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Abstract

Abstract

Female genital mutilation (FGM) is almost universal in Guinea and practiced by all ethnic and religious groups and social classes, although the prevalence of the various types of FGM varies by socioeconomic group. A common explanation for FGM practices is that they contribute to the social control over female sexuality and enhance the marriageability of women. These claims were tested using the 1999 Guinea Demographic and Health Survey (DHS) (N = 6753). Event history techniques were used to examine the effect of type of FGM on the age at first sex and the age at first marriage and logistic regression for the effect of FGM on premarital sex. The results showed that the type of FGM had a significant zero-order effect on the age at first marriage and the prevalence of premarital sex, but not on the age at first sex. However, these effects became non-significant once controls for age, religion, ethnicity, education, residence, and wealth were added to the model. Variations in sexual behavior, therefore, were unrelated to type of FGM, but reflected differences in the social characteristics of the participants.

KEY WORDS: female genital mutilation; onset of sexuality; marriage; premarital sex; Guinea

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Introduction

Female genital mutilation (FGM) remains a common practice in large parts of Africa. Attempts by governments and non-governmental organizations to eradicate this practice have been met with only very limited success. Guinea is one of the countries where FGM is almost universal. According to the 1999 Demographic and Health Survey (DHS) (Direction Nationale de la Statistique & Macro International Inc., 2000a; Yoder, Camara, & Soumaoro, 1999), over 98% of women in Guinea experienced some form of FGM. Although some scholars have linked FGM with Islam (Gruenbaum, 2001; Hicks, 1993), in Guinea the practice was common in all communities and cultures, regardless of religion, ethnicity or class. The reason behind the resilience of FGM is its thorough embeddedness in the cultural and social traditions of the societies involved (Gruenbaum, 2001; Hicks, 1993; Yoder et al., 1999; Yoder & Mahy, 2001). Questioning this practice challenges, therefore, the social and religious organization of these societies. One often made claim is that FGM protects the virginity of girls and thus enhances their marriage chances. This article examined whether such claims regarding FGM were supported by data from a large-scale survey in Guinea.

The entrenchment of FGM in the traditions and culture of the societies that practice it obscures both the origins of and the reasons behind the practice. Researchers, as well as members of these societies, have provided a wide range of reasons for it, including honor, control over sexuality, purity, rite of passage, tradition, and aesthetics (Jones, Ehiri, & Anyanwu, 2004; Rajadurai & Igras, 2005; Shaaban & Harbison, 2005; Yoder et al., 1999). A common trait of all these explanations is that they link the practice of FGM to the social position of women in the societies considered, i.e., to the stratification system of these societies. According to structuration theory, social inequalities are reproduced and potentially transformed by everyday practices and relationships (Giddens, 1973), and FGM is one practice that reproduces the social position of women (Toubia & Sharief, 2003). Blaming FGM on patriarchy or male domination is too narrow a view (Epstein, 2007; Gruenbaum, 2001; Lee, 2007). Stratification in these societies is much more complex, and FGM defines the social position of women, not only with regard to men, but also with regard to other women and as members of their

communities. Women play an important role in perpetuating the practice as they derive their social status and position within society from their role as wives and mothers and thus by ensuring the status and marriageability of their daughters they enhance their own status (Gruenbaum, 2001; Walley, 2002).

In relatively closed societies (Hicks, 1993), the extended family is the main unit of social organization. An individual's identity and status depends to a considerable degree on the family he/she belongs to. Honor and dignity are important facets of a family's status and are measured against the behavior of its members. Dishonorable behavior can severely damage a family's status in the community. For women, this involves upholding strict modesty and chastity codes that ensure virginity at marriage and marital fidelity (Gruenbaum, 2001; Hicks, 1993; Nordenstam, 1968). Inappropriate sexual behavior, especially on the part of women, can severely damage a family's honor and dignity and, therefore, needs to be controlled. FGM is one, but by no means the only, strategy to control female sexuality. In combination with other strategies, such as dress codes and limits on interactions between the sexes, FGM is perceived as an important guarantee that girls remain virgins until marriage. It thus also ensures the woman's marriageability (Almroth et al., 2001; Baker, Gilson, Vill, & Curet, 1993; Gruenbaum, 2001; Hicks, 1993; Missailidis & Gebre-Medhin, 2000; United Nations Population Fund (UNFPA), 1997; World Health Organization, 1986). The practice of FGM in these societies is thus intimately related to the status of women.

Douglas (2004) has argued that the concepts of dirt and purity are used to define the moral order as well as appropriate behavior and that the use of such concepts became more outspoken the stricter the boundaries between different statuses were delineated. Societies that practice FGM tend to have strict separations between male and female roles and statuses. Having undergone FGM marks women as pure and thus as moral (Epstein, 2007; Lee, 2007), a view further reinforced by aesthetic values and beliefs about sexual desirability (Gruenbaum, 2006; James & Robertson, 2002).

FGM defines not only a woman's morality, but her gender and ethnic identity as well as her social status within the community (Gruenbaum, 2001; Jones et al., 2004; Little, 2003; Rajadurai & Igras, 2005; Toubia & Sharief, 2003; World Health Organization, 1999a). Although being "cut" emphasizes the subordinate status of women in the community, it also symbolizes the entry into the

world of women and defines a woman as a member of the community, or, in other words, provides women with status as well, while being “uncut” means being labeled an outcast, an immoral woman. Women face a tremendous social pressure to have their daughters “cut.” Several studies report that non-circumcised women were indeed ostracized by their communities (Almroth et al., 2001; Gruenbaum, 2006; Yoder et al., 1999). FGM is part of women's socialization into their adult roles, in which they are taught how to behave towards their husband and family and what their roles in the community are (Yoder et al., 1999).

Marriage in these societies is an important source of status for women, and therefore the marriageability of girls becomes an important consideration. It not only brings status to the girls themselves, but also to their mothers and families. In such a context, maximizing the marriage chances of daughters makes sense, even if it means to have them cut. In fact, parents who do not have their daughter cut might be considered neglectful and harming their daughter's future (Lee, 2007). Enhancing marriageability is an often mentioned reason for FGM (Almroth et al., 2001; Baker et al., 1993; Gruenbaum, 2001; Gruenbaum, 2006; James & Robertson, 2002; Jones et al., 2004; Missailidis & Gebre-Medhin, 2000; Shaaban & Harbison, 2005; Shell-Duncan, 2001; UNFPA, United Nations Population Fund, 1997; Walley, 2002; World Health Organization, 1986).

One argument linking FGM and marriageability holds that FGM is an effective mechanism for the social control of women's sexuality (Gruenbaum, 2001; Gruenbaum, 2006; Mandara, 2004; World Health Organization, 1999a). By ensuring virginity prior to marriage and fidelity after marriage, FGM increases a woman's marriage chances. As FGM reduces a woman's ability to experience sexual pleasure, it would also lower her chance of engaging in premarital sex or being unfaithful in marriage. If this argument holds, one would expect to find a clear relationship between the type of FGM a woman had experienced and her sexual history, including her age at first sex, her age at first marriage, and the probability of premarital sex. The logic behind this argument also predicts that the more severe the form of FGM a woman underwent, the more pronounced its effect would be.

This argument, however, has met with some resistance as it is doubted that FGM is an effective means of control over women's sexuality, and it has been argued that the effects of FGM are primarily social and cultural, defining a woman as member of a community, her social status, and her identity (Gruenbaum, 2001; Little, 2003; Magoha & Magoha, 2000; Toubia & Sharief, 2003; World Health Organization, 1999a). According to this view, FGM, or the type of FGM, has no effect on the onset of sexuality or the marriageability of women.

Even at best, FGM is an imperfect tool to control female sexuality. It certainly does not guarantee that women would not engage in premarital sex or remain faithful. In fact, it could even create a false sense of security and allow “deviant” sexual behavior to be covered up (Gruenbaum, 2001; Hicks, 1993). There is some evidence that control over female sexuality and safeguarding virginity are indeed not that important reasons for perpetuating FGM. For instance, in a study of a Sudanese village, the most commonly mentioned reasons for having one's daughter undergo FGM were tradition and social prestige. Ensuring a woman's virginity was only rarely mentioned and mainly by men (Almroth et al., 2001). Likewise, in a qualitative study on FGM ordered by the Demographic and Health Survey (DHS) in Guinea, one did find that women saw FGM as part of their socialization process and as an initiation rite into the world of women (Yoder et al., 1999), i.e., as part of their community tradition. Again, it was mainly men who stated that FGM reduced female sexual desire.

In case FGM functioned as a marker of social status rather than as an effective tool of sexual control, and thus did not affect the onset of sexuality or ensure virginity, it might still have affected women's marriageability. As FGM is a marker of a woman's social status, it identifies a woman in good standing as a member of her community, while non-cut women are socially excluded and considered of a lower status. To the extent that a woman's social status determines her marriage chances, the type of FGM a woman underwent could still affect marriageability.

Method

PARTICIPANTS

The primary data for this study came from 6364 women aged 15-49 years who were interviewed in the 1999 Guinea DHS (Direction Nationale de la Statistique & Macro International Inc, 2000b). The survey used a two-stage cluster sampling design to collect data on a wide range of health issues. Face-to-face interviews were conducted with participants after obtaining their consent. The questionnaire collected information on whether the participant had undergone FGM and, if so, at what age and the type of practitioner and cutting, on attitudes and beliefs about FGM, as well as on their sexual and marital history. Additional data about men's beliefs about FGM came from the 1851 men surveyed in this DHS. The survey procedures and instruments were approved by the Institutional Review Board at ORC Macro. For more information on the survey, see the country report

(Direction Nationale de la Statistique & Macro International Inc., 2000a).

MEASURES

DEPENDENT VARIABLES

The dependent variables for the analyses were: age at first sex (in years), age at first marriage (in years), and whether or not the participant engaged in premarital sex. This last variable was conservative in the sense that it underestimated the prevalence of premarital sex. A participant was defined to have had premarital sex if the age at first sex (in years) was lower than the age at first marriage (in years). This means that premarital sex in the same year as the first marriage was not identified as such.

INDEPENDENT VARIABLES

The focal independent variable was the type of FGM. To operationalize this variable, we made use of the World Health Organization's (2000) FGM typology, which distinguished four different types of FGM: Type I or clitoridectomy: excision of the prepuce, with or without partial or total excision of the clitoris; Type II or excision: the excision of the clitoris with partial or total excision of the labia minora; Type III or infibulation: the most severe form of FGM consisting of the partial or total excision of the external genitalia and stitching or narrowing of the raw labial surfaces, leaving a small posterior opening for urinary and menstrual flow; and Type IV: a residual category of FGM consisting of pricking, piercing or incising the clitoris and/or labia, cauterization of tissues, scrapping of the vaginal orifice or cutting of the vagina. Two additional categories were distinguished for the analysis: "no FGM" and "another form/no answer." In the 1999 Guinea DHS sample, Type II was the most common form of FGM with 45.3% (3057/6753), followed closely by Type I (43.9% or 2967/6753). The most severe form of FGM, Type III, was reported by 6.9% (466/6753) of the women, while Type IV was fairly rare (1.8% or 116/6753). Only 1.4% (94/6753) of the women reported not to have undergone any form of FGM, while the remaining .8% (53/6753) reported another form of FGM or did not respond to the question.

The control variables were sociodemographic factors known to be associated with the different types of FGM (Direction Nationale de la Statistique & Macro International Inc., 2000a; Yoder & Mahy, 2001). Age at assessment was included as an indicator of the birth cohort of the participant. Other variables included were education (years of schooling), ethnicity (Sosso, Fulani, Malinke, and other), religion (Muslim vs. other), residence (rural, urban, capital) and a principal component based assets index as an indicator of household wealth (Filmer & Pritchett, 1999). The mean age of the women in the sample was 29 years; 14% of them were never (or not yet) married and 9% had not been sexually active. For the married women, the mean age at first marriage was 16.3 years, while among the sexually active the mean age at first sex was 15.8 years. Twelve percent of the women indicated they had engaged in premarital sex. The mean level of education was quite low. On the average, women had only 1.5 years of education. Eighty percent reported no formal education at all and only nine percent had more than six years of education. Approximately two-thirds of participants lived in rural areas, about a fifth in the capital Conakry, and the remainder in smaller towns. Eighty-five percent of the sample was Muslim and about one third of the sample belonged to the Fulani ethnic group, about 30 percent to the Malinke, and 21 percent to the Sosso.

STATISTICAL ANALYSIS

To examine the effects of type of FGM on age at first sex and age at first marriage, proportional hazard models were used (Allison, 1984). The dependent variable was the log of the hazard that an event will occur in the next time unit. For premarital sex, logistic regression was used as the dependent variable was dichotomous.

For each dependent variable, two models were estimated: a first model (Model 1) included only the type of FGM variable and estimated the gross effect of FGM on the dependent variable, while a second model (Model 2) added the control variables to the equation and estimated the net effect of FGM controlling for the sociodemographic characteristics.

Results

Table 1: Beliefs about effects of FGM on premarital sex and marriage chances

	Women	Men	<i>t</i>	<i>df</i>	<i>p(t)</i>
FGM reduces risk of premarital sex	17.1% (1150/6710)	15.9% (309/1946)	1.329	3230	.184
FGM improves marriage chances	27.5% (1840/6692)	41.3% (810/1962)	-11.133	2970	.000

BELIEFS ABOUT BENEFITS OF FGM

Table 1 shows the level of acceptance of the beliefs that FGM reduced the risk of premarital sex and improved marriage chances. For this part of the analysis, data were used from both the men and women DHS surveys. The data showed that only a minority of the participants believed that FGM actually protected against premarital sex. Less than one fifth of the participants agreed with this statement. The belief that FGM enhanced marriage chances was more widely shared, but still only by a minority of the participants. Men were significantly more likely than women to agree with this statement, 41% vs. 27%, respectively.

TYPE OF FGM

Although FGM was almost universal in Guinea, the type of FGM a woman experienced varied with sociodemographic characteristics as shown in Table 2. In this table, cross-tabulations

between the type of FGM and the control variables are shown. For this purpose, the continuous control variables (education, age, assets) were recoded into categories.

Table 2 shows that the likelihood of Type II FGM increased with the age at assessment of the participant while that of Type I declined. For the education level of the participant, the reverse trend was observed. The effect of socioeconomic status on type of FGM was less linear but Type I tended to become more common and Type II less common as household wealth increased.

Among the Sosso, Type I FGM was more common than among the other ethnic groups, while Type II was less common. The Fulani and Malinke showed similar patterns of FGM, except that, among the Fulani, Type III FGM was considerably more common than among the other groups. Among the "other" ethnic group, Type II FGM was clearly the preferred form while Type I was relatively rare. Among Muslims, compared to non-Muslims, Type I was more common while Types II and IV were less

Table 2: Bivariate relationships between type of FGM and control variables

	No FGM	Type I	Type II	Type III	Type IV	Other/ Missing	N	χ^2	df
Age at assessment								125.3**	10
15-24	2.5%	49.1%	38.6%	6.6%	2.4%	.8%	2438	*	
25-34	.9%	42.6%	46.8%	7.1%	2.0%	.7%	2209		
35-49	.7%	39.4%	51.4%	7.1%	.6%	.8%	2106		
Education								78.6***	10
None	1.2%	42.7%	46.6%	7.5%	1.3%	.7%	5368		
≤ 6 years	1.8%	47.3%	42.6%	4.3%	3.3%	.7%	725		
> 6 years	2.5%	50.1%	37.8%	4.6%	3.6%	1.4%	635		
Assets index								99.3***	15
Q1	.7%	41.3%	50.1%	6.3%	1.0%	.6%	1742		
Q2	1.2%	45.8%	42.3%	8.6%	1.6%	.6%	1606		
Q3	2.0%	38.9%	49.0%	7.5%	1.8%	.7%	1592		
Q4	1.5%	49.7%	39.8%	5.2%	2.6%	1.3%	1648		
Ethnicity								911.0**	15
Sosso	.4%	60.8%	32.3%	5.3%	.9%	.4%	1389	*	
Fulani	.3%	44.4%	42.0%	11.1%	1.6%	.6%	2222		
Malinke	.6%	49.4%	43.5%	3.6%	1.8%	1.1%	1985		
Other	6.2%	13.5%	70.2%	6.4%	2.8%	1.0%	1157		
Religion								709.6**	5
Muslim	.5%	49.8%	40.5%	6.9%	1.5%	.8%	5734	*	
Other	6.4%	11.1%	72.0%	6.9%	2.9%	.7%	1019		
Urban residence								124.8**	10
Rural	1.0%	43.4%	46.0%	7.8%	1.2%	.6%	4409	*	
Urban	2.8%	48.9%	37.6%	7.9%	1.3%	1.5%	1007		
Capital	1.7%	42.0%	48.5%	3.1%	3.7%	1.0%	1337		

*: $p < .05$; **: $p < .01$; ***: $p < .001$

common. Although there were clear differences in FGM practices among different ethnic and religious groups, none of them exclusively practiced a single type of FGM.

Urban residents, but not residents of the capital, compared to rural residents had a greater risk for Type I FGM and a lower one for Type II. The effects of all control variables remained significant (at $p < .001$) when they were entered together in a multinomial logistic regression analysis (results not shown). The Nagelkerke pseudo- R^2 for this model was 21.5%.

ONSET OF SEXUALITY

Table 3 shows the results of the proportional hazard models for age at first sex and age at first marriage. For both dependent variables, the gross effect of FGM (Model 1) and its net effect (Model 2) are shown. In the table, the exponent of the coefficient and its 95% confidence interval are presented.

According to these data, the type of FGM a woman experienced was unrelated to the age at first sex. No significant difference in age at first sex was observed by type of FGM, with or without taking into account the effects of the control variables.

Higher levels of schooling and a higher SES (as indicated by the assets index) led to a delay of the onset of sexual activity. Ethnicity also had an effect on age at first sex. Among the Malinke, the onset of sexual activity tended to be at a later age than among the Sosso. Participants from the capital also reported a later onset of sexual activity than rural participants. Religion and age at assessment had no significant effect on age at first sex.

AGE AT FIRST MARRIAGE

Regarding the age at first marriage, differences were observed according to the type of FGM the participant experienced. Women with Type I or Type IV FGM were at a significantly lower hazard for first marriage, i.e., tended to marry later, than women with a Type II FGM. However, these differences disappeared when the sociodemographic controls were added to the model. Older cohort women married at an earlier age than the younger cohorts. Better educated and wealthier women also tended to marry later than less educated and less wealthy ones. Ethnicity also had an effect on age at first marriage. The Fulani and the "other" ethnic group tended to marry earlier than the Sosso. The age at first marriage was also higher among residents of the capital than among rural residents. Religion had no significant effect on age at first marriage.

PREMARITAL SEX

To examine whether the type of FGM affected the likelihood of premarital sex, logistic regression analysis was used. Again, both the gross effect of FGM type and the net effect controlling for sociodemographic factors were estimated. In Table 4, the odds-ratios (OR) and their 95% confidence intervals are shown for this analysis.

Model 1 indicated that there were clear differences in the risk of premarital sex according to the type of FGM a woman experienced. Women who were not cut or who underwent Type IV FGM were significantly more likely to have engaged in premarital sex than women with Type II FGM, while those who experienced the most severe form of FGM were less likely to have had premarital sex. At first glance, more severe forms of FGM seem to have been more effective against premarital sex than no or milder forms of FGM. However, as Model 2 shows, the effect of FGM on premarital sex disappeared after controlling for the sociodemographic characteristics of the participants.

The probability of premarital sex decreased with the age of the participant, and increased with level of education. Fulani women were significantly less likely than Sosso ones to have engaged in premarital sex. Women residing in the capital were more likely to have engaged in premarital sex than rural women. SES, as indicated by wealth, and religion did not have significant effects on this dependent variable.

Discussion

The results showed that in Guinea, where FGM is near universal, some of the most commonly mentioned reasons for FGM were not supported by statistical analysis. Although at first glance we found a significant relationship between the type of FGM a woman experienced and age at first marriage and risk of premarital sex, these effects disappeared after controlling for sociodemographic characteristics that were known to affect FGM. If the argument held that FGM reduced the sexual pleasure of women and thus their desire for sex (which in turn would guarantee chastity and fidelity), one could expect that more severe forms of FGM would be more effective in reducing women's likelihood of engaging in premarital sex (assuming consensual sexual relations) and increase the likelihood of marrying early compared to less severe forms of FGM, and that these effects would be robust for any controls. However, the results showed that FGM in Guinea was not an effective means to control female sexuality, and, even more important, also did not affect the marriageability of women. The latter finding not only questions the function of FGM as a means of sexual control, but also as a status

FGM AND THE ONSET OF SEXUALITY

Table 3: Proportional hazard model results for age at first sex and age at first marriage

	Age at first sex				Age at first marriage			
	Model 1		Model 2		Model 1		Model 2	
	e ^b	95% C.I.	e ^b	95% C.I.	e ^b	95% C.I.	e ^b	95% C.I.
FGM type (reference: Type II)					***			
No FGM	.838	.660-1.064	.841	.659-1.072	.783	.605-1.014	.934	.719-1.214
Type I	.968	.917-1.021	1.032	.974-1.093	.889***	.841-.940	.978	.921-1.037
Type III	1.003	.905-1.112	.963	.868-1.069	1.020	.918-1.132	.955	.859-1.062
Type IV	.872	.707-1.074	1.081	.876-1.335	.756*	.606-.945	.977	.781-1.223
other/missing	.837	.621-1.127	.924	.685-1.246	.807	.591-1.103	.970	.709-1.328
Age at assessment			.999	.996-1.002			1.005***	1.002-1.008
Education level			.963***	.954-.971			.944***	.934-.953
Assets index			.950**	.919-.982			.908***	.876-.941
Ethnicity (reference: Sousou)			**				***	.000-.000
Peulh			.951	.881-1.026			1.237***	1.142-1.339
Malinke			.882**	.816-.953			1.015	.935-1.101
Other			1.044	.888-1.227			1.233*	1.042-1.458
Religion: Muslim			.953	.811-1.119			1.092	.925-1.288
Urban residence (reference: Rural)			**				***	
Urban			.951	.878-1.030			.931	.857-1.011
Capital			.852**	.772-.939			.814***	.734-.903

*: $p < .05$; **: $p < .01$; ***: $p < .001$

FGM AND THE ONSET OF SEXUALITY

Table 4: Logistic regression results for premarital sex

	Model 1		Model 2	
	O.R.	95% C.I.	O.R.	95% C.I.
FGM type (reference: Type II)	***			
No FGM	3.018***	1.859-4.900	1.345	.801-2.260
Type I	1.082	.923-1.269	1.023	.858-1.221
Type III	.536**	.362-.794	.622*	.415-.932
Type IV	2.079**	1.307-3.307	1.285	.789-2.091
other/missing	1.451	.676-3.111	1.228	.554-2.724
Age at assessment			.945***	.937-.954
Education level			1.068***	1.045-1.091
Assets index			1.061	.982-1.146
Ethnicity (reference: Sousou)			***	
Peulh			.545***	.433-.686
Malinke			.852	.683-1.062
Other			1.126	.739-1.717
Religion: Muslim			.779	.511-1.188
Urban residence (reference: Rural)			**	
Urban			1.228	.973-1.550
Capital			1.622***	1.254-2.098
Constant	.128***	.115-.144	.670	.398-1.127
Nagelkerke R ²	1.2%		11.9%	

*: $p < .05$; **: $p < .01$; ***: $p < .001$

indicator. The findings suggested that any relation between FGM and the likelihood of premarital sex and marriage was explained by socioeconomic factors.

It is remarkable that although most researchers still report the importance of FGM as either a means of sexual control and/or to enhance marriageability, only a minority of the participants believed that FGM served these functions. Only about one sixth of the DHS participants stated that they believed that FGM reduced the risk for premarital sex, while a somewhat larger minority believed that FGM enhanced marriageability. These findings indicate that traditional beliefs and rationalizations regarding FGM are eroding. A recent study demonstrated that in Guinea support for the discontinuation of FGM was negatively related to the belief that it enhanced marriageability (Gage & Van Rossem, 2006).

This, of course, begs the question as to why the practice has survived. If FGM indeed is a practice that contributes to the reproduction of the stratification system and thus to the definition of the social position and status of women, it does not do so by ensuring virginity and thus preserving family honor while also increasing marriage chances. That, however, does not mean that the entire practice becomes meaningless, but that the importance of FGM lies more in the delineation of group membership and the definition of women's social identity and status. As no ethnic, religious or social group exclusively relied on a single form of FGM, the relevant reference group here could be considerably smaller: a local community or kinship group.

The finding that type of FGM does not affect marriageability did not necessarily mean that it has lost all importance for these matters. It is conceivable that in some circles FGM is still used as a criterion to judge women's marriageability, but that the marriage market as a whole has become more segmented, offering sufficient opportunities for marriage, regardless of FGM type. This could reflect the increased social, economic, and cultural heterogeneity of Guinean society. There is also evidence that the social support for the more severe forms for FGM is eroding (see also Gage & Van Rossem, 2006). The DHS data showed that among younger participants Type I had replaced Type II as the dominant form of FGM. Such a shift is consistent with the view that FGM is more important as source of identity and status than as an actual means of sexual control.

Most FGM prevention programs strive for people to abandon the practice, usually by stressing the physical harm done by it, including medical risks (Shell-Duncan, 2001; World Health Organization., 1999b). As such programs tend to be imposed by external agencies without much respect for local culture or social organization, it should not be surprising that they meet with considerable

resistance and have, at best, a limited success (Gruenbaum, 2001; Jones et al., 2004; World Health Organization., 1999b). These programs not only challenge specific behaviors but also more generally the traditions and cultures of the affected communities, their social structures, and the social identities of their members. For individual women, without social support from within the community, the price for not being "cut" is too high, as it may result in social exclusion (Shell-Duncan, 2001).

Although the complete eradication of FGM should remain the long-term goal of any campaign, it might be more effective to pursue more indirect strategies that in a first phase focus on harm reduction rather than on the elimination of the practice (Shell-Duncan, 2001). Harm reduction in this case refers to developing alternative practices. Rather than headlong challenging existing traditions, such an approach would build upon existing traditions, community values, and social roles and redefine some of its elements without rejecting the entire frame (Jones et al., 2004), and thus provide a culturally acceptable alternative (Mackie, 2000). Such an approach would maintain the cultural relevance of the practice without the physical harm to the women. As FGM had no detectable impact on the onset of sexuality or the marriageability of women, such a substitution might be easier to implement. This way an alternative manner of defining a woman's social identity and position may be achieved. In communities where female circumcision involves public rituals, the introduction of alternative rites has proven successful (Toubia & Sharief, 2003). For such a strategy to be effective, however, it would need to be community based, have a broader scope than merely the elimination of FGM, and have the support of the parties involved: young women and men, parents, FGM practitioners as well as social, religious, and other opinion leaders (Toubia & Sharief, 2003; World Health Organization., 1999b). In the long run, such a shift in practices might contribute to the improvement of women's status in these societies.

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