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Challenges in the eradication of female genital mutilation/cutting

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Introduction

Despite more than 40 y of discussion and debate regarding female genital mutilation/cutting (FGM/C), this topic remains controversial and emotive, and the practice continues. FGM/C is defined as ‘all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs, whether for cultural or other non-therapeutic reasons’.¹ There are four main classifications of FGM/C (Table 1).¹ Type III, or ‘infibulation’, is the most severe form and accounts for 10% of cases.² It is estimated that more than 200 million girls and women worldwide are living with the effects of FGM/C.² Of these, 44 million are <15 y of age.² FGM/C is practised mainly in Africa, with the highest prevalence in Somalia, Egypt, Mali and Sudan, where more than 80% of all women between 15 and 49 y of age have undergone FGM/C.^{2,3} However, FGM/C is also prevalent in other settings including the Middle East, India and Indonesia. The specific type of FGM/C varies within and between countries.⁴

FGM/C has severe harmful consequences

FGM/C offers no health benefit and causes serious immediate and long-term physical, psychological and sexual harm, including chronic pain, recurrent urinary and vaginal infections, post-traumatic stress and severe pain during sexual intercourse.⁵ The immediate effects of FGM/C (significant pain and heavy bleeding) recur and are often exacerbated during and after childbirth, especially in women with type III FGM/C.⁵

FGM/C is a violation of human rights

FGM/C reflects deep-rooted inequality and constitutes an extreme form of discrimination against women.¹ FGM/C is often performed on young girls (before the age of 5 y) and is therefore

also a violation of the rights of the child.^{1–3} FGM/C interferes with normal healthy female genital tissue and sexuality, and is a violation of every girl’s and woman’s right to the highest attainable standard of health.¹ Furthermore, FGM/C violates the rights to health, security and physical integrity of girls and women; the right to be free from torture, cruelty and inhuman or degrading treatment and violates the right to life when the procedure results in death.^{1–3}

Why does the practice of FGM/C continue?

There are significant social, cultural, traditional and/or religious aspects to consider regarding the practice of FGM/C.^{6,7} A variety of social and cultural reasons for continuing with FGM/C are reported, including female cleanliness, cultural identity, protection of virginity, prevention of immorality, better marriage prospects, greater pleasure for the husband and improvement of fertility.^{1,6,7} FGM/C is also often seen as a necessary ritual for initiation into womanhood and is linked to cultural ideals of femininity and modesty.^{1–3} FGM/C is often believed to reduce a woman’s libido and this is considered to help her resist ‘illicit’ sexual intercourse.^{1,3} All of these reasons are non-evidence-based. Family pressure to conform to traditional practice is another strong motivation to continue with the practice, and women who depart from the societal norm may face condemnation, harassment and rejection.¹

No religious scripts prescribe the practice of FGM/C, although there are variations in how different religious leaders regard FGM/C; some promote it, some consider it irrelevant to religion and others advocate actively for its elimination. This is exemplified by Somalia, a country with a previously reported prevalence of FGM/C of 98%, where respected religious leaders have worked in partnership with community groups to create awareness and openness for discussion, thereby educating the community and ultimately reducing the number of girls and young women

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suffering FGM/C.³ It is well recognized that local community and religious leaders have pivotal roles and opportunities to either influence change and to help change attitudes and understanding or, conversely, to contribute to and support continuation of the practice of FGM/C.^{3,4}

International response

The international community's position is that FGM/C violates the choice of a young girl or woman regarding her sexual and reproductive health (Table 2).¹ The first joint statement specifically addressing FGM/C was issued by the World Health Organization (WHO) in 1997 in conjunction with the United Nations Children's Fund (UNICEF) and the United Nations Population Fund (UNFPA).⁴ Since that time the international response has gained momentum. In 2008, the WHO, together with nine other UN partners, demonstrated increased support for the abandonment of FGM/C across the world.¹ A key document was developed with evidence collected over the previous decade regarding FGM/C. The 2008 document highlighted human rights and the legal dimensions of FGM/C, and provided more comprehensive data on the prevalence of FGM/C.¹ Research regarding the damaging effects of FGM/C on the reproductive and sexual health of girls and young women, and the reasons why FGM/C continues was reported and recommendations for the eradication of FGM/C were made. In 2010, the WHO, in collaboration with the other key UN agencies and international organizations, published a document entitled 'Global strategy to stop health care providers from performing female genital mutilation'.⁸ This was followed by action in 2013 when the UN General Assembly adopted a resolution on the elimination of FGM/C.⁹ This progress was the culmination of efforts of many organizations working together to bring attention to this harmful practice over a long period of time. The UNICEF report in 2013 highlighted that before the intervention of international agencies, there were already well-established local and regional campaigns in Egypt, Burkina Faso, Kenya and Senegal, where organizations were working with religious, political, women's groups and the medical professional to raise awareness and to advocate for the eradication of the practice of FGM/C.¹⁰

Eradication of FGM/C

The 2008 World Health Assembly resolution emphasized the need for concerted action in all sectors of health, education, finance, justice and women's affairs, with recommendations that focus on strengthening the health sector response, including guidelines, training and policies to ensure that all health professionals can provide medical care and counselling to girls and women living with FGM/C; building evidence, including generating knowledge and accurate data regarding the prevalence, types, causes and consequences of the practice; and increasing advocacy, including developing publications and advocacy tools for international, regional and local efforts to end FGM/C within a generation.¹¹

Progress in FGM/C eradication

Since 1997, great efforts have been made to eradicate FGM/C through culturally sensitive research, the engagement of communities and

Table 1. Classifications of female genital mutilation/cutting¹

Type	Description
I	Clitoridectomy: partial or total removal of the clitoris and/or the prepuce
Ia	Removal of the clitoral hood or prepuce only
Ib	Removal of the clitoris with the prepuce
II	Excision: partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora
IIa	Removal of the labia minora only
IIb	Partial or total removal of the clitoris and the labia minora
IIc	Partial or total removal of the clitoris, the labia minora and the labia majora
III	Infibulation: narrowing of the vaginal orifice with creation of a covering seal by cutting and apposition of the labia minora and/or the labia majora, with or without excision of the clitoris
IIIa	Removal and apposition of the labia minora
IIIb	Removal and apposition of the labia majora
IV	All other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterization

changes in public policy.⁴ Progress to stop FGM/C has been made possible because of the establishment of international monitoring bodies, agreements on resolutions that condemn the practice, revised legal frameworks and growing political support to end FGM/C. Of the 29 countries where FGM/C is most prevalent, 24 governments have enacted laws against continuation of the practice. For example, the governments of South Africa and Zambia have banned the practice. In line with this, professional associations such as the International Federation of Obstetricians and Gynaecologists, the International Confederation of Midwives, the Royal College of Obstetricians and Gynaecologists and the Royal College of Midwives in the UK condemn the practice of FGM/C and are vocal in calling on all professional associations worldwide to oppose the practice.¹²

As a result of international combined efforts and legal frameworks being put in place in many countries, an ever-increasing number of women and men in practising communities support eradication of the practice of FGM/C and the overall prevalence is decreasing. However, progress in the eradication of FGM/C is too slow.

Challenges include the implementation of recommendations and enforcement of the legal frameworks regarding FGM/C. For example, in Sudan, FGM/C type III was banned in 1946, but continues to be practised, and there have not been any successful prosecutions. Furthermore, there is international concern regarding an increasing trend of medically trained personnel being asked to perform FGM/C.^{1,5} For example, in Malaysia, FGM/C is carried out legally by health care providers in hospitals. Some health care providers consider the medicalization of

Table 2. Timeline of key international policy drivers

Year	Agency/organization	Event
1979	United Nations	The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), adopted in 1979 by the UN General Assembly
1979	WHO	Khartoum seminar on traditional practices that affect the health of women and children
1982	Raqiya Haji Dualeh Abdalla, Sisters in affliction: circumcision and infibulation of women in Africa; Asma El Dareer, Why do you weep? Circumcision and its consequences	Asma El Dareer's study was the first to quantify the issue
1984	Inter-African Committee on Traditional Practices Affecting the Health of Women and Children (Dakar)	Calls for an end to FGM/C
1989	United Nations	The UN General Assembly adopted the Convention on the Rights of the Child (CRC); this includes the protection of children from harmful practices
1990–1999	African Union	The African Charter on the Rights and Welfare of the Child was adopted by the Organization of African Unity (now the African Union) and entered into force in 1999. It calls upon states to take appropriate measures to eliminate harmful social and cultural practices
1993	United Nations	World conference calls for the elimination of violence against women
1994	United Nations	International Conference on Population and Development (Egypt): consensus reached on active discouragement of FGM
1997	WHO, UNICEF and UNFPA	A joint statement is released against FGM/C
2002	United Nations	The UN General Assembly, in its resolution on 'Traditional or customary practices affecting the health of women and girls', calls for all states to adopt national measures to prohibit practices such as FGM/C
2003		The first International Day of Zero Tolerance for Female Genital Mutilation. This is held on 6 February every year
2005	Maputo Protocol	The Protocol of the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, better known as the Maputo Protocol was developed. It calls upon states to take measures to eliminate FGM/C and other traditional practices that are harmful to women
2007–2010	United Nations	The United Nations Commission on the Status of Women adopted resolutions on ending FGM/C in 2007, 2008 and 2010
2008	United Nations	'Eliminating female genital mutilation: an interagency statement' is signed by 10 UN agencies
2013	UNICEF	Produced estimated prevalence of FGM/C in different settings and examined how change can be supported
2016	WHO	WHO guidelines on the management of health complications from female genital mutilation

FGM/C as a harm-reduction strategy and support the notion that with this approach, some of the risks associated with immediate health complications are reduced and 'less damage' is done.^{1,3} However, this practice is unacceptable, contravenes the essence of the Hippocratic Oath and is against the ethical framework of health care of 'do no harm'.^{1,5}

More recently, there has been a shift in emphasis from considering FGM/C as a purely health-related issue to adopting a more holistic approach in which the role and sexual and reproductive rights of women in societies are addressed.^{1,5} However, some communities continue to argue that FGM/C is a traditional and cultural practice and that Western countries should not impose their

'imperialist' and 'colonialist' views on this long-standing custom.^{13,14} Increased media coverage and statements by ministers, religious leaders, faith-based groups, celebrities and non-governmental organizations have led to more discussion of the topic both at the international level and in countries where FGM/C is prevalent. However, there is an ongoing need for a stronger coordinated and combined approach in which societal opinion and norms are challenged, community awareness and engagement are mobilized and legal, and medical frameworks supporting eradication are in place and proactively implemented. Often as countries develop and diversify from within, cultural practices do change and there is a realization that condoning acts that contravene human rights has no place within any moral or ethical framework.^{13,14}

Accurate data regarding FGM/C are lacking and greater efforts should be made to address this. Finally, any campaigns or interventions that aim to eradicate FGM/C should be medium to long term (at least 5 y) and should include clear methodologies for implementation and evaluation of the effectiveness (or not) of such interventions to better inform public policy.

Call to action

The eradication of FGM/C can only be achieved through a strong and coordinated approach implemented at local, regional, national and international levels. Supportive education and targeted training are recommended to enable all stakeholders to sensitively and respectfully address this complex and long-standing practice. Health care providers have a duty of care and are in many ways uniquely positioned to support the eradication of FGM/C. It is crucial that all healthcare providers are aware of and meet the requirements of the ethical and legal frameworks that are currently in place to support the eradication of FGM/C. This includes continued promotion of community understanding and objection to FGM/C as a practice that is contrary to human rights, including the right to physical as well as reproductive and sexual health for women.

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