Methodology paper female genital mutilation nursing essay

The controversial and complex practice of female circumcision also known as Female Genital Mutilation is one that carries important negative consequences for the quality of life of those who have undergone the procedure. The objective of this paper is to highlight the importance of health professionals having a thorough understand of FGM in order to address the conflicts that may occur when they provide care to such patients, whose practices and beliefs differ from their own. The cultural significance and medical complications that arise as a result of this practice require a code of conduct on how to provide ethically sensitive care from an ethically sensitive perspective, which is more than just technical advice on the management, but more of integrity preservation and cultivation of relationships based on responsiveness and receptivity by the women who have undergone Female Genital Mutilation. The focus therefore is on the implications of Female Genital Mutilated women getting healthcare services appropriate for their needs and the need for more knowledge in this area for healthcare professionals.

A large percentage of immigrants are from countries that encourage this practice and my contention is that health professionals will greatly benefit from education that will facilitate development of knowledge to offer sensitive clinical guidelines while providing care to circumcised women. The idea of female circumcision may evoke reactions of criticism, shock, disgust in other people, including healthcare professionals. As a result of this ethnocentric shock, women who have undergone FGM are usually reluctant to divulge their condition to anyone outside their community, and this may be detrimental to their health physically and psychologically. They are often

fearful of the medical establishment and have a poor uptake of health care services (Momoh et al 2001). Such a reaction especially from health professionals can cause the woman to further isolate herself, and this may lead to receiving inappropriate medical intervention and care. Furthermore, cultures that practice FGM may find healthcare services in their outside of their usual surrounding intimidating, frightening, and unfamiliar. Part of this fear of accessing health care comes from the fear of being judged. With altered genitals, these women are afraid of how they will be perceived and whether the health professional will inadvertently communicate their negative reaction to them, which may create further isolation and embarrassment for them (Schott and Henley, 2000). Such women also have different health expectations and needs, and therefore it is important that those involved directly or indirectly in their care, acknowledge and incorporate a care plan that is specifically tailored to accommodate their needs.

Since this is an area that is unfamiliar to most health professionals, there is inadequate communication due to a lack of understanding on the part of the caregivers and reluctance by the women involved to talk about undergoing the procedure, their health issues for fear of being stigmatized (Momoh et al 2001). The damage physically and psychologically is traumatic to them, resulting in flashbacks, anxiety, depression, chronic irritability, and reluctance to open up (WHO, 1996). Gynaecological and screening procedures (pap smears) and childbirth, which involve exposing the vulva and being touched is an extremely stressful process for them. Due to some cultural restrictions, it may be inappropriate for a male care provider to

touch or examine a woman and it becomes even more difficult to be at ease in their presence for fear of being judged. Health professionals who are unsure of how to provide care to this population should seek advice from more experienced colleagues or refer them to a specialist. Gaining an understanding of female genital mutilation is important in breaking down barriers between the isolated ethnic group and healthcare professionals. This will lead to an improved and sensitive health care delivery for the women who have undergone the procedure. A sound understanding and knowledge in this area will allow development of protocols that will aid in making informed decisions, development of guidelines on counseling, referral procedures, and communication strategies, from an ethically sensitive perspective. Although there seems to be a general understanding of FGM amongst the medical professionals, I predict that there will be a requirement to gain further knowledge in order to provide care that is more than satisfactory for this population. The rationale behind research in this area is to describe how much the medical world knows in regards to caring for women who have undergone FGM, considering the fact that they need specialized care. I will also be looking at data that builds upon previous research as well as current research being studied on this subject, the feasibility and access to the data, ethical issues surrounding research studies in this area, and whether there is published material from the study that shows an increase of knowledge in this area.

DISCUSSION

For the literature review the following different countries were intentionally chosen: Canada, United States of America, Sweden, Switzerland and Spain.

This will give a global outlook of the challenges faced by circumcised immigrant women while accessing healthcare. Additionally, it will identify the countries that have recognized and are addressing this barrier to health care access that Canada can emulate. The literature covers research conducted from 2005 to 2012 which will provide insight on the progression of this research field and any existing gaps that still need addressing. Methodology included snowball sampling which was useful in recruiting participants. Most of the articles used quantitative methods: mainly self-administered and hetero-administered surveys. Another quantitative tool was the use of focus groups and face to face interviews. It was interesting to note that most researchers used both a quantitative and qualitative component to establish their findings. Focus groups were described by one researcher as being extremely effective when conducting cross-cultural research were highly favored as a qualitative research tool by Upvall et al (2009). The literature studies focused mostly on the attitudes and perceptions of healthcare delivery by health professionals to migrant women who have experienced FGM. To define the concept of adequate and appropriate care delivery, researchers sought to know how knowledgeable health providers were and whether they reacted negatively or positively upon realizing that the woman had undergone FGM.

METHODS

A study consisting of a questionnaire created by two senior clinicians based on the standards set in the Royal College of Obstetricians and Gynecologists guidelines in the UK was circulated anonymously amongst 45 participants consisting of midwives working in the labour ward, antenatal clinics and

community midwifes (CMW), obstetric Senior House Officers, Specialist Registrars and Consultants. The aim of the study was to assess these professionals´ level of knowledge about FGM and in relation to RCOG guidelines on FGM. Due to increasing migration, clinicians in the UK are increasingly exposed to women who have suffered FGM. Recognizing this trend, the RCOG has set standards for guidance of health professionals caring for women with FGM. . Only 40% were familiar with the regulations in the FGM Act of 2003; 58% were unable to list the different categories of FGM; 47% incorrectly thought that caesarean section is the best way of managing FGM if vaginal examination is not possible in the first stage of labour and 54% chose anterior episiotomy as the treatment of choice during the second stage. The study revealed significant gaps both in theoretical knowledge and practice citing a need for more awareness and understanding of issues involving childbirth (Onuh, Igberase, & Umeora 2006). A similar transversal descriptive study was also administered in the UK to family physicians, paediatricians, nurses, midwives and gynecologists to analyze trends changes in two periods studied (2001 and 2004). Out of the 225 professionals who answered the questionnaire in 2001 and 184 in 2004, Eighteen percent stated that they had no interest in FGM. Less than 40% correctly identified the typology, while less than 30% knew the countries in which the practice is carried out and 82% normally attended to patients from these countries. It was also determined that Female genital mutilations are present in primary healthcare medical offices with paediatricians and gynecologists having the closest contact with the problem. This concluded a need for interventions designed to acquire more knowledge, which will promote sensitized care delivery (Zaidi, Khalil, Roberts, & Browne 2007). In

Barcelona and Girona Spain, the study conducted was key to the evolution of research in this field, as it measured the knowledge (types, cultural origin, geographic distribution and ethnicity), and evaluate attitudes and beliefs of health professionals as well as previous contact or experience with cases or risk situations. A transversal descriptive study in the form of a questionnaire was used to obtain this information. It was determined that, training strategies and the development of guidelines to enable primary care professionals to know how to work with such a population should be implemented. However, the Spanish study which builds on previous research conducted in 2001 and 2004 also did not explicitly state the expected duration of developing and implementing these guidelines (Kaplan-Marcusan, Natividad, Nogueras, & Mongui-Avila 2010). A separate psychological test in the form of questionnaires was administered in Spain to health professionals to fill out at their convenience. The psychological and sexual consequences of FGM as well as data on child and family history, employment, medical and psychiatric history, and the genital mutilation experienced was gathered. The results showed lack of understanding in designing a care plan specifically tailored to these women, and therefore there is a need for European professionals to develop greater knowledge about FGM and its serious consequences, especially in regards to sexuality given the large numbers of immigrant women now residing within European Union countries (Pereda, Arch & Perez-Gonzalez 2012).

A focus group session of 23 Somali women in South-western Pennsylvania, USA as well as a physician conducted interview was used to collect data in this population. The results yielded showed that healthcare providers needed

to develop culturally competent delivery of care that included not focusing so much on the circumcision, but rather providing sensitive care for routine clinical procedures regardless of anatomical difference. This will facilitate trust and minimize apprehension of the healthcare system by the women involved. It was determined that communication skills are fundamental to providing culturally competent care for these women. Additionally, healthcare providers must take responsibility for acquiring knowledge of the Somali women's challenges as refugees living with circumcision and as immigrants in need of healthcare services (Upvall, Mohammed, & Dodge 2009). Similar results were also yielded from in-depth interviews from 8 health professional Somali women between the ages of 23-57who had previously undergone FGM. They felt encounters with their fellow health professionals including doctors, nurses, midwives and health visitors were being met with stereotyped judgments that led to feelings of patronization, due to their circumcised status, implying they were not capable to make sound judgment in regards to childbirth. Many midwives and doctors in the UK are not trained or familiar with the required intervention for circumcised women, especially during child birth, and many deliveries were reported as being excessively traumatizing for Somali women. This was further compounded by the reluctance of health professional staff to actively seek knowledge of circumcised Somali women who would be in a better position to provide the needed information (Straus, McEwen, & Hussein2009). Similarly, interviews of 432 Somali women with previous female genital mutilation, who had given birth to a baby in Canada in the past five years conducted at their homes by a Somali woman interviewer showed a lack of lack experience by many health care professionals in assisting women with

female genital mutilation during pregnancy and birth, and they are usually untrained in this aspect of care. Findings suggested that these women's needs are not always adequately met during their pregnancy and birth care. Women reported unhappiness with both quality of care and clinical practice. Changes in clinical obstetric practice are necessary to incorporate women's perceptions and needs, to use fewer interventions, and to demonstrate greater sensitivity for crossâ€ cultural practices and more respectful treatment than is currently available in the present system of care (Straus, McEwen, & Hussein 2009). The problem of communication between midwives and circumcised women seems to be a recurring theme as evidenced by a descriptive survey designed to select a random sample of 600 certified nurse-midwives from the member list of the American College of Nurse-Midwives. Two hundred forty-three CNMs completed a survey of FGM knowledge and provider experience. The respondents demonstrated more correct medical knowledge about FGM than knowledge of cultural and legal issues. The results found that discussions regarding FGM related concerns and complications between CNMs and clients who were circumcised minimal due to inadequate knowledge on the culture of their clients leading communication breakdown between these two populations. The conclusions reached determined need to learn more about FGM and the cultures of their clients in order to provide culturally competent care (Kontoyannis & Katsetos 2010).

From January 2003 to September 2004, questionnaires were mailed to 22 circumcised women from Somalia, Eritrea, and Sudan residing in Ostergotland to explore the encounters had with the healthcare system. A

subsequent gynecological examination by a female African gynecologist conducted at an off-hospital site. Participants were to go to the hospital after previous negative experiences of the participants with the health care system; these examinations were carried out an alternative location. The Swiss researchers also conducted a closed-ended questionnaire interviews with health care workers by telephone. To create a gender-sensitive environment, 2 female moderators: the principal investigator and a female translator conducted four focus groups with the women. The women experienced being different and vulnerable, suffering from being abandoned and mutilated, and they felt exposed in the encounters they had with the Swedish health care personnel and were less than enthusiastic to adapt to a new cultural context. The results of this study indicated a lack of the right knowledge on the part of the healthcare workers and a subsequent need for more individualized, culturally adjusted care and support was established. Also it was documented that a systematic education about female genital cutting for Swedish health care workers would be important in achieving the individualized care (Berggren, Bergstrohm & Edberg 2006).

This was also true for health professionals in Toronto in regards to gaining more in depth education. A one on one interview conducted with 16 key informants from various disciplines employed by healthcare agencies providing care to postpartum immigrant women in Toronto revealed the challenges experienced by healthcare providers working with this population. These were categorized into professional limitations (fear of incompetence, language barriers, and inadequate assessment tools) and social/cultural barriers (experience of cultural uncertainty). The results suggested that not

only are there important barriers to accessing postpartum care for recent immigrant women (knowing where and how to access services, and language difficulties and cultural barriers such as fear of stigma and lack of validation of depressive symptoms by family and society) but it is a challenge for healthcare workers to deliver such needed care. Understanding some of these barriers and challenges from the perspective of healthcare providers is an important step forward to resolving gaps and obstacles in the service system (Teng, Blackmore &Stewart 2007). A different method of study focusing on Female Genital Mutilation that included bibliography research from both the research literature and review in the Pubmed data base showed that women who had undergone FGM require a challenging type of care during childbirth due to the traumatic experience. The care should be delivered in a non-judgmental approach with psychological support. The attitude of health professionals should be thoughtful, non-critical, and intensely knowledgeable about FGM consequences. It was concluded that a greater understanding of FGM by the health professionals will improve the care provided and cease alienation of the women involved. Increasing awareness by educating the communities involved could help to challenge themselves harmful practices. Changing traditional practices that have existed for centuries is a slow and uphill process that requires an interest in Female Genital Mutilation to foster change (Kontoyannis & Katsetos 2010).

CONCLUSION

The literature studied unanimously confirmed that women who have been circumcised felt stigmatized by their condition during and after receiving care from health professionals who lack inter-cultural skills and knowledge to

accommodate their cultural and physiological needs. There is an evident need for establishment of clear guidelines for health professionals on specialized care delivery to such women and most of the researchers promoted the need for intense and extensive training for health professionals. Apart from their needs during childbirth and pregnancy, little research has been done on what support can be offered to alleviate the challenges of self-esteem, daily living, and sexual experience. Research should also be done on whether an updated curriculum for training health professionals is necessary to reflect and address this growing phenomenon of FGM. The researchers in their studies used a culturally sensitive approach without outright demonizing this practice in outlining the significance of more knowledge in dealing with this population. The definition and measurement of knowledge, stigma, and attitudes seemed appropriately valid. In terms of reliability, it was evident that most of the studies arrived at the same conclusion and most if not all confirmed findings about the stigmatization of post FGM women in healthcare settings, cultural distribution of the practice and the need for more education n FGM. In the UK where FGM health care guidelines have been established, it would be interesting to know whether the stigmatization of this population has decreased. The recurring conclusion by the researchers is the stigma experienced by circumcised women in the health care system, and what interventions will improve their access to culturally sensitive health care provision. I found that lack of sensitivity by the care givers as well as a genuine interest in learning more about the practice was a great barrier to providing appropriate care. Most of the articles focused on the implications and eradication of FGM, but very little study has been done on how to help

the women who have already undergone the procedure. Most of them have to live in shame and feel defeminized coupled by low self-esteem. Given the literature review, my intial question of how much knowledge do health professionals have on this phenomenon has been modified to identify and implement solutions to the inadequate knowledge and stigmatization as confirmed by the literature. Stigmatization and discrimination being the biggest barrier to accessing appropriate healthcare what can be done to better equip health professionals with knowledge that will enable them to provide culturally-sensitive and adequate care to circumcised women?