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Understanding the Social Determinants of Female Genital Mutilation

The contested practice of female genital mutilation (FGM) is rooted in several social and cultural norms and prevalent in more than 30 countries across the world. This article aims to illustrate FGM's geographical and historical prevalence, root causes, and clinical, social, and economic implications. Despite a higher prevalence in countries in Africa, the Middle East, and Asia, FGM is also practiced in the U.S., U.K., Australia, and Canada. With substantial regional variability in prevalence, a girl's or woman's place of residence, education level, and wealth status significantly shape their personal FGM experiences. In applying a human rights lens to FGM, there is a strong case for eradicating its practice. Progress towards a world free of FGM will require tailored and data-centred policy solutions, contextualized to each FGM-practicing community.

Keywords: Female genital mutilation, social determinants of health, policy, human rights

The interconnectedness of the 21st century allows us to remain informed of the global events, circumstances, and decisions shaping our world. As human rights violations—including genocides, torture, and arbitrary arrests—are publicly reported, we can collectively mobilize against these injustices. One contested practice is female genital mutilation (FGM). A social determinants of health lens allows us to understand FGM in its wider social, economic, and cultural conditions—extending beyond the mere biomedical and symptomatic presentation. Despite efforts from international organizations and governments to abolish its practice, FGM continues to persist today. Factors such as a girl's (or her parents') socioeconomic status, level of education, and access to quality health care inextricably affect the FGM experience. I argue that, when examining FGM in its social, environmental, and cultural context, it becomes clear that this global health issue requires holistic and empowering solutions in order to improve health equity for girls and women.

This article has two main sections. The first section applies a multidisciplinary lens to FGM, illustrating its geographical and historical prevalence, root causes, and

clinical, social, and economic implications. It also highlights the course in which a girl's or woman's place of residence, education level, and wealth status situate their personal FGM experiences. The second section examines FGM as a human rights issue and features select policy and community-based interventions around the world.

UNDERSTANDING FEMALE GENITAL MUTILATION

Mapping the Prevalence of FGM

Over 200 million women today have undergone some form of FGM (Unicef, 2020). The practice appears to be concentrated in western, eastern, and north-eastern regions of Africa and in some countries of the Middle East and Asia (see figure 1). According to Unicef, the countries of Djibouti, Guinea, and Somalia report some of the highest rates of girls and women 15–49 years of age having undergone FGM (94%, 95%, and 98%, respectively).[1] However, it is important to emphasize that FGM is practiced globally and not only limited to regions in Africa and/or Asia.

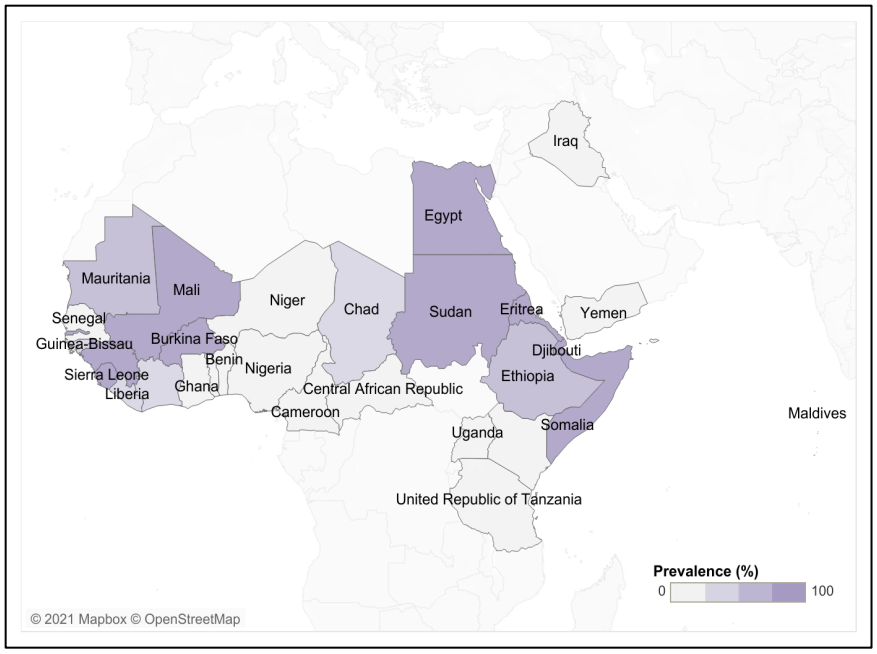
Outside of Africa and Asia, cases of FGM are reappearing in North America and Europe. Until the 1950s, *clitoridectomies* (a form of FGM where the clitoris is surgically removed or reduced) were performed medically, both in the United States and in Europe. Take, for example, Victorian England, where these procedures were used to "cure" middle-class girls and women of so-called non-feminine behaviour in the mid-20th century (Green, 2005). Fast forward to the mid 1900s, when clitoridectomies were used until the 21st century to "treat" intersex infants and children with ''ambiguous genitalia'' (Green, 2005). Today, FGM prevalence in North America, Europe, and Australia is driven in large by migrant populations who practice or have undergone the procedures themselves. Although the exact prevalence of FGM remains unknown due to the lack of routine data collection, recent estimates suggest that 137,000 women and girls have undergone FGM in the U.K., while 507,000 others are at risk in the U.S. (Goldberg et al., 2016; Macfarlane & Dorkenoo, 2015). Monitoring the global incidence and prevalence of FGM cases is crucial to understanding the trends shaping its uptake and prioritizing populations that may benefit from targeted interventions.

Despite considerable improvements in survey design and statistical analysis, data analysis tools are only as good as the quality of data collected; eradicating FGM is hindered by poor quality and inconsistent data collection. In low- and middle-income countries, there are limited resources for governments and health systems to routinely collect data and conduct sound epidemiological surveillance. On the contrary, high-income countries with the resources and infrastructure to securely collect medical data may rank FGM lower on the public health agenda (given lower estimated prevalence of FGM as compared to other diseases). Additionally, the definitions for what constitutes FGM vary across the globe, thus making it difficult to

[1] Available data for Somalia was updated in 2006.

compare and to track detailed progress. But, in all cases for girls and women, reporting FGM is sensitive and progress may be undermined by substantial under-reporting (Reisel & Creighton, 2015). Victims of FGM may believe that parents who subjected them to the procedure have done it out of love and care, irrespective of how harmful the procedure may be. Ensuring FGM-practising communities are well-resourced and well-positioned to collect high-quality data will help us untap the potential of data-centred decision-making.

Figure 1. Map of FGM Prevalence



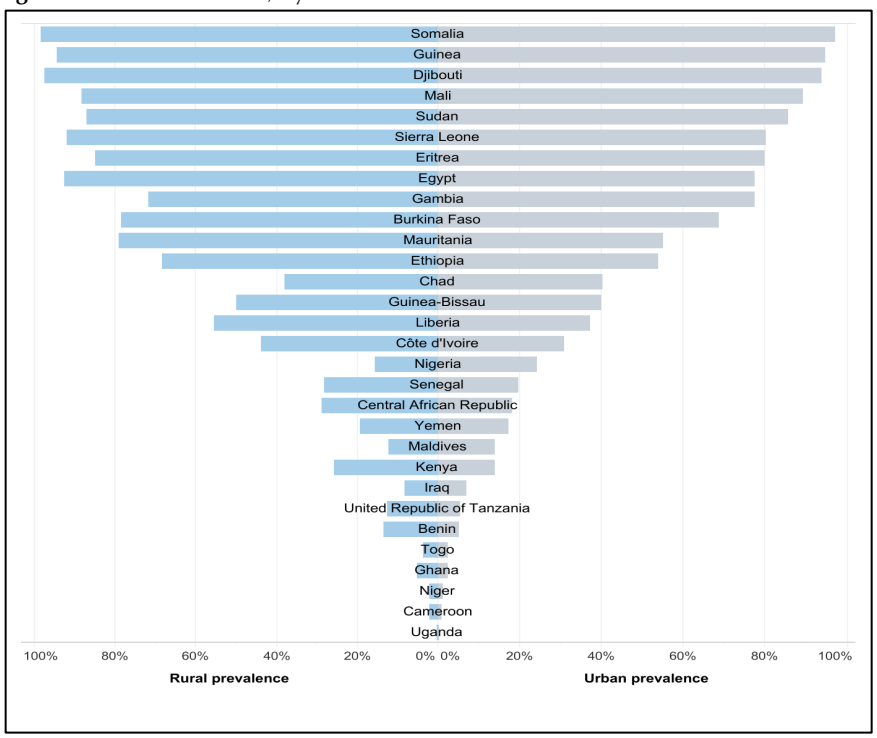
Note. Prevalence captures the percentage of girls and women 15–49 who have undergone FGM in countries for which data is available. Figure generated by author with open-access data provided by Unicef.

Factors Shaping the FGM Experience for Girls and Women

Place of residence is one of many factors that play a critical role in shaping the FGM experience for girls and women. By way of illustration, Unicef data indicates that rural areas in Africa, the Middle East, and Asia often have higher prevalence rates of FGM. Nineteen out of the 30 countries for which data was reported saw a higher prevalence of girls and women 15–49 who have undergone FGM in rural areas, as compared to urban areas (see figure 2). For example, in Ethiopia, the FGM prevalence is 14% higher in rural areas than in urban areas. One study found that women in rural Ethiopia were more likely to favour continuing FGM than those residing in urban areas (Masho & Matthews, 2009). The higher rural prevalence could be

attributed to the isolation of communities in rural settings, with limited exposure to the non-traditional practices and values found in urban centres (Masho & Matthews, 2009). In contrast, some countries do show the opposite trend in regional prevalence, where the prevalence of FGM is lower in rural areas than in urban. For example, Nigeria's urban prevalence is 18% higher than its rural prevalence. However, there are reports that, in recent years, this appears to be changing, and more than 20% of daughters aged 14 and under living in urban areas have experienced FGM, compared to 29% of those living in rural areas (*28 Too Many*, n.d.). The rural and urban migration patterns in sub-Saharan Africa provide insight into the variation in regional FGM prevalence (Ahinkorah et al., 2020; Temin et al., 2013). In particular, rural to urban migration is high in many countries. Yet not all women who migrate to urban regions remain there; some return to their rural communities with potentially "unfilled expectations and aspirations" (Ahinkorah et al., 2020). These short moves to urban regions may expose women to a more diverse range of ideas and opinions about harmful practices, often different from traditional perceptions in their rural homes (Mackie, 1996; Shell-Duncan & Hernlund, 2001). For meaningful impact on eradicating FGM, a woman's place of residence, along with other determinants, can help us design solutions that address the root determinants.

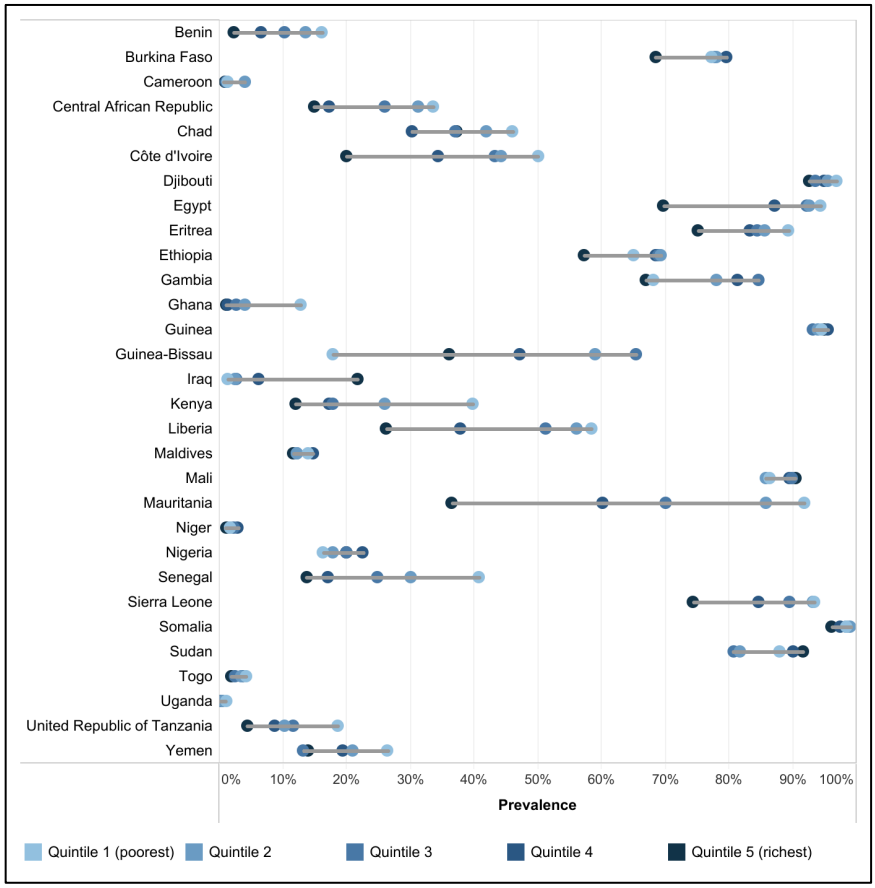
Figure 2. FGM Prevalence, by Rural and Urban Areas



Note. Prevalence captures the percentage of girls and women 15–49 who have undergone female genital mutilation in countries for which data is available. Figure generated by author with open-access data provided by Unicef.

Together with a girl's or woman's place of residence, wealth, and education level are two additional influences on the FGM experience. Twenty-four out of the 30 countries represented in the Unicef database showed a higher prevalence of girls and women 15–49 who have undergone FGM in the wealthiest 20% of the population as compared to the poorest (see figure 3).

Figure 3. FGM Prevalence, by Wealth Quintiles



Note. Prevalence captures the percentage of girls and women 15–49 who have undergone FGM in countries for which data is available. Figure generated by author with open-access data provided by Unicef.

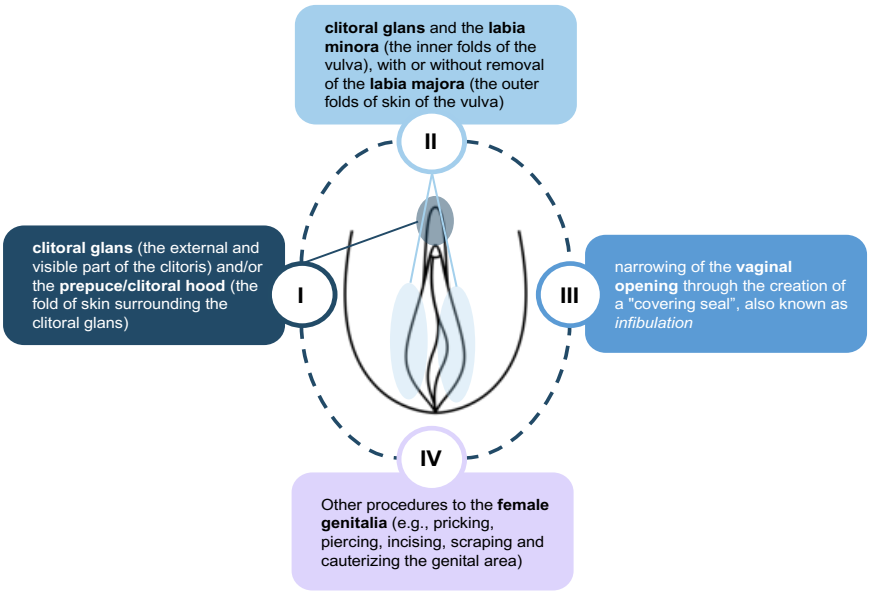
In sub-Saharan Africa, women in the richest wealth quintile and their daughters are less likely to undergo FGM compared to those in the poorest wealth quintile

(Ahinkorah et al., 2020). Women in wealthier households have strong decision-making power, particularly on practices such as FGM (Setegn et al., 2016). The odds of women and their daughters undergoing FGM decrease with increasing levels of education and wealth—two significant protective factors (Ahinkorah et al., 2020). Moreover, fathers also influence the likelihood of their daughters' undergoing FGM. A study of FGM practices in Egypt found that a father's education and area of residence appear to be the most significant factors influencing FGM (Dandash et al., 2001). The same study showed that paternal illiteracy and rural residence were the factors most responsible for the continuation of FGM in Egypt (Dandash et al., 2001). Place of residence, wealth, and education are three of the many social determinants affecting the FGM experience for girls and women—echoing the need for multi-faceted and data-driven policy solutions.

Clinical, Social, and Economic Impacts of a Medically Unnecessary Procedure

There are myriad clinical, social, and economic consequences stemming from the practice of FGM, effectively building the case for its abolishment. Clinically, FGM is any procedure that "involves partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons" (World Health Organization, n.d.). There are four different types of FGM procedures, loosely categorized based on the specific area of the female genitalia that is cut (see figure 4). The global medical community unanimously agrees that FGM provides no health benefits for the girls and women undergoing it, and results only in immediate, medium-term, and long-term harm (see table 1).

Figure 4. Four Types of Female Genital Mutilation Procedures



Note. Four types of procedures include Type I (mutilation of the clitoral glans), Type II (mutilation of the clitorial glans and labia minora), Type III (narrowing of vaginal opening), and Type VI (other procedures to the genitalia). Figure designed by author with data provided by WHO (n.d.) and open-source image.

Table 1. Complications from FGM/Cutting

	PHYSICAL	PSYCHOLOGICAL
Immediate complications	• Severe pain • Excessive bleeding (hemorrhage) • Fever • Wound healing problems, swelling, and infections e.g., tetanus • Urinary problems • Injury to surrounding genital tissue • Death • Shock	• Depression • Anxiety • Post-traumatic stress disorder • Low self-esteem • Societal stigma • Sexual problems (e.g., decreased satisfaction)
Long-term complications	• Urinary problems (e.g., painful urination, urinary tract infections) • Vaginal problems (e.g., discharge, itching) • Menstrual problems (e.g., painful menstruations, difficulty in passing menstrual blood, etc.) • Sexual problems (e.g., pain during intercourse)	

Note. Table designed by author with data provided by the World Health Organization (n.d.).

Generally, more invasive mutilations present a higher risk of serious complications. According to a systematic review of 22,052 patients in African countries, a majority had undergone a Type II procedure. The highest number of infections was identified among those who underwent a Type III procedure and included urinary tract infections, genitourinary tract infections, abscess formation, septicemia, and HIV (Iavazzo et al., 2013). Despite the slow but steady decline of FGM in some regions, the high rate of a Type III procedure is worrisome as these cases result in more complications than other types. One econometric study, which

included 22 sub-Saharan African and Middle Eastern countries, estimates the prevalence of all types of FGM fell significantly between 1965 and 2000 (Koski & Heymann, 2017). However, the prevalence of all women who report that their genitals were sewn (infibulation, Type III) has increased in Mali (from 6% to 15%) and in Sierra Leone (from 6% to 8%) (Koski & Heymann, 2017). The different types of FGM procedures and the range in severity of subsequent complications on individual girls and women point to the breadth and specialization of supports victims may require for a lifetime.

The clinical complications experienced by individual girls and women amount to a significant economic burden. The economic cost is not limited to the FGM procedure alone, but includes the treatment of all resulting medical complications. One estimate suggests that the total cost of complications could reach as much as 1% annually of total government expenditures for women of reproductive age (Adam et al., 2010). The World Health Organization (WHO) estimates that treating the health complications from FGM procedures in the 27 countries of Africa, Middle East, and Asia where data were available amounted to $1.4 billion in 2018. Given that governments in resource-constrained countries have many competing priorities, targeting FGM practices could relieve the pressures placed on public health care systems and on the economy.

The Role of the Wider Community

The decision-making process varies from region to region and generally involves members of the immediate and/or extended family (Alradie-Mohamed et al., 2020). When there is conflict, each family member has a different degree of power and influence over the final decision (Alradie-Mohamed et al., 2020). Fathers, mothers, and grandmothers are the main decision-makers and open dialogue regarding FGM between both genders may free mothers from the social pressure and responsibility of maintaining tradition (Alradie-Mohamed et al., 2020). For example, in the Somali and Harari societies of Eastern Ethiopia, mothers are the main decision-makers, followed by grandmothers, and, to a lesser extent, fathers (Bogale et al., 2014). The same study in Ethiopia also reported that 5% of the girls in the sample made the decision to undergo FGM themselves (Bogale et al., 2014).

The wider community—including traditional community leaders and medical professionals—directly enables FGM through their respective roles. In many communities, FGM is performed by older women at the homes of the girls and women undergoing the procedure. These "traditional cutters" in the home setting may make use of blades, unsterilized kitchen knives, scissors, glass, sharpened rocks, or even fingernails (Odukogbe et al., 2017). In some cases, barbers are solicited for their precise blade-handling skills. Those who perform the ceremonial cut may accept compensation through money or gifts, while others see it as public service to the community. The community conditions where FGM is performed are generally

unhygienic, and there is limited use of anesthesia to numb the pain. For example, a 2007 report published in *The Lancet* relates that the same unsterilized cutting instrument was used on up to 30 females (Wakabi, 2007). In some regions, health-care professionals also perform FGM, motivated by the fact that the medical setting will prove to be safer for patients; however, health-care professionals could also be enticed by the remuneration they receive from the girls' families (Serour, 2013). This "medicalization" of FGM is widely controversial, with some arguing that medicalization normalizes the behaviour and others, that it prevents the pain and complications from what would otherwise be unhygienic procedures in the community. Given the role that the broader community plays in perpetuating FGM, solutions for changing attitudes must be geared to the entire community, and not only to individual girls and women.

Social, Cultural, and Religious Reasons Behind FGM

As a practice, FGM is the product of several deeply rooted cultural, religious, and social beliefs, with cutting being only one aspect of a girl's socialization. Sociocultural influences continue to vary and evolve regionally. In some regions, FGM is associated with cultural ideals of modesty and femininity (Gruenbaum, 2005). It is common for these societies to preserve unequal gender relationships, believing that the sexuality of women must be controlled. With the desire to exert control over women's sexuality, FGM is seen as necessary to dull libidos and ensure extramarital sex is circumvented (Gruenbaum, 2005). Infibulation (i.e., sewing the genitals shut), in particular, is defended in this context and serves as proof of virginity. In other regions, FGM is held to be essential in raising a girl and preparing her for adulthood and marriage (World Health Organization, n.d.). In these societies, a girl's social acceptance and survival depends on successful marriage and childbearing. Although FGM can cause severe medical complications, forgoing the practice could exclude girls from participating meaningfully in their societies. Many of the social and cultural beliefs promoting FGM are based on myth or misinformation, as the intended results are rarely achieved. For example, in investigating the relationship between FGM and women's sexual behaviour, a study of 23,628 women across Kenya and Nigeria found no correlation between FGM and any particular sexual behaviour outcome (Mpofu et al., 2017). Specifically, female circumcision was not significantly related to the age at which women first engaged in sexual activity or to the number of their lifetime sexual partners (Mpofu et al., 2017). The contentious nature of FGM—where, on one hand, the procedure is medically harmful but, on the other, it is an important rite of passage—requires solutions rooted in cultural sensitivity, empathy, and understanding.

FGM has existed in almost all known civilisations throughout history and is not confined to any one culture or religion; its origins predate Christianity and Islam (Serour, 2013). It is practiced by people from various religions, including Christianity,

Islam, and a minority group of Ethiopian Jews (El-Damanhoury, 2013). Within Islam, the opinions of religious scholars are divided about the practice. For example, the use of the Islamic term *Sunna circumcision* is described by some Islamic scholars as a form of deceit, in that it gives the misguided impression that FGM is one of the common Islamic practices like profession of faith, prayer, fasting, and pilgrimage (MET, n.d.; Serour, 2013). Furthermore, it is important to note that FGM is not mentioned in the Jewish Torah or in the Christian Gospels (El-Damanhoury, 2013). Given the role that religion has in shaping the attitudes and beliefs surrounding FGM, solutions should involve a diverse range of religious leaders.

For all the social and religious influences in the community that perpetuate FGM, there are equally protective community factors that discourage the practice as well. For example, when FGM's dangerous health consequences are promoted as undesirable or when religious leaders address the misconceptions of FGM as a religious requirement, girls and women may be less pressured into or even dissuaded from engaging in the practice. Nigeria has achieved mixed results in addressing these socio-cultural norms, and therefore that country's persistently high prevalence rates account for 10% of the global prevalence rate (*28 Too Many*, n.d.). The mixed nature of the results makes it explicit that interventions cannot thrive without involving community-leaders, medical practitioners, and religious leaders.

FGM as a Human Rights Issue: A Spotlight on Policy Solutions

Because the procedures can be a torturous experience resulting in severe health complications or death, FGM violates several articles of the United Nations' Declaration of Human Rights (Universal Declaration of Human Rights, 1948). There is a clear violation of Articles 03, 05, and 25—the right to life; the right to freedom from torture, cruel, inhuman, and degrading treatment or punishment; and the right to the highest attainable standard of health. Progress on addressing FGM in the global community is structured around policy interventions, which could be in the form of targeted programs, large-scale initiatives, and legislation.

Policy and Community-Based Interventions

Policy interventions for FGM can target a change in knowledge, attitudes, and beliefs, and be directed towards different actors—girls and women, caregivers and parents, healthcare professionals, and community leaders. Interventions may include training health personnel, educating female students, conducting multi-faceted community activities, and village empowerment. For example, one community-based, village-empowerment intervention provided education to community members in Senegal on hygiene, problem-solving, women's health, and human rights (Diop & Askew, 2009). The prevalence of FGM amongst the daughters of the women who participated decreased in the villages where this intervention was

implemented, but not in neighbouring villages. This decrease provides a clear indication of the positive effect of the community-based initiative.

In North America and Europe, preventative activities include legislative action, health persuasion, fostering engagement with the local community through outreach and the involvement of community champions, and training health-care professionals (Njue et al., 2019). In the U.K., Europe, and Canada, interventions seek primarily to increase individual, professional, and community awareness and understanding of FGM as a human rights issue, as well as the negative impact of FGM on health outcomes (Njue et al., 2019). In Winnipeg, Canada, one successful initiative involved a targeted awareness campaign whereby migrant women from select communities were given translated information pamphlets and community service providers were trained through specialized workshops (Daniel et al., 2013). Community-level programs and initiatives are essential to strategically tailor solutions to different contexts.

In addition to community-based interventions and programs, legislation shows some potential benefit in addressing FGM. Because FGM fosters inequality between genders and promotes discrimination against women, its continued practice violates several global commitments. In adapting a rights-based approach to this contested issue, many states around the world have banned the practice through national or regional legislation. Of the 29 African countries with a high prevalence of FGM, 25 have laws prohibiting the practice (Center for Reproductive Rights, 2008). Among those, practitioners and parents procuring services could face penalties that range from monetary fines to life in prison (Center for Reproductive Rights, 2008). However, enforcing legislation is a great challenge because of the sensitive position in which FGM victims are placed—reporting the crime would mean implicating their own parents.

FGM has been illegal in the U.K. since 1985, since 1996 in the U.S., and since 1997 in Canada, but court hearings shed light on how FGM can take place when girls or women travel abroad or in physicians' offices in their home countries (Packer et al., 2015). For example, the U.K. used its FGM law in 2015 to review the case of a doctor who was accused of performing the procedure on a woman in the U.K., at the request of her husband, after she had given birth (BBC News, 2015). Similarly, in 2009, a Danish case resulted in a two-year sentence for a mother who allowed her daughters to be subjected to FGM during a stay in Sudan (Packer et al., 2015). Well-designed and enforced legislation and grass-roots community-level programs and initiatives are part of the solution to combat FGM.

CONCLUSION

FGM is a human rights issue with intricately linked social determinants that shape its continued practice. Embedding the practice in the wider social determinants serves a useful purpose in designing and delivering tailored and targeted policy

interventions. There is seldom a one-size-fits-all approach, but interventions will benefit from data-centred approaches. Rooting policy solutions in social and religious factors and engaging community leaders, religious leaders, and medical practitioners will enable progress on the path to eradicating FGM.

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