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Female genital mutilation in Switzerland: a survey among gynaecologists

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Summary

Question under study: To evaluate the situation of Female Genital Mutilation (FGM) in Switzerland.

Methods: Through a questionnaire, Swiss gynaecologists were asked if they have been confronted to FGMs, if they have had requests to perform reinfibulations and FGMs. The health representatives (Kantonsärzte / médecins cantonaux) were interviewed on FGM activity at the Canton level. Swiss Medical Schools were asked if FGM was included in the pregraduate curriculum, and an estimated prevalence rate for FGMs in Switzerland was calculated.

Results: Among Swiss gynaecologists, 20% reported having been confronted with patients presenting with FGM and among them 40% had been asked about reinfibulation. Gynaecologists are occasionally asked about the possibility of performing FGMs in Switzerland. No activity concerning FGM is reported by health authorities in the Cantons. Teaching about FGM is not included in the curriculum of any of the Swiss medical schools. Approximately 6,700 girls at risk and women who have undergone FGM live in Switzerland.

Conclusion: The extent to which gynaecologists are confronted to women with FGM may justify further action to try to better understand the situation in Switzerland. Improvement of care by proper education of health care providers (guidelines) and prevention of new cases by women's education should also be considered.

Key words: female genital mutilation; female circumcision; Switzerland; reinfibulation; prevalence

Introduction

Female Genital Mutilation (FGM), also called Female Circumcision or more neutrally Female Genital Cutting, is defined as a procedure involving partial or total removal of the external female genitalia or injury to the female genital organs whether for cultural or other non therapeutic reasons [1]. It is performed traditionally in sub-Saharan countries with prevalence rates varying from 5 to 98% [1]. WHO estimates that some 100–140 million women have experienced FGM and that approximately two million girls are at risk of undergoing the procedure every year [2].

The form of FGM performed varies from one ethnic group to another. It can involve the excision of the prepuce with or without excision of part or all of the clitoris (Type I), additional partial or total excision of the labia minora (Type II), or infibulation (Type III) which implies excision of the external genitalia and closing of the vagina leaving only a small opening. This form is observed in 15% of the affected women [3] and is traditionally performed in certain parts of Egypt, Eritrea, Northern Kenya, Mali, Ethiopia and nearly all of Somalia, Djibouti and Northern Sudan [2]. Health consequences vary depending on the degree of cutting and are most severe in case of infibulation. Immediate complications include severe pain, infections, haemorrhage, urine retention, injuries to neighbouring organs and even death. Long term consequences such as dermal cysts, scar neuromas, repeated urinary and reproductive tract infections, sterility, dysmenorrhoea and psychological problems are possible. In the case of infibulation, complications during labour and delivery can also occur [1]. Through migration, European countries and their health services have been increasingly confronted with FGMs and their medical consequences [4–6].

The aim of this study was to evaluate the situation concerning FGM in Switzerland, focusing on how and to what extent Swiss gynaecologists are confronted with the issue of FGM. The attitude of health authorities and the pre-graduate curricula in medical schools were also evaluated.

Methods

In order to evaluate the situation of FGM in Switzerland, the Swiss Society of Gynaecology and Obstetrics in association with the Swiss Committee for UNICEF sent a questionnaire containing five questions to all its members. A total of 1,162 questionnaires were sent out in March 2001 and had to be returned by the end of April 2001.

The questions asked were as follows:
1. Have you already been confronted with a patient presenting with FGM?
2. In cases of infibulation: have you been asked to perform reinfibulation after delivery?
3. Have you already been asked to perform FGM on a girl or a young woman?
4. Have you been asked about the possibility of performing FGM in Switzerland?
5. Have you heard of FGMs being performed in Switzerland?

Answers were examined according to the total population studied and the respondents. For the analysis according to the different Cantons, only those providing their address were taken into account (n = 340). The Cantons of Schwyz, Uri, Obwalden and Nidwalden were regrouped under the heading: Central Switzerland. The data were analysed using Fisher's exact tests.

The five Swiss medical schools having clinical curricula were asked if FGM was a topic in their curriculum. The health representatives of the Swiss cantons (Kantonsärzte/Médecins cantonaux) were contacted in November 2001. The following questions were asked:
1. Are guidelines available?
2. Is there a reporting system for FGMs in your Canton?
3. As a health official, have you been confronted with the problem?
4. Are you aware of any activities at the Canton level?

The number of individuals (girls at risk and women presenting with FGM) living in Switzerland was evaluated by multiplying the number of females from countries where FGMs are traditionally performed with the specific countries' prevalence rates for FGM. The Swiss Federal Statistics Office and the Federal Office for Refugees provided figures on foreign population and refugees.

Results

Among the 1,162 questionnaires, 454 were returned (39.1% responding rate), including 114 anonymous answers. Two hundred and thirty-three gynaecologists stated having been confronted with patients presenting with FGMs. This is equal to 51.3% of the respondents and 20.0% of the whole population studied. Significantly higher Yes responding rates were found in Western

Table 1

Confrontation rates for FGM among Swiss Gynaecologists (*total number includes 114 anonymous answers).

Swiss Cantons	number of specialists	confrontation rate	response rate	confrontation rate among respondents	demand for reinfibulation among respondents
Aargau	70	5.7%	21.4%	26.7%	75.0%
Appenzell	6	0.0%	33.3%	0.0%	–
Berne	155	20.6%	35.5%	58.2%	37.5%
Basel-Country	37	13.5%	18.9%	71.4%	80.0%
Basel-City	69	10.1%	15.9%	63.6%	42.9%
Central Switzerland	18	27.8%	50.0%	55.6%	100.0%
Fribourg	29	24.1%	34.5%	70.0%	0.0%
Geneva	104	25.0%	33.7%	74.3%	61.5%
Glarus	7	14.3%	14.3%	100.0%	100.0%
Graubünden	20	20.0%	35.0%	57.1%	25.0%
Jura	10	20.0%	50.0%	40.0%	50.0%
Lucerne	44	20.5%	29.5%	69.2%	55.6%
Neuchâtel	28	42.9%	46.4%	92.3%	50.0%
St. Gallen	55	16.4%	23.6%	69.2%	22.2%
Schaffhausen	15	20.0%	40.0%	50.0%	66.7%
Solothurn	23	21.7%	52.2%	41.7%	40.0%
Thurgau	26	11.5%	30.8%	37.5%	66.7%
Ticino	49	8.2%	18.4%	44.4%	50.0%
Vaud	119	21.0%	31.1%	67.6%	52.0%
Valais	27	33.3%	40.7%	81.8%	22.2%
Zug	15	6.7%	13.3%	50.0%	0.0%
Zurich	236	16.1%	25.0%	64.4%	34.2%
Total*/Overall Rates	1162	20.0%	39.0%	51.3%	40.7%

Figure 1

Confrontation rates for FGM among Swiss Gynaecologists according to the different Cantons.

Table 2

Estimated number of girls at risk and women who underwent FGM according to WHO Prevalence Rates 2001 [3] (numbers do not include women holding a Swiss passport).

Country of origin	estimated prevalence of FGM	asylum seekers or related	permanent residents	totals	estimated number of girls at risk and women who underwent FGM
Benin	50%	4	51	55	27
Burkina Faso	72%	8	69	77	55
Cameroon	20%	115	1128	1243	249
Central African Rep.	43%	2	11	13	6
Chad	60%	1	28	29	17
Djibouti	98%	0	7	7	7
Egypt	97%	4	540	544	528
Eritrea	95%	333	312	645	613
Ethiopia	85%	649	505	1154	981
Gambia	80%	0	19	19	15
Ghana	30%	9	567	576	173
Guinea	99%	26	66	92	91
Guinea-Bisau	50%	2	11	13	7
Ivory Coast	43%	26	457	483	208
Kenya	38%	11	531	542	206
Liberia	60%	8	54	62	37
Mali	94%	2	42	44	41
Mauritania	25%	2	15	17	4
Niger	5%	0	15	15	1
Nigeria	25%	49	294	343	86
Senegal	20%	7	330	337	67
Sierra Leone	90%	35	38	73	66
Somalia	98%	2147	739	2886	2828
Sudan	89%	39	193	232	206
Tanzania	18%	3	120	123	22
Togo	12%	46	126	172	21
Uganda	5%	3	162	165	8
Yemen	23%	83	38	121	28
Zaire	5%	925	1333	2258	113
Totals		**4539**	**7801**	**12 340**	**6711**

Switzerland where 81/317 gynaecologists had been confronted with women presenting with FGMs, as compared to 130/845 (15.4%) for the rest of Switzerland ($p < 0.0001$). This corresponds to 25.5% of all gynaecologists in the French speaking part of Switzerland and 73% of the respondents in that region. A maximum was observed in the Swiss Canton of Neuchâtel where 42.9% of all gynaecologists (92.3% of the respondents) had already treated women presenting with FGMs, followed by Valais with 33% (table 1). The remaining French Cantons, Berne, Solothurn and Lucerne together with the Central part of Switzerland showed rates of at least twenty percent. The overall rate for the region of Zurich and Eastern Switzerland was 16%. Lowest contact rates were observed in Ticino (8.2%), Zug, Appenzell and parts of North Western Switzerland (figure 1).

Ninety-five of the 454 respondents had been asked to perform reinfibulation after delivery. This corresponds to every fifth respondent (20.9%), and to 8.2% of the total population studied. It corresponds to 40.7% of gynaecologists confronted with the problem in Switzerland. In most Cantons of the French part of Switzerland at least 50% of the gynaecologists confronted with FGM were asked to perform reinfibulation. High percentages of gynaecologists confronted with the question of reinfibulation after delivery were also observed in Lucerne (55.6%) and in regions with lower contact rates such as Aargau (75.0%), Basel-Country (80.0%), Ticino (50.0%) and Thurgau (66.7%).

As for the possibility of performing FGM on girls, two gynaecologists reported having been asked to do so. When asked if they have been confronted with the question of where FGMs can be performed in Switzerland four gynaecologists gave a positive answer. Twelve respondents had heard of FGMs being performed in Switzerland.

In the 5 Swiss Medical schools, FGM is not included in the pre-graduate curriculum. None of the Cantons' health representatives knew about existing guidelines in their Canton. No reporting system exists. Only two have been confronted with problems related to FGM. One concerning the request of a family to circumcise both their son and their daughter, and the other by the police asking if medical precautions were necessary as a family had requested using school rooms to perform female circumcision. No activities concerning FGM were reported from any of the Health Departments.

An estimated 6,711 girls at risk and women who had undergone FGM live in Switzerland, 3,499 as permanent residents and 3,212 asking for political asylum or related procedures (table 2). More than one third (2,828) are of Somali origin, thus from a region where FGM is performed in nearly 100% of women. These numbers do not include women holding a Swiss passport.

Discussion

Very little information is available on FGM in Switzerland. In 1991 the number of women at risk or affected by FGM was estimated to be 1,951 [7]. Presently it is estimated to be approximately 6,700, but these numbers do not allow conclusions to be drawn on how the Swiss health care system is confronted with the issue. This study showed that one fifth (20%) of all Swiss gynaecologists (51% of respondents) had been confronted with patients presenting with FGMs. The responses showed that gynaecologists all over Switzerland were confronted with FGMs. The higher prevalence in the French speaking part of Switzerland could be explained by the fact that French is spoken in many sub-Saharan countries, although this does not apply for other groups such as the Somalis.

Most of the gynaecologists were probably confronted with infibulation, as Type I and II often go unnoticed [8]. Management of related health problems may be difficult. While the excision of a dermoid cyst in case of Type I circumcision may be rather simple [9], gynaecologists may face difficulties in obtaining cervical smears or performing vaginal examinations if the introitus is too narrow [8,10,11]. After delivery, obstetricians have to deal with the repair of the vulva, which in case of previous infibulation can be performed in order to restore normal vulva opening whereas reinfibulation, responsible for medical complications, is practised in the women's country of origin. Women may find an "exposed vulva" unacceptable, and sometimes insist on reinfibulation arguing this is part of their identity and will ensure her husband's fidelity and sexual satisfaction [12–14]. The British College of Obstetricians and Gynaecologists recommends that surgery can be performed for purposes connected with labour or birth, but that it is illegal to repair the labia intentionally in such a way that intercourse is difficult or impossible. According to these recommendations, surgery may be performed for mental health reasons, but not as a matter of custom or ritual [15]. There is no official guideline in Switzerland and the legal aspects have yet to be clarified.

This study showed that among Swiss gynaecologists confronted with FGM, 40.7% had been asked about the possibility of performing some form of reinfibulation. In a study among 432 Somali women in Canada, $^1/_3$ thought their husband should take the decision and $^1/_5$ declared it was the obstetrician's responsibility [16]. Approximately $^2/_3$ reported that their husband would not favour

reinfibulation. This shows that husbands should be involved in the discussion and that doctors' influence may be important. The timing of counselling may have an impact as well. If a patient is confronted for the first time with the issue in the labour ward, she will probably find it more difficult to agree to a practice that is foreign to her and is contradictory to her tradition. Specifically trained health workers should discuss the issue during the prenatal period, as specialised clinics seem to be less confronted with the demand for reinfibulation [5].

During pregnancy, the timing for defibulation remains controversial. Defibulation in the second trimester has been suggested [17] in order to avoid acute problems during delivery: when on call staff might not be familiar with the problem. Moreover, vaginal examination at the beginning of labour might be easier. Finally, it could help reduce blood loss at delivery and decrease the risk of transmission of infectious diseases. We think this procedure is almost never necessary, since it would mean additional surgery and anaesthesia during pregnancy, while other authors have shown that there was no difference in terms of labour duration, rates of episiotomy or vaginal tears, amount of blood loss, APGAR scores or hospital stay [18].

The fact that two gynaecologists have been asked to perform FGMs on girls and that four have been asked if they could provide information on where FGM could be performed in Switzerland shows a certain demand. No case of FGM has yet been brought to court in Switzerland but twelve gynaecologists have heard of FGMs performed in Switzerland. Law suits in France [4] show that girls are also affected in Europe and it may be unrealistic to believe that an immigrant population is ready to give up this tradition, especially as it can be a source of identification in a foreign setting [19]. It should not be forgotten that the parents who have their daughters circumcised according to their traditions do so with best intentions. Many circumcised women do not see a link between possible health problems and circumcision and do not consider circumcision as a mutilation, expressing positive feelings towards it [16]. Some may also hope to protect their daughters growing up in a Western society. Immigrants may not understand the special interest paid to FGM [20], especially as they may be confronted to other more acute problems [20] upon arrival in a foreign country. Those in Switzerland not ready to abandon this tradition may either leave the country to have it performed during a trip back home [21], or be forced to go underground and thus try to avoid medical treatment when complications occur. In using a harm reducing approach, a medicalisation of the practice had been proposed in the USA in 1996. The Seattle compromise involved only nicking the clitoral prepuce to draw a single drop of blood under anaesthesia, to offer a less harmful solution [15]. This is clearly rejected by WHO [22] which condemns all forms of FGMs in order not to hinder the eradication of the practice, whereas others [15] recommend careful consideration of the consequences of various forms of medicalisation in order to evaluate whether it has the potential to reduce harm and serve as an engine of change.

Several African countries such as Burkina Faso, Central Africa Republic, Ivory Coast, Djibouti, Ghana Guinea, Tanzania, Togo and Senegal have passed laws against FGM [3]. Britain, Sweden, Norway, Belgium [6] and the US [23] have specific laws against FGM. In Switzerland, Art. 122 of the Penal Code and the Swiss Academy for Medical Sciences [24] condemn FGM, and in 2000 the Swiss Federal Government wanted to increase attention paid to FGM [19]. In 2001, the European Parliament Women's Rights Committee adopted a report asking for further action in the EU [6]. In Africa [25, 26] as well as in Western countries [5, 16, 27] many are ready to abandon the tradition. These people need to be supported and may be a key to the change of attitudes of their fellow countrymen. Immigrant women who gave up FGM should be considered as partners. Trained as mediators they can deal with this culturally sensitive issue, are not considered as intruders, and are more likely to be trusted.

The fact that only two Canton health representatives have been confronted with problems regarding FGMs may explain why it is often considered a non-medical issue and no activity seems to be carried out by Health Departments. On the other hand, physicians can play a key role in prevention since they have a closer contact [12] with the affected group than any other professional group. When facing FGM, physicians are not only confronted to a legal and medical issue but also to an ethically and culturally sensitive issue. Facing the results of a practice they probably condemn as a mutilation, health care workers' reactions may even be a source of added humiliation for the patients [21]. As medical aspects are strong arguments against FGM and as management of affected women may be difficult, guidelines for health personnel are needed and teaching of FGM should be included in medical school curricula because the problem may concern family doctors in the first place. In a study among physicians in the European Union, 78% said they would welcome a code of conduct [28]. Such guidelines are being developed in several European countries and already exist on a national level in England and Norway [29, 30]. They could easily be adapted for Switzerland. Fact sheets providing useful information and addresses should also be made available.

Compared to other health problems, FGM may not seem very frequent. Considering that approximately every fifth gynaecologist in Switzerland has treated patients presenting FGM, that 40% of them are facing delicate questions such as reinfibulation, that there are hints that FGM might be performed in Switzerland, further action is justified to try to better understand the situation

in this country and prevent the occurrence of new cases. Improvement of care by proper education of health care providers and prevention of new cases by women's education should also be considered.

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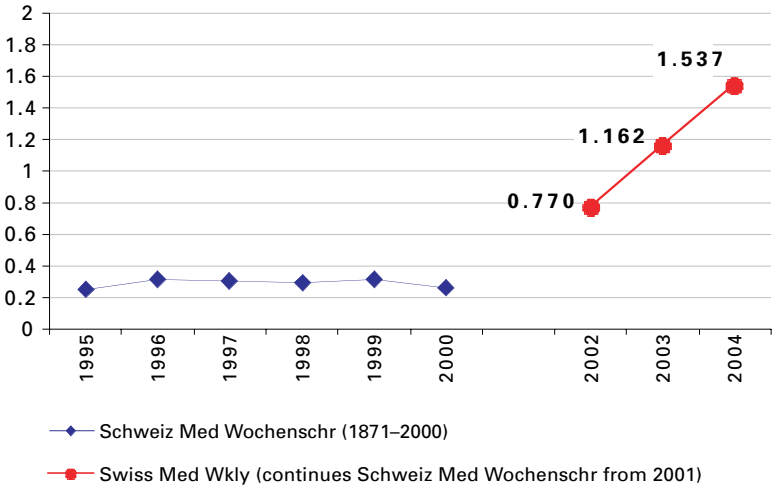

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