*President Message - (continued from page 4.)*

The first networking session was held in Halifax, NS for one and one half days beginning at noon on Friday, June 18th immediately following ORNAC's National Conference and ending on Saturday afternoon. A prominent speaker, Dr. Tim Porter-O'Grady, EdD, PhD, who is committed to the concept or reality of Shared Governance or Shared Leadership, kept the delegates spellbound with his humorous and highly-motivational address. Time was scheduled for the delegates to discuss common issues and concerns and develop possible resolutions. As this was a trial event, members were asked for input on areas for improvement in future. Although much feedback was positive, recommendations have been reviewed with revisions included in plans for the future.

## CORL Network meets May 28-30, 2000

The next session begins on Sunday, May 28, 2000 with meetings scheduled for May, 29th and 30th at the Delta Meadowvale Resort and Conference Centre in Toronto. This will follow the spring ORNAC Board Meeting as many leaders will be attending that event.

## CORL Network Contact:

The contact person, Pat Pocock, may be reached at: Phone: (w) (519) 646-6100 ext. 65707, Fax: (w) (519) 646-6006 or e-mail: patpo@stjosephs.london.on.ca.

The meeting will further evolve in 2001 as seven hours of program content pertaining to management and leadership will be included in the 17th ORNAC National Conference to be held in Banff in April, 2001. ORNAC recognizes the importance of expanding its horizons to include information pertinent to other members not directly involved with patient care and encourages the efforts of others to ensure the future of O.R nursing. This is a giant step forward and a true act of collaboration.

Watch for further information that will be available at a later date. Discuss these worthwhile meetings with colleagues. Plan to attend the sessions and actively participate by sharing your experiences and comments/concerns. Aid in forming a viable and productive Canadian resource network to provide necessary information and help through the use of telephone, Fax, and other electronic means. Help strengthen and enhance the role of O.R. Leader and manager.

You can make a difference !







# Transcultural Nursing and Female Circumcision

**By Jennifer Heatherly, R.N**

Two years ago while working in a paediatric operating room I met a young Somalian refu gee girl whose family had only recently immigrated to Canada. The family spoke very little English and had brought their six year old daughter to the hospital to have a urological procedure performed to treat her urethral strictures.

As part of my usual preoperative assessment I read the girl's clinic note which outlined the reason for her hospital admission. This young girl had been experiencing frequent urinary tract infections due to having been circumcised. Her circumcision, which had taken place at an early age in Somalia, had caused a narrowing of her meatal opening and was trapping urine in her lower urinary track causing the passage for urine to be partially obstructed. The resultant trapping of urine was causing frequent, painful urinary tract infections. The medical treatment she required to correct this was an examination under general anesthesia to rule out damage to her upper urinary track as well as dilation of her urethra to create a sufficient passage for urine.

## Cultural Shock

This was my first experience with the issue of female circumcision. This was my first exposure to the cultural practice, and with other members of the health care team in the operating room I shook my head and thought how tragic and unnecessary. All this pain could have been avoided if she had not been "mutilated" in the first place.

As a second generation Canadian with English heritage, I was experiencing a culture shock which left me confused and angered. I perceived this as a crime committed not only to this young girl, but to all women. This was a cultural practice unlike my own, and one which I needed to learn more about if I was going to be able to come to terms with this issue in order to better address the needs of my clients and their families.

In this article I will identify and examine the cultural practice of female circumcision and the prevalent issues which affect health care providers. By integrating current transcultural nursing I will discuss how this is an ethical issue in which Western health care and ethnocentric values meet diverse cultural practice's head on in the arena of debate. I will demonstrate how this issue is enmeshed at the crossroads of cultural values and becomes a topic which holds issue's for all women trying to live cohesively in a multicultural society. The current policies and strategies by which universal health care systems can be responsive to these culturally and racially diverse clients will be identified. And finally I will examine my own resolution to the cultural experience of female circumcision as a result of some transformed ideals.

Female genital circumcision (FC), female genital mutilation (FGM) or female genital modification are the terminology interchangeably used in the searing debates over this women's health issue. The World Health Organization's defines it as, "Female genital mutilation which constitutes all procedures that involve 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 (WHO, 1996). There are varying degrees of circumcision which are dependent upon the country,

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tribe, traditional culture or religious value. There is the Sunna (meaning to conform to the tradition of Mohammed) which is practiced in some Muslim religious circles. It involves the removal of the clitoral hood or prepuce and/or tip of the clitoris. Second, there is the clitoridectomy which may or may not include the excision of the labia minora. The third most extreme form is called infibulation. It involves excision of part of all of the clitoris, labia minora and the medial aspect of the labia majora.

Infibulation constitutes 15% of all procedures and causes the most damage to girl's and women's health in the immediate and long term. The age at which females are circumcised varies. Intercultural variations influence whether it is carried out during infancy, childhood, at the time of marriage or during a first pregnancy.

During infibulation the excised edges are drawn together over the vagina and held together with sutures, thorns, or paste-like material so that the opposite sides heal together and form a wall that closes the upper vestibule. The small opening is preserved by the insertion of a foreign body to allow for the passage of urine and menstrual blood. The procedure takes 15 to 20 minutes depending on the struggle of the girl who is made to strip naked, lay flat on a bed, the floor or to sit on a low stool. Assistants and/or family members hold the girl down to prevent her struggling. Generally, antiseptics and anaesthesia are not used. The procedure is usually carried out by an elderly women of the village who has been specially designated the task. In Somalia the excisors are from the Midgan clan and these women derive high status and income for their work (Wright, 1996). Traditional matrons, midwives and a few physicians also hold the responsibility.

Females who have been circumcised are likely to suffer from immediate and long term health consequences. The immediate complications may include hemorrhage; shock due to not only bleeding but also to the severe pain; infection due to the aseptic conditions and urinary retention from the inflammation or injury to the urethra. Some of the long term complications may include keloid formation; urinary tract infections; rectovaginal fistula; dysmenorrhea; pelvic inflammatory disease; incontinence; dyspareunia and sexual dysfunction. Psychosexual complications include lack of libido; less frequent coitus; absence of orgasm; depression and psychosis.

The reasons given to justify the practice of female circumcision are numerous and reflect the historical and ideological evolution of the societies where it is practiced. Tradition and custom, religious demands, purification, family honor, hygiene and aesthetics are among some of the reasons for the practice. Protection of virginity, prevention of promiscuity, increasing sexual pleasure for the husband, enhanced fertility, increasing matrimonial opportunities and a sense of belonging to a group are all evolutional principals spawned from generations of sociological dictates which females were to comply with. Today, these dictates ensure the female's acceptance within a community, and are considered an essential aspect of a woman's identity.

## WHO estimates over 100 million girls and women have undergone FGM

The World Health Organization,(WHO) estimates that around the world there are between 100 to 132 million girls and women who have undergone FGM. Each year a further two million girls are estimated to be at risk of the practice. Most of them live in 28 African countries, a few in the Middle East and Asian countries, and increasingly in Europe, Canada, Australia, New Zealand and the United States ( WHO, 1996).

Over the past decade 70, 000 Somalians have become residents in Canada, 50, 000 of whom live in Toronto, Ontario. The World Health Organizations' 1996 statistics on Prevalence and Distribution estimates that 4, 580 000 females in Somalia are circumcised or 98% of the female population, of which, approximately 80% of the operations are infibulation. Canada is not a melting pot of cultures but is a mosaic. The people who come to live here do so because they are not forced to abandon their cultural heritage and accept a homogeneous cultural identity. Canada encourages its people to preserve their cultural heritage. Therefore, in Ontario, which has an ever increasing multicultural population, the practice of female circumcision raises many issues as more females are entering Western health care facilities.

Leininger (1995), a pioneer of transcultural nursing theory defines culture as learned and shared values, beliefs, and rules of behavior or standards of living that are valued and passed on intergenerationally. One assumption of her theory is that caring is the essence of nursing and a distinct, dominant, central, and unifying focus. It also assumes that nursing is a transcultural humanistic and scientific care discipline and profession with the central purpose to serve human beings worldwide. Leininger's Sunrise Model is a conceptual

discovery guide to help nurses expand their knowledge base and discover multiple factors that can influence decisions and practices transculturally. In applying the Sunrise Model the nurse begins to discover the cultural and social structure dimensions which influence culture care worldwide. One factor which Leininger suggests in the model for nurses to discover are the influences of Cultural Values and Lifeways which affect individuals, groups, families or communities (Leininger, 1995).

## Rationale for Female Genital Mutilation in Third World Counties

In discovering the Cultural Value and Lifeway factors of circumcision for those who practice it I find many ethical issues in which Western health care and ethnocentric values conflict. In third world countries to get married and have children is a survival strategy in a society that is plagued by poverty, disease and illiteracy. Mothers believe that by not following the local traditions and customs that their daughters will loose their cultural identity, become social outcasts and develop poor self esteem. Proof of virginity is an important part of the patrimonial system of marriage in some cultures. It is a way for the father of the bride to guarantee the daughters virginity. Uncircumcised and unmarried these women are destined to a future of social exclusion and poverty. In contrast to the North American gender roles and demands, women must be circumcised, docile, fertile, marriageable, hardworking, asexual and obedient. However, in Western society, women and young girls succumb to traditional gender roles and demands as well. Females starve themselves and undergo painful and potentially dangerous medical procedures in order to alter their outward appearance. Liposuction, breast augmentation and facelifts have become a norm for females in this country who strive to alter themselves to conform to what Western society considers beauty and femininity.

In Canada, even if a women competently and voluntarily requests the circumcision for herself and fully understands the nature and implications of what she is asking then it is not unlike any other procedure which requires medical skill or expertise. Essentially it is a request for cosmetic surgery, albeit an extreme version. However, Western physicians and medical ethics agree that it is inappropriate to perform a nonmedical procedure which is harmful and demeaning only because they do not want to offend a misplaced cultural sensitivity by not doing so. The request for female circumcision is usually made by a women on behalf of a child which makes the women acting as proxy decision maker. In Western society the laws which cover legal consent to treatment deny person ( Kluge, 1995). Yet in the United States 60% of male infants are circumcised and rarely for medical reasons. Personal preferences or religious values of the parents usually underlie the request. This is what I feel is an example of what Leininger ( 1995) terms a cultural bias. "Cultural bias is a firm position or stance that one's own values and beliefs must govern the situation or decision" (p.66). With due alteration of detail, the same ethical reasoning for male circumcision does not apply in Western society since both male and female circumcision involve nonconsensual mutilation of a minor for nonmedical reasons.

In addition to the complex Cultural Values and Lifeway factors, when applying the Sunrise Model to the cultural practice of female circumcision, are the Political and Legal factors. In Canada by charter and law it is illegal to discriminate on the basis of culture, heritage or background. This cultural attitude is the fundamental principle of respect for people and every person is someone of incommensurable value, and the beliefs of that person are worthy of respect ( Kluge, 1993). However, in Western society, the cultural practice of female circumcision is outlawed. Canada's 1993 Bill C-126 to amend the Criminal Code and Young Offenders Act states clearly that the offense applies to anyone engaging in the prohibited conduct in Canada. Additionally, its protection extends to all children orginally residents in Canada, whether citizens or landed immigrants. The College of Physicians and Surgeons of Ontario has declared that any doctor performing female genital mutilation could be found guilty of professional misconduct (NOCIRC, 1998).

## The Views of Western Society

Female circumcision has sparked a passionate debate in the West with feminist circles demanding its prohibition. In stark contrast to the cultures who practice it, Western society views it as a violation of the dignity and integrity of women. Their anti-mutilation crusade is driven by such precedents as the abolishment of widow burning and foot binding in India and China. Advocates for an end to the practice should not ignore the victims especially when those victims are fellow women. Their cultural and social structure dimensions show that women have a socio-economic dependence on men which colours their attitude toward circumcision. Infibulation in particular is considered beneficial in increasing a girl's marriageability. Perhaps for myself who lives in a society where females make up a significant portion of the work force it is easy to say that these culturally diverse women exact too high a price for their part in society, however, ending circumcision is not a top priority for millions where access to the basics of human life, clean water, food, sanitation, education and health care do not exist. The issue's of female circumcision are not just for those who practice it but universally it is a representation of the male oppression which affects the culture care of women worldwide. I truly believe that when all women gain the social equality, economic opportunities and equity, fair access to health care and education, women alone will end the practice of female circumcision.

## What Can Nurses Do ?

Currently there are a variety of projects aimed at ending genital cutting. In several African countries programs have aimed at finding other ways for midwives and traditional healers to make a living. Many African governments have launched public information campaigns in which national committees have held awareness meetings and distributed teaching material (Abusharaf, 1998). Increasing numbers of health and human rights organizations are devoting attention to it. Nurses in Toronto can refer anyone to seek help or advise from the Women's Health in Women's Hands Center or The Canadian Centre for Victims of Torture. For nurses who wish to support the elimination of female circumcision I would suggest that they encourage politicians, other professionals, religious and community leaders and the media to cooperate in influencing attitudes supporting its elimination. Nurses can collect and distribute information throughout universities and women's groups which will educate women about the medical consequences of this procedure.

## Caring for circumcised patients

When caring for a patient who has previously been circumcised it is essential to remain culturally sensitive and nonjudgemental. In doing so nurses will be able to establish a trusting relationship, gain confidence and maintain a good rapport. The client may view circumcision as a source of pride and acceptance by the community and be unaware of the physical health consequences.

## Educate The Family

Health care providers need to educate the family about the medical consequences especially if she has daughters who may be at risk of having the procedure done. This could be achieved through engaging in a sensitive conversation and allowing the client time to express her own feelings about circumcision and what its cultural value means for her.

Take the time to explain the health risks and potential complications through the use of a hospital interpreter and use simple easy to understand words if language is a barrier.

I would suggest that nurses use the term modification rather than mutilation while working with those involved. Use of the term mutilation can be counter productive to the establishment of effective caring relationships. Without the development of such relationships it may not be possible to meaningfully address the difficult and sensitive issues which a female effected by this practice may need assistance with. Blatant hostility and insensitivity from health professionals may only provoke the parents to seek someone within the community or outside the country to perpetuate the practice. It is not unlikely that nurses will meet resistance from a client to discuss this subject. They may not only feel threatened by Western health care providers who they feel do not understand their culture but they also may be very modest and reluctant to discuss such private issues with a caregiver. The client is only responding to her deeply felt psychological and social needs of propriety as her culture defines it.

## Under Canadian Law Cases of Female Circumcision Must be Reported

Nursing care decisions and actions for girls under the age of eighteen are governed by Canadian law. Nurses must report any cases in which a girl has been circumcised in this country because it's now legally considered child abuse. The appropriate route of action for nurses in this case would be to inform the physician and the social worker and together a report to the Children's Aid Society can be implemented. If the health care provider has strong ethical conflicts which will interfere with being able to provide care then it is appropriate to refer the client to someone else.

It has been two years since I first met the Somalian girl with the urological complications. Perhaps she has been back to have additional medical procedures done. What I have learned and read over the last two years has given me the freedom to empower my feelings of anger and transform my ideals. Should there be a time in the future when I am exposed to a similar patient I will be prepared. Where I once felt confusion I now have understanding. I can acknowledge the cultural and social structures which influence female circumcision. This is not to say that as a women I have rejected my own beliefs but as a nurse I have accepted that this is a cultural practice unlike my own which does exist and one with sensitive issues for all who encounter it. Where once I felt anger I now can redirect these feelings to a more positive approach to these patients. Knowledge has provided me with a tool to take a more holistic approach to my perioperative nursing care. ■

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# Conference Calendar 2000

**April, 2000** - American OR Nurses Assn. Annual Conference - New Orleans, LA

**April 28 & 29, 2000**
New Brunswick OR Nurses "The Spring Institute" @ Conference Centre, Fredericton, NewBrunswick.

**May 3 - 6, 2000**
British Columbia Operating Room Nurses Group, Whistler, BC
Contact: swynne@stpaulshosp.bc.ca

**May 7 - 10, 2000**
ORNAO's 6th Provincial Conference, International Plaza Hotel, 655 Dixon Road,Toronto, Ontario. www.neai.com/neai/ornao.htm Exhibit Chairperson: Alaine Young

**October, 2000**
Newfoundland & Labrador Operating Room Nurses Group, Corner Brook, Nfld.

**October 11 - 14, 2000**
Operating Room Nurses Association of Alberta - 19th Provincial Conference - Lethbridge Lodge Hotel, Lethbridge, AB
Contact: Gloria Nemecek , Conference Chair
(403) 732-4667

**November 3 - 5, 2000**
Saskatchewan Operating Room Nurses Assn. Annual Weekend Conference - Quality Inn, Saskatoon. **Contact**: Marla Ewen, Royal University Hospital. Speaker: Judith Shamian

**November 14 - 17, 2000**
28th Provincial Conference, Operating Room Nurses of Québec - Québec City

## Conference Calendar 2001

**June, 2001**
ORNAC 17th National Conference, Banff, Alberta.
Gloria Nemecek , Conference Chair.

**Fall, 2001**
The Atlantic Operating Room Nurses Group
Charlottetown, Prince Edward Island.

**May 3 - 6, 2000**
BCORNG Conference
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**Lots of entertainment & Fun, including dinner atop Whistler Mountain ! Great Exhibits.** Watch for more information from the British Columbia Operating Room Nurses Group about this 17th Biennial Conference.

Contact: swynne@stpaulshosp.bc.ca

**May 7 - 10, 2000**

**ORNAO's 6th Provincial Conference,**
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