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Original research article

The issue of genital mutilation in the care of immigrants from the perspective of midwives

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ABSTRACT

At present, the number of migrants is globally increasing. Although the foreigners in the Czech Republic are pleading asylum less than in other countries of the EU (foreigners in the Czech Republic make up less than 5% of the whole population), there were 2,015,467,562 legally registered foreigners at the end of the last year, which was 15,639 more than in 2014. Migration is also associated with the presented issue of female genital mutilation. This article informs of female genital mutilation (FGM). The research was carried out in 2016.

The goal was to find the specifics of the care of women with genital mutilation during pregnancy, delivery and puerperium, from the perspective of midwives.

The research used a qualitative method of in-depth interviews with midwives who had experience with nursing women with genital mutilation during pregnancy, delivery and puerperium. The data were analyzed using the method of open coding and then categorized.

We found that the interviewed midwives had a negative approach to the practices of genital mutilation. The results showed that midwives met obstacles in nursing women with FGM. The complications during pregnancy, delivery and puerperium, which appear in women after the genital mutilation procedure, depend on the extent of the procedure and the later individual periods.

Growing migration suggests the number of women with genital mutilation is increasing. For this reason, it is important that midwives are informed of this issue and that they have knowledge in nursing women with FGM during pregnancy, delivery and puerperium.

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Introduction

In 2015, more than one million refugees and immigrants came to Europe, and the increasing trend of population migration is recorded worldwide. It is only a question of time before the midwives in Czech medical facilities will commonly provide care to women with FGM and different customs and cultural traditions.

The WHO differentiates between 4 major types of genital mutilation depending on the extent of the procedure: type I – clitoridectomy (total or partial removal of the clitoris or, in very rare cases, only the prepuce of the clitoris); type II – excision (total or partial removal of the clitoris and the *labia minora* with or without excision of the *labia majora*); type III – infibulation (narrowing of the vaginal opening, which occurs after removing a part or the whole of the *labia minora* and the following stitching of the *labia majora*; the procedure may be followed by the excision of the *labia majora* and a total or partial clitoridectomy). The result of the infibulation (the so-called pharaonic circumcision) is a few-centimetre opening which channels urine and menstrual blood; type IV includes other forms of genital mutilation, such as all other forms of mutilation procedures on the exterior female genitalia that are carried out for non-medical reasons (e.g. pricking, scraping, incising, cauterizing, piercing, etc.) [1].

Genital mutilation has no health benefits. On the contrary, it threatens women's physical, mental and reproductive health and violates their rights. People in western countries may perceive such practices as very barbaric and incomprehensible. Nevertheless, many countries embed it as a cultural custom. It is thought that there are more than 130 million women and girls who have been victims of such mutilation procedure.

We assume that it is very important to be informed about the issue of genital mutilation as well as to gain professional knowledge, which is crucial in nursing women with FGM during pregnancy, delivery and puerperium. Considering the particularity of the issue, it can be assumed that Czech midwives are not informed about nursing women with FGM very much.

FGM is a global concern [2]. Despite a lack of rational reasons, it is carried out in many countries. Mutilation procedures exist despite legislative regulations, educational activities and the effort of many world organizations to fight against this ritual.

Definition of genital mutilation

The definition by the World Health Organization (WHO) can be used to exactly describe genital mutilation: "*Female genital mutilation (FGM) comprises all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons*" [3].

The procedure is frequently associated with faith and religion [4]. It is the reflection of cultures and social customs that can be found in Christian, Islamic, Jewish and animistic societies [5]. FGM is a devastating and extremely painful procedure, which has further consequences on a woman's life and health [5].

History of genital mutilation

In human history, genital mutilation has been carried out for centuries [6]. Vachala [7] presents mutilation in ancient Egypt. The only proof of FGM is from 163 BC, in the Ptolemaic period. In the 2nd century AD, one of the most significant doctors of the Roman period, Soranus of Ephesus, described the removal of the exterior part of the clitoris in his book Gynaikeia. An important assertion on mutilation procedures goes back to the 4th century AD and comes from Saint Ambrose. In the 6th century AD, a detailed written record of the practices of genital mutilation was brought by the Byzantine court doctor Aetius of Amida in Biblia iatrika [7].

In every culture, the authorization to carry out genital mutilation is different: religious, hygienic, aesthetic, or sociological. Changes in the genitalia may be part of the ritual of growing up [8].

Geographical spreading of genital mutilation

Genital mutilation represents an old tradition that is strongly associated with cultural and ethnic cohesion [9]. The practices of genital mutilation can be found in many communities in a great part of Africa, Asia or the Middle East [10].

In Africa, genital mutilation is carried out in certain groups in approximately 28–30 countries. The greatest prevalence in Africa is in Somalia, Egypt, Guinea, Sierra Leone or Djibouti. It is possible to find genital mutilation practices in certain ethnic groups in Asian countries, such as India, Indonesia, Malaysia, Pakistan and Sri Lanka. In the Middle East, this procedure is carried out in Oman, United Arab Emirates, Yemen, Iraq, Palestine and Israel. Genital mutilation procedures in women occur in some communities in South America, primarily in Columbia, Ecuador, Peru but also in the groups of immigrants in many western countries, such as Australia, Canada, Europe, the USA and Great Britain [11].

Health complications and consequences

Genital mutilation procedure has serious consequences on the reproductive and sexual health of girls and women. The complications that may arise immediately after the procedure are severe pain, haemorrhagic shock, haemorrhage, tetanus, wound infection, impaired wound healing, injuries to the surrounding tissues, sepsis or death [11].

In some cases, a woman may perceive mutilation positively (respect for tradition, beauty, purity, pride), which leads to the denial of all physical, mental and sexual complications [9]. To provide quality care to such women, it is necessary to understand the history, the culture, health complications and the methods of surgical reconstruction [12].

If a woman with a genital mutation of type I and II stays pregnant, the pregnancy itself is not a complication [6]. Complications during pregnancy may occur in women with type III – infibulation, there is an increased risk of urinary tract infections, vaginal infections and a partial abortion [13]. The presence of cysts, abscesses or keloids contributes to the discomfort during pregnancy [14].

The organization UNFPA [11] states that women with FGM are at a greater risk of complications during delivery than those who have never undergone the procedure. The most serious obstetric complications are associated with the heaviest mutilation degree – infibulation. During delivery,

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