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Nurses Knowledge and Perceptions of Female Genital Mutilation (FGM)
A Literature Review

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Female genital mutilation (FGM) is affecting at least 200 million women across the globe in 30 different countries. The act of cutting healthy genital organs for non-medical causes, is a basic violation of women's rights. There are many ways to justify FGM, and different communities have their own reasons for tradition. Reasons for FGM may include, for example, sexuality control, social and economic pressure, aesthetics, and beliefs about health benefits. Even though FGM is a crime in Finland, the nurses here must face victims of FGM due to increasing immigration.

The aim of this study was to explore nurses' knowledge on FGM. The purpose was to provide information on different types-, risks-, effects- and cultural background of FGM. This was intended to provide information, which could be used in educating future nurses and others working with females who have faced- or are at risk of FGM.

Two main categories were generated from the data found: Information gap/lack of knowledge and post-care. Literature review found out that there is significant gap in nurses knowledge to FGM. Future research suggested on need for further education in university programmes and mapping out nurses current knowledge.

Keywords (subjects)

Female genital mutilation, female circumcision, nurse, defibulation

Miscellanous

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1 INTRODUCTION

Female genital mutilation (FGM), also known as female circumcision, refers to deliberate partial or external genitalia removal for non-medical reasons (Kuismanen, 2018; WHO, n.d.). Depending on the culture, FGM is usually performed on girls between the age of four and twelve. For many communities it symbolizes the girl's transit to “womanhood”. (Rahman, 2000). In modern world FGM is considered a crime (UNICEF, 2016). It has no health benefits and carries a high risk of lifelong damage to physical and psychological health (Creighton, 2016). However, FGM is affecting at least 200 million women across the globe in 30 different countries (UNICEF, 2016). The act of cutting healthy genital organs for non-medical causes is a basic violation of women's rights (Rahman, 2000). Even though FGM is a crime in Finland, the nurses here must face victims of FGM due to increasing immigration (Kuismanen, 2018).

This research aims to explore nurses knowledge on FGM. The purpose was to provide information on different types-, risks-, effects- and cultural background of FGM. This was intended to provide information, which could be used in educating future nurses and others working with females who have faced- or are at risk of FGM.

2 FEMALE GENITAL MUTILATION (FGM)

2.1 Definition of FGM

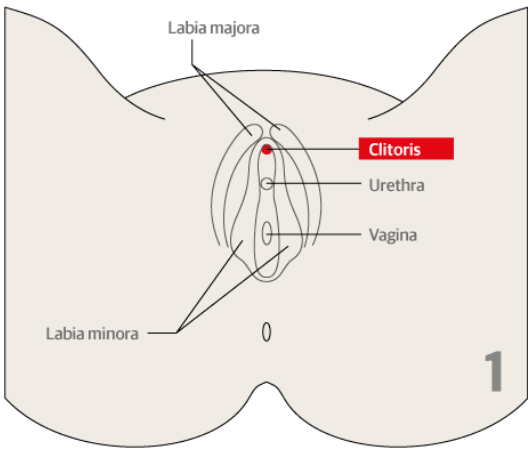
The World Health Organization (WHO, n.d.) defines female circumcision, nowadays called female genital mutilation (FGM) to be all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons (UNICEF, 2016).

The procedure is done by midwives, traditional birth attendants or elderly women. Commonly used instruments in FGM include razor blade, knives, sharp rock, broken glass or scalpels. Analgesics, anesthesia or antiseptics are not normally used, so the girls suffer critical pain. (Koukkula, 2019.)

A girl's mutilation age varies from country, region and from one ethnic group to another. A girl's genitals can be mutilated, for example, as a baby, as a child, as a teenager, during her first pregnancy or only after childbirth. In most cases, the genitals of girls are mutilated between the ages of four and ten. (THL, 2019; Kuismanen, 2018)

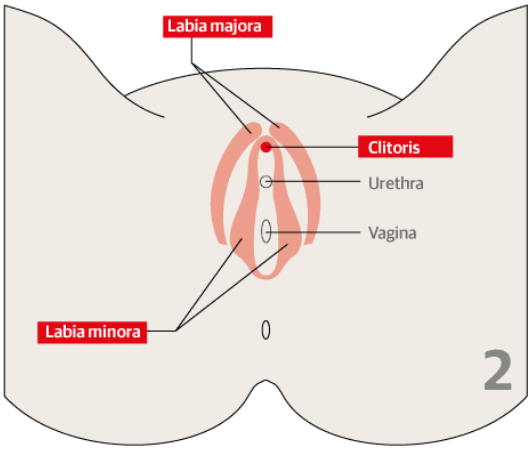
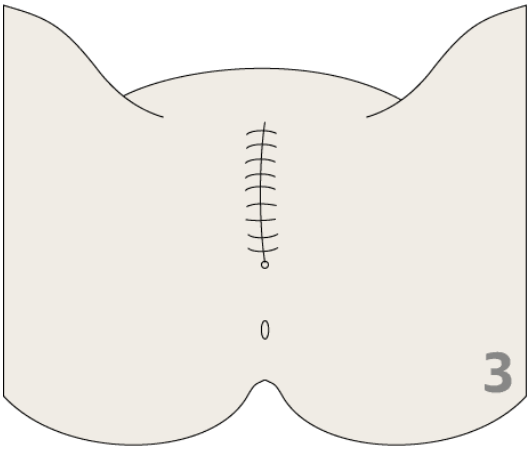
FGM is divided into four different types that can be seen in figure 1.

Figure 1. Types of FGM



Type I is referred to as clitoridectomy. In clitoridectomy, the clitoris is either completely or partially removed, in rare cases only the fold of skin surrounding the clitoris.
(EIGE, 2013; WHO, n.d..)

(Image: Fishwick, C. & Allen, P., 2014)

	**Type II** is referred to as excision. In this the clitoris and the labia minora are either partly or completely removed. (EIGE, 2013; WHO, n.d..) (Image: Fishwick, C. & Allen, P., 2014)
	**Type III** is referred to as infibulation. Infibulation means narrowing of the vaginal opening by creating a covering seal. The seal is made by cutting and repositioning the inner or outer labia. Clitoris may also be removed. (EIGE, 2013; WHO, n.d..) (Image: Fishwick, C. & Allen, P., 2014)
	Type IV includes all other harmful procedures done to the female genitalia for non-medical purpose. Examples of this include piercing, scraping or cauterizing the genitals. (EIGE, 2013; WHO, n.d..)

2.2 FGM Globally

FGM is a thousand-year-old non-religious East African ritual that is criminalized in Finland, but also in the countries where FGM is performed the most (Abdel-Ghani, 2013). As migration has increased, FGM has become a global concern (WHO, n.d.). It is described as a contravention of the UN Charter of Human Rights, the UN Charter of Women's Rights, the Charter of the Rights of the Child, and the Charter of Rights of the African Child (Zurynski, 2015).

FGM is affecting at least 200 million women across the globe in 30 different countries (UNICEF, 2016). FGM is practiced mostly in the western, eastern, and north-eastern regions of Africa, in some countries the Middle East and Asia, as well as among migrants from these areas (WHO, n.d.). In East African areas female genital mutilation is practiced by Ethiopian Jews, Muslims and Christians (Abdel-Ghani, 2013). None of the religions instruct the circumcision of girls, even though it is practiced in the name of religion (THL, 2018). There is no mention of FGM in the Qur'an or the Bible (Abdel-Ghani, 2013). A variety of reasons, ranging from country, region and culture, are behind the tradition (THL, 2018).

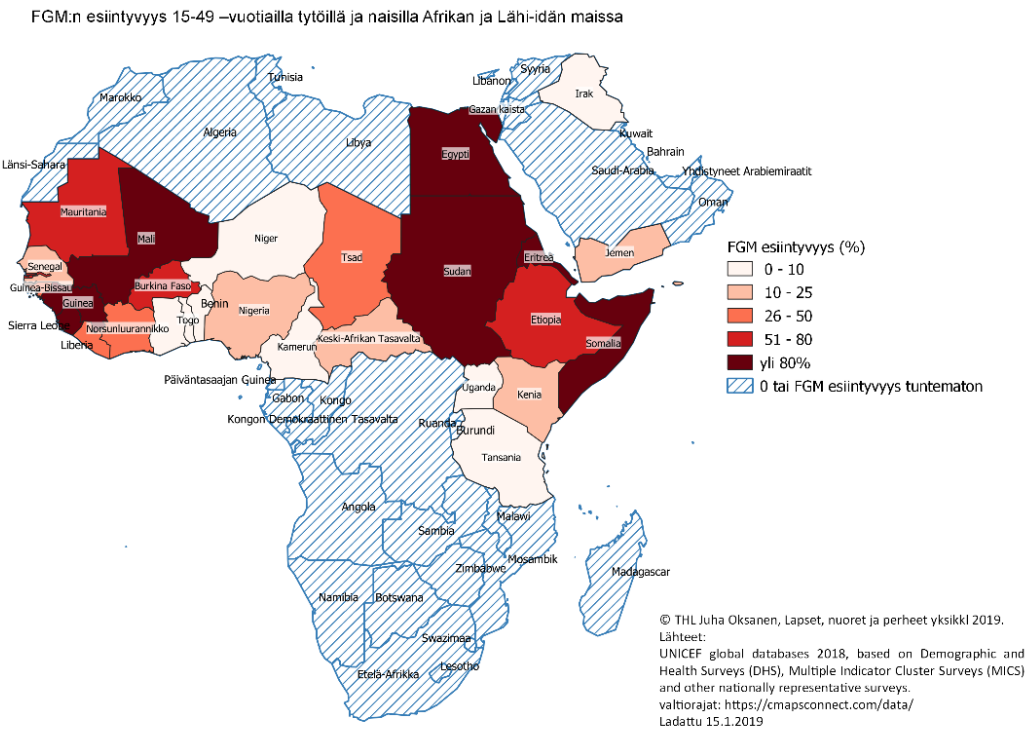


Figure 2. Prevalence of FGM with women aged 15-49 in African and Middle East countries. (Oskanen, 2019)

Any form of FGM performed by medical practitioners or “cultural practitioners” are illegal in over 20 countries in Africa including Kenya, Nigeria and Egypt. Furthermore, Australia, New Zealand, Canada, United Kingdom, Republic of Ireland and many other European countries. For example, 12 of the 52 States of the USA prosecute parents/guardians and circumcisers if FGM is carried out. (Zurynski, 2015.)

WHO denounced the participation of health care providers in FGM since they do not prevent any long-term medical or psychological problems. In most cases families lean to run such procedures outside any health system and therefore FGM incidents are not collected or coded in medical records. Moreover, it is common for girls to be taken to their family's country of origin for FGM. Often health care professionals recognize these FGM when young women visit because of complication or obstetric and gynecological care. Additionally, with more immigration and increasing cultural and ethnic diversity, health care professionals must be more attentive to identifying women and girls with FGM or at risk of FGM, at their work. (Zurynski, 2015.)

2.3 FGM in Finland

It is estimated that 38,000 girls and women originating from countries where FGM is practiced live in Finland. Approximately 10,000 girls and women have undergone FGM, and about 650–3,080 are at risk of mutilation. (Koukkula, 2019.)

In Finland, FGM is criminalized and considered a crime against human rights (Abdel-Ghani, 2013). In Finland, FGM became more known in the early 1990s, when the number of immigrants grew rapidly. Somalis are the biggest, although not the only circumcision performing group in Finland. Other immigrant groups, which have female circumcision at least in certain regions are Ethiopians, Eritreans, Egyptians, Sudanese, Kenyan, Ghanaian and Nigerian. (Ihmisoikeusliitto, 2011; THL, 2018.)

FGM fulfills the criteria for aggravated assault (causing permanent bodily injury) and is punishable by a maximum term of imprisonment of 10 years. According to the Child Welfare Act, social and health authorities have a duty of notification if there is any doubt about a child's genital mutilation planning. (Kuismanen, 2018.)

According to the Finnish league of human rights, the rate of circumcision in families with FGM traditions brought from their home countries has started to decrease while in Finland. There is a possibility that FGM could be given up in Europe, but the problem comes when a girl returns to her country of origin, circumcision may become important again because of family pressure and culture. (Ihmisoikeusliitto, 2011.)

The Finnish Ministry of Social Affairs and Health has an action plan for the prevention of FGM in Finland. It broadly defines the legislative background (Kuismanen, 2018). The main goal of the action plan is to prevent FGM happening in Finland and

preventing the girls living in Finland to be cut abroad, and to increase the well-being and quality of life of girls and women who have undergone FGM (Koukkula, 2019).

2.4 The Tradition of FGM

Mothers, grandmothers and older relatives are most influential in the decision to mutilate the girl. Other local influences, such as village elders, leaders, religious leaders, and health representatives, may also maintain the tradition. The tradition of circumcision can also spread from one community to another, for example through the spread of religious movements, even if the tradition itself is not religious. (Koukkula, 2019.)

The tradition of FGM is still so strong, that even though the mother has refused to put her child through the procedure, the elders of the family will go through with the procedure in secret. (Abdel-Ghani, 2013). There are many ways to justify FGM, and different communities have their own reasons for tradition. Reasons for FGM may include, for example, sexuality control, social and economic pressure, aesthetics, and beliefs about health benefits (Vuorio, 2017).

Traditions of FGM are explained in table 1.

Table 1. Different traditions of FGM

Social pressure: FGM is a transition ritual from girl to woman. In many communities, it is seen as a central and unquestionable part of women's growth. For example, in the Kisii community, uncircumcised women may be discriminated against and considered forever children. (Vuorio, 2017; THL, 2019.)
Economic pressure: In many places, women are financially dependent on men. FGM seeks to secure their chances of marriage. A daughter who has gone through

FGM is financially valuable to her family. In many communities, only a cut woman is married. (Vuorio, 2017; THL, 2019.)
Sexuality Control: In some communities, it is believed that FGM inhibits a woman's sexuality. FGM is seen to increase the likelihood that the woman is a virgin when she is married and will not commit adultery. The uncut girl is feared to grow into an immoral woman with reckless sexual behavior. (Vuorio, 2017; THL, 2019.)
Health reasoning: FGM is believed to be good for the girl. It is seen to strengthen a girl as she grows into a healthy woman. Health hazards are not necessarily associated with mutilation, but pain is thought to be a normal part of every woman's life. For example, in the Kisii community, there is a belief that, without circumcision, a girl's clitoris will continue to grow up to tens of centimeters. (Vuorio, 2017; THL, 2019.)
Aesthetics: In some communities, genital mutilation is a norm of beauty (Vuorio, 2017; THL, 2019).

2.5 Defibulation

Defibulation is the opening or/and reconstructive surgery of the infibulated scar**.** During pregnancy, and especially after the birth of a baby girl, it is important to inform families of the normal genitalia, the harmfulness of their mutilation and the fact that under Finnish law the measure is unequivocally punishable under criminal law. Immigrants should also be informed that defibulation is possible in Finland. (Kuismanen, 2018.)

In Finland girls and women who have undergone FGM must be given the opportunity to have opening surgery: defibulation. Defibulation would be a good idea before a person starts to have sexual intercourse or before pregnancy. After defibulation, urination and menstruation, as well as pregnancy and childbirth monitoring will be easier. Sexual well-being has also been shown to improve intercourse and ease because of the possibility of clitoral stimulation. (Koukkula, 2019.)

The procedure usually takes 10 to 15 minutes and recovery takes 1-2 days. Complications are rare; the most common are post-operative mild urinary tract infections, wound infections and adhesions of the labia. (Kuismanen, 2018.) Opening surgery is performed in an outpatient setting under local anesthesia, but it can also be performed under mild general anesthesia if the situation evokes particularly traumatic memories in the patient. In the procedure, the connective tissue connecting the labia is opened at the midline. (Kuismanen, 2018.)

3 HEALTH DISADVANTAGES OF FGM

3.1 Physical effects of FGM

Physical health disadvantages of FGM include various immediate health hazards. In addition to excruciating pain, female genital mutilation causes massive bleeding. This bleeding can cause anemia, hypotension, shock and even death. FGM also causes urinary difficulties such as urethral damage, urinary retention and urinary tract infection. An immediate health hazard of FGM is infection. Infections such as wound inflammation, pelvic inflammation, sepsis, tetanus, virus infection (B- & C- hepatitis and HIV), septic shock and death caused by infections are common health hazards after FGM. During the FGM procedure, it is common to suffer from tissue- and organ damage. Bone fractures and dislocations come from the participants who immobilize the FGM victim during the cutting. (THL, 2019; Abdel-Ghani, 2013.)

Furthermore, there are also long-term health hazards. The pain of FGM does not end when the procedure is finished. Urination pain and other urinary problems that occur long term are urinary tract infections, incontinence problems and urinary stones. The scarring aftermaths of FGM are accumulation of menstrual bleeding in the vagina, cysts and abscesses on the vulva, nerve tumors, scar tumors, bladder and colon fistulas, tissue inflexibility and gynecological examination difficulties. (THL, 2019.)

Intercourse pain and -difficulty are common due to vaginal stenosis and complications of FGM. Genital sensation disorders reduce sexual enjoyment and cause sexual reluctance (Kuismanen, 2018).

The usual difficulties in the fertility- and sexual area are fear of intercourse, pain during intercourse, the impossibility of intercourse due to close stitched genitals,

orgasm difficulties and infertility. Chronic infections such as Hepatitis B, -C and HIV are common long term health hazards of FGM. (THL, 2019.)

Childbirth and antenatal problems are common difficulties, due to FGM, before and during childbirth are difficulty of tracking the birth and the wellbeing of the fetus (THL, 2019). Circumcision can lead to many problems during childbirth, such as caesarean section, prolonged or delayed delivery, unnecessary caesarian sections, rupture of the circumcision scar, bleeding and passing the chronic infection (Hepatitis B, -C or HIV) to the fetus (Myntti, 2018; THL, 2019).

3.2 Psychological effects of FGM

Females who have undergone FGM are likely experiencing psychological problems due to the genital mutilation (Smith, 2017).

FGM has immediate as well as long-term psychological effects. The immediate effects of FGM are fear, shock, stress and nightmares. The long-term psychological effects of FGM can be post-traumatic stress reaction, nightmares, insomnia, eating disorders, cognitive disorders, low self-esteem, anxiety and depression. (THL, 2019.) Furthermore, FGM can cause psychological childbirth- and antenatal complications, such as fear of giving birth, flashbacks of the genital mutilation and reluctance of giving birth again (Myntti, 2018; THL, 2019).

3.3 Nurses' role when facing FGM

FGM is a sensitive topic and may be difficult to talk about. Girls' mutilations can come up for example in maternity- and childcare clinics, day care, school, college or social work (Koukkula, 2019; THL, 2019).

It is important for health care professionals to be able to address the problems of circumcision, especially when women are pregnant. The parents of a newborn should be made aware, that circumcision of girls is prohibited in Finland. (Kuismanen, 2018.)

A culture-sensitive approach is paramount. It is good to remember that FGM is a normal and respected practice in their own cultural environment. In a new environment, girls and women who have undergone mutilation feel different, which can make it difficult for them to meet a health care professional. This should be addressed in good time for the success of preventive work. (Koukkula, 2019; THL, 2019.)

Discussing about female circumcision may be difficult on many levels, because in their own community women and men are not used to communicate with one another about sexuality (Ihmisoikeusliitto, 2011).

According to experts who have developed dialogue methods, dialogue is an open and direct discussion that seeks common understanding. The dialogue creates a space where the situation is studied together. In it, the reality of each participant in the dialogue must exist and be of interest to both. The conversation may not be hearing based if both parties are in a one-on-one bilateral conversation or if a professional uses the expert language with the client. (THL, 2016.)

Emotionally charged topics, such as FGM, may be difficult to discuss for the patient but also for the nurse alike. Therefore, when having a dialogue with a patient, it is important to build trust between one another. A patient should be able to feel that the nurse is guiding the patient rather than pressuring them on a topic. In a nursing-based dialogue that aims in health prevention, conversation should motivate, and support patients opposed to demanding them. Use of a questionnaire is advised as it is shown to keep the conversation from steering away from irrelevant topics.

However, the nurse should aim to be adjusting to patients rather than steering the conversation. (Hörnsten, 2014.)

It is important for nurses to know that FGM is a matter of child protection and must be reported to authorities. Also, health care professionals who observe children with FGM or who might be under the risk of FGM need to report the case to authorities. (Zurynski, 2015.)

There needs to be more professional education and training in the future. Furthermore, health care professions need to enhance the care of women with FGM and advise and support them against the practice with the help of a working environment supported by guidelines and responsive policy and community education. (Zurynski, 2015.) The role and training of health care professionals in helping women and preventing new cases of FGM is paramount (Kuismanen, 2018).

3.4 Health care education interventions

Because of the clear interaction amongst social factor and health interaction, there are certain issues and access barriers for migrants to health care service (Wimmer-Puchinger, 2006). One main key point is health education. The goal is to support individuals and communities to help them with their health by enhancing knowledge and attitude towards FGM. The focus is in motivation, skills, confidence and communication of information. Besides, differences in economic, social and environmental conditions, individual risk factors and behaviors and use of health systems are important to take into consideration. In this case, any health education interventions require to aim for long-term health changes assigned to their health problems. (Waigwa, 2018.)

Moreover, the quality of care is an important aspect for a woman to search out for care. In addition to this many times female migrants experience gender

discrimination (Wimmer-Puchinger, 2006). One of the main key factors is a valuable client-nurse relation, which enhances the quality of service. In this case health programs procure better outcomes when women's needs are being met. Those could be competently trained staff, treatment, female health professionals and confirming privacy and confidentiality. (Tinker, 2000.)

In the study six sociodemographic factors were listed. It included age, ethnicity, language, gender, marital status and residential status. These are further explained in table 2.

Table 2. Sociodemographic factors

Age: The studies reported that younger people were more open minded towards health education interventions. Moreover, the knowledge of FGM of older parents compared to younger parents was notable different. The main reason mentioned is that younger people are more likely to be school educated; it raises their awareness of FGM and confidence in abandoning the practice. (Waigwa, 2018.)
Ethnicity: The studies claim that if health care professionals and clients were of different ethnicity, it was crucial for health care professionals to get to know their culture and structural traditions such as their communities before (Waigwa, 2018).
Language: Moreover, health care professionals and clients experienced difficulties in communication. For example, health care professionals giving information and clients understanding the content which is not in their mother language. It is beneficial to invite a “cultural broker” who is a translator to those conversations. (Waigwa, 2018.)
Gender: The studies found a slight dissimilarity of the awareness between women and men. Especially, the personal experience of a women undergoing FGM makes it much easier in understanding the subject matter. (Waigwa, 2018.)
Marital status: In the study, both male and females who were married did not benefit from health education. This is due to their belief that FGM means

promiscuity of females. However, it was found that marital status does not influence the effectiveness of health care education as there was no correlation between support/opposition for FGM and effectiveness of health care education. (Waigwa, 2018.)
Residential Status: It shows that the residential status of the participants affected their opinion regarding FGM and following health education interventions. In particular immigrants and refugees had familiar worries in the health care matter of FGM (Waigwa, 2018).

4 AIM, PURPOSE AND RESEARCH QUESTION

The aim of this study was to explore what knowledge the nurse needs about patients with FGM. The purpose was to provide information on different types, risks, effects and cultural background of FGM. This was intended to provide information on FGM and to give the necessary knowledge to nurses about it.

The research question:

- What does a nurse need to know about Female Genital Mutilation (FGM)

5 METHODS AND IMPLEMENTATION OF THE STUDY

5.1 Literature review

Literature review is the process of finding relevant articles from multiple search engines using specific keywords. Depending on the issue at hand, articles from one, two or three sources may be used. All articles used in the review should be inspected critically and carefully assessed. (Ward-Smith, 2016.)

Literature review consists of six steps: selecting the topic, search for related literature, developing an argument, survey of the literature, critique of the literature and finally writing of the review (Machi L. & McEvoy B., 2009).

This method was chosen to give a better understanding of the phenomenon FGM, and tools and knowledge for patient-nurse dialogue.

5.2 Literature search

First a research question was formed, followed by search terms, after which inclusion and exclusion criteria were decided upon. Three researchers conducted the literature review using two databases, PubMed and CINHAL (Ebsco). Inclusion criteria can be seen in table 3. Studies not meeting the inclusion criteria were excluded.

Table 3. Inclusion criteria

Inclusion Criteria
• Scientific publication • Published between 2009-2019 • Full-text availability for JAMK students • English language

Results of data research from CINAHL and PubMed databases shown, with number of included studies in table 4.

Table 4. Literature review

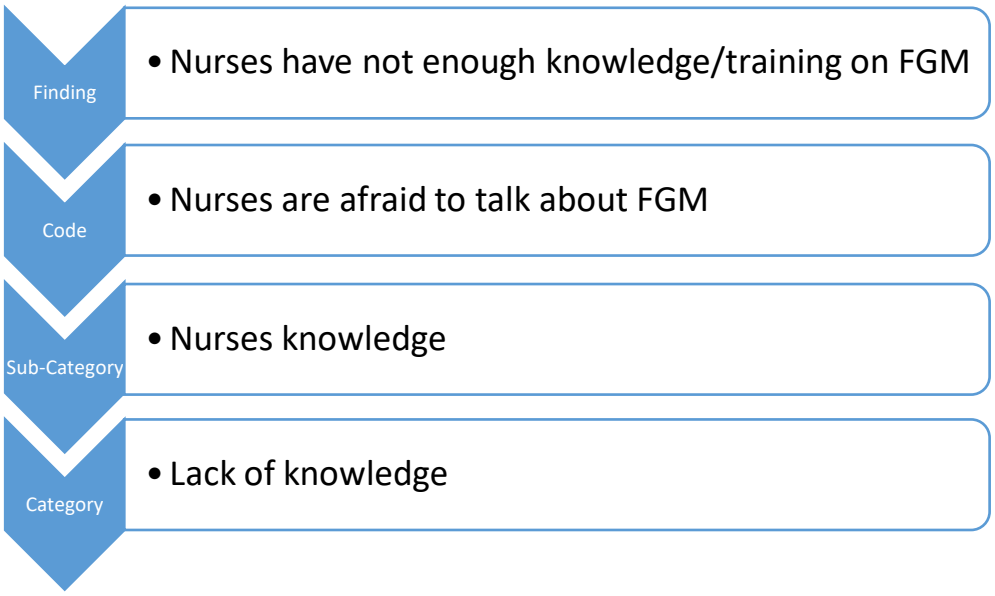
Database	**Search terms**	**Results**	**Chosen based on title and abstract**	**Relevant studies**
Cinahl	Female genital mutilation AND Nurse	16	5	4
PubMed	Female genital mutilation AND Western AND Nurse	5	1	1

5.3 Data analysis

Articles chosen for closer inspection were analyzed in a careful manner. The technique used was inductive content analysis. This means open coding, category creating and abstraction. Open coding means coding of the similar main findings, and then creating and organizing them into categories. The abstraction stage means creating of theoretical concepts and conclusions. (Elo & Kyngäs, 2011; Tuomi & Sarajärvi 2009.)

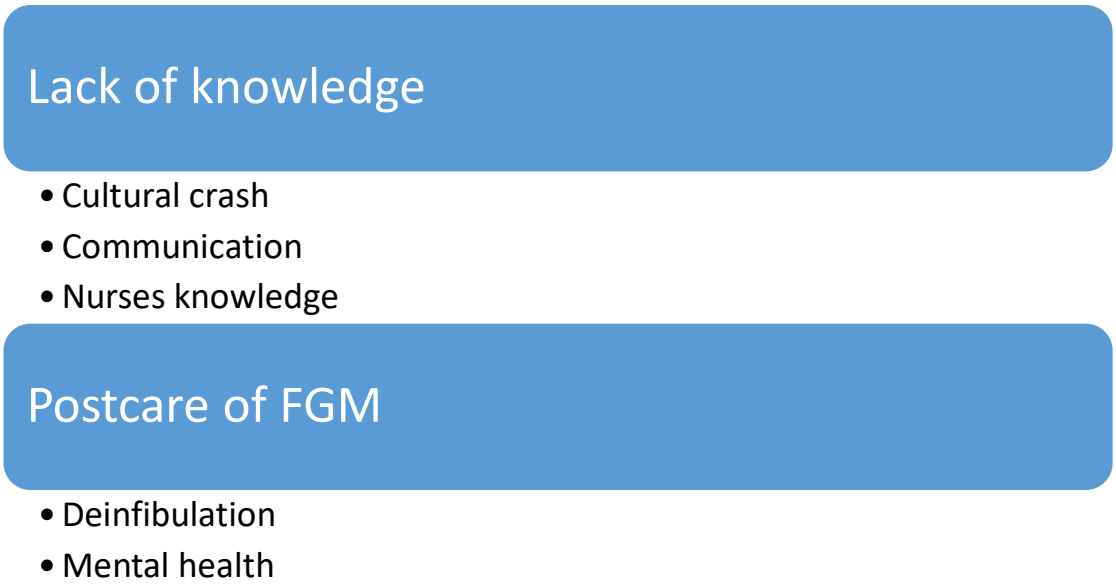
Example of data analysis process demonstrated in figure 3.

Figure 3. Example of data analysis



Results were divided into two categories and five subcategories that can be seen in figure 4. Results are elucidated in the next part.

Figure 4. Categories and subcategories of the literature review findings



6 RESULTS

6.1 Lack of knowledge

Cultural crash

Immigration is increasing and on numerous occasions, “cultural crash” occurs on both sides. These reviewed articles describe for instance the cultural and religious aspects of FGM. It also explains the nurses perception towards various topics concerning FGM.

FGM is practiced in approximately 30 countries, most of which lie in sub-Saharan Africa, the Middle East and Asia. Because of globalization and migration, FGM has also been recorded in North America, Australia and Europe. Some immigrant communities want to continue FGM for the reason of keeping their traditions and building up their cultural identities. (González-Timoneda, 2018.) Momoh 2016 suggests that FGM has been used for centuries and continues due to compound

interaction between social and cultural circumstances. It is described as a cultural tradition, protection of a girl's virginity, preparation for marriage and lower the libido to keep her faithfulness. More than often, a woman who does not follow this practice is excluded and unmarriageable.

A major risk factor for young girls is being born into a community where FGM is practiced. An estimated 70,000 under the age of 15 are at risk of FGM. Young immigrant women and -children are often taken back to visit their country of origin for summer holidays where FGM takes place. The young girls' integration process into western society and socialization is affected negatively due to the psychological repercussions of the FGM. (Caroppo, 2014; Momoh, 2016)

WHO calculated that around 500,000 women have undergone FGM and around 180,000 young girls are at risk in Europe every year. Those numbers may however be underrated due to undocumented cases and second-generation immigrants. (González-Timoneda, 2018.) When facing FGM, health care professionals are faced with, not only a medically, but also ethically and culturally sensitive issue. People working in health care should realize the cultural background of FGM through which they see not only the health care aspect and issue, but also recognize the human from a different culture. (Caroppo, 2014.) Bethany R. agrees as the study states that nurses require culturally sensitive training, including understanding of the history and culture of FGM. It is important to understand the origins of the practice, in order to create a trusting patient-nurse relationship. Furthermore, the understanding of the history and culture allows the nurse to treat the patient individually whilst avoiding stereotypes. González-Timoneda & Caroppo state that health care professionals must receive proper training to gain knowledge about different cultures. This helps in the approach required to ensure quality of care and respect for women and families that have faced FGM.

Ethnicity is the most influential factor noticeable. In cultures where people believe in the practice of FGM, men and women mostly behold FGM as part of the social and cultural identity. In this case, it becomes difficult to convince the abandonment of FGM. (Momoh, 2016.)

It is difficult for the immigrant females to talk and share about their FGM experiences or other gynecological issues. This is, because they are afraid of being judged by the western way of seeing FGM. (Caroppo, 2014.) On the other hand, nurses may be hesitant to act on bringing up FGM as they are afraid to be appearing racist (Bethany R. 2019).

Communication

The articles describe the significant factors of communication between nurses and women. The nurse should acknowledge and emphasized different things in the conversation. In general, all findings are explaining how to counsel, support and handle situations where women have undergone FGM.

For example, a few of the reviewed studies had similarities in how to address the patient about FGM. First, the women should be met alone. The patient may not feel comfortable sharing in the presence of family or friends. There should be a sensitive approach, using language and explanations, which are candid and non-judgmental towards their culture and values. (Régé I. & Campion D. 2007.) The fear of judgment may prevent women to talk with health professionals about their health problems due to FGM (Momoh, 2016).

Nurses must be prepared to behave properly and with kind manners when seeing genitalia which have undergone FGM (Mohom, 2016). Terms like “mutilation”,

should not be used, as this may be taken as judgmental causing the patient to be hesitant to unveil if they have had FGM done (Régе I. & Campion D. 2007). As well as not to show unintentional signs of shock or displeasure. After a woman receives a negative response, it can keep her from seeing any health professionals in the future because of this fear of response. (Mohom, 2016.) Furthermore, the term FGM may not be understood by all, so the nurse should aim to use phrases like circumcision or cutting (Régе I. & Campion D. 2007).

Especially school nurses might have gained their trust to girls which are at risk of FGM. While having a conversation with these girls or their parents, it is necessary to be aware of any signs that the act of FGM is upcoming, for example, description of a special occasion to “become a woman”, talking of long holidays in a country where FGM is practiced or overhearing a girl talking to other friends about FGM. (Mohom, 2016.)

Furthermore, nurses being equipped with knowledge about FGM in overall can support the nurse-client relationship (Momoh, 2016). Health care professionals without FGM specified training might not recognize the symptoms and health issues caused by female genital mutilation. This leads to the health care professional failing to give health promotion to the FGM patient. (Caroppo, 2014.) Official translators should be used whenever possible. However, the translator should not be a relative of the patient or someone who has influence in the patient’s community. (Régе I. & Campion D. 2007.)

Nurses knowledge

Almost all reviewed literary texts mentioned nurses and other professionals lack of knowledge of FGM. There were also multiple questionnaires and statistical findings done about FGM and the nurses knowledge and perception.

In Italy only a small percentage of social- and health care staff working with asylum seekers state to know female genital mutilation well. Some of the workers state, that they do not know anything about it. Most of the staff working with asylum seekers state that they have never been in contact with a woman who has been through FGM. (Caroppo, 2014.) In the González-Timoneda study only 15% (including social workers, GPS, pediatricians and midwives) have said to been given training on FGM. Out of the 146 nurses participating, only 19 reported to have received training on the topic (González-Timoneda, 2018.) Fewer than 25% of practitioners have had training on FGM in the UK. This shows a significant gap in the knowledge in order to deal with FGM, hence proper training is needed in nursing programs as well as in working life (Bethany R. 2019). Balfour supported this, as he explains that FGM management and the need to enhance evidence-based guidelines and professional individual and service capacities is one of the main important roles for nurses and midwives. The reviewed literature points out health care professionals lack of knowledge about FGM. A study carried out by González-Timoneda in Catalonia showed that less than a fifth noticed the case where women suffered from FGM. Moreover, half of the health care professionals were aware of the FGM type and about one in five realized the origin country of FGM tradition. Even though great amount of FGM publications exists there is a deficiency of more research about this topic. The systematic review focused on the necessity of resources and evidence-based guidelines for health care professionals. In 2013 the National Union of Family Associations (UNAF) brought out a guide for health care professionals. It tells more about the primer concern of FGM prevention and to “inform sensitize” the communities and families to change their point of view. (González-Timoneda, 2018)

In Gonzáles-Timoneda study it appeared, that in cases where FGM was discovered, one person payed no further attention and others acted with the help of different professionals. Besides, some were questioning if they have any daughters to prevent the risk of FGM continuing. However, none of the respondents informed the discoveries forward. The results in Caroppo study tells, that the social and health

care staff working with asylum seekers admitted, that if they would face a woman with female genital mutilation, they would send her to other health care professionals as they would not know how to work in such situation. (González-Timoneda, 2018; Caroppo, 2014.) Balfour suggests that after the training sessions midwifes expressed themselves feeling more confident in the clinical and obstetric management of women suffering from FGM. There was a significant improvement in self-courage, recognition of type and management of each type.

In an interview very few of the clients felt that they got FGM-related information. The authors state, health care providers complain about need of appropriate space, lack of time and feeling uncomfortable to begin a conversation about FGM. In addition, it seemed challenging to guide any IEC activities and the period for the IEC training was described as too short (Balfour, 2016). Rége I. & Campion D. suggest that some patients may not have seen unmutilated genitalia, therefore, showing of diagrams of both, mutilated and unmutilated may be suitable.

In 2015, in the UK a mandatory reporting duty was decided. Teachers, health and social care professionals must report to the police known cases of FGM where girls are under the age of 18. The recommendation says the report must be filed as soon as possible and best in one working day. Significant to know is that the report does not break the rule of confidentiality between nurse and client and the dismiss of the report leads to serious consequences. All details are needed such as consultation, along the examination findings. With some clients photographic evidence may be considered. Furthermore, the Health and Social Care Information Center must be informed (HSCIC) and it is important to explain the client that the data will become anonymized in statistical analysis. (Mohom, 2016.)

People who have gone through FGM in their childhood may encounter traumatic memories brought back during examinations and medical encounters. However, women have reported that, for example, birth giving may be healing and therapeutic

if they trust the healthcare professionals and feel in control of the situation. (Rége I. & Campion D. 2007.)

In the study of Jacoby and Smith, participants described the session with the Somali cultural broker as the most powerful from the training. The collaboration with certified interpreters and cultural brokers could improve the program, especially in an environment where FGM is rarely present. (Balfour, 2016.)

6.2 Postcare of FGM

For the postcare of FGM all literature reviewed focused on the topic of deinfibulation and its health benefits.

Deinfibulation

Deinfibulation plays an important role in the way of seeing oneself and in the integration process. Deinfibulation has many health benefits for a female with FGM, such as natural outflow of menstruation blood and urine, vaginal delivery and sexual intercourse. If significant physical changes have been made during FGM, a surgical procedure is recommended to the woman with FGM to restore anatomical functionality. Deinfibulation should be offered by the National Health System. (Caroppo, 2014.)

Deinfibulation is recommended for prevention and treatment of childbirth complications, with type 3 FGM. However, there is only low-quality evidence of this. (Rége I. & Campion D. 2007.)

Mental health

Mental health support for women suffering from FGM is an important topic to mention. The articles describe which group of women should be taken into consideration and what method could be used.

According to WHO, mental-health support is recommended for patients that have gone through deinfibulation as it may trigger memories of the FGM procedure and patient may be worried of the physical changes or the labia's display. Patients with anxiety disorder, depression or post-traumatic stress disorder (PTSD) due to FGM, WHO has recommended cognitive behavioral therapy (CBT). However, there is no direct evidence to support the need for CBT. (Rége I. & Campion D. 2007.)

Psychological difficulties occur during the integration to the western society. The difficulties arise between the female image and -identity of a woman who has undergone mutilation and the Western female image. (Caroppo, 2014.)

7 DISCUSSIONS

7.1 Ethical considerations, validity and reliability

Ethical consideration in this research leaned on guidelines drawn out by Medical Research act, drafted by Finnish Ministry of Social Affairs and Health (Medical Research Act, 2010). Research team also followed the Finnish National Advisory Board on Research Ethics guidelines drafted out for research. Research should be carried out in a way that is meticulous and done with integrity. Data collection should follow criteria that is not only scientific but also ethically sustainable. (Finnish Advisory Board on Research Integrity, 2012.) Research team also followed the ethical principle guidelines of Jyväskylä University of Applied Sciences (JAMK) to ensure the research to be ethically acceptable. JAMK´s ethical principles aim to enhance the truthfulness to academic community. Guidelines go alongside with the Finnish Advisory board's guidelines (JAMK University of Applied Sciences, 2018.)

Validity of the research was ensured with using of two databases, carefully documenting and planning of the literature review. Research was limited to free

articles available to JAMK students. None in the research team speaks English as their first language, hence there is the risk of misinterpreting literature. Studies used in the research were written in England, Spain, Switzerland and Italy. Differences in each country's healthcare may affect the researches reliability negatively; it may not be possible to implement the findings on all countries. Furthermore, other factors listed may affect the validity and reliability of the research also negatively (Paler-Calmorin L. & Calmorin M., 2007)

Besides, the topic of FGM is a culturally sensitive topic and nurses must approach it carefully. As mentioned earlier, nurses with different ethnicity should try to learn and understand about the women culture and tradition as well as their community before hands (Waigwa, 2018). It is advised to use the term Female Genital Mutilation, yet there are more words in usage such as circumcision or cutting (Rége I. & Campion D. 2007). For any kind of visualizing, no appalling graphic pictures, but diagrams and drawings were applied in this review.

In order to avoid research misconduct, all research articles were cited, thoroughly analyzed and documented. Furthermore, the final draft of the research was submitted to Urkund, to ensure research not having plagiarism.

7.2 Discussion on the results

FGM related health problems have become an increased health issue in western society due to increased immigration. Health care professionals have a challenge to keep up with the culturally versatile society and the new health issues that come with it. (Caroppo, 2014.)

This topic was chosen due to the lack of knowledge about the issue of FGM; though it is such important topic to address. It might be a challenge to talk about the topic due

to the rareness and having not enough knowledge and information about it, as mentioned in latter part; FGM might be sort of a “taboo” topic to openly speak about. Therefore, for us nurses it is significant to have an understanding about FGM and knowledge of how to keep an open dialogue with women who are in this situation (Bethany R. 2019.)

When studying about FGM, the cultural view on the topic rose from every source. The nurses and other health care professionals fail to confront the patient due to the lack of knowledge of the cultural tradition and background of FGM. The western society has a view of FGM being a cruel and barbaric tradition, especially because people who go through it try keep the tradition believe that FGM is a necessary operation for a female to fit in a community. This creates a “cultural crash” when a health care professional faces a female who has been cut. (Caroppo, 2014.)

There are many aspects to be considered while talking to someone who has FGM. The research findings showed us that it is difficult, due to the cultural difference, for the patient to feel comfortable to tell about their personal history with a health care professional because of feeling shame, fear of judgement and exposure. It is needed to create a safe environment for the woman and try to discuss the topic. Nurses should be able to try to understand, empathize and support the female with FGM (Bethany R. 2019 & González-Timoneda, 2018.)

The results of this literature review show how important it is to have a specific training for health care professionals about FGM (Caroppo, 2014). Findings strongly suggest more education on FGM, in working life as well as at the time of studying. Increasing immigration has shaped a new and diverse society and the health care system and new trainings should be shaped with it.

Based on the results of this literature review, further research on need for education during nurses university programmes is adviced. Furthermore, mapping out nurse's

knowledge on FGM is recommended, to justify the need for further education on the topic.

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APPENDICES

Author(s)	Publishing year and country	Title	Research method	Main findings
Caroppo E, Almadori A, Giannuzzi V, Brogna P, Diodati A, Pietro B	2014, Italy	Health care for immigrant women in Italy: are we really ready? A survey on knowledge about female genital mutilation	Quantitative research, questionnaire	There is not enough knowledge and training about FGM amongst social- and health care staff working with asylum seekers.
Rége I. & Campion D.	2017, England	Female genital mutilation: implications for clinical practice	Literature review	Importance and techniques of communication about FGM, deinfibulation, and mental problems related to FGM to patient.
Rose Bethany	2019, England	Female genital mutilation in the UK: considerations for best nursing practice	Literature review	Problem of lack of knowledge about FGM with healthcare personnel in UK, and suggestions to nursing practices on FGM.
Mohom C., Olufade O. and Redman-Pinard P.	2016, England	What nurses need to know about female genital mutilation	Literature review	Nurses detecting, reporting and preventing FGM, short and long-term complications.
González-Timoneda A., Ros V.R., González-	2018, Spain	Knowledge, attitudes and practices of primary healthcare professionals to	Quantitative research, questionnaire	Health care professionals lack of knowledge, but also perceptions, attitudes and

Timoneda M. and Sánchez, A.C.		female genital mutilation in Valencia, Spain: are we ready for this challenge?		practices towards FGM
Balfour, J., Abdulcadir, J., Say, L. and Hindin, M.J.	2016, Switzerland	Interventions for healthcare providers to improve treatment and prevention of female genital mutilation: a systematic review	Quantitative research, questionnaire	Developing effective interventions, health care providers and knowledge about the prevention + treatment of FGM.