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Culturally Sensitive and Holistic Care for Women Who Have Undergone Female Genital Circumcision

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CULTURALLY SENSITIVE AND HOLISTIC CARE FOR WOMEN WHO HAVE UNDERGONE FEMALE GENITAL CIRCUMCISION

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Culturally Sensitive and Holistic Obstetric Care for Women
Who Have Undergone Female Genital Circumcision

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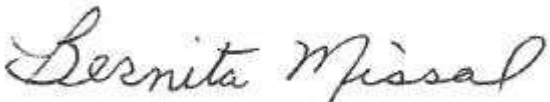
Project Advisor Signature: 

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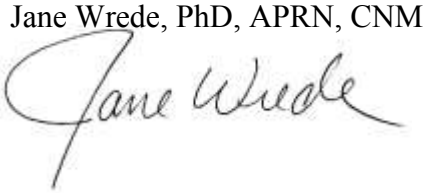
Director of Graduate Nursing Program Signature: 

Acknowledgments

This work is dedicated

To my husband Ted, you are my best friend and the love of my life. I would not be where I am without you.

To my wonderful children Alexander Harold, Anna Isabel, and John Luis, you are my life and my everything. I love you with all my heart.

To my mother Marianita, you are a strong woman who gave up many things to give your children love, courage, and a better future.

To all my family and friends who supported me in many ways.

And, to all the women who have undergone Female Genital Circumcision. This work is for you, because you deserve to be treated with respect, sensitivity and consideration. This is my contribution toward a better future for you.

"Donde haya un árbol que plantar, plántalo tú. Donde haya un error que enmendar, enmiéndalo tú. Donde haya un esfuerzo que todos esquivan, hazlo tú. Sé tú el que aparta la piedra del camino."

"Where a tree needs to be planted, you plant it. Where there is a mistake that needs to be fixed, you fix it. Where there is hard work to be done and everyone avoids it, you do it. Be you the one that removes the stone from the road."

— Gabriela Mistral

Abstract

Background: Around the world, immigration is part of many people's lives. In that context, obstetric healthcare providers must be ready to deliver culturally sensitive care to women of different backgrounds. Some of these women have undergone female genital circumcision (FGC). As a result, they have unique healthcare needs.

Purpose: Conduct a critical literature review designed to discover and evaluate culturally holistic care guidelines being used to provide healthcare to women who have undergone FGC.

Results: There is a lack of clinical guidelines for healthcare providers as they care for circumcised women. Randomized controlled trials are not being done due to ethical issues that could arise. Providers believe that the lack of evidence-based guidance can make it difficult to know the best way to provide healthcare to circumcised women.

Conclusions: Healthcare providers need more information about FGC. They need education on the types of FGC and its possible complications, and they need guidelines for providing quality, culturally sensitive and holistic care to circumcised women. These guidelines do not exist in the United States and must be created.

Implications for Research and Practice: The findings support future research directed toward creation of clinical guidelines for the care of circumcised female patients, and toward development of healthcare education programs. Guidelines and education will help obstetric practitioners to provide quality, culturally sensitive and holistic care.

Keywords: Female genital circumcision (FGC), female genital mutilation (FGM), culturally sensitive care, quality care, holistic care.

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Chapter I: Introduction

Female Genital Circumcision (FGC) is also known as female genital mutilation and female genital cutting. There are many theories that speculate on its origins. According to archeological findings, there is evidence that FGC has been practiced since before the 16th century B.C. (Chalmers & Omer-Hashi, 2003). According to the World Health Organization (WHO, 2008), FGC occurs all over the world, there are 30 countries where FGC is more prevalent (Woman Stats Project, n.d.). However, is has been found to be more prevalent in at least 30 countries, many of them in Africa and Asia (Chalmers & Omer-Hashi, 2003). FGC may be performed on women of any culture, religion, ethnic group, socio-economic status, or educational level (Chalmers & Omer-Hashi, 2003).

FGC is a traditional procedure that involves the partial or total removal of or damage to the external female genitals. This definition includes any type of injury caused for non-medical reasons (WHO, 2008). There are several degrees of the procedure. The WHO (2017) has created a table that helps to identify the different types.

- Type 1: Also known as clitoridectomy, it is the partial or total removal of the clitoris, and in very rare cases, only the prepuce.
- Type 2: Known as excision, it is the partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora.
- Type 3: Referred to as infibulation, the opening of the vagina is narrowed through the creation of a covering seal. It is the most serious type of FGC.
- Type 4: This includes all other harmful procedures to the female genitalia for non-medical purposes.

At least 200 million girls and women living worldwide have undergone FGC (United Nations International Children's Emergency Fund [UNICEF], 2016). According to Mather and Feldman-Jacobs (n.d.), in the State of Minnesota the number of women and girls who are potentially at risk for FGC is 37,417 and in the United States of America this number is greater than 500,000. Because of this, healthcare professionals must be prepared to care for circumcised women, which they are sure to encounter during their careers.

Evidence Demonstrating Need for Critical Review

Female circumcision interferes with the normal life of a woman and affects her in different ways. It may cause several immediate and long-term complications including severe pain, excessive bleeding, shock, swelling of genital tissues, infections, infection with human immunodeficiency virus, difficulties with urination, impaired wound-healing, death, menstrual problems, keloids, and interfere with her sexual health (WHO, n.d.). In addition, there are associated obstetric complications including a higher likelihood of cesarean sections, post-partum hemorrhage, episiotomies, difficult or prolonged labor, extended maternal in-hospital stays, and obstetric fistulas. The likelihood of psychological complications is greater, including postpartum depression and anxiety disorders. Perinatal risks include higher incidence of infant resuscitation, intrapartum stillbirth, and neonatal death (WHO, n.d.).

According to Balogun, Hirayama, Wariki, Koyanagi, and Mori (2012), there is a lack of clinical research comparing which interventions will result in better outcomes for patients who have undergone female circumcision. The lack of research is, at least in part, due to ethical difficulties encountered in investigating questions related to FGC. The net effect of this lack of research is that evidence-based clinical guidelines are non-existent, leaving providers unsure of how to proceed when evaluating and treating circumcised women. This results in a case-by-case

clinical approach which relies exclusively on the judgment of the provider, and which is not informed by consensus opinion or evidence. This is a concerning situation which necessitates investigation of potential guidelines for treatment of women who have undergone FGC.

Significance to Nurse-Midwifery

There is a need for professional education and training that will enable midwives to provide culturally competent care when treating a patient who has undergone circumcision (Dawson, Turkmani, Fray, Nanayakkara, Varol, & Homer, 2015). It is the norm for female circumcised patients to prefer midwifery care during their pregnancies. This is why midwives must be prepared to meet the expectations and needs of circumcised women. Midwives in several parts of the world have been appointed as the designated healthcare providers for women who have undergone FGC. In some cases, they are the managers of clinics that specialize in the treatment of these women. Midwives must be prepared to provide ethically sensitive care, and to understand the legal implications of female circumcision as well (Leye, Powell, Nienhuis, Claeys, & Temmerman, 2006). This literature review will attempt to answer the question "Are there clinical practice guidelines on providing quality, culturally sensitive and holistic care to women who have undergone female genital circumcision in order to decrease fear and increase patient satisfaction?"

Theoretical Framework

The most pertinent theory of nursing for this critical review of literature, which deals with obstetric care for immigrant women who have undergone FGC, is the Transcultural Nursing Theory, which was developed by Madeline Leininger (Olin, 2011). This theoretical framework is focused on understanding and describing various cultures in the context of healthcare, specifically their values, cultural practices, and more generally their ways of life, and how those

aspects translate into varying healthcare attitudes and practices. It is not an entirely academic framework, however, as its ultimate goal is to foment healthcare practices that are tailored for specific communities and that will succeed in those communities, as well as practices that can succeed across cultures (Mulholland, 1995).

The Transcultural Nursing Theory was developed not long ago, and it can be attributed to the recent and rapidly increasing diversity of our world, ethnically, culturally and racially. As human populations have become more and more mobile, resulting in increased diversity around the world, there has been a growing need for healthcare professionals, especially nurses with arguably the highest level of interaction with patients, to adapt and be able to provide culturally sensitive care that incorporates facets of diverse individual patients' beliefs and values. Providing individualized care to patients with beliefs, values and identities far different from our own is an immense challenge, and needs an appropriate theoretical framework to help us achieve it.

Transcultural Nursing provides an ideal foundation to enable nurses to understand and treat patients of varying backgrounds. It is also an ideal conceptual framework for research into providing nursing care for these populations. Leininger's research method, ethnonursing, is a crucial tool in conducting such research, and will be used in this project to investigate the culturally appropriate care of obstetric immigrant women that have undergone female circumcision (Andrews, 2008). Ethnonursing is a powerful tool. It allows the researcher to interact with individuals of different cultural backgrounds in order to understand the way others see the world and how this impacts their views and approach to healthcare. It requires the researcher to be a "co-participant" in the healthcare process, allowing them to more directly understand and experience healthcare systems in other cultures. This first-hand knowledge

facilitates learning about the expectations, limitations, and practical outcomes of these systems from the viewpoint of both patients and professionals. Ethnonursing is a "bottom-up" approach that seeks to infer the broader outlines of a culture through interaction with individuals, and rejects the more aloof and distanced approach to understanding other cultures that has been traditionally used (McFarland, Mixer, Webhe-Alamah, & Burk, 2012).

The ethnonursing model requires that the researcher become intimately and directly associated with the population whose care is being studied. This would mean trying to see the world, including the experience of being a patient, through the eyes of members of a distinct group of people. This kind of effort is required of most people on a day-to-day basis, whether consciously or not, although the extent of their shift in worldview is certainly variable. In the case of female patients who have undergone female circumcision, the use of this model would be expected to result in a significant shift in the author's understanding of this unique population and its culture.

In order to properly incorporate the ethnonursing model into the current research project, the reasons behind the ritual of FGM need to be understood. It is crucial to understand the traditions and beliefs of these patients. This will help midwives to better appreciate their point of view, and may help us to elucidate for them the reason for practices that are considered-routine and ordinary in clinics and hospitals in this country, but could be seen as unusual or bewildering to these particular women. It would be equally important to learn about the health care provided within their own cultures to women who have been circumcised. Finally, it is critical to reflect on what the expectations of circumcised women are in order to understand what will be the most appropriate way to care for them.

After becoming familiar with this topic, it will be possible to see the healthcare system through eyes of these patients. The next step is to develop guidelines that can teach other healthcare professionals how to properly care for circumcised women. The education process would consist of two steps.

The first step would be education for healthcare providers regarding the FGC procedure, and the history and tradition behind it. In this step, healthcare providers would also become informed on how circumcised female patients view healthcare, specifically their expectations of who will provide it, what the care will consist of, and how, when, and where it will be provided. Care identical to what is provided in their home countries is clearly not the goal, but knowing about traditional practices could help providers to communicate more clearly with their patients and better meet their needs.

The second step would be the education of circumcised women, prior to and upon entering the healthcare system, regarding what to expect as they receive care so that it seems more comfortable and less foreign. This step would include education regarding the culture of healthcare in the United States. Through this two-step education process, providers and patients both gain a better understanding of each other's point of view.

By incorporating the conceptual framework of Transcultural Nursing Theory, it may be possible to improve the care of female circumcised patients, as well as help the healthcare providers that care for this unique group of women. The end result should be making the healthcare system less anxiety-provoking and more reassuring for female circumcised patients. Also, providers would understand these patients better and feel more confident in treating a patient who may be ethnically, culturally, and religiously distinct from themselves.

Statement of Purpose

Like any other patient seen in a clinic or hospital, circumcised girls and women deserve quality, culturally sensitive and holistic care. However, there is a lack of knowledge about female circumcision among healthcare providers. This causes them to be unsure of how to interact with and treat patients. The purpose of this project is to conduct a critical literature review to answer the practice question: "Are there clinical practice guidelines on providing quality, culturally sensitive and holistic care to women who have undergone female genital circumcision"?

Summary

In a world that is becoming ever more interconnected, midwives must understand the culture, traditions, beliefs and practices of the diverse populations that we care for. Female circumcision has been practiced for thousands of years in at least 30 countries. Circumcised women come from different cultures, religions, socioeconomic backgrounds, and levels of educational attainment. We need to consider that the number of women who have undergone the FGC procedure around the world is alarming, and is likely to continue to grow.

This is a unique group of women, who have experienced not only physical harm to their bodies but in some cases associated psychological trauma. Girls and women who have survived this procedure deserve to be treated with respect. A non-judgmental attitude is the first step toward building a good connection with patients so they are able to trust their providers. This trust must be established early on in care in order to improve patient satisfaction and diminish fear. Healthcare professionals, especially midwives, must be prepared mentally and have the knowledge base needed to provide the highest quality, culturally sensitive and holistic care possible for female circumcised patients.

Chapter II: Methods

This chapter will review the methodology utilized to locate and evaluate scholarly articles investigating the clinical guidelines that health care practitioners follow when caring for women who have undergone female genital circumcision (FGC). Three main databases of medical literature were searched, yielding 33 articles which were reviewed and appraised. Of these, 22 were selected for final inclusion in this analysis.

Search Strategies Used to Identify Research Studies

A literature search was performed through the EBSCO Academic Source Premier, PubMed database, and Google Scholar. Terms searched included: "Female circumcision and genital mutilation," "Female circumcision and genital mutilation: A practical and sensitive approach," "Female genital mutilation: What ob/gyns need to know," and "Clinical guidelines for care of patients who have undergone female genital circumcision/mutilation."

Criteria for Including or Excluding Research Studies

The literature review included randomized controlled trials, literature reviews, cross-sectional studies, non-experimental descriptive case-control studies, non-experimental quantitative studies, retrospective audits, qualitative phenomenological studies and expert opinions. Articles were included based on their origin in countries where large numbers of women have undergone FGC, whether native-born or immigrant women. Studies prior to 2002 were excluded from the search criteria. A single article was excluded because it referenced data from 1995. Articles meeting the above-referenced criteria were included based on the level and quality of the study.

Number and Types of Studies Selected

A total of 22 studies were appraised, including six qualitative phenomenological studies, one randomized controlled trial, five literature reviews, two cross-sectional studies, one non-experimental quantitative study, one non-experimental case control study, five expert opinion studies, and one retrospective audit. Of these 22 studies, six were based on information gathering or research that occurred in the United States, two were from Nigeria, two from Sudan, one from Japan, one from Kuwait, one from Kenya, three from Australia, five from the United Kingdom, one from the Netherlands, one from Sweden, one from Denmark, one from Spain, and one from Belgium.

Criteria for Evaluating Research Studies

The quality, value, and strengths of the studies encountered in the literature review were evaluated using the Johns Hopkins Research Evidence Appraisal Tool (JHREAT) (Dearholt & Dang, 2012). The results of the evaluation were classified on an evidence level scale of I to V. Per the JHREAT, Level I evidence includes experimental studies, randomized controlled trials (RCTs), or systematic reviews of RCTs, with or without meta-analyses. Level II evidence includes quasi-experimental studies, systematic reviews including a combination of quasi-experimental studies and RCTs, or quasi-experimental only studies, with or without meta-analysis. Level III evidence includes non-experimental studies, qualitative studies, or meta-syntheses. Level IV evidence includes types of expert opinion including clinical practice guidelines and consensus panels. Level V evidence is based on experiential and non-research evidence, and includes literature reviews, quality improvement programs or financial evaluations, case reports, and the opinion of nationally recognized experts based on experiential evidence (Dearholt & Dang, 2012).

Once the level of evidence for the included studies had been determined with the JHREAT, the quality of the studies was ascertained. Criteria for high, good and low quality are the same for evidence levels I, II and III. Criteria are unique for determining high, good and low quality for evidence levels IV and V. Considerations for determining quality for studies included in evidence levels I-III include consistency of results, applicability to a broad range of practice, sufficient sample size/study power, sufficient controls, consistent recommendations, and definitive conclusions. Considerations for determining quality for studies included in evidence levels IV and V include sponsorship by a public, private, or professional organization, or by an agency of the government, documentation of a standardized literature search strategy, consistent results with adequate numbers of studies, evaluation of the strength/quality of the included studies, definite conclusions, and readily apparent national expertise (LoBiondo-Wood & Haber, 2014).

Summary

A comprehensive literature review was conducted using EBSCO Academic Source Premier, PubMed database, and Google Scholar in order to find appropriate articles for review. It was found that FGC has been researched in numerous locations around the world and within various cultures, as it is a question of interest for healthcare practitioners in various settings. Inclusion and exclusion criteria were used to ensure that the most applicable articles were included, resulting in a total of 22 reviewed articles. The JHREAT was subsequently used to determine the level of evidence provided by each study, as well as the quality of those studies.

Chapter III: Literature Review and Analysis

This chapter incorporates the findings from the literature review of 22 studies about Female Genital Circumcision (FGC). The principal findings from the reviewed literature include:

1. A general gap in knowledge among healthcare providers in developed countries about management of patients who have undergone FGC.
2. Limited cultural competency among healthcare providers when dealing with patients who have undergone FGC.
3. A corresponding need for further education, training, supportive policies, guidelines and protocols for midwives who care for women that have undergone FGC.
4. A need for further education for mothers and the community regarding the types and consequences of FGC.

Attitudes toward FGC have changed dramatically in communities and countries where it is practiced in recent years. However, as the literature will report, the corresponding change in behavior has been very slow. There is ample evidence that FGC is a long-standing tradition in those communities where it is still practiced, and therefore it is more than simply a cultural or religious practice (Chalmers & Omer-Hashi, 2003). Research will be put forward showing that its pervasiveness and sense of being a "normal" practice represents one of the greatest barriers to its abandonment in those communities (Ahanonu & Victor 2014).

The Matrix

Included within the matrix are six qualitative studies, one randomized controlled trial, five literature reviews, two cross-sectional studies, one non-experimental quantitative study, one non-experimental case control study, five expert opinion studies, and one retrospective audit. Of these 22 studies, six were based on information gathering or research that occurred in the United

States, two were from Nigeria, two from Sudan, one from Japan, one from Kuwait, one from Kenya, three from Australia, five from the United Kingdom, one from the Netherlands, one from Sweden, one from Denmark, one from Spain, and one from Belgium. The purpose, sample, design, measurement, level of evidence, quality of the studies, conclusions and recommendations from each study were identified and included in the matrix. This is documented in Appendix A.

Major Findings

General Gap in Knowledge Among Healthcare Providers

One of the main obstacles to be overcome in providing care to women who have undergone FGC is lack of knowledge regarding the consequences of and types of FGC. Chibber, El-saleh & El harmi (2010), in their study done in Kuwait, reported that in some regions women may be fearful to disclose FGC due to the possible reappreciations. According to, Dawson, Turkmani, Fray, Nanayakkara, Varol, and Homer (2015), during midwife training, female genital circumcision is only mentioned briefly in Australia. However, the reality of clinical practice is far different. Health care providers must be prepared to care for women who have undergone FGC as they will certainly be faced with these patients at some point. Lazar, Johnson-Agbakwu, Davis, and Shipp (2013) demonstrate that many of the 14 healthcare providers among them, 9 obstetricians, 1 family practice, 3 midwives and women's heath practitioner included in their study based in the United States had no exposure to training regarding FGC whatsoever, and had to learn about the care of these women "on the job". Chalmers and Omer-Hashi, (2003) document in their book that the perception among Somali immigrant women in Canada is that providers lack familiarity and comfort with providing care to those who have undergone FGC. They obtained this data by listening to women that have been subjected to FGC and have experience childbirth in Canada. Leye et al. (2006) make the argument that more assessment is

needed of the educational requirements of western healthcare professionals. The training of various providers including medical students, nurses and midwives should include varying levels of information on counselling, clinical care, prevention of, communication surrounding, and attitudes toward FGC.

Limited Cultural Competency Among Healthcare Providers

Odemerho & Baier, (2012) reported that in Illinois, USA an area closely related to that of clinical and technical education of healthcare providers is the need for more robust cultural competency. Within developed countries, healthcare providers are often unaware that FGC is not a practice that is specific to any one country, region, race, culture or ethnicity. According to Chalmers and Omer-Hashi, (2003) FGC is practiced for many reasons, including the prevention of female promiscuity and masturbation, increased fertility, increased sexual pleasure for men, and to ensure chastity before marriage. Twenty-three circumcised Somali women in Boston reported feeling that their healthcare providers do not want to discuss FGC with them and do not have clinical knowledge about how it may affect them during delivery (Ameresekere, Borg, Frederick, Vragovic, Saia, & Raj, 2011). According to Obstetrician-Gynecologist and researcher Dr. Nour from Harvard Medical School (2015), women who have undergone FGC often find themselves needing to educate their caregivers about this practice because of their evident provider's lack of knowledge. Admittedly, this is a difficult topic for providers with limited training and knowledge in this area. Providers caring for women with FGC may need to overcome language barriers and sense of discomfort in broaching the topic. Healthcare providers often feel frustrated when confronted with patient's resistance to interventions they recommend and sense that they are not trusted (Lazar et al., 2013). Knowledgeable healthcare providers who are confident with their training and skills and who are culturally sensitive and nonjudgmental

will ensure that patients have more trust and less fear in the care that they receive and will be more open to their providers' care management and suggestions.

Need for Further Education and Training of Healthcare Providers, and for Clinical Protocols and Guidelines

Because of the ever-increasing mobility of human populations, healthcare providers in developed countries are increasingly presented with patients from other cultural and social backgrounds. This includes women originating from developing countries where FGC is performed on a high percentage of the female population. According to Lazar et al. (2003), the three nurse-midwife participants in their semi structured interviews uniformly indicated a lack of formal protocols at their clinical sites for the care of women who had undergone FGC. Dawson et al. (2015) also mention a Swedish study done by Widmark, Tishelman, and Ahlberg, (2002) in which midwives indicate it was "frightening to experience FGM for the first time with no knowledge" (p. 235).

This study found that some attempts to respond to healthcare providers needs for more education and support have been made by creating educational programs. For example, Jacoby and Smith developed a course for American nurse-midwives that gave them the opportunity to practice deinfibulation of women that had undergone FGC type 3 using a pelvic anatomical model (Zurynski, Sureshkumar, Phu, & Elliott, 2015). Also, several European countries have developed resources to support those who care for this group of patients. Belgium has created guidelines and a practical manual for healthcare providers involved in the care of women who had undergone infibulation, also known as FGC type 3 (Leye et al., 2006). The manual provides clinical advice regarding prenatal consultations, delivery, and postpartum care. The National Board of Health in Denmark created a reference book outlining FGC and ways to provide care in

a culturally sensitive way (Leye et al., 2006). In Denmark, there is an antenatal clinic at the Frederiksberg Hospital that specializes in the treatment of women who have undergone infibulation. Many providers in Denmark will refer their pregnant infibulated patients to this clinic (Leye et al., 2006). Sweden has developed guidelines for the care of women who have undergone FGC, including "the management of genitally mutilated women in antenatal care, the performance of gynaecological examination, and delivery among genitally mutilated women" (Leye et al., 2006, p. 370). In the Netherlands, a commission of experts handles situations in which FGC of girls has been requested by patients (Leye et al., 2006). The United Kingdom has developed codes of conduct which instruct providers on how to provide culturally sensitive and ethical care to women who have undergone FGC. They have also created a series of African Well Women Clinics in the UK because of the ever-increasing numbers of women with FGC presenting to clinics and hospitals for delivery, family planning, and gynecologic care (Leye et al., 2006).

As demonstrated by this literature review, several European countries have been responding to the need for culturally sensitive care for women who have undergone FGC by training, educating and supporting health care providers about this practice. In some places, they have created guidelines and even built specialty clinics that serve this unique population. However, the situation is different in the United States of America. According Goldberg, Stupp, Okoroh, Besera, Goodman, and Danel (2016), in the United States there are around 513,000 girls and women who are at risk for or have undergone FGC and yet there are no comparable systems in place here. Therefore, there is a great need for clinical guidelines, as well as more education and training for American healthcare providers to ensure the quality and culturally sensitive care that these girls and women deserve.

Need for Education of Mothers and the Community

Improving the education and training of healthcare providers is not enough. Women and their communities also need education. Education is important because traditional justifications for the practice of FGC are largely based on "misinformation in the countries in which it occurs" (Chalmers & Omer-Hashi, 2003, p. 11). There is typically a lack of education in these countries about the sexual function of women, or about the practice of FGC and its sequelae, including in medical schools (Chalmers & Omer-Hashi, 2003). Ahanonu and Victor (2014) conducted a qualitative study in Laos, Nigeria with a sample of 95 mothers 45 years old or younger where they found that, one-third of mothers are unaware of the gynecological complications which may result from FGC. Likely for this reason, daughters of uneducated women are at higher risk to undergo FGC. Women from communities that typically practice FGC should be aware that there are numerous complications which can arise from the procedure, including "prolonged maternal hospitalization, premature labor, kidney infection, cesarean section, prolonged and/or obstructed labor, fetal distress hepatitis C positive, post-traumatic stress disorder and anxiety" (Chibber et al., 2010, p. 834), and infertility.

Descriptive statistics show that "community-wide behavior change needs to happen in order to abandon the practice of FGC" (Cloward, 2015, p. 404). Abubakar (2013) indicates that efforts to develop community awareness of the practice of FGC and to develop advocacy efforts against it are equally important. Paliwal, Ali, Bradshaw, Hughes, and Jolly (2014), conducted a retrospective audit in Birmingham, UK with a sample of 253 women that had a type 3 FGC and gave birth in a midwifery-led hospital. They found that properly educating mothers who have undergone FGC type 3 can result in lower rates of newborn girls undergoing this procedure in the future. Varol, Fraser, Ng, Jaldesa, & Hall, (2014) conducted a qualitative study in

Newcastle, Australia, they concluded that the abandonment of FGC is likely to result once a community receives education on the consequences, harm and risks of the procedure

Conflicting Research

There is limited conflicting research that supports the continuation of performing FGC. Most medical research originates in already developed countries where FGC is seen as a crime or assault, reducing the likelihood of finding studies supporting its use. Abubakar (2013, p. 481) conducted a qualitative phenomenological study in Columbus, Ohio home to the second largest Somali diaspora population in the US (after Minneapolis Minnesota). The participants were recruited by snowball method. They divided the participants into 3 focus groups: 1) Younger women age: 21-34, 2) Older women age: 45-80 and 3) Men age: 20-70. The researchers lead a focus group were the participants were asked for the opinions of Somali women who had undergone FGC and found that although younger (21-34) women were against the practice, older women (45-80) felt that FGC is an important part of their cultural tradition and that it should be continued. There was concern among this group that not undergoing FGC could result in a lower likelihood of securing marriage for a woman (Abubakar, 2013). Ahanonu and Victor (2014) found that 44.2% of mothers in Lagos, Nigeria felt that uncircumcised women would go on to become sexually promiscuous. In one study performed in Eastern Sudan, 76.4% of the 154 traditional birth attendants stated that they did not see FGC as a harmful practice (Ali, 2012).

Strengths and Weaknesses of the Research Studies

One of the major strengths of this literature review is its incorporation of articles from all around the world, which reflects the scope of the countries and communities where it is practiced. FGC is a worldwide problem, and so studies looking at ending the practice must come from around the world. Another major strength is the quality of the research that was included.

Most studies were mostly qualitative and expert opinion due to the nature of the topic it would be unethical to conduct randomized controlled trials. However, the study conducted by Almroth, et al. (2005) was an experimental randomized controlled trial this study investigated the possibility that FGC is associated with primary infertility. This study was able to demonstrate that there is an association between severe forms of FGC (type 3 and 4) and infertility. Finally, the studies were overall of good quality and seven of them had high quality.

A major weakness in this area of research is that due to ethical concerns regarding studies into FGC, no randomized controlled trials (RCTs) have been performed to evaluate possible interventions. The nonexistence of RCTs could be a major contributing factor for the lack of clinical guidelines in the United States for the care of women who have undergone FGC.

Summary

Many health organizations around the world view FGC as a violation of human rights (WHO, 2008). Many of these organizations and many independent scholars are leading efforts to end this practice. Until then, healthcare professionals must be prepared to care for this unique group of women. In order to be sufficiently ready, they need proper guidelines, protocols and training. However, this need has not been met in the United States. This research identifies some examples of what can be done to start meeting this need.

Circumcised women have already suffered and they need culturally sensitive and ethical care. The best way to care for them is by understanding their culture, respecting their traditions, and being prepared to provide the highest quality care possible including, in some cases, deinfibulation and reinfibulation. It is hoped that the practice of FGC will eventually disappear. In order for this to happen, worldwide health organizations and healthcare professionals

including nurse-midwives must work to educate the communities they serve by creating awareness of the short-term and long-term consequences of this painful practice (WHO, n.d.).

Chapter IV: Discussion, Implications, and Conclusions

Synthesis of the Literature to Answer the Practice Question

Events around the world today have resulted in the mass exodus of emigrants, immigrants, and refugees from locations where female genital circumcision has been practiced for thousands of years into developed countries where this practice is seen as a violation of human rights. Their arrival has come as a shock to healthcare providers in developed countries, including nurse-midwives, who have not been accustomed to caring for women with this unique modification to their anatomy.

The purpose of this literature review was to answer the question of interest: "Are there clinical practice guidelines for providing quality, culturally sensitive and holistic care to women who have undergone female genital circumcision?" Twenty-two articles were reviewed and appraised following the guidelines of the Johns Hopkins Research Evidence Appraisal Tool. The research evidence suggests that the shock of FGC has translated into unpreparedness in caring for these patients and an associated lack of clinical practice guidelines for their care.

Once the articles were reviewed, the implications of the findings for the practice of nurse-midwifery were subsequently analyzed. Needs for avenues of future research were also identified. The Transcultural Nursing Theory, developed by Madeline Leininger (Olin, 2011), was utilized to understand the cultures that practice female genital circumcision. This theoretical framework was found to be useful in comprehending the origins of the practice of female genital circumcision, and the feelings of the women and healthcare providers exposed to this procedure.

Implications for Nurse-Midwifery Practice

Nurse-midwives need to be ready to care for every patient. The evidence of unpreparedness for providing healthcare to women having undergone FGC has many

implications for nurse-midwife practice because in many cases nurse-midwives are the primary health care providers for these women, not only during prenatal visits but also during labor and delivery, postpartum, and yearly well woman exams.

Randomized controlled trials (RTC) are one of the best ways to create evidence based guidelines for health care. However, this literature review has shown that, due to the nature of the procedure of female genital circumcision, RTCs are unethical. Therefore, developing guidelines for treating women with FGC based on RTCs is not an option and other approaches are needed.

This research found that some efforts have been made to prepare nurse-midwives to properly care for circumcised women. Zurynski et al. (2015) mention a course developed by Jacoby and Smith for training American nurse-midwives. In this course, nurse-midwives had the opportunity to practice deinfibulation of women who had undergone FGC type 3 using a pelvic anatomical model (no suggestions or guidelines where mentioned in the study). Other developed countries, especially in Europe, have become more aware of healthcare providers' need for tools and are making progress. They have created protocols, benchmarks, and guidelines (clinical and ethical) to be followed by health care providers that care for this group of women (Leye et al., 2006). Hesperian Health Guides (2016) also have some information on FGC and can be utilized as an educational tool for healthcare providers.

Another finding is that in order to continue to make medical advances and provide quality care to all patients, nurse-midwives must become sensitive to the culture, traditions, and beliefs of their patients. For this they can utilize the Transcultural Nursing Theory (Olin, 2011) to help them understand and accommodate the increasing diversity of our world.

The literature review has shown that nurse midwives, and healthcare providers in general, need to be prepared to properly manage the care of patients of any culture, especially female patients who have been circumcised. To be prepared, nurse-midwives must become more educated about FGC types, their short- and long-term consequences, and understand the reasoning, culture and tradition behind this practice. Also, nurse-midwives can have a role in educating communities where FGC is prevalent and where women and girls are most at risk for being circumcised (Ali, 2012). Abubakar (2013) suggests that healthcare providers conduct conferences, seminars, visits to mosques, radio or television programs to reach communities that have a population of immigrants where FGC is prevalent. By educating the community, nurse-midwives can contribute to the cessation of this practice.

In an effort to understand the point of view of the community, this researcher conducted a face to face interview with Deka Abdulle (personal communication, December 26, 2016), a Somali immigrant and now Minnesota resident, to discuss FGC. During this interview, it was found that many circumcised women are not even aware of the various types of circumcision that exist. A lack of knowledge about the immediate and long term consequences of FGC was also evident. This interview reinforced the literature search suggestion that to meet the goal of eradication of this practice, community education is essential.

Furthermore, Abdulle (personal communication, December 26, 2016) suggested that a lack of knowledge of FGC is evident in healthcare professionals. As a mother of four children and woman who has undergone FGC, she has had to face the same questions and judgments about FGC over and over again. Her life experience corroborates the findings in this literature review and shows that healthcare professionals must become sensitive to the culture and

traditions of their patients in order to provide nonjudgmental care and improve patient satisfaction.

Recommendations for Future Research

As no clinical guidelines currently exist in the United States to guide practitioners, what exactly constitutes appropriate care of female circumcised patients is somewhat nebulous. Having reliable information about FGC, such as the various types of circumcision, is an essential first step toward being able to manage the care of female circumcised patients, so informative educational materials are needed. Also needed is knowledge of how post-FGC women are treated by healthcare providers in countries where FGC is prevalent, so an investigation to discover practices that can be adapted into the western healthcare system is also called for.

One research recommendation is to survey members of the American Congress of Obstetrics and Gynecologist (ACOG) and the members of the American College of Nurse-Midwives (ACNM) to find out what guidelines members are following now to care for these patients, what they have found to benefit their patients, and what has been found to have a negative outcome. Once this data is collected, model guidelines can be created and compared to those produced in European countries (Purchase, Lamoudi, Colman, Allen, Latthe, & Jolly, 2013).

Possible avenues for future research would be executing retrospective chart reviews, such as a review on the outcomes of medical interventions made during birth for female circumcised patients, especially those with type 3 circumcision. This study would help us understand what procedures are helpful, and could help incorporate what is done in countries where FGC is prevalent into a western form of healthcare. Another retrospective chart review could evaluate

whether deinfibulation during the second trimester can prevent complications during birth, or prevent postpartum hemorrhage (Chalmers & Omer-Hashi, 2003).

Research is also needed on how to communicate with women who have undergone FGC in a way that will result in increased trust and compliance with medical interventions. These studies would ideally be conducted as face to face interviews with female circumcised patients and/or their providers (Ameresekere et al., 2011).

Integration and Applications of Selected Theoretical Framework

Once a community's history, culture and tradition are well-understood, it becomes possible to care for its people (Varol, Fraser, Ng, Jaldesa, & Hall, 2014). Healthcare providers need to understand, be sensitive toward, and treat patients of various cultures, including those who have undergone FGC. Madeline Leininger left a profound legacy with regards to how providers' attitudes can be harmful or beneficial to the outcome of healthcare interventions and management. By utilizing Madeline Leininger's Transcultural Nursing Theory (Olin, 2011), healthcare providers will become more aware of the background behind the practice of FGC, and they can respect and understand their patients' culture.

Nurse-midwives should learn Madeline Leininger's Transcultural Nursing Theory (Olin, 2011) so they are able to practice what Leininger calls culture care accommodation. Culture care accommodation stimulates creative nursing actions that help patients adapt to or negotiate with their healthcare providers in order to accomplish their shared goal of optimal health outcome. Leininger's framework should be integrated into all healthcare providers' education because it will enrich their understanding and build the proper foundation for becoming holistic and culturally sensitive providers. This theory also would encourage nurse-midwives to teach their patients and their communities about FGC.

Conclusion

Female circumcision is a procedure that has been performed for thousands of years (Chalmers & Omer-Hashi, 2003). It is performed in many countries, some with a very high prevalence (~99%) (UNICEF, 2016). There are four basic types of female circumcision (Abdulcadir, Catania, Hindin, Say, Petignat, & Abdulcadir, 2016). Types 1 and 2 do not affect women during conception, prenatally, during labor and delivery, or post-partum. Type 3 female circumcision is associated with many serious complications, including infertility, infections, prolonged labor, post-partum hemorrhage, as well as fetal and maternal death, among others (WHO, 2017).

Due to the immigration of patients to developed countries, healthcare providers in the United States must be ready to care for women who have been circumcised, including women who have undergone type 3 circumcision. Women who have been circumcised, and have been cared for by a provider who is not familiar with this practice, will undergo cesarean section much more frequently than non-circumcised patients. The result is fear and lack of trust toward western medicine within communities with high incidence of FGC (Ameresekere et al. 2011). This causes frustration and pain for both providers and patients.

This literature review has found that the lack of guidelines and randomized controlled trials providing evidence-based data regarding proper management of these patients in developed countries has resulted in sub-optimal care including unnecessary procedures. The lack of culturally sensitive care is creating a divide between healthcare providers and patients. This chasm can be bridged by properly educating healthcare providers, providing them with guidelines for care, and supporting them through the ethical and emotional challenges that they will face while caring for this unique group of patients.

According to the literature, other developed countries are going through a similar process. Some have already found ways to support their healthcare providers, including creating specialized clinics that care for women who have undergone FGC (Leye et al., 2006). In some cases, they have developed evidence-based guidelines for care. In the United States, organizations such as the American College of Obstetrics and Gynecology and the American College of Nurse Midwifery have contributed in this area by presenting position statements. However, no guidelines yet exist in this country. Dawson, Turkmani, Fray, Nanayakkara, Varol, and Homer (2015) stress the importance of education, training, and a supportive work environments for nurse-midwives involved in the health care of women that have undergone FGC. It is possible for healthcare providers in the United States to adapt guidelines developed in other countries, and to create our own guidelines through research-based investigations, and so begin a new era in which healthcare providers feel prepared to provide high quality, culturally sensitive care for their patients.

Ali (2012) suggests that education could be the key for achieving the eradication of FGC. Women who have undergone FGC have suggested that conferences, seminars, visits to mosques, and radio or television shows can facilitate advocacy for cessation of the practice (Abudakar, 2013). Some of the educational points for the community should include:

- The inexistent relationship between FGC and sexual promiscuity.
- Awareness of immediate and long term complications related to FGC including female infertility (Almroth, Elmusharaf, El Hadi, Obeid, El Sheikh, Elfadil, & Bergström, 2005).
- The community must be made aware that FGC is illegal in the United States, and is now considered a violation against human rights around the world (Hearst & Molnar, 2013).

Education for healthcare providers and the community will benefit everyone. Women who have undergone FGC will receive the quality and sensitive care that they deserve and the community can work together with healthcare organizations (such as WHO, UNICEF, ACNM, and ACOG) to eradicate this practice.

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Appendix A

Matrix of the Literature

Citation	Purpose	Sample	Design	Measurement	Results/Conclusions	Recommendations	Level & Quality
Abubakar, N. (2013). Global discourse, local practice: Female circumcision and inter-generational conflict in a Somali diaspora community. *Perspectives on Global Development & Technology, 12(4),* 476-488. doi: 10.1163/15691497-12341268	The purpose of this research was to contribute to ongoing efforts to eradicate the practice of Female Genital Circumcision (FGC) worldwide by under-standing the reasoning behind it.	Snowball sampling. Three groups. Younger women age: 21-34, Older women age: 45- 80, Men age: 20-70. No specific age range for (younger and older groups) **Setting:** Ohio, United States of America (USA).	Qualitative phenomeno-logical method.	Three focus group discussions on female circumcision.	**Younger women (21-34)** were against FGC. FGC is a cultural, not religious, tradition. They do not want women to endure this practice anymore. **Older women (21-34)** had undergone FGC themselves. They feel it is an important part of culture and should be continued. Some are concerned that not having it reduces chances of marriage. **Younger men** were angrily opposed to FGC. They assert that it is not advocated by Islam. **Older men** expressed sorrow at the loss of a Somali tradition.	Participants suggested that conferences, seminars, visits to mosques, a radio call-in show, and a live television audience are ways to discuss FGC and facilitate advocacy for cessation of the practice.	Level III. Good quality.

Citation	Purpose	Sample	Design	Measurement	Results/Conclusions	Recommendations	Level & Quality
Ahanonu, E. L., & Victor, O. (2014). Mothers' perceptions of female genital mutilation. *Health Education Research, 29*(4), 683-689. doi: 10.1093/her/cyt118	The purpose of this study was to explore the perceptions of FGC among mothers that were patients of a primary health center in Lagos, Nigeria.	Convenien-ce sample of 95 mothers under the age of 45 years. Education level: Primary 19.0% Secondary 52.6 % Tertiary 28.4 % **Setting:** Lagos, Nigeria.	Qualitative study with meta-synthesis.	Mothers completed a pre-tested semi-structured question-naire.	56.8% think FGC is not beneficial. However, 44.2% believe uncircum-cised women will become sexually promiscuous. One-third of mothers are not aware of gynecologic complications of FGC. **Conclusions**: Mothers have ambivalent feelings about FGC. Uneducated mothers may have daughters circumcised due to misconceptions and false beliefs. Many women do not understand the health consequences of FGC.	Further research about this topic is recommended. Women need to be educated about the inexistent relation-ship between FGC and sexual promiscuity. Also, women need to be aware of the complications that FGC can cause. To promote the abandonment of this practice, support from community leaders is necessary.	Level III. Good quality.

Citation	Purpose	Sample	Design	Measurement	Results/Conclusions	Recommendations	Level & Quality
Ali, A. (2012). Knowledge and attitudes of female genital mutilation among midwives in Eastern Sudan. *Reproductive Health, 9* (1), 23. doi:10.1186/1742-4755-9-23	The purpose of this study was to assess knowledge and attitudes of midwives towards Female Genital Mutilation (FGM) in Eastern Sudan.	The sample was composed of 154 "midwives" who were traditional birth attendants. These women were identified by local community members and were selected randomly. **Setting:** Eastern Sudan	Qualitative phenomeno-logical method.	Face to face interviews were conducted at the participants' homes and used an open-ended questionnaire.	Not all the "midwives" or traditional birth attendants performed FGM: 127 did and 30 did not. 6.3% of the circumciser midwives were able to identify all types of FGM correctly. 66.2% planned to continue to practice FGM. **Conclusions:** FGM is classified in 4 types. Type 3, known as infibulation or pharaonic, is most commonly performed in Sudan. The majority (76.4%) of participants do not see FGM as a harmful practice.	The author does not present specific recommendations. However, in the conclusions section the author states: "Substantial effort should be made to discourage the continuation of the practice among midwives in Sudan" (p.3). The author suggests that education could be the key to achieving this goal.	Level III. Low quality. The study has a mistake in the numbers. Also, it lacks validity and was found to not be reliable.

Citation	Purpose	Sample	Design	Measurement	Results/Conclusions	Recommendations	Level & Quality
Almroth, L., Elmusharaf, S., El Hadi, N., Obeid, A., El Sheikh, M. A., Elfadil, S. M., & Bergström, S. (2005). Primary infertility after genital mutilation in girlhood in Sudan: a case-control study. *The Lancet, 366*(9483), 385–391. doi:10.1016/s0140-6736(05)67023-7	The purpose of this study was to investigate the possibility that FGC is associated with primary infertility.	99 infertile women were examined. As part of the study. 89 women were used as control. **Setting:** Sudan	Experiment-al randomized controlled trial.	Cases and controls were recruited and examined in the same clinical settings by the same specially trained doctors. Data was obtained through the use of several laboratory test A genital examination was performed on every woman, noting the extent of FGC. Women having primary infertility had inspections of their internal genital organs using diagnostic laparoscopy.	Of the 99 women with primary infertility who underwent laparoscopic inspection, 48 with extreme cases of FGC were found to have adnexal pathology suggestive of previous inflammation. **Conclusion:** The findings of this study demonstrate an association between severe forms of FGC (type 3 and 4) and primary infertility.	The authors do not present specific recommendations. However, in the conclusions section they state that the findings are highly relevant as evidence to support advocating against FGC.	Level I. High quality.

Citation	Purpose	Sample	Design	Measurement	Results/Conclusions	Recommendations	Level & Quality
Ameresekere, M., Borg, R., Frederick, J., Vragovic, O., Saia, K., & Raj, A. (2011). Somali immigrant women's perceptions of cesarean delivery and patient-provider communication surrounding female circumcision and childbirth in the USA. *International Journal of Gynecology and Obstetrics, 115*(3), 227-230. doi: 10.1016/j.ijgo.2011.07.019	The purpose of this study was to explore the perceptions of cesarean delivery and patient-provider communica-tion surrounding female circumcision and child birth by Somali immigrant women living in Boston.	23 Somali immigrant women living in Boston who had given birth in the USA and Africa. Participants were aged 25-52 years and had been living in the USA. All women had undergone FGC. Five women had a history of Cesarean Section. **Setting:** USA	Qualitative phenomeno-logical method.	Semi-structured, in-depth interviews. The interviewers asked about birth experiences in the USA and Africa.	Women who have undergone FGC feared cesarean delivery because they felt it would result in disability or death. Women felt that U.S. health care providers did not discuss FGC with them and that they did not know how it may affect the process of delivery. **Conclusions**: Previous experiences and cultural beliefs can affect how Somali immigrant women understand labor and delivery. Providers need to have a conversation with their patients about the care they will receive during labor and delivery.	No recommenda-tions were made. However, it was clearly stated that Somali immigrant women living in the USA fear cesarean section. Furthermore, they feel that their providers lack communication skills and do not address their concerns or clarify how circumcision will or will not affect childbirth. Educating providers and encouraging patient-provider communication would be a good step forward.	Level III. High quality.

Citation	Purpose	Sample	Design	Measurement	Results/Conclusions	Recommendations	Level & Quality
Balogun, O. O., Hirayama, F., Wariki, W. M., Koyanagi, A., & Mori, R. (2012). Interventions for improving outcomes for pregnant women who have experienced genital cutting. *Cochrane Database of Systematic Reviews, 2013*(2), 1-13. doi:10.1002/14651858.cd009872	The researchers conducted this review to focus attention on the key interven-tions that have been found to improve the outcome and quality of life for women who have undergone FGC and are pregnant or planning to become pregnant.	30 journals were reviewed. Weekly alerts for another 44 journals and monthly BioMed Central emails were also reviewed. **Setting:** Tokyo, Japan	Cochrane database of systematic reviews.	Several tables were created to compare and contrast the outcomes of the studies reviewed.	No randomized control trials, cluster-randomized trials, or quasi-randomized control trials were found. There is no data about inter-vention outcomes in women who are pregnant or planning to get pregnant and have undergone FGC. The grand majority of research about this topic is observational. **Conclusion:** Due to ethical concerns, randomized control trials, cluster-randomized trials, or quasi-randomized control trials may never be conducted.	Cluster-randomized control trials of a policy on clinical management of women who have undergone FGC could provide evidence about appropriate clinical care of women that have undergone FGC.	Level I. High quality.

Citation	Purpose	Sample	Design	Measurement	Results/Conclusions	Recommendations	Level & Quality
Chibber, R., El-saleh, E., & El harmi, J. (2010). Female circumcision: Obstetrical and psychological sequelae continues unabated in the 21st century. *The Journal of Maternal-Fetal & Neonatal Medicine, 24*(6), 833–836. doi:10.3109/14767058.2010.531318	The purpose of this study was to evaluate the incidence of FGC among pregnant women attending the antenatal clinics of the University of Kuwait. The authors also describe the obstetric and psycho-logical conse-quences of FGC.	4800 consecutive women in the first trimester of pregnancy who attended the antenatal clinics of the University of Kuwait once the ethics committee had approved the study. **Setting:** Kuwait	Non-experimental descriptive case-control design.	Calculation of prevalence of FGC was done by odd ratio and confidence interval. Morbidity and mortality analysis were adjusted according to demographic variations. Logistic regression was utilized to calculate the odd ratio, the confidence interval, and to measure the association of maternal conditions and outcomes with FGC in pregnancy.	1842 women were found to have undergone FGC (38% of the total participants). Complications of FGC that were found are: Prolonged maternal hospitalization. Premature labor. Kidney infection. Cesarean section. Prolonged and/or obstructed labor. Fetal distress. Hepatitis C positive. Post-traumatic stress disorder. Anxiety. **Conclusions:** Serious complications may arise from FGC. FGC is found in women in all ranks of economic and educational status.	No recommendations were given by the authors.	Level III. Good quality.

Citation	Purpose	Sample	Design	Measurement	Results/Conclusions	Recommendations	Level & Quality
Cloward, K. (2015). Elites, exit options, and social barriers to norm change: The complex case of female genital mutilation. *Studies in Comparative International Development, 50*(3), 378–407. doi:10.1007/s12116-015-9175-5	The purpose of this study was to identify conditions that would support a change from the practice of female genital circumcision (FGC). It also looks at the likelihood of overcoming support for FGC if that practice is not part of the culture nearby.	Female and male Maa-speakers (n=200), randomly selected from three case study areas (Random walk procedure). Participant ages ranged from 15-85. **Setting:** Kenya	Descriptive cross-sectional study administered verbally in the Maa language.	The survey included indicators of behavior and intentions with respect to FGM.	First, it does appear that the practice of FGC is lagging considerably behind attitude change towards this practice. Second, the descriptive statistics show that community-wide behavior change needs to happen in order to abandon the practice of FGC. **Conclusions:** Existing group differences and local activism appear to contribute toward an individual's decision to turn away from FGC. International norm pressures may trickle down to a wide geographical area if education is provided.	No recommendations were given.	Level III. Good quality.

Citation	Purpose	Sample	Design	Measurement	Results/Conclusions	Recommendations	Level & Quality
Dawson, A., Turkmani, S., Fray, S., Nanayakkara, S., Varol, N., & Homer, C. (2015). Evidence to inform education, training and supportive work environments for midwives involved in the care of women with female genital mutilation: A review of global experience. *Midwifery, 31*(1), 229–238. doi: 10.1016/j.midw.2014.08.012	This study focused on identifying how midwives care for women with FGC and their challenges. It also explored professional development and workforce strategies that could help midwives provide appropriate, quality care to these patients.	10 research studies published between 2004 and 2014. **Setting:** Sydney, Australia	Systematic review of observation-al, quasi-experimen-tal, and non-experimental descriptive studies.	Narrative synthesis was used to analyze the literature selected.	The researchers found that there is a lack of technical knowledge, limited cultural competency, and socio-cultural challenges to abandonment of the practice of FGC. **Conclusion:** There is a great need for education, training, supportive policies, guidelines and protocols for midwives to follow while caring for women who have undergone FGC.	Research is necessary, especially in low- and middle-income countries where FGC is practiced, in order to develop guidelines that will help midwives and other healthcare professionals to properly care for these patients. These guidelines could help providers to educate the community and support the abandonment of this practice.	Level II. High quality.

Citation	Purpose	Sample	Design	Measurement	Results/Conclusions	Recommendations	Level & Quality
Gayle, C., & Rymer, J. (2016). Female genital mutilation and pregnancy: Associated risks. *British Journal of Nursing, 25*(17), 978-983. doi:10.12968/bjon.2016.25.17.978	The purpose of this paper was to review the obstetrical risks to women who have undergone FGC.	Not applicable. **Setting:** England	Opinion of Experts.	Not applicable.	There is a connection between FGC and increased risks in pregnancy. Such as: Most of the studies about FGC are conducted in Africa and data may not be relevant to the cohort of patients that live in developed countries.	More studies, such as randomized controlled trials, need to be conducted in order to evaluate the risks during pregnancy for women who have undergone FGC and live in developed countries. Also, more studies are needed to create guidelines for the adequate timing of deinfibulation (prenatal or during delivery).	Level IV. High quality.

Citation	Purpose	Sample	Design	Measurement	Results/Conclusions	Recommendations	Level & Quality
Hall, S., & Brown, D. J. (2009). Management of female genital trauma. *Trauma, 11*(2), 133-138. doi:10.1177/1460860910415 4	The purpose of this clinical paper was to guide and advise non-specialist health care providers in the appropriate management and treatment of several female genital traumas not related to childbirth, including FGC.	Not applicable. **Setting:** England	Opinion of experts.	Not applicable.	This paper gives general management advice for non-specialist health care providers so that patients can receive adequate treatment before specialists arrive. **Conclusions:** Female genital trauma is a type of injury that is very delicate and could be the result of crime or assault according to the World Health Organization (WHO). Proper documentation is a must. Also, fast and appropriate treatment will ensure good physical and psychological outcomes.	The authors recommend that non-specialist health care providers who are faced with a case of female genital trauma should obtain history and perform examination carefully. Documentation should be complete. They should not remove or invalidate evidence that may be needed later on in court.	Level IV. Good quality.

Citation	Purpose	Sample	Design	Measurement	Results/Conclusions	Recommendations	Level & Quality
Hearst, A. A., & Molnar, A. M. (2013). Female genital cutting: An evidence-based approach to clinical management for the primary care physician. *Mayo Clinic Proceedings, 88*(6), 618–629. doi: 10.1016/j.mayocp.2013.04.004	The purpose of this study was to provide an introduction to the practice of FGC and offer practice guidelines for the primary care physician.	Not applicable. **Setting:** USA	Expert opinion based on literature review.	Not applicable.	Due to immigration, it is likely that primary care physicians will care for women who have undergone FGC. This paper is meant to be used as a starting point for primary care physicians so they can become familiar with the culture, background, and classification of FGC. The authors hope that this paper will ensure that FGC patients will receive culturally sensitive care.	Suggested readings were presented as sources for more information about obstetric and pediatric care for FGC patients.	Level IV. Low quality.

Citation	Purpose	Sample	Design	Measurement	Results/Conclusions	Recommendations	Level & Quality
Larsen, U., & Okonofua, F. E. (2002). Female circumcision and obstetric complications. *International Journal of Gynecology and Obstetrics, 77 (3),* 255-265. doi: 10.1016/S0020-7292(02)00028-0	The purpose of this study was to evaluate whether or not there is an association between female circumcision and complica-tions at delivery.	1851 women (ages 15-49) seeking family planning or antenatal care in three southwest Nigerian Hospitals were interviewed and had a medical exam. **Setting:** Nigeria	Descriptive, cross-sectional reproductiv e health survey and brief examination .	Women were surveyed on obstetric history, socio-demographic characteristics, circumcision status, and characteristics of the circumcision seen upon examination. This analysis also examined type of circumcision by socio-demographic characteristics.	The interviewers found that many women are not aware of which type of circumcision they have. Also, they cannot remember if they had any problems following the circumcision. This study found: 1. Obstetric compli-cations and stillbirth rates were higher at first pregnancy in women with FGC. 2. Higher risks of tearing and stillbirth. 3. Type 2 FGC had more tears. 4. Risks of prolonged labor, episiotomy, and cesarean section in women with type 1 and 2 FGC were equal to other women. 5. No evidence that the effects of FGC increased with parity.	The authors recommend replication of the study with a larger sample in order to better determine the association between type of circumcision and obstetric complications. Also, analyses of other populations having higher proportions of women with type 2 and 3 FGC need to be done.	Level III. Good Quality.

Citation	Purpose	Sample	Design	Measurement	Results/Conclusions	Recommendations	Level & Quality
Lazar, J. N., Johnson-Agbakwu, C. E., Davis, O. I., & Shipp, M. P. (2013). Providers' perceptions of challenges in obstetrical care for Somali women. *Obstetrics and Gynecology International*, *2013*, 1-12. doi:10.1155/2013/149640	The purpose of this study was to report on the experiences, training, practices, and attitudes of providers who give prenatal, delivery, and health management care to women with female genital cutting (FGC).	Providers (n=14), 9 obstetri-cians, 1 family practice, 3 midwives, and 1 women's health nurse practitioner. Ages ranged from 30-70, with a self-reported 3–17 years of experience working with Somali women. **Setting:** Ohio, USA	Qualitative phenomeno-logical method.	Semi structured interview (approximately 45 minutes in length). Interviews were audio recorded, with the interviewee's permission.	Healthcare providers caring for women who have undergone FGC face challenges: 1. Patient-provider communication with no shared language, poor interpretation. 2. Provider discomfort talking with patients about FGC. 3. Provider frustra-tion with patients' resistance to obstetric interventions. 4. Provider perception of not being trusted. 5. Suboptimal provider training in the care and management of women with FGC, who have unique reproductive healthcare needs.	To improve quality of care, create partnerships between providers and patients. Recommended strategy: 1. Improve patient–provider communications. 2. Enhance patient trust. 3. Increase provider understanding of patient's culture. 4. Educate patients about intrapartum interventions. 5. Train providers on FGC. 6. Teach patients about Western pregnancy and delivery practices. More research is needed.	Level III. High quality.

Citation	Purpose	Sample	Design	Measurement	Results/Conclusions	Recommendations	Level & Quality
Leye, E., Powell, R. A., Nienhuis, G., Claeys, P., & Temmerman, M. (2006). Health care in Europe for women with genital mutilation *Health Care for Women International, 27*(4), 362–378. doi:10.1080/07399330500511717	The purpose of this study was to evaluate the key findings of two major research projects that investigated health care in Europe for women who have undergone FGC. Also, to examine the implications of FGC and ethical issues that this practice brings to health care providers.	Two major research projects conducted in Europe. The 1st one included The 2nd was a meeting of experts from 6 countries in Europe including **Setting:** United Kingdom, Netherlands, Sweden, Denmark, Belgium	Qualitative data analysis.	Key findings were identified for both studies. Data was analyzed from the first study trough questionnaires. The second study included a narrative summarization of each country way to manage care of women that have been circumcised.	Key findings were identification of: 1. Ethical issues for Western healthcare providers. 2. Responses of European healthcare providers. 3. Issues that are raised during obstetrical care of women who have undergone FGC. **Conclusions:** Proper care for women who have been circumcised should include appropriate clinical care and culturally sensitive professional counseling. Adequate and detailed guidelines need to be provided to healthcare professionals who care for this unique group of women.	All healthcare professionals should receive training in FGC. To create proper guidelines and protocols, all agencies related with FGC should be involved. Members of the community that is affected should also be included.	Level IV. High quality.

Citation	Purpose	Sample	Design	Measurement	Results/Conclusions	Recommendations	Level & Quality
Nour, N. M. (2015). Female genital cutting: Impact on women's health. *Seminars in Reproductive Medicine, 33*(1), 41-46. doi:10.1055/s-0034-1395278	The purpose of this study was to explore the impact of FGC on women's health.	Not applicable. **Setting:** Massachusetts, USA	Expert opinion	Not applicable.	FGC is a complex practice that brings emotional challenges for the patient and her healthcare providers. FGC may be seen as a violation of human rights. **Conclusions:** 1. Providers should treat each woman individually and show respect. 2. Having an understanding of why this practice is done could help providers give culturally and linguistically sensitive care to their patients. 3. Due to providers' lack of knowledge, circumcised women often educate their providers about FGC.	Education and training of healthcare professionals could help them provide adequate care.	Level III. Good quality.

Citation	Purpose	Sample	Design	Measurement	Results/Conclusions	Recommendations	Level & Quality
Odemerho, B. I., & Baier, M. (2012). Female genital cutting and the need for culturally competent communication. *The Journal for Nurse Practitioners, 8*(6), 452–457. doi: 10.1016/j.nurpra.2011.10.003	The purpose of this study was to stress the importance of culturally competent communication. It defines the types of FGC. It also recognizes the legal and ethical issues that FGC brings to the health care system. Finally, it presents a list of the possible complications of FGC.	Not applicable. **Setting:** Illinois, USA	Non-experimental qualitative narrative analysis.	Not applicable.	Healthcare providers such as nurse-practitioners should learn about FGC. Basic knowledge should include (but not be limited to): 1. Types of FGC 2. Reasons it is done 3. Potential complications. Good communication skills should be based on respect for cultural variations.	A culturally competent provider can encourage patients who have undergone FGC to communicate their feelings, including their feelings about their health status.	Level III. Good quality.

Citation	Purpose	Sample	Design	Measurement	Results/Conclusions	Recommendations	Level & Quality
Paliwal, P., Ali, S., Bradshaw, S., Hughes, A., & Jolly, K. (2014). Management of type III female genital mutilation in Birmingham, UK: A retrospective audit. *Midwifery, 30*(3), 282–288. doi: 10.1016/j.midw.2013.04.008	The purpose of this study was to audit the clinical management of women with Type III FGC. Also, to compare the obstetric outcomes of antenatal vs. intrapartum deinfibulation.	253 women with type III FGC who gave birth in a midwifery-led hospital in Birmingham, UK between January 2008 and December 2009. **Setting:** Birmingham, UK	Retrospective audit.	Retrospective case analysis using patients' medical records.	FGC type III was not found to be indication for cesarean section. Improvements that are needed in medical record keeping were identified. Appropriate education of mothers with FGC type III can help prevent newborn girls from undergoing FGC in the future. **Conclusions:** Women with type III FGC who are not prenatally deinfibulated may suffer unnecessary harm. It is important to document the status of the genital area during the first clinical encounter. More training is needed to stress the importance of proper documentation.	Larger multi-site studies should be done to obtain a statistically significant sample size. Further qualitative research is needed to gain better understanding of FGC and the issues that it may cause for women during labor.	Level III. Good quality.

Citation	Purpose	Sample	Design	Measurement	Results/Conclusions	Recommendations	Level & Quality
Purchase, T. C. D., Lamoudi, M., Colman, S., Allen, S., Latthe, P., & Jolly, K. (2013). A survey on knowledge of female genital mutilation guidelines. *Acta Obstetricia et Gynecologica Scandinavica, 92*(7), 858–861. doi:10.1111/aogs.12144	The purpose of this study was to assess knowledge of Royal College of Obstetri-cians and Gynaecol-ogists (RCOG) guidelines on FGC among RCOG-affiliated doctors working in obstetrics and gyne-cology in the UK. This was the first study on this topic done in the UK.	3027 online question-naires sent, 618 responded. **Setting:** Birmingham, UK	Non-experimental quantitative.	The knowledge score was evaluated using the Mann–Whitney U test for years of practice. Statistical analyses were accomplished using SPSS. Multiple linear regression.	Practitioners in developed countries were still newly seeing FGC. Many practitioners were not aware there was a FGC specialist (midwife or obstetrician) in their area that they could refer patients to. Providers demon-strated high levels of knowledge of complications of FGC, which was related to their level of training and experience. However, they lack knowledge of the psychological complications of FGC. **Conclusion:** A gap in knowledge of FGC management still exists.	There is a need for education and training about FGC. Other professionals, such as midwives and nurses, should be included in order to ensure multidisciplinary team work and adequate manage-ment of care.	Level III. Good quality.

Citation	Purpose	Sample	Design	Measurement	Results/Conclusions	Recommendations	Level & Quality
Reig Alcaraz, M., Siles González, J., & Solano Ruiz, C. (2013). Attitudes towards female genital mutilation: An integrative review. *International Nursing Review, 61*(1), 25–34. doi:10.1111/inr.12070	The purpose of this literature review was to describe attitudes toward FGC in various healthcare systems, and to identify factors that support its discontinuation.	16 studies, published 2006–2013. **Setting:** Alicante, Spain	Integrative literature review.	A table was created to compare the 16 studies, evaluate their characteristics, and analyze their results.	There are many factors that support eradication of FGC. There is a paucity of systematic review articles about FGC. There is a lack of literature about FGC in Spanish, especially qualitative studies.	Culturally sensitive nursing care is a must for women who have been circumcised. Public sector and global organizations must continue working toward eradication of FGC.	Level III. Good quality.

Citation	Purpose	Sample	Design	Measurement	Results/Conclusions	Recommendations	Level & Quality
Varol, N., Fraser, I. S., Ng, C. H. M., Jaldesa, G., & Hall, J. (2014). Female genital mutilation/cutting - Towards abandonment of a harmful cultural practice. *Australian and New Zealand Journal of Obstetrics and Gynaecology, 54*(5), 400–405. doi:10.1111/ajo.12206	The purpose of this study was to explore and explain the reasoning behind the global desire for eradication of FGC.	Not applicable. **Setting:** Newcastle, Australia	Qualitative study, grounded theory.	Not applicable.	FGC is a global issue. It causes unnecessary pain and suffering. It negatively affects both men and women. Abandonment of FGC is likely to happen once a community becomes educated. Local communities where women have been circumcised should collaborate with government to eradicate this practice.	None given.	Level III. Good quality.

Citation	Purpose	Sample	Design	Measurement	Results/Conclusions	Recommendations	Level & Quality
Zurynski, Y., Sureshkumar, P., Phu, A., & Elliott, E. (2015). Female genital mutilation and cutting: A systematic literature review of health professionals' knowledge, attitudes and clinical practice. *BMC International Health and Human Rights, 15*(1), 32. doi:10.1186/s12914-015-0070-y	The purpose of this systematic review was to close the gap in knowledge about female genital mutilation (FGM) in healthcare professionals in high-income countries.	159 unique articles, published from 2000 to 2014, were reviewed. 18 of the articles met criteria for inclusion. **Setting:** Sydney, Australia	Systematic review.	A literature search was conducted using the terms: "female genital mutilation" "female genital cutting" and "female circumcision" combined with MESH terms: "Pediatrics" and "Child Health" and the keywords: "paediatrician" "practice guidelines" "attitudes" "knowledge" and "education." Databases, including MEDLINE, CINHAL and SCOPUS, were searched applying the limits: year of publication 2000–2014, human, English language.	159 articles were found in the search, but only 18 met the inclusion criteria. No studies that included pediatricians were found. **Conclusions:** This topic is under-researched. Health professionals need education about FGM and training in how to care for women who have undergone it. Further research is needed to close knowledge gaps and increase the skill of healthcare practitioners.	Culturally sensitive medical and psychological care is needed by girls and women who have undergone FGM. Health care professionals, especially pediatricians and family doctors, need more educational materials and evidence-based guidelines for clinical practice.	Level III. Good quality.