Female Genital Mutilation/Cutting: sharing data and experiences to accelerate eradication and improve care: part 2

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I. Healthcare professionals: training and curricula. Medicalization

1 Healthcare professionals training on FGM: challenges and opportunities: a commentary
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Healthcare professionals have a critical role to play in the prevention and management of FGM. However, several KAP (Knowledge, Attitudes and Practices) studies conducted in high and low income countries have shown a lack of knowledge on WHO classification, diagnosis and management of FGM. Although several countries have developed FGM guidelines for professionals and have voted specific laws against the practice, the studies showed that these measures are not sufficient and that educational activities are needed to implement existing guidelines. Integration of the thematic in the curriculum of health professionals is a longstanding recommendation, but few countries have done it. Evidence of best practices in educational programs is lacking; a recent review only found two studies meeting the study selection criteria. There is a need for high-quality research on educational strategies using common indicators in order to allow comparisons between country programs. Professionals need operational tools: case studies, videos, and pictures. New technology is an opportunity: e-learning tools and visual tools to identify different types of FGM could make the difference. The KAP studies have also shown the ambivalence of health staff who are caring for women affected by FGM but may also perform FGM in some contexts (medicalization). There is a need for the integration of a discussion on ethics and the role of professionals in prevention in training programs. The last point highlighted by the KAP studies is the lack of knowledge of professionals on the cultural context and on psychological and sexual consequences of FGM (and its management). This should be the new focus of training modules on FGM, established with the active participation of psychologists, sexologists, and peer educators from the community.

2 Quality improvement method to optimize Female Genital Mutilation (FGM): protocol for an in-service training package targeting community midwives in Northern and River Nile states in Sudan
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Reproductive Health 2017, 14(Suppl 2):2

Introduction
The implementation of methods to increase knowledge and skills among health workers adapted to the contextual settings and its effectiveness on medicalization is not much studied. Sudan has a high FGM prevalence with increasing medicalization rates, mostly performed by trained midwives. This method paper details a four-step protocol for an analysis and improvement intervention designed to develop a tailored in-service training package to community midwives in two states in Sudan is currently underway.

Methods
This study employs a two-arm, longitudinal randomized trial design targeting 1,000 community midwives. The Consolidated Framework for Implementation Research (CFIR) will be used to guide collection and analysis of qualitative data on implementation process. Plan Do Study Act cycles will be used to rapidly and regularly assess knowledge, attitudes and skills sets to iteratively improve on the intervention.

Results
This study is expected to provide guidance for improving knowledge and skill sets for community midwives and evaluating the effectiveness of this intervention on type of interventions on FGM de-medicalization.

Conclusion
Implementation research is a much-needed area to study the delivery of strategic approaches to accelerate de-medicalization.

3 The New Zealand (NZ) national FGM education program: case study of a successful training and prevention model for NZ healthcare professionals
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Reproductive Health 2017, 14(Suppl 2):3

Introduction
The New Zealand Female Genital Mutilation (FGM) Education Programme (NZFGMP) is a strong case study of a successful national FGM healthcare training and curricular programme. Established in 1997, the NZFGMP has worked in collaboration with, and health professionals delivering robust healthcare training and prevention initiatives.

Methods
The development of a comprehensive range of pre and post-graduate national FGM curricular, clinical guidelines, web material, resources and recommended best practices. Methods used included FGM research both qualitative and quantitative on the
health care experiences of women with FGM. We conducted national FGM training projects on the management and prevention of FGM/C for a wide range of health professionals and medical/nursing universities. We also conducted national FGM health promotion campaigns including consultation, training and community driven FGM programmes. All projects were reviewed using “Results Based Accountability (RBA)” to monitor, evaluate and inform practice.

**Results**

We found improved sexual and reproductive health outcomes of women with FGM (increased satisfaction with maternity services and increased FGM knowledge amongst health professionals). There was a decline in FGM support (from 76% to 43% for type 1 and from 54% to 0% for types 2 and 3) and increased prevention of FGM in New Zealand.

**Conclusion**

The NZFGMP has seen improved sexual and reproductive health outcomes and a decline in support for FGM amongst communities, as a result of the Programme’s consultation, training, resources and community driven initiatives undertaken in close collaboration with communities affected by FGM and health professionals.

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**Evidence to inform education, training, and supportive work environments for doctors and midwives involved in the care of women with female genital mutilation: a review of global experience**

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Reproductive Health 2017, 14(Suppl 2):4

**Introduction**

There is little available knowledge to inform the design of medical and midwifery education programs or supportive workplace practices in low-, middle-, and high-income countries with respect to caring for pregnant women with female genital mutilation (FGM). We undertook two systematic reviews [1, 2] to examine the experiences and educational needs of doctors and midwives.

**Methods**

Narrative syntheses of peer reviewed primary research literature retrieved through searches of electronic bibliographic databases between 2004 and 2014 were undertaken and guided by the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) framework.

**Results**

A lack of health professional technical knowledge, clinical skills, and limited cultural competency was identified. Studies examining the impact of educational programs are limited and providers in FGM prevalent countries face socio-cultural challenges with respect to the prevention of the practice.

**Conclusion**

There is a need for improved medical and midwifery education and training to build knowledge and skills, and to change attitudes concerning the medicalization of FGM and reinfibulation. Supportive working environments sustained by guidelines and responsive policy and community education are necessary to enable doctors and midwives to improve the care of women with FGM and advocate against the practice.

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Conclusion
Programs to reduce medicalization should address both the demand and supply factors. FGM prevention should combine social norm changes and trainings with livelihood options.

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7 Medicalization of Female Genital Mutilation/Cutting: what do the data reveal?
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Introduction
Despite international consensus that FGM/C is a violation of human rights, a focus on medicalization remains salient because of concerns that in certain countries FGM/C continues to be performed by healthcare professionals, and may be impeding progress toward abandonment of FGM/C.

Methods
We drew on a nationally representative survey data from 25 countries and asked: What are the major patterns and trends in medicalization? What is the association between medicalization and prevalence of or support for FGM/C? What is the association between medicalization and rates of abandonment of FGM/C?

Results
Among women between ages 15-49, medicalization is highest in 5 countries: Egypt (38%), Sudan (67%), Guinea (15%), Kenya (15%) and Nigeria (13%). Comparing mothers and daughters, rates of medicalization are rising substantially in all of these countries except Nigeria. Nearly 15 million women in the 25 countries with data on medicalization have been cut by healthcare professionals. Of these, 51% live in Egypt and 34% live in Sudan. Overall, there is no discernible association between rates of medicalization and rates of decline in prevalence of FGM/C and no discernible association between rates of medicalization and support for continuation of FGM/C. Although data are limited, it appears that medicalization is associated with a trend toward less severe forms of cutting (away from infibulation and toward nicking).

Conclusion
Medicalized cutting is concentrated in three countries: 93% of women who report having been cut by a health care professional live in Egypt, Sudan and Nigeria. Elsewhere medicalized cutting is rare, or restricted to geographically defined pockets. Medicalized cutting can occur alongside declining prevalence of FGM/C, and hence does not appear to completely counteract abandonment of the practice. The degree to which it potentially slows abandonment or influences the ability of medical care practitioners to participate in anti-FGM/C advocacy is unclear, and requires further research.

8 A clinical pathway of sensitization and care for pregnant women with FGM/C in a level II hospital
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Introduction
The HIS maternity unit in Brussels is a level II structure of 2500 annual births serving a largely (approximately 75%) migrant population with a broad component of patients from countries where FGM/C is prevalent.

Methods
In this context, pregnancy and childbirth care providers have been trained in identification, classification, obstetrical aspects, management, and prevention of risk of FGM/C in the unborn child. A Train the Trainer course was organized at the Group for the Abolition of Sexual Mutilation (GAMS) and was attended by 4 members of staff, who then conducted training of all health care providers and health visitors of the department.

Results
A clinical pathway was established based on three principles: (1) all care providers are competent to identify and classify FMC/C, (2) a large map with incidence per country is posted on the wall of all the consulting rooms, (3) there is a compulsory "FGM/C" box to be checked in the electronic file. The care-giver is responsible for tailored maternal care and prevention of FGM/C in the unborn child. The Health Information System data were compared to the estimated indirect prevalence using maternal country of origin and provided by civil registration of births. This showed that 72 patients had been identified and cared for within the pathway out of a theoretical estimate of 99.

Conclusion
The clinical pathway introduced into maternity leads to a good identification and care of pregnant women with FGM/C by the obstetric team.

9 Knowledge of Female Genital Mutilation/Cutting (FGM/C) among nurse-midwives working in high-prevalence counties in Kenya: pre-post KAP study
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Introduction
Female Genital Mutilation/Cutting is implicated in health impacts, women’s rights violation and capacity building for Nurse-Midwives as care givers and change agents rather than providers of medicalized FGM/C is critical. We determined the level of knowledge on FGM/C among Nurse/Midwives from FGM/C prevalent counties.

Methods
Nurse-Midwives (n = 26) selected from FGM/C prevalent counties took an objective pre/post-quiz administered before and after a 3-day training. The quiz assessed FGM/C key themes namely; definition, classification, perpetuating factors, epidemiology, medicalization/its prevention, health consequences, and Nurse-Midwives roles. The themes formed the components covered in the 3-day training. The individual and overall scores for all the questions were computed and compared across the quizzes.

Results
The overall mean scores on the quiz were 64.8% before and 96.2% post-training. The scores on specific FGM/C components were: practice types (84.6%), link between cutting and health problems (96.2%), complications (96.2%), cutting communities (61.5%), knowledge of medicalization (43.6%), re-infibulation (46.2%), and illegality of cutting (46.2%), before training. The performance on FGM/C complications was: physical (69.2%), psychological (69.2%), sexual (57.2%), and social (38.5%), before training. Moreover, the participants awareness of their roles in FGM/C interventions included: counsellor (69.2%), advocate (80.8%), leadership (26.9%), role model (42.3%), and caregiver (34.6%) before training. The scores on all FGM/C themes improved significantly after the 3-day training.
Conclusion
Nurse-Midwives exhibited knowledge gaps on FGM/C that may affect their capacity to manage and prevent the practice. This underscores the need to develop and rollout innovative training interventions such as implementing the eTool approach on salient issues on FGM/C.

II. Healthcare and prevention

1 FGM: healthcare experience and prevention efforts in Mali: cross sectional study
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Introduction
The prevalence of female genital mutilation (FGM) of women aged 15 to 49 years in Mali is very high (91%). The objective of this study was to evaluate the current practice of FGM among children aged 0 to 15 years old.

Methods
Cross sectional study of 898 girls between 0 and 15 years old in 3 villages where the Mali Red Cross and NGOs are active. The NGOs work on different health domains including FGM/C. They work on healthcare professionals training and to increase sensitization on the topic among the communities. Participants underwent a clinical examination and their parent/legally responsible person in charge answered a questionnaire.

Results
The prevalence of FGM/C was 56%, similar to that of the Demographic and Health Survey, which was 58% for the age group concerned. It was lower in the areas covered by an NGO; 45.5% of children were circumcised before their first birthday. Excision was performed at the parents’ home in 56.9% of cases. The two main reasons for performing FGM/C were respected traditions (46.4%) and religion (20%). The decision-makers for excision were mainly the grandmothers (56.9%) and mothers (31.9%). The practice was performed by medical staff in 2.4% of cases. The main complications were: secondary infibulation/dysuria (54.1%) and vulval cysts (16.2%). The majority (73.6%) of respondents were against a law penalizing the practice; 26.4% in favour.

Conclusion
The prevalence of the practice of FGM among children from 0 to 15 is still high in the villages studied. We noted a positive impact of sensitization in areas covered by NGOs, where prevalence was lower than the non-covered areas. Individuals in these communities did not seem to be in favour of a law penalizing the practice. Intensification of awareness campaigns may be useful.

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2 FGM/C: healthcare experiences and prevention efforts from the U.S. context: mixed methods, community-based participatory research
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Since 1970 the United States has experienced a rapid growth of African-born immigrants, with over 1.7 million current residents. The CDC estimates that 513,000 women and girls have undergone or are at risk of FGM/C [1]. FGM/C-affected women possess profound distrust of the health care system, experience stigmatization, face language barriers, and fear interventions; therefore, they often delay or refuse needed care. This may result in adverse reproductive health outcomes [2,3,4,5]. Providers possess widespread knowledge gaps and lack the formal training and cultural knowledge on FGM/C-related care.

A nationally recognized best practice model for improving culturally competent care for FGM/C-affected populations and engaging in Community-Based Participatory Research (CBPR) exists at the Refugee Women’s Health Clinic (RWHC), Maricopa Integrated Health System in Phoenix, Arizona [6]. Cultural Health Navigators, who are employed, bi-cultural, and multilingual staff, facilitate the coordination of culturally competent care, services and support. An infrastructure of community partnership, engagement, and shared community leadership exists through the Refugee Women’s Health Community Advisory Coalition, which is comprised of ethnic community-based organizations, refugee resettlement agencies, as well as public health and academic partners. These entities partner with the RWHC to address FGM/C-associated reproductive health disparities, enhance provider training and clinical documentation and the provision of culturally informed health care that is built on a foundation of established trust, enhanced clinical care, CBPR, and community engagement.

The first ever U.S. “End Violence Against Girls: The Summit on FGM/C” was held in Washington, DC in December 2016, bringing together multiple stakeholders from across governmental agencies, the health, social service, legal and education sectors, as well as FGM/C survivors, community activists, youth, men, and religious leaders [7]. The Healthcare Sector Working Group of the Summit proposed key strategies to respond to FGM/C in the U.S. Multi-pronged efforts are needed that mobilize FGM/C-affected communities and providers in addressing the social determinants of health, ameliorating structural barriers to care, engaging men as partners, enhancing sustained provider education, and supporting the dissemination of interprofessional clinical practice guidelines. Future research must utilize validated instruments, provide ethno-cultural specificity, incorporate WHO FGM/C typology, design quality improvement metrics, and encourage multi-center research partnerships.

3 Clitoral reconstruction (CR) after female genital cutting (FGC).
Women’s motives, expectations and experiences: qualitative study
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Introduction
Clitoral reconstruction (CR) has recently been introduced in Sweden.

Methods
Qualitative study aimed at exploring motives, expectations, and experiences in relation to surgery.

Results
Fifteen women requesting surgery were recruited at Karolinska University Hospital. Preliminary analysis of 15 pre-operative and 4 post-operative semi-structured individual interviews revealed that the women feel FGC has deprived them of something important for their sexual capacity, resulting in grief and feelings of inferiority. They wanted to reclaim this body part, physically and symbolically, although aware that surgery might not ‘fix everything’. They hoped their genitalia after surgery would resemble uncut genitalia so that they could look and feel more ‘normal’. They also hoped to regain clitoral sensation and improve sexual capacity. This, they reported, could make them more ‘equal’ with uncut women. One year post-operatively, the women were satisfied with surgery on at least some levels, despite strong immediate post-operative pain. Improved sexual pleasure and a newfound ability to reach orgasm, was experienced, but some women reported no difference in sexual pleasure and capacity. The women were satisfied with the visual aspects and happy to have gone through surgery.

Conclusion
The complexities involved in CR, including social, psychological and emotional attributes, should be taken into consideration in future studies.

Table 1 (abstract 4) Examples of quotes. All names used in this table are pseudonyms

| Speaker | Interview verbatim transcripts |
|---------|--------------------------------|
| Female speaker “Awat” 1, 23-years-old, market vendor, married, 2 children | “All women, at a certain moment, are up to make love. If this need comes, it does not manifest equally for every woman. It is said that if a woman is circumcised and feels this mood for sex, she can sustain it. But those who are not circumcised, if they feel this need, their vagina tempts them. She cannot stay calm if she does not make love.” |
| Male speaker “Haroun” 3, 39-years-old, unemployed photographer, married, 4 children | “It was said, ‘A woman who is not circumcised, she always wants to make love. The moment she is in bed with her husband, it is tough. The man has to make an effort. […] Effectively, later others said, ‘Cut away there and you have to stimulate her tirelessly, and it does not mean anything for her. In bed, they are lovers.’ Others even say that it even hurts them. That is, it cannot heal just like that.” |
| Female speaker “Tatoumata”, 18-years-old, high-school student graduation class, unmarried, no children | “What they have to establish, in my view, is to circumcise the young in the hospital, and to avoid traditional female circumcision. It is not good. It is risky. Especially the rusty knives and all that… It elicits illnesses in the genital apparatus of the woman. The boys, there are no consequences. But the girls have consequences due to the cutting. They have to establish one law for all the young, boys and girls alike, so that they all are circumcised in the hospital.” |
| Male speaker “Boureima”, 44-years-old, tailor, married, 3 children | “I… In the past, it was possible to lose blood [during excision]. Going to the hospital, you would find blood to give fast. But nowadays, when you lose blood, to have good blood to replace it in the body, this would not be easy. I have seen it myself, but not in connection to excision. There is a woman, who […] got blood, but found that the person had hepatitis. She died… Nowadays one should not take that risk. When you do the cutting, if the girl loses a lot of blood, in the hospital, this will not be easy.” |
| Male speaker “Le Lion”, 22-years-old, market vendor, unmarried, 1 child | “I consider excision as a crime. It is the mangeling of bodies, which God has created. It is an enormous pain, which influences the life of the small girls. […] They are mangled, they are cut, and this hurts me. I do not like it. I fight against it.”

FGM/C as a health concern - lay people's views on the bodily practice in Burkina Faso: an ethnographic study
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Introduction
In Burkina Faso, there is a legal ban of FGM/C. Nationwide anti-FGM/C campaigns tackling related health and social issues aim at societal change. Different media, such as TV, radio, films, theatre, forum discussions, and music videos, are used to spread information. This study was conducted to identify current social and cultural perceptions, validations, and norms pertaining to this traditional, yet contested, cultural practice.

Methods
Ethnographic, qualitative fieldwork has been conducted in Bobo-Dioulasso, Burkina Faso. A narrative approach was used to elicit how people subjectively explain and make sense of FGM/C. Participant observation with informal interviews, as well as expert interviews with stakeholders of the campaigns were conducted. Furthermore, semi-structured interviews were made with 55 female and male city dwellers of various religions and ethnic origins between the ages of 18 and 55+ years.

Results
Amongst others, health, and disease, physical inadequacy, or physical problems are part of the public discourse on FGM/C. People debate and contest the reality of health consequences of the practice in the framework of related gender notions, e.g. the view of the circumcised body, which was overall considered to be healthy and imperious for the wellbeing of the individual woman, her family, and society at large, is changing. It is now also viewed as an abnormal, unhealthy, incomplete and perilous matter for both the cut individual and her socio-environment. (Table 1)

Conclusion
Participants seemed to view FGM/C as a health topic and it was discussed as a health concern. It is possible that this was due to the strong emphasis on health-related issues in the campaigns. As shown in the narratives, both proponents and opponents internalised the health arguments of the campaigns against FGM/C. Both deemed it as a negative that FGM/C might result in poor health outcomes.
Improving FGM/C healthcare and clinical guidelines through community engagement and leadership: a review

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Introduction
There is a growing recognition of the need to engage communities and individuals in the effort to improve health outcomes, especially among those at risk of and survivors of female genital mutilation/cutting (FGM/C). As part of a larger project aimed at developing more ethical, culturally-competent clinical guidelines for FGM/C, we seek to develop a set of key elements for effective engagement of women and girls at risk of FGM/C, based on a review of current and ongoing efforts across a variety of settings.

Methods
We reviewed a total of 22 organizations working with those at risk and survivors of FGM/C in the United States, the United Kingdom, Uganda, The Gambia, Guinea, and Kenya. Recognizing the importance of interdisciplinary approaches to improving health, we looked at organizations in healthcare (5), community-based education and training (7), advocacy and support (9), and legal services (1). Organizational goals, programming, and resources were included in the review.

Results
Key elements identified could be categorized into three areas: promoting communication and dialogue, tailoring healthcare to community needs, and forming sustainable partnerships. Elements of effective communication and dialogue included: a) creating spaces and platforms where goals, values, and needs of community members can be made explicit, and b) recognizing the unique context of community members, so as to avoid judgment, labeling or blame. Those related to healthcare included: a) tailoring training for health professionals to facilitate understanding of the type, history, consequences and significance of FGM/C in specific communities, b) advocating for the development of clinical and professional guidelines that reflect community needs & women’s empowerment, c) developing clearly defined, system-wide referral procedures, and d) implementing continual monitoring and evaluation procedures. The final set of elements relate to forming sustainable partnerships: a) integrating community assets and characteristics (strengths, history, and limitations), b) recognizing, prioritizing, and promoting diversity in leadership, c) engaging and empowering communities to take responsibility for change; supporting survivor-led and community-based efforts, d) implementing concrete feedback and evaluation procedures, and e) requiring a research component to measure change and validate progress.

Conclusion
Current efforts to address FGM/C are multidisciplinary and diverse, but have key elements in common. These key elements may be used to engage communities in the development and implementation of organizational programming, public health interventions, and clinical guidelines that work with those survivors of and those at risk of FGM/C.

III. Knowledge, Evidence and Consensus Gaps

1 Implementation of the guidelines on management of complications of FGM, research gaps and research implications: a commentary
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WHO plays an important role in strengthening a health sector response to FGM, including the development of evidence-based guidance and practical tools for healthcare providers; supporting countries to implement guidance and generating evidence to inform policy and programs related to the health sector. The WHO Guidelines on the Management of Health Complications from FGM - published in May, 2016 - provide up-to-date, evidence-informed recommendations on the management of health complications from FGM. The guidelines were developed using standard WHO guideline development operating procedures, which involve a rigorous, step-by-step process with multiple levels of review by internal and external committees and experts. The process resulted in the formulation of 5 recommendations and 8 best practice statements grouped in four main areas: (1) deinfibulation to prevent and treat obstetric complications, and urological conditions; (2) mental health; (3) female sexual health; and (4) information and education interventions for both healthcare providers and women living with FGM. Using these guidelines as a foundation, WHO is currently developing training materials for healthcare providers, which will be developed and tested as part of an implementation research process to prevent the medicalization of FGM and improve the care for women and girls living with FGM.

WHOF. WHO Guidelines on the Management of Health Complications from Female Genital Mutilation. Geneva: World Health Organization 2016.
Introduction

Female Genital Mutilation/Cutting (FGM/C) can cause both psychosexual and physical consequences including pelvic floor disorders. FGM/C and pelvic floor disorders are both under diagnosed and undertreated conditions that can significantly impact women’s life quality. The aim of the study is to determine the prevalence of pelvic floor symptoms and disorders among women with FGM/C and to test available validated questionnaires.

Methods

Cross-sectional study started in April 2016, at the Department of Gynecology and Obstetrics of the Geneva University Hospitals on 121 women with different types of FGM/C. Six validated questionnaire scores (PFDI-20, PRQ-7, PISQ-IR, FGSSS, FSI, and Wechsner constipation questionnaire) and sociodemographic information were collected. The questionnaires were administered in French or in English, when needed with a certified and accepted female interpreter. The scores of the questionnaires validation studies on women without FGM/C with or without pelvic floor symptoms were used as reference.

Results

Data on 60 women are presented as preliminary results. Fourteen (23%) have FGM/C type 3. The remaining women have FGM/C type 1, 2 or debilitated type 3. Forty percent of women referred other past traumatic sexual, psychological or physical events different than FGM/C or forced marriage. Women with FGM/C reported questionnaires’ scores indicating a negative impact on the quality of life due to pelvic floor symptoms (PFDI-20 and PFRIQ-7) and a lower satisfaction of the genital self-image (FGSSS).

Conclusion

Preliminary results indicate that women with FGM/C report scores similar to those of women without FGM/C but who experienced pelvic floor symptoms and disorders.

The impact of the law in the prevention of FGM: legal analysis

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Introduction

Among policies developed to abandon FGM, an important role has been attributed to legal instruments. Within the demand for a comprehensive approach to prevent and protect against FGM, many European Member States have developed specific criminal laws dealing with FGM and provided civil measures for protecting minors. However, the implementation of these laws seems to be weak and adequate and complete information concerning the actual effect of the law in the prevention of FGM is lacking. Using the 2016 Italian Sampling Survey, developed under the EU Daphne Project (“methodology for estimating FGM prevalence in Belgium and Italy”). We assessed: a) how much knowledge of laws against FGM existed among migrants and b) if and how being aware of these laws influenced abandoning FGM.

Methods

In the Survey women were asked about their knowledge of the law; moreover, if the criminalization of FGM was included among the possible reasons reported by women who declared their intention not to cut their daughters. The survey ended in December 2016.

Results

The majority of women agreed on state intervention to prevent cutting of girls. The pattern of the agreement is similar to Italy and countries of birth. Agreement on awareness of the law as a prevention tool was lower among women from Burkina Faso, Egypt, and Nigeria, the communities with the highest FGM prevalence in Italy. As per the knowledge of the law, migrant women know much more about laws in their country of origin than about laws in Italy. Lack of knowledge was higher among Nigerian, Egyptian, and Burkinabe women.

Conclusion

Our results suggest that knowing about anti-FGM/C laws could contribute to the abandonment of cutting. However, knowledge of laws was less relevant to women from high prevalence FGM/C communities.

Persistent norms and tipping points: Female Genital Cutting in Burkina Faso: theory testing

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Introduction

Female Genital Cutting (FGC) has persisted for generations because deviating from the norm can be costly. The prevailing theory in the study of FGC is that it is a social coordination norm—that is, households will abandon FGC if and only if a sufficient proportion of households within the community agree to abandon the practice. Under this theory, if a sufficient number of community members agree to abandon FGC, a tipping point is reached and FGC could be eliminated. However, recent empirical evidence rejects that theory.

Methods

I contributed to this important debate by generating a new theory of why FGC persists, and I tested that theory using a dataset of 7,500 women born between 1949 and 1995 in Burkina Faso.

Results

Households within a community have heterogeneous preferences for FGC, such that each household may require a different proportion of community members to abandon FGC before they also reject FGC. This heterogeneity makes the existence of a tipping point uncertain, and stable interior equilibria in FGC rates are possible.

Conclusion

My findings suggest that individuals and households are in fact able to deviate from an entrenched, gender-biased social norm and that policies to reduce the prevalence of FGC perhaps should prioritize targeting individual and household, rather than village-level, preferences.

What is the evidence on safety and efficacy of clitoral reconstruction after FGM/C?: systematic review

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Introduction

Clitoral reconstruction or transposition after female genital mutilation/cutting (FGM/C) is a procedure that consists of a resection of the periclitoral fibrous tissue and re-exposition of a healthy clitoral neo-glans. This surgery aims to improve pain symptoms, sexual function, body image, and female identity. However, some recent guidelines do not recommend the procedure due to a lack of conclusive evidence.

Methods

A systematic review was performed in 2014 (PubMed and Cochrane) including any design/language study reporting on safety and clinical outcomes of clitoral reconstruction after FGM/C.
Introduction
Sexual dysfunction in FGM presents is complex and can include hypoactive desire, decreased arousability and anorgasmia. FGM can also cause chronic urogenital pain and perineal scarring. Clitoral reconstructive surgery can improve some sexual dysfunction, but psychosexual therapies also have an important role to play. However, there is a need for standard evaluation for relevant management.

Methods
The available literature on sexual dysfunction after FGM was identified by searching PubMed and Cochrane databases from January 1990 to Dec 31, 2016. Search terms related to FGM and sexual function were used in various combinations.

Results
A total of 9 studies evaluated sexual function after FGM with the validated Female Sexual Function Index (FSFI). Seven were cross-sectional studies, and two were reports of sexual function after clitoral reconstructive surgery. There were no studies evaluating the impact of psychosexual therapies in FGM. One study used the validated Female Sexual Distress Scale (FSDS). Other studied parameters included depression, body image, and clitoral sensations.

Conclusion
There is a need for prospective studies using validated questionnaires to assess the integrative approach of sexual function after FGM. For now, available qualitative data and validated tools used in Sexual Medicine could help in assessing sexual function after FGM.

Results
The review shows that FGCS is not a new phenomenon but is part of a continuity of bodily practices that have their roots in the classical period. Furthermore, there are sociohistorical connections between ‘female circumcision’ and FGCS and clear references to the former by European physicians performing several types of female genital modification throughout the centuries well into the beginning of the 20th century. In fact, the review reveals that ‘female circumcision’ and FGCS have had and still have a similar capacity to modify female genitalia according to social norms of aesthetics and sexuality.

Conclusion
The assertion of a radical distinction between ‘female circumcision’ and FGCS is not sustainable based on the sociohistorical evidence.
Female Genital Mutilation in Sudan: are pediactricians ready to fight this practice? A preliminary analysis of a pre-post intervention study
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Reproductive Health 2017, 14(Suppl 2):3

Introduction
Female Genital Mutilation (FGM) is an ancient practice in Sudan, of unclear origin and commonly practiced in many Sudanese societies for different reasons. In Sudan, 86.6% of females (15-49 years) have undergone FGM mostly in its most severe form, WHO type III (77%). Secondary FGM defined as circumcision in last 12 months is highest among women between 15-19 years (31.2%) compared to 20 - 39 years (23 -24%). Obstetricians and gynaecologists can play an important role at both community and individual level in the prevention and care of FGM/C and against this practice (primary and secondary FGM) and its medicalization. To function effectively clinicians need to acquire knowledge and skills on FGM epidemiology, social norm concepts, and FGM health complications’ management.

Methods
Sudanese Obstetricians & Gynecologists (OBGYNs), who attended their annual scientific conference in February 2017, participated in a KAP assessment on various aspects of FGM. Before this event, pediatricians participated in the same assessment. To collect the required data a questionnaire was developed and reviewed by experts. Four senior medical students were nominated by the conference organizers and having correctly managed them per WHO guidelines. Specialists or in-specialist trainees tended to identify FGM as abuse of rights compared to junior staff (OR 3.48; P-value 0.03) and showed similar results with 67% of urban and 45.5% of rural women favoring FGMC abandonment. Logistic regression analysis showed that older age showed that 97% of them would not encourage it, 67.7% thought FGM is an ancient practice in Sudan, of unclear origin and commonly practiced in many Sudanese societies for different reasons. In Sudan, 86.6% of females (15-49 years) have undergone FGM mostly in its most severe form, WHO type III (77%). Secondary FGM defined as circumcision in last 12 months is highest among women between 15-19 years (31.2%) compared to 20 - 39 years (23 -24%). Obstetricians and gynaecologists can play an important role at both community and individual level in the prevention and care of FGM/C and against this practice (primary and secondary FGM) and its medicalization. To function effectively clinicians need to acquire knowledge and skills on FGM epidemiology, social norm concepts, and FGM health complications’ management.

Methods
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Results
Analysis of 154 questionnaires (with most of the questions answered >85%) showed that mean age of respondents was 37 years, 52% were females, 96.1% were Muslims, 47.3% were specialists (47.4%) or specialists-in-training (32.5%). A few (9.7%) reported never having received any type of FGM training. Only 2% of pediatricians showed correct knowledge of the 4 types of FGM in Sudan; 60% were able to list 3 WHO FGM complications. Knowledge of correct management of WHO complications was much lower (11%), although 51% managed FGM complications in their practice. The attitudes of pediatricians towards FGM showed that 97% of them would not encourage it, 67.7% thought it needed to be criminalized, and 63% considered the practice a violation of women’s and girls’ rights. Seventeen percent of respondents believed there are religious benefits to it, and 16% said they would have their daughters cut. Attitudes of the general population in other surveys showed similar results with 67% of urban and 45.5% of rural women favoring FGMC abandonment. Logistic regression analysis showed that specialists and specialists-in-training had more knowledge on FGM typology compared to Junior doctors (OR = 2.2e-09; P-value = 0.00). No association was found between previous FGM training and FGM knowledge. Specialists or in-specialist residents tended to identify FGM as abuse of rights compared to junior staff (OR 3.48; P-value 0.03) and (OR 3.16; P-value 0.06) respectively. Results also showed that older age was associated with an increased likelihood of having seen FGM complications and having correctly managed them per WHO guidelines.

Conclusion
This study identified knowledge, attitudes and skills gaps and the need to integrate FGM training content within medical and specialization curricula. Concepts of social norm change also needs to be strengthened among pediatricians.
Continuing professional education on Female Genital Mutilation for obstetricians, gynecologists, and midwives in Australia: educational program development

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Introduction
Australia has experienced a growth in the number of women and girls arriving from countries where Female Genital Mutilation (FGM) is prevalent. Obstetricians, gynaecologists, and midwives are therefore caring for increasing numbers of affected women, highlighting the need for additional education and training. We developed the first nationally accredited continuing professional development program for the Royal Australian and New Zealand College of Obstetricians and Gynaecologists.

Methods
An expert panel of medical and midwifery clinicians, social scientists, and educators formed a consortium to develop and trial four on-line training modules.

Results
The online modules introduce health professionals to the issue of FGM in Australia, outline the sexual and reproductive health consequences of FGM and address the care and clinical support that women require. Information to support education and advocacy is also provided. An evaluation found the modules to be relevant and applicable to clinical practice. Fifty-five of the 61 specialists who provided feedback since mid-2016 have rated the modules as “very good” or “excellent”. Qualitative comments noted the importance of graphics and videos in preparing to manage the next patient with FGM, and also noted the usefulness of the modules as part of an orientation for volunteer work in high prevalence FGM countries. In one State this training has been supported by clinical guidelines and a healthcare professional counselling aid.

Conclusion
A national approach to training and education for Australian health professionals was an important part of preparing clinicians to deliver optimal care to pregnant women with FGM. However, supportive workplace environments also are needed to ensure learning can be applied in practice.

V. Healthcare and prevention

1 “The ‘heat’ goes away”: sexual disorders among married women with Female Genital Mutilation/Cutting in Kenya: a mixed methods study
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Reproductive Health 2017, 14(Suppl 2):1

Introduction
There is paucity of research investigating sexual experiences among married women with Female Genital Mutilation/Cutting (FGM/C). This study investigated the sexual experiences among married women in Kenya.

Methods
The study used a mixed methodology. A total of 318 married women enrolled were categorized into three clusters; those cut before marriage, those cut after marriage, and those who were uncut. Data was collected using a psychometric instrument (FSFI), entered and analysed using SPSS Version 22. Focus group discussions, interviews and case narratives were also conducted. Data was transcribed verbatim, thematized, analyzed and interpreted.

Results
The reported overall sexual functioning was significantly (p = 0.019) different across the three groups. Women cut after marriage (mean = 22.81 ± 4.87) scored significantly lower (p = 0.056) than women who were uncut (mean = 25.35 ± 3.56). However, in comparison to those cut before marriage, there was no significant difference (mean = 23.99 ± 6.63). Among the sexual functioning domains, lubrication (p = 0.008), orgasm (p = 0.019) and satisfaction (p = 0.042) were significantly different across the three groups. However, desire, arousal and pain were not statistically different. Subjectively, women cut after marriage had negative sexual experiences, specifically adverse changes in experiences of desire, arousal, and satisfaction.

Conclusion
This study revealed sexual disorders associated with FGM/C existed among married women. Thus, mitigating strategies need to be designed to adequately address psycho-sexual complications to improve women’s general well being.
Women speak out: Female Genital Cutting, qualitative research
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Reproductive Health 2017, 14(Suppl 2):3

Introduction
Women who have undergone Female Genital Cutting (FGC) may have had varied experiences. This proposed ethnographic, naturalistic inquiry seeks to elucidate the lived experiences of women with FGM/C currently living in the United States. It also examines how women view FGC and the various ways in which the practice has impacted their lives.

Methods
Women with FGM/C were identified by the co-principal investigators at the Metropolitan Hospital Center Department of Obstetrics and Gynecology. A semi-structured interview was conducted using standardized and open-ended questions in English. A telephone interpreter service called CYRACOM was utilized for non-English speaking patients. Qualitative data analysis utilized the Health Belief Model and Social Learning or Social Cognitive Theory methodology.

Results
Twenty-six women out of 50 identified with FGC agreed to be interviewed. The impact of their experiences was greatest on their sexual activity and spousal relationships. Seventy-two percent of patients reported that being cut affected their sexual relationships in multiple ways including “lack of desire,” “pain,” “lack of pleasure,” and “no feeling during intercourse.” Sixty percent explained that historical, cultural and social pressures influenced having been cut. Thirty percent cited social/personal pressures, as well as an attempt to reduce sexual desire and promiscuity as important contributing factors to FGC. The age at which the patient was cut, family expectations and pressures (from mothers, grandmothers, elder women) and adherence to traditions by the socio-cultural group also contributed to their FGC experience.

Conclusion
By understanding the quality and meaning of the patients’ lived experiences with FGC, programs could be developed for health care providers that might lead to their better understanding of the women’s needs.

A Belgian multi-disciplinary Female Genital Mutilation medical reference center: a descriptive report of three years of practice
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Introduction
The University Saint Pierre Hospital Medical Center for Assistance to Victims of Excision (CeMAVIE) is a public institution located in Brussels, Belgium. Due to its social vocation and location, USPH/CeMAVIE welcomes the most people from countries where female genital mutilation/cutting (FGM/C) is practiced. To meet the increasing demand for care, CeMAVIE opened its doors in April 2014. CeMAVIE is one of the two Belgian reference centers for women with genital mutilations/cutting. In our country, the medical care of women with FGM/C is mandatorily performed only in reference centers approved by the government.

Methods
A team consisting of a midwife, a psychologist, a sexologist and a gynaecologist offer multi-disciplinary care and support to the women. Our psychologist uses the Eye Movement Desensitisation and Reprocessing method, a cognitive behavioural therapy. Psychological and sexological care is the first line of treatment. We also perform reconstructive surgery of the clitoris when needed.

Results
In three years, we met 667 women during 2000 consultations. Sixty-two surgical procedures were performed, including 29 clitoral reconstructions. The other 33 surgeries were defibrillations, excision of cysts and drainage of vulvar abscesses. The majority of our population is between 20 and 39 years old. Their countries of origin are mainly Guinea (51%), Somalia (17%) and Djibouti (11%). They are mainly referred by refugee centers, NGOs and medical doctors. Women come to CeMAVIE to consult for medical certificates and to ask questions about reconstruction and gynecological pathology. The feedback from our patients and partners is very positive, which encourages us to continue.

Conclusion
Multi-disciplinary care seems to be a good approach to evaluate and treat women with FGM/C. We agree that reference centers must depend on the approval of health authorities. Evidence-based data are now needed to confirm our preliminary impressions: a mixed-methods study, both qualitative and quantitative, will start in the second semester of 2017.

The pseudo-clitoris, a particular Female Genital Mutilation: case series
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Reproductive Health 2017, 14(Suppl 2):5

Introduction
The “pseudo-clitoris” is a consequence of a particular way of cutting the clitoris in some countries, such as in Guinea. This FGM is unknown among many healthcare professionals. I present a series of 120 cases of “pseudoclitores”.

Methods
Analysis of 5500 women with FGM who underwent clitoral reconstruction according to Foldès technique. All women attended for reconstructive surgery and underwent local examination and contact ultrasound of the clitoris. All selected women underwent reconstructive surgery and were followed up from 6 to 18 months post surgery.

Results
Pseudo-clitores is a particular type of FGM that was found in 120 out of 5500 cases. The clinical vulvar preoperative anatomy seems normal, but the women report clitoral pain. They often face denial of their story and condition, as the clinical appearance seems normal. There is a single scar above the hood of the clitoris. The clitoral glans and the labia look normal, but the clitoris has been probably injured by the FGM/C. Reconstructive clitoral surgery according to the Foldès technique has improved sexual function in 76% and pain in 87% of the 120 women.

Conclusion
The “Pseudo-Clitoris” must be recognized by experts and professionals who counsel and treat women with FGM/C. It must be considered a real excision/cutting of the clitoris, and managed accordingly.

VI. Knowledge, Evidence and Consensus Gaps

Integrative sexual management of Female Genital Mutilation: “Mind Body” proposals. Literature review
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Reproductive Health 2017, 14(Suppl 2):1
Introduction
Sexual management of Female Genital Mutilation (FGM) is an under-researched and neglected issue. Available data reported that symptoms, mainly pain and reduced sexual satisfaction and desire, sometimes could be improved by reconstructive clitoral surgery (RCS). Posttraumatic stress disorder (PTSD) is also frequent among women with FGM/C and psychosexual therapies (PST) should be proposed.

Methods
The available literature on Sexual Dysfunction (SD) after FGM was identified by searching the PubMed and Cochrane databases from January 1990 to Dec 31, 2016. Search terms related to FGM, SD, RCS, PTSD, PST were used in various combinations.

Results
14 studies were found using both terms, FGM and PTSD; only one described results of psychotherapy using eye movement desensitization and reprocessing (EMDR), 6 surgical teams published limited series about RCS effect on sexual improvement with few details on postoperative rehabilitation protocols. No PST study on FGM was found. Looking only at PTSD management, evidence-based therapies are cognitive behavioural therapy (CBT) and EMDR. Mindfulness and osteopathic treatment could be also considered areas of interest to be studied as psychosexual therapies after FGM.

Conclusion
In FGM, coping styles of women and PTSD should be considered. An integrative psychosexual therapy, including RCS, CBT, osteopathic treatment and EMDR might be relevant research areas. Research could also be conducted on RCS postoperative rehabilitation protocols.

Comparative study of sexual function in women post clitoral reconstruction for Female Genital Mutilation/Cutting (FGM/C) and women without FGM/C
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Reproductive Health 2017, 14(Suppl 2):2

Introduction
The aim of this study was to compare sexual function scores in women who had undergone clitoral reconstruction for Female Genital Mutilation/Cutting (FGM/C) to the sexual function scores of women without FGM/C.

Methods
Women with FGM/C who underwent clitoral reconstruction at the Nantes University Hospital between 2008 and 2014 were interviewed at least six month after the surgery. They completed a questionnaire describing their sociodemographic and FGM/C characteristics as well as the female Sexual Function Index (FSFI). Each woman with FGM/C was matched with three women without FGM/C of the same age.

Results
On the 82 women having had clitoral reconstruction, 34 were included. Of them, 23 (68%) had FGM/C Type II. The median summary FSFI score was 29.8 for women with clitoral reconstruction versus 28.8 in the control group. After adjustment, the summary FSFI score was shown to be significantly higher for women with clitoral reconstruction (p-value = 0.05). The same result was observed for desire, satisfaction and pain FSFI subscores.

Conclusion
Sexual function scores of women with FGM/C after clitoral reconstruction appeared to be comparable to the scores of a sample of women without FGM/C.

FGM alerts and expert assessments from healthcare providers: legal case analysis
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Reproductive Health 2017, 14(Suppl 2):3

Introduction
Sweden legislated against FGM in 1982. Since then, nearly 90 suspected cases have reached the police and prosecutor. A few of the reports were alerts from healthcare professionals, but the bulk of them originated from daycare and social services sectors. Healthcare providers play a prominent role as experts in forensic investigations.

Methods
Cases of suspected FGM originating from healthcare providers who have reported suspected, performed, or planned FGM were analyzed to determine the role of healthcare providers as experts in assessing whether FGM has been performed, and, if so, to what extent.

Results
Very few cases analyzed had sufficient indictable evidence; two cases during 35 years were brought to court. The review revealed inconsistencies in the medical assessment processes during which medical experts reached divergent conclusions about FGM status.

Conclusion
Variations in normal anatomy and also in cutting procedures make genital assessments by healthcare providers very difficult. It is of utmost importance that appropriate medical experts are summoned in FGM criminal investigations, since these processes often involve radical measures from the police and prosecutor, such as detention of legal custodians and compulsory medical genital examinations of young girls in order to obtain a legally valid medical certificate for an eventual court proceeding.

Genital reconstructive surgery after female genital mutilation: a pre-post study
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Reproductive Health 2017, 14(Suppl 2):4

Background
Female genital mutilation (FGM), is a cultural tradition widely practiced in Africa and other parts of the world. It can cause serious complications to women’s physical and psychological health. Increased global awareness of the long term consequences of FGM has increased the demand for restorative procedures, yet few doctors are trained in methods of genital cosmetic & reconstructive surgery. Women with FGM/C may be unaware of the availability of clitoral reconstructive surgery to reverse the adverse effects of FGM.

Method
One hundred seventeen women with FGM Type II and III between the ages of 18 and 36 years old were selected. They presented to the urogynecology unit at El Galaa Teaching Hospital in Cairo Egypt. Patients answered a female sexual function index (FSFI) questionnaire on admission, noting their sexual characteristics, and pain level. Postoperatively, patients were asked to return for follow up every three months for one year.

Results
Clitoral reconstructive surgery after female genital mutilation provided an improvement in the women’s psychology and mood, reflected by an increase in confidence, self-esteem, and body image by 82%. We noted improvement in sexual desire in 24%, arousal in 27% and satisfaction in 16% with moderate improvement in pain
Making an ethical decision in the exam room: a brief review of the legal, ethical and moral aspects of the clinical management of FGM/C. Case reviews

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Reproductive Health 2017, 14(Suppl 2):5

Introduction
Clinicians who work with women who with FGM/C can face a clash of medical, moral, ethical and legal obligations surrounding professional duty, obligations to the patient, respect for her autonomy and culture, and regard for local laws, regulations, policies and human rights. Conflicts arise whether local laws exist or not: What should a clinician do when asked to reinfibulate? How is FGM/C or reinfibulation different from labiaplasty? Are there potential harms to reporting ‘vacation cutting’? Is performing FGM/C in a health facility an ethically legitimate means of harm reduction?

Methods
We briefly review six cases highlighting real-life ethical and legal conflicts and propose an ethical decision making framework and an affiliated online and smart phone App to use to help guide clinical and professional decisions. There are 6 simulated cases that illustrate real-life situations.

Results
Cases featured include vacation cutting, reinfibulation after delivery, the practice of vaginoplasty, the medicalization of FGM/C, reporting on colleagues who are believed to engage in FGM/C, and considering alternative FGM/C practices.

Conclusion
This is an educational intervention using an app, and it has not yet been evaluated. It is an exercise in ethical decision making for residents and physicians to consider the various approaches and options for action, to discuss and reflect on how their individual decisions can be implemented with the greatest care and attention to the concerns of all stakeholders.

Reparative approaches: the different meanings of ‘reparation’ for women living with FGM in France and Switzerland.

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Reproductive Health 2017, 14(Suppl 2):6

Introduction
Based on two qualitative studies, we aim to explore the sexual health of women living with FGM in France and in Switzerland.

Methods
We conducted semi-structured, in-depth interviews with a group of 8 immigrant women of sub-Saharan origin living in Switzerland with Type III FGM (infibulation) and 32 women of first and second generation living in France with Type II FGM (excision). All of the participants had either had or asked for a clitoris reconstruction. All women described their own perceptions of health, reproductive life and sexuality.

Results
The group of women with infibulation and the group of women with excision differ in their socio-demographic characteristics and the context of FGM. Both groups affirmed their desire to improve, or at least change, their conditions. Reparative approaches are sought by women in order to ‘<repair>’ something ‘<lost>’; the word ‘repayment’ acquires a large scale of meanings. The first type of request relates to the physical reparation, expressed by the women’s feeling of “having been damaged”. Excised/infibulated women living in the North say they feel “dissatisfied” or “unhappy” with their sexual experiences. The feeling that something has been “lost” or “stolen” seems to produce the desire to seek justice. The reconstructed clitoris then may be perceived as a material symbol of a kind of reward for endured suffering - that I call here the “moral reparation” (or symbolic reparation). Gender also plays an important role in terms of body image and gender models that differ from those of previous generations of women in their family.

Conclusion
In this study, women chose reparative approaches for a number of reasons. Specific socio-sexual management is recommended when caring for immigrant women living with FGM in order to respond to their specific health care needs. Multidisciplinary approaches may be able to offer more comprehensive health care, in order to improve dialogue.
8 Could efforts to eliminate female genital cutting be strengthened by extending protections to male and intersex children too? A commentary
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Reproductive Health 2017, 14(Suppl 2):8

Introduction
Activists and academics disagree about the most effective ways to eliminate non-therapeutic female genital cutting (FGC). Some argue that efforts to reduce FGC are undermined by conflations of the least and most invasive types, unsubstantiated claims about universally negative effects, and inflammatory language. Scholars also argue that failing to apply the principles of bodily integrity to children of all sexes will ultimately backfire due to (a) incompatibility with equality principles, and (b) recent calls by defenders of male circumcision to permit ritual nicking of females for intellectual consistency.

Methods
Drawing on ethical critiques and anthropological studies, we ask: Would the campaign against FGC be strengthened or weakened by including male and intersex children?

Results
We find that a gender-inclusive approach would: (1) neutralize accusations of cultural imperialism by applying the same standards to white children in the USA as to children of color in Africa; (2) weaken accusations of sexism by recognizing that boys and intersex children are also vulnerable to non-therapeutic genital alteration; (3) redress the moral confusion in communities that practice both female and male genital-alterations caused by Western attempts to eliminate only the female “half” of their initiation rites.

Conclusion
We find that efforts to eliminate FGC will be more successful if they expand to include vulnerable persons of all genders.

VII. Abstracts presenting already published papers

1 Female genital mutilation: Knowledge, attitude and practices of Flemish midwives (Belgium)
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This abstract was previously published as
Cappon S, L'Ecluse C, Clays E, Tency I, Leye E. Female genital mutilation: knowledge, attitude and practices of Flemish midwives. Midwifery. 2015 Mar;31(3):e29-35. doi: 10.1016/j.midw.2014.11.012

2 Cultural values affecting the acceptance of surgical defibulations
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Reproductive Health 2017, 14(Suppl 2):2

This abstract was previously published as
Johansen RE. Undoing female genital cutting: perceptions and experiences of infibulation, defibulation and virginy among Somali and Sudanese migrants in Norway. Cult Health Sex. 2017 Apr;19(4):528-542. doi: 10.1080/13691058.2016.1239838.

3 Clitoral reconstruction at CHU Yalgado of Ouagadougou, Burkina Faso
Ouedraogo CM1, Madzou S2, Simporé A3, Combaud V3, Ouattara A1, Millogo F1, Ouedraogo A1, Kiemtore S1, Zamane H1, Sawadogo YA1, Kaïn P1, Dramé B1, Thieba B1, Lankoandé J1, Descamps P2
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This abstract was previously published as
Ouedraogo CM, Madzou S, Simporé A, Combaud V, Ouattara A, Millogo F, Ouedraogo A, Kiemtore S, Zamane H, Sawadogo YA, Kaïn P, Dramé B, Thieba B, Lankoandé J, Descamps P. Clitoral reconstruction after female genital mutilation at CHU Yalgado of Ouagadougou, Burkina Faso. About 68 patients operated. J Gynecol Obstet Biol Reprod (Paris). 2016 Nov;45(9):1099-1106

4 Male perspectives on FGM among communities of African heritage in Italy
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This abstract was previously published as
Catania L, Mastrullo R, Caselli A, Cecere R, Abdulcadir O, Abdulcadir J. Male perspectives on FGM among communities of African heritage in Italy. International Journal of Human Rights in Healthcare, Vol. 9 Iss: 1, pp.41 – 51. DOI http://dx.doi.org/10.1108/IJHRH-07-2015-0023.

5 Changing cultural attitudes on FGC: Experimental randomized trial
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This abstract was previously published as
Efferson C, Vogt S, Elhadi A, El Fadil Ahmed H, Fehr E. Female genital cutting is not a social coordination norm. Science 25 Sep 2015: Vol. 349, Issue 6255, pp. 1446-1447. DOI: 10.1126/science.aaa7978.
Men have a role to play but they don’t play it. A mixed methods study exploring men’s involvement in Female Genital Mutilation in Belgium, the Netherlands and the UK

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This abstract was previously published as

O’Neill S, Dubour D, Florquin S, Bos M, Zewolde S, Richard F. “Men have a role to play but they don’t play it”. A mixed methods study exploring men’s involvement in Female Genital Mutilation in Belgium, the Netherlands and the UK. Men Speak Out Project, Brussels, 2017.

Obstetric outcomes for women with female genital mutilation at an Australian hospital, 2006-2012: a descriptive study

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This abstract was previously published as

Varol N, Dawson A, Turkmani S, Hall JJ, Nanayakkara S, Jenkins G, Homer CS, McGeechan K. Obstetric outcomes for women with female genital mutilation at an Australian hospital, 2006-2012: a descriptive study. BMC Pregnancy Childbirth. 2016 Oct 28;16(1):328.

Using the Female Sexual Function Index (FSFI) to evaluate sexual function in women with genital mutilation undergoing surgical reconstruction: a pilot prospective study

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This abstract was previously published as

Vital M, de Visne S, Hanf M, Philippe HJ, Winer N, Wylomanski S. Using the Female Sexual Function Index (FSFI) to evaluate sexual function in women with genital mutilation undergoing surgical reconstruction: a pilot prospective study. Eur Obstet Gynecol Reprod Biol. 2016 Jul;202:71-4. doi: 10.1016/j.ejogr.2016.04.029.

Interventions to Address Sexual Function in Women Affected by Female Genital Cutting: a Scoping Review

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This abstract was previously published as

Johnson-Agbakwu C, Warren N. Interventions to Address Sexual Function in Women Affected by Female Genital Cutting: a Scoping Review. Curr Sex Health Rep (2017) 9: 20. doi:10.1007/s11930-017-0099-0.

Estimation of the prevalence of female genital mutilation/cutting among migrant women living in England and Wales

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Macfarlane A, Dorkenoo W. Prevalence of Female Genital Mutilation in England and Wales: National and local estimates. Published by City University London, Northampton Square, London EC1V 0HB and Equality Now, 1 Birdcage Walk, London SW1H 9JJ July 2015 ISBN 978-1-900804-93-6. http://openaccess.city.ac.uk/12382/

The role of medical doctors and the role of the Child Protection Services in detecting cases of female genital mutilation within the system of law in Norway: legal case reviews

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This abstract was previously published as

Lien IL, Schultz JH. Prosecution of the Offence of Female Genital Mutilation/Cutting in Norway. Int J Law Policy Family 2017 ebx003. doi: 10.1093/lawfam/ebx003.

Lien IL, Schultz JH. Interpreting Signs of Female Genital Mutilation Within a Risky Legal Framework. Int J Law Policy Family, 2014, 28(2): 194–211 doi: 10.1093/lawfam/ebu002.