Int Urogynecol J (2017) 28:537–541
DOI 10.1007/s00192-016-3202-6

SPECIAL CONTRIBUTION

Female genital mutilation: the role of medical professional organizations

Tony Bazi[1]

Received: 18 October 2016 / Accepted: 30 October 2016 / Published online: 17 November 2016
© The International Urogynecological Association 2016

Abstract Female genital mutilation (FGM) refers to alteration of the external genitalia of girls without medical benefit. It is estimated by United Nations agencies that 200 million living girls and women have been subjected to different forms of FGM worldwide. Despite the criminalization of the procedure in the vast majority of countries where it is practiced, the decline in the incidence of this ritual is far from satisfactory. Immediate and long-term ill effects are well documented. Most publications of relevance originate from countries outside the map of FGM. In addition, there are major gaps in research related to this issue, considering the magnitude of the problem. International medical organizations and societies should assume their responsibility by providing a platform to professionals engaged in the prevention and treatment of the consequences of FGM, especially those living in the communities where the practice is endemic.

Keywords Female genital mutilation · Ritual · Female circumcision · Female genital alteration · Infibulation · Clitoridectomy

Introduction

Male and female genital alterations during infancy and childhood have been practiced since ancient times. This is supported by the writings of Herodotus, a Greek historian, who allegedly described male and female circumcisions when he visited ancient Egypt during the fifth century BC [1]. Despite older accounts of harmful procedures performed during rituals on the external genitalia of young girls, reliable data about the prevalence and ubiquity of such procedures has become available only in the last few decades following the Hosken report [2]. The term "female genital mutilation" has gained recognition since the 1970s. In1991, the World Health Organization (WHO), in an attempt to point to the gravity and harm of female genital alteration, and to linguistically differentiate it from male circumcision, recommended adopting the term "female genital mutilation" (FGM) to refer to all practices of altering female genitalia without proven medical benefit [3].

The ritual is native to 30 countries spanning from the Atlantic coast to the Horn of Africa, in addition to isolated areas in Iraq and Yemen, and some Asian countries including Indonesia, India and Malaysia [4]. FGM has also been reported in some communities in South American countries such as Columbia, Ecuador and Peru. Furthermore, the practice can be found, on a smaller scale, in isolated communities of immigrants in Europe and North America [5]. More than half of women on whom FGM is inflicted live in just three countries (the most populous): Indonesia, Egypt and Ethiopia [4]. In terms of prevalence, between the years 2004 and 2015, Somalia had the highest percentage of girls and women aged 15 to 49 years subjected to FGM (98%), while Gambia had the highest percentage among girls younger than 14 years (56%) [4].

It is estimated that 200 million girls and women have been subjected to FGM [4]. This estimate is mostly based on household surveys usually undertaken by international organizations. Recently, attempts have been introduced by some local governmental agencies to obtain "national prevalence" data. Obviously, there continues to be an incomplete assessment of the magnitude of the problem, especially in view of the criminalization of this procedure in the majority of countries over

✉ Tony Bazi
tb14@aub.edu.lb

1 Department of Obstetrics and Gynecology, Faculty of Medicine, American University of Beirut Medical Center, Riad El-Solh, Beirut1107 2020, Lebanon

the last several years. More than three million girls are estimated to be at risk of FGM annually [6].

Terminology

The extent of cutting during FGM varies according to the communities where it is practiced. In 2008, WHO issued a revised classification (from 1995) of FGM [3]:

Type I. Partial or total removal of the clitoris and/or the prepuce.
Type II. Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora.
Type III. Narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation).
Type IV. Unclassified: All other harmful procedures to the female genitalia for nonmedical purposes for example, pricking, piercing, incising, scraping and cauterization.

Each of the first three types is further classified into subtypes depending on the extent of excision. Type I is the most common, while type III, that is most likely to occur in Somalia, northern Sudan and Djibouti, is experienced by about 10% of all affected women. In most communities, the cutting is traditionally assigned to the local birth attendant, an elderly woman in most instances [7]. In other areas, it comes with the job description of the local barber who also assumes the role of the health-care giver. The procedure is carried out with sharp objects such as scissors, razors, glass, or sharpened rocks, often without the use of anesthetics. Home-made remedies are used to stop bleeding. However, estimates from a 2016 publication reveal that, in some countries such as Egypt, Indonesia, Kenya and Sudan, more than 50% of the procedures are carried out by "health professionals" [4]. "Medicalization" of FGM refers to its performance by a licensed health-care provider. In fear that medicalization may perpetuate FGM, WHO issued a guiding principle stating that medicalization is "never acceptable", as it violates medical ethics [8].

FGM is a cultural rather than a religious practice. There is no mention of alteration of the female genitalia in any officially adopted text of any religion. Whether any one of the WHO classification types of FGM is uniformly adopted within each community is a manifestation of the sociocultural background of this ritual. Ethnicity is by far the strongest predictor of the practice of FGM. As an illustration, the ritual is practiced in 98% of ethnic Somalis living in Kenya (similar to the rate in Somalia) compared with a far lower national Kenyan average of 27% [9]. In other words, the practice is not constrained by national borders.

Timing

FGM may take place any time between infancy and adulthood; but its scheduled timing is closely linked to its "functional objectives". It is essential to recognize that functional objectives are not only diverse, but can be even divergent, depending on the cultural background of the community. These could include identity preservation, maintenance of cleanliness or esthetics, ensuring virginity until marriage, assumption of male sexual pleasure enhancement, or – most commonly – a rite of passage from one status to another (initiation into womanhood) [10]. Furthermore, it may be carried after the birth of the first child. To reiterate, communities where FGM is practiced are heterogeneous and do not necessarily share common beliefs.

United Nations involvement

In 1979, the Commission on Human Rights, a United Nations agency, issued a statement calling for the elimination of FGM [11]. Involvement of WHO was mostly publicized in 1997, when it issued a joint statement with the United Nations Children's Fund (UNICEF) and the United Nations Population Fund (UNFPA) addressing the implications of FGM with regard to public health and human rights, and calling for its abandonment [12]. In December 2012, the United Nations General Assembly adopted a historic resolution on the elimination of FGM across the globe, urging "states to pursue a comprehensive, culturally sensitive, systematic approach that incorporates a social perspective and is based on human rights and gender-equality principles" [13]. An international day of "zero tolerance to FGM" (6 February each year) has been recognized.

Consequences

The immediate complications of FGM include hemorrhage, urethral or bladder trauma, urinary retention, sepsis and death [14]. It is important to note that such complications are usually reported only when health care is actively sought, and therefore may represent only the tip of the iceberg.

Well-documented morbidities occur mostly with type III FGM, and include voiding dysfunction, hematocolpos, clitoral neuroma, dyspareunia, urethral stricture, fistula, urine retention, urinary tract infections, prolonged labor, and difficult delivery [15, 16]. Repeat cutting, for the purpose of defibulation is often necessary to allow vaginal birth in women subjected to type III FGM [17]. Tetanus, hepatitis, and HIV transmission can occur secondary to repeated use of nonsterile cutting objects. Data from some referral centers in the developed world where women with FGM have been cared for, reveal that many of the obstetric complications can be prevented with a dedicated professional multidisciplinary approach [18].

The impact of FGM on sexuality is difficult to evaluate for many reasons. First, there is a differential effect on organs and nerves, depending on the type and extension of FGM. Second, the psychological aspect in affected women cannot be independently evaluated. Furthermore, the concept of sexuality largely depends on social acceptance, and is variable across cultures, thus hindering a proper objective evaluation by "outside" researchers. While most data point to a negative effect, there is evidence that women who have not suffered negative health consequences, and who regarded FGM as a positive experience continue to have sexual fulfillment, including orgasm [19]. Using magnetic resonance imaging and validated sexual function questionnaires, a unique study conducted in Switzerland evaluating 15 women with FGM concluded that sexual erectile tissue for arousal and orgasm is mostly preserved, and participants did not score lower on many Sexual Function Index subscores, when compared with a matched group without FGM [20]. It is noteworthy that surgical reversal of the anatomic alterations after clitoridectomy does not guarantee "normalization" [21].

Interventions to eliminate FGM

There is scarcity of evidence regarding the efficacy of interventions to stop, or at least curb the practice of, FGM [22]. Different approaches have been empirically adopted, including targeting FGM practitioners, health risk education about the harmful effects of the practice, alternative rites of passage (ARP), integrated social development, and others [23]. None of these approaches can be universally adopted in all communities. FGM is now considered illegal in the vast majority of countries where it is practiced [9]. However, passing laws against FGM has not been as effective as hoped in having a serious impact on the frequency of FGM, except where strict enforcement has been coupled with strong advocacy efforts [24]. The adoption of ARP involves replacing obviously harmful with "symbolic" procedures that do not cause morbidity, such as a "skin prick" with minimal blood-letting [25]. This approach may be successful only in communities where FGM is strictly a ritual rather than aiming at specific discernible anatomical alterations of functional significance. Attempts by some US health professionals to adopt ARP as a culturally sensitive solution that prevents harm while appeasing immigrant communities have been met with strong resistance by US-based activists [5, 10], and ARP has never become acceptable. A holistic approach such as integrated social development seems to be most promising. In Senegal, a multidimensional program including empowerment of women, supporting literacy, involving men in discussions, and seeking the support of religious and community leaders, has proved to be very successful in sharply decreasing the incidence of FGM [23].

Curbing the practice of FGM has been inconsistent among communities and countries. Over the last two decades, the incidence of FGM has been halved or more than halved in some countries including Liberia, Burkina Faso, Benin, Senegal, Central African Republic, Kenya, and Nigeria. The same is not true in Djibouti, Guinea, and Somalia. where the incidence has barely changed [6]. This is proof that the legal framework, while carrying limited persuasive power, is not enough to produce significant change.

In an attempt to objectively evaluate the morbidities related to FGM, Arora and Jacobs suggested adopting a new classification system, with the contention that the WHO classification inadequately reflects the health consequences of the procedure [26]. In their proposal, there are five categories strictly related to health consequences, and not based on anatomical description. Category I includes procedures where no lasting effect on morphology or function is expected, while category V, at the end of spectrum, includes any procedure likely to cause major physiological dysfunction or even death. For comparison, a "small nick" on the vulvar skin (WHO type IV) would be category I, while (theoretically) an intentional avulsion of the clitoris that results in uncontrollable hemorrhage and death (WHO type I) would be classified as category V. Arora and Jacobs went on to suggest that parents should be granted authority to determine whether their girls should undergo category I or II, as long as no long-term harm is expected. WHO strongly opposed the suggestion and labeled this stand a call "to perpetuate female genital alteration" [27].

What is the role of the medical profession?

Far from "cultural judgement", the strong evidence of physical and emotional harm resulting from the vast majority of these procedure calls for a more serious involvement of health professionals. As a start, there is a need for serious documentation of observational data, and for provision of unbiased analysis. There continue to be real gaps in research related to FGM, considering the gravity of the problem and the number of affected women [28]. FGM has received far more coverage in the literature related to ethics, human rights, and anthropology than in the medical literature. Searching the electronic database of the *International Urogynecology Journal* from 1995 to the present for "female genital mutilation" or "female genital cutting" or "female circumcision" revealed a total of 11 results (including meeting abstracts) [29–39], while a search for "painful bladder syndrome" revealed 108 results. For comparison, the number of women affected with painful bladder syndrome, roughly estimated at 0.5% of the female population, is almost one tenth the number of women with FGM. What is noticeable is that most of the research (health-related or otherwise) has been taking place in countries not on the map of FGM, where resources and support cannot be compared with those available in the native environment of most women with FGM. This partly explains the inconsistency in the health-related outcomes described in different publications. Evaluation of IUGA membership in 2016 revealed that only 24 members (out of a total of 3,100 members) originate from 30 countries on the map of FGM.

There is a call on medical organizations of relevance to provide a platform to professionals and advocates from the geographic areas where the problem continues to exist to raise awareness, present first-hand data, and most importantly, identify research topics of interest.

In August 2016, IUGA hosted, during its 41st Annual Meeting in Cape Town, Dr. S. Tall and Dr. J. Kulea as speakers in a "state of the art lecture" entitled "Female Genital Mutilation: Health Concern and Rights Violation". Dr. Tall, from the Cape Town office of UNFPA, presented a brief synopsis on the current data regarding FGM and the involvement of United Nations agencies. Dr. Kulea is the founder of Samburu Girls Foundation in Kenya, a grass roots organization involved in empowering girls, rescuing them from FGM and early marriage and providing assistance in school attendance. It is through such platforms that an international audience gets first-hand exposure to a large-scale problem. In view of the nature of the morbidity resulting from FGM, our association (IUGA) whose motto is "Advancing Urogynecological Knowledge Around the World", is called upon to continue to provide such platforms and to dedicate proportionate interest to an issue of this magnitude.

Compliance with ethical standards

Conflicts of interest None.

References

1. Kouba LJ, Muasher J. Female circumcision in Africa: an overview. Afr Stud Rev. 1985;28:95–110.
2. Hosken FP. The Hosken report: genital and sexual mutilation of females. Lexington: Women's International Network News; 1979.
3. World Health Organization. Eliminating female genital mutilation. An interagency statement (OHCHR, UNAIDS, UNDP, UNECA, UNESCO, UNFPA, UNHCR, UNICEF, UNIFEM). Geneva: World Health Organization; 2008. http://www.un.org/womenwatch/daw/csw/csw52/statements_missions/Interagency_Statement_on_Eliminating_FGM.pdf. Accessed 11 Nov 2016.
4. United Nations Children's Fund. Female genital mutilation/cutting: a global concern. New York: United Nations Children's Fund; 2016. https://data.unicef.org/wp-content/uploads/2016/04/FGMC-2016-brochure_250.pdf. Accessed 11 Nov 2016.
5. Equality Now. Female genital mutilation (FGM) in the United States. New York: Equality Now; 2016. http://www.equalitynow.org/sites/default/files/FGM_US_fact_sheet.pdf. Accessed 11 Nov 2016.
6. United Nations Children's Fund. Female genital mutilation/cutting: a statistical overview and exploration of the dynamics of change. New York: United Nations Children's Fund; 2013. http://data.unicef.org/wp-content/uploads/2015/12/FGMC_Lo_res_Final_26.pdf. Accessed 11 Nov 2016.
7. Arbesman M, Kahler L, Buck G. Assessment of the impact of female circumcision on the gynecological, genitourinary and obstetrical health problems of women from Somalia: literature review and case series. Women Health. 1993;20:27–42.
8. World Health Organization. WHO guidelines on the management of health complications from female genital mutilation. Geneva: World Health Organization; 2016. http://www.who.int/reproductivehealth/topics/fgm/management-health-complications-fgm/en/. Accessed 11 Nov 2016.
9. United Nations Population Fund. Female genital mutilation (FGM) frequently asked questions. New York: United Nations Population Fund; 2015. http://www.unfpa.org/resources/female-genital-mutilation-fgm-frequently-asked-questions. Accessed 11 Nov 2016.
10. Vissandjée B, Kantiébo M, Levine A, N'Dejuru R. The cultural context of gender, identity: female genital, excision and infibulation. Health Care Women Int. 2003;24:115–124.
11. Office of the United Nations High Commissioner for Human Rights. Fact sheet no. 23: Harmful traditional practices affecting the health of women and children. Geneva: Office of the United Nations High Commissioner for Human Rights; 1979. http://www.ohchr.org/Documents/Publications/FactSheet23en.pdf. Accessed 11 Nov 2016.
12. World Health Organization. Female genital mutilation: a joint WHO/UNICEF/UNFPA statement. Geneva: World Health Organization; 1997. http://apps.who.int/iris/bitstream/10665/41903/1/9241561866.pdf. Accessed 11 Nov 2016.
13. United Nations. General Assembly. Resolution adopted by the General Assembly on 20 December 2012: 67/146. Intensifying global efforts for the elimination of female genital mutilations. New York: United Nations; 2012. http://www.un.org/ga/search/view_doc.asp?symbol=A/RES/67/146. Accessed 11 Nov 2016.
14. Dare FO, Oboro VO, Fadiora SO, Orji EO, Sule-Odu AO, Olabode TO. Female genital mutilation: an analysis of 522 cases in South-Western Nigeria. J Obstet Gynaecol. 2004;24:281–283.
15. WHO Study Group on Female Genital Mutilation and Obstetric Outcome, Banks E, Meirik O, Farley T, Akande O, Bathija H, Ali M. Female genital mutilation and obstetric outcome: WHO collaborative prospective study in six African countries. Lancet. 2006;367:1835–1841.
16. Berg RC, Underland V, Odgaard-Jensen J, Fretheim A, Vist GE. Effects of female genital cutting on physical health outcomes: a systematic review and meta-analysis. BMJ Open. 2014;4(11), e006316. doi:10.1136/bmjopen-2014-006316.
17. Collinet P, Sabban F, Lucot JP, Boukerrou M, Stien L, Leroy JL. Management of type III female genital mutilation. J Gynecol Obstet Biol Reprod. 2004;33:720–4.
18. Wuest S, Raio L, Wyssmueller D, Mueller MD, Stadlmayr W, Surbek DV, et al. Effects of female genital mutilation on birth outcomes in Switzerland. BJOG. 2009;116:1204–1209.
19. Catania L, Abdulcadir O, Puppo V, Verde JB, Abdulcadir J, Abdulcadir D. Pleasure and orgasm in women with female genital mutilation/cutting (FGM/C). J Sex Med. 2007;4:1666–1678.
20. Abdulcadir J, Botsikas D, Bolmont M, Bilancioni A, Djema DA, Bianchi Demicheli F, et al. Sexual anatomy and function in women with and without genital mutilation: a cross-sectional study. J Sex Med. 2016;13:226–237.
21. Abdulcadir J, Rodriguez MI, Say L. A systematic review of the evidence on clitoral reconstruction after female genital mutilation/cutting. Int J Gynaecol Obstet. 2015;129:93–97.

22. Balfour J, Abdulcadir J, Say L, Hindin MJ. Interventions for healthcare providers to improve treatment and prevention of female genital mutilation: a systematic review. BMC Health Serv Res. 2016;16:409. doi:10.1186/s12913-016-1674-1.
23. Toubia NF, Sharief EH. Female genital mutilation: have we made progress? Int J Gynaecol Obstet. 2003;82:251–261.
24. Muthumbi J, Svanemyr J, Scolaro E, Temmerman M, Say L. Female genital mutilation: a literature review of the current status of legislation and policies in 27 African countries and Yemen. Afr J Reprod Health. 2015;19:32–40.
25. Puppo V. Female genital mutilation and cutting: an anatomical review and alternative rites. Clin Anat. 2016. doi:10.1002/ca.22763.
26. Arora KS, Jacobs AJ. Female genital alteration: a compromise solution. J Med Ethics. 2016;42:148–54.
27. Arora KS, Jacobs AJ. Response to WHO. J Med Ethics. 2016;42:620.
28. Abdulcadir J, Rodriguez MI, Say L. Research gaps in the care of women with female genital mutilation: an analysis. BJOG. 2015;122:294–303.
29. Wall LL. Obstetric fistulas: hope for a new beginning. Int Urogynecol J. 1995;6:292–295.
30. Norman AM, Breen M, Richter HE. Prevention of obstetric urogenital fistulae: some thoughts on a daunting task. Int Urogynecol J. 2007;18:485–491.
31. Espuña Pons M. Sexual health of women with pelvic floor disorders. Int Urogynecol J Pelvic Floor Dysfunct. 2009;20 Suppl 1:S5–S7.
32. Dirim A, Hasirci E. Labial fusion causing urinary incontinence and recurrent urinary tract infection in a postmenopausal female: a case report. Int Urogynecol J. 2011;22:119–120.
33. Bazi T, Abou-Ghannam G, Khauli R. Female urethral dilation. Int Urogynecol J. 2013;24:1435–1444.
34. Iglesia C, Yurteri-Kaplan L, Alinsod R. Female genital cosmetic surgery: a review of techniques and outcomes. Int Urogynecol J. 2013;24:1997–2009.
35. Teufel K, Dörfler DM. Female genital circumcision/mutilation: implications for female urogynaecological health. Int Urogynecol J. 2013;24:2021–2027.
36. Numann PJ. Women's health care in low income countries. Int Urogynecol J. 2014;25:721–723.
37. Anand M, Occhino JA, Stanhope T. Female genital mutilation reversal: a general approach. Int Urogynecol J. 2014;25:985–986.
38. Duvalla S, Naidu M, Johnson A. Female genital mutilation and obstetric outcomes. In: Selected abstracts from the annual research meeting of the British Society of Urogynaecology 2014. Int Urogynecol J. 2015;26:1701. doi:10.1007/s00192-015-2664-2.
39. Singh A, Swift S, Khullar V, Digesu GA. Laser vaginal rejuvenation: not ready for prime time. Int Urogynecol J. 2015;26:163–164.