ISPN Position Statement on the practice of Female Genital Mutilation [FGM]: Implications for health and Psychiatric Mental Health Nursing

V. Hines-Martin PhD RN FAAN
J.F. Echeozo MSN
P. Killian MSN PMHNP

The World Health Organization (WHO) defines female genital mutilation (FGM) as comprising all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons. FGM has no health benefits, and harms girls and women in many ways.

It involves removing and damaging healthy and normal female genital tissue, and hence interferes with the natural function of girls' and women's bodies. The practice causes severe pain and has several immediate and long-term health consequences, including difficulties in childbirth also causing danger to the child. (http://www.who.int/topics/female_genital_mutilation/en/)

The procedure is predominantly practiced in Africa, Asia, Middle East countries and by immigrants in Europe, North, Central and South America

Classification

- ✓ There are four major types of FGM
  Type 1= Excision of the prepuce with or without partial clitoral excision. (clitoridectomy).
- ✓ Type 2= Total removal of the clitoris and partial or total removal of the labia minora without excision of the labia majora.
- ✓ Type 3= Narrowing of the vaginal orifice and the excision of part or all the external genitalia (infibulation).
- ✓ Type 4= This is unclassified but comprises all other harmful practice, like pricking, piercing, and incising, cauterization of the external genitalia for non medicinal purpose.

Prevalence, Historical and cultural background

It is estimated that 100 –140 million women and girls are subjected to this practice around the world and about 2 million girls are at risk to undergo this practice each year. This practice is primarily performed on girls between the ages of 0-15 (generally 4 - 10 years), although adult females are in lesser instances targets of this practice (UNICEF, 2005). In the United States, 168,000 girls and women, mostly from Africa are at risk of having FGM. Of this number, 48,000 girls are under the age of 18 years of age (US DHHS, 1990 Census). Although this practice has been done for centuries within various cultures, a call to cease this practice began in the 1940's and received increased recognition as a human rights violation and a serious women's health threat worldwide since the 1960's (Hopkins, 1999).

The secondary role and status of women is central to the ongoing implementation of the practice. Culturally, this practice confers full social acceptability upon females and integration into their communities. As a result of this pressure on girls and their families, many girls are left in an unjust position of having to jeopardize either their right to health, bodily and psychological integrity or esteemed privilege of social acceptance. This practice may also be viewed as assurance of virginity before marriage and fidelity after marriage by suppressing sexuality. Other beliefs include the unclean nature of female genitalia or that the clitoris as a male organ that must be excised to be fully female. Other rationale includes the identification of religious tenets as the

foundation of the practice. Although all these reasons have been sufficiently and successfully argued against, the custom continues to be perpetuated. Therefore, the social and societal pressures to continue the practice are strong in both native and immigrant community settings.

Legal and Public Health Policy

Increasingly FGM has been outlawed in many Islamic and African countries as well as all of Europe and the United States. The World Health Organization and other human rights and women's health organizations have identified that in the context of international human rights, FGM is a physical, moral and psychological assault on the female child that can have life long consequences. Individual European governments and the European Union address FGM and direct member countries to take specific action to prevent FGM. The U.S. has specific federal legislation prohibiting FGM with or without consent. However, legislation and policy are only two of the factors that influence eradication of this practice. To be effective, law and policy must be aligned with education, counseling, socioeconomic and attitudinal change. Research and intervention in these critical areas are vital (Hopkins, 1999).

Physical Health Consequences of FGM

It has been well documented that FGM holds significant negative sequelae which vary according to type. These include acute problems such as pain, hemorrhage, and infection. Long term problems include lack of sexual sensation, extended micturation (15-20 minute duration), obstructive uropathy (which may result in hydronephrosis), barriers to menstruation, endometriosis, painful intercourse or inability to have intercourse, increased risk of maternal mortality, adverse obstetric and perinatal outcomes including an increase in perinatal deaths (Epstein, Graham & Rimsza, 2001; WHO, 2006; WHO, 2008; Ball, 2008).

Psychological/Mental Health Consequences of FGM

Although most emphasis has been placed on the physical outcomes of FGM, there must also be consideration of the mental health consequences across the life span. As with other acute traumatic sexual events, feelings of powerlessness, fear, submission, inhibition and suppression of feelings and cognition are experienced. Because FGM occurs during childhood, the magnitude of emotional pain endured results in loss of confidence and trust in family that can affect the child-parent relationship and has implications for later intimate relationships between the now-adult victim and her own children and partner. Victims of this practice may idealize the practice because of social norms (Nwajei &Otiono, 2003) and have a significant incidence of being perpetrators themselves. Women may feel powerless against the societal norm and therefore consent to FGM of their female children. Both outcomes support transgenerational continuation of the practice (WHO, 1996).

The research of Berhrendt & Moritz, (2005), Abor (2006) and others have begun to identify some of the negative mental health outcomes of this practice which include significantly higher rates of post traumatic stress disorder (PTSD), affective disorders, anxiety, memory loss and dissociation. Much more research is needed in this area to articulate the largely unexplored mental health consequences of FGM.

ISPN Position on FGM

The International Society of Psychiatric Mental Health Nurses supports WHO, UNICEF, and ICN and others in their united efforts to end the practice of FGM. ISPN also recognizes that psychiatric mental health nurses, through our specialty and other nursing organizations, must develop culturally informed, research-based educational programs on FGM for mental health nurses, nursing students and other health care professionals. Because of our specialty and expertise, the emphasis of ISPN emphasis must be on understanding the mental health dynamics,

interpersonal communication needs, self esteem and empowerment issues that are relevant to women and female children who are at risk or have experienced FGM. Our expertise must also focus on the public, decision makers, religious leaders and other appropriate community groups to increase understanding of this issue and develop strategies that are culturally appropriate and supportive of change.

Recommendations:

As members of ISPN, we can act individually, as an organization and with other organizations to support action in the following areas:

- Promote routine assessment of women and children at higher risk for FGM;
- Facilitate the development and use of therapeutic interventions that assist families affected by or at risk for FGM
- Promote professional education and intervention using FGM laws and research as foundations for evidence based practice; and
- Advocate against, prevent and ultimately eliminate FGM through strategic alliances and planned action.

ISPN has a critical role to play in stressing the importance of body *and* mind, in promoting public and professional awareness of the psychological toll of FGM and in supporting action on behalf of girls and women in order to end the practice of FGM.

References

Abor, PA . (2006). Female Genital Mutilation: Psychological and reproductive health consequences Gender and Behaviour, 2006 Jun;4(1):659-684.

Ball, T. (2008) Female genital mutilation. Nursing Standard, 23(5),43-47.

Behrendt. A., & Moritz. S., (2005) Posttraumatic Stress Disorder and memory problems after female genitalia mutilation. The American Psychiatry 162: 1000-1002

_____Briefing Paper: Legislation on female genital mutilation in the United States. Center for reproductive rights.

Epstein, D., Graham, P. & Rimsza, M. (2001). Medical complications of female genital mutilation. Journal of American College Health, 49(6), 275-280.

Hopkins, S. (1999). A discussion of the legal aspects of female genital mutilation. Journal of Advanced Nursing, 30(4), 926-933.

Nwajei, S.D., & Otiono, A.I. (2003) Female genital mutilation: Implications for female sexuality. Women's Studies International Forum, 26(6), 575-580.

UNICEF (2008) Female genitalia mutilation/cutting: A statistical exploration. Retrieved from http://www.reproductive rights .org 5/10/08

US department of health and human services, 1990 census report. Retrieved from http://www.state.gov on 5/10/08

World Health Organization (1996) Female Genital Mutilation: Report of WHO technical working group-10. Geneva.

World Health Organization Study Group on Female Genital mutilation on Obstetric Outcomes (2006). Female genital mutilation and obstetric outcomes: WHO collaborative prospective. The Lancet, 367, 9525, 1835-1841.

World Health Organization (2008) Eliminating Female Genital

mutilation: An interagency statement UNAIDS, UNDP, UNECA, UNESCO, UNFPA, UNHCHR, UNHCR, UNICEF, UNIFEM, WHO. Geneva.

World Health Organization (2008). Female genital mutilation fact sheet number 242. Retrieved from http://www.who.int/mediacentre/factsheet/fs241/en/ accessed September 2008.