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Review

Female genital mutilation: A tragedy for women's reproductive health

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Abstract
Female genital mutilation/cutting (FGM/FGC) constitutes a tragic health and human rights issue of girls and women in a number of countries, mainly in Africa. The practice has serious health consequences, both physical and psychological. Attempts to eradicate the practice have not been successful over the past few decades. Medicalisation of the practice has added to its propagation, and this is not valid from ethical and professional standpoints. Further efforts need to be exerted to eliminate the practice and alleviate the sufferings that millions of girls and women worldwide are unnecessarily subjected to. This article reviews the problem and discusses the consequences to health for women and girls, and suggests ways to eradicate the practice.

Introduction

In 1976, the World Health Organization (WHO) convened a regional conference on 'Traditional Practices Affecting the Health of Women and Children', in Khartoum, Sudan.

This was the first meeting in which WHO, or any other United Nations agency, ever discussed the issue of female circumcision as a harmful traditional practice. Previously, the topic was taboo, and governments also resisted open discussion about what appeared to be popular in some countries, mainly in Africa [1].

The term 'Female Genital Mutilation' (FGM) came into being in the early 1980s (until then, the term 'female circumcision' had been used). The term was formally adopted at the third conference of the Inter-African Committee on Traditional Practices Affecting the Health of Women and Children in Addis Ababa, Ethiopia, and in 1991 WHO recommended its use to the United Nations. This was

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in an effort to demonstrate the severity of the procedure for the girl child or woman. Some governments and organisations resented the use of the word 'mutilation' as they thought it was not the aim of the family to subject their daughter to this, even though the practice achieves this end result – this is how the term 'Female Genital Cutting' (FGC) came into existence.

The origins of FGM stretch far back in time – it has been practiced in many places [2,3]. Today it survives primarily in large areas of Africa among Islamic and non-Islamic population groups. Excision is common from the east coast of Africa to the west; from Ethiopia to Senegal; from Egypt down to Tanzania. Infibulation is widespread in Sudan, in Ethiopia skirting the Red Sea; in Eritrea and the Ogaden; in Djibouti, Somalia, and the adjacent part of Kenya. In southern Egypt infibulation continues as well; cases have also been reported from Mali and Nigeria.

Excision is found, too, towards the southern end of the Arabian Peninsula and along the Persian Gulf. Muslims in Malaysia and Indonesia practice a mild form of circumcision as well.

Immigrants from African and Middle Eastern countries to Europe and the United States and elsewhere continue to circumcise their daughters in their adopted homelands, according to traditional custom. Examples have been known in France, Sweden and Spain in recent years [4–6].

It appears FGM may be losing ground globally. Formerly excision was reported in Pakistan. It has been reported in Australia, as well, the only country where introcision has also been observed, among some aboriginal tribes. Clitoridectomy, in addition, was known in eastern Mexico, Peru and Western Brazil [7,8].

Several varieties of FGM have been carried out in Europe in the past, although evidence indicates that such operations were not common. Only one group is known, the Christian Skoptzy sect in Russia, which practiced excision and infibulation as a matter of routine [9]. Infibulation by inserting one or more rings through the labia, a rare technique, has been recorded of slaves in ancient Rome. The term 'infibulation' actually derives from the Latin 'fibula' or 'clasp'. Insertion of rings has also been documented from time to time, beginning in the Middle Ages, and up until as recently as 1906, in many areas of Europe, including what are currently Italy, France, Germany and Czechoslovakia [10].

Mention should also be made of the fact that, during the 19th century, there were gynaecological surgeons who performed clitoridectomies for allegedly medical reasons, as a cure for 'nymphomania', for example, or to prevent masturbation. In England such operations took place, but they were also performed elsewhere on the European continent and in the United States. Minor surgery to remove the prepuce or hood of the clitoris has been performed as a treatment for 'frigidity'. Even today, such operations are not unheard of; in addition, plastic surgery on the female genitalia has not been discontinued [11,12].

Reasons for the practice

FGM is often presented as part of a girl's initiation into womanhood within her own particular community, and also as a way in which to control women's sexuality.

Families and individuals perform it because they believe that their community expects them to – they expect to suffer derision, marginalisation and loss of status if they do not do so.

It is important to mention that, while the practice is often linked to religious doctrine, no major religion, in fact, actively encourages it. For example, within Islam, the subject has often been shrouded in misconception and based on outdated medical opinion. In fact, Islamic religious scholars have concluded that the practice is not an obligation to Islam.

While FGM is – in effect – violent, it is not intended as an act of violence, but rather as a necessary step to enable girls to 'become women' and to be accepted into the community.

Scale of the problem

The scale of the problem is significant. In African countries, more than 90 million girls and women over the age of 10 are estimated to have undergone FGM, with some three million girls at risk every year. The practice has been reported from all over the world, but is today most prevalent in 28 countries in Africa and some countries in Asia and the Middle East. As a result of migration, a growing number of girls in Europe, North America, Australia and New Zealand are also affected.

Health consequences

Many complications may arise from an operation as serious as infibulation, or even from milder forms of FGM. Where hygienic conditions and skills are optimal, risks exist; where they are deplorable, such operations are distinctly hazardous to the patient's health [13].

Physical consequences of FGM
Immediate complications

1 **Bleeding:** FGM involves damages to arteries and veins. Primary haemorrhaging during the operation is unavoidable (secondary haemorrhaging may appear later if, for example, the wound becomes infected). As a result of serious bleeding, shock and even death is possible. Anaemia can also result.
2 **Shock:** It may arise not only from bleeding, but from pain and fear as well. It can prove fatal.
3 **Infection and septicaemia:** In less than optimal conditions, with instruments that have not been sterilised, in closed, poorly lit spaces, infection is a likely outcome of any operation. The practice of binding a patient's legs after FGM aggravates any infection by preventing drainage of the wound. Infection may spread inwards, penetrating the vagina, passing into the uterus and ovaries, causing chronic pelvic infection and infertility. Development of tetanus may cost the patient her life. Septicaemia, also potentially fatal, is a possible complication from serious infection, too.
4 **Urine retention:** After FGM, urination may be difficult or impossible. The urinary canal may be partially or entirely obstructed. Pain, or fear of pain, during urination may prevent natural flow. Oedema or other wound reactions (e.g. granulation tissue or fibrosis) may contribute to obstruction. The taut bridge of skin created by infibulation may leave insufficient space for passing liquid waste. Urine retention can lead to infection.

5 **Injury to adjacent tissue:** An operator not gifted with precise technique, or a patient who struggles or flinches with pain, can inflict damage to areas of the body surrounding the genitalia, including the urinary canal, the vagina, perineum or rectum. Incontinency can result.

Later complications and problems

Infibulation that appears to succeed without complications at the time can still create later problems. Virtual closure of the vaginal introitus makes obstetrical and gynaecological examination difficult. Insertion of a catheter may no longer proceed readily. It happens at times that a foreign body enters the vagina - a matchstick, for example, intended to keep a small hole open during the healing process, or some tiny object introduced by the patient in playing, or out of curiosity. This foreign body may remain trapped inside and become the source of irritation and infection. Decircumcision is often needed in such instances.

A variety of deferred complications can arise from FGM.

1 **Keloid formation:** Wound infection may involve a hardening of scars, thus forming a so-called keloid. Keloids may cause problems at the time of first intercourse and during delivery. They also make surgery more difficult.
2 **Dermoid or inclusion cysts:** As a result of the inclusion of epithelium from skin during FGM, cysts may develop. These cysts are a kind of swelling or pockets composed of skin and products secreted by the skin, including fats, hair and cells. The cysts may even outgrow the size of an orange.
3 **Vulval abscesses:** Infected cysts, as well as other infections at the site of circumcision, may form abscesses.
4 **Menstrual problems:** Normal menstruation may be hindered by partial or total occlusion of the vaginal opening. This may result in dysmenorrhea, painful menstruation, or, in acute cases, in haematocolpos, the accumulation of menstrual blood in the vagina and uterus. Distension of the abdomen induced by the accumulation of menstrual blood, together with the lack of any outward evidence of menstruation, may prompt suspicion of pregnancy. In a society where men jealously guard the honour of their families, should thoughts of extra-marital relations arise, the unfortunate woman may even be put to death [14,15].
5 **Difficult micturition:** Obstruction of the urinary opening or damage to the urinary canal may in time cause several complications: passing water may be extremely painful, and possible only a few drops at a time; the need to urinate may be practically non-stop, with minimal relief each time. Urinary tract infection can lead to a similar state.
6 **Urinary tract infection:** Infibulation creates a bridge of skin which obscures the opening of the urinary canal. The normal flow of urine is deflected, and the area remains constantly wet and susceptible to bacterial infection. Such infection may spread throughout the urinary tract, affecting both bladder and kidneys.
7 **Calculus formation:** Menstrual debris or urinary deposits in the vagina or behind the bridge of skin created during FGM may calcify, forming a kind of stone or stones. Calculus, or stone formation, is also possible, encapsulating foreign matter in the vagina. Calculus formation may cause fistulae.
8 **Fistulae and incontinence:** A fistula is a canal or connection between the urinary tract and vagina (vesico-vaginal) or between the rectum and vagina (recto-vaginal) which causes incontinence. Fistulae may form as the result of an injury during FGM or de- or recircumcision, intercourse or obstructed labour. Calculus formation can also be their cause.
9 **Chronic pelvic infection:** Infibulated women belong to a high-risk group for chronic infections of the pelvis. FGM and occlusion of the vagina and urinary canal increase the likelihood of infection, diminishing the effectiveness of natural mechanisms of protection. Infections that spread inwards to affect the uterus, ovaries and other organs may become chronic. Infertility is a possible consequence. Chronic pelvic infections are painful and may be accompanied by a noxious discharge.
10 **Infertility:** Infections as a consequence of FGM may do irreparable damage to the reproductive organs. Too tight a circumcision may prevent coitus and require decircumcision to solve the problem.
11 **Problems at pregnancy and delivery:** After FGM, the vaginal opening may be so small – conception may even occur without penetration – that in the event of a miscarriage the foetus may be retained inside. This can give rise to serious infection.

    At the time of delivery, fear or obstruction (if the scar fails to dilate, for example) may cause delay and a prolonged second state of labour. In turn, fatigue from protracted labour may induce uterine inertia i.e. labour may be interrupted by exhaustion.

    Obstructed labour may be dangerous to mother and child: the mother may suffer lacerations or tears and the formation of fistulae; the baby may suffer brain damage as the result of an insufficiency of oxygen (anoxia). Death for both is possible. To facilitate delivery, decircumcision is required.
12 **Decircumcision and recircumcision – complications:** As a consequence of decircumcision a woman may suffer additional loss of blood, injury to surrounding parts, fistulae, uterine prolapse, and infection. Recircumcision, a common operation after decircumcision, is replete with all the hazards of initial FGM. Repetition of de- and recircumcision may weaken scar tissue exceedingly.
13 **Sexual problems:** For a woman who has been infibulated, first coitus is invariably a difficult process; it may be very painful and require long and repeated efforts before penetration succeeds. Tissue may be torn or cut with some instruments with the danger of serious injury, infection, and, in extreme cases, death. Ignorance and maladroitness may lead to urethral coitus, or the formation of a false vagina through internalisation of skin as the result of repeated penial pressure.

Even later intercourse may be painful (dyspareunia). Dissatisfaction with vaginal intercourse may prompt anal penetration.

Removal of sensitive organs at the time of FGM may destroy the woman's capacity to experience orgasm. Exceptions have been reported, however.

Psychological and social problems

Psychological disturbances: FGM, or its delayed complications, may trigger the onset of anxieties, depression, neuroses and psychoses [16]. Too little research has been performed to date, however, to establish the true weight of FGM in cases of subsequent mental disorders.

Negative social consequences of FGM: These consequences may also interfere with a girl's social life. Ill health, incontinency – such problems are not conducive to full participation in social activities.

Difficult penetration, suspicion of barrenness – these may be arguments for divorce. Apparent pregnancy, as previously described, has resulted in tragedy. Suicide is not out of the question, either.

Medicalisation

People are increasingly turning to healthcare providers to perform the procedure in the hope that it will reduce the risk of complications.

Recent analysis from WHO shows that more than 18 per cent of all girls and women who have been subjected to FGM in the countries from which data is available have had the procedure performed on them by a healthcare provider. There are large variations between countries regarding health provider involvement – less than one per cent in several countries to between nine per cent and 74 per cent in six countries.

More research is needed to estimate whether this phenomenon is also observed among migrants, refugees and asylum seekers from FGM-practicing countries. Available data suggest that in countries with these immigrant populations, involvement of healthcare providers in FGM mainly concerns the act of reinfibulation.

Categories of healthcare providers found to carry out FGM include physicians, assistant physicians, clinical officers, nurses, midwives, trained traditional birth attendants and other personnel providing healthcare to the population in both the private and public sectors. Some providers are officially retired, but continue to provide FGM, as well as other health services.

Medicalisation gives the misleading impression that the procedure is good for health or that it is harmless. As an unfortunate consequence of this, some providers may develop a professional and financial interest in continuing the practice.

There are organisations that support medicalisation, as it is seen to reduce the risks and pain involved; many feel that it is a logical 'stepping stone' towards full abandonment of the practice.

However, it must be stated that the performance of FGM by healthcare providers is a harmful practice and a violation of human rights. It constitutes a break in medical professionalism and ethical responsibility and, in most countries, it also constitutes a violation of the law.

Several key barriers to stopping medicalisation include lack of protocols, manuals and guidelines to guide healthcare providers; insufficient training and support for healthcare providers; lack of involvement of the local health sector in the prevention of FGM; and the lack of laws and the will to prosecute.

Strategies for elimination of FGM

Any effective strategy to eliminate FGM will need the following components: the mobilisation of political will and funding e.g. building advocacy support; the strengthening of the understanding and knowledge of healthcare providers (e.g. training modules); the creation of a supporting legislative and regulatory framework (e.g. states to adopt and enforce specific legislation); and the strengthening of monitoring, evaluation and accountability aspects (e.g. routinely collecting data such as ante-natal records).

Involvement of community leaders, religious leaders, youth, and women's groups is essential in achieving societal changes to discourage FGM as a proven harmful traditional practice in the community.

Regarding the issue of medicalisation, according to the World Medical Association's 'Declaration of Helsinki', 1964, it is the mission of the physician to safeguard the health of the people. Health professionals who perform FGM are violating girls' and women's right to life, right to physical integrity, and right to health. They are also violating the fundamental ethical principle: 'Do no harm'.

Conclusion

FGM constitutes a major public health problem affecting the health of women and girls in the countries where it is practiced, subjecting them to serious health consequences.

Concerted efforts need to be exerted by the community, policy-makers, healthcare professionals and others to eliminate this tragic practice.

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