European Journal of Obstetrics & Gynecology and Reproductive Biology 214 (2017) 192–193

Contents lists available at ScienceDirect

European Journal of Obstetrics & Gynecology and Reproductive Biology

journal homepage: www.elsevier.com/locate/ejogrb

Review article

# EBCOG position statement on female genital mutilation

European Board and College of Obstetrics and Gynaecology (EBCOG)

ARTICLE INFO

*Article history:*
Received 7 April 2017
Accepted 7 April 2017

**Contents**



Female Genital Mutilation (FGM) affects more than 200 million girls and women in at least 30 countries, mostly in Africa, but also in the Middle East and Asia [1]. WHO defines FGM as "all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons" [2]. Although FGM is traditional in many cultures, it is harmful to women's health and wellbeing. The development of effective strategies to diminish and prevent detrimental procedures is now a public health priority. At the same time the delivery of appropriate medical care and supportive help for affected women is crucial and relevant to doctors throughout Europe.

According to WHO, FGM can be classified into four types. Type I is the partial or total removal of the clitoris and/or prepuce, often referred to as *clitoridectomy*. Type II means the removal of parts or all of the clitoris and the inner labia (sometimes with parts of the external labia), often referred to as *excision*. Type III means the narrowing of the vulva by cutting the inner and external labia and sewing them together (the clitoris may also be removed), and is referred to as *infibulation*. Type IV includes all other harmful interventions done to the vulva [2,3]. The medical problems that arise from FGM include heavy bleeding, severe pain, infection, and in a few cases death. Procedures are commonly done without anaesthesia and in unhygienic circumstances. Chronic pain is a long- term problem and dyspareunia as well as lack of libido is seen after all types of FGM [2]. Women are frequently traumatised by the procedure, and post traumatic stress disorder and other psychological problems can result [4]. When the vulva is sealed, menstrual blood may not drain properly causing dysmenorrhea and prolonged menstruation. Urinary retention and infection of both the urinary and genital tracts also occur [2].

For women who do encounter complications after FGM type III, surgical reopening of the vulva or *defibulation* will be necessary [5]. However even necessary intervention has to be approached sensitively as cultural influences are strong and FGM may be a taboo issue. In pregnant women *defibulation* may be necessary before (or even during) vaginal birth, if not already done to allow intercourse [5]. Regardless of which type of FGM a woman has experienced, it is important that a relationship is established so that counselling and advice are effective. If the newborn is a girl, there is also the risk that she in turn may undergo a similar procedure. Speaking to both mother and father about the risks of FGM, as well as the legal framework, is crucial as FGM is illegal in most European countries.

Prevention is the major public health issue, however it is important to appreciate the strong cultural and social influences. Many women believe FGM is required by Islam or Christianity, although neither the Koran nor the Bible mention FGM and no religious scripts prescribe the practice [4]. Often FGM is mistakenly believed to have a role in woman's health and sexuality and these beliefs need to be explored and the health risks of FGM explained to women and their partners. The importance of establishing a dialogue in which difficult issues can be discussed meaningfully is central to clinical care.

EBCOG recommends that all clinicians are fully aware of the negative effects of FGM and are able to inform women about the likely medical problems. It is essential to establish a trusting relationship with those who are already circumcised. Treatment should be offered in accordance with the health needs of the individual woman.

## Consent

The first draft was written by Dr Katharina Teufel and Dr Daniela Dörfler, University of Vienna, and peer reviewed by the following:

http://dx.doi.org/10.1016/j.ejogrb.2017.04.019

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## Approval

The final draft was approved by the President, Executive and Council of EBCOG.

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