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NURSING CARE FOR SURVIVORS OF FEMALE GENITAL MUTILATION

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A senior research paper submitted in partial fulfillment
of the requirements for the degree of
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Acknowledgments

I would like to acknowledge my family members who have supported me throughout this process, healthcare providers across the world seeking to provide better care to all they offer their skills to, and most importantly the women who have experienced FGM. They are the true champions.

Abstract

Female Genital Mutilation is a genital alteration that affects women for the rest of their lives. With limited research regarding the long-term effects and treatments for the survivors of FGM, this literature review seeks to find the most effective nursing interventions to promote quality of care for these women. Sample: 24 articles were identified in the literature on the topic of FGM resulting in a purposive sample of 13 studies. Methodology: The databases utilized were “EBSCOhost MEDLINE with Full Text.” Keywords included “Female Genital Mutilation, Female Circumcision, nursing, and nursing interventions. Articles were critiqued, and the inclusion criteria were that articles had to be published within the last five years, available with full text, in English, and from a peer-reviewed journal. Results: Interventions commonly found to be effective were the education of the nurses, nursing management of both short and long-term complications, and advocacy. In addition, coordinating care for the women, surgical interventions and education for the women themselves were also effective. Nursing education will be benefited by increasing nurses’ knowledge about FGM. This is then useful for practice because implementing evidence-based-research interventions into patient care could increase nurse’s confidence in delivering care and positively affect patient outcomes. Future research is needed to get a better understanding of long-term effects and the efficacy of different interventions as there is very little research on this currently.

Nursing Care for Survivors of Female Genital Mutilation

Imagine having forced removal of a part of your genitalia, often without anything to numb the pain, and almost assuredly without your permission. This is a cultural epidemic that many women face, leaving them forever changed. It has no proven health benefits for the woman but leaves them scarred, physically, emotionally, and frequently with an excruciating recovery (Little, 2015). Over 100 million females are survivors of female genital mutilation (FGM), or female genital circumcision (FGC), living with the consequences of this cultural practice.

Found in 29 African countries as well as some of the Middle East and Asia (Allen and Oshikanlu, 2015), this procedure has been known to be performed by midwives, barbers, or local traditional healers without any surgical skills. On occasion, for the fortunate few, FGM is performed by a physician (Little, 2015). There are different reasons FGM is practiced as well as different kinds that vary in severity. The main idea behind FGM is to exert greater control over women by altering their genitalia and often removing some or all physical pleasure of sexual activities for them.

For nurses and caregivers around the world education about this act and how it affects the individual is imperative. What nursing interventions can possibly prevent the act of FGM, and what interventions can be established post-mutilation to give holistic care and promote the highest level of functioning for the patient. This issue extends beyond the medical field and into legal and ethical issues as people are rallying behind these women and saying this is a human rights issue.

Background

FGM, as defined by the World Health Organization includes “All procedures that involve partial or total removal of the external female genitalia or other injury to the female genital organs for nonmedical reasons” (Momoh, Olufade, & Redman-Pinard, 2016, p. S30). FGM survives as a practice because of deep cultural traditions. While it does not physically benefit the young female, it does cause both physical and mental trauma for her lifetime. This is a practice performed from infancy up through adulthood.

The World Health Organization made a public statement to bring awareness to FGM and gain public support in eradicating the practice in 1997. Since then there has been a decrease in the practice, with daughters less likely to experience the mutilation than their mothers (Momoh, Olufade, & Redman-Pinard, 2016). Still, eradication has not occurred due to the deep entanglement in culture.

The Practice of FGM from Culture to Culture

There are four identified practices of FGM: clitoridectomy, excision, infibulation, and all other forms of nonmedical mutilation. A type 1 clitoridectomy involves the partial or total removal of the clitoris and or the prepuce. Type 2 excisions include the removal of the clitoris, labia minora and possibly the labia majora. Infibulation, type 3, requires the narrowing of the vaginal opening by surgically repositioning the labia and stitching around the vaginal opening. This may or may not also include a clitoridectomy. Type 4 FGM is a catch-all referring to all other “harmful procedures to the female genitalia for

non-medical reasons, e.g., pricking, piercing, incising, scraping and cauterization”

(Momoh, Olufade, & Redman-Pinard, 2016, p. S30).

Around 80% of all FGM is comprised of the clitoridectomy and excision practices. While FGM is performed across the globe, it is primarily practiced in Africa, as well as in the Middle East and South East Asia (Momoh, Olufade, & Redman-Pinard, 2016). Different countries practice different types of FGM and on girls of different ages depending on their cultural reasoning. Mainly due to immigration, people with FGM or the practice of doing it has spread to Australia, American and Europe (Martínez & Turetsky, 2015). The United Kingdom is known to practice infibulation, the most damaging type of FGM. Though not labeled as such in literature, FGM can be seen as a religio-cultural ritual. Culturally, some women are offended by the term FGM because they do not necessarily view themselves as having been ‘mutilated’ (Momoh, Olufade, & Redman-Pinard, 2016). This terminology can increase the perceived victimization if the woman is coping well or did not view the practice as abnormal or harmful. In some cultures, FGM is presented as an “act of love by preparing a girl for adulthood” (Momoh, Olufade, & Redman-Pinard, 2016). One survivor’s mother defended the practice to her daughter by saying “I did it for your own good. It was in your best interest. Your grandmother did it to me, and I did it to you. It's made you a woman" (Gbla, 2014, p. 3).

Consequences of FGM

FGM results on physical and mental consequences. The physical consequences of FGM are varied and can be mild or severe, including death. Urinary problems are the

most common adverse effect, but pain, infection, bleeding, fractures, and injury to local organs are also known to occur. There is also an increased risk of acquiring HIV and becoming infertile (Allen & Oshikanlu, 2015).

Mentally, the results of FGM can result in emotional shock, Post-Traumatic Stress Disorder, anxiety, and a variety of psychosocial problems (Little, 2015). Victims of FGM report feeling embarrassed to go to the gynecologist and even in dealing with their midwives because of the altered physical appearance of their genitals (Dawson, Turkmani, Varol, Nanayakkara, Sullivan, & Homer, C. E. 2015).

Barriers for Nurses

There are obstacles that nurses encounter when giving care to at-risk girls and the victims of FGM. Initially, there is the challenge of gaining the woman's trust to the point where she feels comfortable disclosing what has been done or the potential that the mutilation will occur (Ogunsiji, 2016). The fear of judgement keeps some women from being open with nurses. One patient reported, "I can never go to my gynecologist and feel comfortable, I always have to let them know they are about to see something they are not familiar with. As a woman, it takes every pride and dignity away from me" (Naughton, 2013, p. 23).

Other barriers to care include Midwives also report feeling inexperienced in caring for women who've experienced FGM (Dawson, Turkmani, Varol, Nanayakkara, Sullivan, & Homer, C. E. 2015). Considering the practical and procedural side of nursing, it may be difficult to do vaginal and rectal exams, testing for sexually transmitted

diseases, or doing a cervical smear due to the altered anatomy of some women; depending on the type of mutilation performed.

Legal Considerations

Legally FGM is considered a violation of human rights and some countries are beginning to outlaw the practice and enforce mandatory reporting (Momoh, Olufade, & Redman-Pinard, 2016). Some girls and women are not even aware that they have experienced FGM, supporting the critical need for increased awareness and education of the topic. International legislation against the practice is highly controversial because of the varied socio-cultural and religious reasons behind FGM. Even with laws in place, there remains the issue of creating consistency in enforcing the regulation (Allen & Oshikanlu, 2015).

Nurses have a duty and obligation to advocate for their patients, and as awareness for FGM increases, many nurses have mandatory reporting guidelines to which they must adhere. In the United Kingdom, FGM is considered to be illegal in any woman born after 1969, and nurses are required to report all actual or suspected cases of FGM in girls under the age of 18, documenting assessment of all women regardless of age (Allen and Oshikanlu, 2015). In Australia, performing and assisting in the performance of any type of FGM is illegal, whether consent is given or not (Dawson, Turkmani, Varol, Nanayakkara, Sullivan, & Homer, C. E. 2015).

Mandatory reporting is difficult. The nurse is at risk for prosecution if she does not abide by the policy, and the patients are at risk for a variety of consequences that could result from the reporting. The women face more possible embarrassment, as well as

the prosecution of whoever performed the procedure on the female. Sometimes these charges could be against abusers, and other times they could be against beloved family members, complicating the situation. However, “The sense of social obligation to cut one’s daughter is so entrenched that it overrides any potentially positive influence from moral and legal norms” (Dawson, Turkmani, Varol, Nanayakkara, Sullivan, & Homer, C. E. 2015, p. 208).

Encountering FGM Survivors

The prevalence of custom and care for FGM patients varies greatly on where a nurse is practicing. Outside of the major countries aforementioned, nurses in multicultural societies may encounter immigrants who hold this tradition. School nurses see the girls who might otherwise slip through the cracks because “school nurses are with children during a key formative period in their lives,” they have a unique and invaluable opportunity to “[advocate] for children potentially impacted by FGM” (Naughton, 2013, p. 23).

FGM is a deeply culturally rooted practice that creates barriers between nurses and women who have undergone the procedure. Legislation and competent nurses are key mediations in closing this gap and moving towards eradication of the practice.

Significance

Care of women who have experienced FGM is important in the nursing community because it is a preventable harm that is detrimental to female patients. Nurses will need to understand the care for women who have been affected by FGM because it is no longer confined to a limited population outside the United States. The chances of

encountering a woman who has gone through this procedure have increased, not because the prevalence of the practice is increasing but because the people in the cultures that practice FGM have begun to immigrate and are now in places that were formerly without FGM.

Educating nurses on how to care for these women holistically is essential because the procedure does not only affect them physically. Nurses must be prepared to care for the physical, psychological and spiritual needs of the patient while maintaining cultural sensitivity and educating the women about the practice from a medical perspective. Nurses must be prepared for the variety of procedural effects they may see to increase their competence in caring for the individuals.

Due to the recent emergence of widespread awareness of FGM, there is a general deficit in the nursing realm on how to care for these patients. At present, there is little in the literature about it as well as studies and testimonies from individuals. This review is important to synthesize the practices currently available regarding how to best care for survivors of FGM. This review will add to the knowledge accessible on how nurses can specifically and effectively care for women who have undergone FGM.

Problem & Purpose Statement

Given the prevalence of women affected by FGM, it is crucial to determine the most effective methods of caring for those who have endured the procedure to reduce physical, mental and spiritual consequences and promote optimal health. This systematic research answers the question, “What are the most effective nursing interventions to promote quality of care for survivors of FGM?” The purpose of this review is to explore

nursing interventions that provide quality of care for these patients. This review will also provide updated and synthesized information regarding nursing care for FGM which is crucial for nurses to give the highest quality care.

Definition of Variables

The variables identified in the systematic review include the dependent variable of quality of care and the independent variable of nursing interventions which includes physical, mental and spiritual health. ‘Quality of care’ refers to actively pursuing the highest excellence and safety to minimize the opportunity for errors in providing health care to patients (Gulanick 2014, Lough 2015). A ‘nursing intervention’ encompasses any action taken by a nurse using clinical experience of critical thinking knowledge to improve a patient’s overall health and well-being, including using a holistic approach to take into account a patient’s physical, mental, and spiritual health (Varcarolis 2009). ‘Interventions for physical health’ refers to using evidence-based practice to plan and deliver care to patients in an attempt to restore, maintain and promote their bodily functions (Gulanick 2014). ‘Interventions for mental health’ refers to, delivering and adapting care while considering a patient’s psychological status, as well as how a patient’s illness may affect their psyche (Varcarolis 2009). ‘Nursing interventions for spiritual health’ refers to assisting patients with coping by planning, accommodating and delivering personalized, culturally and religiously coherent care to foster the best-individualized patient outcomes (Varcolis 2009). This study explored the independent nursing interventions that have outcomes of quality of care and holistic actions by the nurses resulting in the restoration, maintenance, and promotion of health.

Methodology

The searches for this systematic research review were conducted between January 25, 2018-August 22, 2018. The databases utilized were “EBSCOhost MEDLINE with Full Text.” Keywords included “Female Genital Mutilation, Female Circumcision, nursing, and nursing interventions.

The various databases used and the keywords applied individually and in combination, provided the most comprehensive number of hits. Limiters (inclusion criteria) were that articles had to be published within the last five years, available with full text, in English, and from a peer-reviewed journal. This combination of criteria allowed the most credible information on the topic. The total number of hits from all the searches was approximately 752. To accomplish the necessary task of narrowing the results, titles were scanned. Those that did not appear to relate to answering the research question directly were excluded. If articles could not be excluded based on the title, abstracts were read. Those that sounded promising in answering the research question were saved, and the full-text article was reviewed and critiqued. Out of all the searches, 24 studies were saved as possible inclusion in the sample. Snowballing of article references was also used to find more possible sample articles. Saved articles were critiqued for quality and the ability to answer the research question. Once critiqued, the sample size was 13.

Findings

The sample was comprised of articles published in ten different journals. One study was a case-control study, (Biglu, Farnam, Abotalebi, Biglu, & Ghavami, 2016),

five were qualitative (Dawson, Tukmani, Varol, Nanayakkara, Sullivan, and Homer, 2015; Khaja, Lay, & Boys, 2010; Momoh, Olufade, & Redman-Pinard, 2016; Ogunsiyi, 2016; and Ruiz, Martínez, & Del Mar Pastor Bravo, 2016), five were systematic reviews of the literature (Abdulcadir, Rodriguez, and Say, 2015; Balfour, Abdulcadire, Say & Hindin, 2016; Berg, Taraldsen, Said, Sørbye, & Vangen, 2017; and Reisel and Creighton, 2015), and two were mixed methods study (Allen & Oshikanlu, 2015 and Goldstein, 2014). The literature is primarily descriptive in nature with little correlational data. Table 1 gives the basic demographic information for each study including authors, year published, journal name, and type of study.

Table 1

Findings Table

Author(s)	Journal Name & Year	Type of Study/ Level of Evidence	Sample Size	Findings
Allen & Oshikanlu	Community Practitioner 2015	Level IV Evidence from integrated reviews (Mixed Methods)	None	Physical & Mental -Public health nurses play a critical role by advocating for and coordinating care with health care, social work, legislation & education
Abdulcadir, Rodriguez and Say	International Journal of Gynecology & Obstetrics 2015	Level IV Systematic Review	4 studies	Physical -Intervention: Clitoral reconstruction
Balfour, Abdulcadir, Say, & Hindin	BMC Health Services Research 2016	Level IV Systematic Review	2 studies	Physical & Mental -Intervention of e-learning tools ex: videos, & learning platforms

Berg, Taraldsen, Said, Sørbye, & Vangen	The Journal of Sexual Medicine 2017	Level IV Systematic Review	71 studies	Physical & Mental -3 surgical interventions: defibulation, excision of a cyst, & clitoral/labial reconstruction
Biglu, Farnam, Abotalebi, Biglu & Ghavami	Sexual & Reproductive Healthcare 2016	Level III Case-Control Study	140 circumcised & 140 non-circumcised married women	Physical & Spiritual -Created a scoring system for female sexual function and compared “circumcised vs uncircumcised”
Dawson, Tukmani, Varol, Nanayakkara, Sullivan, and Homer	Women and Birth 2015	Level IV Qualitative	48 Midwives	Physical & Mental -Midwives need education, training & supervision for FGM -Community outreach for antenatal & postnatal home care -Culturally sensitive terminology

Author(s)	Journal Name & Year	Type of Study/ Level of Evidence	Sample Size	Findings
Khaja, Lay, & Boys	Health Care for Women International 2010	Level IV Qualitative	17 circumcised Somali women	Mental -Intervention: Culturally sensitive counseling -Support of male figures imperative
Momoh, Olufade, & Redman-Pinard	British Journal of Nursing 2016	Level IV Qualitative	None	Physical & Mental -Cultural sensitivity in using terminology of ‘mutilation’
Ogunsiji	Healthcare for Women International 2016	Level IV Qualitative	Two expert midwives	Physical, Mental, & Spiritual -Interventions: teach relaxation techniques prior to vaginal exam, counseling, referral to relevant allied health, & empathy
Reisel & Creighton	Maturitas 2015	Level IV Systematic Review	None	Physical & Mental

Ruiz, Martínez, & Del Mar Pastor Bravo	Midwifery 2016	Level IV Qualitative	21 men familiar with FGM	-Interventions: defibulation & episiotomy relating to pregnancies Mental -Intervention of investigative research for creation & implementation of FGM specific education programs
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Findings Summary

There were seven categories, with a total of 60 interventions of interventions. Categories included short and long-term symptom management as well as advocacy, coordinating care, education of the victim, education of nurses, and surgical procedures. Advocacy included legislation, using honor, empathy, easing cultural tension, conflict, and data collection. Coordinating/community care included social work, community outreach for ante- and post-natal home care, and support of male figures. Education of the victim included education of possible complications, relaxation techniques, and more investigative research for the creation and implementation of FGM specific programs, educating others. Education of nurses included midwife-specific education, role-playing, roundtable discussions with cultural leaders, collaborating with interpreters, health talks at clinics, visual aids to present to patients, skills laboratories, PowerPoint presentations, a scoring system for female sexual function, and professional mentoring. Surgical procedures included genital reconstruction, defibulation, cyst excision, and episiotomies. Short-term symptom management included Hepatitis, HIV, infection, UTI's, septicemia, gangrene, tetanus, bleeding, pain, shock and giving fluid restrictions. Long-term symptom management included dermatoid cysts, labial fusion, genital infection,

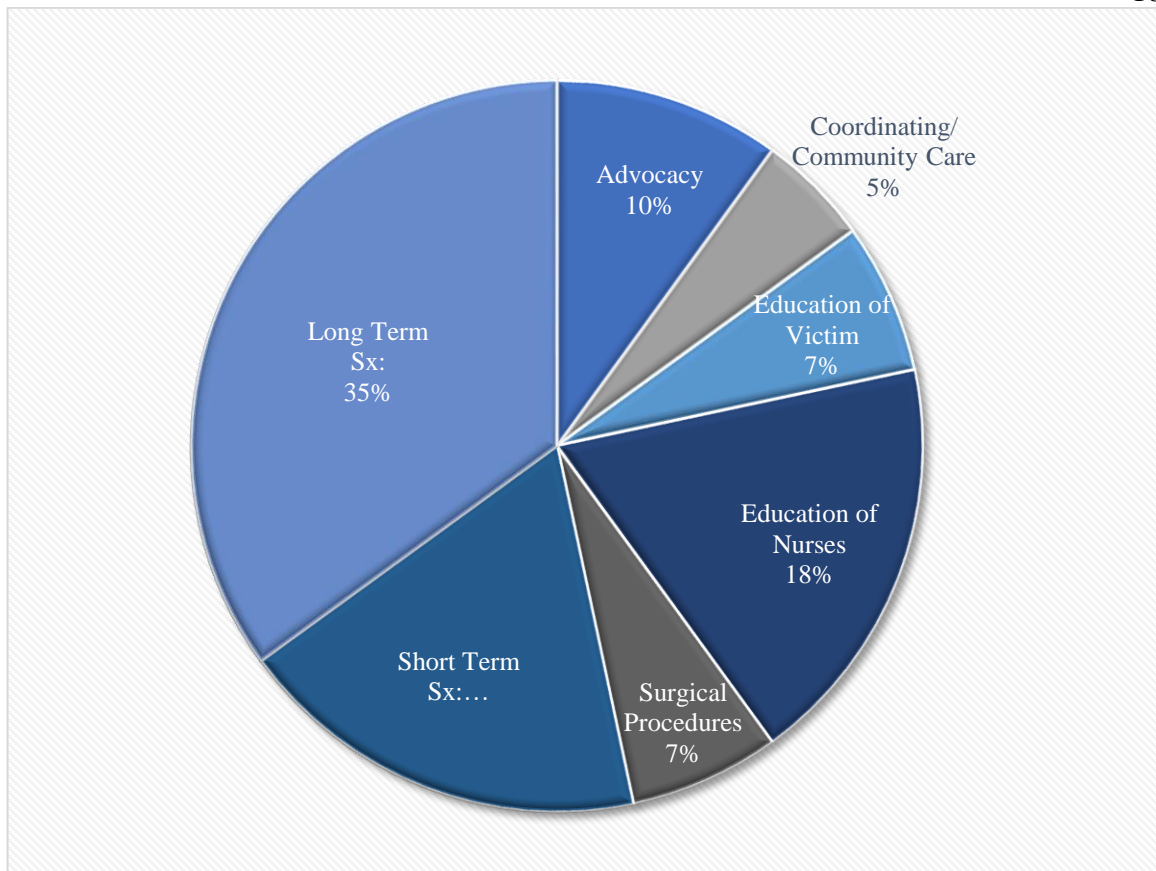
apareunia, abscesses, keloids, hematocolpos, dyspareunia, urinary retention, neuromas, menstrual difficulties, ulcers, increased risk for infertility, death, PTSD, memory problems, depression, chronic anxiety, fear, and psychosexual discomfort. The most common intervention found was education. The category that required a variety of interventions was long-term side effects. Individual interventions will be reviewed in the discussion.

Although cultural sensitivity was not found in the data to be a specific intervention, it was a prevalent topic in much of the literature and therefore warrants mentioning. It was found that practicing culturally sensitive word usage such as refraining from the term “mutilation” because many women do not feel as though they have been mutilated, is important in providing care and gaining trust with survivors of FGM (Momoh, Olufade, & Redman-Pinard, 2016). One study found that the term ‘circumcision is widely accepted, and female cutting is actually a little bit softer’ of an expression. Also, “the use of ‘traditional practice’ as compared to ‘genital surgery’ is more well-received to women to have experienced FGM (Dawson, Turkmani, Varol, Nanayakkara, Sullivan, & Homer, C. E. 2015). Culturally sensitive counseling has also proven effective for women to understand what has happened to them, their individual implications and complications, and allow them to share their feelings about the procedure. “Husbands may be the decision makers to have their newborn daughter cut, or their wife re-infibulated after delivery,” therefore counseling couples together is important to discuss the benefits of de-infibulation (Dawson, Turkmani, Varol, Nanayakkara, Sullivan, & Homer, C. E. 2015, p. 212). When using interpreters,

considering the use of female interpreters is highly recommended as many women feel embarrassed communicating the subject of FGM with male interpreters (Dawson, Turkmani, Varol, Nanayakkara, Sullivan, & Homer, C. E. 2015). Four elements of care have been identified to increase cultural sensitivity in giving care to survivors of FGM, “attentiveness, responsibility, competence, and responsiveness” (Khaja, Lay, & Boys, 2010, p. 695). Figure 1 demonstrated the breakdown by percentage of the total number of interventions identified in the literature into their respective categories.

Figure 1

Intervention Chart



Discussion

Intervention categories will be included as quality care. These examined interactions promoted holistic improvement for women with FGM

Advocacy

Advocacy includes legislation to prevent and prosecute the perpetrators of FGM as it is “legally classified as permanent injury (Khaja, Lay, & Boys, 2010). Also, demonstrating honor and empathy related to their individual backgrounds as an intervention means being culturally competent as healthcare workers to allow women to feel comfortable during physical exams as well as feeling safe to discuss their cultural upbringings and history. Advocating for women within their family structure to ease

cultural tension and conflict is imperative as evidenced by the sample. Data collection and analysis of women who have undergone FGM procedures, has allowed for a scoring system to be created to compare circumcised and uncircumcised women in multiple areas. Women who have undergone FGM across the board scored lower in sexual function including “desire, arousal, lubrication, orgasm, satisfaction and pain” compared with uncircumcised women (Biglu, Farnam, Abotalebi, Biglu, & Ghavami, 2016). Data collection such as this can be used to objectively educate legislators, health providers, cultural leaders, and family units on the consequences of FGM.

Coordinating/Community Care

Health professionals must collaborate with social workers to holistically pursue the best possible outcomes for the women who’ve experienced FGM. The implementation of community outreach for antenatal and postnatal home care to help the women adjust to motherhood in light of their FGM as well as build trust with healthcare workers. Providing antenatal services does require additional time and sensitivity to build rapport and understand a woman’s cultural context, needs and complete history (Dawson, Turkmani, Varol, Nanayakkara, Sullivan, & Homer, C. E. 2015). “Community outreach programs can be pivotal in improving the care of women with FGM, as well as preventing the practice. Examples include midwifery continuity of care models, health professional engagement in community activities and the involvement of other health professionals such as general practitioners, and health promotion into homes through initiatives such as the community-based midwifery program” (Dawson, Turkmani, Varol,

Nanayakkara, Sullivan, & Homer, C. E. 2015). Pursuing the support of male figures is a key intervention in eradicating this practice and having them support their wives and children who have already undergone the procedure.

Education of Victim

According to the literature, educating the victim on the possible complications post-circumcision is vital for those who are not aware of the permanent effects it can have. Teaching women relaxation techniques prior to any sort of physical exam that will be assessing the affected areas helps to decrease anxiety as well as reduce muscle tension and therefore reduce pain and discomfort during examination. One study suggests educating the women on pelvic floor physical therapy, utilizing sexual counseling, and the use of vibrators to enhance genital response (Berg, Taraldsen, Said, Sørbye, & Vangen, 2017), as these have shown to be beneficial to some women. Women with FGM experiences can also get involved in the education of others through the process of investigating research to create and implement FGM-specific programs. This is needed across the world but specifically in areas where high numbers of women are experiencing the circumcision. Specifically utilizing educators who are women that have personally experienced FGM is highly effective (Ruiz, Martínez, & Del Mar Pastor Bravo, 2016). Focusing education on raising awareness as well as educating women on their rights must be promoted to empower women to advocate for their own health (Ruiz, Martínez, & Del Mar Pastor Bravo, 2016).

Education of Nurses

Many of the studies in this review pointed to the fact that healthcare specific training for those who will be dealing with victims of FGM is critical to provide them the

best care as well as have them feel safe enough to comply with necessary procedures and treatments regarding FGM. Midwives need education and training on how to deal with all possibilities of what they may see in the genital region of their patients as well as the possible obstetric complication they may have to combat during the birthing process and how to help the women in the midst of it. Such educational programs have included health talks at clinics, videos on defibulation, visual aids to provide clients during consultations, role-playing to simulate counseling, and roundtable discussions with cultural leaders, collaborating with certified interpreters, and hands-on skills laboratories on defibulation (Balfour, Abdulcadire, Say & Hindin, 2016). The most common education tool used are PowerPoint presentations (Balfour, Abdulcadire, Say & Hindin, 2016). Another educational strategy is the mentoring of younger professionals and including a competency standard requirement (Dawson, Turkmani, Varol, Nanayakkara, Sullivan, & Homer, C. E. 2015).

Surgical Procedures

The main surgical interventions found in this review that are used to treat FGM include genital reconstruction, defibulation, cyst excision, and episiotomies. The main reason for women seeking surgical interventions is because of physical functional problems. In one study, this was the motivation for 92% of women to seek surgical intervention (Berg, Taraldsen, Said, Sørbye, & Vangen, 2017, p. 983).

The clitoral-labial reconstruction is mainly used to recreate a clitoris and/or labium that has been removed and attempt to give women greater sexual stimulation and

satisfaction and improve genital appearance. This particular procedure may require a plastic or cosmetic surgeon under generalized anesthesia (Berg, Taraldsen, Said, Sørbye, & Vangen, 2017). The long-term efficacy of this procedure has not been well researched, and reviews have been mixed. Additionally, the reconstructive surgery can be expensive and be inaccessible due to limited surgeons with the necessary skills. For women who had their clitoris removed prior to puberty, they often do not have clitoral reconstruction because they developed their sexuality without it and therefore reintroducing a clitoris is foreign to them and can even result in a loss of sexual identity (Diouf, Diallo, Mbodj, Gassama, Guèye, Moreau, & Diouf, 2017).

Defibulation is the process of reopening the vaginal opening after it has been sutured together from FGM type III, and is usually performed with scissors (Berg, Taraldsen, Said, Sørbye, & Vangen, 2017). Many women require this for their marriage. Episiotomies are performed typically after type III FGM, infibulation has occurred, and the baby does not have enough room to fit through the vaginal opening. After defibulation has been performed, some women wish to be reinfibulated due to personal preference and cultural views.

Cyst excision is performed as a treatment to remove cysts that form as a common complication after FGM is performed. These cysts can be uncomfortable, painful and/or obstructive to urination, and intercourse. Frequently, the cysts are diagnosed long after the procedure and often during the women's wedding night as she attempts to have intercourse for the first time. They are formed from "sub-dermal inclusions of epithelial

fragments or a reversal of the wound edges at the time of healing of the excision” (Diouf, Diallo, Mbodj, Gassama, Guèye, Moreau, & Diouf, 2017).

Complications

No articles specifically addressed interventions for the physical complications these women have been known to experience, but the complications need to be addressed by the nurses and is therefore considered an intervention category in this review.

Short-term Complications

The main short-term complications identified as a result of FGM were the immediate transmission of Hepatitis and HIV due to the lack of proper sanitation of instruments. This also was shown to increase the risk of infection leading to a high occurrence of UTI's, and septicemia, gangrene, and tetanus (Reisel & Creighton, 2015).

Bleeding is also a common short-term complication because of the high vascularity of the peritoneal area. Pain is often excruciating because anesthetic is rarely used, and the women are held down (many times by other women) while the procedure is being performed, leading to shock (Goldstein, 2014). Necrotizing fasciitis has also been reported as a complication (Reisel & Creighton, 2015). One nursing intervention called for fluid restriction post-operatively to FGM because urination, while the area is still raw, can be agonizing and increase the risk of infection.

Long-term Complications

Although specific interventions for long-term complications were not discussed in the sample, this literature review identified a variety of twenty physical and mental needs for women who have encountered FGM. The long-term physical complications of FGM included dermoid cysts, apareunia, abscesses, keloids, hematocolpos, dyspareunia, urinary complications, neuromas, chronic ulcers, and in some cases, death. (Diouf, Diallo, Mbodj, Gassama, Guèye, Moreau, & Diouf, 2017; Reisel & Creighton, 2015).

Obstetric complications also included labial fusion (from type III), recurring genital infection, menstrual difficulties, and an increased risk for infertility (Diouf, Diallo, Mbodj, Gassama, Guèye, Moreau, & Diouf, 2017; Reisel & Creighton, 2015).

Nurses need to be prepared to address and care for the following complications. Apareunia, the inability to engage in sexual intercourse due to a physical psychosexual disruption. Keloids, which are raised scar tissue over the injured tissue. They can be painful, and itch, causing discomfort and altered genital appearance. Hematocolpos, which occurs when the vagina fills with blood. This is understandable in the case of infibulation where the vaginal opening is greatly reduced in size, restricting the outflow of menstrual blood. Damage to the urethra. This can lead to both fistulas and urethral strictures as well as urinary retention; which itself leads to an increased risk of infertility. This, in particular, has little evidence to concretely support the claim, however, beliefs lend to the thought that painful intercourse and pelvic infection could contribute to infertility (Reisel & Creighton, 2015).

Obstetric complications including the risk of prolonged labor, postpartum hemorrhage, perineal trauma, increased need for Caesarean section, neonatal

resuscitation, low birthrate and early neonatal death/stillbirth (Reisel & Creighton, 2015).

Mental long-term complications also requiring nursing care include PTSD, memory problems, depression, chronic anxiety, fear, psychosexual discomfort (Reisel & Creighton, 2015). Each of these complications requires individualized care and treatment, whether that be nurses, doctors, medications administrations, and counseling.

Implications

The research findings from this review support and influence changes regarding nursing education, practice, and future research.

Education

Nursing education address care for women who have experienced FGM stressing cultural sensitivity and a basic understanding of the procedures and interventions. Nurses who are in maternity or are midwives training should have competencies as part of orientation.

Practice

The results of this literature synthesis can positively affect confidence in delivering specialized care to women with FGM. Implementing evidence-based-research interventions into patient care could positively affect patient outcomes and address health disparities specifically for FGM-related populations.

Future Research

Future research to improve outcomes for females with FGM should include studies that test nursing interventions for effectiveness, education and influence on attitudes, methods to decrease the practice, and on side effects of the procedure.

Strengths and Limitations

Several strengths and limitations of this study need to be addressed. Strengths of this study included the use of a research mentor experienced in nursing research, the interest of the author in the topic selection, and having two academic semesters to complete the project. The strength of most of the studies was level IV, with a few being level III.

Limitations of this study included the inexperience of the nursing researcher, other obligations and classes occurring at the same time as the research, inability to use all databases and fees associated with some journals, and time limitations of the mentors. Another limitation of this study included the lack of availability of current, rich data sources on the topic.

Cultural biases could also contribute to a bias of the study. Due to the fact that the researcher is from a westernized society without any personal experience related to FGM, ignorance and ethnocentrism in opposition to the practice may exist.

Recommendations

Recommendations for replication of this study include the use of more current research, use of a larger sample, more focused time on the research project, peer review input during the research process, and better time management without extended breaks

during the research process. A live sample would also greatly benefit this study to get first-hand testimonials and an actual evaluation of FGM and its effects.

Conclusion

The findings of the literature synthesis support the findings that there are effective nursing interventions to promote quality care for survivors of FGM. These include the many roles for the nurses including advocacy, coordinating care, education of the nurses and victims, surgical procedures, and short and long-term complications requiring nursing care. To operate at the highest level, nurses must increase their confidence and competence in caring for FGM through education and mentoring. Nurses must also learn to manage short and long-term symptoms to promote physical, mental and spiritual health. Nurses can be a professional, caring force who have the ability to interact personally with the individual as well as communicate with authorities and initiate change in societies through advocacy and education.

Little progress has been made in understanding the complex care needs of the women who have experienced FGM. The importance of explaining, promoting, implementing and improving evidence-based practice is necessary to provide quality of life and care to FGM survivors.

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