



## Female Genital Mutilation: A Review

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### ABSTRACT

Female genital mutilation is a cultural practice that can adversely affect the health of a woman. It is not practiced solely in one area of the world. Of the estimated 85 to 114 million girls who have undergone genital mutilation, most live in Africa. Despite efforts to abolish it, it is still widely practiced in Nigeria. The national prevalence is between 50 and 60%. The timing of FGM varies from one part of the country to another. Also, the reasons for performing it differ amongst ethnic groups. The extent of female genital mutilation varies from simple excision of the clitoris and labia minora (types 1 and 2) as practiced in most part of Nigeria, to infibulation with excision of the clitoris, labia minora and majora (Type 3) as practiced in Sudan and Eritrea. Invariably, the procedure is performed by traditional healers, traditional birth attendants, trained midwives, and to a much lesser extent by doctors in some countries, notably Egypt, Sudan and Sierra Leone. In most cases, no anaesthesia is given and the procedure is done under very poor hygienic conditions. While the immediate complications of female circumcision include haemorrhage, infection and urinary retention, the long-term complications are labial adhesions, clitoral retention cysts, gynaetresia, cryptomenorrhoea, vaginal fistulae, infertility, obstetric complications and HIV/AIDS. Emphasising the reproductive health implications of this practice could prove an effective strategy towards eradication of female genital mutilation.

**Key Words:** FGM, Female genital mutilation, Female circumcision, female genital cutting, FGC

Female genital mutilation has recently generated much controversy because the custom has drastic consequences for women's health and fertility. Female circumcision is another term for this procedure (i.e. the cutting off of some or all a child's genitalia) but the critics of this term are of the opinion that it gives the wrong impression that the medical complications of male and female circumcisions are parallel (Kirangu, 1995). It is the collective name given to different traditional practices involving partial or total removal of the external female genitalia or other injury to the female genital organs, whether for ritual, cultural or other non-therapeutic reasons. The genitalia of a female comprise the mons pubis, clitoris, labia minora, labia majora, urethral and vaginal openings. Another nomenclature being used is female genital cutting (FGC) (Eliah 1996). There is growing concern worldwide regarding the reproductive health complications of FGM. This is evident from the number of reports on the subject from various parts of the world (Egwuatu and Agugua, 1981; Baker *et al*, 1993; Sundby and Austveg, 1993; Alibhai, 1995; Hanly and Ojeda, 1995; Shorten, 1995). FGM is recognized by many as an issue of medical, social and legal concern. It was, and remains, a cultural, not a religious practice. Because mutilation of the female

genitalia takes different forms in different societies and is performed for different reasons, it is not easy to trace the origin of this practice to any particular point or place in history. The practice has a long and complex history. Toubia cited the famous historian Heroditus as saying that female circumcision was practiced by Phoenicians, Hittites Ethiopians and Egyptians as early as the 5<sup>th</sup> Century BC (Toubia, 1993; Ghalioungul, 1963). In the 1969 report of the German Scientific Expedition, female circumcision was reportedly fairly common in some countries in the middle and near East (Berhane, 1979). It is known that in ancient Egypt, FGM was a symbol of status and prestige among the aristocracy, and the practice has been documented in other countries including pre-Islamic Arabia, ancient Rome, Tsarist Russia, the United States and Europe (Hedly *et al*, 1992).

Female genital mutilation is common in many cultures in Africa and the Middle East, varying in form and severity as a result of each group's socio-cultural norms and belief systems. Of the estimated 85 to 114 million girls and women who have undergone genital mutilation, most live in Africa (Hicks, 1993), a few in Asia, and increasingly, the practice is seen in the United States and Canada (Toubia, 1993; Tawbech, 1979). It is estimated by the WHO that some two million women undergo some

form of genital mutilation annually (Toubia N 1993). The prevalence of FGM in Africa is estimated to range from 5% to 98% (Dorkenoo, 1996). The prevalence in Nigeria varies with locality being more widely practiced in rural areas by illiterate mothers and parents (Odujinrin et al; Adinma, 1997). The national prevalence is between 50-60%. (Sule, 1997). An influx of young couples, refugees and students from countries where circumcision is still widely practiced has meant that health care providers in the United Kingdom and other European countries are seeing these women in hospital outpatient clinics and GP practices (Ahmed, 2000).

### Classification Of Female Circumcision

**TYPE 1:** Excision of the clitoral prepuce, with or without excision of part or the entire clitoris. It is known in Muslim countries as the Sunnah circumcision.

**TYPE 2:** Excision of the clitoris with partial or total excision of the labia minora. This is often referred to simply as excision.

**TYPE 3:** Excision of part or all of the external genitalia and stitching/narrowing of the vaginal opening (infibulation). It is also referred to as Pharaonic circumcision. The main objective is to render pre-marital sexual intercourse impossible. It is the most drastic procedure and the one resulting in the most serious adverse health effects. It involves removal of the whole clitoris, the whole of the labia minora and the medial parts of the labia majora. The latter structures are then approximated with thorns, catgut or silk sutures (depending on the operator). Immediately following the procedure, the girl's legs are usually braced to keep her immobilised for a period of up to 40 days as the vulva heals. During this healing process, a tiny hole is created in the wound by inserting a small object (for example a piece of wood or bamboo) in it to allow for the passage of urine and menstrual blood (Hedley et al, 1992). At the time of sexual intercourse or childbirth, the scar tissue needs to be cut open. After childbirth, women are often re-infibulated.

**TYPE 4:** Unclassified, which includes pricking, piercing or incising of the clitoris and /or labia, stretching of the clitoris and /or labia, cauterization of tissues; scraping (Angurya cuts) of the vaginal orifice or cutting (Gishiri cuts) of the vagina; introduction of corrosive substance into the vagina with the aim of tightening or narrowing the vagina;

and any other procedure with falls under the definition of FGM given above.

SOURCE: WHO (1996).

**Gishiri cut or 'Yakan Gishiri':** This is a traditional surgical cut performed on any aspect of the vaginal wall using a razor blade, or a pen knife, The commonest site is the anterior vaginal wall and less commonly the posterior and lateral walls. This is practiced commonly in parts of Northern Nigeria. Unlike female circumcision, Gishiri is performed commonly as a "cure" for a variety of ailments. These include obstructed labour, amenorrhoea, infertility, pruritis vulvae and dyspareunia (Mandara, 2004). It is usually performed by a traditional birth attendant or a local herbalist.

**Hymenectomy:** Hymenectomy refers to the excision of the hymen, usually performed by a traditional herbalist-barber (Wanzami) on infant girls soon after birth. Other operations include scarification of the external genitalia, the use of rings on the genitals, and 'Zurzur' cut. The "Zur-zur" cut is an incision done on the cervix in cases of prolonged labour to aid delivery of the fetus.

**Introcision:** This is the least frequently performed and documented type of FGM. Introcision involves the cutting into the vagina and /or splitting the perineum in order to widen the vaginal opening (Sanderson, 1981).

Type 1 and 2 are practised in most parts of Nigeria. Infibulation is practised in Sudan and Eritea (Baker; 1993, Mustafa, 1996). Type 4 now affects all regions of the world (Toubia, 1995)

The timing of female genital mutilation varies from place to place (Verzin, 1975). In Nigeria, the period of circumcision also varies from one ethnic group to other. Among the Igbo's, FGM is performed in early infancy between 7 to 21 days of birth like the male. (Egwuatu and Agugua, 1981; Meniru, 1991). The practice is almost universal among the Igbos, but for a few areas around Nsukka (Enugu State) where the practice is rare. In a few areas like Oha-ozara (Ebonyi State) and Obioma Ngwa (Abia State) female genital mutilation is performed during adolescence, while in the Ogbaru riverine area (Anambra State) the ritual is performed during the first pregnancy and is believed to prepare the woman for the pains of labour (Adinma and Agbai, 1999). In Western Nigeria, many female children undergo the procedure as part of a traditional christening ceremony during the neonatal period (Badejo, 1983; Diejomaoh and Faal, 1981). In some Edo communities of Nigeria it is performed at about the

age of 10 years as practiced in Somalia (Bayouduh et al ,1995) and the Sara tribe in Chad (Leonard,1996). The operation is usually performed by traditional healers, traditional birth attendant, trained midwives, and to a much lesser extent by doctors in some countries notably Egypt, Sudan, and Sierra-Leone. In most cases no anaesthesia is given and the procedure is done under very poor hygienic conditions (Inter African Committee,1997; Aziza,1993)

Various reasons have been given for performing female circumcision. In some communities, the procedure is observed as a religious rite, even though the role of religion in propagating the practice is extremely controversial. Interestingly, this practice is carried out among Muslims, Christians and others in the communities where it is seen. There is no clear evidence in the Bible or Qur'an supporting female circumcision (Meniru,1991) Female circumcision is sometimes performed as an initiation rite into womanhood or into the tribe. The clitoris holds as massive number of nerve endings that generate feelings of sexual arousal when stimulated. Another important reason suggested by others for this practice is to safeguard the virginity of girls until marriage, or as a means of attenuating sexual desire of the girls thus rendering them less vulnerable to sexual temptation (WHO,1996). Uncircumcised women in countries where FGM is normally performed have difficulty finding a marriage partner. Men typically prefer a circumcised wife because they are considered less likely to be unfaithful.

Among the Yoruba of Ekiti and Atakumasi in Osun State, clitoridectomy is performed so that the head of the newborn does not come into contact with the clitoris during delivery. If it does, these people believe it will result in the death of the newborn infant (Oguntuyi,1979). In cases of hypertrophy of the labia minora, circumcision is done for hygienic reasons. It is also done for such reasons as reduction of vaginal discharge and as a symbol of femininity (Calder et al ,1993;Ntiri,1993;Johnson and Rodgers,1994). Other claims in support of FGM include:

- To keep the genital region smooth for aesthetic reasons.
- To tighten the vagina to increase sexual pleasure for men
- The clitoris is dangerous and must be removed for health reasons.
- Some believe it is a poisonous organ

that can cause a man to fall ill and die if contacted by a man's penis.

- The man can become impotent by contacting a clitoris.
- A baby will be born hydrocephalic if it's head contacts the clitoris during delivery.
- The mother's breast milk will become poisonous if her clitoris touches the baby during childbirth
- FGM prevents vaginal cancer
- To increase fertility.

### Complications Of Female Genital Mutilation

Medical reports document many immediate and long-term consequences of FGM. The form and severity of these effects depend on several factors: the age of the girl on whom FGM is performed: The conditions in which the procedure is performed, the overall health of the girl and the skill of the person performing the procedure.

#### Immediate Complications

Safe removal of only the prepuce of the clitoris requires that the operator performing the procedure has advanced medical and anatomical knowledge, good quality surgical tools, and that the girl on whom the procedure is to be performed be motionless and anaesthetized. These factors are almost always absent when Sunna is performed in African and Middle Eastern cultures (Bardach,1993).

There is excruciating pain of the procedure, as no anaesthesia is used in most cases. This is the most common complication. Acute urinary retention may result due to excessive pain. Sudden movement by the girl can result in damage to adjacent organs, cutting of an artery or shock which would harm or even prove fatal to the girl or woman. As the clitoris is rich in blood vessels, haemorrhage may occur as a result of complete removal of the prepuce and clitoris. Infection can easily set in and damage the urethra, bladder, and anus by way of tears and fistule formation both of which could be physically agonizing and associated with psychological problems.

Tetanus and septicaemia may ensue from the use of unsterilised tools and from unsanitary working conditions (Brown *et al* ,1989)

Where reversal is required to treat early complications, repeat infibulation may be carried out at a later date (Momoh *et al* ,2001)

There is evidence from Africa that doctors and nurses are performing an increasing proportion of procedures: Thus 'medicalisation' is occurring in the belief that complications occur less frequently (El-Gibaly et al ,2002;Shell-Duncan,2001).

### Delayed Complications

Transmission of human immunodeficiency virus through this cultural practice has been reported (Hrdy,1987;Bongers,1994). Numerous mechanisms whereby FGM may enhance the risk of HIV are plausible (Kun,1997). First, the initial narrowing which may cause superficial dyspareunia, inadequate vaginal penetration and futile attempts at intercourse (Iregbulem,1980) may result in greater risk of inflammation and bleeding during coitus (Kun,1997).The disruption to the genital epithelium and exposure to blood during coitus would probably enhance the risk of infection (European Study Group,1992). Secondly, when substantially reduced vaginal opening exists, abrasions may occur in men attempting penetration (Lightfoot-Klein,1989) which may potentially facilitate HIV transmission (Kun,1997). Thirdly, treatment of haemorrhage may require blood transfusion that may contribute to an efficient transmission of HIV especially in sub-Saharan African.

Once the lacerations resulting from FGM have healed a scar forms. There may be subsequent inability to consummate marriage. Labial adhesions, clitoral retention cysts and obstetric complications can also occur (Dirie and Lindmark,1991;Arbesman et al ,1993;McSwiney and Saunders,1992).

In a study of over 4000 women with genital mutilation attending hospital in Khartoum (most commonly with type 3), Shandall (1967) reported the following:

1. The most frequent encountered problems were sexual difficulties, with anorgasmia reported in over 80% of cases
2. Pain and tenderness may occur in the scar tissue, leading to dyspareunia, even if the vaginal opening is sufficient to allow penetration, ie. it occurs even in type 1 and 2
3. Penetration or attempts at penetration may cause lacerations and haematoma, requiring medical intervention.
4. Keloid scar formation may result
5. Chronic local irritation and inflammation may lead to further scarring and narrowing resulting in deteriorating flow, retention of urine and haematocolpos.
6. Variable degree of urinary outflow obstruction are common, leading to poor flow, painful micturition and recurrent urinary tract infection. Bacteria was found

in 28% and infection in 16% of infibulated women. Rarely, vaginal urinary calculi may form..

7. Dysmenorrhoea is commonly reported, and is not only related to inhibition of menstrual outflow.
8. Retention cysts occur with types 1,2 and 3 and may reach quite a large size or become infected, presenting with pain, urinary retention and dyspareunia.
9. Pelvic infection may occur, with subsequent infertility. High vaginal swabs positive for *Escherichia coli*, *Candida albicans* and *Trichomonas vaginalis* were found in 10%, 15% and 10%, respectively
10. Fistulae are rare, but can be the result of injury at the initial procedure or at defibulation or following laceration in labour.

### Obstetric Complications

Obstetric complication occurs as a result of scarring. Due to the inelasticity of scar tissue childbirth can become complicated and painful. During pregnancy women with FGM require sensitive antenatal and intrapartum care (Ahmed, 2000). In addition, the mechanical barrier posed by infibulation in type 3 leads to prolonged or obstructed labour. Women who have undergone Type 4 mutilation may have such severe scarring that vaginal stenosis results.

The problems encountered are numerous (RCOG,2003)

- 1) Fear of laceration and difficult birth or of the need for Caesarean Section
- 2) Difficulty performing vaginal examinations and hence inadequate monitoring in labour. Pelvic examination to diagnose and assess progress of labour can be very painful for the infibulated women. Some obstetricians in the Western world would feel it best to reverse the condition in the midtrimester, if a woman presents for the first time with infibulation (Gordon,1998).
- 3) Retention of urine and difficulty in catheterizing the urethra in labour or prior to Caesarean Section
- 4) Prolonged labour
- 5) The need to perform defibulation in the first stage of labour, with associated blood loss, or anterior midline episiotomy in the second stage. During the second stage of labour, the circumcision scar must be incised before an episiotomy can be given (Gabar,1985). In

women with more severe stenosis, a probe should be inserted through the pinhole opening and an incision made along the probe to excise the scar tissue (Lightfoot-Klein and Shaw,1991). After delivery, a continuous suture around the raw edges of the labia majora should be inserted leaving the vulval area open (Toubia,1994). This will allow free flow of urine and menstrual blood. This also facilitates intercourse and may relieve dyspareunia.

- 6) Lacerations in scar tissue may cause postpartum haemorrhage; more severe lacerations rarely extend to involve the urethra, bladder or rectum..
- 7) Wound infection and retention of lochia, leading to puerperal sepsis
- 8) Reinfibulation, causing even more dense scar tissue with implications for sexual function and later obstetric complications.
- 9) Difficulty in gynaecological examination and evacuation of the uterus following abortion.

### Laws And Policies

The prevalence of female genital mutilation in Nigeria of between 50 and 60% shows that the practice is still common. The reason for this may be partly weak condemnation of the practice (Toubia,1994). Several attempts have been made by various pressure groups to outlaw the practice. A bill has been moved in the National Assembly but political and cultural divergent views have been obstacles to smooth passage. Edo State has been the only state that has formally outlawed female genital mutilation in Nigeria. Because of this problem emphasis should therefore be placed on the risk to which the victims are exposed including HIV /AIDS.

### Eradicating The Practice

Obstetricians and gynaecologist can influence women not to subject their daughters to genital mutilation, by emphasising the risks to health and the difficulties in childbirth. In view of its health hazards eradicating FGM does demand a willingness to re-examine closely and critically our value structure. It definitely requires political support and culturally sensitive education and community development. Emphasising the reproductive health implications if this evil practice should continue to prove to be an effective strategy.

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