Circumcision of Female Genitalia: What Health Care Providers Must Know

Jessica A. Anderson

University of Kansas School of Nursing

Circumcision of Female Genitalia: What Health Care Providers Must Know

Introduction

Living in a world familiar with immigration, one encounters cultures and practices that may be unfamiliar on a regular basis. One such cultural custom is that of female genital circumcision. According to Wallis (2005), 90% of female circumcision procedures occur in Egypt, Mali, and Somalia, but it is also prevalent among the black and minority communities in America, Canada, Europe, Australia, and New Zealand. As a growing number of females, who may be immigrants or descendents of immigrants, are receiving health care in the United States and Canada, the evidence and results of this cultural practice are being observed more regularly. It is the responsibility of health care providers to be educated on this common cultural custom, sometimes also referred to as female genital mutilation, in order to best care for and educate the women who have undergone such a procedure.

Health care providers, regardless of the level of licensure, are responsible for providing quality care to all patients. Studies have shown that this does not always occur, especially with women who have undergone female genital circumcision (Chalmers & Hashi, 2000). The purpose of this paper is to raise awareness of an extremely prevalent cultural practice and informs health care providers about topics related to the tradition. An understanding of cultural customs and sensitivity to those who practice them is a first step toward cultural competency. Only then can we, as health care providers, respect, serve, and educate our clients from these cultures appropriately.

Review of Literature

In 1990, The Centers for Disease Control and Prevention estimated that 168,000 girls and women in the United States who had either undergone genital mutilation or were at risk for the

procedure (Jones, Smith, Kieke, & Wilcox, 1997). The procedure is typically performed when a girl is between the ages of 4 and 14, but may also occur during infancy or adulthood. Jones et al. (1997) further reported that in 1996, legislation was passed by the United States Congress making it illegal to perform genital mutilation or circumcision on girls under 18 years of age in the United States.

The greatest concerns for health care providers are the immediate and long-term complications that commonly occur after female circumcision. The procedure is usually performed in non-medical settings by highly respected women in the community with little or no medical training. It is often executed without the use of sterile technique, and the instruments used may be razor blades, knives, or even objects as primitive as sharpened stones (Jones, et al., 1997).

Hellsten (2004) pointed out that there are several justifications for the practice of circumcision, depending upon the culture being considered, and that female genital mutilation tends to continue in cultures that have a more patriarchal social structure, where a women's lack of education and decision making power in their communities allows for its maintenance. Hellsten (2004) noted that the World Health Organization has three classifications of female genital mutilation. Type I entails removing the tip of the clitoris, while type II consists of removing the clitoris in addition to all or portions of the labia minora. Type III is also known as infibulation. In this procedure, the clitoris and labia minora are removed, and incisions are made on the labia majora. With the third type of circumcision, the wound is sutured closed, leaving a small opening through which urine and menstrual blood may flow. According to Hellsten (2004), a gradual dilatation must occur before sexual intercourse because of the previous closure and

growth of scar tissue, and it is not uncommon for the opening to be widened with a sharp object on the wedding night if necessary.

Female genital mutilation lacks medical justification and is generally considered to be more socially suppressive and cruel than male circumcision. Depending upon the culture, rationalization for the operation may include children's initiation to adulthood, maturity, and reproductive age; aesthetic values; taboos about human sexuality; the demands set by various religions, and to hygienic, individual, and public health medical beliefs (Hellsten, 2004). The arguments against this practice are that it causes unnecessary pain, harms the physical integrity of children and women, can lead to irreversible physical or psychological harm (Hellsten, 2004). Hellsten (2004) also noted: "In most cases it appears that whether the practice withers away or remains an integral part of that culture's identity, depends on the strength of the rationalizations and the availability of education in that culture" (p. 250). Therefore, only by providing education and knowledge of options and healthy outcomes, can we break through the barriers of long standing tradition.

Nearly 140 million girls and women in the world have undergone female genital mutilation, with 6,000 new cases occurring daily (Wallis, 2005). Wallis interviewed the clinical staff of one of eight African Women's Clinics throughout the United Kingdom and learned that the term female circumcision does not communicate the full horror of what is being done to women's bodies, making the term female genital mutilation the one more commonly used to describe the practice. The mean age of the females presenting to the clinics with problems is 25, but the results of a recent audit confirmed that women as old as 60 still experience physical and psychological suffering related to childhood genital mutilation. Wallis reported that the short and long-term effects are numerous. They include common urinary tract infections, painful

menstruation and sexual intercourse, complications during childbirth, limited sexual pleasure due to destruction or removal of the clitoris, and flashbacks of the trauma that occurred during the procedure. To prevent irreversible complications during childbirth, the clinic offers pregnant women a reversal of the procedure around 20 weeks' gestation. This reversal widens the opening, increasing the probability of a vaginal delivery without complications (Wallis, 2005).

Chalmers & Hashi (2000) found that of 432 Somali women reporting on the health care they received during pregnancy and delivery, many perceived that their needs were not adequately met and that they received less than quality care. All 432 women interviewed during this study had been previously circumcised and had given birth in Canada within the preceding five years. When asked about their recent experiences with health care, they reported feeling subjected to the following: lack of sensitivity and verbal and nonverbal reactions revolving around their circumcision, nurses unwilling to acknowledge their severe postpartum pain, and having little choice in, or discussion about, procedures associated with childbirth and pain management (Chalmers & Hashi, 2000). This evidence provides reason to further educate health care providers about the needs of these women, cultural differences, and the obligation to treat all patients with sensitivity and respect.

Mwangi & Smith-Stoner (2002) declared that caring for the patient holistically and within the context of culture provides the basis of most effective care. One strategy they provide for appropriately caring for women who have undergone genital circumcision is to understand the importance of being nonjudgmental and framing conversations in a culturally sensitive manner. They pointed out that it is important to consider the fact that in many of these practicing cultures, the tradition of circumcision is not considered abusive; rather, it is believed to effectively ensure a happy marriage. Other strategies include allowing the woman to express her

feelings and concerns about female circumcision, developing trust before having such conversations with a patient, avoiding the use of family members for translation, and resisting the urge to discuss the practice with other members of the family. In addition, they recommended providing information about the short and long-term effects of the procedure and current trends in female genital mutilation, and if appropriate, visiting these women in their homes and eating with them as a sign of respect and trustworthiness (Mwangi & Smith-Stoner, 2002). There is a definite cultural barrier between these women and many individuals, but health care providers have the responsibility of breaking through the wall in an effort to provide them with appropriate care and health education.

The practice of female genital mutilation dates back thousands of years, but multiple groups, organizations, and countries have continued to make efforts to end the tradition (Affara, 2000). According to Affara (2000), The World Health Organization delivered recommendations for opposing the practice during a 1979 seminar in Sudan and continues to make it a priority consideration. The American Nurses Association supported the Federal Prohibition of Female Genital Mutilation Act of 1995, which currently requires federal authorities to inform individuals emigrating from countries where female genital mutilation is practiced that spending up to five years in prison is the punishment for performing or arranging the procedure (Affara, 2000). The Nigerian Nurses and Midwives Association and The Royal College of Nursing in the U.K. are just a few driving forces in educating health care providers, community leaders, and the public about the custom, its effects, and how to talk about it (Affara, 2000). These efforts are making gradual progress toward ending female genital mutilation, but much education is still necessary worldwide.

Conclusion

Female genital circumcision, often referred to as mutilation, is a common practice with a long history in many cultures. Although it is an illegal operation in the United States, women and children who have undergone the procedure are living here and receiving health care. There are three types of this procedure, depending upon the extent of the operation. Regardless of the type, there are multiple short and long-term physical and psychological complications that the girls and women may experience. These women have also reported experiencing unpleasant health care delivery by providers in Canada. Multiple considerations should be made when working with and educating these patients, as they deserve to be treated with sensitivity, dignity, and respect.

As nurses and members of a health care team, it is our responsibility to educate ourselves on the tradition of female genital circumcision and examine our own cultural beliefs and bias. It is probable that each nurse will, at some point during his or her career, encounter and care for a woman who has undergone the procedure. With knowledge about the rationale for such a practice and about the potential complications that may result, nurses should be better prepared to provide quality care without judgment. Cultural competency is a necessary skill for nurses serving in the United States, as the country becomes more populated with diversity on a daily basis.

This assignment has added a great deal to my personal knowledge. Before researching the topic, I only knew that there was a practice known as female genital circumcision. Learning about the rationale behind the historical practice and its importance to those who use it has been very beneficial to my understanding of a custom which seems so violent to me. Most importantly, through education, I have been able to change my attitude toward the practice and those who carry it out.

References

Affara, F.A. (2000). Correspondence from abroad: when tradition maims. *American Journal of Nursing*, 100(8), 52-55, 57, 59-60.

Chalmers, B. & Hashi, K.O. (2000). 432 Somali women's birth experiences in Canada after earlier female genital mutilation. *Birth*, 27(4), 227-234.

Hellsten, S.K. (2004). Rationalising circumcision: from tradition to fashion, from public health to individual freedom – critical notes on cultural persistence of the practice of genital mutilation. *Journal of Medical Ethics*, 30(3), 248-253.

Jones, W.K., Smith, J., Kieke, B., & Wilcox L. (1997). Female genital mutilation/female circumcision: who is at risk in the U.S.? *Public Health Reports*, 112(5), 368-377.

Mwangi, R. & Smith-Stoner, M. (2002). Caring for the patient who has undergone female circumcision. *Home Healthcare Nurse*, 20(1), 30-35.

Wallis L. (2005). When rites are wrong. *Nursing Standard*, 20(4), 24-26.