Female Genital Mutilation

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Introduction

The term FGM (Female Genital Mutilation) is a phrase that has been presented to reference any form of the procedure that is performed on the genital areas of young girls and women that involves the removal of part or whole areas of the genitalia. The practice of FGM has been identified as being performed in many regions all across the world. The practice is; however, deeply rooted in the African continent and is heavily prevalent mostly in the countries that have a strong connection to the Islamic religion.

Definitions

Female genital cutting (FGC), also known as female genital mutilation (FGM), female circumcision comprises all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons.

Historical perspective:

Where and when FGM was first practiced is not known. Evidence from Egyptian mummies, suggests that a form of female circumcision was routinely practised there some 5000 years ago.

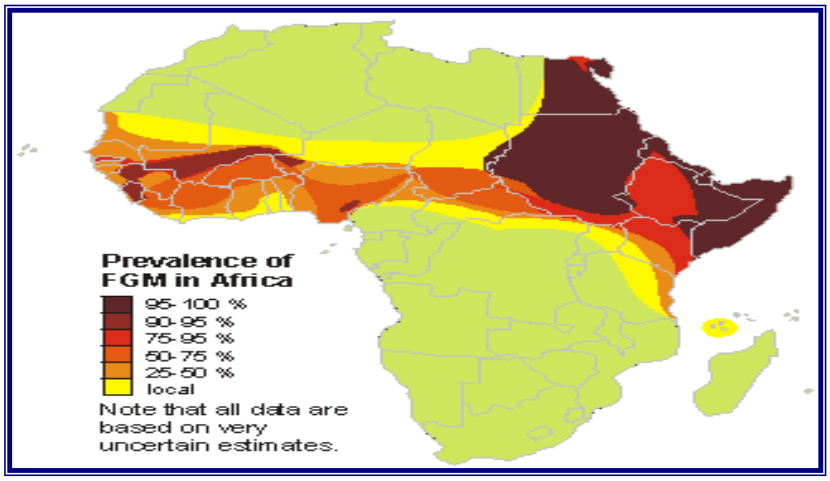
Incidence and Prevalence

An estimated 100 to 140 million girls and women worldwide are currently living with the consequences of FGM.
In Africa, about three million girls are at risk for FGM annually.

It is common in a band that stretches from Senegal in West Africa to Ethiopia on the East coast, as well as from Egypt in the north to Tanzania in the south; see Map. It is also practiced by some groups in the Arabian

Peninsula. FGM is most prevalent in Egypt, followed by Sudan, Ethiopia, and Mali. In 2007, Egypt passed a law completely banning FGM.

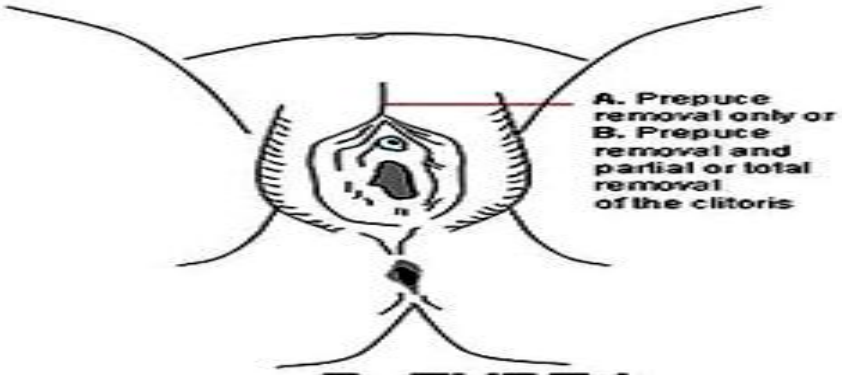
Figure 1 Prevalence Rate of FGM in Africa



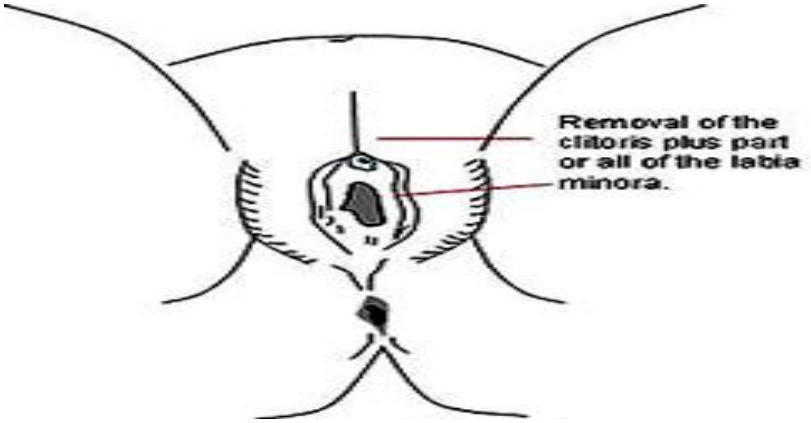
Types of female genital mutilation:

WHO which uses the term Female Genital Mutilation (FGM) divides the procedure into four major types:-

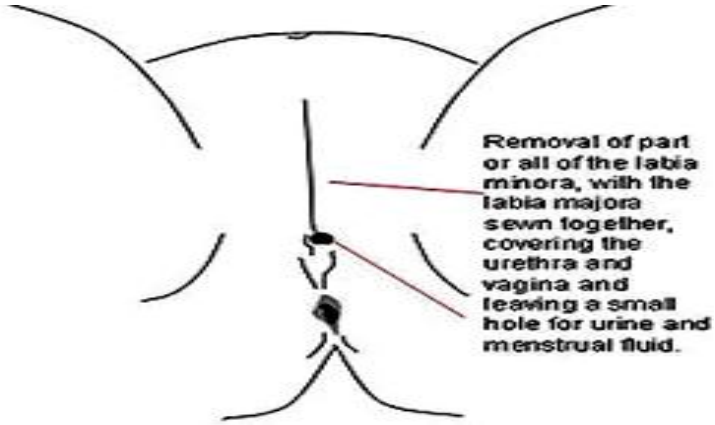
1. **Clitoridectomy (type I)**: partial or total removal of the clitoris (a small, sensitive and erectile part of the female genitals) and, in very rare cases, only the prepuce (the fold of skin surrounding the clitoris).



2. **Excision (type II):** partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (the labia are "the lips" that surround the vagina).



3. **Infibulation (type III):** narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the inner, or outer, labia, with or without removal of the clitoris.



4. **Other (Type IV):** all other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterizing the genital area.

<u>Why FGM is still practiced:</u>

A. The continuation of FGM in a practicing community is motivated by a complex mix of interlinked sociocultural factors

B. FGM is generally practiced as a matter of social convention, and is interlinked with social acceptance, peer pressure, the fear of not

having access to resources and opportunities as a young woman and to secure prospects of marriage.

C. It has been performed as a means of decreasing women's libido and promiscuity to ensure spousal fidelity, as a rite of passage for girls from adolescence into womanhood, to uphold and maintain cultural or religious traditions, and as a form of medical treatment.

The age at which FGM is performed:

It depends on the ethnic group or geographical location.

1. In Eritrea, for example, baby girls are excised around the seventh day after birth. However it is more common for children to be excised between the ages of 4 and 10 years.

2. Alternatively, FGM may be performed during adolescence, at the time of marriage (or subsequent marriages), during a first pregnancy or even during labour if it was not performed before.

Complications of female genital mutilation:

FGM has no health benefits, and it harms girls and women in many ways. It involves removing and damaging healthy and normal female genital tissue, and interferes with the natural functions of girls' and women's bodies.

Immediate complications can include:

- Severe pain
- Shock and hemorrhage (bleeding),
- Tetanus or sepsis (bacterial infection)
- Urine retention
- Open sores in the genital region and injury to nearby genital tissue.

Long-term consequences can include:

- Recurrent bladder and urinary tract infections;
- Cysts
- Infertility
- An increased risk of childbirth complications and newborn deaths
- The need for later surgeries. For example, the FGM procedure that seals or narrows a vaginal opening (type 3 above) needs to be cut open later to allow for sexual intercourse and childbirth.

Impact on health:

1. The most common short-term consequences of FGM include severe pain, shock caused by pain and/or excessive bleeding (haemorrhage), difficulty in passing urine and faeces because of swelling, oedema and pain, as well as infections. Death can be caused by haemorrhage or infections, including tetanus and shock. A study from one country.
2. An update on WHO's work on FGM that practices Type I and II FGM, and in which 600 women were questioned about their daughters' complications after FGM Type I and II, reported a death rate of 2.3%.
3. FGM of any type is also associated with a series of long-term health risks.
4. The most common complications are dermoid cysts and abscesses. Chronic pelvic infections that can cause chronic back and pelvic pain, and repeated urinary tract infections have been documented in both girls and adults.
5. A recent WHO-led study showed that FGM is associated with increased risk for complications for both mother and child during childbirth.

6. Rates of caesarean section (29% increase for Type II and 31% increase for Type III FGM) and postpartum hemorrhage (21% for Type II and 69% for Type III FGM) were both more frequent among women with FGM compared with those without FGM.
7. In addition, there was an increased probability of tearing and recourse to episiotomies. The risk of birth complication increases with the severity of FGM.
8. FGM of the mother is also a risk factor for the infant. The study found significantly higher death rates (including stillbirths) among infants born from mothers who have undergone FGM than women with no FGM. The increase was 15% increase for Type I FGM, 32% increase for Type II FGM and 55% increase for Type III FGM.
9. FGM can also lead to negative psychological consequences. Documented effects include post-traumatic stress disorder, anxiety, depression, and psychosexual problems.
10. Women with FGM were found to be 1.5 times more likely to experience pain during sexual intercourse, experience significantly less sexual satisfaction and they were twice as likely to report that they did not experience sexual desire.
11. The male partner can also experience pain and complications. Type III FGM is also associated with infertility. Evidence suggests that the more tissue is removed, the higher the risk for infection.

Cultural and Ethical Issues:

FGM has been documented in individuals from many religions, including Christians, Muslims, and Jews. Some proponents of the practice claim that it is required by the Islamic faith. However, scholars and theologians of Islam state that female circumcision is not prescribed by their religious

doctrine, emphasizing that the procedure is almost never performed in many major Muslim countries such as Saudi Arabia, Iran, and Pakistan.

FGM as a violation against girls and women:

1. FGM of any type has been recognized as a harmful practice and a violation of the human rights of girls and women.

2. The legal regime is complemented by a series of political consensus documents, such as those resulting from the UN world conferences and summits, which reaffirm human rights and call upon governments to strive for their full respect, protection and fulfillment.

3. The Committee on the Elimination of All Forms of Discrimination against Women, the Committee on the Rights of the Child, and the Human Rights Committee have been active in condemning the practice and recommending measures to combat it, including the criminalization of the practice.

Female Genital Mutilation in Egypt:

- In Egypt 90% of girls who had undergone FGM were between 5 & 14 years old when subjected to the procedure. 50% of those in Ethiopia. Mali & Mauritania were under 5 years of age and 76% of those in Yemen were not more than two weeks old.
- The practice of female genital mutilation (FGM) is still widespread in Egypt, with 91% prevalence in 2008 (Demographic Health Survey (DHS).

  The limited reduction in spite of many years of campaigns against the practice indicate a limited understanding of factors influencing

decision making. Particularly there is limited understanding of sexual concerns influencing the continuation or abandonment of FGM.

- Support for FGM was deeply rooted in people's mind, and the major motivation was a belief that FGM was a necessary and effective way of ensuring women's virtue.
- It was believed that women's sexual desire resided in the clitoris, and that by cutting it, women's sexual desire would decrease. This was believed to be a necessary and useful measure to ensure premarital virginity and marital faithfulness.

The age of FGM in Egypt.

- The age of girls is increased. This is explained by the fact that physicians preferred to deal with older children, considering that this would reduce the risks of serious complications.
- Local religious leaders play an important role in decisions around FGM, but their views were conflicting. This reflects often contradictory messages from official religious scholars and religious figures that are portrayed in the media.
- Many participants saw FGM as a family affair and a personal decision, and were skeptical and critical towards official interference, including legal regulations.

Recommendations for prevention FGM in Egypt:

- Comprehensive sexuality and reproductive education in schools will help youth to understand the functions of the reproductive system and correct existing misconceptions about sexual desire, sexual anatomy and sexual practice and morality.

- Political support for eliminating the practice is important to keep the topic high on the agenda.
- Health-care providers should receive comprehensive training on all aspects relevant to FGM, including its relationship with sexuality.
- Medical students and physicians, nurses, midwifes, as well as other health-care providers, should be trained in sexual counseling to deal with couples' sexual problems, and to be able to counsel parents against FGM for their daughters.
- Inclusion of sexuality sensitive anti-FGM messages in popular media should be encouraged, particularly in popular movies, drama and soap operas that are shown on television.
- Comprehensive training of religious leaders on all levels on female anatomy, sexuality, tradition and religion, and discussions that support them in publicly speaking against FGM.
- Community-based programs should develop sound anti-FGM messages correcting misconceptions about the link between the clitoris and sexual drive/desire and chastity.
- FGM should be included in a package of education and training to eliminate harmful traditional practices such as manual defloration (dokhla baladi), early marriage, and girls' lack of education. Such educational packages could be easily introduced through community programs.

Nursing role:

Competent, knowledgeable, and culturally sensitive nurses and other health care providers are essential to fight harmful cultural practices including FGM. They are also essential in the care and support of women and girls who suffer from the dire consequences of the procedure. Nurses and midwives need to be trained to open up Type III FGM

(deinfibulation), to ensure that care is safe and effective, and to prevent further complications. In addition, appropriate training is necessary to handle families who expect them to perform reinfibulation (stitching again to narrow the vaginal opening, sometimes performed after each child birth), which all health care providers are forbidden to do.

Antenatal care and reversal of infibulation (deinfibulation)

It is important to identify women who have been cut when they first seek pregnancy care, and find out what type of FGM has been performed.

Apart from the usual screening and antenatal care, it is important to provide pregnant women with support specific to their needs around FGM. They may need counseling, advice, information and social and psychological support.

Surgical reversal (deinfibulation) should be offered where appropriate. Partners should be involved in decision-making when the woman is willing for this. It is important to work out a care plan with the woman early in pregnancy, and to involve interpreters as necessary. Even fairly competent English speakers may have problems understanding medical terminology, and using a trained interpreter may be wise in order to avoid misunderstandings. Caesarean section is not indicated just because a woman has had FGM performed.

Reversal is best performed before pregnancy (commencing before the wedding night), or at least within the second trimester of pregnancy at around 20 weeks of gestation:

- This avoids the need to cut the scar tissue in labor.
- Reduces the possibility of extensive lacerations that can occur when the fetal head stretches the scarred or closed introitus and

perineum. These may involve the urethra, bladder and rectum if uncontrolled and leave the woman with a fistula.

- Reduces the chances of fetal asphyxia or stillbirth if a woman progresses unaided to the second stage of labor.
- It helps to reduce the incidence of bacterial vaginosis that is associated with pre-term labor.

The surgical procedure

The aim of reversal is to restore normal anatomy as far as possible. The procedure is the same in principle whether it is carried out as an elective procedure before pregnancy, in the antenatal period, or in labor itself. It can be performed by a midwife if necessary during the second stage of labor once the presenting part is low:

- Adequate pain relief (general, regional or local anesthesia) is essential. Women may prefer to have general anesthesia when reversal is performed before labor commences because the procedure can bring back very traumatic memories of when they were cut
- Use aseptic techniques following cleansing of the vulval area, also pay careful attention to hand washing and wear gloves
- Examine the vulval area carefully, infiltrate with local anesthetic and then open the scar in the midline, exposing the underlying tissue which sometimes includes the clitoris. A midline incision along the scar is less likely to bleed heavily and will follow a line that may already have areas of weakness where the original healing of the edges was incomplete.
- Suture the raw edge on each side of the labia with fine dissolvable sutures to ensure homeostasis and an over-sewing stitch. This is important also to ensure the raw edges do not fuse together

- Provide adequate analgesia following the deinfibulation
- Provide advice on keeping the area clean
- Couples should be advised to avoid intercourse until healing has occurred and to use a lubricant if necessary
- Women need to be advised that urine and menstrual flow will appear heavier because of the removal of the scar-tissue barrier.

Care in labor

- Normal care is required during the first stage of labor
- Sensitivity is essential at all times
- There is no need to pass a catheter unless the woman is unable to pass urine
- Reversal may need to be carried out during the first stage of labor (see overleaf) midwives need to watch women who have undergone type 3 FGM closely during the second stage of labor even when the woman's introitus has previously been assessed as adequate for the birth. Unexpected problems may occur with descent of the fetal head or stretching of the perineum because the scar tissue around the vagina and perineum may be unstable
- A medio-lateral episiotomy should be performed in the second stage of labor only if unavoidable
- It is important to explain the requirements of the UK law. It is not permissible to reinfibulate or stitch the woman back closed after the birth.

Reversal in labor for type 3 FGM

If reversal of the infibulation has not already been performed, it needs to be carried out during the first stage of labor using adequate analgesia as

in pregnancy. If the second stage has already been reached, a midline incision must be used.

Re-suturing or reinfibulation

Re-suturing, often known as reinfibulation, or closing, should never be done because it is illegal in UK. This may mean that careful discussions have to be held with the woman and family to explain the law and why reinfibulation has to be refused. Women may themselves request reinfibulation for social reasons or because they have known nothing else. It is necessary to follow up with the woman during the postnatal period as reinfibulation may be performed illegally at this point. Support, information and counseling continue to be very important.

Health care professionals who participate in FGM or reinfibulation may be removed from their respective professional registers. The presence of infibulation should also be considered even when a woman has had previous vaginal births. This should be addressed during pregnancy or, if admitted in labor, it is important to check the state of the vulva in case the woman has been re-sutured. the most important points to remember are to:

- Arrange for reversal during the first stage of labor with adequate pain relief
- Support the woman with sensitivity to her feelings
- Notify her health visitor and other professionals if the baby born is a girl, with regard to safeguarding the child
- Continue to provide postnatal support
- Consider referring to an organization that can offer support and information.