Caring for women who have undergone genital mutilation

AUTHOR Anna Daley, RM, DipHE, BSc Midwifery, is a staff midwife, John Radcliffe Hospital, Oxford.


The term ‘female genital mutilation’ refers to a range of irreversible procedures that alter the anatomy of a woman’s genitalia. It is estimated that 132 million women worldwide have undergone such procedures, and a significant number are now living in the UK. Health care professionals need to understand the physical consequences of these procedures and the cultural issues surrounding them if they are to provide sensitive care that meets the needs of this group of women.

The term female genital mutilation (FGM) refers to all procedures involving partial or total removal of the external genitalia or other injury to the female genital organs for non-therapeutic reasons. It is practised across all socioeconomic classes by a range of ethnic, cultural, and religious groups (Toubia, 1994; Momoh, 2000). The practice, which is also known as female circumcision, is irreversible and has no health benefits for the woman (Dorkenoo and Elworthy, 1996). Indeed it can be fatal and almost certainly causes some physiological and psychological distress to every survivor (Holmes, 1984).

The United Nations (UN) and the World Health Organization (WHO) consider FGM to be a human rights issue and have been pressing for its eradication. However, despite worldwide condemnation, FGM is thought to persist in approximately 30 African countries, the Middle East, parts of South East Asia, and South America. Figures suggest that two million young women are subjected to FGM every year, which equates to approximately 6,000 cases per day or five girls every minute (WHO, 1993, 1995; 2000; Momoh, 2000). As a result of immigration, there are significant numbers of women living in the UK who have undergone FGM, although the practice is illegal here.

The idea of FGM may provoke reactions of shock, disgust, and criticism in other people. As a result of this negative response, known as ‘ethnocentric shock’, women with altered genitalia are often reluctant to disclose their condition to anyone outside their community, they are fearful of the medical establishment and have a poor uptake of health care services (Momoh et al, 2001). A reaction of ethnocentric shock from a nurse can cause the woman to become further isolated and lead to her receiving inappropriate care and medical intervention.

What is FGM?

Although it is most commonly performed on girls aged between four and 10 years, FGM can be undertaken at any age, from a few days after birth, through childhood, adolescence and even after marriage, or during pregnancy or childbirth, depending on the society’s tradition (Momoh et al, 2001).

There are four categories of FGM, grouped according to how much anatomical alteration takes place (Box 1). However, scarring and damage to the adjacent structures can make the type of FGM difficult to categorise (Rushwan, 2000; Ahmed, 1996).

The procedure is usually performed by a female village elder or circumciser, a traditional birth attendant, or a female family member such as an aunt, mother or grandmother (Mays and Stockley, 1983). A variety of implements are used including razor blades, knives, pieces of glass and sharpened flints. In many cases no anaesthetic is used and the girl is physically restrained during the operation. She may then lie with her legs bound together for days following the procedure and could be operated on again if the wound does not heal properly (Denholm, 1997).

Why is FGM performed?

Historical context

The origins of FGM are unknown but it is thought to have evolved independently on different continents. Records

BOX 1: CATEGORIES OF GENITAL MUTILATION

| Type 1 | Excision of the prepuce with or without the excision of part or the entire clitoris (clitoridectomy) |
| Type 2 | The same as type 1 but with the partial or total excision of the labia minora |
| Type 3 | The most severe form of FGM, involving excision of all external genitalia and the stitching of the vaginal opening (infibulation). During the operation an object such as a sliver of wood may be inserted to preserve a hole, allowing the passage of urine and menstrual blood once the wound has healed |
| Type 4 | Unclassified alteration to the genitalia including piercing, pricking, stretching, cauterisation, cutting of the vaginal wall (Gishiri cuts) and the introduction of corrosive herbal substances to induce bleeding |
suggest that it existed as early as the fifth century BC, while a Greek papyrus dated 163BC refers to circumcised girls in Egypt.

This may explain why it is sometimes referred to as pharaonic circumcision (Ahmed, 1996). It was probably part of the culture of sub-Saharan Africa for thousands of years, pre-dating any written record, and was performed in the mid 19th century in England, Germany, France, and the US as a cure for what were considered female conditions such as excessive masturbation, nymphomania, hysteria, melancholia, insanity, and epilepsy (Magoha and Magoha, 2000).

One theory suggests that FGM emerged in patriarchal societies in which men needed to be sure they were the father of their wife’s children. El Saadawi (1980) argues that men believed female sexuality, if unchecked, could lead to confusion about the legitimacy of children and precipitate the collapse of the patriarchal family structure, especially in cultures where inheritance and bloodline pass through the father. She argues that systems that allowed men to take several wives but permitted women to have only one husband gave rise to the use of chastity belts and FGM (El Saadawi, 1980).

Other theories suggest that infibulation — stitching of the vaginal opening — developed to protect the women of nomadic tribes against rape and to ensure their fidelity while the men were away from the group (Holmes, 1984).

Although many practising Muslims believe there is a religious obligation to circumcise women, this is a misconception. FGM pre-dates Islam, is not mentioned in the Koran and is not practised in Saudi Arabia, the focus of Islam. One theory suggests that the high value placed by Islam on chastity made FGM tolerable in many Islamic cultures (Ahmed, 1996), which may explain why type 1 FGM is sometimes referred to as ‘sunna’, which means ‘following the Prophet’s tradition’ (Knot, 1996). Some women are re-sutured (re-infibulated) before religious pilgrimages, to regain a virginal state (Frances, 2000).

### The sociological context

People in the UK can find it difficult to comprehend why loving parents would willingly subject their daughter to such a harmful act. However, we tend to view our own society as ‘normal’ and the unfamiliar beliefs and practices of other cultural groups as ‘strange’, using culture as a measure against which to judge others. Sociologists call this ‘ethnocentrism’ (Stanton, 1993).

This ethnocentric way of thinking applies to all societies. While people raised under British cultural norms will view FGM as incomprehensible, by the same token those from groups that practise FGM may see British culture as strange.

### Key considerations

#### Terminology and phrasing
- The woman may not think of FGM as an operation
- The word ‘mutilation’ may cause offence
- Find out how the woman refers to FGM herself
- Rephrase questions, such as: ‘Have you been closed?’ or ‘Do you have any problems passing urine?’ An alternative approach could be: ‘I know that they practise female circumcision in your country, have you been cut or had circumcision performed?’ (RCM, 1998)

#### Speaking English and interpreters
- If the woman does not speak English an interpreter should be provided
- The interpreter should be female, have good language skills with some knowledge of translation of medical terms and ensure the woman’s confidentiality
- Make sure the woman, not the interpreter, is in control and makes the decisions
- It is preferable if the woman and interpreter do not know each other socially
- The interpreter should not let personal beliefs influence the way she translates
- Relatives and children should not be used as interpreters
- Visual aids and leaflets in the appropriate language will improve communication and give the woman and family a clearer understanding of the health care services and benefits available to them

#### Cultural sensitivity and privacy
- Ideally only female health professionals should care for women with FGM as care by men can be seen as degrading or sexually abusive and may be refused, even if the woman is dangerously ill. All male health care professionals should be chaperoned
- Birth partners are likely to be female as traditionally men do not attend births
- It is usual for men to make all decisions regarding the care of their wives and they must be included in this process
- Keep the number of people in a delivery room to a minimum
- Do not leave the woman’s legs or vulva exposed or uncovered for longer than necessary
- Always obtain informed consent from the woman for those procedures to be performed

### References


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This article has been double-blind peer-reviewed.

For related articles on this subject and links to relevant websites see www.nursingtimes.net


**REFERENCES**


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**BOX 3. HEALTH COMPLICATIONS ASSOCIATED WITH FEMALE GENITAL MUTILATION**

**IMMEDIATE**
- Extreme pain and shock
- Haemorrhage
- Injury to adjacent tissues
- Transmission of infection
- Tetanus and sepsis
- Urine retention
- Urinary tract infection
- Death

**INTERMEDIATE**
- Delayed healing
- Scarring (keloid)
- Recto-vaginal fistula (RVF)
- Vesico-vaginal fistula (VVF)
- Cystocele
- Urinary or faecal retention
- Recurrent infection
- Vulval ulceration/abscess
- Vulval neuromata

**LONG-TERM**
- Dysmenorrhoea
- Endometriosis
- Pelvic inflammatory disease
- Infertility
- Odour and poor hygiene
- Painful coitus
- Impaired sexual response
- Impaired penetrative sex
- De-infibulation
- Re-infibulation following childbirth

An important milestone in her life (Booth, 1985). Ahmed (1996) believes infibulation to be a source of cultural identity that unites the community. Ex-patriot Somali women in Canada expressed feelings of pride and purity about their circumcision, despite having suffered significant health complications and pain as a result (Chalmers and Omer-Hashi, 2000).

These societies tend to have a high level of segregation between males and females, and sexual intercourse and genitalia are not openly discussed. There is no concept of what normal female genitalia should look like and women tend to regard their genitals as belonging to their husband. Sexual intercourse is regarded as a gift for having children, which is degraded if discussed.

Marriage is the only route to a fulfilling and significant life for many women living in these cultures, because unmarried women are socially isolated and impoverished. In Nigeria, those who support FGM consider uncircumcised women to be ‘as low as a dog’ (Communicating for Change, 2002), while in Somalia an uncircumcised woman is thought of as unclean, and is therefore regarded as unmarriageable.

Research conducted in Nigeria found a complex range of motives for performing FGM, many of which apply to other communities that practise it. The reduction or elimination of the sensitive tissue of the outer genitalia, particularly the clitoris, was cited as a means to curb sexual desire, helping women to maintain chastity and virginity before marriage and fidelity during marriage. Some also thought FGM increased male sexual pleasure.

Sociological reasons cited included identification with a cultural heritage, initiation into womanhood, social integration and the maintenance of social cohesion. There were also reasons associated with hygiene and aesthetic appearance, with some considering the external female genitalia to be dirty and unsightly. They believed it should be removed to promote hygiene and increase aesthetic appeal.

Myths also appeared to have a significant influence on the practice of FGM, such as the enhancement of fertility and promotion of child survival. Some believed that if the baby touched the clitoris during childbirth the child or mother would die. Others considered the clitoris to be poisonous and a danger to the man if he came into contact with it, or believed it would continue to grow if not removed. Tradition was the most common reason given for the practice of FGM by the Nigerians who took part in this research (Okonofua, 2000; Communicating for Change, 2002).

**Considerations for patient care**

Nurses should be aware that women from cultures originating outside the UK may find our health care services alien, frightening, and intimidating. Such women have different needs and expectations, which should be acknowledged and incorporated into an individualised care plan.

When FGM became a high-profile issue and legislation was passed outlawing the practice in the UK, a Somali
refugee was said to feel as if women from her country were judged by what their genitals looked like before anything else (Schott and Henley, 2000). Nurses should take care not to inadvertently communicate their negative reaction to the patient, which would create further isolation and embarrassment for her.

There has been little research into the psychological effects of FGM because women may be reluctant to disclose the fact that they have undergone the procedure and are embarrassed to talk about it, sexual intercourse or women’s health issues (Momoh et al., 2001). However, the WHO regards psychological damage to be inevitable (Johnson and Rodgers, 1994). Forms of psychological trauma that have been reported include flashbacks, anxiety, depression, chronic irritability, and reluctance to have sexual intercourse (Momoh, 2000; WHO, 1996). In addition, childbirth, gynaecological investigations or screening procedures such as cervical smears, which involve exposing the vulva and it being touched, can be deeply distressing (Schott and Henley, 2000).

Cultural requirements, such as prohibition from bodily contact with men other than their husband or the need to obtain permission from their husband or father before examinations can take place, may make women reluctant to be examined by a man and render routine care frightening and unacceptable. Fear can be compounded when the women do not speak English. Nurses who are unsure how to provide optimum care for women with FGM can refer them to a specialist clinic or seek advice from a more experienced colleague. Box 2 summarises the implications for nursing and midwifery practice. The Foundation for Women’s Health, Research and Development (FORWARD) provides specialist study days for all health care professionals.

Health consequences
There are adverse health outcomes and physiological complications with any type of FGM, but the most severe are associated with infibulation (Hindley and Montagu, 1997). The problems may be immediate, intermediate, or long-term and can be exacerbated by pregnancy and childbirth (Box 3). If surgical de-infibulation is performed in an non-sterile environment it re-exposes women to these risks (WHO, 1996).

Child protection
Although FGM is illegal in the UK, research suggests a significant percentage of parents from practising communities whose daughters are born in the UK consider it (FORWARD, 1999; Momoh et al., 2001). It is thought between 10,000 and 20,000 females living in the UK have undergone some form of FGM, and as many as 2,000 British girls are circumcised every year (Shorten, 1995; FORWARD, 1999). Most girls are taken out of the country to have the procedure but the Female Genital Mutilation Act 2003 made it illegal for UK nationals or permanent UK residents to carry out FGM abroad, or to aid, abet, counsel or procure the carrying out of FGM abroad, even in countries where the practice is legal. Although child protection is the statutory responsibility of social services departments, the Children Act 1989 states that everyone has a responsibility to protect children. Health professionals must protect any child, regardless of ethnic group, race or gender, who is suffering or likely to suffer significant harm and to take appropriate action to promote that child’s welfare. Nurses, midwives and health visitors have a duty to share information and raise concerns if they believe there is a possibility that FGM has taken place or is likely to.

FORWARD recommends that any suspicion that FGM is likely to be undertaken is reported to child protection professionals, who should appoint a specialist in FGM who can investigate sensitively (Hedley and Dorkenoo, 1996). Expressing concern about FGM should not be seen as racist. The African Rights Charter, which endorses positive traditional values but promotes the eradication of practices that prejudice children, is an example of African states themselves endorsing the eradication of FGM (Hedley and Dorkenoo, 1996).

Multi-agency working is vital to prevent FGM and protect young girls. Social services departments have primary responsibility for child protection and should have systems in place to assess levels of risk. Communication is the key component and no group of people, be they professionals, family, FGM survivors or members of the community, should be left isolated. It is rare for a child at risk of FGM to be removed from her family. As a last resort a Prohibitive Steps Order (section 8, Children Act 1989) may be implemented, which means that the court rather than the child’s parents makes decisions on her behalf. This would prevent a child from being taken abroad to have FGM performed (Hedley and Dorkenoo, 1996).

Individual health care professionals may find it difficult to provide appropriate care if the organisational infrastructure does not accommodate the needs of circumcised women (Shorten, 1995). It is important to remember that providing culturally sensitive care is not the sole responsibility of individual professionals — the health care system also has a significant part to play.

Conclusion
Despite considerable efforts worldwide to eradicate FGM, it continues to be practised with a complex range of motives that are not easily understood by people from a British culture. A significant number of women affected by FGM now live and access health care services in the UK. They require knowledgeable and sensitive care that accommodates any special needs they may have.

A number of services are available to which nurses can refer women, or that they can contact themselves for professional support and advice.

Gaining an understanding of why FGM is practised can help nurses to break down barriers between health care professionals and isolated ethnic groups and lead to improved health care for both women who have undergone the procedure and their families.

REFERENCES