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RESEARCH ARTICLE

Female Genital Mutilation: A Violent Practice in Need of Change

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Abstract

Female Genital Mutilation or Cutting (FGM/C) is related to deep rooted beliefs of some cultures and religions. The procedure involves mutilation of the female genital organs with no medical benefits. There is a global knowledge of this practice, due to increased immigration to western world where this practice is unknown. FGM/C promotes the mutilation and abuse of females, including infants and also inflicts physical and psychological pain. In addition there are immediate and long term health complications from the procedure that sometimes results to death. The practice and health complications of FGM/C clearly raise the issue of violation of the rights of its victims and undermining their status and equality in their various cultures and society as a whole. Although available data through multi agencies like the World Health Organization and United Nations Population Funds suggest that global effort to eliminate the practice is yielding some favorable results, relevant literature also suggest that the prevalence and trend of the practice especially in the African region of the world speaks to the need for increased effort to eliminate this violent practice. Ultimately understanding female genital mutilation and the consequences of the procedure in a globalized age will contribute immensely to an improved multicultural and sensitive care for women who have undergone the procedure or who intend to practice it on their daughters.

Keyword: Female cutting, Female genital mutilation, female circumcision

Introduction

What is Female genital Mutilation (FGM)? It is “all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medicals reasons” (World Health Organization [WHO] 2008, on Female Genital Mutilation, 2008). While this procedure is done mostly due to cultural, psychosexual, aesthetic, religious or other non- therapeutic reasons, there is no reported health benefit to this practice that harms young girls and women globally (Ball, 2008; WHO, 2009). Spencer, 2002 as cited in Ogunsiji et al. (2007) advise that referring to FGM as female circumcision is misleading, because unlike the male circumcision, FGM often entails the removal of the entire healthy genital organs.

Tag- Eldin et al. (2008) adds that the practice of female genital cutting (FGC) has traditionally been referred to as female circumcision however “recognition of the harmful physical, psychological and human right consequences has led to the use of the term Female genital mutilation or FGM” (p. 269). Even so, many women who have undergone FGM/C do not consider themselves to have been mutilated, and thus are often offended by the use of the term (Anuforo, Oyedele, & Pacquiao, 2004, as cited in Turner, 2007). Because this is a global issue, academic literatures from across the world will be utilized in this paper. The acronym FMG and FGC will be used interchangeably or concurrently (FGM/C) to mean the same thing. Ogunsiji et al. (2007), note that issues surrounding FGM is fast gaining global recognition due to the increase in immigration from Africa, Asia and other nations, where this practice is more common; to the western countries such as Australia, the United Kingdom (UK), and the United States of America (USA) where such practice is unknown.

Origin of FGM

While the origin of FGM remains unknown, the practice has been traced back to the Egyptian and Phoenician Cultures during the sovereignty of the Pharaohs, as a means of controlling fertility (Awuah, 2008; Ball, 2008). The practice of female circumcision is performed in both Muslim and Christian countries as well as by other forms of religions. Ironically though, western world medicine practiced clitoridectomy well into the 20th century as a treatment for melancholy, epilepsy, lesbianism, masturbation, and control of high sex drive (Dawson, 1915 as cited in Ball, 2008).

Background

An estimated 100-140 million girls and women worldwide are currently living with the consequences of FGM. In Africa alone, about 92 million girls from age ten years and above are estimated to have undergone FGM/C (WHO, 2008). Annually about three million girls are at risk for FGM in Africa, which accounts for 6,000 girls each day (Ogunsuji et al., 2007).

Awuah in a 2008, study on FGM in Aboabo-Ghana, reported that in the last quarter of 1999; eighty females out of one hundred and thirty-five (60%) who presented with post-delivery complication cases to a teaching hospital, had all undergone some form of FGM. WHO (2008) adds that the procedure which is mostly performed on young girls between infancy and 15 years of age, is often associated with health complications such as severe bleeding, problems urinating, potential childbirth complications at a later stage and in some cases infant mortality.

FGM/C is commonly performed on girls who are between ages four and 12, though it may be practiced in some cultures as early as a few days after birth or as late as just prior to marriage. Feldman-Jacobs and Clifton (2008) report that 90% of girls in Egypt who had undergone FGM were between five and 14 years of age when subjected to the procedure, while

50% of those in Ethiopia, Mali and Mauritania were under five years of age; and 76% of those in the Yemen were not more than two weeks old. In general traditional practitioners have carried out the procedure, but recently a discouraging trend has showed that in some countries medical professionals are increasingly performing the procedure (Population Census Bureau, 2008).

Prevalence and Incident of FGM/C

The prevalence of FGM despite international outcry against its practice varies from country to country. Tag- Eldin et al. (2008) report that eighteen African countries have prevalence rates of 50% or higher. In a research study conducted by same authors that measured the prevalence of FGC among schoolgirls in Egypt. 38,816 females were interviewed, and the findings showed that; FGC was prevalent amongst schoolgirls at 50.3%; with 46.2% in government urban schools, 9.2% in private urban schools, and 61.7% in rural schools. Educational levels of both parents were negatively associated with FGC ($P<0.001$), and the mean age of the time of FGC was 10.1 ± 2.3years. Also, in reference to the country's result of the Demographic Health Survey in 2000 as cited by Tag-Eldin et al. (2008), 97% of married women included in the survey had experienced FGC.

The African Women's Health Center 2000 census data showed that in the USA alone, 227,887 women were at risk of FGM out of which 62,519 were under18 years of age. Additionally, key findings from the report show that from 1990 to 2000, the number of women with or at risk for FGC grew by approximately 35 percent. Also more than 165,000 females living in the United States over the age of 18 are with or considered at risk for FGC, while 27 percent of the women with or at risk are under the age of 18. Further, given the increase in immigration and refugee influx to the USA, California, New York and Maryland have the most female immigrants and

refugees from countries where FGC is prevalent. In Massachusetts alone, it is estimated that about 5,231 women and girls at risk for FGC live there (African Women's Health Center, 2008). Ball (2008) reports that majority of the black African women who were booked for delivery in the UK hospitals in 2002 had increased by 10%, and had all undergone FGM. Approximately 1,000 women, who had undergone FGM, had been identified during patient registration and through gynecology services; and according to statistical reports cited by Ball almost 66,000 females in England and Wales were affected by FGM, with thousands of children and young females still at risk.

The WHO Classification of FGM/C

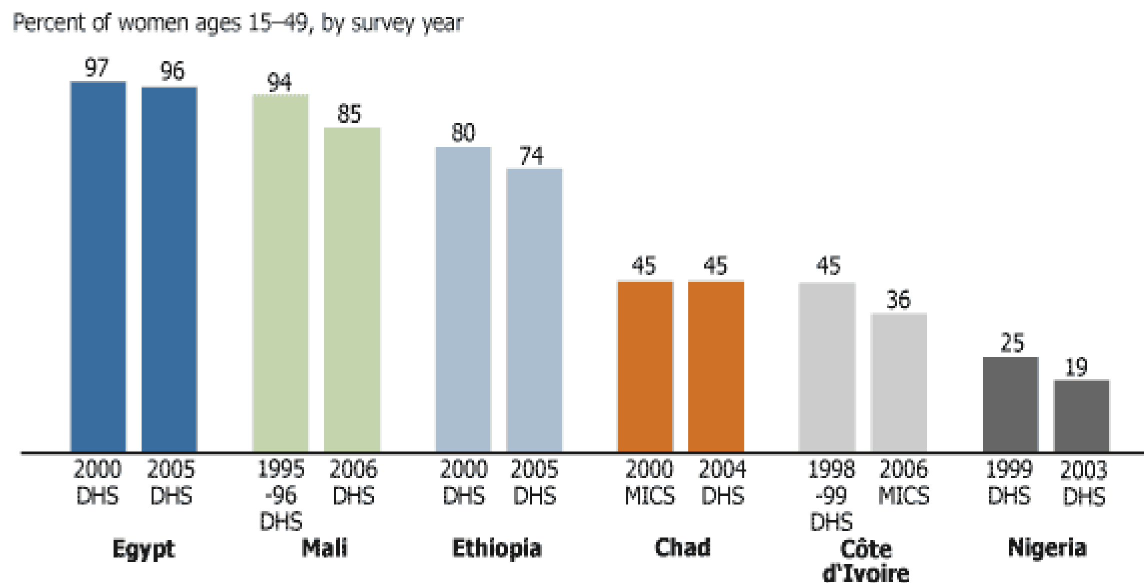
The WHO (2008) classified FGM/C into four broad categories, namely:

- Type 1 or Clitoridectomy: Partial or total removal of the clitoris and/or the clitoral hood.
- Type 2 or Excision: Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora.
- Type 3 or Infibulation: Narrowing of the vaginal orifice with creation of a covering seal by cutting and placing together the labia minora and/or the labia majora, with or without excision of the clitoris.
- Type 4 or Unclassified: All other harmful procedures to the female genitalia for non-medical purposes, for example, pricking, piercing, incising, scraping, and cauterization. Types of procedures performed varies with ethnicity, but predominantly 90% of FGM cases include Types I or II and 10% comprise type III; these three types have been documented in 28 countries and in a few Asian and Middle East Countries (WHO, 2008).

Health Complications of FGM/C

There are Physical, Obstetric, and Psychological effects of this practice on health. In addition to the immediate health problems noted above, there are long term complications of recurrent bladder and urinary tract infection, dermoid inclusion cysts, infertility, difficult menstrual bleeding, urinary incontinence, pelvic inflammation disease, and sexual dysfunction (Ogunsiji et al., 2007; Turner, 2007; WHO, 2009). There are also increased risks of childbirth complications and newborn death. From a psychological point of view, feelings of diminished femininity, depression, posttraumatic stress disorder (PTSD), neurosis, frigidity, psychosocial problems of anxiety, regret regarding FGM and intergenerational problems surrounding the practice have all been reported; and these feelings are worse in women requesting deinfibulation (Ogunsiji et al., 2007; McGargill, 2009; Turner, 2007).

Trends in FGM/C Prevalence



Source: Feldman-Jacobs and Clifton, *Female Genital Mutilation/Cutting: Data and Trends* (Washington DC: Population Reference Bureau, 2008).

In a research study conducted by Afifi and Bothmer (2007) regarding Egyptian women's attitude and beliefs about female genital cutting and its association with childhood maltreatment, they concluded that 69.8% had slapped or hit their children during the year prior to the survey, while 76% intended to continue the practice of FGM. It is apparent that some of the women exposed to the trauma of FGM/C in childhood might become adult perpetuators of violence and may then practice FGC on their daughters; symbolically re-enacting their repressed trauma by physically abusing their children. Holding on to positive beliefs regarding the practice, or the intention to continue FGM/C has significant implications for health and for the society in general.

Global Economic Cost for FGM/C

A paper reporting the findings of the 2008 study on the economic cost of FGM is expected to be published in 2009. The study used the findings from the WHO study on the association between the different types of FGM and obstetric outcome to examine three issues: (a) To estimate the economic costs of managing the obstetric and newborn health complications related to female genital mutilation; (b) model the economic costs to society (using a DALY burden of disease methodology) attributable to FGM ; and (c) evaluate the cost effectiveness of a hypothetical intervention that can lower the incidence of FGM by 10% (WHO, 2009).

A paper Dr. Gebreselassie Okubagzhi presented on behalf of the World Bank Group was cited in the United Nations Population Fund (UNFPA) Global consultation on FGM/C in 2009, in which it was noted that costing FGM/C is important for advocacy purposes. The paper explained that while it may be fairly easy to calculate the direct costs related to personal expenditures on treatment of complications (for example, individual or family spending and public expenditures such as spending on facility maintenance, staff salaries and infrastructure), it is difficult to cost pain and suffering or identify the social costs related to FGM/C.

While comprehensive FGM/C studies have yet to be carried out by many African countries, studies from other regions reveal that; FGM/C leads to a decline in family earnings, limits girls' potential for education, erodes household savings and investment and leads to high cost of treatment, resulting in the accumulation of debts which deepen household poverty (Okubagzhi 2009, as cited in UNFPA, 2009). Based on this, it is therefore imperative to carry out a methodical study to compile data on economic cost implications of FGM/C, bearing in mind that the results of such a study would be crucial for launching valuable community and international advocacy and for designing evidence-based national programs.

Issue of Human Rights and Gender Inequality

FGM/C is acknowledged globally, and in particular by some countries like Ghana, U.K, USA, and multi agencies such as the WHO, Office of the United Nations High Commissioner for Human Right (OHCHR), United Nations Children's Fund (UNICEF) as a women's health issue, violation of women's rights, and a strong case of gender inequality in the societies where the practice is inherent. FGM/C is practiced mainly for some the following reasons: Prevention of immorality, preparation of the female for marriage, prevention of labia hypertrophy, improvement of fertility, preservation of family honor, assurance of cleanliness, and provision of more sexual pleasure to the male as the main justification for practice of FGM (Ogunsiji, Wilkes, & Jackson, 2007). Evidently there are lack of medically sufficient evidence to support this inhumane practice that subjects women, young girls and female infants to extreme physical and psycho-social trauma, for the sake of cultural beliefs. McGargill (2009) advises that to encourage this practice is to encourage the mutilation and abuse of females.

It is fair to conclude that the consequences and complications of FGM/C noted above violates the articles of the Universal Declaration of Human Rights as cited, in United Nations, (2009).

Ultimately FGM: (a) is a form of violence against women, girls, and children, (b) discriminates against women across cultures irrespective of religious background; (c) violates a victim's right to choice, and freedom from cruelty; (d) violates a person's right to physical and Mental health, and to a large extent; (e) it has been reported that FGM in Africa may precede enforced child marriages with associated denial of education.

Medicalizing FGM/C and Ethical/Legal Considerations

Despite the efforts to abolish the practice of FGM/C, it was reported at the 2009 UNFPA multi organization meeting on global consultation on female genital mutilation / cutting that medical professionals are increasingly performing FGM/C; and unfortunately non-governmental organizations (NGOs) and researchers are reportedly promoting its practice. Although the level of medicalizing FGM/C varies between countries, it is rapidly spreading in many countries where an estimated one third of women have subjected their daughters to the practice, using a trained health professional. Conversely reports also indicate that immigrants to Europe and North America have had re-infibulation performed by medical personnel even though the law specifically prohibits it (UNFPA, 2009).

If medicalizing FGM/C is not abolished, UNFPA (2009) report the following anticipated problems: (a) legitimization of FGM/C as medically beneficial to girls and women; (b) institutionalization of the practice by medical personnel because they command respect and are highly regarded; (c) it will constitute a misuse of the professional role of medical personnel, especially in countries where FGM originates; some medical professionals perform FGM/C as a means of upholding their communities culture and women's value in the society, while also aiming to reduce some immediate health complications associated with the practice; (d) hindering the abolishment, as there is no evidence that medicalizing FGM/C will lead to

abandoning the practice, but instead will more likely encourage its continuation; (e) it will foster the spread of the practice, confuse the question of human rights and finally, will not reduce the complications associated with the practice.

It is nonetheless imperative to intensify efforts against its practice and in particular develop strategies that will target health workers. The same report noted that in Egypt for example, more families are seeking the advice of medical personnel in an effort to avoid the dangers of unskilled operations performed in otherwise unsanitary conditions (UNFPA, 2009). The global rise of genital mutilation by circumcisers who torture child – victims incorporates unusual violation of human rights; bearing in mind that it causes 'body-dysmorphic disorders, genital destruction, psycho-social impairment, and spiritual death, (Zavales, 1996). Thus, violation of the laws in countries where the practice of FGM/C is prohibited attracts penalties that include monetary fines plus jail terms from six months to up to fourteen years; and in the USA for example the practice constitutes a federal crime (Ball, 2008; Griffith & Tengnah, 2009; Women's health.gov, 2005).

Ironically though the American Medical Association condemns the practice of FGM and supports the legislation to criminalize the practice, under the existing law however, reinfibulation after deinfibulation after childbirth is not illegal on a woman older than eighteen years of age (Turner, 2007). Nonetheless the WHO (2001) guidelines for nurses and midwives advises that health workers must not "reinfibulate (close up) a vagina or an opened vulva or vagina in a girl or woman with type III FGM in a manner that makes intercourse and child birth difficult" (p.12).

Steps to Eliminate the Practice of FGM/C

In view of the above, it is imperative to identify ways to promote a multi-system (Global, national, community, individual) intervention using existing clinical and legal guidelines to

eliminate the practice of FGM/C. Eliminating the practice of FGM/C will help in achieving the first six WHO 2000 millennium development goals (MDG) for 2015, as it charges member states to promote gender equality and the empowerment of women as an effective way to combat poverty, hunger and disease as well as stimulate a sustainable development (WHO, 2009). Understanding women's position and gender relations within a given culture is vital in the steps to eliminating this practice; therefore, efforts to eradicate the problem should not be limited to a conventional medical model of disease prevention, but must incorporate a multidisciplinary and multisystem approach. Complete eradication of a deep rooted cultural and traditional practice that has been in existence for many centuries is a complex and delicate task. Currently, there are efforts by multitude of governments and national and international non-governmental organizations to abolish the practice of FGM/C. While a multi system approach will be effective with those who firmly oppose the practice of FGM/C there are bound to be opponents to the idea of abolishing a practice that is consider a vital part of their culture and ethnical belief.

At the international level, the World Health Organization (WHO, 2008) in collaboration with the United Nations Children's Fund (UNICEF) and the United Nations Population Fund (UNFPA) has made great efforts to eliminate the practice of FGM, through:

- Advocacy, by developing publications and advocacy tools for international, regional and local efforts to end FGM within a generation.
- research, by generating knowledge about the causes and consequences of the practice, how to eliminate it, and how to care for those who have experienced FGM; and

- Guidance for health systems: developing training materials and guidelines for health professionals to help them treat and counsel women who have undergone procedures (WHO, 2008).

In addition, international and regional treaties as well as consensus documents such as Convention on the Elimination of All Forms of Discrimination against Women, the Convention on the Rights of the Child, International Conference on Population and Development, the 1995 Fourth World Conference on Women and the 2002 United Nations General Assembly Special Session on Children, the African Charter on the Rights and Welfare of the Child, the Protocol on the Rights of Women in Africa, also called the 'Maputo Protocol'; European Convention for the Protection of Human Rights and Fundamental Freedoms; General Assembly Declaration on the Elimination of Violence against Women, Program of Action of the International Conference on Population and Development (ICPD), can be utilized to advocate with governments to take ownership for enforcing the elimination of FGM/C. Also under international law, States have the obligation to prevent, investigate, and punish violence against women in accordance with the United Nations Declaration on the violence against women, which provides that: "states should nit invoke any custom, tradition or religious consideration to avoid their obligation to eliminate violence against women. And they must exhibit due diligence in investigating and imposing penalties for violence, and establishing effective protective measures" (UNFPA, 2009, p.28). There should be an established interagency team that brings together relevant government ministries, non-governmental organizations and associations to adopt clear national policies and legislation for the abolition of FGM.

At the Community level, targeting of information and provision of training to traditional practitioners who are key actors of FGM, is crucial, as they may use their influence within the

community to continue to promote the practice or destabilize efforts for abandonment. Possibly if they decide to abandon FGM, then they can be very helpful in convincing others to abandon it as well (WHO, 2009). Providing alternative means of income and financial stability for traditional practitioners to replace the practice of FGM; Creating awareness through community outreach and educating stakeholders on the health consequences of FGM; media influence through positive public education and awareness to abandon FGM; availability of relevant easy to understand literature on the health complications of FGM on women, avoidance of intervention strategies that may create cultural vacuums; training of health care providers, are all the various positive steps proposed by numerous relevant article as positive steps to eliminating FGM/C.

At the individual level the WHO (2008) suggests that eradicating the practice as a health risk and a violation of women's rights must be led by women from communities where FGM/C is practiced; thus, educating women and girls to be empowered within their communities and cultures to fight the practice, mobilizing local women to advocate for a stop to the practice of FGM; enlisting support from boys, men (as women's attitude may begin to change once they find support from their brothers fathers or husbands) , community and faith based leaders, and other cultures that have moves away from the practice, are positive ways towards abolishing FGM.

By and large, the responsibility for action lies with many actors/players such as faith-based leader, health care providers and NGOs in addition to others whom have been mentioned above. "accountability ultimately rests with the government of a country, to prevent female genital mutilation, to promote its abandonment, to respond to its consequences, and to hold those who perpetrate it criminally responsible for inflicting harm on girls and women" (WHO, 2009,

Country		Estimated prevalence of female genital mutilation in girls and women
		15 – 49 years (%)
Burkina Faso	2005	72.5
Cameroon	2004	1.4
Central African Republic	2005	25.7
Chad	2004	44.9
Côte d'Ivoire	2005	41.7
Djibouti	2006	93.1
Egypt	2005	95.8
Eritrea	2002	88.7
Ethiopia	2005	74.3
Gambia	2005	78.3
Ghana	2005	3.8
Guinea	2005	95.6
Guinea-Bissau	2005	44.5
Kenya	2003	32.2
Liberia*		45
Mali	2001	91.6
Mauritania	2001	71.3
Niger	2006	2.2
Nigeria	2003	19
Senegal	2005	28.2
Sierra Leone	2005	94
Somalia	2005	97.9
Sudan, northern (approximately 80% of total population in survey)	2000	90
Togo	2005	5.8
Uganda	2006	0.6
United Republic of Tanzania	2004	14.6
Yemen	1997	22.6

The estimate is derived from a variety of local and sub-national studies (Yoder and Khan, 2007 as cited in WHO, 2009- http://www.who.int/reproductivehealth/topics/fgm/prevalence/en/index.html).

Eliminating Female genital mutilation, p.17). Over the years, there have been marked efforts to counteract FGM with progress at both international and local levels that include (a) wider international involvement to stop FGM; (b) the development of international monitoring bodies and resolutions that condemn the practice; (c) revised legal frameworks and growing political support to end FGM; (d) in some countries, decreasing practice of FGM, and (e) an increasing number of women and men in practicing communities who declare their support to end it (WHO, 2009).

Implication for nursing practice

Given the globalization of FGM/C and the cultural diversity of the western worlds, it is imperative for all health care providers' especially public health practitioners to have an understanding of the abuse and immense pressure women and young girls are put under by their culture and families. Hence health care practitioners should:

- Have sound knowledge and understanding of diverse cultures which is essential in providing high quality care.
- Have a sound knowledge of FGM/C as it can open doors to communication and education to eradicate the practice.
- Understand that community assessment is crucial for a successful public health education and intervention outcome.
- Identify and work with key stakeholders in the community as a means of targeting a wider audience for change.
- Advocate strongly against female genital mutilation.
- Be sensitive and receptive to patients who have undergone FGM/C bearing in mind that they are in need of professional support and empathy.

- Be mindful with the use of the FGM terminology to avoid being culturally insensitive.
- Be able to comprehend the complexity of diverse cultural issues relative to the target population, because doing so enables the nurse address important health needs of the patient.
- Are encouraged to promote trust, encourage health seeking behavior, address patient's fears and concerns.
- Report suspected practice of FGM as this is a crime in countries where such practices are prohibited.
- Be conversant of the state statutes and laws that protect women and children from the practice of FGM/C.
- Be conversant with available support resources for victims of FGM/C.

Personal thoughts and Conclusion

Reflectively, female genital mutilation is inherent in human right violation of women and children, disparity between sexes, and represents tremendous form of gender discrimination and inequality against women. Further, this practice specifically violates their right to health, security, and physical integrity, right to freedom from torture and cruelty, inhuman or degrading treatment and above all the right to life when the procedure may result in death. Human rights standards and practices as expressed through the Universal Declaration of Human Rights (1948) and subsequent multi agency and government programs, call for the eradication of all forms of genital mutilation to promote spiritual integrity and freedom; gender equality and equity; sexual integrity and mental health; economic and social development; educational and scientific rights; religious and cultural freedoms; and, mostly, children's rights.

The exposure from this study has engendered extensive learning about this and other prevailing global health issues. While I firmly respect and believe in upholding the cultural values and beliefs of any ethnic group or society, there is a clear difference between a rich and pain free cultural practice and a practice, shrouded in abuse and pain.

In conclusion "Even though cultural practices may appear senseless or destructive from the standpoint of others, they have meaning and fulfill a function for those who practice them. However, culture is not static; it is in constant flux, adapting and reforming. People will change their behavior when they understand the hazards and indignity of harmful practices and when they realize that it is possible to give harmful practices without giving up meaningful aspects of their culture" (Female Genital Mutilation, A joint WHO/UNICEF/UNFPA statement, World Health Organization, Geneva, 1997 as cited in UNICEF, 2005;WHO,2008).

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Key words: *Female cutting, Female genital mutilation, female circumcision*