**Challenges in the eradication of Female Genital Mutilation / Cutting**

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Introduction

Despite over 40 years 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: (I) Clitoridectomy - partial or total removal of the clitoris and/or the prepuce (II) Excision - partial or total removal of the clitoris and the labia minora, with or without excision of 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; and (IV): All other harmful procedures to the female genitalia for non-medical purposes.Type III or ‘infibulation’ is the most severe form and accounts for 10% of cases.1 It is estimated that over 200 million girls and women worldwide are living with the effects of FGM/C. Of these, 44 million are aged <15 years.1 FGM/C offers no health benefit and causes significant physical, psychological, and sexual harm.2

FGM/C is practised mainly in Africa, with the highest prevalence in Somalia, Egypt, Mali and Sudan, where over 80% of all women between 15-49 years of age have undergone FGM/C. 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.2,3

# FGM/C as a human rights issue

FGM/C reflects deep-rooted inequality between male and female, and constitutes an extreme form of discrimination against women.2 FGM/C is a violation of the human rights of girls and women, including every person’s right to the highest attainable standard of health.2 FGM/C is often performed on young girls and is therefore a violation of the rights of the child. In more than half of countries surveyed, FGM/C occurs before 5 years of age.7 FGM/C violates the rights to health, security and physical integrity of the young girl and women, the right to be free from torture and cruelty, inhuman or degrading treatment, and violates the right to life when the procedure results in death.2

There are significant influences of cultural, traditional and/or religious aspects to consider regarding understanding why the practice of FGM/C continues to occur. Some communities argue that FGM/C is a traditional and cultural practice and that high-income countries should not impose their views on this long-standing custom.8,9 However, often as countries develop and diversify from within, cultural practices change and there is often a realisation that condoning acts that contravene human rights has no place within any moral or ethical framework.8,9

# Why is FGM still being performed?

Communities that practice FGM/C report a variety of social and cultural reasons for continuing with this practice. Female cleanliness, protection of virginity, prevention of immorality, better marriage prospects, greater pleasure for the husband, and improvement of fertility are common reasons given for FGM/C.2 FGM/C is also often seen as a necessary ritual for initiation into womanhood and is linked to cultural ideals of femininity and modesty.2 FGM/C is often believed to reduce a woman's libido and therefore believed to help her resist "illicit" sexual intercourse.12 All of these reasons are non-evidence based. Community pressure to conform to traditional practice is often the strongest motivation to continue with the practice. No religious scripts prescribe the practice of FGM/C, although there is variation 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 suffering FGM/C.4,7 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, they may contribute and support the continuation of the practice of FGM/C.

# International response

The international community advocate that FGM/C violates the choice of a young girl or woman regarding her sexual and reproductive health7,13 (**Table 1**). The first joint statement specifically addressing FGM/C was issued by the WHO in 1997 in conjunction with United Nations Children’s Fund (UNICEF) and the United Nations Population Fund (UNFPA).1 From that time the international response has gained momentum. In 2008, the WHO together with nine other United Nations partners demonstrated increased support for the abandonment of FGM/C across the world.2 A key document was developed and highlighted evidence collected over the previous decade regarding FGM/C highlights the increased recognition of the human rights and legal dimensions of FGM/C and provided more comprehensive data on the prevalence of FGM/C. This document summarizes research regarding damaging effects on the reproductive and sexual health of girls and young women, the reasons why FGM/C continues, and recommendations for the eradication of FGM/C.2 In 2010, the WHO in collaboration with the other key UN agencies and international organisations published a document entitled "Global strategy to stop health care providers from performing Female Genital Mutilation".17 This was followed by action in December 2012 by the UN General Assembly, adopting a resolution on the elimination of FGM/C.16 This progress is the culmination of efforts of many organisations working together to bring attention to this harmful practice over a long period of time. The UNICEF report in 2013 acknowledges that before the intervention of international agencies, there were already well established local and regional campaigns in Egypt, Burkina Faso, Kenya and Senegal, where organisations were working with religious, political, women’s groups and the medical professional associations to raise awareness for and to advocate for the eradication of the practice of FGM/C.7

# Eradication of FGM/C

In order to eradicate FGM/C, the 2008 World Health Assembly resolution emphasised the need for concerted action in all sectors of health, education, finance, justice and women's affairs18 with recommendations that focus on (1) strengthening the health sector response: guidelines, training and policy to ensure that all health professionals can provide medical care and counselling to girls and women living with FGM/C; (2) building evidence: generating knowledge about the causes and consequences of the practice; (3) increasing advocacy: developing publications and advocacy tools for international, regional and local efforts to end FGM/C within a generation.2,7 There is international concern regarding an increasing trend for medically trained personnel to perform FGM/C. This practice is unacceptable and against the ethical framework of healthcare of “do no harm”.7

# Progress of eradication of FGM/C

Since 1997, great efforts have been made to counteract FGM/C through research, work within communities, and changes in public policy. Progress at both international and local levels includes wider international involvement to stop FGM/C, the establishment of international monitoring bodies, agreement on resolutions that condemn the practice, and, 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 the continuation of the practice. For example, the governments of South Africa and Zambia have banned the practice. Furthermore, in an united international effort 33 countries across the world have banned the practice of FGM/C as a means of protecting the rights of the child and to commit national support to all aspects of reproductive rights within a human rights context.7 In line with this, international professional associations such as the International Federation of Obstetricians and Gynaecologists (FIGO), the International Confederation of Midwives (ICM), the Royal College of Obstetricians and Gynaecologists (RCOG) and Royal College of Midwives (RCM) in the UK, condemn the practice of FGM/C and are vocal in calling all professional associations worldwide to oppose the practice which contravenes the essence of the Hippocratic Oath. They are committed to the eradication of FGM/C through working with governments and by the education of healthcare providers worldwide. Because of these combined efforts and legal frameworks put in place in many countries, an ever-increasing number of women and men in practicing communities support the eradication of the practice of FGM/C and the overall prevalence of FGM is decreasing. However, change is too slow.22,23

Although the majority of European and many African countries have passed legislation forbidding FGM/C, there is an increasing awareness of the urgency of legislation to be implemented in Asian countries, where in Malaysia for example, FGM/C is still carried out legally by healthcare providers in hospitals.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 is addressed. Increased media coverage, statements by ministers, religious leaders and non-governmental organisations have led to more discussion of the topic both at local and national level. There is an ongoing need for a combined approach in which community awareness is raised, and legal and medical frameworks supporting eradication are in place in each country.24 Moreover, any campaigns or interventions which aim to eradicate FGM/C should be of long term (at least 5 years) and include clear methodologies for implementation and evaluation.4

# Summary

The eradication of FGM/C can only be achieved through a coordinated approach implemented at local, regional, national and international levels. Healthcare providers have a duty of care to be aware of the ethical, social and legal aspects of FGM/C. Supportive education and targeted training is recommended to enable for all cadres of healthcare providers to sensitively and respectfully address this complex cultural practice. Healthcare providers must be updated on the current international recommendations towards the full eradication of FGM/C and understand the important role they play in promoting community understanding and debate of FGM/C as both a health and human right.

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**Table 1.** Timeline of key international policy drivers

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| Year | Agency/Organisation | Event |
| 1979 | United Nations (UN) | 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 | Abdalla, Raqiya Haji Dualeh.  Sisters in Affliction: Circumcision and Infibulation of Women in Africa Dareer A El; Why do you weep? Circumcision and its consequences. | Athma El Dareer’s study was the first to quantify the issue. |
| 1984 | Inter African committee on traditional  practices (Dakar) | Calls for end to FGM/C. |
| 1989 | UN | The UN General Assembly adopts 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 is adopted by the Organization of African Unity (now the African Union) and enters into force in  1999. It calls upon States to take appropriate measures to eliminate harmful social and cultural practices. |
| 1993 | UN | World Conference calls for Elimination of Violence against women. |
| 1994 | UN | ICPD (International Conference on Population and Development) Egypt -consensus reached on active discouragement of FGM. |
| 1997 | WHO, UNICEF, UNFPA | A joint statement is released against FGM/C. |
| 2002 | UN | 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 to Female Genital Mutilation. This is held on Feb 6th every year. |
| 2005 | Maputo Protocol | The Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa, better known as the Maputo Protocol is developed. It calls upon States to take measures to eliminate FGM/C and other traditional practices that are harmful to women. |
| 2007-2010 | UN | The United Nations Commission on the Status of Women adopts resolutions on ending FGM/C in 2007, 2008 and 2010. |
| 2008 | UN | Eliminating Female Genital Mutilation: An Interagency statement is signed by 10 United Nations agencies. |
| 2013 | UNICEF | Produced estimated prevalence of FGM/C in different settings and examined how change can be supported. |
| 2018 | WHO | Care of girls and women living with female genital mutilation: A clinical handbook. |