Mapping Care Recommendations for Women Affected by Female Genital Cutting

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Background

Female Genital Cutting (FGC) is defined by WHO as "all procedures that involve the partial or total removal of external genitalia or other injury to the female genital organs for non-medical reasons."
Internationally it is recognized as a human rights violation and legislature has been put in place to prohibit this behavior in many countries yet to date FGC is being practiced in 30 countries in Africa and in a few countries in Asia and Middle east.
In the United States it is federal crime to perform any unnecessary medical surgery on female genitalia.
The WHO estimates that 200 million girls and women around the world are living with the effects of FGC. Albeit efforts to eradicate this practice every year 3 million girls and woman are at risk for FGM and therefore exposed to the negative health consequences of FGC. This continues to be a threat to women and children's health worldwide.

Furthermore, there is a lack in healthcare provider preparedness that has significant impact on women and newborns in affected communities: poor outcomes for this population have been attributed to suboptimal care, poor communication and a lack of trust in providers (Essen et al., 2000; Essen et al. 2002; Chalmers, 2001; Varol, 2016). A recent qualitative synthesis highlights the potential for unprepared providers to re-traumatize women during their reproductive lives and acculturation processes (Hamid et al., 2017).

Currently there is no updated American guideline to support health care professionals in caring for women with FGC. Clinical guidelines provide essential tools to ensure high quality of care is delivered to patients, and should represent the highest level of evidence based practice with expert opinion (Shekelle et al., 1999). With FGC there is a need for guidelines to direct clinical decision making and promote standardized care.

Types of Female Genital Cutting

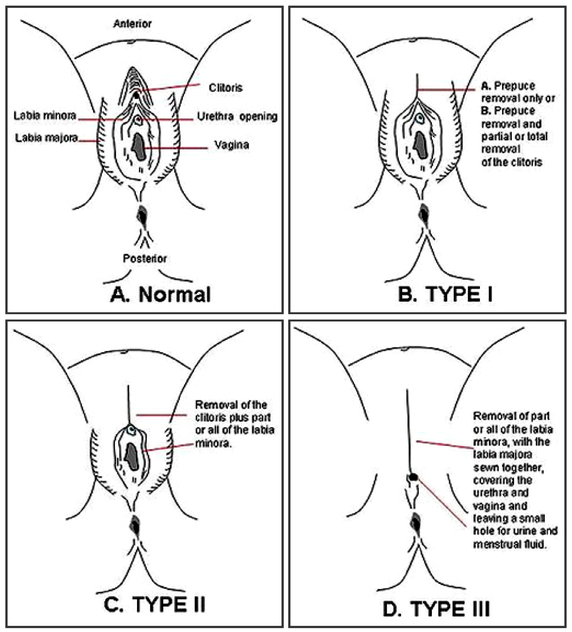

Figure 1. Types of FGM

Reasons for FGM

- It is part of history and cultural traditions of the community.
- Social acceptance
- Rite of passage for adulthood and to confer a sense of ethnic and gender identity.
- Safeguard virginity before marriage, promoting marriageability, ensuring fidelity after marriage, providing a sense of income for circumcisers.

Purpose

The goal of the project is to collect and compare and contrast any and all management guidelines related to caring for women with female genital cutting (FGC). This map will provide the fundamental building blocks for clinical guidelines to be created for US use. Also, in this paper existing international clinical guidelines will be synthesized to identify areas of consensus.

Methods

Database searched: PUBMED and EMBASE
Citation criteria:
written in English
Published by health professions or governmental organizations
offered clinically relevant guidelines..
Results: **167 articles**

Two authors reviewed citations titles and abstracts.
Final sample: **11 guidelines**

Each guideline mapped based on predetermined set of themes:
Screening for FGC/M
antenatal, intra- and postpartum care
gynecologic care
sexual health
mental health
adolescent and child health
Legal reporting

GUIDELINES USED	
World Health Organization FGM 2016 Management guideline (1)	South Australia Perinatal Practice Guideline (8)
ACOG (2)	Royal College of Nursing (RCN) FGM guideline (9)
Canada FGM Guidelines (3)	Royal Australia and New Zealand College of Obstetricians and Gynecologists (RANZCOG) (10)
New Zealand FGM Guidelines (4)	Intercollegiate FGM Guideline (11)
UK Royal College of Obstetrician & Gynecologist FGM Guidelines (6)	FGM Safeguarding report UK (12)
Royals Womens Hospital Australia Guidelines (7)	

Results

Screening:
- All citations provided guidelines on how to identify women with FGC/M and provided examples of questions to use to inquire about FGC/M. It is important to use the appropriate language and avoid using the term "mutilation".
- Canadian guidelines encourage identifying how women refer to the practice.
- Canadian and Australian guidelines suggest asking about specific questions. UK guidelines emphasize on screening questions.

Antenatal Care:
- WHO guidelines provided limited information about defibulation
- Canadian Guidelines stress antenatal care is an opportunity for birth preparation and to create a birth plan.
- RCOG & RCN stressed the importance of creating and documenting a plan of defibulation.
- There were variations in regards to timing for vaginal exams and when to perform defibulation.
  - RCOG suggest a vaginal exam at the first OB visit where as New Zealand suggest it during pre-birth visits.
  - UK and NZ suggest defubulation during antenatal care where as AU and CA encourage encourage offering it but no over intrapartum defibulation.
- Other advice include referral to FGC/M specialty services or providers, and report to data collection agencies.

Communication (Respect/ Rapport):
- Communication indicates the attitude providers should take, tips on culturally sensitive communication and what should be communicated.
- Canadian guidelines put a strong emphasis on respectful, non-stigmatizing, nonjudgmental approaches toward clients
- The UK's RCN encouraged avoiding facial expressions, tones of voice, or body language that may stigmatize patients.
- Australia and Canadian guidelines provide specific questions for screening.
- Canadian guideline provided the most detailed guideline about what should be communicated for women such as general women health concerns, reproductive rights etc.,

Mental Health:
- Most of the guidelines associated PTSD, anxiety and depression to FGC/M.
- WHO recommends CBT and psychological support for women/ girls receiving corrective surgery.
- Others recommend referrals to psychologist and FGC/M specialist.

Sexual Health:
- All guidelines agree that sexual dysfunction, dyspareunia, and complications with menstruation are a result of FGC.
- WHO provides sets of recommendations for sexual counseling accompanied with EP and rationales.
- Canadian guideline assert that defibulation may decrease sexual desire.

Adolescent Health:
- Only two guidelines have comprehensive sections about adolescent health.
- The complications and management of FGC in adolescent is the same as those in adult women.
- Providers should be sensitive sexual issues, increase knowledge on FGC, and be attentive to self destructive behaviors.
- WHO recommends the use of Education, Information, and communication however most adolescents lack access and information about their bodies.

Child Health:
- The RCN and New Zealand guidelines place the responsibility on health workers and school teachers to safeguard children from FGC by educating parents about the legality of FGC. RCOG also recommends safeguarding and provides a plan of care for women with FGC/M.

Legal:
- All guidelines recommend the use of social or child welfare services.
- Some of the guidelines list the criminal codes, what actions constitutes a crime and sentences if convicted of taking part in FGC
- All healthcare providers are required to report to police officers or social services if they suspect FGC/M or risk for FGM/C.

Limitations of Review

The inclusion criteria meant we did not review diversity of guidance available to providers. This included non- English citations which are important, especially given the patterns of migration to French and other non English speaking countries. Hospital specific guidelines may have provided helpful information for those seeking guidance on their own units. Such guidelines where not reviewed in this sample.

Information missing from the guideline:
- Trauma informed care
- Cultural sensitivity/ implicit biased
- Prevention of re-traumatization
- Minimize abuse and disrespect
- Utility of pelvic floor PT.

Conclusion

Guidelines from professional organizations in Canada, the United Kingdom, Australia, and New Zealand provide valuable references but are not sufficient to guide maternity care in the US for several reasons. They do not reflect WHO 2016 guidelines for caring for women with FGC. Also the guidelines are not written for the U.S healthcare system thus do not reflect the important differences such as scopes of practice, referral pattern, and legal reporting requirements. They also lack information on sexual and mental health perspectives on caring for women affected by trauma, and counseling regarding girl children. Lastly, the guidelines lack heterogeneity of women affected by FGC/M as they are not all refugees, thus limiting proposed strategies for catering care to this population.

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Acknowledgements

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