



FEMALE GENITAL MUTILATION IN CAMEROON

Country Information

The Republic of Cameroon, situated in the Western crook of Africa, is home to almost 16 million people, who belong to more than 200 different ethnic groups, most of which are of Bantu origin. About half the population is Christian. The other half is split almost equally between the Animist and Muslim faiths. More than 50 % of the population live in urban centres, and two thirds have access to health services. Average life expectancy at birth is 51 years for women, and 50 years for men. The fertility rate is 4.5. 29 % of women under the age of 20 have already had at least one child or have been pregnant. Certain discriminatory cultural attitudes and practices, policies and laws prevent women enjoying a social status equal to that of men. This is expressed for instance in a lower level of literacy (35 % of women are illiterate compared to 18 % of men), severely restricted access to land and credit, and traditional discriminatory practices, including forced marriage, female genital mutilation (FGM) and the practice of breast ironing.

Prevalence

The Demographic and Health Survey 2004 (DHS) indicates that about 1 % of the female population has been subjected to FGM. This low overall prevalence conceals wide regional disparities: FGM is only practiced in the south-west and the extreme north of the country, in Manyu, Logone, and Chari provinces. Among the communities affected, religious denomination plays a role in determining whether or not a woman is subjected to the practice. All Muslim women, and two thirds of Christian women are victims of the practice, but no female Animists are affected.

Most women victims have their clitoris removed (Type I according to the WHO classification), while some also have the labia minora removed (Type II) and around 5 % suffer infibulation (Type III).

The age at which FGM is performed varies from region to region. In some areas, baby girls are operated only a few days after they are born; in others, girls are fifteen or older before they are subjected to the practice. Most girls are, however, operated before reaching the age of puberty. Almost half suffer FGM between the ages of 5 and 9, and another fifth between their tenth and fourteenth birthdays.

WHO Classification

Type I: Partial or total removal of the clitoris and/or the prepuce (clitoridectomy).

Type II: Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision).

Type III: Narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation).

Type IV: All other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, piercing, incising, scraping and cauterization.

An “experienced grandmother” or traditional birth attendant carries out the practice without anaesthetics. Sometimes hospital or health centre staff performs the cutting (in 4 % of cases). Although medicalising the practice might prevent some immediate health hazards, it does not preclude the long-term consequences, and continues to seriously undermine women’s human rights. Few people appear to be aware of the problems of FGM. On the contrary, some communities perform FGM in the belief that it prevents certain diseases or infertility.

The most common reasons given for continuing the practice, however, is respect for tradition and religious requirements. Other reasons given include better hygiene, preserving the virginity of

young girls and improving their chances on the marriage market.

Often, where the majority of women are affected, there is a huge social pressure on individuals to perpetuate the practice. Material considerations also play a role, since circumcisers are remunerated in money or kind for their activity, and the circumcised girl receives gifts.

Nevertheless, a large proportion of younger women would like to abandon the practice of FGM, either because they do not identify with the justifications or because they are aware of the risks involved.

'The practice of female circumcision is only to the benefit of the man', opines a middle-aged woman in a national study (IAC 1997).

Another form of mutilation is the practice of breast ironing. When young girls' breasts begin to develop, hot stones or other hot objects are pressed firmly onto the breasts and moved back and forth, like an iron. Another variation is bandaging breasts with hot towels or fabrics, known as a breast band. This is used in conjunction with hot stones, pounding with a pestle or working the breasts with a spatula. The purpose of these practices is to retard breast growth.

The study, "Etude sur le modelage des seins au Cameroun" (Study of breast modelling in Cameroon), conducted in 2006 by the Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ), indicated that at least 24 % of girls are affected by this practice. The earlier their breasts begin to develop, the more likely they are to suffer this form of breast mutilation. Fifty percent of all girls whose breasts begin to develop before they reach the age of nine are subjected to breast ironing.

Breast ironing is found more frequently in the cities than in rural areas (affecting 53 % of girls in Douala for instance). The background appears to be the fear that the girls' growing breasts will attract the sexual interest of men and that they might thus become victims of sexual advances at an early age. The practice is intended to protect girls from teenage pregnancies and the social consequences thereof. The extremely painful procedure is repeated every day, until it has the desired results. The consequences are damaged tissue, open wounds, abscesses, infections, an elevated cancer risk, and in later life difficulties with breast-feeding and trauma.

Approaches

The Government of Cameroon has been actively involved in efforts to combat FGM since the mid-1980s, and adopted the National Action Plan against FGM in 1999. It is signatory to most relevant international treaties and conventions on the rights of women and children.

While the Penal Code does not criminalize the practice, the Constitution recognises and protects 'traditional values that conform to democratic principles, human rights and the law'. No prosecutions have been recorded with regard to FGM, nor has the government-created National Human Rights Commission yet addressed practices discriminatory to girls and women.

On behalf of the German Federal Ministry for Economic Cooperation and Development (BMZ), GTZ has supported the national chapter of the Inter-African Committee on Traditional Practices Affecting the Health of Women and Children (IAC) by devising IEC (information, education, communication) material for the mobilisation and sensitisation of community change agents, and organising seminars for awareness raising in areas where FGM is practiced. Community change agents may include those members of a given community, who play a role in the decision-making process with regard to the practice of FGM, i.e. parents, health and education staff, religious and political authorities, and young people. The project also lobbies governmental and non-governmental institutions in an effort to win the administration and judiciary over to the cause of ending FGM.

Along with RENATA, a network of young mothers in Cameroon, GTZ has launched an education campaign on breast ironing. Radio and television spots, flyers and articles run in the national and international press are providing information about the practice.

References:

ORC Macro: Republique du Cameroun: Enquête Démographique et de Santé Cameroun 2004
WHO: Country Health System Fact Sheet 2006 - Cameroon
GTZ: 'Etude sur le modelage des seins au Cameroun', 2006