# MENTAL HEALTH AND ENDING FEMALE GENITAL MUTILATION AND CUTTING:

## RECOMMENDATIONS FOR U.S. FOREIGN POLICY AND PROGRAMS

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## BACKGROUND

In 30 countries, mainly concentrated in Africa, the Middle East and Asia, at least 200 million girls and women have undergone female genital mutilation/cutting (FGM/C).[i] 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 of FGM/C are diverse and multi-dimensional, and include gender inequality, prevailing social norms and a desire to control female sexuality. It is a highly concentrated practice, with two-thirds of all women who have experienced FGM/C residing in just four countries: Egypt, Ethiopia, Nigeria and Sudan.[ii] Nonetheless, it is important to understand that FGM/C is associated with several cultural traditions but is not limited to any one region or religion.

While the physiological health impacts from FGM/C have been widely documented,[1] psychological health risks have been less well explored.[iii,iv] As such, ICRW is exploring the mental health impacts of FGM/C and lessons we might take from the evidence for policy and programming. We know that many girls who have undergone FGM/C report that they do not know in advance that they are going to be cut, making this a highly traumatic experience. We also know that the trauma, pain and complications due to the experience can lead to both short- and long-term psychological harm, including post-traumatic stress, flashbacks, fear, anxiety and depression.[v] Some studies have also reported positive feelings, which we explore later in this brief as it relates to social norms.[vi] The limited evidence that exists suggests that the psychological impact of FGM/C is related to the type of FGM/C a girl experiences, complications that have arisen and the socio-cultural context of her belief system, marital relationship and support networks.[vii] This brief summarizes the evidence and recommendations for U.S. foreign policy.

## WHAT THE EVIDENCE SHOWS

Working with the World Bank, ICRW recently undertook a three-year multi-country study to document the economic impacts of a practice highly tied to FGM/C: child marriage. For this brief, ICRW analyzed data from Ethiopia to explore the relationship between FGM/C and psychological well-being among a sample of 4,149 women who have ever been married (18-45 years). Measures of well-being were obtained from the Psychological General Well-being Index (PGWBI), a widely-used scale to measure the psychological quality of life of general populations as well as people with chronic diseases.[viii] The index consisted of 22 items, which were rated on a six-point scale and assessed psychological and general well-being of respondents in six health related quality of life domains: Anxiety, Depressed Mood, Positive Well-being, Self-Control, General Health and Vitality.

Approximately 63 percent of women surveyed had undergone FGM/C. On average, women who had undergone FGM/C were older and were less likely to have completed primary schooling. Findings from the data are consistent with DHS data in high-prevalence countries suggesting that the likelihood of experiencing FGM/C increases with age and income. Results may also be related to under-reporting in younger cohorts as FGM/C is increasingly criminalized, but further research is needed to fully explain the difference in reported prevalence rates. Women who reported undergoing FGM/C had a higher overall psychological well-being as compared to women who had not undergone the procedure. A plausible explanation for these findings could indicate the central role social norms play in

1 According to the World Health Organization, physiological health impacts resulting from FGM/C may include: severe pain, excessive bleeding, infection, urinary issues, shock, death, long-term painful urination and urinary tract infections, menstrual problems, sexual problems, increased risks during childbirth and scarring.

"FGM/C is a human rights abuse that has no health benefits and is not rooted in any religious or theological tradition. It is typically practiced as an initiation rite that reflects locally held beliefs around the need to control women's sexuality and preserve and prove their virginity for marriage. Depending on the degree of the cutting, the practice can lead to intense life-long pain and a range of physical and mental health problems, including psychological trauma, chronic infection, infertility, fistula, hemorrhaging, and life-threatening complications during pregnancy and childbirth."

- U.S. GLOBAL STRATEGY TO EMPOWER ADOLESCENT GIRLS

influencing behavior. FGM/C is strongly tied to social norms. Hence adhering to the practice could contribute to greater psychological well-being for women who are circumcised, as they avoid the stigma, societal pressure or social isolation that uncircumcised women may face within their communities. Case studies have found cultural stigma toward women who remain uncircumcised.[ix] Evidence suggests that social norms are key to the continued practice of FGM/C. This data indicates that women who do not conform to these social expectations may be at risk for reduced psychological well-being. Other research also suggests that the psychological impact of FGM/C in countries where it is culturally acceptable or prevalent is minimal and have noted that *not* undergoing FGM/C in certain communities has a greater psychological impact than the trauma caused by FGM/C itself, as a woman without FGM/C may 'become a social pariah.'[x]

## RECOMMENDATIONS FOR U.S. FOREIGN POLICY AND ASSISTANCE

Ending FGM/C is a target in the Sustainable Development Goals (SDGs), in policies and frameworks of numerous inter-governmental organizations, including the African Union and the European Union, and in three resolutions of the United Nations General Assembly. Yet U.S. foreign policy lags in this area, despite several calls from congressional leaders and Government Accountability Office (GAO) indicating a paltry track record in investing to end this harmful practice.[2]

**More than half** of the top 20 recipient countries for U.S. foreign assistance tied to gender equality are among the top FGM/C prevalence countries[3]. These countries should immediately incorporate specific tactics for ending the practice in their country development cooperation strategies. As a global leader in development and humanitarian affairs, the United States should build off previous successes by way of implementing existing policies and strategies, and through the funding of new and continued research and programming to prevent and respond to the long-term consequences of FGM/C. The United States has a checkered history of response to FGM/C. The U.S. Agency for International Development (USAID) first released guidance on the practice in 2000, and Congress has appropriated various amounts towards FGM/C response since then, although these efforts have been limited in scope and sustainability. As the United States government itself has documented both in GAO reports and within the U.S. Global Strategy to Empower Adolescent Girls, the level of investment in FGM/C response and prevention is insufficient to address the problem and shift social norms to eradicate the practice.[xi]

2 Two GAO reports in 2016 rightly note that U.S. investments to eradicate FGM/C have been insufficient to address the issue as monetary investments have been few and far between. USAID first released guidance on the practice in 2000, which was updated in April of 2017. Over the course of the 2000s Congress appropriated up to $5 million for efforts to end the practice abroad. In 2012, USAID incorporated FGM/C in gender- and GBV- related strategies, and in 2014 the United States made twelve public commitments to address FGM/C at a pledging conference in London (five domestic and seven international)[2]. Most recently, the Senate included a $5m appropriation for U.S. contributions to a UN program on FGM/C in the committee-reported draft of its 2017 State and Foreign Operations appropriations bill, and the State Department, USAID, Millennium Challenge Corporation and Peace Corps released the *U.S. Global Strategy to Empower Adolescent Girls,* which includes an explicit section on ending FGM/C. The U.S. also joined the Donors Working Group on FGM/C, which includes 11 governments and aims to coordinate efforts for large-scale transformation.

3 Tanzania, Ethiopia, Zambia, Egypt, Rwanda, Nigeria, Senegal, Sudan, Liberia, Kenya, Mali and Somalia

## HONOR & EXPAND EXISTING U.S. COMMITMENTS TO END FGM/C

**USAID Guidance on FGM/C**

- All USAID Missions and desk staff at HQ should be provided with the new guidance on FGM/C, and should report to the CSO community against the three areas of work under this guidance.

**U.S. Global Strategy to Empower Adolescent Girls**

- All participating agencies should fully implement this Strategy, setting out explicit efforts to end FGM/C.
- Agencies should report out to civil society in consistent and transparent ways any progress against their stated plans.

**U.S. Strategy to Prevent and Respond to Gender-based Violence Globally**

- FGM/C should be included in the suite of GBV indicators used to measure USG efforts in this area

Research has shown that the most effective interventions to end FGM/C are community-led and work to reduce stigma and address the underlying gender norms that cause FGM/C.[xiii]

Moving forward, the U.S. government should continue to fund the implementation and oversight of the U.S. Global Strategy to Empower Adolescent Girls and the recently updated U.S. Strategy to Prevent and Respond to Gender-based Violence Globally. These two strategies both contain valuable definitions of FGM/C and outline agency-specific commitments to ending this harmful practice. The recently released USAID Guidance on Female Genital Mutilation/Cutting (FGM/C): A Mandatory Reference for ADS Chapter 205[xiv], should be disseminated to mission staff and relevant desk staff at headquarters as the guidance aligns with existing policies and evidence-based solutions to tackle FGM/C. The guidance states that USAID will work to eliminate FGM/C through legal and policy frameworks in host countries, the implementation of those laws and community-based programming where the practice is prevalent. This guidance should not only be disseminated but discussed regularly, particularly with mission staff in high-prevalence countries.

While all of the aforementioned strategies and guidance are critical to addressing and preventing FGM/C, *none* adequately address mental health, access to adolescent mental health services, the stigma for those who remain uncut or address the need for community-wide abandonment of FGM/C. In fact, both adolescent health broadly and adolescent mental health specifically are blind spots in the United States' international development and humanitarian policies and programming. The United States is not alone. As a recent Lancet study revealed,[xv] self-harm is one of the leading causes of death for adolescent girls ages 15-19, yet fewer than 25 percent of countries surveyed have national health policies that even mention adolescent mental health. Understanding adolescent girls' unique vulnerabilities to mental health risks, including the impacts of harmful gender norms and the factors that can protect and enhance their mental health and wellbeing, are crucial when considering appropriate policies and interventions.[xvi]

Additionally, the U.S. government should continue to fund best-practices for adolescent girls at risk of FGM/C by addressing the barriers keeping girls out of secondary school, improving knowledge of and access to mental health services and right-of-passage alternatives that do not involve cutting. Further research is needed to fully understand the long-term mental health consequences of female genital mutilation and/or cutting, and the United States should be at the forefront of funding such research to understand the long-range consequences of this and other abuses on adolescents. Since 2007, UNICEF and UNFPA have operated a joint program for the abandonment of FGM/C, to which the United States has contributed once, in FY17.

## RECOMMENDATIONS FOR PROGRAMS AND FURTHER RESEARCH

Recommendations for how researchers, implementers and advocates can address some of the gaps in understanding the connection between FGM/C and mental health and mental health, as well as eliminating the practice of FGM/C across the globe, include:

- **Community Advocacy and Mobilization**: Changing social norms requires awareness-raising through education and community mobilization in order to shift beliefs, expectations and values regarding FGM/C. To promote the abandonment of FGM/C, coordinated and systematic efforts are needed, and they must engage whole communities and focus on human rights and gender equality. These efforts should emphasize intergenerational dialogue and the empowerment of communities to act collectively to end the practice. They must not only address both the sexual and reproductive health needs of women and girls who suffer from its cconsequences, but their mental health needs, as well. Eradication of FGM/C is a long-term approach which involves participatory and community ownership of these initiatives by engagement of key stakeholders such as elders, religious leaders, health workers, women, youth and family members. Since there may be stigma and discrimination attached to abandoning the practices, it is important that interventions include advocacy and community mobilization efforts in order to change social norms and behaviors.

- **Interventions:** It is important to design and implement culturally-responsive programming that takes into account ethnicity, culture and community social norms. Strengthening the health sector response is also important, by providing health care professionals with training on how to treat and care for women and girls who are suffering physical and mental health problems that result from having FGM/C.

- **Research**: More investments in research to build the evidence base on the associations between FGM/C and mental health, as well as to inform the development of psychological support for women who have experienced FGM/C, is needed. Research can also shed light on the effectiveness of the types of psychological interventions that would be sensitive and appropriate for women who have experienced FGM/C.

## ENDNOTES & CITATIONS


[i] United Nations Children's Fund (2016). *Female Genital Mutilation/Cutting: A global concern*. UNICEF: New York. Retrieved September 15, 2017, from https://www.unicef.org/media/files/FGMC_2016_brochure_final_UNICEF_SPREAD.pdf

[ii] Shell-Duncan, B., Naik, R. & Feldman-Jacobs. (2016). A State-of-the-Art Synthesis on Female Genital Mutilation/Cutting: What Do We Know Now? October 2016. Evidence to End FGM/C: Research to Help Women Thrive. New York: Population Council.

[iii] Reisel, D. and Creighton, S. M. (2015). Long term health consequences of female genital mutilation (FGM). *Maturitas*, 80(1):48-51.

[iv] Wagner, N. (2015). Female genital cutting and long-term health consequences nationally representative estimates across 13 countries. The Journal of Development Studies, 51(3):226- 246.

[v] UNFPA. (2011). *International Conference on Research, Health Care and Preventive Measures for Female Genital Mutilation/Cutting and the Strengthening of Leadership and Research in Africa.* Nairobi, Kenya.

[vi] Denholm N. (2004). Psychological and social consequences. In *Female Genital Mutilation in New Zealand: Understanding and Responding:* pp. 69-72. Refugee Health Education Programme.

[vii] Mulongo, P., Hollins Martin, C., McAndrew, S. (2014).Psychological impact of Female Genital Mutilation/Cutting (FGM/C) on girls/women's mental health: a narrative literature review. *Journal of Reproductive and Infant Psychology*, 32(5), 469-85.

[viii] Chassany, et al. Op cit.

[ix] United Nations Children's Fund (UNICEF). (2013). Eradication of Female Genital Mutilation/cutting in Somalia.New York. Retrieved September 15, 2017, from https://www.unicef.org/somalia/SOM_FGM_Advocacy_Paper.pdf

[x] Whitehorn, J., Ayonrinde, O., & Maingay, S. (2002). Female genital mutilation: Cultural and psychological implications, *Sexual and Relationship Therapy, 17(2)*, pp.161-170.

[xi] United States Government Accountability Office. (2016). *Female Genital Mutilation/Cutting: U.S. Assistance to Combat this Harmful Practice Abroad is Limited*. (GAO Publication No. 16-485). Washington, D.C. U.S. government Printing Office.

[xii] United States Government Accountability Office. (2016). *Female Genital Mutilation/Cutting: Existing Federal Efforts to Increase Awareness Should Be Improved*. (GAO Publication No.16-645). Washington, D.C. U.S. government Printing Office.

[xiii] International Center for Research on Women, (2016). *Leveraging Education to End Female Genital Mutilation/Cutting Worldwide.* Washington, DC.

[xiv] USAID. (2017). *USAID Guidance on Female Genital Mutilation/Cutting (FGM/C) A Mandatory Reference for ADS Chapter 205*. USAID, Washington, DC; 2017. https://www.usaid.gov/sites/default/files/documents/1870/205maa.pdf

[xv] Petroni,S., Patel, V., & Patton, G., Why is suicide the leading killer of older adolescent girls?, *The Lancet*, Volume 386, Issue 10008, 21–27 November 2015, Pages 2031-2032. (http://www.sciencedirect.com/science/article/pii/S0140673615010193)

[xvi] Kapungu, C. and Petroni, S. (2017). *Understanding and Tackling the Gendered Drivers of Poor Adolescent Mental Health*. Washington, DC: International Center for Research on Women.