Høgskulen på Vestlandet

Bacheloroppgave

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Western Norway University of Applied Sciences

Caring for women living with female genital mutilation/cutting: the nurse's role

Omsorg for kvinner som lever med kvinnelig kjønnslemlestelse: sykepleierens rolle

Candidate number: 424

Bachelor in Nursing
Institute for Health and Care Sciences
Submission Date: 05.06.2020

I confirm that the work is self-prepared and that references/source references to all sources used in the work are provided, cf. Regulation relating to academic studies and examinations at the Western Norway University of Applied Sciences (HVL), § 12-1.

Abstract

Background: Female genital mutilation/cutting has become a relevant topic in health care in Norway due to the increase of immigration to Norway from countries where female genital mutilation/cutting is practiced. The clinical picture of a woman living with female genital mutilation may be affected by the multiple long-term health consequences that can result from female genital mutilation/cutting. It is therefore important that nurses know how they can therapeutically care for this population. This study aims to investigate how nurses should approach care for women living with female genital mutilation/cutting.

Method: A literature review was conducted with the use of a systematic search in academic databases. Four articles were gathered based on their quality and relevancy to the thesis question.

Results: It is essential that the nurse can provide culturally competent care to patients living with female genital mutilation/cutting. To be able to provide culturally competent care, the nurse's awareness of female genital mutilation/cutting, its health consequences, and the cultural background of the patient is paramount. The nurse's counselling role comes forward in a focus on effective communication with patients living with female genital mutilation/cutting. Information and health education can empower patients living with female genital mutilation/cutting to make their own decisions regarding their health.

Conclusion: An increased awareness of female genital mutilation among nurses would aid in their readiness to provide a high quality of care. Once nurses have an awareness of female genital mutilation and the details surrounding the situation, therapeutic care for women living with female genital mutilation/cutting can be offered through culturally competent care and communication. Newer research on female genital mutilation/cutting from both an immigration perspective in Norway and internationally would be beneficial in providing a realistic view of the present-day situation.

Sammendrag

Bakgrunn: Kvinnelig kjønnslemlestelse/omskjæring er blitt et aktuelt tema i helsevesenet i Norge på grunn av økende innvandring til Norge fra land hvor kvinnelig kjønnslemlestelse/omskjæring praktiseres. Det kliniske bildet av en kvinne som lever med kjønnslemlestelse/omskæring kan bli påvirket av langsiktige helsemessige konsekvenser som kan følge av kvinnelig kjønnslemlestelse /omskjæring. Det er derfor viktig at sykepleiere vet hvordan de kan gi terapeutisk omsorg til denne populasjonen. Denne studien fokuserer på å undersøke hvordan sykepleiere kan tilby terapeutisk omsorg til kvinner som lever med kjønnslemlestelse/omskjæring.

Metode: Det ble gjennomført en litteraturstudie med bruk av et systematisk søk i akademiske databaser. Fire artikler ble inkludert på bakgrunn av deres kvalitet og relevans til problemstillingen.

Resultater: Det er viktig at sykepleieren kan gi kulturell kompetent omsorg til kvinner som lever med kjønnslemlestelse/omskjæring. For å kunne gi kulturell kompetent omsorg, er sykepleierens bevissthet på kjønnslemlestelse/omskjæring, helsemessige konsekvenser og pasientens kulturelle bakgrunn viktig. Sykepleierens rådgivningsrolle kommer frem med fokus på effektiv kommunikasjon med pasienter som lever med kjønnslemlestelse/omskjæring. Informasjon og opplæring kan gi pasienter som lever med kjønnslemlestelse/omskjæring muligheten til å ta egne beslutninger angående deres helse.

Konklusjon: En økt bevissthet på kvinnelig kjønnslemlestelse/omskjæring blant sykepleiere vil hjelpe dem til å kunne tilby en høy kvalitet omsorg. Når sykepleiere er bevisst over detaljene rundt kvinnelig kjønnslemlestelse/omskjæring kan terapeutisk omsorg for kvinner som lever med kjønnslemlestelse/omskjæring tilbys gjennom kulturell kompetent omsorg og kommunikasjon. Nyere forskning på kjønnslemlestelse både fra et innvandringsperspektiv i Norge og internasjonalt vil være gunstig for å kunne gi realistisk informasjon på dagens situasjon.

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APPENDIX

1. Introduction

Norwegian society has become increasingly multicultural due to an influx in immigration. Currently, immigrants comprise 14.7% of the Norwegian population (Statistics Norway, 2020). While the vast majority of nurses working in the Norwegian health care system can expect to meet patients with different cultural backgrounds throughout their career, it can be difficult for nurses to know how to navigate cultural differences. Customs and traditions within cultures can strongly contrast the cultural background that a nurse might have. These meetings of cultural incongruency can lead to dilemmas in practice. One example of such a custom is female genital mutilation/cutting (FGM/C).

An estimated 17 300 girls and women in Norway are living with FGM/C (Ziyada, Norberg-Schulz, & Johansen, 2016, p. 7). In a study of healthcare seeking patterns for FGM/C among young Somalis in Norway, it was revealed that one-fifth of women with FGM/C sought care for FGM/C-related health problems (Mbanya, Gele, Diaz, & Kumar, 2018, p. 5). Though this study does not answer why a minority of the population sought out healthcare services, multiple other articles draw a connection between a woman's negative perception of disclosing their FGM/C to healthcare workers of a different cultural background and their hesitancy to consult healthcare services (Goldenstein, 2014, p. 98).

According to the Ethical Guidelines for Nurses produced by the Norwegian Nurses' Organization (2019), it is a nurse's ethical mandate to provide comprehensive care to their patients, regardless of their cultural background. This mandate can be especially challenging when a patient's health is affected by a practice that either goes unnoticed or is considered

inherently wrong by a nurse. A nurse who meets a patient living with FGM/C stands in a unique position where his or her interactions can influence how the patient experiences cross-cultural health care. The purpose of this paper is to bring to light useful information that can be used to guide nurses in providing therapeutic care for women who are living with FGM/C.

1.1 Justification of chosen topic

There is a growing need for nurses who are culturally competent as the amount of the Norwegian population that consists of immigrants grows. This includes immigration from countries where FGM/C is widely practiced (Statistics Norway, 2020). However, a minority of the women who live with FGM/C in Norway are willing to consult healthcare services due to undetermined barriers (Mbanya, Gele, Diaz, & Kumar, 2018). Learning what these barriers are and how to break them down is key in being able to provide therapeutic care to this patient group. A nurse stands in a unique position where he or she has the opportunity to explore and remove these barriers in meeting with patients who are living with FGM/C.

1.2 Thesis question

Many health care related topics about FGM/C can be explored due to the many health-related consequences that the practice creates. What is an appropriate reaction to the discovery that a patient has undergone FGM/C? How should nurses approach the topic of FGM/C to women who are living with it? What sort of resources might such a patient need? The above questions can be summed up in one thesis question that is the focus of this paper:

How can nurses provide therapeutic care for immigrant women who are living with FGM/C?

1.3 Clarification of perspective

This paper is aimed at guiding nurses who are providing healthcare services to immigrant women living with FGM/C who have immigrated to Norway, where FGM/C is considered a foreign practice. Since a focus on immigrant women has been chosen for this paper, it will be assumed that the short-term health consequences of FGM/C have been addressed. Therefore, I will focus on care for women who are experiencing the long-term consequences of FGM/C.

1.4 Definition of concepts

1.4.1 Female Genital Mutilation/Cutting

Terminology used to refer to the practice of FGM/C varies greatly depending on the culture and view that the individual has on the practice. From the process of searching for literature on the subject, it was observed that female genital mutilation, female genital cutting, and female circumcision were terminologies most often used to refer to the practice. For this thesis, it has been determined that female genital mutilation/cutting will be used to refer to the practice. While using the word mutilation can be an inflammatory term for those who practice FGM/C when used by people outside of their culture, it is important to recognize that the practice has no health benefits and is therefore a breach of human rights (World Health Organization, 2016, p. 9). At the same time, one must also consider cultural competence. Using the term cutting or circumcision can be a more appropriate choice when discussing FGM/C with people who adhere to cultures which practice FGM/C, as it shows an understanding that those who practice it are not doing so to inflict harm (Odemerho & Baier, 2012, p. 452) (Goldenstein, 2014, p. 99).

According to World Health Organization (2020), FGM/C is an umbrella term for "all procedures that involve the partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons" (para. 1). Variations of FGM/C fall under four main categories:

> Type 1 (clitoridectomy): The partial or total removal of the clitoris. In a minority of cases, only the prepuce is removed.
>
> Type 2 (Excision): The partial or total removal of the clitoris and labia minora, with or without the removal of the labia majora.
>
> Type 3 (Infibulation): The narrowing of the vaginal opening by the sewing together of the labia minora or majora, with or without the removal of the clitoris. Infibulation comprises an estimated 50% of the cases of FGM/C in Norway (Mbanya, Gele, Diaz, & Kumar, 2018, p. 8).
>
> Type 4: All other procedures causing harm to the female genitalia without medical reason, including but not limited to piercing, pricing, incising, scraping, and cauterization.

The procedure is conducted with varying amounts of professionality. While some girls are cut by trained healthcare workers in sanitary conditions, many others are cut in unsanitary conditions by traditional circumcisers who have no formal health education. Many women who have undergone FGM/C have had a traumatic experience. (World Health Organization, 2016, pp. 1-4)

The World Health Organization (2020) states that FGM/C has no known health benefits. Rather, the list of potential short- and long-term negative health consequences that can result from FGM/C is long.

Short-term negative health consequences that can occur after the practice is performed include severe pain, hemorrhage, shock, infection, genital tissue swelling, urinary problems, impaired wound healing, and death. (World Health Organization, 2020)

Long-term negative health consequences of FGM/C include urinary problems, vaginal problems, menstrual complications, scarring and keloid development, complications in sexual functioning, obstetric complications, and psychological problems such as depression, anxiety, post-traumatic stress disorder, et cetera. (World Health Organization, 2020)

Girls in practicing cultures are at risk of undergoing FGM/C from early childhood to around the age of 15 years. The reason that FGM/C is performed varies from culture to culture. In most cultures, it is a coming-of-age custom that marks a girl's transition to womanhood. The practice of FGM/C can be strictly to continue a cultural practice, or it can be considered religiously obligatory. It can be done to ensure a girl's virginity, to make her viable for marriage, or strictly for social acceptance. Regardless of the reason, the lack of health benefits and presence of serious health complications makes FGM/C a human rights violation. (World Health Organization, 2020)

1.4.2 Deinfibulation

Deinfibulation is a correctional surgery used to reverse infibulation. It involves surgically opening the genital tissue closed under infibulation. This procedure can aid in reversing the

negative health consequences of infibulation, as well as opening the introitus for intercourse or birth. (World Health Organization, 2020)

1.4.3 Culture

According to transcultural nursing theorist Madeleine Leininger, culture is "patterned lifeways, values beliefs, norms, symbols, and practices of individuals, groups, or institutions that are learned, shared and usually transmitted intergenerationally over time" (Leininger & McFarland, 2002, p. 83).

1.4.4 Culturally competent nursing care

Culturally competent nursing care is helping the patient to find meaningful improvement of health and well-being through the consideration of the lifeway to which that patient adheres (Leininger & McFarland, 2002, p. 84). Leininger's theory of culture care is described more in-depth under section 2.1.

1.4.5 Nursing

Nursing, as defined by the International Counsel of Nurses, is "autonomous and collaborative care of individuals of all ages, families, groups and communities, sick or well and in all settings" (International Council of Nurses, 2002). The nursing profession is broad and spans internationally. The Norwegian Nurses Organization (2019) provides a list of ethical guidelines that direct a nurse's work. According to these guidelines, nursing cannot be ethically practiced without a focus on promoting health and preventing sickness. Nurses should promote patient empowerment and be competent in offering comprehensive care.

2. Theory

2.1 Interpersonal Aspects of Nursing – Joyce Travelbee (1971)

Joyce Travelbee is a well-acclaimed nursing theorist whose focus on the human-to-human relationship between the nurse and the patient lead to the creation of her theory on Interpersonal Aspects of Nursing. Travelbee states that the nurse's main task using oneself therapeutically to alleviate the patient's suffering and to potentially guide them in finding meaning in their experiences (p. 16).

According to Travelbee, the human-to-human relationship is "primarily an experience or series of experiences between a nurse and the recipient(s) of her care" (p. 123). There are five phases that occur in the creation of the human-to-human relationship:

The initial meeting of the nurse and patient is referred to as the original encounter and is characterized with observations that lead to initial judgements and stereotyping. This is a phenomenon that is mutual between the nurse and patient. It is important that the nurse is aware of this phase and the distortion these early observations can create in the nurse-patient relationship. (pp. 130-132)

The next phase is referred to as emerging identities. This phase occurs when one party can recognize and find meaning in the uniqueness of the other. The recognition of the patient's personality and how it affects their uniqueness brings light to how the patient perceives his or her experience and/or suffering. In this phase, Travelbee warns against comparing the patient to oneself, as this tendency has roots in envy and disillusions of superiority or inferiority. (pp. 132-135)

Empathy is the third phase, which Travelbee defines as “the ability to enter into, or share in and comprehend the momentary psychological state of another individual” (p. 135). Empathy happens when the nurse understands the significance that the patient’s expressions has on their personal experience of their situation. Predictability of behaviour is a result of the development of empathy. (p. 136)

Sympathy is the phase that follows empathy and is differed from empathy by the nurse’s wish to ease the patient’s suffering. Sympathy can be used as the motivating factor to the inauguration of therapeutic nursing interventions. (pp. 141-142)

Rapport is built after the above four phases have occurred. Rapport can manifest itself differently, due to the individuality of each nurse, patient, and situation. Travelbee describes the unifying characteristic of rapport as being the culmination of meaningful experiences between the nurse and patient. (p. 150)

The human-to-human relationship between the nurse and patient is created through communication, which Travelbee describes as a process. Communication can be verbal or non-verbal, and there are goals to be met with the communication. Travelbee states that observation is an essential part of communication. (p. 93)

2.2 Culture Care Theory – Madeleine Leininger & Marilyn R. McFarland (2002)

Madeleine Leininger is a nursing professor and theorist who cultivated the concept of transcultural nursing. Her theory and model are based on the idea that nurses play an important role in bridging the gap between professional nursing care and cultural characteristics, traditions and customs. By being a mediator, a nurse can successfully improve quality of care provided to ethnic minorities. According to Leininger, to be a mediator that successfully bridges this gap, a

nurse must have a solid understanding of the patient's culture. Her sunrise model of culture care depicts how different cultural factors influence individuals, families, groups, communities or institutions, and the nurse's vital role in the function of this model. (Sagar, 2012, pp. 1-3)

This theory helps nurses to better understand their role in providing care for patients who come from a different cultural background than that of their own. Leininger suggests three action modes nurses can use to provide holistic and culturally competent care to patients:

1. Preservation and/or maintenance: This refers to the preservation of practices and values that are beneficial to the patient.
2. Accommodation and/or negotiation: This is the process of adapting care to fit the culture of the patient or family more adequately.
3. Repatterning and /or restructuring: nursing care that creates better health outcomes through decisions congruently made by both the nurse and patient. (Sagar, 2012, pp. 10-12)

By using Leininger's model and theory, nurses can gain an understanding of the importance of having knowledge about a patient's cultural background before they attempt to provide care. By interacting with the patient and gathering knowledge about the culture itself, nurses can use their competence within professional nursing in combination with their knowledge of the patient's cultural background to guide the type of care that is provided to the patient.

2.3 Basic Counselling Skills – Richard Nelson-Jones (2016)

Richard Nelson-Jones is a counsellor trainer and psychotherapist who wrote Basic Counselling Skills. This book describes what counselling is, what kinds of professions offer counselling, and basic communication skills that can be used in counselling across professions.

Nelson-Jones' guidance on counselling is highly relevant to nurses who wish to increase their focus on and improve their role as a counsellor.

Nelson-Jones states that there are six types of "helpers" that offer counselling in varying levels of professionality:

1. Professional counsellors and psychotherapists
2. Paraprofessional and quasi-counsellors
3. Professions that use counselling and helping skills in their work life
4. Voluntary counsellors
5. Those who are involved in support networks
6. Informal helpers

Nurses fall into the third category, where they use counselling and helping skills their everyday work life to optimize the comprehensiveness of health care given. (p. 4)

Elements of a counselling skill include the area of skill, a level of competence in the skill, and the method of application of the skill. The use of a skill always has an objective or goal. (p. 10)

Nelson-Jones also breaks down counselling skills into two categories: communication and action skills, and mental skills. The first category is very tangible. A nurse can desire to provide counselling to a patient, but the action of providing said counselling involves communication and action skills, which are observable elements. For example, when a nurse meets a patient, the words used, tone of voice, body language, use of touch and action-taking are all perceptible by both parties. (p. 11)

Mental skills, according to Nelson-Jones, are something that the counsellor incorporates in his or her own mind to promote better communication. One's mind can either strengthen or inhibit communication and action skills. However, these skills can also be used by those receiving help. The three skills are creating self-talk, rules, and perceptions. (pp. 12-13)

Nelson-Jones also recognizes that culture affects how counselling is given by the nurse and experienced by the patient. Different cultures allow for varying degrees of help from those who are not friends or family, and the amount of information disclosed to such strangers varies from culture to culture. (pp. 16-17)

2.4 Legislation and guidelines

The Norwegian Nurses' Organization has created a set of professional ethical guidelines (2019) that give a framework for a nurse's ethical practice. These guidelines have been created based off the postulation that nursing involves mercifulness, care, and respect for human rights. These guidelines help nurses ethically relate themselves to their profession, patients, the patient's family, colleagues, their workplace, and society. Nurses who care for women living with FGM/C can find themselves in ethically difficult situations, and the use of these guidelines can help with navigation through such situations.

In Norwegian legislation, the Patients' Rights Act of 1999 protects the peoples' rights to accessible health care services of good quality and has its foundation in an innate respect for human life, integrity, and dignity. It gives details on who has the right to different types of healthcare services and the quality that these healthcare services should uphold. This act can therefore be referred to as a standard for how nurses should approach healthcare for immigrant women living with FGM/C.

3. Method

The use of a method makes the collection of information to answer the thesis question systematic and repeatable (Thidemann, 2019, p. 74). This section will be used to describe how data collection was approached. The process used to critically analyze the articles for both relevance and quality will also be described.

3.1 Literature Review

According to Inger-Johanne Thidemann (2019), a literature review is a type of study that systemizes knowledge from multiple written sources (p. 77). A literature review is structured to allow for the collection, critical analyzation, and summarization of literature (p. 77). The mark of a good literature review is a collection of up-to-date information that answers the thesis question (p. 78). A literature review is the method chosen for this thesis as it gives the opportunity to compare and summarize a selection of existing information that answers the thesis question. While there are multiple variations of structures that can be used to write a literature review, IMRaD (introduction, method, results, discussion, conclusion) structure has been chosen as it gives a sensible layout that serves to the purpose of this literature review.

3.2 Initial literature search

An initial literature search to to gain a general overview of the amount and quality of literature existing on care for women living with female genital mutilation. The initial literature search was completed using PubMed and Google Scholar. The search words *female genital mutilation, nursing,* and *care* were used to gain a general overview of the literature found on the subject. Most results relevant to the thesis question were general and systematic literature reviews, qualitative studies, and opinion pieces. The diversity of FGM/C-related topics in the

literature appeared limited, and many of the publication dates of the articles were older than 10 years. However, it was determined that the findings from the initial literature search were enough to support the writing of a literature review.

One article, World Health Organization's Guidelines on the management of health complications from female genital mutilation (2016), was gathered through the initial literature search. It was chosen based on its clear relevancy to the thesis question. This article was put through the same critical appraisal process as the articles found through the systematic literature search.

3.3 Systematic literature search

A systematic literature search is a structured search that is "planned, justified, documented and verifiable" (Thidemann, 2019, p. 82). Results from the initial literature search were used to strategize how the systematic literature search would be completed.

3.3.1 PICO

PICO is a framework used to formulate a general question into a searchable question. It helps to create a concise focus, create search terms and inclusion and exclusion criteria for a systematic search (Thidemann, 2019, p. 83). The use of PICO in this literature review is described in Attachment 1 (see appendix).

3.3.2 Inclusion/exclusion criteria

The use of inclusion and exclusion criteria helps to limit search results to those of relevance and omit those which should not or cannot be used to gather findings (Thidemann, 2019, p. 83). Inclusion criteria for this review was scholarly or peer-reviewed literature, literature published between the years 2010 to 2020, qualitative and quantitative studies, literature reviews,

publishing language in either English or Norwegian, and articles that had a perspective based on the provision of healthcare to women living with FGM/C.

During the initial literature search, it became evident that it was necessary to limit the amount of exclusion criteria due to the lack of literature on the subject. Literature published over 10 years ago was not included in the study to exclude outdated information. Literature written in other languages than English or Norwegian were not included, as I otherwise would not be able to interpret the results with an acceptable level of accuracy. Studies that focused on care for women living with FGM/C in countries where FGM/C is widespread were also not included due to the immigration focus of this paper. Articles that focused on FGM/C from perspectives outside of the provision of healthcare were also not included.

3.3.3 Choice of databases

The choice of databases was made based on relevance and availability. Academic research databases that included nursing-relevant literature were used in the systematic search.

3.3.5 Choice of search words

A list of search terms was made based off the PICO framework to give structure to my search strategy and create verifiability. Search words used to find results were a combination of “female genital mutilation”, “female circumcision”, or “female genital cutting”, and “nursing” or “nurse”, and “care”.

The use of Medical Subject Headings (MeSH) is an indexing tool used to find journal articles on specific topics in certain medical databases. The MeSH terms “circumcision, female” and “nursing”, “care plan, nursing” or “care, nursing” were used when searching in the PubMed database.

3.3.6 Evaluation of search strategy

A concise summary of searches is given in this section. For more detailed information, see Attachment 2 in the appendix.

The Cumulative Index to Nursing and Allied Health Literature (CINAHL) is a database that contains several types of academic nursing literature. Searching in this database produced 228 results. By looking for key inclusion/exclusion criteria in the titles of articles, 30 articles were determined to be potentially relevant to this literature study.

PubMed is an international database that contains many academic nursing articles published in journals. When searching in PubMed, MeSH search terms were used. MEDLINE, which contains much of the same material as PubMed, was also searched in using general search terms. In total, 129 results were produced, of which 23 were determined to be apparently relevant.

The British Nursing Index has literature relevant to both nursing and midwifery. The first search in this database produced 144 results, of which 15 were relevant based on their titles. A second search with different terms produced 177 results, of which 3 were relevant based on their titles.

Cochrane Library is a database that contains literature that informs on the effects of different types of interventions based on the results of both qualitative and quantitative research. Due to the lack of research done on the effects of different types of interventions for females living with FGM/C, Cochrane Library did not produce many relevant results. After using multiple different search strategies, 2 new articles were found that were relevant based on their title.

BMJ Best Practice and BMJ Evidence Based Nursing are international databases that provide research-based information for healthcare professionals. No new literature about FGM/C and nursing was produced after multiple searches attempted in these databases.

3.4 Literature study

In total, 73 articles that appeared relevant based on their title were produced through the systematic search. To determine how well these articles answered the thesis question, the abstracts were read and critically appraised with regard to its relevancy to the thesis question. After eliminating articles that were irrelevant based off their abstract, the full text of the remaining articles was critically read to determine their relevancy. The remaining articles were then appraised for their quality by using CASP checklists for systematic reviews and qualitative studies. CASP checklists are designed to pose critical questions about the quality of the articles and studies. This gives the appraiser an overview of whether the evidence and contents of an article can be trusted. Using these checklists, three articles were determined to be robust in quality. One of the articles that has been included focuses on the quality of health care in Murcia, Spain, which diverges from the focus on health care services in Norway. However, an older study of similar structure and focus completed in Norway in 2003 gave similar results to the more recent study completed in Spain (Vangen, Johansen, Sundby, Træen, & Stray-Pedersen, 2003). Therefore, the study that took place in Murcia, Spain was included.

An overview of this process can be seen in Attachment 3 in the appendix.

3.5 Strengths and weaknesses of method

A strength in completing a literature study is that one can compare and present multiple literary sources, showing a wider range of results than through completing one's own research

project. A weakness of this thesis is the use of secondary sources in this literature study. The author's personal opinions and biases can affect the interpretation of the primary sources included in the secondary sources. A strength with the use of secondary sources is the analyzation and interpretation of multiple studies by an author who has competence within the topic.

With regards to the type of literature that was chosen for this literature study, qualitative literature was preferred. Data from qualitative research focuses more on characteristics and qualities than that of quantitative research, which focuses more on measurable data (Rognsaa, 2018, p. 32). In this literature study, the goal is to determine the characteristics of high-quality care provided to women who are living with FGM/C, which makes finding qualitative data reasonable. However, the use of qualitative articles can also be a weakness, as there can be significant variability in the interpretation of the data collected.

3.6 Ethical considerations

According to Leininger & McFarland (2002), effective cultural nursing care can only be practiced with an understanding of and respect for the patient's perspective. It is based on this perspective that one can determine effective nursing interventions (p. 79). I have therefore included one study which gives insight into how immigrant women living with FGM/C experience health care based in a country of primarily Western culture.

The qualitative study included in this literature study is approved by an ethical committee. Participants involved in the articles have been anonymized. The results are presented in this literature study without conscious changes based on personal opinion or bias made to the original author's findings. In-text citations and the bibliography included in this literature study follow Western Norway University of Applied Science's guidelines for referencing.

4. Results

4.1 WHO guidelines on the management of health complications from female genital mutilation (World Health Organization, 2016)

4.1.1 Purpose

The purpose of this guideline is threefold. Firstly, it informs healthcare providers on how to manage the health consequences of FGM/C based on the best available evidence. Secondly, it focuses on topics related to FGM/C that were decided as internationally critically important. Thirdly, it helps to map out the knowledge gaps related to FGM/C and its complications so that further research can be completed.

4.1.2 Method

The guideline is created with the use of the *WHO handbook for guideline development, second edition.* The research question was decided upon and critically approved. Evidence was gathered and its quality assessed based off a decided set of criteria. The recommendations were then formulated and peer reviewed.

4.1.3 Results

4.1.3.1 Deinfibulation

Deinfibulation is strongly, but conditionally recommended to both prevent and treat obstetric and urinary complications in women with type III FGM/C.

Both antepartum and intrapartum deinfibulation are conditionally recommended depending on factors such as the patient's wishes, and the quality of and access to health care, both for the deinfibulation procedure and delivery. Urological complications, especially

recurring urinary tract infections and urine retention, can be resolved through deinfibulation, according to the guidelines.

Patients who show interest in deinfibulation should be given comprehensive preoperative information before the procedure. They should be informed of the benefits and risks, and the anatomy and physiological changes that can be a result of deinfibulation. This is important for any procedure, but unbiased information aids the patient in making an informed choice.

4.1.3.2 Mental health

WHO has indicated that women who will undergo or have undergone any surgical intervention to reverse health complications caused by FGM/C should be offered psychological support. Since FGM/C is often a traumatic experience, interacting and recalling these memories can trigger strong reactions. It is therefore important that psychological care is available.

Patients living with female genital mutilation who display symptoms of post-traumatic stress disorder, anxiety disorders, or depression should be offered cognitive behavioural therapy (CBT), in the context where competent healthcare professionals are available. There is no direct evidence for this statement. However, based on the efficacy of CBT in reducing symptomology of people who have experienced other types of traumatic scenarios, it is assumed that women who have undergone FGM/C can also benefit from CBT.

4.1.3.3 Female sexual health

Sexual counselling for women who have undergone FGM/C and are experiencing female sexual dysfunction is recommended conditionally, though it is not based on any direct evidence. WHO includes this recommendation based on a systematic review that concluded that women who have undergone FGM/C have an increased risk of experiencing pain and reduced sexual

satisfaction and desire than women who have not undergone FGM/C. Given that sexual topics are thought of as sensitive among many populations that practice FGM/C, primary solutions such as lubricant may be considered unacceptable. Sexual counselling is therefore considered a good alternative.

4.1.3.4 Information and education

Information, education and communication interventions about women's health and FGM/C should be made available to women who have undergone any type of FGM/C procedure. Women who live with type III FGM/C should have access to health education and information about deinfibulation. The language and method used to educate women living with FGM/C should be easily understandable to those being educated.

Education of healthcare providers on the immediate and long-term health consequences of FGM/C is necessary for those who care for women who have undergone FGM/C. Healthcare providers should be informed that medicalization of FGM/C is not an acceptable solution.

4.1.4 Conclusion

These guidelines claim that both information on deinfibulation and the procedure itself should be made available to women living with type III FGM/C. Deinfibulation should be carried out by healthcare professionals who are educated on the procedure, and local anesthesia should be given.

The guidelines also focus on the mental health of women living with FGM, claiming that cognitive behavioural therapy can be beneficial for women living with FGM/C who present with diagnoses such as anxiety disorders, depression, and post-traumatic stress disorder when offered

by a qualified health professional. In addition, women who undergo procedures to reduce/reverse health complications related to FGM/C should be offered psychological support.

Sexual counselling is recommended for women who have undergone FGM/C and experience sexual dysfunction as a result, depending on the context.

The concluding best practice statements have a focus on health education and information. They emphasize that women who have undergone FGM/C and healthcare professionals who care for these women should have respective health education based on their needs.

4.2 Female Genital Cutting: Nursing Implications (Goldenstein, 2014)

4.2.1 Purpose

This article highlights the nurse's important role in caring for women who have undergone FGM/C by having a thorough knowledge of what FGM/C is in its cultural context and advocating for the women living with it.

4.2.2 Contents

The article informs of the historical roots of FGM/C, beliefs about the procedure, its hygiene and aesthetical consequences, legal issues surrounding FGM/C, and the short- and long-term consequences of FGM/C.

4.2.3 Nursing Implications

Nurses need to be aware of their own thoughts and opinions surrounding FGC before caring for women living with FGC. Negative words and glances can lead women living with

FGC to feel estranged and abnormal and can create a counteracting effect where the opportunity to provide a high quality of care is lost.

4.2.4 Psychosocial support

Nurses can help women who have undergone FGC by offering psychosocial support. This can be done by western nurses understanding their position in the eyes of women who live with FGC. Cultures that perform FGC tend to have a culture of modesty, and the debate and discussion of FGC in itself can be considered highly inappropriate. In addition, due to the traumatic and painful experience that many women who live with FGC have gone through, it can often be uncomfortable for these women to share information surrounding their FGC with a western nurse.

4.2.5 Cultural sensitivity:

Nurses can offer women in their care cultural sensitivity by recognizing the significance of concepts and values that are held by the cultures their patients have a background in. Honour is a value that directly relates to FGC. Women who have undergone FGC feel a sense of honour than contributes to a collective belonging with the culture that surrounds or surrounded her.

4.2.6 Health education:

A nurse can play a key role in providing health education to women living with FGM/C. Health education is necessary to break the cycle of FGM/C. Education on the long-term complications and risks associated with FGM/C, as well as topics such as hygiene, sexuality, self-esteem, and peer pressure and all contribute to changing perspectives on FGM/C and its practice. Its religious elements can also be discussed and disproved, as there is no religion that directly encourages the continuation of FGM/C. It is also noted that men need to be included in

health education, as they have great influence in whether this practice continues. It is important to provide information about what the law says regarding FGM/C in each country, especially in those countries where FGM/C is illegal.

However, before effective health education can be provided, the western nurse must recognize that perpetuators of FGM/C are not doing so with the intent of harm. If western nurses go into health education with this perspective, they can appear ignorant and presumptuous.

4.2.7 Alternative practices:

The encouragement of alternative practices can also contribute to breaking the cycle of FGM/C. As FGM/C is a coming of age ritual for a woman, its value is placed greatly in its symbolism. Alternative practices that are not harmful to the female body, such as a celebration without the cutting, can be effective in reducing rates of FGM/C. However, for this to be effective, whole communities must be involved so that girls are not singled out based on whether or not they have been cut.

4.2.8 Conclusion

Because of the detrimental and foreign nature of FGM/C, it is easy to shame the cultures in which it has origins. However, providing effective help to women who live with FGM/C and changing perspectives on the procedure can only happen through the education and empowerment of the individuals in the communities in which it occurs. For nurses to be able to do so, they must have a thorough understanding and knowledge of FGM/C and a cultural sensitivity when working with these communities.

4.3 Living with mutilation: A qualitative study on the consequences of female genital mutilation in women's health and the healthcare system in Spain (del Mar Pastor-Bravo, Almansa-Martínez, & Jiménez-Ruiz, 2018)

4.3.1 Purpose

This studied chronicled the experiences of sub-Saharan women living in Spain related to healthcare received for FGM/C and the biopsychosocial consequences of FGM/C.

4.3.2 Method

14 women living with type I or II FGM who resided in Murcia, Spain and had received obstetric healthcare were included. Intentional sampling based off a set of criteria was used to determine the population. Three informants participated initially, and a snowball effect was used to find the rest of the population. Informal interviews, sociodemographic questionnaires and life histories were used as sources of data. The core question to the unstructured interview was, "How has female genital mutilation affected your life and health?" Information was stored in audio format and field diaries. Recurring topics were then categorized.

4.3.3 Results

The results fall under two categories: health consequences and healthcare received.

The physical health consequences named during the interviews include immediate physical consequences such as "intense pain, itch, hemorrhage, difficulty urinating and stinging in the groin". Long-term consequences such as recurring urinary tract infections and other genital problems were named.

Psychological health consequences named included “traumatic recall, sleeping disorders, feelings of fear, hopelessness, loss of identity states of rage, anguish and sadness” (p. 121).

The women also identified sexual repercussions of FGM, stating that fear and pain occurred upon initiation of sexual relations. Sexual pleasure was said to be affected as some women named that they rarely experience sexual desire and struggle with anorgasmia. Marital troubles were mentioned due to some women not having felt satisfied during sexual relations.

Attitudes towards the healthcare the participants received was also documented. Due to feelings of embarrassment for being anatomically different in the genital area, the participants viewed routine vaginal exams as negative. However, the participants reported that they received a professional attitude and good information before vaginal exams.

There was a lack of information provided to the participants by healthcare professionals. This information was grouped into four categories: pregnancy and childbirth, contraceptive methods, FGM/C-related complications, and the prospect of reparative surgery.

Participants felt that information about FGM/C and procedures done during delivery were not given sufficiently. Information about contraceptives and family planning was reported to have been lacking, and that cultural factors were not taken into consideration. In addition, complications of FGM/C were a topic on which participants reported being underinformed about. Participants felt that they were not given adequate information about reconstructive surgery.

4.3.4 Conclusion

This study brings awareness to the information and healthcare deficit received by women who are living with female genital cutting. This awareness highlights the importance of

prioritizing the provision of better healthcare to women living with FGM/C through the education and training of healthcare professionals

4.4 Female Genital Cutting and the need for Culturally Competent Communication (Odemerho & Baier, 2012)

4.4.1 Purpose

This article provides information for nurse practitioners that aim to incorporate practices of cultural sensitivity into the care of immigrant women who have undergone FGM/C.

4.4.2 Contents

The article gives background information about FGM/C, as well as an overview of its global prevalence. It gives concise information about the ethical and legal aspects of FGM/C within the context of WHO and the United States of America.

4.4.3 Culturally Competent Care

The dynamic quality of the patient's culture and that of the nurse practitioner makes the ability to observe the interaction of the two possible. In this way, the nurse practitioner can evaluate the quality of care being provided and reform to best meet the needs of the patient. For this to be done effectively, it is a prerequisite that the nurse practitioner is aware of his or her own values concerning cultural relativism and universal human rights.

A compassionate nature, a knowledge of the cultural background of the patient, and a willingness to be a patient advocate all aid in providing effective, culturally competent care. Cultural humility, which is an ongoing process and development, is necessary to balance out the power dynamic and improve communication between practitioner and patient.

Practitioners must recognize that caring for women who live with FGC extends from the strictly somatic to the cultural and spiritual aspects of the patient. While the nurse practitioner should have a sound knowledge about the short- and long-term complications of FGM, cultural and spiritual care should not be forgotten.

A focus on the facilitation of good communication is necessary to be able to provide effective patient care. The nurse practitioner should convey his or her openness and willingness to listen, discuss and inform, both verbally and nonverbally. Using the same terminology which the patient uses to describe FGM/C can build bridges. Permission from the patient's side is of utmost importance and can aid in building a rapport of trust.

The focus of education should be related to the health needs that the patient presents with. The nurse practitioner must remember the individuality of each patient who is living with FGM/C and approach the care with an open mind.

Prenatal patient education should be adapted to care specifically for women living with FGM/C. Giving the patient time to express their thoughts and feelings surrounding their situation is important to identify potential misconceptions and be able to address areas of concern.

It should be determined if the use of a female interpreter would increase the quality of care provided to the patient.

4.4.4 Conclusion

While knowledge surrounding FGM/C and the cultures to which it originates is important, it is only one of many facets that can aid in providing a high quality of care to patients living with FGM/C.

4.6 Summary of results

To summarize shortly, the articles I have chosen to include in this literature study contain one or several of the following conclusions relevant to my thesis. A more detailed literature review matrix can be found in Attachment 4 in the appendix.

Healthcare professionals working with women living with FGM/C should be able to provide culturally competent care. How the healthcare professional communicates with the patient is a determining factor on the quality of care received and the patient's willingness to consult healthcare services in the future.

Healthcare professionals should have a solid knowledge about what FGM/C is, why the procedure happens, the short- and long-term health consequences of the procedure and other factors surrounding FGM/C.

Women living with FGM/C have a need for information surrounding care options that can be offered to them, and it is the healthcare professional's responsibility to provide this information in a manner that is understandable for the individual.

Health education is an important part of caring for women who are living with FGM/C as it can help mitigate misconceptions or misinformation surrounding FGM/C.

There is a lack of evidence-based information about how healthcare professionals can offer women living with FGM/C the highest quality of care. Newer research of higher quality is encouraged.

5. Discussion

The original intention of this literature study was to determine which practical nursing care interventions were key in producing positive health outcomes in patients living with FGM/C. After gaining more academic insight into the relationship between nurses and immigrant patients, and how immigrant women living with FGM/C experience healthcare services in new countries, it became clear that the practical elements of how to care for women with FGM/C are details that build on a foundation. The foundation is built of the nurse's awareness of FGM/C and the therapeutic use of communication with the patient.

5.1 Awareness of FGM/C and willingness to address it

In order to provide high-quality, culturally competent nursing care to women living with FGM/C, it is first essential to be aware of what FGM/C is, why it happens, its cultural context, and the negative health consequences that it can result in (del Mar Pastor-Bravo, Almansa-Martínez, & Jiménez-Ruiz, 2018, p. 124; Goldenstein, 2014, p. 98; Odemerho & Baier, 2012, p. 454). This awareness can make the difference between a nurse effectively meeting the patient's comprehensive health needs and overlooking a critical element in a patient's holistic clinical picture.

The results of the study conducted by del Mar Pastor-Bravo, Almansa-Martínez, & Jiménez-Ruiz (2018) show that health care given to women living with FGM/C is insufficient. Lack of identification of FGM/C, communication of treatment options, and health education are listed as contributing factors as to why overall care was deemed as inadequate (p. 123).

Nurses should gain an awareness of FGM/C, why it happens, how it appears, and the potential health consequences related to it (del Mar Pastor-Bravo, Almansa-Martínez, &

Jiménez-Ruiz, 2018; Odemerho & Baier, 2012, p. 455; World Health Organization, 2016, p. 29). It is our mandate as nurses to be aware of FGM/C and to confidently address it with the patient. In the Professional Ethical Guidelines for Nurses from the Norwegian Nurses' Association, it is stated that a nurse must "safeguard the dignity and integrity of the individual patient, including the right to professionally sound and caring help…", and more specifically that it is the nurse's ethical duty to "take care of the individual patient's need for comprehensive care" (Norwegian Nurses Organization, 2019). Comprehensive care includes the recognition and addressing of the mental, physical, spiritual, social, and cultural factors that can affect a patient's health. FGM/C can interfere with all of these factors, and it is therefore of high relevance that the nurse addresses it with the patient (Odemerho & Baier, 2012, p. 455).

According to Leininger's theory, nursing education should include education in transcultural nursing care (Sagar, 2012, s. 6). This education would aid in remedying insufficient preparedness nurses may have in therapeutically caring for women living with FGM/C. Formal training would give nurses a base knowledge about the issue that can be built off in the future. For practicing nurses who have not received a formal education about FGM/C and its health consequences, the Professional Ethical Guidelines for Nurses states that the nurse must "recognize the limits of one's own competence, practice within these and seek guidance in difficult situations" (Norwegian Nurses Organization, 2019). In other words, nurses have the responsibility to take learning into their own hands when their competence is insufficient. This can be done through the reading of trustable academic literature about FGM/C, its cultural origins, and its health-related consequences.

To be able to provide culturally competent care, the nurse must also have an awareness of her own personal attitudes towards the practice and the people who partake in this practice

(Goldenstein, 2014, p. 28; Odemerho & Baier, 2012, p. 454). Periodical reflection that brings awareness to one's own views of FGM/C and the cultures that practice it can contribute to a more trusting nurse-patient relationship. Negative attitudes can result from the violent and drastic nature of the practice, but these attitudes do not benefit the women who are living with the results of FGM/C and can actually end up curbing all efforts to help (Goldenstein, 2014, p. 98). Leininger's theory of cultural care diversity and universality discusses cultural imposition, where healthcare professionals meet patients with feelings of cultural superiority that lead to the infliction of their own values and beliefs on a patient (Sagar, 2012, s. 10). Women living with FGM/C may be deterred from consulting healthcare services when they are met with negativity and estrangement. Odemerho & Baier argue that a nurse can explore any potential stereotypes that he or she might have towards the patient, her culture of origin, and her FGM/C (2012, p. 454). This aids in promoting therapeutic and harmonizing communication instead of contributing to the cultural schism that can create barriers (Odemerho & Baier, 2012, p. 454). Such reflection is an ongoing reflective process that can contribute to a sense of cultural humility (Odemerho & Baier, 2012, p. 454).

Cultural humility towards patients living with FGM/C can grow from the recognition that those who think positively of the practice and continue it do not have harmful intent, and many who are cut do not perceive themselves as mutilated (Goldenstein, 2014, p. 98; Odemerho & Baier, 2012, p. 454). The nurse can benefit greatly with this understanding as it can lead to a drastic change in how the nurse approaches therapeutic care and communication with a patient living with FGM/C. The fact that FGM/C is not widely practiced within the nurse's culture can lead to feelings of cultural superiority. According to Leininger's transcultural nursing theory, a sense of cultural superiority can create a situation where the nurse imposes his or her own

cultural beliefs and values onto the patient, assuming they too should partake in these beliefs and values (Leininger & McFarland, 2002, pp. 51-52). Therapeutic care and communication is inhibited when discrepancies between cultures and cultural imposition takes place between the nursing patient (Leininger & McFarland, 2002, p. 79). These discrepancies can take place because the women whom nurses are interacting with most often adhere to the culture that promotes FGM/C (Goldenstein, 2014, p. 98). Avoiding cultural imposition and obtaining a sense of cultural humility is facilitated through understanding the cultural values that are held by the patient's culture of origin. For example, the value of honour plays a large role in FGM/C's continuation, and honour in and of itself is not an objectively negative value (Goldenstein, 2014, p. 99). With this understanding, a nurse has a deeper understanding of the nuances that the cultural practice of FGM/C carries, and can communicate on a more relatable level with a patient living with FGM/C.

5.2 The nurse's role as a counsellor and communication as a means of mediation

The results of the included studies show that communication can be used to create and maintain a safe environment in which the nurse-patient relationship can cultivate. Fear of negative reactions make immigrant women living with FGM/C hesitant to disclose information about their FGM/C to a nurse of a different cultural background (del Mar Pastor-Bravo, Almansa-Martínez, & Jiménez-Ruiz, 2018, p. 123; Odemerho & Baier, 2012, p. 452; Goldenstein, 2014, p. 98). The nurse should facilitate an environment that allows the patient to feel safe in disclosing information about her FGM/C and how it is affecting her health and increases her willingness to consult health care services. The nurse's use of culturally competent communication skills is key in developing such an environment.

Joyce Travelbee's well-acknowledged nursing theory about the Interpersonal Aspects of Nursing (1971) states that nursing is made possible through interpersonal relationships that can go through stages over time, and that nursing is "an interpersonal process whereby the professional nurse assists an individual… to cope with the experiences of illness and suffering and, if necessary, to find meaning in these experiences" (p. 7). Nurses can use Travelbee's theory to gain a deeper understanding of how to relate to patients who live with FGM/C when the nurse-patient dynamic becomes clouded with cultural differences. By recognizing the human dynamic between the nurse and patient, the nurse can use effective communication to bring about therapeutic outcomes (p. 93).

For a therapeutic nurse-patient relationship to develop, the nurse must understand the patient's perspective of her experience with FGM/C (Odemerho & Baier, 2012, p. 454). While FGM/C is often a traumatic experience with detrimental side effects, many of those who are living with FGM/C also recognize it as a valuable part of their culture (Goldenstein, 2014, p. 98). Women living with FGM/C are individuals who come from different cultural backgrounds and adhere to those cultures to varying degrees. Two useful skills the nurse can use to strengthen the therapeutic nurse-patient relationship is the use of empathy and unconditional positive regard, which Nelson-Jones describes as core conditions of helping relationships (2016, p. 34). Empathy is described as "the capacity to identify yourself mentally with and fully to comprehend the [patient's] world" (Nelson-Jones, 2016, p. 34). Nurses who use empathy actively have a more comprehensive understanding of experiences and feelings that the patient shares. Unconditional positive regard is the concept that the patient is viewed non-judgmentally and constantly by the nurse in a positive light (Nelson-Jones, 2016, p. 36). It entails the recognition that the way in which the patient interacts with the world is due to their subjective experience of the world

around them (Nelson-Jones, 2016, p. 36). Adopting unconditional positive regard opens the channel for effective nurse-patient communication and provides a non-judgmental attitude that is necessary to build rapport with the patient.

Recognizing and resolving cultural differences that can arise between the nurse and patient leads to more effective provision of care (Odemerho & Baier, 2012, p. 454). This result is in concordance with our legal mandate as nurses to provide individualized care. According to the Patients' Rights Act in Norwegian legislation, "information must be adapted to the recipient's individual conditions, such as age, maturity, experience, and cultural and language background. The information must be given in a considerate manner" (1999, § 3-5). Additionally, the Professional Ethical Guidelines for Nurses states that "the nurse promotes the patient's ability to make independent decisions by providing adequate, customized information and ensuring that the information is understood" (Norwegian Nurses Organization, 2019). These laws and guidelines defend the quality of care that is given to patients who originate from different cultural backgrounds. It is therefore the nurse's responsibility to ensure that the nurse-patient communication is understandable for the patient. Adapting communication to that which makes the patient feel most comfortable will provide her with the safe environment in which a nurse-patient relationship can be built. This can be done by focusing on communication that adapts to the cultural norms that the patient living with FGM/C has her background in. In addition, if there are any language barriers, an interpreter should be used (Odemerho & Baier, 2012, p. 456).

Body language varies among cultures, and nurses can greatly increase the patient's level of comfort and openness by adapting their body language to create a more comfortable experience for the patient (Odemerho & Baier, 2012, p. 456). The nurse should use body language to show that they are paying attention and are interested in what the patient is sharing.

This can be done through cues such as showing that one has the time to spend with the patient, presenting with a body language that shows relaxation and interest, the management of facial expressions, gestures, touch, personal space and height, clothing, and adapting the amount of eye contact used (Nelson-Jones, 2016, pp. 52-56).

Showing the patient that the nurse is interested and attentive to information that the patient is giving is key to encouraging further nurse-patient relationship building (Odemerho & Baier, 2012, p. 455). Active listening is a communication skill that nurses should use in communicating with women living with FGM/C. Nelson-Jones describes active listening as not only listening to the patient, but also showing that one has understood what has been said (2016, p. 48). When the nurse uses active listening, the patient trusts that she has been heard and understood comprehensively. As discussed by Travelbee, this trust builds rapport and gives meaning and detail to the clinical picture of the patient based off the information that is shared (1971, pp. 153-154).

It is recommended that the nurse use the same terminology as the patient to address their FGM/C (Odemerho & Baier, 2012, p. 456). Choosing to speak about FGM/C in the same manner as the patient is one example of how the nurse can use paraphrasing and reflection, which are techniques used in therapeutic communication according to Nelson-Jones (2016, p. 59). Paraphrasing and reflection skills involve the repetition of that which is expressed in a reflective manner to the patient using either the same or different words (Nelson-Jones, 2016, p. 59). These skills aid the patient in reflection and recognition of feelings, in addition to showing that the nurse understands the patient's perspective and is listened actively to the patient (Nelson-Jones, 2016, p. 61).

Nurses should also be conscious of the type of questions they choose to ask patients living with FGM/C. Many of the cultures that practice FGM/C also value modesty to a high degree, and FGM/C can be a topic that a woman is not readily open to discussing with a stranger, especially one from a different cultural background (Goldenstein, 2014, p. 98). Asking permission from the patient to ask personal questions about their cultural background shows a respect for the patient's private life and displays to the patient that she has the choice over the amount of information she wants to disclose (Odemerho & Baier, 2012, p. 456). The use of open-ended questions gives the patient the grounds to share their feelings and experiences in a comprehensive manner (Nelson-Jones, 2016, pp. 59-63).

Health education and information on treatment options should be given to patients who are experiencing negative health consequences of FGM/C (World Health Organization, 2016, pp. 27-30; Odemerho & Baier, 2012, p. 456; del Mar Pastor-Bravo, Almansa-Martínez, & Jiménez-Ruiz, 2018, p. 124). The Norwegian Patients' Rights Act states that "the patient should have the information needed to gain insight into their health and the content of health care" (1999, § 3-2). This right to information and health education empowers the patient through having a more accurate understanding of her health, and increases the patient's autonomy in choosing treatment options (World Health Organization, 2016, pp. 28-29). Contents of health education and information should be individualized to meet the patient's needs. The nurse may see a need to discuss complications that are related to FGM/C, as the patient might not automatically connect symptoms to their FGM/C (Goldenstein, 2014, p. 99). It is important that the patient receives information about treatment options that are relevant for her, such as deinfibulation (World Health Organization, 2016, p. 28). Interventions that can improve mental health are also important to discuss when the patient shows symptoms of anxiety, depression or post-traumatic

stress disorder, which are potential common long-term consequences of FGM/C (World Health Organization, 2016, p. 23). According to Leininger & McFarland (2002), individuals within different cultures have varying ways of interpreting and discussing mental health (p. 240) Considering the concept of mental health through the perspective of the patient and their cultural origin can allow for a discussion about mental health that the patient will understand (Leininger & McFarland, 2002, p. 239). Other topics, such as deinfibulation, correct information about FGM/C's lack of origins in religion, laws regarding FGM/C in the country where the patient is living, sexual health, and pre-, peri- and postnatal care adaptions may be relevant (Goldenstein, 2014; Odemerho & Baier, 2012; del Mar Pastor-Bravo, Almansa-Martínez, & Jiménez-Ruiz, 2018; World Health Organization, 2016).

An immigrant woman living with FGM/C may be in need of specialized health care services, such as cognitive behavioural therapy, deinfibulation services, psychological support services, and sexual counselling (World Health Organization, 2016, pp. 17-30). The nurse can accomplish this by processing the information that a patient shares and planning further care in concordance with the patient and doctor. The patient should be well-informed about the service and give informed consent to the consultation of such services.

6. Conclusion

The purpose of this paper was to determine how a nurse can therapeutically meet an immigrant woman who is living with FGM/C. Nurses in Norway work in a multicultural setting where quality of communication is a determining factor in how care is experienced. The nurse can, through preparation, bridge cross-cultural gaps and provide therapeutic care to women living

with FGM/C. The results of the included studies analyzed against well-acknowledged nursing theories, guidelines, and legislation detail how this is possible.

Therapeutic care can only happen when nurses have an awareness of what FGM/C is, why it is practiced, its health consequences, the culture of each individual patient, and the nurse's own attitudes towards FGM/C and the cultures to which the practice occurs within. Lack of awareness could be remedied by a higher focus on culturally competent care and FGM/C in nursing education. Comprehensive interpersonal care that takes into consideration the mental, physical, spiritual, social, and cultural facets of the individual is also important for care to be successful.

Because FGM/C can be a sensitive topic for both those who have undergone it and nurses who view the practice as foreign, therapeutic communication is a catalyst for effective provision of care. The nurse should recognize his or her counselling role in meeting with women living with FGM/C and have a focus on developing therapeutic communication techniques between the nurse and patient. Counselling techniques, such as empathy, unconditional positive regard, adaption of body language, active listening, paraphrasing, and reflection skills are useful in allowing the patient to feel comfortable and safe in conversation with the nurse.

Due to the highly multicultural nature of the Norwegian society, it is important that nurses are culturally competent and have an awareness of FGM/C. To be able to guide a nurse's evidence-based care, high quality, academic research must be available. A lack of research on FGM/C was observable throughout the completion of the initial and systematic search for this literature review. Up-to-date qualitative studies on women's experiences in living with FGM/C and the consultation of health care services, their hesitancy to consult health care services, and best practice guidelines related to health-related consequences would be enlightening. I hope that

through this bachelor thesis, others will be encouraged to complete more studies on FGM/C so that an up-to-date, high quality of evidence is made available.

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Attachment 1: PICO Table

			Search Terms
P: Patient/problem	Which patient group or population is the focus on?	This literature review's population is immigrant women living in Norway who have undergone female genital mutilation.	Female genital mutilation, female genital cutting, female circumcision
I: Intervention	What about this patient group is of interest? Is there an intervention or exposure of the population to something?	Nursing care is the intervention that is being explored in this literature review.	Nursing, nursing care, care plan
C: Comparison	Is there a comparison of two types of interventions?	There is no comparison of interventions in this literature review.	N/A
O: Outcome	What endpoint or outcome is in focus?	The outcome that this literature review will focus on is increased quality of care.	Initially, the search term "quality of life" was used to define the outcome. However, due to the limited amount of research on this subject, defining the outcome limited the amount of results excessively. Through trial and error, defining the outcome in the search terms was omitted to open for more results.

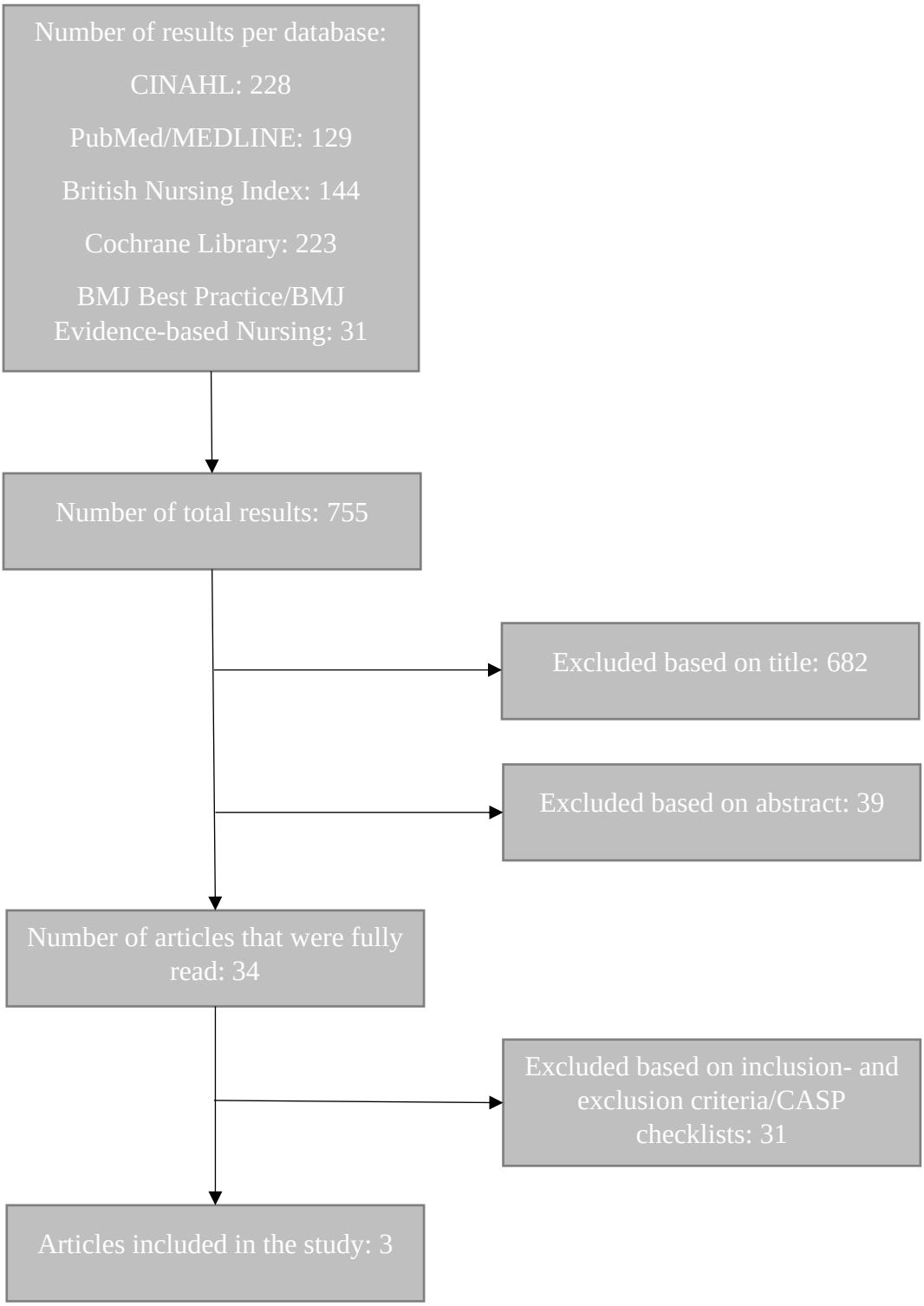
Attachment 2: Search History

Date	Database	Search Criteria	# of Results	# of Apparently Relevant Results
13.01	CINAHL	Female genital mutilation **AND** nursing Limiters: Linked full text, peer reviewed, English language, publishing date 2010-2020 Expanders: apply equivalent subjects Search modes: Boolean/phrase	228	30
29.01	PubMed	(female circumcision[MeSH Terms]) **AND** care, nursing[MeSH Terms] Limiters: Full text available, 10 year publication date range	2	2
04.02	PubMed	(female circumcision[MeSH Terms]) **AND** care plan, nursing[MeSH Terms]	1	1
08.02	PubMed	("circumcision, female"[MeSH Terms] **OR** ("circumcision"[All Fields] **AND** "female"[All Fields]) **OR** "female circumcision"[All Fields] **OR** ("female"[All Fields] **AND** "genital"[All Fields] **AND** "mutilation"[All Fields]) **OR** "female genital mutilation"[All Fields]) **AND** ("nursing"[Subheading] **OR** "nursing"[All Fields] **OR** "nursing"[MeSH Terms] Text availability: Free full text Publication dates: 10 years	49	9
09.02	MEDLINE	(female genital mutilation **OR** female genital cutting **OR** fgm **OR** female circumcision **OR** fgc) **AND** nursing	3	1

		Limiters: scholarly (peer reviewed) journals; linked full text; date of publication Jan. 2010- Feb. 2020; English language Expanders: apply equivalent subjects Search modes – Boolean/Phrase		
09.02	MEDLINE	female circumcision **AND** nursing Limiters: scholarly (peer reviewed) journals; linked full text; date of publication Jan. 2010- Feb. 2020; English language Expanders: apply equivalent subjects Search modes – Boolean/Phrase	3	0
09.02	MEDLINE	Female circumcision	71	10
09.02	British Nursing Index	(circumcision female) **AND** nursing care Additional limits - Date: After January 01 2010; Source type: Scholarly Journals; Language: English	144	15
09.02	British Nursing Index	(Female Genital Mutilation) **AND** (Nursing Care) Additional limits - Date: After January 01 2010; Source type: Scholarly Journals; Language: English	177	3
10.02	Cochrane Library	Medical Terms (MeSH) Circumcision, female - explode all trees	4	1
10.02	Cochrane Library	"female genital mutilation" **OR** "female genital cutting" **OR** female circumcision **AND** nursing Limiters: date Jan 2010 to Feb 2020	29	0

10.02	Cochrane Library	"female genital mutilation" **OR** "female genital cutting" **OR** female circumcision Limiters: date Jan 2010 to Feb 2020	169	0
10.02	Cochrane Library	"female genital mutilation" **OR** "female genital cutting" **OR** "female circumcision" **OR** "circumcision of females" **OR** "circumcision female" Limiters: date Jan 2010 to Feb 2020	31	1
11.02	BMJ Best Practice	Female circumcision	19	0
11.02	BMJ Best Practice	Female genital mutilation	7	0
11.02	BMJ Best Practice	Female genital cutting	2	0
11.02	BMJ Evidence-Based Nursing	Female circumcision Limiters: Published Jan 2010 – Feb 2020	0	0
11.02	BMJ Evidence-Based Nursing	Female genital mutilation Limiters: Published Jan 2010 – Feb 2020	2	0
11.02	BMJ Evidence-based Nursing	Female genital cutting Limiters: Published Jan 2010 – Feb 2020	1	0

Attachment 3: Literature Review Flowchart



Attachment 4: Literature Review Matrix

Author/Publication Date/Country/ Journal	Title	Purpose of the Study	Type of Study/Method	Population/Number of included articles	Results	Quality Assessment	Ethical Considerations
World Health Organization 2016	WHO Guidelines on the Management of Health Complications from Female Genital Mutilation	Provide evidence-based guidelines on how health care workers should manage health complications of FGM	Systematic review	88 included articles	Relevant health care interventions for women living with health complication related to FGM/C are deinfibulation, mental health care, female sexual health care, provision of information and health education.	Approved through use of CASP Systematic Review Checklist	People who worked directly with women and girls living with FGM were consulted to aid in the wording of the guidelines. Two separate literature reviews were included by an external group of human rights experts to gain insight how

							public health and human rights relates to FGM. Those working with the writing of the guidelines presented no conflicting interests that might affect the development of the guidelines.
Rachel A. Goldstein, MSN, RN 2014	Female Genital Cutting: Nursing Implications	Through the exploration of research articles, this article describes the nurse's role in	Journal article	33 included articles	Psychosocial support, cultural sensitivity, health education and the encouragement of alternative practices can all be	Approved through use of CASP Systematic Review Checklist	The author states that she has no conflicts of interest that might affect the interpretation of

United States of America Journal of Transcultural Nursing		providing care for women living with female genital cutting			realistic methods of caring for women living with female genital cutting.		the included research.
María del Mar Pastor-Bravo, Pilar Almansa-Martínez, Jiménez-Ruiz 2018 Midwifery	Living with mutilation: A qualitative study on the consequences of female genital mutilation in women's health and the healthcare system in Spain	Through interviews, the study explores how women living with female genital mutilation from sub-Sahara who are residing in Spain experience the consequences of the procedure and	Life-history qualitative research	14 women, aged 23-41 from Senegal, Nigeria and Gambia	Immediate somatic health consequences and long-lasting psychological and sexual health consequences were reported. When consulting health care, feelings of embarrassment were reported. Lack of information pre-,	Approved through use of CASP Qualitative Checklist	The study is approved by the Research Ethics Committee of the University of de Murcia. Information about the project was given to participants both verbally and in a letter. Participants gave their

		the health care they receive.			peri- and post-intervention was provided to the individuals. Individuals reported professional behaviour from the health care professionals.		consent to have their audio recorded. Participants were informed that they could leave the interview at any point. Participants were made anonymous in the article. The authors declared no conflicts of interest that might affect the interpretation of data and results

							presented in the article.
Benedicta I. Odemerho, FNP-BC Marjorie Baier, PhD 2012 The Journal for Nurse Practitioners	Female Genital Cutting and the Need for Culturally Competent Communication	The article uses research findings to provide information on how nurse practitioners can use culturally competent communication to improve nurse-patient relationships with women living with female genital cutting.	Journal article	30 included articles	To provide culturally competent care to patients living with female genital cutting, the nurse practitioner must have a focus on effective communication. Awareness of what female genital mutilation is, its cultural background, the health consequences related to it, and the nurse practitioner's	Approved through the CASP Systematic Review Checklist	The authors state that they have no conflicts of interest that might affect the interpretation of the included research.

					personal views on female genital mutilation all can aid in improving cross-cultural communication. Information and health education should be provided to the patient in a culturally competent manner.		