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Short Report

The impact of pharaonic female genital mutilation on sexuality: two cases from Sudan highlighting the need for widespread dissemination of sexual and reproductive health education in Africa

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Abstract

It is well documented that female genital mutilation (FGM) can have numerous physical and psychosocial consequences. The increased awareness about FGM and its impact on female health over the past few decades has led to a ban on FGM in many countries, however, this has yet to translate into measurable changes in prevalence. Efforts to enforce legislation have been unsuccessful in part because the general public lacks information about the negative consequences of FGM. In this report we present two cases of sexual difficulties as a result of FGM from Sudan, where the most severe form of FGM is still being practiced. During an interview about infertility, these two women volunteered information about how FGM has affected their sexuality. The lack of information about the impact of FGM on sexuality reflected in these cases, highlighted the significant need for widespread dissemination of sexual and reproductive health education in Africa.

Keywords: Female genital mutilation, pharaonic, Female genital mutilation type III, sexuality, sexual education and reproductive health.

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Introduction

Female Genital Mutilation overview:

Female Genital Mutilation (FGM), is practiced in over 27 African countries and some Asian regions¹⁻², with the highest reported rates in Somalia (98%), Egypt (91%) and Sudan (88%)². Type I and II are milder forms of the practice, while Type III, also known as pharaonic or infibulation is more severe and is mostly practiced in north-eastern Africa, predominantly in Djibouti, Eritrea, Ethiopia, Somalia and Sudan³. The World Health Organization (WHO) defines Type III FGM, as “the narrowing of the vaginal opening through the creation of a covering seal”⁴. During the procedure, the covering seal is formed by cutting and moving the labia (inner or outer), with or without the clitoris. The procedure can be done with or without clitoridectomy (removal of the clitoral hood and glans)⁴. It is important to note that a woman who has undergone infibulation will require defibulation for childbirth (incision to the vulva to open the vagina) and re-infibulation post birth (re-suturing of the vulvar opening). However, practitioners should be aware that although women may request re-infibulation for cultural reasons, it is illegal in many parts of the world, including the UK.

The practice of FGM may have stemmed from a patriarchal structure of social control of sexuality and fertility and women are the primary social group to suffer from it. However, it also appears that women are the perpetrators of the practice². Social pressure from extended family and society, living in rural areas, being uneducated, and having undergone FGM themselves may be factors affecting why mothers continue to cut their daughters⁵. Attitudes that perpetuate the practice include the idea that FGM preserves purity and cleanliness and the belief among some women that it improves sexual pleasure for their husbands⁵.

The impact of FGM on sexual and reproductive health:

The effect of FGM on reproduction and sexuality has been demonstrated quantitatively⁶⁻⁸. Long-term consequences include labour complications like post-partum haemorrhage, difficult delivery, emergency Caesarean section, pre-labour foetal death and still births, while the most serious short-term consequences included haemorrhage and death⁶⁻⁸. Sexual consequences such as reduced sexual desire, arousal and satisfaction, lack of orgasm, reduced lubrication, painful sexual intercourse and overall reduced quality of sexual life, have also been reported⁶⁻⁷.

Although, most clinicians and healthcare experts know the serious obstetric complications (i.e., post-partum haemorrhage and pre-labour foetal death)⁶⁻⁸, they are ill-equipped to address the sexual side-effects partly because of the inconsistency of available data on how FGM impacts sexuality. The inconsistency in the published data could be the result of weak methodology due to the sensitive nature of the topic and the varied ways of defining the different forms of FGM⁷⁻⁸. The trustworthiness of self-report regarding sexual topics can be questionable because women might be hesitant to report sexual difficulties due to shame, inadequacy and in some cases even misinformation, leading to distorted data. Several qualitative studies from the Middle East and Africa have reported the negative impact of FGM on sexuality⁹⁻¹². However, issues of self-disclosure and wanting to present ‘normality’ might be at play when participants are asked directly. In the current report, these two cases illustrating sexual consequences of Type III FGM in Sudan are particularly interesting because the women were not asked about the impact of FGM on their

*Text in brackets within a quote is added by the interviewer to explain the quote.

sexuality, they volunteered this information in an interview about infertility, increasing the trustworthiness of the information.

Cross sectional fertility study in Sudan

We recently conducted a cross sectional study in Sudan using qualitative interviews on risk factors for infertility¹³. Ethical approval for the project was sought and provided by Cardiff University and The University of Khartoum. The participants were recruited from a fertility clinic in Khartoum, Sudan and all were infertile. The interviews were conducted by RRB, a Sudanese female health psychologist. During the interviews, women were asked if they had undergone FGM which triggered two participants to spontaneously report their experiences regarding the impact of FGM on their sexuality. This was remarkable given that this topic is taboo, because it combines two issues that Sudanese women are cautious to discuss, namely sexuality and FGM, hence it provided an opportunity for insight.

Case 1:

A 43-year-old woman, married for 14 years, presented for secondary infertility. At the end of the interview, after being debriefed about the study, the interviewer asked if the participant had any more questions, to which the participant spontaneously began to discuss her lack of sexual satisfaction:

“there’s this one thing that has affected my life the most. Like a teacher of mine once said, if there was a way to get an implant, I would get one [anatomically correct genitalia]. Honestly, I’m suffering from the pharaonic cutting. You know in pharaonic cutting, there’s nothing, do you understand me? I don’t feel like other women, I don’t feel comfortable and stuff...I’m convinced that this [FGM] has had an impact on me! I won’t lie to you, it has an effect, you feel like you are cold [sexual frigidity]. This coldness comes, for no reason, not from you, they took your stuff [genitalia]. They tell you it’s from the brain [sexual arousal], the brain sends a signal to the stomach that you are full, but how can it send a signal, where to send it? There’s nothing there [no genitalia to receive the signal of sexual arousal from the brain]. People would have trained themselves, if it was from the brain. This is something [the genitals] God put there, did he just put it there for nothing? And when I read about the nerve endings that are there, more than the rest of the body, when you just take it all away, what does that mean and when you close it up like that...I mean people like us, how can we treat ourselves? without surgery, some people say they take pills, like Viagra for women, but it [the pill] is supposed to go and work on this organ, but the organ is not there! Wouldn’t you feel that was a problem?”*

This woman was visibly very upset while explaining her sexual difficulties and she was unsure of what was ‘normal’ and what was a consequence of the FGM with regards to her sexuality. Her case demonstrated the sexual dysfunction, the suffering and the frustration that can occur as a result of FGM, especially the most severe form, pharaonic. The case also demonstrated the impact on self-understanding of sexuality and the misalignment between the biological and experiential understanding, which led to a need to validate her perception.

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Case 2:

A 38-year-old educator from Darfur, presented at the fertility clinic for primary infertility. She had been married three years but had not been cohabitated with her husband for longer than a few weeks each year because her husband lives far away. After being asked whether she had undergone FGM, the patient asked the interviewer about sexual intercourse and seemed very perplexed by the physical aspects of intercourse:

“when we are laying together [implying sexual intimacy], you know because I have pharaonic [FGM] sometimes it goes in and other times it doesn’t. I mean when it is big, why does it get big? When it gets big it can’t go in, but when it’s small it can go in. You see the hole [vaginal opening] is this big [indicating ~1 cm with her fingers].”

The interviewer discovered that the participant had not discussed this with her doctor, a midwife or nurse nor had she been examined by any medical professional despite having been in treatment for over a year, which shows a lack of adherence to WHO guidelines for the management of infertility¹⁴. The fact that this woman had been ‘seen’ by medical professionals none of whom had questioned whether intercourse had occurred or physically examined her shows how taboo these topics can be and how even a physician might be reluctant to ask such questions. On the other hand, it might have been the case that she reported that intercourse occurred but her complete lack of knowledge regarding basics of sexual intercourse might have mislead the doctors. This conversation indicated the participant’s lack of knowledge about basic sexual functioning and the difficulties of intercourse with pharaonic FGM. It also demonstrated that the initiation of intercourse for the first time for women who have undergone Type III FGM requires that the women and men have knowledge of the anatomical distortion that the procedure has caused, and implications for sexual function and fertility.

Implications

These illustrative cases demonstrated the sexual and reproductive dysfunction and resulting frustration that women who have undergone pharaonic cutting experience. These cases also revealed the immense lack of information about sexuality and reproductive functions that might be contributing to the continuation of the practice, highlighting the need for improved fertility awareness through educational and screening tools such as the Fertility Awareness Tool (FertiSTAT)¹⁵. Moreover, comprehensive sexual and reproductive health educational materials that consider all aspects of a woman’s reproductive health and the possible negative impacts of FGM at different points of the life cycle is essential in developing countries¹⁶, especially those where FGM is still being practiced. Mothers and fathers who are unaware of the consequences of FGM will continue to perpetuate the practice. Therefore, increased sexual and reproductive health awareness in the general public can influence the successful enforcement of existing legislation and acceptance of new laws. Additionally, these public health education programs need to address and slowly begin to challenge the cultural and presumed religious justifications for the practice, because these are the main barriers to the enforcement of the legislation. We suggest that these programs should be conducted in schools, towns, villages and at all levels of the community to help change erroneous views about the religious underpinnings of the practice (which have been shown to be false). Only when everyone in the community knows about the detrimental impact of FGM on women’s lives and in turn on society at large, will there be compliance with legislation. These

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programs need to be governmental public health programs (to boost trustworthiness) that are designed by healthcare specialists from professional societies and clinicians working in the field. The effective implementation of such programs would then need to be examined in longitudinal studies to determine cultural appropriateness, efficacy, and long-term impact on the prevalence of FGM. These types of programs can also be applicable to migrant populations in Europe and North America, who require education that highlights the impact of FGM and demystifies the cultural and religious underpinnings of this dangerous practice.

These cases also draw attention to the sexual and reproductive needs of women who have already undergone this procedure, that should not be neglected. Current reproductive health policies and strategies should target these needs, congruent with published reports^{6-8, 17-19}. Clinicians treating women who have undergone FGM should be made aware of these sexual and reproductive issues, be responsive to these women's unique physiological and psychological needs and know how to treat or refer them to the necessary specialists¹⁷. To aid clinicians, professional societies (e.g., national and regional societies of obstetricians and gynaecologists) and ministries of health should develop and update national and regional reproductive health guidelines (currently focused on reproductive needs like defibulation before labour) to incorporate the sexual dysfunctions that can result from FGM, how they can be identified and addressed, as reported in international guidelines such as the Royal College of Obstetricians and Gynaecologists⁸. These professional bodies can then also create professional development courses to educate practitioners on how to use the guidelines, including identification of problems, remedial procedures and referral pathways to the appropriate medical specialists and to counselling services.

Future research should include methodologically rigorous studies examining the sexual consequences of FGM to ensure reliability of results that is essential to understand and address these consequences. However, this might be hindered by the shortcomings of the existing research infrastructure and lack of methodological know-how in countries with high prevalence of FGM. This gap in research methods and capabilities requires the engagement of international partners in research capacity building to train local researchers and securing international collaborations and funding which could help build the required research infrastructure.

Finally, these cases emphasized the tremendous need to eradicate this outdated cultural practice that can be both physiologically and psychologically devastating. The sexual and reproductive consequences of FGM can be used to influence policy makers to ban FGM, and to ensure that legislation is adequately enforced. Advocates for policy change and enforcement of legislation, should engage the relevant stakeholders to ensure that these regulations and policy changes are culturally appropriate to increase the likelihood that law and policy will translate into practice. Stakeholders should include, but not be limited to, professional obstetric and gynaecological societies, professional societies of psychologists and counsellors, patient advocacy groups, women's societies and faith organizations. Professional societies should play a leading role in lobbying governments for policy and legislative changes. These different stakeholders can help ensure that policies and legislation do not ignore the cultural bases of the practice of FGM and address those directly instead of just being blanket statements about the need to eradicate the procedure. This is critical because FGM has been illegal in many countries where the practice is still widespread²⁰, indicating a disconnect between legislation and practice that is due in part to the cultural underpinnings of FGM.

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