STUDENT PAPER

FEMALE GENITAL MUTILATION

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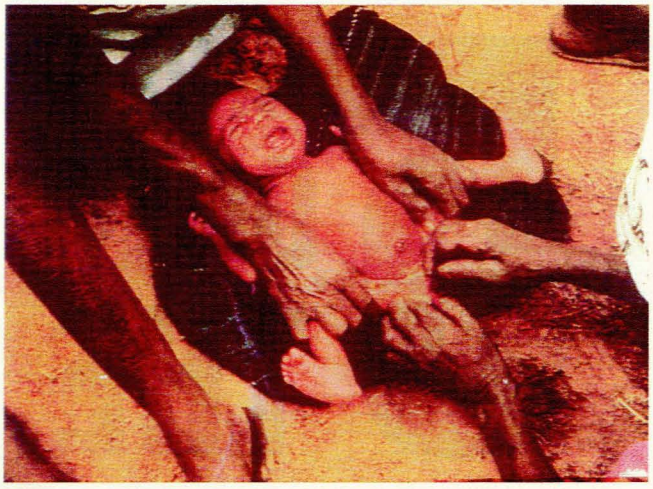
Female genital mutilation (FGM) or female circumcision refers to a group of traditional practices that involve partial or total removal of the external female genitalia for cultural, religious or other non-therapeutic reasons.

The practice of female genital mutilation is widespread in many developing countries, yet health care practitioners trained in Western medicine typically know very little about the care of circumcised women. The influx of immigrants and refugees into Western cultures has made it important for health care practitioners to understand some of the customs, beliefs and traditions surrounding female circumcision. This is especially the case in South Africa with its 8 million illegal immigrants. It is a major health problem in those countries in which it is practised, and its management imposes an immense burden on already strained health budgets and facilities.

It is estimated that approximately 2 million procedures are performed annually (World Health Organisation, 1997) in areas such as Central and East Africa, as well as in certain communities in middle and East Asia.

This ritualistic tradition dates back to the 5th century BC, and has become entrenched in certain cultures because of various misconceptions, such as that it is demanded by the Islamic faith, that the secretions of uncircumcised girls kill spermatozoa, thereby making them infertile, or that the clitoris has the power to kill the first-born during delivery. Culturally, it increases a girl's chances of marriage by ensuring that her virginity is kept intact and preventing promiscuity; it is also believed to improve fertility and promote cleanliness. Genital scars, like ornamental scarring and tattoos, are ethnically distinctive and confer on women a higher status due to the training that is associated with this rite. Circumcision also promotes social cohesion and integration within cultures, as it confers social acceptability.

The authors are 5th-year medical students at the University of Cape Town. They wrote this review as part of the gynaecology course, for which they were required to do a project on any topic relating to women's health. It was submitted to us by their course convenor, Dr Lynette Denny.

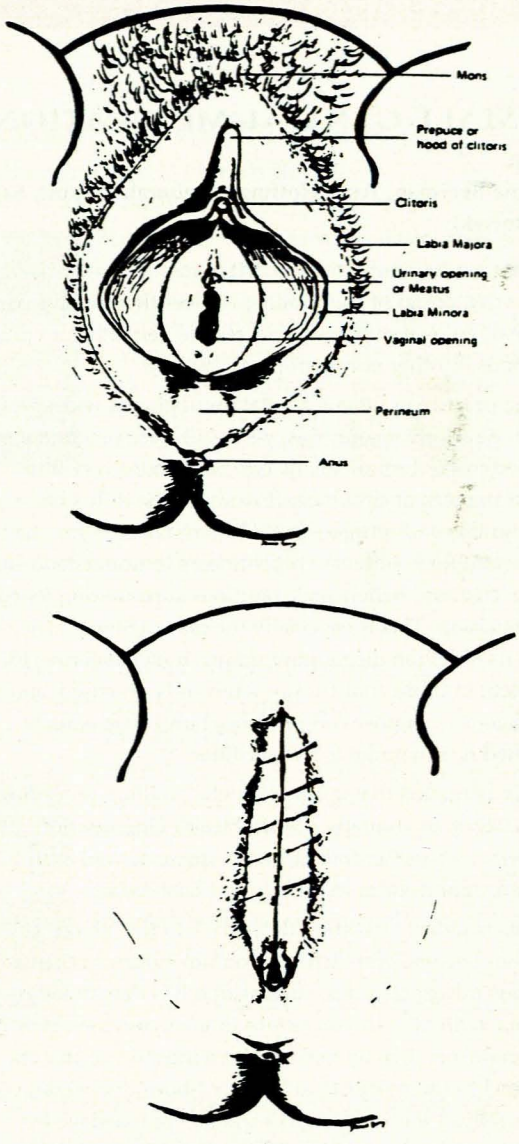


A village elder operates on a baby girl.

It has therefore become accepted as part of a ceremonial induction into adult society.

The operation is generally differentiated into four basic types according to degree of severity. Type 1 is analogous to male circumcision and consists of cutting the clitorial prepuce circumferentially to remove it. This is the least drastic operation. Type 2 involves removing the glans clitoris or even the entire clitoris; part or even all the labia minora may be removed as well. Type 3, infibulation or 'pharaonic circumcision', involves removing not only the clitoris and labia minora, but the labia majora as well. The raw edges of the wounds are sewn together leaving only a tiny opening for urination and menstruation. Type 4, which is rarely practised, is referred to as introcision and involves enlarging the vaginal opening by cutting the perineum.

Female circumcision is usually performed on girls when they are 7 - 8 years old, although this varies between cultures from as young as 1 week to 14 years old. It is usually performed by traditional birth attendants, midwives, the mother or grandmother or the (male) village barber. The ceremony is conducted with varying degrees of ritual and celebration in hospitals, houses, huts, tents or the open air. Except when in a hospital, the operation is performed under poor hygienic conditions with no anaesthetic, and the child is held down by family members with her legs open. Different tools such as a knife, razor blade, sharpened stone or a burning piece of wood or coal are used to mutilate the genitalia; the two raw edges of the vulva are sometimes pinned together by long acacia thorns, or pasted with gum Arabic, sugar or egg. In several cultures, the girl's legs are then bound together from ankles to hips, and she is immobilised for 10 to 40 days to allow the formation of scar tissue. A woman is de-infibulated or opened up on her wedding night so that the marriage can be consummated. A razor, knife or specially grown fingernail is used by the



Above: normal adolescent female genitalia. Below: infibulated genitalia.

husband or midwife to enlarge the orifice so that penetration is made possible. A widowed or divorced woman is re-infibulated to ensure that sexual intercourse is once again impossible.

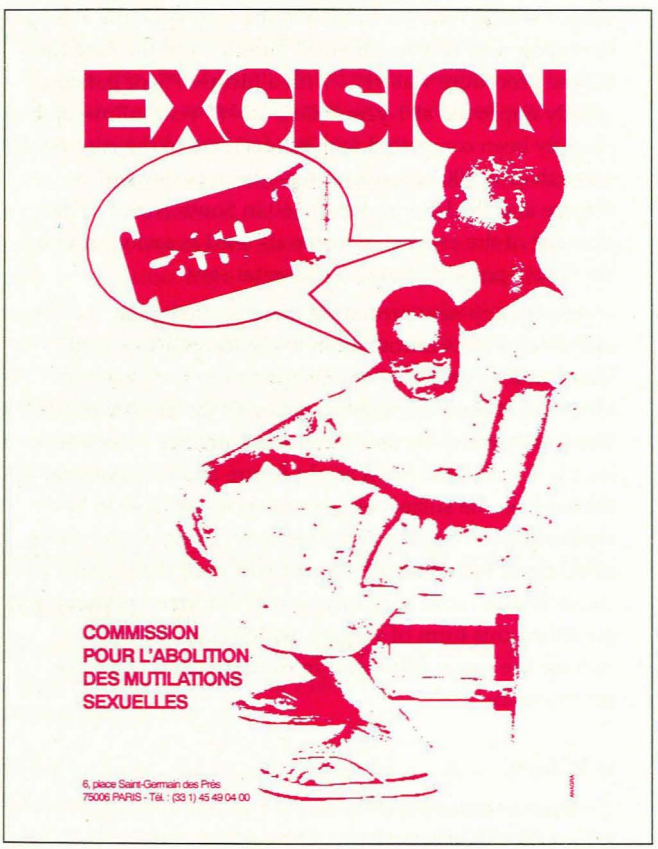
Some of the medical complications common to all types of FGM, but occurring more often in infibulation, are haemorrhage, prolonged bleeding causing shock and death, local and systemic infection, abscess and ulcer formation, septicaemia, anaemia, tetanus, gangrene, cystitis, chronic pelvic inflammation, dysmenorrhoea, dyspareunia, damage to Bartholin's glands, fistula formation and infertility, as well as the transmission of HIV. Unfortunately complications are often

treated by the unskilled operators themselves. Obstetric and gynaecological complications include severe haemorrhage, bladder injuries, lacerations of the urethra and rectum, and fetal brain damage or fetal loss because of obstructed labour.

Very little research has been done on the psychological and sexual complications of female circumcision because of the taboos and personal inhibitions surrounding the subject. A circumcised woman's sexual desire is usually not affected by the procedure, but the ability to achieve orgasm varies, depending on the severity of the operation. The anticipation and pain of the procedure, painful menstruation and pain during intercourse may all lead to substantial anxiety and depression. Mutilated women may view their own sexuality in terms of pleasing their spouse, and may accept the fact that their only sexual pleasure is received indirectly by giving him pleasure.

According to a 1995 Somalian survey,[1] 96% of circumcised women advocated this practice and would pass it on to their daughters despite the horrors that they themselves endured during and after mutilation. This statistic shows how embedded female circumcision is in many cultures. Outlawing female circumcision is not the answer to the problem, as illustrated in Sudan, where FGM has been outlawed. This practice continues in greater secrecy as an underground operation, and people are less likely to seek medical attention for fear of prosecution, thereby further raising the mortality rate. This failure should be taken into consideration, and additional legislative attempts to ban FGM should be combined with increased educational initiatives. Major factors that will lead to the abolition of the practice are role modelling by influential members of the local community, improving general awareness regarding complications of this practice, and correcting the misconception that female circumcision is a requirement of Islam.

It must be recognised that attitudes towards such an ancient custom cannot be changed overnight, although moves to replace the practice gradually must be taken — mere repression is counterproductive. Women need to find social status, approval and respectability in other ways.



A poster used in the campaign against FGM in France.

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