**Aims of Workshop**
The ICS has recently published a White Paper on the issue of Female Genital Cutting/Mutilation. Among other actions, in this paper the ICS pledges to "Educate our members--raising awareness, exploring ethical issues, stimulating interest". The Aim of this workshop is to serve as an initial action by the ICS to fulfill the promise. The Aims of the Workshop are to:

1. Explain the background of FGM/C
2. Describe the current scope of the problem
3. Evaluate prevention efforts
4. Provide a general clinical approach to a patient after FGM/C

**Learning Objectives**
1. Describe this history of FGM/C and the socio-cultural milieu that supports its current practice.
2. Become prepared to identify, counsel and treat patients following FGM/C
3. Understand the ICS Action Plan for FGM/C

**Target Audience**
Urology, Urogynaecology, Conservative Management

**Advanced/Basic**
Basic

**Suggested Learning before Workshop Attendance**

**Description**
Female Genital Mutilation/Cutting (FGM/C), in its official World Health Organization Definition, “comprises all procedures that involve the partial or total removal of external genitalia or other injury to the female genital organs for non-medical reasons.” FGM/C is distinguished from female genital cosmetic surgery by consensual and other factors. There are no health benefits to this procedure and exposes women and girls to significant short and long-term risks. FGM is a deeply ingrained sociocultural practice in many countries. The practice is seen within a range of cultures including Muslim, Animist and Christian; it predates the Islamic and Christian religions and mention is absent from both the Koran and the Bible.

The WHO Guidelines state that “FGM violates a series of well-established human rights principles”, many other international groups have called for an end to the practice, and it is outlawed in many countries. Despite this, FGM is practiced in 30 countries around the world. An estimated 200 million women have undergone FGM to date and 3 million are at risk each year. The vast majority of FGM occurs in children prior to the age of 15. Although the majority procedures are performed in sub-Saharan, women with FGM live throughout the world. Providers understand the potential medical, psychological, and cultural factors surrounding FGM. ICS members from all countries may encounter such women in their clinics and should be prepared to care for them with insight, skill and compassion.
The WHO classification distinguishes four basic types of FGM with subclassifications. These comprise a very wide range of practices from the extreme of removing all the external genitalia and covering/narrowing the introitus to genital piercings. Accurate classification requires examination by a trained observer. Classification may have value to those living with FGM—in research to understand the potential risks associated with the condition, optimal treatments, and in communication among caregivers of these patients. For example, there are many studies focused on obstetric issues surrounding FGM—particularly type III.

There is a dominant view in the mass media and among authorities in Western host countries, stating that FGM is secretively practiced on a large scale among some immigrant groups in western countries. In contrast to this, a growing body of research in these host countries indicates that processes of cultural change are occurring among immigrant communities from areas where girls traditionally are subjected to what is construed as ‘circumcision’. Many studies show growing opposition to these practices among people who have migrated to the West, and there is little evidence to support the assertion that large-scale illegal activities are prevalent.

Inadequate ideas among healthcare providers and other professionals – ideas about widespread illegal activities among these immigrants – may negatively affect women and girls with their origin in these countries. When they seek care from healthcare staff, the encounters may be influenced by unfounded suspicions and concerns about illegal FGM procedures.

Before management, it is important that clinicians be able to screen and recognize FGM/C and its eventual complications. It behooves ICS members to be aware of the condition and to be prepared to identify and care for these patients. Women who have experienced FGM/C may not know what unaltered anatomy looks like, what type of FGM/C they have personally experienced, and the current symptoms may be so remote from the FGM/C that they do not associate the cause and effect. Because FGM/C can be viewed as a “coming of age” event many women are proud of having undergone the procedure and may not be experiencing any ill effects. Therefore; it is important that the clinician bring an open mind (and heart) to the consultation. It is essential to evaluate and counsel her within the context of her heritage and life experiences.

There are many ethical controversies surrounding FGM/C; two especially relevant concerns for ICS members are Type IV procedures and re-infundibulation.

Court cases in the US and Australia have concerned Type IV procedures in the form of nicking or scraping, with no removal of tissue. These procedures are legally challenging, since many legislations do not include this kind of Type IV acts in the wording of the laws. Many Western adult women seek out labial piercings which would be considered a Type IV procedure. Further, they are difficult for medical experts to assess, since such procedures generally do not leave any scarring or other physical signs.

The harm resulting from nicking or scraping is disputed, especially among scholars who compare with the ubiquitously accepted circumcision of infant boys. Yet, the WHO thus far include pricking, nicking, and scraping in their classification of different forms of ‘female genital mutilation’ following their zero-tolerance approach. They assert that acceptance of some of these Type 4 procedures may led to a legitimization of FGM and create an opening for more invasive procedures.

This lack of gender equality, and ongoing inconsistency in how harm is assessed in children of different genders, gives rise to increasing criticisms in international debates.

Women who have experienced Type III FGM/C should typically undergo defibulation to open the vagina prior to delivery. It is not uncommon for these women to ask to undergo reinfibulation in the post-partum period. These women may perceive the infibulated genitalia as normal, more beautiful, and “sexier,” as well as a need to be “as before” (before delivery), to be recognized by the family as honorable, and to provide more pleasure to the husband. This situation presents a unique challenge to a clinician who may view the procedure with abhorrence. A Prepartum, peripartum, and postpartum counseling protocol for women who request reinfibulation has been proposed and will be reviewed.

The ICS position is that:

1. FGM/C should be prevented and progressively eradicated.
2. Healthcare professionals should not perform FGM/C, as medicalization of the practice does not prevent many of the complications. Healthcare professionals should be trusted promoters of prevention/abandonment of the practice and care of already affected women and girls.
3. FGM/C complications should be screened, recognized, treated, and recorded appropriately and ultimately prevented.

ICS and its Members will lend support and act to:

1. Educate:
   • Support the work of practitioners treating high volumes of patients with FGM/C throughout the world through assistance in creating, presenting, filming and distributing educational material (See www.ics.org/tv, https://www.ics.org/committees/education/icssops).
• Educate health care workers, patients, and communities regarding FGM/C—raising awareness, exploring medical, ethical and cultural issues, consequences of FGM/C, and management.
• Work within communities to engage women and men regarding the medical risks of FGM/C and to lift the myths perpetuating this practice.

2. Research:
   • Lend our expertise to define the benefits and risks of post-FGM/C intervention, and to further characterize the health consequences.
   • Support and/or conduct studies to define optimal care of those with FGM/C.

3. Provide Care:
   • Provide neutral, clear, non-alienating information to women and girls who have experienced FGM/C regarding its meaning to her individual situation, and options for care.
   • To provide holistic care always, high quality reconstructive surgery where appropriate, and to support colleagues in high prevalence areas of the world when opportunities arise.

4. Advocate:
   • Partner with affected women and girls and other associations regarding FGM/C.
   • Promote government support for medical care of women who have had FGM/C, including culturally fluent psychological care.
   • Work within communities to promote the healthy coming-of-age rituals associated with FGM/C while removing the permanently damaging risks associated with FGM/C.
Female Genital Cutting/Mutilation: Background

Christopher K. Payne, MD
Vista Urology & Pelvic Pain Partners
Emeritus Professor of Urology at Stanford

FGM/C Definition

“comprises all procedures that involve the partial or total removal of external genitalia or other injury to the female genital organs for non-medical reasons.”

WHO Guidelines 2016

FGM/C Facts

- An engrained sociocultural practice
- There is no medical benefit
- There are well documented harms
- Most of those who are cut are children
- It violates basic human rights

100 to 140 million women living with FGM/C
3 million new procedures each year
30 million girls at risk/10 years

FGM/C Myths

- It is based in religion
- It has widespread support where practiced
- The solution is to ban the procedure
- Women & girls are universally ashamed and traumatized by FGM/C

Rationale Given for FGM/C

- Tradition/Convention
- Marriageability
- Chastity
- Fertility
- Rite of Passage
- Religious
- Hygiene/Beauty
- Increase male sexual pleasure

From Dr. Anwal Nour
Laws against FGM/C

In US: Federal Law and at least 17 state laws

Center for Reproductive Rights 2009

Who is Cut--Geography

UNICEF 2013

FGM/C Classification

- Type I: Partial or total removal of the clitoral glans (clitoridectomy) and/or the prepuce
- Type II: Partial or total removal of the clitoral glans and the labia minora, +/- excision of labia majora (excision)
- Type III: Narrowing and sealing the vaginal opening by cutting and suturing the labia minora or labia majora, +/- excision of the clitoris (infibulation)
- Type IV: All other harmful procedures for non-medical purposes, for example pricking, piercing, incising, scraping and cauterization

UNICEF 2013
Type I

- **Type I**: Partial or total removal of the clitoral glans (clitoridectomy) and/or the prepuce

Type II

- **Type II**: Partial or total removal of the clitoral glans and the labia minora, +/- excision of labia majora (excision)

Type III

- **Type III**: Narrowing and sealing the vaginal opening by cutting and suturing the labia minora or labia majora, +/- excision of the clitoris (infibulation)

Type IV

- **Type IV**: All other harmful procedures for non-medical purposes, for example pricking, piercing, incising, scraping and cauterization
Type IV

Geographic Prevalence

Geography of FGM/C

• Type 1: Primarily East Africa
• Type 2: Primarily West Africa
• Type 3: Somalia, North Sudan, Southern Egypt

Immediate Complications

• Hemorrhage
• Infection—sepsis, tetanus, etc.
• Pain
• Psychological trauma

Geographic Utilization
Long-term complications

- Sexual—pain, dysorgasmia
- Obstetric
- Urinary—voiding, UTIs
- Pain
- Psychological/PTSD
- Male sexual pain/difficulty
- Other
FGM/C in immigrant communities

Sara Johnsdotter
Professor in Medical Anthropology
Malmö University
Sweden

FGM illegal in western countries

Legal ban in Australia, Canada, New Zealand, USA and countries in Western Europe

Illegal FGM secretly going on in immigrant communities?

African midwives flown in for FGM ‘parties’

Mother jailed for 11 years in first British FGM conviction

EUROPE
Fewer than 25 FGM criminal court cases since 1990

POSSIBLE SCENARIO 1
“FGM is going on in Europe but in the form of underground activities”
“High number of unreported cases”

POSSIBLE SCENARIO 2
“Large-scale cultural change is happening”
“General abandonment of FGC practices”

1
2
3
4
5
6
Clinical encounters

- Try to put aside your preconceptions of FGM/C
- Be an active listener
APPROACH TO THE PATIENT WITH FEMALE GENITAL MUTILATION/CUTTING

Jasmine Abdulcadir, MD PD FECSM
Department of the woman, the child and the adolescent
jasmine.abdulcadir@hcuge.ch

DIVERSITY AMONG WOMEN AND GIRLS WITH FGM/C

Biological factors
- Type of FGM/C, severity, involvement of the clitoris
- Long term complications (cysts, neuromas, fissures, recurrent genitourinary infections)
- Past obstetric perineal trauma

Psychological factors
- Depression, Anxiety, PTSD
- Personal coping strategies of the past experience of FGM/C
- Other past traumatic event (war, rape, forced marriage)

Sociocultural factors
- More than 30 countries (different cultures, religions)
- Education, attitude about FGM/C, anatomy, physiology, sexuality
- Myths, beliefs, taboos, social norms
- Migration, Acculturation

A considerable number of women are capable of coping with most impediments and may regard the ritual as ‘normal’ and not sickening. Diversity in interpreting the events and the level of remembrance is crucial for experiencing psychopathology.

Knipsher 2015

NEED OF TRUSTED AND TRAINED CERTIFIED INTERPRETERS, CULTURAL MEDIATORS, CULTURAL EXPERTISE
<table>
<thead>
<tr>
<th>Country</th>
<th>Language</th>
<th>Traditional word</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Egypt</td>
<td>Arabic</td>
<td>Tahara</td>
<td>Tahara= clean, purified, circumcision</td>
</tr>
<tr>
<td></td>
<td>Khitan</td>
<td>Khitan</td>
<td>Khat = reduction</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>Amharic</td>
<td>Megrez</td>
<td>Circumcision</td>
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<td></td>
<td>Harrari</td>
<td>Abures</td>
<td>Ritual</td>
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<td></td>
<td>Tiogna</td>
<td>Mekhishab</td>
<td>Circumcision/Cutting</td>
</tr>
<tr>
<td>Kenya</td>
<td>Swahili</td>
<td>Kutori (masho)</td>
<td>Circumcision</td>
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<tr>
<td>Nigeria</td>
<td>Igbo</td>
<td>Ik/Mpeku</td>
<td>Cutting</td>
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<tr>
<td>Sierra Lea</td>
<td>Temneé</td>
<td>Bondo</td>
<td>Initiations/Ritual/Training</td>
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<td>Mandingue</td>
<td>Limba</td>
<td>Bondo</td>
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<td>Temneé</td>
<td>Bondo</td>
<td>Bondo</td>
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<tr>
<td>Somalí</td>
<td>Somali</td>
<td>Gudniin</td>
<td>Circumcision/Cleaning</td>
</tr>
</tbody>
</table>

FOR HEALTH PROFESSIONALS AND SOME PATIENTS

1. Social implications
   - Important rooted traditional practice
   - Social and Economic status to child and family
   - If refused: stigma, shame and social exclusion

2. Gender implications
   - The child becomes a woman (individually and in the community)
   - Honour, pride of being part of the group, social and cultural identity
   - Guarantee of wedding
   - Clitoris and female genitals: false beliefs

3. Aesthetic and personal implications
   - Genitals considered more beautiful, sexier, cleaner
   - Guarantee of virginity, chastity and marital fidelity

FOR HEALTH PROFESSIONALS AND SOME PATIENTS

1. Biological implications
   - Genital mutilation; elimination of sexual pleasure-preservation of reproductive function
   - Health consequences and risks
   - Unnecessary psychophysical damage

2. Ethical implications
   - Wrong value of female identity and women’s value
   - Unfair inequality of sexual freedom between man (control of female sexuality) and woman
   - Remaining of an ancient patriarchal and primitive practice

3. Legal implications
   - Abuse and violence on children/women
   - Severe and irreversible lesion to female psychophysical integrity
   - International human rights
   - Migrated

PERSONALISED HOLISTIC APPROACH TO THE PATIENT WITH FGM/C

WELCOME no stigma/prejudices

MEDICAL HISTORY AND EXAM

DIAGNOSIS
- Delivery
- Medical history

TREATMENT
- Surgical/non-surgical/psychosexual/information

RECORDING, DOCUMENTATION, CODING, CERTIFICATES FOR ASYLUM SEEKING PROCEDURES

HOW TO START....

1. Opening the conversation:
   - Ask during routine history, in a neutral tone, among routine questions, prior to the exam

2. Discussing FGM/C
   - Does the patient know if she is cut? Does she need to further discuss about it (e.g. medical condition related to FGM/C)? Is she ready to discuss?

3. Providing information and developing a care plan:
   - Explain treatment options. Give time. Check if the patient understood. Make sure you know her expectations, fears, beliefs. Include the partner if needed and in agreement with the patient. Use a preferably female certified interpreter, who is accepted by the patient

WHO 2018

1. Social implications
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COMPLICATIONS IN WOMEN AND GIRLS WITH FGM/C

SHORT TERM
- Haemorrhage
- Pain
- Shock
- Haemorrhagic, neurogenic or septic

INFECTIONS
- Abscess, local infection, tetanus, septicaemia, genital and reproductive tract infections, urinary tract infections
- The direct association between FGM and HIV remains unclear, although the disruption of genital tissues may increase the risk of HIV transmission.

URINARY
- Acute urine retention, dysuria, pain passing urine, injury to the urethra

WOUND HEALING PROBLEMS
- Dehiscence

WHO 2016
**Complications in Women and Girls with FGM/C**

### Long Term

<table>
<thead>
<tr>
<th>Domain</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obstetric</td>
<td>Caesarean section (mainly due to inappropriate obstetrical practices)</td>
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<tr>
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<td>Difficult/impossible-urinary catheterisation</td>
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<td></td>
<td>Increased risk of episiotomy, perineal tears, postpartum haemorrhage, prolonged second stage of labour</td>
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<td>Prolonged labour</td>
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<td></td>
<td>Negative neonatal outcome</td>
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<td></td>
<td>Extended maternal/hospital stay</td>
</tr>
<tr>
<td>Genitourinary</td>
<td>Dysesthesia, sensory increased frequency, urinary incontinence (e.g., executive bladder IV type III), voiding problems, intermenstrual, terminal dribbling, straining and slow stream, post-micturition dribbling, incomplete emptying, external behind the scar of infibulation due to urine stagnation</td>
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<tr>
<td></td>
<td>Obstetric urinary infection</td>
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<tr>
<td></td>
<td>Obstructed micturition flow in case of type III</td>
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<tr>
<td></td>
<td>Vaginal/lower urethra (e.g., epidermoid cyst, post-traumatic neuroma of the clitoris)</td>
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<tr>
<td></td>
<td>Recurrent vulvar fissures, Vulvar bridles, Painful incarcerations of the clitoris</td>
</tr>
<tr>
<td>Sexual</td>
<td>Difficult or impossible penetration</td>
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<tr>
<td></td>
<td>Dyspareunia</td>
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<tr>
<td></td>
<td>Vaginismus (e.g., secondary to pain)</td>
</tr>
<tr>
<td></td>
<td>All phases of sexual response negatively affected</td>
</tr>
<tr>
<td>Psychological</td>
<td>Post-traumatic stress disorder, Anxiety disorder, Depression</td>
</tr>
</tbody>
</table>

### Case Report

**Overactive bladder after female genital mutilation/cutting (FGM/C) type III**

Jasmine Abdulcadir, Patrick Dähnert


- Defibulation
- Pelvic floor therapy

### 1.1 FGM/C Type III

- Patient: 27 yo, Somalia
- Conditions: Primary dysmenorrhea, superficial dyspareunia and impossible penetration

### 1.2 FGM/C Type III

- Patient: 17 yo, Gambia
- Conditions: History of violence, human trafficking, incitement to prostitution

### 2. Bridles

- Conditions: Superficial dyspareunia, coital bleeding, pain during movement (e.g., sport)
- Antimycotic
- Local treatment (ointment, dexamethasone)
- UIMPV

### 1.2 FGM/C Type III

- Posterior and superior defibulation
- Antimycotic
- Local treatment (ointment, dexamethasone)

### 2. BRIDLES

- Antimycotic
- Local treatment (ointment, dexamethasone)
- UIMPV
3.1 PAINFUL PARACLITORAL CYST

17 YO. 0G. Somalia

Unaccompanied immigrant minor

Forced marriage and defibulation before marriage in Somalia

Chronic pain and coital para-clitoral pain. Currently non sexually active

Partially defibulated FGM/C type III. Para-clitoral cyst (1.5 cm, independent from the clitoris at MRI)

3.1 PAINFUL PARACLITORAL CYST: epidermoid cyst

Surgical cystectomy

Defibulation completed

Epidermoid cysts after FGM/C are NOT always painful

3.2 PAINFUL PARACLITORAL CYST

31 yo 4G3P. Somalia

Defibulated FGM/C type III (defibulation in labor)

Cyst appeared after the second delivery. Chronic and coital pain. Sexual pleasure and orgasm.

Increase in size of the cyst during period. Asymptomatic during her 3rd pregnancy

No other symptoms of endometriosis

3.2 PAINFUL PARACLITORAL CYST: benign inflamed mullerian cyst

Surgical excision

Resolution of pain

Epidermoid cysts and mullerian cysts are NOT always painful!
3.2 PAINFUL PARA CLITORAL CYST

24 yo. 0G. Somalia
Primary dysmenorrhea, painful paracitoral cyst
Neuropathic chronic pain
FGM/C type III. Painful supra-clitoral cyst

PAINFUL PARA CLITORAL CYST

4. CLITORAL PAIN

21 yo. 0G. Ivory Coast
Coital and post-coital clitoral pain. Sexual pleasure and orgasm. Clitoral reconstruction request (to decrease pain and improve genital self image)
FGM/C type III. Pain during palpation of the clitoral region. No palpable mass

CLITORAL PAIN

4.1 CLITORAL PAIN

Resolution of PTSD
Resolution of clitoral pain
Improvement of sexual function and body image/gender identity/feeling of “having back what was stolen from her without permission”
4.3 CLITORAL PAIN

- 23-year-old. OG. Somalia
- FGM/C type I. Clitoral pain and superficial dyspareunia. Several inconclusive gynecological examinations
- Clitoris entrapped under the scar of the clitoral hood (phimosis)

Abdulcadir 2019

4.3 CLITORAL PAIN

- Exposure of the intact clitoral glans and reconstruction of the prepuce of the clitoris.
- Resolution of pain. Improved sexual response

Abdulcadir 2019

SURGICAL TREATMENTS for women with FGM/C

- Defibulation
- Surgical treatment of scar complications: cysts (epidermoid/mullerian/abscess), bridles/adhesions, post-traumatic neuroma, keloids (?)
- Clitoral reconstruction

Abdulcadir 2019

DEFIBULATION

- Simple surgery
- Local, loco-regional, general anesthesia
- Complex change
- Recall of past traumatic events or past FGM/C
- PROMOTION OF THE HEALTH OF THE INFIBULATED WOMAN/GIRL
- Any time: during pregnancy/fist phase of labour/outside of pregnancy
- Treatment of genitourinary, obstetric and psychosexual complications
- Possibility of gynaecological screenings and exams

For us, the health professionals
• Better looking genitals
• Physiological genitals
• Improvement of sexual function
• Decrease of obstetric and infectious risks
• Physiological micturition
• Treatment of a ritual that is "barbaric and violent"
• Virginity/hymen≠infibulation

For her, the woman/girl
• Ugly genitals
• "Wide vagina"
• Fear of decreased sexual pleasure for the partner
• Wind can come in/Baby can fall out during pregnancy
• Fast micturition is vulgar, masculine and impolite
• Cultural change
• Fear of loss of premarital virginity

DEFIBULATION

Abdulcadir 2018
2nd trimester defibulation: advantages?

CLITORAL RECONSTRUCTION

WHO: Inconclusive evidence to state a recommendation in favor of clitoral reconstruction
RCOG: Clitoral reconstruction should not be performed because current evidence suggests unacceptable complication rates without conclusive evidence of benefit
2018
WHO: Little evidence. Women should be informed about this. If surgery is contemplated, it should be part of a multidisciplinary approach (psychosexual therapy, CBT, care of other past traumatic events)

Surgical techniques
Foldès 2004-2012
Uncut flap
(n=841 followed up at 1 year)
Resection of the cutaneous scar covering the clitoris. Isolation of the clitoral stump. Section of the suspensory ligament respecting the neurovascular bundle. Removal of periclitoral subcutaneous scar tissues. Repositioning of the neoglans in a physiologic position with a superior "anchorage" stitch fixing the neoglans to the two bulbocavernous muscles. This stitch would prevent/limit future retraction of the neoglans.

Ouedraogo et al. 2017
Gynaecologists
(n=68 followed up at 1 year)
Modification of the Foldès technique: no superior "anchorage" fixing the neoglans to the two bulbocavernous muscles. Such modification would not increase the rate of retraction of the neo-clitoris but would reduce post-operative pain.

O'Dey 2017
Plastic surgeon
(n=not available)
Anterior obturator artery perforator flap (aOAP flap) for clitoral reconstruction; an omega dermal flap (OD flap) for clitoral prepuce reconstruction, and a microsurgical procedure called neurotising and moulding of the clitoral stump (NMC3 procedure) for the clitoral tip.

Chang et al. 2017
Plastic surgeons
(n=3)
No mobilization of the clitoris, preservation of the scar tissue. Specific post-operative treatments with ointment and a suture dressing. Fat grafting.

Mañero, Lablanca 2018
Plastic surgeons
(n=32)
Foldès technique modified with a posterior vaginal wall graft grafted over the neo-clitoris. Bed rest, urinary catheter and antibiotherapy follow the surgery.
CLITORAL RECONSTRUCTION

I want what every other woman has: reasons for wanting clitoral reconstructive surgery after female genital cutting - a qualitative study from Sweden

Malin Jordal, Gabrielle Griffin & Inanne Sigurjonsdottir

• 5 core themes

Symbolic restitution: undoing the harm of FGC

Improving sex and intimacy through physical, aesthetic and symbolic recovery

CR as a personal project: offering hope

Eliminating physical pain

CLITORAL RECONSTRUCTION

Intérêt de la prise en charge multidisciplinaire des femmes excisées: bénéfices de la thérapie psychosexuelle pour excisées

E. Antonetti-Neyrat, E. Feil, L. Reiller

• Long multidisciplinary care

• Needs met by NON surgical care: surgery finally on 27/169 (15.9%)

• Screening and care of traumatic events other than FGM/C: 82/110 (74.6%) mainly sexual trauma (61 forced marriage, 52 rape during childhood)

NON SURGICAL TREATMENTS for women with FGM/C

• Pelvic floor therapy

• Psychosexual therapy/Sexual Counseling

• Health and Sex education (genital anatomy and physiology, sexual response, deconstruction of myths and false beliefs)

• Cognitive behavioral therapy

• Trauma(s) treatment

• “Resilience strategies”:
  ✓ Finding or creating positive meanings
  ✓ Treating anxiety and depression
  ✓ Enhancing social and partner’s support and communication
  ✓ Finding and exploring sexual activities and adaptive strategies that are culturally appropriate and without pain
  ✓ Couple therapy
  ✓ Acceptance and commitment therapy (a form of mindfulness based therapy, theorizing that greater well-being can be attained by overcoming negative thoughts and feelings)

Johnson Agboola 2017, Abdulcadir 2015 and submitted, Connor 2019

IN CONCLUSION

• Few available studies. Need of further research

• Surgical, non surgical and psychosexual treatments are available, safe and effective: defibulation, clitoral reconstruction, pelvic floor therapy, counseling, psychotherapy, CBT, psychosexual therapy, screening and management of other past traumatic events

• Women and girls with FGM/C should receive scientific, personalised, holistic, multidisciplinary and culturally sensitive care

• Women and girls with FGM/C should receive non stigmatising and scientific information

http://www.clitoraid.org

Happy is the Camped woman! An online website aimed at giving women with FGM/C a voice to talk about their experience

http://www.clitoraid.org/

http://baadon.com/en/
Ethical Issues in FGM/C
Type IV procedures

Sara Johnsdotter
Professor in Medical Anthropology
Malmö University
Sweden

The WHO classification

Type I
Type II
Type III
Type IV — All other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, piercing, incising, scraping and cauterization.

The WHO position

“legitimizes the practice of FGM and creates an opening for more invasive procedures”

(WHO et al. 2010)

Medical aspects

- Risk of infection
- Risk of nerve damage

No studies on complications following pricking

Difficult to establish through genital examination
Medical, legal, and political aspects

Next to impossible to find evidence of pricking through medical examination

Implications for healthcare

Implications for policymaking

Implications for legal action

Legal and ethical aspects

Difficult to substantiate legal action

→ Often rests on medical affidavits

Medical experts often disagree in their assessments

→ Impacts girl children and their families

The Australian case

Three sentenced to 15 months in landmark female genital mutilation trial

The US case

Michigan doctor and wife charged over alleged role in performing FGM on girls

Some of the initiatives suggesting approval of a type IV procedure

1992 The Ministry of Welfare, Health and Culture in the Netherlands

1996 Harborview Medical Center, Seattle

2004 Centre for the prevention and therapy of PMG, Careggi Hospital, Florence

2005 Royal Australian & New Zealand College of Obstetricians and Gynaecologists

2010 American Academy of Pediatrics

[Image 94x297 to 207x397]
[Image 295x293 to 455x401]
[Image 106x81 to 182x141]
[Image 322x102 to 455x215]
Growing scholarly debate: Ethically dubious stance?

- FGM/C
- Circumcision of boys
- Female cosmetic genital surgery
- Intersex surgery

FGM/C: No
Circumcision of boys: No
Female cosmetic genital surgery: No
Intersex surgery: Yes
ETHICAL ISSUES IN FGM/C
REINFIBULATION

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Department of the woman, the child and the adolescent
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CASE 2

- 36 years old, G2P1, Sudanese
- Fluent in Arabic and English
- High socioeconomic and cultural background
- 34 weeks of pregnancy. Girl
- FGM/C in Sudan when she was 6 yo
- First vaginal delivery in Switzerland 3 years ago. Boy
- Travelled to Sudan at 2 months post-partum for reinfibulation
- She asks for reinfibulation immediately after her second delivery... because she feels "MORE BEAUTIFUL, SEXY AND NORMAL WHEN HER GENITALS ARE CLOSED/TIGHT"

LET'S GO BACK TO CASE 2

- FGM/C type III a/b
- Vulvar varicose veins

REINFIBULATION, according to RCOG and others societies

Green Top Guideline 53 2015

The doctor, who qualified in 2005 and began specialising in obstetrics and gynaecology in 2008, had joined the Whittington hospital in London some six weeks before the incident in November 2012.

He said he had not had training in FGM during his undergraduate medical degree, or his postgraduate studies. He also admitted he had not read the hospital policy on FGM.
REINFIBULATION, according to ACOG and AAFP

NO GUIDELINES

While allowed by federal law, reinfibulation is ethically complex and should merit careful thought and discussions with the patient and her family.

Reinfibulation itself is not considered FGM, but if performed by a physician, it may appear to condone the practice. Therefore, the AAFP strongly cautions its members against performing reinfibulation.

Where possible, physicians should refer the patient to social support groups that can help them cope with changing societal mores.

https://www.aafp.org/about/policies/all/genital-mutilation.html

REINFIBULATION, according to WHO

The risks of re-infibulation
- It can cause severe health problems in the mother during the postpartum period - including pain, infections and destruction to the urinary tract and vaginal cavity - and in future pregnancies.
- Women born in future generations will be at risk of FGM.
- It is illegal in several countries to the practice.
- Re-infibulation is never medically indicated. Regardless of the legal status of FGM or re-infibulation in the country, every effort should be made to discourage the practice of re-infibulation.

FEMALE GENITAL COSMETIC SURGERIES

Non medically indicated cosmetic surgical procedures which change the structure and appearance of the healthy external genitalia of women, or internally in the case of vaginal tightening. This definition includes labiaplasty, hymenoplasty and vaginoplasty, also known as vaginal reconstruction or vaginal rejuvenation.

- Clitoral Hood Reduction
- Clitoral Repositioning
- Clitoral Lift
- Clitoridectomy
- Labiaplasty
- Labia Majora Reduction or Augmentation
- Liposuction (Mons Pubis, Labia Majora)
- Vaginal Tightening/Rejuvenation
- G-Spot Amplification
- Bleaching (Labial, Anal)
- Etc.

What can you do if a woman asks for reinfibulation?

Certified interpreter
Time
Clark the advantages of defibulation
Explore myths, false beliefs, fears on defibulated genitals
Education and information. Respectful and neutral approach. Make the woman choose between a partial or total defibulation and respect her choice!

Pelvic floor therapy and global health during the post-partum.
PARTIAL DEFBULATION, COUNSELING, FOLLOW-UP, if anterior tear, do reconstruct the physiologic anatomy...

Overall, RI and sexuality were perceived as very intimate issues and both women and men mentioned the silent culture between the sexes as one of the major obstacles for change. On the

<table>
<thead>
<tr>
<th>Women</th>
<th>Men</th>
</tr>
</thead>
<tbody>
<tr>
<td>Viewing oneself as being normal, in having undergone FGC and RI</td>
<td>Suffering from the consequences of female genital cutting and reinfiltration</td>
</tr>
<tr>
<td>Being caught between different perspectives</td>
<td>Trying to counterbalance the negative sexual effects of female genital cutting</td>
</tr>
<tr>
<td>Having limited influence on the decision to perform female genital cutting and reinfiltration</td>
<td>Striving in vain to change female traditions</td>
</tr>
</tbody>
</table>
Female Genital Cutting/Mutilation: ICS Action Plan

Christopher K. Payne, MD
Vista Urology & Pelvic Pain Partners
Emeritus Professor of Urology at Stanford

Payne CK, Abdulcadir J, Ouedraogo C, et. al.: SU & UDS 2019
ICS Ethics Committee

ICS Position Statements

1. FGM/C should be prevented and progressively eradicated.
2. Healthcare professionals should not perform FGM/C, as medicalization of the practice does not prevent many of the complications. Healthcare professionals should be trusted promoters of prevention/abandonment of FGM/C and care of already affected women and girls.
3. FGM/C complications should be screened, recognized, treated, and recorded appropriately and ultimately prevented.

Role for all specialities

- Pediatrics
- Gynecology
- Obstetrics
- Urology
- Nursing
- Physiotherapy
- Researchers

ICS Action Plan Overview

- Education
- Research
- Patient Care
- Advocacy

Individual and Organization

Education re: FGM/C

- Support the work of practitioners treating high volumes of patients with FGM/C throughout the world through assistance in creating, presenting, filming and distributing educational material.
- Work within communities to engage women and men regarding the medical risks of FGM/C and to lift the myths perpetuating this practice.
**Education re: FGM/C**

- Support the work of practitioners treating high volumes of patients with FGM/C throughout the world through assistance in creating, presenting, filming and distributing educational material.
- Educate health care workers, patients, and communities regarding FGM/C—raising awareness, exploring medical, ethical and cultural issues, consequences of FGM/C, and management.
- Work within communities to engage women and men regarding the medical risks of FGM/C and to lift the myths perpetuating this practice.

**FGM/C Research**

- Lend our expertise to define the benefits and risks of post-FGM/C intervention, and to further characterize the health consequences.
- Support and/or conduct studies to define optimal care of those with FGM/C.

**FGM/C Patient Care**

- Provide neutral, clear, non-alienating information to women and girls who have experienced FGM/C regarding its meaning to her individual situation, and options for care.
- To provide holistic care always, high quality reconstructive surgery where appropriate, and to support colleagues in high prevalence areas of the world when opportunities arise.

Download the electronic version at no cost.
FGM/C Patient Care

- Provide neutral, clear, non-alienating information to women and girls who have experienced FGM/C regarding its meaning to her individual situation, and options for care.
- To provide holistic care always, high quality reconstructive surgery where appropriate, and to support colleagues in high prevalence areas of the world when opportunities arise.

FGM/C Advocacy

- Partner with affected women and girls and other associations regarding FGM/C.
- Promote government support for medical care of women who have had FGM/C, including culturally fluent psychological care.
- Work within communities to promote the healthy coming-of-age rituals associated with FGM/C while removing the permanently damaging risks associated with FGM/C.