BEYOND THE CUT:

A student perspective on navigating female genital mutilation

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Female Genital Mutilation (FGM) refers to "all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for nonmedical reasons."[1] More than 230 million girls and women worldwide have undergone FGM, primarily in Africa (144 million), Asia (80 million), the Middle East (six million), and destination countries for migration (one to two million), including the United States.[1,2]

I first learned about FGM in 2014, as a high schooler on a summer service trip in Tanzania. I remember my peers and I gasping in horror as members of a local nonprofit dedicated to ending FGM recounted details of their experiences with the practice and reflected on the greater impact on their community. Over time, I found my mind periodically returning to the practice I'd learned about that summer, but my understanding of FGM remained limited.

It wasn't until the end of my second year of medical school when I was asked to write a paper on a reproductive health issue that I engaged with the global FGM conversation in any meaningful way. There exists a cultural basis of the practice, and a significant prevalence in the U.S., where the Centers for Disease Control and Prevention estimates 513,000 women and girls are at risk for FGM or its consequences annually.[3] This rate reflects a threefold increase in the overall number of women and girls at risk for FGM in the U.S. since the 1990s, with a fourfold increase for girls younger than 18 years of age. This is largely a result of rapid growth in the number of immigrants from FGM-practicing countries.[3]

Most recent data, from 2016, highlights state-by-state variability, with California having the largest at-risk population (57,000), followed by New York (48,000), and Minnesota (44,000), predominantly in large metropolitan areas.[4] The cultural and legal sensitivity of FGM make it challenging to gather reliable survey data to definitively quantify the extent of FGM in the U.S., but these estimates signal a need for greater awareness and prevention at the community level. Considering this prevalence, it is surprising that the first half of the medical school curriculum does not included any mention of FGM.

Setting the stage

FGM has no health benefits—rather, it puts girls and women at increased risk of health complications including pain, bleeding, infection, shock, and death.[1] FGM contributes to an estimated 44,320 deaths per year across African countries where it is practiced. It accounts for more deaths of girls than HIV/AIDS, measles, meningitis, starvation (nutritional deficiencies), injuries, or whooping cough.[5] Under Sustainable Development Goal (SDG) 5.3, the United Nations (UN) intends to fully eradicate FGM by 2030.[2] According to U.S. federal law (18 U.S. Code § 116), it is illegal to perform FGM in the U.S. on anyone under the age of 18 years; it is also illegal to knowingly transport a girl out of the U.S. for the purpose of having FGM performed.[6] Many state laws also prohibit FGM on minors, and some states prohibit the practice on adult women.

The American College of Obstetricians and Gynecologists (ACOG), the American Medical Association (AMA), and the American Academy of Family Physicians echo the World Health Organization (WHO) in condemning the practice of FGM and supporting all eradication efforts in the U.S. and internationally.[6] The AMA further commits to ensuring that "medical students, residents, and practicing physicians are made aware of the continued practice and existence of FGM in the United States, its physical effects on patients, and any requirements for reporting FGM."[7]

Despite these powerful statements and definitive stances, FGM and its health consequences remain highly prevalent in the U.S., indicating the importance of medical student and physician awareness.

Cultural and historical context

FGM is a deeply entrenched social norm in the communities where it is practiced. FGM conveys immense social power, and failure to complete the operations may ostracize a woman from her community. FGM is an initiation rite, signifying the passage from girlhood to womanhood. Traditionally performed on girls at the onset of menstruation, FGM has been considered a normal part of puberty, and a requirement for marriage.[8]

Gender distinctions rely on FGM to distinguish between males and females, and in some practicing cultures, sex is not decided at birth, but rather, by the removal of the foreskin of a boy and the clitoris of a girl.[9] Only after undergoing FGM is a woman formally accepted in society. An uncircumcised woman is vulnerable to prejudice and exclusion, and can be viewed as inferior to those whose femininity is fully recognized.[8,9] As a result, removing FGM from the communities where it is practiced can be damaging to the cultural fabric.

Perceived health and safety reasons further compound the reliance on FGM as a protective measure. In some cultures, the clitoris and labia, considered to be "masculine parts," are seen as dangerous and poisonous organs that must be removed.[9,10] If they are not removed, the uncircumcised woman is believed to inflict harm on her baby during birth, produce poisonous breast milk, and cause men difficulty during intercourse.[10] Additionally, the removal of the clitoris and labia is thought to improve sexual satisfaction and overall desirability.[9]

FGM is believed to contribute to the cleanliness and beauty of women. An uncircumcised woman may be considered "unclean" and "unpure," and runs the risk of an unmarried future, as well as alienation from their family and friends.[9,10] Parents may elect to circumcise their daughters out of love, to optimize their marriageability and prospects of a good life.[8] Historically, it has been argued that the significance of FGM in some communities serves to enhance girls' well-being by elevating their social status, and affording better life opportunities.

Health consequences

FGM entails a wide range of procedures that can be grouped into four broad categories:

- Type I: Partial or total removal of the clitoris and/or the prepuce.
- Type II: Partial or total removal of the clitoris and labia minora, with or without excision of the labia majora.
- Type III: Narrowing of the vaginal orifice by cutting and bringing together the labia minora and/or the labia majora to create a type of seal, with or without excision of the clitoris, and stitching the labia together, referred to as infibulation.
- Type IV: All other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, piercing, incising, scraping and cauterization.[1]

Typically, these procedures are carried out by circumcisers skilled in traditional medicine. Their lack of surgical training, poor equipment, and limited sanitation can exacerbate the resulting complications that girls may face.[11]

More than half of circumcised women experience medical complications of varying severity, including, but not limited to, scarring, keloids, adhesions, dermoid cysts, vaginal and urinary tract infections, and infertility.[11] Additional problems arise when the circumcised woman becomes sexually active, and intercourse leads to increased risk of infection and painful lacerations if the circumcision incision is not given proper healing attention and recovery time. The incidence of these health problems is multiplied by "defibulation, [the] cutting or tearing open of the scarred vaginal tissue, [that] occurs partly when an infibulated woman has intercourse, and more extensively when she gives birth."[11]

Social codes enable a husband to defibulate his bride after recognizing she is a virgin, or prompt a sexually active, unmarried woman to use "reinfibulation to create a false appearance of virginity."[11] A 2020 study found that women who underwent FGM were twice as likely as non-FGM women to experience dyspareunia, perineal tears, prolonged labor, and episiotomy.[12]

These cultural demands leave women vulnerable for developing infection and serious reproductive issues, highlighting the need for physician preparedness in diagnosing, managing, and treating FGM patients.

The physician's role

It is often instinctive for Western clinicians to respond with judgment, fear, and outrage sounding alarms embedded in us from years of medical ethics training. Yet, when confronted with the ethical dilemma presented by FGM, the physician's role becomes muddied. Do physicians respect the patient's request for FGM? Do they adhere to their definition of right and wrong, refuse the request, and protect the patient from physical harm?

In committing to medicine, we take the Hippocratic Oath—to serve our patients' best interests, and to above all, "do no harm."[13] In the U.S., federal law prohibits FGM, but that does not make it a nonissue.

Consider the case of a 28-year-old patient presenting in labor at a U.S. tertiary care Labor and Delivery unit. She had undergone FGM in her Northeastern African country of origin at age 10, resulting in Type III female circumcision involving total removal of the clitoris and labia minora, and infibulation (sewing together of the labia majora).[14]

After delivery, the patient insisted on reinfibulation of the labia majora. Despite counseling on the risks of infection and poor wound healing, the patient's desire for restoration of the circumcised anatomy for cultural acceptance led the obstetrician to perform a partial reinfibulation.[14] Was this the right decision? Does the charge to do no harm only apply to the physical health of the patient? What about the harm to their mental and emotional health because of deinfibulation?

How should physicians navigate this scenario—refuse the patient's request, or perform a procedure that many unequivocally view as wrong? And not only the FGM procedure itself, what about complications from past operations, are U.S. physicians equipped to handle those cases?

These are difficult questions to answer, and there may not be a single answer that satisfies all parties when cultural beliefs are incongruous. In the U.S., it is not only the ethical route to refuse FGM/reinfibulation—it is the law. The task is to ensure that providers are aware of this and prepared to act accordingly in the event that they are confronted with FGM-affected patients.

Guidelines

FGM constitutes discrimination against women's social status, perpetuation of gender-based violence within traditional practices; infringement of children's rights; and forced subjection to painful and harmful health treatment.[15] For these reasons, the WHO developed a set of guidelines for preventing and treating health risks of FGM.[16] Broadly, these describe best practices for addressing deinfibulation, mental health, and female sexual

health. Recommendations for treating vulvodynia and clitoral pain following FGM are less clear.[16] These guidelines provide a much needed starting point, but how effective are they in practice? In a recent survey study of 288 OB/GYNs in the U.S., 10.1 percent reported caring for at least one patient who requested virginity testing, 5.6 percent cared for a patient who requested virginity restoration, and 58.3 percent provided care to a patient who had previously undergone FGM.[17] Only 3.5 percent of surveyed OB/GYNs were aware of any institutional policies regarding receiving such requests. Further, three OB/GYNs reported seeing patients who underwent FGM in the U.S., and only 34 percent of OB/GYNs were aware that federal laws prohibit FGM.[17]

Where do we go from here?

These statistics, and the previous case example, reveal an urgent need for more, and earlier, training on caring for FGM-affected patients and increasing familiarity with the WHO guidelines. In their 2020 study, researchers at the Weill Cornell Center for Human Rights found a significant relationship between health care providers' unfamiliarity with FGM and the negative effects experienced by patients, compounding the already detrimental obstetric and gynecological outcomes FGM patients face.[18]

Nearly 90 percent of Somali refugees in Canada giving birth after FGM reported offensive comments from their providers because of their cutting.[17] For this reason, Lurie, et al. published a trauma-informed care (TIC) framework for caring for FGM-affected patients.[18] Core tenants include meeting patients where they are, connecting patients with resources, and above all, preventing re-traumatization.[18] For example, avoiding potentially triggering terminology by using patient-preferred language when referring to FGM and facilitating a patient-driven physical exam including self-swabbing for STI testing, or speculum self-insertion, if that is indicated.[18] Emphasizing patient autonomy in this way is crucial to providing TIC for all patients, and especially in caring for FGM-affected patients.

Among practicing countries, shifting attitudes reflect a resounding opposition to FGM. According to UNICEF, 400 million people—two-thirds of the population—in practicing countries in Africa and the Middle East say they want the practice to end.[2]

Anti-FGM activism has gained momentum in the last few decades, with international efforts mounting in many Sub-Saharan African nations. Grassroots efforts have spurred demonstrations against the practices and garnered significant media attention. In Kenya, at a "ceremony of achievement" hosted by non-profit Manga HEART, 100 girls sang songs and recited rhymes calling for their parents to "save [them] from FGM."[19] Survivor Naima Abdullahi spoke to *The Guardian* about her experience undergoing FGM in Kenya when she was nine years old, and the lasting trauma and hip problems related to "struggling when she was being pinned down by two women in order to be cut."[20]

In Guinea-Bissau, advocates like Djenabu Sano work at the community level to educate neighbors and religious leaders about the dangers of FGM. In a 2023 interview with the United Nations, Sano describes the harmful consequences of FGM on her life, having suffered hemorrhages during delivery for all four of her children, which has motivated her to "sensitize others and save lives."

Sano's work led to the creation of four men's and boy's clubs to initiate behavior change and address gender stereotypes that have historically contributed to FGM's continuation.[21] In doing so, activists have been able to deconstruct FGM while still strengthening community collaboration and preserving shared identity.

Declining FGM rates in Sierra Leone, Ethiopia, Burkina Faso, Liberia, and Kenya are cause for celebration, but the trajectory of this progress remains unknown.[2] Unfortunately, even in areas where FGM has been outlawed—both internationally and in the U.S.—the practice is kept alive, concealed in the shadows of backroom clinics or private homes. UNICEF estimates that approximately one in four survivors of FGM, or 52 million survivors worldwide, were cut by a health care provider.[22]

This medicalized FGM is defended by practitioners and communities as a safe way to preserve the custom, enabling it to continue unabated in Kenya, despite the country's 2011 ban.[23] According to national data in Kenya, more than 15 percent of FGM procedures are carried out by health workers, a sobering indication of the need for greater intervention at the institutional level.[23] A 2020 study of several communities in Kenya found that some clinicians perform FGM under the pretext of "genital modification," labeling it as plastic surgery to strengthen the appeal.[24] Beyond legislative change, eradication efforts must work with health care systems to educate about the serious medical risks inherent to FGM, regardless of who is performing it. Recognizing the existence of these backroom clinics, even on American soil, is crucial for health care teams to connect with

their affected patients. As has been proven, making something illegal does not make it impossible.

What can we learn?

Culture provides identity, a purpose in life, and a unity among people that transcends barriers of generation, class, and gender. Culture can instill a sense of meaning in oneself and trust in others. Culture manifests in practices that serve these end goals, building on a commitment to intellect and communal growth. This is what culture is supposed to do, and in these ways, cultural relativism can protect societies from the imposing paternalism of others, particularly Western nations. However, when the practices that claim to promote culture coincide with human rights violations that harm patients, physicians have a duty to learn, recognize, and intervene.

The international movement to eradicate FGM is predicated on the practice's dangerous health outcomes. Yet, the ethical dilemma that patients may face in breaking from their cultural norms by refusing the practice must be recognized. In the U.S., medical trainees need an earlier introduction to FGM, and guidance in caring for patients from FGM-practicing cultures. This starts with awareness of the prevalence of FGM globally and in the U.S., a reality that is unbeknownst to many medical students.

As long as FGM is performed anywhere in the world, physicians will be confronted with the consequences, and must be prepared to care for their patients holistically. This includes protecting them from physical harm, while also aiming to minimize psychological and emotional distress.

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