

Female Circumcision

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Introduction

The thought of circumcising a girl may seem like a perplexing and abhorrent practice for most American citizens, but for many cultures it is a celebrated rite of passage for women. While this custom has since been outlawed in the United States, it is still commonplace in other countries. The World Health Organization estimates that female circumcision, also referred to as female genital mutilation (FGM), has been performed on approximately 100 to 140 million girls and women, predominantly in Africa (WHO, 2008). It is also prevalent in the Middle East, Asia, South American and Pacific countries. With the growing rate of immigration to the United States, health professionals are encountering more patients who have undergone this procedure. A lack of education has left many clinicians unprepared to manage some of the physical and psychological sequelae of female circumcision.

Health care professionals have a duty to provide culturally competent care to individuals of diverse backgrounds. Despite the legal and ethical questions surrounding female circumcision, every individual is entitled to the same care and respect. Learning about the cultural beliefs and practices behind this tradition is mandatory to providing culturally competent care. The purpose of this paper is to educate the healthcare workforce about female circumcision and establish a culturally competent foundation for serving patients. Understanding the beliefs of a particular culture allows for the establishment of a respectful, nonjudgmental and trusting relationship between the provider and their patient.

Review of Literature

Female circumcision began centuries ago, predominantly as an attempt by men to exert control over women (Whitehorn, Ayondrinde, & Maingay, 2002). Four major types of

procedures are performed. Type I entails removing the clitoris, also known as clitoridectomy. Type II involves the removal of the prepuce, clitoris, and parts of the labia. Type III combines clitoridectomy with infibulation. The majority of the labia is excised, then the vulva is sutured back together, leaving a single small hole for urine and menstruation. Type IV is rare and consists of manipulations such as burning, piercing, or stretching the labia (Morris, 1999). These rituals are commonly performed between the ages of four and twelve as a rite of passage into womanhood (Morris, 1999). A woman in the community, usually with no medical knowledge, oftentimes performs the procedure without anesthesia or sterile instruments. (Whitehorn et al., 2002).

The health consequences of female circumcision vary depending on the type of procedure performed, sterility of the instruments, and skill of the woman performing the circumcision. Complications immediately following the procedure can include hemorrhage, hypotension, shock, acute infections, abscess, cellulitis, gangrene, tetanus, sepsis, oliguria, and urinary retention. Laceration of the urethra, bladder, or vagina can also occur. Injured organs or fractured bones occur secondary to restraining the child during the procedure (Nour, 2004). Long term complications that can occur after a type II or III circumcision are urinary scarring, pain, infertility, sexual dysfunction and dyspareunia (Nour, 2004). Women who have undergone infibulation may be at increased risk for obstetrical difficulties such as fetal complications, perineal tears, wound infections, and episiotomy separation (Nour, 2004).

In addition to the physical complications that can result from female circumcision, various degrees of psychological problems can develop. Some consequences of this traumatic experience include post-traumatic stress disorder, chronic anxiety, depression, loss of sexuality, low self-esteem, fear of conceiving, and loss of sleep (Morris, 1999). Because of the social

rejection that would result from not undergoing the procedure, “authors argue that not to be circumcised in certain communities has a greater psychological impact than the trauma caused by the circumcision itself” (Whitehorn et al., 2002, p. 165).

Despite the complications that can occur, many cultural rationales encourage women to undergo this procedure. Girls view this ceremony as a rite of passage signifying their womanhood. The young female undergoing circumcision is given special food and clothing, then educated on her expected role as a woman (Gibeau, 1998). Female circumcision ensures the virginity of the girl, therefore resulting in a high bride price. Many men will not marry an uncircumcised woman. This practice is also viewed as making a woman more sexually attractive, ensuring fidelity, maintaining sexual harmony, preventing stillbirths, and as an essential part of overall health (Morris, 1999).

This medically unnecessary procedure originated as a means of controlling female sexuality and is perpetuated by women who believe in its necessity to ensure social acceptance and marriage. The eradication of these rituals and beliefs demands a combination of community education and legislation. In 1958, the United Nations urged the World Health Organization (WHO) to carry out studies about the harmful cultural practices done to females. Both the WHO and the International Planned Parenthood Foundation condemned female circumcision in 1986 (Morris, 2008). In 1994, “UNICEF declared that female circumcision constituted both a health risk and a violation of human rights for girl children” (Gibeau, 1997, p. 89). According to the Center for Reproductive Rights (2009), the U.S. Congress declared the practice of female circumcision on a minor a criminal offense in 1996. Subsequently 16 states have passed legislation relating to female circumcision, many following the example of criminalizing this practice.

Women's health and social rights are international concern. Other countries, including Britain, Sweden, and some African nations, have outlawed this practice. Legislation may not be the best means to enact change because it can result in underground practices. "Education also helps, but simply explaining the medical hazard is not enough" (The unkindest cut, 2004, p.1). Legislation in addition to providing culturally sensitive education may be a more effective solution to eradicating this practice.

Many organizations have worked to abolish female circumcision on the basis that it is a violation of female human rights. "It seems easy to resolve an ethical dilemma by providing a legal solution"(Gibeau, 1998, p. 89), but legislation does not account for ethical issues such as autonomy and patient rights. While female circumcision is viewed as a form of mutilation and abuse in western cultures, it is important to consider the egocentrism of such judgments. If a woman requests this procedure in America, her autonomy and cultural beliefs should be respected. Alternatively, the provider has a right to preserve his/her integrity and refuse a procedure he or she deems unethical, according to Provision 5.4 of the ANA code of Ethics (2005).

While Western cultures may find female circumcision to be an unethical practice, health professionals have a duty to provide culturally competent care when working with patients. Women have reported feeling distressed, resentful, and hurt when their providers react with pity or disgust upon seeing the infibulated scar (Nour, 2004). "Women have described being left in stirrups while residents and medical students are brought to view the scar" (Nour, 2004, p. 277). Experiences such as these discourage circumcised women from visiting health care providers in America for fear of being judged and humiliated.

It is essential for providers to be educated about the cultural beliefs underlying female circumcision in order to provide culturally competent care for their patients. By understanding the practice of female circumcision, health care providers can respond more sensitively and respectfully. For example, speculum examinations are not routinely performed in some countries, therefore the provider should prepare the patient by explaining the procedure, showing the tools that will be used, and if necessary, using a smaller speculum (Nour, 2004). By recognizing diverse cultural values and beliefs, educating staff about the various forms of female circumcision, using the patient's terminology in regards to their specific case, and acknowledging personal discomfort, health care professionals can provide culturally competent care with a nonjudgmental approach.

Conclusion

Although female circumcision is no longer legal in most developed nations, the increasing number of immigrants utilizing their healthcare systems has drawn attention to this abolished practice. Ignorance in regards to this procedure results in an unfriendly and resentful healthcare experience for circumcised women. Regardless of the legal and ethical implications surrounding female circumcision, each patient has a right to respect and culturally competent care. Health care staff that are knowledgeable about the beliefs of other cultures can more easily establish a trusting relationship with their patients.

Patient trust can allow for valuable education to take place, and possibly alter attitudes and beliefs regarding female circumcision. In order for the practice to be eliminated, "there must be fundamental changes in both the attitudes of men and women and in attitudes about women and female sexuality across cultures" (Whitehorn et al., 2002, p. 165). With cultural knowledge and the establishment of a trusting relationship, health care professionals can educate

circumcised women and their spouses about the implications of female circumcision in an effort to eradicate this suppressive female practice.

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