

The Role of Culture in Contributing to the Spread of HIV/AIDS

Understanding How Cultural Norms and Practices, Specifically Female Genital Mutilation Facilitate the Spread of HIV/AIDS

Tholoana Mofolo

The practice of female genital mutilation is very common in Africa and has also been shown to occur in the West, specifically in the USA and the UK. Reasons given for this practice range from ensuring fidelity during marriage; enhancing sexual pleasure for men; observing 'religious' custom; upholding traditional values/rite of passage; and so forth. This practice has received widespread global concern and has resulted in the enactment of various laws advocating for its complete abolition internationally, and in various African countries. This policy brief sets out to explore the role of culture in its potential contribution to the practice of female genital mutilation, and goes further to articulate the health related hazards and implications of this practice, with specific reference to explaining its facilitation to the spread of HIV/AIDS. Furthermore, the brief makes recommendations encompassing continental integration in the promotion and implementation of eradicating female genital mutilation, and ensuring that harsh punitive measures are put in place for those aware of its dangers yet continuing to have it carried out.

Introduction

The role of culture has been particularly problematic in the fight against HIV/AIDS. When one talks of culture, especially in the context of HIV/AIDS,

what comes to mind is the patriarchal society in which we live, as well as the gender inequalities which it has given rise to. This paper will focus on how culture in general has facilitated the spread of HIV, with specific reference to cultural norms

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(i.e. gender roles and relations) and their potential contribution to the adoption of various practices, such as female genital mutilation, which may, in turn, lead to the further spread of HIV.

Culture

In simple terms, culture basically refers to the traditions and customs upheld by societies and communities because of their belief systems and values. Culture is defined as the learned, shared and transmitted values, beliefs, norms and life ways carried by groups of people, which guides their decisions, thinking and actions in patterned ways. The individual in society is bound by rules of his/her culture. Cultures are different in that the same events that may be fear-inducing in one culture may be anger-inducing in another.¹ A more comprehensive definition of culture is:

The pattern of human activity and the symbols that give significance to these activities. Culture manifests itself in terms of the art, literature, costumes, customs, language, religion and religious rituals. The people and their pattern of life make up the culture of a region. Cultures vary in different parts of the world. They are different across land boundaries and the diversity in cultures results in the diversity in people around the world. Culture also consists of a system of beliefs held by the people of a region, their principles of life and their moral values. The patterns of behaviour of people of a particular region also forms a part of that region's culture. The word 'culture' hails from the Latin word 'cultura,' derived from 'colere,' means, 'to cultivate.' Hence, the way in which the minds of the masses inhabiting a particular region are cultivated, in some way determines the culture of a region.²

Gender roles and relations also constitute some aspect of culture. These roles and relations arise out of a process of socialisation, where young boys and girls are taught their respective roles in society as well as in relation to one other. In black African culture, the male figure has always held the dominant position in the household. Men in pre-colonial times were hunters and have always been the providers and breadwinners for their families. Women ploughed the fields and took care of the household duties which involved cooking, cleaning and washing clothes, etc. It can be said that men have always maintained a 'superior' status over their wives to some degree. African boys are taught from a young age that they are to provide

for their families and are to also be the 'heads' of their households. Young African girls, on the other hand, are socialised to become nurturers and caregivers to their children and husbands. They are to take care of their families and taught to be humble, as well as respectful to their husbands. This is common knowledge among black Africans and these patterns of socialisation are not only taught, but learned through daily observation within one's family and other black African families. As a result, the gender roles learned and adopted by young boys and girls influence the ways in which they relate to one another later in life. Men are labeled 'provider/head' and women 'caregiver/subordinate' and, as a result, begin to internalise and assume these respective roles.

It can be argued that these gender differences/inequalities contribute to the spread of sexually transmitted diseases, such as HIV/AIDS, in that unequal power relations also come to exist when it comes to sexual intercourse. Sex in some traditional African cultures has mainly been for the pleasure of the 'man.' This idea was further emphasised during the Apartheid era when black African men migrated to the urban centres in search of employment in the mines. Men in the mines felt that they worked very hard and constantly faced the risk of death as a result of working in highly adverse and dangerous conditions. This, they felt, entitled them to various sexual partners, ultimately creating an opportunity in which to relieve, sexually, the stress and tension they experienced on a daily basis, thus simultaneously providing an avenue in which to express their masculinities.³

Masculinity has been cited as 'a place in gender relations, the practices through which men and women engage that place in gender, and the effects of these practices in bodily experience, personality and culture.'⁴ It has been posited that power imbalance[s] pervade all social relationships between men and women.⁵ To contextualise this even more, there is an unequal balance of power between men and their sexual partners – an imbalance whose detrimental effects have resulted in [black] women becoming the face of HIV/AIDS, both in Africa and in the USA.⁶ Lack of power by African women in relationships means that they have very limited decision-making abilities in the relationship and are unable to negotiate safer sex and, therefore, risk infection to please the man.⁷ This is particularly the case if the woman's husband/partner is the sole breadwinner of the household, or if the woman has a low educational background. Her husband or partner may easily exploit her, resulting in her, ultimately, giving in

to all his needs and demands. HIV contraction has spread widely in such cases, especially as studies have revealed that some black African men prefer sexual intercourse without the use of a condom.⁸ It can be seen how these conditions themselves could have created an environment conducive to the practice of female genital mutilation as a way of ensuring maximum pleasure for men during sexual intercourse. This suggests that highly patriarchal African societies may have created an environment which spearheaded the adoption of this practice, by way of maintaining men's 'superior' statuses and, consequently, finding ways for women to please them. This sheds some degree of light on how culture contributes to the spread of HIV/AIDS, thus simultaneously creating an environment conducive to practices such as female genital mutilation (FGM), which further facilitate the spread of this epidemic.

Female Genital Mutilation

The World Health Organisation's (WHO) Technical Working Group defines FGM as "the removal of part or all of the external female genitalia and/or injury to the female genital organs for cultural or other non-therapeutic reasons."⁹ The age at which female children are subjected to genital mutilation varies widely in different societies. In some groups, this operation is performed on babies only a few days old, in others, at about seven years old, and yet others at adolescence. Although FGM is not espoused by a specific religion, it is a practice steeped in tradition that is closely linked with certain ethnic groups.¹⁰

Types of FGM

The WHO differentiates between four types of FGM, ranging from the mildest Type I form, which involves the removal of the clitoral hood to complete clitoridectomy. In Type II operation, part of the labia minora are removed, along with the clitoris. Type III, known as infibulation, involves the complete removal of the clitoris and labia minora, together with the inner surface of the labia majora.¹¹ The raw edges of the labia majora are then stitched together with thorns, silk or catgut sutures, so that when the skin of the remaining labia majora heals, a bridge of scar tissue forms over the vagina. A small opening is preserved to allow the passage of urine and menstrual blood.¹² Type IV is a new category to cover other surgical practices, for example, "cauterizing by burning of

the clitoris and surrounding tissue" and the introduction of substances into the vagina to tighten or narrow it.¹³ It has been estimated that 80% of all the FGMs performed qualify as Type II, whereas about 15% constitutes Type III, which is widely practiced in Somalia, Sudan, Ethiopia, Eritrea, northern Kenya, and small regions in Mali and northern Nigeria.¹⁴

Reasons Given for the Practice of FGM

The continuance of this practice is fostered by many views and cultural beliefs. FGM may be conducted as a rite of passage, to maintain virginity before marriage, for social and sexual control of women, to decrease sexual pleasure for women while enhancing sexual pleasure for men, and to ensure fidelity during marriage.¹⁵ The pressure to participate in the practice can be substantial. Women who do not conform to these societal norms are often ostracised, excluded from the community, and made ineligible for marriage.¹⁶

Other reasons for FGM, as cited by the *Center of Reproductive Rights* in New York are: custom and tradition; women's sexuality; religion; and social pressures. Communities that practice FGM maintain their customs and preserve their cultural identity by continuing the practice. In fact, while FGM is practiced by Jews, Christians, Muslims and members of other indigenous religions in Africa, none of these religions actually require it.¹⁷ While religious duty is commonly cited as a justification for the practice, it is important to note that FGM is a cultural, not religious, practice. In a community in which most women are circumcised, family and friends create an environment in which the practice becomes common and is promoted across communities and societies at large. In other societies, it is believed to control women's sexuality by reducing their sexual fulfillment.¹⁸ It has also been cited to raise the social status of parents, whereby dowry demands are high for girls who have been excised, thus increasing their chances of infection when married off to older men who are already infected. An interview with Ms Thoraya Obaid, Executive Director of the United Nations Population Fund (UNFPA), revealed that

Individual families who elect not to have their daughters excised undergo FGM risk stigmatisation and social exclusion, particularly in communities where the practice is ubiquitous. In these settings, FGM is often seen as a pre-requisite for marriage; girls who have not undergone the procedure may

be deemed unmarriageable. Despite the pain and consequences associated with FGM, including the risk of fatal complications, the practice continues to persist because it is deeply entrenched in social and cultural tradition.¹⁹

The UNFPA has, in fact, conducted a number of research studies/intervention programmes in a number of African countries, with the intention of improving the health and wellbeing of women, men and adolescents, with special focus on reproductive health and rights. It was found that social and cultural realities present challenges, and also opportunities for advancing development goals and human rights, particularly when dealing with issues of gender equality, HIV/AIDS, female genital cutting, gender based violence, and maternal health and planning.²⁰ For instance, in an intervention programme carried out in Uganda, it was found that although some of Uganda's elders had been strong supporters of female genital cutting, they eventually became advocates for the elimination of this harmful traditional practice.²¹ Similarly, it has been stated that previous efforts aimed at discouraging female genital cutting in Uganda were met with considerable resistance, until a new project known as REACH (Reproductive, Educative and Community Health Project) was introduced, as it worked to eliminate the practice while reinforcing the cultural dignity of the community.²² The next section on 'research studies on the practice of FGM' highlights two points: (1) the prevalence of this practice in certain parts of Africa; and (2) attempts to uncover the reasons as to why this practice is carried out.

Research Studies on FGM

Due to the health related complications of FGM, there has been widespread concern across the globe and various research studies have been undertaken to try and understand as well as eradicate this practice. One qualitative research study was undertaken in Togo by the US Department of State to reflect attitudes and beliefs of circumcised women about the actual practice. First and foremost, the study found that 12%, or one Togolese female in eight, had undergone this procedure.

The study revealed that women over 40 were more likely to have been excised than younger women. Educational levels also made a difference, with an incidence of 15,7% among the women with no education; 6,1% among those with primary education; and 4% for those with secondary or higher education. Broken down by religion, the figures

were 63,9% for Muslims; 3,2% for Christians; 6,1% for Animists; and 10% for those claiming 'other' religions.²³

Public awareness of the dangers of this practice was much higher in urban areas than in the more remote rural regions. Excisors usually traveled to remote villages to perform this procedure, and families have been reported to come across the border from neighboring Burkina Faso (where laws outlawing this practice reportedly are more strictly enforced) to have the procedure performed in Dapaong, a community in the north of Togo. In this research project, 60% of the excised women interviewed were in favor of abolition of the practice. The women cited infection, hemorrhage and other health issues as particular problems for the excised. Thirty percent, however, felt that it remained an important cultural practice and would like it to continue. They intended to have their daughters excised.²⁴

Furthermore, the Demographic Research Unit, working with women's associations, local women's groups, health workers and others, organised eight focus group discussions on this practice in Togo. The groups covered younger women, older women, excised and non-excised, urban and rural women and two groups of men, one Muslim and the other predominately Christian. Focus group discussions were concentrated in regions and among ethnic groups where the practice occurs. Every group insisted that the practice was founded on traditions and was not called for in any religion practiced by these groups.²⁵

Below is an excerpt as cited in Aldeeb Abu-Sahlieh (1994), articulating that

On a social level, the non-circumcision of a female has serious consequences. In some countries, the non-circumcised girls do not get married and people start talking about them, as if they were guilty of misbehavior, possessed by the devil [religious connotation]. In the Egyptian countryside, the matron practicing female circumcision delivers a certificate which is used for marriage.²⁶ Zenie-Ziegler writes that the Egyptian country women are surprised to learn that their sisters in Cairo are not excised. They burst into laughter, interrupted by scandalised comments; "Really, it is not done? Girls remain like that, uncut? And they don't become wild?"²⁷

In Sudan, where infibulations [are] practiced, brothers have tried to protect their younger sisters from this torture. Most of them were evicted from the parental home after terrible quarrels, the parents accusing them of being depraved and trying to transform their sisters into shameless creatures.²⁸

The above excerpt definitely brings to light the societal pressures and customary traditions which promote the practice of FGM. The implication here is that those who do not have their daughters excised are looked down upon and, ultimately, discriminated against, along with their daughters, of course. How then can one feel as though they are part of a community if they do not have the procedure carried out? One possible answer to this question may be found in the next study conducted in Senegal.

This study was conducted in the period 1998-1999, and reflected perceptions and opinions of FGM among community members after receiving education and knowledge of its harmful effects. The study included twelve villages in total. The younger women who attended the educational classes were in favour of abolishing the practice but were at first met with opposition from the older women. The older women basically expressed that they could not just abandon the practice because it was their custom.²⁹ A meeting was then held whereby older and younger women came together to discuss their different viewpoints. After much debate a decision was finally taken to abolish the practice.

In light of this, it has been stated that not a lot of studies have been done which [scientifically/empirically] establish non sexual modes of HIV transmission [as a result of female genital mutilation].³⁰ However, a study was undertaken to assess the relation between male and female circumcision (genital cutting) and prevalent HIV infection in Kenyan, Lesotho and Tanzanian virgins and adolescents respectively, using recent cross-sectional national probability sample surveys of adolescents and adults in households, focusing on populations in which circumcision was common and usually occurring in puberty or later.³¹ The study concluded that HIV transmission may, in fact, occur through circumcision-related blood exposures in the eastern and southern parts of Africa.

Health Related Implications of FGM (Mainly HIV/AIDS)

This section is mainly aimed at establishing, or rather explaining, how the practice has been found to lead to the spread of HIV/AIDS.

The WHO and the International Federation of Gynaecologists and Obstetricians have hypothesised that a link exists between female genital mutilation and the transmission of HIV.³² The reasons for this presumed association include the

following: after FGM the vaginal neointroitus is reduced in size, especially with type III FGM. This reduction in size may increase bleeding, inflammation or abrasions with sexual intercourse, thereby facilitating HIV transmission. Also, the adequacy of blood supply screening in many African countries has been questioned, and African women typically require multiple blood transfusions at or around the time of childbirth, especially if they have had FGM. The use of unsterilised instruments on multiple women during circumcision rituals also increases the risk of viral transmission.³³

The tendency of mutilated genitals to bleed also puts genitally mutilated women at high risk of contracting HIV/AIDS. The more severe the form and the more widespread the practice of FGM, the more this atrocity contributes to the massive numbers of women and girls infected by HIV.³⁴

Furthermore, women who have been excised have often been sewn up so tightly that intercourse can easily cause bleeding as a result of vaginal tearing. This means they are far more at risk of being infected by HIV. Bleeding also occurs when newlywed men frequently cut open their brides' tightly-sewn vaginas on the wedding night in order to consummate the wedding. Women are also sewn up when their husbands leave home for an extended time, and cut open again when they return. If a husband resumes intercourse before his wife's wounds have healed, bleeding is especially likely to occur. In addition, pregnant women often have to be cut open to give birth, after which they are tightly sewn up.³⁵

Global Interventions to the Practice of FGM

Due to complications and fatal effects of FGM, it has been banned in the West and health experts have regularly called for it to be stopped in the Middle East, Asia, Africa and other Muslim countries.³⁶ Many countries such as Canada, England, Sweden, Australia and others have enacted statutes prohibiting FGM and reinfibulation after delivery. In the United States, a law was passed in 1997 which criminalises FGM performed on a person who has not reached the age of 18 years, but it does not address women older than 18, or reinfibulation after delivery. In Sudan, infibulation was made illegal in 1946 and still today nearly 90% of the women in Sudan have been subjected to it. Because FGM is now illegal, many young girls are taken out of the country to have it performed.³⁷ In 2008, British police were commissioned to stage high profile checks on flights

to a number of African states in an attempt to stop young girls being forcibly infibulated with the consent of their parents.

The Center for Disease Control and Prevention estimates that there are over 150,000 females at risk in the United States for undergoing the procedure. “Clearly, it will take more than legislation to eradicate this practice that can no longer be seen as a religious or traditional custom.”³⁸

Many individuals, countries, groups of countries and international bodies have and continue to work toward the eradication of FGM.³⁹

In the early 1950s, the UN Commission of the Status of Women and other UN bodies first began to focus on FGM.⁴⁰ Their goal was to “confront the problems of customs, ancient laws and rituals that harm women’s health and well-being and trample on their rights.”⁴⁰

In 1997, a Symposium for Legislators was held in Addis Ababa, Ethiopia of which the outcome was the ‘Addis Ababa Declaration,’ which called on African countries to adopt clear policies and concrete measures aimed at eradicating or drastically reducing FGM by the year 2005.

In addition, there is also the Female Genital Mutilation and International Human Rights Standards Act (ACT 77/14/97), which member States are obligated to comply with.⁴¹

Following is a partial list of examples of progress made since 2002, as cited in Kolucki (2007):

- The outcome document of the UN General Special Session on Children, endorsed by 69 Heads of States and Government and 190 high-level national delegations, including young people, set a goal to end FGM by the year 2010;
- Amnesty International issued a press release on 6 February 2004 calling for “International Zero Tolerance to FGM”;
- Amnesty International (AI) also supports a ‘Special Project on Female Genital Mutilation and Human Rights.’ The aim is to conduct research on FGM in order to support advocacy and education campaigns in Sudan, Kenya and Senegal, but also works within the broader movement in Africa and the world.;
- In Kenya, a group of young women from various homes defied their families’ wishes and went to see a lawyer to prevent them from having to submit to FGM. The lawyer brought the case to trial and was able to get an injunction stating that the parents could not make them submit to FGM without their consent; and
- In February 2003, the first ladies of Burkina Faso, Nigeria, Mali and Guinea jointly condemned FGM at a meeting in Ethiopia. They called it “the most widespread and deadly of

all violence victimising women and girls in Africa.” WHO has developed training materials for integrating the prevention of FGM into nursing, midwifery and medical curricula, as well as for in-service training of health workers.⁴²

Table 1 Statistics of Human Genital Mutilation in Africa: (DHS) 1990 – 2004

Prevalence of female genital cutting in DHS surveys: ational level data			
Country	Year of survey	Overall prevalence	Sample size
Guinea	1999	99%	6 753
Egypt	1995	97%	14 779
Egypt	2000	97%	15 573
Mali	1996	94%	9 704
Mali	2001	92%	12 849
Eritrea	1995	95%	5 054
Eritrea	2002	89%	8 754
Northern Sudan	1989–90	89%	5 860
Ethiopia	2000	80%	15 367
Burkina Faso	1998–99	72%	6 445
Burkina Faso	2003	76%	12 477
Mauritania	2000–01	71%	7 728
Côte d’Ivoire	1998–99	45%	3 040
Chad	2004	45%	6 087
Côte d’Ivoire	1994	43%	8 099
Central African Rep.	1994–95	43%	5 884
Kenya	1998	38%	7 881
Kenya	2003	32%	8 195
Nigeria	2000	25%	3 365
Nigeria	2003	19%	7 620
Yemen	1997	23%	10 414
Tanzania	1996	18%	8 120
Tanzania	2004	18%	6 863
Benin	2001	17%	6 219
Ghana	2004	5%	5 691
Niger	1998	5%	7 577
Cameroon	2004	1%	10 656

Source: DHS website – <http://www.measuredhs.com/gender/fgc-cd/start.cfm>

Conclusion

This brief has provided thorough and detailed information on culture, explaining how culture in itself has contributed to the spread of HIV/AIDS, as well as indicating how gender differences and inequalities have created an environment conducive to the practice of FGM. One of the reasons cited for this practice was to increase the social status of a family which has had their daughter excised

because she would have a much higher chance of marrying. This reason actually emphasises the idea that FGM is, in fact, carried out for the pleasure of the 'man,' hence the promotion of the practice as it increase the chances of daughters being married. While this may be the case, it is important to try as much as possible not to make any value judgement to those who have the procedure carried out on their daughters, as it may be a way of ensuring future social and financial security for them. However, FGM was also shown to contribute significantly to the spread of HIV/AIDS, as well as leading to other health related complications, resulting in increased bleeding, risk of viral transmission, inflammation, abrasions resulting from sexual intercourse, and haemorrhaging.

This practice has been viewed by the international community as a violation of human rights, and this view has also somewhat penetrated African societies, as can be seen by the response from various African countries listed earlier in the section on 'global interventions.' The global interventions to the practice of FGM mentioned show that the matter has been given significant and widespread attention, meaning that policies have been put in place in an attempt to have it abolished.

It can also be seen by the intervention of the British police that African countries can also put into place their own practical programme of action to identify women who have been recently infibulated. This enables them to trace the individuals who carried out the procedure in an attempt to determine and evaluate the degree to which the practice is still being carried out and, consequently, finding ways to have it completely eradicated, if possible.

Recommendations

It is therefore recommended that:

- African governments at large collectively come together, lobby and advocate for a unified objective policy stressing the importance of eradicating FGM. In doing so, reasons for its eradication should be provided as a way of making communities understand the necessity of having it stopped. It is also imperative that African communities be educated and informed about the dangers and health-related implications of FGM.
- African governments adopt practical and effective educational interventions and evaluations to determine whether or not there has been progress following interventions. In other words, are people still carrying out the

procedure even when aware of the dangers? If this is the case, punitive measures may be put into place stipulating that those aware of FGM associated risks will be punished/jailed if continuing to undertake the procedure. Alternatively, instead of immediately introducing punitive measures, communities may be provided with other alternatives. For instance, since one of the reasons cited for FGM was increasing the social status of the family with an excised daughter (for future social and financial security), education for female children should be highly promoted and perhaps even government funded so as to reduce social pressures of having the procedure carried out. This will ensure that female children will receive education and be in a better position to take care of themselves at a later stage in life.

- Work be done with families and communities, as recommended by UNICEF executive director Carol Bellamy, in order to change attitudes, traditions, customs and practices to promote gender equality for all.
- Specific reference to the complete **eradication** of FGM be made in the African Charter, the New Development For Africa's Development (NEPAD), the African Union (AU), the South African Development Community (SADC), East African Community (EAC) countries, and the like. This is very important as it will emphasise the importance of having it completely abolished because there really does not seem to be a valid reason for having it carried out other than for financial security and, perhaps, as a rite of passage into adulthood. Other educational 'rites of passage' may be introduced as a way of ensuring that young girls do have a proper transition into adulthood, where they are taught by their elders the necessary values and 'virtues' of being a woman.
- Specific systems of monitoring be put into place, as in the case of the UK. For instance, young black African girls coming into hospitals and clinics may be checked on a regular basis, especially if they show any symptoms of diseases or illnesses which may be attributable to FGM. Thereafter, the relevant authorities should be contacted in order to have the matter thoroughly investigated to determine why the practice still continues.

It is imperative that these recommendations be accompanied by a clear message to African society/communities relaying the health related hazards and adverse implications of FGM. It is also important that African communities understand that their

'culture' is not being taken away, but is, in certain instances, harmful to females and their reproductive health and should, therefore, be discontinued.

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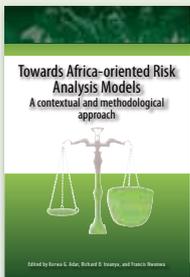
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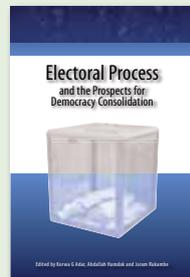
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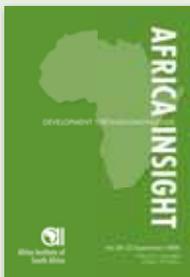
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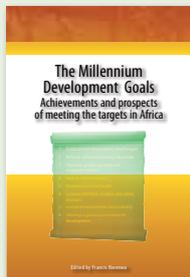
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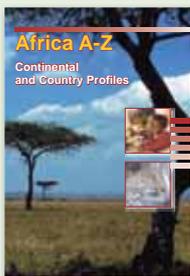
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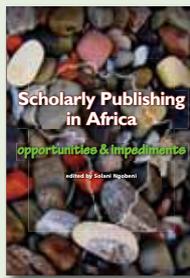
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