NURSING CARE CONSIDERATIONS AMONG MATERNITY PATIENTS WHO HAVE UNDERGONE FEMALE GENITAL MUTILATION/ FEMALE CIRCUMCISION

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Abstract

Female Genital Mutilation (FGM) is defined as "procedures that intentionally alter and cause injury to the female genital organs for non-medical reasons" by the World Health Organization (2018). FGM is a complicated subject matter to explore, not only because of what it entails, but also due to the identified gap in research about the proper care for these women here in the US. FGM can be very traumatizing and can affect so many aspects of these women's lives. The alteration and injury to the female's genital organs complicate and change the normal care plans for a pregnant patient that has undergone FGM. According to UNICEF, "there are approximately three million women and girls who have undergone FGC (Female Genital Circumcision) living in the United States" (Little, 2015). This number was estimated 5 years ago, and due to recent immigration patterns it is likely that this number will continue to rise. The increasing number of girls and women who have undergone FGM that live here in the US and the limited amount of identified research on this subject supports the need for this inquiry.

A review of the literature was conducted using the Cumulative Index of Nursing and Allied Health Literature (CINAHL) database and PubMed for years 2012-2018. A review of eight identified articles substantiate that significant risks and complications exist for women who have undergone *female genital mutilation.* The obstetrical complications of FGM include hemorrhage, injuries due to tearing and episiotomies, extended hospital stays, and emotional and cultural insensitivity experienced by patients. A gap in research exists related to nursing care considerations for this population. Research suggests that education about this topic and becoming culturally sensitive can help nurses provide appropriate care. There are also a number of obstetrical procedures

that can lower the complications that FGM may cause during labor/birth. Further research should focus on nursing implications and interventions for the safe and appropriate care for these women.

Keywords: Female Genital Mutilation, FGM, Obstetrics, Nursing,

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Background

Female Genital Mutilation or "FGM" is defined as "the partial or total removal of the female external genitalia or other injury to the female genital organs for non-medical reasons" (Siddig, 2016, p.912). Throughout the years the affected community has deemed the term "female genital mutilation" offensive preferring the term "female genital cutting", but the World Health Organization continues to use *Female Genital Mutilation* to emphasize the gravity of this act **(**Little, 2015). FGM is commonly practiced in 29 countries in Africa, some parts of Asia, and the Middle East. The country with the highest prevalence of FGM is Egypt, where ninety-one percent of women undergo female genital cutting (Little, 2015 p. 292)**.** According to the United Nations Children's Fund (UNICEF), there are more than 125 million women and girls that have experienced some form of FGC and more than 30 million continue to be at risk (Little, 2015, p. 293). FGM has become a global health issue due to the international migration of women from countries where this is practiced, to westernized countries like the United States, United Kingdom, Australia, and Canada. UNICEF approximates that there are three million women who have undergone FGM living in the United States (Little, 2015). In 2014, using the national migration statistics, it was estimated that were over 130,000 women and girls that have undergone FGM, from the age of 15 to 49 years living in the UK (Siddig, 2016). These approximations do not included girls who are at risk for FGM. Goldberg, Stupp, Okoroh, Besera, Goodman, & Danel (2016), conducted a study that included updating statistics from 1990. Using similar methodology and data they estimated that in 2012, about 513,000 women and girls were at risk for FGM/C or its consequences here in the United States. The increase in population of women with FGM

in westernized countries increases the chances that health care providers in these countries will have contact with patients seeking care, especially obstetrical care. (Ogunsiji, 2016). Understanding the different types of FGM (see Table 1), and their short-term and long-term effects on women is key to providing care for these women.

Table 1

Types of Female Genital Mutilation/Cutting

Type of FGM	Description
Type 1	**Clitorectomy** Partial or total removal of the clitoris and sometimes the prepuce (fold of the skin surrounding the clitoris)
Type 2	**Excision** Partial or total removal of the clitoris and labia minora, with or without excision of the labia majora
Type 3	**Infibulation** Narrowing of the vaginal opening through the creation of the covering seal. The seal is typically formed by cutting and repositioning the inner and sometimes the outer labia, with or without the removal of the clitoris
Type 4	**Other** All other harmful procedures to the female genitalia for non-medical purposes, such as pricking, piercing, incision and cauterization, or pulling and stretching of the labia or clitoris

(Siddig, 2016, p.914 -Table 1.)

Complications

Many negative health implications exist due to the nature of FGM, with both short term and long-term complications. Some short-term or acute complications include

hemorrhage, local infections, urine retention, urinary tract infections, injury to the vagina, and urine and fecal incontinence (Little, 2015). Of all the acute complications, hemorrhage is the most common at rates of 25%. The second most common complication is infections at rates of 15% (Little, 2015). Long-term complications of FGM are most common in women with infibulation (Type 3). They include chronic UTIs that typically lead to severe kidney infections and vesicovaginal fistulas. Besides the obvious obstetrical complications, urinary complications make up 29% of long-term complications. They can also suffer from menstrual problems, painful intercourse, vaginal dryness, decreased satisfaction, and decreased or lack of desire (Little, 2015).

Obstetrical Complications

Type 3 or 'infibulation' is the most severe type of female genital mutilation. It is invasive and is performed by narrowing the vaginal opening and creating a seal. This seal makes women who have undergone this type of procedure at a higher risk for childbirth complications. There are general risks for pregnancy, but having undergone FGM makes those risks even greater. For example if a miscarriage occurs during any stages of pregnancy, it could be retained due to the seal of the vaginal opening (Little, 2015). This could lead to a serious infection or even sepsis. This procedure may also interfere with labor. If there is an obstruction to the birthing canal/passage during labor, this could be very dangerous for the mother and the infant. Prolonged labor causes stress to both and may lead to emergency situations. Women could also suffer from multiple types of lacerations from the tearing of the seal. Deinfibulation is described as "an anterior midline incision of the scar" (Little, 2015 p. 294). This procedure is usually performed before or during labor, to help facilitate the passage of the child through the birth canal.

According to Siddig (2016), in general women who have undergone FGM have increased risks of obstetric hemorrhage, perineal lacerations, prolonged labor, and instrumental delivery. In some cases infant resuscitation has been needed after delivery.

Methods

For this systematic review a literature search was conducted using the databases CINAHL and PubMed. The databases were searched using the terms and keywords, 'female genital mutilation', 'obstetric care', and 'nursing care considerations'. Thirty full text articles were assessed for eligibility. All articles had to meet the criteria of full text, peer reviewed, published in a credible journal between the years of 2012-2018. Thirteen articles addressed the topic of female genital mutilation and obstetric care. Eight articles met all inclusion criteria. Eight articles were included in the systematic review of the literature. Articles used were published in the United States, United Kingdom, Australia, and Canada. Designs included Retrospective Observational studies, Systematic Review, and Heideggerian Qualitative Interpretive Study.

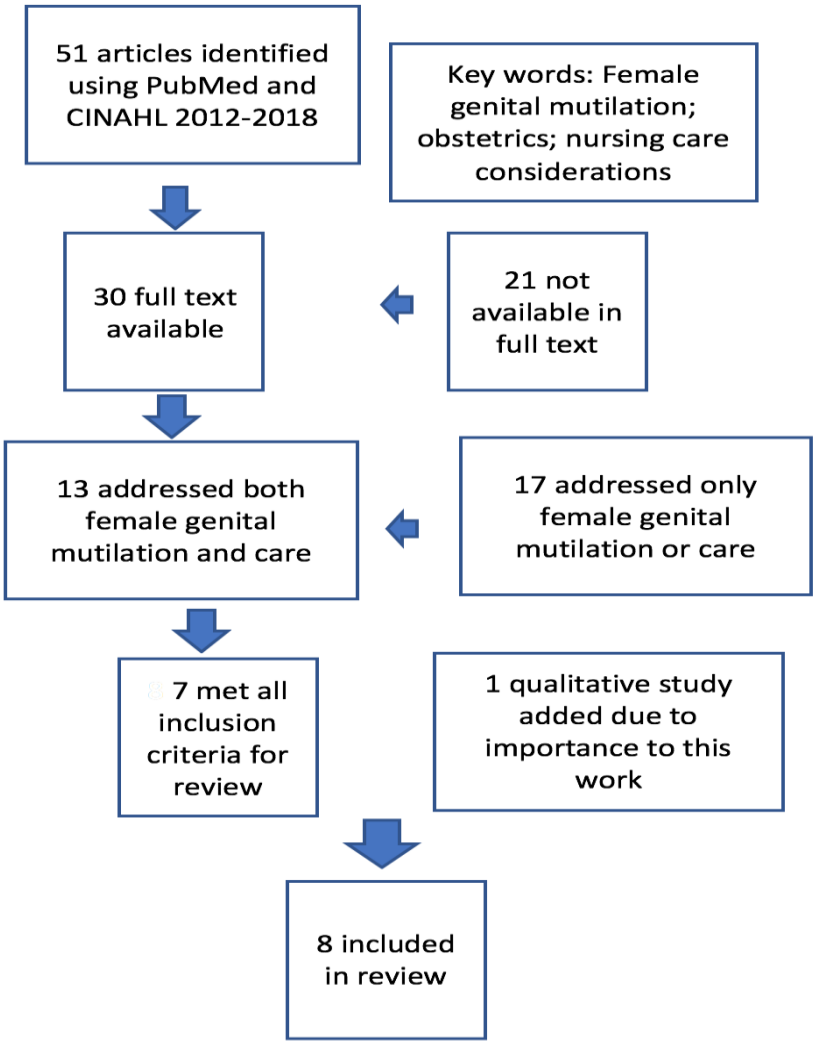
Results

The literature revealed a consensus that female genital mutilation was associated with obstetrical risks and complications. Gayle & Rymer (2016) conducted a systematic review with literature primarily from published African journals. They concluded that studies are needed that address deinfibulation and the timing of the procedure, or assess the psychological well being of women who have had a deinfibulation under local anesthetic in an outpatient setting (Gayle & Rymer, 2016). Albert et al. (2015) addressed the topic that the Gayle & Rymer (2016) review called for. A retrospective observational study done in the United Kingdom aimed to determine if the timing of deinfibulation

influences obstetric outcomes for women with type 3 female genital mutilations. In this study outcomes described in maternity notes of women with ‘deinfibulation prior to labor’ (n=62) were compared with ‘not deinfibulated

Figure 1.

Flow Chart of Literature Search



women with ‘deinfibulation prior to labor’ (n=62) were compared with ‘not deinfibulated before labor’ (n=32). Women who had caesarean sections were excluded when a

secondary analysis was performed. They found that women who were ‘not deinfibulated before labor’ had a significantly greater risk of episiotomy (RR 1.67, P <0.05) and prolonged hospital stay of >2 days (RR 1.33, P <0.05). They also had a statistically insignificant increased risk of a postpartum hemorrhage (RR 1.15, P=0.58); a prolonged second stage (RR 1.77, P=0.16); and required vaginal packing in theater (operating room) (RR 2.6, P=0.17). It was concluded that Type 3 *female genital mutilation* is associated with complications and morbidities in childbirth. When deinfibulation is not performed before labor, the risk of these complications and morbidities is increased (Albert, Bailey & Duaso, 2015, p.431).

Chalmers & Omer-Hashi (2002), gathered information about the experiences of Somali women in terms of the obstetrical care they received. The study consisted of 391 Somali women who had given birth to a baby in Canada in the past 5 years (1997-2002). Two Somali midwives interviewed them. This helped strengthen the study by eliminating a language barrier. The interviews took place in their homes or another mutually agreed upon space. At first, the questionnaire was primarily focused on covering the experiences of the women's birth experiences in Canada, but after a few interviews it was expressed that, “to truly understand their birth experiences, as affected by their female genital mutilation, the research needed to explore their earlier experience as well” (Chalmers & Omer-Hashi, 2002, p.270). The women were suggesting that the inclusion of their past experiences would be helpful to understand FGM from a Somali perspective. The interview was predominantly a closed-ended format. The questions covered biographical issue, pregnancy history, early experiences of female genital mutilation, giving birth in Canada, and women’s attitudes to conditions in Canada regarding female genital

mutilation. Once all the interviews were conducted, their responses were later categorized with regards to their content. In total, 12 issues were raised by the Somali women (see Table 2). From the study they concluded that overall the women were dissatisfied with the care they received from medical and nursing staff. Based on their comments it was clear that Canadian health services for women with FGM needed to be reevaluated and that education for nurses and providers needs to be applied.

Table 2

Themes Arising from Interviews with Somali Women

Categories	N	%
Wanted help with the baby	319	75.4
Wanted warm, caring and sympathetic staff	244	57.7
Wanted respectful treatment	242	57.2
Wanted non-judgmental care	148	35.0
Wanted privacy in labor and in the	109	25.8
Wanted clinical care appropriate for FGM	93	22.0
Appreciative of good health care, saved lives of mother/baby	83	19.6
Wanted visitors to be treated respectfully	79	18.7
Wanted a restful, quiet room	73	17.3
Language difficulties	35	8.2
Difficulties with roommates	27	6.4
Wanted familiar, Somali or female caregivers	18	4.2

(Chalmers & Omer-Hashi, 2002, p. 271- Table 1)

For nurses to properly care for these patients they must be educated regarding FGM and its effects on obstetrical care. Jacoby and Smith's (2013) focused on increasing the confidence of midwives caring for women with FGM by creating an educational program, using Brenner's theory of "novice to expert" as a theoretical framework. It included case studies, didactic information, a cultural roundtable, and a hands-on skills laboratory of deinfibulation and repair. Eleven certified nurse-midwives (CNMs) participated in the study. A measure-of-confidence survey tool was filled out

upon the completion of the educational program. This survey measured the effectiveness of the program. The result of the study was that the midwives reported an increase in confidence in their ability to provide care to immigrant women who have undergone FGM. These results were based on comparing the post education responses to the pre education surveys. According to Jacoby & Smith (2013), the largest increase in confidence was noticed with the midwives' ability to identify factors that are contraindications for CNMs to perform deinfibulation and repair (increased from 1.63 to 4.27 on a scale of one to five). The lowest increase was in the capability of comprehending the historical, cultural, legal and ethical considerations of Female Genital Mutilation/Cutting (increased from 2.64 to 4.09 on a scale of one to five).

Limitations

One limitation to this review was the dearth of identified studies examining the topic of nursing care of women who underwent FGM. Most articles from the initial search were outdated and did not address nursing considerations, as they focused mainly on physicians' roles. No identified studies were from the US, however the majority were from westernized countries like the United Kingdom, Canada, and Australia. Aside from one article that reviewed literature from Africa, there is a general scarcity in representation of African studies. There was also a study included in the review that is outside of the parameters for the inclusion criteria. This is a study conducted in 2002, almost 16 years ago. It was included because it provides patient opinions and comments on care they received. The results of this study are important to include, because they provide nursing considerations that still apply in today's care for women who have undergone female genital mutilation.

Discussion/Conclusion

After reviewing the literature there was a clear consensus that further research is needed to fully be able to provide culturally competent care for women who have undergone female genital mutilation. There was a staggering amount of risks and complications associated with FGM. Due to the increasing immigration and migration of these women to the United States and other Westernized countries, it is important to understand FGM and the best ways of providing obstetric care to these women. Based on the literature, it is first and foremost important to know what FGM is and who it affects. Understanding the different types of FGM helps with determining what interventions are required at the time of labor/birth. It was determined that women with type 3 FGM, had better postpartum outcomes when deinfibulated before labor (Albert et al., 2015). In general, women from all countries require a level of understanding form their nurses about cultural considerations. Nursing care should be holistic. Just considering invasive medical procedures as some of the only aspects of care physicians and nurses can provide would be a limitation to this review. Although Chalmers & Omer-Hashi, (2002) was published before the inclusion years (2012-2018) of this review, it was important to include because it provided detailed qualitative responses to nursing care from Somali patients that have undergone FGM and received obstetrical care. This study from Canada showed that women were not fully satisfied with the care they received. Nurses should learn and understand the areas in which patients feel dissatisfied. To learn more about FGM an educational program similar to the one developed by Jacoby & Smith (2015) should be provided for maternity nurses here in the United States. If nurses feel

more comfortable caring for these patients, then patients will have better outcomes and satisfaction with the care provided.

This review breeds many issues with practice and policy that needs to be addressed. Here in the United States there is a lack of research for culturally competent care considerations for these women. Female genital mutilation is a procedure that affects many women and girls around the globe, many of whom now migrate to westernized countries. Providers, nurses, and researchers must work on easing the deficit in care and knowledge that has been alluded to in this review.

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