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CLINICAL ARTICLE

Missed opportunities for diagnosis of female genital mutilation



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ABSTRACT

Objective: To investigate missed opportunities for diagnosing female genital mutilation (FGM) at an obstetrics and gynecology (OB/GYN) department in Switzerland. **Methods:** In a retrospective study, we included 129 consecutive women with FGM who attended the FGM outpatient clinic at the Department of Gynecology and Obstetrics at the University Hospitals of Geneva between 2010 and 2012. The medical files of all women who had undergone at least 1 previous gynecologic exam performed by an OB/GYN doctor or a midwife at the study institution were reviewed. The type of FGM reported in the files was considered correct if it corresponded to that reported by the specialized gynecologist at the FGM clinic, according to WHO classification. **Results:** In 48 (37.2%) cases, FGM was not mentioned in the medical file. In 34 (26.4%) women, the diagnosis was correct. FGM was identified but erroneously classified in 28 (21.7%) cases. There were no factors (women's characteristics or FGM type) associated with missed diagnosis. **Conclusion:** Opportunities to identify FGM are frequently missed. Measures should be taken to improve FGM diagnosis and care.

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1. Introduction

Female genital mutilation (FGM)—of which WHO defines 4 different types [1]—involves partial or total removal of the external female genitals for non-therapeutic reasons. This traditional practice is prevalent in East and West Africa but also occurs among other ethnic groups such as in Indonesia, Malaysia, and areas of the Persian Gulf [1]. Owing to migration, FGM has become increasingly common in high-resource countries. The European Institute for Gender Equality recently reported that there are women who have undergone FGM who live in at least 13 European countries (Austria, Belgium, Denmark, Germany, Spain, Finland, France, Ireland, Italy, Netherlands, Portugal, Sweden, and the UK) and that thousands of women and girls have been subjected to the practice either before moving to Europe or while traveling outside Europe [2]. The estimated prevalence varies from 170–350 women in Hungary (2012) to 65,790 in the UK (2007) [3].

In 2012, the Federal Statistical Office of Switzerland estimated that 10 700 African women in the country have undergone or are at risk for FGM, mainly in Geneva and Lausanne [4], compared with an estimated 6700 in 2001 [5]. These data were estimated via extrapolation of

African prevalence data and are probably underestimations because they did not include women without a Swiss residence permit, women who were not African, or women who already had a Swiss passport [4]. In July 2012, Switzerland approved a specific article of law (art. 124) punishing FGM, even if committed abroad, by a Swiss resident [6].

Laws, community education programs, and women's health support groups have been promoted in different European countries in order to increase awareness and knowledge and to provide information for the abandonment of the practice. In addition, women already affected by FGM need adequate and trained medical, psychological, and sexual care. Healthcare professionals are also required to identify children at risk in order to prevent the practice. For example, the Royal College of Obstetricians and Gynaecologists Green-top Guideline on FGM states that professionals should demonstrate knowledge, respect, and awareness of the physical and psychological implications of FGM [7].

Studies have investigated knowledge, awareness, and attitudes of healthcare professionals in high-resource centers and African settings. In Canada, it was reported that women's needs are not always adequately met: for example, during pregnancy and birth care [8]. Teaching about FGM is not included in the curriculum of medical schools [9,10], and recommendations about clinical management, reinfibulation, and legislation on FGM are not well known [10]. Of the 45 professionals who completed a questionnaire at a university hospital in the UK, 47% incorrectly thought that cesarean delivery was the best way of managing FGM if vaginal examination was not possible during the first stage of labor [11]. In Egypt, where FGM is considered endemic, poor

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knowledge regarding the issue was reported among medical students in Alexandria—most of whom thought that learning about the practice should be part of the undergraduate medical curriculum [12]. Insufficient basic knowledge regarding diagnosis and classification was recently reported by Relph et al. [13], who found that, even though 100% knew of FGM, only 58.2% of 79 respondents to the administered questionnaire were aware that there are 4 types. Previously, Zaidi et al. [11] also found that 58% of respondents were unable to list the different categories. In Sudan, a country in which there is a high prevalence of FGM, a study among midwives reported that only 7% identified the 4 types correctly, despite the fact that 80.9% of the respondents had previously practiced FGM [14]. Healthcare professionals, in particular gynecologists, obstetricians, and midwives, often find it difficult to identify FGM according to the 4 types described by WHO. However, they have an essential role in both screening and caring for women who have undergone the practice. Obstetrics and gynecology (OB/GYN) clinics should be the setting in which FGM is correctly diagnosed and where women with complications are informed and referred for appropriate care. There are reports on the relevant skills of physicians, gynecologists, obstetricians, and midwives evaluated by questionnaires [15–17] and a study in which FGM was often not identified until the moment of labor [18]. However, no study exists about missed/incorrect diagnoses or current capacities regarding recognition and classification of FGM in daily practice. The aim of the present study was to investigate missed opportunities to diagnose and identify FGM at an OB/GYN department in Switzerland.

2. Materials and methods

A retrospective study was conducted at the outpatient clinic for the care of women with FGM at the Department of Gynecology and Obstetrics of the University Hospitals of Geneva. The study department is a public teaching hospital at which there are approximately 4000 deliveries per year. The same patient can be attended for gynecologic or obstetric reasons by different members of staff (junior or senior doctors and midwives) at different consultations. All of the health professionals at the department are informed about FGM because there are official hospital guidelines on the issue covering OB/GYN aspects. At the outpatient clinic for the care of women with FGM—which was established in April 2010—women are attended by a gynecologist who is specifically trained in FGM (J.A.). The women either present on their own initiative or are referred by other health professionals. We reviewed the medical files of 129 consecutive women with FGM who attended the outpatient clinic between April 1, 2010, and April 1, 2012, and who had at least 1 previous gynecologic exam performed by an OB/GYN doctor or a midwife at the study institution. We checked whether the type of FGM had been correctly classified in the medical file. It was considered correct if it corresponded to the type reported by the specialized gynecologist at the outpatient clinic for FGM, according to the WHO classification [1] (Box 1). The research protocol was approved by the institutional review board of the University Hospitals of Geneva. Informed consent was waived.

Data were double-checked by 2 of the authors (J.A. and A.D.) and collected using SPSS version 19 (IBM, Armonk, NY, USA). Determinants of missed diagnosis were evaluated via univariate analysis, and differences were tested using the Fisher exact test. $P < 0.05$ was considered to be statistically significant. A sample of 129 women was sufficient for a precision of $\pm 8\%$ in proportions.

3. Results

The majority of the 129 women came from East Africa, particularly Eritrea (32.6%) and Somalia (27.9%). Type III (infibulation) was the most common form of FGM (76%). There were no cases involving type IV FGM. Review of the medical files (medical history and vulvar exam) showed that FGM was correctly diagnosed and classified in 34 (26.4%)

Box 1

Female genital mutilation according to WHO [1]

Type I: partial or total removal of the clitoris^a and/or the prepuce (clitoridectomy)

Type Ia: removal of the clitoral hood or prepuce only

Type Ib: removal of the clitoris^a with the prepuce

Type II: partial or total removal of the clitoris^a and the labia minora, with or without excision of the labia majora (excision)

Type IIa: removal of the labia minora only

Type IIb: partial or total removal of the clitoris^a and the labia minora

Type IIc: partial or total removal of the clitoris^a, the labia minora, and the labia majora

Type III: narrowing of the vaginal orifice with creation of a covering seal by cutting and apposition of the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation)

Type IIIa: removal and apposition of the labia minora

Type IIIb: removal and apposition of the labia majora

Type IV: unclassified

All other harmful procedures to the female genitalia for non-medical purposes: for example, pricking, piercing, incising, scraping, and cauterization

^aWhen total removal of the clitoris is reported, it refers to the total removal of the glans of the clitoris [28].

cases, erroneously classified in 28 (21.7%) cases, not mentioned in 48 (37.2%) cases, and either not mentioned or incorrectly reported by different professionals in the same file in 19 (14.7%) cases (Table 1).

No factors were identified associated with missed opportunity for FGM diagnosis such as country of origin, FGM type, time spent in Switzerland, employment status, need for an interpreter, age at time of FGM, past deliveries, and complications of FGM. There were no significant differences between women for whom FGM diagnosis was missed ($n = 67$) and those for whom diagnosis was not missed ($n = 62$) (Table 2).

4. Discussion

The present results indicate that missed opportunities to diagnose FGM are frequent at the study department. Consistent with results from available studies among healthcare professionals [8–18], we observed that gynecologists, obstetricians, residents, and midwives found it difficult to recognize and classify FGM (classification was correct for only 26.4% of women). In 37.2% of the medical files reviewed, FGM was not mentioned in the medical history or after clinical examination, which is surprising considering that the most common type of FGM in the study sample was infibulation (type III) (Fig. 1)—often the most recognizable type. There may be several reasons for missed FGM

Table 1
Diagnosis of FGM reported in medical files.

Diagnosis and classification	N (%)
Correct classification of FGM	34 (26.4)
Genitalia reported as normal (FGM not mentioned in medical history or vulvar exam)	48 (37.2)
Incorrect classification	28 (21.7)
Incorrect classification or genitalia reported as normal in the same file	19 (14.7)
Total	129 (100.0)

Abbreviation: FGM, female genital mutilation.

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