Ritual female genital mutilation: management of women during the reproductive years

Mauricio C. Tajada[1,2,†], Lía Ornat[1,3,†], María Skinner[1], Peter Chedraui[4], Faustino R. Pérez-López[1,3]

[1] Departamento de Obstetricia y Gynecología, Universidad de Zaragoza, Zaragoza, Spain; [2] Departamento de Obstetricia y Gynecología, Hospital Universitario Miguel Servet, Zaragoza, Spain; [3] Departamento de Obstetricia y Ginecología, Hospital Universitario Dr Lozano-Blesa, Zaragoza, Spain; [4] Instituto de Investigación e Innovación en Salud Integral, Facultad de Ciencias Médicas, Universidad Católica de Santiago de Guayaquil, Guayaquil, Ecuador; [†] *Mauricio C. Tajada and Lía Ornat contributed equally to the study*

ABSTRACT

Female genital mutilation (FGM) has consequences on several aspects of women's health, especially in the psychosexual field. Furthermore, the sociocultural and familial characteristics of women requesting genital reconstructive surgery after FGM are diverse. Our aim was to identify the benefits and complications of this surgery and to determine female satisfaction after the procedure, as well as to analyze the different types of approach to the treatment of any health problem related to FGM. Various factors lie behind requests for genital reconstruction after FGM, and they are often interconnected and related to the desire for improvement of body image and sexuality. Surgical interventions should be appropriately selected according to the genital lesions. Among the many supposed beneficial effects of reconstructive surgery, there is evidence only to support improvements in genital pain and dyspareunia. There is a need to define, standardize and adopt common definitions for clinical findings and reported outcomes of the surgeries used to manage the problem, considering the characteristics of the individual and the extent of the lesions. Additional research is needed to evaluate the efficacy of psychosexual therapy *versus* reconstructive surgery for the treatment of FGM-related complications.

KEYWORDS

Female genital mutilation/cutting; female genital mutilation; genital reconstruction; clitoral reconstruction; genital surgery; Female Sexual Function Index.

Introduction

The term female genital mutilation (FGM), also called female genital cutting or female circumcision, includes all procedures involving partial or total resection of the female external genitalia, or other injury to female genital organs for non-medical reasons [1]. In nearly half of the countries where FGM is practiced, girls are cut before the age of five, with more than 125 million women and girls being subjected to FGM in Africa, the Middle East, and Southeast Asia [2]. Furthermore, UNICEF estimates that at least 200 million girls and women in 30 countries are at risk of this practice [3]. The etiology of FGM can be linked to a set of cultural, religious, social and community factors. The motivations and meanings associated with the practice may vary between countries and ethnic groups, and are not necessarily shared by all groups. However, there is a common denominator among all of them, namely the desire to uphold traditions and be part of them. "Many women who have had genital surgeries view the procedure as a cosmetic beautification, moral enhancement, or improvement of the appearance of the human body" [4]. The practice of FGM perpetuates the fundamental discriminatory belief in the subordinate role of girls and women in society, and reveals a deep-seated gender inequity [5]. In recent years, migration has made FGM a global phenomenon. The fact that more than half a million mutilated women and girls now live in Europe has led to the development of different policies to eradicate this practice. Although many women already begin to reflect on FGM before migration, and perceive it as a negative and harmful practice for their health, this belief is enhanced once they are living in developed countries where they are more exposed to anti-FGM messages and new ideals regarding body image and female sexuality. In some cases, this move to a culturally different society, where they are categorized as "mutilated", is related to the development of a negative body image, body shame, and sexual dysfunction [6], since they absorb this concept of mutilated genitalia, outside of the norm, that they did not have before. Therefore, a correct and respectful approach to this problem on the part of health services is essential, since the stigmatization and re-victimization of these women can also result in damage to their self-image, and negatively affect their sexual life.

Article history

Received 26 Jul 2020 - Accepted 27 Nov 2020

Contact

Faustino R. Pérez-López; faustino.perez@unizar.es

Department of Obstetrics and Gynecology, University of Zaragoza

Faculty of Medicine, Zaragoza 50009, Spain

Classification and symptomatology of genital mutilation

In 1995, the WHO, UNICEF and UNFPA, in a joint declaration, classified FGM into four types, to which, in 2008, some modifications were incorporated in order to avoid ambiguities

that had arisen with its use over the years [1]. Despite these modifications, the usefulness and relevance of the classification continue to be debated; there are also questions regarding its clinical applicability, and the correlation of lesion severity with degree of symptoms. Most studies dealing with the different types of FGM rely heavily on women's autobiographical testimonies. However, those studies that do include clinical examination of these women have documented large discrepancies between the types of mutilation women claim to have undergone and the types clinically observed. With regard to the types of FGM detailed in the especially between types I (a, b and c) and II (a and b) (Table 1) [7].

Approximately 90% of procedures performed in Africa are types I and II, while infibulation is carried out approximately in 10%. The latter type is related to the highest rate of complications, and also to the most serious ones [3,8,9], even though this 10% includes surgeries performed hygienically in medical clinics or hospitals, where complication rates are lower than the rates associated with procedures performed in the traditional way [4]. In many cases, cuts are made using precarious means such as knives and other irregular cutting elements, and without anesthesia, making it likely that the girl will move and hinder the precision of the procedure. For these reasons, cuts are often irregular and difficult to classify. Another controversial issue is the poor relationship found between classification type and actual observed symptoms, except in the greater differences seen from types I-II (cut, Figures 1 and 2) to type III (infibulation, Figure 3) [9].

Table 1 World Health Organization classification of types of female genital mutilation.

TYPE I: Partial or total removal of the clitoris and/or the prepuce (Clitoridectomy)
Type Ia: Removal of the clitoral hood or prepuce only
Type Ib: Removal of the clitoris with the prepuce
TYPE II: Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (Excision)
Type IIa: Removal of the labia minora only
Type IIb: Partial or total removal of the clitoris and the labia minora
Type IIc: Partial or total removal of the clitoris, the labia minora and the labia majora
TYPE III: Narrowing of the vaginal orifice with the creation of a covering and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris (Infibulation)
Type IIIa: Removal and apposition of the labia minora
Type IIIb: Removal and apposition of the labia majora
TYPE IV: Unclassified. All other harmful procedures to the female genitalia for non-medical purposes

FGM has a negative impact on various aspects of women's health, as it can lead to gynecological, obstetric, psychological, psychosexual and social complications, especially urinary tract infections, painful sexual intercourse, and difficulties in childbirth [10,11]. Furthermore, the risk of complications varies accord-

Figure 1 (Left) Type I female genital mutilation: partial or total removal of the clitoral glans and/or prepuce (clitoridectomy). (Right) Genital appearance of a 24-year-old woman from Gambia, of Sarahole ethnicity. Female genital mutilation was performed during the first months of life. Subsequently, she delivered a baby in Zaragoza, Spain.

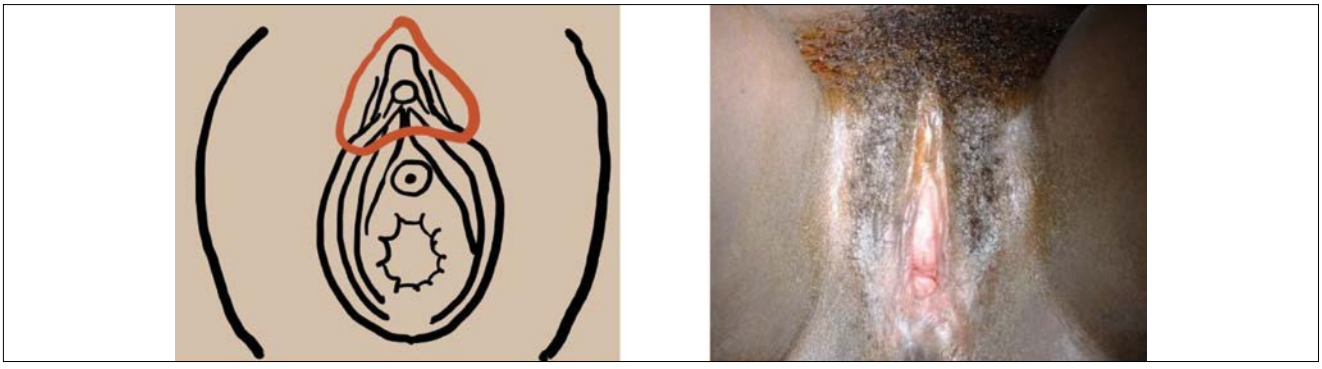


Figure 2 (Left) Type II female genital mutilation: partial or total removal of the clitoral glans and labia minora with or without removal of the labia majora (excision). (Right) Genital appearance of a 21-year-old woman from Mali, of Bambara ethnicity. Female genital mutilation was performed at the age of three. Subsequently, she delivered a baby in Zaragoza, Spain.

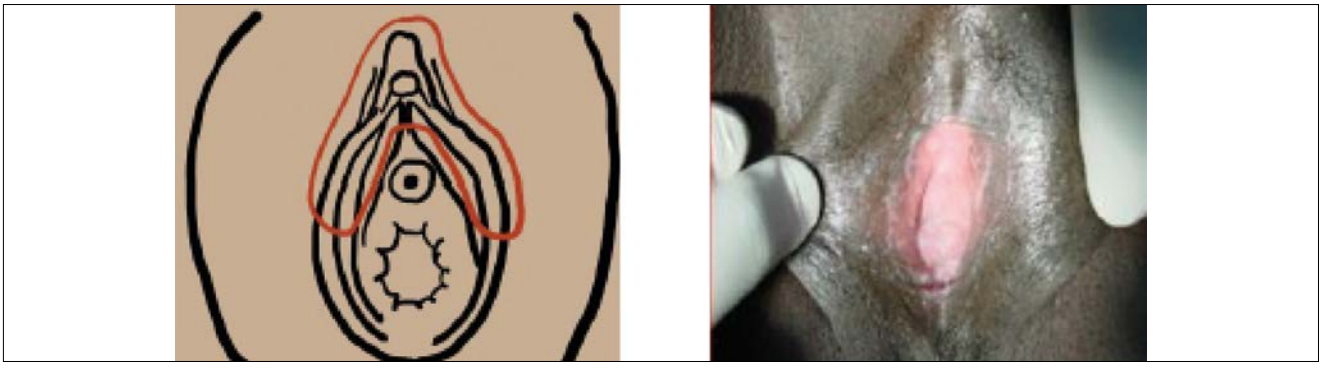
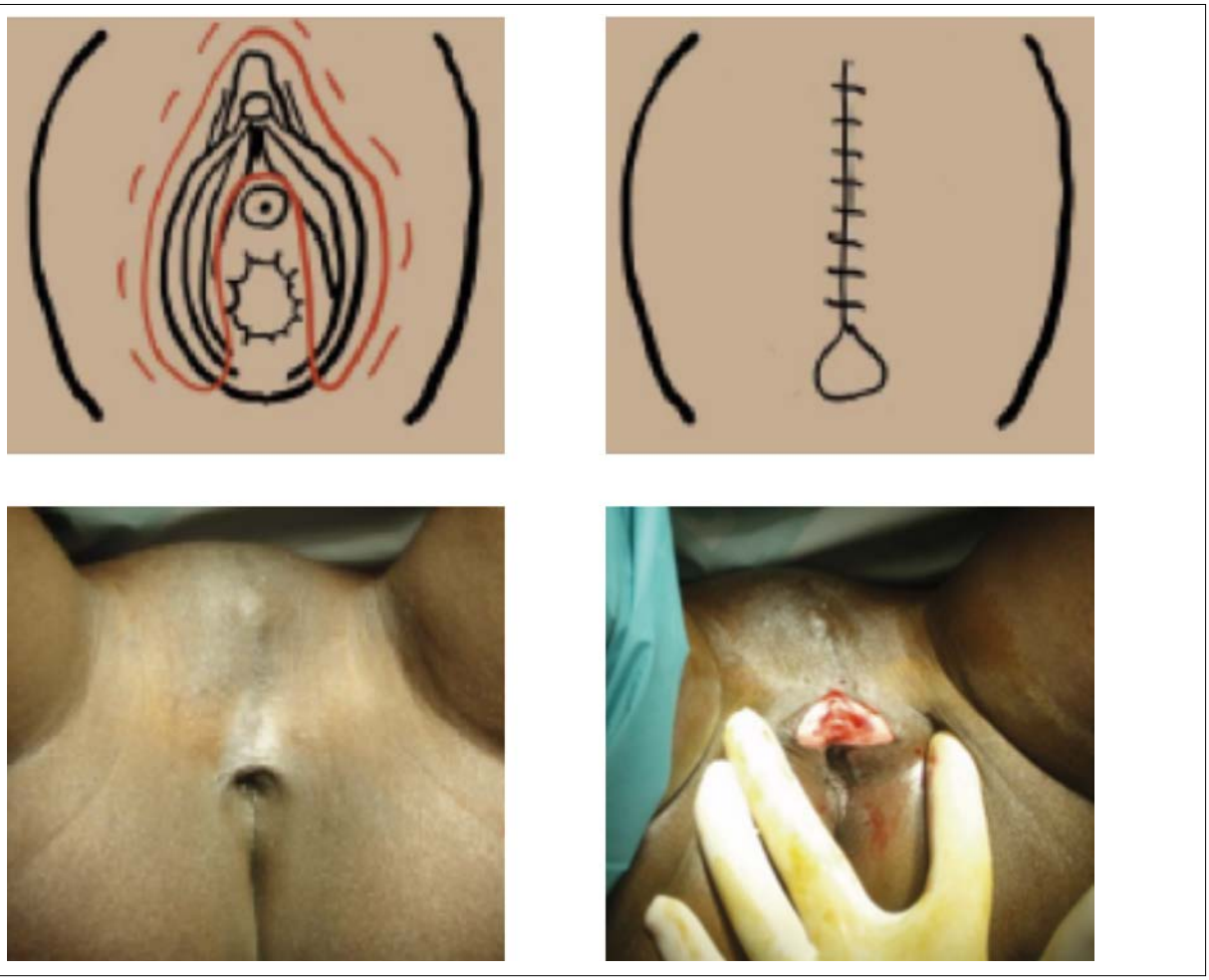


Figure 3 (Left) Type III female genital mutilation: narrowing of the vaginal opening, which is sealed by cutting and repositioning the labia minora or labia majora, sometimes by stitching them, with or without clitoridectomy (infibulation). (Right) Genital appearance of a 21-year-old woman from Sudan who consulted for infertility. De-infibulation was performed in Zaragoza, Spain and the patient subsequently had a normal gestation and delivery one year later.



ing to the type of FGM performed, with a greater immediate risk of genital bleeding, urinary retention and inflammation of the genital tissue being reported in types III and IV as compared with types I and II [12]. However, these results are not consistent, since some authors have not found significant differences in pain during sex, infertility, prolapse and other reproductive tract infections between cut women (especially type II) and uncut ones, or have presented results in a generalized way, without specifying differences between the types of mutilation [13].

Many survivors of FGM have never been able to explore their uncut genitalia because the procedure was performed at a very young age. In many cases, only a small part of the clitoral glans has been removed or covered, while the majority of genitalia remains intact and functional after FGM. Women are often unaware of this. It is important to highlight that the structure of the clitoris (bulbs, elbow, body, crura and glans) was described and confirmed by a pelvic magnetic resonance imaging study in 2016 [14], and it greatly differs from the small size of the clitoris considered in the WHO 2007 classification. Female sexual dysfunction and dyspareunia have been linked to damage to the clitoral nerves, as well as to scars at the site of mutilation. In clinical studies, sexuality is found to be impaired or not reported. Our recent systematic review and meta-analysis of 15 studies reported that women with FGM displayed lower total and per domain scores on the Female Sexual Function Index (FSFI) as compared with non-mutilated women [15].

Along with the anatomical assessment, it is important to study other aspects according to the subject's age, reproductive factors, and general health. In this sense, Cottler-Casanova *et al*. [16] have emphasized the need to accurately identify the genital anatomy in order to assess medical interventions for FGM according to four groups/objectives: i) physical, ii) psychological, iii) sexual health, and iv) obstetrical, perinatal, and fetal complications. Such an approach would allow standardization of basal clinical status, therapeutic procedures and complications. These authors also suggest the use of the International Classification of Diseases to monitor the clinical evolution of FGM and its complications in different countries.

Reasons for requesting reconstructive surgery

In recent years, more and more women have requested surgical procedures, mainly reconstructive surgery, to "undo" the genital modification they underwent and allow them to recover the original anatomy and functionality of their genitalia. This

phenomenon is more frequent among women who were cut in their country of origin and have moved to a developed country where FGM is not practiced [6]. Despite this, there is no quality evidence that confirms the supposed medium- and long-term beneficial effects of reconstructive surgery [17]. On the other hand, the supposed autonomy of women who have previously undergone FGM and now request reconstructive surgery is seriously questioned. In most cases, the preoperative information received by these women exaggerates the supposed beneficial effects of reconstructive surgery as a remedy for all the health problems women with FGM face, and places little emphasis on the possible complications or sub-optimal results. Reconstruction of the clitoris in women with FGM who do not present painful symptoms or alterations in their sexual function has been classified as "psychosocial surgery", since health risks are assumed in order to obtain esthetic results in accordance with society's narrow concept of "normal" [18].

The factors and reasons that motivate women subjected to FGM to seek reconstructive surgery are highly interconnected, and are often multiple and complex. In the early years of genital reconstruction surgery, women consulted mainly for pain (especially women with FGM type III) and other complications resulting from FGM. Nevertheless, this trend has changed over time [19]. In recent years, and in particular since the inclusion of this surgery in the portfolio of public healthcare systems in several European countries, most women who request this surgery do so to improve their sexual life, their physical appearance, or to recover their identity as women, and pain has become a less frequent reason [20].

The identity of a woman is a complex concept that is influenced by a wide variety of factors such as individual beliefs and the sociocultural environment, and therefore not solely by the external presence of the clitoral glans. In general, women with FGM perceive this practice as normal during childhood and early adolescence and do not associate it with a loss of their female identity. After all, it is the practice of FGM that allows them be part of the social group they belong to as women. However, this perception changes when they are a little older and have a greater interest in sexuality and body image, as well as greater exposure to anti-FGM messages [20].

The sexual experiences of some of these women have been clearly captured in case stories. The following excerpt from the account of a 30-year-old woman from Mali, mother of two children, cut at birth and married at 17, who arrived in Spain in 2008, is emblematic of the reasons some women request reconstructive surgery:

"When I arrived in Spain I started to see porn and genital images on Google. Through a cousin that had undergone reconstructive surgery, I knew that these interventions were carried out in Spain. I didn't enjoy sex because I only had sex when my husband wanted and in his own way: once a day at least and focused almost exclusively on penetration. I wanted to feel good about my body and feel more pleasure. Moreover, I wanted my genitalia to look like those of white women who enjoy sex a lot and always have orgasms because they have a clitoris. […] After the surgery I am happier with the external appearance of my genitals. They are prettier and more normal because they look more like the ones that appear on TV".

It should be borne in mind that, in some cases, reconstructive surgery can lead to a worsening of female body self-image [21]. In this sense, the role of the media and the internet is very important. A clear example is the pornographic film industry, where the image of homogeneous genitalia (models with "perfect" symmetrical vulva) prevails. To understand what is happening, we must also consider that there is no such thing as a normal or "perfect" genital appearance; genitalia show hundreds of anatomical variations with different sizes, shapes and colors [22], but this reality is rarely shown. Consequently, more and more women become concerned about the appearance of their vulva, and this includes both mutilated and non-mutilated women who undergo clitoral reconstruction. Labiaplasty and reconstructive surgery after FGM are both undertaken in the quest to achieve esthetically beautiful genitalia, that fall within the standards of normality established by the society in which women live [23, 24].

Sharif *et al*. [10] draw attention to the ethical aspects of informed consent in reconstructive surgery, observing striking deficits in the information women are given about the expected results and possible complications of the procedure. Added to this is the confusion generated by numerous organizations, foundations and advertising campaigns, which promote reconstructive surgery as a miracle cure that will lead these women to experience their first orgasm. Moreover, this is based on a misconception, namely that FGM involves total excision of the clitoris, whereas in real practice, it consists of partial or total removal of the clitoral glans, and leaves most of the organ intact.

Results of reconstructive surgery

Although the data of analyzed studies show an improvement in overall sexual health after reconstructive surgery, it remains unclear whether surgical externalization of part of the clitoris is the cause of this improvement [9,10,24,25]. Of the many beneficial effects attributed to reconstructive surgery, there is evidence only to support improvement in terms of reduction of genital pain and dyspareunia [17,19,26-28], and curiously, this problem is one of the reasons least often given for requesting the treatment [20]. Furthermore, there are no publications reporting on large series of cases using standardized tools.

The tool most widely used to evaluate female sexual function in women subjected to FGM undergoing reconstructive surgery is the FSFI [29]. However, this tool does not assess the role of the clitoris in sexuality. It should be borne in mind that sexual pleasure is determined by a large number of variables, and that mutilation, psychosexual taboos, cultural and social aspects, the relationship with the partner, and personal experiences all play very important roles. After the desire for an improvement in sexual relations, other reasons sometimes given for wanting reconstructive surgery are relationship difficulties and marital conflicts, gender violence, and it is also not uncommon for the demand to originate from the husband, who blames the woman for sexual dissatisfaction [25]. Although the clitoris is a crucial organ for female pleasure and orgasms, its presence alone is not enough to guarantee enjoyment of sex; it is necessary to be familiar with it, and to know how to stimulate it. As

we have already observed, after FGM, much of the clitoris is still present and some structures fundamental for orgasm remain in place; this would explain why other women with FGM are sexually satisfied [30]. Women without long-term complications from the mutilation can have normal sexual function in terms of desire, arousal, and orgasm [26], and can increase their sexual response by stimulating the clitoris correctly.

On the other hand, we must consider that reconstructive surgery is not free from complications. Evaluation of this aspect is difficult, since patient attendance at follow-up consultations is low. In an extensive study carried out by Foldès *et al*.[26], only 29% of women attended follow-up one year after their surgery. This could be due to the social characteristics of these women, such as low income and frequent change of place of residence, which can make subsequent contacts for clinical follow up difficult. In addition to these limitations, patients were followed up for a maximum of one year, which makes it impossible to know about other complications that may have arisen later. In fact, both the WHO and the Royal College of Obstetricians and Gynaecologists in the United Kingdom do not currently recommend performing genital reconstruction, given the absence of conclusive evidence of its beneficial effects and the rate (still to be quantified in the long term) of possible complications [31].

Another aspect that must be taken into account is the frustration that can arise when patients develop expectations that are not met, and also when certain circumstances (in particular personal or relating to these women's partners) are also not modified.

Multidisciplinary approach to genital mutilation

The sexuality of women with FGM is poorly understood and often neglected by gynecologists, urologists, and sexologists. It is essential to thoroughly examine these patients' wishes and motivations. If their main desire or motivation is to improve their sex life, it is not clear whether surgery is the answer. It therefore seems more appropriate to adopt a multidisciplinary approach that includes psychosexual and medical treatment. With such an approach, possible physical and psychological risks associated with expectations surrounding the surgical intervention could be avoided.

Although some studies only evaluate the results of clitoral reconstruction, in most cases, the surgery was complemented by a multidisciplinary approach to the problem, including gynecological consultations, psychological support, and sexual therapy [26,30,32,33]. However, in other studies, a multidisciplinary approach (psychology, sexology and gynecology) was offered before considering surgical treatment, after which the need for surgery was re-assessed [25, 34]. In the study carried out by Antonetti *et al*.[25], only 13% of 270 women attending a care unit finally decided to have reconstructive surgery. The main reason for not undergoing surgery was that they were satisfied with the treatment received, both medical and psychosexual. Many women who come from countries or territories where FGM is a common practice report problems with their sexuality that they attribute to it. However, in most cases, external genitalia are found on examination to be intact or virtually intact. This supports the idea that discussion of FGM should not focus solely on the physical complications derived from the practice, as stigmatization of these women could generate a series of problems that would not otherwise exist. However, taking into account that women with FGM retain much of the erectile sexual tissue, those who do present sexual dysfunction should receive adequate counseling and psychosexual treatment.

Conclusions

The sociocultural and family characteristics of women who request reconstruction surgery after FGM are diverse. However, surgical management should be clearly individualized according to the woman's age and the extent of the lesions. It is essential to deeply analyze the real reasons why these women want surgery, since in those whose main motivation is the desire for improved esthetics or sexual function, surgery may not be the most appropriate response. On the other hand, evaluation of the benefits derived from reconstructive surgery is difficult due to the variety of methods used to assess the results of the procedure in clinical research. Therefore, standardization of clinical findings, interventions and follow up using pre-defined outcomes is urgently needed at international level in order to be able to compare results and improve the management of FGM. Furthermore, although it is clear that FGM can have detrimental consequences for women's health, there is a great limitation, especially in long-term complications, due to difficulties in patient follow-up.

Mutilated women should be adequately informed about available treatment options and receive education about genital anatomy and any myths surrounding female sexual function. This will allow them to choose the best path to follow based on individual characteristics. Reconstructive surgery may be indicated as a treatment for complications deriving from FGM, especially in the presence of pain or sexual dysfunction, but only when these problems have failed to respond to more conservative measures. There is a need for additional research on the real benefits of surgery and its possible long-term complications, as well as studies that independently evaluate the efficacy of psychosexual therapy in treating complications of FGM.

References

1. World Health Organization, Department of Reproductive Health and Research. Eliminating Female genital mutilation: an interagency statement - OHCHR, UNAIDS, UNDP, UNECA, UNESCO, UNFPA, UNHCR, UNICEF, UNIFEM, WHO; 2008. Available at: https://www.who.int/reproductivehealth/publications/fgm/9789241596442/en/.
2. United Nations Children's Fund. Female Genital Mutilation/Cutting - A statistical overview and exploration of the dynamics of change. UNICEF; 2013. Available at:https://www.unicef.org/media/files/UNICEF_FGM_report_July_2013_Hi_res.pdf.
3. UNICEF. Female Genital Mutilation/Cutting: A Global Concern. UNICEF; 2016. Available at: https://www.unicef.org/media/files/FGMC_2016_brochure_final_UNICEF_SPREAD.pdf.
4. Public Policy Advisory Network on Female Genital Surgeries in Africa. Seven things to know about female genital surgeries in Africa. Hastings Cent Rep. 2012;42:19-27.

5. World Health Organization. WHO guidelines on the management of health complications from female genital mutilation. WHO; 2016. Available at: https://www.who.int/reproductivehealth/topics/fgm/management-health-complications-fgm/en/.
6. Johnsdotter S. The impact of migration on attitudes to female genital cutting and experiences of sexual dysfunction among migrant women with FGC. Curr Sex Health Rep. 2018;10:18-24.
7. Gómez M. Mutilación genital femenina en población inmigrante de origen subsahariano: implicaciones socio-sanitarias. Repercusiones en la calidad de vida y la sexualidad. University of Zaragoza; Doctoral thesis, 2015.
8. Ouédraogo CM, Madzou S, Touré B, Ouédraogo A, Ouédraogo S, Lankoandé J. [Practice of reconstructive plastic surgery of the clitoris after genital mutilation in Burkina Faso. Report of 94 cases]. Ann Chir Plast Esthet. 2013;58:208-15.
9. Sánchez L. Aspectos psicosociales, satisfacción con la vida y sexualidad en inmigrantes subsaharianas en relación a la mutilación genital femenina. University of Zaragoza; Doctoral thesis, 2017.
10. Iavazzo C, Sardi TA, Gkegkes ID. Female genital mutilation and infections: a systematic review of the clinical evidence. Arch Gynecol Obstet. 2013;287:1137-49.
11. Biglu MH, Farnam A, Abotalebi P, Biglu S, Ghavami M. Effect of female genital mutilation/cutting on sexual functions. Sex Reprod Healthc. 2016;10:3-8.
12. Berg RC, Underland V, Odgaard-Jensen J, Fretheim A, Vist GE. Effects of female genital cutting on physical health outcomes: a systematic review and meta-analysis. BMJ Open. 2014;4:e006316.
13. Morison L, Scherf C, Ekpo G, et al. The long-term reproductive health consequences of female genital cutting in rural Gambia: a community-based survey. Trop Med Int Health. 2001;6:643-53.
14. Abdulcadir J, Botsikas D, Bolmont M, et al. Sexual anatomy and function in women with and without genital mutilation: a cross-sectional study. J Sex Med. 2016;13:226-37.
15. Pérez-López FR, Ornat L, López-Baena MT, Santabárbara J, Savirón-Cornudella R, Pérez-Roncero GR. Association of female genital mutilation and female sexual dysfunction: a systematic review and meta-analysis. Eur J Obstet Gynecol Reprod Biol. 2021;260:85-98.
16. Cottler-Casanova S, Horowicz M, Gieszl S, Johnson-Agbakwu C, Abdulcadir J. Coding female genital mutilation/cutting and its complications using the International Classification of Diseases: a commentary. BJOG. 2020;127:660-4.
17. Abdulcadir J, Rodriguez MI, Say L. A systematic review of the evidence on clitoral reconstruction after female genital mutilation/cutting. Int J Gynaecol Obstet. 2015;129:93-97.
18. Sharif Mohamed F, Wild V, Earp BD, Johnson-Agbakwu C, Abdulcadir J. Clitoral reconstruction after Female Genital Mutilation/Cutting:a review of surgical techniques and ethical debate. J Sex Med. 2020;17:531-42.
19. Berg RC, Taraldsen S, Said MA, Sørbye IK, Vangen S. Reasons for and experiences with surgical interventions for Female Genital Mutilation/Cutting (FGM/C): a systematic review. J Sex Med. 2017;14:977-90.
20. Jordal M, Griffin G, Sigurjonsson H. 'I want what every other woman has': reasons for wanting clitoral reconstructive surgery after female genital cutting - a qualitative study from Sweden. Cult Health Sex. 2019;21:701-16.
21. Mestre-Bach G, Tolosa-Sola I, Barri-Soldevila P, Jiménez-Bonora M, Lasheras G, Farré JM. Clinical, sexual and psychopathological changes after clitoral reconstruction in a Type II Female Genital Mutilation/Cutting: a case report. Afr J Reprod Health. 2019;23:154-62.
22. Lloyd J, Crouch NS, Minto CL, Liao LM, Creighton SM. Female genital appearance: "normality" unfolds. BJOG. 2005;112:643-6.
23. Boddy J. The normal and the aberrant in female genital cutting: shifting paradigms. HAU J Ethnogr Theory. 2016;6:41-69.
24. Clerico C, Lari A, Mojallal A, Boucher F. Anatomy and aesthetics of the labia minora: the ideal vulva? Aesthetic Plast Surg. 2017;41:714-9.
25. Antonetti Ndiaye E, Fall S, Beltran L. [Benefits of multidisciplinary care for excised women]. J Gynecol Obstet Biol Reprod (Paris). 2015;44:862-9.
26. Foldès P, Cuzin B, Andro A. Reconstructive surgery after female genital mutilation: a prospective cohort study. Lancet. 2012;380:134-41.
27. Berg RC, Taraldsen S, Said MA, Sørbye IK, Vangen S. The effectiveness of surgical interventions for women with FGM/C: a systematic review. BJOG. 2018;125:278-87.
28. Abdulcadir J, Tille JC, Petignat P. Management of painful clitoral neuroma after female genital mutilation/cutting. Reprod Health. 2017;14:22.
29. Vital M, de Visme S, Hanf M, Philippe HJ, Winer N, Wylomanski S. Using the Female Sexual Function Index (FSFI) to evaluate sexual function in women with genital mutilation undergoing surgical reconstruction: a pilot prospective study. Eur J Obstet Gynecol Reprod Biol. 2016;202:71-4.
30. Catania L, Abdulcadir O, Puppo V, Verde JB, Abdulcadir J, Abdulcadir D. Pleasure and orgasm in women with Female Genital Mutilation/Cutting (FGM/C). J Sex Med. 2007;4:1666-78.
31. Royal College of Obstetricians and Gynaecologists (RCOG). Female Genital Mutilation and its Management. Green-top Guideline No.53. London, UK; 2015. Available at: https://www.rcog.org.uk/en/guidelines-research-services/guidelines/gtg53/.
32. Mestre-Bach G, Tolosa-Sola I, Rodríguez I, Barri-Soldevila P, Lasheras G, Farré JM. Changes in sexual distress, depression and sexual function after clitoral reconstruction in women with female genital mutilation/cutting. International Journal of Sexual Health. 2018;30:412-21.
33. De Schrijver L, Leye E, Merckx M. A multidisciplinary approach to clitoral reconstruction after female genital mutilation: the crucial role of counselling. Eur J Contracept Reprod Health Care. 2016;21:269-75.
34. Merckelbagh HM, Nicolas MN, Piketty MP, Benifla JL. [Assessment of a multidisciplinary care for 169 excised women with an initial reconstructive surgery project]. Gynecol Obstet Fertil. 2015;43:633-9.

Conflict of Interest: *the authors declare no conflict of interest*