

The Route to End FGM: Moving From 'Multi-Agency' Via Multi-Disciplinary to Public Health and Economics

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Abstract

In this opinion piece written primarily as a 'conversation' with obstetric and gynaecological clinicians whether in the 'developed' or the 'developing' world, I seek to

- Create connections between the clinical treatment/care of women and girls with female genital ('sexual') mutilation (FGM) and various of the environments in which the practice continues;
- Establish that two themes - economics and patriarchy - are critical to a full understanding of this harmful practice; and
- Explore ways in which colleague support across disciplinary boundaries, along with a willingness to try new approaches to the problem, may help to enable a Public Health framework leading to the eradication of FGM.

I also note in the above contexts some of the personal discomforts and very different circumstances which various professionals, amongst them clinicians, may experience as they move towards a wider perspective on FGM; and I explore, in anticipation I hope of further discussion, possible ways forward to resolve these valid potential challenges or problems.

Keywords: *Economics; FGM; Multi-Agency; Multi-Disciplinary; Patriarchy Incarnate; Public Health*

There is a fundamental truth which many find difficult to acknowledge: female genital mutilation (FGM) and other gendered/sexual violence almost certainly won't be stopped until the entrenched power and wealth which underpins them are acknowledged and challenged.

Of course this is an over-simplification and of course this observation must be balanced by full and fair recognition of the invaluable work of many 'EndFGM' activists and lobbyists in many parts of the world. There is no one action or strategy which alone will eradicate FGM; and building synergies between different approaches is also a crucial aspect of eradication.

Nonetheless, FGM and similar harmful gendered/sexual 'traditions'[1] are serious public health issues embedded within certain socio-economic contexts. Given these contexts there are two important and often overlooked factors which shape the behaviours:

1. FGM is a form of what I now insist must be termed 'patriarchy incarnate' - the imposition of (some) men's will on the minds and, quite literally, the bodies of women; and
2. FGM is essentially an economic strategy which enriches these powerful men.

These claims will be seen by some as stark, perhaps unfair and even irrelevant. It is however this apparent irrelevance which enables FGM, despite so much sincere hard work towards its eradication, to continue.

In public health terms, current EndFGM strategies and efforts, whilst absolutely necessary in themselves, could be compared to hygienic good practice and treating the symptoms of a viral disease, whilst ignoring the strategic benefits of widespread vaccination.

Further, those most involved in the clinical aspects of FGM are not in any case public health practitioners. The contribution to women's and girls' health of gynaecologists and obstetricians is essential to every individual victim and survivor but it is not adequate alone to achieve eradication. Similarly, the work of community activists and law enforcement officers in stopping FGM and enabling girls and women to receive a decent education is urgently and unquestionably vital; but again it cannot alone consign FGM to history.

So, what is missing even as these enormously important strategies to end FGM - education, medical care and, where the legal prohibition exists, law enforcement - are pursued?

Patriarchy incarnate

Firstly, there is still too little focus on men[2]; and by that is meant not 'only' the engagement of men in efforts to eradicate FGM [3], but also an acknowledgement, as above of the power of men over the minds and bodies of women and girls.

The physical and mental scars of FGM (and other sexual and gendered violence) are often life-long and life-changing; they are bespoke tools in the subordination of female human beings by some male members of their species. Whether female genital mutilation, child marriage, breast binding, violence against widows, polygamy or other comparable harmful practices, the fundamental intention is to diminish and subordinate women to men.

As strategies go, there can be few if any more effective and durable ways to intimidate and control a girl or woman, than for a man (or, under his often implied orders, a woman on his behalf) to attack her sexual anatomy and her fundamental sexual and gendered sense of self. This is patriarchy incarnate [4] in the most essential meaning of the term, however much it is disguised or presented as convention, tradition or even 'religious' requirement.

Power and economics

The other often missing aspect of strategy to end FGM is economics, at every level from the micro/individual to the macro/state and global.

It is sometimes acknowledged that fathers (or other family members) may require girls to undergo FGM in order to acquire a larger bride price from prospective future husbands[5]. When this occurs the girl or woman becomes nothing more than a commercial commodity to be sold to the highest bidder.

Like other females of any age who are sold in marriage (often as one of a number of wives) the girl or woman is simply equity to be disposed of as her father chooses, to another owner, her intended husband. Given that sometimes the understanding is that this exchange will also ensure support in old age of the bride's parents, the girl thus becomes no more than an economic 'investment' for her seller.

There are now however also a few studies which estimate the costs globally or to a nation of current medical care for women with FGM. These costings are vital tools in campaigns demanding eradication - the financial burden is massive - but they barely touch the economic impact overall [5] of FGM.

Rarely, if ever, is it acknowledged that 'uncut' women remain in local understandings 'children', and therefore may not be permitted to own land or other resources; women who have undergone FGM may experience life-long suboptimal health (or even the ultimate horror of obstetric fistula and social rejection) with all the life and death repercussions for themselves and their family/children of inadequate levels of care provision and economic underperformance; FGM usually limits a girl's likelihood of receiving a full education for adult financial autonomy; and so on... For many in affected communities the economic power and influence of men over the lives of their wives and daughters is close to absolute.

Further, sometimes clinicians themselves deliver FGM; they may work in places where salaries are paid unreliably, or where those concerned have convinced themselves that it is 'safer' to do the FGM than to leave it to the traditional midwives or practitioners who would otherwise do it. In some countries (such as Egypt [6]) this 'medicalization' is a growing and dangerous obstacle in efforts to end FGM.

All these economic factors are however vital aspects of any strategic policy analysis which aims to eradicate FGM; but, like patriarchy incarnate as an essential element in such analyses, they are usually unacknowledged and/or ignored.

Community health and conventional medicine

For many of clinicians who must deal with FGM as a medical fact, issues such as those above will seem superfluous both to their professional focus and to their responsibilities. Sex/gender politics and economics are matters a long way removed from immediate and life-and-death clinical practice.

Dismissing such matters is however an opportunity wasted.

Evidence from other 'emergency' and critical interventions suggests there are times when the right word or post-clinical referral can make a significant difference to the future life of both victims and assailants.

As one (imperfect, but challenging) example: the 2017 London Knife Crime Strategy [7], which takes 'a trauma-informed and culturally competent approach' to reducing knife crime. This observation is in no way a suggestion that in reality FGM and (other) knife crime are parallel assaults. One is traditional, very specifically sexually targeted and almost always planned, the other is more often random, urban and unexpected; but both may result in serious harm to victims - all who suffer at the knife are, and must be understood to be, 'victims' as well as 'survivors' - and both necessarily should involve immediate services for the victim provided by the state, including clinical care and law enforcement. The 'aftermath intervention' [8] knife crime strategy suggests that included in that immediate service for victims who may also be potential perpetrators should be an opportunity to support the idea of 'no more; let's end this cruelty for good.' But most importantly, there is now an important emphasis on public health [9] approaches. These harms have complex causations and require sustained and wide-reaching resolutions.

Clinicians in locales where FGM is practised can be uniquely placed, as highly skilled and respected professionals, to coalesce the unique personal experience of a patient (and her family/community) and the wider socio-economic contexts.

The immediate 'connecting' task for the clinician - whether obstetrician, gynaecologist, midwife, or other medical professional - may be simply to ensure that in some way the patient is pointed towards people who can advise or care for her later on. Such a person might be a teacher, 'reformed' ex-practitioner, media campaigner [10], health advisor, 'grandmother leader' [11], faith leader [12] or other informed

influencer [13] within the community; someone who will consolidate the position that, whatever the 'motive' for FGM, it is unacceptable and, usually, illegal.

Connecting women who may feel powerless with support to speak out is however only part of the challenge for any clinician working with those who have experienced FGM. The other important element in this strategy must be to ensure that community and political leaders in locations or regions where FGM is practised are properly aware of its economic dynamics and impacts.

Such dynamics and impacts will vary by locale but there it is important to record at least some evidence of the damage FGM imposes. Senior clinicians especially are almost always particularly well placed to gain the ear of policy decision makers; that privileged position must wherever possible be put to good use.

Further, in both connecting FGM survivors with support to end FGM, and in influencing policy decisions, a public health approach [14] is likely to be helpful. A coherent overall perspective on eradication is the 'vaccine' which will, as we noted above, support success.

Personal and professional perspectives

It may be difficult for some clinical professionals to feel comfortable with various of the suggestions above. Acute medicine is stressful and demanding; time to take a broader perspective is often a luxury curtailed; to some men especially the concept of patriarchy [15] may feel threatening. Likewise, male clinicians and activists, especially, may have difficulty in positioning their thoughts on FGM in the context also of male 'circumcision' or 'MGM' (which this writer at least sees as a parallel assault [16]). but there is scope for a plurality of approaches.

Amongst those who read this Opinion we may all be agreed that FGM is a crime and must stop, but different people are at different points in perceptions and understandings of such human rights abuses and the contexts in which they operate. That is inevitable and perhaps also valuable, if perceptions are shared and explored.

Nonetheless, the biggest underlying factor in FGM, economic patriarchy, remains largely unacknowledged.

The reason that economics and patriarchal power must be brought into focus is that it takes us to the vast costs of FGM at every level from the local to the global. These costs will be eradicated if and when FGM stops; and stopping will happen when people decide not to tolerate it any longer. Until this simple fact is acknowledged and addressed women and girls, and their families and communities, will continue to suffer.

It is therefore vital that the economic damage of FGM [17] is recognised and wherever possible quantified across all its impacts. And in the same way the interests and types of person who benefit financially from FGM must be identified; some will be practitioners ('midwives', errant clinicians etc), but a much larger number will be men at one remove who have the power and financial incentive to permit and enable the practice to continue.

We need to be sure that politicians and policy makers are conscious of the wealth – human resources and money both – which FGM wastes, even where the needs of members of their communities may be direly unmet.

It is necessary now to spell out the costs of FGM at every level in places where it happens, and it is also essential to be clear about who is gaining financial benefit from these traditional arrangements. Determination of these costs will require research by experts in policy, economics and related disciplines, and clear evidence of who most benefits will also require proper research. Critically, evidence is required to show that traditions such as FGM cannot be supported as 'normal'; it is their supposed normality which is so costly in so many ways.

In all this work the role of public health is critical. Liaising with clinicians and policy makers, public health practitioners have knowledge and skills which can help to determine the direction of such research, and they can also support the development of appropriate services, based on the evidence, to eradicate FGM.

It is not always be easy for clinicians, law enforcers and others actively to engage in research and policy determination of the sort here proposed, but support for such positioning may be a step towards at last making FGM history.

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