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SPECIAL COMMUNICATION

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Conducting an asylum evaluation focused on female genital mutilation/cutting status or risk

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Abstract

Background: Female genital mutilation or cutting (FGM/C) is considered a human rights violation and is practiced all over the world. It has been used as a basis for seeking asylum in various countries, including in the USA since 1996, and the precedent-setting matter of Kissindja. Clinicians in the USA and elsewhere who perform asylum evaluations may be called upon to evaluate women who seek asylum based on their FGM/C status or risk. In this manuscript, we provide expert-informed best practices to conduct asylum evaluations based specifically on FGM/C. We review evidence-based history taking, physical examination unique to the population of women and girls affected by FGM/C, and consider the evaluation in the context of trauma-informed care.

Conclusion: Although general clinical skills often suffice to perform asylum evaluations, FGM/C represents a unique niche within the field of gynecological asylum evaluations and requires additional background knowledge and clinical competencies.

Ethical approval: As this is a clinical review and does not involve patients or research subjects no ethical approval was sought or was necessary.

KEYWORDS

Asylum evaluations, Asylum seekers, Female genital mutilation/cutting, Human rights, Immigrants, Medico-legal medicine, Violence against women

1 | BACKGROUND

Female genital mutilation or cutting (FGM/C) is practiced all over the world and is defined by WHO as a practice that “comprises all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons”. It is estimated that more than 200 million girls and women have undergone FGM/C.[1] The practice is most commonly carried out on girls between the ages of 2 and 15 years.[2] FGM/C is illegal in many countries but remains prevalent in many cultures and ethnic groups and is considered a human rights violation.[1,2] FGM/C has been used as a basis for seeking asylum in various countries.[3–11] In the USA, FGM/C has been used as a basis for seeking asylum since 1996, and the precedent-setting matter of Kissindja.[12,13]

Asylum cases related to FGM/C must demonstrate an alignment with protected grounds defined as race, religion, nationality, political opinion, or membership in a “particular social group”. Although FGM/C is recognized as a form of persecution, affected girls and women have the burden of proof to show a credible fear of being forced to undergo FGM/C, or to show that they suffer long-term and significant consequences as a result of the procedure. According to international law, as well as to US legal precedent, it is a form of gender-based violence, a child-specific form of persecution, a violation of the right to non-discrimination, a violation of health and bodily integrity, and even a form of torture. In some cases, it can be considered as a continuous form of persecution, because of its potential chronic health issues.[3–11] Immigration relief can be claimed on any or all of these grounds.

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Women and girls may be considered members of a "particular social group" because they are at risk for undergoing this procedure as a result of their immutable characteristics of gender and anatomy. Some clients may also claim protection on the basis of "nationality" if FGM/C in their home country is practiced as a 'rite of passage' by an ethnic group, justified on the basis of religious obligation, or in the absence of in-country legal protection from FGM/C. Finally, anti-FGM/C activists may be able to claim persecution based on their political or advocacy activities against this practice.[3–11]

There are no available data on the number of asylum cases in the USA specifically related to FGM/C. However, anecdotal information suggests that this is a common means of seeking asylum in the USA, and may be a primary or only reason that asylum is granted, regardless of other persecutory or torture history. Little guidance has been published for clinicians who conduct asylum evaluations based on FGM/C status.[14] The authors have performed, collectively, over 100 such evaluations in the past 15 years, and have conducted multiple training workshops for asylum evaluators on best practices in addressing FGM/C as part of a forensic asylum evaluation. In this manuscript, we provide best practices related specifically to cases of FGM/C based on their experience. Guidance about conducting asylum evaluations in general can be found elsewhere.[15]

2 | IMPORTANT ELEMENTS IN THE HISTORY

Clinicians receive referrals for asylum evaluations through legal partners, asylum programs associated with human rights organizations, or medical schools. An asylum evaluation is meant to provide expert assessment and corroboration of allegations of ill-treatment, torture, or abuse presented by the client. As such, the goals of the encounter are different from those for a therapeutic physician/patient encounter and do not involve providing diagnoses, ongoing care, or treatment recommendations. Asylum evaluations, therefore, are not considered medical encounters, those evaluated are referred to as clients or asylum seekers, not as patients, and those performing them are described as clinician experts, forensic experts, or asylum evaluators not as healthcare providers. Although many clients receive this information from their lawyer, because of the potential for cultural and language barriers or misunderstandings, it is important to clarify this with the client before the evaluation, including that this is not a medical evaluation and that a detailed description of the encounter (an affidavit) will be written and given to their lawyer and the courts.

The history obtained from the asylum seeker is meant to help corroborate the alleged effects of the practice of FGM/C on the client (or their family member), with physical or psychological evidence. Always start with a general medical history, including past medical history, hospitalizations, medications, surgeries, injuries, fecundity, and obstetric history. The evaluator should then proceed to focus on specific FGM/C-related practices and issues.

Importantly, FGM/C is sometimes noted as part of a continuum of gender-based violence, or other violations of human rights, including child and forced marriage, rape, and sexual assault.[16] Before proceeding with an FGM/C-focused evaluation it is imperative that the clinician check with the client's legal representative to determine whether those elements should be part of the assessment. For the purpose of this manuscript, we only focus on FGM/C.

It is also important to note that not all women who have undergone FGM/C suffer long-term consequences.

Table 1 describes specific elements of the history that should be obtained when evaluating a client seeking asylum based on FGM/C.

3 | THE PHYSICAL EXAMINATION

It is critical to take a trauma-informed approach to the history taking and physical examination. Trauma-informed care is an approach that assumes the person in front of you has experienced trauma. Its principles emphasize establishing trust, ensuring safety, and yielding control to the client, while striving to minimize discomfort, re-traumatization, and shame.[17] This is particularly important in the context of inquiring about intimate details of the client's sexual life and performing a genital examination, which may elicit strong emotional reactions. A critical part of creating a safe environment for the client is to clearly describe the purpose of the evaluation, provide a concrete description of the steps in the evaluation, and reassure her that she may pause or even stop the evaluation at any time.

The physical examination itself should not be confined to the genitals, unless specifically requested by the client or the attorney. The identification of the specific type of FGM/C undergone by the client can be challenging given the evolving appearance of the genitalia with age and childbirth. For adults, there is a visual reference atlas,[18] though not every client will fit clearly into a particular category. WHO describes four primary types and several sub-types. Figures 1–5 provide visual representations.[19]

The clinician should document exactly what structures were removed (e.g. clitoral hood, labia minora, labia majora) or altered. In addition, the clinician must document the presence of keloids or other dermatologic findings. It is important to note that if the client has had vaginal deliveries, the appearance of her genitalia—and thus evidence of her FGM/C—may be dramatically altered. Identification of episiotomy scars can help to substantiate a client's report of a difficult vaginal delivery. Additionally, a previously infibulated woman who has delivered vaginally, may appear on examination as if she has undergone Type 2a/b FGM/C rather than Type 3. This may need to be addressed in the affidavit, in order to educate the adjudicator, particularly if the client reports infibulation or Type 3 FGM/C as part of her history.

A brief psychological assessment can be informative to document the mental health consequences of FGM/C, which may include depression, anxiety and post-traumatic stress disorder.[20] In settings where a separate psychological evaluation with a mental health expert is not feasible, standardized outpatient screening or diagnostic instruments can be used. Several studies have also shown

TABLE 1 Specific elements of the history that should be obtained when evaluating a client seeking asylum based on FGM/C.

History element	Specific questions	Reasons
Ethnic, tribal, and religious history	▪ Ask about ethnic/tribal and religious affiliation of the client, her spouse, parents, grandparents.	Ethnic, tribal and religious variations exist, and are reflected in different FGM/C prevalence rates. The client data can be compared with published statistics.[16] Family members' affiliations may be an important element in discussions about fear of the practice being forced on daughters. The role of patrilocal marriage traditions should be ascertained as well. Anecdotally, we have seen cases when even if a girl's parents did not believe in the practice, she was forced to undergo the practice in deference to the groom's parents' demands.
Geographic location	▪ Ask about place of birth (country, village/town, region) and residence prior to migration.	Regional variations exist in FGM/C prevalence. The client's personal information can be presented in the context of published regional statistics.[16] Bear in mind that the geographic distribution of ethnic/tribal groups does not always fall neatly within national borders. A high-prevalence ethnic group may reside in a low-prevalence nation.
FGM/C status of other female family members	▪ Inquire about the FGM/C status of sisters, mother, grandmothers, daughters.	This information may help establish the community social norms about FGM/C as well as the potential threat of FGM/C if the asylum seeker is, as yet, uncut.
The procedure[27]	▪ Obtain detailed information about the practice the client has undergone: • At what age; how do they know about the details (what do they personally recall versus what a family member told them happened)? • Who did it (grandparent, midwife, medical professional)? • The social situation surrounding it • Where was it done (village, hospital, house)? • Was it done in a group? If so, did anyone die? • Was there kidnapping/ trickery involved? • Was it done with parental consent or against their wishes? • What tools were used? • Memories of restraints (ropes or held down) • What kinds of hygiene measures were taken? • What was done immediately after the procedure for hemostasis, pain control? • Ask about other genital modification practices such as use of caustic substances, pricking, nicking, and labial elongation practices.	Such details offer more data, which can be described in context with common practices published in the literature.[1,2] Such details can also offer additional hints to facilitate further probing about acute and chronic complications. Type IV FGM/C may not be visible on physical examination, but is still considered a human rights violation.[1] Labia minora elongation is practiced in some countries (Rwanda, Uganda, Mozambique) and is considered a form of FGM/C in some contexts.[17]
Acute complications[27]	▪ Ask the client to recall any acute reactions or complications suffered during or immediately after the procedure, including bleeding, pain at the wound, pain with urination, infections, musculoskeletal injuries, fear, anxiety. ▪ Inquire about how those were addressed (use of local remedies, need to see physician, hospitalizations).	This information may establish the severity of the event (especially if linking it with allegations of torture). The history of intense fear, anxiety, and panic at being removed from loved ones or being injured by one's loved ones, held down against one's will and injured painfully contribute significantly to the chronic psychological effects, such as PTSD.
Chronic Complications[27]	▪ Inquire about long-term physical and mental health complications the client associates with undergoing FGM/C. ▪ Inquire about difficulty with routine reproductive health activities, such as use of tampons, undergoing preventive health exams and cervical smears.	Those may include chronic pelvic pain, sexual dysfunction (vaginismus, low/ no satisfaction, inability to achieve an orgasm), chronic urinary problems, scars/keloids, PTSD, anxiety and depression, permanent avoidance of marriage or intimacy, which may result in rejection and anger by a husband if married, or if single, ostracization by family and social group, as being single is not acceptable. This information may help establish lasting physical and mental health effects of the practice.

(Continues)

Table 1 (Continued)

History element	Specific questions	Reasons
Issues related to pregnancy and delivery[27]	▪ Assess whether the client had any pregnancy-related complications potentially related to FGM/C during the prenatal, perinatal, and postnatal periods. ▪ Inquire about a history of undergoing defibulation and when. ▪ Inquire about a history of reinfibulation and if done, at whose request it was carried out.	For example: whether a cesarean or an episiotomy was required; whether the birth attendant attributed the need for the intervention to the FGM/C specifically; or whether they recall a significant tear/laceration requiring lengthy repair, which may be from FGM/C. There are some (low-quality) studies and case reports about an association between FGM/C and stillbirth, cesarean section, need for assisted delivery.[21]
Other Human Rights Violations	▪ Assess whether the client has experienced other forms of sexual and gender-based violence, such as child marriage, forced marriage, rape, IPV, sexual assault.	Some studies suggest that FGM/C co-occurs with other forms of gender-based violence.[15] Such information may help establish the need for protection under the "specific social group" criterion.
Status of daughters	▪ Inquire about the asylum seeker's daughters' FGM/C status, and, if not cut, assess their risk of being cut if forced to return to the family's country of origin.	This may help establish fear of future persecution and may offer an opportunity to also assess the risk to daughters of "vacation cutting" and associated legal issues.
Activism	▪ Ask about any political, social, advocacy anti-FGM/C activities the client may have been involved with.	This may help bolster claims of persecution due to political activities.
Status of friends/ family	▪ Ask about deaths or significant morbidity/chronic complications witnessed directly after FGM/C or in childbirth due to FGM/C.	May bolster claims of harm from the practice.

Abbreviations: FGM/C, femal genital mutilation/cutting; IPV, intimate partner violence; PTSD, post-traumatic stress disorder.

an association between FGM/C and sexual dysfunction,[19,21–24] so screening for female sexual dysfunction may be warranted.

Table 2 lists some of the screening instruments that can be used during an asylum evaluation of a person alleging FGM/C.

Presenting additional evidence in the form of mental health or sexual health dysfunction, in addition to documenting the physical signs of the client's FGM/C, may help corroborate the allegations and strengthen her case. However, it is important to note that many of these screening tools have not been validated in the languages and cultural contexts where the majority of clients alleging FGM/C will be coming from.

4 | WRITING THE AFFIDAVIT

The medical affidavit is a summary of the information collected by the clinician and serves as the clinician's expert assessment of the case. Because the target audience is members of the legal profession, the clinician should make every effort to avoid using medical jargon. The affidavit should include: the clinician's qualifications, the client's medical history, her FGM/C history, and the physical examination findings.[15]

It is considered best practice to offer an interpretation of the findings that is based on the principles of the Istanbul Protocol,[25] which seek to integrate the degree of consistency between the alleged abuse (in this case FGM/C) and the client's history, physical examination findings, and continuing related physical or mental health effects. Table 3 summarizes the recommended Istanbul Protocol language.

It is important to remember that a clinician should never render judgment or make legal suggestions regarding the merits of the case. The clinician's sole role is to report the data and medical findings and put them in context. One such contextual supplement may be a summary of country, regional, or ethnic statistics to further support the client's allegations, because it helps

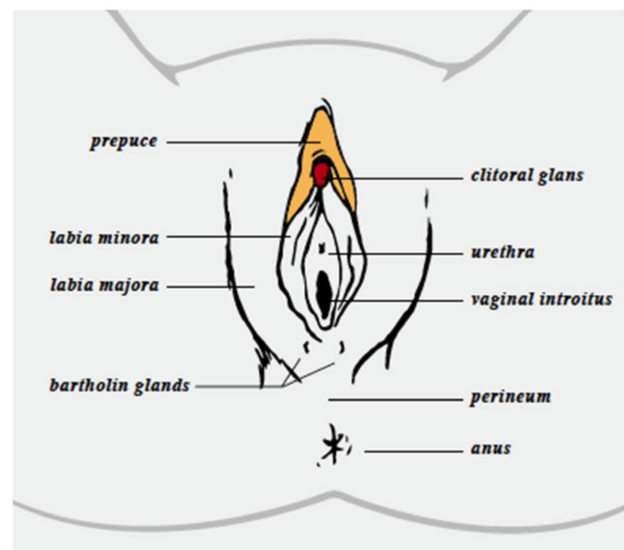

FIGURE 1 FGM/C Types Ia and Ib.

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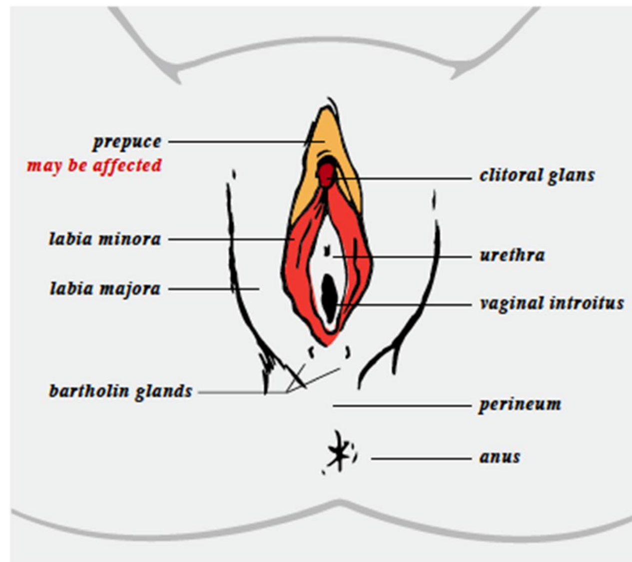
TYPE II

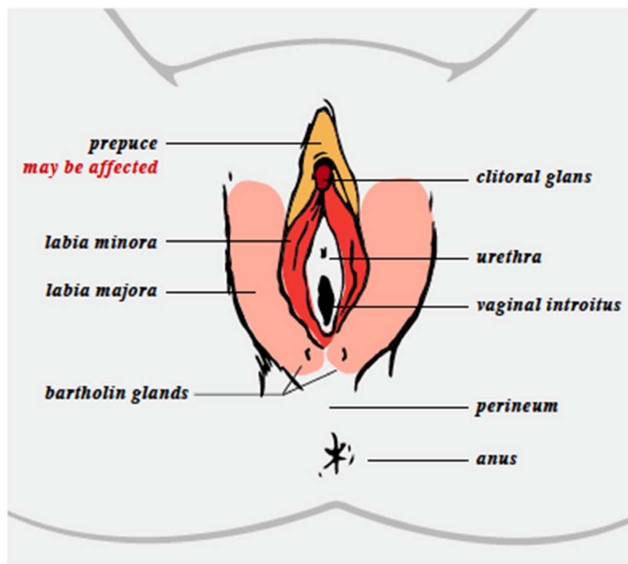
Partial or total removal of the clitoral glans and the labia minora, with or without excision of the labia majora (excision)



Type II (A): removal of the labia minora only

+ + Type II(B): partial or total removal of the clitoral glans and the labia minora *(prepuce may be affected)*

FIGURE 2 FGM/C Types IIa, IIb, and IIc.

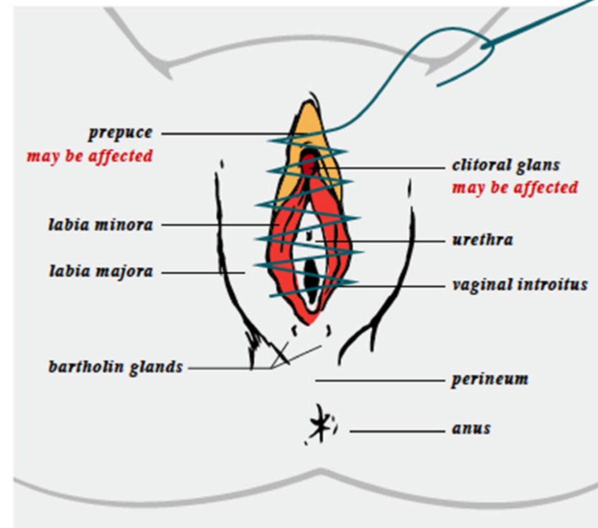


+ + + Type II(C): partial or total removal of the clitoral glans, the labia minora and the labia majora *(prepuce may be affected)*

FIGURE 3 FGM/C Types IIIa, IIIb.

TYPE III

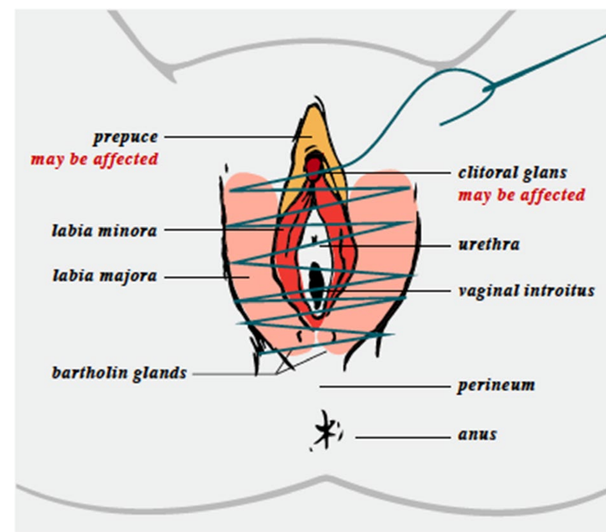
Narrowing of the vaginal opening with the creation of a covering seal by cutting and appositioning the labia minora or labia majora with or without excision of the clitoral prepuce and glans (infibulation)



Type III(A):

+ + + appositioning of the labia minora

FIGURE 4 WHO classification Type 3a



Type III(B):

+ + + + appositioning of the labia majora

FIGURE 5 WHO classification Type 3b

to place the experience of the asylum seeker into a larger socio-cultural context. Use of scholarly citations (not news articles) is recommended and may bolster the evaluator's designation as an expert in the field.

TABLE 2 Common Screening tools and checklists.

Name of tool	Purpose	Link
PHQ–9 Patient Health Questionnaire	An instrument for screening, diagnosing, monitoring and measuring the severity of depression	https://www.phqscreeners.com/sites/g/files/g10016261/f/201412/PHQ-9_English.pdf
GAD–7 Generalized Anxiety Disorder 7-item	Rapid screening for the presence of a clinically significant anxiety disorder, especially in outpatient settings	https://www.integration.samhsa.gov/clinical-practice/gad708.19.08cartwright.pdf
PCL–5 PTSD Checklist for DSM–5	The PCL–5 is a 20-item self-report measure that assesses the 20 DSM–5 symptoms of PTSD; it serves as a screening tool for PTSD and for making a provisional PTSD diagnosis	https://www.ptsd.va.gov/professional/assessment/documents/PCL5_Standard_form.PDF https://www.ptsd.va.gov/professional/assessment/adult-sr/ptsd-checklist.asp
HTQ Harvard Trauma Questionnaire	Developed to measure torture, trauma, and PTSD symptoms in refugee populations	http://hprt-cambridge.org/screening/harvard-trauma-questionnaire/
HSCL–25 Hopkins Symptom Checklist–25	The HSCL–25 is a symptom inventory that measures symptoms of anxiety and depression and has been translated into many languages	http://hprt-cambridge.org/screening/hopkins-symptom-checklist/ https://www.healtorture.org/mental-health-evaluators/screening-tools
RHS–15 Refugee Health Screener–15	The RHS–15 is a tool developed to sensitively detect the range of emotional distress common across refugee groups	https://x9yjk2t4l9ghu7ty7bhu81ac-wpengine.netdna-ssl.com/wp-content/uploads/2012/09/RHS15_Packet_PathwaysToWellness-1.pdf
FSFI Female Sexual Function Index	A brief questionnaire measuring sexual functioning in women, in the following domains: sexual arousal, orgasm, satisfaction, pain. It is not a measure of sexual experience, knowledge, attitudes, or interpersonal functioning in women	https://www.fsfiquestionnaire.com/

Abbreviations: DSM-5, Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition; PTSD, post-traumatic stress disorder.

5 | OTHER CONSIDERATIONS

5.1 | Referrals

Although the purpose of the encounter is not to offer a medical service, the clinician may determine that clinical services are necessary to address FGM/C-related, or other, issues. The clinician has a duty to refer the client for additional services such as primary care, psychology, psychiatry, social work, sex therapy, pelvic physical therapy, urology, gynecological service, or plastic surgery follow ups.

5.2 | Photography

Forensic photography is sometimes helpful as an additional form of evidence.[26] Given the intimate anatomical location of FGM/C, clinicians generally forgo photography. If the clinician feels that a photograph would provide stronger evidence than a written description or illustrations, a separate, written consent should be sought from the client to photograph the genitalia. Alternatively, an illustration from the WHO classifications may be included in the affidavit as an approximate representation of what was observed on examination.

5.3 | An educational opportunity

Though the goals of an asylum evaluation are very specific, the encounter may be an opportunity to educate the client about various issues. For example, discussion of uncut or unaltered female genital anatomy may be useful, as many of the clients may come from countries and cultures where such discussions are not the norm, or are

TABLE 3 Istanbul Protocol language.[24]

Level of consistency	Description
Not consistent	The physical/psychological finding could not have been caused by the trauma described.
Consistent	The physical/psychological finding could have been caused by the trauma described, but it is non-specific and there are many other possible causes.
Highly consistent	The physical/psychological finding could have been caused by the trauma described, and there are few other possible causes.
Typical of	This is an appearance that is usually found with this type of trauma, but there are other possible causes.
Diagnostic of	This appearance could not have been caused in any way other than that described.

associated with stigma. The clinician may show the client illustrations or photographs of a similar FGM/C type to hers, or propose using a mirror to view her own external genitalia. The clinician may also use this opportunity to review and answer questions about sexual function and dysfunction, the menstrual cycle, or other reproductive health issues, and to let the client know there are options for improving the chronic side effects, even many years following FGM/C.

6 | SUMMARY

Clinicians in the USA and elsewhere who perform medico-legal asylum evaluations may be called upon to evaluate women who seek asylum based on their FGM/C status or risk. General clinical skills often suffice to perform asylum evaluations, but FGM/C represents a unique niche within the field of asylum medicine and requires additional background knowledge and clinical competencies.

CONFLICTS OF INTEREST

The authors report no conflicts of interest. RM, DO, and EM perform pro-bono asylum evaluations, on behalf of Physicians for Human Rights and other organizations. RM is a paid Senior Medical Advisor to Physicians for Human Rights and a former member of the steering committee of the US End FGM/C Network. DO is a current member of the steering committee.

AUTHOR CONTRIBUTIONS

RM generated the idea, and all authors contributed to drafting, writing, reviewing and editing the article.

REFERENCES

1. World Health Organization. Fact Sheet: Female genital mutilation. https://www.who.int/news-room/fact-sheets/detail/female-genital-mutilation. Accessed October 12, 2019
2. UNICEF. Female Genital Mutilation Country Profiles. Published 2019. https://data.unicef.org/resources/fgm-country-profiles/. Accessed October 12, 2019.
3. United Nations High Commissioner for Refugees. UNHCR Protection Policy and Legal Advice Section Division of International Protection Services. Guidance Note on Refugee Claims Relating to Female Genital Mutilation. Geneva. May 2009. https://www.refworld.org/pdfid/4a0c28492.pdf. Accessed November 1, 2019
4. Harivandi ZE. Invisible and Involuntary: Female Genital Mutilation as a Basis for Asylum. Cornell Law Review. Vol 95: 599. 2010. http://cornelllawreview.org/articles/invisible-and-involuntary-female-genital-mutilation-as-a-basis-for-asylum/ Accessed November 1, 2019
5. Kim Y. CRS Report to Congress. Asylum Law and Female Genital Mutilation: Recent Developments. February 2008. https://fas.org/sgp/crs/misc/RS22810.pdf. Accessed November 1, 2019
6. Schaefer K. Asylum Granted Based on FGM and Domestic Violence. Schaefer Law Firm. Published 2011. https://immigrationidaho.com/asylum-granted-fgm-domestic-violence/. Accessed November 1, 2019
7. Zakari Z. FGM Asylum Cases Forge New Legal Standing. Women's eNews. https://womensenews.org/2008/11/fgm-asylum-cases-forge-new-legal-standing/. Accessed November 1, 2019
8. Blizzard KSA, Parent's Predicament: Theories of Relief for Deportable Parents of Children Who Face Female Genital Mutilation. Cornell Law Review. Vol 91: 899. 2006. http://cornelllawreview.org/articles/a-parents-predicament-theories-of-relief-for-deportable-parents-of-children-who-face-female-genital-mutilation/. Accessed November 1, 2019
9. Female Genital Mutilation/Cutting: Asylum Claims and Appeals | Rights in Exile Programme. http://www.refugeelegalaidinformation.org/female-genital-mutilationcutting-asylum-claims-and-appeals. Accessed November 1, 2019
10. Flamand C. FGM: challenges for asylum applicants and officials | Forced Migration Review. Volume 49; May 2015. http://www.fmreview.org/climatechange-disasters/flamand.html. Accessed November 1, 2019
11. Middelburg A, Balta A. Female genital mutilation/cutting as a ground for asylum in Europe. *Int J Refugee Law*. 2016;28(3): 416-452.
12. Female Genital Mutilation or Cutting (FGM/C). USCIS. https://www.uscis.gov/fgmc. Accessed November 1, 2019
13. US Department of Justice. Matter of Kasindja. 1996. https://www.justice.gov/sites/default/files/eoir/legacy/2014/07/25/3278.pdf. Accessed July 12, 2019
14. Muñoz JM, Beausang J, Finley E, Wolf S. Protocol for evaluating women with female genital mutilation seeking asylum. *Int J Legal Med*. 2020;134(4):1495-1500.
15. Ferdowsian H, McKenzie K, Zeidan A. Asylum Medicine: Standard and Best Practices – Health and Human Rights Journal. May 6, 2019 https://www.hhrjournal.org/2019/05/asylum-medicine-standard-and-best-practices/. Accessed November 17, 2019
16. Wikholm K, Mishori R, Ottenheimer D, et al. FGM/C as the Basis for Asylum Claims in the US: An Analysis of Recent Cases. 3rd International Expert Meeting on FGM/C. Brussels, Belgium, May 2019. Article Currently Under Consideration. 28 Too Many. https://www.28toomany.org/. Accessed July 12, 2019
17. Griffin D. SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach. The National Child Traumatic Stress Network. Published 2018. https://www.nctsn.org/resources/samhsas-concept-of-trauma-and-guidance-for-a-trauma-informed-approach. Accessed November 17, 2019
18. Abdulcadir J, Catania L, Hindin MJ, Say L, Petignat P, Abdulcadir O. Female genital mutilation: A visual reference and learning tool for health care professionals. *Obstet Gynecol*. 2016;128(5):958-963.
19. WHO. WHO guidelines on the management of health complications from female genital mutilation. http://www.who.int/reproductivehealth/topics/fgm/management-health-complications-fgm/en/. Accessed November 17, 2019
20. Lever H, Ottenheimer D, Teysir J, et al. Depression, Anxiety, Post-traumatic Stress Disorder and a History of Pervasive Gender-Based Violence Among Women Asylum Seekers Who Have Undergone Female Genital Mutilation/Cutting: A Retrospective Case Review. J Immigrant Minority Health. First online: July 2, 2018.
21. WHO. Care of girls and women living with female genital mutilation. WHO. http://www.who.int/reproductivehealth/publications/health-care-girls-women-living-with-FGM/en/. Accessed November 17, 2019
22. Elneil S. Female sexual dysfunction in female genital mutilation. *Trop Doct*. 2016;46(1):2-11.
23. Vital M, de Visme S, Hanf M, Philippe H-J, 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;202:71-74.
24. Alsibiani SA, Rouzi AA. Sexual function in women with female genital mutilation. *Fertil Steril*. 2010;93(3):722-724.

25. The Istanbul Protocol. Physicians for Human Rights. https://phr.org/issues/istanbul-protocol/. Accessed November 17, 2019
26. Ozkalipci O, Volpellier M. Photographic documentation, a practical guide for non professional forensic photography. *Torture*. 2010;20(1):45-52.
27. Pérez GM, Aznar CT, Bagnol B. Labia Minora Elongation and its Implications on the Health of Women: A systematic review. *Int J Sex Health*. 2014;26(3):155-171.

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