



## Living with mutilation: A qualitative study on the consequences of female genital mutilation in women's health and the healthcare system in Spain

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### ABSTRACT

**Introduction:** Female genital mutilation is a health and human rights issue which extends to western countries. It is estimated that there are some seventeen thousand women and girls living in Spain who have either been mutilated or are at risk of being so. Healthcare professionals face the challenge of providing adequate care in response to this emerging problem.

**Aim:** To discover the repercussions of female genital mutilation on the health of sub-Saharan women residing in Spain, as well as the healthcare received.

**Methods:** A life-history qualitative research design was utilized. The study population included 14 genitally mutilated women residing in the Region of Murcia who had given birth in Spain and been attended to by the national public healthcare system.

**Results:** Women suffer physical, psychological, obstetric and sexual health issues as a result of female genital mutilation and despite having a favourable perception of the healthcare received during the pregnancy and the delivery, the provision of health education, detection and treatment of female genital mutilation by healthcare professionals was seen to be lacking.

**Conclusions and practical implications:** Healthcare policy must address insufficiencies in delivering adequate care to immigrant women who have been the victim of female genital mutilation by implementing the necessary resources and training for professionals to effectively meet the specific healthcare needs of this population and prevent this cruel practice from being perpetuated.

### Introduction

Female Genital Mutilation (FGM) is one of the most extreme expressions of gender-based violence and a violation of women's rights. This traditional practice is defined by the World Health Organization (WHO, 2018) as "all procedures that involve...injury to the female genital organs for non-medical reasons" and has been classified into 4 types: (i) Type 1 or clitoridectomy, involving the partial or total removal of the clitoris or the clitoral prepuce, (ii) Type 2 or excision, defined as the partial or total removal of the clitoris and the labia minora, with or without the excision of the labia majora, (iii) Type 3 or infibulation, involving the narrowing of the vaginal opening, sometimes by stitching the labia, with or without removal of the clitoris, (iv) Type 4 which includes all other harmful procedures to the female genitalia for non-medical reasons (WHO, 2018).

Although, a priori, it may appear to be an exotic and infrequent practice, the fact is this public health and human rights issue affects some two hundred million women and girls in over forty countries from five continents. It extends mainly throughout thirty countries in Africa, the Middle East and Indonesia (UNICEF, 2015) yet these countries' high birth rates, together with migratory flow and settlement in western countries, have seen this traditional practice reach countries which assimilate migrant populations. In this sense, the European Parliament Committee on Women's Rights and Gender Equality (2009) estimated that 500,000 women living in the EU have been subjected to FGM, and that 180,000 girls and women are at risk of undergoing FGM every year. In 2013, there was an increase in immigrant women arriving to the EU seeking asylum, of which 16,000 women and girls could potentially have been submitted to FGM (UNHCR, 2013). In Spain the number is estimated at seventeen thousand (Kaplan-Marcusan & López Gay, 2013a).

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This practice is perpetuated under the auspices of tradition, in order to maintain cultural identity, as a rite of passage into adulthood, maintaining sexual morality, religion and the supposed medical pretext of female hygiene or care (Berg & Denison, 2013; Van Bavel et al., 2017). Researching family and community reasons underlying this tradition is paramount to achieving a respectful and effective approach to FGM in countries receiving people from affected communities.

Further to its wide distribution, FGM is known to have serious consequences for women's health, since it increases the risks of morbidity and mortality and can cause complications of a physical (Pastor Bravo et al., 2013; Reisel & Creighton, 2015; Berg et al., 2014), psychosocial (Pastor Bravo et al., 2013; Ballesteros Meseguer et al., 2014; Andro et al., 2014), obstetric (Ballesteros Meseguer et al., 2014; Biglu et al., 2016) and sexual (Reisel & Creighton, 2015; Biglu et al., 2016) nature. Although the severity and intensity of such complications will depend on the type of FGM; factor related with holistic health of young girls, such as malnutrition, immunodeficiencies and/or concomitant diseases, as well as the conditions in which this practice is performed (Jiménez-Ruiz, 2015).

The viewpoint of the very women who suffer these complications has not been well documented in western countries, despite migration transmitting the practice of FGM to these locations (Reig-Alcaraz et al., 2016). Consequently the need for training and practice guidelines aimed at providing qualified healthcare professionals and adequate care plans for the issues these women present is greater (UNICEF, 2013). In order to provide transcultural, respectful care, understanding the experience of the women who suffer the consequences of FGM in western countries is necessary. Thus, the present study is based along the lines of a WHO priority (WHO, 2018), namely that of eradicating FGM, by documenting evidence of its consequences.

In an international context, initiatives, protocols, guidelines and tools for a socio-sanitary approach to FGM. Nonetheless, the fact it is a traditional practice, deeply rooted in the cultures in which it is performed, greatly hinders its visibility, identification and restricts opportunities to work with women at risk or affected by FGM. Thus, knowledge and know-how are required which might allow both the level of risk to be determined as well as provide a means of working with family and community values and beliefs. In this regard, the acceptance of the diagnosis "Risk of Female Genital Mutilation" in the upcoming edition of NANDA-International 2018–2020 demonstrates Nursing and Obstetrics to be a key element in the early detection of both the risk and consummated cases of FGM. Yet these proposals would be incomplete without an extensive knowledge of the socio-cultural significance of FGM, its health consequences, as well as the viewpoint and needs of women, survivors of this type of traditional practice. Therefore, studies have been carried out into the knowledge and attitudes of healthcare professionals with regard to this practice in western countries (Isman et al., 2013; Dawson et al., 2014; Abdulcadir et al., 2017) and more specifically in Spain (García Aguado & Sánchez López, 2013). Nonetheless, the present study sheds light on the healthcare received by such women, within the Spanish national healthcare system, as described from their own perspective. The current manuscript presents results from merely the first part of a larger research project taking place within the doctoral thesis of the primary author in order to identify the knowledge, attitudes and experiences of a group of sub-Saharan women with regard to genital mutilation.

Given that FGM may act as an element of multiple discriminations and a transversal condition for exclusion in areas where its practice is unknown and social and healthcare workers sensitive to the varied socio-cultural contexts of these women and young girls are not available. The aim of the present study is to analyse the experience of sub-Saharan women who have survived FGM and reside in Spain, with a focus on their perception of the resultant health consequences and the healthcare received from the Spanish Public Healthcare System.

**Table 1**  
Participant profiles.

Code	Country of origin	Ethnicity	Age	Type of mutilation	No. of children
E1	Senegal	Jola	28	Uncertain 1 or 2	2
E2	Senegal	Jola	37	Type 1	1
E3	Gambia		29	Type 1	3
E4	Senegal	Jola	24	Uncertain 1 or 2	1
E5	Senegal	Jola	36	Type 1	1
E6	Senegal	Jola	35	Type 1	1
E7	Senegal	Jola	34	Type 1	4
E8	Senegal	Mandinka	36	Type 1	1
E9	Senegal	Jola	28	Type 1	3
E10	Gambia	Jola	34	Type 1	2
E11	Senegal	Fula	41	Type 1	4
E12	Nigeria	Igbo	38	Type 1	2
E13	Senegal	Fula	23	Type 1	1
E14	Senegal		39	Type2	1

## Methods

### Design

A qualitative study design with a phenomenological approach was applied. The chosen methodology is not intended to provide generalized results, but to allow the experience of living with genital mutilation to be understood, to explore the health complications derived from FGM and to document the experience of the care received from Spanish healthcare services. Thus, an interpretive phenomenological focus, based on the understanding of lived experiences and the expression of similarities and differences in the significance of living with female genital mutilation, may be the most appropriate in order to achieve the proposed study objectives.

COREQ (Consolidated Criteria for Reporting Qualitative Research) criteria, utilized for revising qualitative articles, were applied in order to enhance the quality and transparency of the study here presented (Tong and Sainsbury, 2007).

### Study population

A total of 14 women from 23 to 41 years of age from Senegal, Nigeria and Gambia participated in the study. All had been subject to type I or type II genital mutilation in their infancy. They currently reside in the Region of Murcia (Spain) and have given birth at public healthcare services in the region. Table 1 shows the participants' profiles.

The study population was achieved via intentional sampling based on the following inclusion criteria: female, from a country where FGM is performed, 18 years or older, having been subject to FGM, residing in the Region of Murcia (Spain), having given birth and being fluent in Spanish.

Contact with the target population was made via African associations in the Region of Murcia. Three key informants were identified initially and the remaining participants were incorporated in snowball fashion until reaching theoretical saturation of data. In this regard, subsequent to 11 interviews no new data were generated, thus three interviews more were performed as recommended by Patton (2015).

### Data collection and instruments utilised

The instruments utilized were: informal interviews, socio-demographic questionnaires and life histories (Table 2). The main information-gathering instrument was that of life histories via individual open-ended interviews. The interview consisted of an open-ended question, with no predetermined script, thus allowing the narrative to be steered by the subjects (Bertaux, 2010), from their own worldview

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