Female Genital Cutting: A Maternity Nurse’s Guide to Providing Culturally Competent Care

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Abstract

As a result of immigration trends, maternity nurses in the United States are likely to encounter women who have undergone female genital cutting. There is a lack of knowledge and awareness about female genital cutting among nurses. Chalmers and Hashi (2000) found that women who had undergone female genital cutting at a younger age and gave birth in Canadian hospitals perceived their nurses to be insensitive to their needs. In addition, one study of the birth experiences of Somali immigrant women found that healthcare providers in the United States rarely discussed female genital cutting or how it could affect the women’s birth experiences (Ameresekere, Borg, Frederick, Vragovic, Saia, & Raj, 2011). An extensive literature search was performed utilizing CINAHL, PubMed, and Google Scholar. The objectives of this literature review are to inform maternity nurses of the following: 1) the prevalence of female genital cutting and regions where it is commonly practiced, 2) the reasons why female genital cutting is practiced, 3) the complications of female genital cutting, and 4) the nursing care needs of women who have undergone female genital cutting. This review of literature elucidates that: female genital cutting rates are high in Africa and the Middle East, maternity nurses in United States hospitals will increasingly care for women who have undergone female genital cutting, there are serious complications related to female genital cutting, and there is a need for culturally competent maternity nurses to care for women who have undergone female genital cutting.
AM was in active labor at six centimeters dilated when she arrived on the labor and delivery unit. Susan, a registered nurse, was assigned to care for AM. Susan performed a thorough assessment and learned AM and her husband were Islamic, and they were originally from Somalia, Africa. She was in labor with her second child and had received very little prenatal care during this pregnancy. AM’s obstetric history was significant for a fourth degree perineal laceration during her first birth. AM had previously undergone female genital cutting at a young age and corrective surgery prior to giving birth to her first child. Susan noticed that AM was extremely anxious. AM explained to Susan that she was nervous to give birth because of the immense pain she experienced during her first birth. Although she was in a lot of pain, she declined an epidural and pain medications during labor. AM’s husband was present during the labor and birth, but he did not offer support. Susan supported AM during her contractions by applying cool compresses to her forehead, holding her hand, and sharing words of encouragement. Despite Susan’s efforts to support AM, she became panicked and inconsolable during the second stage of labor. She winced and screamed in pain, attempted to grab the obstetrician’s hands, and flailed her arms and legs. During the birth, AM suffered a third degree perineal laceration.

AM is one of more than 125 million women and girls who have experienced female genital cutting (United Nations Children’s Fund [UNICEF], 2013). Female genital cutting (FGC), also known as female genital mutilation (FGM) and female circumcision (FC), is defined by the World Health Organization as the “partial or total removal of the female external genitalia, or other injury to the female genital organs for non-medical reasons” (World Health
Organization [WHO], 2011, p. 1). Genital cutting has no known health benefits. Many physical, psychological, and sexual complications have been associated with this practice (WHO, 2008). FGC of girls younger than 18 years is a federal crime in the United States (Omnibus Consolidated Appropriations Act, 1997). However, due to the growing number of immigrants from Africa and other regions where the procedure is practiced, nurses in the United States will increasingly encounter women who have undergone FGC (Nour, 2013). In order to provide culturally competent care, nurses must understand the practice of FGC, the complications of FGC, and areas for nursing interventions. This is a resource for maternity nurses caring for mothers who have undergone FGC.

The Practice of Female Genital Cutting

Countries Where Genital Cutting is Performed

FGC is practiced in 28 countries throughout Africa as well as the Middle East (WHO, 2008). Regions with the highest rates include Somalia, Guinea, Djibouti, Egypt, Eritrea, Mali, Sierra Leone, and Sudan (UNICEF, 2013). In some areas, genital cutting is performed on 90% or more of girls (Figure 1). Due to immigration, girls and women who have been affected by FGC are now living in Westernized countries, such as Australia, Canada, Europe, and the United States (International Council of Nurses, 2009). According to data based on the 2000 United States Census, approximately 228,000 women and girls in the United States are either living with or at risk for FGC (Nour, 2013).
Types of Genital Cutting

As depicted in Figure 2, the World Health Organization has classified FGC into four types depending on the extent of tissue removed. Type I, also known as clitoridectomy, is the removal of the prepuce, with or without removal of the clitoris (WHO, 2008). Type II, also known as excision, is the removal of the clitoris and part or all of the labia minora (WHO, 2008). Type III, the most severe form, is known as infibulation (WHO, 2008). It involves the removal of part or all of the external genitalia and narrowing of the vaginal opening, leaving a small hole for urine and menstrual fluid (WHO, 2008). Chalmers and Hashi (2000) found that over 96% of Somalian women who experienced FGC were infibulated. Type IV is considered the mildest form and includes all other harmful procedures to the female genitalia for non-medical purposes, including pricking, piercing, incising, scraping, and cauterization (WHO, 2008).
The Procedure of Genital Cutting

FGC is traditionally performed by an elderly woman of the village, often known as a circumciser, who is not medically trained but is a powerful and well-respected member of the community (WHO, 2001). The cutting is carried out using knives, scissors, razors, glass, or sharp stones, which may not be cleaned before they are re-used, and is commonly performed without
anesthesia, antibiotics, or sterile technique (Braddy & Files, 2007; Nour, 2008). Women and girls are frequently held down by a number of females, including their own relatives (WHO, 2001). Following excision of the tissue, sutures, thread, and local concoctions such as oil, honey, dough, or tree sap are used to ease the bleeding, and the women and girls’ legs may be bound together until healing is complete (Nour, 2008). In some cases of FGC, trained medical providers, such as physicians, nurses, and midwives, are replacing traditional circumcisers and performing the procedure using sterile surgical instruments and anesthesia to reduce the risk of complications (WHO, 2012; Shell-Duncan, 2001). According to Shell-Duncan (2001), “In Urban regions of Nigeria and Mali, for example, it is becoming increasingly common for nurses to perform genital cutting” (p. 1018). This trend, referred to as the medicalization of FGC, is becoming common across Africa (Shell-Duncan, 2001). Medicalization of FGC is a highly debated issue. Those who are opposed argue that medicalization counteracts efforts to eliminate the practice (Shell-Duncan, 2001). However, medicalization may reduce harm associated with FGC and improve women’s health in areas where abandonment of the practice is not currently attainable (Shell-Duncan, 2001).

The age at which girls and women undergo FGC varies widely, depending on the beliefs and traditions of the social group (WHO, 2001). It is most often performed on girls between the ages of 6 and 12 (Nour, 2004). However, cutting is also performed on infants, at menarche, and prior to marriage (Nour, 2008). Often, immigrant girls who live in the United States are sent back to their countries of origin during summer vacations to have the procedure performed (Jones, Smith, Kieke, & Wilcox, 1997; Burke, 2011).
Reasons for Performing Genital Cutting

There is a mix of social, cultural, and religious factors within families and communities, which determine the reasons for performing FGC (WHO, 2014). In many areas where it is practiced, FGC is regarded as a customary rule of behavior and is considered a social norm (UNICEF, 2013). It often occurs as a rite of passage ceremony with festivities and gift giving (Nour, 2008). Within many societies, FGC is a cultural tradition and the pressure to conform to what others do and have been doing is a strong motivator to continue the practice (WHO, 2014). Some of the reasons noted for performing FGC include the following: to preserve virginity, maintain cleanliness, decrease sexual pleasure for women while enhancing sexual pleasure for men, and ensure fidelity during marriage (Braddy & Files, 2007). Proponents of FGC believe an unexcised girl has an over-active and uncontrollable sex drive and will likely lose her virginity prematurely (WHO, 2001). In many practicing communities, a female’s external genitalia are believed to be ugly and dirty (WHO, 2001).

Mothers are often the strongest advocates of FGC, because they believe it will ensure marriageability and protect their daughters from harm (Nour, 2008). The pressure to participate in the practice is substantial (Braddy & Files, 2007). Women who do not conform to the social norm are often declared ineligible for marriage, ostracized and banned from their communities, seen as unclean and unhygienic, and may even be labeled as a prostitute (Burke, 2011; Nour, 2008).

The practice of FGC predates the major religions believed to promote it, including Islam, Christianity, and Judaism (Porterfield, 2006). Although religious texts do not subscribe to the practice, FGC is frequently carried out with the belief that it is supported by religious teachings (WHO, 2001). There is a great amount of religious controversy surrounding FGC, with leaders
taking varying positions with regard to the practice. Some religious leaders consider it a religious act, and others participate in efforts to eliminate it (WHO, 2008). Religious leaders who avoid the issue are often perceived as supporters of FGC (WHO, 2008).

**Complications of Female Genital Cutting**

**Short-Term Complications**

Although they will likely care for women long after FGC occurred, it is important for maternity nurses in the U.S. to be aware of the acute complications their patients may have experienced. Common immediate complications include: pain, hemorrhage, urinary retention, infection, shock, sepsis, and death (Nour, 2004). Urinary retention frequently occurs because the urethra was sutured while closing the vulva or the girl tries to avoid passing urine due to the pain it causes when it irritates the raw parts of the genitalia (Dirie & Lindmark, 1992). Skin flaps and blood clots are also causes of urinary retention (Brady, 1999). Girls often limit the amount of fluids they drink to avoid painful urination, which can lead to dehydration and urinary tract infection (Brady, 1998). Infection most often occurs when FGC is performed under unsterile conditions (Braddy & Files, 2007). One study performed on 7,350 girls less than 16 years old found that “97% of the time, the same equipment could be used on 15-20 girls” (Brady, 1999, p. 712). Tetanus and HIV are serious infections linked to the use of the same equipment without sterilization between girls (Braddy & Files, 2007). Fractures of the clavicle, femur, and humerus as a result of the pressure used to hold young girls in the lithotomy position also occur (Nour, 2004). A study performed by Behrendt and Moritz (2005) found that when questioned about the event of FGC, “over 90% of the women described feelings of intense fear, helplessness, horror, and severe pain” (p. 1001). “For 78% of the subjects, the event was performed unexpectedly and without any preliminary explanation” (Behrendt & Moritz, 2005, p. 1001). On the other hand,
Chalmers and Hashi (2000) found that for many girls, FGC is planned. These girls eagerly anticipate the day they will undergo FGC (Chalmers & Hashi, 2000).

**Long-Term Complications**

The risk of long-term complications increases with the extent of cutting (WHO, 2012). The most common long-term physical problems are related to the genitourinary system (Brady, 1998). Women and girls who have been tightly infibulated must urinate drop by drop, sometimes needing 15 minutes to void (Brady, 1998). As a result, urine may become stagnant leading to chronic urinary tract infections (Little, 2003). Because the urinary meatus is covered by infibulation, vaginal fluid and menstrual blood accumulate, which favors the growth of bacteria (Brady, 1999). FGC is a leading cause of chronic pelvic infections and pelvic inflammatory disease, with chronic pelvic disease being three times more likely in an infibulated woman (Brady, 1999). Women and girls who undergo FGC are at an increased risk of becoming infected with HIV (Brady, 1999). After FGC occurs, especially Type III, the vaginal opening is reduced in size and sexual intercourse often results in tissue damage and bleeding, thus facilitating the possible transmission of HIV (Brady, 1999). Due to the obstructed outflow, menses is both painful and embarrassingly malodorous (Nour, 2004). The most common long-term complication of FGC is the formation of dermoid cysts, which occurs when keratinized epithelial cells and sebaceous glands are embedded in the scar, usually where the clitoral tissue has been excised (Toubia, 1994; Braddy & Files, 2007). These cysts grow in size and can become as large as a grapefruit (Toubia, 1994). Other long-term complications of FGC include keloids, excessive scar tissue at the site of the cutting, and neuromas, extremely painful tumors consisting of nerve endings in the scar (Little, 2003).
Women who have undergone FGC are more likely to have pain during sexual intercourse, experience less sexual satisfaction, and lack sexual desire as compared to women who have not undergone FGC (Berg, Denison, & Fretheim, 2010). A study of the sexual quality of life of women who have undergone FGC found that type III FGC is associated with the lowest sexual quality of life (Andersson, Rymer, Joyce, Momoh, & Gayle, 2012). Women commonly suffer from painful sexual intercourse because of narrowing of the vaginal opening, scarring, and infection (WHO, 2001). Some women have reported that the pain during sexual intercourse is almost as bad as the initial experience of genital cutting (WHO, 2001). Because vaginal stenosis creates a physical barrier preventing penile penetration of the vagina, women with type III FGC have infertility rates as high as 30% (Nour, 2004). Decreased sexual satisfaction and desire are related to the removal of or damage to highly sensitive genital tissue, especially the clitoris (WHO, 2008).

The sexual complications of FGC have a negative impact on women’s psychological health (Andersson et al., 2012). Women are commonly fearful of sexual intercourse due to the extreme pain it causes (Nour, 2004). The inability to achieve penetration and subsequent infertility creates stress and frustration (Nour, 2004). This is particularly psychologically distressing, because fertility is prized among populations who perform FGC (Shell-Duncan & Hernlund, 2000). The inability to bear children is often grounds for divorce (Brady, 1999). Due to feelings of intense fear, hopelessness, horror, and severe pain women experience during FGC, they are at an increased risk of developing psychiatric disorders, including anxiety, depression, and post-traumatic stress disorder (Salihu, August, Salemi, Weldeeselasse, Sarro, & Alio, 2012). A study found that 30% of women suffer from post-traumatic stress disorder after FGC (Behrendt & Moritz, 2005). These women often have recurrent memories of trauma and
nightmares for the rest of their lives (Vloeberghs, van der Kwaak, Knipscheer, & van den Muijsenbergh, 2012). Childbirth can cause extreme psychological anguish for women with FGC, because for many, it is distressing for their genitals to be exposed (Daley, 2004). In addition, women who undergo FGC are two to three times more likely to experience a type of intimate partner violence, including physical, sexual, and emotional (Salihu et al., 2012).

**Obstetric Complications**

Women who have undergone FGC are much more likely to experience complications during childbirth including: caesarean section, postpartum hemorrhage, episiotomy, extended maternal hospital stay, infant resuscitation, and stillbirth or early neonatal death (Banks, E., Meirik, O., Farley, T., Akande, O., Bathija, H., & Ali, M., 2006). These women also experience severe pain during labor and the postpartum period (Chalmers & Hashi, 2000). The risk of adverse obstetric outcomes increases with the severity of FGC (Nour, 2008). According to one study of obstetric outcomes in six African hospitals, women who have undergone type III FGC are 30% more likely to have a cesarean section and have a 70% higher risk of postpartum blood loss of 500 mL or greater compared to women who have not had FGC (WHO, 2008). The same study found that women with type III FGC have a 70% higher risk of postpartum hemorrhage (WHO, 2008). These serious obstetric complications are mainly due to rigid and inelastic scar tissue formation resulting from FGC (Banks et al., 2006). Scar tissue prevents relaxation of the birth canal and significantly prolongs stage II of labor by inhibiting fetal descent (Nour, 2004; WHO, 2000). During prolonged, obstructed labor, the fetus may suffer from hypoxia with possible brain damage or death (Daley, 2004; Nour, 2004). The rate of infant resuscitation is 66% greater for infants born to mothers with type III FGC compared to resuscitation of infants born to mothers who have not undergone FGC (WHO, 2008). The stillbirth and neonatal death
rates are 15% higher for women with type I FGC, 32% higher for those with type II, and 55% higher for those with type III (WHO, 2008). Scar tissue increases rates of perineal tears, episiotomies, and postpartum hemorrhage among women who have had FGC (Banks et al., 2006). The narrow introitus of an infibulated mother with type III FGC can make a pelvic exam to assess cervical dilation difficult, if not impossible, which inhibits accurate monitoring of labor (Brady, 1999). During labor, procedures such as the artificial rupture of membranes, application of fetal scalp electrodes, or catheterization may be limited because of the reduced size of the vaginal opening (Daley, 2004). To reduce the chance of these complications, defibulation is recommended prior to pregnancy or during the second trimester (Nour, 2000). The American College of Obstetricians and Gynecologists (ACOG) recommends offering defibulation during the second trimester under spinal anesthesia (Rosenberg, Gibson, & Shulman, 2009). Defibulation is the surgical opening of the infibulated scar, exposing the urethral meatus and vaginal opening (Ibe & Johnson-Agbakwu, 2011). In a study, Nour et al. found that defibulation significantly reduced the associated risks and 100% of the women interviewed were satisfied with the procedure (Nour, Michels, & Bryant, 2006).

Table 1

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<th>Complications of FGC</th>
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<td><strong>Short-term complications</strong></td>
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Nursing Care of Women Who Have Undergone Female Genital Cutting

Develop a Trusting Nurse-Patient Relationship

When caring for a woman who has undergone FGC, maternity nurses must remain nonjudgmental in order to gain the patient’s confidence and develop a trusting nurse-patient relationship (Brady, 1998). It is common for women who have undergone FGC to be fearful of the reaction of healthcare providers and embarrassed to expose their genitals when living in a society that strongly disapproves of the practice (Daley, 2004). Nurses need to be mindful that FGC is considered a normal practice in many cultures. Many women view FGC as a source of pride and acceptance by her community and experience hurt when healthcare providers display horror or disgust at the sight of FGC (Brady, 1998; Nour, 2004). Because exposure of the woman’s body is often distressing, the nurse should not leave the woman exposed or uncovered for longer than necessary.

Advocate for the Patient

A study by Johnson-Agbakwu et al. found that prenatal care is a foreign concept to many women who have undergone FGC (Johnson-Agbakwu, Helm, Killawi, & Padela, 2013). According to Chalmers and Hashi (2000), over 70% of women with FGC living in Canada reported being afraid to seek prenatal care. The maternity nurse may be the first healthcare professional a woman who has experienced FGC comes in contact with during pregnancy. By being aware of regions where FGC is commonly practiced and obtaining a thorough and culturally sensitive history, the nurse may be able to identify women who have undergone FGC before the physical examination (Nour, 2004; Ibe & Johnson-Agbakwu, 2011). In many cultures, the woman is prohibited from exposing her body to a man other than her husband (Daley, 2004). If possible, the maternity nurse should give the woman the option of receiving care from female
healthcare providers (Braddy & Files, 2007). It is especially important for the nurse to identify language barriers, and ensure a professional, female interpreter is consulted if the woman is non-English speaking (Nour, 2004). Maternity nurses should advocate for gentle and sensitive examinations. A pelvic examination can trigger posttraumatic stress disorder in women who have undergone FGC (Rosenberg et al., 2009). If it is the woman’s first pelvic examination, the maternity nurse should prepare the patient and help ease her anxiety by showing her the speculum and explaining what will happen (Nour, 2004). The size of the woman’s vaginal introitus should be considered when determining if a speculum should be used (Braddy & Files, 2007). If the opening is small, the maternity nurse should suggest the provider use a pediatric speculum (Nour, 2004). The nurse should also anticipate the increased possibility of complications during childbirth and prepare the healthcare team.

Support the Patient During Childbirth

Maternity nurses need to educate primigravid women who have undergone FGC about the challenges they may face during childbirth. According to Chalmers and Hashi (2000), over 60% of women did not think FGC would have an impact on their birth experience. During labor, the pain and psychological trauma the woman experienced during FGC can be re-stimulated (Daley, 2004). Although an epidural may provide the most effective pain relief, Chalmers and Hashi (2000) found that almost 50% of women wanted a vaginal delivery without pharmacologic pain relief. Good communication and a trusting relationship with the maternity nurse are instrumental in pain management (Daley, 2004). The nurse should use nonpharmacologic pain management interventions such as relaxation, distraction, and massage to help manage the woman’s pain during labor and the postpartum period. Traditionally, husbands are not present with their wives or involved during labor or birth (Johnson-Agbakwu et al., 2013). According
Chalmers and Hashi (2000), many women preferred female companions rather than their partners during childbirth. The maternity nurse should act as the woman’s support person during labor by holding her hand, breathing through contractions with her, and encouraging her with positive words. The nurse might also recommend a doula to provide the woman with continuous support throughout her birth.

**Conclusion**

Due to immigration, a large number of women who have undergone FGC live and give birth in the United States. In a study by Johnson-Agbakwu et al. (2013), men in a Somali refugee community expressed the need for healthcare providers to become more informed about the practice of FGC so they can provide culturally sensitive care to their wives. Maternity nurses must be knowledgeable of FGC in order to provide culturally competent care to women who have undergone this procedure. Although Western society disapproves of the practice of FGC, it is the cultural norm in many parts of the world and is often a source of pride for many women. A culturally competent nurse respects the woman’s health beliefs, practices, and behaviors (Nour, 2004). It is crucial for the nurse to remain sensitive to the woman’s values and beliefs and use a nonjudgmental approach when caring for women who have experienced FGC. Maternity nurses are in an optimal position to develop trusting relationships with women who have undergone FGC, advocate for them, and ultimately optimize their birth experiences.
References


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