FEMALE GENITAL CUTTING: ETHNOCENTRISM, CULTURAL RELATIVISM, AND UNIVERSAL MORALITY

By

MARISSA DEANNA LIRA

A Thesis Submitted to The Honors College
In Partial Fulfillment of the Bachelors Degree
With Honors In
Interdisciplinary Studies
THE UNIVERSITY OF ARIZONA
MAY 2014

Approved by:

Dr. Ivy Pike
Department of Anthropology
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IDS - International Studies

Date thesis submitted to Honors College:
5/7/2014

Title of Honors thesis:
Female Genital Cutting - Ethnocentrism, Cultural Relativism, Universal Morality

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Female Genital Cutting: Ethnocentrism, Cultural Relativism, and Universal Morality

Abstract:
This essay critiques the ethnocentric nature of the literature and discourse relative to the debate surrounding female genital cutting. It identifies the sensationalized misconceptions about the practice as well as the lack of clinical evidence and empirically grounded information regarding female genital cutting. An extension of this critique also requires an examination of the tensions that exist between the notions of universal morality and cultural relativism in regards to female genital cutting. In an attempt to reconcile the tension between the two theories, I offer a hybrid approach toward framing female genital cutting, which calls for cross-cultural empirical research that would identify values shared by all cultures, and would confer legitimacy on specific human rights standards that are historically dictated by Western ideologies and morals. This approach conserves the strengths and negates the weaknesses of both cultural relativism and universal morality, and offers an alternative method of framing female genital cutting in a manner that may produce an objective environment for both Western and non-Western interlocutors to participate in the debate regarding female genital cutting.
Fran Hosken, an American writer, feminist, and social activist published the infamous *Hosken Report: Genital and Sexual Mutilation of Females* in 1979. She shirked the term "female circumcision" and coined the more explicit and sensationalized term of “female genital mutilation,” which evokes a sense of implicit immorality, alludes to the ideas of torture and barbarism, and effectively others any cultures that still practice the custom of female genital cutting. The *Hosken Report* turned the issue of female genital cutting into a hot button topic, especially within the healthcare and feminist communities. At a time when Western feminists were very concerned about taking ownership of one’s sexuality, and when the clitoris was gaining notoriety as the source of the female orgasm, the notion of a cultural practice that involved the removal or alteration of the female sex organs shocked, appalled and enraged people.

The Hosken Report set the precedence for how the global community discussed female genital cutting such that the discourse surrounding the issue tends to be extremely ethnocentric. Westerners and their standards of what constitutes civility and propriety exclusively dictate the debate surrounding female genital cutting. It is imperative to critique how the discourse surrounding the issue is constructed, who constructs that discourse, and how the issue is presented on a global scale. An extension of this critique also requires an examination of the tensions that exist between the notions of universal morality and cultural relativism in regards to female genital cutting. This is not to say that I condone the practice or that I radically adhere to the theory of cultural relativity, however, it is necessary to disentangle the cultural nuances of the debate that
surrounds female genital cutting, and acknowledge that the ethnocentric bias that tends to characterize the literature regarding the debate dictates how we as a global community discuss the issue. Christine J. Walley (1997) aptly describes the sensitive nature of the topic of female genital cutting by stating that, “The issue strikes numerous nerves, as it challenges fundamental understandings of body, self, sexuality, family, and morality, and as it plays upon tensions relating to cultural difference, the relationship between women and ‘tradition,’ and the legacy of colonial-era depictions of gender relations in non-Western countries.”

However, the sensitive nature of the subject should not serve as an excuse for misrepresentation or as a means of perpetuating Western ideologies, but as a source of motivation for cultivating a more culturally inclusive discourse about the practice. Walley (1997) also points out that there is a tendency to understand female genital cutting in “either/or terms,” or in other words, in terms of either cultural relativity or universal morality. In this essay I offer an alternative approach to understanding female genital cutting, as prescribed by Alison Dundes Renteln (1990) that would potentially resolve the existing tension between the two schools of thought.

The World Health Organization classifies female genital mutilation into four broad categories based upon the extent and severity of the procedure.

<table>
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<tr>
<th>Classification</th>
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<tr>
<td><strong>Type I-Clitoridectomy</strong></td>
<td>Involves the partial or total removal of the clitoris and/or prepuse. Includes the ritual practice of <em>Suna</em>, which is widely practiced in Muslim cultures and entails the pricking of the clitoris.</td>
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**Type II - Excision**
Entails the partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora.

**Type III - Infibulation**
Entails the narrowing of the vaginal orifice with the creation of a covering seal by cutting and appositioning the labia minora and/or labia majora, with or without the excision of the clitoris. Infibulation is the type of female circumcision that is most often discussed and condemned within the literature surrounding the practice.

**Type IV - Other**
Entails all other harmful procedures to the female genitalia for non-medical purposes, such as pricking, piercing, incising, scraping and cauterization. The Western practices of piercing the genitals and labiaplasty fall into this category.

(World Health Organization 2014)

The fact that labiaplasty and the piercing of the clitoris for aesthetic or sexual enhancement are widely accepted Western practices despite qualifying as a form of female genital mutilation as per the WHO is a point that will be further explored later on in this essay.

The WHO’s Study Group on Female Genital Mutilation and Obstetric Outcome was published in the prestigious medical journal, *The Lancet*, in 2006. To this day, the study is often quoted for its statistical information. For example, the *New York Times* cited the study by saying that, “[female genital mutilation] has deadly consequences when the women give birth, raising by more than 50 percent the likelihood that the woman or her baby will die” (Rosenthal 1995). The results of the study support the sensationalized claims of Western feminists,
health care workers, and media; thus, the results of the study have remained largely un-scrutinized and un-criticized. However, a close examination reveals the complexity of the results reported within the study as well as flaws in the study’s methodology. For example, the perinatal death rate for the women in the sample who had Type III surgery (what is considered to be the most severe form of female genital cutting) was lower (193 infant deaths out of 6,595 births) than those who had no surgery at all (296 infant deaths out of 7,171 births), and became statistically significant only through nontransparent statistical adjustment of the data. In addition, there was no significant difference in risk of maternal mortality when comparing uncut women with the sample of women with Type I and Type III surgeries, but there was higher rate of maternal mortality amongst women who had undergone Type II surgeries. Methodological shortcomings of the study included the failure to control for the quality of health care available for cut versus uncut women across six different nations, which produced a sample of subjects that is not representative of whole populations (Public Policy Advisory Network on Female Genital Surgeries in Africa). Although, the Public Policy Advisory Network on Female Genital Surgeries in Africa adheres to what some would consider a radical agenda of cultural relativity, their work is useful in that it challenges the sensationalized claims about female genital cutting made popular by Western scholars, activists and the media. Additionally, many other reports and bodies of medical literature suggest that death or extreme medical complications resulting from female genital modification are infrequent and are the exception rather than the rule. In fact, many bodies of literature have found
that from a public health standpoint, female genital surgeries are relatively safe even when carried out with crude medical equipment or in subpar conditions (Bell 2005, Obermeyer 1999).

At one point in her study, Obermeyer (1999), explicitly addressing the shortcomings of the Hosken Report, acknowledges that the Hosken Report was excluded from the study because of, “the poor quality of the evidence they use, and the methodological shortcomings of their estimations” (1999). It’s astonishing, and quite frankly appalling, that the most widely accepted and cited piece of female genital cutting literature was deemed unacceptable as soon as someone decided to objectively evaluate it. In regards to the literature that was actually included in the study, Obermeyer found that, “while information regarding the prevalence of female genital surgeries is becoming increasingly available, the powerful discourse that depicts these practices as inevitably causing death and serious ill health, and as unequivocally destroying sexual pleasure, is not sufficiently supported by the evidence” (1999). Thus, there have been very few clinical studies that reliably establish a correlation between female genital cutting and rates of maternal mortality, vaginal tearing, sepsis, prolonged labor, fistula, loss of sexual pleasure, and the mental/emotional trauma that may be associated with the procedure. This is not to say that the correlations do not exist, but the absence of reliable clinical studies has two implications. First, it indicates the reluctance of scholars and academics to critically examine studies about female genital cutting, and reflects their unwillingness to address the issue in an objective, culturally sensitive manner. This unwillingness to critically examine
female genital cutting illustrates the power of sensationalized media coverage, which essentially ensures that scholars and activists who take an opposing or more culturally nuanced stance on the issue are effectively ostracized or identified as morally suspect. Second, it implies that Westerners are in a position to demonize the practice without sufficient evidence, while African and Middle Eastern women are unworthy of the right to reliable clinical evidence about their own cultural practices. This is a testament to the ethnocentric nature of the debate surrounding female genital cutting.

The biggest misconceptions about female genital cutting relate to why the operation occurs in the first place. Western scholars, feminists, and activists, often identify patriarchal control over female sexuality as the reason why the tradition of female genital cutting persists. The theme of patriarchal control over the female body runs rampant throughout the Hosken Report:

“The objective of all patriarchal societies everywhere is to control women’s sexuality and fertility as strictly as possible” (270).

“Female fertility is, of course, the greatest good. Men are aware of and have internalized their own inferiority vis-à-vis women which haunts them and leads them to violence” (289).

“It is men who collectively and individually are responsible for continuing the practice of FGM” (316).

Fueled by radical feminism and her Western oriented views of propriety, Hosken makes a number of observations that are not only drastically over simplified, but are quite frankly just plain wrong. There are many flaws in the argument that identifies female genital cutting as a perpetuation of patriarchal control. First, almost all societies that customarily practice female genital cutting practice male
genital cutting as well. Within these societies genital cutting is often practiced as a coming of age ceremony in which both males and females are expected to participate if they want to be full-fledged members of their community (Ahmadu 2000, Public Policy Advisory Network on Female Genital Surgeries 2012). Thus, genital cutting does not exclusively target females. Second, “the empirical association between patriarchy and genital surgeries is not well established” (The Public Policy Advisory Network on Female Genital Surgeries in Africa 2012).

Many of the world’s societies can be described as patriarchal, and the majority of these societies either do not modify the genitals of either sex, or they exclusively modify the genitals of males (i.e. the circumcision of infant males in the United States). There are almost no patriarchal societies that practice genital modification exclusively on females.

In addition, the argument for patriarchal control over female sexuality is discredited by the fact that many cultures that traditionally practice female genital modifications are rather permissive and encouraging of sexual experimentation before marriage (i.e. the Kono people of Sierra Leone). Similarly, not all cultures that hold chastity and purity in high regard practice female genital modification (i.e. the Turkana people of Northern Kenya), which you would think would be the case if men had figured out such an effective method of controlling female sexuality. In any case, there are correlations that have been drawn between female genital cutting and patriarchal societies that are not grounded in empirical evidence.

An additional, and what I find to be the most compelling reason why
patriarchal control over female sexuality is an invalid explanation for the continuing practice of female genital modification is the fact that female genital cutting is often controlled and managed by women themselves. Despite numerous efforts to eradicate the practice of female genital cutting, many women remain staunch and fervent supporters of the practice. I have come across numerous instances of women being cited as saying they would require their own daughters to undergo the procedure despite any discomfort or complications they may have faced with their own genital modifications. Secret societies of women, which are often very powerful and highly respected within their communities, are usually responsible for conducting the ceremonies associated with genital modification as well as the actual genital cutting itself. Fuambai Ahmadu, an African writer who has undergone ritual genital modification and has chosen to share her experience with the public makes it very clear that her account of the events that took place is abridged because of her, “desire to respect the secrecy and sensitivity of women’s esoteric ritual and supernatural knowledge” (2000). This illustrates a deep respect and regard for the traditions and customs of her people. Similarly, many women view the eradication of such practices as a defilement of ancient customs that are often practiced to appease some sort of higher being. If we were operating within a feminist framework, eradicating female genital cutting would serve to empower women and enable them to gain control over their sexuality, but for many African women eradicating the practice would mean forfeiting the power that is associated with secret female societies and would ultimately diminish their status within the community.
Western scholars have often attempted to reconcile the discrepancy between the notion of female genital cutting as a manifestation of patriarchal control over female sexuality and the fact that female genital cutting is often controlled and performed by women by citing a theory of “false consciousness” among African women (Johnsdotter 2014, Thiam 1986). This theory argues that African women have been abused and controlled by men for so long that they have been brainwashed into accepting and embracing patriarchal attempts to control female sexuality. In other words, women believe that female genital cutting is necessary because their male counterparts have forced them to believe so via physical, emotional, and mental abuse. The absurdity and condescension that props this theory up is extremely offensive. It portrays African women as impotent, weak, creatures that are incapable of being free thinkers or making decisions about the state of their own bodies. The theory of false consciousness robs African women of having agency over their sexuality and physical state, which ironically, is what feminists and Western scholars are so fervently advocating for. The theory effectively casts African women into the role of the inferior other and perpetuates ideas of Western propriety in regards to the female body and sexuality.

Many scholars readily accept the explanation of female genital modification as a manifestation of patriarchal control over female sexuality because they operate under the assumption that female genital modification completely obliterates a female’s ability to experience sexual pleasure or achieve an orgasm. This is an assumption that is not grounded in any scientific or
empirical evidence. That is not to say that there have not been any reports of painful or uncomfortable intercourse among women who have undergone female genital cutting, especially among women who have been infibulated. However, the majority of the women who have had undergone female genital cutting report healthy and active sex lives. In fact, many women who had not had any sexual experiences before their genital modifications and who remained virgins until marriage are able to aptly describe what an orgasm feels like and report experiencing them on a regular basis (Abusharaf 2001, Einstein 2008). We often equate the female clitoris to the male penis, thus we assume that the removal of the clitoris would have the same effect on a woman as the removal of penis would have on a man (Bell 2005). However, despite the fact that both the penis and the clitoris function as the epicenter of the orgasm, they are drastically different biologically. There has been little to no research on the neurological consequences of female genital modification, a point that Gillian Einstein in (2008) aptly outlines. She explains how, “the clitoris actually extends extensively internally, suggesting that there is erectile tissue that could mediate orgasm independently of the glans [external clitoris].” Thus, the removal of the external clitoris does not necessarily result in the elimination of a woman’s ability to orgasm.

In addition to women who report healthy libidos and satisfying sexual experiences, there are a number of women who also report a significant decrease in their libido following their genital surgery, however, many of these women do not view the decrease in sex drive as a negative side effect. Many
women view it as a means of exercising extensive control over one’s sexual emotions, which acts as leverage against their husbands such that they are able to fend off sexual advances until their husbands are willing to submit to their requests within the family structure. One woman explains,

“I want to say to everyone who does not prefer circumcision that it gives women a lot of power in the household. For example, if she has a fight or if she wants her husband to do something for her, her circumcision will allow her to take control and be able to refrain from sex for a long time until she brings him to see the problem exactly from her view. I don’t think that uncircumcised women can do that; those women, when they fight with men, maybe two days later after a fight, if the man touches them they become aroused and immediately forget the problems just to have sex. That is why in Sudanese families, women are very, very strong. I swear that in some houses the woman is so strong that her husband can’t breathe without her consent. I think this true because of her power over her sexual desire” (Abusharaf 2001: 130).

Therefore, contrary to Western ideology, many women who have undergone female genital modification feel as though the procedure gave them power and greater control over their own sexuality rather than depriving them of sexual agency over their bodies. Additionally, the existence of widely varying sexual experiences among women who have undergone genital cutting exemplifies varying notions of what constitutes a “healthy” sense of sexuality within different cultures, and is a testament to the lack of comprehensive information regarding the practice.

However, if patriarchal control over female sexuality is not the reason why female genital cutting is still practiced, then why would women subject themselves to such painful procedures? The reality is that there is no easy or direct answer to this question. Historically, scholars have been unable to pinpoint the exact origins of female genital cutting, which is mostly due to the fact that
African histories are passed down orally from generation to generation and are often lost entirely or are highly susceptible to embellishment (Johnsdotter 2012). However, a recurring aspect of many African myths and oral histories is the, “inherent bisexuality,” of human beings at birth (Fuambi 2000). A male’s foreskin is a soft and fleshy fold of skin that is reminiscent of the female reproductive organs. Similarly, a female’s clitoris protrudes and is erect during times of sexual arousal, just as a penis is. Thus, the removal of these organs, often times at coming of age ceremonies, consists of the forfeiture of the physical appendages that are deemed to be characteristic of the opposite sex. This is done in order to gain entry and acceptance into a specific gender group. The following testimony about female genital cutting echoes this sentiment:

“Circumcision is what makes one a woman because by removing the clitoris, there is no way that her genitals will look like a man’s. The woman with a big clitoris is just like a man. How can a woman carry such a long organ between her legs and pretend that things are normal? That is why we say that circumcision is good because after it is done the girl’s genital area becomes beautiful and smooth” (Abusharaf 2001).

This comment also implies that female genital cutting produces results that are aesthetically enhancing and make a woman more desirable.

Altering one’s genitals in order to make them more aesthetically appealing is not a practice that is unique to the global South. In response to beauty standards that are exemplified and perpetuated by popular culture and pornography, an increasing number of women have taken to piercing their genitalia or permanently altering the appearance of their genitals through surgery. According to the WHO’s official definition, these practices fall under the
umbrella of Type IV female genital mutilation, but genital piercings or labiaplasty have not generated the same sort of outrage among the international community as female cutting has. One could argue that the medicalization of these processes in the West has made them safer, and thus, more culturally acceptable. However, women practicing female genital cutting in the global South have increasingly taken to having the ceremony carried out by a medical practitioner in sanitary conditions, and the acceptance of the practice by Western critics has not seemed to increase. A small number of Western feminists have attempted to discredit the practice of female genital modifications in the West by using the same argument that is often used to discredit female circumcision in Africa and the Middle East; patriarchal control over female sexuality (Jeffreys 2005). However, the overwhelming public consensus about female genital modification in the West is that women should be able to make informed decisions about the appearance of their genitalia in relation to their sexuality. Thus, it seems that Western women are deemed capable of making decisions about their genitalia, but when non-Western women attempt to make the same type of decision it is labeled as “mutilation.” This sentiment serves as a testament to the ethnocentric and imperial characteristics of the existing critique of female genital cutting in the global South.

Female genital cutting is often cited as an international human rights issue, and within the human rights framework female genital modification often pits the opposing theories of universal morality and cultural relativity against each other. Many academics (myself included) recognize the tension that exists
between the two theories, especially in regards to female genital modification, and that tension often makes it difficult to take a decisive stance on the issue. I recognize my status as an outside interlocutor and understand that my critiques of female genital modification will always be dictated by the morals of my own culture, thus, I recognize that addressing female genital cutting requires a profound sense of cultural sensitivity. However, despite my extensive critique of the discourse surrounding female genital modification, I do not necessarily feel that it is morally acceptable for women to be required to modify their genitals in order to adhere to social norms. This personal sentiment holds true for gender based genital modification practices in Western and non-Western cultures alike. Thus, personal feelings about cultural relativity and universal morality tend to clash. However, the truth is that both theories are flawed in their relation to female genital cutting.

Scholars like Franz Boas, Ruth Benedict, and Melville Herskovitz initially championed the theory of cultural relativism. Herskovitz described cultural relativism as, "a philosophy, which, in recognizing the values set up by every society to guide its own life, lays stress on the dignity inherent in every body of custom and on the need for tolerance of conventions though they may differ from one’s own" (1948). Thus, the two defining characteristics of cultural relativism are enculturation, or the process by which people learn the requirements of their culture and behaviors appropriate or necessary in that culture, and tolerance. Alison Dundes Renteln (1985) cites enculturation as cultural relativism’s greatest strength because it enables us to challenge the “presumed universality of
standards,” which in reality are only constructed by one culture and are largely ethnocentric in nature. However, cultural relativism’s biggest weakness is that tolerance is often considered to be an implicit and integral part of the theory. “If one follows out literally and logically the implications of [cultural relativism] one is compelled to accept any cultural pattern as vindicated precisely by its cultural status: slavery, cannibalism, Naziism, or communism may not be congenial to Christians or to contemporary Western societies, but moral criticism of the cultural patterns of other people is precluded” (Kluckhohn 1955). Therefore, in relation to female genital cutting, many scholars and activists would argue that intense criticism of the practice and intervention are lesser evils than perpetuating their ethnocentric ideologies.

The theory of universal morality serves as the foundation for the human rights framework. “A human right by definition is a universal moral right, something which all men, everywhere, at all times ought to have, something of which no one may be deprived without a grave affront to justice, something which is owing to every human being simply because he is human” (Cranston 1973). This definition simultaneously describes the biggest strength and weakness of universalism. It is honorable, and I would even say imperative, that all people are awarded certain rights simply by virtue of being human, regardless of gender, race, religion, sexual orientation, or socioeconomic status. However, the issue with universalism is that the concept of a universal moral code is presumed and not based in empirical evidence. The fact of the matter is that the concept of human rights and universal morality is a theory that is wholly constructed by
Westerners (Patman 2000, James 2007, Evans 1996). Universalism requires one to operate under the assumption that, “the abstract rational process is presumed to bear a single and universal result, irrespective of cultural difference,” or in other words it assumes that everybody in the world thinks in the same way (Renteln 1985). Therefore, in relation to the issue of female genital cutting, universalism serves to perpetuate a sort of cultural imperialism. Tension is created as Western scholars and activists attempt to impart their ideas of what is morally acceptable upon non-Western women, and non-Western women feel oppressed and unable to make decisions about their own body without fear of being judged by their Western counterparts.

Neither cultural relativism nor the theory of universal morality are completely adept at resolving the debate surrounding female genital cutting, thus, I propose a hybrid strategy towards approaching the issue that is modeled after the method proposed by Alison Dundes Renteln in her book, *International Human Rights: Universalism Versus Relativism*. Conducting cross-cultural empirical research would identify values shared by all cultures, and would confer legitimacy on specific human rights standards. Since the debate surrounding female genital modification is largely centered around a human rights framework, this sort of research would result in the identification of morals shared by both Western and non-Western societies in regards to sexuality and agency over one’s body and would cultivate a more culturally objective environment for conducting the debate surrounding the issue. This approach conserves the strengths and negates the weaknesses of both cultural relativism and universal
morality. It maintains the aspect of enculturation that is characteristic of cultural relativism while simultaneously eliminating the presumed and ethnocentric sense of universal morality. In order to eliminate the practice of female genital cutting it is imperative that the opinions and ideals of non-Western women are acknowledge and represented. Ensuring that non-Western women function as equal interlocutors, if not superior interlocutors, in regards to female genital cutting, would eliminate the othering and stigmatizing nature of the ethnocentric discourse the currently surrounds the practice.
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