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MENTAL HEALTH AND FEMALE GENITAL MUTILATION/CUTTING (FGM/C):

Recommendations for Accelerating Action in Research, Programs and Policy

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ABOUT THE U.S. END FGM/C NETWORK

The U.S. End FGM/C Network is a collaborative group of FGM/C survivors, civil society organizations, foundations, activists, policymakers, researchers, healthcare providers and others committed to promoting the abandonment of female genital mutilation or cutting (FGM/C) in the U.S. and around the world. To learn more about our work, please visit endfgmnetwork.org.

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INTRODUCTION

Like other forms of gender-based violence, female genital mutilation or cutting (FGM/C) is a practice that affects women and girls globally and is not limited to any one country, region, religion, socio-economic status or culture. In 30 of the high prevalence countries that report national data, it is estimated that at least 200 million girls and women have undergone FGM/C.¹

The practice involves the cutting or removal of the external female genitalia or other injury to the female genital organs, and most girls are cut between the ages of 5-14. The root causes behind the practice are diverse and multi-dimensional and include gender inequality, prevailing social norms and a desire to control female sexuality.² The procedure is often performed for the purpose of controlling women's sexuality, which some proponents note is "insatiable" if parts of the genitalia, especially the clitoris, are not removed. Similarly, FGM/C is considered a means of ensuring virginity before marriage and fidelity afterward, as well as a way to increase male sexual pleasure. While the physiological health impacts from FGM/C have been widely documented, psychological health risks have been minimally explored.^{2,3,4} The limited evidence suggests there is a clear and urgent need to investigate the links between FGM/C and mental health.

To better understand the intersections between FGM/C and mental health and prioritize action steps, the International

Center for Research on Women and Wallace Global Fund convened experts from academia, civil society, U.S. federal agencies, women who have undergone FGM/C and donors for a consultation. This brief summarizes our review of the evidence and the recommendations that emerged from the expert convening, which are organized by sector: activists and advocates; researchers; program implementers; government, law and policymakers; and donors.

OVERVIEW OF FEMALE GENITAL MUTILATION/CUTTING (FGM/C)

FGM/C poses serious medical, physical and psychological health risks, ranging in severity from urinary tract infections to Post-Traumatic Stress Disorder (PTSD), complications in childbirth and death.^{2,4,5} Exposure to FGM/C places one at risk of immediate physical consequences, including severe pain, bleeding and shock, difficulty in passing urine and feces and the resulting infections, prolonged labor and fistulas. Chronic pelvic infections can spread to the uterus, fallopian tubes and ovaries, leading to pelvic inflammatory disease which can result in infertility. Given these health and human rights concerns, significant work has been undertaken to eliminate the practice, particularly through interventions that combine health and human rights approaches.

While FGM/C is primarily performed on children and adolescents, age at cutting varies

The World Health Organization (WHO) defines four types of FGM/C, using a numerical classification system ranging from I-IV (WHO, 2016). Type I is defined as partial or total removal of the clitoris, and Type II is partial or total removal of the clitoris and labia minora, with or without excision of the labia majora. Type III is narrowing of the vaginal orifice, by cutting and a portion the labia minora and/or the labia majora, with or without excision of the clitoris to then create a seal for this newly created opening (infibulation). Type 4 comprises all other harmful procedures to the female genitalia for non-medical purposes (e.g., pricking, piercing, scraping).

FGM/C has no health benefits, and it harms girls and women in many ways. Risks are heightened with increasing severity of the procedure. WHO strongly urges health professionals not to perform these procedures.

widely. While some girls undergo FGM/C during infancy, other girls and women undergo FGM/C later in life, often in preparation for marriage. Out of the 22 countries where nationally representative data on age at cutting is available, the majority of girls in 12 countries were cut before the age of five. Notable exceptions include Egypt, Kenya and the Central African Republic, where cutting continues well into the teen years. In high-income countries, FGM/C occurs predominantly among diaspora communities representing countries where FGM/C is prevalent. FGM/C is reported in Western Europe, the United States, Australia, New Zealand and Canada, although data in these diaspora communities has been difficult to obtain.² According to estimates largely based on immigrants from FGM/C-practicing countries, approximately 513,000 women and girls in the United States have undergone or were at risk for FGM/C in 2012, which is more than three times higher than 1990 data.⁶ In 2011, there were at least 103,000 immigrant women and girls in the United Kingdom who had experienced FGM/C.⁷

Girls living in diaspora communities are also at risk for so-called “vacation cutting,” in which they are sent to their family’s country of origin or across the border to a neighboring country under the guise of vacation or cultural learning, but instead are forced to be cut while abroad (Equality Now, 2016). In the United States, vacation cutting is illegal.⁸ Today, close to 43 countries, 25 of which are in Africa, criminalize FGM/C.⁹

Numerous international non-governmental organizations, governments and advocacy groups have called for an end to FGM/C, which was first recognized as a human rights violation under the 1993 Vienna World Conference on Human Rights.¹⁰ In 2008, WHO and nine United Nations organizations issued a joint statement reaffirming the need to eliminate FGM/C more doggedly, as progress has been made.¹¹ The statement also suggested legal actions that governments could take to support the elimination of FGM/C, including constitutional recognition of girls’ and women’s rights, criminal and civil penalties, child protection laws and immigration asylum on the basis of gender-based violence. In 2012, the UN General

Assembly capitalized on this momentum to pass a resolution calling for the global ban of FGM/C.¹²

Since FGM/C predominantly affects girls under the age of 18, the issue should be framed in relation to the protection of the rights of children. FGM/C is listed as a harmful practice in Article 5 of the Maputo Protocol, which was adopted by the African Union and integrated into the African Charter on Human and People’s Rights in 2003.¹³ More recently, the Sustainable Development Goals (SDGs), which include a target under Goal 5 to eliminate harmful practices including child, early and forced marriage and FGM/C by the year 2030, signify the international development community’s commitment to working together to accelerate action towards ending FGM/C globally.

WHAT THE EVIDENCE SHOWS

Many survivors report that FGM/C is a highly traumatic experience. The trauma, pain and complications can contribute to both short- and long-term mental health complications, which can include an increased risk of depression and anxiety, reduced social functioning, post-traumatic stress disorder (PTSD), re-experiencing the trauma through intrusive distressing memories of the event. They can also include flashbacks, sleep difficulties and nightmares, memory problems, obsessive-compulsive tendencies, irritability and frustration, phobia, paranoid thoughts, emotional numbness, somatic disorders (i.e. physical complaints caused by psychological distress such as headaches, joint pain, etc.) and dissociation.^{5,14,15,16,17}

The limited evidence that exists suggests that the psychological impact of FGM/C can be related to the type of FGM/C experienced, the age at which FGM/C was performed, ensuing medical complications that have risen and support from familial and social networks.^{5,14,18,19}

Studies have also indicated that the prevalence of FGM/C as a practice is strongly tied to social norms. Consequently, the global evidence that has been produced regarding the psychological consequences of FGM/C has varied accordingly. It has also been influenced by efforts to account

for social norm factors, such as the socio-cultural context, belief systems and immigrant identity – all of which have been shown to impact the manifestation of psychological symptoms and disorders.^{5,10,20,21} For example, FGM/C-affected women, living in countries where this practice is not the social norm or is illegal, face additional social stressors of living in communities with different value systems, where dominant discourse categorizes them as “mutilated”, and where their self-esteem and body image are challenged.^{20,21,22} In countries where the practice is prevalent and culturally accepted, uncircumcised women face stigma, societal pressure or social isolation within their communities.^{22,23} However, various researchers have argued that the cultural significance of the practice does not necessarily mitigate the psychological impact of FGM/C and that more research is needed to better understand this process.¹⁶

Studies have demonstrated that some women with FGM/C experience painful intercourse, sex phobia, somatization (i.e., physical symptoms caused by psychological distress, including headaches, joint pain, etc.), shame about intimacy and reduced sexual desire and satisfaction.^{10,16,19,24,25} Male partners of women who have undergone FGM/C also cite complications from FGM/C, including difficulty with penetration and associated pain and the development of wounds or infections to the penis.²⁶ Some men also reported being concerned about inflicting pain upon their wives.²⁷ Physical and psychosexual difficulties that reduce pleasure for both women and men can impact intimacy in sexual and marital relationships.²⁸

Activists who are working to end this practice face many psychosocial challenges, as well, including social stigmatization and harassment within their communities (both online and in person), threats to



their safety, increased stress at work and secondary trauma from working with survivors.²⁹ Many activists and leaders of the global movement to end the practice are themselves survivors of FGM/C.³⁰ As with other forms of sexual violence, anecdotal evidence shows that survivor activists face additional mental health stressors, such as re-traumatization and exploitation within their advocacy efforts.³¹

KEY RECOMMENDATIONS

This expert convening on mental health brought together a range of stakeholders in the field of mental health, including survivors, activists, grassroots organization, academics, health and social care providers and policy makers. Stakeholders presented their research and programs, examined the evidence and engaged in brainstorming activities to identify gaps and needs. Key priority areas and recommendations identified through these discussions are listed below. The recommendations listed are reflective of the programmatic experiences, perceptions and particular needs of those who participated in the consultation. These recommendations lay the groundwork for how activists, advocates, researchers, implementers and policymakers can address the gaps in understanding the intersection between FGM/C and mental health.

RECOMMENDATIONS FOR ACTIVISTS AND ADVOCATES

- Partner with organizations to provide trainings on best practices for activists to respond to online harassment and support self-care;
- Develop local and global networks of activists that facilitate information sharing and connections in order to break down siloes and decrease isolation;
- Conduct research on the specific mental health needs of activists who are FGM/C survivors;
- Develop a pilot project on mental health support, specific to FGM/C activists and focused on (1) preparing future activists for advocacy and self-care (particularly survivor activists); (2) building networks to decrease isolation; (3)

creating an environment to encourage more people to disclose and share their experiences with FGM/C; and (4) mitigating community backlash that is often normalized;

- Identify organizations that can help to protect survivor activists and enhance safety measures and security for those who may face backlash, such as harassment online and in-person, community ostracization and threats to their personal safety (i.e., leverage existing domestic violence organizations);
- Increase awareness among activists, clinicians and organizations working to end FGM/C on the connections between FGM/C and mental health;
- Integrate and translate mental health research into advocacy and programming;
- Encourage activists to engage in self-care; and
- Attend activist retreats, initiate dialogue among activists and create support groups and networks in local areas.

RECOMMENDATIONS FOR RESEARCHERS

- Investigate the impact of FGM/C on women's sexuality, including pleasure, arousal and genital self-image;
- Explore the effectiveness of psycho-sexual interventions, including body-positive approaches;
- Conduct research on the psycho-social trauma related to the different types of FGM/C, trauma-associated impacts, re-traumatization for survivors and secondary traumatization for advocates, anxiety-associated impacts, transgenerational trauma, etc.;
- Investigate the impact of FGM/C advocacy on the mental health of survivor-advocates;
- Conduct qualitative assessments of ex-cutters;
- Explore the mental health effects of FGM/C during the prenatal, pregnancy, delivery and post-partum periods;
- Investigate the longitudinal physical and mental health impact of FGM/C for girls who were cut as infants and toddlers;

- Understand the attitudes, behaviors and practices of individuals who have deviated from their communities' FGM/C socially accepted behavioural norms (positive deviance);
- Conduct research on mental health effects on those who defied social norms and set themselves apart from their communities' FGM/C practices;
- Investigate how men are affected by FGM/C, with regards to their wives, daughters and communities; and
- Evaluate current trainings that use a human rights lens and child abuse or gender equity framework, and identify those with maximum impact.

RECOMMENDATIONS FOR PROGRAM IMPLEMENTERS

- Enhance the capacity of institutions to provide counselling and support services for hospital staff and medical clinicians;
- Train teachers, counsellors and school nurses on safeguarding policies and procedures for FGM/C;
- Deliver programming tailored for men and boys in order to increase awareness on the long-term impact of FGM/C on the life-course (their wives, sisters, sexual partners, etc.);
- Develop evidence-based and survivor-informed training for health professionals (i.e., academic coursework, continuing education and community health models) to educate both upcoming and practicing frontline health care providers on the immediate physical, sexual, psychological and social impacts associated with FGM/C;
 - Health care providers should be aware of FGM/C and be prepared to provide appropriate assessment, culturally sensitive screening and clinically informed care, including early recognition and management of the complications.
- Develop culturally appropriate and gender-sensitive adolescent mental health measures;
- Conduct participatory development programming (e.g., participatory action research) with survivors in order to tailor programming to those affected;
- Integrate FGM/C into other sectors such as livelihood and education programs that may reach vulnerable populations;
- Rigorously evaluate programs to assess impact of intervention;



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- Develop partnerships with community service programs, in order to communicate more effectively with other agencies and stakeholders and provide linkages to additional support services tailored to meet the mental health needs of survivors, activists and advocates (i.e., develop a community resource center);
- Tailor community specific mental health interventions (i.e., humanitarian and emergency contexts, refugee communities, etc.);
- Develop multidisciplinary partnerships which can facilitate access to mental health and psychosocial support and help build the evidence base on the long-term impacts of FGM/C; and
- Enhance professional networks, knowledge sharing and collaboration among multiple stakeholders, which include teachers, health service providers, community and religious leaders, law enforcement, civil society, transportation security administration and airline staff, child protection workers, immigration officers, translators, advocates, parents and community members.
- Implement laws that take a multi-sectoral approach, including healthcare and prevention;
- Ensure that legal and law enforcement structures are in place for effectively mitigating unintended consequences for children and families and prioritizing the needs of child survivors and potential victims; and
 - While this is a serious human rights abuse with lasting consequences, criminalization and prosecution alone may lead to the trauma of being taken away from one's parents or feeling responsible for parental infractions with the law. The best interest of the child needs to be front and center.
- Provide trainings for relevant practitioners, frontline law enforcement responders and other relevant government employees on safeguarding policies and procedures for FGM/C.

RECOMMENDATIONS FOR GOVERNMENT, LAW AND POLICYMAKERS

- Institute mandatory education in schools on health, including topic areas like abuse, FGM/C and mental health;
- Ensure that policies aimed at tackling FGM/C go above and beyond laws and their enforcement. Policies should address the mental health needs of FGM/C survivors and include provision for the adequate engagement and mobilization of communities;

RECOMMENDATIONS FOR DONORS

- Ensure financial resources are allocated for supporting research intended to increase understanding of how FGM/C impacts mental health;
- Fund the implementation and rigorous evaluation of programs addressing the intersection of FGM/C and mental health; and
- Create funding schemes that are more flexible, to ensure longer-term sustainable support for the integration of mental health service provision within FGM/C programs and interventions, while also ensuring sustained survivor input and community engagement.

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