



Pan African Urological Surgeons' Association

African Journal of Urology

[www.ees.elsevier.com/afju](http://www.ees.elsevier.com/afju)  
[www.sciencedirect.com](http://www.sciencedirect.com)



## Review

# Medicalization of female genital mutilation/cutting

G.I. Serour<sup>a,b,1,\*</sup>

<sup>a</sup> *International Islamic Center for Population Studies and Research, Al-Azhar University, Egypt*

<sup>b</sup> *Clinical director, the Egyptian IVF&ET center, Maadi, Egypt*

Received 1st November 2012; received in revised form 28 January 2013; accepted 28 January 2013

### KEYWORDS

Genital Mutilation;  
Medicalization;  
Female

### Abstract

Globally 100–140 million women and girls have been subjected to female genital mutilation/cutting (FGM/C) which is a harmful practice, associated with immediate and long term complications, has no benefit what so ever, is unethical and has no religious basis. In spite of global efforts to eradicate FGM/C every year 3 million girls are subjected to this harmful practice mostly in Africa and Asia.

In some countries FGM/C is increasingly performed by health-care providers, which is alarming. Medicalization of FGM/C is proposed by some health professionals to reduce the incidence of its complications. However medicalization of FGM/C will not reduce the long term complications of FGM, has no benefit what so ever, has no medical indication, and thus its performance violates the code of medical ethics. Furthermore its medicalization would result in a setback in the global efforts to eradicate this harmful practice, and will give the green light to its performance by non health-care providers with subsequent increased incidence of complications.

In some Muslim countries where FGM/C is prevalent it is often wrongly quoted that the basis for performing FGM/C is religious instruction. FGM/C has no religious basis what so ever and has been condemned by Al-Azhar based on several verses in the Holy Quraan that relates explicitly or implicitly to female circumcision. The use of the gender term “Sunna circumcision” is nothing but a form of deceit used to misguide people

\* Correspondence address: International Islamic Center for Population Studies and Research, Al-Azhar University, Egypt. Tel.: +20 225755869; fax: +20 225754271.

E-mail address: [giserour1@link.net](mailto:giserour1@link.net)

<sup>1</sup> FIGO Past President.

Peer review under responsibility of Pan African Urological Surgeons' Association.



Production and hosting by Elsevier

and give the impression that this act is one of the Islamic practices. As for the traditions attributed to Prophet Mohamed (PBUH), scholars of the past and present have agreed that none of these traditions are authentic and therefore should not be attributed to the Prophet (PBUH).

© 2013 Pan African Urological Surgeons' Association. Production and hosting by Elsevier B.V. All rights reserved.

Female genital mutilation/cutting (FGM/C) comprises all procedures that involve partial or total removal of female external genitalia and/or injury to the female genital organs for cultural or any other nontherapeutic reasons [1]. While the term “mutilation” reinforces the idea that this practice is a violation of the human rights of girls and women, at the community and individual levels the term can be problematic and offensive, and the term “cutting” may be more acceptable. FGM/C is practiced in 28 African countries and in some nations in Asia and the Middle East. As a result of international migration, FGM/C is a global problem and is not limited to any cultural or religious groups [2]. The World Health Organization classifies FGM/C into 4 types, varying in severity from partial or total removal of the clitoris to extensive mutilation of the external genitalia [3]. The type of FGM/C practiced varies within and between countries [1–4]. According to WHO modified typology, type III FGM/C – known as infibulation – is narrowing of the vaginal orifice through the creation of a covering seal formed by cutting and apposition of the labia minora and/or the labia majora, with or without excision of the clitoris [3]. The term infibulation is derived from the Latin “fibula” meaning tightening of the vaginal introitus to leave only a very small opening for the flow of urine and menstrual blood. Defibulation is an anterior midline vulval incision of the scar, commonly performed before gynecological operations, such as cervical biopsy, evacuation colposcopy or, polypectomy, and before urological operation such as cystoscopy, to allow access to the female genital organs or the lower urinary tract through the vagina. It is also performed at the time of delivery or prenatally to avoid acute problems at the time of delivery, such as obstructed labour, vesicovaginal and rectovaginal fistulas, and laceration of the scar tissue which results in various obstetric complications such as laceration of the perineum, maternal haemorrhage or perinatal asphyxia.

Resuturing of the vulva after delivery, gynecological or urological procedures of the incised scar tissue is known as reinfibulation. Sometimes what is locally interpreted as reinfibulation is also performed on women who have not been infibulated in the first place [5,6].

An estimated 91.5 million girls and women aged 10 years and older have been subjected to FGM/C in African countries where prevalence data is available [7]. The number of women who are likely to have undergone reinfibulation is estimated to be around 6.5–10.4 million women [6].

The prevalence of reinfibulation differs markedly in different countries. Reinfibulation is most prevalent in countries where type III FGM/C is prevailing, such as Somalia (98–100%), Sudan (82%), Djibouti (50%), and Eritrea (34%). Reinfibulation is less prevalent in other countries where infibulation is rarely performed, such as Egypt (9%), Chad, Ethiopia, Kenya, and Nigeria, where infibulation is only

performed in certain regions. It is less prevalent in Burkina Faso, Central African Republic, Ivory Coast, Guinea, Liberia, Senegal, Sierra Leone, Cameroon, Democratic Republic of Congo, Guinea-Bissau, Mauritania, and Uganda where type I and type II FGM is performed [2–8]. Reinfibulation is occasionally performed among immigrants in Europe and North America even though FGM/C is prohibited in these countries [9].

Despite efforts to abandon FGM/C, it is estimated that each year approximately 3 million girls in Africa alone are at risk of being subjected to FGM [10].

Despite global strategy to stop health care providers from performing FGM it is still being performed by health care providers in many parts of the world [5].

#### Risks of FGM/C on medical grounds

FGM/C is physically invasive, emotionally damaging, and is associated with complications that may seriously affect the reproductive health of women and increase the risks for the unborn child. FGM/C violates human right to the highest attainable standard of health and to bodily integrity [11].

FGM/C is associated with the potentials of localized infection or abscess formation, septicemia, tetanus, hemorrhage, shock, death, acute retention of urine, and contraction of hepatitis and/or HIV particularly when it is performed in non sterile settings [1–3]. Although the medicalization of FGM/C may reduce the incidence of these acute complications, it has no effect on the incidence of late gynecological and obstetric complications. The gynecological complications of FGM/C include sexual dysfunction, apareunia, superficial dyspareunia, chronic pain, scar formation, dysmenorrhea, vaginal laceration during sexual intercourse, difficulty passing urine, and difficulty during gynecological or urological examination and procedures [2].

A multicenteric study by WHO had shown that there are increased relative risks for cesarean delivery (RR 1.31), postpartum hemorrhage (RR 1.69), extended maternal hospital stay (RR 1.98), infant resuscitation (RR 1.66), and stillbirth or early neonatal death (RR 1.55) [12]. Justification for performing FGM/C appears to be a deeply rooted and ancient custom. The practice of this custom in ancient Egypt was reported by Herodotus (500 B.C.) and Strabo, the Greek geographer. Herodotus reported 500 years BC that female circumcision was practiced by Phoenicians, Hittites, Ethiopians as well as the Egyptians.

FGM is mostly performed to emphasize a cultural identity. Custom and tradition are by far the most frequently cited reasons for undergoing FGM and often perpetuated by older women who were subjected to FGM.

In a FGM practicing society a girl cannot be considered as an adult, unless she has undergone FGM. It is done because it always has been done. It is also performed to identify a gender identity. For a girl to be considered a complete woman FGM is often deemed necessary. FGM marks the divergence of the sexes concerning their roles in life and marriage. FGM is supported by the widespread belief that the human body is androgynous at birth. To ensure adulthood, girls must be relieved of their male part, the clitoris and or/labia [13]. Excision of such parts of a woman's body is thought to enhance the girl's femininity.

FGC/M is also performed with the wrong assumption that it controls women's sexuality and reproductive functions and reduces women's desire for sex.

One of the reasons given to support FGM in some cultures is enhancement of the man's sexual pleasure [14–17].

Cleanliness and hygiene are frequently quoted as justifications for FGM. Terms for mutilation are synonymous with purification (Tahara (Egypt), Tuhara (Sudan), Sili-ji (Bambarra in Mali).

Circumcision is also quoted to promote virginity and chastity and guards young girls from sexual frustration by deadening their sexual desire.

#### **FGC/M and informed consent**

FGM/C is a surgical procedure and the code of medical ethics necessitates obtaining free informed consent from the patient before performing the procedure. The majority FMC/M procedures are performed on girls between ages of 4 and 14 years or sometimes young infants. All these victims are non capable of autonomy and consequently cannot give their free informed consent. Even when FGM/C is performed on adult women they are not included in the decision making process and the midwife and female relatives are usually behind the decision to perform reinfibulation. This may protect them from being deserted or divorced by their husbands. Lack of women's rights and economic dependence on men influences a woman's acceptance of reinfibulation.

#### **Who performs FGC/M, when, where, and why?**

While FGC/M is usually performed by traditional healers, barbers or dayas on young girls or infants reinfibulation is usually performed by doctors or midwives between 2 h and 40 days after delivery. It may also be performed following gynaecological or urological operations on the vagina, cervix, uterus urethra and bladder. A worrying trend is that, FGM/C is increasingly performed by health professionals [6]. They claim that they are fulfilling the cultural demands of the community, enhancement of women's value in the society, and respecting patients' cultural rights since some of those making the decisions are of mature age and capable of autonomy [17–19]. However, the real reason is that it is a source of income for those who perform it; the fees are high, especially in countries where it is illegal.

It is also argued that when the procedure is performed by health care providers the incidence of complications is significantly reduced but not eliminated. It is often quoted that women who undergo reinfibulation are adult consenting women who are fully capable

of autonomy. The analogy of consenting women undergoing body piercing procedures and cosmetic surgery is often used. However, in body piercing and cosmetic surgery the woman is counseled and gives her informed consent, which she can withdraw at any time before the procedure. In contrast, women who undergo reinfibulation are not usually included in the decision-making process or provided with the information that enables them to make a freely-informed consenting decision [6]. A woman may perceive that cosmetic procedures have some benefits, and the procedures are typically performed only after careful consideration of their implications [1–12].

A health professional performing FGC/M or reinfibulation has a conflict of interest. While he/she should advise the guardian of the female child or women against FGM/C and reinfibulation, based on its risks, best medical practice evidence and medical ethics, it is in his/her best interest to perform FGM/C or reinfibulation for personal financial gain.

#### **Medicalization of FGM/C**

A joint technical consultation on the medicalization of FGM/C held by WHO, UNICEF, and UNFPA in Nairobi, Kenya, from 20 to 22 July, 2009, condemned the practice of female genital cutting by medical professionals in any setting, including hospitals and other health establishments. Demographic and Health Surveys data show that the medicalization of FGM/C has increased substantially in recent years, particularly in Egypt, Guinea, Kenya, Nigeria, Northern Sudan, Mali, and Yemen and recently in Indonesia. In many of these countries one-third or more of women had their daughters cut by a trained health professional. An increased number of younger compared with older women are undergoing FGM/C by medical personnel, demonstrating a trend toward the practice [10]. There are various arguments made by medical doctors who excise women and girls. Some believe that FGM/C including reinfibulation is a medical necessity; others argue that performing FGM/C under sanitary conditions reduces its risks; while others consider their personal economic benefits. Sadly medicalization of various forms of FGM/C including reinfibulation has been supported by some international humanitarian organizations, professional organizations and governments. In 1994, the Egyptian minister of health stated that doctors could perform FGM/C on girls in designated facilities at fixed times and prices, claiming that medicalization of the practice would reduce complications and eventually end the practice [20]. Subsequent pressure from international agencies, as well as the reported deaths of girls who were cut in hospitals, instigated a renewed ban on the practice in public hospitals in Egypt [10].

In 1999, the international medical aid agency, Medicines Sans Frontiers (MSF), said its workers provided surgical equipment for FGM/C, but claimed it did not support the procedure. MSF argued that providing clean instruments was a "first aid response," since female genital mutilation can result in infections and cause "horrific complications" in childbirth and during intercourse [21]. Following public condemnation by advocacy groups, MSF issued a policy paper in the same year opposing female genital cutting. The organization stated that the procedure would not be undertaken in any of its facilities and that instruments it supplied would not be used for the procedure [21]. In 2010, The American Academy of Pediatrics organization in the USA recommended to its members

performing minor forms of FGM/C for girls to maintain the traditions and customs for some communities in the USA. The International Federation of Obstetrics and Gynecology (FIGO) immediately responded by the following statement:

Professor Gamal Serour – FIGO President – is deeply concerned and alarmed at the terrible news that has recently surfaced supporting medicalisation of some forms of Female Genital Mutilation/Cutting (FGM/C). FIGO—an international Federation embracing 124 member societies of obstetricians and gynecologists in the developed and developing world—strongly condemns all forms of FGM/C, performed by traditional or medical personnel in all countries and all communities around the globe, as they are harmful, unethical, with no benefits whatsoever, and are against the code of medical practice. FIGO strongly condemns all past, present or future calls to medicalise any form of FGM/C. FIGO affirms its firm stance on this issue as outlined in its previous resolution, guidelines, publications and conjoint statements. FIGO welcomes the withdrawal of the decision of the few organisations who issued or considered the issue of statements implying the support of any form of FGM/C.

The professional organization in USA responded to the Plea of FIGO and the pressure of many Humanitarian groups by withdrawing its recommendation. In 2011, the MOH of one government in Asia issued its clinical guideline on FGC/M to be performed by health professionals in hospitals. The rationale behind these regulations – that when conducted by a qualified healthcare professional, under sterile conditions, the procedure is a safer option than if it were to be carried out by a traditional healer. The MOH argument was that this first contact presents doctors, midwives and nurses with the opportunity to counsel mothers about the futility of the procedure, thereby discouraging future practice. On December 14th, 2011, FIGO responded by a communiqué to the MOH stating that the fundamental issue that FIGO President has with the guidelines is that it legitimises a procedure which has no known medical or health benefit. This places pressure on healthcare workers to be involved in a ritual practice which they may be professionally and/or morally opposed to. Urging MOH to visit FIGO Ethical Guidelines on FGM at [www.figo.org](http://www.figo.org). FIGO's President highlighted that the recent MOH guidelines call for the medicalization of FGM contravenes the principles in the previous UN and WHO resolutions and statement signed by member countries. They are a retrograde step. Egypt has gone before through the same path and legalized medicalization of FGM. However after a short period of practice, little mortality occurred from FGM performed by doctors in hospitals. Consequently, the government of Egypt banned the procedure totally. Implementation of the national guidelines is a clear signal to other countries that female circumcision is an acceptable form of FGM. The good work that has been done to eradicate the practice over the past two decades will be in jeopardy. The author as the Director of the International Islamic Center for Population Studies and Research (IICPSR), Al-Azhar University has pointed out to the MOH that (IICPSR) dealt with the issue in its book titled "Children in Islam: their care, upbringing and protection", published by the Al Azhar University in cooperation with UNICEF 2005, and condemned medicalization of FGM/C [www.unicef.org](http://www.unicef.org), p: 61–62 [22].

FGM/C is an extreme example of discrimination based on sex as a way to control women's sexuality. FGM/C denies girls and women full enjoyment of their personal, physical, and psychological integrity, rights, and liberties. FGM/C is an irreparable,

irreversible abuse of the female child. It violates girls' "right to the enjoyment of the highest attainable standard of health and to protection," contrary to the ethical principles of beneficence, justice, and non-maleficence. Health professionals who support the practice are contravening the medical code of ethics to "do no harm." Educating the public, members of the health profession and practitioners of traditional health care, community leaders, educators, social scientists, human rights activists, and others who implement policies is necessary to trigger awareness of the extent of the problem and the dangers of medicalization of all types of FGM/C, including reinfibulation. The medicalization of all types of FGM/C should be condemned at national and international levels. It is the duty of professional bodies and organizations to advise members and all health workers not to undertake FGM/C, including reinfibulation, and to hold them accountable for this unethical practice. We need a concerted effort and collaboration of UN agencies, world professional organizations, and their member societies including obstetricians, midwives, and pediatricians. These agencies and bodies must be supported by the commitments of governments, politicians, parliamentarians, legislators, mass media, religious leaders, and NGOs.

Women who have been infibulated should be counseled with their spouses about the harmful effects of reinfibulation during prenatal care whenever possible to encourage them not to undergo reinfibulation after childbirth. Women of all ages who have been subjected to infibulation should be treated at all stages, including pregnancy and childbirth, with sympathy, respect, and medically evidence-based care. Depending on local laws, properly informed women who have been infibulated and who, following childbirth, independently request resuturing, should be treated carefully. The practitioner should explain the benefits of unsuturing and advise the patient on the immediate and long-term complications of reinfibulation. The practitioner should also emphasize that all FGM/C procedures are professionally condemned [11].

**In conclusion**, the medicalization of FGM/C, including reinfibulation, although it may reduce the immediate health hazards of the procedure, underestimates its overall physical and psychological complications. Medicalization of all forms of FGM/C violates human rights, ethical principles of justice, beneficence and non-maleficence and the medical code of ethics. It creates tacit approval that only propels this harmful cultural behavior, rather than tacit disapproval and encouragement to change the behavior.

## References

- [1] World Health Organization. *Female genital mutilation. An overview*. Geneva: WHO; 1998.
- [2] Royal College of Obstetricians Gynaecologists. *Female genital mutilation and its management Green-top guideline No. 53* May 2009. London: RCOG Press; 2009. Available at: <http://www.rcog.org.uk/files/rcog-corp/GreenTop53FemaleGenitalMutilation.pdf>
- [3] World Health Organization. *Eliminating female genital mutilation. An interagency statement*. Geneva: WHO; 2008.
- [4] Satti A, Elmusharaf S, Bedri H, Idris T, Hashim MS, Suliman GI, et al. Prevalence and determinants of the practice of genital mutilation of girls in Khartoum, Sudan. *Annals of Tropical Paediatrics* 2006;26(4):303–10.
- [5] Global Strategy to stop health – care providers from performing FGM. UNAIDS, UNDP, UNFPA, UNHCR, UNICEF, UNIFEM, WHO, FIGO, ICN, IOM, MWIA, WCPT, WMA. WHO/RHR/10.9; 2010. Technical.
- [6] Serour GI. *The issue of reinfibulation*. *International Journal of Gynaecology and Obstetrics* 2010;109(May (2)):93–6.

- [7] Yoder PS, Khan S. Numbers of women circumcised in Africa: the production of a total. DHS Working Papers No. 39. Calverton: Macro International Inc.; 2008. Available at: <http://www.measuredhs.com/pubs/pdf/WP39/WP39.pdf>
- [8] World Health Organization. A systematic review of the health complications of female genital mutilation including sequelae in childbirth. Geneva: WHO; 2000. Available at: [http://www.who.int/reproductivehealth/publications/fgm/who\\_fch\\_wmh\\_00.2/en/index.html](http://www.who.int/reproductivehealth/publications/fgm/who_fch_wmh_00.2/en/index.html)
- [9] Vangen S, Johansen RE, Sundby J, Traeen B, Stray-Pedersen B. Qualitative study of perinatal care experiences among Somali women and local health care professionals in Norway. *European Journal of Obstetrics, Gynecology, and Reproductive Biology* 2004;112(1):29–35.
- [10] UNICEF, Innocenti Research Centre. Changing a harmful social convention: female genital mutilation/cutting. *Innocenti Digest*. Florence: UNICEF; 2005. Available at: <http://www.unicef-irc.org/cgi-bin/unicef/Lunga.sql?ProductID=396>
- [11] FIGO Committee for the Ethical Aspects of Human Reproduction and Women's Health, FIGO Committee on Women's Sexual and Reproductive Rights. Female genital cutting. *International Journal of Gynecology & Obstetrics* 2006;94(2):176–7.
- [12] Banks E, Meirik O, Farley T, Akande O, Bathija H, Ali M. WHO study group on female genital mutilation and obstetric outcome: WHO collaborative prospective study in six African countries. *Lancet* 2006;367(9525):1835–41.
- [13] Shannon Brownlee, et al. In the Name of Ritual: An Unprecedented Legal Case focuses on Genital Politics. *US News & World Report* 1994;116(5):1–4. WL 11127978.
- [14] Sami IR. Female circumcision with special reference to the Sudan. *Annals of Tropical Paediatrics* 1986;6(2):99–115.
- [15] Khaled K, Vause S. Genital mutilation: a continued abuse. *British Journal of Obstetrics & Gynaecology* 1996;103(1):86–7.
- [16] Almroth-Berggren V, Almroth L, Bergstrom S, Hassanein OM, Hadi NE, Lithell UB. Reinfibulation among women in a rural area in Central Sudan. *Health Care for Women International* 2001;22(8):711–21.
- [17] Berggren V, Abdel Salam G, Bergstrom S, Johansson E, Edberg AK. An explorative study of Sudanese midwives' motives, perceptions and experiences of reinfibulation after birth. *Midwifery* 2004;20(4):299–311.
- [18] Budiharsana M, Amaliah L, Utomo B. Female circumcision in Indonesia: extent, implications and possible interventions to uphold women's health rights. Jakarta: Population Council; 2003.
- [19] Leye E, Ysebaert I, Deblonde J, Claeys P, Vermeulen G, Jacquemyn Y, et al. Female genital mutilation: knowledge, attitudes and practices of Flemish gynecologists. *European Journal of Contraception & Reproductive Health Care* 2008;13(2):182–90.
- [20] Shell-Duncan B. The medicalization of female circumcision: harm reduction or promotion of a dangerous practice? *Social Science & Medicine* 2001;52(7):1013–28.
- [21] U.N. Wire Aid group caught in controversy. Tuesday, August 27, 1999. Available at: [http://www.unwire.org/unwire/19990824/4516\\_story.asp](http://www.unwire.org/unwire/19990824/4516_story.asp)
- [22] Children in Islam: their care, development and protection. International Islamic Center for Population Studies and Research-Al Azhar University in cooperation with UNICEF. Nov. 29th 2005 and condemned medicalization of FGM/C [www.unicef.org](http://www.unicef.org). p. 61–2.