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NURSING CARE

Intervention of the hospital midwife in the case of a pregnant women who had undergone female genital mutilation. A case study☆

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Abstract Female genital mutilation, condemned by all UN member countries has spread throughout the world as a result of migratory flows and is practiced under the guise of a custom, tradition or culture. In Spain, it is punishable as a personal injury offence under the current penal code. A clinical case study reviewed the main actions of the midwife in this kind of injury in a pregnant woman during labour. The data collected from the physical examination and the midwife's assessment according to the Virginia Henderson model are presented and a complete care plan developed. From the case it can be concluded that in the hospital area, midwives can and should reinforce and complete the work with these women and their families, of informing, educating and reinforcing the decision not to mutilate. This work should have been started in, the health centre.

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Intervención de la matrona hospitalaria en una gestante con mutilación genital femenina. A propósito de un caso

Resumen La mutilación genital femenina, condenada por todos los países miembros de la Organización de las Naciones Unidas, se ha extendido alrededor del mundo como consecuencia de los flujos migratorios, y se realiza al amparo de una costumbre, tradición o cultura. En España está penada como delito de lesiones según el Código Penal vigente. Mediante un caso clínico se revisan las principales actuaciones de la matrona ante dicha lesión en una gestante en el trabajo de parto. Se exponen los datos recogidos en la exploración física y valoración según el modelo de Virginia Henderson, y se desarrolla un plan de cuidados completo. Del caso se puede concluir que, en el ámbito hospitalario, las matronas pueden y deben reforzar y completar el trabajo con estas mujeres y sus familias de informar, educar y fortalecer la decisión de no mutilar, el cual debería haber sido iniciado en el centro de salud.

Introduction

Female genital mutilation (FGM) comprises all partial or total ablation procedures to the external genitalia and other injuries caused to them for no therapeutic purpose.[1,2]

According to the 2013 UNICEF[3] report, more than 125 million live girls and women have been subjected to this practice, and 30 million girls might be in a situation of risk in the next decade.

It is currently difficult to obtain information on the states where FGM is carried out; this can merely be estimated and does not reflect the real scope of the problem. Data presented by international organisations such as the World Health Organisation (WHO) or UNICEF show that FGM is commonly practiced in more than 40 countries, principally Africa (the procedure is performed in more than 28 countries) and the Middle East (Arab Emirates, Oman, Yemen and Egypt).[3]

As a consequence of migratory flows, the practice of ablation has extended to areas where it was not traditionally undertaken, such as certain areas of Asia (members of the Muslim sect *Dawoodi Bohra* in India), in the Pacific (Indonesia, Malaysia, Sri Lanka and neighbouring states), North America (the United States and Canada), Latin America (certain communities in Central and South America), Australia and Europe (countries such as Sweden, Denmark, France, Italy, the Netherlands and the United Kingdom). Thus, immigrants have preserved the practice of ablation in their host industrialised countries, where it is either performed their new area of residence or girls are sent back to their country of origin to be subjected to the procedure.[3] In 2012, 10,600 girls had come to Spain from countries where FGM is still practiced and therefore at risk.[2]

The arguments to continue the practice are put forward as social, religious and cultural reasons. The connection with tradition depends more on ethnic identity than country of origin. Different justifications are argued depending on ethnicity: *custom and tradition* that underpin the role of women within the community, *control of sexuality* and *promotion of chastity*, since the practice is believed to reduce sexual desire, ensure fidelity and increase male sexual enjoyment. The practice is argued to have *reproductive functions*; it is believed that women who have not been mutilated cannot conceive, and that FGM improves and facilitates labour. There is also the belief that the life of the newborn child can be put at risk if it were to touch the clitoris during labour. *Reasons of hygiene* are argued, a woman who has not been cut is considered unclean and the community forbids her to touch water and food. *Aesthetic reasons* are argued, the genitalia are considered lacking in beauty. FGM is often justified on religious grounds, under the false belief that it is an Islamic precept derived from the Koran.[2] In fact, in Islamic countries such as Saudi Arabia or Iraq FGM is not practiced, and it is routinely practiced in Coptic Christian groups from Egypt, Ethiopia, Nigeria and Sudan.

According to the WHO[1,2] there are 4 types of FGM: type I or clitoridectomy, part or all of the clitoris, on rare occasions only the clitoral prepuce is removed; type II or excision, partial or total resection of the clitoris and the labia minora, with or without excision of the labia majora; type III or infibulation, narrowing of the vaginal opening and relocating the labia minora or labia major, with or without resection of the clitoris; and type IV, which comprises a wide range of other practices such as pricking, incising, scraping or cauterising the genital area. Infibulation constitutes approximately 15% of female genital mutilation practiced in Africa, clitoridectomy and excisions being the most usual practice (85%). These percentages vary depending on the region or state. Infibulation, in particular, is performed in Sudan, Somalia and Djibouti, where more than 82% of women undergo this intervention.[2]

The type of genital mutilation, form of intervention and age at which it is performed vary according to external factors such as the woman's ethic group, country of residence, type of area (rural or urban) and socioeconomic origin.[4] According to the WHO, the majority of ablations are performed from the ages of 0–15 years,[4] although generally it is performed on girls between the ages of 4 and 8.

The person in charge is usually a woman from the community; she might be an elder and have inherited the role from her own mother, a traditional healer or a midwife. She is a highly respected individual within her social group.