Medically Unnecessary Female Genital Alteration

Implications for Health Care Workers

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Abstract: Medically unnecessary female genital alteration (MUFGA) aka female genital mutilation or female circumcision is a cultural practice in several countries in the Middle East and Africa. There are four major types of MUFGA where parts of external genitalia of a girl are removed to varying levels leading to several complications such as infection, hemorrhage, obstetric complications, and even death. The United Nations has condemned this practice and called for abolition of MUFGA. However, this practice is continued in these countries, and when people migrate, they continue the practice. It is considered abuse or violation of human rights. Knowledge about MUFGA is scanty among health care providers in the West. This brief article attempts to raise awareness among health care providers, particularly nurses, so that they will provide the right care, both physical and emotional, to the girls and women who have experienced having MUFGA.

KEY WORDS: female circumcision, female genital mutilation, FGM, genital alteration, human rights, medically unnecessary female genital alteration

In January 2020, Nada Hassan Abdel-Maqsoud, 12 years old, was taken by her parents and aunt to a retired physician's private clinic in Southern Egypt to have a scheduled female genital alteration (Provincial News, 2020). The 30-minute procedure left the young girl unconscious because of massive hemorrhaging. Despite multiple attempts to stop the hemorrhage, all resuscitation efforts failed and Nada died at the clinic. Nada is not alone. Many events associated with this procedure have led to the deaths and complications of other young girls (female children), yet these stories do not make it into the mainstream media. Their stories die with them. This article attempts to explore the world health issues, cultural aspects, and the role of health care workers (HCWs) when caring for females affected by medically unnecessary female genital alterations (MUFGAs). Although the common terms found in the literature include "female genital mutilation" (FGM) or "female circumcision" (FC), for the purposes of this article, the term "medically unnecessary female genital alteration" or MUFGA will be used.

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BACKGROUND

Prevalence

According to the World Health Organization (WHO), approximately 200 million females worldwide (Dixon et al., 2018; WHO, 2019) have been affected by MUFGA. Because of both psychological and physiological complications, it costs global health care systems an estimated 1.4 billion USD annually (WHO, 2019). Furthermore, 3 million females between the ages of infancy and 15 years old are at risk for MUFGA each year (WHO, 2019). This is commonly practiced mostly in rural communities within 28 countries across Africa, the Middle East, and Asia (Dixon et al., 2018; Sirazhudinova, 2019). In Gambia, 75% of the female population have undergone a MUFGA procedure (Shell-Duncan, Moreau, Wander, & Smith, 2018). In Egypt, about 87% of female adolescents and adults, between the ages of 15 and 49 years old, have undergone MUFGA (Ministry of Health and Population, 2015). In Somalia, on the Horn of Africa, MUFGA procedures are even more prevalent, with 98% of females within this demographic having undergone a procedure and 77% experiencing the most invasive form of genital alteration, Type 3, or infibulation (Yussuf, Matanda, & Powell, 2020).

The MUFGA procedures are not limited to lower- and lower-middle-income, growing countries; they are

also practiced in many immigrant communities across North America, Australia, and Europe (Basher, 2016). According to a 2016 report published by the Centers for Disease Control and Prevention, as many as 513,000 residents of the United States are affected by MUFGA (Centers for Disease Control and Prevention, 2020). Approximately 137,000 people living in the United Kingdom are MUFGA survivors (Evans et al., 2017).

Definition

MUFGA is known by many names; most common are "female circumcision" or FC, "female cutting," or "female genital mutilation" or FGM. Whatever the chosen terminology, the concept is the same: surgical removal of female genitalia for nonmedical reasons (Dixon et al., 2018; WHO, 2019). The WHO refers to this type of alteration as FGM and has identified four major types, based on the increasing degree of invasiveness and danger to the client (Arora & Jacobs, 2016). Type 1 is the partial or total removal of the prepuce, or clitoral hood, with or without a clitorectomy (Arora & Jacobs, 2016; WHO, 2019). Type 2 includes the partial or total removal of the clitoris and labia minora and possibly partial removal of the labia majora (Coreas & Delis, 2018; Sirazhudinova, 2019; WHO, 2019). Type 3, known as infibulation or pharaonic type, is the progressive destruction of the external genitalia that includes Type 1 and Type 2, as well as suturing the edges of the vulva. As a result, the vaginal opening is narrowed and tissue covers the urethra (Arora & Jacobs, 2016; Coreas & Delis, 2018; Sirazhudinova, 2019). Finally, Type 4 involves any harmful procedure to the female genitalia, such as pricking, piercing, incision and cauterization, or pulling and stretching of the labia or clitoris (Coreas & Delis, 2018; Siddig, 2016; WHO, 2019). In addition, the International Federation of Gynecology and Obstetrics agrees with this classification system of MUFGA based on the alteration of genital anatomy and genital disfigurement (Wittich, 2017).

Although the WHO has blanketed any alteration in the female genitalia as mutilation, Type 1 and Type 2 are commonly offered as elective female genital cosmetic surgery in Western medicine (Wilkie & Bartz, 2018). For example, a clitoral hood reduction, or hoodectomy, is considered a Type 1 MUFGA (Arora & Jacobs, 2016). This elective surgical procedure is offered by plastic surgeons to improve the appearance of the woman's external genitalia and enhance sexual arousal (Magon & Alinsod, 2017; Wilkie & Bartz, 2018). In addition, the most common surgical female reconstructive surgery performed is a reduction of the length of the labia minora or labia majora (Magon & Alinsod, 2017). Labiaplasty, according to the WHO's list of definitions, would be classified as a Type 2 MUFGA.

It is apparent the definitions of FGM offered by the WHO are, at best, oversimplified and inconsistent. The emotionally charged verbiage "female mutilation" used by the WHO is accepted internationally when referring to MUFGAs. Nevertheless, the imagery and negative connotation associated with "mutilation" can provoke an unwarranted cultural bias against the person who underwent the MUFGA procedure.

CULTURAL AWARENESS

Cultural History of MUFGA

A MUFGA procedure often contributes to an established, cultural obligation that spans many generations. Many times, the traditional aspects are justified by cultural practices, fear of being ostracized, hygienic reasons, religion, and sexual control (Shell-Duncan et al., 2018). Depending on the cultural and traditional norms of the population, FC usually occurs from infancy to adolescence (WHO, 2019). Jungari reports the procedure is performed on an adolescent before he or she reaches the age of 15 years (Jungari, 2016); however, most of the time, it is performed on children under 3 years old who are not yet intellectually developed (Sirazhudinova, 2019). Indeed, these traditional rituals are performed to uphold the values of the culture, satisfy religious obligations, control female sexuality (Mpofu, Odimegwu, De Wet, Adedini, & Akinyemi, 2017), reduce libido, and ensure premarital virginity (Wittich, 2017).

Different cultures view this differently. FC, when practiced as a sacred, spiritual ritual, marks the transition from adolescence to adulthood (Shell-Duncan et al., 2018). The ceremonious occasion is frequently characterized by a communal, sacred song and dance and the female's anointment with a buttery liniment (Simuli, 2017). On the day of celebration, the "candidates" are dressed in beautiful headgear and jewelry, while others sing songs of bravery and joy (Simuli, 2017). After the ceremonious cut, the "initiates" are secluded to learn "women's secrets" and "teachings" associated with womanhood (Shell-Duncan et al., 2018; Simuli, 2017; Tarr-Attia, Boiwu, & Martínez-Pérez, 2019). The seclusion period varies, depending on each community's sacred traditions. For the secret society of women in Liberia, the Sande initiation involves a seclusion period, referred to as "bush," of approximately 6 weeks (Tarr-Attia et al., 2019). After the training in the "bush" and circumcision are complete, the girls are expected to be faithful to their husband, because their sexual desire has been removed (Tarr-Attia et al., 2019).

Not only is the procedure thought to eliminate promiscuity, but the young women are also considered "clean" and honorable (Shell-Duncan et al., 2018). The circumcised females are now worthy of respect within the community and stand as examples who exemplify the traditions of the culture. Conversely, those who are not cut or circumcised are ostracized from the community, not allowed to marry, and considered sexually promiscuous. Frequently, they are victims of ruthless bullying and verbal abuse (Shell-Duncan et al., 2018; Tarr-Attia et al., 2019). Contributing to the verbal abuse is the traditional misconception, prominent in some cultures, that the clitoris will grow into a penis and provoke masculine aggression (Sakeah et al., 2019; Tarr-Attia et al., 2019). This burden continues into adult life: The uncircumcised woman will not be able to participate in her daughter's circumcision ceremony, as well as the decision-making process, or visit during her daughter's seclusion and healing process (Shell-Duncan et al., 2018). In addition, the uncircumcised woman is also excluded from family events, such as weddings (Shell-Duncan et al., 2018).

Not all cultures practice a single circumcision; some require multiple circumcisions. For example, in the large Muslim community of Maranao, near Lake Lanao in the Philippines, tradition dictates three FCs, which are spread throughout a female's life (Basher, 2016). To encourage menses and attract male suitors, the first occurrence is near the age of 10 years (Basher, 2016), whereas the second occurrence happens soon after marriage, because it is thought to strengthen the bonds of marriage and faithfulness (Basher, 2016). The final circumcision occurs when the woman reaches middle adulthood and serves to symbolize washing away a lifetime of sins (Basher, 2016).

Religious teachings are also cited for the practice of MUFGA. In 2017, an emergency room doctor in Detroit was arrested for performing MUFGA on seven minors ranging in age from 6 to 8 years (*United States v. Nagarwala*, 2018). The three families charged are members of the Dawoodi Bohra, a small, Shiite Muslim community near Detroit. This wealthy and educated Muslim population is guided by strong religious beliefs taught by Muhammad (Taher, 2017; Zakir, 2016). Following the teachings of the Prophet Muhammad, the members of Dawoodi Bohra believe the human body is the perfect gift from God and should not be harmed in any way. They also believe a small incision, to shorten the prepuce, improves the sexual satisfaction of both the woman and the husband as described in the "sunnah" (Zakir, 2016). The sunnah refers to the living habits and practices of the Prophet Muhammad (Arora & Jacobs, 2016; Taher, 2017). As a result, the members fiercely reject the global assertion that FC is genital mutilation (Zakir, 2016). Whereas Zakir equates FC with male circumcision, the Quran does not address the topic of FC. It is worth noting that some Islamic scholars conclude these teachings are not supported by the Qur'an, and as such, Islam does not require this procedure (Arora & Jacobs, 2016; Sirazhudinova, 2019; Taher, 2017).

Experience of MUFGA Women

The responses from women who experience a MUFGA procedure are varied. Most prefer the practice to be continued, not because of their preference to have it done or a lack of appreciation for the pain and trauma they endure, but to have a good standing in the community and a "desire" to have a good future for their daughters (Siddig, 2016). In Somalia, however, approximately 85.7% of affected women want the practice discontinued (Mbanya, Gele, Diaz, & Kumar, 2018). Type 3, characterized by a surgical narrowing of the vaginal opening, is more commonly performed in Somalia (Johnsdotter & Essén, 2016; Shell-Duncan et al., 2018; Villani & Bodenmann, 2016).

It is interesting to note that 56% of women in Nigeria who had a MUFGA procedure also circumcised their daughters (Gbadebo et al., 2015); the practice is more common among Muslims than Christians. Mothers become facilitators of MUFGA, sometimes silently, even after they migrate, as occurred in the Detroit case. Children born in Australia to immigrant parents were also found to have undergone the procedure, which poses a challenge for pediatricians who are unfamiliar with the process (Zurynski et al., 2017).

Attitude of Men and Religious Leaders

With the predominant focus on women when referring to MUFGA, it is also important to explore the role and attitudes of men in these patriarchal social structures. Globally, men usually remain silent on this matter (Sirazhudinova, 2019), and when surveyed, many of the men did not have an accurate understanding of MUFGA and were unaware of the complications (Varol, Turkmani, Black, Hall, & Dawson, 2015). However, the men were aware of the traditional justifications, such as decreased promiscuity and infidelity, as well as improved marriage and pressure to conform. In addition, just like an uncircumcised woman is treated as an outsider, a man who does not marry a circumcised woman is treated in a similar fashion by the community (Brown, Mwangi-Powell, Jerotich, & le May, 2016). This trepidation of not belonging overrides one's personal views against the continuation of the procedure

(Varol et al., 2015). Personal preference also dominates as a reason for MUFGA. Among Somali men, 96% were found to prefer marriage to a circumcised woman (Varol et al., 2015).

Muslim religious leaders also remain silent. Sirazhudinova (2019) examined the attitude of Muslim religious leaders, known as Imams. Most Imams will not speak against the practice, although they do not consider it mandatory. Some of these leaders believe this will suppress sexuality, to differentiate oneself from those who do not follow the Muslim faith (Sirazhudinova, 2019). Involving men and religious leaders may help eliminate myths that MUFGA is a religious "requirement."

RISKS/COMPLICATIONS OF MUFGA

There are both physiological and psychological short- and long-term consequences that can arise from a MUFGA procedure. The most common short-term complications are hemorrhage, infection, and extreme pain (Coreas & Delis, 2018; Jungari, 2016; Little, 2015). Aware of these risks, traditional circumcizers incorporate local herbs to control bleeding and act as a local anesthesia (Tarr-Attia et al., 2019; Simuli, 2017). As in the case of 12-year-old Nada, hemorrhage can be life-threatening (Biglu, Farnam, Abotalebi, Biglu, & Ghavami, 2016; Buggio et al., 2019). While working in Oman, located on the southeast coast of the Asian peninsula, the first author has personally encountered newborns who underwent a MUFGA procedure and died from hemorrhagic shock. Typically, traditional "cutters" would use a single, unsterile cutting tool like a blade or straight razor. This blade would be shared among all candidates, thus increasing the risk of acquiring blood-borne pathogens (Buggio et al., 2019; Tarr-Attia et al., 2019). In addition, an unsterilized blade could result in urinary tract or reproductive tract infections, gangrene, or tetanus (Buggio et al., 2019; Tarr-Attia et al., 2019).

Not only are females at risk for immediate short-term complications, those living with genital alterations are also susceptible to long-term consequences such as urogynecological disorders, obstetrical complications, and psychological disorders. For example, the woman may experience chronic urinary tract or renal infections and is at a higher risk for abscesses. Obstetric complications include postpartum hemorrhage, perineal lacerations, and prolonged labor; furthermore, instrumental delivery and infant resuscitation also can occur (Siddig, 2016). MUFGA may increase maternal and fetal morbidity (Buggio et al., 2019), not to mention infertility, complications in childbirth, and increased risk of newborn deaths (Elduma, 2018; Jungari, 2016).

Another complication of MUFGA is sexual dysfunction. Researchers used the Female Sexual Function Index to assess six domains of sexual function in married Iranian women with FGM and without FGM (N = 280 matched, 140 + 140). It was determined that noncircumcised women had significantly higher sexual function, as determined by the Persian Female Sexual Function Index total score (25.3 ± 4.34), when compared with circumcised women (17.9 ± 5.39; Biglu et al., 2016). The circumcised women experienced decreased sexual arousal, lubrication, and sexual satisfaction. In addition, researchers found a direct correlation in sexual dysfunction, including arousal, lubrication, and sexual satisfaction commensurate with the type of genital alteration (Coreas & Delis, 2018; Rouzi et al., 2017). Interestingly, MUFGA is often justified to decrease sexual desire in brides, but evidence does not support this claim. When 7,344 women from Kenya and 16,294 women from Nigeria participated in a study that explored the relationship between FC and sexual chastity, it was determined there was not an association between FC and decreased sexual promiscuity (Mpofu et al., 2017).

Not only are women at an increased risk of physiological consequences, the MUFGA procedure may also cause psychological trauma. For example, women who have undergone MUFGA are more likely to experience anxiety, low self-esteem, and depression (Buggio et al., 2019.) Several studies conclude that posttraumatic stress disorder, resulting in flashbacks to the event, was 30% more prevalent in this population (Buggio et al., 2019). The WHO recommends cognitive behavioral therapy for females experiencing anxiety disorders, depression, or posttraumatic stress disorder related to FGM (Smith & Stein, 2017). Unfortunately, sociocultural barriers prevent women from discussing or disclosing such intimate issues (Siddig, 2016), thus preventing them from obtaining emotional support. As a result, psychological support must be offered to those entering the health care system (Smith & Stein, 2017).

WORLD HEALTH ISSUE

What was once tucked away into small communities around the world has now moved to the forefront of global politics. What was once a cultural tradition has become a topic of interest because of continued practice on migration. When the tradition conflicts with local rules and practice in the West, the safety and ethics of this practice are examined carefully. On the basis of

moral principles and health care risks, the United States, as well as international human rights organizations, has responded to prevent this medically unnecessary procedure.

United States' Response

In 1993, out of concern for the health and well-being of females subjected to MUFGA, the United States House of Representatives introduced the Federal Prohibition of Female Genital Mutilation Act. This federal law, passed in 1996, prohibits and criminalizes any alteration of the external genitalia in females under the age of 18 years, unless the procedure is performed for medical reasons by a licensed practitioner (H.R. 941, Federal Prohibition of Female Genital Mutilation Act of 1995, n.d.). In 2013, the federal law was amended to include the criminality of knowingly transporting a minor out of the United States to obtain external genital surgery for nonmedical reasons (Goldberg et al., 2016).

In 2017, the constitutionality of this federal law was challenged in the United States v. Nagarwala. On the basis of the Federal Prohibition of Female Genital Mutilation Act of 1996, federal charges were brought against Dr. Jumana Nagarwala, an emergency room physician, as well as two defendants who assisted her in the procedure, four mothers of the victims, and the owner of the clinic (*United States v. Nagarwala*, 2018). Many of the charges were dropped against the other defendants; however, the female physician was charged with the mutilation of Dawoodi Bohra, Muslim adolescents from three different states (*United States v. Nagarwala*, 2018). The U.S. District Judge Bernard Friedman condemned the practice but ruled that the U.S. government did not have the legislative authority outlined by the constitution to federally prohibit this procedure (*United States v. Nagarwala*, 2018). Therefore, 22 years after the Federal Prohibition of Female Genital Mutilation Act of 1996 was passed, it was deemed unconstitutional and was overturned.

There are currently 39 states with felony charges and varying levels of criminal sanctions against parents, guardians, and those knowingly performing MUFGA (AHA Foundation, 2020). Although MUGFA is mainly practiced in the Middle East and African nations, people from these ethnicities continue the practice after migrating to the West, where most health care personnel are less aware of this practice (Mbanya et al., 2018; Sirazhudinova, 2019; Wahlberg, Essén, & Johnsdotter, 2019).

World Response

In 1997, three international human rights organizations, namely, the WHO, the United Nations Children's Fund, and the United Nations Population Fund, entered into a joint agreement to prevent what they termed as FGM to improve the health of girls and women across the globe (WHO, 1997). The joint statements stated the practice of "FGM" violates the protected, universal rights of the female child and discriminates against women citing physiological or psychological acute and long-term complications. As previously mentioned, this standard interpretation may influence conventional analysis of the facts related to the traditional beliefs of the culture. In addition, these international organizations called for a multidisciplinary, coordinated approach that incorporates community awareness and outreach programs, national legislative policies, and research into FGM (WHO, 1997).

IMPLICATIONS FOR HCWS

Attitude of HCWs: Nurses, Midwives, and Physicians

Although MUFGA is a traditional practice in many cultures, HCWs within those cultures may hold a different attitude. The literature on perceptions and attitudes of nurses, midwives, and physicians regarding FGM was examined. Although this practice is known to be prevalent in Africa and the Middle East, the indigenous Dagestan people in North Caucasus (South Russia) also practice this mandatory imperative practice (Sirazhudinova, 2019). Most physicians here remain silent, whereas some say it is a custom that is mandatory or at least desirable (Sirazhudinova, 2019), and still, other physicians within the region tried to hide and deny the practice existed (Sirazhudinova, 2019). In the country of Somalia, nurses and nursing students have varying perceptions about MUFGA and report that, in the current practice, less extensive types are seen in practice (Vestbøstad & Blystad, 2014).

Lack of knowledge about MUFGA is also prevalent among HCWs. Iranian midwives' knowledge and attitudes were examined ($N = 168$), and it was determined that only 20% had adequate knowledge about complications (Khalesi, Beiranvand, & Ebtekar, 2017). On the other hand, Australian midwives were definitely aware of the complications and expressed anger toward the procedure and empathy for the women living with MUFGA (Ogunsiji, 2016). The knowledge deficit by midwives from Finland indicates an inability to provide adequate, safe care for women subjected to this traditional practice (Cappon, L'Ecluse, Clays, Tency, & Leye, 2015). Knowledge deficits in the social complications were also identified (Kimani et al., 2018).

More troubling are the portrayed occurrences with medical professionals described by women who experienced MUFGA, thus creating barriers to access the appropriate health care. The interactions were described as uncomfortable, disrespectful, and neglectful

(Mbanya et al., 2018). Often, women were left to communicate needs without the benefit of an interpreter. In addition, health care providers were perceived as speaking unpleasant and uttering hurtful comments. These comments left the client with feelings of humiliation, especially during delivery (Mbanya et al., 2018). Similar findings were shared by researchers Coreas and Delis (2018). It is worth noting many of the women who have experienced MUFGA are aware of the bias accompanying the Western views of the procedure, the stigma associated with the "mutilation" terminology, and the criminality of the cultural practice. As a result, the trust developed in a nurse–patient relationship is grossly impaired. To improve the quality of care for this diverse population, practicing midwives, obstetricians, pediatricians, pediatric nurses, and the general public should be educated on the cultural practices including the implications associated with MUFGA.

Implications for Practice

HCWs need to be educated about the existence of this cultural practice. To address the issue effectively, HCWs should be trained in multiple aspects of MUFGA, including the types of procedures and the complications. Many HCWs may be unfamiliar with the types of MUFGA as found in Australia and Norway (Wahlberg et al., 2019; Zurynski et al., 2017). In addition, policies regarding MUFGA and the implications of the practice should be made public to raise community awareness of MUFGA procedures. In the United Kingdom, these unnecessary medical procedures are considered a form of child abuse and are illegal (Simpson, Robinson, Creighton, & Hodes, 2012), with mandatory reporting in effect for any clinical worker (Ashby, Richardson, Brawley, Hamlyn, & BASHH Adolescent Special Interest Group, 2019). MUFGA procedures will remain hidden under a cloak of darkness unless the practice is questioned and explored in the light, where open discussion and mandatory reporting may help prevent or reduce the incidence of MUFGA.

Although the perceptions of men, affected women, or other HCWs vary, it is the nurse, as a patient advocate, who has a moral obligation to women who are sometimes under social pressure to have their daughters undergo this procedure. Professional nurses are positioned in the prime location to advocate for the patient and offer a genuine cultural understanding of MUFGA. In addition, the nurse can provide culturally sensitive education about MUFGA. It was found that, as the education about MUFGA increases, the incidence decreases, particularly with those who migrated (Elduma, 2018). With its close association to child abuse, the education of men and women is essential, particularly for those who migrate to Western countries (Johnsdotter & Essén, 2016). Education on the universal human right to protect a woman's body may provide insight and prevent MUFGA. A limited listing is provided in Supplemental Digital Content, Table 1 (available at http://links.lww.com/JPSN/A30).

CONCLUSION

MUFGA is a cultural tradition among the people of the Middle East and Africa. Females undergo this procedure before puberty or the age of 15 years, where the external genitalia are altered in varying degrees. The WHO classifies MUFGA as FGM and identifies four types, with Type 3, known as infibulation, associated with severe long-term complication. Although international agencies condemn the practice of MUFGA, people continue their cultural traditions, even on migration to other countries, with the intention to control female sexuality, reduce libido, ensure premarital virginity, and prevent infidelity. According to the WHO, MUFGA, or as they classify it, FGM, is considered a form of abuse and a violation of human rights. Mandatory reporting policies exist in some countries, where it continues to be prevalent, and HCWs lack knowledge or sensitivity to educate others on the dangers of the practice. The education of HCWs, family members, and religious leaders is a major first step to address the barriers that lead to this continued practice.

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