W35: Female Genital Mutilation/Cutting: The Role of the ICS

Workshop Chair: Christopher Payne, United States
06 September 2019 09:00 - 10:30

Start	End	Topic	Speakers
09:00	09:05	Welcome and Introduction	Christopher Payne
09:05	09:15	Background, Current Status and Impact of FGM/C	Christopher Payne
09:15	09:25	FGM/C in immigrant communities	Sara Johnsdotter
09:25	09:35	Approach to the patient after FGM/C	Jasmine Abdulcadir
09:35	09:50	Treatment of FGM/C	Jasmine Abdulcadir
09:50	10:00	Ethical Issues in FGM/C--Type IV procedures	Sara Johnsdotter
10:00	10:10	Ethical Issues in FGM/C--Reinfibulation	Jasmine Abdulcadir
10:10	10:20	FGM/C: The ICS Action Plan	Christopher Payne
10:20	10:30	Questions	All

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

Payne CK, Abduladir J, Ouedraogo C, Madzou S, Kabore FA, and De EJB. International Continence Society White Paper Regarding Female Genital Mutilation/Cutting. NeuroUrology & Urodynamics, 2019;38:857-867. *This document provides the necessary background along with extensive references for those with special interest in the field. It includes links to relevant videos.*

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 is 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 percive 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 medicalization1 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.