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Female Genital Mutilation/Cutting

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TERMINOLOGY

The term "female genital mutilation/cutting" (FGM/C) refers to all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for nonmedical reasons.[1] The terminology for these procedures has undergone various changes over the last few decades. The term "female circumcision" was widely used for many years to describe the practice; it has been largely abandoned, however, as it implies an analogy with the circumcision of newborn boys, a low-risk procedure with medical benefits.[2,3] The expression "female genital mutilation" gained growing support from women's rights and health advocates in the late 1970s to emphasize the serious harm associated with the practice and to define it as a violation of girls' and women's human rights. The World Health Organization (WHO) recommended that the United Nations (UN) adopt this term in 1991 and it has subsequently been widely used by WHO and in other UN documents.

In the mid-1990s many practicing communities and activists decided to use a more neutral term, "female genital cutting" (FGC), because they considered the term FGM to be stigmatizing to those who had undergone the procedure. In addition, it appeared that the word was estranging practicing communities and perhaps hindering the process of social change necessary for the elimination of FGM.

While the UN continues to use FGM in official documents, some of its agencies (United Nations Children's Fund [UNICEF] and United Nations Population Fund [UNFPA]) have started to use the combined term female genital mutilation/cutting (FGM/C) to capture the significance of the term "mutilation" at the policy level and at the same time to use less judgmental terminology for practicing communities.[4] It is important that health care providers use culturally sensitive terms with patients when discussing this practice and its consequences.

PREVALENCE AND GEOGRAPHIC DISTRIBUTION

The World Health Organization estimates that between 100 million and 140 million girls and women worldwide have undergone some type of FGM, and that currently, about 3 million girls, most of them under 15 years of age, undergo the procedure every year.[4] The great majority of affected women live in 28 countries in Africa, but the practice has also been reported in parts of the Middle East, Asia, and Latin America. Countries on the African continent with the highest likelihood of FGM being practiced are Djibouti, Egypt, Eritrea, Ethiopia, Gambia, Guinea, Mali, Sierra Leone, Somalia, and Sudan.

Growing migration has increased the number of girls and women living outside their country of origin; many who now live in Europe, the United States, Canada, New Zealand, and Australia have undergone FGM or may be at risk of being subjected to the practice.[5-7] Some families arrange for their daughters to undergo FGM while on vacation in their home countries.

Female genital mutilation is practiced by people from all education levels and social classes, including urban and rural residents, and different religious and ethnic groups. It is generally practiced on girls between the ages of 4 and 10 years, although in some communities it is performed shortly after birth, during adolescence, just before marriage, during first pregnancy, or after the first birth. In some practicing cultures, women are re-infibulated (re-stitched) following childbirth as a matter of routine. The age at which female genital mutilation is performed varies with local traditions and circumstances, and is reported to be decreasing in some countries.[4]

The procedure is usually performed by traditional birth attendants or older women in the community who do not have formal training. It is often carried out using primitive instruments, razor blades or pieces of glass, and without anesthetic or attention to hygiene.[8] The child can be subjected to the procedure unexpectedly and held down on the floor by several attendants. Often a number of girls undergo the procedure during a single ritual ceremony and in these cases the same instrument is commonly used on all the girls. Increasingly, in some communities, FGM is being "medicalized" and performed in modern clinical settings by a physician or other health professional in the belief that complications occur less frequently.[4]

TYPES OF FEMALE GENITAL MUTILATION

Recognition of the different types of FGM is important because the complications differ with the severity of the procedure.

Table 17-1 World Health Organization Classification of Female Genital Mutilation[4]

- Type I: Clitoridectomy: Partial or total removal of the clitoris and/or the prepuce (Figure 17-2)
  - Type Ia, removal of the clitoral hood or prepuce only
  - Type Ib, removal of the clitoris with the prepuce
- Type II: Excision*: Partial or total removal of the clitoris and the labia minora with or without excision of the labia majora (Figure 17-3).
  - Type IIa, removal of the labia minora only
  - Type IIb, partial or total removal of the clitoris and the labia minora
  - Type IIc, partial or total removal of the clitoris, the labia minora, and the labia majora
- Type III: Infibulation†: narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris (Figures 17-4 and 17-5).
  - Type IIIa: removal and apposition of the labia minora
  - Type IIIb: removal and apposition of the labia majora
- Type IV: Unclassified: All other harmful procedures to the female genitalia for nonmedical purposes, for example, pricking, piercing, incising, scraping, and cauterization

*Note that in French the term "excision" is often used as a general term covering all types of female genital mutilation.
†Reinfibulation is covered under this definition. This is a procedure to recreate an infibulation usually after childbirth in which defibulation was necessary.

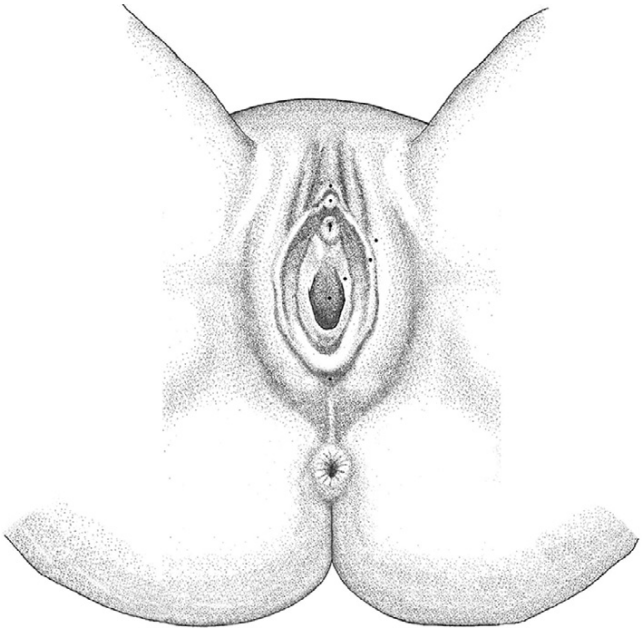

FIGURE 17-1 Normal, unmutilated female genitalia. *(From Cooper SW, Estes RJ, Girardino AP, et al:* Child sexual exploitation, *ed 1, GW Medical Publishing, Inc, St Louis, 2005.)*

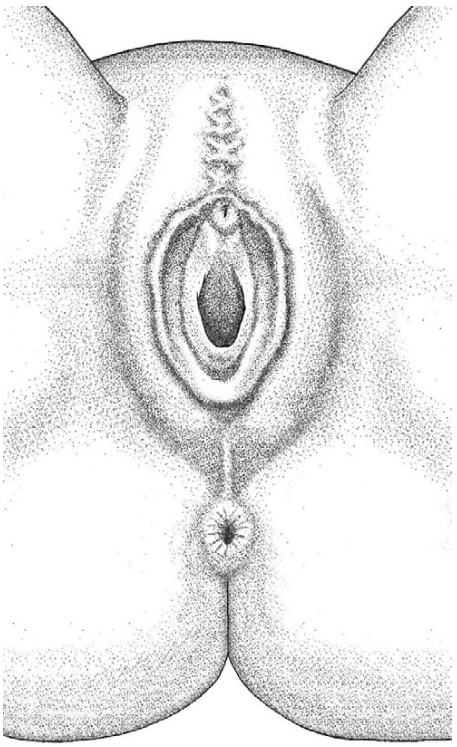

FIGURE 17-2 Type I female genital mutilation. *(From Cooper SW, Estes RJ, Girardino AP, et al:* Child sexual exploitation, *ed 1, GW Medical Publishing, Inc, St Louis, 2005.)*

The WHO/UNICEF/UNFPA 1997 Joint Statement classifies FGM into four types based on the severity of structural disfigurement.[1] This was slightly modified in 2008.[4] Within each type of FGM there will be variation with respect to the amount of tissue removed. Table 17-1 lists the classifications of FGM. Figure 17-1 represents normal, unmutilated female genitalia. Figures 17-2, 17-3, and 17-4 represent various types of FGM. Current estimates indicate that about 90% of female genital mutilation cases include Types I or II and IV and about 10% are Type III.

The type of FGM varies by region and ethnicity.[9] In reality, the extent of cutting and stitching varies considerably since the excisor is usually a layperson with limited knowledge of anatomy and surgical technique. With local or no anesthesia, the girls often move to the extent that cutting cannot be accurately controlled.

CULTURAL ISSUES

It is not known when or where the tradition of FGM originated. Evidence from Egyptian mummies suggests that infibulation (also known as the pharaonic procedure) was practiced there some 5000 years ago.[10] Cliteroidectomy was used in western medicine up to the late 1950s as a treatment for nymphomania, promiscuity, and masturbation.[11,12]

FGM continues within a complex web of social, cultural, and economic justification and is deeply embedded in local traditional belief systems. These beliefs involve continuing long-standing custom and tradition, maintaining virginity, enhancement of girls' ability to marry, promotion of fidelity in married women, enhancement of male sexual pleasure, increasing fertility and child survival, upholding family honor, perceived religious dictates, and contributing to social stability.[4]

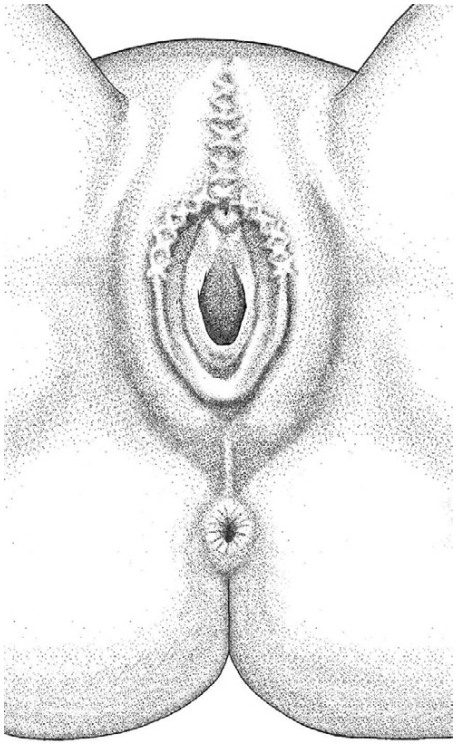

FIGURE 17-3 Type II female genital mutilation. *(From Cooper SW, Estes RJ, Girardino AP, et al:* Child sexual exploitation, *ed 1, GW Medical Publishing, Inc, St Louis, 2005.)*

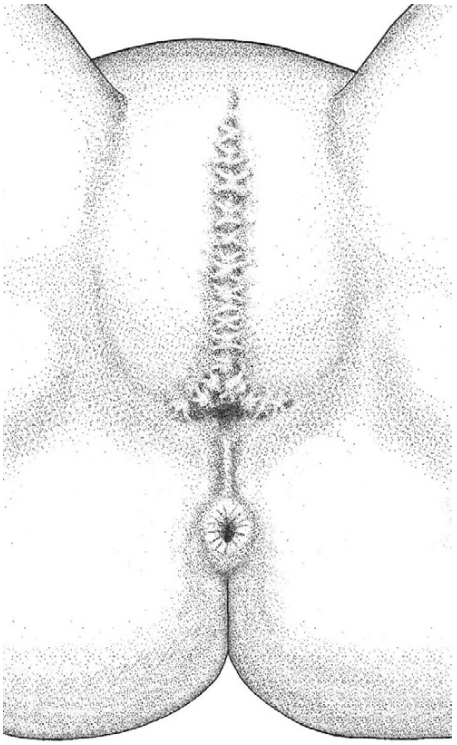

FIGURE 17-4 Type III female genital mutilation. *(From Cooper SW, Estes RJ, Girardino AP, et al:* Child sexual exploitation, *ed 1, GW Medical Publishing, Inc, St Louis, 2005.)*

Preservation of Cultural Identity

In communities where it is widely practiced, FGM is considered an honorable tradition that is an important part of the cultural identity of girls and women. In some societies, the practice is embedded in coming-of-age rituals and girls who undergo the procedure are given rewards such as celebrations, public recognition, and gifts.

Marriage

Some of the other justifications offered for FGM are also linked to girls' marriage prospects. Marriage is essential to the social and economic security for women in FGM practicing communities. FGM becomes a physical sign of virginity and is regarded in many societies as a prerequisite for an honorable marriage. In some communities, it is thought to restrain sexual desire, thereby ensuring marital fidelity. A belief sometimes expressed is that FGM enhances a man's sexual pleasure.

Religion

While religious duty is commonly cited as justification for the practice of FGM, it is important to note that FGM is a cultural and not a religious requirement. Even though the practice can be found among Christians, Jews, and Muslims, none of the holy texts of any of these religions prescribes FGM and the practice predates both Christianity and Islam.

Health

FGM is thought to improve fertility and prevent infant and maternal mortality.

Hygiene and Aesthetic Reasons

FGM is also considered to promote cleanliness. In some cultures it is believed that a girl who has not undergone FGM is unclean and not able to handle food or drink. Removal of genital parts is thought of as eliminating "masculine" parts such as the clitoris or in the case of infibulations, to achieve smoothness which is considered to be beautiful.

Contributing to Social Stability

The practice of FGM is often upheld by local structures of power and authority such as traditional leaders, religious leaders, circumcisers, elders, and even some medical personnel. It can be a lucrative source of income in some communities. It is often practiced even when known to inflict harm upon girls because the perceived social benefits of the practice are deemed higher than its disadvantages. Parents who support the practice of FGM say that they are acting in the child's best interests and risk their child's marriage prospects and being ostracized by their community should they resist the practice.

HEALTH COMPLICATIONS

A wide range of complications of FGM are documented, including short-term and long-term physical, sexual, and psychosocial problems.[13] The type and severity of the consequences vary according to the type of procedure performed; the extent of the cutting; the skill of the incisor; the hygienic conditions; the physical and mental health of the girl undergoing the procedure; the child's access to adequate health care; and particular characteristics of the child, including age, ethnicity, and family and societal support.

For many women the most difficult physical problems coincide with various life cycle events such as immediately after cutting, at menstruation, at time of marriage, and during childbirth. The physical complications are summarized in Table 17-2.

Findings from a recent large scale WHO multicountry study confirm that women who had undergone FGM had significantly increased risks for adverse events during childbirth.[15] Higher incidences of cesarean section and postpartum hemorrhage were found in women with type I, II, and III FGM compared to those who had not undergone FGM, and the risk increased with the severity of the procedure.

A striking new finding from the study is that the FGM of mothers has negative effects on their newborn babies. Most seriously, death rates among babies, during and immediately after birth, were higher for those born to mothers who had undergone FGM compared with those who had not: 15% higher for those whose mothers had type I, 32% higher for those with Type II, and 55% higher for those with type III FGM. The consequences of FGM for most women who deliver outside the hospital setting are expected to be even more severe. The high incidence of postpartum hemorrhage, a life-threatening condition, is of particular concern where health services are poor or inaccessible to women.

In contrast to numerous studies and case reports on the physical complications of FGM, little scientific research is available on the sexual and psychosocial consequences of the practice. This is partly due to difficulties in measuring psychological distress and partly due to women's reluctance to discuss these issues.

For many girls and women, FGM is an acutely traumatic experience that leaves a lasting psychological mark and may adversely affect full emotional development. Girls are generally conscious when the operation is performed and for many it is a shocking experience marked by acute pain, fear, and confusion. The experience of FGM has been related to a range of psychological and psychosomatic disturbances, including changes in eating and sleeping habits, loss of appetite, weight loss or excessive weight gain, panic attacks, difficulties in concentrating and learning, and symptoms of posttraumatic stress disorder.[4,16] In many cases, women and girls who have been traumatized by FGM remain silent about their experience. In some cultures they have no socially acceptable means of expressing their feelings or distress.

There may be additional psychological implications for immigrant women who live in western societies where FGM is not traditionally practiced. These women confront the conflicting attitudes of their traditional culture and of western culture towards FGM, sexuality, and women's rights. Some community groups and agencies have reported girls

Table 17-2 Possible Complications of Female Genital Mutilation

- Short-term complications*
  - Severe pain
  - Severe hemorrhage
  - Shock
  - Injury to adjacent tissues (e.g., urethra)
  - Injury due to restraint (e.g., fractures, dislocations)
  - Acute retention of urine
  - Infections after use of contaminated instruments and during the healing period (wound infections, septicemia, tetanus, pelvic inflammatory disease, urinary tract infections, HIV, hepatitis B and C)
  - Death from hemorrhagic shock, neurogenic shock as a result of extreme pain and trauma, or severe, overwhelming infection and septicemia
- Long-term complications
  - Girls and women undergoing FGM Type III are particularly likely to suffer serious and long-term complications; the stitching of the labia majora to create a flap of skin covering the vaginal opening causes a direct mechanical barrier to urination, menstruation, sexual intercourse, and to delivery of infants.
  - Local vulval problems: retention cysts, abscesses, keloids, excess scar tissue at site of cutting, and painful neuromas as a result of the entrapment of nerve endings in the scar
  - Chronic upper and lower urinary tract infection potentially resulting in renal failure, septicemia, and death
  - Calculus formation in the vagina
  - Chronic vaginal and pelvic infections leading to scarring and infertility
  - Increased risk of HIV
    - From the use of the same instruments used for other initiates
    - Secondary to increased need for blood transfusions due to hemorrhages either when the procedure is performed, at childbirth or as a result of vaginal tearing during defibulation and injurious sexual intercourse[14]
  - Dysmenorrhea and blocked menstrual flow with hematocolpos, which can lead to endometriosis
  - Hemorrhage due to recurrent trauma, possibly resulting in anemia
  - Complications in pregnancy and childbirth
    - Prolonged and obstructed labor due to unyielding scar tissue
    - Tearing of the perineum, hemorrhage, fistula formation (vesico-vaginal or recto-vaginal)
    - Uterine inertia, rupture, or prolapse
  - Postpartum wound infection and retention of lochia may lead to puerperal sepsis
  - Neonatal problems from obstructed or prolonged labor. If deinfibulation is not performed and delivery of the head is delayed, anoxia and fetal death can occur.

*Immediate consequences are usually only documented when hospital treatment is sought, therefore the true extent of immediate complications is unknown.

experiencing difficulties with their peer group (e.g., a young man rejecting a girlfriend when he discovers she was subjected to FGM as a child, or a girl discovering that other girls have not been subjected to FGM).[5]

Much of the qualitative research regarding the effects of FGM on the sexuality of women has suggested that all types of FGM inhibit sexual fulfillment and pleasure for women. The physical damage resulting from FGM combined with the psychological trauma and pain can compromise an adult woman's sexual life. Moreover, women who have been infibulated may be defibulated upon marriage, a process that is a source of both pain and further psychological trauma. Marital problems can arise and can eventually lead to divorce, which in turn jeopardizes women's social and economic status and that of their children.[16]

MANAGEMENT OF FGM

The influx of refugees and immigrants from different parts of Africa to North America, Europe, and Australasia in the past two decades requires that physicians and other health professionals familiarize themselves with the practice of FGM, its causes, cultural meanings, and health and legal ramifications. Health professionals play a key role in the prevention of FGM, including educating patients and communities about the harmful consequences and promoting the benefits in eliminating the practice, along with providing early identification and treatment of complications of the procedure. The training of health professionals has been identified as a priority strategy for the elimination of FGM.[4]

The World Health Assembly (the highest authority of the WHO),[17] the World Medical Association,[18] and the International Federation of Gynecology,[19] and medical associations in many countries have opposed FGM as a medically unnecessary practice with serious, potentially life-threatening complications. These organizations have issued statements condemning the practice as harmful and calling for coalitions to abolish it. Performing FGM in pain-free and sterile conditions does not alleviate the long-term detrimental effects and can wrongly legitimize the practice as medically sound or beneficial for girls' or women's health, thereby perpetuating rather than preventing or reducing the practice.

A number of professional bodies have published guidelines for medical professionals such as nurses, midwives, and obstetricians and gynecologists for the provision of antenatal, delivery, and postpartum care for women who have undergone FGM. Such guidelines include management of specific procedures such as deinfibulation and care of women with complications from the practice, including compromises in menstrual and sexual health.[20-29]

Multiagency child protection guidelines have also been developed for professionals from the health, social services, law enforcement, and education sectors in the developed world to respond to children at risk and to children and women who have undergone FGM.[30-33]

Child Protection Management

There are two circumstances relating to FGM that require identification and intervention. The first is to identify children at risk of being subjected to FGM and responding appropriately to protect them. The second is to identify children who have been subjected to FGM and providing appropriate support for them. Table 17-3 lists indicators of girls at risk for FGM.

Table 17-3 Indicators of Girls at Risk of FGM

Indicators that FGM Might Soon Occur
• The family comes from a community that is known to practice FGM. • Any female child born to a woman who has been subjected to FGM or who has existing daughters who have undergone FGM. • Parents state that they or a relative will take the girl out of country for a prolonged period. • A girl who talks about a long holiday to her country of origin or another country where the practice is prevalent. • A girl who confides that she is to have a special procedure or attend a special celebration for her.
Indicators that FGM May Have Already Occurred
• Prolonged absence from school with noticeable behavior change on her return • Long periods away from classes or other activities, possibly with bladder or menstrual problems

Clinicians and child protection professionals should discuss the issue of FGM with parents who wish to continue the practice and educate them about the health consequences and legal restrictions. Every attempt should be made to work with parents on a voluntary basis to prevent FGM and includes the use of community organizations and/or community leaders to facilitate the work with parents and families. Suspicion of intent to perform FGM should be addressed immediately as there is the risk that the child could suddenly disappear or be sent abroad. A report should be made to child protection services if a child is in need of protection.

On physical examination of a girl who has undergone FGM, there can be little or no evidence of genital scarring or only attenuation of clitoral tissue, as many FGM procedures do not involve removal of significant amounts of tissue. Minor changes are difficult to evaluate when no history is available. However, the physical findings in girls who have had procedures involving extensive removal of tissue and major changes in the size of the introitus are sufficiently dramatic not to be missed on careful examination.[34] Procedures are often performed under less-than-sterile conditions and carry a risk of viral and bacterial infection transmitted by instruments used in surgery. Serology for HIV, hepatitis B, and hepatitis C are indicated in children who have evidence of FGM.

Young immigrant women who come from cultures and communities where FGM is commonly performed are likely to face conflicting cultural messages about the meaning of FGM as they grow up. Their families may be concerned primarily about the social consequences of noncompliance with the tradition. Conflicting messages are a potential source of confusion and distress. The psychosocial needs of

children and adolescents who have undergone FGM should be recognized specifically and appropriate counselors and networks identified.

Medical Management

Defibulation is a surgical procedure to reverse infibulations. Defibulation can be performed before marriage, before or during pregnancy, or at childbirth. Adolescents who have undergone some form of FGM in childhood might wish to have the procedure reversed at a time other than that which is culturally preferred or acceptable.[35] The procedure allows them to use vaginal tampons, have penetrative sex, reduces the likelihood of complications with a vaginal delivery at a later date, and may satisfy their body image concerns. Like all operative procedures, it is obviously most desirable that the procedure is sanctioned by the young woman's parents. In most cases the girl should be encouraged to involve her parents and there should be detailed consideration of the most extreme possible consequences of not involving them. Justification of reversal of FGM on medical grounds might potentially be less threatening to parents and community members.

Women with FGM Type III require special care during pregnancy and childbirth, especially if it is the first pregnancy or the woman has had a previous caesarian section or past reinfibulation. Elective defibulation during the antenatal period, ideally around 20 weeks, reduces lacerations and avoids the necessity of performing defibulation or anterior episiotomy during labor, thereby reducing the risk of caesarian section. The operation should be carried out under adequate anesthesia, which can be general or spinal. Inadequate pain relief could cause traumatic flashbacks.

Obstetricians and midwives might be asked to reinfibulate (re-stitch) a woman following a vaginal delivery. While legal in some countries, requests by women in western countries for reinfibulation following childbirth are outlawed on the grounds that this is damaging to their health and well-being. Any repair carried out after birth, whether following spontaneous laceration or deliberate defibulation to facilitate delivery, must not be to the degree that makes intercourse difficult or impossible.

Culturally competent and compassionate care for women and their partners is important to dissuade them from resorting to illegal community practitioners who may operate under inadequate and unhygienic conditions. Health care professionals should be aware of the mental health needs of women who have experienced FGM and refer them (where necessary) to culturally appropriate services.

INTERNATIONAL RESPONSE

Over the last several decades there has been a shift from the perspective of FGM as a cultural and health issue to recognizing it as a pressing human rights and public health issue among governments, the international community, and professional health organizations.[16] FGM is a practice that is discriminatory on the basis of sex and violates women's rights in many ways including: (1) The right to the highest attainable standard of physical and mental health; (2) the right to security; (3) the right to freedom from all forms of physical and mental violence; (4) the right to freedom from cruel, inhuman, or degrading treatment; (5) the right to protection from harmful traditional practices; and, (6) the right to life when the procedure results in death. These rights are protected in international law. A number of human rights conventions and declarations are directly or indirectly violated by the practice of FGM, including the Universal Declaration of Human Rights (1948),[36] the UN Convention on the Elimination of All Forms of Discrimination against Women (1979),[37] the UN Convention on the Rights of the Child (1990),[38] and the Beijing Declaration and Platform for Action of the Fourth World Conference on Women (1995).[39] Signatory states have an obligation under these standards to take legal action against FGM.

In 1997, a joint statement was issued by WHO, UNICEF, and UNFPA expressing commitment from all three organizations towards abolition of the practice.[1] A new 2008 Interagency Statement, based on new evidence over the last decade, has been signed by a wider group of United Nations agencies than the previous one.[4]

Nongovernmental organizations (NGOs) play a central role in generating national and international commitment to end the practice of FGM. At a regional level the Inter-African Committee on Traditional Practices Affecting the Health of Women and Children (IAC)[40] is the oldest NGO network dedicated to the abandonment of FGM in Africa. In other parts of the World, other NGOs have been involved with the work of abolishing FGM, including the Foundation for Women's Health Research and Development (FORWARD),[41] the Research, Action and Information Network for the Bodily Integrity of Women (Rainbo),[42] and the European Network for the prevention of FGM (euronet-FGM).[43]

Laws pertaining to FGM include both criminal and child protection laws. In some countries, the existing provision of criminal codes have been or can be applied to FGM. In Africa and in the Middle East, a large number of countries have introduced specific legislation to address FGM. Laws prohibiting FGM have also been introduced in a number of countries where the issue has arisen among immigrant communities including Australia, New Zealand, Canada, the United States, and several countries in Western Europe. Many countries have recognized the right to asylum for women and girls at risk of FGM.[6,44]

A number of countries have declared the applicability of their child protection laws to FGM while others have enacted and applied specific provisions for the elimination of harmful practices including FGM. Child protection laws provide for state intervention in cases in which the state has reason to believe that child abuse has occurred or might occur.

Despite the existence of laws forbidding the practice, enforcement of the laws can be lax or nonexistent. Furthermore, cultural norms in these countries or regions render women unwilling to seek protection or compensation under the law. Imposing sanctions alone runs the risk of driving the practice underground and having a very limited impact on the occurrence of FGM.

Clearly, the elimination of FGM is not simply a law enforcement issue. FGM is acknowledged as a unique, deeply rooted cultural practice and ending FGM requires a long-term commitment to establishing a foundation for sustained behavior change. Gender discrimination underlies the practice of FGM and the most effective strategies for

dealing with FGM involve empowering and educating women and girls within their own communities and cultures. In addition, recognition that the support of men and community leaders, both religious and secular, is vital to ending the practice. The approach to FGM is part of a larger commitment to combat violence against women and children around the world.[45-47]

Actions taken at international, regional, and national levels over the past decade or more have begun to bear fruit and, in some areas, the prevalence of female genital mutilation has decreased. Key lessons learned are that actions and interventions must be multisectoral, sustained, and community led.[16,48]

The Millennium Development Goals[49] establish measurable targets and indicators of development that are relevant to ending FGM; namely, to promote gender equality and empower women, to reduce child mortality, and to improve maternal health. A World Fit for Children,[50] the outcome document of the 2002 UN General Assembly Special Session on Children, explicitly calls for an end to harmful traditional or customary practices such as female genital mutilation. The UN Study on Violence against Children[45] report provides another important opportunity to highlight the issue and generate action to realize the goal of the abandonment of FGM.

Processes of social change leading to abandonment of the practice, while ensuring the marriageability of daughters and the social status of families who do not cut their girls, are underway in a number of countries, creating a new social norm that does not harm girls or violate their rights. With global support, it is conceivable that FGM can be abandoned in practicing communities within a single generation.[16] The United Nations has designated February 6 as the International Day of Zero Tolerance of Female Genital Mutilation.

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