

The International Activities Section

The International Activities Section serves as a forum for opinion exchange for all those dermatologists who, all over the world, do not consent to the construction of artificial boundaries, in our speciality and beyond, established on race, religion, or national origin, and work for giving voice to the most vulnerable populations.

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Stop female genital mutilation: appeal to the international dermatologic community

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Abstract

Female genital mutilation (FGM) is a traditional cultural practice, but also a form of violence against girls, which affects their lives as adult women. FGM comprises a wide range of procedures: the excision of the prepuce; the partial or total excision of the clitoris (clitoridectomy) and labia; or the stitching and narrowing of the vaginal orifice (infibulation).

The number of girls and women who have been subjected to FGM is estimated at around 137 million worldwide and 2 million girls per year are considered at risk. Most females who have undergone mutilation live in 28 African countries.

Globalization and international migration have brought an increased presence of circumcised women in Europe and developed countries. Healthcare specialists need to be made aware and trained in the physical, psychosexual, and cultural aspects and effects of FGM and in the response to the needs of genitally mutilated women. Health education programs targeted at immigrant communities should include information on sexuality, FGM, and reproduction. Moreover, healthcare workers should both discourage women from performing FGM on their daughters and receive information on codes of conduct and existing laws. The aim is the total eradication of all forms of FGM.

Introduction

Recently, immigrant female patients have come to our clinics for the diagnosis and treatment of sexually transmitted infections (i.e. molluscum contagiosum, viral warts, etc.). Some of these patients showed signs of previous genital mutilation. This prompted us to investigate the phenomenon of female

genital mutilation (FGM). We soon realized that the problem is of interdisciplinary relevance (dermatovenereologic, gynecologic, sociologic, psychological, etc.) and that the dermatologic community should be aware of this.

The migration of millions of people from southern areas of the world to affluent countries in search of a better future for themselves and their children has produced cultural and

social changes, in addition to remarkable effects from a medical viewpoint. Diseases such as tuberculosis, malaria, leprosy, and tropical dermatoses, considered to have been eradicated in industrialized countries, are reappearing. Migrations to northern industrialized countries have exposed the populations to different cultures and habits. Recently, in the European Union, the USA, Canada, and Australia, the phenomenon of FGM has been encountered. The presence of an increasing number of refugees and immigrants from countries in which this procedure is practiced has aroused much interest in this issue. As a result, several countries have passed laws against FGM. In some countries, programs have been started to produce awareness of the issue and to alert health and social services in order to protect girls at risk of FGM.

Terminology

The terminology used for FGM procedures varies considerably, depending on the regional and ethnic group. In the international arena, the term "female genital mutilation" is widely used. At the local level, the term "female circumcision" is commonly used, or a woman is referred to as being "open" or "closed." In analogy with male circumcision, the term "female circumcision" could be used to describe excision of the prepuce. A number of researchers have expressed disagreement with this definition, however, because the term "circumcision" is used to describe a specific male procedure, which is less invasive. Analogous operations for men would involve the partial or complete removal of the penis rather than just removal of the foreskin.¹ Also used is the expression "ritual female genital surgery," which refers to the non-therapeutic nature of the procedures and has a less emotional connotation than "female genital mutilation."^{2,3}

It is because of the severity and irreversibility of the damage inflicted on a girl's body that the procedure has been termed "female genital mutilation." This is the term currently used in all official documents of the United Nations.

We believe that the term "mutilation" should be maintained, because it clearly describes the severe physical impact of the practice.

Historical data

The ritual cutting and alteration of the genitalia of female infants, girls, and adolescents have been traditional practices since antiquity. The origin of the practice is unknown and there is no certain evidence to indicate how and when it began and propagated. Apparently, in all communities in which female circumcision is carried out, male circumcision is also present. Male circumcision is portrayed in some reliefs of the Egyptian tomb of Ankh-Ma-Hor (sixth dynasty, 2340–2180 BC) and other representations concerning different dynasties. It is not known whether excision and infibulation shared a

parallel development. With regard to the first millennium, however, the practice is documented as existing in Egypt. The most ancient authority reporting circumcision was Herodotus (484–424 BC). He asserted that the Phoenicians, Hittites, and Ethiopians, as well as the Egyptians, practiced excision. At about 25 BC, the Greek geographer and historian Strabone related that the Egyptians circumcised boys and practiced excision on girls.

Definition and classification

The traditional practice of FGM has attracted increasing international attention over the past 10 years. The joint statement on FGM issued in April 1997 by the World Health Organization (WHO), United Nations International Children's Emergency Fund (UNICEF), and United Nations Population Fund (UNFPA) reported the following definition of the practice: "Female genital mutilation comprises all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs whether for cultural or other non-therapeutic reasons."⁴

The three agencies classified the different types of FGM as follows.

Type I. Excision of the prepuce (clitoridectomy). It involves excision of the skin surrounding the clitoris with or without excision of part or the entire clitoris.

Type II. Excision of the entire clitoris with partial or total excision of the labia minora. The vaginal opening is not covered in this type of procedure.

Type III. Excision of part or all of the external genitalia and stitching/narrowing of the vaginal opening, known as infibulation. It is the most severe form in which the entire clitoris and some or all of the labia minora are excised.

Type IV. Unclassified. This includes a variety of procedures, most of which are self-explanatory.

There is considerable evidence in the literature that the classification of these procedures can only be done theoretically. Categorizing the different types of FGM in an anatomically precise and simplified system is only an attempt to help clinicians and researchers standardize their descriptions of a multitude of operations⁵ (Figs 1–6; the schematic drawings are examples only; considerable variations occur within FGM types).

Description of the different types of FGM

FGM is usually performed by traditional practitioners – generally, elderly women specially designated for this task, or traditional birth attendants. The operation lasts about 15–20 min, is carried out with special knives, scissors, scalpels, pieces of glass, or razor blades, and the instruments may be reused without cleaning. Anesthetics and antiseptics are not generally used, and pastes containing herbs, local porridge, or



Figure 1 Unaltered female genitalia



Figure 3 Type II female genital mutilation. Excision of clitoris with partial or total labia minor removal



Figure 2 Type I female genital mutilation. Excision of prepuce with or without partial or total clitoris removal. Area of tissue removed

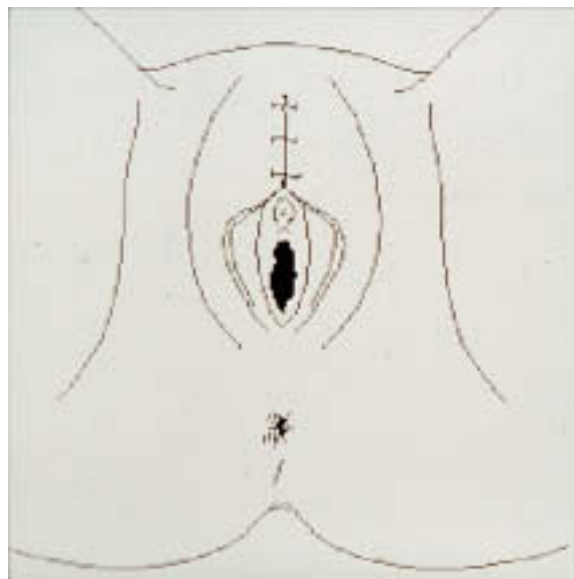


Figure 4 Type II female genital mutilation. Appearance after suture

ashes are frequently rubbed on the wounds to stop bleeding. Unintended additional damage is often caused because of the crude tools, poor light, poor eyesight of the practitioner, and septic conditions, or because of the struggling of the girls or women during the procedure.

In some countries, health professionals – trained midwives and physicians – are increasingly being used to perform FGM. In Egypt, for example, preliminary results from the 1995 Demographic and Health Survey indicated that the pro-

portion of women who reported having been “circumcised” by a doctor was 13%. In contrast, among their most recently “circumcised” daughters, 46% had been “circumcised” by a doctor. Some groups have proposed that FGM be accepted as a medical procedure, in order to prevent the consequences and complications of FGM carried out in uncontrolled and unsterile conditions. This medicalization of the procedure is unacceptable and the aim is the total eradication of all forms of FGM.



Figure 5 Partial or total external genitalia excision. Area of tissue removed



Figure 6 Infibulation (suture/reduction of vaginal opening). Appearance after suture

Type I

In the most common form of this procedure, the clitoris is held between the thumb and the index finger, pulled out, and amputated with one stroke of a sharp object. Packing the wound with gauzes or other substances and applying a pressure bandage usually stops bleeding. Modern trained practitioners may insert one or two stitches around the clitoral artery to stop the bleeding (Fig. 7).



Figure 7 Type I female genital mutilation in a patient with genital warts

Type II

The degree of the severity of cutting varies considerably in this type. Commonly, the clitoris is amputated as described above and the labia minora are partially or totally removed, often with the same stroke. Bleeding is stopped with packing and bandages, or by a few circular stitches that may or may not cover the urethra and part of the vaginal opening. There are reported cases of extensive excisions that heal with the fusion of the raw surfaces, resulting in pseudo-infibulation even though there has been no stitching⁶⁻⁸ (Fig. 8).

Types I and II generally account for 80-85% of all FGM, although the proportion may vary greatly from country to country.⁵

Type III

The amount of tissue removed is extensive. The most extreme form involves the complete removal of the clitoris and labia minora, together with the inner surface of the labia majora. The raw edges of the labia majora are brought together to



Figure 8 Type II female genital mutilation in a patient with genital warts

fuse, using thorns, poultices, or stitching to hold them in place, and the legs are tied together for 2–6 weeks.^{9,10} A small opening is left at the back to allow the flow of urine and menstrual blood. The opening is surrounded by skin and scar tissue and is usually 2–3 cm in diameter, but may be as small as the head of a matchstick.^{11,12} The healed scar creates a “hood of skin” which covers the urethra and part or most of the vagina, and which acts as a physical barrier to intercourse.¹³ During sexual intercourse, the infibulated woman has to undergo gradual dilation by her husband over a period of days, weeks, or even months. This painful process does not always result in successful vaginal penetration and the opening may have to be recut. At childbirth, the woman has to be cut once more (defibulation) to allow the passage of the baby. After birth, the raw edges are again stitched together to create a small posterior opening, often of the same size as that which existed before marriage (re-infibulation). This is performed to create the illusion of virginity, as a tight vaginal opening is culturally perceived as more pleasurable to the man.¹⁴ Because of the extent of both the initial and repeated cutting



Figure 9 Type III female genital mutilation. Almost complete absence of the normal vulvar anatomic structures is observed in this case

and suturing, the physical, sexual, and psychologic effects of infibulation are greater and longer lasting than those of other types of FGM. Although only an estimated 15–20% of all women who experience genital mutilation undergo type III, in certain countries, such as Djibouti, Somalia, and Sudan, the proportion approaches 80–90% (Figs 9 and 10).

Type IV

Type IV includes different practices of variable severity, including pricking, piercing, or incision of the clitoris and/or labia; stretching of the clitoris and/or labia; cauterization by burning of the clitoris and surrounding tissue; scraping of tissue surrounding the vaginal orifice (“angurya cuts”) or cutting of the vagina (“gishiri cuts”); posterior or backward cuts from the vagina into the perineum, as an attempt to increase the vaginal outlet to relieve obstructed labor, that often result in vesicovaginal fistulae and damage to the anal sphincter; introduction of corrosive substances or herbs into the vagina to cause bleeding or for the purposes of tightening or narrowing the vagina.¹⁵



Figure 10 Type III female genital mutilation in a patient with dermoid cyst

The age of performance of FGM

The age at which FGM is performed varies widely, depending on the ethnic group and geographic location. In some groups, it is performed on babies; more commonly, it is performed between the ages of 4 and 10 years, but it may also be carried out in adolescence or even at the time of marriage or during a first pregnancy.

Prevalence and epidemiology

Current information on the types of mutilation and their prevalence derives from inadequate and often fragmentary data.¹⁶ Although FGM is illegal and prosecuted in several countries, the number of girls and women who have been subjected to genital mutilation is estimated at around 137 million worldwide and 2 million girls per year are considered to be at risk.¹⁷ The documentation of FGM began in the early twentieth century with reports of European travellers and missionaries. Since the 1950s, small studies have been undertaken by

physicians and gynecologists in some countries, using clinical records or direct interviews with patients.^{18–20}

The first national survey ever to be undertaken was conducted by the Faculty of Medicine of the University of Khartoum in Sudan in 1979. The Sudan Fertility Survey, also performed in 1979, and the Demographic and Health Survey of Sudan in 1990 included questions on FGM. Sudan is the only country with comprehensive and reliable national prevalence data over time.

In 1978, Hosken published the first comprehensive article on the epidemiology of FGM worldwide.²¹ In the first edition of *The Hosken Report*, in 1979, the author presented a global review and country estimates of the prevalence of the practice.²² Although the report did not specify the exact methodology by which data were collected, these figures remain a major source for global estimates of FGM. A literature review of available studies by Toubia, published in 1993,²³ modified Hosken's figures on the basis of more recent country studies and reports. These figures were updated again in 1995²⁴ and 1996.

Current estimates of prevalence are based on an extensive review of the most recently published literature and unpublished reports and on the most recent results from completed Demographic and Health Surveys. In countries in which results of studies with an adequate sample size or regional representation are available, estimates are based on these. The majority of published studies and surveys have sample sizes that are too small and are neither representative nor clinically based. In addition, some reports do not state clearly how samples have been selected. The authors are also aware of a number of studies, including several Demographic and Health Surveys and a comparative study of the results obtained using the Demographic and Health Survey module in African countries, which are currently underway.

Geographic distribution

There have been no comprehensive global surveys of the geographic distribution of FGM. Most of the girls and women who have undergone mutilation live in 28 African countries. FGM is practiced by many ethnic groups, from the east to the west coast of Africa, in the southern parts of the Arabian Peninsula and along the Persian Gulf, and increasingly among immigrant populations in Europe, Australia, Canada, and the USA. It has also been practiced by Daudi Bohra Muslims who live in India and amongst Muslims in Malaysia and Indonesia. Infibulation is widespread in Somalia, northern Sudan, and Djibouti, and has been reported in Gambia, Egypt, Ethiopia, Eritrea, northern Kenya, some parts of Mali, and northern Nigeria; it may also occur in other communities where information is lacking or still incomplete. On the basis of government reports, anecdotal evidence, and limited surveys with nonrepresentative samples, the prevalence of

mutilation in countries where it is practiced is estimated to range from 5% to 98%. Sudan is the only country to have carried out nationwide surveys (Sudan Fertility Survey, 1979; Sudan Demographic and Health Survey, 1989/1990).^{25,26} They were based on a national sample, which excluded the three southern provinces, where the practice is unknown (except by adoption or through marriage with members of northern groups where mutilation is practiced), and indicated an initial prevalence of 89%, which subsequently declined by 8%.

A study by the Nigerian Association of Nurses and Nurse-midwives conducted in 1985–86 using a sample of 400 women and men in each state showed that 13 out of the 21 states had populations practicing some form of FGM, with a prevalence ranging from 35% to 90%.²⁷ The data could not be extrapolated to give a national picture, however. Similar surveys exist for Chad, Ethiopia, Gambia, Ghana, Kenya, and Senegal.

The Central African Republic and the Ivory Coast have incorporated a few questions on FGM in their national Demographic and Health Surveys (1994 and 1994–95, respectively). A full module on FGM containing 20 questions (DHS III) was tested in Mali and in Eritrea in 1995, and Egypt integrated 34 questions on FGM in its national Demographic and Health Survey in the same year. It is hoped that these attempts will generate more reliable incidence and prevalence data in future years.

Religious and health beliefs

It is not known when or where the tradition of FGM originated, and a variety of reasons (sociocultural, psychosexual, hygienic, aesthetic, and religious) have been given for its maintenance. FGM is practiced by followers of a number of different religions, including Muslims and Christians (Catholics, Protestants, and Copts), by animists and Jews (Falashas in Ethiopia), and also by nonbelievers in the countries concerned. The practice is deeply embedded in local traditional belief systems.

In some countries, the practice seems to be more common among Muslim groups, and many people falsely believe that FGM is required by Islam. In the Ivory Coast, 80% of Muslim vs. 16% of Christian women have been genitally cut; in Burkina Faso, Muslim women have undergone FGM due to the belief that God does not listen to the prayers of uncut women. Debate has been ongoing among Islamic scholars as to whether or not Islamic teaching mandates FGM. It is now generally conceded by many Islamic authorities that there are no authenticated Islamic texts requiring the practice.

It is important to stress, however, that even though communities are aware that it is not a religious requirement, the practice continues because it serves as a way of controlling women's sexuality. It is therefore necessary to work with women first, before approaching religious leaders, so that

they become convinced of the need to stop FGM due to health consequences.

Consequences and complications

The exact incidence of morbidity and mortality associated with FGM is difficult to measure. Until now, few studies have dealt with this subject. It is known that the physical and psychological effects of the practice are often very extensive, affecting health, in particular sexual, reproductive, and mental health, and well-being. The damage done to female sexual organs and to their functioning is deep and irreversible. Furthermore, FGM reinforces the inequities suffered by women in the communities in which it is practiced. Despite the recognition of the importance of this sensitive issue, and the realization that it must be addressed if the health, social, and economic needs of women are to be met, major gaps still exist in our knowledge about the extent and nature of the problem and the kinds of intervention that can be successful in eliminating it. Only 15–20% of complications ever come to the attention of medical personnel due to the unavailability of or distance from health care, ignorance, or fear of legal retribution. Most practitioners of FGM take care of the complications themselves, sometimes with devastating results. Only the more serious complications are referred to the health sector.²⁸ Complications requiring hospitalization pose a significant constraint on already scarce resources.

Because many women underwent FGM as infants, they may not remember any immediate adverse effects. Women may not link complications arising during childbirth or later in life to the genital cutting they underwent as children. In addition, FGM-related complications may be considered as normal and natural to women, especially among populations where FGM is nearly universal. The effects of FGM depend on the type performed (in general, infibulation is considered to be far more hazardous than other types of FGM), the expertise of the practitioner, the hygiene conditions under which the operation was conducted, and the cooperation and health of the child at the time of the operation.²⁹

The effects of FGM may be divided into the following categories: (i) physical consequences; (ii) sexual, mental, and social consequences.

Physical consequences

FGM causes severe damage to girls and women and frequently results in immediate, short-, and long-term health consequences.

Immediate complications

1 Death. While anecdotal evidence is frequently mentioned, no study has ever been undertaken to determine the proportion of female child mortality that is attributable to FGM.^{13,30} Death can result from severe bleeding, from pain and trauma, or from severe and overwhelming infection.

Short-term complications

- 1 Pain. The majority of mutilation procedures are undertaken without anesthetics and cause severe pain.
- 2 Injury to adjacent tissue of the urethra, vagina, perineum, and rectum sometimes occurs.
- 3 Hemorrhage. Excision of the clitoris involves cutting the clitoral artery, which has a strong flow and high pressure.
- 4 Shock. Immediately after the procedure, the girl may develop shock as a result of the sudden blood loss (hemorrhagic shock) and severe pain and trauma (neurogenic shock), which can be fatal.
- 5 Tetanus can occur due to the use of unsterilized equipment and the lack of tetanus toxoid injection.
- 6 Acute urine retention can result from swelling and inflammation around the wound, the girl's fear of the pain of passing urine on the raw wound, or injury to the urethra.
- 7 Fracture or dislocation. Fractures of the clavicle, femur, or humerus, or dislocation of the hip joint, can occur if heavy pressure is applied to the struggling girl during the operation.
- 8 Infection is the most common consequence for obvious reasons.
- 9 Failure to heal. The wounds may fail to heal quickly because of infection, irritation from urine or rubbing when walking, or an underlying condition, such as anemia or malnutrition.

Long-term complications

- 1 Difficulty in passing urine can occur due to damage to the urethral opening or scarring of the meatus.
- 2 Recurrent urinary tract infection. Infection near the urethra can result in ascending urinary tract infections.
- 3 Pelvic infections are common in infibulated women.
- 4 Infertility can result if pelvic infection causes irreparable damage to the reproductive organs.
- 5 Keloid scar. Slow and incomplete healing of the wound and postoperative infection can lead to the production of excess connective tissue in the scar.
- 6 Abscess. Deep infection resulting from faulty healing or an embedded stitch can result in the formation of an abscess, which may require surgical incision.
- 7 Cysts and abscesses on the vulva. Implantation dermoid cysts are the most common complications of infibulation.
- 8 Clitoral neuroma. A painful neuroma can develop as a consequence of trapping of the clitoral nerve in a stitch or in the scar tissue of the healed wound, leading to hypersensitivity and dyspareunia.
- 9 Difficulties in menstruation can occur as a result of partial or total occlusion of the vaginal opening. Calculus formation in the vagina can occur as a result of the accumulation of menstrual debris and urinary deposits in the vagina or in the space behind the bridge of scar tissue formed after infibulation.

10 Fistulae (holes or tunnels) between the bladder and the vagina (vesicovaginal) and between the rectum and vagina (rectovaginal) can form as a result of injury during mutilation, de-infibulation, or re-infibulation, sexual intercourse, or obstructed labor.

11 Development of a "false vagina" is possible in infibulated women if, during repeated sexual intercourse, the scar tissue fails to dilate sufficiently to allow normal penetration.

12 Dyspareunia is a consequence of many forms of FGM because of scarring, reduced vaginal opening, and complications such as infection.

13 Sexual dysfunction can result in both partners because of painful intercourse, difficulty in vaginal penetration, and reduced sexual sensitivity following clitoridectomy.

14 Difficulties in providing gynecologic care. The scarring resulting from type III mutilation may reduce the vaginal opening to such an extent that an adequate gynecologic examination cannot be performed without cutting.

15 Problems in pregnancy and childbirth are common, particularly following type III mutilation, because the tough scar tissue that forms causes partial or total occlusion of the vaginal opening and prevents dilation of the birth canal.

Psychosexual, mental, and social consequences

Little research on the psychologic, sexual, and social consequences of FGM has been conducted. The personal accounts of women who have suffered ritual genital procedures, however, recount anxiety before the event, terror at being seized and forcibly held during the event, great difficulty during childbirth, and lack of sexual pleasure during intercourse.

FGM can have lifelong effects on the minds of those who experience it.

Sexual consequences

1 Malfunctions of female external genitalia. The clitoris is the key to the normal functioning and mental and physical development of female sexuality. The clitoris and labia minora are supplied with a large number of sensory nerve receptors and fibres, with a particularly high concentration in the tip of the clitoris.

2 Frigidity due to dyspareunia, injuries sustained during early intercourse, or pelvic infection.

3 Lack of orgasm due to the amputation of the glans clitoris. A study conducted on 651 circumcised Egyptian women showed that their sexual desire was not affected by the procedures, but the ability to achieve orgasm depended on the severity of the operation and the extent to which social messages inhibiting sexual expression were internalized.³¹

4 Coital difficulty or inability to have vaginal intercourse because of stenosis of the vagina may affect up to 35% of infibulated women.³²

5 Marital conflicts.

6 Psychologic problems, such as post-traumatic stress disorder, behavioral disturbances, psychosomatic illnesses, anxiety, nightmares, depression, psychosis, neurosis, and suicide, are due to the painful FGM procedures, painful menstruation afterwards, painful intercourse, recurring episodes of frigidity, formation of dermoid cysts, and urine incontinence. A syndrome of genitally focused anxiety and depression, characterized by constant worry over the state of their genitals, intolerable dysmenorrhea, and fear of infertility, has been described in Sudan among infibulated women.

7 In communities in which FGM has a high social value, girls and women who are not mutilated may be ostracized.

8 Genitally mutilated women in immigrant communities may face problems concerning their sexual identity when confronted with nonmutilated Western girls and women and with the strong opposition to FGM in their host country.^{33,34}

Mental and social consequences

1 Genital mutilation is commonly performed when girls are quite young and uninformed and is often preceded by acts of deception, intimidation, coercion, and violence by trusted parents, relatives, and friends. Girls are generally conscious when the painful operation is undertaken and they have to be physically restrained as they struggle. In some instances, they are also made to watch the mutilation of other girls.

2 For many girls, genital mutilation is a major experience of fear, submission, inhibition, and suppression of feelings and thinking. This experience becomes a vivid landmark in their mental development, the memory of which persists throughout life.

FGM in immigrant communities in Western countries

Countries in which FGM is not a traditional practice should be aware that it may be practiced in immigrant communities, or that immigrant survivors who have undergone the procedure in their home countries may need special medical help. Of major concern are the possible adverse psychosocial consequences for women and girls who have moved from a country in which FGM has familial and social acceptance to one in which it is illegal and raises general community abhorrence. Because immigrant populations practicing FGM are marginalized groups within Western nations, their needs may not be visible. State resources should be set aside for the education of immigrant groups practicing FGM and to investigate the health needs of immigrant women and girls.

The prevention of FGM should be integrated within broader national healthcare policies. One possibility would be the creation of a lead agency that could act as a bridge between local communities and the statutory agencies to find the best possible ways of developing a sensitive system for the prevention of FGM, the protection of girls at risk of FGM,

and the rehabilitation of women and girls who have already experienced this procedure. A rapid survey could be undertaken to study the distribution of the problem and to examine the entry points within childcare law and the healthcare and educational systems through which prevention could be furthered. The approach should stress support to families through counselling and persuasion.

Leaving a dangerous practice without betraying a culture

FGM is considered to be a barbaric practice inflicted on women and girls in remote villages of foreign countries. This is not so. The dignity of the family, cleanliness, protection against sorcery, and guarantee of virginity and fidelity to the husband are the motivational factors sometimes cited as reasons for the practice.

One of the most frequent explanations for FGM is that it is a local cultural custom and women are often unwilling to change this habit because of its long-lasting use. Moreover, people using this kind of practice often ignore the true implications of FGM and the severe risks to health involved.

Owing to the large number of cases of FGM sometimes followed by death, the practice is now forbidden in some European countries (UK, France, Sweden, Switzerland) and in some African countries (Egypt, Kenya, Senegal). It is important to note, however, that, even though FGM is illegal in many African and Middle Eastern countries, the number of girls mutilated every year has not decreased, as the governments of these countries are unable to monitor the extent of the practice.

The United Nations, UNICEF, and WHO consider FGM to be a violation of human rights and recommend the eradication of the practice. Also, many nongovernmental organizations are trying to increase the consciousness of the need to eliminate FGM.

What can the international dermatologic community do?

FGM is a problem unfamiliar to most Western physicians and dermatovenereologists. In addition to a lack of clinical knowledge of FGM procedures and complications, information about the underlying sociocultural beliefs and traditions is incomplete. For example, in many communities in which FGM is a traditional practice, women are reluctant to discuss sexual matters with health personnel and are shy to complain about painful intercourse or inability to consummate marriage. In northern Sudan, women have a defibulation procedure performed immediately after marriage. This procedure is carried out by a local midwife or birth attendant and facilitates the consummation of marriage. Many Somali women living in the UK experience difficulties in obtaining such a facility.³⁴ The physiologic, psychosexual, and cultural aspects

of FGM should be incorporated into the training of health-care personnel working with immigrant communities who practice FGM.

European politicians need to create an environment that does not contribute to the further marginalization of refugees and immigrants. This means that they must evaluate current social policies and statements about immigrants in this context. For example, immigration and asylum laws should be assessed as to how they affect identity and for which the potential links of the immigrants in favour of FGM. Women should be able to request political asylum on their own and not only as dependants of men. Girls should be made aware of the possibility of seeking help and refuge, e.g. through telephone helplines, social services, and battered women's shelters.

It is the responsibility of politicians to meet with communities; these consultations can be employed to identify important issues, which can then be used as a basis for developing a policy framework to tackle the medical, economic, social, and legislative aspects of FGM. Immigrant and refugee workers need to be supplied with systematic information on groups that still perform FGM and on groups that provide services to deal with FGM. Policy makers should stress that a holistic approach is needed towards immigrants and that immigrant women have rights too. Funds should be raised in order to tackle more than one aspect of immigrant women's lives.

Dermatovenereologists, anthropologists, educators, social assistants, and health operators should be able to reach villages and districts and inform practitioners about the dangers of FGM. In order to successfully eliminate this practice, it will be necessary to act with great delicacy, as cultural beliefs are very strongly held.

In order to eradicate FGM, we believe that the following measures will be necessary.

- 1 Training and awareness of dermatovenereologists, nurses, and healthcare workers in developed countries because international migration has increased the number of circumcised women in these countries.
- 2 Health education programs for immigrant communities.
- 3 Attempts by healthcare workers to discourage women from performing FGM on their daughters.
- 4 Education and prevention campaigns aimed at different target groups: adolescents, refugees, men and women of the communities involved, and healthcare professionals who work with communities with a high FGM risk factor.
- 5 Cultural facilitators involved in working with immigrant communities. Furthermore, intensive education on FGM should be included in the official curricula of midwives, nurses, and medical doctors, and the subject should also be tackled through publications in medical journals.
- 6 Consultation and interaction between healthcare professionals and affected communities as a basis for the preparation of guidelines for dermatovenereologists, medical doctors, and healthcare workers.

We consider FGM to be more than a health problem; it is also a social means of controlling women's sexuality. We therefore do not strive for the eradication of FGM as such. Instead, we wish to label it as a social behavior, using gender as a basis. This means that our message is not only "do not practice FGM;" rather, we aim to facilitate social and economic change. We consider that FGM is a form of gender-based violence, while recognizing that it is not an intentional and deliberate effort to produce injury.

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