Female genital mutilation

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Abstract

The need for health care professionals to be aware of the reasons and the numerous health issues associated with Female Genital Mutilation (FGM) is addressed here.
Aim : The purpose of this study was to outline the significance of the health professionals' role while dealing with excised women.
The **method** of this study included bibliography research from both the review and the research literature, mainly in the "pubmed data base" which referred to Female Genital Mutilation (FGM).
Results : According to the literature these women due to their traumatic experience which frequently occurs in childhood, require a challenging type of care so that to accomplish an improved childbirth outcome. This special type of care has to be offered through a non-judgemental approach with an emphasis on psychological support. Attitude of health professionals is a matter of great importance and more in detail needs to be thoughtful, non-critical and intensely knowledgeable of the profound consequences FGM. Most importantly the provision of education to affected women and their families in order to assist or at least-diminishing this harmful practice, has to be offered continuously through consultations and meetings.
Conclusions : A greater understanding of FGM will help health professionals to improve the health care provided and cease further alienation of the women involved. Increasing awareness by educating the communities involved could help to challenge themselves harmful practices. Changing traditional practices that have existed for centuries is a slow and uphill process.

Keywords: feminism, culture, ethics, patriarchy, mutilation, excision, genital, clitoris, sexual

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Introduction

Female Genital Mutilation (FGM) is a procedure which involves partial or total removal of the external female genital organs. The World Health Organisation recognises degrees of severity of mutilation:

a) Clitoridectomy or 'sunna' in which the hood of the clitoris and surrounding tissue are removed,
b) Excision, in which the clitoris and the labia minora are removed and

c) Infibulation, in which the clitoris, the labia minora and at least the anterior two thirds and often the whole of the medial part of the labia majora are removed. As a result raw surfaces are created on the labia majora so that they can be stitched together to form a seal over the urethra and most of the introitus of the vagina.[1,2]

There is evidence that classification could be unhelpful since there is a huge variation in mutilation and clitoral damage could be unpredictable. The age at which FGM is performed varies: it could be done at any time between a few months old until puberty, on the first wedding night, or even during the delivery of the first baby. [1, 3, 4]

Infibulation is widespread in Somalia, Djibouti, parts of Mali, northern Nigeria, some parts of Ethiopia and Sudan. Clitoridectomy and excision are practiced on the west coast of Africa, Chad, the Central African Republic, southern Egypt, Kenya and Tanzania. The practice is also common among Muslim groups in the Philippines, Malaysia, Pakistan and Indonesia. Female circumcision is also practiced in Muslim United Arab Emirates, Oman, Bahrain, and South Yemen but it is not practiced in the cradle of Islam, Saudi Arabia. In each area it has different explanations and it is done in a different way. [3, 4]

Why should we use the term "mutilation"? For years people tend to use the terminology "female genital circumcision". The facts prove, by medical standards, that by removing a healthy, normal organ from a human body when there is no medical or aesthetic reason to do so is a mutilation.

During the First Study Conference on Genital Mutilation of Girls in Europe organized by the Foundation for Women's Health Research and Development in July 1992, defines genital mutilation as the "removal of, or injury to, any part of female genital organ which the conference defines as a violation of the basic human rights of the girl-child, which should be abolished". [1, 5,6]

Although it is difficult to trace the origins of FGM in the literature, there are strong beliefs that it existed for at least 5000 years. Its origins do not lie in Islam as it is practiced in Muslim as well as in some Christian communities and it is not mentioned in the Koran. Other practices less harmful, such as facial scarification have not spread to that extent and never managed to become that popular. There must be a strong cultural value behind this procedure because it managed to survive fifty years of criminalization and many propaganda campaigns. It is estimated that 130 million women alive today have suffered genital mutilation. Two million girls suffer this practiced annually according to WHO. Female genital mutilation has been condemned as a violation of human rights by the International Conference on Population and Development, the Fourth World Conference on Women in Beijing, the World Health Organisation, UNICEF and the United Nations Planning Authority. Due to immigration the practice of FGM has spread, in varying degrees in many different continents such as Latin America, North America, Western Europe and Australia making female genital mutilation an international issue. [1, 3, 4, 6]

Reasons for the existence of FGM

As part of our working lives as health professionals many of us deal with women who have been excised. Therefore it is imperative that we understand the reasoning and why women have FGM. In traditional, rural areas where FGM is practiced community is convinced of the necessity of the operations. It has always been done this way; it is the norm, it is tradition. Many women believe that it is practiced everywhere and therefore there is no alternative. According to Gruenbaum, Momoh and WHO, among the reasons for the existence of FGM the following are included: it is performed for prevention of promiscuity and to keep moral behaviour of women in society. The clitoris is a source of sexual fulfilment and enjoyment. Women who have their clitoris intact are in danger of becoming oversexed. The female genitalia

have the potential to grow exactly like the male genitalia do. In order to preserve femininity, female organs need to be excised. Other ethnic groups consider the female genitalia very ugly to look at or to touch. A flat, smooth area of skin without the fleshy encumbrances appears more pleasing to the sight and touch. Additionally, the clitoris could be dangerous for the man who would sleep with a non excised woman because it may kill him during intercourse. It could also be the cause of death for the first born child. [1, 3, 4]

Furthermore, it is believed that the secretions produced by the external female organs are dirty, smelling and unhygienic. It is a woman's duty and a measure of pride to keep her self clean and free from the danger of contaminating her husband. Supporters of FGM believe that without the performance of the operation women can not have children because the secretions produced by the glands of the genitalia can kill the spermatozoa. The status of African and Middle Eastern women depends on the number of children they produce, especially sons Lack of fertility is a cause for divorce. Furthermore, men refuse to marry women who are not excised. Since marriage is the only carrier for many women in Africa and the Middle East, the operations continue. Mutilation is considered to be a proof of virginity. Its preservation reflects the moral quality of the girl's family and as a result a non mutilated girl is not considered to be marriageable.[6, 7, 8]

Cultural identity is very important in many African families. The ritual of FGM is a pathway to full social acceptability. Without it women are in danger of losing their right to participate in community life, something that will eventually affect the male head of the family. Mutilation is credited with healing powers. Although there is evidence of girls and women who have suffered serious immediate or long term complication from the performance of FGM, it is believed that it cures from conditions like hysteria, depression or nymphomania.[6,7]

Additionally, the clitoris could cause premature ejaculation due to additional excitement of the male. Because it is the man, not the woman who should control sexual relations, the clitoris has to go out of the way. In case of infibulation, the size of the orifice is calculated to bring increased pleasure to the male during intercourse. Although religion is given as a reason of mutilation, religious scriptures show little evidence of FGM as a religious obligation. However there are authors who suggest that religion is used to legitimate FGM as a means of social control, hence omen's low status in the community. [3, 6]

Obviously, male power and male control over women has a lot to do with the practice. Although it is women who perform the ritual to other women, it is under rules and regulations that have been decided from the male part of the community. Women do not participate in major decisions concerning their lives and well being. Lack of awareness due to the absence of sex education and education on biological facts of life, what in the West is referred to as 'myths' is the reality for many people in Africa and the Middle East. FGM is controlled by supernatural powers. It is usually performed in a ritualistic way. Women who go through this experience believe there is a spiritual uplift and they wish for their children to experience the same blessing. As previously mentioned for many women FGM is not through choice as it may have been performed any time throughout childhood.[3]

Complications

Because of the nature of FGM there are short and long term complications which depend on the type performed, the expertise of the circumciser, the hygiene conditions under which the operation was conducted and the health of the child at the time of the operation. In rural parts of Africa the operation takes place in poor conditions with poor lighting, using the same instrument from girl to girl, increasing the concern for the possible spread of HIV. The instrument could be a broken neck of a bottle or a kitchen knife, which might not work

effectively so the operator would have to repeat the cut times again. [1, 3]

Short term complications include death due to shock, haemorrhage and sepsis. In some areas the operator would throw dirt on the wound to stop the bleeding. Animal faeces could also be used resulting in fatal infections. The mortality rate is not properly assessed but according to WHO, it is estimated at 10% of the affected population. In accordance with the myths and the supernatural beliefs that follow FGM, if a girl dies during the operation that would be because she has done something wrong in the past and she's been punished. [1]

In contradiction to what is believed by the supporters of FGM the operation could lead to infertility due to chronic urinary and pelvic infection. Further long term complications include painful menstruation, dyspareunia, cysts and keloid formation. Painful coitus is the most frequent result of the operation due to the small opening of the vagina and often recalls the pain of the mutilation. Lack in orgasm is commonly met and women are not aware that sexual intercourse could be pleasurable for them too. Depression might occur due to episodes of frigidity and anxiety, because they are unable to satisfy the husband's needs. The life long psychological effects on the mentality of mutilated women have not been investigated enough. Although the WHO has reported on some emotional and behavioural problems commonly met among mutilated women, this is an area that needs to be researched deeply. Phobias as well as emotional alienation and flash backs that take them back to traumatised experiences contribute to their life long suffering: many women have no acceptable means of expressing their fears and problems as this is considered to be a taboo. [1, 2]

The role of the health professionals

For the health professionals dealing with these women it is important to consider the effects during pregnancy and childbirth. The excision scars could lead to obstructed labour that could result in brain damage or death of the baby. In cases of infibulation unassisted childbirth is impossible. Without the performance of de-infibulation, both mum and baby might die. It is understandable that not all women who undergo FGM suffer the same problems. Some may be affected more than others. It is important to have a full understanding of the emotional and physical state of the woman during pregnancy, childbirth and postnatal period. This is a difficult task as not all women are open about their experience and especially to a stranger. Pregnancy is a developmental crisis in a woman's life. Her psychological status is based on several factors, including her past, the way she views her self and her ability to cope with stress. Some women might seek little or no prenatal care while others will be keen in seeking support and advice. Giving birth is a significant event in a woman's life. Experience during childbirth can have a life long impact on the way a woman views her self, her relationship with her baby, with other family members and the ability to mother her child. For women who have undergo FGM, birth can recall or re-enact previous violations of her body because the anatomy involved in childbirth is the same anatomy involved in the procedure of FGM. [8-12]

Recommendations for the future

From the above it is obvious that caring for women with FGM requires health professional to have a wide range of skills including advocator, counsellor and educator liaisor. It is important to be aware of the environmental and socio-economic issues involved in FGM. Midwives, nurses and doctors have to approach women in a non judgmental way. The family has to be involved in decisions with the valuable assistance of an interpreter and information given has to be clear, concise and sensitive. Advocacy, communication and the provision of researched based information are of the main responsibilities for health professionals. Guidelines for safe practice based on research of all aspects of FGM should be

available in order to enable the maternity services to provide the care these women require. Protocols which outline the management of female genital mutilation need to be written and health professionals have to be fully aware of the existence, implications and management of FGM women. This involves the organisation of training courses for professionals based on a personal level needs assessment and should focus on ways of best meeting the needs of mutilated women.[13-15]

In view of the varied implications of FGM outlined above, on the lives of the women who go through it, the Foundation for Women's Health, Research and Development conference (FORWARD) recommended that the issue of FGM should be included in the teaching of schools of midwifery, nursing, health visiting and medicine. This will make professionals aware from an early stage for the issue of FGM and be better equipped to deal with it. Also, expertise should be available so that those encountering FGM for the first time are able to call on those health professionals who have developed their skills.[16-19]

The International Code of Ethics for Midwives (ICM), states that 'midwives should provide care for women and childbearing families with respect for cultural diversity, while also working to eliminate harmful practices within those same cultures'. A greater understanding of FGM will help health professionals to improve the health care provided and cease further alienation of the women involved. Increasing awareness by educating the communities involved could help to challenge themselves harmful practices. Changing traditional practices that have existed for centuries is a slow and uphill process. Like the burning of Indian widows and the binding of feet of Chinese girls, FGM is an outdated custom reflecting the oppression of women in some societies.[20-23]

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