

Ethical and Cultural Issues in Genital Cutting and Strategic Suggestions for Reduction

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In April 2017, a physician in Detroit, Michigan was charged with performing female genital mutilation/cutting (FGM/C) on girls aged six to eight. A few weeks later, another physician and his wife were also indicted for participating in or facilitating the procedures. At least two young girls had been transported across state lines to a clinic in Eastern Michigan where the procedure occurred, bringing this case under federal jurisdiction and leading to the indictment of the accused by the Federal Bureau of Investigation.¹

As the most recent, or perhaps the only, case to be brought under federal law, it brings renewed attention to the issue of FGM/C in the United States. FGM/C, is defined as circumcision, excision, or infibulation of the labia majora, labia minora, or clitoris.² Since

1996, FGM/C performed on minors has been considered illegal in the U.S. and is punishable by fines and imprisonment of up to five years.² In 2013, “vacation cutting” or transporting a girl to a country outside the U.S. to undergo the procedure was also outlawed. Additionally, state-level legislation, with even harsher penalties in some cases, has been introduced in 23 states.³

Adding to the already complex legislative landscape, laws regarding FGM/C may overlap with child abuse laws, depending on the state. As a result, there is variation among the states in what is considered “child abuse,” and what is considered culturally excusable medical treatment of children.³ Such variation in state-level policies makes for unclear guidelines and obligations for mandated reporters, including physicians.

The Catholic Moral Tradition and FGM/C

Catholic moral theology considers FGM/C to be non-therapeutic surgery that violates the principle of totality. It is therefore morally equivalent to mutilation. This principle is stated clearly in the *Catechism* (#2297), as well as in the 1995 edition of the *Charter for Health Care Workers* where it says, ... [surgical] interventions are acceptable “for the restoration of the person to health” (#66). Elsewhere, the document quotes Pius XII regarding the principle of totality: “It is not lawful to sacrifice to the whole, by mutilating it, modifying it or removing it, a part which is not pathologically related to the whole” (note #144). This principle is reiterated in *the New Charter for Health Care Workers* (2017), especially in #88 and #89.

There are also serious ethical questions about the ability of young women to understand or consent to the procedures involved in FGM/C. Informed consent is one of the most basic principles in health care ethics; procedures performed without it – or without the informed consent of parents or guardians for minors – are serious violations of basic ethics.

More recently, Pope Francis has made explicit reference to FGM/C. On February 1, 2015, in an address that was part of a meeting on women’s issues hosted by the Vatican’s Council for Culture, he associated the practice with violence against women: “The many

forms of slavery, the commercialization, and mutilation of bodies of women call out to us to be committed to defeat these types of degradation that reduce them to mere objects that are bought and sold,” he said. “Although it is a symbol of life, the female body is unfortunately not rarely attacked and disfigured, even by those who should be its protector and life companion.”⁴

There are also local efforts to end FGM. In Kenya, the church has established a child education and Rescue Centre in Suguta Mar Parish premises, located 42 kilometres away from Samburu County headquarters where they provide shelter for girls who leave home to avoid FGM.⁵

Elsewhere in Kenya, Sr. Ephigenia Gachiri has tried to replace cutting with an alternative “coming of age” ceremony.⁶ Efforts in the United States, such as those sponsored by the Diocese of Rochester, New York (described elsewhere in this article) are aimed at recent immigrants in the U.S. who might still be at risk for FGM.

FGM/C in the Clinic: A Complex Legal and Ethical Landscape

Regarding FGM/C, physician behavior and decision-making in the clinic are a delicate balance of legal obligations, professional guidelines and medical ethics. Legal obligations are often unclear, and, in practice, provide little in the way of how to provide care that is in the best interest of the up to 507,000 U.S. women and girls that have either undergone FGM/C or are at risk.³

Guidelines from The American Academy of Family Physicians (AAFP) that pertain to FGM/C are consistent with U.S. federal law. They encourage physicians to provide the patient and family with “culturally sensitive counseling and education”, as well as referral to social support groups, to discourage them from carrying out the procedure.⁷ While the AAFP’s policy reflects consideration for the sociocultural context of patients and the cultural aspects of FGM/C—a consideration not present in most legislation—these professional guidelines alone do not go far enough to address the complex ethical

challenges that an increasing number of physicians face when treating FGM/C survivors and at-risk populations.

The U.S. has a growing immigrant and refugee population, with approximately 39,000 refugees arriving between October 2016 and March 2017 alone.⁸ Socioeconomic status, lack of insurance coverage, language and cultural barriers, ability to navigate the health care system, and immigration status can contribute to this population's experience of poor access to quality health care.⁹ Although not a risk exclusive to women and girls in immigrant and refugee communities, FGM/C is viewed as a cultural, religious, and/or social tradition in some of the communities from which these populations have emigrated. For communities of newcomers that already have difficulty in accessing health care and in receiving quality care (i.e., reproductive and maternal care¹⁰), policies and practices that seek to build trust in the clinic are urgently needed.

Policies on FGM/C in the U.S. are often seen through the lens of human rights, viewing the practice as gender-based violence that is an affront to women and girls, and, hence, as a practice that needs to be eliminated. At the core of these policies, is the intent to reduce harm and to respect the value and dignity of affected women and girls. Indeed, the AAFP guidelines and those from other medical and professional organizations are informed by these legal and ethical principles. In the clinic, however, these criminalizing policies are not easy to implement.

Ethical Considerations

Both policymakers and physicians face several ethical questions and challenges when it comes to FGM/C in the clinic. The first is whether FGM/C can ever be considered a legitimate, non-therapeutic, surgical procedure. Here, it is worthwhile to consider the risks and potential complications associated with the practice, namely: short-term (e.g., infection, sepsis, hemorrhage) and long-term (cysts, recurrent infections, labor complications) physical, mental (e.g., PTSD, trauma)¹¹, and social risks (exclusion and marginalization).¹² These significant risks make FGM/C distinct from and potentially

more harmful than other procedures that are usually considered legitimate, non-therapeutic, surgical procedures, such as body piercings or body ink.

While most in the medical community advocate against performing FGM/C procedures due to their associated complications and the desire to do what is in the best interest of the patient, criminalizing policies may not be the best approach for treating patients who have survived FGM/C, or for preventing the practice.¹³ Similar questions about legitimacy and medical risks are being raised in regards to male circumcision – a practice that is currently tolerated both legally and clinically – by some who express concern over respect for autonomy, and a lack of benefits of circumcision.¹⁴ While FGM/C and male circumcision are distinct from one another in many ways, male circumcision may face similar challenges in the future.

Appropriate patient care and effective prevention of FGM/C are contingent upon the ability of policymakers and physicians to navigate these complex ethical and cultural issues. While approaches to addressing FGM/C in communities and in clinics have taken on a variety of forms (such as advocacy groups, community clinics, community organizing and mobilizing, and so on) and guiding principles (diversity, empowerment, trust, etc.), what these efforts have in common is a commitment to meaningful engagement with groups of interest, typically to both assess and meet community needs.

The Need and Rationale for Community/Patient Engagement

Health systems and providers are uniquely positioned to engage in important considerations of the practice of FGM/C. Physicians are tasked with identifying and treating the physical and psychological effects of cutting. In some cases, the physician may be among the first to discover that a woman or girl has been cut—whether recently or not—and is then faced with several questions related to legal obligations and to the ethical care of the patient.

If the physician is legally obligated to report the case, would reporting it be in the best interest of the patient? If the patient is a minor, what might happen to the patient if the parents are imprisoned? Will reporting this case prevent future cases of FGM/C, or will it lead to greater distrust of physicians in the community, and, perhaps increased secrecy? How does FGM/C impact a patient's medical care? How do the patient, her family, and her community view FGM/C?

Given the lack of clear legal guidance, insufficient and under-evaluated training for health professionals¹⁵, and the dearth of best practices on how to care for survivors of FGM/C and those at risk, many providers and health systems are currently ill equipped to address these pertinent questions. As a result, there has been a consistent pattern of women with FGM/C receiving inadequate preventive and reproductive care¹¹, as well as underreporting in the health care sector. There is also a lost opportunity to build partnerships and trust with communities that practice cutting.

While, indeed, the practice of FGM/C has harmful consequences – physical, mental, and social—the practice derives meaning from its cultural, religious, and/or social origins. If prevention attempts are to be effective, efforts must be made to understand these sources and how each patient's sociocultural context informs their conceptualizations of the harms, and purported benefits, of FGM/C. Community engagement offers the opportunity to understand sociocultural contexts, as well as values and motives, that may be encouraging the continued practice of FGM/C.

Key Elements of Effective Community Engagement

In the U.S. and other countries with growing immigrant and refugee populations, such as the UK and Canada, organizations and clinics are engaging with these communities in a variety of ways to reduce health disparities, improve health outcomes, and address unique health needs. A brief review of these diverse engagement efforts, as well as published resources on community engagement, reveal some key characteristics of effective approaches both in the clinic and within communities. The elements identified in these

ongoing programs, and in the literature, fall into three main categories: communication and dialogue, work within the health sector, and sustainable partnerships (see Table 1).

Table 1. Elements of Effective Community Engagement. Based on a brief review of ongoing community engagement efforts to address health disparities in U.S. refugee and immigrant communities (and in some cases, FGM/C directly), as well as published resources on community engagement from the U.S. and other receiving countries (UK, Canada).^{16,17,18,19,20,22,23,24,25}

COMMUNICATION & DIALOGUE	HEALTH	SUSTAINABLE PARTNERSHIPS
<p>Spaces and platforms for goals, values, needs</p> <ul style="list-style-type: none"> • Reflection • Listening • Validation 	<p>Training for health professionals</p> <ul style="list-style-type: none"> • Types of FGM/C • History, Consequences & Significance of FGM/C in the community 	<p>Integrate community assets & characteristics</p> <ul style="list-style-type: none"> • Identify strengths and limitations of your partners • Recognize the community’s history of change and relationships
<p>Recognition of context</p> <ul style="list-style-type: none"> • Avoid judgment, labeling, or blame • Self-awareness • Acknowledgement of potential biases 	<p>Guidelines for Medical Management of FGM/C</p> <ul style="list-style-type: none"> • Reflect community needs & women’s empowerment • Considers community’s values and goals 	<p>Recognize, prioritize, and promote diversity in</p> <ul style="list-style-type: none"> • Representation • Participation • Leadership
	<p>Develop & Disseminate Referral Procedures</p> <ul style="list-style-type: none"> • Clearly defined • System-wide 	<p>Engage and empower communities to take responsibility for change</p> <ul style="list-style-type: none"> • Support survivor-led and community-based efforts to change behaviors & attitudes
	<p>Integration with community and legal support networks</p> <ul style="list-style-type: none"> • Legal counseling services • Community health advisors 	<p>Design and implement comprehensive, flexible programming</p> <ul style="list-style-type: none"> • Create “learning systems”
	<p>Implement continual monitoring & evaluation</p>	<p>Implement concrete feedback and evaluation procedures</p> <ul style="list-style-type: none"> • Direct communication between community and service providers
		<p>Require a research component</p> <ul style="list-style-type: none"> • Identify and understand the causes and consequences of FGM/C within particular communities • Learn from previous and ongoing engagement efforts • Identify areas for improvement • Measure change & validate progress

Examples of Key Elements in Practice

Maricopa County, Arizona: The Refugee Women's Health Clinic

Maricopa County, has a population of 4,242,997 (July 2016 population estimate), of which 14.8% are foreign-born persons.²¹ The Refugee Women's Health Clinic (RWHC) was founded in 2008 to provide refugee women in this population with comprehensive, culturally-appropriate care. The clinic sees patients from countries such as Burma, Somalia, Iraq, Burundi, and the Democratic Republic of Congo, some of whom are survivors of, or at risk for, FGM/C.²² Notably, the stated mission of the clinic is not specifically to eliminate FGM/C in the communities that it serves. Such a statement would jeopardize the relationship it has built with the local refugee communities. Instead, the clinic's stated mission is to address health inequalities and cultural barriers to care.

To achieve its mission, the RWHC has implemented programming focused on empowering and mentoring refugee women. The clinic employs members of the community as patient navigators, "who act as liaisons between the health care system and patients" and offer interpretation services that can facilitate communication and access to appropriate care.²² Furthermore, the clinic offers educational classes and focus groups on childbirth, newborn care, breast cancer screening and sexual health education. In addition, the RWHC is integrated into a network of local and state agencies that conduct screenings, vaccinations and referrals of new arrivals to the state. Within the network, RWHC specifically supports the improvement of screening and referral for behavioral health.

Program design and clinical practices are informed by ongoing research – specifically, community-based participatory research (CBPR)—carried out by the clinic and its founding director, Crista Johnson-Agbakwu, MD. For example, in partnership with members of the Somali refugee community in Phoenix, Johnson-Agbakwu, et al. (2014),

conducted focus groups and interviews to determine Somali male perspectives on FGM/C and childbirth.²³ This study had important insights for culturally-appropriate reproductive health care for Somali women: for example, male participants expressed awareness and concern over the risks of FGM/C, and attributed poor relationships between women with FGM/C and the health care system to the unfamiliarity of physicians with the practice.

Programming that focuses on empowering and mentoring refugee women and their communities, paired with CBPR aimed at understanding community perspectives on FGM/C and creating dialogue between providers and patients, has contributed to improved, culturally-appropriate reproductive health care at RWHC.

Buffalo, New York: Hope Refugee Drop-in Center

The Hope Refugee Drop-in Center in Buffalo is another noteworthy example of community-based organizing and multidisciplinary collaboration. The center is part of the Jericho Road Community Health Center, and is grounded in a community-based participatory development model that allows its constituents to identify their own needs and goals – medical, financial, educational, or other—and the center then facilitates reaching that goal or fulfilling that need.²⁴

Also focused on empowerment and diversity, the center offers services including client-driven case management, transportation, advocacy, education, referrals, and medical services. It also has integrated itself into a community support network that includes ethnic-based community organizations and other service providers (i.e. legal and employment services).^{24,25}

Rochester, New York: General Medical Group, Catholic Family Center, and the Monroe Department of Public Health

Rochester is in Monroe County, and is home to approximately 225,000 residents. Each year, Monroe County receives, on average, 800 refugees from countries such as Bhutan, Nepal, Burma, Afghanistan, Iraq, Cuba, and Somalia. The Rochester General Medical Group (RGMG, now part of Rochester Regional Health), in collaboration with the Monroe County Department of Public Health and the Catholic Family Center, stepped up to meet the primary care needs of this population. Services offered through these organizations include: primary care, TB screening, lead testing, referrals, mental health, employment, education, and housing services.^{26,27}

Collaboration and identification of each partner's strengths were key to developing a plan that worked to meet the needs of the community. Along the way, flexibility was invaluable, as adjustments had to be made for scheduling, space, and unanticipated challenges. Efforts met with relative success: in a single year, 98% of refugees who arrived in Monroe County were seen within a week of arrival. Additionally, all refugees were vaccinated and put into the care of a primary care physician.²⁰ This collaboration helps the Catholic Family Center provide a Refugee Resettlement Program that addresses the needs of refugees in a "holistic and culturally appropriate manner, supporting their successful integration, fostering their independence and promoting their earliest possible self-sufficiency."²⁸

Ethical Implications for FGM/C: A Framework for Policy and Guideline Development

All projects mentioned in this article emphasize empowerment, diversity, collaboration, and reflection. Developing policies and guidelines for medical management of FGM/C within such a social and ethical framework gives greater consideration to sociocultural context and creates room for more open communication between physicians and patients

who have either undergone FGM/C or who may be at risk. This public engagement framework not only empowers all the principle stakeholders involved in the FGM/C issue to greater self-reflection and self-determination, but it does so in a manner that also fosters greater community level reflection and cultural interaction that can result in an improved understanding of health and health care for all involved. Hence, in the end, not only are basic human rights protected, but everyone in the community benefits from improved health care systems and delivery.

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