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ORIGINAL PAPER

Female genital mutilation and its prevention: a challenge for paediatricians

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Abstract Female genital mutilation (FGM) is defined as an injury of the external female genitalia for cultural or non-therapeutic reasons. FGM is mainly performed in sub-Saharan and Eastern Africa. The western health care systems are confronted with migrants from this cultural background. The aim is to offer information on how to approach this subject. The degree of FGM can vary from excision of the prepuce and clitoris to infibulation. Infections, urinary retention, pain, lesions of neighbouring organs, bleeding, psychological trauma and even death are possible acute complications. The different long-term complications include the risk of reduced fertility and difficulties during labour, which are key arguments against FGM in the migrant community. Paediatricians often have questions on how to approach the subject. With an open, neutral approach and basic knowledge, discussions with parents are constructive. Talking about the newborn, delivery or traditions may be a good starting point. Once they feel accepted, they speak surprisingly openly. FGM is performed out of love for their daughters. We have to be aware of their arguments and fears, but we should also stress the parents' responsibility in taking a health risk for their daughters. It is important to know the family's opinion on FGM. Some may need support, especially against community pressure. As FGM is often performed on newborns or at 4–9 years of age, paediatricians should have an active role in the prevention of FGM, especially as they have repeated close contact with those concerned and medical consequences are the main arguments against FGM.

Keywords Female genital mutilation · Paediatrics · Prevention · Female circumcision · Female genital cutting

Abbreviations
FGM Female genital mutilation
WHO World Health Organization

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Introduction

Female genital mutilation (FGM), also referred to as female genital cutting or female circumcision, is defined as a procedure involving any injury of the external female genitalia for cultural or non-therapeutic reasons [20]. Traditionally, this is mainly practiced in sub-Saharan and Eastern Africa (Fig. 1), Egypt, among some groups in the Middle East [22], e.g. some iraki Kurds, and some regions of Asia (e.g. Malaysia). Through migration, the population concerned has also moved to Europe. The local health systems in the west are, thus, confronted with these traditions. While there has been progress in the gynaecological care of complications, there is still a lot of work to

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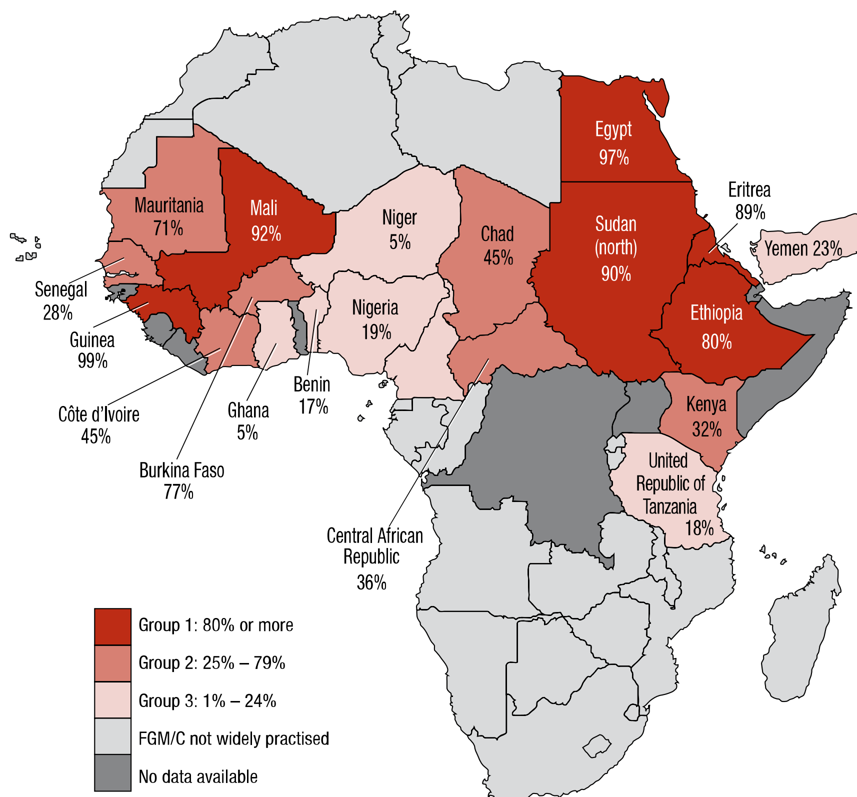

Fig. 1 The prevalence of female genital mutilation (FGM) in Africa among woman aged 15–49 years. Source: UNICEF, 2005, http://www.unicef.org (reproduced with the permission of UNICEF, Geneva, from: Female genital mutilation/cutting: a428 statistical exploration; UNICEF, New York, 2005)

be done on the paediatric side and in terms of prevention. Although, especially, paediatricians claim to be motivated to become active in prevention, there seems to be substantial obstacles in doing so. The aim of this article is to give basic information on how to approach the subject.

FGM in Europe

In 2003, it was estimated that more than 6,700 women and girls who had either undergone a form of FGM or were at risk lived in Switzerland [5]. The number of migrants from concerned regions is still increasing. In some countries, numbers are much more important; it is estimated that some 74,000 woman who had undergone FGM and some 7000 girls younger than 17 years of age, potentially at risk, live in the United Kingdom [14]. Several cases of FGM performed in France and Italy have become public [17]. Swiss gynaecologists have already been asked about the possibility of performing female circumcision in Switzerland [5, 9]. In 2007, Somali parents have been accused by the prosecutor of having had FGM performed on their daughter in Switzerland.

Forms of FGM

According to the World Health Organization (WHO), there are different types of FGM. Type 1 implies the excision of the prepuce with or without partial or complete excision of the clitoris [20]. This type is sometimes referred to as Sunna. The term has a religious connotation and should be avoided. Sunna also means a Muslim tradition, thus, something that should be considered by a good Muslim. The Koran gives no justification for FGM; there are fatwas against FGM and many Muslim regions, such as the Maghreb, are free of this tradition. In type 2, the excision of the labia minora is also performed. The term “excision” is often used for this type, but it is also used as a generic term for all types 1–3. Type 3, also called infibulation, involves the additional suturing of the labia majora, leaving a minor opening. The WHO also refers to this form as pharaonic circumcision. In Egypt, some of the less severe forms are also called pharaonic in order to put emphasis on their pre-Islamic character.

The fourth type regroups all further practices involving injury of the female genitalia, including the introduction of corrosive substances, the stretching of the labia minora (e.g.

among the Bemba in Zambia), cuts or burns inflicted on purpose to the labiae or the clitoris [20] etc.

The populations concerned often have very little knowledge of their own anatomy and tend to underestimate the extension of the cutting they undertake [3].

Medical issues

FGM is usually performed at the age of 4–8 years. Among some communities in Malaysia, the Democratic Republic of Congo and Eritrea, it is performed on newborn girls. Complications vary, depending on the degree of FGM and the way it has been performed. In some regions, girls are circumcised in groups; in others, individually. While rich families sometimes have it performed in hospitals under anaesthesia, FGM is often performed without anaesthesia under non-sterile conditions. In order to avoid medicalisation of the procedure, which hinders its eradication, the WHO clearly bans FGM from hospitals.

Local and generalised infections (including HIV and hepatitis B), acute haemorrhage, injury of neighbouring organs, severe pain and even death are possible short-term consequences of all types 1–3 [4, 22]. Abdominal pain [8], gynaecological infections, infertility, dyspareunia (male and female) and complications during labour are possible long-term complications [2, 4, 22] (Table 1). According to the WHO, the risk of caesarean section, post-partum bleeding and prolonged hospitalisation increases with the degree of FGM. Reanimation of the newborn, stillbirth and perinatal death are more frequent [19].

Table 1 Long-term complications, adapted with permission from the Swiss Guidelines [4]

Complications	
Gynaecological, sexual, menstruation	Infertility, sterility, dysmenorrhoea, dyspareunia, sexual dysfunction, vaginal stenosis, chronic vaginitis, pelvic inflammatory disease, chronic endometritis
Urinary tract	Urinary tract infections, urinary difficulties and Incontinence
Scarred tissue	Recurrent abscesses, haematocolpos, dermoid cysts, neurinomas
Problems during pregnancy and labour	Prolonged second stage of labour, increased perinatal mortality, difficulties during vaginal examination, bladder catheterism impossible, perineal injuries, infection of perineal lesions, fistulas, post-partum haemorrhage, foetal scalp pH measurement not possible
Psychological problems	Depression, post-traumatic stress disorder Stress through feeling different

Recurrent urinary tract infections, problems related to scarred tissue and psychological difficulties can be consequences of FGM. Often, the woman does not see the relationship between their complaints and what happened to them. It is not easy to quantify the impact of FGM. Some of the complaints, for example, pain during menstruation, can be explained by FGM, but are also frequent in non-circumcised women and may not be linked to FGM. Moreover, some of the women do not have any complaints. Pain is one of the consequences most often recognised: Somali women often refer to the three major sources of pain in a woman's life: the excision, the reopening on their wedding and during child deliveries.

In girls, abdominal pain, prolonged duration of micturition, vulvitis, recurrent urinary tract infections [1] or changes in behaviour can be a indicator for FGM.

The psychological pressure and trauma of being torn apart between two cultures and feeling different may lay heavily on the girls growing up in a setting where FGM is banned. This stands in contrast with the experience of many of their older female family members who may have had FGM performed on them in a setting that valued FGM and made them a proud part of the community. Intervention on the genitals can cause painful memories [6].

Active prevention

As a paediatrician and practitioner in charge of possible victims of FGM, thanks to close contact with the families

Table 2 How to get started

Opening a dialogue with the parents, families and patients
1. Know your own position and be well informed
Read national guidelines if available
For example: Swiss guidelines: Mutilations génitales féminines recommendations Suisses à l'intention des professionnels de la santé, Hohlfeld P et al., http://www.saez.ch; http://www.caritas.ch/gesundheit
Brochure for parents in various languages: Lets protect our daughters, Terre des Femmes, http://www.terre-des-femmes.ch [8]
2. Assure an adequate setting
Privacy, take your time
3. Have an open approach
Neutral, respectful, not emotional, ready to be confronted with the mother's experience
Avoid the term mutilation
4. Introduce the subject via talking about traditions, delivery etc.
Possible opening phrases:
"Some people of similar origin perform some form of excision..."
"... is it a tradition where you come from?"
"... is it performed in your community?"
"Any difficulties during labour?"

and the unique position as a guardian of the child's good health, discussions for the prevention of FGM are possible when the necessary openness is observed (Table 2). Fears of not being up to the patient's culture are understandable, but they may lead to unfounded projections and may be counter-productive. FGM is not such a great taboo [6] and with the necessary respect, it can be discussed openly.

Knowing your own position and being well informed

It is important to be well informed about the motivations and cultural background, together with the possible complications, of FGM, as these are valid arguments against FGM. The Swiss guidelines, Mutilations génitales féminines—recommendations Suisses à l'intention des professionnels de la santé [4], give a survey on the topic (available in German and French). A brochure for parents by Terre des Femmes may also be helpful [13]. A variety of national guidelines and position papers have also been developed in Belgium, Denmark, Sweden, the Netherlands, Germany, the UK and others [8], providing information on the subject.

It is crucial to be aware of ones' own position regarding FGM. Cultural differences violating the health of minors are not acceptable. The consequences of traditional FGM and anatomical changes do not correspond with a traditional male circumcision.

Appropriate setting

The discussion requires an adequate amount of time. A short conversation in the emergency ward is not likely to be appropriate. It is also necessary to build a relation of trust. In case a translator is needed, he or she has to be chosen carefully. A child or an adult male is rarely helpful when talking with a mother. One should be informed about the translator's ideas on FGM—a short separate exchange may be necessary—and be sure that the interlocutor will be ready to open up in front of the translator, as within migrant communities, there is sometimes a lot of gossip.

It may be helpful to be aware of the fact that harmful traditions also existed in our countries and that even amputations of the clitoris were performed in Europe for so-called medical reasons at the end of the 19th century. A neutral, respectful and unemotional attitude is essential. The term "mutilation" should, at least at the beginning, be avoided. Once people feel accepted, they speak surprisingly openly about the topic.

As it is possible to be confronted with the person's trauma, it is important to be ready to handle the emerging emotions caused by painful memories.

With whom and when

Countries of origin give an indication on whom to talk to. In some regions in Switzerland, midwives are asked to note the FGM status on the newborn's file. As FGM is, e.g. in Eritrea and Malaysia, also performed on newborns and the memories of a possibly difficult delivery are recent, it is helpful to address the topic for the first time at the postnatal visit and then again at the age of 3–5 years and, sometimes, even later again.

Starting the conversation on FGM

Different opening questions allow an introduction to the topic:

> Some people of your origin perform some form of female circumcision. Is this also the case in your community?

Talking about the newborn and the delivery can also be a possible introduction:

> Were there any difficulties at the delivery?

In case FGM is performed in the concerned community, it is important to find out rapidly if there is pressure or if there even exist concrete plans to perform FGM. Even if the desire for FGM is denied, it is important to talk about it and to reinforce the argument through repeating the cons against FGM.

Key points during the conversation

The conversations should address the pros and cons of FGM, allowing the parents to reach the conclusion that FGM should not be performed after the consideration of all aspects. Next to traditional motivations, medical arguments

Table 3 Conversation points

Topics of conversation
1. Know the family members' opinions on FGM
Intention to perform FGM? Community pressure?
2. Listen to their arguments and fears
Reasons for FGM?
3. Give information on medical complications
See Table 1 and repeat, as they are main arguments
4. Give short summary of information on the legal consequences
FGM is illegal in Europe and abroad/countries of origin
5. Evaluate the need for support/other steps
Need for support/empowerment? Social situation? Resources?
Repeat arguments/discussions and offer help

and the family setting should be discussed. The legal aspects can rapidly be explained (Table 3).

Even in case an attitude against FGM is declared by the parents, it is often useful to repeat arguments in order to reinforce the decision against FGM.

The medical arguments

Noone would want to harm their own child. Medical complications are well-recognised arguments among the migrant community. Complications from which family members are suffering are clear examples. The risk of reduced fertility, complications during delivery and disadvantages for the newborn are valuable arguments against FGM in the migrant community. The parents' responsibility in inflicting pain and the possible consequences of such a tradition can be eye-openers. Just shifting to a so-called less severe form of FGM is not a solution.

For a long time, concerned women were afraid of accepting gynaecological care [15]. It is helpful to make them aware that health care professionals know how to manage complications, but that it is not possible to undo it. Moreover, it should be stressed that FGM is no indication for a caesarean section.

During normal paediatric follow-up, it is reasonable to examine the genitalia in small girls (as is normally done). This also makes parents aware that changes in that region may not go unnoticed. However, types 1 and 2 can sometimes also go unnoticed if they are not carefully searched for [11].

Table 4 Arguments and fears

Reasons for FGM	Arguments against FGM
"Increased fertility"	Reduced fertility or sterility and difficulties during labour
Condition for marriage	More and more men among the migrants and in the home country no longer require FGM
Religion	Not mentioned in the Koran, the Bible nor the Torah, fatwas against FGM
Control of female sexuality, protects girl from western society/ensures virginity and fidelity/husband's satisfaction	False security, importance of education, male lesions during intercourse
Provides better hygiene	Infections
Sign of femininity and beauty	
Tradition	Change of harmful traditions
Social pressure	Support parents' decision-making/responsibility for their children

The traditional arguments

It is useful to be aware of the parents' motivations, as well as their fears, should they renounce FGM (Table 4). We also accept inflicting pain through certain interventions on our children, hoping to grant them a better start in life (e.g. vaccines, operations for protruding ears etc.). In the same way, FGM is organised by parents loving their children. They can be torn apart in a true conflict of loyalty between their family, their culture of origin, the migrant community, medical aspects and their new home.

In some countries of origin, FGM has, for a long time, been a condition for marriage, the only social security a girl could have. This condition is slowly changing in many African countries. The fact that the daughter might, one day, want to get married to a European may be rather counter-productive argument in some families.

There are communities in which FGM is a condition to be regarded as a true woman and peer pressure can be very strong. It is, thus, possible that a small girl growing up in such a community, ignoring what is to come, can hardly await her own circumcision. Through circumcision, some families also hope to protect their daughters from western society, which they may consider as lacking morality. They often forget that clitoridectomy only reduces the possibility of having a satisfying sex life, but does not quell a teenage girl's desire for sexuality. It may be helpful to point out that good education may lead to better results and that marriage may last longer if the woman is not always suffering from dyspareunia.

The fact that neither the Koran nor the Bible command FGM as obligatory is important in a community which often asks its religious leaders for advice. A ruling of the Al-Azhar University, a conference of Muslim leaders in Egypt, banning FGM has been a very important step in abolishing FGM, as it gave the local Muslim community the religious basis against FGM and underlined FGM as not being a Sunna (religious tradition) [18]. According to Al-Azhar, in Islam, the woman's right to be sexually fulfilled must be respected on an equivalent footing with the right of the man [18] and children should be protected. There is a great variety of reasons given for FGM. It is better to ask for the interlocutor's reasons than to project wrong arguments when trying desperately to be culturally sensitive and adequate [6].

Living abroad can be an opportunity for change and to abandon harmful traditions. In some Diaspora communities, there is, on the contrary, a reinforcement of certain old traditions. Pointing out that more and more people have given up this tradition in Africa [12], as well as among the migrants, without losing their identity, may be helpful. Valuing the nice and positive sides of the person's cultural heritage can reduce the fear of abandoning one's own identity.

A frequent argument to the continuation of the practice among refugees is the fact that they might return to their country of origin, fearing that the absence of FGM might be negative for their daughter. Pointing out the changes in attitude toward FGM among the educated people in their country of origin can be helpful, because they would probably prefer their daughters to get married to someone educated. Once informed of the health consequences, they can no longer hide behind traditional arguments and pretend to be ignorant of the possible negative impacts that FGM may have on their daughters and it is their responsibility to protect their daughters' physical integrity.

The legal arguments

FGM is a violation of bodily integrity and, thus, is a punishable crime in western European countries [7, 16, 17] and the USA [10]. Sweden and Great Britain were the first European countries to adopt specific laws as early as the 1980s [7]. In Africa, as well as in the west, there are more and more countries adopting specific laws against FGM [7, 10, 21].

In countries like, for example, Austria, Belgium, Switzerland, Spain and Sweden, prosecution can take place, even when the crime was committed abroad [7, 10]. To forward this information is important, as holidays in the home country are sometimes opportunities to perform FGM. An "official" paper stating the legal impact of FGM may help those parents who want to resist the family's pressure in their home country. These families do not have an interest in their members in Europe being prosecuted, as money transfer is a central source of income, and its end would mean a sometimes substantial financial loss for the family in the country of origin.

The environment, the parent's resources and the necessary support

One should enquire about other family members' attitudes towards FGM. In some communities, it is mainly the grandmothers who have an important influence as guardians of tradition. It may be necessary to conduct separate conversations with different family members. Education, religion and socio-economic conditions may influence the parents' opinion. In the context of migration, the people concerned are often facing many problems, and their priority is rarely FGM.

Obviously, a family only exchanging with their, sometimes very strict, migrant community or fearing loss of their permission to stay in the host country will have FGM more readily performed on their daughters in order to assure their social survival if they were sent back to the country of origin than a family that is well integrated and expecting to create permanent living in the new country.

Family members who are ready to give up FGM are to be supported, be it through medical arguments, discussions with their family or referral to groups sharing the same view. Some African migrants also emphasise the importance of education opportunities and women's groups, which help them rise socially and give them the opportunity to exchange. This helps them fight for women's rights and the protection of their daughters from FGM. It is also helpful to use mediators and activists of the same migrant group.

The concrete suspicion and the committed case

In case of a serious suspicion of imminent FGM, it is helpful to inform child protection groups or the authorities. Even though the legal bases may not always be completely clear, it is still generally recommended to become active in order to protect the daughters and not to be prosecuted for failure to give assistance to a child in danger.

It is important to be informed on the local legal situation, as legal aspects can vary. In Switzerland, for example, in case of a recently performed FGM, only some Cantons' law command to inform officials. It can be legally argued that this obligation can also be applied for cases of imminent danger to a minor. Especially when other girls live in the same greater family, it is important to act rapidly when a new FGM case has occurred.

Conclusion

Paediatricians can play a central role in the prevention of female genital mutilation (FGM), as they are in repeated close contact with the girls and their families. As a doctor and, thus, guardian of the child's health, paediatricians have a privileged role. Medical complications are the main arguments against FGM and the wish for good health is well recognised. With an open approach and some basic knowledge, discussions with parents can be very constructive.

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