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Female genital mutilation (FGM)

With **Jean Kagia**, MD, Upper Hill Medical Centre, Kenya

More than 200 million women and girls[2] are victims of female genital mutilation (FGM) around the globe. The practice of female genital mutilation is most common in western, eastern, and north-eastern regions of Africa and some Asian and Middle Eastern countries. In light of a disturbing increase in the number of cases found in the USA, UK, and other western countries, it is important for women's health practitioners to understand the healthcare repercussions of FGM.

It is equally important to get to know the human faces behind these statistics. We spoke with Dr. Jean Kagia, consultant OBGYN at the Upper Hill Medical Centre in Nairobi, Kenya, who estimates that 30% of her patients have experienced FGM. She shares her personal experience working with this population.

Why is female genital mutilation practiced?

The World Health Organization (WHO) characterizes female genital mutilation as any "procedure that intentionally alters or causes injury to the female genital organs for non-medical reasons."[3] There are many deep-seated cultural factors behind FGM prevalence. Although no religious scripts call for FGM, many who perform FGM believe that the practice is religiously required. FGM is frequently associated with female sexual 'purity' and 'modesty', with the implication that FGM will reduce a women's libido and cause her to maintain 'correct' sexual behavior. There is also an association with 'cleanliness' surrounding FGM, arguing that a woman is more clean or beautiful after undergoing the procedure.

Prevalence of FGM varies significantly depending on the region. In some countries, it is so widespread that as many as 90% of women and girls ages 16-49 are survivors of FGM. The practice is almost universal[4] in Somalia, Guinea, and Djibouti. There is evidence that FGM is on the decline in some areas, however, in other countries, the practice remains unchallenged. With an increasingly mobile population, immigrants and refugees have brought a number of FGM survivors to the US, Europe, and other developed nations, along with the cultural practice.

Many social groups in Kenya still activitely practice female genital mutilation. WHO statistics put the frequency of FGM in Kenya at 28%. Dr. Kagia explains that for her patients FGM is a 'part of life' despite public health campaigns to stop the practice. "Women see it as part of their culture. For many, it's just the way that things are done."

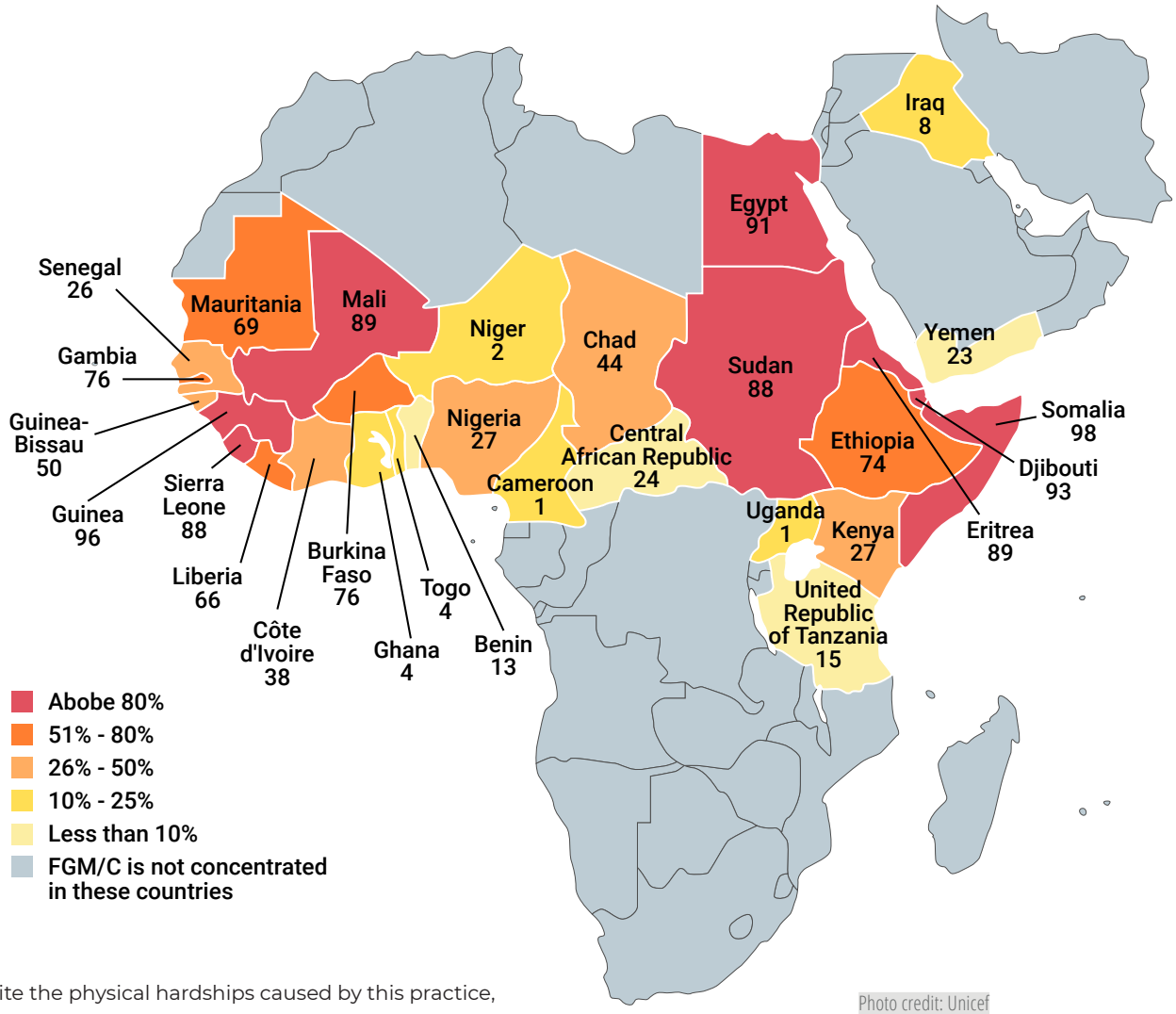

Photo credit: Unicef

Despite the physical hardships caused by this practice, many parents still believe it is their responsibility to have FGM performed on their daughters. Some of the effective public health campaigns against FGM have leveraged the support of local women and religious leaders to change prevailing attitudes from within.

Types of female genital mutilation

FGM is performed in various ways depending on the region. WHO categorizes them into four groups:

Type 1 —
Clitorectomy

The partial or total removal of the clitoris and/or the prepuce.

Type 2 —
Excision

The partial or total removal of the clitoris and the labia minora with or without excision of the labia majora.

Type 3 —
Infibulation

Narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or labia majora, with or without excision of the clitoris.

Type 4 —
Other

All other harmful procedures to the female genitalia for non-medical purposes, for example, pricking, piercing, incising, scraping, and cauterization.

Immediate health risks of FGM

Numerous health risks are associated with female genital mutilation. Immediate risks include hemorrhage, hemorrhagic/neurogenic/septic shock, genital tissue swelling, and urination problems. Risks of infection include acute local infections, the formation of abscesses, septicaemia, genital and reproductive tract infections, and urinary tract infections. Some evidence shows that FGM increases HIV rates, although direct causality has not been established.

Obstetric complications resulting from FGM

The removal of the vulva tissue and the closing of the labia creates numerous obstetric complications, especially in those women who have experienced type 3 FGM. Risks include an increased rate of cesarean section, episiotomy, obstetric lacerations, dystocia, instrumental delivery, and postpartum hemorrhage.

Dr. Kagia reports that many of her patients who have experienced FGM require additional intervention during delivery. “Often I need to perform either a generous or bilateral episiotomy, depending on the extent and type of FGM,” she explains.

There is also an increased risk to infants[5] born to survivors of FGM. FGM causes an estimated 1 -2 infant deaths per 100 deliveries in the regions where this practice prevails.

The psychological impact of FGM can be as profound as the physical impacts.

Other long term risks

FGM has a significant effect on sexual functioning, one of the goals behind this practice. Issues can include dyspareunia, anorgasmia, and reduced arousal, even among women who can achieve orgasm. Decreased vaginal lubrication can add to pain during intercourse. Damage to genital tissue can cause chronic vulvar and clitoral pain.

FGM can disrupt regular menstruation with women experiencing dysmenorrhea, irregular menses, and difficulty in passing menstrual blood.

Many women suffer from chronic infections, both genital and urinary tract infections, which may lead to painful urination.

Treatment for FGM

Deinfibulation represents the most common treatment for female genital mutilation, primarily performed in cases of type 3 FGM. This minor surgical procedure involves re-opening the vaginal introitus. An incision is made in the midline scar tissue that covers the vaginal introitus until the external urethral meatus, and eventually, the clitoris, are visible. The cut edges are then sutured, which allows the introitus to remain open.

Dr. Kagia performs deinfibulation on her patients, particularly to help sexual functioning. “Some of these women find it hard to consummate their marriages as a result of their FGM. They come to me to separate the labia.”

The World Health Organization[6] recommended deinfibulation, with the caveat that any intervention must be carried out with the full consent and understanding of the patient. The ability to make informed choices about their body proves an important aspect of psychological healing after experiencing FGM.

The psychological impact of FGM can be as profound as the physical impacts.

WHO Guidelines on the Management of Health Complications from Female Genital Mutilation recommend both sexual counseling and cognitive behavioral therapy (CBT) to help women recover from their experience.

In recent years, increasingly more surgeons[7] offer clitoral reconstruction surgery to restore sexual function to women who have experienced all forms of FGM. This procedure involves opening the scar tissue around the clitoris, exposing the remaining nerves underneath, and grafting on fresh tissue. This procedure is currently only performed by a small number of specialists in the field.

Eradication of FGM

A number of intensive public health efforts have helped to eradicate the practice. The World Health Organization[8] has led the way in documenting and counteracting the practice, publishing regular figures on FGM and guidelines for healthcare workers treating patients who have experienced FGM.

This campaign has helped reduce the prevalence of FGM in some areas. However, 'medicalization'[9] of female genital mutilation has become a worrying trend. An increasing number of FGM cases are being carried out by local healthcare workers either in homes or clinics. While the message that FGM is unsafe has made an impact in the public consciousness, it has not led to the widespread abandonment of the practice. Instead, parents seek a 'safer' form of FGM. According to the WHO, FGM can never be called safe and is a violation of human rights in all circumstances.

FGM in the USA

An estimated 513,000 women and girls in the USA[10] have experienced FGM, many of whom are immigrants from regions where the practice is prevalent. However, some affected are American citizens who returned to their family's country of origin to undergo FGM. US federal law has made it a crime to perform FGM on a child younger than 18 or to take that girl out of the US to perform FGM.

Recent press has brought the issue of FGM in the USA to greater attention. Survivors living in the US report a deep sense of shame[11] surrounding their experience, with some afraid to discuss their suffering even with their spouse. However, for many of those who have sought medical attention, advanced technology in the US has enabled them to receive reconstructive surgery more readily than in lower resource settings.

How to approach patients who have FGM

For women's health clinicians unfamiliar with the practice, FGM is a challenging issue to broach. Dr. Kagia stresses the need to approach survivors with compassion and understanding. "Remember that this was 'normal' in the cultures they come from," she says. "Be non-judgemental."

Dr. Kagia echoes the WHO Guidelines in emphasizing the need to equip women with information about their own healthcare. "I explain possible complications that might result from their FGM, especially during delivery."

Victims of female genital mutilation have had their human rights and their agency over their bodies violated. Women's health clinicians have the power to restore their rights, both through appropriate medical intervention and by showing compassion for their experience and respect for their choices.

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