Types

Without a physical examination, obtaining precise information about the type of genital cutting a woman underwent is difficult. DHS findings on type are based on the self-reports of women, many of whom were operated on as children. A number of women may not remember or know what tissue was removed. Given the high prevalence levels in some countries and the limited access to information, some women may not be familiar with "uncut" genitalia.

Field research suggests that the nature of these procedures can vary markedly within and between communities, depending on the practitioner, girl, and family. Most likely, operators do not employ terms like clitoridectomy, excision or infibulation to describe their work. For the most part, these procedures are usually performed by traditional practitioners. Any number of factors—poor eyesight in the operator or the struggling of a child—could result in imprecise cutting.

Among the countries surveyed, Egypt is unique in having clinically-validated information available on the type of tissue removed from women during these procedures. In this section, findings from the clinical study conducted in Egypt will be discussed. Additionally, DHS survey findings on type will be presented, focusing on the prevalence of and support for infibulation among women.

Clinic-based study in Egypt on type of genital cutting

To investigate the type of genital cutting Egyptian women commonly undergo, the Egyptian Fertility Care Society conducted a study featuring two major components: a) interviews with women using the questions on genital cutting from the Egypt DHS survey; and b) post-interview pelvic examinations of the same women by gynecologists (Egyptian Fertility Care Society, 1996).[1] The study included 1,339 incoming family planning or gynecological clients of five University hospitals, several rural hospitals, and two urban clinics. In contrast to the EDHS 1995, the sample of women included in the clinic-based study was not nationally representative. Women in the clinic-based study tended to be younger, were less likely to reside in Lower Egypt, and had fewer children than the respondents in the EDHS 1995 sample (El-Zanaty et al., 1996).

The findings indicate agreement between self-reports and physical exams

The clinic-based study indicates a high level of agreement between women's self-reports of genital cutting and the evidence found by doctors through pelvic examinations. In more than 90 percent of the cases, women's self-reports match the findings from the physical examinations. Nearly 5 percent reported genital cutting in their interview, but doctors found no physical evidence. In about 2 percent of cases, women reported no genital cutting, but physical evidence was found.

[1] The study was funded jointly by the DHS Program and the Asia and Near East Operations Research and Technical Assistance Project of USAID.

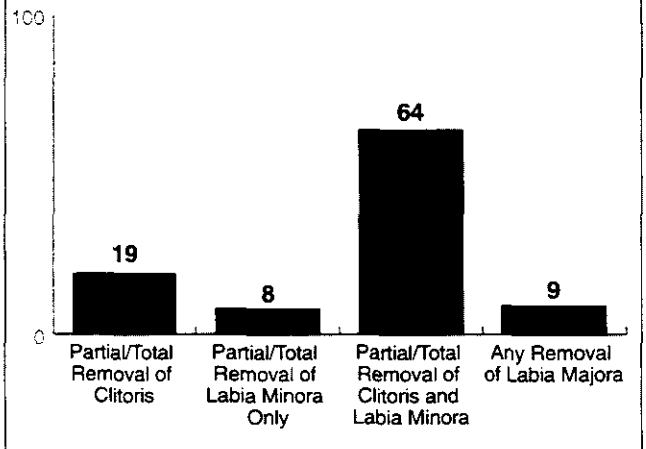
Cutting status in the clinic-based study, Egypt 1996	
Genital cutting in self-report and exam	91.8%
No genital cutting in self-report or exam	2.2%
Genital cutting in self-report, no evidence in exam	4.6%
Evidence in exam, but no genital cutting in self-report	1.5%

Source: El-Zanaty et al., 1996

Physical exams indicate that extensive cutting is common in Egypt

The majority of women in the clinic study population underwent extensive cutting. More than six of 10 women studied experienced at least partial removal of the clitoris and labia minora. Nearly 20 percent of the women underwent clitoridectomy. The most extreme type of cutting, however, is relatively rare. Doctors found that about one of 10 women underwent cutting of the clitoris, labia minora, and labia majora.

Types of genital cutting found by physical examination



Percent of sample population of Egyptian women who have undergone cutting

The amount of tissue removed varies little by the woman's age, urban-rural residence, education level, or type of operator (El-Zanaty et al., 1996). Of particular note, no detectable shift is evident toward less extensive forms of cutting over time in Egypt. For instance, 60 percent of women ages 15 to 24 underwent partial or total removal of the clitoris and labia minora, compared with 64 percent of women 35 to 39.

Infibulation: the most extreme form of cutting

Although many variations in cutting take place, DHS data are probably only reasonably accurate using two categories, differentiating infibulation from other usually less extensive procedures such as clitoridectomy or excision. Infibulation, which involves the excision of genitalia and closure of the vaginal opening by stitching, is generally considered the most extreme procedure. Often, an infibulated woman is left with only a small opening for urine and menstrual blood.

In practice, however, the continuum of extremity implicit in the genital cutting typology may not be wholly reliable. A number of researchers point out that an extensive excision can have the same barrier-like effect of infibulation if the wound heals improperly. Practitioners may also purposefully achieve infibulation without stitching by immobilizing a girl's legs after cutting until the wounded flesh fuses together (Andu, 1993). Finally, infibulation does not necessarily entail the removal of all external genitalia, with some operators infibulating women without performing clitoridectomy so as to reduce the risk of hemorrhage (Andu, 1993).

Infibulation is widespread in Eritrea and northern Sudan

Based on women's self-reports, infibulation is rare in Egypt and Mali, but widespread in Eritrea and northern Sudan. Among Eritrean women that have been cut, one-third have been infibulated. Although infibulation has been against the law in Sudan since the 1940s,[2] this procedure is still common. More than 80 percent of northern Sudanese women who have undergone cutting have been infibulated.

Percent of women who have experienced infibulation

Country	Genital cutting with closure of the vulva
Egypt	1
Eritrea	34
Mali	1
Sudan	85[a]

a. In Sudan, roughly 3 percent of women in this category reported undergoing the "intermediate" form of circumcision. Although this form can vary, it usually involves the extensive cutting and vulval closure characteristic of infibulation. Reportedly, this procedure may leave women with a slightly larger vaginal aperture than the "standard" infibulation. Since this type involves vulval closure, it is considered a form of infibulation throughout the tables in this section (Kheir et al., 1991).

[2] According to Toubia (1995), this law was eliminated from the country's 1991 legal revisions, leaving its current authority uncertain.

The prevalence of infibulation in Sudan varies most by religion and region

In northern Sudan, the prevalence of infibulation shows the greatest variation by woman's religion and region of residence (see Appendix Table 7). Among those who have undergone genital cutting in Sudan, 86 percent of Muslim women have been infibulated, compared with 54 percent of Christian women. Infibulation also appears to be nearly universally practiced among women in the Northern region, but is somewhat less prevalent in the Eastern and Darfur regions.

The prevalence of infibulation in Eritrea varies by education, religion, ethnicity, and residence

In Eritrea, the prevalence of infibulation varies markedly by education, religion, ethnic group, and residence (see Appendix Table 7). Among those who have undergone cutting, 46 percent of women who have never been to school have been infibulated, compared with fewer than 13 percent of women with some education. As in Sudan, the differences between Muslims and Christians are substantial. Among Muslim women, 82 percent report having undergone infibulation, compared with 2 percent of the Christian women.

In some ethnic groups, infibulation is nearly universal. Among those who have undergone cutting, more than 90 percent have been infibulated among the Hedarib, Nara, Tigre, Bilen, and Afar. Substantially fewer women have experienced the most extreme form of cutting among the Saho (41 percent), Kunama (31 percent), and Tigrigna (1 percent). Infibulation is more common among rural women (44 percent) than urban women (13 percent). Regional differences, which probably reflect religious and ethnic affiliation, are also striking. Infibulation, for instance, appears to be nearly nonexistent among women in the Southern and Central zones of the country.

Attitudes toward infibulation among Eritrean and Sudanese women

> "When asked why is FGM a part of our culture and still practiced, many men and women gave me different answers...The most common response was that chastity is a woman's only virtue and all measures have to be taken to maintain it. A popular analogy given was: A closed door is definitely less inviting to a thief than an open one...Women have to be protected, and infibulation is the defense mechanism..."
> *Almaz Andu, Eritrea (Andu, 1993)*

Many women would like to see infibulation continue

In Eritrea and Sudan, a number of women support the continuation of infibulation.[3] Nearly one-fourth of women in Eritrea favor its continuation. Male support in Eritrea, however, is consistently lower than female approval. In Sudan, two in five ever-married women would like to see infibulation continue. However, there is considerable variation in support for infibulation among Sudanese women. Those much less likely to favor continuation of infibulation include educated women, Christians, and residents of urban areas and the Khartoum and Darfur regions (DOS and IRD, 1991).

Support for genital cutting and infibulation among all respondents

Country	Percentage who support continuation of: Genital cutting without closure	Infibulation	Number of respondents
Eritrea			
Women	32	24	5,054
Men	31	13	1,114
Sudan			
Women	38	40	5,860

Note: All women 15-49 and all men 15-59 in Eritrea; ever-married women 15-49 in northern Sudan.

Many infibulated women support the continuation of infibulation

Support for infibulation is widespread among women who have been infibulated. The majority of infibulated women in Eritrea and Sudan would prefer to see this most extreme form of cutting continue. In Eritrea, three of four infibulated women favor infibulation. Support in Sudan is somewhat less pronounced, with about half of infibulated women favoring continuation. Very few women in Eritrea or Sudan with less extensive types of cutting endorse infibulation.

[3] Women who oppose genital cutting were not asked questions about the type they would prefer to see continue.

In Sudan, most women who have undergone genital cutting support the continuation of these practices. Only those who have not experienced cutting are substantially less likely to favor continuation. In Eritrea, support for these practices is only very high among women who have been infibulated. Support is substantially less pronounced among women who experienced less extensive forms of cutting.

Women's attitudes toward the continuation of genital cutting and infibulation, by cutting status

Cutting status	Support continuation of genital cutting (%)	Support continuation of infibulation (%)	Number of women
Eritrea			
Not cut	14	3	279
Infibulated	81	75	1,624
Cut, but not infibulated	48	<1	3,144
Sudan			
Not cut	17	3	634
Infibulated	85	52	4,442
Cut, but not infibulated	90	3	775