ENDING FGC:

A TOOLKIT ON ENGAGING MEDICAL PRACTITIONERS

ASIA NETWORK TO END FGM/C

arrow
asian-pacific resource & research centre for women

ORCHID PROJECT
WORKING TOGETHER TO END FEMALE GENITAL CUTTING

WELCOME

INTRODUCTION

Female genital mutilation/cutting (FGM/C) comprises procedures that cut, remove partially or totally, parts of the female genitalia for non-medical reasons. At least 200 million girls and women alive today in 31 countries have undergone FGM/C.[1] Previously the global anti-FGM/C discourse has been largely focused on African countries, while FGM/C is still practised in Asia with over a million girls in the region predicted to be affected by the practice by 2030.[2]

The Asia Network to End FGM/C brings together engaged and informed civil society organisations across Asia to end all forms of FGM/C in the region, to highlight this underreported issue through evidence-gathering and research, advocate for laws and policies, and create awareness among stakeholders. Stakeholders include medically trained professionals as evidence shows medicalisation of this practice in Asia.[3–6]

AIM OF TOOLKIT

The aim of this toolkit is to provide guidance to activists and civil society organisations to engage with healthcare professionals to end FGM/C in Asia. However, it must be emphasised that this toolkit should be used as a guide and not an overarching prescriptive "playbook" for ending FGM/C across Asia. Asia is a large continent, and it is impossible to ensure or anticipate the different scenarios that you will encounter in advocating against FGM/C due to the different cultural practices, religions, and legislations. Therefore, this toolkit should be used in tandem with your own expertise and knowledge about the cultural practices of FGM/C in your own communities to start conversations and discussions surrounding FGM/C with healthcare professionals to end this practice.

For the purpose of this toolkit, we will use the term "female genital cutting" (FGC).

STRATEGIC PARTNERS

The Asia Network to End FGM/C is a collaboration between Malaysia-based regional feminist NGO, the Asian Pacific Resource and Research Centre for Women (ARROW), and Orchid Project, a global NGO working to end female genital cutting.

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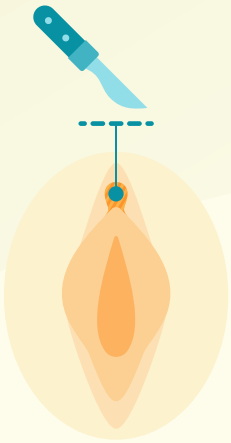
CONTENTS

WHAT IS FEMALE GENITAL CUTTING (FGC)?

WHO CLASSIFICATION OF FGC

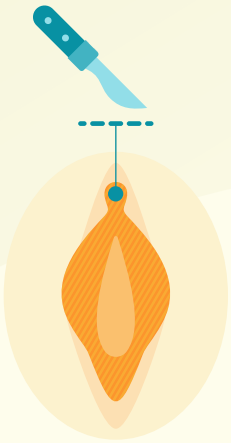
The World Health Organization's (WHO) 2007 update classifies FGC into four categories:[1]

FIGURE 1: WHO CLASSIFICATION OF FGC TYPES 1 TO 4



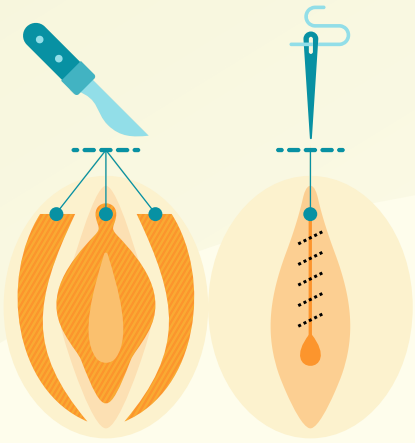
TYPE 1: CLITORIDECTOMY

Partial or total removal of the clitoris and/or clitoral hood (prepuce).



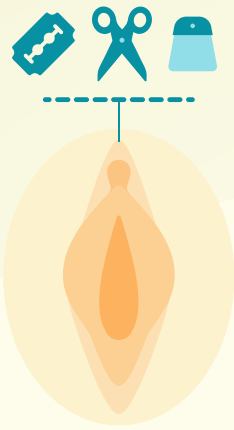
TYPE 2: EXCISION

Partial or total removal of clitoris and *labia minora* (the inner *labia* surrounding the vagina) with or without the removal of *labia majora* (the outer labia).



TYPE 3: INFIBULATION

Cutting and bringing together the *labia minora* and/or *labia majora* to create a narrow seal covering the vaginal orifice.



TYPE 4: ALL OTHER HARMFUL PROCEDURES

Any other harmful procedures including piercing, incising, scraping, cauterising, and pricking the female genitalia for non-medical reasons.

HEALTH COMPLICATIONS ACCORDING TO FGC TYPES 1, 2, AND 3

Health complications of FGC vary with types, with severe health consequences and death predominating Types 1 to 3. Below are the complications of FGC Types 1 to 3:

TABLE 1: HEALTH COMPLICATIONS OF FGC TYPES 1, 2, AND 3

IMMEDIATE COMPLICATIONS[7, 8]	LONG TERM COMPLICATIONS
> Severe pain. > Genital swelling. > Haemorrhage: Excessive bleeding due to the cut which can lead to anaemia and death. > Urinary retention. > Wound infections can lead to septicaemia (blood poisoning, where the body's response to infection causes damage to its own organs) and death.	> Keloid scarring: Excessive growth of scar tissue over cut area[9] and is a source of anxiety and shame for women. > Girls and women who have undergone FGC Type 3 can be left with a small orifice (2-3 mm). Women who have undergone FGC can also suffer from *synechia vulvae*: Partial or total adhesions and fusion of *labia majora/minora*. These can cause obstructive voiding symptoms, painful periods due to obstruction of menstrual flow causing *haematocolpos/haemotometra* (vagina and uterus filled with menstrual blood), and *dyspareunia* (painful intercourse). First intercourse requires gradual, painful dilation and cutting might be necessary.[10] > Neuroma:[10] Growth of nerve tissues causing pain during intercourse. > Cysts which could become infected.[11] > *Fistulae*:[12] Vesicovaginal (abnormal connection between bladder and vagina causing involuntary discharge of urine into vagina) or rectovaginal (abnormal connection between rectum and vagina causing involuntary discharge of faeces into vagina) *fistulae*, causing recurrent infections, urinary and faecal incontinence, and a significant source of emotional distress for women. > Obstetric complications:[13] Labour can be prolonged and obstructed. If possible, most women should be assessed early in pregnancy and planned for Caesarean section or deinfibulation for vaginal delivery. Failing that, women are at risk of third-degree tears (anal sphincter lacerations) and emergency Caesarean sections. High mortality rates to mother due to haemorrhage, and to baby, due to prolonged second stage of labour. > Post-traumatic stress disorder (PTSD), anxiety, depression.[14] Pregnancy and childbirth can cause women psychological stress due to lack of knowledge and sensitivity by healthcare professionals, and having to relive the traumatic experience.[15]

HEALTH COMPLICATIONS OF FGC TYPE 4

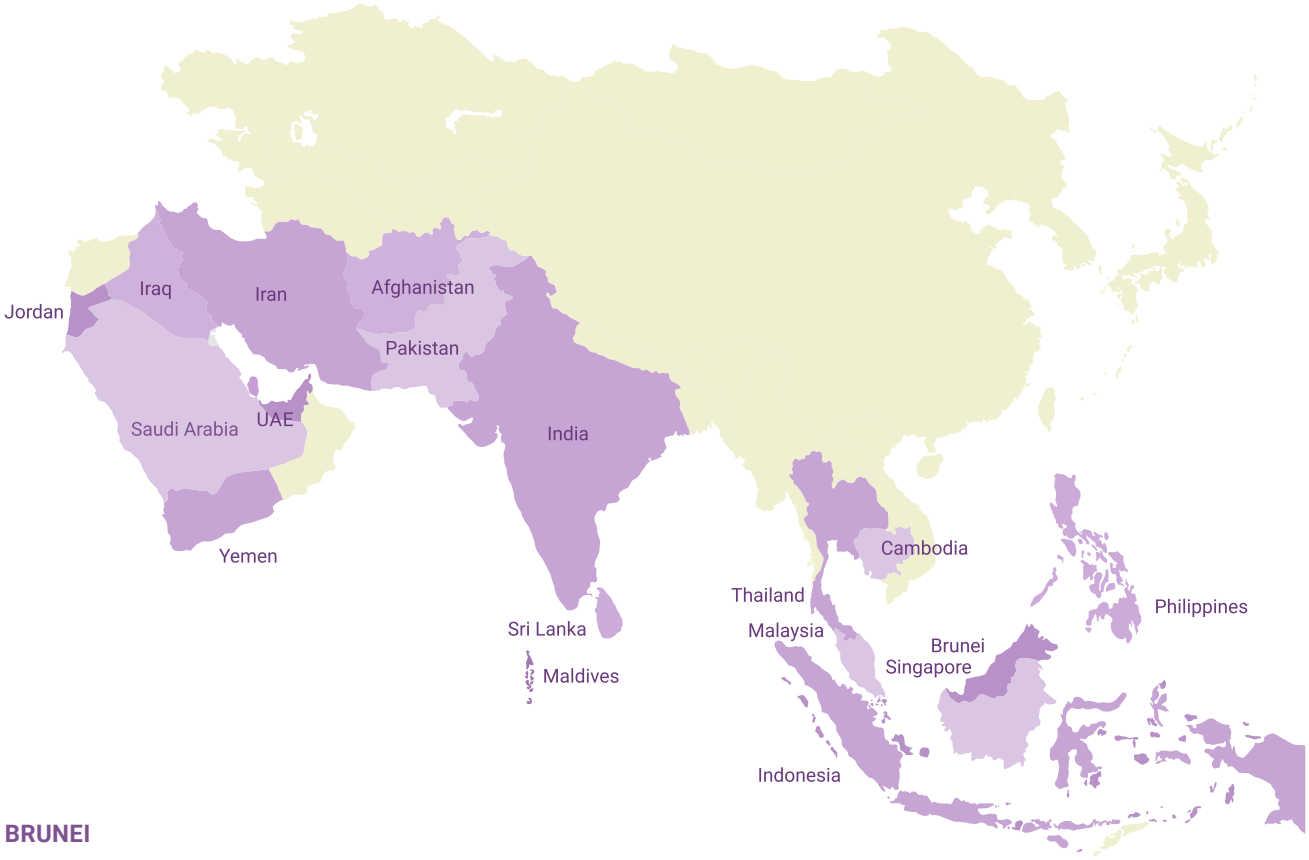
Depending on subtype, complications of FGC Type 4 can vary.

TABLE 2: HEALTH COMPLICATIONS OF FGC TYPE 4

PIERCING	Historically, labial rings were locked together over the *labia minora/majora* to form a chastity ring and were worn by wives and slaves to prevent infidelity.[16] Today, labia and clitoral hood piercings are worn for self-expression and enhanced sexual pleasure. Common complications from this procedure can include cellulitis (skin infection), Hepatitis B and C, HIV, tetanus, local irritation, allergic reaction, keloid scarring, gynaecological complications such as *dyspareunia*, post-coital bleeding (bleeding after sex), condom tearing, pelvic inflammatory disease, recurrent urinary tract infections and obstetric complications.[17] Clitoral glans piercing is associated with a higher risk of clitoral nerve and blood supply damage compared to clitoral hood piercing, leading to scarring, and retained piercing.[18]

	The UK Royal College of Obstetricians & Gynaecologists recommends recording genital piercings as Type IV FGC as per WHO classification.[19] Guidance from the UK Crown Prosecution Service[20] stated that genital piercings are unlikely to involve excision, infibulation, or mutilation, therefore unlikely to meet the evidential stage required for prosecution under the FGM Act 2003, performed chiefly with the consent of an adult woman (over the age of 18 years) with the capacity to make such decisions. Note that there is no statutory definition of excision, infibulation or mutilation[20]. It is arguable whether female genital piercing is classed as "self-mutilation" which is not an offence.[20]
INCISION	> *Ukugcaba*: This involves small, shallow incisions on the genitals, and oftentimes the abdomen and breast, using a razor blade to introduce herbal love medicines by traditional healers or a trusted friend in KwaZulu-Natal, South Africa.[21] Motivations for this practice are to cement relationships and enhance sexual pleasure. Complications include scarring on the genitals leading to urinary tract infections, genital itchiness and irritation and wound burns as the herbal medicine is rubbed into the wound.[21] > Other practices include the South Sotho people's ritual breaking of the hymen with a finger or animal horn and the Lobedu people's practice of making a small incision above the clitoris, as a part of a female's rite of passage.[21, 22] > *Gishiri* (meaning salt): Practised by Hausa and Fulani ethnic groups in Northern Nigeria, involving a cut at the anterior or posterior vaginal wall with a razor to treat gynaecological conditions not limited to infertility issues, vulval itching, menstrual problems, vaginal prolapses, and difficulties during labour.[23, 24] Usually performed by traditional barbers and birth attendants. Complications from *girshiri* cuts are vaginal swelling[25], vesicovaginal *fistulae*[26] and partial or total destruction of the urethra.[27]
INCISION OR SCRAPING	*Angurya* (or *gurya* – meaning cottonseed): Involves scraping of the vaginal orifice[23, 24] practised by the Hausa of Northern Nigeria due to the belief that a girl could be born with a tiny "seed" within her vagina that can grow over time causing diminished vaginal capacity, lack of sexual desire or *dyspareunia*.[27] Complications of an *angurya* cut are vesicovaginal *fistulae* with partial or total destruction of the urethra.[27]
PRICKING	Pricking, or needling of the clitoris is touted to be the least harmful of all FGC practices. Pricking is commonly practised in Indonesia,[28, 29] Malaysia,[3, 4] Philippines,[30] Singapore,[6] and Thailand[31] (see data in Figure 2). In a study looking into the effects of FGC in 262 women admitted to the labour ward in Kelantan, Malaysia, no clinical evidence of injury to the clitoris or the labia and no physical sign of excised tissue were found.[32] However, what is often missed and poorly discussed, is the psychological impact on women who had this procedure done. More peer-reviewed studies need to be done to investigate this. The realisation in adulthood that one had the procedure done as an infant or child may induce further mental stress and psychosexual issues especially in girls or women who have been suffering from other forms of gender-based violence, or those with chronic pelvic conditions with no obvious gynaecological cause or treatment. But we cannot assume that all women who had pricking see themselves as "FGC survivors" – some women may find this term offensive as they do not see themselves as harmed or "mutilated". Nonetheless, harm or no harm, there are ethical concerns about this practice when it is done to infants or children as discussed in "Strategies to communicate with your healthcare professional."

FIGURE 2: PREVALENCE OF FGC AND ITS TYPES IN ASIA



BRUNEI

Ministry of Religious Affairs[33] described the removal of the clitoral hood (Type 1 FGC) typically done within 40 days of the postpartum period as *sunat* (obligatory practice in Islam) and does not consider this FGC, but no official statistics or data available.

CAMBODIA

A case report[34] documented a new subtype of Type 4 FGC with the inferior *labia minora* stitched to narrow the vaginal orifice in a consenting adult to attract a new partner. This procedure is performed by a certified surgeon under local anaesthesia.

INDIA

Possibly Types 1 or 4 FGC with none to minimal bleeding (known as *khafd*) within the minority Dawoodi Bohra community[5, 35] with a growing number of female medical professionals from the community involved in the practice. There is an ongoing debate on the criminalisation of the practice versus medicalisation.[5]

INDONESIA

Type 1 FGC (cutting off the "excess" part of the clitoris) and Type 4 (rubbing off the skin of the clitoris using a pincer or piece of bamboo or needling of the clitoris to extract a single drop of blood) were described.[28] Recently, this practice is increasingly being done by midwives which may be more invasive as they use scissors, and it is offered as part of birth delivery package at no extra cost.[29]

IRAN (AND AFGHANISTAN)

68.5% (out of 535) had undergone FGC in Southern Iran.[36] This practice is prevalent among those of increased age, who were illiterate, of Afghan nationality as opposed to being Iranian, expressed Sunni Islam as a religious belief and had a history of previous family practices. A study over six years (3,000 women and 1,000 men) demonstrated the prevalence of FGC in the rural areas of the West Azerbaijan (21%), Kurdistan (16%), Kermanshah (18%) and Hormozgan (60%, Type 1 FGC).[37, 38]

IRAQ

Prevalent in the Iraqi Kurdistan region, practised by Muslim Kurds:[39] 58.6% among 15 to 49-year-olds in Erbil City (99.6% Type 1 FGC),[40] and 23% for below 20-year-old women (76% had Type 1 FGC),[41] with a prevalence of up to 70% reported in specific rural areas where there is high prevalence of illiteracy and conservative Islamic practices.[39]

JORDAN

The practice was found prevalent among the 500 inhabitants of Rahmah, but no official statistics or studies.[38]

MALAYSIA

99.3% of Malay Muslim infants as young as one month or two months old (median age: six years old) experienced Type 4 FGC (pricking).[3]

MALDIVES

A Demographic Health and Survey[42] reported 12.9% of women aged 15 to 49 years old had FGC with 1.1% of girls under 14 years old undergoing the procedure. 65.9% of women aged 15 to 49 years old agreed that FGC should be eliminated.

PAKISTAN

No official data but believed to be practised among the Pakistani Dawoodi Bohra[5] community.

PHILIPPINES

> Unpublished master's thesis by Calsalin (2008)[43] observed the Yakan Muslim community's (based in the province of Basilan, Bangsamoro, Philippines) rite of passage "symbolic circumcision" for all girls, which involved scraping of the labia majora with a blunt knife (bleeding is not intended).

> The "Exploratory Action-Research on Female Genital Mutilation Practices in the Philippines" report[30] documented Type 4 FGC practised in Bangsamoro which involved subjecting infants up to nine-year-old girls to the scraping or pricking of the clitoris or labia and extracting a "whitish substance" from the clitoris using a thin bamboo strip, nail-cutting knife (or other small knife), or needle. This practice is linked to child marriage as girls are assumed to be ready for marriage following circumcision.

QATAR

No official statistics or studies, only anecdotal evidence.

SAUDI ARABIA

Two studies observed 18.2% of Saudi and non-Saudi women in Jeddah (963 participants, ages 18 to 75 years old, 79.1% Muslims)[44, 45] had FGC done. FGC was associated with older, married women, and a lower monthly income. If done, Saudi women usually had it performed at a younger age. In Hali,[45, 46] a semi-urban region in Saudi Arabia, 59.4% of women had it done at less than seven years of age. 91.4% of FGC were performed by doctors in Hali. There are no specific laws against FGC in Saudi Arabia and FGC is not done in clinical settings at least unofficially, therefore prevalence is difficult to ascertain.[45]

SINGAPORE

Type 1 FGC (cutting of the clitoral prepuce) performed on female infants within the Malay Muslim community, increasingly in clinical settings.[6] Data was obtained from 15 Malay women, two doctors who performed the procedure, 10 Muslim men, and three religious teachers.

SRI LANKA

Type 1 or Type 4 FGC (cutting, nicking, pricking, scraping and scarring) within the minority Muslim community.[47]

THAILAND

Type 1 or Type 4 FGC (mild cutting or pricking of the clitoris) within the Muslim community in Southern Thailand after 40 days of the postpartum period (at the end of the mother's seclusion period) by the traditional midwife.[31]

UNITED ARAB EMIRATES

In a 2011 survey of 200 women and men, 34% of women had undergone FGC.[38, 48]

YEMEN

The percentage of most-recently-born daughters who had undergone FGC declined from 29.3% in 1997 to 22.4% in 2003. The percentage of daughters of women who underwent FGC also declined from 61.9% in 1997 to 56.5% in 2003. A decline in the support for continuation of FGC among women who had undergone FGC (78.2% in 1997, to 70.9% in 2003) and husbands (60.1% in 1997, to 49.5% in 2003) was observed.[49]

MEDICALISATION OF FGC IN ASIA

Medicalisation "refers to situations in which FGC is practised by any category of healthcare provider, whether in a public or a private clinic, at home or elsewhere"[50] even though this practice is not taught or advocated in medical schools, or any healthcare degree courses.

Instead, this practice is taught informally by senior healthcare professionals (doctors, midwives, or nurses) to their junior colleagues (often from the same communities that practise FGC). This could be driven by increasing demand from parents who have become more acquainted with the potential health complications of FGC customarily done by traditional healers using unsterilised equipment.[4, 50–52] Therefore, harm reduction, religion, and financial motivation (though not necessarily the primary motivation)[4, 50–52] are reasons for medical practitioners to continue performing FGC.

In Asia, medicalisation of FGC is observed in Malaysia,[4] India,[5] Indonesia,[29] Singapore,[6] and possibly Brunei. The harm reduction argument for medicalising FGC is a contentious area of debate. However, studies done in Malaysia[4] and Indonesia have shown that there is a trend towards more invasive methods of FGC (despite the lift of regulations allowing medical personnel to perform FGC in 2014).[29] 20.5% of Malaysian Muslim doctors involved in the practice predominantly prick the prepuce of the clitoris, but some described cutting a small part of the clitoris (Type I FGC) which was unheard of when done by traditional midwives.[4] In Indonesia,[29] midwives tend to cut with scissors versus traditional birth attendants who use pen knives for symbolic acts of scraping or rubbing.

Therefore: Should clinical guidelines be produced on how to perform FGC safely? The answer is a resounding no – this practice is not a medical procedure, has no medical benefits (in different subtypes of Type 4 FGC, a lack of harm is not a benefit), and therefore should not be performed by healthcare professionals. Notably, within the Southeast Asian context (except for the Cambodian case report),[34] FGC is done on infants up to 9 years of age, thus, consent cannot be taken, and parental consent is not appropriate for procedures that are not medically necessary.

STRATEGIES TO COMMUNICATE WITH YOUR HEALTHCARE PROFESSIONAL

> **FIND MEDICAL ALLIES AND COLLABORATE WITH ACADEMIC INSTITUTIONS.** Find medical allies who can provide advice for your organisation. This healthcare professional is also an important conduit to bridge the gap between activists, civil society organisations, and other healthcare professionals. Ensure research done within your organisation has the input of academics and healthcare professionals who have expertise in this area as early as at the study design level. That means involving healthcare professionals within obstetrics and gynaecology, paediatrics, and public health, as well as non-medical researchers involved in this area. This ensures that research done by your organisation can be peer-reviewed and published in high quality journals. If possible, it is best to seek healthcare professional allies within the communities that practice FGC.

> **USE MEDICAL LANGUAGE BACKED WITH PUBLISHED PEER-REVIEWED STUDIES TO SPEAK OF MEDICAL HARMS.** Equip yourself with the knowledge of FGC practices within your communities by corroborating your on-the-ground findings with peer-reviewed studies. Seek the advice of your medical ally to understand medical jargon and perspectives of healthcare professionals involved in the care of these girls and women. Healthcare professionals are likely to be more receptive to persons who are medically well-versed in the subject area and those who have sought the opinions of medical experts.

> EMPHASISE THAT PROVIDING NON-BENEFICIAL, NON-MEDICAL PROCEDURES GO AGAINST MEDICAL ETHICS. It must be emphasised that healthcare professionals do not wish to harm their patients as this goes against their personal and *medical ethics[53]. The practice of FGC is complex and healthcare professionals are not impervious to the influence of religious and cultural beliefs of the practice. Many who practice FGC believe that they are providing the best care to their patients and ensuring harm reduction. Therefore, challenge the beliefs of these healthcare professionals with care and respect for their medical knowledge and religious belief. By using your knowledge of FGC practices within your communities and across Asia, explain how FGC differs in reasons and application even in communities who practice FGC due to religion across the world.

With such differing perspectives within the same religion across different communities, and potential harm and lack of benefit (please note that the intricate differences between religion-informed practices of FGC is out of the scope of this toolkit), it is best not to perform FGC on patients, especially on those who cannot give informed consent. Informed consent means permission is granted in the full knowledge of the benefits and complications of the procedure. A female infant cannot give informed consent and exercise their autonomy on any procedures done to her body as she does not have the **capacity to make decisions. A female child who may have the capacity to make decisions, technically, cannot give informed consent and exercise autonomy on any procedures done to her genitalia especially in communities where FGC is seen as a beneficial practice as the societal pressure must be immense! Additionally, the capacity to make decisions can change depending on situations - consenting to ear piercing is different to consenting to needling of the clitoris, as the genitalia holds a special status. Parental consent is not appropriate for procedures that do not aim to treat or have no medical benefit.

These discussions can hopefully help healthcare professionals reflect on their medical practice and educate parents.

> INFORMING HEALTHCARE PROFESSIONALS OF INTERNATIONAL HUMAN RIGHTS CONSENSUS ON FGC AND DISPELLING THE MYTH THAT HUMAN RIGHTS ARE A WESTERN INVENTION. Not many healthcare professionals who practice FGC are aware of the international human rights consensus on FGC, at least in Malaysia.[4] Therefore, it is important to inform healthcare professionals about FGC as a violation of human rights.

FGC is a violation of human rights, as it involves injuring or removing healthy tissue without medical necessity. This violates the human right to health and bodily integrity (Article 25 of the Universal Declaration of Human Rights). As FGC is mainly done to girls under the age of consent, this is a violation of the Convention on the Rights of the Child. FGC is a form of gender-based violence and therefore is a violation of the UN Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW).[1] 187 countries (90% of the UN membership) have ratified or acceded to CEDAW which stipulates prohibition of FGC and other harmful practices against women. This includes all Asian countries except for Iran.

The idea that human rights are a Western invention without significant input from non-Western nations is a myth. Asian women were involved in shaping the Universal Declaration

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* **The Beauchamp and Childress' four principles of medical ethics:[53]**
- > Autonomy (patient has the right to choose or decline treatment or procedure)
- > Beneficence (healthcare professionals should act in the best interest of the patient)
- > Non-maleficence (healthcare professionals must do no harm)
- > Justice (concerns with the distribution of resources and ensuring those who need medical care get the medical care they deserve)

** **Capacity is present if the patient is able to understand, retain, reflect and repeat the information to the medical practitioner.**

of Human Rights (UDHR). Hansa Mehta from India[54] and Begum Shaista Ikramullah from Pakistan[54] were Asian women involved in shaping the declaration. Hansa Mehta is famously known for changing the language of the declaration from "all men are born free and equal" to "all human beings are born free and equal."[55] Begum Shaista Ikramullah advocated for Article 16 of the UDHR to combat child and forced marriage. Article 16[56] speaks about the rights of men and women of full age to marry and form a family without any limitations of race, nationality or religion, and that marriage can only be entered with the free and full consent of both parties who both have equal rights in the partnership.

> DISPELLING THE MYTH THAT FGC IS A WESTERN AGENDA TO LIMIT OR CURB THE TRADITIONS OF NON-WESTERN CULTURES. Unfortunately, misogyny happens across the world regardless of culture or tradition. The idea that FGC is solely a non-Western practice is erroneous. It is not an African problem. It is not an Asian problem. It is a global problem. In fact, clitoridectomy used to be advocated for women with various ailments not limited to "hysteria", excessive masturbation, and difficult behaviour – none of which were legitimate medical reasons by Victorian doctors.[57] Many who advocated against FGC in the West expressed disgust at "barbaric" African/Eastern cultures, but it must be remembered that none of the parents of these girls had any intention of harming these girls however convoluted that may seem to outsiders of the culture. In fact, many of these FGC practices are held in celebratory occasions: the birth of a female child, or as a coming-of-age tradition,[43] though these do not justify FGC! One may argue that FGC no longer happens in so-called Western religions and cultures, however this is not true, as depicted in two cases[58, 59] of White Christian women subjected to FGC as children in modern times. Arguably, is female genital cosmetic surgery (FGCS) a form of socially and legally acceptable FGC in the West? This topic is discussed in "Areas of debate".

AREAS OF DEBATE

> FEMALE GENITAL COSMETIC SURGERIES (FGCS) VS FGC. FGCS comprises procedures including labiaplasty, hymenoplasty (reconstruction of the hymen with or without consent is illegal in the UK, as the practice is closely related to virginity testing),[60] clitoral hood reduction, surgeries to tighten the vaginal opening, vaginoplasty, monsplasty, and G-spot augmentation. You may find healthcare professionals using the argument of how a certain subtype of type IV FGC is a less invasive procedure than FGCS, to justify performing FGC. FGCS may also be used to support medicalisation of FGC. Importantly, what does it mean to have a "zero-tolerance" stance against FGC in the age of burgeoning FGCS respectability and acceptance? Some see this debate as a Western versus non-Western debate which reeks of hypocrisy and colonialism.

Undeniably, labiaplasty, for example, is a procedure more invasive than some subtypes of type IV FGC such as "pricking" or "needling". The two main oppositions by those who are against FGC but not FGCS are that unlike FGCS, FGC, especially in many parts of Asia, are done on children and that the risks and complications of FGCS are reduced in an aseptic theatre environment with appropriate anaesthesia by a trained surgeon.

While FGCS is mostly performed on consenting ***adults, is informed consent truly obtained? We know that idealised forms of the female genitalia in lieu of celebrating normal genital diversity in mainstream online content and pornography is a driving force behind many women's decisions to pursue FGCS.[61] Erroneous beliefs such as the belief that the female body is degenerative and how

*** British Society for Paediatric & Adolescent Gynaecology[63] does not recommend labiaplasty for non-medical reasons for girls under 18 years old. Notably, 267 labiaplasties were performed on girls under the age of 14 between 2008 and 2012 for unknown reasons within the NHS.

surgical correction can resolve this issue (as seen in how vaginoplasty is promoted as vaginal rejuvenation procedure) contribute to increased rates of FGCS. Are women counselled adequately regarding how perfectly normal their vulvas are when they are consented for surgery? The idealised appearance of one's vulva is so important to these women that it affects personal wellbeing and sexual enjoyment – is it not surprising that women report better sexual experience following FGCS? Sexual experience is a subjective metric, could these women have better sexual experience with re-education about female genital diversity? Many underestimate the risks and complications of FGCS (Table 2). Why subject one's body to the stressors of anaesthesia and surgery to "correct" a perfectly normal vulva?

Women are more likely to seek FGCS when they are exposed to more online content with idealised forms of the vulva and positive promotions of FGCS, peer pressure, and receiving negative comments about the appearance of their vulva from their partners.[62]

In the British context, two hypothetical case studies mentioned by Kelly & Foster (2012)[16] come to mind. Firstly, a 19-year-old British-born Eritrean woman requesting for her labia minora to be shortened and sewn together, and secondly, a 21-year-old woman (presumably non-ethnic minority British, as her ethnicity was not mentioned in the paper) who came to the gynaecology clinic requesting labiaplasty. In which of the two case studies would we assume that the woman is requesting FGC?

TABLE 3: TYPE OF PROCEDURE , ITS BENEFITS AND COMPLICATIONS

	TYPE OF PROCEDURE	PURPORTED BENEFIT*	PROCEDURES USED	REPORTED OR POTENTIAL COMPLICATIONS
SURGICAL PROCEDURES	**Clitoral Hood Reduction**	To improve sexual function by increasing sensitivity and allowing more direct clitoral contact	Hoodectomy Note: Often combined with labiaplasty to create *labia minora* symmetry and prevent clitoral hood sagging	> Scarring > Infection > Hematoma > Hypersensitivity > Damage to the glans
	Labiaplasty	To eliminate unwanted tissue of the *labia minora* or *labia majora*	> Trim or edge resection > Wedge resection using a V-shaped or y-shaped incision > Z-plasty > De-epithelialisation	> Scarring > Infection > Hypersensitivity or loss of sensation > *Dyspareunia* > Wound dehiscence
	Labia Majora Augmentation	To create a full, symmetric look	> Autologous fat transplantation > Injectable fillers (hyaluronic acid)	> Palpabale fatty cysts
	Hymenoplasty	To recreate the virginal state of the hymen; has cultural roots in regions that place a value on an unmarried woman's virginity	Reconstruction of hymenal remnants, vaginal mucosal flaps, or both	Wound dehiscence
	Vaginoplasty	To tighten vaginal contour and increase sexual satisfaction	> Anterior, posterior, or lateral colporrhaphy > Rugation restoration** > Energy-based devices	> Infection > *Dyspareunia* > Dehiscence > Fistulla

* This may not be the patient's goal, but these procedures are often marketed with these outcomes.

** U.S. Food and Drug Administration (FDA) warns against use of energy-based devices to perform vaginal "rejuvenation" or vaginal cosmetic procedures: FDA safety communication. Silver Spring (MD): FDA, 2018. Available at: https://www.fda.gov/MedicalDevices/Safety/AlertsandNotices/ucm615013.htm. Retrieved August 26, 2019.

TYPE OF PROCEDURE		PURPORTED BENEFIT*	PROCEDURES USED	REPORTED OR POTENTIAL COMPLICATIONS
ENERGY-BASED INTERVENTIONS	**Energy-based Vaginal Procedures****	To tighten vaginal contour and increase sexual satisfaction	Laser radiofrequency	> Burns > Scarring > Pain during sexual intercourse > Recurring or chronic pain
INJECTIONS	**G-spot Amplification**	To augment G-spot and heighten sexual satisfaction	> Autologous fat transfer > Hyaluronic acid	> Urinary tract infection > Infection

** U.S. Food and Drug Administration (FDA) warns against use of energy-based devices to perform vaginal "rejuvenation" or vaginal cosmetic procedures: FDA safety communication. Silver Spring (MD): FDA, 2018. Available at: https://www.fda.gov/MedicalDevices/Safety/Alertsand Notices/ucm615013.htm. Retrieved August 26, 2019.

Adapted from the American College of Obstetricians & Gynaecologists. First accessed on 11 September 2022.

Three important points are stressed here: 1) Societies' "fascination" with the female genitalia is a universal phenomenon, and reasons for "correcting" the female genitalia will differ from culture to culture; 2) Advocating against FGC (and FGCS!) is not an advocacy against a particular tradition or culture, it is an advocacy against harming girls and women; 3) Informed consent and respect for patient's autonomy and bodily integrity should be the driving force behind the clinical decisions of all healthcare professionals.

> **MALE VS FEMALE GENITAL CIRCUMCISION.** You may be challenged with the idea that male genital circumcision (MGC) for non-medical reasons is a more invasive procedure than some subtypes of type IV FGC. Yet MGC is acceptable among the medical fraternity worldwide, practised in cultures that do not condone FGC, and not considered "mutilation". A central argument in legitimising MGC for non-medical reasons is its proposed medical benefits. This is compared to FGC, which has no medical benefits.

A potential benefit of MGC is the reduction of urinary tract infection (UTI) in boys. The risk of UTI in normal boys is approximately 1% and the number-needed-to-treat to prevent one UTI is 111,[64] which means 111 boys need to undergo MGC before any benefit of preventing one UTI is seen. Given this statistic and that there are effective antibiotics to treat UTI, MGC is not necessary. Another potential benefit of MGC is reduction in HIV risk in heterosexual men[65] and this is promoted by the WHO[66] as a preventative measure to combat the spread of HIV/AIDS in high-risk populations. However, these studies were conducted on male adults who volunteered to undergo MGC. MGC does not protect women from HIV if they had sexual intercourse with HIV-positive circumcised men. No added benefit is seen if the men are faithful to the HIV-negative women and use condoms. In conclusion, any procedures done to the genitalia, male or female, must be done in full knowledge (informed consent) and autonomy of the person undergoing the procedure.

However, medical necessity arguments aside, the misogyny-fraught sociocultural motivations and the negative impact of FGC on girls and women worldwide compared to MGC cannot be understated. It is in this regard that FGC is incomparably harmful to MGC.

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