

# Female Genital Mutilation and Reinfibulation: Considerations in Obstetrics

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## Abstract

This paper provides current information about female genital mutilation (FGM) and reinfibulation so that health providers can make informed decisions about obstetric treatment of women with history of FGM. A review of literature is conducted, revealing extensive health risks of reinfibulation in obstetric patients and discontent and concerns within sub-Saharan African populations related to genital cutting practices. Suggestions for change in current management of patients with history of genital cutting are offered, including extensive counseling and education of the patient. The paper concludes that the healthcare provider must remain sensitive to patients' needs and concerns about FGM in order to devise a solution for moving forward with their obstetric care.

It is difficult to imagine female genital mutilation (FGM), a procedure unfamiliar among native-born Americans, as a traditional practice; according to Rosenberg, Gibson, and Shulman (2009), an estimated 140 million women are subjected to this procedure, as it is standard practice in more than 26 countries, mostly within sub-Saharan Africa (Wuest et al., 2009). Also known as female genital cutting, the World Health Organization defines it as "partial or total removal of the external female genitalia or other injury to the female genital organs for nonmedical reasons" (World Health Organization, 2008). The WHO recognizes four types of FGM: a clitoridectomy (Type I), a clitoridectomy and more extensive labia minora removal (Type II), infibulation, which is narrowing of the introitus by cutting and sewing the labia majora (Type III), and other nonmedical procedures such as cutting, pricking and burning (Type IV) (Rosenberg et al., 2009). Rosenberg et al. (2009) explains that genital cutting is a rite of passage, confirming virginity and suitability for marriage and childbearing. Bergghen et al.'s (2006) study demonstrates that FGM is performed also to decrease female sexuality and pleasure and to increase male sexual pleasure.

The steady migration of sub-Saharan African women to Western countries where genital mutilation is illegal (Wuest et al., 2009) has made genital mutilation a controversial ethical issue, as it

concerns principles of right and wrong where only one choice can be right (Murray & McKinney, 2006). The WHO claims it to be ethically impermissible, as FGM violates and oppresses inherent human rights and specific rights of women and children (Wuest et al., 2009). Medical complications, such as infection, psychological trauma, infertility, and prolonged labor seem avoidable, as the procedure is not medically necessary (Rosenberg et al., 2009). Some cultures, however, consider FGM ethically permissible and necessary to show a woman's honor and commitment. According to Rosenberg et al. (2009), the provider's refusal to reinfibulate, or sew the labia majora together after deinfibulation, may violate the autonomy principle, requiring respect for patients' autonomy including freewill, cultural and family needs. Subsequently, the issue of FGM and reinfibulation becomes an ethical dilemma, a situation with no satisfactory solution (Murray & McKinney, 2006). This issue is relevant to obstetric practitioners who may perform deinfibulation before delivery and may also be asked to reinfibulate (Rosenberg et al., 2009). Many healthcare professionals are uneducated in care of patients who have had FGM (Rosenberg et al., 2009). Rosenberg et al. (2009) states that U.S. laws are vague about reinfibulation, so the provider must be well informed about ethics and cultural rationale before selecting a course of action. This paper will provide current

information about FGM and reinfibulation so health providers can make informed decisions about obstetric treatment of these exceptional patients.

## Review of Literature

The World Health Organization conducted a collaborative study in 2006 on the obstetric outcomes of women in six African countries who had FGM. In 28 birth centers and hospitals in Burkina Faso, Ghana, Kenya, Nigeria, Senegal and Sudan, 28,393 women were sorted by the WHO classification system of FGM and obstetric outcomes were monitored until hospital discharge (World Health Organization, 2006). The study found that women with FGM were much more likely to experience adverse obstetric outcomes, have a caesarean section and have postpartum bleeding equal to or greater than 500 mL than those women who had not had FGM (World Health Organization, 2006). The ability to generalize some of the results of this study may be limited, as the study was performed only in hospitals, so lower-income women without access to hospital care may not be represented (World Health Organization, 2006). Nevertheless, the World Health Organization concluded that the results allow the addition of adverse obstetric outcomes to the list of known harmful effects of FGM, a procedure not medically necessary.

In her 2006 study, R. Elise B. Johansen interviewed Norwegian health care workers about their experiences with birth care of previously infibulated immigrant Somali women. Johansen (2006) analyzed anthropologically the expressions and care methods of the health workers based on the birth care in Norway of a group of Somali women. The study found health workers' desire to be culturally sensitive in the provision of medical care and their own moral and ethical difficulties with infibulation resulted in overemphasis of culture in their interactions with Somali women. The study showed that incorrect preconceptions that health workers had about the wishes of Somali women combined with limited knowledge and communication resulted in care inconsistent with patient needs; Johansen (2006) found the most common reasoning for not performing deinfibulation was the health workers' belief that the patient desired preservation of infibulation, when

many Somali women wanted deinfibulation to ease the labor process. All but one Somali woman interviewed did not want reinfibulation; many were reinfibulated against their wishes (Johansen, 2006).

Another qualitative study published in 2006 by Berggren et al. examined the perceptions of women and men from Sudan, where reinfibulation is common, concerning FGM and reinfibulation postpartum through 22 interviews. Berggren et al. (2006) found that both genders held the other gender responsible for the continued tradition of FGM and reinfibulation, a practice of which both men and women claimed to be victims due to health and sexual problems. According to Berggren et al. (2006), the three themes that emerged from the women's interviews included feeling "normal" by engaging in genital cutting, feeling torn between tradition and desire for change, and having little control over the practices. The three themes present in the men's narrative were suffering from the psychosocial and sexual effects of FGM and reinfibulation, attempting to compensate for negative sexual effects of reinfibulation, and struggling to change these traditions in women (Berggren et al., 2006).

## Clinical Recommendations

The information disseminated in this review has implications for clinical obstetric practice by offering an individualized approach to the care of pregnant and laboring women with a history of FGM. Providers must abide by the principle of beneficence, only doing good for the patient, by not performing nonmedical procedures (Rosenberg et al., 2009). Johansen (2006) highlighted support and communication about the delivery and genital cutting issues between patient and provider as important to the Somali women, as providers held false ideas about patient wishes. It is important for health care workers to ask women about their wishes for deinfibulation, perinatal and postpartum care instead of making assumptions based on overarching cultural norms; ethical considerations for reinfibulation are not necessary when the patient does not desire reinfibulation (Johansen, 2006). Turner (2006) suggests that discussions concerning FGM should be conducted in a nonjudgmental way to establish trust

when presenting alternatives to reinfibulation. Also, Johansen (2006) advises providers to learn how to perform deinfibulations, as lack of knowledge resulted in performing the more familiar episiotomy or a cesarean section instead. The American College of Obstetricians and Gynecologists recommend defibulation during the 2<sup>nd</sup> trimester to reduce obstetric risks (Rosenberg et al, 2009). The patient-provider communication around obstetric issues for those with genital cutting should occur early in the pregnancy, so the patient can make informed decisions about their care (Rosenberg et al., 2009). It is the nurse's responsibility to provide counseling to the patient about risks of reinfibulation and benefits of remaining deinfibulated before and after childbirth. Referencing values already part of a patient's cultural framework, such as importance of family, can help the provider promote informed decision-making by the patient (Moschovis, 2002). While difficult, the health provider must make efforts to educate women about health risks and options related to FGM.

#### Barriers to Practice

One of the main barriers to changing the practice of FGM is the patient is a part of a culture that strongly promotes and expects FGM. Rosenberg et al. (2009) cautions that the woman may be shunned for not adhering to traditional genital mutilation practices, and therefore must struggle with satisfying her own rights and the wishes of her family. Another barrier to the abolishment of FGM is the silent culture that exists between men and women (Berggren et al, 2006). This silent culture is a way of life for men and women who do not discuss intimate issues, including reinfibulation, with each other. Though Berggren et al. (2006) found that men and women may both feel victimized by the practice and its lack of overt acknowledgement. Nurses and health professionals may serve to facilitate open communication between men and women and obstetric encounters during pregnancy may serve as an opportune time to initiate the conversation.

#### Final Remarks

Based on the review of literature, it is evident that the practice of female genital mutilation

and reinfibulation is not always supported by those part of its culture of origin. Though women may not vocalize their discontent with infibulation, the studies in the literature review suggest a feeling of moral wrongness concerning FGM and infibulations in Sudanese and Somali populations. Additional research in the area is needed in order to determine the best way to handle patients with FGM in the United States. For now, practitioners at least have a duty to advocate for patients by asking them about their stance on FGM before assuming that these women automatically support the use of this practice. Additionally, practitioners should provide patients with current medical knowledge concerning reinfibulation and treatment options as well as facilitate communication between patient and family.

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