

Female Genital Cutting: An Evidence-Based Approach to Clinical Management for the Primary Care Physician

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Abstract

The United States has more than 1.5 million immigrants from countries in Africa and the Middle East where female genital cutting (FGC) is known to occur. Often, FGC occurs in infancy and childhood in the countries where it is practiced, but patients of any age can present with complications. Lack of understanding of this common problem can potentially alienate and lower quality of care for this patient population. We provide an introduction to the practice of FGC and practice guidelines for the primary care physician. We reviewed original research, population-based studies, and legal research from PubMed, Scopus, CINAHL plus, PsycINFO, and Legal Trac. The terms searched included *female genital cutting*, *female genital circumcision*, and *female genital mutilation* alone and with the term *complications* or *health consequences*; no limit on date published. Legal databases were searched using the above terms, as well as *international law* and *immigration law*. Editorials and review articles were excluded. This review discusses the different types of FGC, important cultural considerations for physicians caring for patients with FGC, the common early and late medical complications and their management, and psychosocial issues associated with FGC. Current laws pertaining to FGC are briefly reviewed, as well as implications for patients seeking asylum status in the United States because of FGC. Finally, the article presents evidence-based, culturally sensitive approaches to discussions of FGC with girls and women for whom this is an issue.

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Female genital cutting (FGC), also called female genital circumcision or female genital mutilation, occurs throughout the world, with most cases concentrated in Africa, the Middle East, and parts of Asia.^{1,2} Typically, FGC is performed on young girls between infancy and 15 years of age.^{3,4} The World Health Organization (WHO) estimates that between 100 million and 140 million girls and women worldwide have been subjected to FGC,⁵ and approximately 3 million girls are at risk of FGC annually.⁵ In the United States, there may be as many as 400,000 women and girls with FGC according to US Census data from 2000.⁶ Estimates in Europe are slightly higher, with 500,000 women and girls affected and 180,000 at risk.⁷ Female genital cutting remains an issue of active advocacy and legislation around the world. As recently as December 2012, the United Nations voted to ban FGC in all of its member countries.⁸ As the population of foreign-born people continues to grow in the United States, physicians are more likely to encounter patients with

FGC. This review is designed to give primary care physicians the necessary knowledge to care for girls and women with FGC in a culturally aware and clinically informed manner.

We reviewed original research, population-based studies, and legal research from PubMed, Scopus, CINAHL plus, PsycINFO, and Legal Trac. The terms searched included *female genital cutting*, *female genital circumcision*, and *female genital mutilation* alone and with the term *complications* or *health consequences*; no limit on date published. Legal databases were searched using the above terms, as well as *international law* and *immigration law*. Editorials and review articles were excluded. Recent studies have indicated that medical practitioners have limited understanding of the practice and that patients often feel alienated and judged by practitioners. Practitioners lack understanding of the medical and psychosocial consequences, as well as management of the complications associated with FGC.⁹⁻¹² In addition, studies have indicated that patients who have undergone FGC find that physicians have a poor

understanding of the practice and are unable to address the topic in a culturally sensitive manner, leading to overall patient dissatisfaction.¹³⁻¹⁵

Beginning with an introduction to FGC and insight into the context in which FGC takes place, this review also discusses the common early and late complications of FGC and their management, as well as guidelines for culturally appropriate care. Finally, current laws in the United States will be addressed, as well as the role physicians and health care professionals can play in the cases of patients seeking asylum on the basis of FGC.

SOCIAL AND CULTURAL CONTEXT OF FGC

Female genital cutting is practiced all over the world, with variations in prevalence most often related to country, location within a given country (urban vs rural), level of education of a girl's mother, religious affiliation, and ethnicity. Despite legal bans on FGC in the United States and many African countries,¹⁶ as well as international conventions prohibiting the practice,^{16,17} FGC remains deeply rooted in cultural, religious, and social customs within the communities where it is practiced. There are considerable variations in prevalence and type of FGC practiced among countries and even regionally within certain countries, making it challenging to clearly delineate factors that affect either of these issues with any certainty or consistency. Many studies have examined socioeconomic and demographic factors that affect prevalence rates. Although location (urban vs rural), level of education, religion, and ethnicity all appear related to prevalence of FGC within a given country, the nature of the relationship is different in each country. It is important for physicians to understand that many family members who continue this practice believe that they are doing what is best for their daughters by performing FGC. Surveys of attitudes, behaviors, and beliefs in African countries indicate that most mothers believe that FGC is a rite of passage and is necessary to secure marriage prospects and preserve virginity, femininity, and hygiene.

Geography

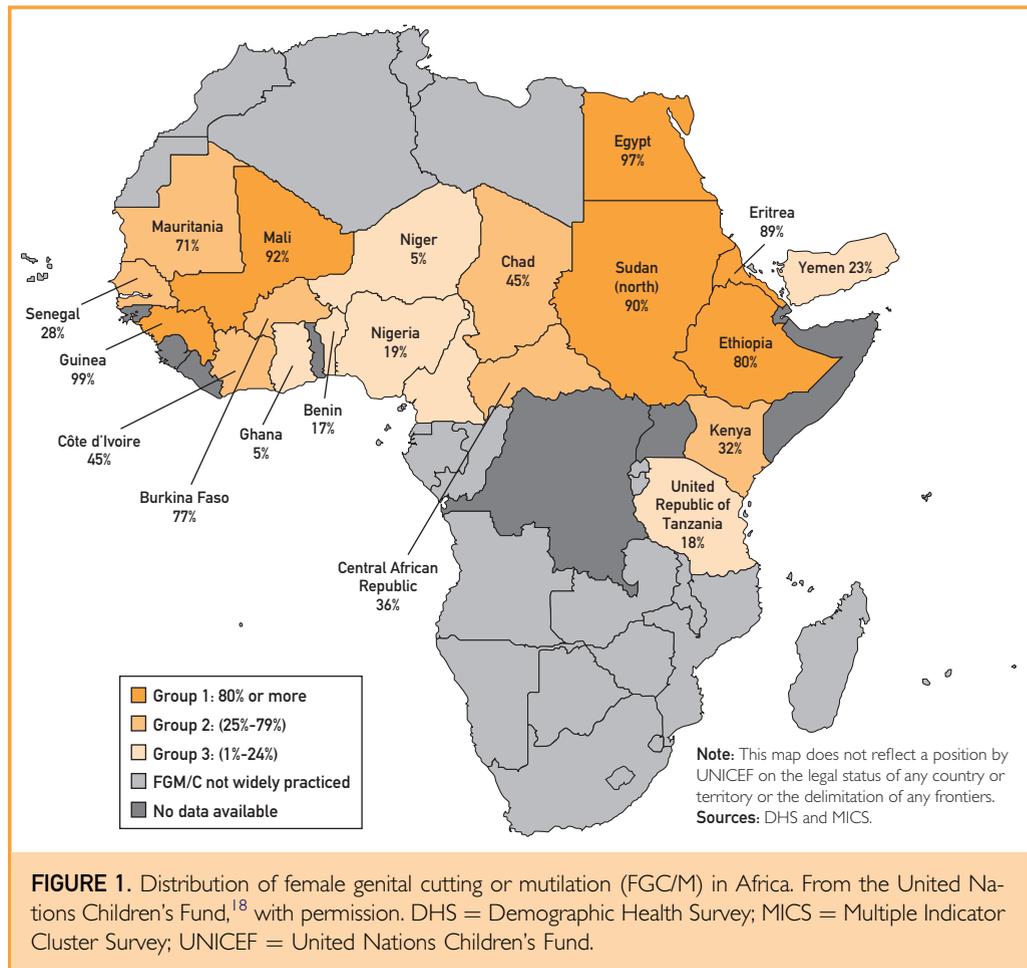
Mostly, FGC is performed in western, eastern, and northeastern regions of Africa, as well as in some countries in the Middle East and Asia.⁵ In Egypt, for example, 97% of girls and women aged 15 to 49 years have undergone FGC.

ARTICLE HIGHLIGHTS

- Mostly, FGC occurs in African countries, but it is also known to occur in India and parts of the Middle East.
- Female genital cutting is a tradition that has been ongoing for thousands of years; it remains a highly prevalent practice in several African countries because it is believed to preserve femininity and cleanliness and ensure marriage.
- The World Health Organization has 4 major classifications of FGC, with type 3 being considered the most severe and leading most commonly to complications.
- Late complications include urinary disorders, scarring, pain, infertility, reduced sexual function, and psychological sequelae.
- There are evidence-based approaches to discussion of FGC in a clinical setting, which are discussed in this review.
- Female genital cutting is illegal in the United States and has been banned by the United Nations as a form of torture.
- Physicians may write a medical affidavit documenting FGC for individuals seeking asylum because of FGC.

Guinea, Ethiopia, Sudan, Somalia, and Mali are also high prevalence regions, with FGC taking place in 99%, 80%, 90%, 97%, and 92%, respectively (Figure 1).¹⁸ Although FGC is nearly universal in some countries, such as Egypt, other countries display considerable variation among ethnic groups within a country, such as in Kenya, where the prevalence is 32%.¹⁸

Place of residence appears to be related to FGC prevalence, but the relationship does not consistently favor urban or rural dwelling. In countries with a high prevalence of FGC, such as Guinea, Egypt, Mali, Sudan, Eritrea, Ethiopia, and Burkina Faso, FGC appears to take place equally in urban and rural areas, so that no one place of living appears to have a higher prevalence.¹⁸ Cote D'Ivoire, Kenya, Senegal, Tanzania, Benin, Ghana, Niger, and Cameroon, on the other hand, appear to have higher proportions of rural women undergoing FGC.¹⁸ Finally, Yemen and Nigeria appear to have lower rates of FGC in rural areas.¹⁸ The lack of a clear, consistently directional relationship with prevalence and location likely reflects the multitude of factors associated with any given location, such as surrounding religious communities, ethnic composition, neighboring countries, and degree of urbanization.¹⁸



Education

Lack of a formal education has been significantly associated with increased rates of FGC in several studies.^{4,19-21} However, because FGC tends to occur before formal education has begun, many argue that education of a mother is a more meaningful variable for assessing the relationship between FGC and education. Education of a child's mother remains an important predictor of completion of FGC in young girls, with several studies reporting that the higher level of education attained by a woman or her partner, the lower the prevalence of FGC in daughters^{18,22} and the higher the level of support for its discontinuation.²³

Religion

Social tradition and a belief that religion requires FGC are major reasons for the continuation of FGC. Despite the fact that there is no scriptural

support for FGC in the Koran or the Bible, many women cite religious duty or cultural tradition as reasons for continuing FGC in their communities.²⁴⁻²⁸ Although it is challenging to find clear evidence of FGC in early literature, FGC has been present in the regions of Africa where it is practiced for hundreds, if not thousands, of years. Writing in approximately 24 AD, Strabo states, "One of the customs most zealously observed among the Egyptians is this, that they rear every child that is born, and circumcise the males, and excise the females..."²⁹

No single religion appears to be associated with a higher prevalence of FGC across locations where FGC is practiced. Much like location, this lack of consistent relationship between prevalence and religion may be because of major variations of religious makeup of individual countries, as well as the interplay between religion and place of residence, local custom, and cultural traditions. In Benin, Cote d'Ivoire,

Ethiopia, Ghana, Kenya, and Senegal, Muslim population groups are more likely to practice FGC than Christian groups.¹⁸ In Niger, Nigeria, and the United Republic of Tanzania, the prevalence is greater among Christian groups.^{18,21}

Ethnicity

Ethnicity correlates with FGC status in a number of studies.^{7,19-21,30,31} Within a given country, the practice of FGC is often more common among certain ethnicities.¹⁸ Because each country has a differing ethnic makeup, this review will not address the various ethnic groups within each country that practice FGC most often.

Preserving Virginity and Ensuring Marriageability. Female genital cutting is believed to preserve virginity, protect from promiscuity, and ensure marriageability. In cultures in which marriage may be the only avenue for a woman's financial security, a family may feel that FGC is important to ensure a safe and secure future for their daughter. In a recent study in Nigeria, respondents held highly negative and stigmatizing attitudes toward un-circumcised women, with 74% reporting un-circumcised women are promiscuous, 49% reporting they are shameful, 14% reporting they are cursed and outcast, and 66% saying they would not recommend them for marriage.³² Similarly, in a study in Ethiopia, 60% reported that FGC was a way to limit female sexual hyperactivity,³¹ which has been echoed in studies in Egypt²⁷ and Nigeria.^{26,28}

Hygiene and Cleanliness. Cleanliness and hygiene are also reasons FGC continues to be practiced. In some regions, local folklore suggests a woman's external genitals are ugly and dirty and will continue to grow ever bigger if they are not cut away.²⁸ Furthermore, female genitalia are believed by some women to make women spiritually unclean.²⁸ In addition, some women believe that unless her clitoris is removed, a girl will not become a mature woman or even perhaps a full member of the human race.^{3,28}

WHO CLASSIFICATIONS

Any ceremonial or nonmedical alteration of the female genitals is termed *female genital circumcision*.³³ The extent of the procedure can vary

considerably, depending on the local culture and the person performing the circumcision. In 1995, the WHO defined 4 classifications of FGC. This system was further subdivided in 2008 to help clarify ambiguities in the original system and to capture the variety of procedures.² Current estimates indicate that approximately 90% of female genital mutilation cases include types 1 or 2 and/or cases in which girls' genitals were "nicked" but no flesh removed (type 4), and approximately 10% or less are type 3.^{1,34,35}

Type 1—Partial or Total Removal of the Clitoris and/or the Prepuce (Clitoridectomy)

When it is important to distinguish between the major variations of type 1 mutilation, the following subdivisions are proposed: type 1a, removal of the clitoral hood or prepuce only; and type 1b, removal of the clitoris with the prepuce (Figure 2, A and B).

Type 2—Partial or Total Removal of the Clitoris and the Labia Minora, With or Without Excision of the Labia Majora (Excision)

When it is important to distinguish between the major variations that have been documented, the following subdivisions are proposed: type 2a, removal of the labia minora only; type 2b, partial or total removal of the clitoris and the labia minora; and type 2c, partial or total removal of the clitoris, the labia minora, and the labia majora (Figure 2, C and D).

Type 3—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)

The following subdivisions are proposed for type 3: type 3a, removal and apposition of the labia minora; and type 3b, removal and apposition of the labia majora (Figure 2, E and F).

Type 4—All Other Harmful Procedures to the Female Genitalia for Nonmedical Purposes

Examples of type 4 FGC include stretching, pricking, piercing, incising, scraping, and cauterization.

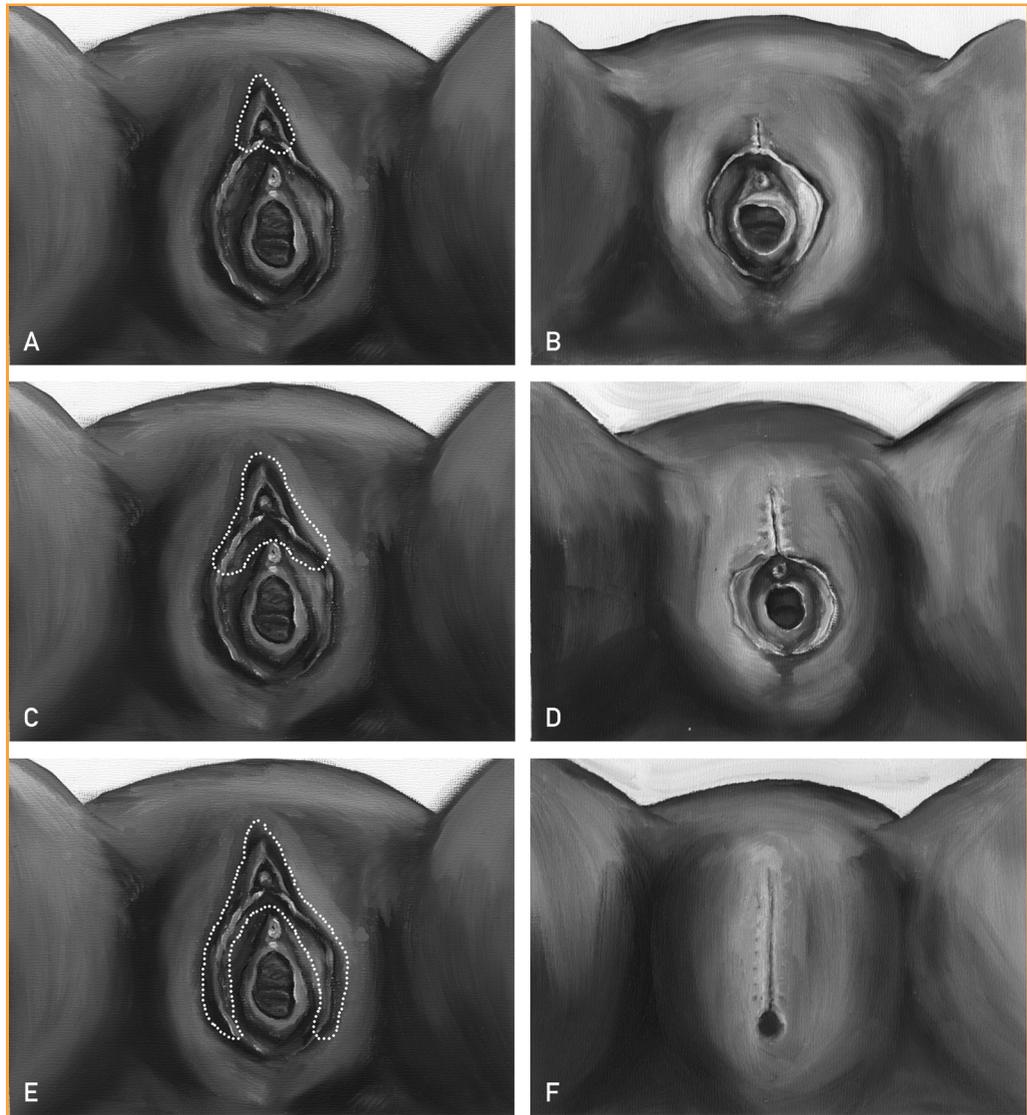


FIGURE 2. Types of female genital cutting (FGC). A, Tissue removed in type 1 FGC: partial or total removal of the clitoris and/or the prepuce (clitoridectomy). B, Appearance after type 1 FGC. C, Tissue removed in type 2 FGC: partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision). D, Appearance after type 2 FGC. E, Tissue removed in type 3 FGC: 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). F, Appearance after type 3 FGC. Illustrations reproduced with permission from the artist, Jessica Stanton, MD.

COMPLICATIONS AND THEIR MANAGEMENT

Complications related to FGC can be divided into early and late complications. Physicians in the United States are more likely to encounter late complications of type 2 and 3, but early complications may present as well, if the procedure was performed in the United States. Although not all women with FGC will

experience a complication, it is important for physicians to keep FGC-related morbidities on the differential diagnosis when treating women who may have undergone FGC.

Caveats

Interpreting data from studies on FGC can be complex because study findings will vary considerably, depending on the mode of participant

enrollment, the presence of a comparison group, and, most importantly, the relative prevalence of the different forms of FGC in the region where the study is performed. The nature and likelihood of various complications will vary, depending on the type of FGC practiced and the conditions under which it is performed (whether it is in a medical setting with sterile technique and a trained professional or a rural setting without antiseptic, sterile instruments, or anesthesia).³⁴ In addition, the setting of the study will affect the type of complications seen. Studies in tertiary centers often have more severe consequences because many patients do not present for specialty care unless the child is very sick, given issues of health care access and the fact that FGC is outlawed in many countries and families may fear legal action.

Early Complications

Frequently seen early complications include bleeding, infection, and urinary retention. In general, fewer immediate complications are seen with type 1 FGC, with bleeding and urinary retention still occurring at low rates. Type 2 and 3 FGC tend to be associated with higher rates of bleeding, infection, and urinary retention.³⁶ Early complications of FGC are often treated by the local midwife or a nonmedical professional performing the procedure. A child may only come to medical attention when complications are severe or treatment from a local practitioner has failed. Bleeding complications are typically the result of laceration of the internal pudendal artery or the clitoral artery. Bleeding may be severe enough to lead to shock or the need for transfusions.³⁷⁻³⁹ Localized infections are documented in up to 15% of cases,³⁸ often as a result of using unsterile or shared instruments.³⁷ Severe infections can lead to sepsis in approximately 1% cases.^{37,38,40} Tetanus after FGC has also been reported in 1% or less of patients.^{39,40} Urinary retention from pain caused by pressure on a healing wound with urination was found in 4%³⁸ to 12% of FGC patients.³⁹ In addition, injuries to the urethral meatus,^{39,40} vagina, bladder, and rectum^{40,41} are possible complications. In general, fewer immediate complications are seen with type 1 FGC, with bleeding and urinary retention still occurring at low rates. Types 2 and 3 FGC tend to be associated with higher rates of bleeding, infection, and urinary retention.³⁶

TABLE 1. Late Complications of Female Genital Cutting (FGC)^a

Complication type	Strongly associated with FGC in case reports and/or cohort studies	Suggested but no clear association found with FGC
Urinary	Urethral stricture Chronic UTIs Urinary crystals Meatal obstruction Meatitis	Incontinence
Scarring	Fibrosis Keloids Sebaceous cysts Vulvar abscesses Hematocolpos Complete labial fusion Partial labial fusion Vaginal stenosis	
Pain	Vaginal Vulvar Lower abdominal Dysmenorrhea Clitoral neuroma	
Fertility/sexuality	Dyspareunia Apareunia Anorgasmia Vaginal dryness Lack of sexual desire Decreased satisfaction	Infertility ^b
Infection	Yeast infection Bacterial vaginosis Herpes simplex virus	Chlamydia Gonorrhea <i>Trichomonas</i> PID Syphilis HIV
Psychological	PTSD Depression Anxiety Somatization	

^aHIV = human immunodeficiency virus; PID = pelvic inflammatory disease; PTSD = posttraumatic stress disorder; UTI = urinary tract infection.
^bData vary. See text for discussion.

Late Complications

Common late complications from FGC can be organized by the type of symptom, with most falling into categories of urinary complications, scarring, pain, infection, infertility, and sexual dysfunction (Table 1).

Urinary Complications. Urinary complications include urethral strictures, chronic urinary tract infections (UTIs), urinary crystals, meatal obstruction, and meatitis. Urinary symptoms comprise nearly 29% of FGC-related complications.⁴⁰

Patients with urinary strictures will often complain of retention, slow stream, or straining.³⁸⁻⁴⁰ Urethral strictures and stenosis merit evaluation for cystoscopy, urethral dilation, and urethroplasty.

Complications related to poor urinary flow below the infibulation scar may also develop. Women with infibulations (type 3) in particular are prone to chronic UTIs.^{36,37} Suppressing antibiotics may be indicated to help prevent chronic UTI. Women with chronic UTIs not well managed with suppressive antibiotics may also be candidates for deinfibulation,⁴² which is a surgical procedure to release the surgical scar tissue from the vulva, exposing the clitoris and introitus and creating a new labia majora.⁴³ Further information about this procedure can be found in [Supplemental Table 1](http://www.mayoclinicproceedings.org) (available online at <http://www.mayoclinicproceedings.org>).

Urinary crystal formation can also occur because scarring often leads to stagnant urine in the vestibule that is created by the closed or sewn labia.⁴¹ Urinary crystals often present as sharp, intermittent pain, not necessarily related to urination. Removal of the calculi may require a deinfibulation procedure.^{42,43}

Scarring. Complications related to scarring are typically fibrosis, keloids, inclusion cysts, vulvar abscesses, hematocolpos, and complete or partial fusion of the labia. Keloids are seen in approximately 3% of FGC patients,³⁹ although one study consisting of mostly type 2 FGC patients had keloid formation rates of up to 62%.³⁴ Fibrosis and keloids can lead to severe pain and perceived disfigurement. Scarring can also lead to labial fusion, requiring surgical separation.⁴⁴ Female genital cutting alone or labial fusion as a result of FGC may in turn lead to hematocolpos, which has been documented in 7% of women in one study.³⁷ Inclusion and sebaceous cysts are also a commonly encountered comorbidity,^{36,37,44,45} also leading to pain. Cysts can grow and extend enough to narrow or even cover the introitus.⁴¹ Cysts leading to pain or discomfort can be surgically excised.⁴⁴

Pain. Vaginal and vulvar pain are common sequelae of FGC. Lower abdominal pain⁴⁶ and dysmenorrhea^{37,47-49} are commonly encountered in women with FGC. Dysmenorrhea can be managed with nonsteroidal anti-inflammatory

drugs and hormonal contraceptives with estrogen-progestin combinations or progestin-only methods. It is important for the practitioner to keep in mind that use of contraceptives may not be culturally acceptable for some patients. Neuroma of the clitoris that leads to severe pain and point tenderness has also been documented.⁵⁰ Treatment of clitoral neuromas is excision.⁴² Excision of neuromas can be technically challenging because new procedures run the risk of further nerve irritation.

Fertility. The relationship between fertility and FGC is multifactorial and may be related to the physical barrier created with certain types of FGC, potential infections that arise during FGC that ascend to the uterus and adnexa, and/or the psychological barriers related to painful intercourse. Physical barriers include vaginal stenosis or scarring from infibulations. Psychological barriers are often related to dyspareunia and apareunia, lack of sexual desire or sexual satisfaction, and fear of sexual relations.

Currently, there is mixed evidence regarding the influence of FGC on a woman's fertility. Several studies suggest higher rates of infertility and painful intercourse in women with FGC,^{37,46-49,51} but other studies that compare women with and without FGC have not found a statistical difference between the 2 groups. Of 3 higher-quality studies, 2 studies comparing women with and without FGC failed to find higher rates of infertility. In the first study, which included women with predominately type 2 FGC, the number of women who were trying to achieve pregnancy for greater than 1 year was the same in both groups.⁴⁷ In the second study, which included women with all types of FGC, the number of couples who were childless after 7 years of marriage was the same between the 2 groups even in subset analysis of the most severe type of FGC.⁵¹ A third smaller case-control study from Sudan found a positive association between the anatomical extent of FGC and primary infertility.⁵²

Sexual Dysfunction. Although there is limited evidence of infertility, there is a growing amount of evidence regarding sexual dysfunction, including dyspareunia, apareunia, anorgasmia, vaginal dryness, and lack of sexual desire. Dyspareunia is reported in up to 78% of women with FGC.^{53,54} One study has suggested higher

rates of anorgasmia and significant differences in desire, arousal, lubrication, orgasm, and satisfaction but not pain in women with type 1 and 2 FGC in Egypt.⁵⁵ Similar reports of decreased desire,^{54,56} arousal,^{46,56} decreased frequency of orgasm,^{46,57} decreased lubrication,^{54,56} and less satisfaction^{54,56-58} have been reported elsewhere.

A recent meta-analysis of 15 studies revealed significant differences between women with and without FGC on several measures. Women with any type of FGC were 1.7 times more likely to experience dyspareunia, were 2.5 times more likely to report no sexual desire compared with uncut women, and had decreased levels of satisfaction.⁵⁹ In the meta-analysis, there was no significant effect found for having orgasm, although FGC significantly decreased the ability to achieve orgasm when pregnant women were excluded from the analysis.⁵⁹

Infections, Human Immunodeficiency Virus, and FGC. Increased incidence of yeast infections⁶⁰ and bacterial vaginosis (BV)⁴⁷ have both been documented in women with FGC. Physicians may consider favoring oral medications in women with type 3 FGC because the infibulated scar may make suppository use difficult.⁴² Increased incidence of herpes simplex virus (HSV) type 2 has also been reported in cut women compared with uncut women.⁴⁷ Similarly, one study that relied on self-report (not physical examination) documented increased rates of white discharge, yellow discharge, and genital ulcers in women with FGC.⁴⁶ Increased rates of HSV and BV have been found in women with different types of FGC, full or partial excision of the clitoris, or full or partial excision of the labia minora.⁴⁷ Rates of chlamydia, gonorrhea, *Trichomonas*, pelvic inflammatory disease, and syphilis infections are found to be similar in women with and without FGC.^{19,47}

The relationship between FGC and human immunodeficiency virus (HIV) infection remains unclear and is still an area of active research. Female genital cutting as a risk factor for HIV infection has been suggested in various case reports, case-control studies, and cross-sectional studies. It is already known that BV and HSV infections are independent risk factors for acquiring HIV infection.^{61,62} Given that these are documented at higher rates in women with FGC, there is a theoretical increase in HIV risk. In addition, shared instruments, need for

transfusions, and possible traumatic intercourse leading to increased risk of skin tears have all been proposed as mechanisms of transmission.⁶³ Despite the theoretical risks, most studies do not support an increased risk of HIV with FGC.^{19,47,61,64-66} To better understand the relationship between HIV and FGC, studies should be designed to include variables such as sexual practice of couples with cut women (including extramarital sexual contacts) and the need for transfusion related to FGC and to verify that BV and HSV are consistently documented in women with FGC.⁶³

Psychological Complications

Research is sparse, but studies have recently started to focus on possible psychiatric effects related to FGC. One study examining psychiatric comorbidity found that 80% of women with types 2 and 3 FGC continued to have flashbacks to the FGC event; 58% had an affective disorder, 38% had other anxiety disorders, and 30% had posttraumatic stress disorder.⁶⁷ This study unfortunately lacked a control group. Another study found that circumcised females had significantly higher rates of somatization, anxiety, and phobia,⁵⁷ as well as posttraumatic stress disorder.⁶⁸

LEGAL ASPECTS

In the United States, it is a felony to perform FGC on a girl younger than 18 years. According to the Illegal Immigration Reform and Immigrant Responsibility Act of 1996, any person who performs FGC or who allows it to be performed on their child (defined as anyone younger than 18 years) in the United States can be subject to fines or up to 5 years in jail or both according to US Code, Title 18, Chapter 7, section 116. There is currently no federal legal penalty for people who allow their daughters to return to their home country to have FGC performed. In addition to federal law, several states have also enacted criminal penalties for FGC. Minnesota, Rhode Island, and Tennessee prohibit the practice of FGC on adult women and on girls younger than 18 years. The statutes enacted in California, Colorado, Delaware, Maryland, Missouri, New York, Oregon, and West Virginia explicitly address the conduct of a parent or guardian who permits or allows FGC to be performed on her or his daughter. In Nevada, a person may be prosecuted for the

removal of a child from that state for the purpose of performing FGC.¹⁶

Female genital cutting can also be the basis of an asylum claim in the United States. Having had FGC or fearing it will be done to a woman or girl if she returns home can be used for claims on the basis of persecution in their home country if she were to return.⁶⁹ Supplemental Tables 1 and 2 (available online at <http://www.mayoclinicproceedings.org>) provide guidance on writing an affidavit (see also the HealthRight website⁷⁰).

Female genital cutting is banned in several African countries but not all. Article 5 of the Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa, also called the Maputo Protocol, imposed a ban on all forms of female genital mutilation in 2003 (including medicalized female genital mutilation), but it has not been signed or ratified by all African countries.¹⁷ As recently as December 2012, the United Nations General Assembly unanimously passed a resolution banning the practice.⁷¹ Benin, Burkina Faso, Central African Republic, Chad, Cote d'Ivoire, Djibouti, Egypt (Ministerial decree), Ghana, Guinea, Kenya, Niger, Nigeria (multiple states), Senegal, Tanzania, and Togo all have laws prohibiting FGC. In Sudan, only infibulation (type 3) is forbidden by law. There are also several international conventions that either directly or indirectly ban FGC, such as the Universal Declaration of Human Rights, articles 2f and 5 of the Convention on the Elimination of All Forms of Discrimination against Women,⁷² articles 10 and 20 of the Rabat Declaration on Child's Issues,⁷³ and article 24(3) of The Convention on the Rights of the Child.^{2,16,74}

DISCUSSING FGC WITH PATIENTS

The first step in placing the individual patient with FGC at ease is a basic understanding of the history, types, and complications related to FGC. Lack of knowledge about the cultural context and clinical best practices can lead to inconsistent care and poor outcomes.⁹

In addition to historical and medical understanding of FGC, it can be helpful to have knowledge of a culturally sensitive discussion approach with the woman with FGC. In practice, many physicians simply avoid discussion of FGC, which can be frustrating and confusing

to the woman with FGC, especially as she anticipates delivery and possible episiotomy.¹³ On the other end of the spectrum, women with FGC have expressed concern that their FGC turns them into "specimens" and the presence of the FGC becomes more fascinating to their physician than her presenting health concern or the woman as a whole.¹⁵ Women with FGC have expressed that they want their physicians in America to know that they are circumcised but do not necessarily want to discuss it unless there is a current or anticipated problem.¹⁴ Terms can be a challenge when discussing FGC. Women who have been cut do not usually use the term *FGC*, much less *female genital mutilation*. Although these terms are used to describe the practice in the medical literature and to create campaigns to eradicate the practice, they are not terms that most women use to describe themselves. *Circumcision* is usually the term that patients (or their interpreters) will understand and is more neutral than *female genital mutilation*.

Studies detailing the findings of focus groups with women who have experienced FGC suggest principles that should guide the discussion between patient and physician.¹³⁻¹⁵ One focus group expressed consensus that they would like physicians to "educate on the health consequences of female circumcision."¹⁵ Another focus group put together a list of ways to approach the topic of FGC (Table 2).¹⁴ Physicians should pick questions from this list as appropriate for appointment length and patient concerns.

Even with culturally sensitive approaches, there continue to be barriers. Women with FGC have expressed, "I wish I had a way to communicate with the doctor directly. There are things that sometimes I want to say or ask but I feel embarrassed saying it through a translator, especially on the phone" and "They never translate what I'm saying. They tell me that is a shameful question..."¹⁴ When the physician (rather than the patient) initiates the questions in a way that is normalized as part of the overall woman's health history, it can help to overcome the patient's or the interpreter's embarrassment about the topic.

Some discussions regarding FGC are more difficult than others. We believe it is within the physician's role to also educate patients about the legal consequences of FGC to help

a patient protect herself and her daughters. We recommend that physicians ask patients what their intentions are for their daughters in an open way and have included some suggested phrasing in Table 2.

Discussing FGC with patients can be challenging, but there are helpful recommendations from women with FGC about the situations and the manner in which they want to discuss their circumcision. There is clear consensus from the few studies that have been performed that most women with FGC would like their physician to proactively discuss the topic with them when it pertains to a current or anticipated problem.¹³⁻¹⁵ Table 2 contains a selection of sample questions that may be useful for starting a discussion.¹⁴

CONCLUSION

As the US immigrant population continues to grow, primary care physicians may encounter FGC in clinical practice more frequently. This review is meant to serve as a starting point for primary care physicians working with women who have undergone FGC. Issues relating to obstetrics and pediatrics are not well covered here, but suggested reading is included in Supplemental Table 1 (available online at <http://www.mayoclinicproceedings.org>). Familiarity with the cultural context in which FGC takes place and with the medical issues that patients may present with will ensure that physicians are able to adequately discuss FGC in a culturally sensitive way and effectively recognize and treat its various complications. Long-term and chronic complications can present as pain, urinary or menstrual symptoms, and sexual dysfunction. Women with FGC may also have recurrent yeast and BV infections and higher rates of HSV. Currently, there is no clear relationship between HIV and FGC. Although many early studies without comparison groups suggest high rates of infertility, this association has not been confirmed in larger studies with comparison groups of uncut women. Women with FGC may, however, have considerably higher rates of dyspareunia and lower rates of orgasm and sexual satisfaction. Some women may benefit from deinfibulation to treat various medical problems associated with FGC. Overall, women prefer physicians to be open about how FGC may affect or be related to their medical conditions. Female genital cutting is outlawed

TABLE 2. Guidelines for Discussing Female Genital Cutting (FGC) With Patients^a

Category	Questions
Basic history	Please share your experience with being circumcised. Where was it done? By whom? What was your age at circumcision?
Community/ context	Do you know anyone who is not circumcised? Do you talk about circumcision with other women? Your daughters? What do you talk about?
Beliefs	What do you think is good about being circumcised? What do you think is bad about being circumcised? Does your religion recommend circumcision? Does your culture recommend it?
Problems	Do you have any pain/discomfort/problems because of your circumcision? Are there other problems? What medical help would you like for any of the problems?
Treatment	As a woman who has been circumcised, what kind of care did you get in the past? How is this different than the care that you've received here? What would be your preference?
Plans/concerns	How would you feel about raising your daughters in America without being circumcised? How do you think your daughter would feel if she is not circumcised? How do you think your daughter's future husband would feel if your daughter is not circumcised?
Difficult scenarios	Do you hope to be able to circumcise your daughter? Are you aware of the laws relating to circumcision in the United States?

^aAdapted with permission from *Int J Nurs Stud*.¹⁴

in most countries where it is practiced and is considered a human rights violation by the US government, the United Nations, and the WHO. Physicians who are willing to do so may write an affidavit on behalf of patients who wish to obtain asylum status because of their history of FGC.

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SUPPLEMENTAL ONLINE MATERIAL

Supplemental material can be found online at <http://www.mayoclinicproceedings.org>.

Abbreviations and Acronyms: **BV** = bacterial vaginosis; **FGC** = female genital cutting; **HIV** = human immunodeficiency virus; **HSV** = herpes simplex virus; **UTI** = urinary tract infection; **WHO** = World Health Organization

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