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A multidisciplinary approach to clitoral reconstruction after female genital mutilation: the crucial role of counselling

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ABSTRACT

Objectives: Female genital mutilation (FGM) is becoming more widely seen in the West, due to immigration and population movement. Health services are being confronted with the need to provide care for women with FGM. One of the more recent trends is the provision of clitoral reconstruction. It remains unclear, however, what constitutes good practice with regard to this type of surgery. Methods: Based on a keynote presentation about reconstructive clitoral surgery, we briefly discuss the possible consequences of FGM and the findings from recent publications on clitoral reconstruction. Recognising individual differences in women, we suggest a multidisciplinary counselling model to provide appropriate care for women requesting clitoral reconstruction. Results: The literature shows that FGM influences physical, mental and sexual health. Clitoral reconstructive surgery can lead to an increase in sexual satisfaction and orgasm in some, but not all, women. A multidisciplinary approach would enable a more satisfactory and individually tailored approach to care. The multidisciplinary team should consist of a midwife, a gynaecological surgeon, a psychologist-psychotherapist, a sexologist and a social worker. Comprehensive health counselling should be the common thread in this model of care. Our proposed care pathway starts with taking a thorough history, followed by medical, psychological and sexological consultations. Conclusions: Women with FGM requesting clitoral reconstruction might primarily be looking to improve their sexual life, to recover their identity and to reduce pain. Surgery may not always be the right answer. Thorough counselling that includes medical, psychological and sexual advice is therefore necessary as part of a multidisciplinary approach.

Introduction

Female genital mutilation (FGM), also known as female genital cutting or female circumcision, is a practice that is carried out on young girls in many populations. The World Health Organization (WHO) estimates that between 100 and 140 million women worldwide have undergone a form of FGM and that each year 3 million girls in Africa are at risk of being cut. [1] The practice is carried out in at least 28 African countries, Yemen and northern Iraq. [2] FGM is also thought to be carried out in Asia, [3–5] the Middle East [3,6–8] and South America, [3,9] but national prevalence numbers are currently lacking. Four types of FGM have been identified by the WHO, namely clitoridectomy (type I), excision (type II), infibulation (type III) and all other kinds of FGM (type IV). [10]

Recent decades have seen a number of initiatives aimed at banishing the practice of FGM. Indeed, the prevalence of FGM is declining in some countries, but at a slow pace. The decline is especially clear in countries where the prevalence of FGM is moderately low to very low, but there is also evidence of a decline in high prevalence countries. [11] Worldwide, thousands of communities have decided to abandon the tradition of FGM, but, unfortunately, there are still many that seek to continue this ritual from generation to generation.

In the last decade, FGM has become more evident in Western regions, such as Europe and North America, due to immigration and population movement. Although there is no hard evidence that girls are being subjected to FGM within the European Union (EU), girls and women have been cut before moving to the EU or while travelling outside the EU. [2] Prevalence studies in the EU estimate that 13,112 girls and women in Belgium [12] and 27,680 girls and women in the Netherlands [13] are most probably victims of FGM.

Migration has confronted Western doctors, who are not always familiar with these practices, with patients seeking advice or treatment after FGM. There has been a general increase in concern about FGM among health care providers in the West. [14] Reconstructive surgery after vulvar FGM is one concern of Western doctors. Since this is a relatively new question, ethical considerations should be taken into account and an evidence-based clinical approach sought.

In this opinion paper on the use of reconstructive surgery after vulvar FGM, we hope to provide food for thought, both in terms of discussion of the topic as well as providing a possible impetus for future research. Based on a review of the literature we hope to challenge experts and add to the ongoing discussion of this complex issue.
Methods

On the basis of a brief literature review, we describe the potential consequences of FGM and the possible treatment options. The differential characteristics of women requesting surgery are summarised from published studies. Based on a recognition of the individual differences and needs of these women, a multidisciplinary counselling model is proposed to guide clinicians seeking a personalised solution appropriate for the individual woman who has undergone FGM.

Results

The consequences of FGM

The bulk of research on FGM focuses on its physical consequences [15–17] and, to a lesser extent, its psychological consequences.[18–20] The WHO identifies direct effects as severe pain, bleeding, infections and urinary difficulties, as well as long-term consequences such as chronic pain and infections.[21] In general, these effects are similar for all types of FGM, but the more invasive the procedure, the more serious and prevalent they are.[19,21] Psychological consequences include post-traumatic stress disorder, amnesia, anxiety and depression.[18–21] Vloeberghs et al. [20] point out that the extent to which these women have memories of what happened, and the way they cope with their memories, are crucial factors in the development of psychopathology. They found that women who had vivid memories of the mutilation, who were not very well integrated into society (work, education, social network), and who used a coping strategy of avoidance, e.g., through the use of drugs, were at risk of developing serious mental health complaints.[20] Migration can also play a significant role in this phenomenon of developing mental health problems after FGM. It is important to keep in mind that interpersonal, religious and cultural influences may change the perception of FGM over time; however, research to substantiate this claim is scarce.[22]

The influence of FGM on sexuality is less well documented.[16,17,19] This is partly due to the delicacy of the subject and the difficulty of conducting research on sexuality. First and foremost, concepts used in the field of sexual health and wellbeing are not always easy to define, translate and communicate. ‘Sexuality’ is a complex construct: too complex to be viewed as a purely physical entity. It consists primarily of various components that are culturally and socially influenced. It is not constant and uniform, but variable. Sexuality is about procreation, relationships, physical actions, cognitive states, biological and gender differences between men and women. Consequently, it cannot be captured in its total quality by single studies.

A meta-analysis by Berg and Denison in 2012 [23] showed a significant difference in the sexual experience of women with and without a history of FGM. Women with any type of FGM were 1.5 times more likely to have symptoms of dyspareunia and reported experiencing no sexual desire twice as often as their uncircumcised peers. Their sexual satisfaction was also lower, and they often reported anorgasmia. However, it is important to keep in mind that these figures were usually obtained in studies that lacked control groups.[17,23] Nevertheless, they cannot be ignored and they suggest a need for surgical enhancement procedures.

Berg and Denison [23] concluded that reduced sexual functioning could be due to neurophysiological consequences of FGM and the scarring that follows the practice, resulting in complaints about pain during sex. Not only will scar tissue and damage to the nerves of the female genitalia lead to pain, they can also decrease the sensitivity of the genitalia and, therefore, sexual pleasure. Sexual pleasure and satisfaction depend both on neurophysiological and psychological mechanisms. Sexuality is bio-psycho-socially determined,[24] in that biological, psychological and social aspects interact with each other to result in a specific perception of sexuality. This means that women who have undergone FGM could compensate for these negative neurophysiological effects through cognitive, affective and neuropsychological mechanisms.[23] The latter mechanisms are conditioned by past sexual experiences [25] and the cultural or religious messages about sexuality with which a person grew up. In communities where it is the social norm, FGM is part of a women’s identity and is a prerequisite for belonging to a particular social group or community. Consequently, when talking about sexuality, all these various perspectives and issues should be taken into account.

Sexual dysfunction is implicated in psychological conditions such as depression and anxiety. Both have a negative influence on sexual desire and satisfaction.[26,27] As depression and anxiety are two important consequences of FGM,[20,21] we assume that women who have undergone FGM are at risk of reduced sexual satisfaction and desire. Consequently, a proportion of requests for surgical aid, as discussed below, are motivated by a wish to improve sexual life. The question whether clitoral reconstruction is necessary for enhancing sexuality requires further research.

Reconstructive surgery after FGM

A brief overview of the reconstructive method after FGM

The technique of reconstructive genital surgery in women with a history of FGM was initially developed by Pierre Foldes. During surgery the skin covering the stump is resected to reveal the clitoris. The suspensory ligament is then sectioned in order to mobilise the stump. The scar tissue is removed from the exposed portion and the glans is brought into a normal position.[28] It is important to let the neoglans protrude 5 mm to compensate for possible diminution in the immediate postoperative period.[29] The reconstruction takes less than half an hour and can be performed under local anaesthesia. However, surgery usually takes place under general anaesthesia in order to prevent the patient from re-experiencing the initial traumatic experience of FGM.[28] More detailed technical information on the procedure can be found elsewhere.[28–30]

Preoperative considerations

As mentioned above, FGM can result in both short- and long-term negative consequences for girls and women of all ages. It is important to take into account that women who ask for clitoral reconstruction might be a subpopulation of those who have experienced FGM. Important issues to address in order to maximise a positive outcome of
surgery include the needs and expectations of these women regarding the procedure.

In 2012, Foldés et al. [28] published the results of a survey of women requesting reconstructive surgery. The survey showed that 99% of the women wanted to recover their identity, 81% expected an improvement in their sexual life and 29% were hoping for pain reduction. The survey also identified other characteristics. It seemed that most of the excisions took place between the ages of 5 and 9 years old. The authors concluded that there was a strong association between preoperative pain and the age at which FGM was carried out. The older the girls were when they underwent FGM, the more pain was reported.

Research by Thabet and Thabet [16] in 2003, however, found that not only the age at which FGM was carried out but also the type of FGM, the quality of suturing and the skills of the person who carried it out played an important role. The authors stated that sexual function depended on a balance between normality of the genital anatomy, correct genital and sexual knowledge and efficient sexual stimulation to obtain a satisfactory response and result. According to these authors, FGM does not lead per se to sexual dysfunction.[16]

In a systematic review of the literature on FGM and women’s sexuality published between 1997 and 2005, Obermeyer [17] demonstrated that the available evidence did not support the hypothesis that FGM destroys sexual function. The review showed that poor study design, inadequate analysis and unclear reporting of results characterised many of the studies on negative sexual effects.

Catania et al. [31] investigated the sexual functioning of different groups of women with a history of FGM. The study confirmed that women could still experience orgasm after FGM: among the 137 women who had undergone different types of FGM, almost 86% reported experiencing orgasm, with 69.23% indicating that they always experienced orgasm. The same group also had orgasms by manual stimulation. However, 10.34% indicated that they never experienced orgasm after manual stimulation, and 1.71% that they never experienced orgasm during penetrative vaginal sex.[31]

Comparison of the different studies shows that the evidence for the effects of FGM on sexuality is weak and that further research is therefore needed.

It is important to bear in mind that in infibulated women, the erectile structures that are crucial for experiencing orgasm might not have been totally excised. A study by Nour et al. [32] showed that 48% of defibulated women had an intact clitoris buried beneath the scar. A recent study by Abdulcadir et al. [33] showed that women with FGM did not have a significantly decreased clitoral glans width and body length; meaning that healthy women who were devoid of long-term consequences of FGM could reach orgasm and enjoy satisfying sexual relationships. However, they did have smaller clitoris plus bulb volume and scored lower on sexual desire and function than women without a history of FGM. They also complained more of dyspareunia.[33]

Neuroma of the clitoris can complicate FGM and lead to hypersensitivity and even severe pain.[34] Its treatment can be another surgical challenge, as reconstructive procedures carry the risk of further nerve damage. In order to prevent this, it is meaningful to identify the type of FGM and, perhaps more importantly, avoid a second negative experience for the patient.

We may conclude from these studies that prior to clitoral reconstruction it is important to assess the type of FGM, the degree of mutilation and complications, and the reason for the request for surgery, since the outcomes might differ considerably.

Postoperative considerations

In order to evaluate whether reconstructive surgery after FGM is successful or not, we must first establish the postoperative effects. Research on this topic is, however, rather scarce.

Foldés et al. [28] reported that surgery generally resulted in a visible glans: 42% had a hoodless glans, 28% had a normal clitoris, 24% had a visible projection, 6% had a non-visible but palpable projection, and in less than 1% there were no changes. Following surgery, 89.4% of patients reported an improvement in sexuality, and 97.7% (821 out of 840 women) reported a decrease in pain, or at least not a worsening of pain; 51.1% reported experiencing orgasm. Those who had reported limited orgasm prior to surgery reported an improvement in orgasm, or at least no decrease in orgasmic functioning, 1 year after surgery. After the procedure, half regularly experienced orgasm. However, 23% of patients who experienced orgasm regularly before surgery reported a reduction in orgasmic frequency postoperatively.[28] Immediate postoperative complications, including haematoma, suture failure and moderate fever, were noted in 5% of patients; 4% were briefly re-admitted to hospital.

Merkelbagh et al. [35] showed that following surgery 17% of patients reported an increase in sexual pleasure, and 56% in libido; 41% reported a decrease in dyspareunia.

Thabet and Thabet [16] drew similar conclusions from their research into postoperative sexual functioning. They found that in women who had experienced complications due to FGM a clitoro-labial reconstruction led to a significant improvement in sexuality, both objectively and subjectively. However, for women with type I FGM, sexuality was not affected by the surgery.[16] We should not forget that reconstructive surgery can allow many women with FGM to become clitorically orgasmic, but it is no guarantee of orgasms. Between 20% and 30% of women without a history of FGM also have difficulties achieving orgasm. Regardless of their genital integrity, these women should be offered psychotherapy to improve their sexual and/or orgasmic functioning, since achievement of orgasm depends on more than anatomy alone.[36]

A systematic review about clitoral reconstruction [37] highlighted that it is important to inform women requesting reconstructive surgery of the scarcity of evidence on the safety and efficacy of the procedure in the long term.

Reconstructive genital surgery after FGM should aim to restore normal anatomy as far as possible; however, as Foldés et al. [28] state, it can only restore the potential for improved sexuality: adequate sexual skills, a healthy desire for a sexual life, and the absence of psychological barriers are equally important. Realisation of this potential depends on the woman’s individual life course and the many complex factors related to sexuality. A period of adaptation after surgery is essential to process these experiences.[28]
The need for a multidisciplinary approach

Despite the paucity of data, and the limitations of existing studies, we strongly believe that a multidisciplinary approach is paramount to providing proper care for women requesting clitoral reconstruction after FGM. However, this does not simplify the decisions that have to be made by the medical team. In some cases it will not be clear whether a woman will benefit from clitoral reconstructive surgery or whether a different path should be followed. In these cases, decisions should be based on evidence-based guidelines and ethical principles, and made in collaboration with the multidisciplinary team.

Multidisciplinary centres for women with FGM are available in some Western European countries. In Belgium, for example, multidisciplinary care for women who have experienced FGM is readily available in two major cities and provides accessible, affordable and specialised care. In these centres, women and girls from the age of 14 receive counselling and have access to medical, psychological and sexual guidance, as well as treatment for the consequences of FGM. Counselling is provided to assess whether or not a woman or girl needs clitoral reconstruction. In the Belgian centres, the multidisciplinary teams consist of a midwife, a psychologist, a sexologist, a plastic surgeon and a gynaecologist. Since March 2014, the care of women in the FGM referral centres, including those undergoing clitoral reconstruction, is reimbursed through the health insurance system.

In other European countries such as the UK, Germany and France, comparable models of care exist. To the best of our knowledge, there has been no study comparing the approaches of the different European centres that provide care for women after FGM and offer genital reconstructive surgery. To date, little is known about what women are looking for exactly, what they expect, and whether their expectations are met through the care they receive in these centres. European guidelines for the organisation of care are not yet available.

Guiding principles

The WHO advocates that all humans have the right to health care that is accessible, acceptable and of good quality. The treatment of women with FGM should be guided by these principles.

Acceptable and good-quality health care for women with FGM should be provided according to the principle of ‘do no harm’. Thus, any procedure that involves a greater risk of harm to the patient is unethical. In the case of reconstructive surgery, however, there are few research reports on the procedure and its outcomes. The true complication rate associated with surgery is unknown; hence, more studies are urgently needed to provide evidence for future practice.

The surgeon should ensure that the patient is not persuaded to have surgery by a third party, e.g., by a (sexual) partner. The patient should also be fully aware of the risks of surgery and should not be put under pressure from the surgeon. Pressure by the surgeon can start at an early stage: for example, even before the patient meets the surgeon, through advertisements for this kind of surgery.

Tailor-made treatment

There is a lack of studies to clarify the intentions and motivations of women requesting clitoral reconstruction after FGM. As clitoral reconstructive surgery after FGM may be considered to be cosmetic genital surgery, research on the motivations for such surgery may give some indication of the intentions of women with FGM who request clitoral reconstruction. Özer et al. classified the various motivations for cosmetic genital surgery into four categories: the wish for normality, aesthetic aspirations, functional complaints, and psychiatric comorbidity.

Studies have shown that there is a correlation between sexual pleasure and the ideas and emotions a woman has regarding her genitalia. If she is convinced that her external genitalia are abnormal, it can lead to preoccupations, shame and a lowering of self-esteem. If the decrease in self-esteem is focused on her perception as a sexual being, it can affect her sexual safety and satisfaction. In these cases, counselling and a psychosexual evaluation are necessary to identify the need for surgical or psychological treatment.

Functional complaints are a third reason why women ask for reconstructive surgery: for example, pain during intercourse, dyspareunia, etc. When it comes to functional adjustments, it seems obvious that surgery will most probably be the best approach to help the patient. However, in some cases sex therapy might also be a solution. Regardless of the quality of intimacy, tenderness and communication in a relationship, we may wonder whether reconstructive surgery contributes to an improvement in the quality of the sexual relationship. Knowing that mental states play a role in sexual dysfunction, it is essential that psychological evaluation should be part of assessing the need for reconstructive surgery after FGM. A woman and her partner undergoing sex therapy can learn different approaches to intimacy and sexuality. Broadening the scope of their sexual knowledge and experience might be felt by the woman, or couple, to be less invasive and may make genital reconstruction superfluous.

Finally, some requests are due to psychiatric comorbidity. For example, some women with a history of sexual violence may request cosmetic surgery such as a labia reduction as a way to cut away the memory of the trauma. Patients with body dysmorphic disorder show signs of a preoccupation with an imagined defect in their appearance, or when there is a real physical anomaly they will be markedly concerned with it. When psychological problems are caused by a real genital abnormality, surgery might lead to a decrease in symptoms. However, when psychological problems produce the idea of abnormality, surgery will only provide a temporary solution. Without proper psychological guidance these patients will soon present themselves again to the surgeon with a new request for adjustments to their body. Making this distinction is paramount to helping patients attain their goal. Psychological guidance should be the minimum in these circumstances. Cognitive behavioural therapy, eye movement desensitisation and reprocessing (EMDR), and other psychological techniques will help the patient to process the trauma and regain acceptance of her body. Counselling can protect women with psychological problems from undergoing unnecessary surgery and assist them in making...
a decision based on facts. The same reasoning might be applied in women with FGM.

A multidisciplinary counselling model of care after FGM

Since guidelines on the best approach to care of women with FGM do not yet exist, we propose some recommendations for a multidisciplinary counselling model. Based on existing guidelines on general female genital cosmetic surgery and findings from studies of two European multidisciplinary teams caring for women with FGM, we believe that a multidisciplinary team should include a midwife, a gynaecological surgeon, a psychologist-psychotherapist, a sexologist and a social worker. Each discipline should be systematically consulted, and health counselling should be included in each patient consultation. A period of reflection should follow the different consultations to help the patient process the new information and gained insights.

Preoperative counselling: As outlined above, it is clear that health counselling should be the starting point for a woman requesting reconstructive surgery after FGM. This type of counselling could be provided by a midwife and/or social worker familiar with the issue of FGM. Ideally, counselling should first and foremost identify the needs and expectations that have led to the request for reconstructive surgery. During the session, the counsellor should explain the next steps and give adequate information on possible complications and what can realistically be expected from reconstruction. At the start of the first consultation, the patient should be given a questionnaire to evaluate the problems she has had and whether there are any language barriers. The questionnaire can also be used to screen for potential financial or social problems. Since there is no validated instrument to date, further research should invest in the development of this type of preoperative screening tool.

During this session, the counsellor should consider not only the woman's past but also her present experiences. It is important to know whether she has a social network on which she can rely, whether she is in a relationship, whether she has a job, and so on. These elements might influence the postoperative period and possibly also the decision-making process.

Medical consultation: The second step should be a consultation with the gynaecological surgeon. During this consultation, a clinical examination should follow the patient's medical history of FGM. The examination could be done using a mirror to include the woman in the process. In this way she can learn about the type of FGM she underwent, her anatomy and the consequences for her sexual and reproductive life. If surgery is requested, the gynaecologist could describe the surgical techniques and their limitations. It is equally important that the woman is informed about the possible outcomes and risks, and whether or not surgery can meet her needs and expectations. Considering that women ask for different kinds of help, it is important to set realistic goals when proposing treatment. Whether reconstruction can enhance sexual pleasure and decrease pain can only be determined after a postsurgical recovery period. The extent to which a potential restoration is achieved will also depend on the life history of each individual woman and on different complex factors linked to her sexuality. Again, providing accurate, tailored information is paramount to enable the woman to make an informed decision. The medical consultation enables the woman to discover, or rediscover, her body, including her clitoris, which, though mutilated, still exists. Even after clitoridectomy, when the external part of the clitoris is removed, the internal structure remains. The woman's recognition of the presence of these genital structures and understanding of her own body are crucial to continuing further on the path to regaining her identity and sexual functioning, or to working through psychological trauma. The medical consultation should aim to initiate a process of appreciation of the body and of reassurance.

Psychological consultation: Following the medical consultation, a psychological consultation should invite the woman to express any psychological suffering related to FGM. This session offers the possibility to evaluate any post-traumatic symptoms of the mutilation or other traumatic life events that can affect her mental or sexual health. The experience of limitations in daily life needs to be identified in order to take them into account when making a therapeutic proposal. Caring for women after FGM is a complex matter, since they have experienced a trauma with multiple consequences; moreover, some women might have had additional traumatic experiences such as early marriage and sexual violence. One of the tasks of psychotherapy is to teach the woman how to live with FGM rather than to keep living it as a trauma. A recent study which evaluated a multidisciplinary approach to women requesting clitoral reconstructive surgery, and the reasons why some then declined surgery, showed that in many cases a psychomedical and social approach alone can produce excellent results in terms of satisfaction among women who initially asked for a surgical intervention: 82% of women who participated in this study were satisfied with the multidisciplinary care pathway.

Sексological consultation: The sexological consultation with the woman and, if possible, her partner should aim to evaluate sexual and relational functioning. Abdulcadir et al. concluded in their research that women with FGM have sexual erectile tissues capable of sexual arousal, orgasm and pleasure. Many women, however, request genital reconstruction despite having a functioning clitoral stump, as they are most probably looking to improve their female identity and genital image. Sexual function can be improved for these women by enhancing body image, female identity and self-confidence. Psychotherapy and sex therapy are in these cases far less invasive than a surgical approach to make the clitoris more accessible. Providing accurate information on sexual anatomy and function could improve the experience of sexuality for women with a history of FGM and their partners, who might presume that a visually missing clitoris makes it impossible to provide sexual stimulation. The use of a series of photographs or video images of female genitalia might help women to reframe their ideas about what normal genitalia look like and the wide variety of appearances. It is essential to help the woman describe her sexual experiences in order to increase her satisfaction if necessary. Women should be encouraged, during the
Integrate his/her voice in the decision-making process. Multidisciplinary team meeting: Each patient file should be presented and discussed at a regularly scheduled multidisciplinary meeting in order to design the most appropriate care case by case. Once the multidisciplinary team has reached an agreement on the best treatment approach, the woman will be invited to a consultation to discuss the next steps and the rationale behind the team’s decision.

Clitoral reconstruction with multidisciplinary care tends to improve the functional and sexual quality of life of FGM women. Some patients drop their initial request for reconstructive surgery, as multidisciplinary care alone meets their needs. A study by Antonetti-N’Diaye et al. showed that after women had consulted the different disciplines the demand for surgery decreased. Surgery is often initially seen as the main remedy to erase a painful past, but psychological pain cannot be cured through surgical intervention. A multidisciplinary approach allows these women to receive holistic care and avoids new, unnecessary suffering.

Ideally, the presence of an interpreter is needed during the whole process to be sure that the patient has fully understood and can give informed consent. The woman’s partner should also be involved in the process in order to integrate his/her voice in the decision-making process.

Conclusions

In this paper we have tried to highlight some of the issues in requests for clitoral reconstruction after FGM. We have suggested that women with FGM might primarily be looking for a way to improve their sexual life, recover their identity and reduce their pain. However, reliable evidence about what women are really looking for when requesting clitoral reconstruction is limited. The limitations of existing studies and the paucity of data concerning this topic might partially explain why there are no guidelines and why it is a challenge to provide guidelines for a gold standard of care. Based on the published literature and our experience in Belgian FGM referral centres, however, we believe that good care pathways for women requesting clitoral reconstructive surgery should be multidisciplinary. It is important to counsel women first, in order to determine the optimal way forward. Based on thorough health counselling, as well as medical, psychological and sexological consultations, the multidisciplinary team can develop a good impression of the patient and her motives. This will help the team to construct a personalised care pathway in consultation with the patient.

Good health counselling helps patients make conscious and informed choices. Empowering patients to find a care pathway that suits them should be one of the goals. Regardless of personal beliefs, it is important to maintain an open, non-judgemental frame of mind when providing care for women with FGM. Reconstructive surgery of the clitoris can be a liberating experience, but, after reconstruction, many women might also struggle to find the right balance between desire, family values and local traditions. Therefore, we believe that multidisciplinary care including medical, psychological and sexological advice is essential.

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Disclosure statement

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