

# International continence society white paper regarding female genital mutilation/cutting

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Female genital mutilation/cutting (FGM/C)—also known as Female Genital Cutting or Mutilation—is defined as the partial or total removal of the female external genitalia for non-therapeutic reasons. This White Paper, prepared under the auspices of the International Continence Society (ICS), is intended by the ICS as a statement promoting the abandonment of this practice. The ICS also supports the respectful and evidence-based care or treatment of women and girls already affected by FGM/C, in keeping with the World Health Organization (WHO) Guidelines on the Management of Health Complications from Female Genital Mutilation.<sup>1</sup> Our members specialize in pelvic floor disorders from perspectives within a range of specialties; we encounter and treat women living with FGM/C and its consequences—particularly incontinence, infections, voiding dysfunction, sexual dysfunction, chronic pelvic pain, and obstetric trauma. Understanding the ethical, sociocultural, medical and surgical factors surrounding FGM/C is central to caring for women and girls with a history of FGM/C. The ICS voices herein state strong opposition to FGM/C. We encourage members to apply their skills to improve prevention strategies and the management of those affected.

## KEYWORDS

circumcision, complications, cutting, defibulation, female genital mutilation, public health

## 1 | INTRODUCTION

Female Genital Mutilation (FGM/C), in its official World Health Organization Definition, “comprises all procedures that involve the partial or total removal of external genitalia or other injury to the female genital organs for non-medical

reasons.”<sup>1</sup> FGM/C is distinguished from female genital cosmetic surgery by consensual and other factors, as discussed below. This paper specifically addresses non-consensual procedures, which are for the most part performed on minors. There are no health benefits to FGM/C. FGM/C violates basic human rights. In addition there are significant immediate and long-term risks associated with FGM/C including obstetric, neonatal, urologic, gynecologic, infectious, sexual, and psychological health consequences as outlined below. FGM/C is a deeply ingrained sociocultural practice in many countries. The practice is seen within a range

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of cultures and ethnicities, and within Muslim, Animist, and Christian societies. However, it predates the Islamic and Christian religions and mention is absent from both the Koran and the Bible. Explanations for the practice may include safeguarding virginity, aesthetics, prevention of rape, ensuring fidelity—and therefore social acceptance, family honor and marriageability—and establishing ethnic identity.<sup>1</sup>

The ICS position is that:

1. FGM/C should be prevented and progressively eradicated.
2. Healthcare professionals should not perform FGM/C, as medicalization<sup>1</sup> of the practice does not prevent many of the complications. Healthcare professionals should be trusted promoters of prevention/abandonment of the practice and care of already affected women and girls.
3. FGM/C complications should be screened, recognized, treated, and recorded appropriately and ultimately prevented.

### 1.1 | Status of FGM/C

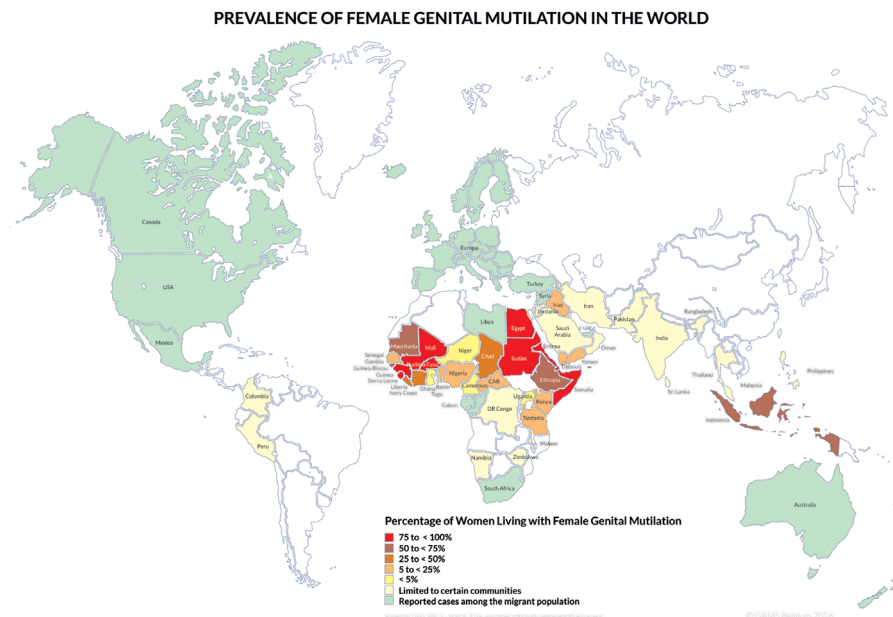
FGM/C is in fact illegal in many countries (Figure 1). However, FGM/C is still practiced in approximately 30 countries around the world,<sup>2</sup> including many where outlawed.<sup>3</sup> An estimated 200 million women have undergone FGM/C to date.<sup>3</sup> A 2013 UNICEF report estimated another 30 million girls are at risk in the coming decade.<sup>3</sup> The vast majority of FGM/C occurs in children prior to the age of 15.<sup>3</sup> Cultural factors continuing the practice of FGM/C are not simple to change and will be explored below.

The WHO classification distinguishes four basic types of FGM/C with subclassifications (See Figure 2). These

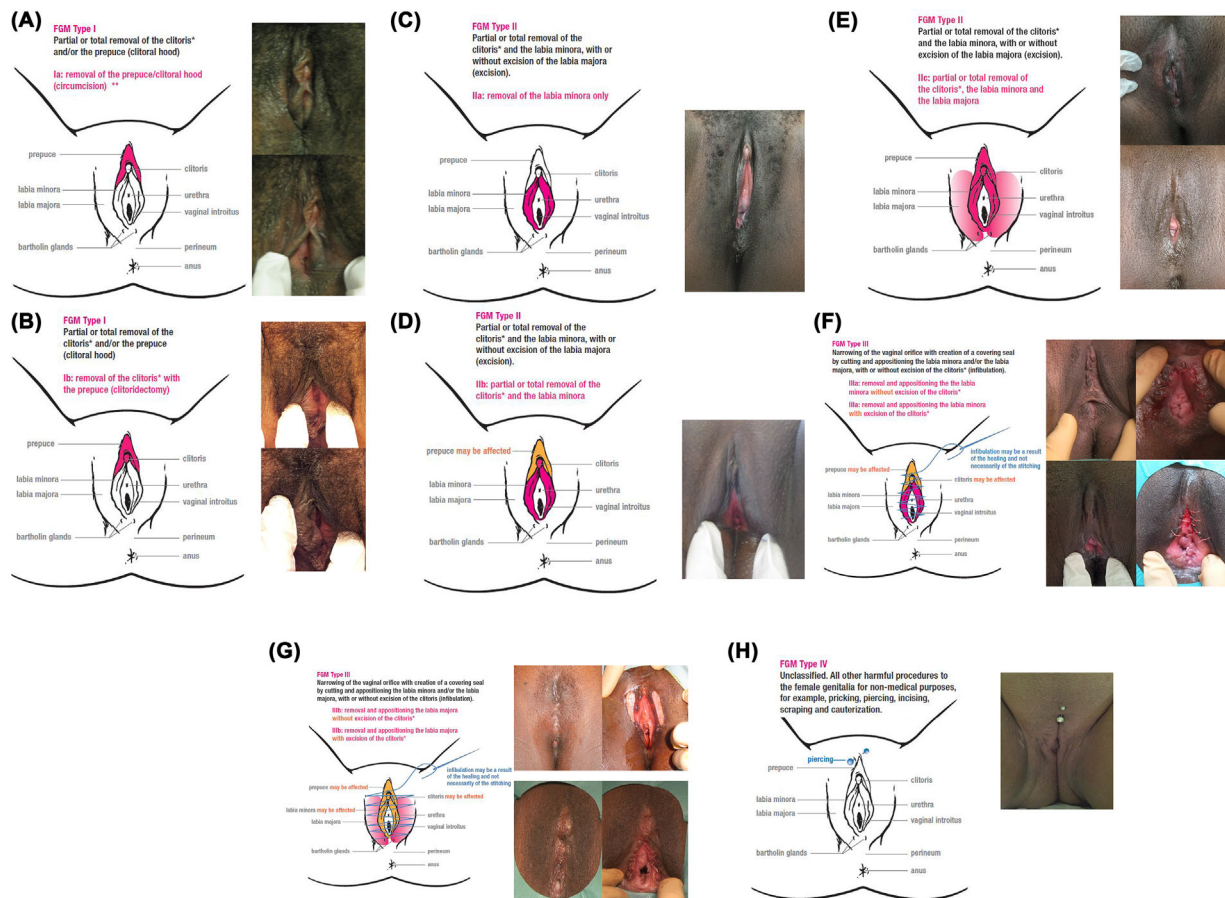
comprise a wide range of practices from the excision of the labia with or without the external part of the clitoris, with or without covering/narrowing the introitus, to performing genital piercing, pricking or stretching. Research shows that women can accurately answer whether they have undergone FGM/C; therefore, simple surveys can provide reasonable estimates of prevalence.<sup>4,5</sup> For the most part, women who have undergone FGM/C cannot correctly identify specifically what was done to them; this is not at all surprising as in many countries the majority of girls are cut before age five. Accurate classification requires examination by a trained observer (a visual reference and learning tool describing the WHO classification, including a video, has been published<sup>6</sup>). Proper classification, recording, and coding may have value clinically to individuals living with FGM/C as well as in research efforts to understand risks associated with the condition, optimal treatments, and in communication for academic and clinical endeavors. Classification is important for epidemiological and statistical purposes, for example, to study changing trends of the practice and the quality of care provided to patients. For example, following campaigns aimed at abandoning FGM/C, there is evidence that FGM/C may be performed at an earlier age and/or in a milder form.<sup>3,7</sup>

### 1.2 | FGM/C should be prevented and ultimately eradicated

It is the position of the ICS that FGM/C should be prevented and thereby eradicated. There are no studies showing any medical benefit to any form of FGM/C. FGM/C causes



**FIGURE 1** Prevalence of Female Genital Mutilation in the world. Courtesy of GAMS, based on DHS, MICS March 2016 and other nationally representative surveys, ©GAMS Belgium <http://gams.be>



**FIGURE 2** Classification of FGM/C. Photos courtesy Jasmine Abdulcadir. Drawings reprinted from World Health Organization. WHO guidelines on the management of health complications from female genital mutilation. <https://www.who.int/reproductivehealth/topics/fgm/management-health-complications-fgm/en/> Geneva (Switzerland): World Health Organization; 2016. Box 1.1 pages 2, 3, 4 (drawings of FGM types). (A) FGM Type Ia. (B) FGM Type Ib. (C) FGM Type IIa. (D) FGM Type IIb. (E) FGM Type IIc. (F) FGM Type IIIa. (G) FGM Type IIIb. (H) FGM Type IV.

significant immediate and long term complications. Most importantly, FGM/C is a violation of basic human rights.

### 1.2.1 | FGM/C violates human rights

As the WHO Guidelines state, “FGM/C violates a series of well-established human rights principles, including the principles of equality and non-discrimination on the basis of sex, the right to life when the procedure results in death, and the right to freedom from torture or cruel, inhuman or degrading treatment or punishment, as well as the rights of the child.” Many other international human rights organizations have called for an end to the practice, including the United Nations Populations Fund (UNFPA)/United Nations International Children's Emergency Fund (UNICEF),<sup>8</sup> the United Nations Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW), the United Nations Convention on the Rights of the Child (CRC), and the Protocol on the Rights of Women in Africa (“the Maputo Protocol”), and the Pan African Parliament (PAP)<sup>9</sup> among others.<sup>10</sup>

### 1.2.2 | Immediate morbidity and mortality of FGM/C

There are no reliable estimates of the morbidity and mortality attributable to FGM/C. Only a portion of the most serious complications ever reach medical attention. Nevertheless, given that the procedures are performed forcibly on young girls who are generally unaware of what will happen, and (the vast majority of the time) without the benefit of anesthesia, it is reasonable to assume that nearly all suffer pain and psychological trauma and that all are at risk of serious adverse events. Most subjects will experience bleeding. In many this will be physically and/or emotionally significant; hemorrhage and death can occur.<sup>11</sup> In a large majority of countries traditional practitioners without medical training do the cutting, typically using crude instruments (Figure 3). The lack of sterile environment and proper antiseptics leads to a risk of tissue infection, sepsis, and even death from infection. Tetanus is a particular risk given the circumstances and the lack of uniform national vaccination programs. Urinary tract infections also occur. There can be inadvertent injury to the urethra or even the





**FIGURE 3** Representative instruments used for typical FGM/C. Courtesy Charlemagne Ouedraogo

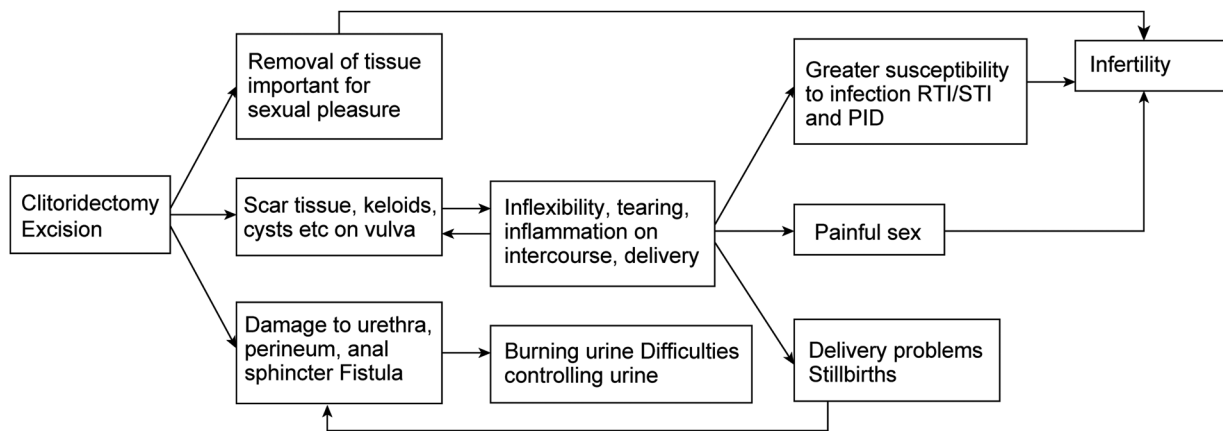
rectum. Swelling and pain can produce acute urinary retention. Although unquantified, these risks are potentially serious and substantial. They are not offset by any type of benefit.

### 1.2.3 | Long-term consequences of FGM/C

Damage caused by FGM/C can have a domino effect leading to many long-term consequences as presented in Figure 4. In 2005, a systematic review regarding the health consequences of FGM/C was published, noting difficulty in study design and capturing the data.<sup>12</sup> Observation itself is complex in limited health delivery systems; reporting may not be accurate (observers or subjects may not identify the FGM/C type correctly); sampling bias is present on multiple levels (incidence of complications, time of data collection, difficulty in finding comparison groups); and confounders abound (FGM/C effect vs poor medical care). Regardless, ICS specialists should be familiar with the spectrum of possible complications following FGM/C, and be prepared to screen, diagnose, record, code and manage them. The WHO has

published a detailed handbook “Care of Girls and Women Living with Female Genital Mutilation” (<http://www.who.int/reproductivehealth/publications/health-care-girls-women-living-with-FGM/en/>) which covers each of these topics as well as the general approach to these patients.

1. Obstetric and Neonatal complications: FGM/C, particularly type III, includes an increased rate of adverse obstetric<sup>13</sup> and neonatal<sup>14</sup> outcomes including hemorrhage, obstructed labor, perineal tears and stillbirth.<sup>15</sup> FGM/C may contribute to the obstetric factors leading to fistula. A 2006 multicenter study by the WHO showed increased relative risks for: cesarean delivery (RR 1.31), postpartum hemorrhage (RR 1.69), extended maternal hospital stay (RR 1.98), infant resuscitation (RR 1.66), and stillbirth or early neonatal death (RR1.55).<sup>16</sup> A secondary analysis of such data showed that women with FGM/C had an increased risk of C-section performed for unclear indications, probably due to a lack of training of providers in performing defibulation or in managing FGM/C.<sup>17</sup> A large systematic review and meta-analysis written in the USA and Europe in 2014<sup>14</sup> as well as a prior review from 2005<sup>12</sup> corroborated these findings. Several studies performed on obstetric outcome after FGM/C in high income countries show that with trained and appropriate management, such risks can be significantly reduced and controlled.<sup>18–20</sup> Educational material on defibulation has been published and is available online.<sup>21</sup> A great concern in managing a pregnant woman with FGM/C, particularly Type II and III, is perineal tearing. More recent studies and secondary analysis of the 2006 WHO paper showed that the high rate of C-section in FGM/C seems related to inappropriate indications for the C-section. This probably relates to unfamiliarity of providers concerning defibulation during/outside pregnancy or in labor and a low threshold for Cesarean for women with FGM/C. One study showed that there was no



**FIGURE 4** Conceptual framework for long term consequences of FGM/C. Reproduced from Morison L, Scherf C, Ekpo G, Paine K, West B, Coleman R, Walraven G. The long-term reproductive health consequences of female genital cutting in rural Gambia: a community-based survey. *Tropical Medicine and International Health* 2001 6(8) 643–653

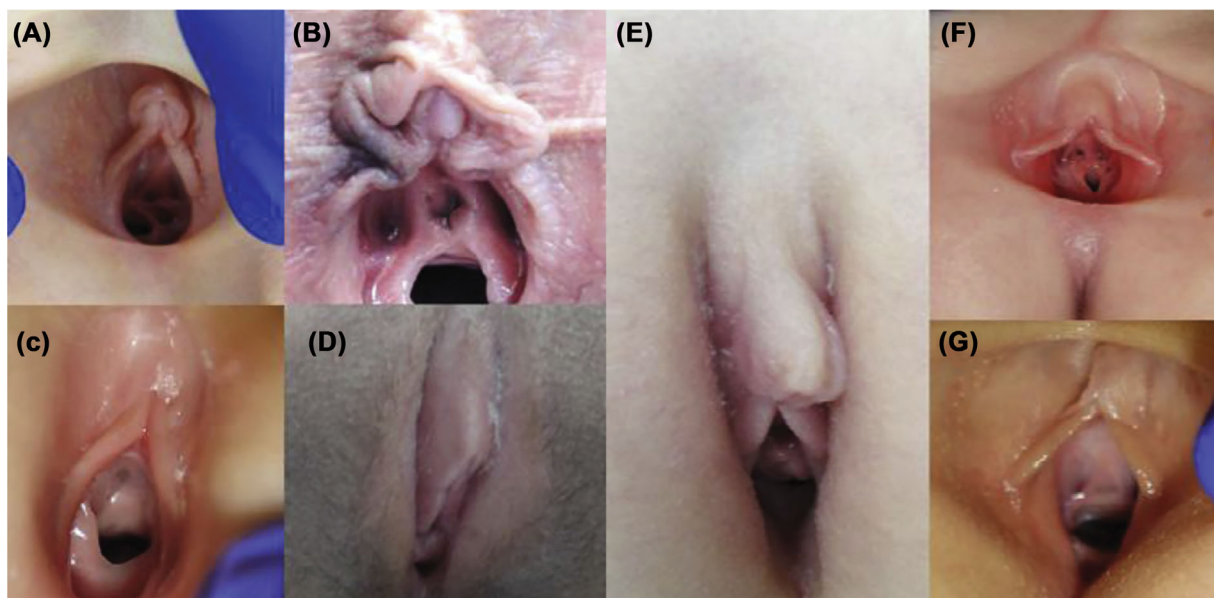
difference in the incidence of strong medical indications for C-section between women with and without FGM/C. However, C-sections were performed more often on women with FGM/C lacking a clear medical indication in relation to various maternal factors or arrest disorders.<sup>16</sup> Another study found that episiotomies were protective against anal sphincter tears and post-partum hemorrhage after Type III FGM/C, however in this study it is unclear if an associated defibulation was also performed.<sup>22</sup> Routine episiotomy is not currently recommended for women with FGM/C in the 2016 WHO guidelines,<sup>i</sup> however a lower threshold for episiotomy is recommended in this group.<sup>23</sup>

**2. Urinary tract complications:** Lower urinary tract complications are of special concern to ICS members and are prevalent following FGM/C.<sup>24</sup> Damage to the urethra at the time of FGM/C is common due to its intimate relation to the clitoris and labia<sup>25</sup> (Figures 5 and 6)—the cephalad apex of the clitoral hood is only 12 mm from the urethral orifice at age 0-3 and 17 mm at age 4-8.<sup>26</sup> Urethral injuries result in scarring/stricture/stenosis and subsequent lower urinary tract dysfunction. Unfortunately, good data on urinary complications is lacking. ICS membership could contribute in research initiatives. A 2005 systematic review reported significant prevalence of dysuria (58-64%), urinary retention (12-70%), urinary tract infection including recurrent UTI (2-38%), incontinence (6%) and unspecified urinary symptoms (15-25%).<sup>12</sup> Another group recruited 251 patients specifically to investigate lower urinary tract symptoms (LUTS). They found at least one LUT symptom was present in 38.8% of women. Nocturia was reported in 38.6%, intermittency in

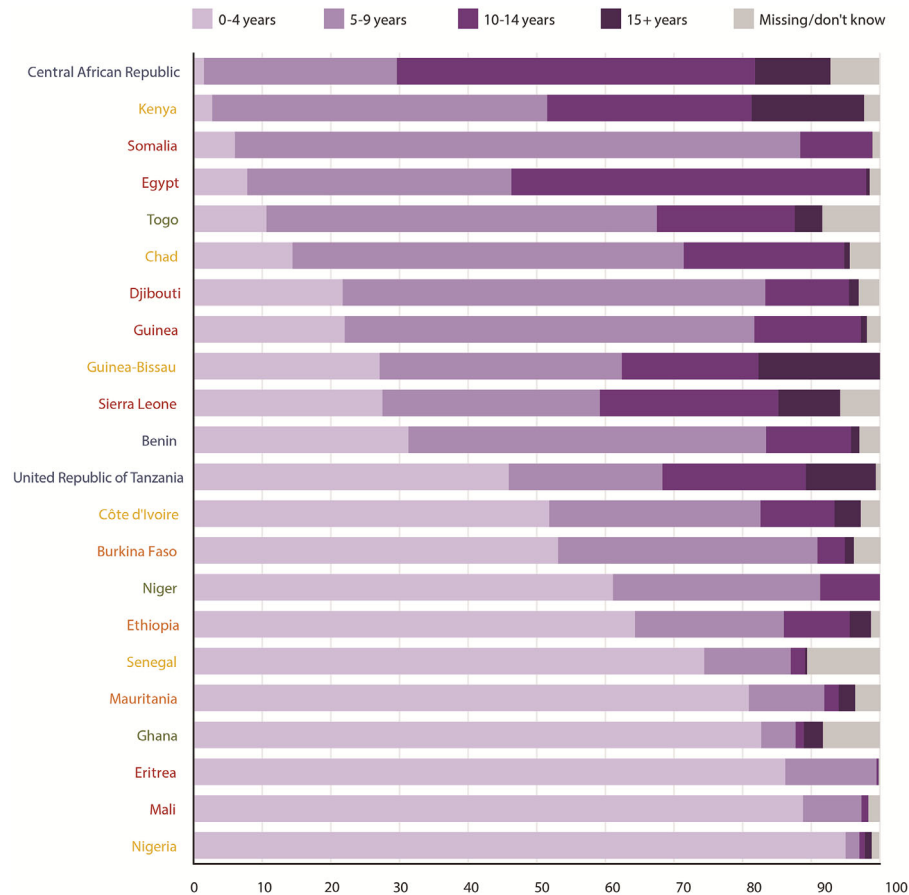
23.5%, and incomplete voiding in 22.7%, with all three reported in 11.6% of the women. Women with a history of Type II and Type III FGM/C had a significantly higher risk of reporting all 3 LUTS than those with Type I.<sup>27</sup>

**3. Infections:** Infection is common in the short term after FGM/C.<sup>28</sup> A Tetanus is a serious potential risk and can even cause death after FGM/C in regions where no vaccination/immunoglobulins are available. In the long term, as noted above, girls and women may be at increased risk of urinary tract infections after FGM/C. However, other serious infections including HIV are also possible long-term sequelae as described in a 2013 systematic review.<sup>29</sup> More infections were identified in those with Type III FGM/C.<sup>29</sup>

**4. Mental health problems:** Women living with FGM/C suffer from psychiatric disorders significantly more commonly than their peers without this history.<sup>30</sup> A small study of Senegalese women who had undergone FGM/C found that over 90% of women recalled their cutting as “appalling and extremely traumatizing” with 30% developing posttraumatic stress disorder and another 47% suffering from other psychiatric disorders.<sup>31</sup> Appreciation of the potential psychiatric sequelae is vital to the approach to many women with FGM/C. However, it is also important for ICS specialists to consider that many women are capable of coping with the impediments and may regard the ritual as “normal” or even enhancing their gender identity or body image rather than a sickness. The experience and memories of FGM/C as well as coping strategies can differ according to the age, conditions, type and consequences of the practice. Diversity in interpreting



**FIGURE 5** Observed clitoral anatomy in the pediatric population. Observed clitoral hood shapes: a) horseshoe; b) trumpet; c) coffee bean; d) tent; and examples of convergence of labia minora under glans and intersection with clitoral hood (e, f, g). Reprinted with permission from Journal of Pediatric Urology, 12/177.e1-177.e6. Brodie KE, Grantham EC, Huguélet PS, Caldwell BT, Westfall NJ, Wilcox DT. Study of the clitoral hood anatomy in the pediatric population. pp e1-e6 (2016), with permission from Elsevier



**FIGURE 6** Percentage distribution of ages at which girls have undergone FGM (as reported by their mothers). United Nations Children's Fund, Female Genital Mutilation/Cutting: A statistical overview and exploration of the dynamics of change, UNICEF, New York, 2013

events and the level of remembrance is crucial for experiencing psychopathology.<sup>32</sup> Migration and a different sociocultural setting can make women more aware of their FGM/C; a woman previously well adapted to her experience may then feel stigmatized, socially excluded or ashamed.<sup>33</sup> To avoid contributing to these feelings, ICS specialists will benefit women with FGM/C by approaching care in a neutral manner. Appropriate therapy interventions should be considered for those who are experiencing symptoms consistent with anxiety disorders, depression or post-traumatic stress disorder (PTSD).

5. Sexual Dysfunction:<sup>34</sup> There are many research gaps regarding sexual function after FGM/C, especially with regards to type of FGM/C and the specific effects of clitoral involvement.<sup>35</sup> A systematic review of sexual consequences of FGM/C representing 12 671 women reported that those with a history of FGM/C were 52% more likely to have dyspareunia and greater than twice as likely to lack desire versus women without a history of FGM/C.<sup>36</sup> Some forms of FGM/C involve excision of the glans or the glans and part of the body of the clitoris. However, the remaining tumescent sexual structures (the body or part of the body; the crura of the clitoris and the vestibular bulbs and the corpus spongiosum of the urethra) are not involved by the cutting. Because of this, women may still

experience sexual pleasure and orgasm, provided other physical or psychological effects do not interfere.<sup>37</sup> The presence and severity of sexual dysfunction can vary greatly and depends on the specific tissues involved, eventual complications, and on biopsychosocial factors that have to be addressed to treat sexual dysfunction after FGM/C. Dyspareunia among women with FGM/C type III can often be treated with defibulation. Clitoral pain and dyspareunia due to post-traumatic neuromas, cysts, adhesions/synechiae or obstetric trauma can be approached surgically. Pelvic floor muscle dysfunction can be treated with pelvic floor physical therapy. Culturally sensitive sexual health counseling (including education on anatomy and the sexual response) is recommended for both those living with FGM/C and their partners.

6. Other Gynecologic Problems: Dysmenorrhea can result from obstructed drainage. Infertility can result from ascending genital infection. Chronic vulvar pain can be a long-term outcome of FGM/C.
7. Effects of FGM/C on Men: FGM/C can also affect men negatively within a marriage, and thereby becomes an issue pertaining to them.<sup>38-40</sup> A Sudanese study of married men ( $n = 59$ ) found that most expressed difficulty with vaginal

penetration, wounds or infections on the penis, and psychosexual problems.<sup>39</sup> The majority perceived their wives' suffering as their own problem, and most stated they would have preferred to be married to "uncut" women. According to UNICEF, 67% of women in 29 countries and 63% of men in 18 countries, all aged 15-49 and who are aware of FGM/C believe it should stop.<sup>41</sup> Wahlberg and Johnsdotter demonstrated that most Somali immigrants, including those newly arrived, opposed all forms of FGM/C with increased opposition over time after migration.<sup>42</sup> O'Neill surveyed immigrants in three European countries and found that most men and women reported that FGM/C affected their sex lives in a negative way.<sup>43</sup>

### 1.3 | Healthcare professionals should not perform FGM/C

The ICS stands firmly against all forms of FGM/C as defined at the outset—those non-consensual procedures mostly performed on minors (and less commonly unconsenting adults). This extends to medicalization<sup>1</sup> of FGM/C where such procedures may be performed by professionals with varying degrees of surgical training, with clean instruments and in safer settings. While it is probable that medicalization can reduce some FGM/C complications such as acute infection, it does not prevent the long-term complications. Most importantly, healthcare professionals should be the trusted promoters of prevention/abandonment of the practice and of sexual and reproductive health literacy as well as the healthcare of women and girls already affected by FGM/C.

The aim of the paper does not extend to address the complex and sometimes controversial issues surrounding adult women who request various forms of genital surgery, including reinfibulation and female genital cosmetic surgery. Several researchers are addressing these topics from a legal, medical, social and ethical perspective. Conflicts between the important principle of autonomy and concerns about coercion or social pressure are not easily resolved. The long-term consequences of such surgery are not easily identified and become more nuanced when taken in a sociocultural context. Male circumcision and the concept of "genital autonomy" in intersex conditions are similarly complex issues—the ICS recognizes these as important discussions but beyond the scope of this work.

### 1.4 | FGM/C complications should be screened and recognized, treated appropriately and ultimately prevented

#### 1.4.1 | Screening for FGM/C

The first step in management is to screen and recognize the FGM/C and its eventual complications. In a study in Eastern

Sudan, only 7% of midwives could identify the four types of FGM/C correctly, whereas 81% had practiced the procedure, and in Alexandria, only 7% of nurses could identify the types; in both studies there was little knowledge among these practitioners regarding the medical consequences of the procedure and the majority planned to continue the practice.<sup>44,45</sup> Similar findings have been reported in diaspora countries; therefore, it behooves ICS members to be aware of the condition and to be prepared to identify and care for these patients.<sup>46</sup> As mentioned above, women who have experienced FGM/C may not know what unaltered anatomy looks like, what type of FGM/C they have personally experienced, and the current symptoms may be so remote from the FGM/C that they do not associate the cause and effect.<sup>47</sup>

#### 1.4.2 | Treatment of FGM/C

The WHO Handbook "Care of Girls and Women Living with Female Genital Mutilation" (<http://www.who.int/reproductivehealth/publications/health-care-girls-women-living-with-FGM/en/>) provides excellent advice to the clinician managing FGM/C patients. However, there is a relative paucity of information in many areas. A primary role for the ICS lies in improving training of its members and in sharing research and expertise, workforce, and resources to improve the care of women with FGM/C. We envision:

- Working with providers in high prevalence areas and diaspora countries to design prospective clinical trials that will inform future care.
- Supporting high quality training for front-line ob-gyn, urologists, pediatricians, general practitioners, infectious disease specialists and surgeons in managing complications of FGM/C, offering defibulation and reconstructive techniques.
- Sharing knowledge through regional meetings and via on-line educational resources.
- For those who wish to submit educational material for ICS online content are invited to submit according to the Standard Operating Procedures for format: <https://www.ics.org/committees/education/icssops>

#### 1.4.3 | Prevention of FGM/C

We need to understand the socio-cultural milieu that supports the practice of FGM/C if we are to prevent it. The most effective and durable change will arise from within the practicing societies rather than being imposed upon them. FGM/C stems from long-standing socio-cultural mores; therefore, efforts toward eradication must align

with cultural factors perpetuating the practice. The updated 2013 UNICEF statistical overview emphasizes the challenging dynamics of cultural change, noting according to social science research it “is difficult for individual families to stop the practice on their own. There is a social obligation to conform to the practice and a widespread belief that if they do not, they are likely to pay a price that could include social exclusion, criticism, ridicule, stigma or the inability to find their daughters suitable marriage partners.”<sup>3</sup> According to Mpfu and colleagues, the practice of FGM/C is deeply embedded in social and cultural traditions dating back generations. Over time, interventions have failed to understand the complexities surrounding the practice.<sup>48</sup> “Most campaigns against FGM/C have come about from a viewpoint of outrage, disgust and condemnation, and therefore are seen as a direct and aggressive attack on a people’s core values, beliefs and traditions which have been a part of their very existence for generations<sup>49–51</sup>” and can lead to further stigmatization of girls and women who have already undergone FGM/C. “FGM/C is said to enhance marriageability, fertility, and to promote purity or virginity of a woman,<sup>52–54</sup> and is also said to “. . .temper female sexual urges thereby preserving a girl’s virginity for marriage.”<sup>50,55</sup>...The belief in the protection of female virtue goes hand in hand with upholding family status and dignity! When one is [circumcised], it is a symbol of entry into womanhood and marks that one fully belongs to a community.” Marriage and reproduction are essential to the long term economic and social security of most women, and FGM/C is regarded in many communities as a normal and acceptable part of raising the girl child.

Programs aimed at preventing FGM/C and its consequences must therefore:

- Be strongly based on facts and evidence as opposed to aversion and disgust
- Evolve from cultural understanding within the society rather than being imposed from outside.
- Avoid stigmatizing the girls and women who have already undergone FGM/C.

The evidence discussed above regarding the effects of FGM/C on men and the changing attitudes of many immigrants are promising, as they may allow strategies to lift the social obligation of FGM/C, once proper dialogue between genders and within community hierarchies can occur. UNICEF<sup>3</sup> has been developing programs in consultation with communities. These participatory programs have a greater impact as individuals within the community state publicly they will not practice FGM/C, and they then educate others. According to WHO, however, programs that educate women and girls about

their bodies and their rights are very rare.<sup>56</sup> According to UN estimates, most young people lack access to education about their bodies and the impact of FGM/C.<sup>57</sup> WHO recommends that to have the most responsible impact, preventing unintended alienation and retraumatization, educational interventions should be evidence-informed and scientifically accurate, non-prejudicial, non-judgmental, sensitive and respectful, non-stereotypical, and when involving adolescents, geared toward their evolving capacities. A culturally integrated educational approach will favor these goals. Mpfu highlights select programs that emphasize the healthy portions of the coming-of-age rituals associated with FGM/C, teaching girls about the responsibilities associated with adult and married life, while omitting the FGM/C itself.

The fundamental question at hand remains: how can FGM/C be most effectively prevented? Although in decline, it remains distressingly prevalent. The Pan African Parliament (PAP) has recently joined the U.N. Population Fund (UNFPA) in an action plan to ban FGM/C for the whole continent. This is a promising legal and cultural statement on the part of the Parliament. The initiative includes legislation, community mobilization, advocacy, and recruitment of men to speak out against FGM/C.<sup>9</sup> There is some evidence that changing hearts and minds at the community level will ultimately be the most effective strategy.<sup>58</sup>

Looking more closely at specific countries country will highlight the complexity of changing the practice of FGM/C. The prevalence in Kenya decreased from 41% in 1984 to 11% in 2014 (however, these numbers differ from those in Mpfu’s study). In 2001, the Kenyan government outlawed the practice, passing the Children’s Act.<sup>59</sup> Further, in 2011 it passed the Prohibition of Female Genital Mutilation Act. Lastly, successful public education campaigns have led to relief of social pressures—for example, young men have had an impact by publicly declaring their preference to marry a woman who has not undergone FGM/C.<sup>60</sup> In 1990 Burkina Faso formed the Committee to Fight the Practice of Excision (Comité National de lutte contre la Pratique De l’excision, CNLPE). In November 1996 a penal code was adopted forbidding female genital mutilation, threatening imprisonment of 6 months to 3 years and large fine for all forms of FGM/C. In addition, special emphasis is placed on education of the girl so that in adulthood, she does not seek FGM/C for her daughters. The CNLPE instituted campaigns of sensitization regarding FGM/C; policemen were trained to intervene in keeping with the law; the subject of FGM/C became part of scholastic programs; and women who had endured complications linked to FGM/C were treated free of charge in certain health initiatives identified by CNLPE, in line with WHO Guidelines. A free telephone line called “SOS Excision” (SOS Female genital cutting), was set up to



gather real-time information on the acts of mutilation. According to UNICEFxi, the prevalence of FGM/C in Burkina Faso declined from 89% in 1980 to 58% in 2010 (however, not unlike Kenya, according to internal statistics, the prevalence of FGM/C may remain significant: 76 % [EDSBF-MICS IV 2010]).<sup>61</sup> The persistent high prevalence, although decreasing and lower than some surrounding countries, is likely multifactorial—including the low level of population education (30% literacy), the persistence of traditional practices impacting the health of women overall (eg, beliefs impacting nutrition during pregnancy), and inadequate funding for the permanent implementation of the national strategy against FGM/C. The continued high incidence of FGM/C in Burkina Faso, Kenya, and other countries also calls into view the complexity of criminalization. It is possible that this strategy may have a diminished effect by driving the practice underground instead of into the light. It is certain that work across health care disciplines in cooperation with government and non-government organizations engaging community leadership will be required for optimal results.

Medical professionals can help prevent FGM/C by providing healthy, non-judgmental messages in every interaction. For example:

- offer health education on FGM/C during pregnancy (preparing for the issue to arise if the future child is a girl),
- primary doctors must build trusting relationships, including the father or other important family elders and exploring the beliefs of the family,
- pediatricians must discuss this issue with parents over time,
- doctors can provide safeguarding/protection measures according to the local laws in case of real and immediate risks.

## 2 | CONCLUSION

FGM/C is relevant to all who practice pelvic medicine, as understanding the unique health issues significantly impacts care for this population. The ICS position on FGM/C is that it should never be performed in any form on a girl or non-consenting woman. ICS members can educate themselves and others on the practice. Those with significant experience in caring for women with FGM/C can offer information, health education, reconstructive and rehabilitative services to women and girls with a history of FGM/C experiencing urogynecological, infectious, obstetric, sexual and functional pelvic floor consequences. A respectful, neutral, non-judgmental, non-stigmatizing and trained approach should be the tone of the individual patient interaction.

The International Continence Society is uniquely positioned to promote the care for women and girls living with FGM/C. Although a smaller percentage of our members have significant experience in managing patients with FGM/C, as a multidisciplinary, international society, we have significant reach with educational needs around the world. We can lend our expertise to many of the preventative and cure needs such as obstetric trauma, urogynecological and psychosexual consequences. Our expertise in education, research methodology, complex reconstructive surgery, nursing, physiotherapy, psychosexual issues can be of great value. We will start by providing educational opportunities to our members so that they can develop appropriate sociocultural, rehabilitative (including physiotherapy), medical and surgical knowledge of the topic.

ICS and its Members will lend support and act to:

### 1) Educate:

- Support the work of practitioners treating high volumes of patients with FGM/C throughout the world through assistance in creating, presenting, filming and distributing educational material (See [www.ics.org/tv](http://www.ics.org/tv), <https://www.ics.org/committees/education/icssops>).
- Educate health care workers, patients, and communities regarding FGM/C—raising awareness, exploring medical, ethical and cultural issues, consequences of FGM/C, and management.
- Work within communities to engage women and men regarding the medical risks of FGM/C and to lift the myths perpetuating this practice.

### 2) Research:

- Lend our expertise to define the benefits and risks of post-FGM/C intervention, and to further characterize the health consequences.
- Support and/or conduct studies to define optimal care of those with FGM/C.

### 3) Provide Care:

- Provide neutral, clear, non-alienating information to women and girls who have experienced FGM/C regarding its meaning to her individual situation, and options for care.
- To provide holistic care always, high quality reconstructive surgery where appropriate, and to support colleagues in high prevalence areas of the world when opportunities arise.

### 4) Advocate:

- Partner with affected women and girls and other associations regarding FGM/C.
- Promote government support for medical care of women who have had FGM/C, including culturally fluent psychological care.
- Work within communities to promote the healthy coming-of-age rituals associated with FGM/C while removing the permanently damaging risks associated with FGM/C.

## CONFLICTS OF INTEREST

No conflicts of interest.

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## REFERENCES

1. WHO guidelines on the management of health complications from female genital mutilation. Geneva: World Health Organization; 2016. Available from: <http://www.ncbi.nlm.nih.gov/books/NBK368483/>
2. Female genital mutilation/cutting: a global concern. Geneva: UNICEF; 2016 (<http://data.unicef.org/resources/female-genitalmutilation-cutting-a-global-concern.html>, accessed 26 April 2016).
3. Female genital mutilation/cutting: a statistical overview and exploration of the dynamics of change. New York: United Nations Children's Fund; 2013 (<https://data.unicef.org/resources/female-genital-mutilation-cutting-a-statistical-overview-and-exploration-of-the-dynamics-of-change-executive-summary/>, accessed 22 September 2018).
4. Elmusharaf F, Elhadi N, Almroth L. Reliability of self-reported form of female genital mutilation and WHO classification: cross sectional study. *BMJ Online First*. 2006;333:124.
5. Bjalkander O, Grant DS, Berggren V, Bathija H, Almroth L. Female genital mutilation in Sierra Leone: forms, reliability of reported status, and accuracy of related demographic and health survey questions. *Ob Gyn Int*. 2013;2013:680926.
6. Abdulcadir J, Catania L, Hindin MJ, Say L, Petignat P, Abdulcadir J. Female Genital Mutilation: a visual reference and learning tool for health care professionals. *Obstet Gynecol*. 2016;128:958–963.
7. Bettina Shell-Duncan, Carolyne Njue, and Zhuzhi Moore “The Medicalization of Female Genital Mutilation /Cutting: What do the Data Reveal?” February 2017,” Evidence to End FGM/C: Research to Help Women Thrive. New York: Population Council.
8. 2014 Annual Report of the UNFPA-UNICEF Joint programme on female genital mutilation/cutting <http://www.unfpa.org/publications/2014-annual-report-unfpa-unicef-joint-programme-female-genital-mutilationcutting>
9. <http://www.ipsnews.net/2016/08/pan-african-parliament-endorses-ban-on-fgm/>
10. Article 5: Elimination of harmful practices. In: Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa. Maputo; African Commission on Human and Peoples' Rights; 2003 ([http://www.achpr.org/files/instruments/women-protocol/achpr\\_instr\\_proto\\_women\\_eng.pdf](http://www.achpr.org/files/instruments/women-protocol/achpr_instr_proto_women_eng.pdf), accessed 4 April 2016).
11. <https://www.irishtimes.com/news/world/africa/we-ve-seen-too-many-girls-bleed-to-death-eradicating-fgm-in-uganda-1.3382765>
12. Obermeyer CM. The consequences of female circumcision for health and sexuality: an update on the evidence. *Cult Health Sex*. 2005;7:443–461.
13. WHO study group on female genital mutilation and obstetric outcome, Banks E, Meirik O, et al. Female genital mutilation and obstetric outcome: WHO collaborative prospective study in six African countries. *Lancet*. 2006;367:1835–1841.
14. Berg RC, Odgaard-Jensen J, Fretheim A, Underland V, Vist G. An updated systematic review and meta-analysis of the obstetric consequences of female genital mutilation/cutting. *Obstet Gynecol Int*. 2014;542859.
15. <http://www.who.int/mediacentre/factsheets/fs241/en/>
16. Banks E, Meirik O, Farley T, Akande O, Bathija H, Ali M. WHO studygroup on female genital mutilation and obstetric outcome Female genital mutilation and obstetric outcome; WHO collaborative prospective study in six African countries. *Lancet*. 2006;367:1835–1841.
17. Rodriguez MI, Say L, Abdulcadir J, Hindin MJ. Clinical indications for cesarean delivery among women living with female genital mutilation. *Int J Gynaecol Obstet*. 2017;139:21–27.
18. Varol N, Dawson A, Turkmani S, et al. Obstetric outcomes for women with female genital mutilation at an Australian hospital, 2006–2012: a descriptive study. *BMC Pregnancy Childbirth*. 2016;16:328.
19. Abdulcadir J, Dugerdil A, Yaron M, Irion O, Boulvain M. Obstetric care of women with female genital mutilation attending a specialized clinic in a tertiary center. *Int J Gynaecol Obstet*. 2016;132:174–178.
20. Wuest S, Raio L, Wyssmueller D, et al. Effects of female genital mutilation on birth outcomes in Switzerland. *BJOG*. 2009;116:1204–1209.
21. Abdulcadir J, Marras S, Catania L, Abdulcadir O, Petignat P. Defibulation: a visual reference and learning tool. *J Sex Med*. 2018;15:601–611.
22. Rodriguez MI, Seuc A, Say L, Hindin MJ. Episiotomy and obstetric outcomes among women living with type 3 female genital mutilation: a secondary analysis. *Reprod Health*. 2016;13:131.
23. Royal College of Obstetricians and Gynecologists, Green-top Guideline No. 53: Female Genital Mutilation and its Management. July 2015 p 17 <https://www.rcog.org.uk/globalassets/documents/guidelines/gtg-53-fgm.pdf>
24. Sharfi AR, Elmegeboul MA, Abdella AA. The continuing challenge of female genital mutilation in Sudan. *Afr J Urol*. 2013;19:136–140.
25. Okwudili OA, Chukwudi OR. Urinary and genital tract obstruction as a complication of female genital mutilation: case report and literature review. *J Surg Tech Case Rep*. 2012;4:64–66.
26. Brodie KE, Grantham EC, Huguette PS, Caldwell BT, Westfall NJ, Wilcox DT. Study of the clitoral hood anatomy in the pediatric population. *J Pediatr Urol*. 2016;12:177 e1–5.
27. Amin MM, Rasheed S, Salem E. Lower urinary tract symptoms following female genital mutilation. *Int J Gynaecol Obstet*. 2013;123:21–23.
28. Bjalkander O, Bangura L, Leigh B, Berggren V, Bergström S, Almroth L. Health complications of female genital mutilation in Sierra Leone. *Int J Womens Health*. 2012;4:321–331.
29. Iavazzo C, Sardi TA, Gkegkes ID. Female genital mutilation and infections: a systematic review of the clinical evidence. *Arch Gynecol Obstet*. 2013;287:1137–1149.
30. Ahmed MR, Shaaban MM, Meky HK, et al. Psychological impact of female genital mutilation among adolescent Egyptian girls: a cross-sectional study. *Eur J Contracept Reprod Health Care*. 2017;22:280–285.
31. Behrendt A, Moritz S. Posttraumatic stress disorder and memory problems after female genital mutilation. *Am J Psychiatry*. 2005;162:1000–1002.
32. Knipscheer J, Vloeberghs E, van der Kwaak A, van den Muijsenbergh M. Mental health problems associated with female genital mutilation. *BJPsych Bull*. 2015;39:273–277.
33. Vloeberghs E, van der Kwaak A, Knipscheer J, van den Muijsenbergh M. Coping and chronic psychosocial consequences

- of female genital mutilation in The Netherlands. *Ethn Health*. 2012;17:677–695.
34. Berg RC, Denison E, Fretheim A. Psychological, social and sexual consequences of female genital mutilation/cutting (FGM/C): a systematic review on quantitative studies. Report from Kunnskaps-senteret nr 13-2010. Oslo: Nasjonalt kunnskaps-senter for helsetje- nesten; 2010.
  35. Abdulcadir J, Rodriguez MI, Say L. Research gaps in the care of women with female genital mutilation: an analysis. *BJOG*. 2015;122:294–303.
  36. Berg RC, Denison E. Does female genital mutilation/cutting (FGM/C) affect women's sexual functioning? A systematic review of the sexual consequences of FGM/C. *Sex Res Social Policy*. 2012;9:41–56.
  37. Abdulcadir J, Botsikas D, Bolmont M, et al. Sexual anatomy and function in women with and without genital mutilation: a cross-Sectional study. *J Sex Med*. 2016;13:226–237.
  38. Varol N, Turkmani S, Black K, Hall J, Dawson A. The role of men in abandonment of female genital mutilation: a systematic review. *BMC Public Health* 2015;15:1034.
  39. Almroth L, Almroth-Berggren V, Hassanein OM, et al. Male complications of female genital mutilation. *Soc Sci Med*. 2001;53:1455–1460.
  40. Berggren V, Ahmed SM, Hernlund Y, Johansson E, Habbani B, Edberg A-K. Being victims or beneficiaries? Perspectives on female genital cutting and reinfibulation in Sudan. *Afr J Reprod Health*. 2006;10:24–36.
  41. United Nations Children's Fund, Female Genital Mutilation/ Cutting: A global concern, UNICEF, New York, 2016. [https://www.unicef.org/media/files/FGMC\\_2016\\_brochure\\_final\\_UNICEF\\_SPREAD.pdf](https://www.unicef.org/media/files/FGMC_2016_brochure_final_UNICEF_SPREAD.pdf)
  42. Wahlberg A, Johndotter S, Selling KE, Källestål C, Essén B. Baseline data from a planned RCT on attitudes to female genital cutting after migration: when are interventions justified? *BMJ Open*. 2017;7:e017506.
  43. O'Neill S, Dubourg D, Florquin S, Bos M, Zewelde S, Richard F. A mixed methods study exploring men's involvement in Female Genital Mutilation in Belgium, the Netherlands and the United Kingdom: Preliminary results. Men Speak Out Project, Brussels, 2016.
  44. Ali AA. Knowledge and attitudes of female genital mutilation among midwives in Eastern Sudan. *Reprod Health*. 2012;9:23.
  45. Ragheb SS, Smith E, Mekhemer SA. Study of knowledge and attitudes of nurses in Alexandria towards female genital circumci- sion. *Bull High Inst Public Health*. 1979;8:293–306.
  46. Abdulcadir J, Dugerdil A, Boulvain M, et al. Missed opportunities for diagnosis of female genital mutilation. *Int J Gyn Obstet*. 2014;125:256–260.
  47. Clarke E. Female genital mutilation: a urology focus. *Br J Nurs*. 2016;25:1022–1028.
  48. Mpofu S. Female genital cutting and sexual behavior in Kenya and Nigeria. Research Report Submitted to the School of Social Science, University of the Witwatersrand, Student Number 0610960A Department of Demography and Population Studies. 2014 [https://genderlinks.org.za/wp-content/uploads/imported/articles/attachments/19539\\_female\\_genital\\_cutting\\_and\\_sexual\\_behaviour\\_in\\_kenya\\_and\\_nig.pdf](https://genderlinks.org.za/wp-content/uploads/imported/articles/attachments/19539_female_genital_cutting_and_sexual_behaviour_in_kenya_and_nig.pdf)
  49. Nnaemeka, O. African women, colonial discourses, and imperialist interventions: female circumcision as impetus. pp 27–46. In: Female Circumcision and the Politics of Knowledge: African Women in Imperialist Discourses, ed. Obioma Nnaemeka. West- port, Connecticut: Praeger 2005. 288 pages.
  50. Van Rossem R, Gage AJ. The effects of female genital mutilation on the onset of sexual activity and marriage in Guinea. *Arch Sex Behav*. 2009;38:178–185.
  51. Gruenbaum E. Sociocultural dynamics of female genital cutting: research findings, gaps and directions. *Cult Health Sex*. 2005;7:429–441.
  52. Sipsma HL, Chen PG, Ofori-Atta A, Ilozumba UO, Karfo K, Bradley EH. Female genital cutting: current practices and beliefs in Western Africa. *Bull World Health Organ*. 2012;90:120–127.
  53. Ondiek CA. The persistence of female genital mutilation (FGM) and its impact on women's access to education and empowerment: A Study of Kuria District, Nyanza Province, Kenya. Thesis, 2010. Institutional Repository. University of South Africa <http://uir.unisa.ac.za/handle/10500/4121>
  54. Odimegwu C, Okemgbo CN. Female circumcision and sexual activity: Any Relationship. *Unilag Sociological Review*, 2000 (1), pp 159–176.
  55. Afifi M. Egyptian ever-married women's attitude towards female genital cutting. *Singapore Med J*. 2010;51:15–20.
  56. Realizing sexual and reproductive rights: a human rights framework. London: Amnesty International; 2012 ([http://www.amnesty.ca/sites/amnesty/files/act\\_350062012\\_english.pdf](http://www.amnesty.ca/sites/amnesty/files/act_350062012_english.pdf), accessed 27 April 2016).
  57. Monitoring of population programmes, focusing on adolescents and youth. Report of the Secretary-General. Commission on Population and Development, Forty-fifth session, 23–27 April 2012. New York (NY): United Nations Economic and Social Council; 2012 (E/ CN.9/2012/5; [http://www.un.org/esa/population/cpd/cpd2012/E.CN.9.2012-5\\_UNFPAPopulation-programmes-report\\_Advance%20Unedited%20Copy.pdf](http://www.un.org/esa/population/cpd/cpd2012/E.CN.9.2012-5_UNFPAPopulation-programmes-report_Advance%20Unedited%20Copy.pdf), accessed 4 April 2016).
  58. Diop NJ, Askew I. The effectiveness of a community-based education program on abandoning female genital mutilation/cutting in Senegal. *Stud Fam Plann*. 2009;40:307–318.
  59. Livermore L, Monteiro R, Rymer J. Attitudes and awareness of female genital mutilation: a questionnaire-based study in a Kenyan hospital. *J Obstet Gynaecol*. 2007;27:816–818.
  60. UNIFPA-UNICEF Annual Report 2011: Joint Programme on Female Genital Mutilation/Cutting: Accelerating Change. <http://www.unfpa.org/publications/accelerating-change-2011-annual-report>
  61. Enquête Démographique et de Santé et à Indicateurs Multiples (EDSBF-MICS IV). Institut National de la Statistique et de la Démographie (INSD). Ministère de l'Économie et des Finances. Ouagadougou, Burkina Faso. ICF International. Calverton, Maryland, USA Avril 2012. [https://www.unicef.org/bfa/french/bf\\_eds\\_2010.pdf](https://www.unicef.org/bfa/french/bf_eds_2010.pdf)

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