Mapping Care Recommendations for Women Affected by Female Genital Cutting

Oumie Ceesay
Johns Hopkins University School of Nursing
Preceptor: Dr. Nicole Warren

Background

Female Genital Cutting (FGC) is defined by WHO as “all procedures that involve partial or total removal of the external genitalia or other injury to the female genital organs for non-medical reasons.” Internationally it is recognized as a human rights violation and legislation 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 a 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 women are at risk for medical surgery on female genitalia. 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; Varek, 2016). A recent qualitative synthesis highlights the potential for unforeseen 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 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

<table>
<thead>
<tr>
<th>Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Normal</td>
<td>No external genitalia removal or alteration.</td>
</tr>
<tr>
<td>B. Type I</td>
<td>Partial or total removal of clitoral prepuce.</td>
</tr>
<tr>
<td>C. Type II</td>
<td>Partial or total clitoral deficiency and partial or total removal of labia minora.</td>
</tr>
<tr>
<td>D. Type III</td>
<td>Partial or total clitoral deficiency and partial or total removal of labia minora and labia majora.</td>
</tr>
</tbody>
</table>

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 marriability, 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 current and future 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

- Clinical trials written in English
- Published by health professions or governmental organizations

**Search terms:** Female genital mutilation, Female genital cutting, FGM

**Inclusion criteria:** Guidelines that are concerned with female genital cutting and its management

**Exclusion criteria:** Guidelines that aren’t concerned with female genital cutting and its management

**Guideline Quality:** Guidelines that are more detailed and standardized over time

**Search duration:** September 2016

**Number of guidelines:** 13

Results

**Screening:**
- All cited providers guidelines on how to identify women with FGC/M and provided examples of questions to use inquiring about FGM. 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 as an opportunity for birth preparation and to create a bank plan.
- RCOG and 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 suggests it during pre-birth visits.
- UK and NC suggest defibulation during antenatal care where as AU and CA encourage encouraging it but no over intrapartum defibulation.
- Other authors point to FGC/M speciality services or providers, and report to data collection agencies.

**Communication (Respect/ Rapport):**
- Communication indicates the medical providers should take, tips on culturally sensitive communication and what should be communicated.
- Canadian guidelines put strong emphasis on respectful, non-stigmatizing, non-judgmental approaches towards clients.
- The UK’s RGN encouraged avoiding facial expressions, tones of voice, or body language that may stigmatize patients.
- Australia and Canadian guidelines provide specific questions for screening.
- Canadian guidelines 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 FGM, anxiety and depression to FGC/M.
- WHO recommends CBT and psychological support for women’s girls receiving corrective surgery.
- Others recommend to psychologists and FGM/C 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 adolescents 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 RCM 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 if they suspect of taking part in FGC/M.
- All healthcare providers are required to report to police officers or social services if they suspect FGC/M or risk for FGC/M.

Limitations of Review

The inclusion criteria meant we did not review diversity of guideline 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 were not reviewed in this sample.

Information missing from the guideline:
- Trauma informed care
- Cultural sensitivity/ implicit bias
- Prevention of re-traumatization
- Information 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 US 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 FGM/C as they are not all refugees, thus limited proposed strategies for catering care to this population.

References


Acknowledgements

All the support, mentorship, and guidance from Dr. Nicole Warren is gratefully acknowledged.