**The experiences and psychological outcomes for pregnant women who have had FGM: A systematic review**

**Abstract**

Female genital mutilation (FGM) is a global issue, with 200 million women and girls thought to be affected. FGM is defined as removal of female external genitalia, either partial or total, for non-medical purposes. FGM is embedded in tradition, including cultural beliefs about sexual behaviour. Associated risks include haemorrhage, infection, death, dyspareunia, childbirth complications and psychological issues. Although FGM negatively impacts on women’s psychological wellbeing, little is known about the impact on pregnancy experiences. Psychological consequences of FGM are likely to be intensified during pregnancy when women have concerns about their own and their baby’s wellbeing. This mixed-method systematic review aimed to provide insight into the psychological impact of FGM on women who subsequently become pregnant. Nine electronic databases were searched, using a search strategy to identify relevant studies. Studies were considered for inclusion if they were primary studies (qualitative, quantitative or mixed-method) involving pregnant women of any age who have previously undergone FGM. Relevant studies were evaluated using the MMAT appraisal tool. Analysis was guided by the review questions and the evidence identified. One quantitative and 9 qualitative papers were included. Qualitative data were analysed using meta-ethnography. Narrative analysis of the quantitative study was conducted. Findings relate to *power of choice* linked to reinfibulation, deinfibulation, birth procedures and pain management; importance of *knowledgeable and sensitive health care professionals*; and *relived trauma* experienced during childbirth. These findings could inform the development of supportive interventions for women with FGM within maternity services.

**Keywords:** *systematic review, FGM, pregnancy, mental health*

**Introduction**

Female genital mutilation (FGM) is a prevalent global healthcare issue. The World Health Organisation (WHO) define FGM as ‘the partial or total removal of external female genitalia or other injury to the female genital organs for non-medical reasons’ (1). Approximately 200 million women and girls are affected by FGM across 30 countries (1) and 4 million girls are estimated to be at risk annually (2). FGM is recognised as a human rights violation (2) and is illegal in many countries. There are four FGM types (1): (*1) removal of the clitoris (partial or total); (2) removal of the clitoris and labia minora (partial or total); (3) narrowing the vaginal opening (infibulation); (4) any non-medical harmful practice e.g., burning or pricking.*

FGM is embedded in cultural beliefs and tradition; the motivation often linked to sexual behaviour e.g. preserving virginity, deterring promiscuity, and conserving marital faithfulness (3). FGM is also underpinned by patriarchal beliefs which reinforce oppression of female sexuality (4), and is considered a rite of passage in many cultures (5).

FGM is associated with many health risks. Immediate risks include haemorrhage, infection, shock, fever, and death (1). Long-term risks include sexual problems e.g. dyspareunia, urinary complications, childbirth complications and psychological issues (1). The impact of FGM on mental health includes depression, anxiety, nightmares, psychosis and neurosis (6, 7). The psychological impact of FGM can have lasting life-long consequences; these are likely to be compounded during pregnancy when women have concerns about their own and their baby’s wellbeing.

This review synthesises existing evidence concerning the psychological impact of FGM during pregnancy. The review sought to address the following research questions: (1) What matters to women who have experienced FGM and subsequently become pregnant?; (2) What impact does FGM have on the psychological outcomes of women who subsequently become pregnant?

**Methods**

The review protocol was registered with PROSPERO (CRD42020193260). The PRISMA statement (8) guided the reporting of this systematic review. The review was conducted on behalf of the FGM National Clinical Group.

Search strategy

A structured search strategy identified relevant studies, using Medical Subject Headings (MeSH), truncations and Boolean searching. The search strategy was applied to the following databases: Cochrane, Medline, CINAHL, Embase, PsycINFO, ASSIA, Sociological Abstracts, Maternal and Infant Care and AJOL. Reference lists and bibliographies for identified studies were also considered for possible inclusion.

Search terms were guided by PICO (9), using the following criteria (Table 1):
Table 1: PICO Search Strategy

|  |  |
| --- | --- |
| Population | (Wom\* or female) AND Pregnan\* [Ti or Ab] |
| Intervention | Female Genital Mutilation OR FGM OR circum\* OR cutting |
| Context | antenatal OR prenatal OR antepartum [Ti or Ab] |
| Outcome | want OR like OR desire OR expect\* OR need OR anticipate\* OR view\* OR experience\* OR encounter\* [Ti or Ab] |

Databases were searched in May 2020. Table 2 provides a full example of one of the electronic database searches.

Table 2: Medline Search Strategy

|  |  |  |
| --- | --- | --- |
| **Results** | **Type (Ovid MEDLINE(R) 1946 to May Week 2 2020)** | **Actions** |
| 1 | ((Wom\* or female) and Pregnan\*).mp. [mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms] | 922031 |
| 2 | ("Female Genital Mutilation" or FGM or circum\* or cutting).mp. [mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms] | 221812 |
| 3 | Circumcision, Female/ | 1352 |
| 4 | (antenatal or prenatal or antepartum).mp. [mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms] | 182036 |
| 5 | Prenatal Care/ | 27328 |
| 6 | (want or like or desire or expect\* or need or anticipate\* or view\* or experience\* or encounter\*).mp. [mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms] | 3259756 |
| 7 | 2 or 3 [FGM terms] | 221812 |
| 8 | 4 or 5 [Antenatal terms] | 182036 |
| 9 | 1 and 6 and 7 and 8 | 825 |
| 10 | limit 9 to English language | 768 |

Inclusion criteria

*Types of studies*: Qualitative, quantitative and mixed-methods primary studies relating to the psychological impact of FGM for women who subsequently become pregnant, were considered. Review, commentary, opinion, or editorial articles were excluded; however, they were checked for relevant references. No limitations were placed on publication dates or study settings. Studies published in English were included.

*Types of participants*: Studies involving pregnant women (primigravida or multigravida) of any age who have previously undergone FGM, were considered. Studies involving women who have experienced miscarriage or stillbirth were also considered, where the focus was on the psychological impact of FGM. Studies including other participants, e.g. health care providers, were considered if there were appropriate data related to the aim of the review.

Study screening

Retrieved records were imported into Endnote (version X8.2) and duplicates removed. Remaining studies were screened for relevance based on title and abstract and then underwent full-text screening against the inclusion criteria. Screening was conducted by one researcher (RW). Any uncertainty regarding eligibility was determined through discussion with a second reviewer (TL).

Critical appraisal

The Mixed Methods Appraisal Tool (MMAT) (10) was used to critically appraise the literature as it facilitates the appraisal of qualitative, quantitative, and mixed-method studies. Two reviewers (RW, TL) assessed the study quality; disagreements were discussed with a third reviewer (YR).

Data Collection

Data extracted from included studies, comprised: study features (publication date, authors, setting, study type, research aim), participant information (sample size, age, ethnicity), methods (recruitment, data collection, data analysis) and outcomes (participant views and concerns about psychological impacts of FGM during pregnancy). A summary of the data extracted is displayed in table 3.

Data analysis and synthesis

Analysis was guided by the review questions and evidence identified. Initial analysis was conducted by RW and validated by the remaining authors. Each review question was analysed separately, before observing any commonalities and synthesising the data. As all but one of the studies were qualitative, data were analysed using meta-ethnography. The quantitative study reported descriptive quantitative data, which supported the findings from the meta-ethnography and were reported alongside qualitative results to further validate findings.

**Results**

Study selection

The search strategy identified 2,277 studies (Medline, 768; Cochrane, 168; CINAHL, 165; Embase, 814; PsycINFO 109; ASSIA, 3; Sociological Abstracts, 3; Maternal and Infant Care, 206; AJOL, 41). After duplicates were removed, 2,240 studies remained. These studies underwent title and abstract screening and were excluded if they failed to meet the inclusion criteria. Full-text screening of the remaining 48 studies was then conducted. Ten papers met the inclusion criteria. Figure 1 illustrates the PRISMA process, showing the number of studies included/excluded at each stage, including reasons for exclusion at full-text screening (8).

Study Characteristics
Included studies were conducted in Sweden (n=4), USA (n=1), Canada (n=1), Norway (n=1), Australia (n=1), Liberia (n=1), UK (n=1). Publication dates ranged from 1995-2019. Five studies focused on women, 1 involved women and health care providers, 1 included men and women, 2 focused on midwives, and 1 included women, men, girls, boys, and professionals. Of the 8 studies including women, 6 focused on Somalian women; 1 focused on Eritrean women; and 1 included Somalian, Eritrean, and Sudanese women. Nine studies were qualitative and 1 was quantitative. Qualitative data collection methods comprised interviews (n=7) and focus groups (n= 3). One study used both methods. Qualitative studies used a range of analysis approaches, including thematic (n=5), grounded theory (n=2), and content analysis (n=2). The quantitative study used a structed interview technique for data collection and conducted descriptive analysis.



Figure 1: PRISMA flowchart

Table 3: Data Extraction

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Authors | Year | Study Type | Setting | Aim | Sample size | Age | Ethnicity/Culture/Religion | Recruitment | Data Collection | Data Analysis | Participant Experiences/Concerns | Comments |
| (11) Beine et al. *Conceptions of prenatal care among Somali women in San Diego* | 1995 | Qualitative | San Diego, USA | To understand the beliefs/behaviours of Somali women in San Diego during pregnancy and to understand attitudes towards prenatal care | 14 women | 20-42 | Somali/Muslim | Community social network/Snowball | Focus Groups | Content analysis | Humiliation caused by health care provider reactions to FGM Concerned about the repair of infibulated perineum after birth – wanted to be consulted | Inclusion: pregnant at time of interview or had 1+ baby in San Diego 4 women delivered outside of San Diego (Kenya + Somalia)Not sure of exact number with FGM (some not comfortable discussing) |
| (12) Chalmers & Hashi. *432 Somali women's birth experiences in Canada after earlier female genital mutilation* | 2000 | Quantitative | Ontario, Canada | To explore the perceptions of perinatal care and FGM experiences of Somali women living in Ontario | 432 women | 34 (mean age) | Somali | Approached in local community areas/Snowball | Structured interviews | Descriptive | Concerned with lack of choiceExperienced poor treatment related to lack of knowledge and cultural sensitivity from health care providers | Women had recently given birth in Canada (past 5 years)1 woman uncircumcised |
| (13) Wiklund et al. *Somalis giving birth in Sweden:**a challenge to culture and gender**specific values and behaviours* | 2000 | Qualitative | Sweden | To explore the experiences of birth for Somali women and men in Sweden  | **16:**9 women7 men | 21-55 (women)27-57 (men) | Somali | Selected from Swedish Medical Birth Register and patientrecords | Interviews | Grounded theory | Most women satisfied with care, but some experienced health care professionals who were unaware of FGM Most women did not related FGM to potential delivery complications | All women had FGMThe overall focus of the study was not FGM but general issues around birth experiences |
| (14) Ahlberg et al. *‘It’s only a tradition’: making sense of eradication**interventions and the persistence of female**‘circumcision’ within a Swedish context* | 2004 | Qualitative | Sweden | To examine why FGM continues and to explore the perceptions of Somali immigrants | **110:** 30 men50 women 10 girls5 boys 15 (non-specified) workers dealing with FGM | Not stated | Somali | Reached through local organisations and maternal and child health clinics/Snowball | Interviews + focus groups | Thematic | Women with FGM felt that they received poor care during pregnancy and childbirth | Not clear how many of the women were pregnant or had previous FGM |
| (15) Vangen et al. *Qualitative study of perinatal care experiences among Somali women**and local health care professionals in Norway* | 2004 | Qualitative | Norway | To explore the impact of perinatal care on birth outcomes for women with FGM | **59:**23 women 36 health care providers  | 18-55 (women) | Somali | Reached through the Somali’s association and in health facilities/ Snowball | Interviews | Thematic | Women feared the impact of lack of FGM experience amongst health care professionals on their deliveryHealth care professionals did not recognise FGM as an important issue related to delivery | All women had FGM previously Women experienced childbirth in Norway (timeline not specified) |
| (16) Berggren et al. *Being Different and Vulnerable: Experiences**of Immigrant African Women Who Have Been**Circumcised and Sought Maternity Care in Sweden* | 2006 | Qualitative | Sweden | To explore the experiences of Swedish health care from the perspectives of women from Somalia, Sudan, and Eritrea who have had FGM | 21 women | 24-73 | Eritrean SomalianSudanese/Christian/Muslim | Snowball | Interviews | Latent contentanalysis | Women often felt vulnerable and exposed in the Swedish health care system because of their FGMWomen believed that health care professionals were not knowledgeable about FGM  | 22 interviews but 1 excluded because she had not undergone FGM All women had experiencesof delivery in Sweden |
| (17) Lundberg &Gerezgiher. *Experiences from pregnancy and childbirth related to**female genital mutilation among Eritrean immigrant**women in Sweden* | 2008 | Qualitative | Sweden | To explore pregnancy, birth and postpartum experiences of Eritrean women living in Sweden who have had FGM | 15 women | 31-45 | Eritrean/Muslims/Christians | Snowball | Interviews | Thematic | Women’s experiences included pain and fear. The knowledge of health care professionals about FGM impacted the experience for women | All women had type 3 FGMWomen had delivered at least one child |
| (18) Dawson et al. *Midwives’ experiences of caring for women with female genital**mutilation: Insights and ways forward for practice in Australia* | 2015 | Qualitative | Australia | To explore midwives’ experiences of caring for women with FGM | 48 midwives | Not stated | Not stated | Purposively selected from relevant antenatal clinics and birthing units | Focus groups | Thematic | Participants had some knowledge and skills regarding FGM and pregnancy but lacked confidence in practice.  | Study focused on midwives’ experiences but refers to women’s experiences |
| (19) Moxey &Jones. *A qualitative study exploring how**Somali women exposed to female**genital mutilation experience and**perceive antenatal* *and intrapartum**care in England* | 2016 | Qualitative | UK | To explore the experiences of antenatal and intrapartum care in England for Somali women who have experienced FGM | 10 women | 20-49 | Somali | Recruited from antenatal care/Snowball/Convenience | Interviews | Thematic | FGM impacted women’s lives physically and psychologicallyGreater awareness of FGM amongst health care professionals created a positive experience | Most women (80%) had FGM Women had 1+ children aged under 5 years or were at least 6 months pregnant |
| (20) Tarr-Attia et al.*‘Birds of the same feathers fly together’:**midwives’ experiences with pregnant**women and FGM/C complications - a**grounded theory study in Liberia* | 2019 | Qualitative | Liberia | To explore midwives’ beliefs about the health impact of FGM | 17 midwives | 38-63 | Liberian/Christian | Purposefully selected midwives | Interviews | Grounded theory | Midwives reported that some women hid their FGM due to shameMidwives reported that some women had pain due to tears during delivery because of FGM | Focused on midwives’ experiences but refers to women’s experiencesInclusion: midwives had to be knowledgeable about FGM |

Quality Appraisal

All included studies reached a quality standard which met the MMAT criteria (10). The 9 qualitative studies were exploratory and sought to understand beliefs, experiences and perceptions related to FGM and pregnancy, therefore interviews and focus groups were suitable data collection methods. The quantitative paper also used interviews (structured).

Sample details were limited in some studies. Two papers lacked details on the number of women who had experienced FGM (11, 14); only 4 papers reported the type of FGM experienced (12, 15-17); and one study (14) only provided sample details related to the number of participants and their gender.

Appropriate analysis methods were used (thematic n=5, grounded theory n=2, content n=2, descriptive analysis n=1). In all studies, findings were substantiated by data, using verbatim quotes or relevant statistics to evidence validity/trustworthiness of interpretations. The quantitative study (12) gathered information about Somali women’s perceptions of pregnancy and childbirth in Canada following previous FGM using a large (n=432), representative sample. Although descriptive in design, this aligned with the exploratory nature of the study and a comprehensive illustration of the topic was presented. One qualitative study lacked depth of interpretation related to FGM and childbirth, however FGM was not the sole focus of this study (11). Two further qualitative studies (18, 20) focused on midwives’ experiences of pregnancy and childbirth concerning women with previous FGM, however reference was made to women’s experiences which produced some relevant insights.

Findings

Analysis revealed 3 themes: *power of choice, lack of knowledge and sensitivity amongst health care professionals,* and *relived trauma.*

 ***Power of choice***

Power of choice was an important concern for pregnant women with FGM, particularly related to reinfibulation and deinfibulation. Though reinfibulation is illegal in most countries, there was disagreement amongst women about who should be the decision-maker. Charmers and Hashi report that 35.4% of women believed that a woman has the right to choose reinfibulation, whereas other women felt that their partners should choose (36.1%) or that the decision should be made by health professionals (21.8%) (12, p. 232).

One woman discussed her decision not to request reinfibulation following childbirth, highlighting the importance of her right of choice (17, p. 220):

*“I was re-sewed after my first and second childbirth… But after my third childbirth in Sweden I decided to leave open because I knew that I had the right to do that.” (Woman, Sweden)*

In some cases, however, women were not consulted about their choices. In Lundberg and Gerezgiher’s study one woman explained that she had been reinfibulated without any discussion with her midwife (17, p 220):

*“I was re-sutured twice. The second time was in Sweden. The midwife sewed without asking if I wanted or not. I was surprised, because I knew that it was illegal.” (Woman, Sweden)*

Another woman referred to her lack of choice about reinfibulation as a second experience of suffering:

*“I became a victim in Sudan already when I was 4 years old; I had no choice. Now I have to become a victim again after delivery, when the midwives refuse to resuture me…. I understand that the law forbids them to do any suturing, but I am already injured; why do I have to suffer twice? (Woman, Sweden) (16, p. 53)*

Choice was also important to women in relation to birth procedures and pain management. Chalmers and Hashi (12) highlight that most women in their study described having minimal decision-making powers concerning birth and pain management. Moxey and Jones (19) found that some women in their UK-based study would prefer to choose deinfibulation during the intrapartum period. This decision was based on reluctance to endure two separate procedures. In this study, women reported that they were offered a choice about when to undergo deinfibulation and they believed that the midwives respected them and their cultural beliefs (19). In Australia, (18) midwives also identified that women preferred deinfibulation during birth rather than earlier in the pregnancy. However, not all women are given the opportunity to choose timing of deinfibulation. Vangen et al. report that women were often not involved in this decision-making process and no arrangements were organised prior to labour (15).

Lack of choice and consultation for women often resulted in negative birth experiences. One woman in Sweden characterised her experience as a ‘long fight’ with health professionals (16, p. 54):

*“… I remember the delivery as a long fight from my side. And then I mean not only fighting with the delivering of my baby but fighting in order to get the staff to understand how I would like it.” (Woman, Sweden)*

This illustrates the value women place on being decision-makers in these situations.

***Lack of knowledge and sensitivity amongst health care professionals***

Another concern for women was the ability of health professionals to deal with FGM during pregnancy and labour. Chalmers and Hashi report that over half (52%) of women believed that their doctor was unable to provide adequate care (12, p. 232). The lack of health care professionals’ knowledge of FGM also resulted in fear and anxiety for many women (15, 17).

Ahlberg et al’s. (14) study, demonstrated a hesitancy amongst midwives which prompted instruction from women on how to be cut during labour. One woman recalled:

*“. . . during delivery, we have to ask the midwives to cut. Sometimes the midwife calls a doctor to ask whether she should cut or not. During this argument the baby pops out causing too much tear and bleeding. It is very frustrating to be confronted with a situation where professionals appear to have no control . . .” (Woman, Sweden) (14, p. 60)*

An added concern was overcoming language barriers (14, 16, 18). One woman highlighted the additional difficulties that could be presented for women who do not speak the local language:

*“You can imagine I had to tell them to cut upwards. What of the women who cannot express themselves in English or Swedish?” (Woman, Sweden)* (14, p. 61)

Berggren et al. also found that some women felt vulnerable because of the lack of FGM awareness amongst health professionals during birth (16). Women in this study reported having to advise midwives on cutting (16). Some midwives perceived women as being ‘confident’ when offering advice during labour (18, p. 210). However, the motivation for this advice stemmed from a lack of confidence in health professionals (18, p. 210).

One woman described feeling ‘lucky’ that she had a midwife who was knowledgeable about FGM, suggesting that this was unusual:

*“I was lucky when I met a midwife in Sweden who knew about circumcised women. This was a great help to make me feel secure because it was my first time to be pregnant and to live far from my parents and family” (Woman, Sweden)* (17, p. 219)

Lack of FGM knowledge amongst health professionals is a key concern for pregnant women with FGM. The lack of confidence this causes, creates additional stress and anxiety for women, who often feel that they are being placed in a vulnerable position.

Lack of sensitivity from health professionals when dealing with FGM was an issue that caused women distress and humiliation during pregnancy and childbirth (11). Chalmers and Hashi found that most women (87.5%) had experienced ‘hurtful comments’ made by health professionals concerning their FGM (12, p. 232). Similarly, non-verbal expressions e.g. surprise (78%) and disgust (55.1%) were experienced by many women (12, p. 232). However, in some studies, women reported that the care they received from health care professionals was ‘satisfactory and unproblematic’ (13, p. 108).

In some cases, lack of sensitivity was apparent from the discussions that women had with health professionals. Vangen et al. illustrated this when stating that one woman with FGM had been asked by her doctor if her FGM scars were a result of burns, which caused embarrassment for the woman (15). In another study, one woman discussed the ‘strange’ reaction her doctor had when he examined her:

*“It was a bit strange. I met this doctor for the first time, during the first pregnancy here in Sweden. He was going to examine me…. he said `What is this? Is it an injury or what? Why do you do this?' . . .it felt very odd. . .” (Woman, Sweden)* (13, p. 108)

Lack of sensitivity was also experienced through the facial expressions of health professionals:

*“Another time they looked at me there with faces full of disgust. But nobody has even asked me about it. But they are all kind. I think that they just don’t dare to ask” (Woman, Sweden)* (16, p. 54)

The reaction and expressions of health professionals was also an issue identified as important by some midwives, who understood the significance of how this could impact women’s feelings:

*“…faces tell a thousand (words). . .’’ (Midwife, Australia)* (18, p. 211)

Some women felt that health professionals’ inquisitiveness about FGM made them feel like ‘a study object for curious health personnel’ (16, p. 54). Chalmers and Hashi reported that 58.6% of women experienced health professionals asking additional colleagues to observe their FGM and 34.5% of women were asked to approve this beforehand (12, p. 232). One woman stated:

*“All of them just wanted to look at me. I didn’t understand why and nobody asked me, but I thought that they found it exciting to see when I was cut open” (Woman, Sweden)* (16, p. 54)

The reaction of health professionals can cause shame and embarrassment for women (16), acting as a barrier to future care-seeking (20). One woman stated:

*“I kept it [FGM] hidden because I thought it was kind of like embarrassing…so I didn’t tell her, I didn’t say I was scared or anything. I said, “yeah everything’s okay, yeah”” (Woman, UK)* (19, p. 5)

***Relived Trauma***

Pregnancy and childbirth can cause psychological stress and relived trauma for women who have previously experienced FGM. Women can be reminded of the memories of FGM throughout pregnancy, as the pain experienced through examinations and birth can prompt recollections of pain felt during FGM (15, 16).

One woman shared her memories:

*“When I go to the hospital, a picture comes to me. I remember what she did to me long ago back in Somalia, when I was only 7 years old. I see the features of her face and the razor she was going to cut me with. I remember it all.” (Woman, Sweden)* (16, p. 53)

Another woman highlighted the psychological distress she endured during pregnancy because of the pain felt during FGM and birth:

*“In my dreams, my delivery and my circumcision are sort of mixed up. I am lying there pregnant, but only six years old as I was at my circumcision, and there are people around me with knives cutting me up everywhere. It is just awful”* (Woman, Norway) (15, p. 33)

Fear of birth was also exacerbated by the expectation of birth pain due to FGM. One woman discussed how the anticipation of birth after FGM was a source of fear:

*“I thought it was strange and awkward, would I… you know…. Bleed?, I dunno [don’t know], I was scared of it because of the, you know…. because it was closed for so many [years] …it was terrifying yeah” (Woman, UK)* (19, p. 4)

Whilst FGM can be physically repaired through deinfibulation, the psychological impact of FGM should still be addressed. One woman who underwent deinfibulation illustrates the residual psychological effects she encounters:

 *“In terms of was it fixed in my, you know, mind, it’s not at all…even with my smear test I struggle still, I’m scared of it”* (19, p. 4)

**Discussion**

Whilst the potential psychological impact of FGM is widely understood, little is known about the specific psychological impact of FGM on subsequent pregnancy experiences. This review synthesised existing literature in this area to discover what matters to women who have experienced FGM and subsequently become pregnant and to determine the impact of FGM on psychological outcomes during pregnancy.

Over the last decade there has been a noticeable paradigm shift from a focus solely on clinical outcomes to an awareness that maternal views and experiences matter. Recent papers (22) and international guidance (21) clearly articulate what matters to women, and these resonate with the review finings; informed choice, competent health professionals and respectful care being essential requirements. For women who have experienced FGM, concerns are likely to be amplified due to their vulnerability. These women have usually experienced powerlessness during situations of vulnerability, e.g. social pressures to conform to the FGM procedure (3). Anxieties may be further compounded due to unfamiliar environment, health-service processes, and language; sensitive and knowledgeable communication from health professionals is therefore pivotal to a positive experience.

Vulnerability experienced by women with FGM, as highlighted in the findings, resonates with the conceptual vulnerability model developed by Briscoe et al. (22), which views vulnerability as a process characterised by threats, barriers, and reconciliation (22). Threats relate to possible biological, psychological, and social harms (22). In the context of pregnant women with FGM, the psychological threats dominate; particularly fear and anxiety related to the prospect of insensitive and incompetent health professionals who are unable to provide FGM care. Their anticipation of being unable to choose reinfibulation and deinfibulation was a specific threat. Additionally, the psychological threat of relived trauma of FGM during birth is a concern. Identified barriers contributing to vulnerability related to the lack of knowledge and sensitivity demonstrated by health professionals. Whilst such attributes are important for any woman giving birth, the additional cultural discord that can exist between health professionals and pregnant women with FGM can act as a further barrier to quality care. To ensure optimal care provision, a shared cultural understanding of the needs of pregnant women with FGM is needed. Reparative processes seek to support women and reduce vulnerability (22) e.g. training and development for health professionals. For pregnant women with FGM, the importance of professional development and support from health professionals is crucial. Women experiencing vulnerability during pregnancy, due to previous FGM, must be provided with expert advice, guidance, and support from health professionals to avoid undue stress and anxiety. To reduce vulnerability, health professionals must be aware of the specific psychological circumstances faced by pregnant women with FGM and be capable of providing appropriate care, or referring women to specialised services, throughout the pregnancy and post-partum period.

*Recommendations*

Further research is needed to explore the psychological impact of pregnancy and childbirth for women with FGM in different settings. Despite FGM being a practice that is largely conducted in Africa, only 1 of the included studies was conducted in an African country (Liberia). Research in different geographical settings could provide wider contextual understandings of the challenges faced by pregnant women with FGM. It could also be beneficial to research the potential lasting psychological impact of FGM into the postnatal period to assess the necessity of further targeted interventions.

The care provided by health professionals was identified as pivotal to the psychological outcomes for pregnant women with FGM. It is important for women to be included in their own care provision, with communication about the needs and concerns of women with FGM at the forefront. Knowledge and confidence when caring for pregnant women with FGM is crucial amongst health professionals to foster a safe, compassionate environment. As there are limited opportunities for health professionals to observe FGM, due to the eradication of the procedure in high income countries, other training opportunities could be explored, e.g. digital training. This could provide opportunities to observe FGM without pregnant women feeling intimidated or observed.

*Limitations of the study*

Transferability of findings is limited by the number of included studies; however, the lack of published studies is representative of the need for further research on psychological outcomes for pregnant women with FGM. Only English language papers were included, which may have resulted in missed data from non-English speaking countries. However, the scope of this review was international to encompass a wider range of experiences.

**Conclusion**

This review concludes that what matters to women who have experienced FGM and subsequently become pregnant is (1) power of choice related to pregnancy and birth procedures and (2) knowledgeable, sensitive care provision to minimise psychological distress. This review also identified that relived trauma is an important psychological outcome to consider when caring for pregnant women with FGM. Gaps in the literature have been identified that need further consideration, including geographically widening the scope of research and considering psychological outcomes following birth. This review provides insight into the needs, perceptions, and experiences of pregnant women with FGM, which could inform the development of supportive interventions within maternity services.

Highlights:

* Informed decision-making during pregnancy and birth is essential for women with FGM
* Knowledgeable, sensitive care provision is pivotal to positive pregnancy experiences
* The psychological impact of FGM during pregnancy and birth must be addressed

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