

Female Genital Mutilation – Recent Literature Review

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Abstract:

Research Question (RQ): FGM represents a global concern as 63 million more girls could be subjected to FGM by 2050. It is a deeply embedded cultural tradition that holds a symbolic meaning in numerous communities and is practiced in rural and urban areas.

Purpose: The objective of this paper was to review the current literature on female genital mutilation consequences, to describe and critically assess the theoretical and methodological approaches to treatment options and to describe and assess different methods that aim to stop or reduce the continuation of FGM.

Method: We carried out a literature review of articles published in the last 10 years. Included articles studied consequences following FGM, treatment options and different methods to stop or reduce the continuation of FGM. Literature search was conducted on the following databases PubMed, PEDro, Cochrane database, CINAHL and Medline.

Results: Globally the prevalence is declining, as many actions from legal to community based programmes are being proposed. There are many known consequences that can be divided in to two groups: short and long term. Treatment options are not well documented in the literature, but published studies are of poor quality. Nevertheless there are many treatment options and guidelines on how to treat women with FGM.

Organization: Health care professional should be well informed and sensitive to properly treat women with FGM. They should also inform women about possible consequences and legal aspects.

Society: Society should be informed about this procedure and should encourage open communication within the society, especially between men and women.

Originality: This article offers a new and recent perspective of FGM, consequences and treatment options as well as what we can do to stop this practice.

Limitations / further research: Limitations of this review include the risk of bias, because it is not possible to identify and retrieve all studies. Future research should be of better quality and should focus especially on treatment options.

Keywords: FGM, female genital mutilation, consequences, treatment, deinfibulation, prevention.

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1 Introduction

Female genital mutilation (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 (WHO, 2010). The World health organization defines four main types of FGM that are described in table 1. Even though the term mutilation is widely used, women who have undergone the procedure often refer to it as cutting (United nations development found for Women, 2007).

Table 1. WHO types of FGM

Type I	Partial or total removal of the clitoris and/or the prepuce
Type II	Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora
Type III	Narrowing of the vaginal orifice with creation of a covering seal by cutting and spositioning the labia minora and/or labia majora, with or without excision of the clitoris
Type IV	Unclassified – all other harmful procedures to the female genitalia for non-medical purposes

In: WHO, 2010

In the recet years a lot of new literature was published. The objective of this paper was to review the current literature on female genital mutilation consequences, to describe and critically assess the theoretical and methodological approaches to treatment options and to describe and assess different methods that aim to stop or reduce the continuation od FGM.

2 Theoretical framework

FGM first appeared in ancient Egypt more than 5,000 years ago, as seen in mummies from that period (Inungu and Tou, 2013). In Europe the practice was used as treatment for epilepsy, sterility and masturbation in the 19th century (Whitehorn et a., 2002). Today the age of girls when they are mutilated differs greatly from region to region, from 7 to 8 day old babies in some countries to grown women (some during their first pregnancy) elsewhere. FGM is usually performed at the youngest age possible to avoid questions from education authorities and because older girls might defend themselves against the practice (Varol et al., 2014).

While the exact number of girls and women worldwide who have undergone FGM procedure remains unknown, at least 200 million girls and women in 30 countries have been subjected to the practice (UNICEF, 2016a). Rates have been declining over the past three decades. However, due to population growth, 63 million more girls could be subjected to FGM by 2050 (UNICEF, 2016b).

The practice of FGM is highly concentrated in Africa, in the Middle East and in some Asian countries. Evidence suggests that FGM is practiced in parts of South America, in the southern part of the Arabian Peninsula, and the Persian Gulf. The practice is also found in parts of Europe, Australia and North America, due to displacement caused by civil wars, globalization and migration. Therefore, FGM is a global concern (UNICEF, 2016a; Varol et al., 2014).

Young girls living in Western countries are at risk of undergoing the procedure as their families seek to maintain a cultural practice within their adopted communities, despite laws prohibiting it (Varol et al., 2014; Elneil, 2016).

Female genital mutilation is a deeply embedded cultural tradition that holds a symbolic meaning in numerous communities. The continued practice of FGM is motivated by peer pressure, fear of exclusion from resources and opportunities as a young woman, and marriage ability (Varol et al., 2014). The traditional motivation is very strong, as this is the main reason women let their children undergo FGM. Other reasons include cultural-group identity, family honour, cleanliness and health, preservation of virginity and enhancement of sexual pleasure for men (Kaplan et al., 2013). The belief that FGM is required for spiritual and religious cleanliness is also a strong motivational factor (Mohamud et al., 1999).

The procedure is carried out in remote areas as well as in cities and at all levels of society from the elite and professional classes to the simplest villager (Elneil, 2016). In rural areas older women who are known as traditional ‘cutters’ perform FGM. Crude instruments such as knives, razors, scissors or sharp stones are often used. It is likely to be performed under unhygienic conditions with the same instruments used on different girls (Momoh, 2004).

In urban areas the procedure is more likely to be performed under anaesthetic, with some health workers believing this makes the procedure more acceptable. In this case the term medicalization of FGM is used and refers to situations in which FGM is practiced by any category of health-care provider, whether in a public or a private clinic, at home or elsewhere. WHO states: “Health professionals who perform female genital mutilation (FGM) are violating girls’ and women’s right to life, right to physical integrity and right to health. They are also violating the fundamental ethical principle: do no harm.” (WHO, 2010).

FGM may also be a rite of passage from childhood to womanhood. Another possible reason is fear of sexual violence against girls, as FGM precludes vaginal penetration (WHO, 2011). FGM is sustained by community enforcement mechanisms such as public recognition by celebration (use of rewards and gifts, poems and songs celebrating the circumcised while deriding the uncircumcised), the refusal to marry uncircumcised women and fear of punishment by God (Mohamud et al., 1999). Mothers may subject daughters to FGM to protect them, to secure good prospects of marriage, to ensure acceptance and for economic security (Varol et al., 2014).

Their joint statement of the United Nations Population Fund (UNFPA), the United Nations Children’s Fund (UNICEF), the International Confederation of Midwives and the International Federation of Gynecology and Obstetrics states that FGM of any form should not be practised by health professionals in any setting including hospitals or other health establishments (UNFPA, 2015). A World Medical Association statement (2016) condemned both the practice, regardless of the level of mutilation, and the physicians who carry out the procedure. Most health-care providers who perform FGM are themselves part of the FGM practising community. Some organizations support the medicalization of FGM. They argue

that it may help to reduce the risks of the procedure, limit the extent of mutilation and reduce pain (WHO, 2010).

3 Method

We carried out an integrative literature review. The search strategy used was to conduct a bibliographic study of published articles in the following databases: PEDro, CINAHL, MEDLINE, Cochrane library and PubMed. Key words were: female genital mutilation, FGM, consequences, review, systematic review and practice guidelines.

Literature search was conducted from December 2017 to February 2018. Since FGM is a well-researched topic we searched for articles published between December 2007 and February 2018. This way we managed to find only recent literature. We included articles reporting consequences that can occur following FGM, articles reporting effective and evidence-based treatment options and articles reporting different methods and programmes with the aim to stop or reduce the practice of FGM. We included systematic reviews, other reviews and case reports published between December 2007 and February 2018. The time frame used was applied as we wanted to identify only recently published articles. The exclusion criteria were books, book chapters, comments or reviews that focus on other topics.

We identified a total of 300 publications. After an initial analysis, some articles were excluded as they did not meet any of the inclusion criteria. We included 24 articles in the review.

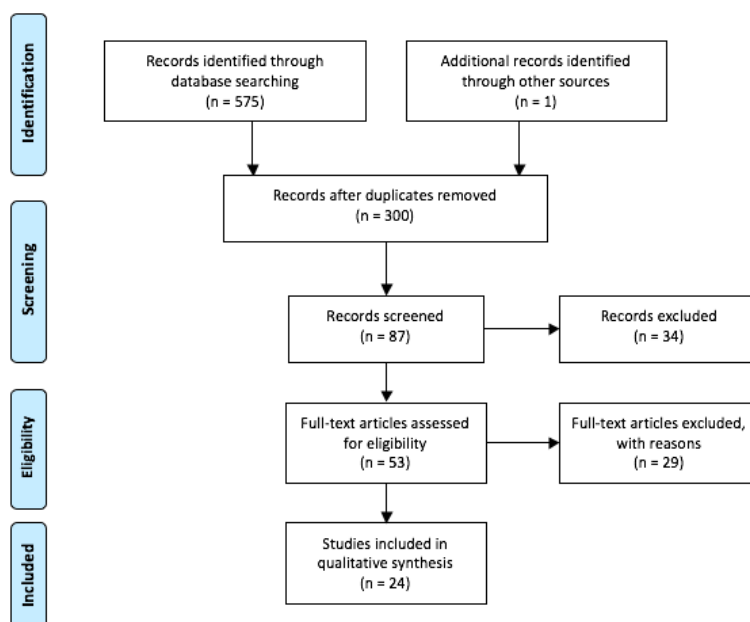


Figure 1. Method representation

4 Results

4.1 Prevalence of FGM

Global prevalence of, and support for, female genital mutilation has been declining in the last three decades. The decline has been uneven and not all countries have made progress. Barriers to abandonment include an entrenched sense of social obligation and lack of open communication between men and women. The importance of human rights in communities and the empowerment of girls in relation to their own development must be accepted (Varol et al., 2014). Change is also more likely when the community priorities are addressed and trust is established (Berg and Denison, 2013; Varol et al., 2014).

Results of an integrative literature review show that the incidence of FGM tends to decline when women migrate to the western countries. The new social context implies greater pressure as FGM is punishable by law. Over the years new attitudes are adopted that contribute to the eradication of FGM. The empowerment of women and girls is also a large factor that contributes to the elimination of FGM (Isman et al., 2013). On the other hand, the legislation that punishes FGM represents a risk of promoting the secret nature of this practice. Furthermore, few laws introduce protection measures for girls at risk and FGM prevention measures (Leye et al., 2007).

Media plays a major role in the eradication of FGM by helping to clarify doubts and misconceptions about it as well as health promotion and FGM eradication programmes. There are different methods of learning about FGM that include television, radio, newspapers, community meetings, discussions with family members or friends, and mosque or church sermons (Reig Alcaraz et al., 2013).

Even though no religious text requires FGM, there is a strong belief of its requirement by some local religious leaders. The practice predates both Christianity and Islam and is unknown in many Muslim countries. In Egypt, Sudan and Senegal, Christian and Muslim religious leaders condemned the practice, declared it violates women's dignity, and have been promoting the uncut girl as happy and healthy, thus helping to abandon the practice (Varol et al., 2014). On the other hand, some religious leaders believe FGM is a requirement and fuel its continuation. Therefore, in Mali, two-thirds of girls and women and about 40% of boys and men believe FGM is required by religion (UNICEF, 2013).

As stated previously, an important reason of the continuation of FGM is marriageability. Men may play a passive role in approving FGM by refusing to marry uncut girls or an active one by initiating the practice. Usually the grandfathers are even more instigated to the process. In a survey that studied the experience of Sudanese men married to a partner with FGM, 63% expressed difficulty with vaginal penetration, wounds or infections on the penis and psycho-sexual problems. They also reported that the awareness of the suffering of their wives during intercourse had a negative impact on their own sexual satisfaction. Men also perceived their wives' as their own problem. Most young men stated that they would prefer to be married to a woman without FGM. The lack of communication between men and women contributes to false beliefs and expectations by both genders (Varol et al., 2014).

4.2 Consequences of FGM

Consequences of FGM can be divided in short term and long term consequences. There are many possible treatment options for treating short and long term complications. This includes physiotherapy, psychology and counselling, pharmacotherapy, reconstructive or restorative surgery, cognitive behavioural therapy (Elneil, 2016).

Short term consequences include pain, risk of haemorrhage, shock, sepsis, inability to urinate, infection, damage to other organs, dislocation and fracture of bones due to struggle while being restrained, psychological trauma and death (Reisel and Creighton, 2015; Terry and Harris, 2013).

Long term consequences can be divided into three main areas: gynaecological, obstetric and psychological. In a study of complications following FGM in a rural part of Gambia, results show that 36,8% of women had complications related to their FGM and in 63,2% of women the complications were long term (Kaplan et al., 2011). There is also a correlation between the severity of FGM and the onset of complications (Iavazzo et al., 2013).

Long term gynaecological complications include infection, inflammatory disease, fistulae, vaginal infections, menorrhagia, recurrent abscess formation, infertility, painful sexual intercourse, obstructed menstrual flow, difficulty passing urine, urinary tract infection, vulvar abscess, chronic pelvic infection, incontinence (Reisel and Creighton, 2015; Terry and Harris 2013).

In a systematic review that examined infection rates in 22052 African women, authors identified types of infections that include abscess formation, septicaemia, urinary and genitourinary tract infections and HIV. It is also suggested that FGM can increase the risk of transmission of Hepatitis B and C and HIV by the use of unsterile instruments (Iavazzo et al., 2013).

The damage to the urethra during FGM is often the cause of fistulae and urethral structures. Up to 22% of women experience poor urinary flow and recurrent urinary tract infections (Amin et al., 2013). The retention of urine is thought to be caused by a combination of fear, pain and local sepsis (Clarke, 2016). Treatment options for urological problems related to FGM are surgery, physiotherapy, catheterisation and additional psychological support and counselling (Duncan, 2016). We found only one study that reported overactive bladder as a consequence of FGM. There is no evidence that deinfibulation is effective to improve urologic complications (Effa et al., 2017). This was a case report of a 27-year old woman with type III mutilation that presented with slow miction, voiding efforts, urgency and urge incontinence. She also reported dysmenorrhoea and superficial dyspareunia. Treatment consisted of deinfibulation surgery, biofeedback (behavioural interventions, teaching techniques to suppress urgency and improve continence) and counselling. At five months' follow-up, urgency and urge incontinence had resolved and she became pregnant (Abdulcadir and Dällenbach, 2013).

There is little good data that suggest that FGM leads to infertility. One study suggested that more extensive FGM might cause primary infertility. Possible mechanisms include difficult or painful intercourse due to the infibulation of the vagina and ascending pelvic floor infections at the time of FGM (Reisel and Creighton, 2015).

The extent of complications that women with FGM will encounter during pregnancy, labour and the post-partum period depends greatly on the context. In resource poor settings where knowledge of antenatal care is limited, there is a greater number of complications (Balogun et al., 2013). A study of 28000 African women with FGM showed that FGM increased the risk of prolonged labour, postpartum haemorrhage, perineal trauma and Caesarean section. There was also an increased risk of neonatal resuscitation, low birth-rate, stillbirth and early neonatal death (Reisel and Creighton, 2015). The risk of complications is increased also in resource-rich settings. In a large systematic review that included studies from USA and Europe, the meta-analyses showed that women with FGM suffer more frequently from prolonged, difficult labour, have a higher rate of obstetric lacerations, often require instrumental delivery and have increased rates of obstetric haemorrhage. This may be due to the inelasticity of scar tissue (Berg and Underland, 2013). Women with type III FGM have an increased rate of perineal tears and higher rate of episiotomy. It is likely that deinfibulation of type III FGM reduces perineal trauma, but there are no studies that confirm this (Balogun et al., 2013).

The psychological effect of FGM is very likely, but there is little high quality evidence supporting this. Small studies identified depression, anxiety and post-traumatic stress disorder as the most common consequences (Vloesberg et al., 2012).

There is also increasing evidence that FGM damages sexual function. A systematic review and meta analysis of sexual consequences following FGM showed that women with FGM were 52% more likely to report dyspareunia, twice as likely to report the absence of sexual desire and reduced sexual satisfaction (Berg et al., 2012). Recent surgical reports claim that clitoral reconstruction may restore sexual function, however there are no long-term follow-up studies with psychosexual assessment (Creighton et al., 2012).

4.3 Working therapeutically

When providing information about FGM it is important to be sensitive. Some women may find talking or hearing about it traumatising as it may bring back memories and question traditions and beliefs. Receiving information about FGM may be empowering for the woman as well as for the community she lives in now and comes from originally (Smith and Stein, 2017).

A study by Jackson (2017) suggests that trauma issues, feelings of shame, embarrassment or guilt, affective disorders and physical issues are common in women with FGM. It is important to educate professionals about some of the most common presenting issues and indicators that a woman may have undergone FGM. This could lead to an increased awareness and facilitate

the communication with clients. The most helpful factor when working with women with FGM is to have cultural respect, knowledge and understanding.

Nursing staff needs to assess the extent to which women identify with their traditional culture but also with the new culture. Health care should reflect a unified understanding of values, beliefs and attitudes of individual acculturation processes (Reig Alcaraz et al., 2013).

FGM has a strong impact on labour and delivery. A plan of care should be agreed and clearly documented. Women should also be counselled and informed about the fact that performing FGM on their daughters is illegal and is prosecuted even if the procedure is performed overseas (von Rege and Campion, 2017).

5 Discussion

Research into FGM focuses especially on ethical, cultural and practical difficulties. A lot of literature is focused on prevention of FGM, reporting consequences and prevalence of FGM. There is a number of recent systematic reviews that cover these topics. If these topics are covered well, there is little literature focusing on treatment options. There are few good quality studies that study treatment options and that could be translated into practice. The current practice guidelines are based on case reports and anecdotal evidence (Effa et al., 2017). The reason for little and poor quality evidence is that FGM is associated with ethical, cultural and practical difficulties. It is also very difficult for researchers to access communities and engage participants in open discussion (Terry and Harris, 2013).

In 2016 the World Health Organization (WHO, 2016) published guidelines on the management of health complications from female genital mutilation. The guidelines are intended for health-care professionals involved in the care of girls and women who have been subjected to any form of FGM. The strength of recommendation is conditional to strong, but there is no direct evidence or very low-quality evidence. Strong recommendations include performing deinfibulation for preventing and treating complications and for preventing and treating urologic complications. We can conclude that even in these guidelines for treating complications associated with FGM the evidence is limited.

On the other hand, the prevalence of FGM is well documented in the literature. In recent years we found that the prevalence is declining globally. This could be due to a lot of new literature and education. Recently this practice received more attention from governments, non-governmental organisations and national and international communities (WHO, 2011). In our literature search, we found a lot of articles reporting on the legal aspects of FGM. There are many countries, where FGM is practiced, that recently passed anti-FGM legislation. These laws offer legal protection to women, provide an official legal platform for project activities and discourage exercises and families fearing prosecution (WHO, 2011). From our literature search, it can be concluded that programmes that aim to stop or reduce the practice of FGM should focus on informing the public of complications that can arise following the mutilation, encourage communication and open discussion between men and women and consider personal experiences of women who have undergone the procedure. Religion and religious

leaders also play a significant role in the process of abandonment of the practice. Since there is no religious text that requires FGM, religious authorities should stop encouraging the practice and religious leaders should condemn the practice on a national and international level (Varol et al., 2014).

Consequences following FGM are well documented in the literature. We found two systematic literature reviews that were very consistent in their reporting (Reisel and Creighton, 2015; Terry and Harris 2013). As seen in this literature review and the two reviews included, there is a lot of evidence regarding obstetric complications and little evidence on gynaecological complications. Again there is the problem of poor research, since conclusions are drawn from different case reports. With increased longevity, there will be a higher number of older adult women living with FGM that will require high quality, sensitive and evidence-based care. This will present an unprecedented challenge for all health care professionals involved (Reisel and Creighton, 2015). It is very important to inform the general public and health care professionals of these consequences, so they can notice, report and treat women. Basic knowledge of consequences will improve the provided care as health care providers will be more confident in choosing the type of treatment the woman needs and who to refer them to (Momoh et al., 2016).

There is also a lot of evidence on how treatment should be conducted by the health care provider. Recent literature focuses mainly on how health care providers should communicate with the women. Healthcare providers need to be culturally competent for the treatment and care. They need to foster trust and communication to put an end to marginalization and discrimination against women with FGM (Reig Alcaraz et al., 2013). Communication needs to be clear, using straightforward, non-judgemental language and explanations. Women may find the term mutilation judgemental, so other terms should be used (Rege and Campion, 2017).

6 Conclusion

The practice of FGM is a global problem that should be addressed as one. In the last decades there is an uneven decline in prevalence that could be due to a lot of new research and common work between governments and non-governmental organizations. There is a lot of work being done on the legal aspects as many countries where FGM is still a part of culture, are passing anti-FGM laws. There is still a need for better communication and for working directly with the communities, especially in the rural parts.

The consequences of FGM are well documented in literature, but there is the need for studies with better methodological aspects. Future research should focus especially on treatment options that can be at some point be translated in clinical guidelines for treating women with FGM. There is a clear need for research into obstetric management. There is little guidance on interventions to reduce risks in pregnancy, performing deinfibulation and the role of episiotomy. There is also a lack of literature on psychological and gynaecological interventions. Available studies have been in general too small to demonstrate effect and have

used inappropriate methodologies and have lacked suitable control groups (Reisel and Creighton, 2015).

A strength of this systematic review is the comprehensive and systematic literature search as well as the inclusion of several study designs. The results of the review and implications for further practice are optimally relevant for researchers, practitioners and policy makers. Limitations of this review include the risk of bias, because it is not possible to identify and retrieve all studies.

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Povzetek: **Obrezovanje žensk – pregled trenutne literature**

Raziskovalno vprašanje (RV): Obrezovanje žensk je globalni problem, saj bi lahko, do leta 2050, še 63 milijonov deklet bilo podvrženi tej praksi. Gre za globoko utrjeno kulturno in tradicionalno dejanje, ki ima velik simbolični pomen v veliko skupnostih. Izvaja se v ruralnih predelih, kot tudi v mestih.

Namen: Namen raziskave je bil pregledati trenutno literaturo o posledicah, opisati in oceniti teoretične kot metodološke pristope k zdravljenju in opisati ter oceniti različne metode za zmanjšanje ali ustavitev izvajanja obrezovanja žensk.

Metoda: Izvedli smo pregled literature. Iskali smo literaturo, ki je bila objavljena v zadnjih 10 letih, v kateri so avtorji preučevali posledice, možnosti zdravljenja in preventivne programe za zmanjšanje obrezovanja žensk. Literaturo smo iskali preko spletnih baz PubMed, PEDro, Cochrane database, CINAHL and Medline.

Rezultati: Globalno prevalenca upada, predvsem zaradi zakonskih pistopov in različnih preventivnih programih, ki temeljijo na skupnostih. Opisanih je veliko posledic, ki jih lahko razdelimo v kratko in dolgoročne. Različne oblike zdravljenja so dobro opisane v literaturi, so pa študije slabe kakovosti.

Organizacija: Zdravstveni delavci morajo biti dobro informirani in delovati sočutno za dobro zdravljenje žensk. Prav tako morajo ženske poučiti o možnih posledicah in zakonskem pregonu.

Družba: Družba mora biti seznanjena s problemom in mora spodbujati odprte poovore znotraj skupnosti, predvsem med obema spoloma.

Originalnost: Raziskava ponuja nov in aktualen pogled na posledice, možnosti zdravljenja in kaj lahko kot posamezniki naredimo za zmanjšanje prevalence.

Omejitve/nadaljnje raziskovanje: Omejitve raziskave vključujejo možnost pristranskosti saj ni mogoče identificirati in pridobiti vse študije. Bodoče raziskave bi morale biti boljše kakovosti in se osredotočati predvsem na možnosti zdravljenja.

Ključne besede: obrezovanje žensk, posledice, zdravljenje, preprečevanje, preventivni programi.

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