Female genital mutilation

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Female genital cutting, circumcision, or mutilation—this controversial practice has many names. Although the procedure resembles something medical, namely surgery, it is most often done by lay people with no formal training in surgical practice or hygiene. The procedure is described and categorised—type I to type IV excision, based on the degree of cutting. The least intrusive form of the procedure is sometimes called sunna, and the most severe, pharaonic circumcision. Thus, this procedure has a medical and a traditional vocabulary.

The cutting of female genitalia for non-medical reasons is a harmful traditional practice. It does not, from a medical point of view, benefit the subject of the procedure. This does not mean, however, that the procedure is never wanted by those who undergo it. In many societies circumcision is a prerequisite for entry to womanhood. It is a cultural phenomenon that affects millions of young women, especially across central Africa, southern Sahara, and some places in the Arab peninsula. Rates vary between regions and ethnic groups. More than 90% of Somali women have the most severe form of the procedure, in which the labia and clitoris are removed and the orifice stitched to leave only a very small opening. Three of four ethnic groups practise cutting in The Gambia, where the clitoris is excised, and sometimes the labia minora as well.

Medical consequences of female genital cutting are many. Immediate difficulties relate to the cutting itself. The immense pain of being cut without anaesthesia probably causes anxiety and horror. Unhygienic practices can introduce immediate infection; unskilled cutting and stitching can result in excessive haemorrhage or scarring. In the worst case, damage to the urethral opening causes incontinence.

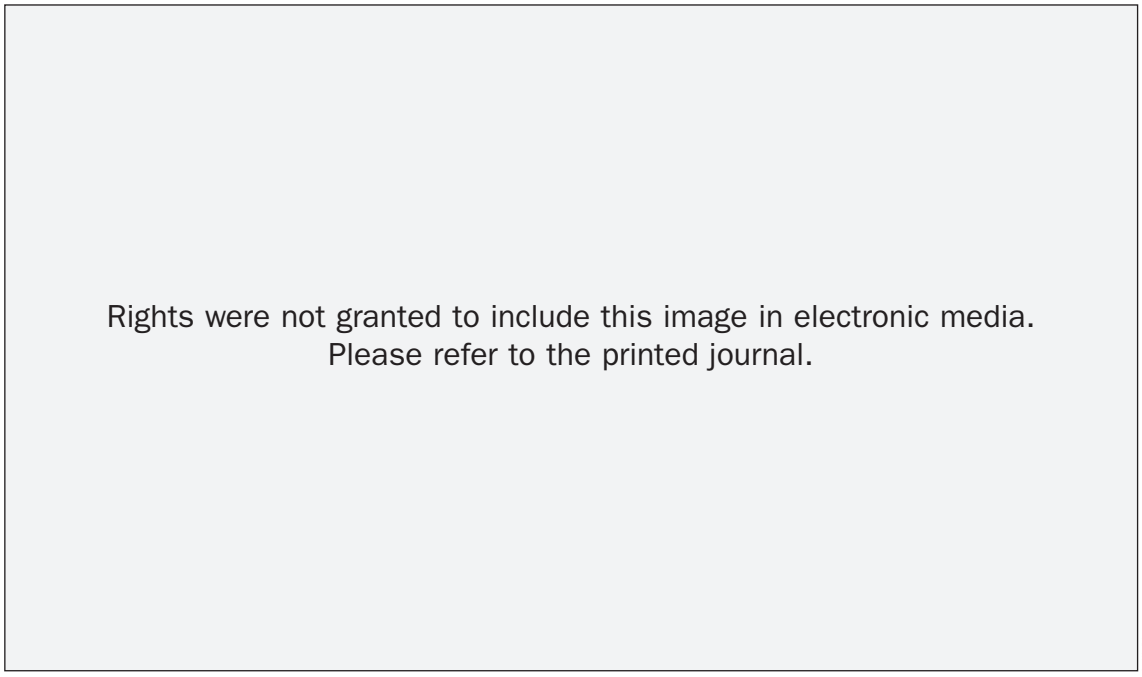
Chronic problems include difficulties with urination or menstruation, extreme sensitivity in clitoral remnants, and pain with attempts at coital penetration. Prolonged psychosocial suffering similar to post-traumatic stress syndromes may arise. Relationship difficulties can be caused by an absence of sexual pleasure, and the inability to reach an orgasm-like sexual climax.

Childbirth and gynaecological examinations can also be problematic if the vaginal entrance is narrowed. Women should be attended by skilled attendants who know when and how to make episiotomies, and how to avoid unecessary surgical deliveries. Vaginal examinations, Papanicolaou (pap) smears, or the fitting of an intrauterine device can be complicated unless smaller than usual instruments are available. Although reconstructive surgery is possible, function cannot always be restored if vital tissue is removed.

The social construction of what constitutes a proper and attractive woman varies between cultures. Surgeons in the developed world do breast augmentations and reductions for cosmetic reasons. In ancient China, girls' feet were bound to prevent them from growing. In most countries, women add colour to their lips and eyes to be more attractive. And for these same reasons, in some African countries, women's genital organs are cut. Medical practicioners in developed countries receive requests to cut genital labia because some women believe that their labia look ugly or are too large. There is as much variation in the shape and size of genitals as there is in noses or fingers; however, some people do not tolerate variation from the norm.

Arguments in support of genital cutting for traditional—ie, non-medical—reasons are many. Some believe the procedure renders women more proper, trustworthy, and feminine. Some cite religious reasons; Animists and Coptic Christians practise cutting, and although African Muslims also engage in the procedure, it is rare in Asian Muslim societies. Muslim scholars do not have consensus on the issue. Some argue that it produces chastity or preserves virginity; others think it is a prerequisite for marriage.

Political and economic instability in some African countries has resulted in many Africans emigrating,



Still Pictures

Custom or cruelty?

and taking their practices with them to the USA, Europe, and other Western countries. Health-care providers in these developed countries have then been faced with the unexpected challenge of delivering a baby from an infibulated Somali woman, or have had to worry about the fate of 6-year-old Ethiopian schoolgirls on their way home for summer vacations. Explicit laws against female genital mutilation do exist in some countries. The practice is categorised as child abuse, and there are laws that make taking your child to another country for circumcision illegal. Those who are cut are usually still younger than 18 years, so there are many reasons to ban the practice and remove the child from parental custody if there are plans to have the girl circumcised. But how can a health practitioner be sure that this is happening? Parents do not set out to deliberately harm their child.

On the other hand, people change. In exile, many people realise that they do not have to, or they cannot, live like they did in their home country. There are reasons to believe that the practice is decreasing. Health arguments are important in the process of change. Illegality and fear of sanctions is another. Literacy and education, modernity, and exposure to alternatives are others.

In studies of perinatal outcome, results of several studies have shown that Somali immigrants had worse outcomes than did native Swedish or Norwegian women, even if all women had optimum perinatal care. However, whether it is the circumcised state of these women that predisposes them to problems is not clear. Alternative explanations are poverty, lack of education, or poor health status in Somali women, or lack of communication between these patients and health-care workers. The association between female genital cutting and other health outcomes like maternal mortality, infertility, and HIV/AIDS are still not established, but research is underway.

Another important issue for health-care workers is their role in the "medicalisation" of this practice. Some doctors and nurses advise that the cutting be done in a medical setting because they believe that conditions are likely to be more hygienic, operators will be more skilled, and that fewer harmful side-effects will result than if the cutting is done by a quack. Perhaps they expect that qualified operators will cut less tissue or that they will reduce the trauma to the woman being cut. But these doctors do it for money, and they have probably sworn to the oath of Hippocrates: do no harm. Ultimately, is it ethical to contribute to the continuation of a procedure that is so harmful and disabling for women? Should doctors who participate in this practice be allowed to remain in the mainstream medical community? Is it not time that international medical organisations raise the issue and ban the participation of colleagues in medical societies, if they prove to be involved in such controversial behaviour? Surely it our duty as doctors to promote and protect the future and current health of girls who are subject to this practice.

Further reading

WHO. Female Genital Mutilation, a teachers's guide. Geneva: WHO, 2003.

B Essen. How to deal with female circumcision as a health issue in the Nordic countries. *Acta Obstet Gynecol Scand*, 2003. **82:** 682–86.

Rainbo. Research, action, and information network for the bodily integrity of women. http://www.rainbo.org/.