

Successful Cultural Change: The Example of Female Circumcision among Israeli Bedouins and Israeli Jews from Ethiopia

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ABSTRACT

Female genital mutilation (FGM) is practiced in many areas of the world, including the Middle East, Africa and Australia. Although it is most common in Muslim populations it is not a dictate of Islam. In the 1980s this practice was reported among Bedouin tribes, originally nomadic, in the southern area of Israel. Almost all of the women interviewed in the first study intended to continue the practice by performing FGM on their daughters including educated women who were teachers, dental assistants or university students. A second study was therefore done based in the obstetrical clinic where only women from tribes reporting to undergo FGM were examined for signs of FGM by an experienced gynecologist, in the presence of an Arabic-speaking female nurse and translator, as part of a gynecologic examination that was indicated for other reasons. In no cases was clitoridectomy or any damage to the labia found. All women had a small scar from a 1cm. incision somewhere on the labia or prepuce of the clitoris. This study concluded that the importance of the ritual in this population was unrelated to its severity. The ritual had apparently become over time a small symbolic scar, even though this population continued to believe in its importance.

By contrast, a group of Ethiopian Jews who had immigrated to Israel was interviewed by an Amharic translator, and examined during routine gynecological examination in the same manner as the Bedouin group above. In Ethiopia, FGM is universal among Christian, Muslim and Jewish groups. All women interviewed reported that FGM was universal in Ethiopia, but none intended to continue this practice with

their daughters. All stated that this was a practice that would be left behind in their country of origin. On physical examination many of the women had amputation of the clitoris. The conclusion of this study was that the severity of the operation performed had no relation to the social and cultural adherence to the operation, since the Ethiopian Jews who practiced a more severe form of the operation intended to abandon this practice while the Muslim Bedouin who had a much milder form intended to continue it.

A follow-up study in 2009 of the Bedouin population of southern Israel has found that FGM had disappeared, both by self-report of women under the age of 30, and by physical examination of women under the age of 30 in an obstetrical clinic. These results suggest an optimistic approach toward cultural change involving unhealthy cultural practices and emphasize the importance of cognitive approaches to cultural change.

INTRODUCTION

Female genital mutilation (FGM) is a practice that is still prevalent in many parts of the world. It has been described in different ethnic groups living in Africa and Asia (1). It is performed more widely than is generally recognized, although many in the Western world are unfamiliar with the procedure (2). Two primary care physicians working with Bedouin patients living in Israel came in contact with two patients with medical complications of FGM (bleeding and infection). They then conducted a preliminary study to estimate the

prevalence and motivation for FGM and physical findings after FGM (3).

FGM is practiced in variable forms among different peoples. The most extreme practice is the Pharaonic operation, also called infibulation, in which the clitoris is removed along with the labia minora and at least two-thirds of the labia majora (4). A less drastic form of FGM is called the Sunni type, and involves removal of the prepuce of the clitoris, similar to male circumcision. The two forms are not clearly separated anthropologically and many groups practice intermediate forms (1).

Lightfoot-Klein (4) described the practice of FGM in the Sudan, where the Pharaonic type is normative. Through structured interviews but without physical examination, she attempted to evaluate the motivation of the women and men for the procedure and its effect on sexual function and health. Lightfoot-Klein collected information over five years in multiple settings in a nonsystematic manner in Sudan. In our 1995 study (3) we attempted a more systematic approach to allow separation of family myth from present practice. In particular, physical examination of a sample seemed critical to confirm or disconfirm subjective impressions of the nature of the FGM performed, since the practice is so variable.

1995 STUDY

Twenty-one Bedouin Arab women were interviewed in the Arabic language by a female social worker trained in human sexuality. Women were recruited for interview on recommendation of the Medical Clinic staff as individuals willing to cooperate and who were thought to know about FGM ("community leaders"). The usual term used in the interviews for FGM was not anatomic but the Arabic word "purification." The interviewing was done in two steps. The first was in groups of five to six women, since the women refused to talk to an outsider alone. The second phase of the interviewing was individual. Each consenting woman was asked about personal details, medical information, beliefs about FGM, and history of her own FGM. The nature of the interview by a non-Bedouin in an undefined setting elicited more information about cultural norms and accepted practice than about personal sexual feelings and experience. None of the women could anatomically describe what part of their female genitalia has been altered or in what way. The nature of the interview was more anthropological (i.e., eliciting beliefs and attitudes

felt to be normative) than psychological (i.e., evocative of the individual's personal history and inner feelings).

Separately, a physical examination was conducted on a sample of 37 women (ages 17-36) from tribes reported to undergo FGM by the original groups of interviewed women (3). The physical examination was conducted during gynecological examination by an experienced gynecologist as part of a comprehensive obstetric or gynecologic examination in the presence of an Arabic-speaking female nurse and translator. In all cases the introitus was carefully examined, the prepuce lifted, the clitoris observed and the labia separated and individually examined for damage or scars.

The sample was a consecutive and unbiased sample of all women attending the clinic from the tribes reported in the previous interview study to perform FGM. No women refused to participate. The sample included 27 housewives, 2 teachers, 1 dental assistant, 4 factory workers, 1 secretary and 2 university students. Age of the women interviewed ranged from 16 to 45 years. All were Muslims, belonging to six different tribes: one black tribe originating from Africa, the others were Caucasian originating from Egypt or Saudi Arabia.

The interviewed women reported that they themselves, all their sisters and the women in their close and extended family underwent FGM. The older women who had daughters reported that the daughters had already undergone FGM or will have FGM when they reach the suitable age. The age of FGM is 12 to 17 years, after menarche but before marriage.

The primary decision-maker for FGM is the mother. When the age of FGM is reached, "pressuring" remarks are made to the girl. These remarks concerning her cooking and baking imply that the food she is preparing is not clean or tasty, and from this she can understand that FGM is needed. The FGM is performed mostly by old women who are known in the tribe as the traditional surgeons. One of the interviewed women performed FGM on herself!

The girl to have FGM is held by two women, one holding her hands and closing her mouth to prevent crying or screaming, the other woman holding her thighs apart. Water and soap are used to clean the external genitalia. A razor is usually used to perform FGM, without anesthesia.

Several reasons are given for FGM. The most common is social pressure to maintain tradition. The second most common is the belief that women without FGM are not good bakers or cooks. Many women believe

that after FGM women are cleaner (the Arabic word for FGM is *tohor* – purification). Other less common reasons given for FGM include enhancement of reproductive ability and decreasing a women's sexual desire. Men are empathically not involved in FGM, according to all informants. Fathers are not aware of whether daughters have had FGM, and husbands-to-be do not inquire and are not told. It is strictly a women's issue.

Most of the women stated that they will continue practicing FGM on their daughters. Two young women age 16 and 18 years said they will not perform FGM on their daughters: They were the younger and better educated women in the group we studied.

On physical examination of 37 women other than those originally interviewed but from the same tribes, none were found to have had clitoridectomy or removal of the labia majora or minora. All had small scars apparently from old incisions, on the prepuce of the clitoris or the upper 1 cm. of the labia minor near the clitoral prepuce. On the clitoral prepuce there were scars in 25 women, always vertical up to 1 cm in length and in the midline. In 31 women there were scars, horizontal less than 1 cm in length, on the upper labia minora, right or left side, below the clitoral fold. In six women from the most educated families there was a single scar on the clitoral prepuce or the labia minora.

In a short interview in the medical setting all the women reported bleeding and pain at the time of the FGM; three of the women reported that they had required medical attention. All of the women reported pain on intercourse in the months after marriage; none felt this to be related to FGM and all approved of the practice and intended to continue the tradition.

This study (3) suggested that FGM among the Bedouin of southern Israel had become a symbolic operation without the major mutilative aspect of Pharaonic circumcision or infibulation as practiced in much of Africa (1, 5). The absence of sterile techniques and the existence of genital scars still carry the risk of occasional acute medical complications or of increased susceptibility of genital transmission of AIDS (6). Moreover, the performance of a genital operation in adolescent girls must have considerable psychological impact in Bedouin culture (5).

The word "circumcision" is still commonly used among anthropologists and lay Israelis to describe the Bedouin custom of FGM. A recent press campaign in Israel assumed that the practice involves clitoridectomy, is motivated by male desire to dominate and humiliate women, and that the practice should be vigorously outlawed. Our

data suggested that motivation is multidetermined culturally, involves mostly female attitudes and always female perpetrators, and in Israel in 1995 was a nonmutilative operation akin to male circumcision. Physical examination as done in our study has been absent in many previous anthropological studies of FGM (4). The fact that none of our interviewed women could describe the anatomy of their own FGM suggested that cultural spokespersons and even the women themselves may be inaccurate sources of information on the nature of FGM performed in their society or even on themselves. Although there is no reason to question the vast medical and anthropological literature to the effect that cruel, mutilative FGM is widespread in Africa and Asia, specific cultures and persons that practice FGM may be involved in a very different practice that they cannot always explain.

The eradication of FGM has become critical in light of the possible role of the scars of FGM in reducing vaginal mucosal barriers to penetration of the AIDS virus (6). We suggested in 1995 that head-on abolition may be a self-defeating approach, much as the Romans were unable to eradicate Jewish circumcision of males and achieved only revolt and Jewish martyrdom. Encouragement of evolution and sublimation of FGM from Pharaonic types, as described by Lightfoot-Klein (4), to symbolic incision of the genital area, could provide a realistic approach to this problem. Our findings among the Bedouin of Israel could provide a model. This kind of evolution may be possible, since FGM is not a religious commandment of the Koran or any other religion but only a widespread and strongly held custom.

THE 2008 FOLLOW-UP STUDY

In the 1995 study of Asali et al. (3) six tribes were found where FGM was the norm according to anthropological interviews. However, on physical examination of women from these tribes who were having routine physical examinations for gynecological or obstetrical reasons, no instances of mutilation of the labia majora or clitoris were found. Scars were found on the prepuce of the clitoris or on the labia about 1cm in length, indicating that a ritual incision had been made but without removal of tissue, WHO classification, FGM Type IV (7). It was speculated (3) that this procedure might have been modified from an earlier original procedure that might have been more severe (8). It was suggested that the process of Westernization that the Bedouin have undergone since Israeli independence, universal health

care and compulsory education of both boys and girls might have led to a modification of the practice without a directed program towards its eradication.

In the last few years, clinicians in southern Israel have had the impression that the practice has disappeared entirely in the Bedouin population. Therefore we decided to survey again the Bedouin population with an emphasis on those tribes previously reported to perform this practice (9). Moreover, we limited our survey to women under age 30, who would have been expected to have had this procedure in the last two decades, rather than older women who might have scars from FGM performed 40-50 years ago.

Eighty percent of the interviews were done by an Arabic-speaking psychiatrist and 20% were done by an Arabic-speaking nurse. The setting of the interviews was the gynecologic clinic of a large Bedouin township or the gynecologic clinic of a smaller Bedouin township. In both township clinics, "specific tribes" that were found in the 1995 study (3) to have a high prevalence of FGM were preferentially invited to participate in the study (we do not disclose the identity of these tribes for ethical reasons.) Women coming for other services and requiring gynecological examination were asked if they would be willing to answer a few questions about their past and if they were willing to have the gynecologist, with no additional procedure, note whether any operation had been performed on their genitalia. This procedure of oral consent was approved by our Helsinki Ethics Committee (IRB). The women were sampled consecutively on days that the psychiatrist or nurse could attend clinic, but only in areas where that practice had been previously described to be prevalent. Attempts were made to interview staff and to identify times and places where women who might still be performing the practice might be available for participation in the study.

One hundred and thirty-two women were examined. No cases of any scarring of the kind reported in the previous study (3) were found on physical examination. Six women reported that they had heard that FGM is still going on but only by word of mouth, and we could not identify a single case that we could be referred to.

The present study (9), in combination with the study (3) published in 1995, represents an almost unique anthropological follow-up study. Few studies of this kind have been reported. Our present results strongly suggest that FGM has disappeared among the Bedouin population of southern Israel and the results are particularly striking since *all* of the 37 women examined

in the 1995 study had evidence of FGM. Of course, isolated incidents may still occur and any kind of mutilation can occur in the setting of psychopathology. (An example might be whether to ask if murder occurs in Paris. Of course murder occurs in Paris, but it is not the cultural norm.) One cannot rule out some continuing FGM, and indeed six women had heard that FGM still occurs. Recently, a case of severe bleeding secondary to FGM in a 16-year-old girl was reported in the Israeli Hebrew press (*Maariv*, June 5, 2008), the first such case at the regional hospital for southern Israel in 10 years, but the family were immigrants from Egypt and this says little about FGM in Israeli Bedouin.

What are the causes of this change? There has been no concerted program in Israel to stop FGM, although it has been discussed on television and is viewed with disapproval by the majority of the population, both Jewish and Arab. The disappearance of FGM in this population has taken place in spite of the fact that in the 1995 study (3) a large number of women said that they planned to continue this custom and would perform it on their daughters. Demographic data show that the health variables in this population, such as infant mortality and mean birth weight, and educational variables, such as percent attending school, number of school years completed and literacy, have continued to improve over the last 15 years, and these may be associated with the decline in FGM (10).

However, the practice of FGM remains prevalent in other countries, despite efforts to eliminate this practice. For example, although the government of Egypt announced that FGM is prohibited by law, a substantial number of women in that country still support this practice (11, 12). Hassanin et al. (13) reported that after six years of putting prohibition law in action, the majority of the 10-14-year-old girls (85%) in Egypt had had FGM within the last six years. Another approach has been suggested in Kenya: a substitution of FGM by "circumcision through words." It includes one week of seclusion, when the girls are taught basic anatomy, physiology, sexual and reproductive health (14). FGM is a culturally entrenched procedure and unless a prohibition of the practice is accompanied by educational efforts, the effectiveness of legal action is low (13).

COMPARISON WITH ETHIOPIAN JEWS

Christians in Ethiopia practice FGM (15), although the exact anatomic nature of their FGM has not been

described (16). Jews from Arab countries where FGM is practiced do not practice FGM. However, major immigration of Jews from Ethiopia to Israel permitted study of this practice. We confirmed the report that Ethiopian Jews did practice FGM in Ethiopia (17). Moreover, we reported the dramatic and total cessation of this custom among this community after immigration to Israel. This study of FGM is one of the few to combine anthropological interviewing techniques with physical gynecological examination. Interviews were conducted in two different absorption centers for recent Ethiopian immigrants. First we interviewed (18) six elderly women from the Tigray area and six elderly women from the Gondar area. They were considered to be good informants by social welfare staff. Two young educated translators, one from Tigray and one from Gondar, were also interviewed. One member of each group had been a professional female circumciser (*Gherazit*) in Ethiopia.

Interviews were conducted by a Jewish-Israeli male psychiatrist with experience in Ethiopian Jewish culture and ties to the Ethiopian community. Nevertheless, the topic was felt to be highly embarrassing and subjects were reluctant to discuss it. Coffee was served at each interview group and confidentiality was guaranteed. In addition, six men of Ethiopian origin presently working in the paramedical field in Israel were interviewed.

An experienced gynecologist examined 113 Ethiopian Jewish women in the course of routine gynecological examinations at Kupat Holim Beersheva gynecological clinic. A high-intensity lamp was used to examine the introitus and clitoris of the women. The women's ages ranged from 16 to 47. Only women who declared themselves Jewish from birth and who were aware of Jewish religious customs were included. Women originated from both Tigray and Gondar.

All interviewed women agreed that FGM was normative among Jews in Ethiopia. None felt that the custom was a result of assimilation into Christianity. In Tigray the ceremony is done on Day 14 of life, in the hut where women remain after childbirth. The ceremony is performed by a special circumciser. The mother is present, as are respected female guests. Males are not allowed. While the ceremony is not considered religious, only a Jewish woman is allowed to perform it on a Jewish infant girl. The infant is dressed in white new cloths. The infant is held with legs spread apart, the clitoris and labial folds are held between thumb and middle finger and cut with a new disposable razor blade. The

Gherazit warned that the base of the clitoris is never to be injured. The amputated clitoris is removed from the room and buried. Blessings are said in the ancient Geez language holy to Ethiopian Jews, including the Biblical Ten Commandments. A feast is then eaten. The purpose of the FGM, in the view of the interviewees, is not to reduce female sexual pleasure but to create adhesions that prevent premarital intercourse.

In Gondar, the RGFS is performed on Day 7. The interviewees reported that in Gondar the clitoris is not cut but the labia minora and clitoral prepuce are removed. The removed parts are buried as in Tigray. In Tigray the reason given for the ceremony is esthetic, since uncircumcised girls would be seen to have a "long and ugly clitoris." Creation of adhesions is not seen as a goal of the FGM. The interviewees rationalized the absence of need for the ceremony after immigration to Israel by saying that in Israel the clitoris does not grow long for some reason.

Two educated young Jewish women of Ethiopian origin, in Israel for more than 10 years, were interviewed at length and in an individual setting without translation. Both were aware of FGM as normative in Ethiopia, and both confirmed the above reports. Men of Ethiopian origin reported being aware of FGM among Jews in Ethiopia but knew no details.

Forty-two (37%) of the women examined had evidence of old scars. In 11 (10%) there was total amputation of the clitoris and prepuce. In 19 (17%) the clitoris was partially amputated. In 8 (7%) other women there was a 1 cm² removal of the labia minora beneath the clitoris; in some this was bilateral and in some unilateral. In 4 (3%) women, there were scars of incision only on the clitoral prepuce, about 4 mm long. In the remaining 71 women (63%), there was no evidence of any genital past incision or ablation.

In contrast to Israeli Bedouin (3), Ethiopian Jews practiced a major form of FGM. The examinations revealed that not all women had FGM, but those who did often had major mutilation, although akin to the moderate "Sunni" rather than the most extreme "Pharaonic" type among Muslims (4). Unfortunately, no physical examination data are available on FGM among Christian Ethiopians. By contrast with the Bedouin, Ethiopian Jews give up FGM immediately on arrival in Israel. They see themselves a part of a Jewish society that does not practice FGM. No signs of distress or nostalgia for the custom were expressed. These data suggest that cultural change is often a function of identity. Rapid cultural change without evident distress may

be possible, if individuals or a group consciously accepts a new identity. An additional finding in this study, as in the Bedouin study (3), was a gap between physical findings and the anthropological report. Although FGM was normative for all Jewish female infants in Ethiopia, only about a third had evidence of old genital scars, and only 27% had clitoridectomy. This illustrates a well-known phenomenon in anthropology whereby interviews elicit descriptions of accepted norms that may reflect behavior of only a minority of individuals in practice. For instance, interviews of Israeli or American adults about marriage would yield various normative customs, although in practice divorce, out of wedlock motherhood, and adultery are commonplace. It would be interesting to discover what factors affect whether a *Gherazit* made a major or minor incision in practice, despite the normative custom of clitoridectomy.

This study and its predecessor (3) are among the few studies of FGM to combine anthropological interviews with physical examination (19, 20). Most knowledge of the physical nature of FGM comes from the occasional cases that reach hospital because of medical complications; these could be only the most extreme forms in the population. Our study also emphasizes the dangers of drawing conclusions from interview data only, since many women are unaware of the anatomical nature of their own FGM. Lightfoot-Klein (4) reported female orgasm among women in a culture where severe FGM is normative, but one could question whether all or even a majority of women undergo the normative operation.

SUMMARY

Our three studies taken together suggest that belief systems and group identity are the key determinants for efforts to eradicate FGM. Ethiopian Jews, who practiced a major form of FGM in Ethiopia, give up the custom upon arrival in Israel and no reports exist among pediatricians, gynecologists or the press of FGM among Jews of Ethiopian origin in Israel. Some Muslim Bedouin tribes in Israel in 1995 saw FGM as an important part of their culture, but in practice performed only a symbolic operation. By 2008 it had effectively disappeared (21).

Conflict of interest:

The author has no conflict of interest with regard to this manuscript.

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