A Health Practitioner's Guide to Providing Culturally Competent Care for Women and Girls Affected by Female Genital Cutting

Female Genital Cutting (FGC) is the practice of total or partial removal of the external female genitals or other injuries associated with the genital organs for cultural, religious, or other non-medical or therapeutic reasons. It is considered a serious violation of human rights that carries physical and psychological health consequences. While it is internationally recognized and almost globally condemned, approximately 200 million women have been affected by the practice and 3 million are at-risk of the practice annually. In the U.S., it is estimated that 513,000 girls under the age of 18 have experienced or are at risk of FGC in the U.S. Take time to learn more about the historical and cultural aspects of the practice and gain insight into the complexity of the issue with BRYCS Community Conversations.

Women and girls affected by FGC represent various cultural, ethnic, and religious groups. Health practitioners have a unique opportunity to work to prevent FGC by educating the patient on the health consequences of the practice. Women recently migrating to the U.S. may not understand western cultural norms related to women's health. Consider the following practice approaches and cultural factors or aspects when providing care for those affected by FGC:

- To provide culturally competent care and affectively treat patients affected by FGC, gain an understanding of the cultural and historical roots of the practice, the different types, and the physical and psychological health consequences. More information as well as resources to help prevent the practice can be found online at BRYCS Community Conversations.
- Health practitioners should prioritize the confidentiality of the female patient who has undergone FGC over the education and training needs of medical students and other physicians.
- Terminology of FGC can be challenging in the medical setting. *Female circumcision* is usually the most understood and least offensive term with patients and interpreters.
- Always have a trained female interpreter present if there are language barriers to ensure adequate understanding of medical information. Women may also request to work with a female physician or nurse as this is a more culturally acceptable practice.
- Women and girls may lack an in-depth understanding of their own anatomy as these can be topics not regularly discussed. Take time to educate the patient regarding the health consequences of FGC as well as other reproductive health topics. With permission, initiate questions about the patient's reproductive health and history, as this can help normalize an uncomfortable topic and overcome embarrassment for the patient, as well as the interpreter.
- Regular gynecological exams or prenatal care may not be a common practice for the patient, in fact, for many this may be their first visit to an OB/GYN. Take time to build trust with patients and provide education and information regarding the importance of regular gynecological exams, prenatal care, and what to expect from obstetric and gynecological care in the U.S.
- Seek permission from patients before performing a gynecological exam. Communicate with the patient during the exam, letting her know the steps and procedures before you begin as this may be her first time undergoing such a procedure.
- Gynecological exams and prenatal care should focus on the patient's health, not only on FGC related topics. Avoid insistent questioning about FGC unless permission is given. The experience may have been traumatic, it may be embarrassing to discuss, or she may not feel comfortable discussing the details of her personal experience.
- Insensitive and discriminatory reactions of physicians seeing FGC for the first-time isolates women and their communities and can further deters women from seeking medical treatment. Such reactions also have negative psychological consequences. Women and girls who have undergone the procedure are not at fault and should not be blamed as they rarely have a choice in the matter.

Four Types of FGC

TYPE I *Clitoridectomy:* This type is often referred to as 'sunna' and typically involves the removal of all or part of the clitoris and sometimes the prepuse.

TYPE II *Excision:* Partial or total removal of the labia minora and the clitoris, and sometimes includes the removal of the labia majora.

TYPE III *Infibulation:* The most extensive form of FGC and may include a clitoridectomy in addition to the removal of the medial parts of the labia majora or labia minora, and the joining together of the sutured parts of two sides of the vulva to narrow the orifice of the vagina. When the procedure heals, a scar forms a seal over the vagina, and a small opening is left for the passage of urine and menstrual blood.

TYPE IV *Other Variations:* Includes piercing or an incision of the clitoris, stretching of the clitoris or labia, or induction of corrosive substances to the vagina causing bleeding and a tightening of the vaginal passage.

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Women who have experienced FGC are at risk for a variety of health consequences. Those who were cut at a later age and can remember the procedure may experience psychological trauma, making visiting a physician a daunting task.

Short-term health consequences include severe pain, excessive bleeding, difficulty passing urine, infection including tetanus, shock, and possible death.

Long-term health consequences include and are not limited to chronic infection, dysmenorrhea, haemocoel in the vagina, pelvic inflammatory disease, cysts, development of a false vagina, vesicovaginal or rectovaginal fistulae, dyspareunia, infertility, and complications during childbirth.

Psychological consequences also exist, especially after having undergone such a painful and traumatic procedure at the hands of loved ones. Women may experience depression, anxiety, PTSD, and fear of sex and childbirth resulting from the procedure. Women affected by FGC migrating to Western countries may also experience feelings of shame, resentment, powerlessness, and a lack of understanding when confronted with the norms and laws in the U.S. surrounding FGC.

Deinfibulation

Deinfibulation is a reconstructive procedure of cutting open and reversing the effects of an infibulated vagina (Type III FGC). It is recommended for women who have had Type III FGC to treat and prevent various health problems associated with infibulation including obstetric and urinary problems, infection, and to facilitate childbirth. Take time to promote the health benefits of deinfibulation with infibulated women and their partners. Providing counseling, education, and opportunities for questions can help improve their acceptability and understanding of the procedure, however the decision of the patient should ultimately be honored. It is also important to educate the patient and her partner on U.S. laws concerning FGC and re-infibulation (often requested after childbirth). The World Health Organization offers practice guidance for performing the procedure as well as resources for counseling. All efforts should be made to find a physician with experience in the practice.

Are there laws against the practice?

In the U.S. it is illegal to perform or assist in performing FGC on anyone under age 18. Traveling outside of the U.S. to have a child undergo FGC is also against the law. The U.S. considers FGC a violation of human rights, gender-based violence, and a form of child abuse.

A woman or girl who has undergone FGC is ***not at fault*** and has not violated any U.S. laws. Federal law makes discrimination against anyone who has undergone these procedures illegal.

Health care providers should learn the intentions of mothers of daughters regarding FGC and work collaboratively with families to prevent the practice in their communities.

If you suspect or have reason to believe that a minor has undergone FGC, mandatory reporting laws must be followed.

Pregnancy and Childbirth

FGC can have serious health implications for women during pregnancy and childbirth and may even cause infertility. Prenatal and postpartum care is not customary in many cultures, therefore the healthcare team working with pregnant women should ensure that information on common practices and health benefits associated with obstetric care are explained. Not only will this improve health outcomes but will also improve the experience of the patient during her pregnancy. Also take time to discuss what to expect on the day of birth to alleviate confusion. In some cultures, it is not customary for men to attend the birth, while female counterparts are preferred. Be sure to discuss birthing companions in prenatal care and planning.

Though risks exist for infibulated women in childbirth, women have repeatedly shown the ability to successfully undergo a vaginal birth when deinfibulation is performed during pregnancy or at birth, therefore Caesarean sections should not automatically be planned. Caesarean deliveries are not culturally desirable, therefore taking time to provide education and information about the procedure and its relevance to the patient and her partner in advance of her due date improves the quality of care received by the patient. Additionally, discuss the benefits of deinfibulation to increase the chances of a vaginal birth.

BRYCS
COMMUNITY CONVERSATIONS
Collective Voices for Improving the Care and Reducing the Risk of FGC
Bridging Refugee Youth and Children's Services
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