

FEMALE GENITAL MUTILATION

In many civilizations, certain surgical procedures have profound cultural and social meanings. Male circumcision, for example, has deep importance as a symbol of religious and ethnic identity and has played a major part in the political and social history of many communities (Remondino, 1891). The practice of female genital mutilation (FGM) is regrettably persistent all over the world (Talle, 2007). The practice is more common in developing countries where it is deeply rooted on culture, religion, tradition and continues to ignore decades of legislation and campaign to eradicate it (Onuh et al., 2006; Momoh, 2003). Globally, about 140 million girls have undergone the practice of female genital mutilation and over 3million girls are at risk of undergoing this procedure annually (Adeyinka et al., 2012). In some communities, female genital mutilation is viewed as an act of love or rite of passage and is often performed on young girls between infancy and age 15 (Toubia, 1994; Karmarker et al., 2011; WHO, 2012). The procedure in practicing communities remain persistent because they find it difficult to understand why the practice is being condemned and believe they are doing what is best for their daughters (RCN, 2006). Studies have proven that female genital mutilation has no health benefits for girls and women; rather, it is seen as a form of child abuse and violence against women and girls (HM Government, 2010). This practice reflects inequalities between sexes and constitutes a great form of discrimination against women (WHO, 2012). Female genital mutilation is beyond a mere health problem but a continued violation of human rights if the practice persists and is not completely eradicated.

DEFINITION:

The World Health Organisation (WHO) defines Female Genital Mutilation (FGM) as any procedure involving the partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons (WHO, 2012). Female genital

mutilation is often synonymously used with female circumcision giving an erroneous idea of it been similar to male circumcision. However, the extent of incision is more extensive, often hindering a woman's sexual and reproductive function and even their ability to pass urine normally (RCN, 2006). Female genital mutilation has been practiced worldwide in various forms and with different justifications and indications (Magoha and Magoha, 2000). The practice has generated global debate and has evolved to be a contentious issue that has divided academic and activist opinion (Irvine, 2011). However well-intentioned female genital mutilation is for those who practice it, studies have proven that it is medically unnecessary, very painful and extremely dangerous (Kaplan-Macusan et al., 2010; Dorkenoo, 1995).

CLASSIFICATION OF FEMALE GENITAL MUTILATION:

Although various types of female genital mutilation has been practiced and observed, people who engage in the act often do not know which one they perform (Black and Debelle, 1995). The World Health Organisation has classified female genital mutilation into four categories namely: Clitoridectomy (Type 1); Excision (Type2); Infibulation (Type 3); and others (Type 4) (WHO, 2012).

Clitoridectomy (Type 1) is the total or partial removal of the clitoris or the total or partial removal of the skin surrounding the clitoris also known as the prepuce (WHO, 2012; RCN, 2006). [Figure 1]

Excision (Type 2) is the total or partial removal of the clitoris with the total or partial removal of the labia minora (WHO, 2012). It is also known as Sunna circumcision (RCN, 2006). [Figure 2]

Infibulation (Type 3) is the partial or total removal of the external genitalia (RCN, 2006). Here, the vaginal opening is narrowed through the creation of a seal developed by cutting and repositioning the inner and outer labia with or without the removal of the clitoris (WHO, 2012). This form is also known as pharaonic circumcision of infibulation (RCN, 2006). [Figure 3]

Others (Type 4) are other harmful procedures such as pricking, piercing, scraping, incising, stretching, cauterising, cutting, introduction of corrosive substances to the female genitalia for non-medical purposes (WHO, 2012). [Figure 4]

PREVALENCE OF FEMALE GENITAL MUTILATION:

Recent data shows that female genital mutilation is practiced in twenty eight African countries including Nigeria (Berg and Denison, 2012; Ibekwe et al., 2012) [Figure 5]. The practice is equally prevalent in some countries in the Middle East, among minority communities in Asia, and migrants from practising communities that have settled in America, Australia and Europe (HRP, 2006; Toubia, 1994). Current estimates for female genital mutilation in African countries shows a prevalence rate of over 70% in places like Egypt, Mali, Burkina Faso, Ethiopia, and Somalia (Yoder and Khan, 2008) (Table 1). Due to the variations that exist between and within countries which often is a reflection of tradition and ethnicity, the United Nations Children's Funds (UNICEF) made a proposition that countries be classified into three groups in accordance with the female genital mutilation prevalence rates present in those countries. Countries with a prevalence rate of 80% and above (Somalia, Mali, and Ethiopia) are classified as group 1; countries with prevalence rate between 25 and 79% (Senegal, Kenya) are classed as group 2; while countries with a prevalence rate below 25% (Nigeria) are classed as group 3 (Berg and Denison, 2012; UNICEF, 2005) (Table 2).

In Nigeria, the prevalence of female genital mutilation ranges from between 0% in the North-Western parts of the country in regions like Kogi State to 100% in Benue and Kebbi States (Onuh et al., 2006). According to the Nigerian Demographic Health Survey (NDHS, 2003), prevalence of female genital mutilation is highest in the South-Western and South-Eastern regions of the country and lowest in the North-Western parts of the country [Figure 6]. On the average, the overall prevalence of female genital mutilation in Nigeria settles at 50%. However, due to her large population size, Nigeria has the highest absolute number of genitally mutilated women globally (Okonofua, 1998). The most common form of female genital mutilation, Type 2, accounts for about 80% of all cases while Type 3, the most severe form, accounts for about 15% of all cases (Onuh et al., 2006). Type 1 and Type 4 account for the remaining 5%. The most commonly practiced form of female genital mutilation in Nigeria is the Type 2 (Excision). However, other forms of the practice are prevalent in different parts of the country (Coulibaly *et al.*, 1996). A very common form of the practice in the Northern part of the country is the Type 4 where it is known as “GISHRI” cuts (NDHS, 2003). [Figure 7]. In Nigeria, the practice is often performed during infancy (42%), mostly by traditional birth attendants (73%) and by circumcision practitioners or traditional healers under unsterile conditions (NDHS, 2000).

STATEMENT OF THE PROBLEM - A Nigerian perspective

From the public health perspective, Female genital mutilation (circumcision) is much more damaging than male circumcision. The mildest form, clitoridectomy, is anatomically equivalent to amputation of the penis. Under the conditions in which most procedures take place, female circumcision constitutes a health hazard with short and long term physical complications and psychological effects (Denison et al., 2011). It continues to be a fundamentally contentious subject. It remains disturbing why the harmful practice remains widespread despite efforts carried out to encourage its abandonment. Using Nigeria as an

example, one of the explanations put forward to justify female the practice is the belief that it reduces sexual feelings in women and therefore reduces the level of sexual promiscuity among them (Orubuloye and Caldwell, 2000). Despite the fact that this argument infringes on the rights of women to full sexual expression and reduces the status of women who are victims of the practice to the extent of their genitals, it nevertheless, has been used by traditional defenders of female genital mutilation to promote the practice in many communities throughout sub-Saharan Africa (Irvine, 2011; Okonofua et al., 2002). If sexual promiscuity is indeed reduced, this could lead to a reduction in the incidence of reproductive tract morbidities especially those that relate to pregnancies and reproductive tract infections and improve the reproductive health of women. However, there is lack of substantive scientific data that describes the impact of female genital mutilation on the sexual and reproductive health of women in many developing countries where the prevalence of female genital cutting is high.

Several researchers have argued that cultural identity is of paramount importance to everyone and defending that identity becomes especially important when the group has faced colonialism as is the case in Nigeria. However well-intentioned it is to preserve a community's cultural identity, there is no clear cut cultural meaning to female genital mutilation neither is there any ethical defence to be made for preserving a cultural practice that damages women's health and interferes with their sexuality. Additionally, irrespective of the fact that female genital mutilation is an unlawful act in most parts of the world, the practice remains common in less developed countries (Adeyinka et al., 2012). In Nigeria, there is no specific federal law banishing female genital mutilation practices (PRB, 2008). Those who fight against the practice rely on Section 34(1) (a) of the 1999 Constitution of the Federal Republic of Nigeria which states that '*no person shall be subjected to torture or inhuman or degrading treatment*' as the basis for banning the practice in the country. The

Constitution rejects any act of torture or barbaric treatment or violence against any person (Kandala et al., 2009). Several states in Nigeria have attempted to ban the practice in Nigeria but this has had little or no impact on the prevalence rate of female the practice in the country despite decades of efforts to terminate the practice (Freymeyer and Johnson, 2007; Babalola et al., 2006). Edo State banned female genital mutilation in October 1999 and mandated that persons found guilty of the offence be charged 1000 Naira (US\$10) fine and imprisonment for six months. While setting up of these laws has been applauded, advocates of the practice have criticised the cheap fine and lack of enforcement of the law (Kandala et al. 2009). Other states in the country that have advocated for the ban of female genital mutilation include: Osun, Ogun, Cross River, Bayelsa and Rivers state (Kandala et al., 2009).

REASONS FOR PERFORMING FEMALE GENITAL MUTILATION:

Several reasons have been given to justify the practice of female genital mutilation. These reasons vary between regions and within communities (De Bruyn, 2003). Among them are justifications based on customs and traditions; religious requirements; purification; family honour; cleanliness and hygiene; aesthetic reasons; prevention of virginity; prevention of promiscuity; and a belief that in enhances fertility (BMA, 2011). However, a summary of the reasons why female genital mutilation is practiced include justifications based on: religion; health; socio-economic reasons; socio-cultural factors; ethics and tradition; and gender related factors (Leye, 2008).

Religion:

Religion is a key reason why female genital mutilation remains prevalent. It is common among Muslims but also practiced within the Christian society. Generally, there is a common misconception that it is an Islamic rule. Although some studies have shown that its incidence in Africa is higher among Muslims than Christians (Leye, 2008), majority of Muslims

globally do not engage in the practice (Morjaria, 2012). Communities that practice female genital mutilation have the belief that it is a religious compulsion. However; there is no doctrinal basis for it, neither is it recognised in any religious text (Morjaria, 2012).

Health:

There is the belief that female genital mutilation promotes cleanliness, enhances male potency, improves fertility, betters the health of babies, and generally reduces the rate of infant and maternal mortalities (Morjaria, 2012; Leye, 2008). In Nigeria, it is believed that it helps to cure infertility in women while in Mali and Burkina Faso, it is believed that the presence of the clitoris can make men impotent (Leye, 2008). In Ghana, it is believed that the presence of the clitoris prevents conception while in Sudan; it is believed that female genital mutilation promotes the health of babies and cures some diseases during infancy (Leye and Deblonde, 2004; Morjaria, 2012).

Ethics and Tradition:

Female genital mutilation is believed to promote the cultural identity of a community and the practice is viewed as a tradition that enhances community coherence. Often women and girls that have not been circumcised are banned from partaking in any community event. In these communities, the cultural stigma of not been circumcised extends to family members of the uncircumcised women and girls (Leye, 2008). Their condition affects other members of their families. In Kenya, a boy with an uncircumcised sister will not be admitted as a warrior.

Gender related factors:

Gender-related ideas linked to beliefs and norms relating to womanhood and female sexuality play vital roles in the practice of female genital mutilation. A couple of authors regard it as a rite of passage for girls where they accept their feminine identity and get them ready for

marriage. Others regard the practice as a distinguishing feature between gender ambiguous children and adults, or as a distinguishing feature between male and female. In Mali, a child is neither male nor female until he or she has been genitally excised. In some communities, it is practiced to ensure women are virgins at marriage and remain faithful to their husbands. It is seen as a form of honour and it is against this the practice is often defended (Leye, 2008).

RISK OF PERFORMING FEMALE GENITAL MUTILATION:

The risk of female genital mutilation is made manifest in the complications that arise after the procedure. Often, many of those who perform the procedure lack the medical training and surgical technicalities needed for the process (De Bruyn, 2003). Customarily, it was the specialization of traditional healers, traditional birth attendants, or community members who were known for the trade. However, in certain parts of Africa, there have been movements to make the practice a medical one. Efforts have been made to replace traditional practitioners with health personnel and community health workers. This has generated extensive debate globally and the World Health Organisation (WHO) has instructed that female genital mutilation must not be institutionalized, nor should any form of it be performed by any health professional in any setting, including hospitals or in the home (FDH, 2007). Despite these warnings, some people have turned deaf ears to the mandate and it is still much practised by health personnel in some countries. Currently, over 18% of female genital mutilation is performed by health personnel and the trend is increasing (WHO, 2012).

The evidence on the frequency of health complications associated with female genital mutilation is very scarce (Obermeyer, 2005). Although there are a wide range of health complications associated with it, the lack of information obscures the extent and gravity of these complications (Talle, 2007). The available evidence on the risk associated with this practice comes from self-reported surveys and epidemiological reports of clinically examined

complications determined in hospitals (Hopkins, 1999). The complications that occur after it has been carried out often depend on the type and degree of excision carried out (RCN, 2006). Several studies have documented various gynaecologic and sexual health complications associated with it and these relate mainly to the more severe forms of female genital mutilation (Okonofua et al., 1998). Obstetric, psychological, sexual and social consequences are other complications that have been described in many literatures however; the morbidities and mortalities related to this practice remain difficult to quantify (Leye, 2008). Generally, the complications are classified as: immediate; intermediate; and long-term complications (RCN, 2006). Tables 4, 5 and 6 give a summary of each class of complications respectively.

Girls and women exposed to female genital mutilation are at risk of immediate physical complications such as severe pain, injury to tissues of the urethra and vagina, haemorrhage, shock, fractures and dislocations, acute urine retention, difficulty in passing faeces, infections and even death (Berg and Denison, 2012; Leye, 2008; WHO, 2008; RCN, 2006). The long term complications are in most cases associated with the Type 3 form of female genital mutilation which often ruins the lives of women that are victims of the practice and causing more health problems and deaths (RCN, 2006). The long term consequences can include pelvic inflammatory diseases (PID); recurrent urinary tract infection (Leye et al., 2004); irregular bleeding and vaginal discharge; painful menstruation (Kwateng-Kluyitse, 2004); cysts and abscesses (LCPC, 2003); keloid formation which occurs due to the slow and incomplete healing of wounds and infections (Dare et al., 2004); infertility (Bop, 2001); clitoral neuroma which occurs when the clitoral nerves are trapped in a stitch (Kwateng-Kluyitse, 2004); haematocolpos which occurs due to sealing of the vaginal opening by scar tissues (Leye et al., 2006); formation of recto-vaginal and vesico-vaginal fistula which occurs as a result of injuries to the soft tissues during excision (Berg and Denison, 2012) ; anal

incontinence and anal fissures which develops due to rectal intercourse when vaginal intercourse is not possible (Dandash et al., 2001); problems during child birth; and possible transmission of HIV, hepatitis B and other blood transmissible diseases (Morisson et al., 2004).

Obstetric complications have also been identified with the practice of female genital mutilation with the most common being prolonged labour; perineal laceration; infection and post-partum sepsis; post-partum haemorrhage; heightened risk of HIV transmission; and maternal and foetal death although there is no sufficient data to back up this claim. A study by the World Health Organisation investigating women attending obstetric centres in six African countries concluded that genitally mutilated women were more likely than their other counterparts to have complicated obstetrics outcomes such as caesarean, post-partum haemorrhage often greater than 500mls of blood loss, delivery of low birth weight babies, infant resuscitation and inpatient perinatal death (WHO study group, 2006). Additionally, they concluded that the risk of obstetric complication was proportional to the degree of excision.

Sexual complications affect both partners in marriage (WHO, 2001). A review on the sexual consequences of female genital mutilation discovered that genitally mutilated women were more likely not to have sexual desire, less likely to be sexually satisfied and more likely to experience pain during intercourse (Berg and Denison, 2011). Excised women experience painful sexual intercourse because of scarring or narrowing of the vaginal opening. Vaginal penetration is sometimes difficult or even impossible without laceration or re-cutting of the scar. Inhibition of intercourse due to the fear of pain causes marital conflict and puts a strain

on marital relationships and sometimes the possibility of divorce is inevitable in some cases (WHO, 2001).

Many girls and women exposed to this practice experience psychological and psychosocial problems (WHO, 2001; Leye, 2008). For most of them, it is a traumatic experience that greatly affects their mental health (Chalmers and Hashi, 2000). There have been reports of posttraumatic stress, behavioural disturbances, anxiety, depression, psychosis, and psychosomatic illnesses all associated with it (Berg et al., 2010; WHO, 2008). Disordered eating and disorientated sleeping habits have also been reported (HRP, 2006). The psychosocial complication often remains throughout life. Commonly, female genital mutilation is practiced when girls are young and naïve. The procedure is often followed by acts of deceit, intimidation and violence from parents and relative. In most cases, the victims are conscious when the procedure is taking place and have to be physically restrained to cope with the pain when they struggle as no anaesthetic is normally administered (WHO, 2001). For most girls, the experience generates a constant feeling of anger, bitterness and betrayal having been subjected to such ordeal. For some, the psychological implications are comparably synonymous to the experience of rape.

The complications do not only affect the victims of the practice but affects many disciplines in the practice of medicine (Magoha and Magoha, 2000). Paediatricians, urologists, obstetricians, gynaecologists, proctologists, psychiatrists, and surgeons are all affected by the practice. The paediatrician experiences problems of haemorrhage and sepsis in neonates and infants (Black and Debelle, 1995); the urologist tackles urethral strictures and vesico-vaginal fistula (Eke, 1996); the obstetrician battles vaginal stenotic impediments to foetal expulsion during labour (Dirie and Landmark, 1992; Erian and Goh, 1995); the gynaecologist is faced with problems of vaginal fistulae and recurrent episodes of urinary tract infections (UTI) and pelvic inflammatory diseases (PID) (McCaffrey *et al.*, 1995); the proctologist attends to

recto-vaginal fistulae; while the psychiatrist tackles the psychological problems of female genital mutilation (Erian and Goh, 1995).

MANAGEMENT OF RISK AND COMPLICATIONS RELATED TO FEMALE GENITAL MUTILATION

No single technique can effectively manage the risk and complications of female genital mutilation. As it has various consequences including health, legal, human rights, religious amongst others, a combination of approaches targeting each of the complications would effectively manage the risk and complications and even help eliminate the practice. Management of the health consequences have been highly documented. This is so as the health consequences often have a terminal effect on the victims if not properly and effectively managed. In addition to the health impact, the human rights aspect has recently gained significance and has been used to plan interventions and strategies needed to stop the practice (Leye, 2008).

Health approach

The physical complications often involve giving support to the victims, counselling and in some cases, surgical interventions are done in situations of extreme complications (WHO, 2008). Similar management measures of support and counselling are applied to the psychosocial, sexual, and psychological complications of female genital mutilation. A very important management measure is counselling of the victims (WHO, 2008). The health risk approach has been greatly used as a motivator to help curb the practice. Strategies using health approaches have addressed the harmful effect of the practice on women's health

(Ugboma et al., 2004). Health professionals serve as agents of change and use the physical complications to enlighten people about the consequences of the act (Leye, 2008).

Legal approach

The legal approach offers protection for women and scares families and practitioners from the fear of legal prosecution. Additionally, it protects health professionals from performing the practice and creates a legal backing for them when they turn down requests to perform the procedure. Legislation should be backed up with efforts to train, educate and enlighten community and family members if they are to successfully stop the practice. Several countries have specific laws against the practice (Senegal, Burkina Faso, Sudan, Egypt, Ghana, and Djibouti) while others have national laws that protect its people against injuries (WHO, 2008). However, passing laws alone is not sufficient neither will a law against the practice be meaningful if it is not enforced and put to practice.

Human Rights approach

Female genital mutilation is seen globally as a violation of human rights. It violates the rights of girls and women to the highest degree of their mental, physical and sexual health. Some intervention programmes have linked it to human rights strategies to help curb the practice. One of the successes of this approach is the Tostan education programme in Senegal which used the human right approach to help eliminate the practice (Tostan, 2010).

Religious approach

In regions where Islam dominates, the religious approach has been used to combat the practice (Leye, 2008). Interventions are focused on Islamic religious leaders, some of whom believe that it should be done on every female and recommend the practice on women. In some African countries, Islamic leaders have supported the campaign to curb the practice

while others have refused to support the campaign and still see it as a recommendation for women. Efforts should be intensified to further target religious leaders and make them see reasons why the practice should be abolished.

ERADICATING FEMALE GENITAL MUTILATION:

Although several attempts have been made to eliminate the practice, these attempts have been short-lived and have not been properly sustained (Eke et al., 1999). For the successful elimination of the practice, there must be a properly coordinated action from international bodies and organisations together with national efforts from the government of practicing countries. The World Health Organisation remains totally committed to the eradication of the practice (Magoha and Magoha, 2000). Other agencies and organisations that have contributed to the abolishment of the practice include: the World Medical Association (WMA); The International Planned Parenthood Federation (IPPF); The British Foundation for Women's Health, Research and Development (FORWARD); The American Medical Association (AMA); The African Charter on Rights and Welfare of the Child and Women International Network (WIN); The International Federation of Gynaecology and Obstetrics; and The Royal Colleges of Obstetrics and Gynaecology in the United Kingdom and Canada (Magoha and Magoha, 2000).

Eradicating the practice requires a solid foundation that can aid behavioural change and a strategy that will address the values and mechanisms that encourage the practice (FDH, 2007). It will require dedication and a long-term commitment to combat the practice. Education has been found to be crucial to the elimination of the practice however; education alone is not enough to fight the practice in regions of the world where it is deeply rooted on culture and tradition (Meniru et al., 2000). Even at that, universal education of females should be sought to help reduce the practice. Legislation against the practice has been attempted in

most countries however; it has had limited impact on the prevalence of the practice. Well-structured social and enlightenment campaigns if properly executed will significantly reduce the prevalence of the practice. An objective and constructive campaign designed with regards to religious and cultural sensitivities would help reduce the practice (American Academy of Paediatrics, 1998).

CONCLUSION

Female genital mutilation is entrenched in the traditions of many communities (Onuh et al., 2006). Efforts should be continually targeted towards suppression and eradication of the practice. Interventions should be focused on education programmes based on scientific evidence relating to the adverse health and social consequences of the practice (Olatunbosun, 2000). Policy initiatives should work on the differences between religious groups. Policy should be sensitive to the diversity and strength of women's beliefs and focus on ensuring that women are empowered to make their own decisions about the practice based on their own fully informed choices (Karmaker et al., 2011). However, a downside to this is that many of the practices are done on children when they are young and incapable of making their own decisions.

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