

# Knowledge of Female Genital Cutting and Experience With Women Who Are Circumcised: A Survey of Nurse-Midwives in the United States

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Thousands of women with a history of female genital cutting (FGC) have immigrated to the United States. The purpose of this study was to assess certified nurse-midwives' (CNMs') knowledge of FGC and to explore their experiences caring for African immigrant women with a history of genital cutting. A descriptive survey design was used. A random sample of 600 CNMs from the member list of the American College of Nurse-Midwives was surveyed. Two hundred forty-three CNMs completed a survey of FGC knowledge and provider experience. The respondents exhibited more correct medical knowledge about FGC than knowledge of cultural and legal issues. Differences in correct or incorrect knowledge were statistically significant based on provider experience. Almost 70% of respondents could identify infibulation. Less than 20% knew that both Muslim and Christian women are circumcised. Fifty-seven percent knew that it is illegal in the United States to circumcise women younger than 18 years of age. We found that discussions between CNMs and clients who were circumcised regarding FGC-related concerns and complications were minimal. Women with a history of FGC want female providers. Reinfibulation poses an ethical dilemma for some CNMs. Nurse-midwives in the United States need to learn more about FGC and the cultures of their clients in order to provide culturally competent care. *J Midwifery Womens Health* 2010;55:46–54 © 2010 by the American College of Nurse-Midwives.

**keywords:** African immigrant women, culturally competent nursing practice, female circumcision, female genital cutting, certified nurse-midwives

## INTRODUCTION

Female genital cutting (FGC), also referred to as female genital mutilation and female circumcision, has been practiced for centuries in many African and Asian cultures. The term “female genital mutilation,” used by the World Health Organization (WHO), is pejorative for some peoples,<sup>1–3</sup> and therefore we have chosen to use the term “female genital cutting” in this article. WHO estimates that 100 to 140 million girls and women have already undergone FGC, and that another two million face it each year.<sup>4</sup>

FGC is differentiated into four main types based on the severity of the procedure. Type 1, sometimes referred to as “sunna,”<sup>5</sup> involves the excision of the prepuce and some of or the entire clitoris. Type 2 is excision of the clitoris and removal of some or all of the labia minora. Type 3 is called infibulation. It involves excision of a portion or all of the external genitalia and the stitching of the remaining tissue to narrow the vaginal opening. Type 4 may include any of the following: piercing, pricking, or incising the labia and/or clitoris; cauterization of the clitoris and surrounding tissue; scraping of the tissue that surrounds the vaginal orifice, cutting into the vagina wall; and placing herbs or corrosive substances into the vagina to promote bleeding or to narrow it.<sup>6,7</sup> Reinfibulation, the resuturing of the orifice of the vagina to regain the size

of primary infibulation, is done in those cultures that practice type 3 genital cutting.<sup>8</sup>

The WHO has led the campaign to stop FGC as a violation of human rights.<sup>6</sup> The American College of Nurse-Midwives (ACNM) concurs with WHO that FGC is a gender-based human rights issue that threatens the basic rights of girls and women including their rights to health, life, physical and sexual integrity, human dignity, self-determination, and freedom from torture, violence, and bodily harm.<sup>7</sup> Many countries have passed laws against the practice, including Sweden and the United Kingdom in 1985, and Canada, Switzerland, and the United States in 1995. In the United States, it is illegal to circumcise, infibulate, or excise any part of the genitalia of a woman under 18 years of age.<sup>9</sup>

Despite mounting opposition, FGC is still practiced for reasons that vary depending on the culture in which it is done. In Nigeria, FGC is seen as a rite of passage into womanhood and is considered vital to social cohesion and important for the tempering of female assertiveness and the enhancement of female passivity.<sup>1</sup> In Somalia, the practice of FGC is perpetuated because it is believed to protect a woman's virginity, increase fertility, and heighten male sexual pleasure.<sup>8,10,11</sup> In Sudan, FGC enhances a woman's value. Sudanese midwives view circumcised genitalia as beautiful and complete.<sup>8</sup> In a study by Elgaali et al.,<sup>12</sup> some of the Somalian immigrants in Scandinavia believed that FGC was required by their religion.

There have been repeated calls from immigrant women and health care providers for an increased awareness of this procedure, its antecedents and consequences, and the need for appropriate care for immigrant women with

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a history of FGC.<sup>1,3,5,13-15</sup> Thousands of women with a history of FGC emigrate from African countries to the United States every year. They lack proper health care because of cultural and language barriers,<sup>16</sup> ignorance of the practice of FGC and its obstetric effects, stigmatization, and the fear of mistreatment.<sup>3,13</sup> Researchers found that health care professionals caring for women with FGC experience cross-cultural conflicts. Midwives and doctors in Norway<sup>17</sup> and the United Kingdom<sup>18</sup> lacked knowledge of FGC, and this negatively impacted their practice. In Switzerland, doctors and midwives reported that problems related to FGC included dyspareunia, dysmenorrhea, dysuria, obstetric complications, and scar tissue and cysts, but they did not discuss FGC with their patients because of cultural and language barriers.<sup>2</sup> Only 8% of those health professionals spoke to their clients with a history of FGC about prevention of their daughters' excision. Rein-fibulation after birth was an ethical dilemma for Swiss health care professionals. Twenty-six Swedish midwives participated in focus groups on perceptions of FGC, their training to care for clients with a history of FGC, and the care they have provided.<sup>19</sup> These midwives discussed FGC in ethnocentric terms, viewed women with a history of FGC as powerless, and though curious, rarely sought information from their clients. American health care providers experienced emotional conflicts when caring for immigrant women with FGC because of differences in cultural values.<sup>20</sup>

The authors conducted a literature search using CINAHL, PubMed, and PsycInfo and using the search terms "female circumcision," "female genital mutilation," "female genital cutting," "midwives," and "nurse-midwives." No studies on the knowledge of FGC and related experiences of nurse-midwives in the United States were found. The purpose of this study was to survey certified nurse-midwives (CNMs) in the United States for their knowledge about FGC and their experiences working with African immigrant women living in the United States who had a history of genital excision.

## METHODS

A survey design with qualitative and quantitative descriptions<sup>21</sup> guided this study. Closed- and open-ended survey questions were developed from information in published sources<sup>1,3,4,8-12,15,17,22-25</sup> and from one of the authors' (R.F.H.) cross-cultural experiences in countries where

FGC is practiced. The survey was reviewed for content validity by three nurses who had experience in women's health and with clients with a history of FGC; it was revised based on their input and distributed to a random sample of members of ACNM (n = 600). There was no pilot study before distribution of the survey.

All respondents were asked to complete the first two sections of the survey; the first part was a demographic questionnaire and the second section contained multiple choice and true and false questions that tested the general knowledge of FGC. Respondents had a "do not know" option for each question and were explicitly instructed not to guess if the correct answer was not known. Respondents who indicated they had ever cared for women with a history of circumcision were asked to complete the third section, which included a written description of their experiences. The CNMs' descriptions were to include the clients' country of origin, types of circumcision, and topics related to prenatal and obstetric care. This section also contained two Likert-type questions, one of topics the midwife may have raised with clients and the second that listed issues women with a history of FGC may have broached with the midwife. Finally, the respondent had the opportunity to write additional comments.

Ethical approval for this study was received from the Human Research Committee of Malone University, Canton, OH. The ACNM Division of Research approved solicitation of its members for the survey, and the ACNM membership office provided names and addresses of a random sample of 600 members. Each selected member was mailed a packet containing a letter of introduction, a consent form, the survey, and a self-addressed stamped envelope for return of the completed survey to the researchers. Participation was voluntary and anonymous, and no reminders were sent. Completion of the survey signified the respondent's consent to participate.

The data collection period spanned 4 months in the fall of 2006. Statistical analysis was done using SPSS (version 16.0; SPSS Inc., Chicago, IL). Frequencies, correlations, and Pearson chi-square values were calculated on appropriate data. Individual survey questions were not included in the analysis if an answer was left blank or marked with more than one answer. Experiences of care described by the midwives who had worked with women with a history of FGC were considered narrative anecdotes of personal experiences; therefore, inductive analysis of these accounts was done.<sup>27</sup> Two authors read through each description, noting key words and phrases. With additional readings, similarities and associations between respondents' comments were noted. These were further refined into themes.<sup>28</sup>

## RESULTS

Of 600 surveys sent to a random sample of ACNM members, 243 were returned, a 40.5% response rate. Detailed

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demographic characteristics of the respondents are illustrated in Table 1. Ninety-eight respondents (40.3%) stated they had provided direct care to women with a history of FGC. Older midwives were less likely to have worked with clients with a history of FGC (Pearson  $r = -0.152$ ;  $P = .018$ ). None of the other demographic characteristics were significantly related to respondents' experience working with women with FGC.

Reliability of the knowledge survey was deemed adequate (Cronbach  $\alpha$  coefficient = .77). CNMs exhibited more correct knowledge of the physical and medical topics related to FGC than of the cultural and legal issues. Only 18% of respondents knew that both Muslim and Christian women may be circumcised, and just 39% knew that neither religion requires women to be circumcised. About 56% of respondents knew that it is against the law in the United States for women under 18 years of age to be circumcised. Fewer than 50% of respondents knew that women with circumcision in the United States avoid health care because of fear related to legal issues of FGC. CNMs with experience caring for women with FGC scored better on the 12-point knowledge survey than those without provider experience (mean = 6.23, SD = 2.17 vs. mean = 4.51, SD 2.57, respectively;  $P < .001$ ). Table 2 details a comparison of within-group responses of CNMs who worked with patients who had FGC to those CNMs who had not.

Table 3 displays frequencies of topics CNMs discussed with their patients during pregnancy. The topics CNMs discussed often or always with their clients in relation to FGC were pain management before birth and examination by male health care providers. Among the least discussed were the topics of infertility, criteria for cesarean birth, and defibulation.

The topic most commonly broached by women who had undergone FGC, according to the respondents, was the issue of male health care providers. Topics of advocacy and circumcision of female relatives were virtually never mentioned by the clients. Table 4 details the number of CNMs that said their clients brought up these topics.

### Themes From Midwives' Descriptions of Clients With a History of Female Genital Cutting

Ninety-eight respondents (40.3%) indicated that they had provided direct care to women with a history of FGC, but only 64 wrote descriptions of their experiences. In those descriptions, some midwives indicated that they had experience with just one or two women, while others wrote that their midwifery practice had a large clientele of women with a history of FGC. Through inductive analysis three themes emerged from those descriptions: reinfibulation after childbirth, complications of FGC, and clients' preference for female providers. The quotes used here are as written by the respondents.

**Table 1.** Demographic Characteristics of Certified Nurse-Midwife Respondents to Survey on Knowledge of Female Circumcision and Practice Experience With Clients With a History of Female Genital Cutting

Characteristic	Respondents (N = 243)
Gender, n (%)	
Female	235 (98.3)
Male	4 (1.7)
No response	4 (1.7)
Age, y	
Range	26–78
Mean (SD)	48.50 (9.01)
Race/ethnicity, n (%)	
African American	8 (3.3)
White	231 (95.1)
American Indian	0 (0.0)
Non-white Hispanic	3 (3.0)
Asian American	0 (0.0)
Other	1 (0.4)
Provided care to FGC patients, n (%)	
Yes	98 (40.3)
No	123 (50.6)
Not sure	7 (2.9)
No response	15 (6.1)
Highest level of education, n (%)	
Bachelors	18 (7.6)
Masters	206 (86.6)
Doctorate	13 (5.5)
Other	1 (0.4)
No Response	5 (2.0)
Years as CNM	
Range	1–40
Mean (SD)	13.67 (8.73)
US states with most respondents, n (%) <sup>a</sup>	
New York	19 (39.6)
California	16 (31.4)
Massachusetts	14 (63.7)
Michigan	13 (56.5)
Georgia	12 (34.3)
Illinois	12 (41.4)
Texas	12 (60.0)
Type of practice facility, n (%) <sup>b</sup>	
Own private practice	43 (17.9)
Physician private practice	34 (14.2)
Hospital	115 (47.9)
Outpatient clinic	71 (29.6)
School of nursing	19 (7.9)
Other	43 (17.9)
Retired or not practicing	9 (3.8)

CNM = certified nurse-midwife; FGC = female genital cutting; SD = standard deviation.

<sup>a</sup>Percentages based on number of surveys sent to that state.

<sup>b</sup>Percentages total more than 100 because more than one choice was possible.

### Reinfibulation

One of the important topics midwives wrote about in relation to the care they have provided to women with a history of FGC was reinfibulation, the resuturing of the labia to restrict the vaginal orifice of a previously infibulated woman after birth of a child. Women with a history of FGC may

**Table 2.** Comparison of Responses on Knowledge Test Between Certified Nurse-Midwives Who Indicated That They Had and Did Not Have Practice Experience With Women Who Were Circumcised (n = 228)<sup>a</sup>

Test Question <sup>b</sup>	CNMs Who Had Practice Experience With Women Who Were Circumcised (n = 98), n (%)				CNMs Who Did Not Have Practice Experience With Women Who Were Circumcised (n = 130), n (%)			
	Correct	Incorrect	Did Not Know	No Response	Correct	Incorrect	Did Not Know	No Response
1. Other terms for FC	15 (15.3)	73 (74.5)	9 (9.2)	1 (1)	6 (15.3)	83 (63.8)	40 (30.8)	1 (0.8)
2. Countries where FC is practiced <sup>c</sup>	55 (56.1)	20 (20.4)	17 (17.3)	6 (6.1)	48 (36.9)	19 (14.6)	62 (47.7)	1 (0.8)
3. "Sunnah" (a type of FC)	14 (14.3)	8 (8.2)	75 (76.5)	1 (1)	7 (5.4)	7 (5.4)	116 (89.2)	0 (0)
4. Description of infibulation <sup>c</sup>	76 (77.6)	4 (4.1)	17 (17.3)	1 (1)	80 (61.5)	0 (0)	48 (36.9)	2 (1.5)
5. Religions of women with FC <sup>c</sup>	27 (27.6)	46 (46.9)	24 (24.5)	1 (1)	17 (13.1)	59 (45.4)	54 (41.5)	0 (0)
6. Religions that require FC	50 (51)	13 (13.3)	32 (32.7)	3 (3.1)	40 (30.8)	28 (21.5)	61 (46.9)	1 (0.8)
7. Beliefs for practice of FC <sup>c</sup>	32 (32.7)	49 (50)	13 (13.3)	4 (4.1)	17 (13.1)	65 (50)	48 (36.9)	0 (0)
8. Legality of FC in the United States	62 (63.3)	4 (4.1)	31 (31.6)	1 (1)	67 (51.5)	5 (3.8)	58 (44.6)	0 (0)
9. Cesarean birth <sup>c</sup>	65 (66.3)	28 (28.6)	4 (4.1)	1 (1)	80 (61.5)	7 (5.4)	43 (33.1)	0 (0)
10. Complications of FC <sup>c</sup>	87 (88.8)	6 (6.1)	4 (4.1)	1 (1)	92 (70.8)	7 (5.4)	29 (22.3)	2 (1.5)
11. Stigmatization by health care	78 (79.6)	1 (1)	18 (18.4)	1 (1)	86 (66.2)	4 (3.1)	40 (30.8)	0 (0)
12. Women with FC avoid care	46 (46.9)	32 (32.7)	20 (20.4)	0 (0)	54 (41.5)	39 (30)	37 (28.5)	0 (0)

CNM = certified nurse-midwife; FC = female circumcision.

<sup>a</sup>The remainder of the respondents (n = 15) did not indicate whether or not they had practice experience with women who were circumcised.

<sup>b</sup>Appendix A provides the questions and answer choices for this test.

<sup>c</sup>Significant difference (P < .05) on  $\chi^2$  test for frequency between correct and incorrect responses, comparing those with provider experience and those without.

request this procedure because of their cultural beliefs. A CNM from Pennsylvania wrote:

*"We have many women from the Sudan, Somalia, and Ethiopia who come to us for care. We always ask about what they want us to do after the delivery. There was only one woman who wanted her labia to remain open. The other 30 women I've delivered wanted the labia closed as before. We always do the repair as requested."*

Reinfibulation was not performed at all facilities. A CNM from Minnesota wrote, "Reinfibulation is comfortable for all of our staff." A midwife working in Nevada described a different situation: "These women were informed during prenatal visits that [we] were not legally

allowed to redo any FC. If they disagreed with this, they would have to seek alternate care."

### Complications of Female Genital Cutting

The FGC-related complications encountered by CNMs included problems with urination, urinary tract infections (UTIs), painful menstruation, and obstructed labor caused by infibulation. A midwife in Ohio who cared for women from Ethiopia and Sudan wrote, "I worked with them as a nurse in L & D [labor and delivery] when they came in to have their babies or presented with problems (UTIs, etc). Always problems with voiding." A midwife from Missouri wrote, "One particular [patient] was 18 and had a vagina the size of a lead pencil. She had extreme

**Table 3.** Frequencies With Which Certified Nurse-Midwives Who Indicated They Had Practice Experience With Women Who Were Circumcised Discussed These Topics With Their Clients (n = 98)

Topic	Total Responses	n (%)				
		Never	Rarely	Sometimes	Often	Always
Painful urination	81 (82.7)	29 (35.8)	15 (18.5)	24 (29.6)	10 (12.3)	3 (3.7)
Painful sexual intercourse	82 (83.7)	21 (25.6)	14 (17.1)	23 (28.0)	16 (19.5)	8 (9.8)
Infertility	78 (79.6)	61 (78.2)	9 (11.5)	7 (9.0)	1 (1.3)	0 (0.0)
Circumcision of daughters, nieces, and granddaughters	79 (80.6)	27 (34.2)	16 (20.3)	20 (25.3)	2 (2.5)	14 (17.7)
Examination by male health care professionals	82 (83.7)	24 (29.3)	14 (17.1)	11 (13.4)	18 (22.0)	15 (18.3)
Defibulation at birth of child	79 (80.6)	45 (57.0)	5 (6.3)	4 (5.1)	10 (12.7)	15 (18.9)
Episiotomy	79 (80.6)	30 (38.0)	7 (8.9)	16 (20.2)	14 (17.7)	12 (15.2)
Criteria for cesarean birth	75 (76.5)	37 (49.3)	13 (17.3)	10 (13.3)	8 (10.7)	7 (9.3)
Pain management options before birth	77 (78.6)	23 (29.8)	6 (7.8)	14 (18.2)	13 (16.9)	21 (27.3)
Pain management options after birth	77 (78.6)	25 (32.5)	10 (13.0)	12 (15.6)	10 (13.0)	20 (25.9)
Reinfibulation after birth	78 (79.6)	38 (48.7)	6 (7.7)	12 (15.4)	12 (15.4)	10 (12.8)

**Table 4.** Frequencies With Which Certified Nurse-Midwives Who Indicated That They Had Practice Experience With Women Who Were Circumcised Said That Those Clients Broached the Listed Topics (n = 98)

Topic	Total Responses	n (%)				
		Never	Rarely	Sometimes	Often	Always
Feeling stigmatized by health care providers because of FGC	82 (83.7)	62 (75.6)	7 (8.5)	8 (9.8)	5 (6.1)	0 (0.0)
Feeling ashamed of being circumcised	79 (80.6)	56 (68.3)	16 (19.5)	7 (8.5)	3 (3.7)	0 (0.0)
Being proud of cultural heritage	82 (83.7)	42 (51.2)	10 (12.2)	16 (19.5)	11 (13.4)	3 (3.7)
Wanting only female health care providers	82 (83.7)	11 (13.4)	3 (3.7)	13 (15.8)	21 (25.6)	34 (41.5)
Asked CNM to circumcise female children	81 (82.7)	75 (92.6)	5 (6.2)	1 (1.2)	0 (0.0)	0 (0.0)
Asked CNM to advocate against FGC in legal process	81 (82.7)	74 (91.4)	5 (6.2)	1 (1.2)	1 (1.2)	0 (0.0)

CNM = certified nurse-midwife; FGC = female genital cutting.

pain with her periods....” Several other respondents specified that a woman’s history of FGC did not cause their clients any problems—that vaginal births were possible with defibulation.

Several midwives wrote about the need for episiotomies because of obstructed labor. One from Minnesota said, “Most require epidurals and episiotomies for delivery. Most wanted anterior repairs of an anterior episiotomy.” A midwife from Massachusetts was frank about the uncertainty of episiotomies when caring for women who have been infibulated:

*“A big problem has been our collective (midwives, MDs [physicians]) ignorance and lack of training as to the best ways to evaluate the ‘stretchability’ of the vaginal opening during childbirth, when episiotomy versus defibulation is necessary.”*

### Preference for Female Providers

Midwives indicated that many women with FGC expressed a preference for female health care providers. A respondent from Virginia wrote, “Examination by male health care providers is very frowned upon by patient and her husband.” Another from Texas reinforced this ideal: “I have cared for many Islamic patients who requested only female providers.”

## DISCUSSION

The findings from this survey indicate that many of the respondents know facts about FGC, but they lack knowledge on the legal and cultural aspects that are important when providing culturally competent care. Almost 80% of the CNMs were familiar with the obstetric and gynecologic complications associated with FGC. Less than 50% of the sample could correctly identify the countries where FGC is still common, and just 21% correctly named the beliefs that perpetuate FGC. The low percentages of correct responses by the midwives who had experience caring for clients with a history of FGC indicates that even they may lack adequate information to care for these women in a culturally competent manner. These results are

similar to those reported for midwives in Europe.<sup>17,18,25</sup> Swedish midwives noted that the understanding of sexuality and cultural practices of women with a history of FGC was limited and biased by personal beliefs.<sup>19</sup> They reported being curious about FGC but remained uneducated on the subject.

Knowledge of a patient’s religion could help health care professionals provide culturally sensitive care.<sup>26</sup> In a study among physicians in Texas who had a clientele of women with a history of FGC, more than two-thirds of them did not know the woman’s religion.<sup>29</sup> In the current study, less than 20% of all respondents knew that both Muslim and Christian women are circumcised. In fact, Christians, Jews, Coptic Christians in the Middle East, and followers of traditional African religions also practice it.<sup>5</sup> A health care provider should not assume that women with a history of FGC are Muslims simply because FGC is commonly performed in Islamic countries.

Most immigrant women from countries where FGC is common prefer female health care providers.<sup>2,13,30</sup> Many of the CNMs in this study who had worked with women with a history of FGC knew of that preference. Highland Midwifery and Women’s Health<sup>31</sup> in Seattle, WA has developed a worksheet for clinicians caring for women with a history of FGC. During the prenatal assessment, the woman has an opportunity to express her concerns, including the presence of male health care providers during obstetric care.

A client’s level of acculturation and language proficiency or her comfort level with a midwife will impact a woman’s ease at broaching a subject with her health care provider, such as the fear of cesarean birth. Almost two-thirds of the respondents to this survey were aware that infibulated women may need a cesarean birth because of anatomic changes resulting from the procedure. But almost 70% of those midwives who had worked with women with a history of FGC indicated that they never or rarely discussed criteria for cesarean births with their clients. Cesarean births are not obligatory simply because a woman is infibulated, but they may be necessary because of related complications.<sup>17</sup> Many African women

**Table 5.** Recommendations for Practitioners Working With Women With a History of Female Genital Cutting

1. If immigrants from countries in which FGC has traditionally been practiced live in your region, learn about the cultures of those people; express interest in their traditions, beliefs, and needs.<sup>15</sup> Leininger's theory of culture care diversity and universality is a likely framework for practitioners who provide holistic care.<sup>35</sup>
2. Recognize your own ethnocentricity. Do not be judgmental or stereotype your clients.<sup>13,15</sup>
3. Be familiar with the types of FGC; learn the appearance of the anatomy and the possible consequences of the procedure.<sup>19,36</sup> Refer appropriately if you are unable to perform care.
4. Provide proper care with respect for the woman's modesty. Do not make a spectacle of a woman with a history of FGC or focus on FGC if the woman's condition is unrelated.<sup>23,36</sup>
5. Perform a cultural and a physical assessment, including a vaginal examination. Awareness and knowledge of the presence and extent of FGC is important for all aspects of obstetric care.<sup>25</sup>
6. Discuss the ethics of reinfibulation with colleagues and people of the particular culture. Refer appropriately if you are unable or unwilling to perform the procedure.<sup>22,36</sup>

FGC = female genital cutting.

Sources: Braddy and Files,<sup>22</sup> Dundek,<sup>13</sup> Horowitz and Jackson,<sup>23</sup> Leininger and MacFarland,<sup>35</sup> Leval et al.,<sup>19</sup> Ogunjsiji et al.,<sup>15</sup> Royal College of Obstetricians and Gynaecologists,<sup>36</sup> and Widmark et al.<sup>25</sup>

fear cesarean births,<sup>2,14</sup> probably because of the high rate of mortality associated with the procedure in Africa. Health care providers' lack of knowledge of FGC and an inability to defibulate the opening of the vagina by cutting away scar tissue led to unnecessary cesarean births of Somalian women in Norway.<sup>17</sup> Somalian women with a history of FGC in Canada often have caesarean birth. Nurses in that country who cared for Somalian women with a history of FGC rarely discussed the possibility of cesarean birth with their clients.<sup>30</sup> A discussion of these topics is of course dependent on the type of circumcision the woman has undergone. The Highland worksheet<sup>31</sup> also contains a question about cesarean births so that midwives discuss this issue with their clients during prenatal care.

The US Federal Prohibition of Female Genital Mutilation Act of 1995 became law in 1996. This law criminalized the practice of circumcision on any woman under the age of 18.<sup>9</sup> The Illegal Immigration Reform and Immigrant Responsibility Act of 1996, Title 6, Subtitle D, Section 645, did the same thing.<sup>32</sup> More than 40% of the midwives in this study did not know of the illegality of this practice in the United States. There is no law in the United States preventing a female from leaving or being taken out of the country to be circumcised. It is against the law in the United Kingdom to aid women to leave that country in order to be circumcised in a country where it is legal.<sup>18</sup>

Although reinfibulation after delivery is not necessary from a medical standpoint, women with a history of FGC may request this procedure because of their cultural beliefs, including the fear of spousal rejection and divorce.<sup>8,33,34</sup> Reinfibulation is not a federal crime in the United States.<sup>22</sup> Health care professionals providing prenatal care should discuss an infibulated woman's preference for reinfibulation with the woman and her spouse so that care after delivery is appropriate.<sup>2,3,30</sup> Midwives working with women with a history of FGC should examine their own ethical stance on this issue.<sup>25</sup>

## Implications and Limitations

The findings of this survey lead to several implications for clinical practice. Clinicians should learn more about the cultural beliefs and traditions of their clients who come from countries where FGC is practiced. Providing culturally competent and culturally sensitive care while respecting an individual's rights and beliefs is possible when the client's individual culture is preserved within the scope of the health professional's practice. This will then decrease stigmatization of women with a history of FGC and break down barriers that are confronted by women who have undergone FGC, leading to better health for both them and their families. For this to happen, accommodations and/or negotiations must be made between the practitioner and the circumcised patient so that appropriate cultural care is provided.<sup>35</sup> Table 5 lists specific clinical practice recommendations.

This study has several limitations. First of all, the response rate of the randomized sample to this survey was just over 40%, and because of the methodology, it was not possible to identify differences between responders and nonresponders. Second, 22 surveys were returned with several unanswered questions. If missing answers were assumed to be incorrect, midwives are even less knowledgeable than the displayed results indicate. Thirdly, the survey was not pilot-tested; a pilot study may have improved the quality of the survey tool.

In the question of topics raised by CNMs with their clients with a history of FGC during pregnancy, there was a high number of "never" or "rarely" responses for some items. Several respondents clarified these choices by writing that they worked with clients with a history of FGC in prenatal clinics but were not involved with them during births when discussion of the topic might be relevant to care. Using the Likert-type questions, we sought the frequency of discussion of specific topics but did not take into account other contextual variables, such as geographic location of the client-provider interactions or the number of clients with a history of FGC the midwife had consulted.

## CONCLUSION

CNMs provide care to a vast array of women in the United States, and among these are immigrants with a history of female circumcision. Culturally congruent care can be realized when actions are supportive, meaningful, and seek to maintain the valued traditions of the individuals receiving care.<sup>36</sup> The findings of the survey indicate that most CNMs knew the reasons for and complications of FGC, but their knowledge of legal and cultural issues was minimal. Reinfibulation was an ethical issue for some midwives. Further research is needed on how midwives resolve this practice dilemma. CNMs working with an immigrant population need to familiarize themselves their clients' culture and recognize their own ethnocentricity. With a thorough understanding of FGC, the clinician can provide the culturally competent and culturally sensitive care that women with a history of FGC deserve.

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#### Appendix A. Test of Knowledge of Female Circumcision

The answers can be found at the end of the test.

1. Female circumcision is also known as:
  - a. Female genital mutilation (FGM)
  - b. Female genital cutting (FGC)
  - c. Female genital operation (FGO)
  - d. a and b
  - e. a, b, and c
  - f. None of the above
  - g. Do not know
2. Female circumcision is still frequently performed in which countries?
  - a. Somalia and Ethiopia
  - b. Sudan and Egypt
  - c. Mali and Senegal
  - d. United States and France
  - e. a, b, and c
  - f. All of the above
  - g. None of the above
  - h. Do not know
3. There are four types of female circumcision. What type is known as "sunna"?
  - a. Excision of all of the clitoris and some or all of the labia minora
  - b. Excision of the tip of the clitoris and/or its hood or covering (prepuce)
  - c. Excision of all the external genitalia
  - d. Do not know

4. What is the term for the excision of the external genitalia and stitching of the vaginal opening to cause it to be very narrow?
  - a. Infibulation
  - b. Defibulation
  - c. Episiotomy
  - d. Cauterization
  - e. Do not know
5. Women of which religion(s) are circumcised?
  - a. Christianity
  - b. Islam
  - c. Both a and b
  - d. Neither a or b
  - e. Do not know
6. Women are required to be circumcised by which religion(s)?
  - a. Christianity
  - b. Islam
  - c. Both a and b
  - d. Neither a or b
  - e. Do not know
7. Women are circumcised because the people of the cultures who practice it believe that:
  - a. It keeps an important tradition alive
  - b. It makes a woman more beautiful
  - c. It makes a woman more marriageable
  - d. It keeps a woman from having pleasure during sexual relations
  - e. It is required by their religion
  - f. a, b, c, and d
  - g. c, d, and e
  - h. All of the above
  - i. None of the above
  - j. Do not know
8. It is illegal in the United States to circumcise a woman under the age of 18.
  - a. True
  - b. False
  - c. Do not know
9. It is necessary for a circumcised woman to have a cesarean birth to deliver a baby because of a restricted vaginal opening.
  - a. Always
  - b. Sometimes
  - c. Never
  - d. Do not know
10. Complications of female circumcision may include:
  - a. Keloid formation in the vagina
  - b. Urinary tract infections

- c. Pain during sexual intercourse
  - d. Infertility
  - e. a, c, and d
  - f. All of the above
  - g. Do not know
11. Some circumcised women in the United States have been stigmatized by health care providers because of their history and physical condition.
- a. True
  - b. False
  - c. Do not know

12. Some circumcised women in the United States avoid health care for pregnancy and related conditions because they feel:
- a. Stigmatized by health care workers
  - b. Shame from health care workers
  - c. Afraid of legal consequences
  - d. a and b
  - e. All of the above
  - f. Do not know

Answers: 1, e; 2, e; 3, b; 4, a; 5, c; 6, d; 7, h; 8, a; 9, b; 10, f; 11, a; and 12, e.

