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Female genital mutilation in high-income countries: A literature review of health care professionals' and students' understanding and experiences

--Manuscript Draft--

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Abstract:	<p>Background: Female genital mutilation is a cultural practise with numerous negative health consequences. Due to migration from FGM prevalent countries into high-income countries, there is increased awareness within non-practicing communities emphasised by FGM's illegal nature and the negative impacts to women. It is therefore vital for healthcare professionals to be knowledgeable to provide adequate patient care. Aim: This review aimed to synthesise literature to report the understanding and experiences of HCPs caring for females affected by FGM in high income countries Methods: A systematic search was conducted on three databases Medline, Embase, and the Cumulative Index to Nursing and Allied Health Literature (CINAHL). Inclusion and exclusion criteria were applied to select the papers. Findings from included papers were synthesised using thematic synthesis.</p> <p>Findings: Eight articles met the criteria. Four themes were generated: FGM knowledge, training, attitudes and caring for FGM patients. Conclusion: Healthcare professionals' knowledge and experiences of FGM tend to be varied. This review highlights the need of training for healthcare professionals in high-income countries to strengthen their FGM knowledge.</p>
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Female genital mutilation in high-income countries: A literature review of health care professionals' and students' understanding and experiences

Abstract

Background: Female genital mutilation is a cultural practise with numerous negative health consequences. Due to migration from FGM prevalent countries into high-income countries, there is increased awareness within non-practicing communities emphasised by FGM's illegal nature and the negative impacts to women. It is therefore vital for healthcare professionals to be knowledgeable to provide adequate patient care. **Aim:** This review aimed to synthesise literature to report the understanding and experiences of HCPs caring for females affected by FGM in high income countries **Methods:** A systematic search was conducted on three databases Medline, Embase, and the Cumulative Index to Nursing and Allied Health Literature (CINAHL). Inclusion and exclusion criteria were applied to select the papers. Findings from included papers were synthesised using thematic synthesis.

Findings: Eight articles met the criteria. Four themes were generated: FGM knowledge, training, attitudes and caring for FGM patients. **Conclusion:** Healthcare professionals' knowledge and experiences of FGM tend to be varied. This review highlights the need of training for healthcare professionals in high-income countries to strengthen their FGM knowledge.

Keywords: Female genital mutilation, Female genital cutting, Female circumcision, knowledge, Literature review

Key points

- Health care practitioners (HCPs) including nurses play an important role in caring for and educating patients and those at risk of FGM.

- HCPs need to have adequate knowledge and confidence in handling this sensitive topic to provide patients with good quality of care.
- There was inconsistent FGM knowledge held by HCPs, with nurses being highlighted to have the least.
- There was a desire from HCPs to have more FGM education, including on FGM management, legislation, culture, and practice knowledge
- Insufficient knowledge held by HCPs on FGM legislation can affect HCPs not to act in detection of FGM.
- The most common barrier to caring for those suffered from FGM was ineffective communication with patients

Reflective questions

- Have you cared for someone with FGM?
- How would you care and provide culturally sensitive support to a patient affected by FGM?
- How will you identify and prevent a person who may be at risk of receiving FGM?
- What legal action do you need to take when you identify a person with FGM?
- As a nursing practitioner, how would you utilise the multi-disciplinary team and ensure sufficient knowledge is held by all practitioners when caring for a female affected by FGM?

1. Introduction

Female genital mutilation (FGM), also known as female genital cutting, is defined by the World Health Organisation (WHO) (2018) as any procedure which damages the external female genitalia for non-medical purposes. It is categorised into four groups (Table 1), each resulting in short to long-term complications

(WHO, 2018). It is estimated that over 200 million females have been subjected to FGM in 31 different countries (Kandl et al. 2018). FGM is child abuse and is against women's human rights laws in copious international treaties. Despite this, it has been estimated that in 2021 alone, 4.16 million girls worldwide were at risk of FGM (UN, 2020). The WHO has set a target for FGM to be eradicated by 2030 (UN, 2018).

FGM is highly prevalent in low-income countries in regions of Africa, the Middle East, and Asia (WHO, 2020). It is practised within a variety of communities, each with their own rationale and unique custom, such as cultural tradition, and social acceptance (WHO, 2018). However, due to global migration, FGM has become an increasing issue in high-income countries (HICs). Due to the sensitive nature of this topic, the exact number of FGM cases in HIC's are unknown. However, in the European Union, it is estimated that over half a million women have been affected (Barrett et al. 2015).

Research has shown that healthcare professionals (HCPs) and students are in the best position to provide initial support and diagnose women affected by FGM (Reig-Alcaraz et al. 2015). Nurses play a vital role as they can educate and provide health promotion to females, assisting in early FGM recognition and prevention (RCN. 2019). HCPs knowledge of FGM is linked with the quality of care and support they provide (Ejiroghene Oigibah Adogho, et al. 2021) and their ability to identify and prevent the continuation of FGM (Zurynski et al.2015). HCPs' knowledge on FGM may be greater in LICs in comparison to HICs, due to more exposure to FGM cases and education.

Recently many HICs have tightened their laws and introduced FGM education for HCPs. For example, in the UK, it has become mandatory to report any individual under 18 who is victim to FGM and to identify anyone committing FGM (Home Office, 2015). The USA has enacted the Stop FGM Act in 2020 (Lee S, congress government. 2020), which makes the practice a federal crime to commit within and outside of the USA. Whilst HICs have strengthened their responses in eradicating FGM, there are variations in how HCP and students' education has been adapted both between HICs and within individual countries. For HCPs working with children in the UK, there are now e-learning packages available in addition to other training services (e.g., safeguarding training: Alladi, et al. 2015 and HM government. 2015). Studies have shown that there is a lack of consistency in FGM training curriculum for HCPs in Nordic countries, Australia, Spain, and the USA (Levy et al. 2020; González-Timoneda et al., 2018; Cappon et al.2015; Turkmani et al., 2018).

Zurynski et al. (2015) conducted a literature review on HCPs' knowledge and attitudes surrounding FGM in ten HICs and eight African countries. This review highlighted the prevalence of FGM, the varied knowledge base held by HCPs, and the need for increased accessible resources to aid HCPs in caring for women affected by FGM (Zurynski, et al. 2015). Despite these findings, due to the increasing proliferation of FGM in HICs, there is a need for an updated review to account for the impacts of recent updates in policy and education with a focus on HICs.

Within our literature review, the term HCPs will incorporate all healthcare staff as well as healthcare students. This term encompasses students due to their inclusion within FGM patient care (Relph et al. 2012) and the importance of utilising the full

multidisciplinary team (HM government. 2016). Our review aimed to report the understanding and experiences of HCPs caring for females affected by FGM in HICs to highlight where further research and education may be needed.

2. Methods

A systematic search was conducted on three databases: Medline, CINAHL, and EMBASE. Keywords used in searching included 'healthcare professionals', 'healthcare students', 'high-income countries', 'female genital mutilation', 'knowledge', and 'attitudes'. A hand search was also completed in the Journal of immigrant and minority health (The Cochrane collaboration. 2018). Inclusion and exclusion criteria are shown in Table 2.

The searches identified 122 papers. Eight papers were included. Thematic synthesis (Thomas and Harden 2008) was undertaken, with four themes generated (Table 3). Table 3 shows each theme and their corresponding papers.

3. Results:

3.1 FGM Knowledge

FGM knowledge refers to the understanding of FGM basics by HCPs (e.g., categorisation, and complications). All 8 studies demonstrated this theme, with inconsistency in the extent of FGM knowledge shown.

The percentage of HCPs being able to identify the four FGM classifications ranged from 22.7% - 78.9%. González-Timoneda et al. (2018) showed only 22.7% of the 321 HCPs

classified FGM correctly, while Mills (2018) found that 78.9% of 521 participants could identify the four classifications.

Cultural knowledge was explored in four papers including where, when and for what purpose FGM is undertaken. In an Australian study the majority of HCPs were knowledgeable about where FGM occurred (Dawson et al., 2015). In contrast, only 6.3% of Spanish professionals knew where FGM was practiced (González-Timoneda et al. 2018). Mills (2018) reported that 99% of HCPs in the UK recognised that FGM occurred in the UK (Mills. 2018).

Motivation for FGM practice was investigated in three papers. Studies presented various understanding of reasons for undertaking FGM. For example, Dawson et al. (2015) reported that all HCPs identified FGM was undertaken for cultural and tribal reasons. However, Cappon et al. (2015) found that 18.7% of HCPs assumed FGM was completed for medical reasons.

Complications that can occur from FGM was another knowledge area highlighted. This included awareness of short and long-term complications. 82% of HCPs in the U.K. recognised the consequences of FGM (Mills. 2018). Similarly, Dawson et al (2015) showed that all Australian midwives knew what FGM involved, and complications that could result in.

Some studies indicated that HCP's FGM knowledge varied by health profession and age of participants. Lane et al (2018) reported that midwives had higher FGM knowledge

than non-obstetric HCPs. Furthermore, HCPs who had cared for FGM patients in the last year had significantly more cultural and clinical knowledge than inexperienced providers. González-Timoneda (2018) highlighted that midwives were the most knowledgeable, with 75% of them being able to identify FGM types while nurses (17.1%) were the least knowledgeable. González-Timoneda et al. (2018) found that HCPs from different generations had varied knowledge regarding why FGM was practiced. Younger professionals believed that FGM was completed for religious reasons whilst those over 50 stated it was a traditional practice.

Knowledge of FGM legislation and policies by HCPs is apparent in half of the papers. All HCPs from the UK and Australia knew FGM was illegal (Mills. 2018, Turkmani et al. 2018, Dawson et al. 2015, Jackson. 2017, Ogunsiji. 2015). However, they were unknowledgeable about the legal specifics, for example midwives *“could not imagine what to say if a patient required further explanation on the Australian laws”* (Ogunsiji 2015, p.1187). In the remaining papers, a high percentage of HCPs were unaware of legal aspects, for example 27% of respondents did not know FGM was illegal in the United States (Lane et al. 2018). Similarly, only 29% of González-Timoneda’s (2018) respondents could identify current Spanish legislation (2018). Additionally, some HCPs had limited knowledge on their duty to act (González-Timoneda et al., 2018, Dawson et al., 2015; Mills. 2018). For instance, 34% of HCPs said they would not take action in detection of FGM because they did not know how to (González-Timoneda et al. 2018).

3.2 FGM training

FGM training received by HCPs was presented in all papers, with the majority identifying training deficits and a desire for more education. For example, 69% of participants stated they had not had FGM training (Jackson 2017). A lack of training was also reported by

Lane et al. (2018) where 37.6% of HCPs gained knowledge and experience through patient care. Nurses out of all HCPs were found to have had the least amount of formal training, with only 13% receiving FGM education (González-Timoneda et al. 2018)

HCPs' desire for more training was highlighted by Turkmani et al. (2018) where 91% of professionals requested in-service training. More specifically, HCPs highlighted their desire for training on management, legislation, culture and overall FGM knowledge (Jackson. 2017; Lane et al.2018; Cappon et al. 2015). HCPs in Levy et al's (2020) study requested for FGM education to be provided through e-learning (68%) and study days (45%).

3.3 Attitudes

The theme of attitudes includes HCPs' beliefs and emotions regarding FGM. Participants in the studies of Ogunsiji (2015) and Dawson et al. (2015) expressed their inability to understand FGM and how they believed it to be 'barbaric'. Ogunsiji (2015) reported that all midwives felt angry at women's suffering emotionally and physically from FGM.

3.4 Caring for Patients with FGM

The number of HCPs who had cared for patients with FGM varied amongst professions and countries. Midwives were found to have the most experience. For example, 56% of U.K. midwives (Mills. 2018) and 50% of Australian midwives (Turkmani et al.2018) had cared for an FGM patient. In contrast, 36.4% of other HCPs (e.g., medics and nurses; midwives were excluded in this study) in Spain reported working with FGM patients (González-Timoneda et al. 2018). In four studies, participants identified the need for a HCP to build patient rapport by being respectful, kind, and culturally sensitive (Dawson et al. 2015, Jackson.2017, Mills 2018, Turkmani et al. 2018).

The most common barrier to caring for patients with FGM was ineffective communication with patients (Dawson et al. (2015), Jackson.2017, Mills. 2018, and Turkmani et al. 2018). The effectiveness of care is linked to HCPs ability to be clear, consistent, and empathic towards patients (Mills. 2018). Communication was particularly impacted by language, cultural differences, and cultural awareness. Being unprepared and uncomfortable with FGM was reported in five studies (Ogunsiji. 2015, González-Timoneda et al. 2018, Levy et al. 2020, Dawson et al. 2015, and Mills 2018). For example, in Levy et al (2020) study 77.5% of participants reported feeling unprepared to discuss FGM with women and believed that they are unprepared to deliver care to patients.

Discussion

Many different types of HCPs care for FGM patients, with knowledge influenced by one's specialty (e.g., midwives, nurses, medics, Mills. 2018; Turkmani et al., 2018). Limited FGM-related knowledge and communication barriers were also inhibitors affecting HCPs' ability to act and provide adequate care. Similar findings in other research confirms these barriers (Jordal and Wahlberg, 2018). Concerningly, while most HCPs may take action, there is a small proportion who may not despite the illegal and harmful nature of FGM (González-Timoneda et al., 2018).

Past research has shown that knowledge of HCPs is key to the quality of care for FGM patients. HCPs' knowledge to identify and classify FGM can be improved (Lane et al., 2018; González-Timoneda et al., 2018). Age and experience also influenced knowledge and confidence (González-Timoneda et al. 2018). Training and clinical exposure to FGM patients are also important to knowledge levels (Levy et al. 2020).

Knowledge of FGM legislation is required by HCPs to comply with legal requirements designed to protect patients. HCPs lacked further detail and knowledge of how to implement legislation into practice (Ogunsiji., 2015). Each HIC has its own guidelines/policies to dictate the knowledge required of each HCP. For example, in the UK, Royal College of Nursing members must have the ability to explain FGM laws and follow legal/regulatory procedures (RCN, 2019). However, the depth of legislative knowledge is limited (Levy et al. 2020), potentially impacting the ability of members to abide by these standards.

HCPs felt empathetic but also angry and unprepared when encountering FGM (Ogunsiji, 2015; Dawson et al., 2015). Ugarte-Gurrutxaga et al. (2020) reported that some FGM-affected women perceived HCPs to have stigmatising attitudes and body language. It is important for HCPs to be aware of their FGM biases and ensure that the care they offered is not affected; for example, not avoiding FGM questions due to discomfort (Jordal and Wahlberg, 2018). In contrast, HCPs in studies conducted in LIC's were found to have favorable biases toward FGM (Adewale et al. 2014). Therefore, one must be cautious when generalising the findings of this review beyond HIC countries.

From HCPs' experiences, building rapport with women and being culturally sensitive increased the quality of care. However, the additional time required to build this rapport with women was found to be a barrier by providers. Due to the current HCP shortage and increased strain on health services in many HICs (Al Thobaity and Alshammari, 2020), one must consider how to continue to provide good practice for this standard to be continuously met (Dawson et al., 2015; Jackson, 2017).

Overall, a deficit in FGM and legislation knowledge is concerning as it may impact the ability of HCPs to provide safe care to affected females within HICs. Indicated within the studies was the vast number of HCPs with limited knowledge that were caring for patients, leading to the concern that cases may go undiagnosed (González-Timoneda et al. 2018). One hypothesis for this lack of knowledge is limited formal training available for HCPs (Levy et al. 2020).

Most HCPs did not receive formal training on FGM, as found in the UK (Jackson, 2017), Italy (González-Timoneda, 2018), and the USA (Lane et al., 2018; Levy et al. 2020). Nurses were shown to have received the least amount of formal training (González-Timoneda et al. 2018). In Australia, the lack of FGM training could be due to the scarcity of consistent and accessible training services (Ogunsiji, 2015). However, it is important to note that since these papers were published, new Australian government-funded e-learning has been developed, potentially improving HCPs' accessibility (True, date not indicated).

HCPs were found to desire more training, specifically on FGM management, legislation, culture, and practice knowledge (Turkmani et al., 2018; Lane et al., 2018). In addition to the papers reviewed, other studies indicated that training can increase HCPs confidence and overall knowledge (Jacoby and Smith, 2013). This in turn aids HCPs' ability to provide care, educate patients and their families, and assist in the overall eradication of FGM. Currently however, it is important to note the limited number of studies evaluating the effectiveness of training (Richard et al. 2017). Whilst many countries have produced training/educational programmes (Alladi et al. 2015) the few studies conducted have shown that existing educational strategies are poor (Richard et al. 2017).

Recommendations

The following key recommendations are presented to support HCPs in HIC in caring for those affected by FGM and therefore contribute to its eradication:

- The inclusion of continuous further mandatory training by all HCPs in HIC on FGM with specific focus on nurses.
- FGM to be taught as mandatory as part of Child Protection for HCPs at all 3 levels
- Including HCPs' cultural sensitivity, emotional response, and potential biases and the impact this can have on patient care in training programmes
- Provision of interprofessional education to facilitate further learning between HCPs and the creation of a coordination system as child protection concerns are shared as continuous risk assessment
- Distribution of specific guidelines to HCPs outlining their role within legislation (For example, health visitors and school nurses have a role to play in prevention of FGM).
- Undertaking research on the effectiveness of implementing FGM education including HCP attitudes, caring practices, and potential biases in university curricula.
- A longitudinal study in countries that have implemented e-learning to explore the effectiveness of such training to assist development of best practice/educational tools.

Conclusion

The findings show that HCP's knowledge of FGM is inconsistent varying by age and profession. HCPs had a desire for more FGM education.

Ineffective communication with patients was shown to be the greatest barrier for HCPs when caring for FGM affected women. Robust future research is needed to

investigate effective FGM educational/training programmes to support HCPs in HIC.

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Table 1

Explanation of each type of FGM table

Type	Explanation
Type 1: Clitoridectomy	when the clitoris is fully or partially removed, with the clitoral hood
Type 2: Excision	when the clitoris and the labia minora are partially or fully removed. This can also be in combination with the removal of the labia majora
Type 3: Infibulation	when the inner or outer labia are cut and moved to create a cover in front of the vaginal opening. This can also be in addition to the full or partial removal of the clitoris.
Type 4: Other	includes any procedure which damages the genitalia for non-therapeutic purposes including piercing, burning, and stretching (Royal College of Nursing, 2019)

Table 2
Inclusion Exclusion criteria

Inclusion	Exclusion	Rationale
English language	Non-English language	This allows for concrete understanding and the avoidance of translational error (Aveyard & Sharp, 2017).
Published academic and peer-reviewed literature	Not-published, not-academic, and not-peer-reviewed literature	To assure a high academic quality (Aveyard & Sharp, 2017).
Research focusing on healthcare staff and students	Research focusing on alternate bodies of staff (e.g., school education, non-healthcare related)	All HCPs are being studied within this review as the full multi-disciplinary team should be utilised when caring for FGM patients (Social Care, Local Government and Care Partnerships/Children, Families and Communities/ Maternity and Starting well, 2016). This will also ensure data collected are

		relevant to the research question.
Research completed since 2015	Any research carried out before 2015	To ensure all up-to-date data were included and to exclude older, irrelevant sources. Studies are included post the last literature review (Zurynski et al. 2015).
Research focusing on female genital mutilation	Other forms of gender-based violence	As this research topic is strictly about FGM, it is important to keep all information relevant to this practice.
Research completed only within high- income countries as defined by the World Bank	Any literature conducted in other countries not indicated as high income by the World Bank	This ensures the results found are relevant to the research question. HICs are defined by the world bank as countries that have a Gross National Income (GNI) per capita of \$12,376 or more (Prydz and Wadwa, 2019).

Research focusing on healthcare professionals' and students' FGM understanding	Literature not focused upon the understanding of healthcare professionals' and students' understanding of FGM.	Allows papers to be focused and strictly related to the research question.
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Table 3

Themes and included papers

	Papers:	Lane et al. 2018	Ogunsiji 2015	González-Timoneda et al. 2018	Levy et al. 2020	Dawson et al. 2015	Emma Mills 2018	Turkmani et al. 2018	Charlie Jackson 2017
Themes:	Knowledge								
	FGM training								
	Attitudes								
	Caring for FGM patients								

Title

Female genital mutilation in high-income countries: A literature review of health care professionals' and students' understanding and experiences

Authors

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Abstract:

Background: Female genital mutilation is a cultural practice with numerous negative health consequences. Due to migration from FGM prevalent countries into high-income countries, there is increased awareness within non-practicing communities emphasized by FGM's illegal nature and the negative impacts to women. It is therefore vital for healthcare professionals to be knowledgeable to provide adequate patient care. Aim:

This review aimed to synthesise literature to report the understanding and experiences of HCPs caring for females affected by FGM in high income countries. Methods: A systematic search was conducted on three databases; Medline, Embase, and the Cumulative Index to Nursing and Allied Health Literature (CINAHL). Inclusion and exclusion criteria were applied to select the papers. Findings from included papers were synthesized using thematic synthesis.

Findings: Eight articles met the criteria. Four themes were generated: FGM knowledge, training, attitudes and caring for FGM patients. Conclusion: Healthcare professionals' knowledge and experiences of FGM tend to be varied. This review highlights the need of training for healthcare professionals in high-income countries to strengthen their FGM knowledge.

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