Sapientia Foundation Journal of Education, Sciences and Gender Studies (SFJESGS), Vol.2 No.4 December, 2020; pg. 265 – 290
ISSN: 2734-2522 (Print); ISSN: 2734-2514 (Online)

THE HISTORY, SEXUAL, AND REPRODUCTIVE CONSEQUENCES OF FEMALE GENITAL MUTILATION ON WOMEN: A FOCUS ON SUB-SAHARAN AFRICA

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Abstract

Female genital mutilation/cutting (FGM/C) is a widespread contemporary and societal issue that is associated with severe health and social complications. It is estimated that over 200 million girls and women are living with FGM/C globally, particularly in the Sub-Saharan Africa where the procedure is predominantly practiced. With the use of historical descriptive method, this work will interrogate the inextricably linked sexual and reproductive health consequences of FGM/C on women from the African region. In its arguments, the paper adopted a framework predicated on the theory of culturalism. The research reveals that FGM/C has resulted to several problems such as: sexual and reproductive health problems/concerns (dyspareunia, reduced sexual desire, pleasure, orgasm and satisfaction, obstructed labour, prolonged labour, fistulas, vaginal infections and need for caesarean section), perceived socio-cultural norms and social pressure, pain and fear, inadequate information, rejection and isolation. Women also suffer from both emotional and psychological distresses following their traumatic FGM/C experiences and abandonment by spouses, families, friends and members of the community due to the development of FGM/C complications such as obstetric fistulas. Therefore, the provision of holistic care and comprehensive cultural-sensitive anti-FGM/C interventions is a sine qua non for health practitioners and policy makers respectively in order to meet the needs of the affected population.

Keywords: Human Sexuality, Reproductive Health, Female Genital Mutilation/Cutting, Womanhood, Sub-Saharan Africa.

Introduction

Female Genital Mutilation /Cutting (FGM/C) is an intentional invasive procedure that involves either total or partial removal of the female external genitalia, or other trauma to the female genital organs for non-medical purposes (WHO, 2008). It is a practice commonly carried out on young girls of mainly African and Arabian ethnicity on the basis of cultural, religious and or social beliefs (Momoh, 2017; Arora & Jacobs, 2016). Consequently, FGM/C represents a grossly harmful and abhorrent traditional practice carried out, without merit, on girls and women (WHO, 2016).

At an international level, the practice of FGM/C is illegal in large number of developed countries such as the UK, Australia and North America, and is globally recognized as the violation of the human rights of women and girls (Wadesango et al., 2011). According to the World Health Organization, FGM/C undermines women's right to security, health, freedom from harm and right to life in extreme cases where the procedure result to death (WHO. 2017). Indeed, Berg and Dension (2012) posit that the practice of FGM/C demonstrates the highest degree of gender inequality and discrimination against women.

Based on current evidence, there is a wide variation of the prevalence of FGM/C across and within countries. For example, according to the United Nations International Children's Emergency Fund, over 200 million women and girls are estimated to have undergone different forms of female genital mutilation in 30 countries (UNICEF, 2016). However, it is observed to be predominantly practiced in Africa, most exclusively in the sub-Saharan region (Koski & Heyman, 2017). Indeed, Feldman-Jacobs and Clifton (2010) assert that more than 3 million girls in Africa are at risk of being genitally mutilated annually.

In addition, Creighton and Hodes (2016) highlight that FGM/C is practiced in less than 28 African countries and approximately 98% of women and girls in Somalia, Guinea and Djibouti are mutilated; this contrasts with only 1% of women and girls in Cameroun and Uganda. Balfour et al (2016) further add that the incidence of female genital mutilation is reported to be relatively low in Asia and the Middle East and mainly concentrated in the rural areas. However, a current survey conducted in Indonesia disclosed that approximately 49% of girls under the age of twelve have been forcefully subjected to FGM/C, particularly in the urban areas (57%) compared to the rural region (46%) (Koski & Heyman, 2017).

Disturbingly, and despite the illegality, there has been a significant increase in the incidence of FGM/C in Europe, Australia and Canada which has been strongly associated to migration trends (UNICEF, 2016). Hodes et al (2017) highlight that over 100,000 girls and women are estimated to have undergone genital mutilation in UK and Asia. However, the International Organization for Migration(IOM) assert that integration issues have contributed to the persistent practice of FGM/C amongst migrant populations to distinguish themselves from the receiving society and retaining their cultural identity (Faraca, 2016; Abusharaf, 2013; Thierfelder et al., 2005).

Female Genital Mutilation/Cutting is commonly performed by traditional circumcisers using sharp and unsterile instruments such as blades, scissors, broken glass, rocks and knives without anaesthetics (Sureshkumar et al., 2016). However, medical professionals have also

been implicated in the practice of FGM/C in an attempt to medicalise the act and reduce immediate complications arising from it although there is no evidence that confirms that medicalization reduces the short or long-term complications associated with the procedure (WHO, 2016; Jungari, 2015). Indeed, the United Nations International Children's Emergency Fund stated that in Sudan, Egypt and Kenya, approximately 55%, 77% and 40% of FGM/C cases, respectively, were conducted by healthcare providers (UNICEF, 2013). Although their engagement has been resoundingly condemned by the World Health Organization as acts which frustrate the efforts directed towards the eradication of the practice (WHO, 2016).

FGM/C is mainly classified into four categories: Type 1, clitoridectomy involves the partial or complete removal of the female sex organ (clitoris) and/or the prepuce. Type 2 is the incomplete or total excision of the clitoris and the labia minora, and sometimes with the cutting of the labia majora. Type 3 otherwise known as infibulation involves the joining of both the labia minora and majora, with or withoutcutting the clitoris, thereby leading to the narrowing of the vaginal orifice. Lastly, type 4 constitutes of all other destructive procedures performed on the female genitalia for non-medical reasons such as prickling, scraping and piercing (Population Reference Bureau, 2017). Consequently, damage to these sensitive organs is irreversible and has been associated with severe short and long-term physical, psychological, obstetric, gynaecological and sexual health complications in women and girls. Additionally, the frequency and severity of the complications increases with the degree of cutting performed (Berg et al., 2012; Adam et al., 2010; WHO, 2008. According to Kaplan et al (2011) quantitative study, which explored the health consequences of FGM/C that involved 871 patients showed that female genital mutilation/cutting resulted in a high percentage of health complications such as haemorrhage, infections and anaemia.

Owing to these profound complications arising from FGM/C, on a worldwide scale, there has been a call for the condemnation and elimination of the practice of female genital mutilation/cutting. Moreover, the abandonment of FGM/C is essential in order to achieve goals 3, 4 and 5 of the Millennium Development Goals (MDGs) which is focused on promoting gender equality, improving maternal health and reducing child mortality (Matzopoulos & Bowman, 2016; WHO, 2015). Indeed, Lawani et al (2014) prospective descriptive study highlight the increased obstetric and perinatal complications, such as, postpartum haemorrhage, perineal tears, early neonatal death associated with women who had undergone female genital mutilation/cutting.

Similarly, a WHO prospective study in six African countries involving 28,393 women, revealed that women who had undergone FGM/C had a higher risk of requiring an episiotomy, a caesarean section, developing post-partum haemorrhage and other life-threatening obstetric complications compared to women who had not been mutilated (GSN et al., 2006)

Evidently, the need to address female genital mutilation/cutting has gained momentum and global recognition in terms of the eradication of all unhealthy cultural practices ranging from female genital mutilation to forced and early child marriage by 2030, as evidenced in the "Sustainable Development Goals" (SDGs) (Powell & Mwangi-Powell, 2017; WHO, 2016). Moreover, in the year 2014, the WHO prioritised the development of a standardized evidence-based clinical guidelines on the management of health complications from FGM/C and

training for healthcare professionals in order to combat the growing prevalence (WHO, 2016; Zurynski et al., 2015). These efforts reflect the unwavering commitment of the international community to end this abhorrent practice (UNICEF, 2016). Additionally, most western countries such as the United Kingdom, Australia, United States, Canada, Belgium, Sweden, New Zealand and some African countries such as Kenya, South Africa, Nigeria, Mauritania amongst others have enacted laws that specifically criminalises the practice of FGM/C (UNICEF, 2010). Nevertheless, despite the progress in the eradication of FGM/C, large number of girls in some countries still remain vulnerable of undergoing female genital mutilation as the practice is observedto be deeply rooted in cultural and religious beliefs (Vogt et al., 2016; Wangila, 2015).

Theoretical Framework

The major factor behind the practice of female genital mutilation/cutting is culture, therefore, the paper adopted the theory of culturalism. The theory was developed by Florian Znaniecki in his book Cultural Reality. The theory of culturalism emphasizes the pivotal significance of culture in the conduct of humans (Halas, 2010). In other words, the existence of humans cannot be separated from their cultural practices.

For Znaniecki, culturalism represents an existential and abstract concept that is devoted to banishing the duplicity which suggests that nature and culture are antithetical (Halas, 2010, p. 21). This approach is based on analytical and systematic knowledge. Znaniecki argued that culture cannot be overlooked- as it shapes the way we conceptualize the world as well as the way we think (Dulczewski, 1984, pp. 187-188).

Furthermore, Znaniecki is of the belief that humans lack the capacity to study the complex physical artifacts inherent in the world- except if these artifacts are appreciated through the spectacles of culture (Dulczewski, 1984, p. 189). Generally, culturalism is based on the following assumptions:

- The nature-culture duplicity must be eliminated and thought should be merged with reality;
- Reality is not an ideal and fixed order but is constantly modified through innovative expansion;
- All images of reality are parallel;
- It is totally wrong to separate nature from culture or to subordinate culture to nature; and
- Value is the best possible way to examine reality (Halas, 2010, p. 52).

History and Prevalence of Female Genital Mutilation/Cutting

The origin of female genital mutilation still remains uncertain. Based on its historical origins, the practice of female genital mutilation/cutting has been in existence for over 5000 years ago, have been evidenced in Egyptian mummies (Andro & Lesclingand, 2017; Clarke & Richens, 2016; Berg et al., 2010). In ancient Rome, the labia minora of women slaves were pierced with metal rings to prevent procreation (Knight, 2001). Although in Western countries, FGM is commonly considered to be a foreign practice, however, the act has been reported to be carried out in Germany, France, USA and England in the nineteenth century (Cutner, 1985). Indeed, Kandela (1999) highlighted that in the 19th century, clitoridectomy (a form of FGM/C) was an acceptable practice for the management of sterility, masturbation and epilepsy in Britain.

Different terminologies have been used to describe this practice and vary across regions, cultures, time, ideological perspectives and organizations. It has been previously referred to as 'female circumcision' and 'female genital cutting' (WHO, 2008). Currently, female genital mutilation is a term globally recognised as it best describes the gravity of the morally reprehensible act and distinguishes it from male circumcision (Momoh, 2017; WHO, 2016). However, female genital cutting is preferably used by the United Nations Children Fund (UNICEF) and other organizations involved in community services as it is perceived to be neutral and non-judgemental (Shell-Duncan et al., 2011).

Female genital mutilation/cutting exists in epidemic proportions and consequently remains a global concern as the practice is associated with potentially life-threatening consequences and violates the rights and health of women (Reisel & Creighton, 2015). FGM/C Type II is considered the most practiced form globally, representing approximately 80% of all FGM/C procedures (Berg et al., 2010). According to World Health Organization, over 130 million girls and women are estimated to have undergone a form of FGM/C worldwide and with an incidence of approximately 6000 new cases daily (WHO, 1997).

Statistically, Yoder and Khan (2008) estimated that over 91.5 million girls and women above the age of nine in Africa are living with FGM/C and its consequences with a large number of them from Somalia, Eritea, Sudan, Sierra Leone, Gambia, Ethiopia, Djibouti, Mali and Egypt. A recent survey data reported that the prevalence of female genital mutilation/cutting varies from 5% to 97% amongst the female population (Miller et al., 2005; UNICEF, 2005). The practice of FGM/C cuts across all ethnicity, educational and religious groups as it has been observed amongst Christians, Muslims, Jews and animists (Creighton & Hodes, 2016; Morris, 1999). Evidence suggests that FGM/C is practiced in Oman, India, Saudi Arabia, Malaysia, Australia and in some countries in the Middle East, Asia and South America (Ghadially, 1992; WY, 2012; Al-Hinai, 2014; Ainslie, 2015; Alsibiani & Rouzi, 2010). Moreover, Macfarlane and Dorkenoo (2014) calculate that approximately 137,000 girls and women are living with FGM/C in the England and Wales, and also an estimate of 60,000 girls under the age of 15 are at risk of been mutilated.

The age at which FGM/C is performed differs across countries, but is most often performed on girls during childhood between the age of two and twelve (Van Rossem et al., 2015). However, in some traditions it is carried out during puberty just before wedlock or during childbirth (WHO, 2016). Ironically, despite the pain and other negative health consequences associated with the procedure, women remain the key perpetrators of FGM/C especially the older women as they believe it to be a means of preserving tradition (Hayes, 1975; UNICEF, 2005). However, Mundara (2003) Nigerian based quantitative study involving 500 women aimed at determining the prevalence and distribution of FGM/C in a Nigerian population highlights that the attitude of women towards the practice of female genital mutilation varies considerably and is dependent on their level of education.

Overall, the epidemiological landscape indicates that there has been a progressive decline in the prevalence of FGM/C especially amongst the younger population over the last two decades; however, the pace has been disproportionate as some countries have remained uncooperative (UNICEF, 2016).

Reasons for the Practice of Female Genital Mutilation/Cutting

The justifications for female genital mutilations are multifactorial and have been put forward to rationalize the practice of FGM/C on the basis of culture, religion and social acceptance. Culturally, FGM/C is reported to be carried out in order to preserve a girl's virginity, safeguard her honour and that of her husband's patriarchal heritage or as a means of suppressing sexual desires in girls thus making them less promiscuous (Dawson et al., 2015). The religious dimension for the propagation of FGM/C is highly controversial. Female genital mutilation is observed to be a religious duty practised by Muslims and Christians although there is no evidence in the Koran or Bible that specifically mandates this practice (Efferson et al., 2015). Moreover, Islamic scholars assert that Islam does not stipulate the practice of FGM/C, reiterating that the act is rarely practiced in most Muslim countries such as Pakistan, Saudi Arabia and Iran (Toubia, 1993; Momoh, 2017). In addition, the Muslim Council of Britain (MCB) in 2014 publicly condemned the practice of FGM/C and clearly stated that the Islamic teachings do not support the act (MCB, 2014).

Societally, FGM/C is a ritual performed on girls to initiate them into adulthood after which they are considered pure and desirable for marriage (WHO, 2016). This appears essential for their societal recognition and acceptance. Other reasons for FGM/C include financial benefits, preservation of ethnic identity and maintenance of hygiene (Biglu et al., 2016).
Against this backdrop, Berg and Underland (2014) suggest that understanding the mechanisms underpinning the practice of FGM/C is very crucial as it helps in planning prevention strategies that are sensitive and tailored to the needs of the people. However, in scoping the background literature, it is evident that culture is a powerful factor which contributes immensely to the persistent practice of female genital mutilation.

Consequences of Female Genital Mutilation/Cutting

The external female genitalia consist of the labia minora, labia majora, clitoris, glands of Bartholin, vestibular bulbs and mons pubis (King et al., 2015). These organs are collectively referred to as the vulva which plays significant physiological, sexual and reproductive functions (Puppo & Puppo, 2015). However, female genital mutilation causes serious damage to the external female genitalia which can potentially lead to severe health consequences in women.

Sexual and Reproductive Health Consequences

The clitoris otherwise known as the female erogenous organ is a small protrusion found between the labia minora (Pauls, 2015). The clitoris is highly innervated, making it very sensitive and capable of erection when sexually stimulated which corresponds to the penis in males (Vaccaro et al., 2014; Puppo, 2013; Ostrzenski, 2012). Moreover, Janini et al (2012) highlight that sexual pleasure and satisfaction is hugely dependent on the integrity and sensitivity of the clitoris and labia minora. As previously stated, FGM/C involves the total or partial removal of a woman's genital parts thus damage to this highly sensitive area including the surrounding tissue and nerves could undoubtedly result to sexual and reproductive dysfunctions (Krissi et al., 2016). Additionally, Yassin et al (2018) posit that FGM/C procedure leads to the formation of scar tissues over the vulva. Consequently, friction of the scarred nervous tissues at the excised region could cause dyspareunia during intercourse (Berg et al., 2014). Although, Tiefer (2018) identified that human sexuality is a complex communication

between series of biochemical and neurophysiological mechanisms, and is also affected by family structure and sociocultural dynamics.

A case-control study involving 73 female genital mutilated women and 37 non-FGM/C as a control group, directed at investigating the sexual quality of life revealed that women who had undergone FGM/C experienced reduced sexual quality of life compared to those who have not (Andersson et al., 2012). However, the type of female genital mutilation procedure undergone by women in the experimental group was self-reported which was not verified unlike in similar studies (Kaplan et al., 2013; Ibrahim et al., 2012). Thus, the findings of the study may be questionable and unreliable due to recall bias (Althubaiti, 2016).

Similarly, Alsibiani and Rouzi (2010) prospective case-control study of 260 sexually active women (130 with FGM/C and the other half without FGM) aimed at investigating the sexual functioning of women with FGM/C reported that the mutilated women experienced dyspareunia, reduced sexual desire, arousal and satisfaction. In contrast, a cross-sectional study on the sexual functioning in women (n=30) 15 with FGM/C and 15 women without FGM/C as a control group found no variation in their sexual drive, orgasm and satisfaction (Abdulcadir et al., 2016). However, the recruitment process was not clearly stated.

Further, Rodriguez et al (2016) posit that FGM/C heightens the risk of gynaecological and obstetric complications such as obstetric lacerations and haemorrhage. These risks tend to be greater with the more invasive forms of the procedure which may be attributed to reduced elasticity of the perineum due to scar formation (Berg et al., 2014). This conclusion is consistent with the outcome of Berg and Underland (2013)

study which showed an increased rate of scar tissue formation, perineal tear, prolonged labour, episiotomies and caesarean sections among women with FGM/C. However, Balachandran et al (2018) retrospective case-control study found no difference in the rates of obstetric lacerations and haemorrhage between women with and without FGM/C although a significant increase in episiotomies in women with FGM/C was noted.

According to the World Health Organization, FGM/C is likely to interfere with some procedures including cytology testing, gynaecological examinations, placement of intrauterine device (IUD) due to the structural damage done to the female genitalia especially in FGM/C type 3 (WHO, 2016). They further add that female genital mutilation/cutting increases the risk of HIV, Hepatitis B and C transmission due to the unsterile and shared equipment used during the procedure (Carpenter, 2010).

Physiological/Psychological Consequences

Several physiological complications have been associated with female genital mutilation/cutting which may be acute or chronic. Indeed, Berg et al (2014) systematic review of the immediate health consequences of female genital mutilation/cutting involving 57 studies revealed that FGM/C procedure result to immediate life-threatening physical complications such as haemorrhage, pain, shock, pelvic inflammatory disease (PID) and urinary retention. They further added that the long-term physical consequences include but not limited to chronic pain, infections, keloid formation, abscesses, tetanus, anaemia and death in extreme cases. Moreover, Amin et al (2013) assert that the alteration of the female

genitalia from its natural anatomical form could potentially result to both structural and physiological damages such as trauma to the surrounding organs, tissues and nerves.
Additionally, evidences suggest that FGM/C is a traumatic procedure that may cause serious psychological disturbances such as phobias, depression and panic disorders (Kizihan, 2011; Reisel & Creighton, 2015). Indeed, Vloeberghs et al (2011) study that comprised of 66 mutilated women focused on exploring the psychosocial impact of FGM/C found that women who had undergone FGM/C suffered from depression, anxiety disorders, post-traumatic stress disorders (PTSD), recurrent nightmares, low self-esteem and feeling of worthlessness. However, the data collection process was not explicitly discussed. These negative effects are further aggravated by the physical consequences of the procedure and appear to be more severe among women who were coerced to undergo the procedure compared to those who underwent it voluntarily (Mulongo et al., 2014). Conversely, some women living with FGM/C have reported feeling complete and proud after the procedure (Chalmers & Hashi, 2000).

Social/Economic Consequences
FGM/C is regarded as a social responsibility in most practicing societies (Momoh, 2017). In effect, girls and families comply to the practice to gain social recognition (UNICEF, 2013). Conversely, non-compliance by families can result in stigmatization, loss of social positions and social exclusion (Vogt et al., 2016; Cappon et al., 2015).

Beyond the negative health consequences associated with FGM/C, female genital mutilation also poses great financial burden on families and the healthcare system. It is estimated that for every 15-year old mutilated girl, an average of $3.7million will be spent in the management of FGM/C-related obstetric complications over the course of her lifetime (Bishai et al., 2010; Adam et al., 2010). Considering that the obstetric complications make up for just a fraction of the entire sequelae of FGM/C and their financial costs is only a portion of the total expenditures associated with FGM/C, it is obvious that the management of FGM/C cases is financially intensive (Gemignani & Wodon, 2015).

Perceived Socio-Cultural Norms and Pressure
Following the synthesis across the four studies that was conducted (see table 1, 2, & 3), the interplay of social-cultural norms and social pressure were observed to be key factors influencing the practice of female genital mutilation/cutting. FGM/C was considered as a 'rite of passage' and a crucial factor in legitimizing the status of women and their marriageability. This is demonstrated in participant's comments:

"I was very young when they did it[FGM/C] to me and back home most girls must do it. If you don't do it, people laugh at you and you will not find someone to marry you." (Mwanri & Gatwiri, 2017).

"You know in Samburu, it is expected that you will do this thing [FGM/C]. They took me early in the morning and poured really cold water on me. It was so painful but I was not allowed to scream." (Mwanri & Gatwirir, 2017).

Additionally, it was also noted that women who had undergone FGM/C were celebrated and perceived to be 'normal'. However, women without FGM/C have less chance of getting

married and face palpable societal pressure such as bullying and sanctions. Participants comments representative of this are:

"Though it's not like before, yet people will say bad things about a girl who is untouched. They will say things like "she is open" or that she is not a virgin." (Fried et al., 2013).

"Such a girl may meet insults if she is known not to be circumcised and that will have an impact on her future marriage. Some men might not like to marry an uncircumcised girl" (Fried et al., 2013).

However, despite the societal pressure and expectations, some participants perceived female genital mutilation to be harmful and have no intentions of allowing their daughters to undergo the procedure. One participant's response was:

"I do not expect I will ever circumcise my daughter. I do not care if she can find a husband or not. I do not want her to have my experience" (Fried et al., 2013).

Sexual and Obstetric Experiences/Concerns

During the data synthesis, the sexual and reproductive health experiences and concerns of women who had undergone female genital mutilation are themes that were evident. The majority of participants with FGM/C reported negative sexual experiences including painful penetration, reduced sexual pleasure/desire and rarely or never experiencing orgasms. One participant explained that:

"it's impossible to feel anything [meaning sexual pleasure] when circumcised…That is why Kisii men are not marrying fellow Kisii women because they say that we are like stones. They want to go to women who get turned on just by a simple touch." (Villani et al., 2016).

However, some of these women believed that sexual experiences vary depending on the type of female genital mutilation performed. A typical example of one participant comment:

"It is evident, infibulation plays a role on pleasure, but it also depends on persons and on which kind of infibulation she has undergone. In Somalia, there are different types of infibulation. For example, girls who have undergone a type sunna like these last years, that's the majority…and they look by their own for men! They have a lot of desire. But the infibulation that I have undergone, there's no desire, we don't look for nothing. If the man comes, we feel that desire but anything else." (Villani et al., 2016).

Conversely, some of the participants commented that the FGM/C procedure tames their sexuality, thus provides them with some form of sexual control which is beneficial to their sexual life.

Additionally, the women reported to have experienced several reproductive health issues including development of fistulas, prolonged labour, stillbirths, vaginal infections and dysmenorrhoea. However, most of the participants perceived that these problems are FGM/C-related:

"When they cut me, my body was never the same again. I really struggled to push the baby that gave me this problem [fistula]. It almost killed me." (Mwanri & Gatwiri, 2017).

"The doctor said that if women can delay getting children and not get cut [FGM/C] this kind of problem can be avoided. The doctors said that if I had waited having children and not been cut, I would not have the problems I have now." (Mwanri & Gatwiri, 2017).

"I do not see any advantages with Pharaonic circumcision … Your genitals are sliced and stitched and the menses is blocked and very painful. All kinds of ills follow." (Fried et al., 2013).

"… during the process of giving birth, the place between my anus and vagina tore open (fistula)." (Fried et al., 2013).
"I used to have very painful menstruations. My periods did not come out normally as the opening was so narrow." (Fried et al., 2013)
"when I developed this problem [fistula] and came to this hospital, one of the nurses said that this thing [FGM/C] and the way it was done, had contributed to me having this urine problem." (Mwanri & Gatwiri, 2017).

On the contrary, despite these women's experiences and their perceptions that some of these health complications are FGM-related, some of them still intend to carry out the procedure on their daughters.

Pain and Fear
The emotions 'pain and fear' were themes that appeared to be overlapping across the four studies. All the women described female genital mutilation/cutting to be a frightening and painful experience. These are some of the participants' comments:

"The worst was the pain…because when you need to go pee or when you have your period, that was screaming, we all waited standing." (Villani et al., 2016).

"I will never forget that night. It was cold and they held me down and did what they did. First, they poured really cold milk on me. They said that would help with the pain. It took me a long time to heal. Going to ease myself was so hard." (Mwanri & Gatwiri, 2017).

"It was very difficult because it doesn't work the first time and they had to do it four times. On several occasions…it was four times. In each region, there's people who are stricter than others…in Mogadishu it's easier, but in the country, it's very hard. They want to be sure that they have well done and so then they did several times to make sure. There are very bad memories for me…four times. I cried, they bound me; they tied my feet, my hands. I was restless." (Villani et al., 2016)."

The women also commented on their convalescent periods, during which they experienced the most pain.

"The worst was the days after when it starts to…when scars start to heal. Then we start to feel the real pain." (Villani et al., 2016).

"I stayed sixty days in the house, without getting out, without seeing people. I needed one month to be good and standing up." (Villani et al., 2016).
"After one week and a half or two, we began to walk, but we always had our legs tied: we made small steps." (Villani et al., 2016)

However, after subsequent years that have passed, it appears that some of the women have not moved past the pain and fear. They voiced that some of their life moments are still embedded in fear and anxiety, especially moments preceding childbirth and intercourse due to their traumatic FGM/C experiences. One of the participant's comment regarding this:

"This is super rough for excised women…I mean the moment of the delivery. Because it is a part of your body, which was always natural, and that has been stitched, closed and so then it makes a double pain when you give birth." (Villani et al., 2016).

Rejection and Isolation
Although female genital mutilation/cutting was identified to be perceived a social-cultural norm, however, the rejection and isolation suffered by women when they develop potential FGM/C-related health problems were also noted in all the four studies. Some of the participants comments indicative of that are:

"….. Especially when the urine passes it burns you so much you turn completely red. So, every time I was sick people would say that I am lying or that am pretending. When you say or do something they tell you to go away with your urine or your faeces. My husband would tell me that I would forever leak urine that it would never go away. It would make feel like I wanted to die." (Mwanri & Gatwiri, 2017).

"I did not know the way they cut[FGM/C] me had anything to do with this urine problem, but when I came here [Gynocare clinic, Eldoret] the nurse told me that I had a big scar and that it might have prevented my children from coming out properly. I am childless now and my husband left me when he saw that this problem was not going away." (Mwanri & Gatwiri, 2017).

However, the participants also revealed that women without FGM/C were stigmatized and avoided including their families.

Inadequate Information
Lack of information and knowledge was the analytical theme that became apparent after synthesizing data from the four studies. The participants expressed little or no knowledge of female genital mutilation and its potential health consequences. However, most of the participants perceived female genital mutilation (Type 4) otherwise referred to as 'Sunna' to be safe and free of health problems. Some of the participants comments that demonstrated this are:

"…there is not much difference between the untouched and the Sunna circumcised girls since neither of them is stitched. Only a small cut at the top is the difference between those who are not touched and those who had the Sunna." (Fried et al., 2013).

"...the reason why I don't tell people I have this condition [fistula] is because most of them will think I am cursed, because not many know about this illness." (Mwanri & Gatwiri, 2017).

"When I was circumcised in the old way, most people thought it was good and I did not see any problems myself. But today things have changed and people are doing the Sunna type. Sunna is better and has no health-related problems and our religion has told us to do it…" (Fried et al., 2013).

In addition, the participants also commented on how lack of information and knowledge as well as shame prevented them from seeking help for their FGM/C-related health concerns:

"I used to have very painful menses when I was a girl and before I got married I used to vomit. The doctor suggested that I be opened, but I did not do it because it was shameful to be opened those days." (Fried et al., 2013).

"I had been hiding my problem from everybody for quite a long time. I was ashamed to tell anybody. It was my secret … I was not married when the cyst appeared. Later, I became too sick and was unable to walk, yet still ashamed until I decided to seek help." (Fried et al., 2013).

In conclusion, this chapter has provided a succinct presentation of the review findings. Details on the search and selection process was given, followed by a clear discussion of the thematic analysis process. Finally, specific details of the six analytical themes generated from the synthesis were presented.

Interventions to reduce the Prevalence of FGM/C

In terms of proactive prevention, several strategies geared towards the elimination of FGM/C have been implemented. These approaches are based on human rights and legal frameworks, training healthcare providers and the integration of comprehensive social development mechanisms (Denison et al., 2011).

Legislation

The use of law is one of the main strategies employed in the eradication of FGM/C. Johansen et al (2013) highlight that most western countries, including United Kingdom, Australia, Norway, Canada, United States, New Zealand and Sweden, have promulgated anti-FGM/C laws to end the practice among immigrant populations from regions where FGM/C is prevalent.

Similarly, in Africa some countries like Central African Republic, Cote d'Ivoire, Chad, Guinea, Eritrea, Burkina Faso, Djibouti, Togo, Ghana, United Republic of Tanzania, Mauritania, Benin, Ethiopia, Senegal, Kenya, Egypt and Niger have instituted laws prohibiting the practice of FGM/C (Muthumbi et al., 2015). However, enforcement varies across countries and is unquestionably challenging due to bribery, unawareness of anti-FGM/C laws by law enforcement agents and the reluctance of the "victims" to publicly testify against their family members (Shell-Duncan et al., 2013).

Conversely, Okonfua et al (2002) suggest that the presence of legislation against FGM/C may result to the concealment of the practice in order to avoid being litigated and may also facilitate the migration of families from countries where the practice is illegal to other countries where it is permissible. Nevertheless, the role of legislation in the elimination of FGM/C is still under-researched and not totally understood (UNICEF, 2010).

Community Empowerment/Training of Healthcare Providers

Community sensitization and education against FGM/C through public campaigns, outreach programmes, radio and television are great intervention strategies adopted for the eradication of the practice (McChesney, 2015). Indeed, Galukande et al (2015) observational study revealed that this approach promotes learning and understanding of the negative consequences of the FGM/C, women's sexual and reproductive health rights.

Obviously, the training of healthcare providers is a necessary intervention due to the increased involvement of health practitioners in the medicalization of FGM/C (WHO, 2016). Moreover, healthcare practitioners can serve as change agents in the prevention and abandonment of FGM/C practice (WHO, 2008). This strategy is aimed at improving healthcare professionals' FGM/C knowledge-base, as well as their clinical skills in the management of potential complications resulting from the procedure (Abdulcadir et al., 2012; Balfour et al., 2016; WHO, 2016). However, Berg and Denison (2012) systematic review that included 8 studies with 7,042 participants, aimed at evaluating interventions designed to prevent FGM/C showed that training of health personnel is not effective in curbing FGM/C.

Consequently, as recommended by Abathun et al (2016) the adoption of a coordinated combined strategy is therefore crucial to ensure a total and sustainable abandonment of female genital mutilation is achieved since the use of a single intervention has proven to be less effective.

A Coordinated Combined Strategy

This preventive approach is holistic and involves the integration of the different FGM/C intervention strategies directed towards the eradication of female genital mutilation. These comprise of community dialogue and mobilization, women and health workers empowerment, collaboration with the government, religious institutions and local authorities, legislation, monitoring and evaluation. However, lack of sufficient fund remains the major setback in the utilization of this strategy (UNFPA, 2009).

Implications for Policy and Practice

The findings of this review provided an in-depth information on the FGM/C-related sexual and reproductive health issues experienced by women with female genital mutilation/cutting. This can be used by policy makers and nurse practitioners in developing strategic FGM/C policies and interventions which can help in the reduction and/or abandonment of female genital mutilation.

Policy implications: There is a need for a multifaceted community based interventions that involves health education, legislation, community mobilization, monitoring and evaluation (Muteshi et al., 2016). This mechanism would help in building strong frameworks that

addresses the social conventions of female genital mutilation (Johansen et al., 2013) which is necessary for the complete eradication of the practice.
Considering that female genital mutilation/cutting is deeply-rooted in culture and mostly practised in patriarchal communities, it is important that anti-FGM/C interventions strategies are culturally-sensitive and particularly involving men throughout the entire process, from planning to implementation (Varol et al., 2015). This will help in addressing the gender and socio-cultural issues facilitating the practice.

Collaboration with relevant stakeholders such as religious organisations, traditional leaders, non-governmental organisations (NGOs), educational institutions, health practitioners, traditional circumcisers, women with FGM/C and their family members, public and private sector organisations is also vital in order to achieve long lasting and sustainable behavioural changes (WHO, 2016; Berg & Denison, 2012).

Implication for practice: This review provided insight on the various sexual and reproductive health problems suffered by women with female genital mutilation/cutting. It is therefore important that health practitioners strive to provide holistic care that is patient-centred in order to meet the enduring needs of the affected population.

The findings of this review also revealed that most of the FGM/C-related sexual and reproductive health problems experienced by the women have not been previously recognized. Most of the participants stated that it was their first time opening up about their FGM/C experiences most especially their sexual issues and concerns. Hence, there is need for the provision of specialized health care services for women living with female genital mutilation such as sexual counselling and rehabilitative care (Dawson et al., 2015; Liebling et al., 2012). This would help in the provision of individualized care and also create room for open and non-judgemental discussions of FGM/C and its related health concerns (Amasanti et al., 2016; Galukande et al., 2015)

Additionally, advocacy against female genital mutilation through robust FGM/C education and dissemination of anti-FGM/C information that strongly emphasizes on the risks and consequences of the practice should be intensified. This invariably would help empower women in making informed decisions regarding female genital mutilation and other sexual and reproductive health issues. It would also help in increasing the awareness of FGM/C-related health consequences which is a necessary step in the abandonment process (Johansen et al., 2013).

Furthermore, there is an immense need for intercultural communication training for nurse practitioners to enhance the provision of culturally competent care to women with female genital mutilation (del Pino et al., 2013; Purnell, 2012).

Conclusion

Unquestionably, the findings of this SLR provides contemporary understanding to the impact of female genital mutilation on the intrinsically linked issues of both sexual and reproductive health which would help nurse practitioners in planning holistic care approaches to meet the needs of the affected population particularly the sexual and reproductive health needs. Additionally, it would also be helpful to policy makers in planning a comprehensive and

effective FGM/C intervention programmes. However, it is paramount for the social and cultural contexts surrounding the practice of female genital mutilation to be fully understood and addressed when planning and/or implementing any anti-FGM/C intervention strategy (Odukogbe et al., 2017; Gallukande et al., 2015).

Selected Studies

The details of the four studies selected for this research are provided in the table below:

Table 1: Summary of Selected Studies

Study Number	Citation References
1	Mwanri, L. and Gatwiri, G.J., 2017. Injured bodies, damaged lives: experiences and narratives of Kenyan women with obstetric fistula and Female Genital Mutilation/Cutting. Reproductive health, 14(1), p.38.
2	Esho, T., 2012. An exploration of the psycho-sexual experiences of women who have undergone female genital cutting: a case of the Maasai in Kenya. Facts, views & vision in ObGyn, 4(2), p.121.
3	Villlani, M., Griffin, J.L. and Bodenmann, P., 2016. In their own words: the health and sexuality of immigrant women with infibulation living in Switzerland. Social Sciences, 5(4), p.71.
4	Fried, S., Mahmoud Warsame, A., Berggren, V., Isman, E. and Johansson, A., 2013. Outpatients' perspectives on problems and needs related to female genital mutilation/cutting: a qualitative study from Somaliland. Obstetrics and gynecology international, 2013.

Table 2: Summary of included studies characteristics

Author, Title, Aim of study/Country	Study Design	Sample Population	Type of FGM/C	Data Collection Method/Process	Data Analysis Method	CASP Score
Mwaniri and Gatwiri (2017) Injured bodies, damaged lives: experiences and narratives of Kenyan women with obstetric fistula and female genital mutilation/cutting. **Aim** To explore women's experiences on the development of	`	**Recruitment** Women waiting to undergo surgical fistula repair at Kenyatta National Hospital in Nairobi and Gynocare centre in Eldoret, Kenya **Sampling Method** Purposive method **Demographics** 30 Black Kenyan women living with vesico- and/or recto-vaginal fistula	Type 3	**Face-to-face, semi-structured, open-ended interviews** **Language used:** Swahili (Kenya native language) Use of a trained Black Kenyan African female translator Duration: 1 hour **Venue**	**Framework Analysis** Analysed by 2 researchers	**18/20**

obstetric fistula post-FGM procedure. **Kenya**		9 women had undergone FGM/C 21 Non-FGM/C women Must be in a treatment facility seeking treatment for fistula **Age:** 18 - 68 years Fluent in Swahili (Kenya national language). **Marital Status**: married, divorced, separated, widowed and single **No. of children**: 0-11 children (Alive) and average of 8 children dead **Ages of excision:** **Educational backgrounds**: different levels of education **Profession/job:** Not provided **Socio-economic class:** low		A private room in the treatment facilities or outside in a quiet garden All interviews were audio-recorded and data files password protected Consent gained		
Esho (2012) An exploration of the psycho-sexual experiences of women who have undergone female genital cutting: a case of the Maasai in Kenya **Aim** To explore the psycho –sexual experiences of Maasai women who have undergone female genital mutilation **Kenya**	**Qualitative exploratory**	**Recruitment** Women who had undergone female genital mutilation and men from Oloolongoi, Narok North District in Narok County, Kenya **Sampling method** Purposive sampling **Demographic** 28 FGM/C women **Ages**:15-80 years **Educational backgrounds**: different levels of education **Profession/Job**: Mixed ranging from Teachers, farmers, housewives, traders, traditional birth attendants, circumcisers to unemployed	Type 2	**Individual interviews and Focused group discussions** **Language used:** Swahili (Maasai native language) and English Use of trained female translators Individual open-ended questions were administered **Duration:** 25-60 minutes for individual interviews and 1-3 hours for focus group discussions **Venue:** not mentioned All interviews were audio-recorded	**Thematic analysis** Analysed with the aid of MAXQDA-an electronic analytical tool	**19/20**
Villani et al (2016) In their own words: The health and sexuality of immigrant women	**Qualitative exploratory**		Type 3	Consent gained **Semi-structured interview using a structured**	**Content analysis**	**18/20**

with infibulation living in Switzerland **Aim** To investigate the sexual health of immigrant women living with female genital mutilation **Switzerland**		**Recruitment** Women with female genital mutilation from the Sub-Saharan African region visiting the department of gynaecology and obstetrics in a university hospital in Switzerland **Sampling method** Purposive method **Demographics** Total of 8 women with Female genital mutilation (7 from Somalia and 1 from Ivory Coast) **Ages**:23-38 years **Marital status:** married, divorced and single **Profession/Job:** Mixed ranging from food service, healthcare assistant, interpreter to unemployed **Educational backgrounds**: Different level of education ranging from tertiary level to nil education **No. of children**: 1-3 children **Ages at excision** 4-10 years old		**questionnaire and Individual open-ended interviews** **Language used:** English Use of specially trained female interpreters Duration: Not specified Venue: The university hospital All interviews were audio-recorded Consent gained		
Fried et al (2013) Outpatients' perspectives on problems and needs related to female genital mutilation/cutting: A qualitative study from Somaliland **Aim** To explore female outpatients' perspectives on female genital mutilation/cutting and related health problems **Somalia**	**Qualitative exploratory**	**Recruitment** Women with female genital mutilation seeking care at the Network Against Female genital mutilation In Somaliland (NAFIS) support centre **Sampling method** Purposive method **Demographics** 7 women with female genital mutilation **Ages:**20-40 years **Marital status:** Married, widowed and single **Educational backgrounds:** Different educational level ranging from primary education to nil education	Type 3	**Semi-structured interview using a prepared semi-structured interview question guide** **Individual open-ended interview** **Language used:** Somali Use of a trained female Somali social scientist **Duration:** 1 hour **Venue:** NAFIS support centre counselling room in the maternity clinic	Content Analysis Data analysed by 5 researchers	**17/20**

		Profession/Job: Mixed ranging from Sales woman to unemployed **No. of children**: 1-4 living children		All interviews were audio-recorded		

Table 3: Summary of extracted themes and original findings

Study	Main Findings	Main Themes/Categories	Sub Themes/Categories
Mwaniri and Gatwiri (2017) Framework analysis	Female genital mutilation/cutting may result in sexual and obstetric consequences such as vesico-vaginal/recto fistula, prolonged labour, dysmenorrhoea, still birth, infections and reduced sexual pleasure Women with FGM/C suffer from rejection and isolation following the development of obstetric fistula- a complication of female genital mutilation Women are not aware of the complications of female genital mutilation The practice of female genital mutilation/cutting is mainly influenced by culture	Fear Isolation & Rejection Factors influencing the practice of female genital mutilation/cutting	– – Lack of knowledge Culture Social pressure and expectations
Esho (2012) Thematic analysis	Culture, through FGM/C informs collective and individual sexuality and its expressions/experiences Women believe that female genital mutilation/cutting enhances the quality of sex as it reduces sexual desire which necessitates longer foreplays.	Factors facilitating FGM/C practice Perceived benefits of female genital mutilation/cutting Change of practice and attitude	Culture Social identity & acceptance Sexual autonomy Positive self-image Low key celebrations

Villani et al (2016) Content analysis	Social context and social status have a big impact on how women understand and remember their FGM/C experiences Women with FGM/C experienced different obstetric and sexual health problems	Fear Perceived social norms and expectations Sexual/obstetric concerns & views Lack of knowledge	Not provided
Fried et al (2013) Content analysis	Women experienced FGM-related health problems Most women believed that female genital mutilation type 4 (Suuna) is free of health risks Women expressed strong disapproval for female genital mutilation (type 3) despite having undergone the procedure Women had a need for more information and education Fear of facing social sanctions if not genitally mutilated	Factors facilitating and inhibiting care seeking Change of practice & attitudes Social pressure Views on different types of female genital mutilation	Accessibility Social support Shame Lack of knowledge Poverty Increased openness Reduced marriageability Bullying –

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APPENDIX 1: CLASSFIFICATION OF FEMALE GENITAL MUTILATION (WHO, 2016)