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Editorial

International efforts on abandoning female genital mutilation

E. Edouard [a], **O. Olatunbosun** [b,*], **L. Edouard** [c]

[a] *Dar-es-Salaam, Tanzania*
[b] *Saskatoon, Canada*
[c] *Port Louis, Mauritius*

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Abstract
Female genital mutilation (FGM), sometimes referred to as female circumcision or female genital cutting, is a harmful cultural practice without any known health benefit. Its short-term and long-term health risks have led to numerous initiatives toward its eradication at international and local levels, over the last two decades. While major challenges remain and millions of girls and women are still at risk of being subjected to FGM, there is growing evidence that interventions that take into account the social dynamics that perpetuate FGM are yielding positive results toward its reduction. Well-recognized as a human rights violation in international treaties, the elimination of female genital mutilation requires ongoing interventions through cross-sectoral approaches that address attitudinal, cultural and behavioral change.

Introduction

Around 130 million women and girls in the world are estimated to have undergone female genital mutilation (FGM) and each year, about 3 million girls and women are at risk of undergoing the procedure. FGM is more prevalent in certain ethnic groups specially in Africa and the Middle East but also in some countries in Asia and lately, it has been reported in countries such as Colombia and Peru in Latin America [1]. In the age group of 15–49 years, its prevalence is more than 85% in Djibouti, Egypt, Eritrea, Guinea, Mali, Sierra Leone and Somalia. With migration, it has become an issue in Europe and North America as well as Australia and New Zealand [1].

The practice of FGM is not affiliated with any particular religion and specifically, it is not mentioned in either the Koran or the Bible. Female genital cutting is an alternative term that is viewed as being

* Corresponding author at: Department of Obstetrics, Gynecology & Reproductive Sciences, College of Medicine, University of Saskatchewan, Royal University Hospital, 103 Hospital Drive, Saskatoon, Saskatchewan, Canada. Tel.: +1 3069662522.
E-mail address: femi.olatunbosun@usask.ca (O. Olatunbosun).
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more neutral by replacing the word mutilation by cutting. As it was previously known as female circumcision, FGM has unfortunately been compared to male circumcision, which is a quite different procedure that is well recognized as a most valuable intervention for reducing the risk of acquiring HIV [2].

Gender and rights

Whereas FGM might have originated as a way to control women, its continuing practice reflects the coercive persuasive role of society in maintaining gender inequality. By reducing the sexual pleasure of a woman, and therefore prolonging her virginity, FGM is seen as a mechanism to ensure marital fidelity. Its current practice, entrenched in social norms, reinforces inequality of women in practicing communities. It has become a prerequisite for marriage in some communities, rendering the practice difficult to abandon without detrimentally affecting the social capital of a girl. Peer pressure from the community and fear of reducing a girl's opportunities perpetuate its practice [3].

The practice of FGM is a clear violation of numerous human rights, namely freedom from gender discrimination and the rights to health, life and to physical integrity. The World Health Organization has been at the forefront of international initiatives for the elimination of FGM since 1979 when it hosted a seminar on "Harmful Traditional Practices Affecting the Health of Women and Children" in Khartoum. The issue has been given much importance at other intergovernmental forums such as the World Conference on Human Rights held in Vienna in 1993, the International Conference on Population and Development in Cairo in 1994 and the Fourth World Conference on Women in Beijing in 1995.

The need to eliminate FGM was well addressed in international treaties such as the Convention on the Elimination of all Forms of Discrimination against Women of 1979 and the Convention on the Rights of the Child of 1989. Besides, the practice of FGM violates regional treaties such as the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa that was adopted by the Assembly of the African Union in 2003. At its last session in 2012, the General Assembly of the United Nations adopted unanimously on 20 December 2012, a resolution for a global ban on FGM that will give more support at a local level for interventions [4]. Whereas national governments have the duty to pass legislation for ending the practice of FGM, challenges continue regarding to the implementation of these laws and treaties. Monitoring bodies of international human rights treaties have repeatedly pointed out the lack of effective actions at the local level.

Health implications

Risks from FGM are higher when the procedure is more extensive. Nevertheless, it usually leads to pain and hemorrhage immediately and long-term risks include psychological trauma, infection and pelvic complications. The severity of the resulting infections or hemorrhage can be life threatening specially in poor sanitary conditions without antibiotics or clinical skills to manage complications. However, such risk does not justify the practice of FGM by a qualified health practitioner.

A WHO study at 28 obstetric facilities in six different African countries demonstrated an association with postpartum hemorrhage, cesarean section and perinatal mortality besides an extended hospital stay [5]. With poorer care outside of hospitals, the extent and severity of those complications are likely to be much more substantial for non-institutional deliveries with implications for increased cost for the provision of resulting services.

With local swelling and pain, there can be some difficulty in passing urine or feces whereas damage to the urethra may lead to pain during urination. Infibulation can lead to dyspareunia besides dribbling of urine possibly caused from interference to bladder functions and the presence of surrounding scar tissue [1,6,7]. There is clearly a role for reconstructive surgery after FGM that aims at restoring clitoral pleasure and reducing local pain [8].

Challenges and progress

Major challenges continue to exist for obtaining statistics on progress made toward the reduction and eradication of FGM due to the lack of reliable survey data. While millions of girls and women are still at risk of being subjected to FGM, there is growing evidence that progress is being made toward ending this harmful practice [9]. An EU funded multi-country study shows that interventions taking into account the social dynamics that perpetuate FGM, have triggered positive results [10]. However, it is likely that the practice of FGM is decreasing because it is discernible that its prevalence is lower in the 15–19 age group as opposed to those who are much older. Whereas progress has been minimal in most countries, there has been some success stories as exemplified by Ethiopia where the prevalence of FGM in the 35–39 age group is 81.2% but only 62.1% in the 15–19 age group (9,10). Similarly in Kenya between 2003 and 2009, the prevalence of FGM declined from 80% to 74% [11]. In Egypt, data from the Reduction of Female Genital Mutilation Project started in 2006 and sponsored by Plan Egypt in collaboration with government, regional and local levels shows that the practice of FGM has become less common among the youngest age groups. A human rights based approach underpins an effective strategy that would successfully reduce and ultimately eliminate FGM by tackling harmful attitudes and beliefs in communities through partnerships between governmental NGOs and local community-based programs and gender committees.

Role of medical practitioners

Although the practice of FGM by medical practitioners violates the medical ethical principle to "Do no harm", about 18% of FGM are performed by medical practitioners [12]. Even when governments have enacted laws prohibiting the practice of FGM by a medical professional, the practice has continued because medical practitioners obtain an additional source of income besides giving way to pressure from community members, especially if they themselves come from a community group that practices FGM. Given the illegal nature of the procedure, providers of FGM receive attractive financial compensation for the service and there have been reports of mass campaigns with temporary clinics during holiday months for up to 50 girls a day [12].

The World Medical Association and the International Federation of Gynecology and Obstetrics as well as the World Health Organization and other agencies of the United Nations have condemned the medicalization of FGM [1]. Initiatives by professional associations are necessary to promote action at the grass-root level. These

statements should go beyond mere condemnation of the procedure by encompassing positive measures that would improve clinical care. For example, the Society of Obstetricians and Gynecologists of Canada has prepared guidelines for medical professionals who provide care to women having undergone FGM [13].

It is vitally important that health care providers are instructed on how to counsel individuals who are considering undergoing FGM or requesting its practice for their daughters. However, a medical practitioner must be able to address the health risks of FGM with patients in various other situations. Opportunities should be seized for identifying FGM within reproductive health services, such as cervical cancer screenings. Furthermore, medical practitioners should be trained in preparing a woman who has undergone FGM for childbirth and as part of preventative action, should discuss her plans for her child as she may want the same for her child. Among immigrant communities known to practice FGM, medical practitioners should be aware of the indications and signs that the parents are planning to seek FGM for their child through planned trips or vacations to their home country [14]. This may be suggested through requests for travel immunization and medication for malaria prophylaxis. The sensitivity of FGM requires a careful approach, and providers without training could do more harm than good. Therefore, the topic of FGM should be included in the training curricula for healthcare providers.

Advocacy for prevention

From a social, legal and medical perspective, ending FGM is not only warranted, but necessary [15]. International agencies, professional organizations, governments and NGOs have campaigned vigorously against FGM for two decades by advocating for its elimination and yet, progress has been slow. Programmatically, limited evaluation of projects, inadequate interventions, the medicalization of the practice and a demonstrated absence of beneficiaries in developing strategies have stagnated efforts. While government and non-governmental organizations have been active in programs to end FGM, efforts need to be coordinated especially within the parameters of the legislative system. The communication of health risks, development of behavior change interventions, legislation and implementation of laws banning FGM, resolution to end the medicalization of FGM by medical practitioners and abandonment by entire communities are all components that need to be set into motion.

Eighteen countries in Africa have enacted legislation criminalizing FGM. Certain countries in Europe and North America have passed laws criminalizing the practice among their immigrant communities but difficulties have arisen on the determination of who to hold responsible, practitioners or parents, as well as how to enforce the sanctions. Criminalizing the practice of FGM, without implementing behavior change strategies and addressing social norms, leads to other problems by driving the practice further underground. In some cases, local experienced lay circumcisers have stopped providing the service and as a result, the community has had to seek the service from less experienced and trustworthy individuals [15]. On the other hand, enlightened individuals have sought to avoid certain health risks of FGM, not by abandoning the practice but by turning to medical practitioners for providing the service.

With the lack of monitoring and evaluation of interventions, the documentation of best practices for the elimination of FGM is limited but recent research has identified key factors for success. These factors include community engagement or inclusion of beneficiaries, move from raising awareness to behavior change, interdependent decision-making between communities practicing FGM, incorporation of legislation that complement grassroots-level activities and linkage of human rights to local values [16]. Emphasis on advocacy through media, including radio, theater and dance in parallel with discussions with community and religious leaders, also has a proven track record. In Senegal in 1991, Tostan [17], initiated its successful community-led FGM abandonment program which has now been replicated in 10 countries in Africa. The success of Tostan's program necessitates wide participation: men, women and youth of all social groups. In each community, it organizes two classes that engage members of the community in discussions on their life, hopes for the future, ways to improve their well-being and human rights. As part of the program, this community engages other nearby communities and villages, which are linked by marriage, trade and other influences, in discussions and debates about the practice. The sharing of information throughout the social network of the community is pivotal to the abandonment of FGM, especially with intermarrying communities. Radio broadcasts, religious leaders and other influential members of the communities facilitate the spread of the discussion, which often results in a public declaration for a community to end the practice of FGM. In Senegal, since the first declaration by a village to abandon FGM in 1997, over 4000 villages have joined in declaring the abandonment of FGM. Furthermore, as part of its work, Tostan produced a film that is shown to spark discussion in other villages in Senegal as well as to immigrants of Senegal now living in Europe [17]. Through its advocacy at the grassroot level, Tostan has demonstrated the value of community engagement for the implementation of effective interventions instead of relying solely on national laws.

A gender-based approach for raising awareness of health risks is also an important step in ending FGM. Research from Senegal and Egypt showed that young men after learning about the health risks of FGM began to question the practice. Furthermore, they feared that it would also reduce their sexual pleasure upon learning that FGM adversely affected women in that way [17].

When laws require a health practitioner to alert legal authorities, police and social workers, the situation can deter women who have undergone FGM from seeking care. Therefore, the modalities for the implementation of laws within the context of medical services need to be carefully assessed.

Due to the sociocultural nature of FGM, a commitment needs to be made by communities as well as governments to ensure the end of its practice. Therefore, it is essential to have cross-sectoral programs providing an environment that is conducive to raising awareness, promoting behavior change and effecting an abandonment of the detrimental practice of FGM in its cultural context. However, the emphasis should be on interventions for behavior change that target individuals and are based on their preferences and life style.

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