Female Genital Mutilation

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A longstanding tradition with uncertain origins, but very real and profound risks

https://www.youtube.com/watch?v=esJu6JI0XAU
Objectives

To understand female genital mutilation from a medical standpoint, and also a socio-economic and anthropologic standpoint, and how this might present in your practice

-Terminology
-Origins
-Prevalence
-Procedure
Objectives (cont.)

- WHO classification
- Complications
- Eradication (?)
- Considerations in your practice
Terminology

• “Female circumcision” was widely used until 1991, when WHO began using FGM, FGC, or FGM/C, to better describe the brutality.

• Local languages use hundreds of terms to describe, with meanings of “purification” and “washing” and similar terms.

• Term infibulation comes from Latin “fibula” meaning “clasp.”
Modern Definition

• 1997 joint statement from WHO, UNICEF, and UNFPA defined female genital mutilation

• FGM: “All procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs whether for cultural or other non-therapeutic reasons.”
STOP
FEMALE CIRCUMCISION
IT IS
DANGEROUS
TO
WOMEN'S HEALTH

FAMILY PLANNING ASSOCIATION OF UGANDA
Origins

• One theory is that when Ancient Romans acquired black slaves, they fastened clasps over their foreskins to prevent intercourse, and the tradition spread.

• Religion is often cited as the origin, but nowhere in the Koran or Bible is female circumcision a requirement.

• Reasons given now include a laundry list of misplaced beliefs, including preservation of virginity, cleanliness, improved fertility and pleasure for the husband.
Prevalence

• Estimates range from 100-160 million girls and women have suffered FGM
• Primarily in Africa, Middle East, and parts of Asia, but with increased immigration there are no borders.
Female Genital Mutilation / Cutting (FGM/C)

100 - 140 millions Girls & Women have undergone in:

28 countries in Africa and in Indonesia, Iraq, India, Pakistan & Yemen

70 millions girls and women

Only in: Egypt, Ethiopia y Nigeria

Source: United Nations
Normal anatomy
WHO Classifications

A. Normal

B. TYPE I

A. Prepare removal only or B. Prepare removal and partial or total removal of the clitoris

C. TYPE II

Removal of part or all of the clitoris plus part or all of the labia minora.

D. TYPE III

Removal of part or all of the labia minora, with the labia majora sewn together, covering the urethra and vagina and leaving a small hole for urine and menstrual fluid.
WHO Classifications

• Type 1: Removal of clitoral hood and usually the glans
• Type II: Removal of inner labia, clitoral glans, and sometimes labia majora
• Type III: Removal of genitalia and closure of introitus to 2-3 mm (Infibulation)
• Type IV: Any other piercing, burning, cutting, or application of caustic agents
Procedure

• Timing was originally around puberty, but often done now as little girls and even babies.

• Usually performed by a travelling “midwife” under non-sterile conditions with a razor or piece of metal or glass.

• Can be performed in homes, or in a remote hut or bush, where the girl is left alone for days to weeks.
Procedure (cont.)

• Occasionally it is performed by doctors, with anesthesia, but that is rare

• Sadly, it is most often without anesthesia, and the girls are tricked by female family into attending a “party” or other fun activity, and the cutter is waiting for them. The girls are always held down by family members, who have to approve the amount removed.
Procedure (cont.)

• The cutter, who is often unskilled, uses their sharp object to remove parts of the genitalia.
• When the family approves, the area is sewn with thread or pinned with thorns.
• Usually, the legs are bound together for up to two to six weeks for optimal scarring.
• Upon marriage, the scar must be ruptured by penetration or cut with a knife.
Complications

• Immediate: severe pain, injury to adjacent organs, hemorrhage, fractures from restraints, psychological trauma, shock, death

• Delayed: Urinary retention, infection, abscess, poor healing, death

• Late: Neuroma, obstructed menses, vaginal calculi, fistulas, obstructed urination, UTIs, pelvic infections, infertility up to 30%, obstructed childbirth, death
FGM in US History

• In the 1800s in US and Europe, the clitoris was removed to treat insanity and masturbation.
• In 1845 in London, Isaac Baker Brown made it his mission to remove as many as he had opportunity, to cure all manner of ills.
• Clitoridectomy was performed in the US into the 1900s to treat hysteria and lesbianism.
Opposition

• Began in 1925 with the missionaries to Africa
• In 1997 Waris Dirie, a Somali who escaped to London, gave a famous interview to “Marie Claire.” One year later she was appointed UN ambassador for eradication of FGM.
• As of 2013, 33 countries outside of Africa had passed legislation banning the procedure.
• Numerous non-profits exist now, putting significant pressure on tradition.
It's hard to go to the bathroom like this. But at least you conform.

female

genital

mutilation

more popular than you'd think
STOP
FEMALE GENITAL MUTILATION
(FGM)
INTERNATIONAL DAY of ZERO TOLERANCE for FEMALE GENITAL MUTILATION

February 6
Counterpoint

• Some anthropologists have accused FGM eradicationists of cultural colonialism, similar to the missionaries, forcing our western ideas about sexuality.

• Eradicationists argue that now, most girls are cut at an age that is too young to consent, thus making it child abuse.
female genital mutilation of young girls is child abuse
Local Considerations

- Immigration has increased significantly the number of women affected by FGM in countries where it is not practiced.
- You will see this if you have not already.
- Some women may ask for deinfibulation, some may be culturally bound to leave it.
- Prior to delivery, the scar must be cut or the lacerations will be difficult to repair.
Local Considerations (cont.)

• Moving to this country does not stop this procedure. Be wary of the family taking a young girl on a “vacation” back home. Often the girl is taken back for her traditional rite of passage FGM.
Case

• 32 year old G2P1 at term presents in early labor. She has had a prior vaginal delivery in her home country with re-infibulation of her Type III FGM.

• A conversation is had with the patient and husband about desires for this delivery, specifically, what does she want done with the incised vulvar scar after delivery. You advise for health reasons to reapproximate the cut edges, but leave the introitus open.

• She refuses and wants it sewn back closed. What do you do?
In the News

• Jan 26, 2015: In the first prosecution of it’s kind, an Egyptian doctor is convicted of FGM and manslaughter in the death of a 13 year old girl from a botched circumcision.

• This week in British news: In November 2014, nearly 500 girls were hospitalized in English hospitals for complications associated with FGM, a dramatic rise.
Resources

• www.who.int/mediacentre
• www.desertflowerfoundation.org
• www.unfpa.org
• en.m.wikipedia.org
• Infidel, by Ayann Hirsi Ali
• Desert Flower, by Waris Dirie