
- infertility
- dysmenorrhoea
- dsyparenia (painful sexual intercourse)
- recurrent urinary tract infections
- difficulty urinating
- calculus (formation of bladder and kidney stones)

C) Complications for labour and delivery

- infibulation scars are thick,and form tough skin that loses elasticity and does not stretch
- tears of infibulation
- perineal tears
- severe labour pain
- prolonged labour
- difficulty in assessing malpresentation of baby through vaginal examinations
- excessive blood loss
- brain damage to fetus
- uterine rupture
- recto-vaginal fistule
- maternal and/or fetal death

CALL FOR PAPERS
Women's Rights Are Human Rights: Focus on Youth

The Centre for Feminist Research and the Centre for Refugee Studies at York University will be hosting an international workshop March 68 1995 entitled "Women's Rights are Human Rights: Focus on Youth." A principal purpose of the workshop is to establish a deeper understanding of issues concerning young women. Paper presentations and panel discussions, in English or in French, will address issues of a timely nature, and will stimulate broader cross cultural analysis in this area. Abstracts (100 words) are invited from academics, service providers, policy makers and, particularly, feminist activists. Subject areas may include: Feminist inquiry into the rights of young women; young women as immigrants/refugees; family; health; sexuality; violence; race, class, ethnicity and religion; family law; the state; the politics of activism; The risk of being conceived female; the silencing of the girl child.

Some travel funds will be available for presenters from Africa, Asia, the Middle East, Latin American and the Caribbean.

Deadline for receipt of abstracts is **September 1, 1994** and should be forwarded to:

Farhana Mather, Workshop Coordinator, Centre for Feminist Research, York Lanes 228, York University, 4700 Keele St., North York, ON Canada M3J 1P3, Tel: (416) 736 2100 ext 20560 • FAX: (416) 736 5837

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