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Clitoridectomy, excision, infibulation- female circumcision ritual and its consequences for women's health

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Abstract

The issue of female mutilation is important for modern gynecology and obstetrics. The article discusses the concepts of ritual, tradition and initiation as the moment of introduction into the world of adulthood. The approach to circumcision was explained for the sake of religion. The essence of the sense of one's sexuality and femininity is also shown. Describes the definition of female genital mutilation as a procedure contributing to the partial or complete elimination of the external genital organs in women. The paper presents recommendations for perinatal care for a circumcised patient developed by the Royal College of Obstetricians and Gynecologist, the South Australian Perinatal Practice Guidelines and the London Safeguarding Children Board. The perspectives of protecting and stopping female mutilation practices that violate a number of human rights are explained.

Key words: FMG, female circumcision, clitoridectomy, infibulation, excision.

Introduction

Female genital mutilation (Female Genital Mutilation/Circumision), also known as circumcision, includes procedures that contribute to the partial or complete removal of external genital organs in women, or other damage to female genitalia for non-medical reasons [1]. Definition (abbreviated FGM/C or FGM) was first adopted by the African Committee for Traditional Practices Affecting Women's and Children's Health in 1990 to highlight the gender-specific nature of female genital mutilation [2].

In 1995 the WHO has developed a terminology (the last update of 2007) according to which four types of FGM are distinguished:

I - clitoridectomy/sunnic circumcision - partial or complete removal of the entire clitoris, clitoris glans and / or foreskin,

II - excision - resection of clitoris and labia minora with or without labia majora,

III - infibulation/pharaonic circumcision - narrowing of the vaginal opening by incision and compression of the labia majora and / or labia majora, with excision or leaving the clitoris. In most cases, the edges remaining after excision of the labia majora are stitched, leaving a small gap. The skin fold completely covers the urethral meatus, completely or partially obscures the entrance of the vagina. To enable sexual intercourse or childbirth, the scar must be open.

IV - so-called symbolic circumcision - all harmful procedures regarding mutilation of female genitalia for purposes other than medical, for example piercing, scraping, cutting, burning, stretching, rubbing caustic substances, herbs, etc. (Fig.1) [1].

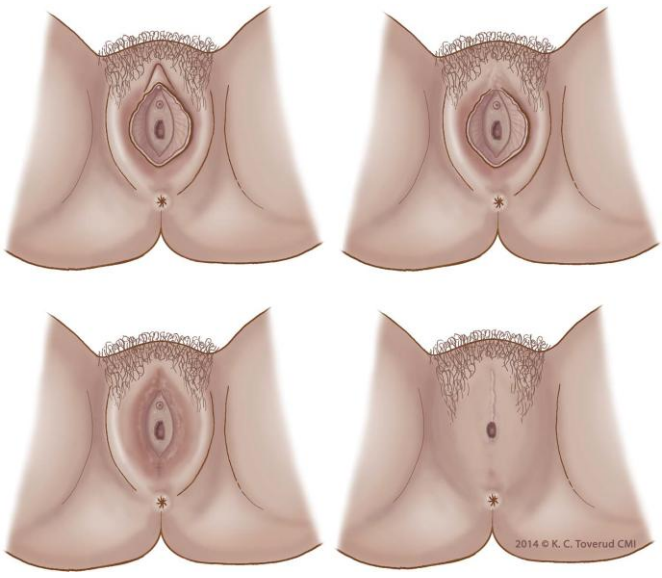

Figure 1.Illustration of unaltered external female genitalia and female genital mutilation/ cutting (FGM/C) types I-III. From top left: unaltered external female genitalia, type I (clitoridectomy), type II (excision) and type III (infibulation).

The course of circumcision

Girls are most often circumcised before the age of 10 (6-12 years). The role of tools is played by pieces of glass, razors, scissors, knives, razor blades, can covers, etc. The procedure is performed by a woman specializing in circumcision, a woman/grandmother/a charlatan from a village who has a high social position. Other women help immobilize the girl, which in turn leads to fractures of the collarbone and thigh bone. In the hole left after the procedure, a plastic straw or match is introduced to prevent the complete fusion during healing and allow urine output after the procedure, and in the future, outflow of menstrual blood. To allow the labia to adhere to each other and can even grow together, the girl is bound with a rope or rags for a period of about 1 month. A paste of myrrh is put on the wound that stops bleeding and compress of herbs, mud, cow excrements [2-4].

Epidemiology

It is estimated that the number of women circumcised around the world is about 125 – 140 million, of which there are about 500.000 in the EU. Each year, another 180 thousand girls are at risk FGM [5].

According to UNICEF data from 2013. the highest percentage of circumcised women comes from Africa. Prevails Somalia- 98% (type III circumcision 63%), Guinea- 96%, Djibouti 93% and Egypt 91%; Eritrea, Malaysia, Sierra Leone and Sudan-88%. Rarely FGM is conducted in Iraq, Ghana and Togo - below 10%, in Nigeria, Cameroon and Uganda - about 1-2% [2]

Consequences of FGM

On the basis of the available studies, there is clear evidence that female genital mutilation has negative consequences for the physical, mental and social health of a woman who has performed the procedure as an infant or child. However, accurate determination of the frequency of complications is not possible [6].

The most frequently mentioned consequences of FGM include:
1. Short-term complications after the procedure:

- bleeding, haemorrhage
- damage to the urethra, bladder, anal sphincter, vagina,
- infection (tetanus, gas gangrene, hepatitis type C, HIV),
- septic shock,
- fracture of the femur and collarbone etc. [7-11].

2. Long-term consequences after the procedure:

- keloids,
- fistulas (recto-vaginal and bladder-vaginal),
- recurrent urinary tract infections,
- bacterial vaginosis,
- chronic pain [7,9,11-25].

3. Obstetric complications:

- prolonged delivery,
- higher percentage of instrumental deliveries,
- higher percentage of cesarean sections,
- extensive crotch injuries,
- bleeding,
- increased risk of shoulder dystocia [14, 15, 23, 25, 27-49].

4. Consequences for sexual functioning

- dyspareunia,
- vaginismus,
- contact bleeding,
- reduced vaginal lubrication,
- inability to penetrate due to scarring or as a consequence of untreated inflammations in the pelvic area [13, 16-18, 23, 50].

In addition to physical consequences, circumcised women have problems with mental and social functioning. Such behaviors as apathy, constant tension, fear, guilt, shame, feelings of helplessness, nightmares, isolation from the environment. There is often a frustration and anger towards men [51].

Among the socio-cultural consequences, there is a risk of marginalization of the position of an uncircumcised woman and even exclusion from society [52].

Obstetrics and gynecology care

In recent years, there has been an increasing migration of people from countries where FGM is practiced. There is a need to develop procedures for dealing with women after circumcision in the aspect of gynecological care, and especially perinatal care. Teachers, pedagogues, basic health care doctors who have contact with a migrant girl can also play an

important role. The answer to two questions: which girl is burdened with the risk of FGM and what may suggest that circumcision has already taken place will allow indicate a group of children requiring special attention and care.

To the endangered procedure of FGM may belong female child, who:

- comes from countries with a high FGM level,
- is born in a family in which women have been subjected to this procedure,
- have mother, sister / sisters after the surgery,
- it is isolated from the local/pre-school/school community,
- defends against understanding her body and her basic rights,
- drew the attention of the educator / doctor to overheard conversations of adults about the "ceremony", "special procedure", which awaits them in the near future,
- she says about a trip to his home country, where the FGM ratio is high [53].

You can suspect the circumcision:

- problems with sitting or long walks,
- problems with physical exercises,
- spending more time in the toilet,
- frequent absences from school caused by painful menstruation, diseases of the urinary tract,
- symptoms suggestive of depression or other psychiatric disorders [53].

Most often, the first contact of a circumcised woman with a gynecologist or midwife takes place during pregnancy. An interview may take place in the presence of an interpreter, provided that he is not a family member, nor is he not related to the family, community or country of the patient [54].

According to the recommendations of the Royal College of Obstetricians and Gynaecologists [55], the London Safeguarding Children Board [56] and South Australian Perinatal Practice Guidelines [57] in the gynecological examination should identify changes in the woman's genitals, determine the type of FGM and describe in the documentation and inform the woman about the need for deinfibulation.

Deinfibulation/defibulation is the surgical opening of the genitalia covered by the skin fold. They are performed only in case of infibulated patients - type III. In the case of pregnancy under gynecological care, it is recommended to perform deinfibulation in anesthesia, in hospital conditions about 20-30 weeks of pregnancy. In the situation when the

diagnosis of FGM occurs in a hospital at the time of delivery, deinfibulation should be performed in the first stage, or in the second stage of delivery.

Childbirth should be carried out by a qualified midwife; the presence of apprentices/ students is not recommended. In the puerperal period, gynecological consultation is recommended 2 weeks after delivery (assessment of crotch condition), avoiding sexual intercourse until full healing, return to physical activity depending on the condition of the crotch. Every woman should get an educational package regarding Kegel muscle exercises recommendations. The midwife should be informed about the circumcised woman. The patient and her family should also be informed about the harmfulness of the use of circumcision in the case of the birth of a female child and of the law consequences associated with it.

Perspectives to protect and stop female mutilation practices

A circumcised patient is not only a challenge for healthcare professionals. Female genital mutilation is an act of violence against women, which is opposed by leading international organizations.

The first law against FGM was adopted in Sweden in 1982 [58]. Following it went the United Kingdom [59], Belgium [60], France [61, Germany [62], Canada [63].

The European Parliament in the resolution of 2001: *The resolution on female genital mutilation* radically opposes the practice of FGM, claiming that it is a violation of fundamental human rights. Stresses the essence of the harmonious action of European states, opposes the medication of FGM, urges "prosecution, condemnation and punishment of conducting these practices", recognizing them as a separate offense and "punishing anyone who helps, encourages, advises and provides support to anyone to conduct any from these acts on the body of a woman or a girl " with the possibility of punishing parents who, for the procedure, went with their child outside the border of the inhabited state [64].

General Assembly of the United Nations December 20, 2012 has adopted a resolution to intensify global forces to eliminate the practice of female mutilation. This resolution recommends a coordinated approach to the subject, and above all developing uniform methods for collecting data on all forms of violence and discrimination against girls, especially undocumented forms such as FGM [2].

November 26, 2006 the most influential Islamic clerics - the Great Sheikh Al-Azhar and the Great Mufti of Egypt - announced that FGM is a practice that is not a reflection of the

religion of Islam. This is a big step towards change, because religion is one of the most common arguments in justifying the continued practice of FGM [64].

February 6 was declared "International Day of Non-Tolerance for Female Genital Mutilation" and November 29 "An International Day Against Female Genital Mutilation" [64].

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