7 Female Genital Mutilation

Harry Gordon

7.1 Female Genital Mutilation – Definition

The World Health Organisation (WHO) defines female genital mutilation (FGM) as any procedure that involves partial or total removal of the external female genitalia, or any other injury to the female genital organs for cultural or non-therapeutic reasons.¹

7.2 History

Various forms of FGM have existed since the fifth century BC.² Herodotus (420 BC) stated that Egyptians, Phoenicians, Hittites and Ethiopians practised female genital excision. A Greek papyrus from 163 BC exists in the British Museum, and refers to circumcised girls in Egypt. The term “pharonic circumcision” is still used, and suggests an origin in ancient Egypt. However, no evidence exists of FGM in Egyptian mummies.

The practice of FGM continues to the present day. The WHO suggests that more than 130 million women and girls have undergone genital mutilation, and it continues at a rate of about 2 million each year. The basis for the practice is related to tradition and culture, and not religion. Although common in some Islamic countries, it is not part of Islam and it is not a religious duty. The extent of the cultural importance attached to the procedure is contained in a paper by Jomo Kenyatta published in the 1930s, and related to the Gikuyu of Kenya:

The real argument lies not in the defence of the surgical operation or in its details but in the understanding of a very important fact in the tribal psychology of the Gikuyu – namely that this operation is still regarded as the very essence of an institution which has enormous educational, social, moral and religious implications, quite apart from the operation itself. For the present, it is impossible for a member of the tribe to imagine an initiation without clitoridectomy.³

The strength of feeling expressed in this quotation still exists in parts of Africa today, and underlies the difficulty in preventing the mutilation of women and young girls when it is supported by hundreds of years of culture and tradition.

7.3 Incidence

The procedure is carried out in various forms in 26 African countries. The incidence varies, e.g. Somalia and Sudan 100%, Ethiopia 90%, Egypt and Nigeria 50%, Central Africa 20%, Uganda <5%. Furthermore there is also variation in the extent of the mutilation. The classification of the extent of mutilation, as suggested by the WHO, is shown in Table 7.1. However, it must be remembered that traditional circumcisers may show extensive variation in what they actually do.

Female genital mutilation also occurs in parts of the Far East – mainly in Malaysia and Indonesia. Refugees from the affected areas have resulted in genital mutilation coming to the attention of western gynaecologists – mainly involving the more severe forms. The incidence varies not only by country, but also by social class. For example,
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in the Sudan and Somalia the incidence is nearly 100% and is independent of social class. In Nigeria the incidence is around 25%, ranging from 1.9% in the north east to 48% in the south west. It is also heavily biased by age and social class. In other words, there is evidence that genital mutilation is being abandoned by younger, better educated and more affluent women. In the hospital-based study quoted, none of the female infants followed up for at least 9 months had been mutilated. Downward trends in the incidence of mutilation have been observed in the Igbos of Nigeria. Igwegbe concluded that at the observed rate of decline, it would take 20 years for the prevalence of 48% to fall to zero among prospective mothers in Nnewu, Nigeria. There is no firm evidence of decline in the incidence of FGM 3 in Somalia and the Sudan.

7.4 Clinical Presentation, Management and Complications

The incidence of serious complications, clinical presentation and management varies with the type (extent) of the mutilation. The outcome also varies according to the available medical facilities. The European and western experience may differ markedly from the African experience. Within Africa, the results for rural and urban populations may also differ. It is therefore best to consider each form of genital mutilation separately.

7.5 FGM 1 (Synonym Sunna)

This involves incision or removal of the hood of the clitoris, or removal of the clitoris (clitoridectomy). This procedure occurs across Africa, and is often regarded as a less traumatic alternative to other forms of mutilation. The main acute complication is haemorrhage, as the dorsal artery of the clitoris is quite large, even in children. Infection and surgical shock may also occur. The operation is usually carried out by a traditional circumciser and no anaesthesia is used. However, in some areas of East Africa where mass circumcisions are common, cold water is used to numb the genital area.

There is certainly a mortality associated with the procedure, but its extent is poorly documented. Once the wound has healed, there are few long-term complications. Para-clitoral epidermal cysts may develop, which may give rise to problems, especially if they are large or infected. Spreading infection may result in contraction at the introitus and cause problems with intercourse and subsequent childbirth. However, most survivors are asymptomatic. The presence of Sunna (FGM 1) may be overlooked at the time of gynaecological or obstetric procedures.

7.6 FGM 2 (Excision)

This is the commonest form of mutilation, and probably accounts for 70–80% of all cases in Africa. This type of mutilation involves the removal of the clitoris, together with excision of part of the labia. This is the most common form of circumcision in West Africa, where FGM 3 is uncommon. The acute complications involve haemorrhage, sepsis, shock, tetanus and urinary retention. Surgical errors may result in vesicovaginal fistula. Although this is the commonest form of mutilation, it is rarely seen in western gynaecological practice. The reason for this paradox relates to the bias by social class, as the lower social classes are less likely to emigrate to the west. As with FGM 1, there is a significant mortality. However, as with FGM 1, there seem to be few long-term complications among the survivors. Over 10 years at the University College