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International Journal of Nursing and Health Care Science

Review Article

McDaniel AT, et al. J Int J Nurs & Healt Car Scie 11: 2022-161

Ethical Considerations: A Discussion of Female Circumcisions & Mutilation. Should the Global Health Community Implement Culturally Sensitive Intervention Strategies?

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Submission Date: 30 October, 2022

Accepted Date: 16 November, 2022

Published Online: 21 November, 2022

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How to cite this article: McDaniel AT, Errante C, Berni A, et al. (2022) Ethical Considerations: A Discussion of Female Circumcisions & Mutilation. Should The Global Health Community Implement Culturally Sensitive Intervention Strategies? Int J Nurs & Healt Car Scie 02(12): 2022-161.

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Abstract

Female genital circumcision, otherwise known as, genital mutilation or cutting, (FGM) refers to a procedure involving the total or partial removal of or injury to female external genitalia. There are three basic types of FGM. Type I is a partial or total removal of the clitoris. Type II is the partial or total removal of the clitoris and labia minora only. Type III is a procedure known as infibulation, and is the bringing together of the labia minora or majora narrowing the vaginal orifice. Often times this can create a seal and is usually accompanied by the removal of the clitoris. The practice of FGM has several cultural reasons as to why it remains in practice. Such as, preparing for adulthood, premarital virginity, or religious. Furthermore, cultural and societal norms which are deeply rooted in religious practice tend to remain set within a society for long-periods of time and are difficult to shift. A shift in cultural norms begin at the micro level of society gaining momentum slowly until change reaches a macro level and occurs within governmental organizations. The purpose of this manuscript is to review the current and historical literature surrounding the ethical considerations of FGM and how this cultural phenomenon may shift as globalization increases.

Keywords: Circumcisions; Female cutting; Gender norms

Introduction

Female genital circumcision, otherwise known as, genital mutilation or cutting, (FGM) refers to a procedure involving the total or partial removal of or injury to female external genitalia for non-medical reasons [1]. There are three basic types of FGM with a fourth type rarely occurring today. Type I is a partial or total removal of the clitoris. Type II is the partial or total removal of the clitoris and labia minora only. Type III is a procedure known as infibulation, and is the bringing together of the labia minora or majora narrowing the vaginal orifice [1]. Often times this can create a seal and is usually accompanied by the removal of the clitoris. Type IV can be a combination of any other types along with other non-medical harmful procedures, such as pricking, piercing, incising, scraping, or cauterization; nevertheless this form does not often occur on a wide scale [1]. In more extreme forms of FGM, women may experience complications with childbirth and even mortality [2]. It is unclear as to the exact number of FGM that occur yearly, however the World Health Organization estimates the total number to be more than 200 million females worldwide [3]. Currently, there have been 30 countries across the globe that have documented FGM. The majority of countries where FGM is still in practice are in Africa and the Middle East [3]. There are some countries in Asia that practice the technique as well, -mostly throughout Indonesia, yet in some Polynesian islands as well. In countries such as Somalia, Guinea, and Djibouti the practice is widely accepted and occurs in approximately 90 percent of the women there [1,3]. It should be noted however, that the prevalence has decreased some due to international laws and increased public awareness. Nevertheless the practice continues throughout many countries and even within regional pockets of Europe, North America, and Australia. This is mostly attributed to migrants from nations where the practice continues [1].

Discussion

Identified Ethical Concepts & Cultural Influence

FGM is considered to be a human rights issue and is condemned through the implementation of several international treaties. Furthermore, many countries have adopted national legislation against the practice of FGM making it illegal [1]. However, aside from declarations and legislation concerning the rights of women and female children what are the underlying ethical concepts, and do they provide enough basis to suggest FGM to be an immoral act against humanity itself?

Before exploring ethical concepts we should first examine why the practice occurs. A common misconception is that the practice occurs as the result of the observance of certain religious requirements. Most often FGM is associated with the Muslim faith. However, FGM is not a specific requirement of the Muslim faith. Circumcision is not mentioned in the Quran per se, however it is a part of the fitrah, which are a set of five cleanliness rules. (Sunan An-Nasai Chapter No: 1, Hadith no: 11) There, it is stated along with shaving, trimming the moustache, cutting the nails and plucking the armpit hairs, whether circumcision is a mandatory law for Muslim men and women. The religious relationship and question of requirement for circumcision is beyond the scope of this report. Nevertheless, it should be noted that many parents and families utilize FGM as a promotion of good faith towards their religion [4-6]. Most often however, FGM is conducted as a means to subjugate female sexuality and force a type of social control. Furthermore, FGM is often seen as a means to preserve the females' virginity and family honor occurring prior to marriage [4-6]. In some cultures, FGM is a form of preparing girls for adulthood; as they begin to become fertile, the families want to ensure premarital virginity [5]. FGM can occur either as an infant or up to adulthood dependent on the cultural norms of said population. Examining cultural influences more closely, Cook [6], has identified some population groups that have prevailed in the practice of FGM through the implementation of type I signifying the purification of the young women.

This practice is essential for the women to marry within this culture, and as Cook [6]. states "...in a society where there is little economic viability for women outside marriage, ensuring that a daughter undergoes genital mutilation as a child or teenager is a loving act to make certain of her marriageability." These cultural concepts are important to understand as they are the basis of arguments for the population groups who continue to practice FGM. The question then is: do these concepts out-weigh basic human rights and modern bioethical duties charged to health care providers? There are two fundamental ethical concepts regarding this that will be discussed and dissected: First the harm-based argument, as defined by the World Health Organization, "...any kind of medically unnecessary, non-consensual alteration of the female genitalia-no matter how minor the incision, no matter what type of tissue is or is not removed, no matter how slim the degree of risk, and no matter how sterile the equipment used - is by definition an impermissible mutilation." [7]. The ethical concern for the harm-based argument is not difficult to discern if utilizing the World Health Organization's definition. Any complications or harmful effects that are due to the FGM intervention that does not have a medical purpose can thus be deemed as morally wrong. Common complications of infibulation or FGM can include chronic pelvic infections, chronic inflammation, excessive scar tissue, gross disfigurement, cysts, and complications with future pregnancies [6]. Thus, the harm-based argument for FGM in non-medical cases identifies a clear ethical concern regarding females and humanity. One may argue that this ethical interpretation can result in disrespect of the cultural norms practiced by a given population group. Nevertheless, there is no denying the lack of 'respect for autonomy' if the procedure is done without consent of the individual - notwithstanding the physical and emotional damage the procedure may cause in the immediate and long-term future of the person's life. The harmful effects experienced are often due to the type of FGM conducted and at what stage of life they occur. Furthermore, from a health care provider's perspective the duty to 'do no harm' is in question and the fundamental ethical principle of non-maleficence is at risk if the person conducting the FGM is a health care professional. This is especially the case for FGM procedures that have no medical basis and are solely conducted due to a cultural phenomenon.

FGM, like other social problems, can be viewed from a social constructionist perspective in sociology [8]. It can become morally unacceptable by the process of claims-making; those who have the ability to make claims that a certain issue is morally unacceptable. To better understand this concept, it is important to know what a social problem is. Social problems must negatively impact many people and be defined as such by society, otherwise known as an objective nature. These social definitions are contingent on time, place, and power. FGM ultimately came to be defined as a social problem through a series of societal constructs. More specifically, governmental and non-governmental groups defining it as morally unacceptable, the claims-makers. Mass media defining it as a social problem. Further, it has evolved into a social problem globally through Andreas and Nadelmann's classic model on the prohibition of a social problem [8]. Refer to (Figure 1) for a flow chart described the above model.

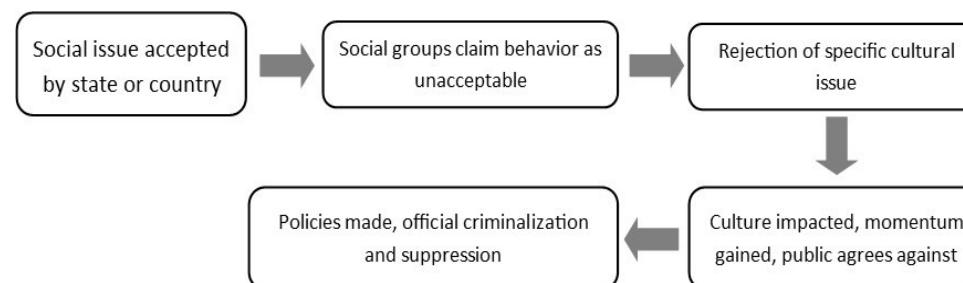


Figure 1: Andreas and Nadelmann's Classic Model on Prohibition of Social Problems.

The social constructionist perspective ties in well with the idea of where our definitions for social norms come from. The social constructionist perspective within the sociological study of social problems could also help to illustrate the need for education [8]. Expanding on the education piece, the policy section to influence major stakeholders of FGM decision making, could follow the above model of social change to potentially illicit a societal change within cultures who view FGM as an appropriate cultural practice. Nevertheless, this would lend to a subsequent ethical dilemma of whether it is ethically acceptable to knowingly attempt to change a cultural or societal acceptance based on another culture or society's opinion on said practice, such as FGM.

An example of the above model in real world practice was highlighted by Choudhary, et al. [9], where the authors identified a series of articles and official statements from 47 organizations across North America, Europe, Australia/New Zealand and other international organizations. The official statements from organization were primarily from physicians, nursing and allied health groups. Of the official statements reviewed, 51% of them had direct statements or recommended practices regarding FGM. The primary message delivered was for healthcare organizations throughout the world to take a clear public stance on FGM, developing clear guidelines specific to their practice for more uniform treatment and response because of health care provider's unique position to often interact directly with patients who have experienced FGM [9]. For example, providers should understand FGM may be more value-laden and make women feel ostracized, choosing language such as FGC may be important in some contexts.

Cultural Norms vs. Ethical Principles

The second ethical concept may hold more weight against the sustainment of cultural norms argument as it is rooted in sociological ethics. As stated earlier, FGM is often conducted to purify a woman and ensure her virginity, and maintain respect and family honor within a community. In addition, a goal of FGM is to reduce a female's drive for sexual satisfaction. These cultural concepts have deeply rooted beliefs in the lower class status of women and the role of the female within society [7]. Thus, the continued practice of FGM would not only undermine the role of women in society it will also help to ensure that females remain lower than males from a moral standpoint. As an aside, this argument is specifically addressing infibulation or full circumcision with the intention of male dominance and sexual control that is associated with the Muslim cultures of north-east Africa [7]. It should also be noted this argument does not necessarily hold true for all cultures who practice FGM, especially those that are not in a male dominance society and the FGM is often times willingly accepted by the females [7]. For instance in Kono of Sierra Leone, both male and female circumcisions occur as a status of reaching adulthood and is not a result of feminine chastity, virginity or a women's sexual fidelity [7]. In these cases the procedure technique is either Type I or type II and usually does not result in long-term impairments or harm. In these cultures the circumcision is welcome and consented by the person receiving it [7].

Interestingly enough, some countries, specifically in Africa, are split as to the societal or cultural wishes to continue or discontinue FGM within their country. In Kenya, a study was conducted attempting to determine the attitude of women towards discontinuation of FGM [10]. The authors' surveyed 2284 circumcised women, 68% wanted to discontinue FGM. However, in the North-Eastern province 92.5% of the women wished to continue FGM. Of the total participant count, 13% of the mothers planned to circumcise their daughters as it represented a coming of age for their culture [10]. The data derived by the authors indicates a potential shift within the culture towards a general decline in prevalence of FGM. Nevertheless, cultural norms and societal dynamics such as constraints of marriage markets may maintain said cultural practices. In these cases, practicing against a cultural norm may be difficult and can often result in said cultural practice without question, even when it involves harm. The idea is often times referred to as a "Belief Trap" [2]. Type III or IV FGM, otherwise known as infibulation is practiced in Nigeria, and often occurs due to a belief that if the baby's head touches the clitoris during delivery, there is a high potential of infant mortality [2]. Thus, due to the fear of infant mortality, individuals within these societies do not question the belief of FGM as a cultural practice [2].

This creates an ethical dilemma among western societies. Should FGM be deemed unethical even in the case as mentioned above, or perhaps, as with many health care related ethical dilemmas should the facts of each case be dissected and understood so that an accurate moral conclusion may be drawn? It is important to note, in the case of non-therapeutic genital alterations performed on non-consenting females for the purpose of social and sexual control, there is a clear unethical stance and such acts should be deemed illegal on a global stage. In other words, FGM in non-consenting children violates the human right of bodily integrity. Meaning, each person has a right to make decisions about what occurs to their own body. In health care this is termed as the 'right to autonomy' or patient preference. The ethical concept of autonomy may be a strong indicator as to what is ethically permissible and what is not. However, if the ethical principle of 'respect for autonomy' is to be implemented in the case of FGM, then so too should it be utilized for male circumcisions, even though male circumcisions is much more ethically acceptable amongst western populations.

To quote Brian Earp [7]. "Children of whatever gender should not have healthy parts of their most intimate sexual organs removed, before such a time as they can understand what is at stake in such a surgery and agree to it themselves". Of course the author of this document believes a caveat should be added, and that is; "unless said procedure is done so due to a medical issue or for future medical benefit."

Culturally Sensitive Intervention Strategies

Given the evidence of physical harm, lack of patient autonomy, and its use in subjugation of women as a social control, it is clear to these authors the global health care community should act in regard to FGM. Yet, in what manner should an intervention be implemented? What intervention strategy would serve to be both culturally sensitive and maintaining of human rights for females? The challenges facing intervention strategies lie in the root of cultural norms for FGM. Many of the advocates for this practice are among the very mothers of these girls and young women [10]. As mentioned previously, this is due to the strict traditional practices of purity and marriage demanded by their societies [11]. Furthermore, when mothers or their daughters disagree with FGM, they may continue the practice to conform to groups or cultural norms and standard [5]. Note also that the chronic conditions and pain associated with FGM have become almost a 'rite of passage' to adulthood for females within these population groups. Vissandjee, et al. [11], referenced this in a survey of FGM population women who migrated to Canada: The women were surveyed regarding their chronic pain thresholds during sex and daily activities along with an assessment of their pressure-pain thresholds that was then compared to Canadian women with vulvar chronic pathologies. The results concluded the FGM women suffered from chronic pain yet they considered it a part of their normal lives. In other words, the females knew nothing different than what they had experienced. This type of cultural norm can be problematic when attempting to provide an alternative option for change of the FGM technique or its elimination altogether.

In addition, FGM has been studied in Mali migrant women where 91.1% of women ages 15-49 have gone through FGM. Predominantly for cultural reasons such as adulthood, premarital virginity, and identity markers for group memberships [5]. Interestingly enough, in Mali there have been feminist campaigns, attempts at legislation change, and financial backing against FGM. Yet, the practice remains. This identifies a complex societal norm and may indicate the need for a multi-factorial intervention approach for change to occur.

The authors of this manuscript have developed three options which should occur in conjunction with one another in an attempt to provide an intervention strategy that is both culturally acceptable and adherent to ethical conditions, such as a respect for autonomy, non-maleficence, and beneficence. Perhaps these interventions may be implemented in a culturally sensitive manner as a pilot program within a culture who is predominantly advocating for change; however, may not move towards a shift in culture due to societal pressures.

First, from an International government perspective, all FGM or circumcision should be made illegal below the age of a conscious consenting adult. In other words, if a procedure is to occur it should only occur by a consenting adult that understands the long-term effects. This concept is discussed in depth by Shell-Duncan [12]. The author identifies the rights of the child are of primary ethical concern. Further, individuals should have the freedom from torture; thus, an examination and determination of whether FGM in children who cannot adequately or consciously consent to FGM should be considered under the Convention against Torture and Other Cruel, Inhumane or Degrading Treatment or Punishment Act [12]. A potential issue or obstacle with this concept is the idea of whether this Act or legislation type could be considered a western culture imposing views and societal norms on another society who may disagree.

Secondly, the procedure conducted should only be allowed if there is no risk for long-term damage. Meaning, evidence based research should be reviewed so that a determination of what type of FGM will result in elimination of long-term chronic conditions. Chronic conditions should include both physical and psychological. Lastly, education regarding sexual health and social interactions for all types of cultures should be included in educational institutions for regions throughout the world and especially within the nations in question where FGM occurs most frequently. The goal of the third intervention technique is to broaden the minds of young women and men on the various cultural norms throughout the world so that they can make an accurate decision as to what they would want as an individual. The individual should not feel forced or coerced into an FGM procedure due to cultural norms. As such, a valuable approach may be to include community leaders, chiefs, or elders in the educational process as research has shown these individuals are influential agents of change in community member's beliefs regarding FGM [13,14]. This would be especially important in communities where FGM with long-term health impacts is still carried out.

Conclusion

A benefit of globalization is the melding of cultures and improvements in education so that one day there may perhaps be a global cultural community where the norms that exist are such that community members treat one another with dignity and as persons worthy of respect. This includes the acceptance of human rights while maintaining some level of localized cultural norms. Norm changes in communities begin amongst the individuals first. Thus, a multi-factorial approach utilizing social and cultural education methods at the micro- and macro-level of societies may be beneficial to result in a cultural norm shift. Further, it seems education regarding chronic and negative health outcomes including both physical and psychological may prove to be effective in shifting the mindset for change. Nevertheless, the ethical dilemma of imposing western ideals into cultures who may wish to continue such practices exists. As such, in communities and cultures who remain accepting of FGM, western cultures may attempt in increasing their understanding of why these practices exist rather than imposing and recommending legislation against said practice. After all, developing legislation against FGM without implementing cultural change could lead to the practice becoming more unsafe as circumcision may happen at earlier ages, hid from the government and parents resulting in underground practices.

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