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CURRENT GLOBAL STATUS OF FEMALE GENITAL MUTILATION: A REVIEW
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ABSTRACT

Objective: **To provide an overview of the current global status of female genital mutilation (FGM) or female circumcision practised in various countries.**
Data source: **Major published series of peer reviewed journals writing about female genital mutilation (FGM) over the last two decades were reviewed using the index medicus and medline search. A few earlier publications related to the FGM ritual as practised earlier were also reviewed including the various techniques and tools used, the "surgeons or perpetrators" of the FGM ritual and the myriad of medical and sexual complications resulting from the procedure. Global efforts to abolish the ritual and why such efforts including legislation has resulted in little or no success were also critically reviewed.**
Conclusion: **FGM remains prevalent in many countries including African countries where over 136 million women have been 'circumcised' despite persistent and consistent efforts by various governments, WHO and other bodies to eradicate the ritual by the year 2000 AD. This is as a result of deep rooted cultures, traditions and religions. Although FGM should be abolished globally, it must involve gradual persuasion which should include sensitisation and adequate community-based educational and medical awareness campaign. Mere repression through legislation has not been successful, and women need to be provided with other avenues for their expression of social status approval and respectability other than through FGM.**

INTRODUCTION

Female genital mutilation (FGM) also known as female circumcision is defined as any unnecessary modification of the normal female genitalia without any medical benefit to the patient(1). It has been practised worldwide in different forms and with different justifications and indications(2). FGM existed as early as the fifth century BC according to Herodotus and was practised among the Phoenicians Hittites and Ethiopians(3). FGM may have existed in the middle belt of Africa long before the records were kept and then spread north and eastward to Egypt. A Greek Papyrus dated 163 BC referred to circumcised girls in Egypt(4), but no evidence of FGM was found in Egyptian mummies. Presently, it is practised in some 28 African countries and affects more than 136 million females in the world(5). Another two million girls are at risk every year(6,7). Like male circumcision, FGM is thought to have evolved independently in Africa, Australia, America and the middle east countries(8,9). In the Western world, FGM was first reported in 1925 in the Lancet(10). In the mid nineteenth century, it was performed in England, Germany, France and the USA. The procedure was thought to be a cure for sexual deviations such as excess masturbation, nymphomania, hysteria, melancholia, insanity, catalepsy, epilepsy(11). Soon, FGM became unpopular in Europe and the last operation performed allegedly on medical grounds was reported in 1924(4). But in recent times in the United States, FGM has been practised for alleged control of female masturbation, achievement of orgasm and sexuality(12).

FGM is currently performed at different ages varying from seven days to 14 years old and according to the specific tradition or culture, FGM is practised in most African countries, Oman, South Yemen, United Arab Emirates, and the Muslim populations of Indonesia, Malaysia, Pakistan, India, Bohra, Malaya, Java, Baluchistan and Summatra. Various ethnic groups in Australia, Western Brazil, Eastern Mexico and Peru practised FGM in the recent past(13-15). Not confined to developing countries, FGM is also practised among the large immigrant populations of France, United Kingdom, and the United States and involves muslims, Christians and other religions. Only Great Britain, Sweden, Belgium and recently the Gambia in Africa have specific legislation banning any form of FGM(16,17). Other Western countries like France and the USA are in the process of enacting laws to ban FGM in the near future. Several complications ranging from slight blood loss to recto-vaginal fistula and

maternal and infant ill health have been encountered and documented(18,19).

CLASSIFICATION AND TECHNIQUES OF FGM

Although many types of FGM have been observed, it is unlikely that the perpetrators of the act know which one they perform(20,21). The different types of FGM are ill defined because the procedures are performed by lay persons with none or limited knowledge of the anatomy of female genitalia and surgical techniques. Toubia(14,22) classified FGM into three broad categories including clitoridectomy (Types i and ii), infibulation (Types iii and iv) and introcision. Clitoridectomy (Type i) involves partial or total excision of the prepuce and sometimes the excision of the tip of the clitoris. Excision (Type ii) is total excision of the prepuce of clitoris, and sometimes the tip of the clitoris and partial or total excision of the labia minora. Modified infibulation (Type iii) involves clitoridectomy and excision of the labia minora and upper two thirds of labia majora leaving a small posterior opening. Total infibulation (Type iv) also called pharaonic circumcision involves the excision of clitoris, labia minora and majora followed by the approximation of raw edges which are then stitched together to cover the urethra and vagina leaving a tiny opening for the passage of urine and menstrual blood. The opening is kept patent with a match stick, piece of wood or metal. Introcision is the most brutal form of FGM which involves incision and inward folding of vaginal introitus with finger or sharp instrument. Different tools such as knife, razor blade or burning piece of wood or coal are used to mutilate the female genitalia. The two raw edges of the vulva are then pasted together with gum Arabic, sugar, egg or sometimes pinned together by long acacia thorns. Rarely surgical materials such as silk or catgut sutures are used. In several cultures, the girls legs are then bound together from either ankle to hip or knees to waist and is immobilised for 10 - 40 days to allow for scar formation(15).

CULTURE AND RITUAL INDICATIONS FOR FGM

It is uncertain why the ritual started though it has been suggested that at the beginning it was a substitute for human sacrifice(15). In Russia for example, the Skoptsi sect used FGM to ensure a state of perpetual virginity in their community(15). Sudanese women perform FGM on their daughters as a means of securing economic and social future for them(4). Another justification for FGM based on ignorance is to secure fertility. Others perform FGM for the misconception that without circumcision the clitoris will grow long enough to dangle like the penis between the women's legs(23). Many however, simply evoke culture and tradition for persisting with the FGM practice(23,24). Very often some members of these societies adhere to this tradition believing for example that it is part of Islamic law and therefore a religious duty to be circumcised. Infact there is no specific support for female circumcision in the Koran, nor is it practised in Saudi Arabia the cradle of Islam(25,26). There are also millions of Muslims in India, Russia, China, Afghanistan, Turkey, Libya, Jordan, Iran and Iraq who do not practice any form of FGM. In Africa and Asia FGM has been linked to many public initiation rites and ceremonies in many societies. In some tribes, girls are secluded for several weeks prior to and after the operation during which period they are taught personal hygiene, child bearing and rearing, nutrition and medical herbs(27). On return to their tribes after the FGM they are received as adults and considered pure and eligible for marriage. African women in particular feel that their genital scars like other tattoos and ornamental scars distinguish them ethnically from other groups and confer on them a higher social status(28, 29). There are also other millions of illiterate women who believe that female circumcision is universal and have never seen uncircumcised adult women in their lifetime.

SURGEONS' WHO PERFORM FGM

The surgeons who perform and perpetuate FGM ritual are mainly untrained quacks and traditional medical practitioners including native circumcisers and traditional birth attendants. In Africa FGM is usually performed by elderly women known as *Gedda* in Somalia or *Daya* in Egypt and Sudan. In Nigeria, Zaire and parts of Egypt, untrained midwives, the mother or grandmother, a tribe elder or the local male village barber performs the operation(29, 30). No anaesthesia is used. The female is usually held down by family members who forcibly hold the girls legs open while the operation is performed. The procedure is usually performed in huts, houses, tents, open air spaces and near rivers. Trained medical personnel including doctors and nurses occasionally connive at and encourage FGM. It has recently been suggested that upto 12% of FGM are performed by medical doctors with sophisticated and sterile medical equipment in hospitals and clinics. Furthermore some of the earliest practitioners of FGM included doctors from USA and Great Britain, and a physician was deregistered in Britain only in 1993 for performing illegal FGM operations(12, 15).

MEDICAL COMPLICATIONS OF FGM

Complications common to all forms of FGM but occuring more with infibulation can be subdivided into immediate, intermediate, long standing and obstetrical(31,32). Immediate complications include haemorrhagic shock, trauma to the urethra and bladder, vaginal walls, and anal sphincter. Infections such as septicaemia, tetanus, wound infection and urinary retention

and infection are also included. Death in this group is usually from haemorrhagic or septic shock or tetanus. Intermediate complications include delay in wound healing, anaemia, malnutrition nectrotising fascitis, pelvic inflammatory disease, dysmenorrhoea vulvar cysts and abscesses, neuromas, keloid formation, vaginismus and dyspareunia. Late complications are vaginal stenosis, haematocolpos, infertility, recto-vaginal fistula, recurrent urinary tract infection, difficulty in urination, urinary incontinence and HIV transmission(15). Obstetric complications include prolonged second stage labour, perineal tears, obstructed labour and vesico-vaginal fistula(33,34).

Complications of the ritual affect many disciplines in medical practice. The paediatrician encounters some acute problems of haemorrhage, sepsis, or tetanus in the neonate or older child(17, 21). The urologist must deal with urethral meatal stenosis, urethral strictures and vesico-vaginal fistulae(17,35). The obstetrician is often faced with vaginal stenotic impediment to foetal expulsion during labour(34,36). This is one of the most serious obstetric problems. De-infibulation is sometimes required by a physician or midwife before labour. This is usually to prevent vesico-vaginal and recto-vaginal fistulae as well as lacerations of scar tissue with subsequent severe maternal haemorrhage(37). Obstructed labour caused by obstructed introitus may lead to foetal asphyxia or death. The scar which is composed of fibrous tissue encloses the upper part of the vestibule which has to be incised during the second stage of labour before anterior episiotomy(38). However, when a trained practitioner is not available, the husband or a female relative cuts the infibulation open using any available sharp object(15). The gynaecologist is confronted with problems of vaginal fistulae, vulvar dermal inclusion cysts, recurrent urinary tract infections, keloid formation, chronic pelvic inflammatory disease, haematocolpos(4,37). The proctologist may have to attend to recto-vaginal fistulae, while the psychiatrist is involved in the psychological sequelae of FGM(36,39). The plastic surgeon is also involved in the various plastic repairs(40). The financial implications of FGM are thus enormous as have been highlighted by a study in Kenya(41).

SEXUAL COMPLICATIONS OF FGM

All types of female genital mutilation operations destroy most or all of the vulvar nerve endings. This destruction leads to the reduction, delay or prevention of arousal and subsequent sexual enjoyment and orgasm. Painful sexual intercourse or dyspareunia is almost universal especially with the more severe types of FGM such as pharaonic circumcision or introcision practised in countries such as Egypt, Sudan and Somali. Coital difficulty or inability to perform vaginal intercourse at all because of vaginal stenosis and fibrosis may affect upto 35% of the pharaonically circumcised women (38). There is also associated painful menstruation and apareunia all of which may lead to sexually related anxiety and reactive depression (42).

Currently there is no surgical technique that is capable of repairing or restructuring clitoridectomy or restoring the erogenous sensitivity of the vulva. Genitally mutilated women in some African and middle Eastern countries view their own sexuality in terms of pleasing the husband and accept the fact that their only sexual pleasure is received indirectly by providing pleasure to the husbands (43).

GLOBAL EFFORTS AND LEGISLATION TO END FGM

The complications from FGM including the mutilatory factor has lead to universal condemnation of the practice all over the world. It was initially championed by women and was seen as a female activist issue (21). Efforts to end the custom of FGM began in Kenya in 1906 by the church of Scotland. In 1946 the British colonial office issued a mandate through local legislature banning pharaonic circumcision in Sudan but without much success (10,44) because some 50 years later 89% of all Sudanese women are still being circumcised (Table 1) (45). In 1978 in Somalia, a commission was set up to abolish infibulation but its recommendations were not enforced (4,46).

Table 1

Current estimates of female genital mutilation (FGM) in African countries

Country	Female population in millions	% prevalence	No in millions
Benin Republic	2. 73	50	1.365
Burkina Faso	5.224	70	3.6568
Cameroon	6.684	20	1.3368
Central African Republic	1.767	43	0.7598
Chad	3.22	60	1. 932
Cote d' Ivoire	7.089	43	3.04827
Democratic Rep. of Congo	22.158	5	1.1079
Djibouti	0.254	98	0.24892
Egypt	28.769	97	27.90593
Eritrea	1.777	90	1.5993
Ethiopia	29.87	85	24.723
Gambia	0.496	80	0.3968
Ghana	8.784	30	2. 6352
Guinea	3.333	60	1.9998
Guinea Bissau	0.545	50	0.2725
Kenya	13.935	50	6.9675
Liberia	1.504	60	0.9024
Mali	5.485	94	5.1559
Mauritania	1.181	25	0. 29525
Niger	4.606	20	0.9212
Nigeria	64.003	40	25 . 6012
Senegal	4.19	20	0. 838
Sierra Leone	2.408	90	2.1672
Somalia	5.137	98	5.03426
Sudan	14.4	89	12.816
Togo	2.089	50	1.0445
Uganda	10.261	5	0.51305
Tanzania	15.52	10	1.552
Total			136.79744

Over the years, the enormity of the FGM ritual has occasionally been brought to sharp focus although this attention has not been sustained (4,12). The World Health Organisation (WHO) has since 1982 consistently stated its displeasure with the health care professionals and other unqualified circumcisers involved in the practice of female genital mutilation (circumcision). WHO remains totally committed to the complete eradication of FGM through its readiness to support national efforts in that direction (48,49). The World Medical Association (WMA) in 1993 released a statement condemning the practice of female genital mutilation FGM (50). Some of the other organisations that have contributed toward the eradication of FGM include the International Planned Parenthood Federation (IPPF), The American Medical Association (AMA), The British Foundation for Women's Health, Research and Development (FORWARD), The African Charter on Rights and Welfare of the Child and Women International Network (WIN) and the Kenya Medical Association (KMA) (51). Others include the Maendeleo Ya Wanawake Organisation in Kenya, The International Federation of Gynaecology and Obstetrics and The Royal Colleges of Obstetrics and Gynaecology in the United Kingdom and Canada.

In 1994, in Addis Ababa, Ethiopia the inter African committee against traditional practices harmful to women and children health passed a resolution with a target to total eradication of FGM by the year 2000 AD (19). Todate only Sweden, The United Kingdom and Belgium and the Gambia in Africa have passed specific legislation making it illegal to perform any form of female genital mutilation (52). Other countries like France, Australia, Holland, Italy and the USA consider FGM illegal under existing child abuse laws (14,19,53).

In recent years, television and radio exposure and programmes in schools and markets, local health care officials and the various groups of educators and organisations have been working to educate and change the attitudes of the public in countries where FGM is practised(54). Major factors that may lead to the abolition of the practice include role modelling by influential female members of the community, and improving the general awareness of the local populations involved about the numerous complications of FGM, and correcting the erroneous misconception that female circumcision is a requirement of Islam and adulthood. In Kenya over the past decade, the Maendeleo Ya Wanawake Organisation has made reasonable progress in this direction. It has made extensive educational and awareness tours of Kisii, Samburu, Narok and Meru districts where FGM is prevalent and where about 80% of the women have undergone FGM. Members of this organisation have made the population aware of the numerous complications of FGM which sometimes result in death. They have also taught the population that an uncircumcised female is a complete adult female who can marry and give birth to children without dying in the process. In Meru in particular, Maendeleo Ya Wanawake Organisation has been very successful in organising 'circumcision' ceremonies for young girls without actually carrying out the physical FGM. All other rituals are carried out and the participants declared adults without FGM.

CONCLUSION

FGM remains prevalent in Africa as indicated by the fact that currently in nine African countries, more than 80% of the women have undergone female genital mutilation as shown in Table 1 (45). They consist of 80.05 million women from Egypt, Somalia, Djibouti, Eritrea, Mali, Sierra Leone, Sudan, Ethiopia and the Gambia representing (58.51%) of women who have undergone FGM. This is despite the fact that there has been continuous and consistent efforts towards the eradication of this ritual. One of the major problems encountered when dealing with FGM is that whenever a government body banned or tried to ban FGM, the practice nevertheless continued but in greater secrecy. This is because there are deep rooted cultures and traditions which are not medically tenable. Even religion has been cited as a major reason for FGM but there is no injunction in Islam or Christianity for the continued practice of FGM ritual. Victims of the various complications have been inhibited from seeking professional help for fear of legal retribution under such circumstances.

FGM should be globally abolished in the same way other anachronistic global traditional and cultural practices have been(55). It must however be recognised that attitudes toward such an ancient traditional and cultural custom cannot be changed overnight and without adequate understanding. Moves should be made to gradually replace the practice but mere repression through legislation has been shown to be counter productive. Women need to find other expressions of their social approval and respectability other than through FGM. This can only be achieved by gradual persuation through community-based educational and medical awareness campaigns like the ones carried out by the Maendeleo Ya Wanawake Organisation in Kenya. Such campaigns should however involve many other interested groups including local community leaders, medical and paramedical personnel. Legislation banning FGM would be more effective and should be effected only after such campaigns have been successfully carried out.

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