

**CARING FOR WOMEN AFFECTED BY  
FEMALE GENITAL CUTTING:  
STRIVING FOR HEALTH EQUITY**

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Thank you, Mary Malotky, MS, APRN, CNM,  
for her contribution to this presentation

# Caring for women with FGC challenges our current worldview and our systems

**Pelvic**    Mark All Normal    Clear    Mark Unanswered Normal

Vulva	Normal	Condyloma	Lesions	Spines	Average	Prominent	Blunt
Vagina	Normal	Discharge	Inflammation	Sacrum	Concave	Straight	Anterior
Cervix	Normal	Lesions	Inflammation	Subpubic Arch	Normal	Wide	Narrow
Uterus (wks)				Diag. Conjugate	Not Done	Reached	
Adnexa	Normal	Mass		(cm)			
Rectum	Normal	Abnormal		Pelvic Type	Gynecoid	Android	Platypelloid

Restore    Close F9    Previous

[Pregnancy Checklist](#)

How would you answer this!  
Who gets to define normal?



# Outline

- Terminology
- FGC basics – where, why, how
- Complications of FGC
- Working with affected women to achieve optimal outcomes
- Clinical and cultural guidelines

# Terminology

“FGM encompasses all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs whether for cultural or any other non-therapeutic reasons.”

World Health Organization, 1997

# Terminology

- Terms
  - Female circumcision
  - Female genital mutilation
  - Female genital cutting
  - Client preference
- Philosophical and political dynamics

# FGC Basics

# Background

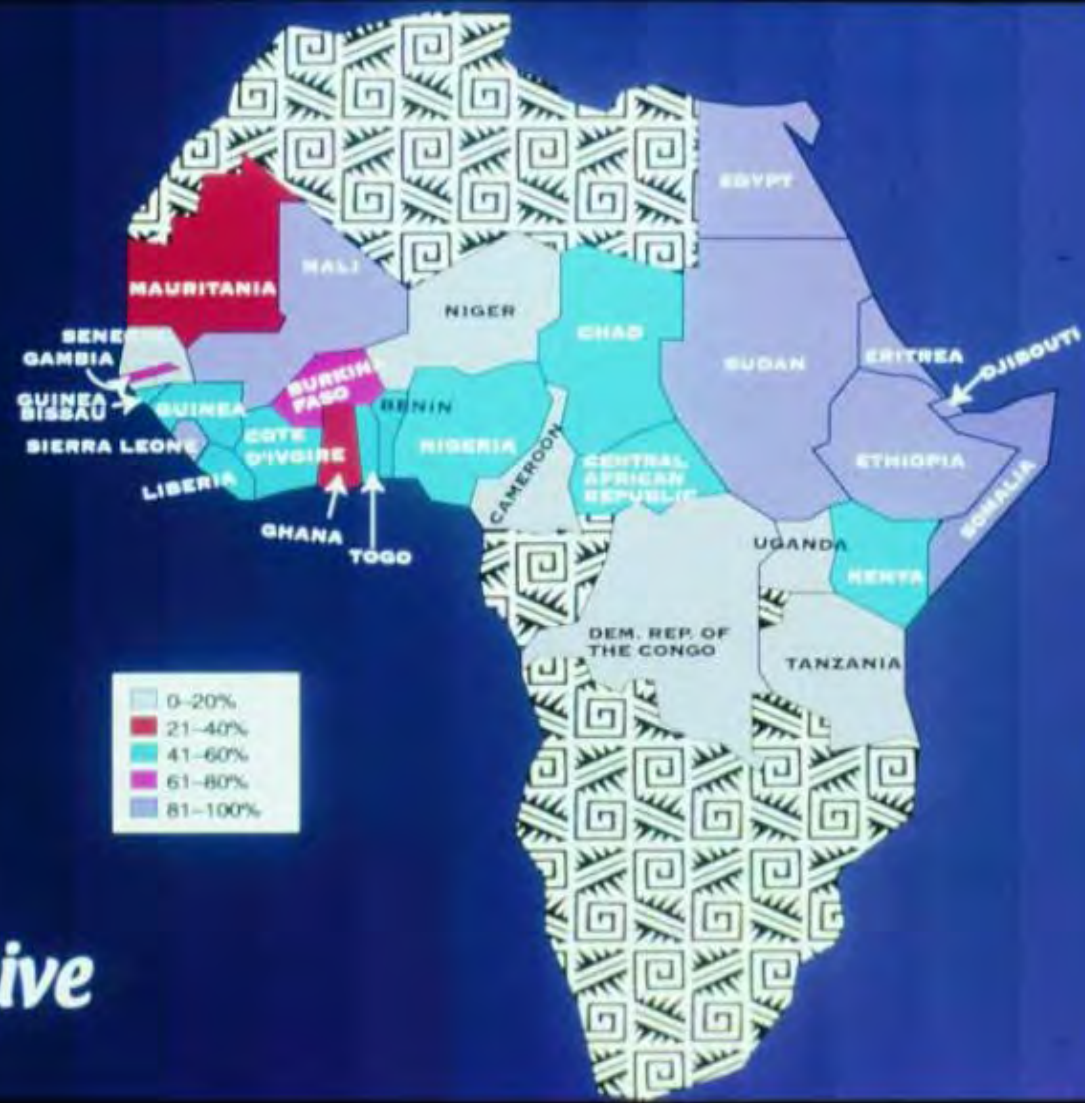
- Practice origins
- History in Africa
- History in the West
- Increased international attention

# Where?

- 28 African countries
- Some Middle Eastern and Southeast Asian communities
- Prevalence rates range 5-97%
- Rates often vary within a country
- Highest prevalence found in Djibouti, Egypt, Eritrea, Ethiopia, Mali, Somalia, Sudan



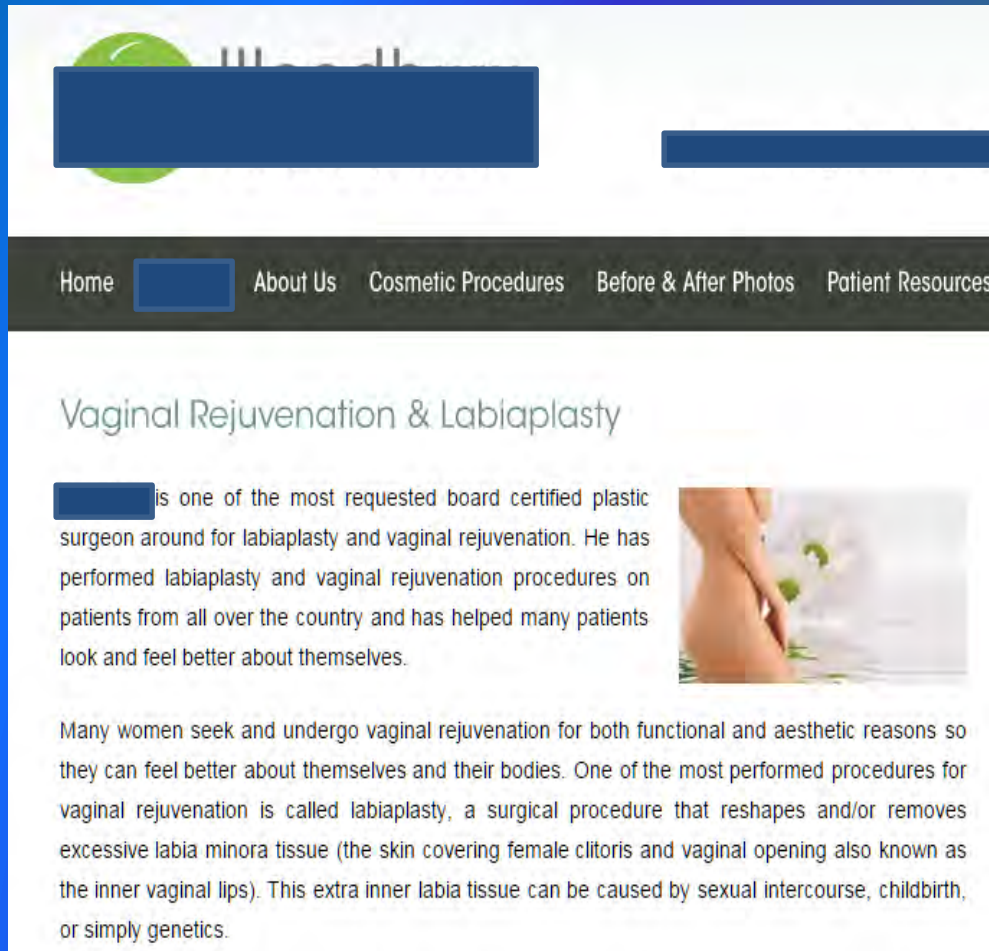
# An African Perspective



# Areas of affected women in the US



# Remember the WHO definition?




The screenshot shows a website for a plastic surgeon. The header includes a logo with a green circle and a silhouette of a city skyline. The navigation menu contains: Home, About Us, Cosmetic Procedures, Before & After Photos, and Patient Resources. The main content area is titled "Vaginal Rejuvenation & Labiaplasty". The text describes a board-certified plastic surgeon who performs these procedures. A small image shows a woman's lower body. The text continues to explain that many women seek these procedures for functional and aesthetic reasons, and that labiaplasty is a surgical procedure to reshape or remove excessive labia minora tissue.

Home About Us Cosmetic Procedures Before & After Photos Patient Resources

## Vaginal Rejuvenation & Labiaplasty

is one of the most requested board certified plastic surgeon around for labiaplasty and vaginal rejuvenation. He has performed labiaplasty and vaginal rejuvenation procedures on patients from all over the country and has helped many patients look and feel better about themselves.



Many women seek and undergo vaginal rejuvenation for both functional and aesthetic reasons so they can feel better about themselves and their bodies. One of the most performed procedures for vaginal rejuvenation is called labiaplasty, a surgical procedure that reshapes and/or removes excessive labia minora tissue (the skin covering female clitoris and vaginal opening also known as the inner vaginal lips). This extra inner labia tissue can be caused by sexual intercourse, childbirth, or simply genetics.



The sign is for a cosmetic clinic and lists various services. The text is as follows:

### Complete Your Transformation With These Services

- HCG Weight Loss
- Vanquish Body Contouring
- Laser Skin Aesthetics
- Botox/ Juvederm
- Vaginal Rejuvenation/ Labiaplasty

*Look Your Best. Feel Your Best.*

**Schedule Today**

In the background, a store named "JOHNSTON & MURPHY" is visible.

# Who? How?

- Practice crosses multiple boundaries
- Age at FGC varies; average 4-10 years old
- Practitioners vary from traditional excisors to trained surgeons
- Tools of the trade – consistent with practitioner
- Use of anesthesia and/or antibiotics

# Why?

Myriad of motivations

- Religious
- Cultural
- Aesthetic
- “Necessity” – our version or theirs?



# FGC Types

- Type I  
Excision of the prepuce with or without excision of part or all of the clitoris
- Type II  
Type I plus partial or total excision of labia minora
- Type III  
Excision of part or all of external genitalia and stitching or narrowing of vaginal opening (infibulation) (15%)
- Type IV  
Unclassified, includes a variety of less common procedures

World Health Organization, 1998

# Type II – Area Cut



# Type III – Area cut and infibulated





# Type III – Area after infibulation



# Contributing factors to health inequity

- Increased immigration of affected women
- Lack of information in healthcare curricula
- Poor quality of available literature
- Lack of national or local strategies
- Reinventing the wheel

# Complications

# Complications

Consistently reported FGC sequelae

- Dysmenorrhea
- Chronic vaginitis
- Urinary problems
- Scars & cysts
- Dyspareunia, apareunia, infertility
- Intrapartum problems

Obermeyer, 1999

# Primary care and prenatal concerns

- Vulvar cysts
- Sebaceous and inclusion cysts
- Obstructive keloids
- Neuroma
- Incontinence
- Vaginal obstruction
- Fertility concerns

# Primary care and perinatal issues

- Vulvar cysts
- Sebaceous and inclusion cysts
- Obstructive keloids
- Neuroma
- Incontinence
- Vaginal obstruction
- Fertility concerns

Toubia, 1999

# **Working with affected women:**

How a cultural approach  
can guide clinical actions  
for the best outcomes

# Cultural Competency Review

- **Humility**

Opportunity to learn about their culture and view of health as well as to teach about ours

- **Honesty and Respect**

Consider immigrants life experiences which are so much different (and more difficult) than our own.

- **Humor**

A great tool for building bridges, and eventually, trust

- **Flexibility**

Time, tasks, priorities



# Misconceptions and Assumptions

## (Our patients)

### During Pregnancy

- Activity
- Diet and weight gain
- Blood draws
- Prenatal care

### During Labor and Birth

- Pain Medications
- Fetal/uterine Monitoring
- Vaginal birth vs. Cesarean
- Provider ignorance/incompetence

## (The health care provider)

### During Pregnancy

- Knowledge of anatomy and physiology
- That we are trustworthy
- We know more than they do

### During Labor and Birth

- Medical interventions represent “advanced” L & D
- We can spare them from a difficult experience
- They are arrogant or belligerent

# The Big Hurdle

## Muslim (Somali) Culture

Value Acquiescence to Allah as supreme authority

## American Culture

Value the supremacy of the individual

*The most difficult healthcare decisions and conflicts swirl around these philosophical differences*

# When to address the topic of FGC

## Deinfibulation and repair counseling:

- Annual visit
- Serendipitous encounters
- Problem visits
- As needed unless the woman communicates otherwise

## Prenatal Education:

- Opportunity to explore feelings related to first experience of FGC and how those feelings may impact her labor.
- Re: deinfibulation. Give specific details on timing and procedure. Her questions are, “How is my baby going to get out?” and “When are you going to do it?”
- Re: repair. Determine her preference and provider preference. Education. (Is a referral necessary?)

# Tips for opening the dialog

- Name it!
- Acknowledge prevalence of FGC and that you know she may not have talked about it before
- Reassure woman of your competency and comfort in dealing with FGC
- Be open to discussion at any time
- Ask open-ended questions



# History and assessment

- Multiple visits and building trust will yield best histories
- Identify cutting type if possible
- Inquire about specific problems
  - Urinary complaints
  - Painful sex

# History and assessment

Sometimes it's best to leave it alone:

- Client's FGC status may not be a concern for her
- Client may be experiencing physical and/or emotional trauma related to displacement and new environment
- Do not neglect other pressing concerns (Maslow's hierarchy of needs)

# History and assessment

- Identify potential need for support if FGC experience was negative for her
- Desire/need for support may vary depending on population:
  - US-raised, school age or adult
  - Nullipara vs. Multipara
  - Recent immigrant
- Local support: Everyday Miracles

# History and assessment

- Assess her knowledge about her original anatomy and her status now (visual aids/pictures)
- Sensitivity to the nature of *her* FGC experience



# Practice implications

- Discuss how her status may impact ob/gyn health (pictures, teaching aids)
- Caution and explanation prior to invasive procedures
- Don't ask patient to completely disrobe
- Warn patient before taking several tubes of blood

# Practice implications

Speculum and bimanual exam challenges and solutions:

- Speculum choice
- Pap smear samples
- Infection work-up
- When to defer or abandon exam effort

# Practice implications

- Diagnosis of UTIs
  - No such thing as a “clean catch”
- Sexuality concerns
  - apareunia
  - dyspareunia
  - lack of sexual enjoyment
  - infertility

**2001 Canadian study**  
**432 Somali women interviewed**  
**96% Type III FGC**

- 78% painful intercourse
- 30% do not enjoy sex
- 37% indifferent
- 20% quite enjoy sex
- 3% enjoy sex very much

Sex is associated with...

- 69% pain
- 30% fear
- 27% endurance

Chalmers, et al.

# Deinfibulation

Toubia & Nour recommendations:

- Pre-coitus
- Second/Third trimester
  - Do you need a cathed urine sample?
  - Is client at high risk for difficult emotional birth experience secondary to infibulation experience?
  - Other complications requiring intervention?
- Second stage

# Practice implications

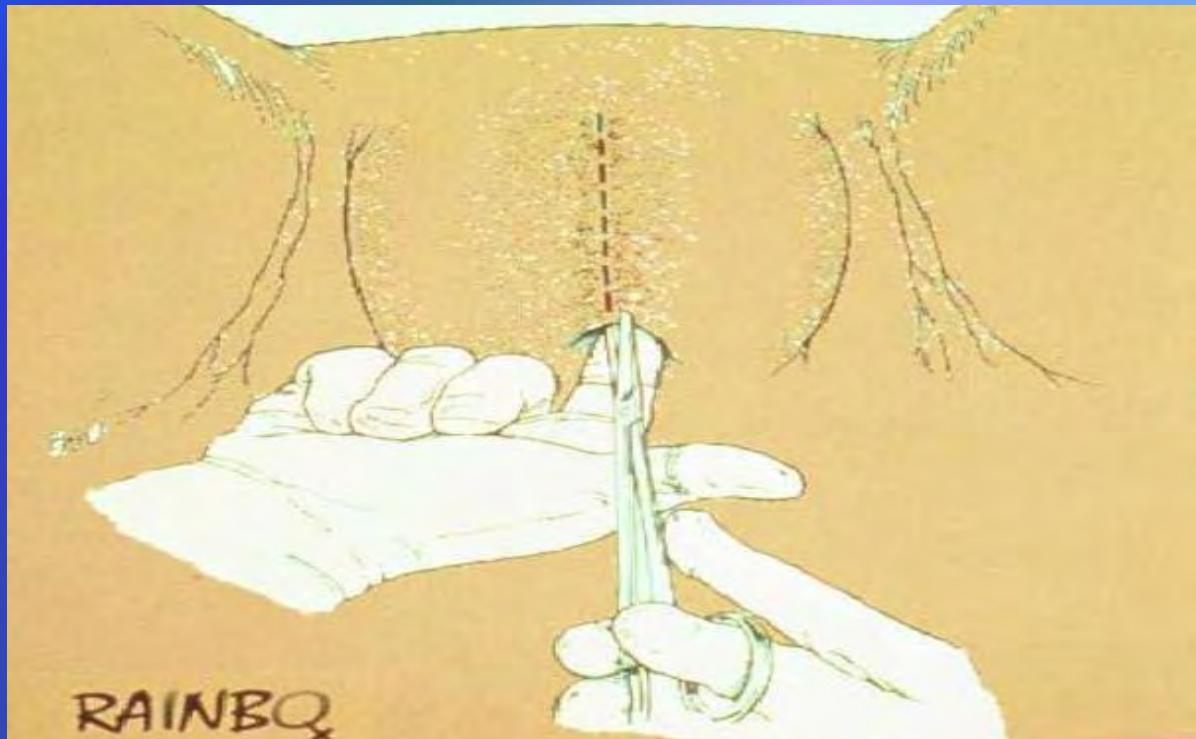
During the birth process:

- Labor and birth as a cathartic
- Role of pain medication- Medical movement toward epidurals: pros/cons
- Provider's facilitative, supportive role
- Support for provider (unfamiliar with deinfibulation and/or repair)

# Deinfibulation

Local or spinal anesthesia (Toubia & Nour)

Technique:



# Repairs

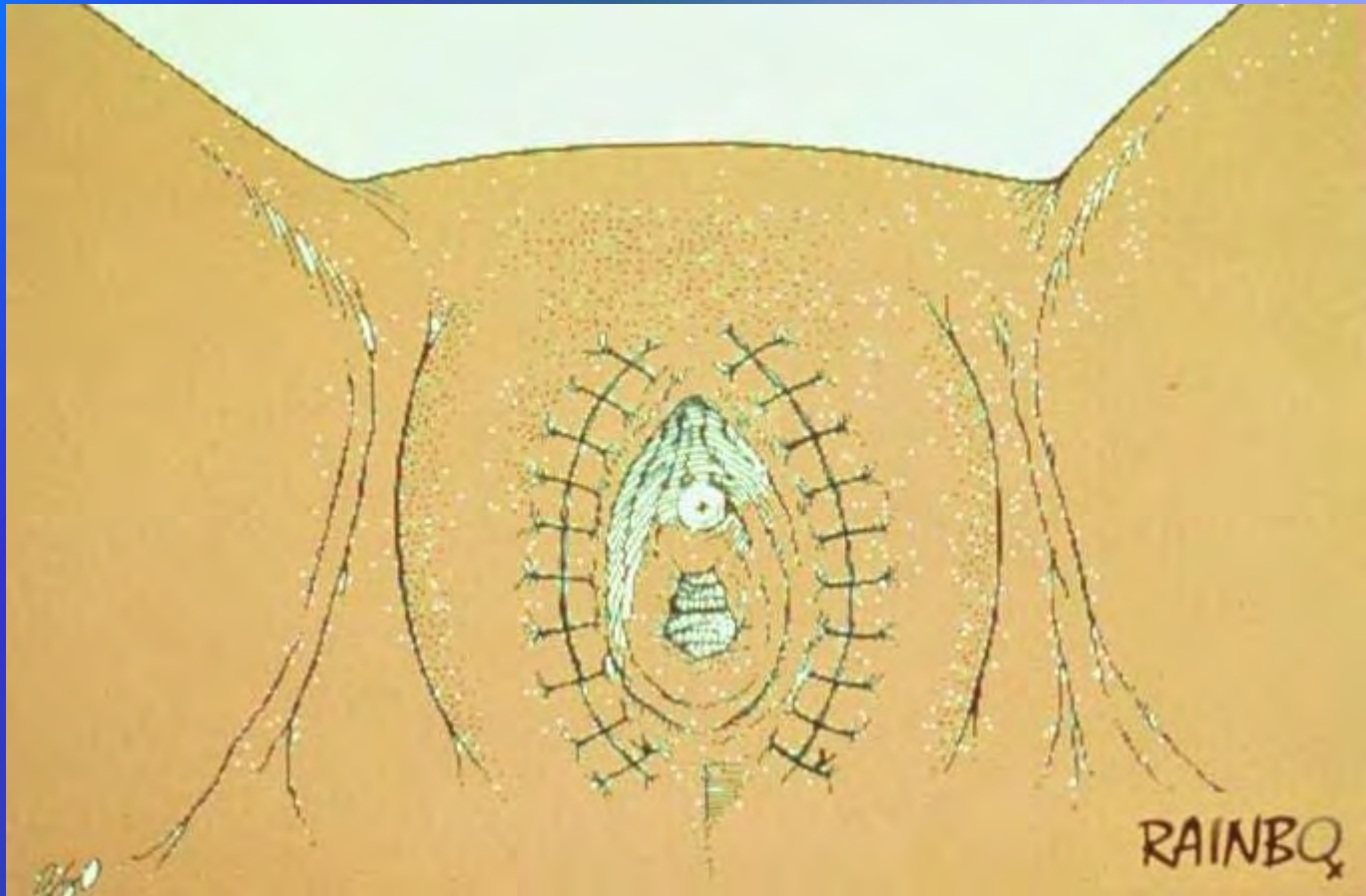
## Handling requests:

- Determine plan prenatally & document clearly
- Avoid surprise or awkward moments
- Clarify provider intentions
- Family member input – consider cultural differences
- What to do if you've never met her before  
ASK HER!
- Leaving woman open/unrepaired is *not* a passive approach  
Counsel patient on how things may feel different!



# Repairs

## Technique



(Toubia)

# Practice Implications

- Being aware of your values/biases/boundaries:
- HCMC press spokesperson: "This isn't about respecting someone's culture – it's about being complicit in mutilating women."
- At the same time, the HCMC Nurse Midwife and OB/GYN services were repairing per woman's request



# Well Child/Postpartum

- Counseling about children's FGC status
  - Influence of your care for the mother
  - Word gets out to community
  - Responsibility to educate parents about laws
  - Provide written information (RAINBO pamphlets)
  - Can be incorporated in to PNC counseling
- Child spacing vs. Birth control
  - Neighborhood Improvement Project

# Provider resources

- Literature – quality and perspective
- References
  - ACOG slide presentation ([www.acog.org](http://www.acog.org))
  - RAINBO ([www.rainbo.org](http://www.rainbo.org))
    - Caring for Women with Circumcision: A Technical Manual for Health Care Providers (Toubia, N)
    - slide presentation ([www.rainbo.org](http://www.rainbo.org))
  - WHO ([www.who.org](http://www.who.org))
    - Policy information
    - Publications with care recommendations

# Provider resources

- Specialty clinics (MN, Boston, San Diego, UK)
- Department of Health and Human Services
  - Office for Women's Health (regional)
  - FGC Working Group (federal)
- Future possibilities
  - On-line information exchange, forum to ask experienced colleagues for advice
  - Website for providers and clients to share information

# References

Chalmers, B., & Hashi, K.O. (2001). 432 Somali women's birth experiences in Canada after earlier female genital mutilation. *Birth*, 27(4), 227-234.

Epstein, D., Graham, P., & Rimsza, M. (2001). Medical complication of female genital mutilation. *Journal of American College Health*, 49(6), 275-280.

Eyega, Z., & Conneely, E. (1997). Facts and fiction regarding female circumcision/female genital mutilation: A pilot study in New York City. *Journal of the American Medical Women's Association*, 52(4), 174-178,187.

Fernandez-Aguilar, S., & Noel, C. (2003). Neuroma of the clitoris after female genital cutting. *Obstetrics & Gynecology*, 101(5), 1053-54. Supplement, Part 2.

Gibeau, A.M. (1998) Female genital mutilation: When a cultural practice generates clinical and ethical dilemmas. *Journal of Obstetric, Gynecological, & Neonatal Nursing*, 27(1), 85-91.

Holden, Meghan. (2015). For victims of female genital cutting, pregnancy brings tough questions. City Pages, 14(October). (<http://www.citypages.com/news/for-victims-of-female-genital-cutting-pregnancy-brings-tough-questions-7749410>)

# References

- Horowitz, C., & Jackson, C. (1997). Female “circumcision”: African women confront American medicine. *Journal of General Internal Medicine*, 12(August), 491-498.
- Nour, N.M. (2000). Female circumcision and genital mutilation: A practical and sensitive approach. *Contemporary OB/GYN*, 45(3), 50-55.
- Obermeyer, C. (1999). Female genital surgeries: The known, the unknown, and the unknowable. *Medical Anthropology Quarterly*, 13(1), 79-106.
- Retzlaff, C. (1999). Female genital mutilation: Not just “over there”. *Journal of the Interanational Association of Physicians in AIDS Care*, 5(5), 28-37.
- Rouzi, A.A., Sindo, O., Radhan, B.F., & Ba’aqeel, H. (2001). Epidermal clitoral cyst after type 1 female genital mutilation. *American Journal of Obstetrics and Gynecology*, 185(3), 569-571.
- Toubia, N. (1999). *Caring for women with circumcision: A technical manual for health care providers*. New York: RAINBO.

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