



### **Position Statement: Female Genital Mutilation**

The International Organization of Physical Therapists in Women's Health (IOPTWH), an official subgroup of the World Confederation for Physical Therapy, takes the following position on female genital mutilation (circumcision):

***In support of the World Health Organization (WHO) we denounce the practice of female genital mutilation and add our name to the efforts to combat it worldwide.***

“After the gypsy sewed me up, the only opening left for urine and menstrual blood was a miniscule hole the diameter of a matchstick. This brilliant strategy ensured that I could never have sex until I was married, and my husband would be guaranteed he was getting a virgin. As the urine collected in my bloody wound and slowly trickled down my legs onto the sand – one drop at a time – I began to sob”. So writes Waris Dirie (1998) of her experience as a five year old Somalian girl.

Female genital mutilation (FGM) refers to all procedures involving partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons (WHO, 2010).

Female genital mutilation is a deeply embedded cultural tradition with meaning and symbolism for many communities. The continued practice of FGM is motivated by peer pressure, fear of exclusion from resources and opportunities as a young woman, and marriage ability (Varol et al., 2014). The practice of FGM is built on a ‘mental map’ of beliefs, values and codes of conduct. These are psychosexual, social and religious in nature and include the maintenance of chastity/virginity, family honour and control over women's sexuality, the belief that FGM is necessary for hygiene and aesthetic reasons (fears of ugliness and bad odour), and the belief that it is a religious requirement for spiritual cleanliness (Mohamud et al., 1999). FGM may also be a rite of passage from childhood to womanhood. Another possible reason is fear of sexual violence against girls, as FGM precludes vaginal penetration (WHO, 2011). FGM is sustained by community enforcement mechanisms such as public recognition by celebration (use of rewards and gifts, poems and songs celebrating the circumcised while deriding the uncircumcised), the refusal to marry uncircumcised women and fear of punishment by God (Mohamud et al., 1999). Mothers may subject daughters to FGM to protect them, to secure good prospects of marriage, to ensure acceptance and for economic security (Varol et al., 2014).



No religious text requires FGM. The practice predates both Christianity and Islam and is unknown in many Muslim countries. In Egypt, Sudan and Senegal, Christian and Muslim religious leaders condemned the practice, declared it violates women's dignity, and have been promoting the uncut girl as happy and healthy, thus helping to abandon the practice (Varol et al., 2014). There are major difficulties in addressing the practice because it is rooted in cultural tradition.

Global prevalence of, and support for, female genital mutilation has been declining in the last three decades. The decline has been uneven and not all countries have made progress. Barriers to abandonment include an entrenched sense of social obligation & lack of open communication between men and women. The importance of human rights in communities and empowerment of girls in relation to their own development must be accepted (Varol et al., 2014). Change is also more likely to happen when priorities of communities are addressed, and trust is established (Berg and Denison, 2013; Varol et al., 2014).

The World Health Organization (WHO, 2010) considers that there are no medical, hygiene or health reasons to support FGM and that it is a form of violence and discrimination against girls and women.

While the exact number of girls and women worldwide who have undergone FGM remains unknown, at least 200 million girls and women in 30 countries have been subjected to the practice (UNICEF, 2016a). Rates have been declining over the past three decades. However, due to population growth, 63 million more girls could be subjected to FGM by 2050 (UNICEF, 2016b).

The practice of FGM is highly concentrated in Africa, the Middle East and some countries of Asia. Evidence suggests that FGM is practiced in parts of South America, southern part of the Arabian Peninsula, and the Persian Gulf. The practice is also found in parts of Europe, Australia and North America, due to displacement by civil wars, globalization and migration. Therefore FGM is a global concern (UNICEF, 2016a; Varol et al., 2014). Young girls living in Western countries are at risk of undergoing the procedure as their families seek to maintain a cultural practice within their adopted communities, despite laws prohibiting it. (Varol et al., 2014; Elneil, 2016).

The procedure is carried out in remote areas as well as in cities and at all levels of society from the elite and professional classes to the simplest villager (Elneil, 2016). The age of girls when they are mutilated differs greatly from region to region, from 7 to 8 day old babies in some countries to grown women (some during their first pregnancy) elsewhere. FGM is usually performed at the youngest



age possible to avoid questions from education authorities and because older girls might defend themselves against the practice (Varol et al., 2014). In rural areas older women who are known as traditional 'cutters' perform FGM. Crude instruments such as knives, razors, scissors or sharp stones are often used. It is likely to be performed under unhygienic conditions with the same instruments used on different girls. In her book *Woman, Why Do You Weep?* El Dareer (1982) reports that all knives she saw were rusty, dirty and old.

In urban areas the procedure is more likely to be performed under anaesthetic, with some health workers believing this makes the procedure more acceptable. In this case the term medicalization of FGM is used and refers to situations in which FGM is practiced by any category of health-care provider, whether in a public or a private clinic, at home or elsewhere. WHO states: "Health professionals who perform female genital mutilation (FGM) are violating girls' and women's right to life, right to physical integrity and right to health. They are also violating the fundamental ethical principle: do no harm." (WHO, 2010). Their joint statement with the United Nations Population Fund (UNFPA), the United Nations Children's Fund (UNICEF), the International Confederation of Midwives and the International Federation of Gynecology and Obstetrics states that FGM of any form should not be practised by health professionals in any setting including hospitals or other health establishments (UNFPA, 2015). A World Medical Association statement (2016) condemned both the practice, regardless of the level of mutilation, and the physicians who carry out the procedure. Most health-care providers who perform FGM are themselves part of the FGM practising community. Some organizations support the medicalization of FGM. They argue that it may help to reduce the risks of the procedure, limit the extent of mutilation and reduce pain (WHO, 2010).

We note the spectrum of invasiveness of FGM as classified by WHO (2010):

**Type I:** Excision of part or the entire clitoris and/or the prepuce. Subtypes: Ia excision of the clitoral hood or prepuce only, Ib excision of the clitoris and prepuce.

**Type II** Excision of the clitoris with partial or total excision of the labia minora; Subtypes: IIa excision of the labia minora only, IIb excision of the labia minora and partial or total removal of the clitoris, IIc excision of the labia minora and majora with partial or total removal of the clitoris

**Type III** Excision and appositioning of part or all of the external genitalia and stitching/narrowing of the vaginal opening (infibulation). Subtypes: IIIa excision



and appositioning of the labia minora, IIIb excision and appositioning of the labia majora

**Type IV** Unclassified: Pricking, piercing, or incision of the clitoris and/or labia and all other harmful procedures to the female genitalia.

Reisel and Creighton (2015) have carried out a systematic review of consequences of FGM. Terry and Harris (2013) also carried out a literature review of FGM. They state the following as consequences:

**Short-term complications** include pain, risk of haemorrhage, shock, sepsis, inability to urinate, infection, damage to other organs, dislocation and fracture of bones due to struggle while being restrained, psychological trauma and death.

**Long term** can be broadly divided into three main areas: gynaecological, obstetric and psychological.

*Gynaecological problems* include infection, inflammatory disease, fistulae, vaginal infections, menorrhagia, recurrent abscess formation, infertility, painful sexual intercourse, obstructed menstrual flow, difficulty passing urine, urinary tract infection, vulval abscess, chronic pelvic infection, incontinence.

*Obstetric complications:* prolonged labour, postpartum haemorrhage, perineal trauma, infertility, maternal death, fetal distress and death, fistulae formation, high rate of episiotomy, difficulty in vaginal examination, urine retention in labour, (Gayle and Rymer, 2016).

*Psychological effects:* depression, anxiety, post-traumatic stress disorder, memory problems, absence of sexual desire, reduced sexual satisfaction.

In gathering information on the effects of FGM for their book *Prisoners of Ritual*, Lightfoot-Klein et al. (1989) noted that women generally were unable to relate their frequent health problems to the procedure, this being due to their ignorance of a cause and effect relationship and a lack of knowledge of what is normal. However, by specific questioning of women who have been infibulated, most reported difficulty with urination often passing urine forcefully, drop by drop.

As Women's Health Physiotherapists / Physical Therapists, our scope of practice covers many of the long-term complications of FGM. These include urinary and faecal incontinence, bladder and/or urethral pain and dysfunction and chronic pelvic pain including dyspareunia and vulvodynia.



A WHO review shows there are some effective programmes, participatory in nature and working at the community level to protect girls and women from FGM. However, this report notes that most anti-FGM programmes do not fully address behaviour-change strategies to reduce FGM (WHO, 2011). In 2012 the United Nations General Assembly adopted a resolution calling on the international community to intensify efforts to end the practice. In September 2015, the global community agreed to new Sustainable Development Goals (SDG) which include the goal to eliminate all harmful practices such as child, early and forced marriage and FGM, by the year 2030 (UNICEF, 2016a).

The International Organization of Physical Therapists in Women's Health condemns the practice of female genital mutilation in all of its forms because of well-documented health problems and the potential for life long suffering and impaired quality of life. As Waris Dirie writes in the preface of her book *Desert Children* (2005): ". . . cutting a girl's genitals is one of the worst things you can do to a human being". We believe every girl has the right to mature to womanhood with a complete body, free from the harmful and irreversible effects of a procedure that has no requirement for medical, hygiene or religious reasons and violates many international declarations and conventions. We express deep concern at the large numbers of girls and women affected worldwide today.

IOPTWH supports the efforts of WHO in their development and promotion of effective programmes working within a cultural context at community level, not only to protect girls and women from the harmful practice of FGM, but also to educate and bring about behavioural change.

## References

Berg RC in Denison E (2013). A tradition in transition: factors Perpetuating and Hindering the Continuance of Female Genital Mutilation/Cutting (FGM/C) summarized in a Systematic Review. *Health Care Women Int* 34: 837-59.

Dirie W (1998). *Desert Flower*. London: Virago, 73.

Dirie W (2005). *Desert Children*. London: Virago, Preface.

El Dareer A (1982). *Woman, why do you weep?*. London: Zed Press, 8.

Elneil S (2016). Female sexual dysfunction in female genital mutilation. *Trop Doct* 46 (1): 2-11.



Gayle C in Rymer J (2016). Female genital mutilation and pregnancy: associated risks. *Br J Nurs* 25(17): 978-83.

Lightfoot Klein H, Cole E, Rothblum ED (1989). *Prisoners of ritual: an Odyssey into female Genital Circumsision in Africa*. Routledge.

Mohamud AA, Ali N, Yinger NV (1999). Female genital mutilation: Programmes to Date: What works and what doesn't – A review. *Programme for Appropriate technology in health (PATH)*: 1-7.

Reisel D in Creighton SM (2015). Long term health consequences of Female Genital Mutilation (FGM). *Maturitas* 80: 48-51.

Terry L, Harris K (2013), Female genital mutilation: a literature review. *Nurs Stand* 28 (1):41-7.

UNFPA (2015). Joint statement on International day of zero tolerance for female genital mutilation (FGM). Available on: <http://www.unfpa.org/press/joint-statement-international-day-zero-tolerance-female-genital-mutilation-fgm> <23.1.2018>.

United Nations Children's Fund (2016a). *Female Genital Mutilation/Cutting: A global concern*. New York: UNICEF.

UNICEF (2016b). Female genital mutilation/cutting. Available from: [https://www.unicef.org/protection/57929\\_58002.html](https://www.unicef.org/protection/57929_58002.html). <23.1.2018>.

Varol N, Fraser IS, Ng CHM, Jaldesa G, Hall J (2014). Female genital mutilation/cutting – towards abandonment of a harmful cultural practice. *Aust N Z J Obstet Gynaecol* 54: 400-5.

WHO (2010). *Global strategy to stop health-care providers from performing female genital mutilation*. World Health Organization: 1-18.

WHO (2011). *Female Genital Mutilation programmes to date: what works and what doesn't*. Policy brief. Available from: [http://www.who.int/reproductivehealth/publications/fgm/wmh\\_99\\_5/en/](http://www.who.int/reproductivehealth/publications/fgm/wmh_99_5/en/). <23.1.2018>.

World Medical Association (2016). *WMA statement on female genital mutilation*. Available from: <https://www.wma.net/policies-post/wma-statement-on-female-genital-mutilation/> <23.1.2018>.