



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 Dirie¹ of her experience as a five year old Somalian girl.

Female genital mutilation (FGM) is a deeply embedded cultural tradition with meaning and symbolism for many communities. 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. 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.²

No religious text requires FGM. The practice predates both Christianity and Islam and is unknown in many Muslim countries.³ The custom cuts across many religions. Internationally it is considered to be a health and human rights issue. There are major difficulties in addressing the practice because it is rooted in cultural tradition.⁴

The World Health Organization (WHO) 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.⁵

While a figure of 2 million per year is widely quoted in the data, a United Nations Children's Fund (UNICEF) press release⁶ gives a figure of 3 million girls and women each year (approximately 8,000 per day) still being subjected to FGM. This higher figure may reflect improved data quality.

Although the practice has in the past been largely confined to African countries, certain ethnic groups in the southern part of the Arabian Peninsula, the Persian Gulf and some groups in Malaysia and Indonesia⁷, it is now a global concern through displacement by civil wars, globalization and migration of peoples around the world. Increasing numbers of women who have undergone FGM now live in Western countries. Consequently young girls are at risk of undergoing the procedure as their families seek to maintain a cultural practice within their adopted communities, despite laws prohibiting the practice.⁸

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 villager⁹ and most commonly on girls between the ages of four and twelve years either alone or in a community group.¹⁰ 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*¹¹ 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 a joint statement with the United Nations Population Fund (UNFPA) and UNICEF, the WHO¹² has stated that "FGM of any form should not be practised by health professionals in any setting including hospitals or other health establishments". A World Medical Association Statement¹³ condemned the practice, including the participation of medical doctors in the execution of the procedure.

We note the spectrum of invasiveness of FGM as classified by WHO: ¹⁴

Type I Excision of the prepuce, with or without excision of part or the entire clitoris;

Type II Excision of the clitoris with partial or total excision of the labia minora;

Type III Excision of part or all of the external genitalia and stitching/narrowing of the vaginal opening (infibulation);

Type IV Unclassified: Pricking, piercing, or incision of the clitoris and/or labia; Stretching of the clitoris and/or labia; Cauterization by burning of the clitoris and surrounding tissues; Scraping (Angurya cuts) of the vaginal orifice or cutting (gishiri cuts) of the vagina; Introduction of corrosive substances into the vagina to cause bleeding or herbs into the vagina with the aim of tightening or narrowing the vagina.

Lovel et al.,¹⁵ have carried out a systematic review of the health complications of FGM for the WHO, including sequelae in childbirth:

Immediate problems are reported as being more important than later effects because of the risk of death and include haemorrhagic and neurogenic shock; urinary retention; inadvertent injury to other tissues; fracture or dislocation of bones and joints as restrained girls struggle; infection (risk of tetanus and HIV/AIDS) contracted from unhygienic instruments or wound contamination from urine and/or faeces; failure to heal from underlying conditions (anaemia, malnutrition); psychological trauma.

Long term effects on health documented in the above review include:

psychosexual problems: dyspareunia; failure in sexual penetration; defloration trauma/haemorrhage with risk of infection (including HIV/AIDS); pregnancy in presence of pinhole introitus; infertility problems; anorgasmia; recircumcision to please husband;

gynaecological problems: painful scars; keloid tissue formation; clitoral neuroma; dysmenorrhoea; obstructed menstrual flow; difficulty passing urine, urinary tract infection; vulval abscess; chronic pelvic infection;

obstetric sequelae: difficulty in vaginal examination; urine retention in labour; vulval and vaginal scarring and adhesions narrow or obliterate the vaginal opening leading to mechanical obstruction to delivery; perineal damage and urethral tears; reluctance to push in 2nd stage labour from defibulation; risk of fistulae formation during pregnancy (as a result of gishiri/vaginal cuts) or as scar tissue tears during delivery with risks to urinary and/or faecal continence; postpartum wound infection; weakened pelvic floor predisposing to prolapse.

More recently a WHO study¹⁶ involving large numbers of African women reported that women with FGM are significantly more likely to have adverse obstetric outcomes and an increased risk of perinatal death with a greater risk to those with more extensive FGM.

In gathering information on the effects of FGM for her book *Prisoners of Ritual*, Lightfoot-Klein¹⁷ 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 review¹⁸ 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 the 'mental map' of beliefs and values underpinning the practice.

The IOPTWH, while acknowledging the cultural context of FGM, condemns its practice 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*:¹⁹ ". . . 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.

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

Endnotes

¹ Waris Dirie, *Desert Flower* (London: Virago, 1998) p. 73.

² Asha A. Mohamud, Nancy A. Ali, Nancy V. Yinger, *Female Genital Mutilation: Programmes to Date: What Works and What Doesn't – A Review*. Programme for Appropriate Technology in Health (PATH), 1999, pp. 1 & 7.

³ Ann Clywd, *The Female Genital Mutilation Bill 21 of 2002-2003*. (London: Research Paper 03/24, House of Commons Library, 2003), pp. 11-12.

⁴ *Ibid.*, p.8.

⁵ WHO, *Female Genital Mutilation: Report of WHO Technical Working Group*. (Geneva, 1996).

- ⁶ UNICEF Press Release, UNICEF hails progress toward ending female genital cutting. *Despite Signs of Hope, 3 Million Girls Still Subjected to Practice Annually*. New York: Press Centre, February 6, 2006 http://www.unicef.org/media_30925.html
- ⁷ Efua Dorkenoo, *Cutting the Rose, Female Genital Mutilation: The Practice and Its Prevention* (London: Minority Rights Group Publications, 1994).
- ⁸ Anika Rahman and Nahid Toubia, *Female Genital Mutilation: A Guide to Laws and Policies Worldwide*. (London: Zed books, 2000).
- ⁹ Hanny Lightfoot-Klein, *Prisoners of Ritual: An Odyssey into Female Genital Circumcision in Africa* (New York-London, The Haworth Press, 1989).
- ¹⁰ Rahman, *op.cit.*, p.1.
- ¹¹ Asma El Dareer, *Woman, Why Do You Weep?* (London: Zed Press, 1982), p. 8.
- ¹² WHO/UNFPA/UNICEF, *Joint Statement*. World Health Organization. Geneva: World Health Organization, 1997).
- ¹³ World Medical Association. *Statement on Condemnation of Female Genital Mutilation*, adopted by the 45th World Medical Assembly, Budapest, Hungary, 1993.
- ¹⁴ WHO Technical Working Group *op.cit.*
- ¹⁵ Hermione Lovel, Claire McGettigan and Zainab Mohammed. *A Systematic Review of the Health Complications of Female Genital Mutilation including Sequelae in Childbirth*. (Geneva: Department of Women's Health Family and Community Health, World Health Organization, 2000)
- ¹⁶ WHO Study Group. *Female genital mutilation and obstetric outcome: WHO collaborative prospective study in six African countries* (Lancet, June 2006) vol 367, pp 1835-1841.
- ¹⁷ Lightfoot-Klein, *op.cit.*, p.22.
- ¹⁸ Mohamud et al., *op.cit.*, p. 124.
- ¹⁹ Waris Dirie, *Desert Children*. (London: Virago, 2005), Preface.