

The need for an evidence-informed, multi-sectoral and community participatory action framework to address the practice of female genital mutilation in Sri Lanka

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Introduction

Female genital mutilation or cutting comprises all procedures that involve partial or total removal of the female external genitalia and or injury to the female genital organs [1]. The World Health Organization (WHO) classifies female genital mutilation into four types, with the most severe form involving infibulation of the external genitalia and stitching or narrowing of the vaginal opening [1]. The WHO estimates that more than 200 million girls and women alive today have been subjected to female genital mutilation [1]. The practice is most common in 30 countries in the Western, Eastern, and North-eastern regions of Africa, and in selected countries the Middle-East and Asia. With increased migration from such countries, health professionals in destination countries

are confronted with the challenge of caring for women and girls subjected to it, and mounting responses to inhibit its practice. Female genital mutilation is therefore a global concern, with international human rights treaties condemning the practice as a gross violation of fundamental human rights of girls and women [2].

Extensive evidence shows female genital mutilation to negatively impact on reproductive morbidity and mental health, as summarised in table 1 [3,4]. These range from the trauma of the cutting itself; memory of it; pain and reduced pleasure during sexual intercourse; taking long or being unable to climax; relationship difficulties; and feelings of being violated because the act had been carried out on them as children without consent [4].

Table 1. Health consequences Type I and II genital cutting on reproductive morbidity and mental health (summarised from [3,4])

Health consequences of FGM	
<p>Excisions of tissue, such as labia, may result in:</p> <ul style="list-style-type: none"> • Scar tissue formation, keloid formation, <i>Bartholin's</i> cysts on vulva • Damage to reproductive tract, urinary tract, gastrointestinal tract 	
<p>Physical health outcomes:</p> <ul style="list-style-type: none"> • Fistula, incontinence • Painful sexual intercourse • Childbirth problems • Stillbirths • Prolapse • Infertility • Abnormal cytology (via HPV infection) • Susceptibility to sexually transmitted infections 	<p>Mental health and psychological impact:</p> <ul style="list-style-type: none"> • Self-esteem (notions of femininity and beauty) • Post-traumatic stress disorder • Depression and anxiety • Sequele that remains throughout her life, and impacts various stages of life as a girl, spouse and as a mother

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Methods

In early 2014, we undertook a review of research, news articles and other gray literature sources to identify any information pertaining to the practice of female genital mutilation in Sri Lanka. We also explored Sri Lanka's domestic legal and policy frameworks in reference to female genital mutilation. This work was prompted by the personal account of a professional colleague who courageously revealed her experience and that of her daughters of female genital mutilation. However, our anxieties about bringing to attention this practice and the potential professional and social backlash inhibited our submission. To put simply, we lacked the courage to publish our piece on female genital mutilation.

Whilst there are no research studies pertaining to the practice of female genital mutilation in Sri Lanka, a number of agency reports and investigative journalist accounts have revealed the practice in Sri Lanka.

Reports in news media

Media reports of the practice has been documented since 1996, where a teacher disclosed the practice on all her five daughters [5]. A medical professional quoted in the report confirmed the practice to be “prevalent” and “kept a jealously guarded secret by women who think an infant who does not undergo the surgical operation will be considered unfit for any respectable man to marry”. A report in June 2017 exploring the experience of three women indicated the amount of genital cutting differs from child to child, and have socio-economic determinants [6]. Interviewed women stated that “poorer families often seek a woman called an ‘Ostha-maami’ from their communities who usually nick the clitoris for a little blood to come and leave it at that”, while “educated families get it done by lady doctors who cut off part of the foreskin of the clitoris”. Based on testimonials of a number of victims, a 2017 article revealed the practice to exist within the Moor, Malay and Dawoodi-Bohra ethnic communities in Sri Lanka, although suggesting the practice varies regionally and amongst religious scholars who either denounce or promote it [7]. Women also testified to discovering the excision of parts of clitoris and labia later only as adults, and to experiencing pain during sexual intercourse. A report in December 2017 highlighted instances where medical practitioners have participated in undertaking the procedure [8]. A gynaecologist quoted as having examined some of the women stating, “even the mildest form of khatna could be traumatic”, and “even if this is done under sterile conditions, trying to do it on a child who is struggling and who may kick or stiffen could mean you cut more than you intend to” [8].

Agency based reports

A report submitted by the Muslim law reforms civil society in March 2017 to the UN Committee on elimination

of all forms of discrimination against women (CEDAW) indicates female genital mutilation (or ‘Khatna’) to be a common practice among sections of the Dawoodi-Bohra community in Sri Lanka [9]. The report refers to case studies indicating female genital mutilation being performed on girls as young as 7 years of age “by registered medical practitioners from within the community”. A UN Report on harmful traditional practices in 2009 outlined the practice to be “exclusive to the Muslim community” [10]. The women who were interviewed reported that “genital incision is practiced on infant girls four to five weeks after birth”, while indicating that some sections of the Borah Muslim community performed on teenage girls. The most concrete evidence on the practice of female genital mutilation in Sri Lanka was presented in testimonies of 15 women to the Parliamentary Sectoral Oversight Committee on Women and Gender (PSOCWG) in December 2017 [11]. The findings of the testimonials are consistent with investigative journalist reports [5-8].

A number of official reports have concluded without evidence that the practice to be non-existent in Sri Lanka. A WHO report on Gender Based Violence (GBV) in 2008 reported a “zero score” for female genital mutilation in Sri Lanka [12]. UNICEF's national report card on essential indicators relevant to maternal and child health in Sri Lanka collected since 2005 states female genital mutilation have remained “nil”. A joint Ministry of Health (MOH) and WHO report on Violence and Health in Sri Lanka in 2008 stated categorically that female genital mutilation “do not exist in Sri Lanka” [13]. The Department of Census and Statistics (DCS) – the state organization recording the status of Sustainable Development Goals (SDG) in Sri Lanka has not included indicator 5.3.2 on ‘Proportion of girls and women aged 15-49 years who have undergone female genital mutilation, by age’ [14].

Despite ratifying the Convention on the Rights of the Child in July 1991, Sri Lanka is yet to adopt any local legislation criminalizing female genital mutilation. Female genital mutilation could be liable to punishment under several domestic laws such as Section-308(A)(1) of the Penal Code that explicitly refers to any “injury to limb or organ of the body or any mental derangement” of a person under the age of eighteen “commits the offence of cruelty to children”, and constitutes as child abuse.



Proposed action agenda

Following the PSOCWG report the Ministry of Health issued a general circular to sensitize health sector authorities to be vigilant in identifying female genital mutilation cases that may attend health institutions, and to condemn the practice as a human rights violation which has major negative health impact on girls and women [15]. However, the potential socio-religious and political issues inherent in this practice may inhibit individual health practitioners and child protection actors from addressing it. It is imperative that the issue is tackled at both national

and community levels. Lessons from other countries have shown that successful programs against female genital mutilation require long-term commitment to induce/support behaviour change at community level and capacitate enforcement mechanisms through communities of practice across health, education and law enforcement sectors [16-20]. The close tethering of the practice to ethnic and

religious communities in Sri Lanka warrants a careful calibration of actors, where evidence-based and community participatory approach is needed. In table 2 we present the broad approaches, enabling factors and possible stakeholders in developing a national action framework for the abandonment of female genital mutilation in Sri Lanka.

Table 2. Approaches, enables, stakeholders and processors in developing a national action framework for the abandonment of female genital mutilation in Sri Lanka

Vision: National action framework for the abandonment of FGM in Sri Lanka	
<p>Underlying approach and enablers determining effectiveness:</p> <ul style="list-style-type: none"> • Evidence-informed approach • Culturally sensitive • Rights-based • Inter-sectoral (whole of government approach) • Multi-disciplinary (e.g. involving health, law, child protection actors) • Participatory approaches (engagement from policy makers and community members to those undergone FGM) • Free and open space for policy engagement which values evidence • High level political, religious and community leadership • Sustained Investment in action against FGM • A conducive legal and regulatory environment 	<p>Stakeholders:</p> <ul style="list-style-type: none"> • Community: Women/girls subjected to FGM; Community leaders (ensuring female leadership); Religious scholars (e.g. Imams); Religious welfare and advocacy organizations (focusing on women led coalitions); Civil society groups; Legal reform groups. • Relevant government agencies: Ministry of Health; National Child Protection Authority; Ministry of Social Service and Social Welfare, Human Rights Commission. • Professional bodies: Sri Lanka Medical Association; Sri Lanka College of Obstetricians & Gynaecologists; Pediatricians; Community Medicine; Forensic Medicine; Medical Administration; College of Law; Government Medical Officers Association etc. • Academia: Scholars at nexus of sexual and reproductive health; child protection; law reform • United Nations agencies: UNICEF, UNFPA, IOM, WHO • NGOs • Media
	
<p>Processors and platforms at:</p> <p>National Level:</p> <p>Establish at National steering committee (NSC) – comprised of stakeholder representatives, to guide action and evaluate progress with government and partners. The NSC can be administratively supported by a relevant national body such as: the Presidential Secretariat, National Child Protection Authority.</p> <ul style="list-style-type: none"> • National Research Commission on FGM – to undertake empirical studies on FGM in Sri Lanka using community participatory methods. • Reforming/enhancing national legal frameworks (could be a sub-group within the NSC). • National media strategy on FGM (using media to mobilize public opinion, IEC materials, talk shows). • Training of health and social welfare professionals on FGM. <p>Community level:</p> <ul style="list-style-type: none"> • Community based steering group at district level to undertake training, community sensitization, media advocacy, religious study circles etc. • Public interest litigation. 	

Relevant actors from health, child protection, law, religious and social welfare agencies at national, provincial, district and village level need to include evidence-informed approaches on female genital mutilation elimination within their strategic work plans. Such collective action is important to catalyse an enabling environment to inhibit practice. For instance, the Ministry of Health demographic health survey including questions on female genital mutilation; research funding organizations prioritizing research into female genital mutilation; the DCS integrating SDG indicator 5.3.2; the Sri Lanka Medical Association and relevant professional associations formulating guidelines and providing training to health professionals in active reporting and case-management; and, targeted awareness raising by the National Committee of Women in partnership with religious/community organizations.

Proponents of female genital mutilation in Sri Lanka have argued that “since the WHO has not studied local practices”, “the local form of the practice somehow does not cause harm and on the contrary is beneficial” [5]. With the paucity of data, we advocate for a carefully constructed research agenda through a multidisciplinary group of experts (for instance, from backgrounds in anthropology, religious studies, forensic medicine, paediatrics, obstetrics and gynaecology) to explore female genital mutilation in Sri Lanka and ways to effectively implement programs encompassing community-based prevention to supporting women living with female genital mutilation. Meaningful engagement with relevant community leaders and religious authorities are essential. An evidence-based and cultural sensitive approach is needed before undertaking any invention or advocacy measures.

Evidence from other countries have shown that efforts to curb female genital mutilation relies on the strength of community advocates, legal experts, researchers, clinicians and administrators working at local, regional and national levels [16-18]. First and foremost, this requires courage on the part of us, the medical professionals. The December 2017 article reported a ‘trusted’ doctor in Colombo had performed the female genital mutilation [8]. Multiple testimonies have indicated medical professionals engaged in undertaking procedures, consistent with studies from other settings [21]. Medical professionals who perform female genital mutilation violate the fundamental medical ethic of ‘Do no harm’.

Advocates of the procedure has called for its ‘medicalization’ in Sri Lanka where there is calls for female genital mutilation “to be carried out by medical professionals in hygienic clinical settings” [22]. A joint technical consultation on the medicalization of female genital mutilation held by WHO-UNICEF-UNFPA condemned the practice of female genital cutting by medical professionals in any setting, including hospitals and other health establishments [23]. As medical professionals it is imperative that we report and take action in culturally appropriate ways to inhibit the practice. Building sound research evidence, generating knowledge

about the causes and consequences of the practice, how to eliminate it, and how to care for those who have experienced female genital mutilation are needed. Not only do we need to be better trained and educated on this issue, but also be courageous to act.

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Conflicts of Interests

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