Sexual health in women with female genital mutilation

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ABSTRACT

Objective: Female genital mutilation or cutting (FGM/C) includes all the procedures which involve the partial or total removal of the external female genitalia for non-medical reasons. FGM/C exposes women to short and long-term health risks, such as sexual health impairment. For this reason, we have designed this review with the aim to investigate the impact of FGM/C on female sexual health.

Methods: We searched Embase, Medline, and the Cochrane library to identify potentially relevant English publications on the effect of FGM/C on women's sexual health.

Results: FGM/C constitutes a violation of sexual rights, including the principle of autonomy, integrity and sexual security of the body, as well as the right to sexual equality. A large proportion of women with FGM/C have female sexual dysfunction. Sexual therapy aims to empower these women to identify their own pleasure, raise their awareness about sensorial perceptions and sensuality, improve their genital image and self-esteem and also the proprioception of their genital area. Reconstructive surgery represents one of the therapeutic alternatives for women with FGM/C.

Conclusions: Sexuality in women with FGM/C needs to be evaluated by a multidisciplinary team in order to offer an appropriate and personalized treatment, considering the physical and psychological dimensions of the individual.

KEYWORDS

Female genital mutilation, female genital cutting, sexual health, sexual rights, reconstructive surgery.

Introduction

Female genital mutilation or cutting (FGM/C) includes all procedures that involve partial or total removal of the female external genitalia for non-medical reasons. This practice is an extreme form of discrimination against women who suffer from it and is internationally recognized as a human rights violation [1]. Despite being mostly performed by traditional circumcisers, the rate of healthcare professionals who practice it is currently increasing [2]. Although it mainly takes place in countries from the Atlantic coast to the Horn of Africa, Middle East and Asia [3], it may occur worldwide due to immigration. It also affects girls and women who live in high-income countries, such as Europe, who return to African countries in the context of a family travel where, frequently under coercion, FGM/C is performed [4,5]. In our experience, based on the attention of these cases, the impact of FGM/C on their lives could be higher because they have grown up with the occidental values of dignity and respect towards female sexual health [6,7]. It is estimated that FGM/C may affect 200 million girls and women [3]. More than three million girls per year are at risk of suffering FGM/C [3]. Such prevalence raises the need to have health and social resources to respond to their demands. The World Health Organization has agreed upon an international classification which divides this condition into four major types depending on the extent of the removed genital tissue (Figure 1).

FGM/C has no health benefits. On the contrary, it has short and long-term health risks, which proportionally increase with the amount of damaged tissue. Some of the immediate complications of this aggression include severe pain, bleeding, fever, infections and even death. The main long-term complications are urinary, vaginal and menstrual problems, childbirth complications, psychological issues and sexual dysfunctions. Literature on FGM/C is scarce and only few studies evaluate sexuality with validated tools [8]. Moreover, most of the studies have small sample sizes and are cross-sectional case series or case-control in design. Our unit has offered care to women complaining for FGM/C from 2015. Additionally, sexual support is offered to these women since 2017. The aim of this review is to investigate the impact of FGM/C on female sexual health.

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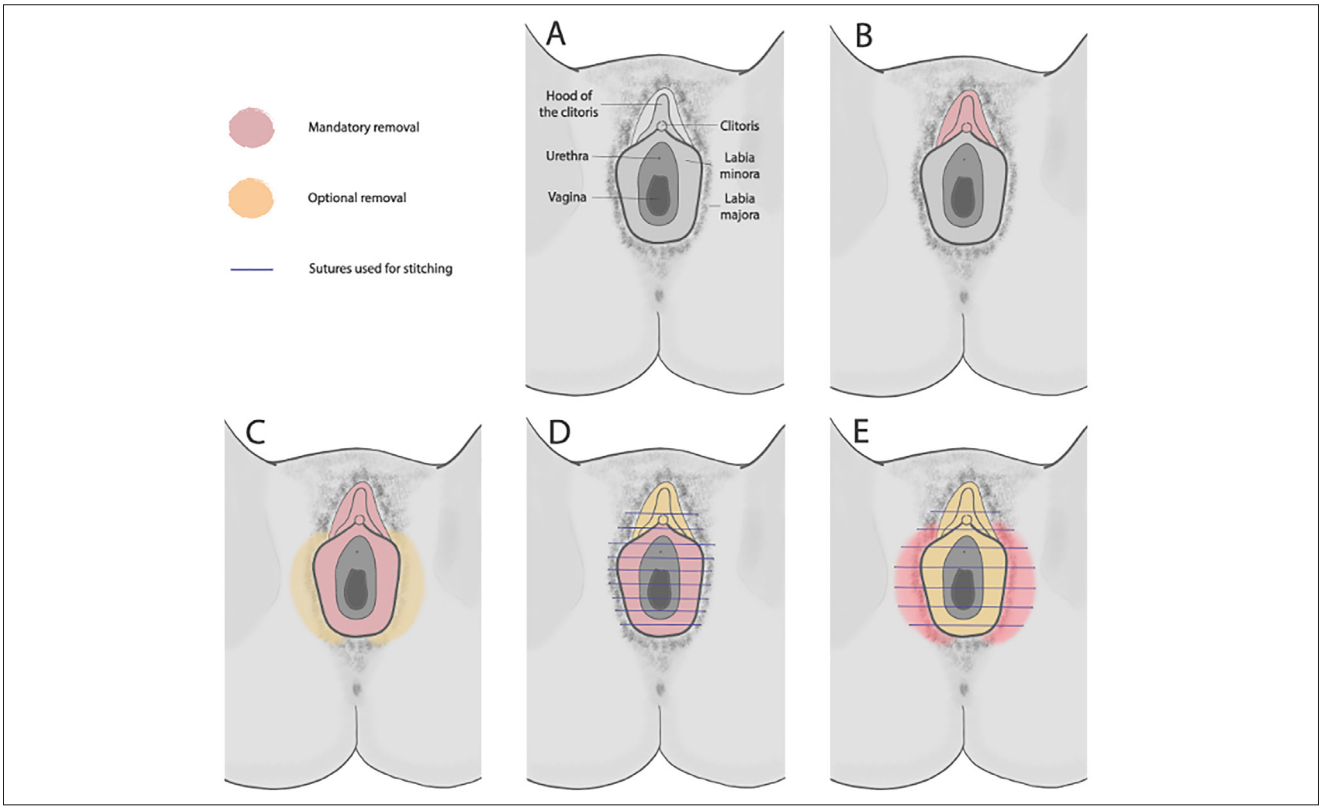
Methodology

We searched Embase, Medline and the Cochrane library to identify potentially relevant publications, giving preference to the most recent and original articles and reviews.

Figure 1 Types of female genital mutilation or cutting (FGM/C). **A**: basal image of the female genital anatomy. **B**: FGM/C Type I or clitoridectomy, which consists of the partial or total resection of the clitoris and, in rare cases, only of its hood. **C**: FGM/C Type II implies the partial or total resection of the clitoris and the labia minora, with or without labia majora. **D**: FGM/C type IIIa, narrowing of the vaginal opening by cutting and centrally repositioning the labia minora through stitching, with or without clitoral resection. **E**: FGM/C type IIIb, narrowing of the vaginal opening by cutting and centrally repositioning the labia majora through stitching, with or without clitoral resection. In addition, there exists the Type IV FGM/C that includes all other harmful procedures to the external female genitalia for non-medical purposes, such as scraping or cauterization of the genital area. **Affected areas (pink):** areas which are always removed in the type of FGM/C indicated; **May be affected areas (orange):** areas which are not always removed in the type of FGM/C indicated.



The search terms used were: "Female Genital Mutilation", "Female Genital Cutting", "sexuality", "sexual health", "sexual function", "sexual problems", "reconstructive surgery" and "quality of life". No limits were set in terms of time of publication or study design. The search was performed for publications in English. Publications were included if the full text of the article was available and data was reported on quality of life or sexuality. All types of clinical studies were included.

Sexual health and female genital mutilation

Sexual health is a state of physical, emotional, mental and social well-being in relation to sexuality which requires the possibility of having safe and pleasant sexual experiences [9]. Therefore, FGM/C constitutes a violation of the sexual rights to autonomy, integrity and sexual security of the body, as well as to sexual equality, since it perpetuates gender discrimination.

When women's sexual health is altered by sexual symptoms which cause distress, a female sexual dysfunction is diagnosed. A large proportion of women with FGM/C suffer from it [10]. Greater sexual problems are found in women with FGM/C type III, in comparison to types I and II [11-14].

FGM/C may cause damage to nerve endings, contribute to the development of scar tissue and adhesions in the removed genital areas and be a cause of impaired sexual function [15]. Female sexual function involves different dimensions: desire, lubrication, arousal, orgasm, satisfaction and pain. There is still controversy on which domains of sexuality are mostly affected in FGM/C, as different results have been published [8]. Women with FGM/C are prone to experience dyspareunia, decreased sexual satisfaction and diminished sexual desire [16]. Contrary, a case-control study did not find differences in the desire domain between the FGM/C and the control group, whereas all the other dimensions were significantly lower amongst the first [2].

Being all these dimensions important, female sexuality represents a much broader concept which includes global aspects such as reproduction, identity, femininity, genital and body image, privacy and personal relations. Women with FGM/C can present with infertility secondary to the suffered injuries and this can negatively impact on their sexual health. Many people still associate female genital organs with the idea of being a woman [17]. Therefore, females with external genitalia lesions due to FGM/C may not feel complete as a woman, have the perception of being less feminine or sexually attractive and suffer from identity problems [18]. Patients who have dissatisfaction with their genital appearance, may also have more self-consciousness of their genital image during physical intimacy, a fact that could be associated with lower sexual confidence and satisfaction [19]. Patients with FGM/C frequently perceive their

genitalia as abnormal or unpleasant, a fact that may affect their body image, self-esteem and both expression and experience of sexuality [18]. As a result, they may have an increased risk of problems in their personal relationships. However, some patients have the ability to overcome the "anatomical barrier" through fantasies or the enhancement of stimulus from other sensory or erotic areas [16]. Additionally, the FGM/C procedure may consist of the excision of the externally visible portion of the clitoris, while the body remains under the scar and may be involved in the maintenance of sexual pleasure. Moreover, in certain contexts and countries where this practice is accepted and considered to be positive, women with FGM/C are less likely to complain about their sexual health problems than in high-income countries, where more awareness of the condition exists [20].

The previous information brings out the complexity of female sexual health among the FGM/C population. While the physical sphere plays a relevant role, it is also important to consider both the psychological and social spheres. Furthermore, such items are difficult to measure with validated tools. In addition, to our knowledge, no specific outcome measures for sexual health have been validated in FGM/C population.

Taking the above information into account, women with FGM/C with sexual health problems need to be evaluated by a multidisciplinary team using a biopsychosocial approach, which considers their current sexual life and expectations to offer the most appropriate and personalized treatment.

Sexual health and reconstructive surgery for female genital mutilation

Although treatment of patients with FGM/C still remains as quite an unexplored field, it is certain that both psychological and physical aspects need to be considered.

Among the potentially therapeutic alternatives, reconstructive surgery surges like one option. Growing interest in this procedure has been raised in recent years from both the female and healthcare system perspective. A study published by Jordal *et al*. [21] showed five factors motivating women's request for clitoral reconstruction: symbolic restitution, repairing the visible stigma of FGM/C, improving sex and intimacy through physical recovery, eliminating physical pain and clitoral reconstruction as an individual project offering hope [21]. According to the data published by Foldès *et al*. [17] in the majority of patients with FGM/C the primary expectation of the surgery was the recovery of identity (99%), followed by sexual life improvement (81%) and the hope of reducing pain (29%) [17]. Therefore, the aim of reconstructive surgery is not only to reestablish sexual function but also improving self-esteem and well-being in order to reestablish sexual function [22].

Likewise, the indication for reconstructive surgery with the only purpose of improving sexual function should be included within a comprehensive approach which considers not only medical and surgical parameters, but also psychosocial ones [22]. Despite the growing interest in this treatment, still few well-designed studies have been published, mostly based on small and heterogeneous populations [23]. Additionally, some of them report their results using different and often non-validated measurement methods [24]. Among validated tools, the Female Sexual Function Index (FSFI) is the mainly chosen one [10]. However, despite the use of validated questionnaires, the assessment of the female sexual function is challenging in this population as sociocultural factors cannot be measured. Hence, scores of validated questionnaires need to be individually assessed, which makes the analysis of results even more complicated.

Most of the studies which evaluate sexual health before and after FGM/C reconstructive surgery report some degree of improvement in sexual function, being pain the dimension which most significantly improves, followed by arousal, while lubrication and orgasm are the least modified ones [25-28]. After surgery, some patients might experience a favorable improvement in the self-perception of their genitalia [26]. However, few studies evaluate genital image, neither other more global aspects of female sexuality.

On the grounds of our practice, although uncommon, sexual function may be impaired after FGM/C reconstructive surgery due to complications such as pain secondary to new scars or the sensory impairment which may appear after any reconstructive surgery of the genital area. In this line, a systematic review showed that after reconstructive surgery some patients with FGM/C could experience a worsening in clitoral pleasure (2.3%), decreased desire (8.2%), decreased sexual frequency (8.2%), pain (2%) and restricted orgasm in women with previous normal orgasm (22.6%) [29]. Hence, more evidence is needed regarding the assessment and setting of the patient profile that mostly benefits from reconstructive surgery without worsening their sexual function.

Treatment recommendations for female genital mutilation patients

According to our experience, and despite limited scientific evidence [22], a multidisciplinary approach to patients with FGM/C needs to be offered following international guideline recommendations [1,30]. Its main aim is to improve sexual health, treat psychological and sexual comorbidities and empower women to take an informed decision on treatment options [321]. Professionals involved in treatment include healthcare providers, psychologists, sexologists, social workers, teachers and interpreters, among others [32], and all of them play an important role in both the prevention and treatment of FGM/C [33.34].

Regarding sexual health care of women with FGM/C, it is necessary to provide appropriate sexual education, as well as counselling and/or sexual therapy to those who require it [1,30]. A published study [35] reported that most women with FGM/C have positive predisposition towards psychosexual counselling and would accept it, if available. However, more studies assessing this kind of intervention are needed, as Okomo *et al*. [7] could not find evidence (randomized or non-randomized studies) of the effects of sexual counselling as a key intervention for treating or preventing sexual dysfunction in women living with FGM/C. From our point of view, sexual therapy, when needed, usually combines self-exploration and masturbation to identify

the own pleasure [33], sensate focus exercises to raise awareness about sensorial perceptions and sensuality, cognitive-behavioral therapy to improve self-genital image and self-esteem and pelvic floor muscle coordination exercises to improve the proprioception of the genital area [36]. Considering the desired objectives and focusing on expectations, the indication of surgical treatment has to be evaluated by the patient and the different members of the multidisciplinary team.

Taking the above information into account, we would be able to identify different patient profiles with the aim of offering, in the near future, more personalized treatments based on an integrative approach to sexuality.

Conclusions

FGM/C has no health benefits. Sexual health impairment is one of the most prevalent consequences of this procedure. Sexual dysfunctions in women with FGM/C frequently involve pain, orgasm disorder, genital image dissatisfaction and identity issues. Sexual therapy aims at empowering these women to identify their own pleasure, raise their awareness about sensorial perceptions and sensuality, improve their genital image and self-esteem and also the proprioception of their genital area. Considering the desired objectives and focusing on expectations, the indication for surgical treatment has to be evaluated by the patient and a multidisciplinary team. A multidisciplinary and integrative approach to women's sexuality will allow the identification of different patient profiles with the aim of offering more personalized treatments in the near future.

The use of validated tools will allow obtaining accurate data. Hence, there is a need for more studies of better scientific quality regarding changes in sexuality after reconstructive surgery in women with FGM/C.

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