

Female genital mutilation/cutting in Africa

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Abstract: Female genital mutilation/cutting (FGM/C) is a traditional practice in which the external female genitalia is partially or totally incised or excised for a non-therapeutic reason, usually without the consent of the individual. FGM/C is common in Africa with varying prevalence in different countries, though the incidence is reducing because it is considered a human rights issue with tremendous advocacy for its elimination by mainly nongovernmental organizations. It is mainly underreported in many countries in Africa especially where it has been declared illegal. FGM/C is often performed by a nonmedical practitioner with the aim of fulfilling religious or cultural rites and sometimes for economic benefits with the resultant acute, intermediate and late complications. It is sometimes performed by medical practitioners when it is speciously believed that its medicalization reduces the complications associated with the practice. The sensitivity of FGM/C is amplified when compared to male circumcision and voluntary alterations of the female external genitalia like piercing and tattooing as similar practices. The magnitude of the physical and psychosocial consequences of FGM/C outweighs the presumed benefits of the procedures highlighting the need for improvement of the multiple preventive measures by all the stakeholders and in all the sectors.

Keywords: Africa; complications; female genital mutilation/cutting (FGM/C); prevention

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Introduction

Female genital mutilation (FGM), also known as female circumcision (FC), but more recently as female genital mutilation/cutting (FGM/C) according to the World Health Organization (WHO), has occurred in many forms in all societies (1).

It involves imposed incisions or excisions on and of the female external genitalia for sociocultural as opposed to medical reasons. Some authors have described it as a form of gender-based torture (2). The social scientist, Ellen Gruenbaum observes in *The Female Circumcision Controversy*, the difficulties in naming correctly the procedures performed, advising of the extreme caution required in

answering the question why FGM/C is practised (3). FGM/C cuts across ethnicities and religious backgrounds, even though religious scholars claim that the holy books do not prescribe the practice. It has been outlawed in the Western world, but their immigrant populations have significant proportions of circumcised females from Africa, parts of Middle East, Asia and the Pacific (4,5). In a 2016 report, Teixeira and Lisboa estimated that in Portugal there may be over 6,500 immigrant women 15 years or older who have been circumcised and 1,830 girls under 15 years who are likely to or have undergone circumcision (4). Similarly, the study by Koukkula *et al.* in Finland demonstrated the burden of FGM/C among immigrant populations

in developed nations with 69% and 32% of women of Somali and Kurdish origins respectively, who had been circumcised (6). Reports have shown that up to 140 million girls and women had undergone FC around the world in 2000; however it is now estimated to be about 200 million in 2016 (7,8).

FGM/C has been associated with wide ranging medical, economic, sociocultural and women rights consequences and is presently receiving global, multifaceted attention to eradicate the practice albeit with slow progress over the years (9,10).

Origin of FGM

The exact origin of FGM/C is not well-known but documented reports, Greek historians and geographers, such as Herodotus (425–484 B.C.) and Strabo (64 B.C.–23 A.D.) point out that FC occurred in Ancient Egypt along the Nile Valley at the time of the Pharaohs and thus Egypt is often considered as the source country (11). The act of FGM/C was also reported long time ago among other nations of the world including the Romans where it was done in order to prevent their female slaves from getting pregnant (12).

In Western Europe and the United States, clitoridectomy was described to be practiced so as to treat perceived ailments like hysteria, epilepsy, mental disorders, masturbation, nymphomania and melancholia in the 1950's (13).

Types

Depending on cultures, traditions, customs and religion, there is a wide range of procedures performed and it is not known what percentage of which is practiced where. In some areas what is now done is just a ceremony simulating FGM/C and not actual surgical procedures (3).

According to WHO, FGM/C is defined as “*all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons.*” In the medical literature, four main types of FGM/C are recognized:

- (I) Type I: excision of the clitoral hood with or without removal of parts or the entire clitoris (clitoridectomy);
- (II) Type II: excision of the clitoris together with parts or all of the labia minora;
- (III) Type III: excision of parts or the whole of the clitoris, labia minora and labia majora and stitching or narrowing of the introitus, with a very small

outlet for passage of urine and menstruum. This is also known as infibulation;

- (IV) Type IV: other harmful procedures to the female genitalia for non-medical purposes. Examples are—pricking, piercing, incising, scraping and cauterization. Others are hymenectomy, cutting of the vagina and introduction of corrosive substances or herbs into the vagina to cause bleeding or to tighten or narrow the vagina.

Prevalence in Africa

The practice of FGM/C in Africa is one that has persisted due to strong sociocultural influences which ensure that it is secretly done and underreported particularly since the last two centuries. Curiously, it is one practice that is embraced by practitioners of all the major faiths prevalent on the continent—Christianity, Islam and traditional worship. Thus its extent is usually estimated and documented figures have been considered to be far less than what they are.

FGM/C is performed at varying age groups, from the first week of life, during infancy, before puberty, before the first childbirth and other periods in the woman's life dependent on the location and major reason underlying the practice (8,14). It is usually performed individually but can be done in groups of girls or women. In Africa, the country specific rates are shown in *Table 1*, from studies done by the United Nations' Children Fund (8). The body further projects that over the next decade 30 million girls less than 15 years old are at risk of FGM/C.

Within each country, there are wide differences in the types of procedure and prevalence of practice as the state—specific figures by Ngianga—Kandala *et al.* in 2009 (15) reveal for the states in Nigeria, in *Table 2*. These figures contrast with those obtained in 2013 for the same geopolitical zones of the country but by the fourth Nigeria Demographic and Health Survey (16) (*Table 2*). It is essentially for this reason that community specific interventions are mandatory in order to eradicate FGM/C.

Reasons for performing FGM/C

Even though a major reason for FC is control of female sexuality, researchers in Kenya and Nigeria observed no association between FC and outcomes for sexual behaviour and concluded that sexual chastity is insufficient to justify the practice (17). Numerous other reasons have been adduced for the sustenance of the practice spanning

Table 1 Prevalence rates of female genital mutilation/cutting (FGM/C) in Africa by country and age periods

Country	Percentage of girls and women aged 15 to 49 years who have undergone FGM/C, 2004–2015	Percentage of girls aged 0 to 14 years who have undergone FGM/C, 2010–2015
Benin	9	0.2
Burkina Faso	76	13.0
Cameroon	1	–
Central African Republic	24	1.0
Chad	44	–
Côte d'Ivoire	38	10.0
Dem. Rep. of Congo (formerly Zaire)	–	–
Djibouti	93	–
Egypt	87	14.0
Eritrea	83	33.0
Ethiopia	74	24.0
Gambia	75	56.0
Ghana	4	1.0
Guinea	97	46.0
Guinea-Bissau	45	30.0
Kenya	21	3.0
Liberia	50	–
Mali	89	–
Mauritania	69	54.0
Niger	2	–
Nigeria	25	17.0
Senegal	25	13.0
Sierra Leone	90	13.0
Somalia	98	–
Sudan	87	32.0
United Republic of Tanzania	15	–
Togo	5	0.3
Uganda	1	1.0

Adapted from UNICEF, 2016 (8). *Table 1* is a UNICEF document that does not need permission.

Table 2 Prevalence and types of female genital mutilation/cutting (FGM/C) in the various states of Nigeria

Geopolitical zone	State	2009 (15)		2013 (16)			
		Prevalence (%)	Types of FGM	Prevalence (%) of women aged 15–49 years			
South West	Oyo	60–70	I	47.5			
	Ogun	35–45	I, II				
	Lagos	20–30	I				
	Ondo	90–98	II				
	Osun	80–90	I				
	North Central	Kogi	1		IV	9.9	
		Niger	–		–		
		Benue	90–100		II		
		Kwara	60–70		I, II		
		Plateau	30–90		I, IV		
North West	Nassarawa	–	–	20.7			
	Federal Capital Territory	–	–				
	Kaduna	50–70	IV				
	Kebbi	90–100	IV				
	Zamfara	–	–				
	Sokoto	–	–				
	Kano	–	–				
	Jigawa	60–70	IV				
	Katsina	–	–				
	North East	Taraba	–		–	2.9	
Borno		10–90	I, III, IV				
Bauchi		50–60	IV				
Adamawa		60–70	IV				
Gombe		–	–				
South East	Yobe	0–1	IV	49.0			
	Ebonyi	–	–				
	Enugu	–	–				
	Imo	40–50	II				
	Abia	–	–				
South South	Anambra	40–60	II	25.8			
	Akwa-Ibom	65–75	II				
	Bayelsa	–	–				
	Edo	30–40	II				
	Cross River	–	–				
	Rivers	60–70	I, II				
	Delta	80–90	II				

Adapted from (15).

tradition, religion and politics. Viewing FGM/C from an economic angle, for the practitioners, it serves as an income earner and for some families it is used to improve the marriage prospects of young girls. In some societies, it is used as a kind of social stratification mechanism with those who have been circumcised perceived to be at a higher status than others and is a prerequisite for the right to inheritance (9,13). Still others perform the procedures for anatomic/aesthetic judgements, prevention of child mortality or for hygiene reasons (9). However, evidence has not supported any medical benefits.

Instruments and methods used for FGM/C

The instruments used in performing FGM/C have included razor blades, unsterilized sharpened kitchen knives, scissors, glass, sharpened rocks and finger nails (18). The person who performs the procedure is often called the circumciser or cutter. In most cases, this is an older woman who does it in the house of the girl or woman, or in circumcision centres. In some communities, it is performed by males, usually barbers because of their skills in handling cutting tools.

Unhygienic procedures are commoner among the traditional circumcisers with the report of repeated use of a single instrument in up to 30 girls (19). In some countries of Africa and Asia such as Egypt, Kenya, Sudan and Indonesia, health professionals often perform the procedures and so it is termed "medicalization" of FGM/C (20-22). Anaesthesia is not used by traditional cutters but medical professionals may use local or general anaesthetic agents (23,24). When the procedure is performed by traditional cutters and especially in types II and III, the girl or woman's legs are usually bound together from the hip to the ankle so she remains immobile for approximately 40 days to allow for the formation of scar tissue (25).

Payments for services

Most circumcisers or cutters collect modest remunerations which could be monetary or in form of gifts though some see it as a public service to their community (26,27). In Sudan and Egypt, it is customary to compensate the circumcisers with gifts and share the food and meat sacrificed during the circumcision feasts with them (26). In other settings where health care providers perform FGM/C, they do it either due to the erroneous belief that the procedure is safer when medicalized or because of the economic benefits (8,26). This is one of the reasons why

its eradication has met with a lot of obstacles since it is a source of income with rather high fees in countries where it is illegal (26,27).

Cost of FGM/C

The costs of FGM/C include not only the price paid for the services but also the cost of treatment of its medical and related obstetric complications (28,29). As much as 1% of government expenditure is spent on the health of women in the reproductive age group as a result of FGM/C-related obstetric complications annually (29). In addition, a loss of 130,000 life years which is equivalent to losing half a month from each lifespan is expected due to complications of FGM/C related to obstetric haemorrhage with a total of \$3.7 million spent in six African countries in a year (29). This is not limited to the monetary value since the psychosocial and emotional effects and their consequences on the family might be unquantifiable.

Complications

On account of the poor surgical skills of most practitioners of FGM/C, the absence of antiseptic techniques and non-use of anaesthetic agents, the procedures are associated with several complications. These sequelae may occur during or immediately after the operations, while others manifest in the medium and long-term to cause poor quality of life for the patient or result in mortality or both. The immediate complications include excruciating pain (when anaesthetic agents are not used), haemorrhage, shock, acute urinary retention, injury to adjacent tissues and death (9,27). A meta-analysis utilizing 185 studies in 57 countries where FGM/C is done detailed the most common immediate complications as excessive bleeding, urine retention and genital tissue swelling (30). For those who survive, medium term complications are infections of the reproductive tract following use of unsterilized or poorly sterilized instruments, septic techniques and septic environment and raw wound surfaces. All these result in urinary tract infection, pelvic inflammatory disease, chronic pelvic pain, infertility and ectopic pregnancy. Others are tetanus infection, infections with hepatitis and human immunodeficiency viruses and also abscess formation (9,27).

Among those who survive the acute and medium term consequences, many long-term morbidities noted are psychological disturbances, low libido, apareunia or

dyspareunia, chronic pain, dysmenorrhoea, gynaetresia, cryptomenorrhoea, vaginal fistulae, labial agglutination, hypertrophic scar/keloids, clitoridal retention cysts, dermoid cysts, vaginal lacerations during coitus, straining at micturition, genital tract lacerations, especially during vaginal delivery, obstructed labour, increased rate of caesarean delivery and postpartum haemorrhage (31,32). Mortality can still occur following the above complications of labour and the puerperium. For the babies conceived by such women, there is increased risk of stillbirth, early neonatal death or babies with neurologic deficits from severe birth asphyxia (32).

The clitoris has extensive innervations and it plays crucial roles in sexual arousal, attainment of orgasm and sexual satisfaction. Its amputation or wholesome removal during FGM/C has been demonstrated to affect these functions. A validated questionnaire, the Female Sexual Function Index (FSFI) has been used by workers in France to determine the sexual, physical and psychological effects of FGM/C (33). Though the number studied was small, the instrument promises to help in the scientific evaluation of these patients.

Management of complications

Given the extent of these complications, the best management is to prevent the occurrence of FGM/C. When it has occurred, the line of management includes responding to the patient-specific complications. This is best done with a multidisciplinary approach and dependent on the time relation of the complications in the individual patient. When patients present in acute emergencies, rapid and skillful resuscitation techniques are imperative to keep them alive in addition to limiting medium and long-term complications. When haemorrhage occurs, ensuring haemostasis along with quick restoration of cardiovascular volume with crystalloids, blood and blood products and administering supplemental oxygen is crucial. For infections, a wound swab should be taken for microscopy, culture and sensitivity and the patient treated initially with potent broad spectrum antibiotics which may be changed if the sensitivity pattern so indicates. When laboratory facilities are unavailable, there should not be delay in commencing antibiotic therapy. Urethral catheterization with adequate analgesics will be helpful in the control of pain and acute urinary retention.

Following type III FGM/C, defibulation can be performed. This is a midline incision of the vulval scar,

made on its anterior part. It may be performed during gynaecological procedures like cervical biopsy, during delivery or before delivery with the quest to prevent acute intrapartum problems such as obstructed labour or varying types of genital fistulae. Psychotherapy is extremely helpful for these women; good emotional support will help them overcome much of the challenges they have. Gynaetresia may require vaginoplasty, depending on severity. Keloids or hypertrophic scar not big enough to disturb sexual function may be left untouched; however large ones especially those causing difficulty during sexual intercourse, or with the possibility of causing obstructed labour will need to be managed by a plastic surgeon (32). Lower genital tract cysts can be managed by excision or marsupialization. Menstrual disorders such as dysmenorrhoea should be evaluated for severity and possible cause. Incision and drainage may be needed to relieve vulval abscesses (31). Fistulae and urinary incontinence are managed by urogynaecologists.

At the community level, other measures include improving health services in rural areas where the practice is more rampant, development of emergency care, referrals to a sex therapist and management of labour by well-trained medical and nursing personnel. Development of guidelines on management and creating help lines is also helpful, especially when accessing these lines is toll-free.

The midwife and the gynaecologist/obstetrician are poised more than other practitioners to manage circumcised women. Therefore these health care workers need additional training to enable case identification, reduce the obstetric and psycho-social effects of FGM/C, and prevent reinfection and the occurrence of new cases (34). Also of importance in the care of these patients are urological nurses, psychologist-psychotherapists, sexologists and social workers (5,35). The training of these health care practitioners needs to be well structured for them to cope (35).

In order to care effectively for girls/women who have had FGM/C, it is necessary to have accurate estimation of those affected or likely to undergo the procedures. The Royal College of Nursing has advocated improved information sharing on FGM/C across health and social care services in order to achieve this (36).

In school age girls who have been circumcised or face the risk of circumcision, the school nurse is in a vantage position to deliver educational and support services in developed countries while dedicated female teachers can perform these roles in resource challenged places (37).

Clitoral reconstructive surgery has been done with good effects. Vital *et al.* in France demonstrated a statistically

significant improvement in median FSFI summary score of 29 from a preoperative score of 17 ($P=0.009$), although 75% of their patients had only type 2 mutilations (33). Similarly, Abramowicz *et al.* showed that 88% to 96% of their study participants expressed satisfaction with anatomic and psychosexual improvement following reconstruction (38).

In the case of adult patients of FGM/C or those likely to undergo the procedures, detailed information and counselling (DIC) has been shown to work. Abdulcadir *et al.* in Geneva, Switzerland examined eight East African women who requested for postpartum infibulation, but after DIC which lasted over 1 year, none except one persisted with the request (39). The factors that may have contributed to success were being away from a conducive environment for reinfibulation and the health resources of the country of emigration.

Effect of FGM/C on sexual satisfaction

One of the cultural and religious reasons for justifying the practice of FGM/C is in the reduction of promiscuity and ensuring virginity before marriage. While attempting to achieve its presumed benefit through reduction in sexual drive and desire it has a negative impact on the overall woman's sexual life. FGM/C deprives women of sexual satisfaction and denies them of their right to sexual health and pleasure to achieve full psychophysical well-being (40). Circumcised women have reported several sexual problems including reduction in sexual desire, arousal, excitement, orgasm and dyspareunia at varying levels (41,42).

The level of sexual dissatisfaction among circumcised women depends on the types of circumcision. Women with types II, III and IV are more likely to experience increased sexual dissatisfaction because of lower levels of sexual functioning, decreased arousal, vaginal dryness during intercourse, and orgasm with increased pain and decreased overall satisfaction than those with type I FGM/C (43,44). In type III, also known as infibulation, the husbands' inability to penetrate into the vagina can result into anal intercourse or even using the urethral meatus as an opening (25,45). However, some studies showed that most circumcised women with type I agreed FGM/C reduces orgasm markedly but does not totally eliminate sexual pleasure (40,43).

An association has been found between the female genital self-image and sexual function and behaviour with women that undergo types II, III and IV genital circumcision

having negative genital image and much more likely to experience sexual dysfunction (46,47). This is corroborated by Krause *et al.* who documented improved sexual desire, arousal, and satisfaction following defibulation surgeries through the use of FSFI (48). A systematic review on FGM and sexual problems revealed women who have undergone FGM are 1.5 times more likely to experience dyspareunia and are twice likely to report a lack of sexual desire (49).

Effect of FGM/C on psychosocial health

The psychological effects of FGM/C depend on the type of the procedure performed, experience of the circumciser and the social atmosphere at the time the cutting is performed (45,50). The psychosocial consequences include post-traumatic stress disorder (PTSD), anxiety disorders, panic disorders, inhibition, depression and suppression of feeling and thinking and sometimes attempted suicide (40,45,51). These effects are due to psychological trauma of the painful procedure, sense of humiliation and being betrayed by parents, use of physical force by those performing the procedure, negative genital image, lack of sense of ownership of their bodies, devastating sexual life, infertility and vesicovaginal fistulae (40,45,51-53).

Women with type III FGM/C have a more distressing psychosocial complication in relation to sexual problems and infertility with a documented infertility rate of 30% (42,44). The purported infibulated scar that ought to protect from pregnancy out of wedlock and enhance men's sexual pleasure serve as the impediment to conception within marriage and sexual pleasure thus causing an unhealthy sexual relationship and creates the fear that the women may never become mothers while their husbands question their masculinity (54). These account for 16.3% of divorce and marital discord in a study among circumcised women (55).

On the contrary, FGM/C provides a psychological relief to a child who is made to believe and celebrate the cultural act in the community where female genitals are seen as dirty or a source of enthralling temptation. The female child feels satisfied despite the pain, of being made clean and marriageable like every other female in the community rather than becoming despised and made the target of ridicule with no one in the community to marry her (56).

Effect of FGM on reproductive health

FGM/C has adverse effects on the reproductive health

of circumcised women. It may cause partial or complete occlusion of the vaginal opening resulting in dysmenorrhea, haematocolpos, haematometria (45). Infertility results from FGM/C due to the consequences of pelvic infections or coital problems and when the circumcised women get pregnant they have higher risks of obstetric complications (32,45).

Circumcised women have increased risks of adverse events during labour and delivery with negative effects on their newborn babies (31,32). These risks increase with the severity of type of FGM and include postpartum hemorrhage, episiotomies, perineal lacerations, prolonged second stage of labour, operative vaginal delivery, caesarean deliveries, prolonged maternal hospital stay, infant resuscitation, stillbirth, or neonatal death (32,57,58). Infibulation may cause obstructed labour and is associated with an increased risk of vaginal/vulval lacerations and sometimes women with infibulation have defibulation performed at the time of delivery (59). In the Gambia, women with FGM/C are 4 times more likely to have complications during delivery, and their newborns are 4 times more likely to have health complications (60).

In the WHO's study on delivery outcomes among 28,393 women with singleton pregnancies admitted for delivery at 28 obstetric centres in six African countries, a higher neonatal death rate was found among circumcised compared to non-circumcised mothers (32). Neonatal death rate was 15% higher for those whose mothers had type I, 32% higher for those with type II and 55% higher for those with type III FGM/C with an estimate of additional one to two babies per 100 deliveries dying as a result of FGM/C (32). Women who do not deliver in hospitals will have more severe obstetric complications with increased neonatal adverse outcome.

Effect of FGM and fistula

FGM/C could be directly or indirectly linked to fistula. Fistula could occur during FGM procedures or defibulation. It can cause prolonged obstructed labour which predispose to obstetric fistulae (45,51). Browning reported that types I and II FGM/C are not independent causative factors in the development of obstetric fistulas from obstructed labour but could not ascertain the relationship of type III FGM/C with obstructed labour. The author documented women with type III FGM/C presenting with fistula after delivery by traditional birth attendants who might have extensively cut the infibulated genitalia and the urinary tract at the time of delivery (61).

Prevention

The morbidities and mortalities associated with FGM/C are enormous without any medical benefits to the patients particularly in the resource poor countries where the practice occurs mostly. Therefore, its prevention and eradication are mandatory for human rights and socioeconomic reasons. Fortunately, the prevention of FGM/C is receiving the deserved global, local and grassroots attention. However, efforts need to be focused on using strategies to build evidence and generate knowledge, to increase advocacy, enforce legislation against FGM/C and strengthen the health sector's response (7,51).

The first step should involve location specific researches to gather baseline community information, detail human and material resources that are available for the control of FGM/C and determine the best methods of prevention in that community. It is now universally agreed that methods of prevention must be holistic consisting of advocacy, general education especially of women, health education and promotion services, trade substitution ventures for the practitioners and legislation usually as the last resort. Also, emphasis should be placed on religious leaders advocating against the practice since it is associated with religious beliefs and they are well respected and have a great influence on their constituents (62).

In countries where the procedures are performed, the attitude of significant stakeholders such as husbands and fathers is important in eradicating the practice. Studies show that men who are against FGM/C can identify its physical, obstetric, psychological, sexuality and social consequences while those who support the practice generally deny the existence of these problems (63). Ten point three percent of women interviewed in Kenya supported the continuation of the practice (64).

Egypt used to have high rates of FGM. It has now recorded great declines in prevalence rates largely through mothers' education and empowerment but also as a result of socioeconomic development of its communities (65). The Egypt Demographic and Health Surveys documented that 90% of girls up to 13 years used to be circumcised but this has now reduced to 28% in 2005 amongst girls aged 0–17 years and 18% in 2014 (66).

Recently in Egypt (Modrek and Liu) and in Kenya (Achia) it was demonstrated that women empowerment, particularly education, significantly affects the likelihood of the daughter becoming circumcised (64,67). But other factors related to the socioeconomic status and anti-FGM/C

messages in the social media account for the decline in the practice of FGM/C (67).

Nongovernmental organizations have been in the forefront and have contributed immensely to the successes achieved so far in the care of girls/women who have been circumcised and in preventing the procedures from being carried out. These have included the United Nations' International Children's Emergency Fund (UNICEF) which in 1980 announced that its anti-FGM program is *"based on the belief that the best way to handle the problem is to trigger awareness through education of the public, members of the medical profession and practitioners of traditional health care with the help of local collectives and their leaders"*. Others are WHO, Inter-African Committee on Traditional Practices Affecting the Health of Women and Children, the 1994 United Nations' International Conference on Population and Development (ICPD) in Cairo, Egypt and so on.

The government has a great responsibility in preventing FGM/C, in promoting its abandonment and holding those who perpetrate it responsible for inflicting harm on girls and violating the child or women's rights (54,68). Some countries have enacted laws against the practice but these laws are usually not enforced (54).

Legislation against FGM/C

The prohibition of FGM/C has been enacted by 26 countries in Africa and the Middle East but the legislation varies from country to country (22). The law in some countries restrict the practice of FGM/C in totality while some restrict the practice in government health facilities and by medical practitioners, for example in Mauritania (22,69). In most African countries legislation against FGM/C involves all age groups while in some non-African countries like United States and Canada the FGM/C is only illegal among minors (22).

The penalties for violating the legislation against FGM/C also vary between countries. While some penalize the circumcisers only, others penalize the circumciser and those that seek for the procedure as an adult or for the minors and some even include anyone who knows that the procedure has been performed and fails to report it (22).

In some African countries, the ban on FGM/C has expanded over the years; for example Kenya expanded its ban to include adult women and extended restrictions to citizens who commit the crime even outside the country's borders since 2011 (22,70).

Despite all these, FGM/C has not reduced significantly

as expected because most of the legislations are not complemented by measures to influence the cultural and religious expectations of the communities within its comprehensive social context (22). Therefore, legislation should be incorporated into strategies to enhance the elimination of FGM/C.

Related practices

While females (particularly when young) are forced by parents, extended family members and their immediate community to undergo FGM/C in developing countries and which practices are globally condemned, individuals in developed countries are voluntarily engaging in practices leading to physical alterations of their body parts and functions. These are piercing, tattooing, enlargement, cosmetic transplantation among others.

Labioplasty, also called "designer vagina" or "vaginal rejuvenation" or "revirgination" is similarly a related practice to FGM/C. This is a genital procedure done to alter the appearance and improve the genital image based on an individual's satisfaction (68-72). The procedure is carried out in women with absent vaginal passage, intersex conditions, those with physical or psychological discomfort after child birth, advanced age as well as in male-to-female sexual reassignment for the creation of neovagina (71). This is a cosmetic genital surgery done of free will and paid for heavily by clients. When medically indicated for physical or psychological reasons, it is not regarded as FGM/C, but sometimes the procedures are not medically indicated (68,72). The procedure also has similar complications as FGM/C and its safety and effectiveness have not been documented for non-medically indicated reasons (72,73).

Comparison has also been made between male circumcision and FC. Proponents who equate both as being the same argue that they both cause pain and are not medically proven to be beneficial. Those arguing based on their religious beliefs propose that while male circumcision was ordained by the Creator, there is no such documentation of the female variety. Others argue that while male circumcision is done to purify the genitalia, FC is carried out to suppress her sexual urge, a form of discrimination as it were (74).

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