The Affects of Female Genital Mutilation

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By:

Akeya Bolden

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This literature review is being done to increase awareness in the medical and mental health communities about Female Genital Mutilation. Not enough is known about how this negatively affects a woman physically and mentally. With Minnesota having one of the largest populations of African immigrants, this information could be very useful. I would like to share with you some information about the background of Female Genital Mutilation, it’s origins, how the procedure is done, the medical and mental health issues and what ways we can bring awareness to this issue.

What is FGM?

Female Genital Mutilation started over 5000 years ago and is practiced within many different cultures. There is evidence from Egyptian mummies that female circumcision was practiced long ago (Whitehorn, et al., 2002 p. 161-162). Countries that participate in FGM range from Africa, Middle East, Asia, South America, Pacific countries, Europe and America. Not all African countries practice FGM and it is not practiced by all ethnic groups in the same country. It is pre-Islamic and is practiced by Muslims, Coptic Christians and Falasha Jews (Kaplan-Marcusan, Fernandez Del Rio, Moreno-Navarro, Castany-Fabregas, & Ruiz Nogueras, 2010, p. 1). Over 130 million girls and women have undergone FGM, and approximately three million are at risk for having this procedure done. It was previously called Female Circumcision and is now called Female Genital Mutilation. The medical term is Mutilation, because it is the removal of a healthy organ (Utz-Billing, & Kentenich, 2008).

Female Genital Mutilation is performed in about 30 countries of the world. Most of them are located in Africa. About 90% of women are mutilated in the Sudan, in Mali,
Djibouti, Egypt, Ethiopia, Somalia and Eritrea. The procedure typically takes place in Mali, Somalia, Sudan, Djibouti, in the South of Egypt and in Eritrea. FGM is also performed in other countries of the Arabian Peninsula and the Persian Gulf (United Arabian Emirates, Yemen and Oman), in Islamic communities in India, Malaysia, Indonesia and in immigrant communities in Europe, Canada, USA, New Zealand and Australia. (Utz-Billing, & Kentenich, 2008, p. 226)

**Where It Originated**

There have been a number of reports on FGM throughout history. It is said that the first historical reference to FGM was found in the writings of Herodotus. Herodotus reported its existence in ancient Egypt in the 5th century B.C. His theory was that the custom had originated in Ethiopia or Egypt, as it was being performed by Ethiopians as well as Phoenicians and Hittites (Taba, 1979). A Greek papyrus in the British Museum dated 163 B.C. mentions circumcisions performed on girls at the age when they received their dowries. In addition, a number of authors have shown that female circumcision was also done by early Romans and Arabs. In some groups it appears to have been a mark of distinction, in others a mark of enslavement and subjugation. (Lightfoot-Klein, 1991, p. 2)

From its possible origins in Egypt and the Nile Valley, female circumcision is thought to have diffused to the Red Sea coastal tribes, along with Arab traders, and from there into eastern Sudan (Modawi, 1974). There are a number of reports by some 18th century travelers, who observed its performance on slave girls by slave traders along the Nile. (Widstrand, 1965; Cloudsley, 1983) A European man named Niebuhr, who was the sole survivor of the first European scientific expedition to Arabia and Egypt reported on
female circumcision in 1767. A 19th century British explorer, Sir Richard Burton, lectured on the subject of sexuality among what he described as primitive Peoples. He stated that while the intent of the custom was to reduce the female sexual drive, its effect was often quite the opposite. He came to the conclusion that excision of the clitoris and labia rendered women to become sexually aroused and caused them to have difficulty being sexually satisfied. "The moral effect of female circumcision is peculiar," writes Burton, "while it diminishes the heat of passion, it increases licentiousness and breeds a debauchery of mind far worse (sic) than bodily unchastity." (Burton, 1954, p. 108)

Christian missionaries have attempted to persuade tribal leaders to discontinue female circumcision and they had no visible success anywhere in Africa. The British colonial governments in Sudan and Kenya attempted to legislate the custom out of existence but failed. Europe had its own means of objectifying women. Female slaves in ancient Rome had rings threaded through their labia to prevent them from becoming pregnant. Crusaders brought the chastity belt to Europe during the twelfth century. Until rather recently, clitoridectomy was the surgical "remedy" for masturbation in Victorian England and even more recently in the United States. (Assad, 1979, p. 12), (Wallerstein, 1980, p. 173). Hanny Lightfoot-Klein explains that:

The methods used to repress female sexuality throughout history up to the present have been many, and have extended worldwide Lerner (1986, p. 139) observes that in ancient Mesopotamia, the Code of Hammurabi marks the beginning of the institutionalization of the patriarchal family. From 1250 B.C. on, public veiling and the sexual control of women have been essential features of patriarchy.

Under this code, fathers were empowered to treat the virginity of their daughters
as a family property asset. This system and others like it also divides women into classes of "respectable", which is to say conforming, male-protected and chaste women, and "disreputable" or unprotected, low class and slave women. Those women who benefited by securing their own safety and, more poignantly, the safety of their children, or those who strove to benefit, not only bowed to the system, but became its staunchest advocates (Lightfoot-Klein, 1991, p. 2).

**Different Methods**

There are four classified types of FGM performed, as well as a fifth unclassified type. The first type is called a Clitorectomy it is considered the least severe. During this procedure, the prepuce or the hood of the clitoris is removed. The second type is called Excision, in this procedure part or all of the clitoris and part of the labia minora are removed. In some instances the labia majora are removed and no stitching is done. This is the most common form of mutilation. The Third type is called Modified Infibulations. During this procedure, the clitoris, labia minora, and at least the anterior two thirds and most of the time all of the labia majora are removed leaving a larger posterior opening. The fourth type is called Intermediate Infibulations. During this procedure the clitoris, labia minora, and the labia majora are removed, and the anterior two-thirds of the labia majora are stitched together covering the urethra and the vagina, leaving only a small opening for the passage of blood and urine. The fifth unclassified type involves scarification of the clitoris, cuts into the clitoris and labia minora, as well as into the vagina (Dorkenoo, 1995, p. 5-8).

The types of instruments used to perform the procedures differ among tribes. Tribes in Mali use a special knife called a saw-toothed knife with razor blades on it, In
Sudan they use what they call a Moos el Shurfa, or they use a piece of glass or scissors. In some cases sharp stones have also been used. In Ethiopia cauterization (burning) is the instrument used for mutilation among the people there, and in Gambia fingernails have been used to pluck out the clitoris of babies. The people responsible for performing the procedure varies also, in Egypt and Sudan it is performed by a person called a Daya, which is generally a birth attendant. In Somalia it is done by excisors from the Midgan Clan, in northern Nigeria and Egypt it is rarely done by the mother (Dorkenoo, 1995 p. 8). Male barbers also carry out the task, but it is usually done by a woman. In Mali, Senegal and Gambia it is done by a woman they call the Ngasingbas (Dorkenoo, 1995 p. 9). The wound is then treated with local herbs, ash, or even a mixture containing cow manure, which could possibly lead to infection (Whitehorn, et al., 2002, p. 163). The ages at which FGM is performed vary between ages 2-12 and can range from a few days old to widows, with adult women it can be performed with their permission. In most cases this only happens when they are married into a different ethnic group, or for political purposes.

The writer feels that the instruments used are very unsanitary and may be the cause of the many health issues related to this procedure. The procedure alone is very painful as no anesthesia is used during the performance of the operation. This procedure is also not performed by a professional, but is performed by someone who has been practicing all their lives. The writer also feels that although this person may have been operating on young girls for most of their adult life they should be trained to use sterilized instruments.
Why is FGM Done?

There are a number of reasons why this is done all: of which all are myths or cultural beliefs. One popular mythological justification for the circumcision of both men and women is the belief that the male prepuce and female clitoris represent feminine and masculine elements, respectively, and must be excised to prevent gender confusion (Moschovis, 2002). In some African countries where FGM is practiced, such as Egypt, Sudan, Somalia, Ethiopia, the external female genitals are considered dirty. In Egypt an uncircumcised girl is called Nigsa (unclean) and all hairs are removed from the body in an effort to achieve a smooth surface and clean body. The same things appears in Somalia and Sudan where the reason for infibulations is to produce a smooth skin surface, and women questioned insisted that it made them cleaner (Dorkenoo, 1995, p. 40). Women who don’t have this done are told that they are ugly or disfiguring in their natural state. However, the idea of female and male genitals being dirty or ugly is not confined to those who practice FGM. It is the responses and practices arising from these deeply held beliefs that are used to justify FGM (Dorkenoo, 1995, p. 40-41).

In Sudan it is believed that the clitoris will grow to the length of a goose's neck until it hangs between the woman’s legs, which would become a rivalry with the male's penis, if it is not cut. It is believed that this concept creates so much repulsion and anxiety in men that they would not under any circumstances consider marrying an uncircumcised or "unclean" girl. Since marriage and childbearing are as yet virtually the only options open to most African women (aside from prostitution in the urban areas), this leaves them little to no choice. The only option is to submit to the practice and to coerce their daughters into having it done (Lightfoot-Klein, 1991, p. 2).
Another myth that women are told is that the clitoris will endanger the life of their unborn baby. These areas already have a high infant mortality, so unfortunately this is used to promote FGM as something that must be done for a healthy baby. Women are also told that they may become infertile if they don’t have this done (Dorkenoo, 1995 p. 46). Hanny Lightfoot-Klein state that “The rationale for female circumcision seems to be consistent in most African societies, and is based for the most part on myth, an ignorance of biological and medical facts, and religion. The clitoris is perceived variously as repulsive, filthy, foul smelling, dangerous to the life of the emerging newborn, and hazardous to the health and potency of the husband.” (Lightfoot-Klein, 1989, p. 2).

Most psycho-sexual justifications, however, are based on controlling women's sexual behavior. In societies where the highest role of a woman is that of a wife and where virginity is an essential prerequisite to marriage, FGM is seen as a way of ensuring chastity and faithfulness. Particularly in Egypt and the Sudan, there is a strong belief that women will be overpowered by raging sexual impulses if not assisted to control themselves through FGM. This fear of female sexuality is reinforced by the connection between a family's irdh (irdh in Arabic (irz in Turkish), pertains to women, or more specifically, to the sexual use of their bodies, their virginity, or their chaste behavior. The honor of the clan was besmirched if unmarried women did not remain virgins, and if married women were unfaithful. Men were to maintain their clan's honor by punishing their errant women if they brought shame on the group, thus maintaining the patrilineal nature of lineage and society) (Zuhur, 2005) or honor, and the chastity of its female members. Honor killings by male family members for a female family member's
transgressions are often found where FGM is practiced. This fear of female sexuality is quite similar in nature to the masturbation insanity scare that resulted in clitoridectomies in America in the nineteenth century (White, 2001, p. 136). Dorkenoo (1995) describes how women were misled into FGM:

The main point to stress is that the practice of FGM is not presented to women in a straightforward manner; it has been shrouded in mystery, magic and fear. Women receive social approval when they undergo FGM and gain certain benefits: being marriageable and thus having access to resources in the community. The concept of becoming a ‘woman’ and being elevated to a higher status after undergoing FGM is a theme which runs through all communities practicing FGM. Because of the social approval, and the sanctions women face if they do not undergo FGM, they inevitably end up viewing it in a positive light. This procedure is also seen as a type of initiation into adulthood (Dorkenoo, 1995, P.46)

In some areas such as in northern Sudan, among the Kikuyu in Kenya, the Tagouna in the Ivory Coast, and the Manbara in Mali, an elaborate ceremony surrounds the event. There are special songs, dances, and chants used to teach the young girl her duties and the acceptable characteristics of a good wife and mother. The ceremony is rich in ritual and symbolism, with special huts used for recovery only for the girls who have undergone FGM. In this hut, the girls are isolated from the rest of society until they emerge, healed, as marriageable women. Very young girls who are not at a marriageable age are greeted with gifts of special clothes and food (Dorkenoo, 1995, p. 39). Utz-
Billing, & Kentenich (2008) explain how the importance of circumcision is for a woman to be accepted:

A woman’s honor is dependent on her being circumcised (Whitehorn p. 163). The aim is to guarantee moral behavior and faithfulness of women to their husband. From the point of view of the persons affected, it serves also for protection of the woman from suspicions and disgrace. The procedure is an initiation ritual. This might be one of the most important reasons for FGM. It can be a symbol of ethnic affiliation, of reception to the society. In some communities, the mutilated genital is a symbol of femininity, of transition from girl to woman and of beauty. Ironically enough, FGM is performed for hygienic and health reasons. Economic reasons probably also play an important role. Parents get money for the pride proportionally to the degree of the operation. Circumcisers are women with good incomes and a high social status. Definitely, there are no proofs of religious origin. Moslems, Christians, animists and atheists perform FGM. The instructions for FGM are mentioned neither in the Bible nor in the Koran.

It is believed that the father was adamant on knowing who his children were. He needed to know this for the purpose of handing down his landed property to them. This system was created solely for economic reasons. It was necessary for society to continuously to create a system of moral, religious and legal values stable enough protect and maintain economic interests. It is also believed female circumcision, the chastity belt and other practices used on women are the result of economic interests and to control society. Because some of these things are still practiced, society implies that these economic interests are still a concern. There
are thousands of dayas, nurses, paramedical staff and doctors who benefit from FGM financially, so it is natural for them to resist any change in the values or practices of FGM (Lightfoot-Klein, 1991 p. 4).

Freud stated in his book, Sexuality and the Psychology of Love, that the "elimination of clitoral sexuality is a necessary precondition for the development of femininity. The writer feels that the only reason for FGM is to oppress women. To make them feel that they will never be good enough. These women have been told that if they do not have this done that they are not good enough, that no man will want a dirty wife, and they will be asked to leave and to never return. The negative thing about this is that it is other women telling them this. Women are the ones that are performing the surgery, telling their daughters all of these myths, and mentally preparing their young for this horrific event. You have to wonder if it is the women or the men that are enforcing this.

The writer feels that there are many different ways to view this issue. Alfred Adler states in Social Interest: A Challenge to Mankind (1938) that "Social feeling means above all a struggle for a communal form that must be thought of as eternally applicable... when humanity has attained its goal of perfection... an ideal society amongst all mankind, the ultimate fulfillment of evolution." (p. 275). This could be what these communities are striving for.
What are the effects of FGM?

Medical

Health risks and ramification depend on the type of FGM, the hygienic conditions, the age of the female, the skill of the practitioner and resistance of the child (Bashir, 1997; El Dareer, 1982; Toubia 1995; Lightfoot-Klein, 1992). The long-term effects from undergoing FGM include having a hard time passing urine and chronic urinary tract infection. If these things go untreated the infections can cause other medical issues like bladder and kidney problems resulting in renal failure, septicemia and even death. It can also cause pelvic infections of the uterus and fallopian tube and is excruciatingly painful. Infertility, colloid scaring, fistulae, dyspareunia and sexual dysfunction are also frequently reported from infibulated (Infibulation, in modern usage, is a practice of surgical closure of the labia majora (outer lips of the vulva) by sewing them together to partially seal the vagina, leaving only a small hole for the passage of urine and menstrual blood (Pieter, & Lowenfels, 1977)) women (Elchalal, Ben-Ami, Gillis & Brzekinski, 1997; Horowitz and Jackson, 1997). FGM affects the physical, psychological and sexual functions of the female causing grave short-term and long-term complications (Williams, Acosta, & McPherson, 1999).

The risks during the procedure or after the scab is removed can lead to heavy bleeding, causing anemia or death. Bleeding and pain can be so severe that it causes the patient to go into shock. Many girls and women experience problems urinating after FGM, due to pain, infections, swelling and injury of the urethra. Infections occur mostly when FGM is performed under unsanitary conditions. Although there are infections of the uterus and ovaries, there are more serious infections, like tetanus
infections, gangrene or sepsis that can cause death. During the procedure the girls try to defend themselves causing fractures of clavicles, humerus and femur. Many women have chronic physical problems during their whole life. Chronic anemia can be caused by repeated defibulation (opening of the vagina) and reinfibulation (closing of the vagina after defibulation) (Utz-Billing, & Kentenich, 2008, pp. 226-227). Another complication that can arise is called Necrotizing Fasciitis. It is an infection of the subcutaneous tissue that destroys Fascia (a sheet of connective tissue covering or binding together body structures (as muscles) (http://www.merriam-webster.com/dictionary/fascias). It begins in the area where the trauma was caused, the area will then become very painful but there is no visible change, the tissue then become swollen within hours, the skin then turns violet and blisters form, with necrosis. Necrosis means a localized death of living tissue (http://www.merriam-webster.com/dictionary/necrosis) (Mohammed & Mohammed, 2010).

Due to chronic infections of uterus and ovaries can make women infertile and formation of keloid scars can cause severe pain, dermoid cysts and abscess formation. Many women suffer from dysmenorrheal which is a disorder that causes pain during urination, because blood accumulates in the partially or totally occluded vagina. Women also experience pain during intercourse and penetration problems. Women after FGM have a higher risk of contracting HIV infections due to unsterilized instruments. There is also a higher risk for injuries during sexual intercourse due to scar tissue and the tightness of the vagina. Type III which is the most debilitating type, gives a 25-30% chance of infertility due to the tightness of the vagina because of scar tissue and chronic
infections of the uterus and the ovaries (Utz-Billing, & Kentenich, 2008, p. 227). White (2001), explains that:

Long-term health problems include loss of sexual function, chronic urinary tract infections, and pelvic inflammatory disease; dermoid cysts may form on the scar line and can grow to the size of an orange or bigger; neurinoma can develop where the dorsal nerve of the clitoris is cut, causing the genital area to become permanently and unbearably painful; and infibulations can result in clot formation during menstruation in the remaining miniscule vaginal opening, leading to severe medical complications (White, 2001, p. 138).

Sudanese women live with the fear that their husbands will divorce them, will take a second, third or fourth wife, or will consort with prostitutes. With this procedure the woman's vagina is resutured once more to a pinhole opening after the birth of each child or before remarriage. When the woman begins to re-engage in sexual intercourse with her husband, the vagina must be partially cut or torn open once more to permit penile penetration. It then must be cut again to give birth, and then cut further to allow the expulsion of the fetus. The woman’s scars are too damaged and unable to stretch due to scar tissue. This again creates profit for midwives and health professionals, because it is a never ending procedure. It has been less than fifty years ago that re-infibulation was brought to light. It has spread from villages to towns. These women believe that it gives more sexual pleasure to a husband (Lightfoot-Klein, 1991, pp. 4-5).

Due to the increase of African immigrants into Europe, and United States, a new problem has developed. Circumcisions are being performed in European countries by local doctors, by members of a girl’s family or by midwives imported for this purpose.
have come to the attention of legal authorities, and appear to have become fairly common (Lightfoot-Klein, 1991, p. 6). In England it was found that Harley Street surgeons were known to perform the procedures for the elite at fancy prices. “In Sweden a scandal developed when it was discovered that a Swedish surgeon was performing the operation in a Swedish hospital under the Swedish socialized medicine system, at the expense of outraged Swedish taxpayers (Lightfoot-Klein, 1989, p.45)”.

In France and Italy a number of hemorrhaging girls were brought into emergency wards after kitchen knife excisions by family members (Lightfoot-Klein, 1991, p. 6).

In the U.S., health care professionals are not knowledgeable about the specialized gynecological care or obstetrical care needed during delivery (Horowitz and Jackson, 1997). The public health issue facing health care workers is that if an infibulated woman is not properly cared for serious complications may occur during delivery including fetal death. An infibulated woman must be cut and re-stitched many times in her life beginning with the wedding night for intercourse of for repeated deliveries when a larger cut is necessary for childbirth (Toubia, 1995). The de-infibulation required to prevent further physical trauma such as further lacerations can lead to possible hemorrhage or vesicovaginal or rectovaginal fistulas (Bashir, 1997, p. 12).

Mental

The psychological problems associated with FGM practices are serious mental health issues due to this form of abuse. Studies show that there are a number of mental health consequences, including "feelings of incompleteness, anxiety, depression, chronic irritability, frigidity, marital conflicts, conversion reactions, or even psychosis."(Utz-Billing, & Kentenich, 2008, p. 138) The WHO experts explain that psychological
complications “include fear of having sexual intercourse, post-traumatic stress disorder, anxiety, and depression” (Morris, 2006, p. 564). Lightfoot-Klein states that “psychological complications include severe, recurrent anxiety, depression and a generalized phobic state. These complications tend to appear at various stress points in a woman's life, such as the period preceding circumcision, at menarche, before and for some time after marriage, and with the birth of each child”. Lightfoot-Klein also says that these women suffer from having a severely depressed self-image, lack of confidence, feelings of sexual inadequacy and worthlessness, repressed rage and anorgasmia. (Lightfoot-Klein, 1989, p. 60)

In a study done by Dirie & Lindmark (1992) it was found that circumcised females frequently report statistically significant psychosexual difficulties in the form of less sexual activity, less enjoyment of sex, less frequency of orgasm, and less synchronism in the timing of orgasm with their husbands. Also these women were more likely to report statistically significant gynecological problems then uncircumcised females, in the form of pain during sex, and extreme pain during menstruation. Behrendt, & Moritz, (2005) also did a study on the affect of female circumcision. He found that all but one of the women in his study remembered the day of her circumcision as extremely horrifying and traumatizing. “Over 90% of the women described feelings of intense fear, helplessness, horror, and severe pain, and over 80% were still suffering from intrusive re-experiences of their circumcision. For 78% of the subjects, the event was performed unexpectedly and without any preliminary explanation” (Behrendt, & Moritz, 2005, p. 1001).
Behrendt’s findings were that FGM is likely the cause of an assortment of mental health issues in its victims, including PTSD. His belief is also that culturally embeddedness does not protect against the development of PTSD and other psychiatric disorders. As well as in other studies it is believed that declarative memory dysfunction is associated with PTSD. He also believes that stress, frustration, pain during sex, and menstrual problems cause infertility in women that have undergone FGM.

The writer feels that there is no true need for FGM to be done. In the end this causes more harm than it does good. These women’s lives are changed forever and something that they were born with was taken away without their consent. The writer feels that the trauma and bloodshed are very unnecessary and would certainly cause medical and mental health issues.

Awareness

There is still a long way to go to bring awareness to FGM. Although the road is a long one, FGM has been banned in several African nations, including Senegal, Burkina Faso, the Central African Republic, Ghana, and Togo (White, 2001, p.141).

There are a number of initiatives that support the abandonment of FGM/C, like UNICEF. UNICEF has coordinated a strategy to attempt to abandon FGM in one generation (Morris, 2006, p. 365). De Vita an activist of FGM: writes that FGM is “a deeply entrenched social convention so powerful that even those parents not wanting to cut their daughters do so anyway because of social pressure”. So the decision to no longer take part in the practice has to come from communities and needs to be agreed upon by everyone in the community. In addition it needs to be reinforced by public deliberations and grounded on a firm human-rights foundation (Morris, 2006 p. 365).
Unfortunately the decrease of FGM has been limited, despite some 25 years of efforts. The WHO program is attempting to create research projects in Europe aimed to increase knowledge on what should be done with the practice, describe successful community interventions and explore relations between cultural concepts of sexuality and FGM (Morris, 2006 p. 368). “Some experts suggest that laws and other methods to reduce practices are ineffective because they do not address demand. Harm minimization, including FGM done within health-care systems, is viewed by some as more helpful than is prohibition” (Morris, 2006, p. 365).

Various studies (Elchalal, Ben-Ami, Gillis, and Brzezinski, 1997; Gallard, 1995; Odoi, Brody and Elkins, 1997; Walder, 1995) state that at any time when the government no longer allows FGM to be practiced, in the original country or the country to which groups immigrate, the practice continues, but in greater secrecy. This is due to those formulating the legislation and prevention strategies ignore the rationale for the practice (Elchalal, et al., 1995 p. 645). The explanation for FGM is fundamentally based on culture and tradition. Elchalal states that “Despite, the increasing awareness in this country of FGM, there is a paucity of statistical, cultural and medical data on groups who have emigrated from countries that practice FGM in the U.S.”

If we would like to bring awareness and prevention of female genital mutilation in the U.S., we must first have an understanding of the immigrant groups', their culture; the reason for this practice must be researched and understood when creating prevention strategies (Williams, Acosta, & McPherson, 1999). In addition to Perez’s belief Bashir brings to our attention another important aspect to keep in mind in our attempt to prevent FGM:
When women move to a society where FGM is not accepted, as in the U.S., they are subject to humiliation and psychological trauma. Consequently, as a result of these adverse reactions and now because of the criminalization of FGM, they may not even seek medical assistance (Bashir, 1997). While U.S. law may assist in deterring the practice, the health community is still faced with an increasing number of women and girls who have already undergone this procedure that presents health complications. Moreover, the CDC predicts that there are still an estimated 168,000 with or at risk for FGM in the U.S. (Jones, Smith, Kieke and Wilcox, 1997).

Conclusion

Increased awareness in the medical and mental health communities about Female Genital Mutilation is vital to bring an end to this practice. More information is being discovered about how this negatively affects a woman physically and mentally. There is a very large population of African immigrants in Minneapolis, Brooklyn Center and the Brooklyn Park areas in Minnesota. The information provided could be very useful to the community, mental health and medical communities in that area. The information provided about the background of Female Genital Mutilation, its origins, how the procedure is done, the medical and mental health issues and what ways we can bring awareness to this issues could be extremely useful to the professions that may be most affected by this issue.

The information found about FGM suggests that the trauma experienced by the victims does indeed cause mental health issues. These issues range from post-traumatic stress to anxiety and depression. The victim also experience medical issues that cause
mental health issues as well. Pain, infertility and being disfigured all cause psychosexual complications for this particular group of women.

To end FGM we must speak to health professionals, community stakeholders and policy makers. We must come at every angle on the community and national levels. It’s clear that this will not be an easy task, but one must be up for the challenge. Every possibility must be used to bring awareness about this issue, and to possibly put mental health program together to help those that have suffered from this traumatic experience.
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