Female genital mutilation in Greece

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Summary

The number of migrants and refugees with a female genital mutilation (FGM) living in Greece is rising. This study explores the characteristics and psychosexual issues of women with FGM who were examined in the 2nd Department of Obstetrics and Gynecology, University of Athens Medical School, Greece during the year 2009. The women were asked to fill out an anonymous questionnaire asking for demographic data, obstetric history, current complaints, and psychosexual problems. The results are presented and discussed, as FGM is a new reality for Greece. Healthcare providers have to familiarize themselves with issues related to FGM and improve their skills in transcultural care, so as to manage and support women with FGM adequately.

Key words: Female genital mutilation; FGM; Migration; Infibulation; Greece; Migrants.

Introduction

Female genital mutilation (FGM) is a procedure involving partial or total removal of the external female genitalia, as well as injury of the female genital organs for non- medical reasons [1]. FGM is practiced in about 28 countries in Africa and the Middle East by Muslims, Animists, Atheists, Catholics, Protestants, Orthodox Copts and others [2]. Of all girls and women 80 to 90% have undergone FGM in Egypt, Ethiopia, Eritrea, Gambia, Mali, Sierra Leone, Somalia and Sudan [3]. According to the World Health Organization (WHO), it is estimated that 100 to 140 million girls and women worldwide are presently living with FGM. The United Nations Children Fund (UNICEF) raises this number to over 150 million. It is also estimated that three million girls are at risk of FGM every year [4].

The first ever reference of FGM appears in an old illustration from ancient Egypt [5, 6]. Although the ritual is older than Christianity and Islam, the Koran does not refer to it. However, a number of "Hadith" (statements by the prophet Mohammed) make reference to FMG [7].

The increasing numbers of migrants and refugee resettlements in Europe mean that the respective national societies are becoming more culturally diverse. Much of this recent adjustment is related to migration of sub-Saharan African populations. Greece, similarly to other Mediterranean countries is the final destination or an ordinary route for African migrants to Europe. Thus more and more Greek gynecologists face cases with FGM due to the progressively increasing rates of migration.

The aim of this prospective study was to explore and analyze the effects and consequences of FGM in women that visited our department and address relevant issues. It is expected that the management of these cases by healthcare providers, and above all gynecologists, will be improved as they will start better understanding better this group of women and their needs.

Revised manuscript accepted for publication April 11, 2011

Methods

This is a prospective study that was undertaken from January 2009 to December 2009 by the 2nd Department of Obstetrics and Gynecology at Aretaieion Hospital in Athens. An anonymous questionnaire was given to women with FGM who attended the family planning clinic.

The participants were informed of the objectives of the study and filled the questionnaire on a voluntary basis. The questionnaire collected information regarding sociodemographic data, extent of knowledge concerning the FGM procedure and type of mutilation, obstetric history, and long-term emerging problems such as sexual dysfunction, psychological and other problems currently being faced.

Moreover, all patients underwent a routine gynecological examination. The questionnaires and the gynaecological exam findings were transcribed and analysed with the help of Excel software (Microsoft Office Excel 2007 1.0).

Results

The sociodemographic characteristics of women with FGM are presented in Table 1 and the psychosexual issues and complications in Table 2. Seven out of 11 women with FGM that visited our gynecology outpatient department accepted to be included in the study and completed the anonymous questionnaire. The median age of the patients was 24.7 years old (19-31 years old), while the median age that FGM was performed was 4.9 years old (3-8 years old). The majority of women were married (86%) and were examined by an obstetrician for first time during their pregnancy. One, four and two women from the study group had undergone FGM type 1, 2 and 3 respectively. None ever experienced orgasm during sexual intercourse. Additionally all of them face psychological problems as shown in Table 2.

For the theoretical question if they would ask for rebuilding in case of vaginal delivery, three out of seven responded positively and four negatively. Additionally all women stated that they had difficulty in accessing the family planning clinic as relevant information was not readily available to them.

Table 1. — *Sociodemographic characteristics of women with FGM.*

Woman	Nationality	Religion	Age (years)	Age undergone FGM (years)	Type of FGM	Age of first sexual intercourse	Pregnancy/ mode of delivery
A	Ethiopian	Muslim	19	3	3	19	No/No
B	Ethiopian	Muslim	24	5	3	23	Yes/CS
C	Egyptian	Christian	31	6	2	28	Yes/CS
D	Egyptian	Muslim	26	5	2	25	Yes/CS
E	Erithrean	Muslim	25	3	2	25	Yes/CS
F	Ethiopian	Muslim	25	8	2	24	Yes/CS
G	Somalian	Muslim	23	4	1	23	Yes/CS

Table 2. — *Complications and psychosexual issues related to FGM.*

Woman	Complications	Psychological problems	Orgasms experienced?
A	Dysuria, pyelonephritis, dyspareunia	Nightmares	No
B	Dysuria, dyspareunia	Depression	No
C	Dysuria	Fear of the future	No
D	No	Depression	No
E	No	Depression	No
F	Dyspareunia	Fear of the future	No
G	Dyspareunia	Fear of the society	No

The women were also asked to make free comments at the conclusion of the questionnaire concerning the procedure and its effects on their lives. Woman A referred to the procedure as: "Until today, I have nightmares of the old woman and the cutting". Woman B described: "I can never forget the bleeding and being left alone outside my village for ten days". Woman C said: "I will never give my consent to perform such a cutting on my daughters". Woman D: "This is the most horrible moment of my life, I have no sexual pleasure, I feel humiliated". In contrast, two women with type 2 FGM had different opinions as shown on their free comments. In particular, woman E stated: "I could not manage to have a good marriage without the cutting; it is a tradition in my country". Woman F said: "The cutting is promoted by our religion, as it is believed that the clitoris is controlled by the devil".

According to the vaginal examinations that took place during their visit to the family planning clinic, the classification of the FGM type agreed with the type stated by each woman.

Discussion

According to our knowledge this is the first study from Greece exploring FGM from the patient's perspective. FGM is carried out as a part of a tradition in girls aged between birth (7 days) and pre-adolescence (10-12 years), always before the first menstruation and marriage [8]. The practice of FGM is spread through the generations by mothers and older women who prepare their daughters for adulthood and marriage. The causes of FGM include among others tradition, cultural ideals of femininity and modesty, aesthetic and hygienic reasons, proper sexual behavior, premarital virginity, protection of the family honor, marital fidelity, increase of fertility, increase of male sexual satisfaction and even fear of sudden newborn death caused by contact of the fetus with the clitoris at the time of birth [1, 8].

According to the current classification by the WHO (World Health Organization), FGM is classified into four types as shown in Figure 1 [1, 8-10]. The removal of the clitoris and the labia minora (type 2) is the most frequent form, amounting to 80% of all cases. The most extreme form, about 15% of all cases, is infibulation (type 3). Furthermore, defibulation describes the opening of an infibulation, whereas refibulation describes the close (restitching) of a previously opened infibulation at the time of vaginal birth.

FGM can lead to direct medical or psychological complications [11].The complications in this group are analogous with those described in the literature, with two patients referring severe hemorrhage from the site of operation that made them feel weak, dizzy, and holding their breath for weeks. Other immediate complications of the study group include shock and severe pain, particularly if FGM was carried without analgesia (Figure 2). Moreover in our study three women complained of dysuria that had not resolved yet. Other chronic long-term consequences described in the literature include cysts, clitoral neuroma, recurrent bladder and urinary tract infections, renal calculus, kidney damage, incontinence, uterus and oviduct inflections, painful menstruation (caused by partially obstructed blood flow), infertility and abdominal cavity infection [10].

Sexual intercourse may be painful throughout life and orgasm may be difficult to achieve. None of the women in our study reported any experience of orgasm and four out of seven women had dyspareunia. The pelvic examination is also difficult for a woman who has undergone FGM, particularly for types 2 and 3. The use of a speculum is determined by the size of the introitus, and in many cases a pediatric speculum is preferable. In a group of 137 women who had undergone different types of FGM there were significant differences between the study group and an equivalent group of controls in desire, arousal, orgasm and satisfaction [12].

During birth, most infibulated women need to be cut open (difibulation). Problems during labor and birth are prolonged second stage of labor, increased perinatal mortality, difficulties with vaginal assessment for progress of labor, bladder catheterization, perineal lesions, fistulas, and post-partum hemorrhage [10, 13-15]. Although no difference in cesarean section rates have been reported for women with FGM in many countries [16], women with FGM living in Greece have an increased risk for cesarean section due to obstetricians' unawareness of the condition and the fear of handling women with FGM. The increased cesarean section rate for cases with FGM in Greece is in accordance with rates reported in Germany and Norway [17, 18]. Some women get stitched (closed) again after vaginal birth in their home countries

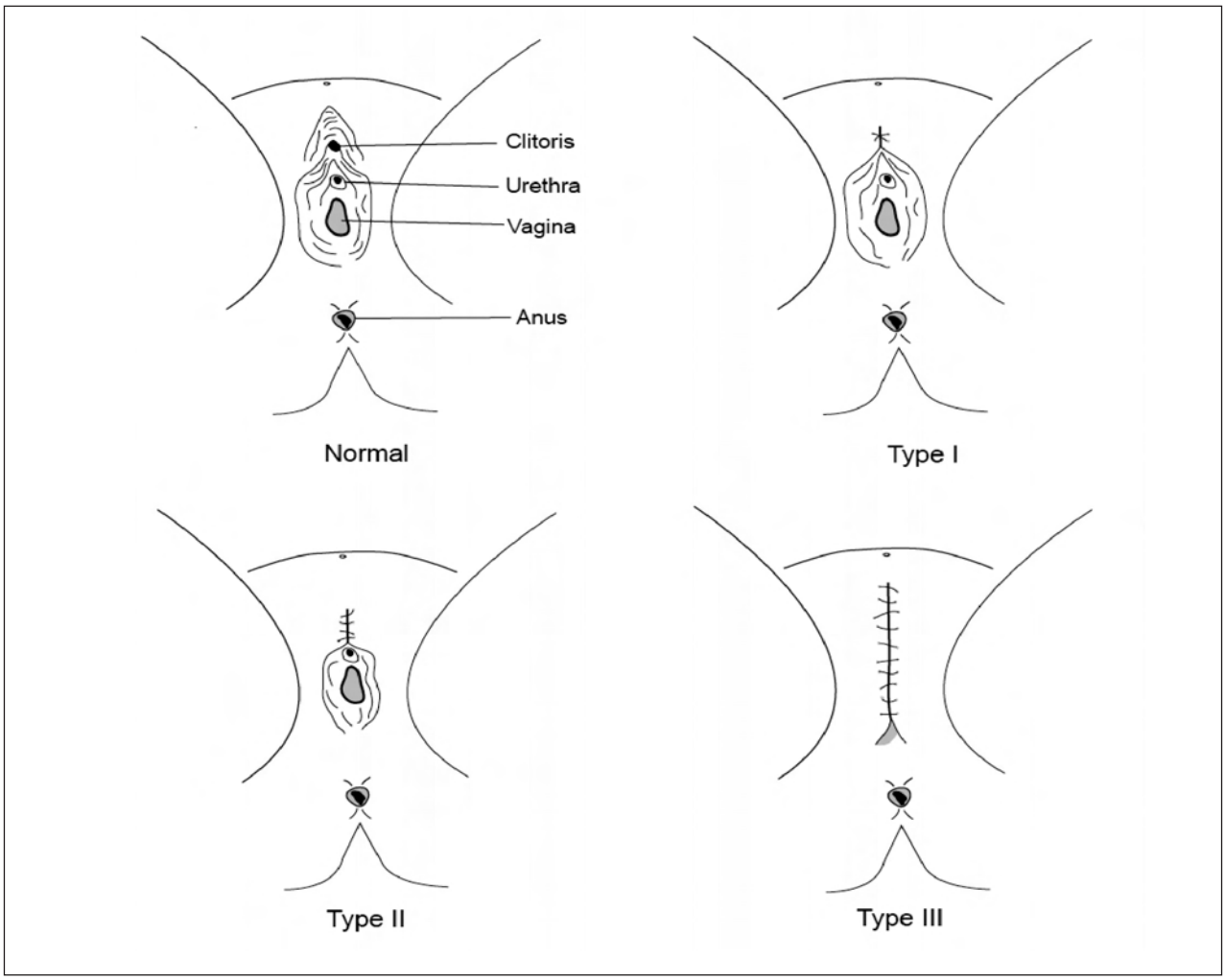

Figure 1. — FGM classification. Type 1, "sunna": removal of the prepuce combined with partial or total removal of the clitoris. Type 2, "excision": partial or whole removal of the clitoris and the labia minora, with or without excision of the labia majora. Type 3, "infibulation": narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the inner, and sometimes outer, labia, with or without removal of the clitoris. Type 4, other: all other harmful and unclassified procedures to the female genitalia for non-medical purposes, i.e. pricking, stretching, piercing, incising, scraping and cauterizing the genital area (type 4 is not shown).

(refibulation). In this study three out of seven women responded positively to the relevant hypothetical question. However, there are guidelines such as those of the Royal College of Obstetricians and Gynecologists (RCOG) stating that women with FGM should not be refibulated after delivery [19]. The procedure itself (refibulation) is often described by many women as traumatic. Emotional effects include anxiety, fear, depression, sleeping and eating disorders, mood disorders, impaired cognition, inferiority feelings, panic attacks, and post-traumatic stress disorder [11]. Women with FGM report chronic irritability and nightmares. They have a higher risk for psychiatric and psychosomatic diseases [11].

To date there are no published data or evidence that FGM is practiced in Greece. Some countries have criminalized FGM with new laws and legislation. The European Council and the European Parliament have specifically condemned FGM and demanded the commitment of the member states to eradicate this practice as FGM violates the human right to physical integrity, health and equality [20, 21]. The legislation in Greece does not specifically focus on FGM practice by gynecologists or other health professionals. However a doctor in Greece would not practice FGM or refibulation, even if asked, as he would be punished under the relevant Greek penal law that prevents corporal injuries [22].

The increasing number of immigrants or refugees from countries practicing FGM raises some concerns in the countries of the European community, as these women constitute a relatively new maternity client group. In Greece, the first women with FGM were recorded in 2003, as reported by healthcare professionals [23]. The

Figure 2. — Woman A of the study described the infibulation procedure carried out "in the bush" by traditional female practicioners without asepsia or analgesia.

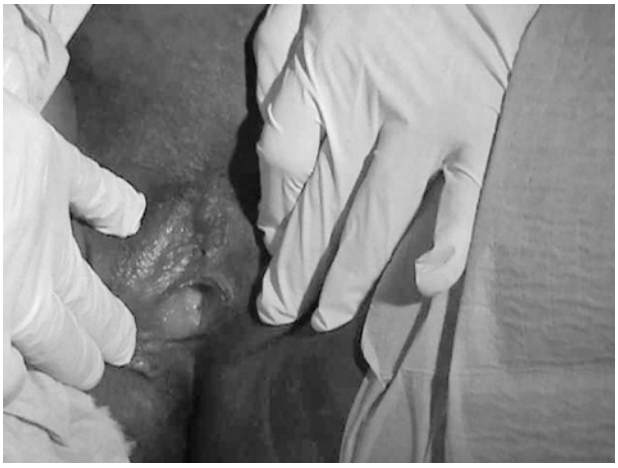

Figure 3. — Type II FGM in patient F.

growing demographic weight of these communities is expected to increase in the future together with the number of women at risk for undergoing FGM. According to our data surgical treatment for FGM is not provided in Greece. Yet a discussion with women who have undergone FGM can help to create an awareness that will benefit their prospective daughters.

A recent study showed that there is a lack of knowledge among gynecologists about FGM in Western societies including its classification, the provision of care and legislation [24]. Only 58% of healthcare professionals in a University teaching hospital in the United Kingdom were able to list the categories of FGM; 47% of them incorrectly thought that cesarean section was the best way to manage the delivery of patients with FGM. Lack of relevant experience and appropriate training for healthcare providers can lead to inadequate treatment, for instance to an unnecessary cesarean section, due to ignorance of the defibulation technique [25]. Healthcare professionals should be able to provide reasonable medical and psychological support, as well as an understanding of the motives and attitudes of women towards FGM. They also need to know the medical facts and treatment possibilities as well as the legal background.

To this end regular education and counselling sessions should be organized and supported by local scientific societies. Greek gynecologists should be educated further and change their attitude towards this group of women. There is a need for a transcultural approach which is closely linked to the identity of the migrants or refugees. The moral commitment of healthcare professionals should be to avoid these traditional practices which imply discriminatory, violent, degrading and painful treatment towards women. Patients with FGM should be encouraged to seek gynecological counselling in family planning clinics. Specialized pediatric and adolescent gynecologists and pediatricians should be made aware of the problems and participate when necessary. As there are no guidelines for FMG in Greece (concerning gynecology and obstetrics), the care of women is based on the gynecologist's experience as to what might constitute the best practice for the case. However the gynecologist in charge may lack experience. Other European countries have issued guidelines and the procedures are standardized [26, 27]. Similar guidelines should be issued in Greece, after the necessary adaptation.

Furthermore there is a need to change and intensify laws in Greece in order to limit any FGM procedures in the future. New legislation should be introduced aiming to prevent FGM. According to the findings of this study, it is important that the education of Greek healthcare professionals provides understanding of FGM and knowledge of the existing Greek law. Till now, no FGM courses are scheduled for doctors, midwives or medical students in Greece. The Greek Family Planning Association and the Advanced life Support in Obstetrics Greek group are going to motivate and promote a dialogue with health professionals and families.

Conclusion

In recent years there has been a growing concern about the problems related to FMG in the Greek society. FGM refers to a spectrum of actions from very minor cutting to more significant procedures. A team approach to affected women and families by obstetricians and gynecologists, pediatricians, midwives and psychologists with specialist training in FGM-related issues are necessary. The adoption of clinical guidelines is recommended. Actions from the Greek state and Europe should aim to put an end to

this brutal tradition, especially to the second generation migrants of the FGM practicing communities in Greece. Improved access to the services for women and families, information leaflets, and help groups will create additional opportunities for change.

Acknowledgement

The authors thank the Greek ALSO (Advanced Life support in Obstetrics) project for the medical illustrations provided.

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