Social Work Practice and Female Genital Mutilation: The Bedouin-Arab Case

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This exploratory case study analysis of female genital mutilation among the Bedouin-Arab of the Negev is based on a semi-structured interview with twenty women who had undergone ritual mutilation. It discusses the psychological impacts and the social contexts in which it occurs, including gender construction, family honor and economic and familial/tribal factors. It then turns attention to four intervention strategies for social work: appreciating its culturally specific contexts, creating opportunities for internally derived responses, allowing for collaborative efforts with multiple parties and facilitating culturally specific ways of (re-)conceptualizing the practice.

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Of a wide body of social work (Swensen, 1995) and anthropological (Cf. Grassivaro, 1986; Van der Kwaak, 1992; Winkel, 1995) literatures examining female genital mutilation, this paper is the first to consider the phenomenon in the context of social work interventions. Data are based on a semi-structured interview with twenty Bedouin-Arab women who had undergone ritual mutilation. It outlines the psychological impacts and the social contexts in which it occurs, including gender construction, family honor and economic and familial/tribal factors. It then turns attention to four intervention strategies for social work: appreciating its culturally-specific contexts, creating opportunities for internally-derived responses, allowing for collaborative efforts with multiple parties and facilitating culturally-specific ways of (re-)conceptualizing the custom.

Mutilation

Female genital mutilation (FGM) occurs, but is not limited to, the Nilotic and Cushitic or Bantu peoples (Webb & Hartly, 1994), the Omans, Eriteans (Black & Debelle, 1995), Somalis, Ethiopians, Sudanese (Hicks, 1993), Yemenis (Milos, 1993), and Egyptians on the African continent and Arabian Peninsula; in Asian countries such as Indonesia, Pakistan, India and Malaysia (French, 1992); in Western countries including the United States, Canada, England, France (Gallard, 1995) the Netherlands (Hicks, 1993) and Australia (Tompkins, 1962); and in South America (Jordan, 1994). It happens within multiple ethnic groups and faiths, including Jews (Falashas) (Grisaru, Lezer, & Belmaker, 1997); North American indigenous religions (Webb, 1995); the Russian Skopotozy Christian sect (Miniru, 1994) and Coptic Christians (Abdalla, cited in Gottschall, 1992); and in many aforementioned Muslim societies (Al-Sadawi, 1985; Al-Safi, 1970; Bishara, 1989; Toubia, 1994; Van der Kwaak, 1992). Prevalence rates among practicing societies range from 5% to 99% (Toubia, 1994). The practice is common in 26 African countries and affects 100 million to 126 million women worldwide (Ortiz, 1998).

While some of the literature uses the term "circumcision," we use "mutilation," on the assumption that the latter term more aptly describes the physical and psychological contexts of what takes place. FGM is illegal in France and the United Kingdom, while in other countries such as Canada and Holland, legislation has been/is being considered (Van der Kwaak, 1992, p. 778). In 1952, the United Nations first identified the phenomenon as a public concern. The Children's Fund, the World Health Organization (WHO) and myriad human rights organizations have responded to FGM. One of the more frequently cited international resolutions occurred under WHO auspices in February 1979 at Khartoum, Sudan, unanimously condemning FGM.

Thus, it should be stressed, knowledge of the phenomenon is needed for successful social work practice among ethno-communities where FGM is, or has been, prevalent. There are several forms of mutilation. 1) The *Sunna*, an Arabic word meaning "tradition," involves the excision of the prepuce of the clitoris, or a small part of the clitoris. 2) Clitoridectomy is when the complete clitoris is excised, together with all or part of the minor labia. The operation often results in scar tissue; sometimes it is "so extensive that it occludes the vaginal opening" (Lightfoot-Klein, 1989, p. 33) 3). Infibulation, also known as Pharaonic or Sudanese circumcision, involves the excision of the whole of the clitoris, the labia minor and the labia major. The two sides of the wound are closed or stitched together so that only a small opening remains for the drainage of urine and menstrual blood. This practice of genital mutilation is associated with the most significant forms of physical trauma such as shock and hemorrhage, infection, urine retention and damage to the adjacent tissue (Asali, Khamaysi, Aburabia, letzer et al., 1995; Lightfoot-Klein, 1989; Van der Kwaak, 1992). Further, there is risk of developing tetanus, hepatitis B, blood poisoning, HIV and AIDS as a result of unsterile and mass mutilation (Asali et al., 1995; Berg, 1997). Berg (1997) points out that from the time of mutilation, sexual health and response is hindered and sexual relations are extremely painful. Long-term impairments of mobility, chronic pain syndrome, infertility and problems in menstruation may also occur (Brighouse, 1992; Lightfoot-Klein, 1993). So, too, is it associated with a variety of obstetrics issues: antenatal, labor, delivery, postpartum pregnancy outcome, maternal mortality and neonatal mortality (McCaffrey, 1995).

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Bedouin-Arab of the Negev

Although originally intended to describe only those who herded camels, Bedouin-Arab has come to be known as the general name for all the Arabic speaking, nomadic tribes in the Middle East (Kay, 1978). The Bedouin-Arab have lived in the Negev region for two millennia (Hebrew Encyclopedia, 1954) and are one national, linguistic, political and geographic entity that ought to be considered distinct from other non-Bedouin communities in Israel and distinct from although related to Bedouin-Arab communities in other countries. Although there are some Christian Bedouin tribes outside the Negev, within it, all, including the present study's subjects, are Muslim. Tribes remain important to this population's self-identity, particularly as social support networks (Al-Krenawi, 1996; Marks, 1974).

Traditionally, the Bedouin-Arab were a nomadic people, but today they are undergoing a rapid and dramatic process of sedenterization; of the Negev's 120,000, 40% now live in recognized villages, and 60% live in unrecognized villages without basic infrastructure and social services (Al-Krenawi & Graham, 1997b). The social structure is highly patriarchal; gender roles are strongly adhered to, marriages are frequently arranged, and women rarely leave the home unescorted. The society is high context (Hall, 1976); that is to say, both a slower pace of societal change and a higher sense of social stability are predominant, and the collective is emphasized over the individual (Al-Krenawi, 1998). Family honor is very important, and tribal/familial social and economic relationships are quite interdependent (Al Krenawi & Graham, 1997b).

Methodology

In late 1996, over a two-month period, a convenience sampling of twenty Bedouin-Arab women were interviewed by a female Bedouin-Arab research assistant and social worker, who was employed in a social welfare office for the Bedouin-Arab of the Negev. The interviewer selected women from her client pool who had self-identified as being mutilated and were willing to participate in the study. Over the course of a two-year period, the social worker had established a professional helping relationship with the research subjects and had developed a good knowledge of their background and a mutual sense of trust. When they were asked to be research subjects, all agreed to participate. Conventional standards of ethical research applied: Their participation or nonparticipation would have no bearing on received services, they could terminate the research process at any time, all findings would be made available to them, they were aware that findings would be published by the two authors, their anonymity would be protected, and their participation would remain confidential. Successful data collection was strongly related to the strength of the social worker's relationship with the subjects and the subjects' commensurate sense of comfort in divulging personal and painful data to someone of the same gender and cultural background.

Research subjects were interviewed in a Bedouin-Arabic dialect, using a semi-structured, open-ended interview questionnaire. Questions included 1) background information such as age, education, marital status, number of children, occupation and age of genital mutilation; 2) the subject's perceptions of societal attitudes towards the ritual: 3) the subject's perception of the strength of social pressure to perform the ritual; 4) the subject's perception of the purpose of the ritual; 5) the subject's personal recollection of the ritual; 6) the subject's feelings of the ritual while it took place; and 7) the subject's opinion of whether the ritual ought to persist. Data were analyzed in light of secondary literatures on the Bedouin-Arab and on the practice of female genital mutilation.

All stages of data collection—from initial contact and instrument development to interview processes—were closely monitored by the first author, himself a Bedouin-Arab. The second author, also a male, is not from the community. The social locations of both authors, then, and those of the research assistant definitely influence all aspects of this research. Feminist scholarship has long appreciated the divergent ways in which FGM may be conceptualized: from those who make legal representations in support of criminal sentences, to others who denounce such ap-

proaches as culturally insensitive, to still others who seek common—and middle—ground between these two positions (Winter, 1994). The present article, as will be discussed, reinforces locally derived solutions, informed, where appropriate, by information from outside the community. Herein a social work role may be especially germane. Finally, it is important to note that the findings rely on samples of quotations from many respondents and, where available, aggregate information to support all discussions.

Findings

Background

The subjects ranged in age from 18 to 48 (average 33). All were Muslim, all were Bedouin-Arab, and each woman in the sample came from a different family, extended family and tribe. None of the research subjects were sisters or relatives. Levels of formal education varied from 0 to 8 years (average 3.5), and all subjects had at least basic levels of literacy. All were married and had children, the number of children ranging from 2 to 11 (average 5.5). None had occupations outside the home. All experienced mutilation between the ages of 12 and 15 (average 13.5), after puberty but before marriage. All subjects reported that their mothers had also been mutilated. All also reported that their fathers were not part of the process of the ritual. All of the subjects' mothers and 17 fathers were identified as illiterate.

Societal Attitude Towards Ritual and Perceived Purpose

Bedouin-Arab society is high context, and so all major life decisions—when to get married, whom to marry, how many children to have, where to live—are made in light of the collective, rather than as individual decisions. By Western standards, Bedouin-Arab society is also strongly gender-divided. In fact, Bedouin-Arab life may be conceived as two different worlds existing at the same time: the man's world in the public sphere, and the woman's world in the domestic sphere (Abu-Lughod, 1985). Women therefore have little contact outside the home or immediate family. Important "others" in their lives include their children; female family members such as their mother, sisters, aunts, and cousins; and immediate male family members, especially those cohabiting in the home, such as a husband, father or brother. The men's public sphere, in contrast, consists principally of other adult men; he returns home to a private sphere consisting of women and children in his immediate family. Social contact between the men's world and the women's world is therefore limited. Each has its own values and customs, inculcated at a young age and uncompromisingly followed over one's life (Mass and Al-Krenawi, 1994; Al-Krenawi, 1996).

Bedouin-Arab men have no involvement in the ritual process, in part because of the gender-segregated worlds, and in part because of taboos of talking to a member of the opposite sex about anything related to human sexuality (Bishara, 1989; Mass and Al-Krenawi, 1994). According to all informants, fathers are not aware whether daughters have had the ritual, and husbands-to-be do not inquire and are not told. As one subject explained, "It is strictly a women's issue." Bedouin men have no part in FGM. Respondents noted that brothers, uncles, fathers, cousins and other men had no awareness of when, where or who performs the rituals. This is not to suggest, however, that men would not approve if they found out their wife or daughter was not mutilated. Indeed, future research might examine patterns of communication between male and female women in the same family to obtain a still richer sense of the meaning of the ritual within the larger cultural context.

At the same time, all respondents equated the ritual with the maintenance of family honor. Doubtless, then, men's participation is implicit throughout, as familial leaders who are ultimately seen as principal guardians of family honor. Other scholars rightly see FGM as culturally designed to subordinate women by controlling their sexuality and preserving patriarchal marital attitudes (DiMaura, 1996). In this very real sense, the ritual may be conceived as yet another example of women's obedience to, and subservience to, patriarchal male authority within the Bedouin-Arab community.

Social Pressures

Within their own private sphere, Bedouin-Arab women are nevertheless powerful. They possess autonomy in decision-making processes, especially when they become older (Mass and Al-Krenawi, 1994). All subjects noted considerable suasion to undertake the ritual from older sisters, cousins, aunts, their mothers and peer group members, all of whom had experienced the ritual or (in the case of some peer group members) intended to do so. From the age of about 11 onward, each subject recalled various "pressuring" remarks and encouragement regarding the ritual, and all subsequently agreed to undertake it. The issue of food and purity were the main concerns of the respondents and were the major strategies used by their women relatives to convince them to perform the ritual.

One respondent recalled an incident typical of several others. Family members had criticized her because the food she prepared no longer tasted good, the inference being that she was impure, and that if she undertook the ritual, her food would taste good again. At first, the girl did not comprehend the message of the comments: "I could not understand why my family stopped eating the food that I prepared. My mother claimed that the food was *Najssh* (impure). I did not understand how this could be so. I was confused, but determined to know why my family felt this way." Like most Bedouin-Arab girls, cooking was extremely important to her self-identity and self-esteem. Moreover, her ability to cook well and manage a house was the main basis upon which she was assessed as a potential wife. "I talked to an aunt about my *Najssh* food. She told me all about the ritual: how it was painful, but how it also would stop my food from being *Najssh*. I was immediately ready to undertake the ritual, even though I had some idea of how it would be painful." A few days later, the girl had the operation performed in her home. It should be noted that some of the respondents refused to participate in the ritual, but later their women relatives imposed it on them. As a different respondent remarked: "A friend of mine told me that the ritual caused suffering and pain. I was afraid even though my relatives and friends convinced me to do it. I refused totally to do it but my mother, my aunt and the Mtahara [the woman who performed the ritual] forced me to do it." No respondent expressed concern to those outside the immediate family. Nor would they, given the cultural construct of family loyalty and of avoiding communication of close personal matters to outsiders.

The literature tends to emphasize the physical and sexual consequences of ritual mutilation. At the same time, the psychological context in which it occurs should not be overlooked. When an adolescent girl is taught that prior to the procedure, her genitals are dirty, smelly and concurrently sexually uncompelling to men, issues of self-concept and self-esteem are called into play (Cohn, 1989). On grounds of human sexuality, a Western perspective would surely equate the ritual with diminished sexual pleasure. But some might counter that the Bedouin-Arab construction of feminine sexuality, like its counterparts in other non-Western societies, "has more," or at least as much, "to do with procreation than with pleasure, and more specifically with the continuation of the patrilineage" (Nelson, quoted in Van der Kwaak, 1992, p. 782).

The ritual itself is inextricably associated with key Bedouin-Arab constructions of womanhood. The practice of female genital mutilation is called "*Thoor*," which derives from the term "*Taharah*," (purification). Thus, the ritual process itself is seen as a *Taharah* (a purification process); it is thereby linked closely to the feminine concept of purity. Social pressures associated with *Taharah* are intense. For a woman to be impure is akin to social and tribal ostracism, and family scapegoating. In Bedouin-Arab society, it should be emphasized, women obtain honor only indirectly, through the honor of their men, families and tribes. As the above scenario amply demonstrates, not undertaking the ritual could damage marital prospects, economic well-being, peer and family relations, and social status (Van der Kwaak, 1992). The ritual is a rite of passage from childhood into womanhood; it signifies that the woman is pure and therefore ready to take her full place in Bedouin-Arab society through the attendant female-constructed responsibilities of being a mother and wife.

The Concept of 'Ard'

The importance of "*Ard*," or honor, was implied throughout the respondents' decision-making processes to undertake the ritual and warrants separate discussion, given its centrality to Bedouin-Arab life. "*Ard*" has deep roots in Bedouin-Arab society. Normally it is translated into other languages to mean "a woman's honor." But when a Bedouin-Arab speaks of unsullied *ard*, it in fact has a wider meaning. First, it signifies that no man has ever dared to dishonor him by dishonoring his wife or daughter. This implies honor in a similar but qualitatively different sense: that he and his forbears were powerful enough to deter any outsider from looting their property or raping their women. Second, it indicates that he owes no moral debt and carries no stain upon his honor that would force him to sacrifice all he has to attempt to remove it. Compromised *ard* has a unique stigma. Indeed, the Bedouin-Arab believes that it is possible to erase any mark of shame, save for the loss of *ard*: no matter what family members do to try to rid themselves of the shame, part of it will always remain (Abu-Lughod, 1985; Arad, 1984; Mass & Al-Krenawi, 1994; Morsy, 1993). Families go to great lengths to re-establish any perceived loss of symmetry between them and other families or larger social units such as hamula or tribes, even if it means seeking blood vengeance against another to re-establish otherwise-compromised power imbalances (Al-Krenawi & Graham, 1997a, 1999). As this paper insists, there is a significant relationship between a family's *Ard* and continuity of the ritual from one generation to the next. Likewise, it should be noted that failure to agree to the ritual was perceived to have imperiled women's marital and life prospects.

Personal Recollection of the Ritual

Each respondent remembered where the ritual took place, who was involved in carrying it out, and what time of day it was performed. Usually it occurred in the morning, when men were outside of the home working. Many respondents were able to remember the exact day and month that it was undertaken. Among all respondents, an older woman who is known in their respective tribe as a traditional surgeon-midwife (Mtahra) performs the ritual. Two women hold the girl, 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 often used to perform the ritual; no anesthesia is used. When the researcher briefly described different types of rituals that are performed in other societies and then asked the respondents to describe which type was performed on them, none could answer. A female general practitioner who treats Bedouin-Arabs in the area subsequently told the researchers that the most common form of mutilation is a clitoridectomy: the removal of part or all of the entire clitoris, as well as about 1 cm of the labium minora nearest the clitoral prepuce.

The informants universally described the performance of the ritual as a traumatic event, accompanied by fear and pain. These traumas can remain with the woman for life. One of the informants noted that she can no longer cover her face at night with a blanket. "When the ritual was performed on me, a woman much stronger than I was held me down and covered my face. Every time my face is covered, particularly at night when I go to sleep, I am reminded of that event." Another divulged that she remembers the ritual performance whenever her husband tries to be intimate with her: "When my husband makes love with me, it feels as though someone is striking me again. I am reminded of that moment [the ritual]. It takes my breath away and I am afraid." Seventeen (85%) of the informants described a similar breathlessness, implying that there was considerable anxiety, and often struggle accompanied with the ritual act.

Subjects' Opinions of Whether the Ritual Ought to Persist

Subjects tended to have ambivalent feelings towards the ritual. On the one hand, all accepted the popular view that the ritual made them pure. On the other hand, they reported that the ritual was traumatic and the cause of emotional suffering and sometimes of behavioral problems such as phobias or sexual dysfunction (see above). Thirteen (65%) of the respondents nonetheless felt that the ritual should be performed on their daughters. This is consistent with findings from studies on similar societies. For example, a survey of Somali women discovered strong advocacy for female genital mutilation, regardless of age, social status, or ethnic extraction (Arbesman, Kahler & Buck, 1993; Grassivaro, 1986). A more recent survey of Sudanese women found 90% of respondents intending to circumcise their daughters and more than half favoring these procedures (Williams & Sobieszczyk, 1997).

Ten of the 20 Bedouin-Arab respondents stated that the ritual should occur, because the benefit of purity outweighed all other disadvantages; some of their number also emphasized the importance of continuing a family tradition. Two (10%) stated that they would not have the ritual performed. The remaining eight (40%) were not certain. They understood the suffering associated with the act, including the bleeding and physical struggle that is sometimes associated with the ritual, but they also referred to the social pressure to have the ritual performed. Indeed, on balance, the issue of social pressure remained the most frequently repeated motivating factor.

Conclusion: Social Work Intervention Strategies

Four principles, we argue, could form the basis of social work practice in the context of Bedouin-Arab female genital mutilation. The first is for those outside the Bedouin-Arab culture to appreciate the culturally specific contexts in which the practice is conceived and carried out. It is strongly linked to Bedouin-Arab notions of family honor, purity of womanhood, female sexuality, patriarchy and gender-proscribed family structure.

This leads to a second major principle, that responses to female genital mutilation be internally derived from within the culture, and not externally imposed. This is not to preclude allies from outside the culture having a potential positive effect on the community. At present, local movements to challenge FGM do not appear as robust as in other countries. The Bedouin-Arab in the present study may learn from countries such as Egypt, where FGM is officially banned, and from other societies that have begun to re-think practices. Efforts of United Nations organizations, outlined at the beginning of this paper, have had some effect at increasing international public attention but are seen by others as having "doubtful" effects on decreasing "the practices' incidence or severity" (Gallagher, 1993, p. 44). Civil tort actions by feminists in Western countries have likewise been described as "impracticable," in efforts to counteract FGM by enforcing injunctions against other nations and non-resident aliens (Karp, 1997, p. 315). Finally, social work and allied disciplines have knowledge and skills that can assist Bedouin-Arab society.

But in order to ensure social change that is authentic rather than ephemeral, and interventions that are culturally appropriate and meaningful to the society, social work practice needs to be collaboratively applied, rather than arbitrarily imposed. As one anthropologist noted with reference to a different society that practices genital mutilation: "What if the women concerned have a different perception" regarding mutilation practices? "What if they do not want to be 'enlightened'" by Western values and approaches? (Van der Kwaak, 1992, p. 785). This point is especially germane to the Bedouin-Arab, where any intervention necessarily enters one into the broader politics of the Middle East, with all of the power differentials and dynamics this implies.

Thus, it is essential that social work and allied disciplines' encounter with the *Thoor* ritual be sensitive to the needs and ethnospecific aspects of the culture . On the other hand, it may be helpful to share information on aspects of the ritual that may not be widely apparent within that society. One such example are the physical risks the ritual produced for young girls who experience the *Thoor*. To this extent, neutrality on the part of any professional is an impossibility, although efforts to help the society adapt and modify its practices may be immediately conceivable. A simple program of public education at schools, for instance, wherein a nurse provides information on the hazards of the ritual, may be an important catalyst to greater community knowledge and change. So too might public education efforts be aligned with public health and women's health care and obstetrics care services.

Some observers associate FGM with poverty, low status of women and illiteracy (McCaffrey, 1995). Thus efforts at addressing any of these social problems could have a positive impact on FGM incidences. Another issue identified in the literature is the relationship between FGM and gender segregation. It is doubtful, for the time being, that the Bedouin-Arab community's high gender segregation will change much. But at the same time, further public education could elicit important allies of social change among men. Such an impetus is particularly promising, given men's power within the community as well as the present study's confirmation of previous research findings on women's continued acceptance of, and participation in, these practices (Arbesman, Kahler, & Buck, 1993; Grassivaro, 1986; Thomas, 1996; Williams & Sobieszczyk, 1997). A growing number of studies insist on grass-roots efforts among women to confront patriarchal attitudes and structures that perpetuate FGM (Robertson, 1996). In time, there may be avenues for the community to pursue that imperative further.

Thus, thirdly, collaborative efforts could be undertaken with important community people implicitly or explicitly involved in the ritual practice: with the traditional surgeon-midwives (*Mtahra*), Bedouin-Arab women, important and powerful tribal members, religious leaders and health care practitioners. Possible objectives could range from the reduction of ritual incidences, to improving the hygienic conditions in which they occur, to minimizing the scarring and other health problems that are associated with the practice, to promoting community awareness of the hazards and of international efforts to eliminate the practice.

Fourthly, on related grounds, several authors provide culturally specific means whereby societies such as the Bedouin-Arab may reconceptualize female genital mutilation and enter into a dialogue within the community and with such professions as social work. As Van der Kwaak wisely points out, discussion of such a broad subject "faces the danger of either getting lost in vague and perhaps meaningless generalities or in some ethnocentric, ideological position." Neither of the two approaches, the author continues, "is very helpful to detect, describe, and explain the intricate web of factors" that are associated with ritual mutilation (1992, p. 785).

Another author sensibly contends that Muslims will be able to enter into a meaningful dialogue about genital mutilation only "as Muslims—not as imitation Westerners" (Murato, 1992, p. 323). To this end, Islamic scholar Eric Winkel argues that the practice should "be put to the test," in religious and legal terms, "of Islamic authenticity" (1995, p. 6). "Islamic discursive systems," he continues, "are broad enough and nuanced enough to accommodate a wide variety of medical and public health endeavors" (Winkel, 1995, p. 6). Here it is essential to emphasize the Koran—the basis of Islam, a holy book consisting of 114 chapters, which Muslims believe to be the eternal, uncreated, literal word of God. The Koran makes *no* mention of female genital mutilation. Neither is there consensus among Islamic religious scholars as to whether the practice should be obligatory *or* condemned. Some scholars argue that the practice is optional but "admirable" (cited in Winkel, 1995, p. 4). Many stress that if it is undertaken, it should not be extensive. For example, Ahmad [in Hanbal] writes that "the women's circumcision is much less [than the man's]... do not overdo it, because it [the clitoris] is a good fortune for the spouse and a delight to her" (cited in Winkel, 1995, p. 4). Other leading Islamic scholars, under the auspices of the World Health Organization, find little to no theological justification for the

practice (*Islamic ruling on male and female circumcision, the right path to health: Health education through religion*, 1996).

Such discussions may fruitfully expose the violence associated with FGM, lay groundwork for challenging legal and cultural frameworks that perpetuate it, and begin to overcome institutions that make women socially and economically disempowered—all outcomes advocated by many feminist scholars (Heise, 1989). So, too, it may be possible for greater dialogue to occur between professionals and community members in understanding FGM. Western scholars, for instance, analyze FGM through the prism of children's rights to protection from abuse (DiMauro, 1996). Others conceive it as a cultural practice that may be seen to violate human rights (Larson, 1996) as elaborated in the Convention on the Elimination of All Forms of Discrimination Against Women (Gray, 1998), among other international documents. Whatever the possible outcome of entering into such dialogue, social work has a value base that raises appropriate questions into many psychosocial/psychosexual dilemmas associated with genital mutilation. This study is a beginning point for the provision of culturally grounded knowledge that can better inform social work practice. Further ethnomethodological research among other cultures may one day provide a basis for transnational, cross-cultural principles of intervention.

The present study is necessarily limited by the small size of the sample, and the convenience sampling from which respondents were selected, both of which preclude generalizability to the whole population. Given the nature of the topic and its sensitivity, such research parameters were nonetheless essential. The potential scope of further research, then, is broad. More comprehensive sampling methods and subject size could be beneficial. So, too, could comparisons be aptly made between those who did and those who did not experience the ritual, as well as between different ethnoracial communities where the practice is prevalent.

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