

Female Circumcision: The History, the Current Prevalence and the Approach to a Patient

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Introduction

Female circumcision, also known as female genital mutilation (FGM) or female genital cutting (FGC), is practiced in many countries spanning parts of Africa, the Middle East and Southeast Asia. Over 100 million women and young girls living today have experienced some form of FGM with millions more being affected annually. With the world becoming a smaller and smaller place via media, travel and international migration, widespread awareness (beyond the regions of its practice) of the history and beliefs that perpetuate this tradition is essential. This paper offers a guide to help practitioners understand the terminology, classifications, origin, proposed purposes, current distribution and prevalence of FGM, closing with recommendations for obtaining a history from and conducting a pelvic exam on this patient population.

Terminology and Classifications

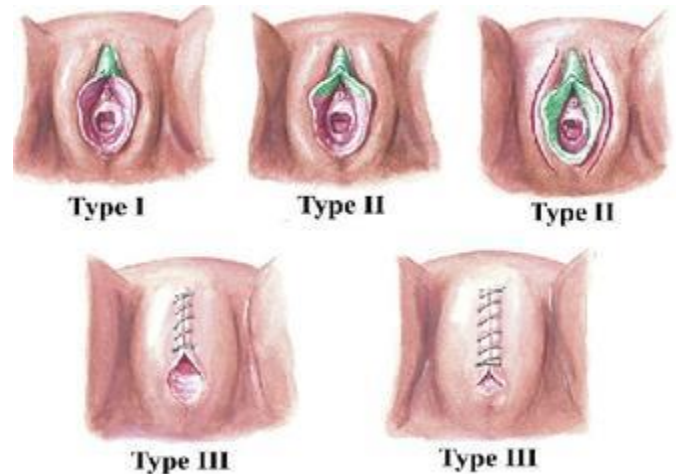
The practice of female genital alterations has been referred to by many different names. The United Nations conducted their earliest studies on these practices using an anthropological approach, adopting the term “female circumcision,” which the World Health Organization adopted as well. However, many believed this term euthanized and “normalized” the practice, making it comparable to widely accepted male circumcisions. In the mid 1970s, feminist activists of the time emphasized the harmful consequences this tradition could have on its recipients. Accordingly, to recognize the damage done to normal, healthy tissue, they began using the term “mutilation” versus “circumcision.”¹ Since the 1990s, “female genital mutilation” (FGM) has been widely accepted.² Its current formal definition is “all procedures involving partial or total removal of the external genitalia or other injury to the female genital organs for non-medical reasons.”³

With the establishment of its internationally-accepted definition came the differentiation of four separate types, or severities, of FGM seen in practice:

- Type 1: Only Prepuce removal or prepuce removal plus partial or total removal of the clitoris (also referred to as clitoridectomy) [1]
- Type 2: Removal of the clitoris plus a portion of or all of the labia minora (excision)
- Type 3: Removal of a portion of or all of the labia minora with the labia majora being sewn

together, covering the urethra and vagina and leaving small opening for urination and menstruation (infibulation)

- Type 4: All other harmful procedures to the female genitalia for non-medical purposes including pricking, piercing, incising, scraping and cauterizing



However, this terminology is not accepted by all, especially by those who originate from areas where these practices occur. In one ethnographic study conducted in Sudan, participants often found the term “mutilation” offensive, suggesting “intentional harm” and “evil intent.” These participants preferred the term “female circumcision.”² In this paper, both terms will be used but only one will be suggested for patient interactions.

Origin of the Practice

Location

The exact origin of female genital mutilation (FGM) remains unclear. Some scholars have proposed Ancient Egypt (present-day Sudan and Egypt) as its site of origin, noting the discovery of circumcised mummies from fifth century BC. Other scholars theorize that the practice spread across the routes of the slave trade, extending from the western shore of the Red Sea to the southern, western African regions, or spread from the Middle to Africa via Arab traders.^{1,4} The practice was also implemented on female slaves in Ancient Rome, deterring recipients from coitus and subsequent pregnancy.¹

With its widespread prevalence, a “multi-source origin” has also been proposed, claiming that FGM spread from “original cores” by merging with pre-

existing initiation rituals for men and women.⁴ Despite the perplexity surrounding its origin, the practice of FGM endears across the globe, serving several theoretical purposes for the communities that propagate its practice.

Proposed Purposes of FGM

For the regions where FGM originated, scholars have proposed three functions for this practice. The first draws from the theories behind the “marriageability” of a woman, emphasizing the ideologies of “virginity, purity, and sexual restraint” that are upheld in the societies where FGM is practiced. By reducing (or increasing, depending on the cultural group) sexual pleasure, the procedure protects young girl’s and women’s “sexual propriety” and “morality,” “demonstrating the obedience and respect required for marriageability.”⁴ In the highly structured social framework of the ancient Egyptian empires, FGM was implemented as a means of perpetuating inequality between the classes, with families cutting young girls and women, signifying their commitment to the wealthy, polygamous men of their society.⁴

However, female circumcision is practiced today in areas where female premarital sexual intercourse is permitted, such as the Rendille women of Kenya. In such areas, the practice is thought to serve its second proposed purpose: a means of solidifying ones “cultural identity” and transition to being an “adult member of society.” For example, the name of the “Kipsigis” of Kenya translates to “we the circumcised,” as, after circumcision, one is thought to be “reborn.”⁴ In areas where FGM is a tradition, parents fear their daughter will be banned from their society.⁵

Its third possible function surrounds the idea of protecting the health of women and their fetus. In some cultures, FGM is believed to improve hygiene and increase a woman’s probability of conception with intercourse. In addition, physical contact between the “toxic” clitoris and a baby during childbirth is thought to be potentially fatal to the fetus.⁴ The procedure also conserves the recipient’s attractiveness, as the clitoris could potentially grow until it “touches the ground.”⁵

Cases of female genital mutilation were reported for centuries in European countries as well. Interest in the practice grew in the 1860s when Isaac Baker Brown – the founder of the London Surgical Home for Women – noted that female epileptics in his hospital tended to masturbate. From this observation, he concluded that masturbation led to hysteria, then epilepsy and subsequent “idiocy and death.” Brown believed the only cure for this path to “feminine weakness” and death was clitoridectomy, which gained widespread acceptance.²

In the late nineteenth century, in Western cultures its primary function unfolded to become a means of regulating certain sexual practices (particularly female masturbation, “hysteria,” and lesbianism) and clitoral enlargement.^{1,5} Masturbation was seen as a disorder with treatment being reserved for its most severe cases. In 1896, for a twenty-nine year old, single female living in Brooklyn, New York, this meant obtaining a clitoridectomy when her concerned father told their doctor, Dr. John Polak, about her acts of masturbation twenty to forty times a day.

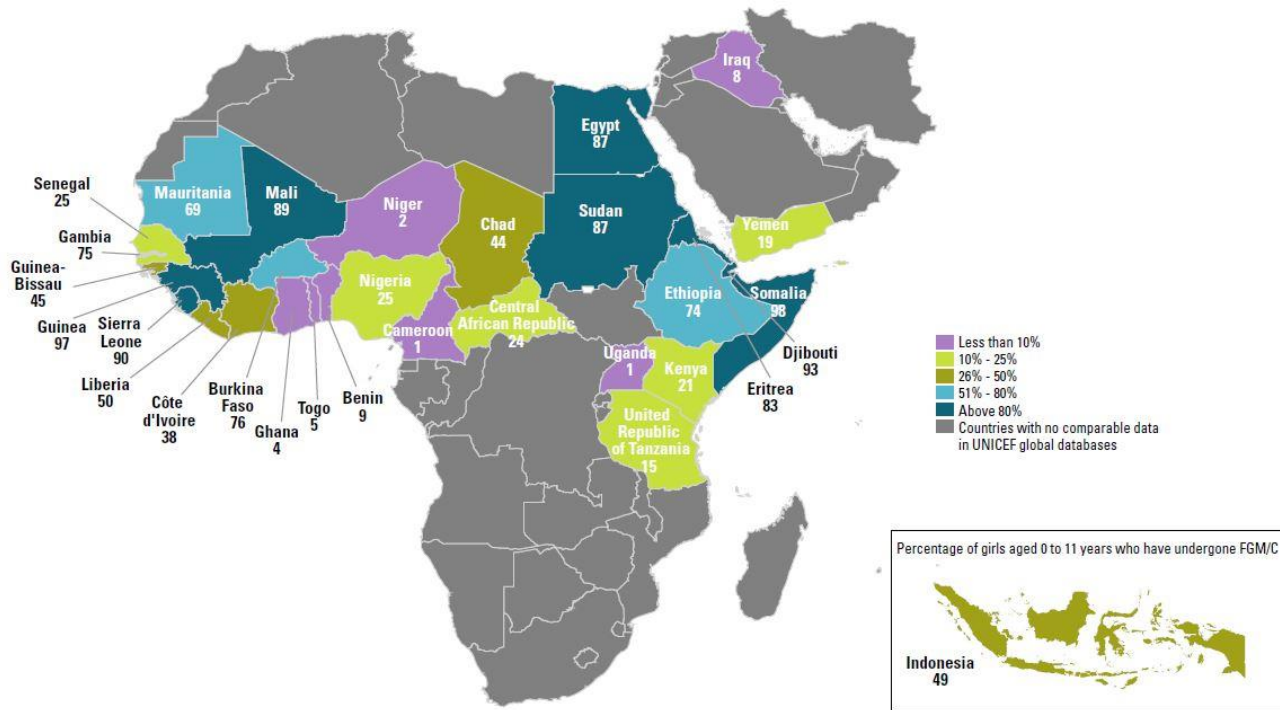
In the late nineteenth century, a wife’s failure to enjoy coitus with her husband was also seen as evidence of a disorder in Western culture. Thought to be secondary to the hood of the clitoris separating it from contact with the penis, doctors removed the adhesions between the clitoris and its hood or removed its hood completely. According to gynecologist, Dr. Howard Kelly of Johns Hopkins University, the adhesions between the clitoris and hood were also believed to cause “irritation,” leading to masturbation. If proficient cleaning was insufficient treatment, circumcision was deemed an appropriate alternative treatment.⁶

After analyzing these practices of American obstetricians that extended as late as the 1960s, Sarah Rodriguez concluded Western practices of FGM emphasized the need to control female sexuality and align it with a purpose beyond women’s own desires: the purpose of contraception and wifely duties.⁶ American physicians’ rationale for FGM closely mirrored the values of hygiene, purity, sexual restraint, and marital commitment that brought FGM to existence thousands of years ago.

The State of the Practice Today

Advances in medicine disproving the beliefs behind FGM in Western Culture, many cultures now denouncing the practice due to advances in women’s rights, the United Nations General Assembly adopting a ban of female genital mutilation in December of 2012— despite all of these factors, this practice still persists in twenty-nine countries spanning Africa, parts of the Middle East and Southeast Asia (Yemen, Iraq, Indonesia and Malaysia) (Figure 2).¹ Today, more than 125 million girls and women have suffered some form of female genital mutilation.⁷ Two million more females are considered at risk of undergoing FGM annually.² Young girls typically undergo FGM prior to puberty, between six and twelve years of age. In some cultures, the procedure may be performed at birth, at menarche or prior to marriage.⁵

Figure 2. Geographic Distribution of Female Genital Mutilation⁷



The prevalence of the four different types of FGM varies geographically. Type I is mostly practiced in Ethiopia, Eritrea and Kenya; Type II, in regions of West Africa such as Benin, Sierra Leone, Gambia and Guinea; Type III, in Somalia, Northern Sudan, eastern Chad, southern Egypt, and Djibouti and Type IV in Northern Nigeria.^{2,5} Eighty percent of Type III, the most severe type, occurs in Somalia.² According to UNICEF’s global databases of 2016, the practice of FGM on girls up to fourteen years old is most prevalent in Gambia (56% of the age group), Mauritania (54%) and Indonesia (49%) (Table 1).⁷ Among 15 to 49 year old females, FGM is mostly heavily practiced in Somalia (98%), Guinea (97%) and Djibouti (93%) (Table 2).⁷

Midwives or trained circumcisers travel across several villages, conducting the surgery without anesthesia, antibiotics or sterile equipment.⁵ Although the majority of women in many of these countries now believe the practice should be ended, some still believe in the tradition. Further complicating efforts for its global eradication, the majority of girls and women in Guinea (76%), Mali (73%), Sierra Leone (69%), Somalia (65%) and Egypt (54%) still support the tradition (Table 3).⁷

Table 1. Female Genital Mutilation Prevalence among Girls 0 to 14 Years of Age⁷

Country	Prevalence (%)
Gambia	56
Mauritania	54
Indonesia	49
Guinea	46
Eritrea	33
Sudan	32
Guinea-Bissau	30
Ethiopia	24
Nigeria	17
Egypt	14
Burkina Faso	13
Senegal	13
Côte d'Ivoire	10
Kenya	3
Central African Republic	1
Ghana	1
Uganda	1
Togo	0.3
Benin	0.2

With the persistent practice of female circumcision and the increase of international migration, awareness outside of the realms of its practice is essential in order to provide these women with proper, culturally-sensitive care.

Table 2. Female Genital Mutilation Prevalence among Girls and Women 15 to 49 Years of Age⁷

Country	Prevalence (%)
Somalia	98
Guinea	97
Djibouti	93
Sierra Leone	90
Mali	89
Egypt	87
Sudan	87
Eritrea	83
Burkina Faso	76
Gambia	75
Ethiopia	74
Mauritania	69
Liberia	50
Guinea-Bissau	45
Chad	44
Côte d'Ivoire	38
Nigeria	25
Senegal	25
Central African Republic	24
Kenya	21
Yemen	19
United Republic of Tanzania	15
Benin	9
Iraq	8
Togo	5
Ghana	4
Niger	2
Cameroon	1
Uganda	1

Table 3. Support for the Continuation of Female Genital Mutilation Among 15-49 Year Old Girls and Women⁷

Country	Percentage of Support
Guinea	76
Mali	73
Sierra Leone	69
Gambia	65
Somalia	65
Egypt	54
Mauritania	41
Sudan	41
Liberia	39
Chad	38
Djibouti	37
Ethiopia	31
Nigeria	23
Yemen	19
Senegal	16
Côte d'Ivoire	14
Guinea-Bissau	13
Eritrea	12
Central African Republic	11
Burkina Faso	9
Uganda	9
Cameroon	7
Kenya	6
Niger	6
United Republic of Tanzania	6
Iraq	5
Benin	3
Ghana	2
Togo	1

Approach to a Patient with a History of Female Circumcision

Obtaining a History

When an immigrant or refugee settles in a new country, a general practitioner is often the first medical provider they see. Nonetheless, many obstacles can impede a physician's ability to identify a woman or child's history of female circumcision. Firstly, the provider must be aware of its risk factors: lineage to a community known to practice FGM or a first- or second-degree, female relative with a history of the procedure. Secondly, the practitioner must feel comfortable asking

the patient about female circumcision. As the lower types of FGM may be more difficult to identify on physical exam, especially by more inexperienced physicians, it is important to ask prior to examination.³ Furthermore, if the examiner does first recognize a history of FGM on exam and appears alarmed or upset, this can be demoralizing to the patient.⁹

As previous studies have shown that the term "female genital mutilation" may offend some patients, I recommend referring to the practice as "female circumcision." If a woman does have a history of female circumcision, their chance of having experienced another form of sexual violence may also be increased,

depending on their country of origin. In the Democratic Republic of Congo (DRC) (where the patient who ignited my interest in FGM was from), forty percent of women and twenty-four percent of men have suffered some form of sexual violence. One study stated that approximately forty-eight women are raped every hour in the DRC.⁸

While some women may spontaneously share their history of sexual violence, others may be more reluctant to share such sensitive information, especially at a first visit. Nonetheless, surveys have shown that the majority of women with a history of sexual trauma prefer routine inquiries versus having to mention the topic themselves.⁹ Accordingly, asking about a history of sexual abuse is recommended, particularly with women who have not had routine pelvic examinations in the past or appear more distressed than normal.

While obtaining a patient's history, physicians must also inquire about a number of possible immediate and long-term complications of the various types of FGM.

Immediate side effects of FGM include pain, infection, hemorrhage, emotional and physical shock, and damage to approximating organs, such as the urethra or bowel.³ If the urethral or vaginal openings are obstructed, the patient may develop urinary retention, amenorrhea, dysmenorrhea or other subsequent problems.² Long-term sequelae of the procedure could include chronic vaginal infections, chronic urinary tract infections resulting in scarring and impaired renal function, blood-borne viral infections (HIV, Hepatitis B or hepatitis C) from unsanitary equipment, dyspareunia, anorgasmia or complications with pregnancy and childbirth.³

Due to the psychological effects of dyspareunia and the anatomic scarring from the procedure, thirty percent of women who undergo infibulation (Type III of FGM) are infertile. If a patient does become pregnant, infibulation increases her chance of many obstetric complications: postpartum hemorrhage, episiotomy, vesicovaginal fistula, cesarean delivery, extended hospital stay, stillbirth and neonatal death.^{5,2}

Approach to the Pelvic Exam

According to the Women's Preventative Services Guidelines, during a routine, preventive women's health evaluation, women should be screened routinely for cervical cancer, sexually transmitted infections, and domestic or interpersonal violence.¹⁰ Many of these components of the visit may make any patient feel uncomfortable and vulnerable. For women with history of FGM or sexual trauma, pelvic examination could be particularly distressing. Considering this truth, Bates et

al. of the Department of Obstetrics and Gynecology at Beth Israel Deaconess Medical Center of Boston, Massachusetts, sought to analyze all of the components the pelvic exam, delineating techniques for minimizing discomfort and optimizing culturally-sensitive care.⁹

Firstly, to avoid placing a patient in a vulnerable position prior to obtaining consent, they suggest conducting patient education while the patient is sitting upright and still fully clothed.⁹ Because of the increased vulnerability of this population, taking extra time to fully explain the components of the exam in the patient's preferred language (using an interpreter, if indicated) is essential, as one would not want the patient to be surprised and ultimately feel violated, diminishing patient-physician trust. This also gives the patient the opportunity to express concerns or decline portions of the exam, if she so desires. Her expression of her concerns allots the provider another opportunity to elaborate on aspects of exam that make the patient feel most uncomfortable.

Even with proper education and consent, speculum and digital examination may still awaken flashbacks of their trauma, igniting anxiety and fear before, during and after the procedure. "Dissociation" during the exam may occur while examining victims of trauma. Signs of this include developing a childlike voice or having a "startle response" to noises in the room or clinic. If this occurs, the exam should be stopped and the patient, once reoriented, should be offered mental health resources.⁹

If the patient has had infibulation, pelvic examination may be physically impossible or significantly painful for the patient, due to scarring with secondary vaginal and introital stenosis. In such cases, the patient should be referred to a gynecologist with experience working with this population, if possible.⁹ A full outline of recommendations is provided in Appendix A.

Conclusion

Female genital mutilation and circumcision is a tradition embedded deeply in the culture and identity of twenty-nine nations worldwide, affecting millions of young girls and women every year. With the significant number of immigrants and refugees in the United States, one's probability of seeing a patient who has undergone some type of FGM is not insignificant. Accordingly, more awareness of the complex history and complications of FGM must be spread, assuring that knowledgeable, empathetic, culturally-sensitive care is provided to this potentially vulnerable population.

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Appendix A¹⁰:

Recommendations for examination in a woman who has experienced trauma

1. Offer the option of mental health counseling
2. Acknowledge that pelvic examinations may be difficult and normalize her anxiety
3. Accommodate requests such as preference for a female examiner as anxiety may be higher with male examiner (56)
4. Offer to have consultation only at the first visit unless she chooses to undergo the examination the same day
5. Offer to have a friend, family member, partner, or treater of the patient's choice present in the examination room; patients can also bring a comfort object such as a stuffed animal.
6. Offer the option to wear a dress or skirt and remove only the underwear for the examination
7. Assure her that if she decides to proceed, she will be able to stop the examination at any time
8. Negotiate what will happen if she asks to stop the examination (see text)
9. Offer positioning alternatives to the dorsal lithotomy position
10. Offer alternatives to speculum insertion including guided self insertion or insertion by a partner (57)
11. With patient's signed consent and a chaperone present, an anxiolytic medication may be taken prior to the examination in rare circumstances.