

Female genital mutilation: an update for primary health-care professionals*

Nikhilesh Todkari MBChB, BAO, PGCertGP, PGCertHSc, PGDipSurgAnat

University of Otago,
Department of Primary
Health Care and General
Practice, Wellington,
New Zealand

ABSTRACT

Female genital mutilation (FGM) has historically been seen as a health concern limited to women living in other parts of the world. However, with the rising number of migrants, refugees and asylum seekers, countries like New Zealand, Australia and Europe have seen a surge in the number of women and girls affected by FGM seeking medical care. This topic is increasingly becoming relevant to primary health-care providers in this country and therefore a good understanding of this practice is important.

KEYWORDS: Female genital mutilation; New Zealand; raising awareness; primary health care

Migrant women seeking refugee or asylum status in New Zealand have some distinct sexual and reproductive health needs due to their gender and cultural backgrounds. Some of the ideas and beliefs that support certain practices in their communities of origin may not be practised in New Zealand. Female genital mutilation (FGM), sometimes referred to as 'cutting', is an example of such a practice. With a rise in the number of refugee and migrant women coming into the country,¹ a good understanding of this practice along with its legal, cultural and health implications is important for health-care providers. This paper examines FGM in New Zealand, the reasons for its ongoing practise, current challenges in the provision of adequate sexual and reproductive health care and approaches that could be taken to raise awareness among primary health-care professionals.

The World Health Organization (WHO) defines FGM as 'all procedures involving the removal of the external female genitalia for cultural or non-therapeutic reasons'. Although prevalence is declining slowly,² the WHO estimates that up to 140 million girls and women worldwide might have been subjected to FGM.³ There are over 28 mainly Sub-Saharan African countries where

this practice is prevalent and could range anywhere from 90% in countries like Somalia, Mali and Sudan to <5% in Uganda and the Dominican Republic of Congo. FGM has also been reported in Egypt, Yemen and parts of Asia such as Indonesia and India.⁴ Female genital mutilation has historically been seen as a health concern limited to women and girls living in these parts of the world.⁴ However, with rising numbers of migrants, refugees and asylum seekers, countries like New Zealand, Australia and Europe have seen a surge in the number of women and girls affected by FGM seeking medical care.⁵⁻⁷

Based on increasing degrees of invasiveness, the WHO has classified FGM into the four types, as shown in Table 1.^{3,4} The procedure is usually carried out on girls aged <15 years³ but, regardless of the age, it may render severe physical and psychological consequences. These procedures are usually carried out by clinically unqualified personnel, such as a traditional so called 'midwife' using crude unsterilized instruments and very little, if any, anaesthesia.⁴ Complications, therefore, mainly depend upon the type of procedure performed (most complications occurring in type 3), experience of the performer and the sterility of the instruments used.

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CORRESPONDENCE TO: Nikhilesh Todkari

67 Mandel Mews, Waiwhetu,
Lower Hutt 5010,
New Zealand
npt_2000@hotmail.com

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There is currently limited information about the physical and psychosexual consequences of FGM-affected women living in New Zealand. Immediate and long-term complications include intractable bleeding, damage to local structures, infection, septicaemia and acute urinary retention. Sexual issues include dyspareunia (76.5%), aparenuia (17%) and the need to have surgery before intercourse (33%).⁷ The risk of an obstetric emergency such as a difficult labour and haemorrhage increases by 33%. The risk of maternal perinatal death increases by 2%, while infant perinatal death rises by 22%.⁸ Psychological sequelae can include post-traumatic stress disorder, anxiety and loss of self-esteem.⁹

Female genital mutilation is illegal in New Zealand as it is considered a discrimination against women, violates their right to health and the right to be free of cruel, inhuman or degrading treatment. Under the New Zealand Crimes Act Amendment of 1996, it is illegal to perform any 'procedure or mutilation of the vagina or clitoris... for reasons of culture, religion or custom' even if the woman or a girl's parents request it. It is also illegal to assist in sending a child overseas to have the procedure performed.^{10,11}

Reasons given for this practice range from preserving family honour, perceptions about appropriate hygiene, rites of passage into adulthood, a prerequisite to social acceptance and to maintain premarital virginity. The association between genital mutilation and premarital virginity can be so strong in some communities that men may refuse to marry an uncircumcised woman. This can result in dire situations for women belonging to a society where marriage is seen as the only path forward for acceptance and economic security.^{3,5,9}

The United Nations has called for elimination of the practice by 2030.¹² In support of this, several African countries such as Burkina Faso, Côte d'Ivoire and Senegal have successfully begun passing laws against FGM. In Senegal, for example, up to 1800 communities have stopped this practice within a decade of passing such laws.⁶ Examples of political support in other countries include the UK government's hosting of the first Girl Summit against FGM in 2014, and two recent high-profile criminal prosecutions against

FGM in the USA.² A similar commitment by the New Zealand political system in identifying, supporting and protecting affected women and girls could help reduce this practice.

In 1997, a New Zealand-based FGM Education Programme was established in response to the rising number of FGM-affected women settling into the country. The aim of this programme was to provide reproductive health services for women affected by FGM and preventing the occurrence in New Zealand through training, support, community education and health promotion. The programme included assistance and support for health professionals working with women affected by FGM, development of FGM guidelines, education resources and protocols.¹⁰

Surveys carried out by the FGM Education Programme in 1997, and subsequently in 2008, showed that nearly all of the women interviewed thought their New Zealand health-care providers were not knowledgeable about this practice. There was a distinct communication gap between the women interviewed and their health-care providers.⁶ Some women have also reported experiencing offensive and condescending reactions from health professionals regarding their circumcisions.¹¹

Primary health-care providers are well positioned to provide support, education and counselling for patients affected by FGM. Sexual and reproductive education provided by health-care providers is often seen as non-threatening and non-judgemental and thus can be used to gain community support against FGM. However, as FGM is a culturally sensitive and complex issue, many health professionals trained in non-prac-

Table 1. World Health Organization classification of female genital mutilation types

Type 1	Partial or total removal of the clitoris and/or the prepuce (clitoridectomy).
Type 2	Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision).
Type 3	Narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation).
Type 4	All other harmful procedures to the female genitalia for non-medical purposes; for example: pricking, piercing, incising, scraping and cauterisation.

ting countries may find this topic challenging. They may feel uncomfortable discussing this due to lack of knowledge and awareness or the uncertainty about framing appropriate questions.^{9,13} This may create a communication gap and affect the clinician–patient relationship. Improving communication by regularly conversing with women, sometimes with the help of appropriate interpreters, can help build stronger relationships of trust over time, offers a chance for greater exchange of information and knowledge and provides an improved quality of care.¹⁴

Women may not seek help for a variety of reasons, including fear that disclosure might bring disrepute to their family or it might lead to trouble with the authorities. As many of these women are refugees, they may fear that it might lead to deportation. Another challenge is that women affected by FGM, even in New Zealand, often have limited or no access to family planning services. They may also have limited knowledge of their reproductive cycles and the different types of contraception available. The Health Care Survey conducted in 2008 showed that only 20% of Somali women were using any form of contraception, while 82% stated they would like more information about sexual and reproductive health issues.¹¹

These women may have fewer available contraceptive options depending on the type of FGM procedure they have undergone. Diaphragms and intrauterine devices such as the Mirena, may be difficult to insert due to a narrowed introitus. Other contraceptive options such as Depo Provera injections, the contraceptive pill or the implant can still be used.

In areas of higher FGM prevalence within countries such as the UK and Australia, specialist clinics have been developed to provide care and support for women affected by FGM. In New Zealand, where the prevalence of FGM is still low, health-care providers could benefit from having clear protocols and referral pathways to similar services.⁹

Studies show that women from FGM practising communities living in non-practising commu-

nities are less likely to want to circumcise their own daughters. However, many women who resist the practice then risk being subjected to community pressures, being ostracised by their community and could have difficulty in finding someone within their own community to marry their daughter.⁹ Therefore, educating communities about possible complications and the legal implications of practising FGM can often empower women who do not want their daughters subjected to FGM but feel compelled by cultural and social pressures.

Initiatives focusing on FGM alone are insufficient. Most of these women are refugees and may also be struggling with non-FGM-related issues such as language barriers, housing and income difficulties, feelings of isolation and anxiety. These issues need to be tackled simultaneously in collaboration with local community and political members.^{5,10}

Female genital mutilation continues to exist under the complexity of social and cultural justifications. A thorough understanding of this practice along with its legal, cultural and health implications is of crucial importance for health-care providers to enable them to provide appropriate, safe and effective care. Changing people's behaviour towards FGM demands a collaborative approach. This incorporates passing health-care laws and policies against this practice, educating FGM-practising communities, raising awareness among health professionals and improving health-care access to these women. Only then can we hope to one day end this inequality and discrimination against women.

KEY POINTS

1. Women affected by FGM have specific sexual and reproductive health needs.
2. A thorough understanding of FGM along with its legal, cultural and health implications is of crucial importance for health-care providers.
3. A collaborative approach, which incorporates passing health-care laws, training health professionals, improving health-care access to these women and educating FGM-practising communities, is needed in order to end this practice.

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COMPETING INTERESTS

None.