Maturitas 80 (2015) 48–51

Contents lists available at ScienceDirect

Maturitas

journal homepage: www.elsevier.com/locate/maturitas

Review

Long term health consequences of Female Genital Mutilation (FGM)

Dan Reisel[a], Sarah. M. Creighton[b,*]

[a] Translational Research Unit, Institute for Women's Health, University College London, UK
[b] Department of Women's Health, University College London Hospital, 250 Euston Road, London WC1 2PG, UK

ARTICLE INFO

Article history:
Received 6 October 2014
Accepted 13 October 2014

Keywords:
Female Genital Mutilation
FGM
Long term health complications

ABSTRACT

Female Genital Mutilation (FGM) comprises various procedures which remove or damage the external female genital organs for no medical reason. FGM has no health benefits and is recognised to cause severe short and long term damage to both physical and psychological health. Although FGM is primarily performed in Africa, Asia and the Middle East, migration of FGM practising communities means that the health complications of FGM will have a global impact. It is important that health professionals world wide are aware of the damage FGM causes to long term health. In some cases it may be possible to offer interventions that will alleviate or improve symptoms. However whilst there is some high quality research on FGM and pregnancy outcomes, little is known about the effects on gynaecological, psychological and sexual function. Research is hampered by the problems of data collection on such a sensitive topic as well as the practical difficulties of analysis of studies based mainly on retrospect recall. Well planned hospital based studies of the impact of FGM on physical and psychological health are urgently need but are currently absent from the medical literature. Such studies could generate robust evidence to allow clinicians to benchmark clinical effectiveness and high quality medical care for survivors of FGM.

Contents

* Corresponding author.
E-mail address: sarah.creighton@uclh.nhs.uk (S.M. Creighton).

http://dx.doi.org/10.1016/j.maturitas.2014.10.009
0378-5122/

1. Introduction

It is a source of continuing concern that the number of women living with the physical and mental scars of Female Genital Mutilation (FGM) is rising worldwide. Of all the factors contributing to this increase in numbers, the one that health professionals of all types can do something about is their own awareness of FGM and their ability to manage it effectively at each life stage. To achieve this, health professionals need to be aware of the adverse impact of FGM on women's long term health and understand how medical interventions may reduce this impact. There is no doubt that FGM can cause serious short and long term damage to the physical and psychological health of women and girls. However there is patchy medical evidence on the magnitude and type of such complications and the efficacy of any medical interventions. The aim of this review is to describe the practice of FGM, review the reported complications and how these may impact upon long term health, identify gaps in available evidence and give suggestions for future research.

2. What is FGM?

FGM is a deeply rooted tradition practiced by specific ethnic groups in Africa, Asia and the Middle East. The World Health Organization (WHO) defines FGM as "all procedures that involve partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons" [1]. The WHO divides the main FGM procedures into four categories, Types 1–4 (Table 1). FGM is carried out in a wide range of settings. Practitioners may in many cases have little training in antiseptic, surgical techniques. In these settings, the risk of short-term complications is obvious. What is less obvious are the long-term sequelae of FGM. The effects of FGM are not confined to the procedure itself but have a long and often traumatic fallout on the life course of each survivor.

3. Prevalence

According to the United Nations Children's Fund (UNICEF), there are an estimated 130 million women and girls living with FGM worldwide. Most of these women are located in 29 African countries [2]. Outside of Africa, Yemen, Iraqi Kurdistan, Indonesia and Malaysia are countries with high prevalence in some specific areas. FGM is increasingly identified in the UK amongst migrants from FGM practising countries. Estimates based on the most recent census data suggest that in 2011 approximately 137 000 women and girls in England and Wales had undergone FGM and came from countries where it is traditionally practised [3]. This estimate included 103 000 women aged 15–49 years, 24 000 women aged 50 years or over, and 10 000 girls aged under 15 years. In addition, an estimated 60 000 girls under 15 are born annually to mothers with FGM.

Table 1
WHO classification of FGM.

Type 1: Clitoridectomy; partial or total removal of the clitoris (a small sensitive and erectile part of the female genitals) and in rare cases only the prepuce (the fold of skin surrounding the clitoris)
Type 2: Excision; partial or total removal or the clitoris and labia minora with or without removal or the labia majora (the labia are "the lips" that surround the vagina)
Type 3: Infibulation; narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the labia minora or majora with or without removal of the clitoris
Type 4: Other; all other harmful procedures to the genital for non-medical reasons e.g. pricking, piercing, incision, scraping and cauterising the genital area

4. Difficulties with FGM data collection

Given that FGM affects so many millions of women, there is little accurate data on the short or long term health implications and this is due to a variety of reasons. The majority of large population based studies of FGM rely on retrospective self report. Recall may not be accurate and of course studies exclude girls who do not survive. Some more recent studies have tried to address recall bias by asking mothers about their daughter's FGM related health complications. Women asked about FGM may be unwilling to disclose symptoms due to the sensitive nature of the subject or because of the legal status of the practice. Studies have shown that although women are usually well aware they have had FGM, they are often unaware of what has actually been done. This may be due to local use of terminology to describe FGM and the different types of procedures performed. The WHO definitions in Table 1 are very detailed however women's genital appearance may not fit neatly into one specific category of FGM and even experienced health professionals can sometimes find it difficult to be definitive about type. To overcome this UNICEF uses a different classification for data collection which whilst less anatomically accurate is simpler to understand. UNICEF classifies FGM into four main categories [2]

(1) cut, no flesh removed,
(2) cut, some flesh removed,
(3) sewn closed,
(4) type not determined/not sure/does not know.

These categories do not fully match the WHO classification typology and this can also cause confusion.

UNICEF Type 1 "Cut, no flesh removed" describes a practice known as "nicking" or pricking, which currently is categorised as WHO Type 4.

UNICEF Type 2 "Cut, some flesh removed" corresponds to WHO Types I and 2 (clitoridectomy) and Type II (excision) combined.

UNICEF Type 3 "Sewn closed" corresponds to WHO Type 3, infibulation

Finally, women may not associate certain health issues with FGM and amongst some populations common consequences of FGM may be considered as normal and so may not be reported. Conversely women may attribute some symptoms to their FGM which in fact are due to other pathology. Hospital based studies may provide more accurate information but as yet there are few high quality studies published.

5. Short-term complications

During and immediately following the procedure, the girl or woman is at significant risk of traumatic bleeding and infection including wound infection, septicaemia, gangrene and tetanus.