

Female genital mutilation

Crossing the cultural and gender divides

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Abstract: Female genital mutilation (FGM) is a global issue, as it is practiced in 29 countries in Africa and the Middle East, Asia, South America, as well as by diaspora in the United States, Europe, Australia and New Zealand. It causes well-known immediate and long-term physical and psychosexual complications to girls and women, and male partners of women with FGM. Two of the main reasons for continuation of this practice are pressure of social obligation in communities and lack of discourse in the public arena and between men and women on this private and sensitive issue. However, overall the prevalence of and support for FGM is declining. Recent data suggests a focus of intervention programs on the role of men and communities' priorities to achieve better education for all and raise the status of girls and women. Approaching communities with a true sense of equality and partnership is important in building trust and achieving an understanding of their culture, and tailoring intervention programs.

Key words: Female genital mutilation; Human rights; Male attitudes; Male complications; Social obligation.

INTRODUCTION

Female genital mutilation (FGM) is a deeply entrenched cultural practice that has persisted for centuries. Despite intervention programs and advocacy for its abandonment for many decades, it continues to cause deaths and significant short- and long-term complications to the health of girls and women. Overall the practice is becoming less common in more than half of the 29 countries in Africa and the Middle East.¹ FGM is no longer regarded as an issue that affects women only, as men married to women with FGM also report physical and psychosexual problems.²

FGM refers to all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons. It is generally performed to girls from birth to age 15. There are four types of FGM (Table 1).³

TABLE 1. – WHO Classification of FGM.

Type 1	Partial or total removal of clitoris and/or prepuce
Type 2	Partial or total removal of clitoris and labia minora, with or without excision of labia majora
Type 3	Infibulation. Excision of part or all of external genitalia and stitching of the two cut sides together to varying degrees
Type 4	All other harmful procedures to female genitalia for non- medical purposes, for example pricking, piercing, incision, stretching, scraping and cauterization

In type III or infibulation, the vaginal entrance is sutured with unsterile suture-like material and usually without anaesthesia. This leads to risk of transmission of infections, including human immunodeficiency virus (HIV),⁴ hepatitis, septicaemia, tetanus, haemorrhage and shock. The World Health Organization (WHO) estimates that more than 125 million girls and women in 29 African and Middle Eastern countries have undergone FGM, with three million at risk each year. It is also prevalent in some countries in Asia and in migrant communities from these countries in Europe, United States, Australia and New Zealand.¹

Overall the support for the practice is declining, even in countries where FGM is almost universal, such as Egypt and Sudan. There is, however, a discrepancy between this declining support and the continuation of this practice.¹

One of the most important issues is the lack of communication between men and women on this private and sensitive issue, which fuels the perpetuation of false beliefs and expectations.² Another is overcoming the cultural barrier to address the social obligation that is a major driving force.

It is important to establish a trusting relationship with communities that practice FGM and appear on the outset culturally very different and cruel to their children to those that do not practice it. The most successful programs have been those that are non-judgemental, non-coercive and address communities' priorities, which invariably are linked to attainment of their human rights.^{5, 6} The true difference between people is whether their lives are protected by human rights as set out by the United Nations in 1948.⁷ A girl subjected to forced child marriage can die at childbirth from obstructed labour due to a combination of underdeveloped pelvis of childhood or malnutrition from poverty, or closed or scarred vaginal introitus from FGM, and lack of access to healthcare facilities. This young girl is not the same as the one who is able to obtain an education, choose her own path in life, and is protected by laws, which are underpinned by human rights. The two girls are different in that one is protected by the human right of the child, the right to life, the right to be free of torture or cruel, inhuman or degrading treatment, the right to equality and non-discrimination on the basis of sex, the right to a standard of living adequate for the health and well-being of herself and her family, amongst others.⁷

HEALTH COMPLICATIONS OF FGM

There is a wide range of well-known immediate and long-term complications in girls and women (Table 2).

If defibulation is not performed antenatally, or a woman does not have access to obstetric health services, obstructed labour occurs with a stillborn baby (Figures 2 and 3). If obstructed labour is prolonged, a vesicovaginal or rectovaginal fistula develops from necrosis of tissues secondary to pressure of the fetal head on the pelvic floor (Figure 4).

The metal urethral catheter depicts a total severance of the urethra from the bladder (Figure 5).

A landmark, prospective, collaborative study conducted by WHO involved approximately 30,000 women across 28 obstetric centres in six African countries.⁸ It clearly showed that women with FGM type 3 had a 30% higher risk of undergoing a Caesarean section, and a 70% in-

TABLE 2. – Complications of FGM in girls and women.

Immediate Complications	Long term complications
Death	Vulval abscess, ulcer, cyst, neuroma, keloid scar
Haemorrhage	Vaginal obstruction with haematocolpos, haematometra, dysmenorrhoea
Infection (HIV, hepatitis, other organisms, wound, septicaemia)	Apareunia, dyspareunia, vaginismus
Shock from haemorrhage or sepsis	Sexual dysfunction, anorgasmia
Acute severe pain	Relationship problems
Psychological trauma	Urinary incontinence, urinary tract obstruction, urinary tract infection, voiding difficulties
Fracture of bones or dislocation of joints from force of being held down	Pelvic inflammatory disease
Acute urinary retention	Chronic vulval and/or pelvic pain
Damage to urethra, anus, rectum and/or perineum	Vesicovaginal or rectovaginal fistula
	Post-traumatic stress disorder
	Depression, anxiety
	Infertility



Figure 1. – Urinary tract obstruction in an infant. This infant developed hydronephrosis and kidney damage as a result of injury to the urethra. (Courtesy: Assoc. Prof. Moustapha Toure, Mali Hospital, Bamako, Mali).



Figure 2. – Obstructed labour in a woman with infibulation. (Courtesy: Assoc. Prof. Moustapha Toure, Mali Hospital, Bamako, Mali).

crease in postpartum haemorrhage compared to women who had not undergone FGM. The perinatal mortality rate was 15%, 32% and 55% higher in women with FGM types

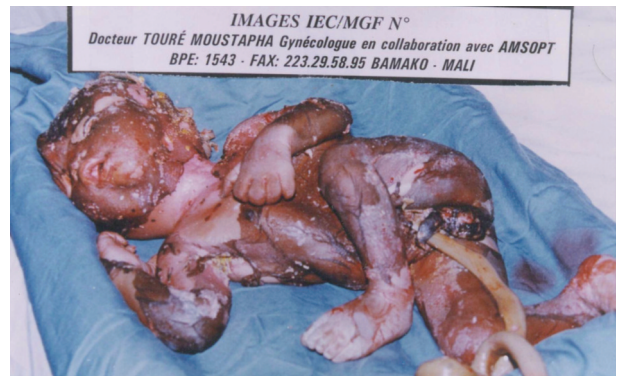


Figure 3. – Stillbirth from obstructed labour in women in Figure 2. (Courtesy: Assoc. Prof. Moustapha Toure, Mali Hospital, Bamako, Mali).



Figure 4. – Vesicovaginal fistula secondary to obstructed labour.

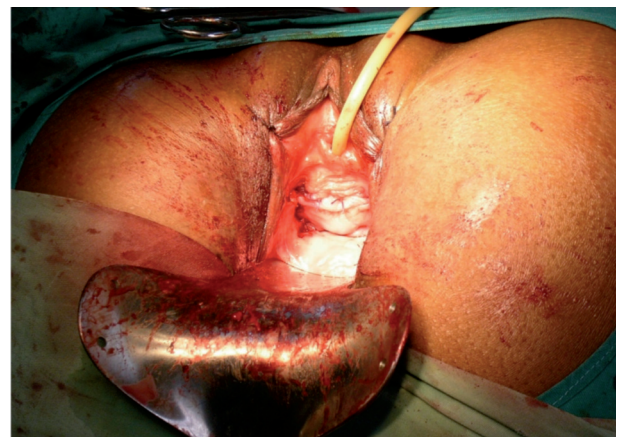


Figure 5. – Repaired vesicovaginal fistula.

1, 2 and 3, respectively. It is estimated that an additional 10 to 20 babies die per 1,000 deliveries as a result of FGM. Furthermore, newborns were 66% more likely to require resuscitation if their mothers had undergone FGM type 3.⁸ These are results for women who delivered in recognised healthcare facilities or hospitals where staff were skilled at dealing with women with FGM. It can be assumed that the outcome for women delivering in remote, rural areas would be more devastating.

There are important implications for the economics of the health care systems of those countries. A WHO study on the obstetric cost of FGM estimated that 2.8 million 15-year-old girls in six African countries would lose about 130,000 years of life as a result of complications related to

obstetric mortality from FGM. It was estimated that I\$ 2.50 and 5.82 (international (purchasing power) dollars adjusted for the cost of living in each country) are required for prevention programs for FGM types 2 and 3, respectively. These costs would be offset by the economic saving of managing obstetric complications from FGM.⁹

Male partners of women with FGM can have complications as well. Interviews of 59 men in Sudan revealed that the majority had difficulty in vaginal penetration, wounds and infections on the penis and psychological problems.² Of particular importance was the fact that the men experienced their wives' suffering as their own problem.

HOW HAS FGM PERSISTED FOR CENTURIES?

Continuation of FGM is motivated by a complex mix of socio-cultural factors, social obligation, peer pressure, fear of exclusion from resources and opportunities as a young woman and marriageability.^{6 10} Whilst the reasons can vary in different communities, it generally relates back to premarital virginity, chastity and marital fidelity, and hence marriageability. FGM may be performed for perceived necessity for spiritual cleanliness, for family honour or as a rite of passage, a transition from childhood to womanhood. Effective punitive social and community measures are in place for nonconformity.^{6 10}

Male attitudes to FGM were investigated in a study that interviewed 59 men in Sudan. Social acceptance or social pressure, followed by tradition, were the main reasons stated by men who preferred to marry a woman with FGM. Respect from the community is intricately linked to being married to a woman of "virtue". Social obligation or normative expectations are also believed to be responsible for the wide variation in prevalence and support for FGM among different ethnic groups in many countries.

Even though no religion condones this practice, the belief that it is a religious requirement by some local religious leaders and communities, fuels its continuation. In Mali, for example, nearly two thirds of girls and women and about 40% of boys and men believe FGM is required by religion.¹

Another possible reason is the reality and fear of sexual violence against girls, particularly in communities where infibulation is practiced, as it precludes vaginal penetration or makes it difficult. While this requires exploration in future research, evidence exists in the literature linking FGM and higher incidences of intimate partner violence (IPV).¹¹

FGM has become a self-enforcing social norm, a socially upheld behavioural rule in communities.¹ People's behaviour is dependent on their beliefs about others, i.e. whether others do or do not support FGM of their daughters, their knowledge about the practice, and the interaction between social, moral and legal norms.¹⁻⁵ Even though communities may understand the harm of FGM to their daughters and that it is illegal in their countries, the pressure of social obligation overrides the positively modifying influence of the other norms.

CROSSING THE CULTURAL AND GENDER DIVIDES

There are two very difficult barriers to cross. Foremost FGM is a highly entrenched part of people's culture. Secondly it is generally not discussed, especially between men and women. To cross the cultural divide, it may be more beneficial to take the focus away from FGM and on to an understanding and provision of the priorities of communities, including improving education of men and women and elevating the socioeconomic status of women

and their communities. Crossing the gender divide requires men taking a leading role in advocacy for abandonment of FGM. Programs need to involve activities that allow open communication between men and women.¹

EDUCATION

There is evidence that prevalence levels of FGM and support for the practice are lower among women and men who have completed higher levels of education, urban residents and those from wealthier households.¹ In a study of interviews of 2,500 men in Ghana the less educated men were three times more likely to prefer a woman who has been cut than the more educated ones.¹²

In Gambia the prevalence of FGM is about 80%. This varies greatly amongst the different ethnic groups from about 10% to almost 100%.¹³ Among almost 1000 men who were interviewed in The Gambia, 72% were unaware of any health consequences. Approximately 60% of these men supported the continuation and indicated they would cut their daughters. Those, that were more educated and aware of the health consequences, wanted it to stop. Seventy-three percent of these men cited complications in women as the major reason for their support of abandonment. They also expressed the highest support of men being involved in its prevention.¹³

Awareness of health consequences by communities has taken an unexpected path of medicalisation in some countries. In Egypt and Kenya, for example, there has been an increase in girls being cut by health care professionals, despite laws criminalising the practice. As long as the pressure of social obligation persists, parents will continue to cut their daughters. They seek out health care professionals to minimise the harm to their children. Education needs to extend to doctors and nurses to become advocates of change towards abandonment.

COMMUNITIES' PRIORITIES

Engagement of high-income countries with low-income ones may be better approached on the basis of partnership instead of a donor-recipient relationship. It empowers the host party and creates better transparency of the intervention program, giving ownership and responsibility for change to the communities. Change is unlikely to happen when imposed on people. As an example, China's long-standing engagement with the continent of Africa has been based on this premise of partnership and cooperation. Its principles of engagement have been equality and mutual benefit, stress on practical results, common progress, and sovereignty of the host. It avoids the paternalism that is associated with "aid" from the West.¹⁴

Perhaps we can translate this "trade rather than aid" principle to our engagement with communities for FGM. The benefits and risks of the program or project, expectations and obligations of both parties are set out clearly at the outset. Requirement of a program, for example, may be a certain number of girls and boys attending school and achieving a certain level. The funding of the program may establish schools and/or pay for teachers' salaries, school transport of the children, payment to families for daily chores that daughters are otherwise obliged to carry out, preventing them from attending school etc. The school curriculum would then include harmful traditional practices, interactions with communities that do not practice FGM, and discussions with religious leaders who understand that FGM is not condoned by religion. These teachings could expand to the wider community.

Improved socioeconomic status of communities, and particularly of women, is associated with lower prevalence of FGM. With higher household wealth, people have more access to information on FGM and exposure to people and communities that do not practice it.¹ These families would see that there is no disadvantage for girls who are not cut and perhaps it gives them other opportunities for marriage where FGM is not a prerequisite.

FGM AND MEN

There is little discourse on this sensitive and private issue between men and women. It is generally assumed that men prefer to marry women who have been cut.¹⁵ Women and girls tend to consistently underestimate the proportion of men and boys who want FGM to end.¹ Moreover, a large proportion of wives do not know their husbands' opinions of FGM.¹ The attitudes of men and women towards FGM are actually more similar than women and men believe. In Guinea, Sierra Leone and Chad, substantially more men than women expressed their support for FGM to end.¹ In a study of interviews of 59 men in Sudan, most young men, all of whom were married to women with FGM, expressed a preference for a woman who had not been cut.² Moreover 86% of them would have accepted a woman without FGM to be his son's or grandson's wife. Most of the older men had the opposite opinions.

It appears that a focus on young men to become advocates of change would be an important step in the abandonment process of FGM. Moreover, men who are well known to and liked by the public, such as football players or musicians, could help raise awareness and bring this issue to the public arena. Intervention programs can foster discussions between women, men, girls and boys,¹ so they hear each other's opinions and the perpetuation of false beliefs and expectations do not continue.

CONCLUSION

FGM remains a difficult harmful practice to abandon, as it embodies culture, sexuality, female genitalia and religion, and the need to discuss all these in public and between men and women. Nevertheless, its prevalence and support are in decline and fewer girls are cut today than their grandmothers. With continuing international commitment and collaboration, we may see the end of FGM within a generation. The way forward challenges men to take leading and active roles in the abandonment process and to assist with opening up a discourse to dispel misconceptions about FGM in general and between the genders. We need to continue to respectfully engage with communities that practice FGM and address their other priorities embodied in human rights.

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Multidisciplinary Uro-Gyne-Procto Editorial Comment

To improve the integration among the three segments of the pelvic floor, some of the articles published in **Pelvipерineology** are commented on by **Urologists, Gynecologists, Proctologists/Colo Rectal Surgeons or other Specialists** with their critical opinion and a teaching purpose. Differences, similarities and possible relationships between the data presented and what is known in the three or more fields of competence are stressed, or the absence of any analogy is indicated. The discussion is not a peer review, it concerns concepts, ideas, theories, not the methodology of the presentation.

Gyneco... Nesrin Varol's review on Female Genital Mutilation (FGM) is quite shocking both in terms of intrinsic violence of the practice and its epidemiological size. Remarkable is the "non-vio-

lent approach" of the Author to the issue of how to promote the decline of the practice. "The most successful programs have been those that are non-judgmental, non-coercive and address commu-

nities' priorities, which invariably are linked to attainment of their human rights." What is more multidisciplinary, let's say multidimensional, than the above statement from Varol?

FMG is a medical problem not only in countries where ethical communities practice it, but also in receiving countries in case of migration of these populations; the two contexts being quite different.

Since the last two decades Italy is experiencing an important migration phenomenon, including migration from geographical area most involved in FGM practices, especially the African ones. Recent data from Lombardia, the most industrialized region in northern Italy are of interest. It has been estimated that 20.000 migrant women with FGM were present in Lombardia at July 2010. The vast majority (63%) had a type I mutilation, while a minority

TABLE 1. - Estimate of FGM in the origin country and in Lombardia at July 1st 2010. Modified from P. Farina, 2011.¹

Country	15-49 yrs in the origin Country (%)	15-49 yrs women with FGM in Lombardia
Egypt	95,8	70,7
Nigeria	10,8	74,3
Eritrea	86,0	67,5
Burkina Faso	73,6	64,5
Ivory Coast	41,2	21,7
Ethiopia	72,7	56,5
Senegal	27,7	6,7
Somalia	87,7	87,1
Ghana	4,7	3,4

(1,7%) refer the most severe type III (infibulation), with a high rate (32%) of answers of unknown mutilation. The prevalence and attitudes within different ethnic communities in Lombardia are strictly correlated with the practice within the origin community (Table 1).

The only exception is Nigeria: differently from every other country the rate in Lombardia is quite higher than in the origin country (74% vs 11%). This comes from the fact that the vast majority of the Nigerian women in Lombardia come from a particular area in Nigeria where the resident ethnic group Edo still fully adhere to traditional rules, including FGM.

The attitude of migrant women through the discontinuation of the practice is of special interest: 75% of the sample intend to discontinue it, while 11,6% plan to continue and another 11% has no clear ideas. Looking the data more in detail the role of education is of paramount importance: none of the women born in Italy and generally very few among the youngest intend to continue the practice, and the same is among the women with a higher level of education¹.

Clinically speaking the review from Varol clearly depicts the potential for a multidisciplinary urological, obstetric-gynecological and colorectal involvement as a direct or indirect consequence of this practice. The most severe complications occur more frequently in the origin country.

In receiving countries significant gaps in health care professionals' knowledge and clinical practice related to FGM are well documented and complications of FGM are underreported². In fact major complications are uncommon. As highlighted by Lombardia's data the type of mutilation most prone to complications is reported by less than 2% of migrant women, dysmenorrhea and disorders at micturition are reported respectively by 8,4% and less than 4% of women.¹

Clinicians in receiving countries need to improve their knowledge to provide a culturally and clinically competent care to migrant women. The cited paper from Perron et al. is specially dedicated to this purpose.²

We are very grateful to Nesrin Varol and to the Editor for driving our attention to this topic.

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Procto... Religious precepts and morals interfere with female sexuality mainly in developing countries and in Muslim communities; in some reports sodomy may preserve the premarital women virginity; nevertheless the published data on these topics are few and spare for the difficulty to break sexual taboos. The female genital mutilation (FGM) is an age-old practice that cause physical and psychological negative well demonstrated consequences. It is still performed in about 30 countries and the immigration in the western countries of the last decades finds doctors unprepared to assist women with FMG. It is demonstrated that they have a "higher risk for a prolonged delivery, wound infections, a postpartum blood loss of more than 500 mL, perineal tears, a resuscitation of the infant and an inpatient perinatal death."¹ Similar conclusions have been reported in the results of a meta-analyses.²

Obviously FGM causes higher risk of post-delivery lesions due to the obstructed labor: as vesicovaginal fistulas, and anal sphincter lesions;³ perineal tears are double in FGM probably related to the higher rate of instrumental deliveries⁴ and recto-vaginal fistula; these lesions are difficult to treat in developing countries and cause women isolation in own communities.

These data should push for a policy to avoid any form of genital mutilation and to prepare western doctors -obstetrics, urogynecologists and proctologists to be aware of these new problems.

Are we ready?

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Uro... This is an excellent article on the biopsychosocial effects of female genital mutilation (FGM), or if one prefers a less graphic description, procedures performed on the female external genitalia for non-medical reasons. It shows that it can have far-reaching consequences on both the subject and her partner. The author has already expounded in some detail the demographics, politics and cultural aspects of FGM. From a urological viewpoint, FGM can lead to multiple immediate and long-term sequelae, the more morbid of which include recurrent urinary sepsis, urinary incontinence and fistulae, chronic bladder outlet obstruction which may lead to stone disease, renal impairment and ultimately irreversible renal loss. Principles of urological management will be aimed at preservation of renal function to avoid subsequent need for dialysis: treating urinary infection, restore normal functional lower urinary tract anatomy, relieve outlet obstruction, and ascertain longer term follow-up to ensure patient's compliance with treatment and that improvement is maintained. Many cases would need a multidisciplinary approach including gynecology, urology, coloproctology, psychology, nursing, physiotherapy, general practice and community medicine. Community awareness by health professionals through outreach programs may lead to better education of the masses of the ill effects of FGM on bodily function, some of which may be life-threatening. Further research and investigation into this area is warranted to minimize its occurrence and its associated aftermath on the affected individuals and their families.

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