

A literature review : female genital mutilation and its implication on eliciting comprehensive health histories and performing physical exam assessments

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A literature review: Female genital mutilation and its implication on eliciting comprehensive health histories and performing physical exam assessments

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Dedication

This literature review encompassing female genital mutilation and performing culturally sensitive health assessments is a testament of my passion and advocacy for women's health. Hopefully, this review will encourage healthcare practitioners to re-evaluate current assessment practices utilized for immigrant and minority women who have endured genital surgery. I would like to dedicate this work to my family, both immediate and extended. Without their support and reassuring spirit, I would not be where I am today. Thanks for everything.

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Introduction

Prior to exploring the topic of female genital mutilation (FGM) at length, this author will pose the following scenario and questions to you, the reader. Picture it, you are a physician assistant (PA) at a local women's health facility in Minnesota. According to office protocol, you receive your patient list for the day and notice several new patients whose names when read mimic a Somali affiliation; more so, you know that these women immigrated to the area following a civil war in their homeland in the late '80s. Being the inquisitive provider that you are, you immediately think of health and cultural concerns that are commonly seen in this patient population. Profoundly, you think of FGM. In fact, you recall that approximately "90-98 percent" of Somalian women undergo this procedure (U. S. Department of State, n.d.). Nevertheless, you as a healthcare provider have not had patient interaction with this group. Given the above scenario, as soon as you knock on the door of the examination room and enter, you'll probably be thinking about how to elicit their health history while being mindful of addressing the sensitive topic of female genital mutilation. Thus, you may ponder the following questions: What do you do?; Should you interact as you would with any other patient?; How should you greet them?

From the scenario just presented, apprehension, fear, and concern for the patient and one's self are normal emotions that might be encountered with such a situation. But rest assured, through this in-depth literature review, one will be presented with cross cultural clinical studies and assessment models with critiques of them in an attempt to support or reject a proposed intervention/assessment model for health care professionals, especially PAs, who are likely to provide care and treatment to Somalian women who have been circumcised. Additionally, this proposed model will also guide PAs in educating not only the circumcised female but her family

as well on the possible negative health related side effects of FGM. Therefore as a healthcare provider, one can mutually promote understanding and cultural awareness in not only close-nit Moslem communities such as Somalians but rather globally in daughters who belong to groups who practice FGM. Additionally, healthcare providers will gain insight to the questions presented in the above scenario and others such as: (1) Do PAs understand the cultural implications that are involved in treating Somalian women with regard to FGM?; and (2) How do these cultural implications impact the PA's ability to perform an accurate assessment? (e.g. elicit a comprehensive history and performing a pelvic examination?).

In order to accomplish the proposed goal in this paper, this author will explore several key elements in the literature review regarding Somalian culture and FGM as a whole. First, historical background and migration patterns will be examined followed by an extensive review of a typical Somalian family. Next, attention will be given to FGM in its entirety, current practice models, and treatment challenges. Subsequently, recommendations for PAs regarding care and treatment of circumcised females will be given. And finally, the paper will culminate with an overview of the findings.

Historical Background of Somalia: How They Came to the United States

In the mid 1800's, countries such as Britain, Ethiopia, France, Italy and Kenya began to encroach upon un-colonized parts of Africa to increase their land holdings. By the end of the encroachment, the terrain was "carved into multiple territories" (New Hampshire Governor's Office of Energy and Community Services, [NHGOECS] n.d.). With respect to Somalia, the French controlled the northernmost region, an area that is presently known as Djibouti while the British colonized northern Somalia (Community University Health Care Center [CUHCC], 2002, October; NHGOECS). The Italians governed southern Somalia, while Ethiopia controlled the inland region of the Ogaden. And Kenya controlled an area named the Northern Frontier District (CUHCC).

Initially, Britain controlled Ogaden. However in 1948, after World War II, Ogaden was designated by the United Nations' mediated agreement to be controlled by Ethiopia (CUHCC, 2002, October). In taking a retrospective look at things, some may argue that this was the initial source of conflict that led to the inevitable civil war lasting from 1988 to 1991. The civil war derived from the Somali ideation that they should be in control of Ogaden. Seeing as how that was not the outcome, ever since that 'trade' in 1948 between Britain and Ethiopia, both Somali and Ethiopian governments have clashed.

As years passed, other parent countries began to relinquish their 'holdings' on the now colonized land thereby granting independence (CUHCC, 2002, October; NHGOECS, n.d.). In fact, in 1960 the areas that were controlled by Britain and Italy united to become the current borders of Somalia. Furthermore, France released its control of Djibouti in 1977. Given this, one would think that life would be grand—each land area could now function independently with the "anti-colonial, pro-Soviet civilian government [that was] formed" (NHGOECS). However, that

was not the case. In 1969, a coup was led by General Mohammed Siad Barre whose leadership and tactics became increasingly oppressive and autocratic.

Unique to the Somali culture is the concept of clans. “Within Somalia, patrilineal clans dominate society’ (Texas Department of Health [TDH], 2001). More so than being affiliated with the clan, loyalty and in a since patriartical behavior is connected with membership. In such a clan-based society, “political, economic, social welfare and physical safety are influenced by membership in the patrimonial clan family”(Carroll, Epstein, Fiscella, Gipson et al., 2007). Also, “much of the current strife in Somalia is centered around clan disputes, as allegiance to the clan far outweighs allegiance to a united Somalia” (NHGOECS, n.d.). Even more profound is that since “Somalis are largely nomadic, it is more common for several sub-clans to live intermixed in a given area” (CUHCC, 2002, October). With this, speculation can support that clan rivalry not only existed within one united region but encompassed borders between neighboring regions too. In addition, one cannot forget that generalized patriotism among united regions is also a key player in this conflict too.

As a result of the new government’s tactics, in the late 70s clan based militias developed in an attempt to overthrow Barre (CUHCC, 2002, October; NHGOECS, n.d.). In 1977, Barre ended his affiliation with the Soviets and they independently supported Ethiopia while the United States supplied aid to Somalia (CUHCC); keeping in line with U.S history, this is the same time period as the Cold War. Ultimately, the civil war that broke out in 1988 was inevitable. Yet, in an attempt to escape oppression, political instability and the negative outcomes of war, more than one million Somalis fled the area (Carroll, Epstein et al. 2007; NHGOECS; TDH 2001). Displaced to refugee camps, resettlement programs were created and

thousands of Somalians immigrated to Europe and the United States, especially Minnesota, bringing their beliefs, customs, and practices often unfamiliar to health care practitioners.

Somalian Migration to the U.S.: Preliminary Implications for Health Care Providers
Relative to Cross-Cultural Assessment and Treatment of Women

In the late '80's during the initial migration of Somalians to the U.S., health care workers were not aware or knowledgeable of their social, religious, and cultural practices and beliefs that impacted on their quality of medical care, especially for women who had been circumcised. Today, almost twenty years after the first group of displaced Somalians came to America, health care providers increasingly are aware, knowledgeable and accomplished at treating and assessing the health status of Somalian women. However, given that new generations of health care providers are being educated coupled with births of second-generation Somalians, especially girls, who still adhere to the historic practice of female circumcision, there is still a need to continue to explore, increase awareness, implement, and evaluate best-practice treatment and assessment models. This is also relevant given the increasing numbers of immigrants coming to America, both Moslem Somalian and non-Somalian who continue to believe in this practice.

In 2035, ethnic minority Americans are projected to comprise 40% of the US population (Carroll, Epstein, Fiscella, Gipson et al., 2007). When compared to the present, only 10% of the US population or roughly 25 million refugees comprise the population (Carroll, Epstein, Fiscella, Gipson et al.; Carroll, Epstein, Fiscella, Volpe et al., 2007). Even more striking is the fact that “immigrants and refugees from Africa represent one of the fastest-growing groups resettling in the United States [and] 45% of African refugees in the United States are of Somali origin” (Carroll, Epstein, Fiscella, Volpe et al.). With projected increases discussed as well as the migration patterns noted by J. Carroll and colleagues, one can attest that as a healthcare provider, one is likely to encounter and furthermore care for an immigrant in his or her practice.

Globally examining the US Census Bureau projections (2004), 363,584,000 individuals is the projected total US population for 2030; of that, 13.9% is expected to identify as black while 13.5% of the projected 308,936,000 individuals for 2010 will identify as black. In an attempt to explore Somalian migration, data from the U.S. Department of Homeland Security (HS) (2007) on legal permanent residents from 2003- 2006 was reviewed, and it was noted that there has been an increase in the number of individuals who identified Somalia as their country of birth. For 2003, individuals seeking permanent resident status totaled 2,444, while in 2006, the number soared to 9,462. Furthermore, for each of those years, the Department of H.S. ranked the top twenty states where these immigrants settled. For years 2003-2005 the same three states were represented in the same order each year; those states were (1) Minnesota; (2) Ohio; and (3) Washington State. In 2006, Washington State ranked fourth with 646 immigrants seeking permanent resident status, while 704 totaled the number of immigrants who sought permanent resident status outside the top twenty mostly likely states of Somalian residency.

Given that Minnesota consecutively held the position of having the most persons of Somalian origin seeking permanent resident status, this author felt that a further investigation of Minnesota's immigrant demographics was warranted. (See Table 1). From the data, one should note that there has been a steady increase in the number of individuals, both male and female who are immigrants from any country as well as those who identify themselves from Somalia seeking permanent resident status in Minnesota.

Prospectively, looking at Minnesota in accordance with the US Census Bureau (2007), by 2030 Minnesota is projected to have a 28.2 % change in total population. Of that change, the projected total number of females of any origin will be 3,147,054. In the distant future, by 2010 Minnesota's projected total female population is said to become 2,717,926. Shifting attention to

individuals in Minnesota who identify themselves as black (i.e., Africans and or African-Americans), within the next eight (8) years (July 1, 2015) it is projected that there will be 233,000 black individuals in Minnesota and of that figure 118,000 will be black females. (See Table 2). Given this in combination with the data provided in Table 1, showing the increase in Minnesota's Somalian female population, one can speculate that in the years to come this portion of the population will increase exponentially.

Given the current immigration patterns as well as those that are projected, healthcare providers such as PAs should be able to appreciate the magnitude at which immigration is taking place in the US. More importantly, for career opportunities these providers should have a desire to learn about the Somali culture since there is a strong possibility that these patients will be seen in practice. To begin our exploration of the Somali culture, it is crucial that one examine many aspects. However, to address the concerns of this literature review, this author will perform an extensive review of the medically influenced customs with regard to the typical Somalian family and their cultural practices.

Islamic tradition is the root of Somalian culture. In fact, almost all Somalis are Sunni Muslims (CUHCC, 2002, October; Heitritter, 1999; McGown, 2003; NHGOECS, n.d.). Furthermore, along with the notion of clanship, Somalis, in general have a strong sense of unity, loyalty, and respect for their culture and their families; family reputation is crucial and if one member of the family engages in a shameful act, shame and dismay is cast toward the entire family.

Within the Islamic religion there is not only a belief system but a hierarchy as well as a structure for both government and one's life (CUHCC, 2002, October; Heitritter, 1999). Additionally, the Koran identifies specific male and female role responsibilities in accordance

with public and private domains (Heitritter; Schott & Henley, 1996). For example, the female functions as a manager of house and home while the male embodies the overall decision making ability and is responsible for home and family (Heitritter; Schott & Henley). In fact, in a survey of 14 women organized by health providers in Minnesota, through interaction in a healthcare setting with Somalians, it was perceived “that Somali men often serve[d] as the family spokesperson and sometimes appear[ed] to make decisions for their wives without consulting them” (Herrel et al., 2004).

Socially speaking, Islamic tradition permits causal greetings like *Alechem Salam Alechem* (“Peace be upon You”) and *Nabadgelyo* (“goodbye”). Also permitted are same-sex handshaking upon greeting (Army, 2007; CUHCC, 2002, October; NHGOECS, n.d.). It is also important to remember that according to Islamic tradition, the right hand is considered clean and is used for eating, writing, and handshaking while the left is used for hygiene purposes thereby deeming it unclean and therefore not used for hand shaking. Within the Moslem faith, much attention is given to manners (Army). With regards to handshakes, it should be cordial and sincere. Also, the non-Moslem greeter should be cognizant of additional touch/contact during the greeting, as this is considered offensive.

Also proscribed in the Muslim tradition are limitations in accordance to female attire and socialization (Army, 2007; CUHCC, 2002, October; NHGOECS, n.d.; TDH 2001). Women typically wear a hejab and are expected to cover their bodies with the exception of the hands and face. More so, “Moslem women do not mingle freely with men” (Army). Also, it should be known that Moslems will loathe and cause trouble to any person who does not treat women according to their standards and customs.

The concept of holidays is also unique to this faith as well (Army, 2007). Many Muslims pray several times a day and take part in Ramadan and Eid. During Ramadan, which occurs earlier each year, Moslems do not eat, drink or smoke between sunrise and sunset (Army). Knowing that the holiday is based on the lunar calendar with each month consisting of only twenty-eight days, investing in an Islamic calendar may be practical. From a healthcare standpoint it should be known that during this period, drawing blood may have serious consequences. Uninformed of this crucial information, can one imagine how hard it would be to obtain a routine blood test, check someone's glucose or HbA1c or obtain a urine sample since we routinely ask individuals to drink something if voiding is an issue. In terms of scheduling appointments, it is worth mentioning that Fridays are considered the Moslem day of rest (Army); therefore this should be taken under advisement when scheduling appointments.

Medically speaking, Somali 'traditional doctors' are the main source of medical knowledge (NHGOECS, n.d.; TDH 2001). These practitioners are mostly men who treat a variety of ailments ranging from psychosomatic disorders, sexually transmitted diseases to respiratory and digestive disorders (NHGOECS; TDH); primarily these practitioners are used to cure illnesses resulting from the concept of the "evil-eye" and upset spirits. In Somalian beliefs, the body houses spirits and when spirits are upset, illness ensues. Further compromising Somali health is the theory behind the "evil-eye" in which illness is obtained either purposefully or inadvertently from another through praise and comments that urge sickness. Some even say that staring for prolonged periods of time at a person places a curse or 'hex' on them (Army, 2007). Furthermore, herbal medicine and fire burning are synonymous to the culture and are used in part with rituals to cast away disease.

In the context of this literature review which included an examination of the medically relevant cultural and social aspects of the Somalian population, attention of this paper will be shifted to providing data that will aid healthcare providers, especially PAs in delivering effective services to circumcised Somalian women. Given the vast amount of publications regarding Somalian women and FGM and migration and immigration patterns presented earlier, the basis of this paper will answer two questions: (1) Do PAs understand the cultural implications that are involved in treating Somalian women with regard to FGM?; and (2) How do these cultural implications impact the PA's ability to perform an accurate assessment? (e.g. elicit a comprehensive history and performing a pelvic examination?).

In review of the literature to this point, no article was located that addressed how a healthcare provider should approach and furthermore explore during a health assessment the concept of FGM with women who have likely been circumcised. There are however, countless articles that address ethical implications of FGM, reproductive health and pregnancy, but few that explore this issue during the general check up. Moreover, no article thus far has been discovered that explains how to perform a pelvic exam on circumcised women or how FGM may alter the exam and or diagnostic assessments and testing. In attempt to fill the "gaps" while simultaneously creating a sense of continuity of care for circumcised patients, this author will attempt to answer the previously stated questions.

Female Genital Mutilation

In order to fully understand the procedure, the author of this paper feels that the reader should hypothetically and emotionally experience it firsthand. In order to “live” the experience, place yourself in the shoes of the two young Moslem females, Dirie (1999) and Ali (2007), depicted in the following true excerpt:

Dirie:

The night before my circumcision, the family made a special fuss over me and I got extra food at dinner. Mama told me not to drink too much water or milk. I lay awake with excitement, until suddenly she was standing over me, motioning. The sky was still dark. I grabbed my little blanket and sleepily stumbled along after her.

We walked out into the brush. ‘We’ll wait here,’ Mama said, and we sat on the cold ground. The day was growing lighter; soon I heard the click-click of the gypsy woman’s sandals. Then, without my seeing her approach, she was right beside me.

‘Sit over there.’ She motioned toward a flat rock. There was no conversation. She was strictly business.

Mama positioned me on the rock. She sat beside me and pulled my head against her chest, her legs straddling my body. I circled my arms around her thighs. She placed a piece of root from an old tree between my teeth. ‘Bite on this.’

Mama leaned over and whispered, ‘Try to be a good girl, baby. Be brave for Mama, and it’ll go fast.’

I peered between my legs and saw the gypsy. The old woman looked at me sternly, a dead look in her eyes, then foraged through an old carpet-bag. She reached inside with her long fingers and fished out a broken razor blade. I saw dried blood on the jagged

edge. She spit on it and wiped it on her dress. While she was scrubbing, my world went dark as Mama tied to blindfold over my eyes.

The next thing I felt was my flesh being cut away. I heard the blade sawing back and forth through my skin. The feeling was indescribable. I didn't move, telling myself the more I did, the longer the torture would take. Unfortunately, my legs began to quiver and shake uncontrollable of their own accord, and I prayed, Please God, let it be over quickly. Soon it was, because I passed out.

When I woke up, my blindfold was off and I saw the gypsy woman had piled a stack of thorns from an acacia tree next to her. She used these to puncture holes in my skin, then poked a strong white thread through the holes to sew me up. My legs were completely numb, but the pain between then was so intense that I wished I would die.

My memory ends at that instant, until I opened my eyes and the woman was gone. My legs had been tied together with strips of cloth binding me from my ankles to my hips so I couldn't move. I turned my head toward the rock; it was drenched with blood as if an animal had been slaughtered there. Pieces of my flesh lay on top, drying in the sun.

Waves of heat beat down on my face, until my mother and older sister, Aman, dragged me into the shade of a bush while they finished making a shelter for me. This was the tradition; a little hut was prepared under a tree, where I would rest and recuperate alone for the next few weeks.

After hours of waiting, I was dying to relieve myself. I called my sister, who rolled me over on my side and scooped out a little hole in the sand. "Go ahead," she said.

The first drop stung as if my skin were being eaten by acid. After the gypsy sewed me up, the only opening left for urine-and later for menstrual blood-was a minuscule hole the diameter of a matchstick.

As the days dragged on and I lay in my hut, I became infected and ran a high fever. I faded in and out of consciousness. Mama brought me food and water for the next two weeks.

Lying there alone with my legs still tied, I could do nothing but wonder, why? What was it all for? At that age I didn't understand anything about sex. All I knew was that I had been butchered with my mother's permission.

I suffered as a result of my circumcision, but I was lucky. Many girls die from bleeding to death, shock, infection or tetanus. Considering the conditions in which the procedure is performed, it's surprising that any of us survive. (Dirie, 1999).

Ali:

I couldn't see what the stranger was doing, but I could see blood. This frightened me. I was next. Grandma swung her hand from side to side and said, 'Once this long *kintir* is removed you and your sister will be pure.' From Grandma's words and gestures I gathered that his hideous *kintir*, my clitoris, would one day grow long that it would swing sideways between my legs. She caught hold of me and gripped my upper body in the same position as she had put Mahad. Two other women held my legs apart. The man, who was probably an itinerant traditional circumciser from the blacksmith clan, picked up a pair of scissors. With the other hand, he caught hold of the place between my legs and started tweaking it, like Grandma milking a goat. 'There it is, there is the *kintir*,' one of the women said.

Then the scissors went down between my legs and the man cut off my inner labia and clitoris. I heard it, like a butcher snipping the fat off a piece of meat. A piercing pain shot up between my legs, indescribable, and I howled. Then came the sewing: the long, blunt needle clumsily pushed into my bleeding outer labia, my loud and anguished protests, Grandma's words of comfort and encouragement. 'It's just this once in your life, Ayaan. Be brave, he's almost finished.' When the sewing was finished, the man cut the thread off with his teeth.

This is all I can recall of it..... We all started wetting our beds after the circumcision.... When Ma came back from her trip this time, she was furious. 'Who asked you to circumcise them?' ...Grandma turned on my mother in fury. She yelled that she had done Ma a huge favor. 'Imagine your daughters ten years from now—who would marry them with long *kintirs* dangling halfway down their legs?' After that, the circumcision was not discussed at all. It was just something that had happened—had *had* to happen.

Everyone was cut. (Ali, 2007).

These excerpts were written respectfully by two famous Somalian women residing in the U.S., namely a European model and a controversial member of Parliament in the Netherlands who both endured the procedure at five years of age (Ali, 2007; Dirie, 1999). To fully experience this culturally embedded rite of passage, review the diagram in the appendix to further capture the agony these young females face when undergoing FGM.

Since the focus of this literature review revolves around Somalian women, it would be unjustified if FGM or this rite of passage into womanhood were not covered in a global prospective. The originating concept of FGM is unknown; however the practice is thought to date back to the fifth century B.C (Little, 2003); yet Daley (2004) argues that a Greek papyrus

cited examples of circumcision on girls in 163 B.C. Furthermore, from several articles and texts it was gathered that FGM was reported in the mid-19th century in the US and European countries as a way to treat excessive masturbation, insanity and epilepsy.

Universally, FGM is prevalent in several African countries, mostly in the sub-Saharan, but the practice is also seen in Islamic countries in both Asia and the Middle East (Daley, 2004; Lee, 2007; UNICEF, n.d.; World Health Organization [WHO], 2000, June). In Africa, reports reveal that in 28 to 30 countries this procedure is performed (Bosch, 2001; Fuller & Lewis, 2001; Lee; UNICEF, n.d.; WHO). Moreover, Little (2003) states that of the African countries that practice FGM, anywhere from 50-90% of the women are mutilated. At the moment, there are estimates of 100-140 million girls and women who have undergone FGM (Little; Serour, 2006; WHO). Even more surprising, is the notion that yearly three million women undergo FGM, while two million girls are at risk for this non benefiting medical/health procedure (UNICEF, 2005; WHO). In most cases, the procedure is performed on young females, usually between the age of five and twelve, yet there have been reported cases of FGM performed on even younger females (Braddy & Files, 2007; Fuller & Lewis; Lee; Little; Nour, 2004; UNICEF, n.d.). Due to the clandestine nature of the ritual, the child has little to no knowledge of what awaits her prior to the procedure (Ali, 2007). In fact, she may be treated differently prior to the initiating event. Several articles reference the notion that these soon to be women are treated like royalty, given gifts and observe the culminating event with a celebration. In its entirety, the procedure lasts anywhere from 20-30 minutes, although some sources cite less (Chalmers & Hashi, 2000; Little; Skaine, 2005). In most cases analgesia is not commonly used while the excisor uses blessed knives, razor blades or broken glass during the mini surgery (Little). In most cases these instruments are not sterilized

between surgeries. (See Figure 1). A lack in sterilization is likely one of the many culprits contributing to the increase in HIV/AIDs and other infectious diseases among African natives.

The procedure is typically performed by a midwife, a trained elderly woman or a traditional healer (Little, 2003). However, in a 1998 Nigerian survey with 600 respondents, it was found that 34.5% of FGM procedures were performed by physicians; and of the 207 physicians respondents, 142 of them were female (Ugboma, Akani, & Babatunde, 2004). Within the same study, evidence also supported that traditional birth attendants performed 33.8% of FGM procedures. Given this, it appears that medical personnel have a firm stake in FGM. Upon further reading in the study, it was found that medical personnel indigenous to the area where FGM is performed live in poverty, therefore being able to perform this procedure serves as a means to generate income for these individuals.

Female genital mutilation has several names; these names range from female circumcision to female cutting (Fuller & Lewis, 2001; Serour, 2006; WHO, 2000, June). The actual procedure defined by WHO states FGM as all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs whether for cultural, religious or other non-therapeutic reasons. Currently, there are four forms of FGM defined by the WHO. (See Figure 2 & 3).

- **Type I** — excision of the prepuce, with or without excision of part or the entire clitoris.
- **Type II** — excision of the clitoris with partial or total excision of the labia minora.
- **Type III** — excision of part or all of the external genitalia and stitching/narrowing of the vaginal opening (infibulation)
- **Type IV** — pricking, piercing or incising of the clitoris and/or labia; stretching of the clitoris and/or labia; cauterization by burning of the clitoris and surrounding tissue;

scraping of tissue surrounding the vaginal orifice (angurya cuts) or cutting of the vagina (gishiri cuts); introduction of corrosive substances or herbs into the vagina to cause bleeding or for the purpose of tightening or narrowing it; and any other procedure that falls under the definition given above.

The extent of the FGM procedure performed is geographically and ethnically unique. For instance, Type I also known as ‘sunna’ is unique to Ethiopians, Eritreans and Nigerians, while Type II is exclusive to women who live in Sierra Leone, Gambia and Guinea (Nour, 2004). Type III or ‘pharaonic’ is exclusive to Somalis and women of the Northern Sudan (Nour). Type IV was not addressed in the literature utilized for this paper.

Generally speaking, excision or Type II is the most common form of FGM practiced (Bosch, 2001; Cameron & Anderson, 1998; Mandara, 2004). Overall, Type III “accounts for approximately 15% of all cutting procedures, being performed on as many as 90% of women in Somalia, Djibouti and northern Sudan” (Powell, Leye, Jayakody, Mwangi-Powell, & Morison, 2004). In comparison, Campbell (2004) found that 95% of Somali women had undergone some form of FGM while Cameron and Anderson attested that infibulation is the most common procedure underwent by Somalian women. In fact, McGown (2003) states that “most girls are infibulated in Somalia, because within the Somali social context, it was the very definition of a both a good Muslim and a woman.” Whatever the case, these women have had the procedure performed for various circumstances and we as healthcare providers need to educate ourselves in how to approach this unique patient population, as the traditional approach utilized in practice will differ for these women.

Prior to addressing how the healthcare provider can elicit from the patient her FGM procedure/experience and treating the resulting co-morbidities, (to be discussed later in this

section), initially healthcare providers need to understand the reasons why females undergo the procedure. In order to accomplish this, the provider should develop a sense of cultural competency. As defined by Nour (2004), “cultural competency is the ability to deliver medical care to people from different cultures.” Furthermore, Nour goes on to state that “it involves the respect of the individual’s health beliefs, practices, and behaviors [and that] one must try to understand the traditional beliefs behind this practice instead of being repulsed by its existence.”

In review of the literature, there is a reoccurring theme of control that surrounds FGM. In fact, one article stated “its true purpose is to keep women under absolute male control” (Lee, 2007). Even so, with the importance of family identified earlier, one can speculate that FGM may also be used to limit female actions that may reflect negatively on the family. Still, it is important to keep in mind that this act is not done to the female but rather for the female. Of the articles reviewed, Baron & Denmark (2006) display a well cohesive structure citing five major premises behind FGM; they are (1) sociological, (2) sexual, (3) aesthetic, (4) health, and (5) religious reasons for having FGM.

Deeply rooted in a cultural context, FGM has become an integrated way to seek and maintain identity and ultimately social control and approval. From the introduction, the concept of clans was presented. With that, FGM is often sought after as another means to conform to society and or to maintain social cohesion. In reality, “in societies where women rely on community and spousal support for survival, a decision to forgo circumcision can have negative outcomes”(Braddy & Files, 2007). More so, women who do not submit to FGM are typically shunned from the community and deemed unfit to marry (Ali, 2007; Braddy & Files; Dirie, 1999; Lee, 2007; Nour, 2004). Baron and Denmark (2006) further state that FGM affords women societal status and is a test of their bravery and preparation for childbirth.

Again in reference to clans and the teachings from the Koran, “modesty and sexual devotion are critical to patrilineal purity and lineage continuity (Baron & Denmark, 2006). Therefore, FGM is performed to suppress a female’s sexuality. More so, FGM is said to insure virginity prior to marriage, decrease sexual pleasure from the female perspective while heightening that of the males during intercourse, and ideally ensure fidelity (Braddy & Files, 2007; Lee, 2007; Serour, 2006).

In an anatomical context, the clitoris is homologous to the male penis. And interestingly enough, within the literature female genitalia are characterized as being unsightly and dirty. With that known, undergoing FGM promotes the idea of cleanliness, hygiene and the removal of masculine qualities. Moreover, it is also thought that if FGM is not performed, then the labia will continue to grow, again adding to the unsightly appearance of the female genitalia. Yet, having the procedure is said to aid menstruation. However, several articles reveal that the extent of infibulation may not leave an adequate opening sufficient enough for menstruation. Strikingly, it has also been proposed that if the clitoris touched the head of an infant during delivery, then the child would be subject to death (Baron & Denmark, 2006; Burstyn, 1995; Cameron & Anderson, 1998). Also, according to Burstyn (1995) it is hypothesized that the clitoris secretes a poisonous substance that results in male impotence during intercourse.

From a religious context, FGM is referenced with Christianity, Judaism, and Animism faiths. Yet, even though virtually all Somalis are Muslim and undergo infibulations, FGM as a whole is not as prevalent as one would imagine. Reported by Lightfoot-Klein (1989), FGM is not practiced in 80% of the Islamic world. Additionally, Baron and Denmark (2006) also reveal that the practice is rare in most Muslim countries. Still, those who endure the procedure feel that it is a requirement of the religion dictated in the Koran and the Sunnah (Baron & Denmark; Moruzzi,

2005). However, some critics say that this ideation may be a misinterpretation of a statement in the Sunnah, where a woman has a portion of her genitalia removed. Nevertheless, the procedure is not referenced in neither the Bible nor the Koran (Fuller & Lewis, 2001; Johnsdotter, 2003). And furthermore, the Koran, as shown by Baron and Denmark and Johnsdotter contains several passages that with reason contest the practice of FGM. The passages presented tackle the initial purpose of the clitoris, sexual pleasure and how it is sought after by both partners and lastly body modification. From those examples, it can be concluded that altering the body through FGM limits the role of the clitoris, limits female pleasure and blatantly alters the body thereby conflicting with the teachings of the Koran.

Having explored the reasons why FGM is prevalent, it is also important to examine the co-morbidities that are associated with this procedure. Initial complications from FGM include: pain, anemia, hemorrhage, hypotension, shock, tetanus, infections, abscesses, fever, lacerations of the urethra, bladder, vagina and rectum, fractures in the pelvic region and upper extremities and even death (Braddy & Files, 2007; Nour, 2004; Powell et al., 2004; WHO, 2000, June). Long term complications include: cysts, abscesses, keloids, urinary incontinence and infection, dyspareunia, difficulty with childbirth, sexual dysfunction, chronic pelvic infections, fistulas and menstruation difficulties (Powell et al.; WHO). Moreover FGM increases the likelihood that one will acquire HIV (Braddy & Files). Also, it is important not only to look at organic disease states, but also to reveal that FGM has a psychosocial component too. In most cases, women who have undergone FGM suffer from feelings of incompleteness, anxiety, depression, psychosis and post traumatic stress disorder (Braddy & Files; Mandara, 2004; WHO).

Current Practice Models Addressing Comprehensive Patient Histories and Physical Exam Assessments

This review of the literature suggests that there is limited information regarding this topic; thus it is significant that FGM and its patient/provider implications be explored in this review with the goal of contributing and advancing the work of healthcare providers. Thus, this author sought to reveal the current approaches/guidelines used in a healthcare setting that would achieve the following: (1) eliciting a comprehensive health history from immigrant/refugee women from FGM practicing countries, and (2) performing a pelvic exam on patients who have had female genital surgery. In review of the literature, this civil war induced epidemic led to migration of thousands of circumcised Moslem women to the U.S. From the migration patterns discussed earlier as well as the predicted population trends, continued research regarding these two areas of concern will be vital in order for future healthcare practitioners to give adequate culturally competent care to women and second generation females who have had female genital surgery or who are at risk for this procedure. In the interim until such information is available, this author will present the information that is in existence in hopes that it will (1) ease anxiety both in the healthcare provider, especially PAs, and the patient when these patients are seen in practice; and (2) establish a positive rapport between provider and patient.

An approach to obtaining a refugee's health history was published in the *BMJ* (Adams, Gardiner, & Assefi, 2004). This is significant because the proposed tool, implemented at refugee camps, uses a checklist of topics in combination with the Harvard trauma questionnaire to examine various components of the health history (see Figure 4 & 5). Through the utilization of interpreter services for non-native speaking practitioners and language specific questionnaires, providers are able to obtain the "life story" that primarily focuses on the refugee's health while in

the home country (Adams et al.). Moreover, the tool also reveals information that gives insight into the refugee's escape, family status, exposure to infectious disease and the use of traditional/herbal practices. Furthermore, African women are questioned about female genital surgery. Once rapport is established, a physical exam is obtained. Per the findings of the health history and physical exam, consideration is given to indigenous health concerns and culturally sensitive diagnostic tests and screenings are ordered.

In its entirety, the checklist approach seems to yield the appropriate information that a provider would seek upon a first encounter with a patient; an example patient being a Somali refugee who had FGM (Adams et al., 2004). A short come of the study is that it appears that nothing in the article explicitly reveals neither how questions are asked nor how to establish rapport with the patient; and even more lacking is the extent of the physical exam. Some attention is given to the role of the interpreter however, stating that they serve as a mediator so that the provider has full cultural awareness of the patient's symptoms. Yet, with regard to FGM, women who also engage in this practice and who are not of African descent (i.e. those from Asia and Middle Eastern Islamic countries) are not given the ability, unless forthcoming to reveal that pertinent information in their history. More so, within the context of FGM, the article reveals that providers should seek a Gynecology referral for these patients; to this author, seeking a referral is a "cop out," even if women's health is not one's specialty, educating one's self on this growing epidemic as opposed to "passing it off" is still beneficial to the practitioner.

In accordance with Braddy and Files (2007), clear clinical generalizations in regard to FGM are given. Ideally, she states that identifying this patient population prior to the actual clinic visit is beneficial in many regards. In her work, it appears that she has reviewed two sources, Nour (2004) and Campbell (2004), which are included in this portion of the review to

reveal that identification prior to the patient visit allows both the provider and clinic staff to educate themselves, afford the opportunity to obtain interpreter services and seek a female provider to reduce patient anxiety. During the actual patient encounter, Braddy and Files, like Campbell suggests the use of a FGM worksheet developed in the mid -1900s by Highline Midwifery and Women's Health in Seattle. (See Figure 6). The worksheet unlike the checklist presented by Adams (2004) focuses solely on FGM with regard to age performed, resulting comorbidities and extensive documentation for the pelvic exam. From a provider standpoint, this worksheet, especially the exam portion, may better serve the provider as this tool gives the provider a step-by-step guide as to what should be looked for and documented during the pelvic exam. Braddy and Files in accordance with Nour and Campbell, reveal that the pelvic exam may be difficult and that a pediatric or Hoffman speculum should be used to determine the size to the patient's introitus. Yet, if the speculum cannot be used, then it is suggested that a bimanual examination be performed using one or two fingers in combination with a rectovaginal exam.

Although these newly presented methods are cited in several articles, (Braddy & Files, 2007; Campbell, 2004; Nour, 2004), in neither Campbell nor Braddy and Files, no additional information is given to aid the provider in culturally sensitive and indigenous communication tactics. However, Nour comes to the rescue and reveals to the provider that the term 'mutilated' may be offensive to most FGM patients as they do not consider themselves mutilated (Chalmers & Hashi, 2000; Horowitz & Jackson, 1997). Moreover Nour, further instructs the provider to utilize as much of the patient's terminology and to provide both feedback and evaluation methods to the patient in an attempt to improve future patient experiences. Again, in reference to the actual pelvic exam, Nour, unlike Braddy and Files or Campbell, invites the provider to explain the procedure prior to performing it, showing the patient the actual speculum that will be

used and if the bi-manual exam is implemented, she suggest that only 1 finger be used, that is if the rectovaginal exam failed to reveal results, as that exam is recommended at least by Nour as a first line diagnostic tool. Through these methods, particularly those involving the speculum, Nour reveals that her patients have been grateful having received warnings or rather information of what the exam will entail. More so, Nour also divulges a cultural concern to the provider that may interfere with traditional patient provider interactions. She states that providers should be aware that husbands are curious to gain knowledge in their partners care and more so, it is acceptable for them to make decisions or grant permission regarding health concerns (Horowitz & Jackson). However, Nour, although she presents more explicit instructions and provides some culturally relevant considerations for the provider, it appears in comparison to Campbell and Braddy and Files, she fails to display actual examples of phrases that can be utilized in practice to establish culturally acceptable communication between provider and patient.

Upon further review, Callister (2001) revealed that in order to fully provide culturally competent care to women from diverse racial, ethnic, religious and social groups, one has to tackle four dimensions. These include (1) understanding the dimensions of culture; (2) moving to a holistic approach; (3) seeking to increase knowledge, change attitudes, and hone clinical skills; and (4) building on women's strengths (Callister). Yet, through this 4-step method, the author of this paper believes that Callister fails to give the provider concrete examples, phrases or words that can be utilized in practice. Yet, through Miller's work, Callister does give relevant questions that the provider can use in a critical thinking manner to formulate their own phrases prior to engaging in conversation with this unique patient population. The questions which she includes for the provider to keep in mind are (1) Do her spiritual beliefs have a strong impact on how she defines life experience, health illness, and death?; (2) How meaningful is her faith?; and (3)

What are her sources of strength and coping? (Miller,1995). Callister furthermore introduces the provider to the notion that “the biotechnological environment of women’s health care delivery may be foreign, frightening, and threatening to such women because issues of control and personal boundaries.” With these thoughts, speculation can occur that Callister hopes that the information presented will help the provider establish a roadmap to deliver effective culturally competent care.

Lastly, Daley (2004), like Callister, divulges that women who have undergone FGM may feel anxious and reluctant to share this detail of their life in fear of embarrassment and isolation from Western healthcare providers. Keep in mind that majority of these providers are male and females of Caucasian American, English speaking non-Moslem decent. Nevertheless, care has to be given and Daley presents a tool that can be utilized by providers with regard to FGM in the context of terminology and phrasing, the use of interpreters and finally ways to provide cultural sensitivity and privacy for the patient. (See Figure 7). Unlike the other clinical approaches presented, this is the first one that offers the provider examples of how to approach the issue of FGM. Simply put, in accordance with Daley and the Royal College of Midwives, the provider can ask one of three questions: ‘Have you been closed?’ or ‘Do you have any problems passing urine?’ or alternatively ‘I know that they practice female circumcision in your country, have you been cut or had circumcision performed?’ (Royal College of Midwives, 1998, June). Equally noted by Fuller (2001), she as well poses a question that the provider can use as an initial starting point in collecting an FGM history. Just asking “Are you closed?” as Fuller states is a phrase that is generally understood (Fuller & Lewis, 2001). Furthermore, Horowitz and Jackson (1997) provide the provider with additional questions that aid in discussing the sensitive topic of FGM. (See Table 3). Again focusing on Daley, aside from the initial question, she provides the

provider with general considerations during the actual interview. Here she states that a female interpreter who is not related to the patient should be used in-conjunction with language specific diagrams and pamphlets for non-English speaking patients. Finally, Daley's tool visits cultural sensitivity and privacy. It is in this section that Daley reveals obtaining informed consent, keeping in mind patient modesty and draping during the physical exam, and that only female providers should care for women with FGM. More so, she also addresses the notion that during delivery, birth partners are usually female and lastly the number of people in the delivery room should be at a minimum.

Like the other tools presented by Callister (2001), Campbell (2004), Nour (2004), Braddy and Files (2007) and Horowitz and Jackson (1997), Daley's guide is satisfactory in its existence. On the whole, it provides specific and generalized approaches that can be used in practice. However, the tool fails to explore pelvic exam guidelines. Nevertheless, if this instrument were combined with the other guides that were presented earlier and were together pooled with additional suggestions that will be explored later, the provider would have an all inclusive navigating instrument to be utilized in practice with FGM patients that ultimately would answer the original question proposed to you, the reader in the introduction: as soon as you knock on the door and enter the exam room, what do you do?

Treatment Challenges

As a result of the civil war in the late 1980s, Somalians immigrated to both Europe and the United States in hopes to start a new beginning. With immigration, not only were surroundings different, but these immigrants were inundated with new rules, social customs and ultimately a new way of life. Within the context of their new societies, Somalis had to implement in addition to their own cultural values and practices those of their new societies. With that, one can assume that bias between the different cultures formed. In the context of this literature review, FGM has been presented and this author can only speculate that ever since that cultural practice was introduced a prejudice toward those who participate in this practice may have ensued. Whatever the reader's thoughts regarding this cultural practice, the fact remains that healthcare practitioners are obligated to render care to such patients. Therefore, it will be vital that healthcare practitioners examine various treatment challenges that have developed since Somali immigration. By doing so, the future provider will gain insight and furthermore a sense of cultural awareness that will allow him to not only provide culturally competent care to Somalians as a whole, but more importantly to those who have undergone FGM. Presented below and summarized in Table 4 are 14 treatment challenges addressed in this literature review; eight (8) are patient focused while the other six (6) are practitioner focused.

To begin the exploration of treatment challenges, one article addresses perceptions and actual clinical experiences of African immigrants with Swedish healthcare providers (Berggren, Bergstrom, & Edberg, 2006). Although, this information was not based on experiences in the United States, the information presented can be used by future providers as "stumbling blocks" to avoid when interacting with this patient population. Of the 22 women that were selected for this study, half of them were from Somalia while the other participants originated from other

African countries that also have extremely high rates of FGM procedures. Through the work of Berggren and colleagues, this author found it very interesting that even though FGM caused horrific pain, it was a unifying element for African female communities lost in migration. Although these women loathed the procedure, they found themselves in Sweden missing the female companionship that FGM created. On the whole, the women selected for this study, prior to seeking healthcare in Sweden, thought FGM was practiced everywhere (Berggren et al.). Also, this article recounts the health care experiences that these women endured. Overall, a sense of shame, inferiority, fear and doubt were introduced. Through the excerpts and discussion it was concluded that these women felt providers lacked knowledge in regard to FGM. Additionally, these women felt that once providers knew of their infibulation, they were stereotyped as having no authority in health-related decisions. Now these women are considered minorities with a negative impact on their self-esteem. With that healthcare providers can begin to understand the emotions depicted in circumcised women. Moreover, several women commented on the notion that they felt 'stared at,' which was validated by provider facial expressions that resembled disgust (Berggren et al.). That said, it was not surprising that these women felt 'reluctant' to return to the health center (Berggren et al.).

Documenting European FGM experiences, Thierfelder and colleagues (2005) interviewed both FGM patients and healthcare providers. In all, 29 women, 24 of which were from Somalia and 37 health care providers (17 gynecologists/obstetricians, 3 general practitioners and 17 midwives) were interviewed. From their research efforts, it was concluded that women, like in Berggren et al. (2006) felt stared at and shamed as they were the object of medical interest; "beforehand I was proud[,] but the medical consultation hurt my pride" (Thierfelder et al.). This theme was again highlighted by a participant in the 1997 Horowitz and Jackson U.S. and

Canadian study. There she revealed “Doctors should know we are modest. We don’t want to be touched just so they can see how we are different, and we don’t want to be shown to other doctors.” In the study conducted by Thierfelder and colleagues, women revealed insight into their pelvic exams. Many of the women reported that the provider had difficulties in performing the vaginal exam and furthermore made the procedure painful and prolonged. However, the most striking finding noted in the article revolves around the fact that FGM was not mentioned during the patient/provider consultation and moreover, most of the gynecologists/obstetricians revealed that they did not address the issue even with women they knew immigrated from FGM practicing countries (Thierfelder et al.).

In the United States, a 2002 Minneapolis study involving 14 Somali women revealed equivalent perceptions as those mentioned in the European studies. Herrel et al. (2004), through focus groups, found that Somali women who had a prior Western health-related interaction perceived providers as supportive but discriminating. For example, one woman stated that “if the nursing staff see you are foreign or of a different color, they treat you badly” (Herrel et al.). Also revisited was the concept of being the center of medical interest with the statement “[the nursing staff] let the medical students practice on us” (Herrel et al.). Nevertheless, this source also mentioned language barriers and how because English was not the patient’s native language, their needs were avoided. Supporting documents in this study, another article cited language as the “biggest obstacle” and additionally cited that because of it, Somali women may not be able to adequately express themselves consequently leading to inaccurate treatment or a misdiagnosis (Hashi, 1994).

Although profound, these cited reasons are not substantial enough to be the key obstacle in rendering culturally sensitive care to Somali women. In a study conducted by Carroll, Epstein

and colleagues (2007), 34 Bantu and non-Bantu Somalian women were interviewed in Rochester N.Y., and it was discovered that the concept of seeking medical care was ideal; yet, these women would rather stay at home and only seek care when they were very ill. This is due to the fact that these women embody fear of practitioners, the unknown, and health services in general (Carroll et al.). An excerpt from a 34-year-old Somalian woman gives this newly presented idea the justice that it deserves:

Some [Somali women] are afraid to go [to medical appointments]. They are afraid of what's going to happen. They don't know about health. Some of them know; some don't know. Education is very important for a person to know different things (Carroll, Epstein, Fiscella, Volpe et al., 2007).

Upon further examining the use of health services, Carroll et al. (2007) surveyed the women in regard to preventive services that are synonymous to gynecological visits. When asked what 'Pap test,' 'GYN check-up,' or 'pelvic exam' meant, only 18 participants or rather 53% of the sample population understood their connotations (Carroll, Epstein, Fiscella, Volpe et al., 2007). This finding appears to be limited because those women who did recognize the terminology associated it solely with pregnancy. For example, when the term 'mammography' was tested, only 6 or 18% of the women recognized the term (Carroll, Epstein, Fiscella, Volpe et al.). Upon further research, at least for Bantu Somalis, although the same reasoning can probably be applied to non-Bantu Somalis, poor health seeking behavior seems to be the reasoning behind the unawareness involving preventive medicine (Owens, 2004); remember the major source of healthcare providers within the Somali population are traditional healers. Given this, not only will the future practitioner have to wrestle with their own prejudices, language barriers and

generalized Somali provider perceptions but they will also have to educate against the culturally embedded notion that medical help is sought after only in face of a crisis.

In addition to the challenges presented earlier that ensue once the FGM patient enters the clinical arena, additional challenges emerge surrounding the patient/provider relationship. Through the work of Cameron and Anderson (1998), it was implied that since providers focus solely on the biological co-morbidities of FGM and little understanding of the cultural implications of FGM are taken into consideration, then provider judgment enters the patient/provider relationship and has the potential of negatively impacting the relationship. Moreover, it divulged that the most common reaction to FGM in a Western country is disgust and rejection (Essen & Wilken-Jensen, 2003). Even more compelling, Bosch (2001) discussed that since Western healthcare workers have strong negative feelings toward FGM, coupled with immigrant hesitation in terms of seeking healthcare, combating the future of FGM may be hindered. Yet, from these ideas, one can ascertain that both negative feelings and immigrant hesitation may additionally hinder care that can be provided to those who have presently endured FGM. Furthermore this union of animosity and hesitation may also stagnate future advances in providing culturally competent care to FGM patients.

Although Western biases have only been marginally addressed in this paper, it is important that one examine additional treatment challenges that if not revealed will also negatively impact the patient/provider relationship. There is an overwhelming lack of knowledge by most providers with regard to FGM. For example, in a six month study carried out in London in 2005 that involved 45 healthcare professionals (midwives, obstetric senior house officers, specialist registrars and consultants) it was found that nearly all participants could define FGM and that 80% had experience in examining FGM patients but only 58% could define the four

types of FGM and none of the midwives or house officers could correctly classify the types (Zaidi, Khalil, Roberts, & Browne, 2007). More so, in review of 34 resettled Somali women in Rochester, NY, participant consensus gave rise to the idea that “clinicians providing preventive care...need to have a basic understanding of this practice” (Carroll, Epstein, Fiscella, Gipson et al., 2007).

As previously mentioned most women who undergo FGM do not feel they have been mutilated (Chalmers & Hashi, 2000; Horowitz & Jackson, 1997; Nour, 2004). In fact, according to Somali women who reside in Tower Hamlets, London, the term ‘mutilation’ is stigmatizing and alienating, hence they prefer the term ‘circumcision’ (Cameron & Anderson, 1998). Initially, in the study performed by Berggren et al. (2006), ‘female genital cutting’ was utilized during the interviews; however, because participants used ‘female circumcision,’ that phrase became the new standard to be utilized during the interview sessions. More so, it was discovered that terming the practice as FGM portrayed the practice as absolutely unjustifiable while ‘female genital cutting’ was more neutral, hence leaving the moral value of the practice to be determined (Johnsdotter, 2003). Nonetheless, the practice was first referred as ‘female circumcision’ and later changed to FGM which became accepted terminology by WHO in the late 1970s and by the United Nations in 1991 (Braddy & Files, 2007). Yet, the fact still remains that the word ‘mutilation’ “reinforces the idea that this practice is a violation of girls’ and women’s human rights” (UNICEF, 2005). Therefore, Braddy and Files offer the use of ‘genital cutting,’ as they feel this nonjudgmental terminology offers a less inflammatory connotation. In accordance with UNICEF it was also found that the term ‘mutilation’ may be misconstrued by parents. With the use of FGM, implication to the parents may form. They may feel as though they mutilated their daughters thereby creating opposition in the patient/provider relationship. Still, to offer the

significance of the term ‘mutilation’ and yet to employ nonjudgmental terminology with practicing communities, the phrase ‘female genital mutilation/cutting’ might be of consideration (UNICEF).

Additionally noted in the literature is the concept of time. Generally speaking, a *laissez faire* attitude is adopted in most non-Western societies and hence this may present a challenge for new comers in Western society, as time is considered a crucial element in one’s life. Speaking clinically, in reference to the Rochester, NY study it was revealed that “being rushed through the visit” was a negative experience that was cited by a few participants (Carroll, Epstein, Fiscella, Gipson et al., 2007). Another assessment revealed that these patients “may not be given the time [needed] to describe her illness and as a result, she might be discouraged from seeking treatment until its too late” (Hashi, 1994). Keeping this in mind, this author urges future practitioners to set aside additional time for these patients.

In order to adequately review and present a comprehensive inventory of treatment challenges, one must examine cultural practices that are recognized within both the Somalian culture as well as those found within the Islamic religion. When working with these ethnic individuals, the healthcare provider should be cognizant of the greetings utilized, male and female roles as defined by the Koran, the hejab, prayers and finally the importance of holidays. However, unexplored to this point, the role of male providers in the context with FGM patients and to Muslim women for that matter must be addressed. Already cited, women undergo FGM for many reasons; furthermore we know that traditional healers are mostly men, however, many women are unwilling to be examined by males (Schott & Henley, 1996). In fact Carroll, Epstein et al. (2007) in their study found that “missing an appointment was preferred to many women over being examined by a male clinician.” Also noted in the study was “participants felt that the

importance of the healthcare clinician's gender was unique to Somali culture; they felt that they could communicate more effectively with female clinicians" (Carroll, Epstein, Fiscella, Gipson et al.). Arguably, some may contribute the preference for certain providers as a cultural and religious embedded ideation resulting from role identification as defined by the Koran.

An exhaustive list of challenges for treating circumcised women has been presented to the future healthcare provider in hopes that awareness and insight had been gained. Presenting treatment obstacles was done so that both current and future practitioners will have knowledge into the many necessary considerations that must be taken into account when treating this unique population. According to Cameron and Anderson (1998) "until information about Somali women's health-care needs is collected systematically and directly from the community itself, inappropriate services will continue to be provided." Given this, education is the one unifying feature that the presented obstacles have in common. Therefore, to insure that culturally competent medical care is rendered, education by the provider is paramount.

Discussion, Recommendations, and Limitations for Physician Assistants
and Other Healthcare Providers

Discussion

Throughout this literature review the notion of educating one's self in regard to FGM has been interjected and implied to the healthcare provider to ensure that culturally competent care is rendered. At this point in the review, current practice models will be reevaluated along with an exploration of recommendations in an attempt to ultimately develop an all-inclusive practice model for FGM patients. Presented below and summarized in Table 5 are eight (8) recommendations that help foster and establish rapport with FGM patients.

Prior to the practitioner revealing that he is knowledgeable about FGM and having the patient enter the clinical setting, Powell and colleagues (2004), implore that "not only do professionals need to appreciate why the practice continues, but also the obstacles encountered assessing appropriate health and social care." In an attempt to provide adequate medical care, these authors feel that an integrated and collaborative approach is needed. Also, like many of the authors utilized in this review, Powell and associates feel that there is a generalized lack of knowledge in regard to FGM. However, these authors feel that at least on an academic level, FGM should be included in both medical and para-medical courses. (Powell et al). More so, it was cited in accordance with a meeting on FGM held in Ghent, Belgium, that there should be national guidelines for health care providers (Powell et al.). Additionally, keeping in line with the workshop held in Ghent, Belgium, FGM training through workshops and or peer education should be targeted to those most likely to see these patients, ideally those being: general practitioners, gynecologists and obstetricians, pediatricians, nurses, midwives, psychologists and

cultural mediators (Powell et al.). However, this author would implore that education regarding FGM be embraced by all medical personnel who come in contact with these patients.

Educational efforts have been addressed; attention must be paid to culturally influencing factors when the patient is in the clinical arena. These factors will define the interactions displaced during the patient/provider encounter. At this point, you the reader should recall the original questions proposed in the introduction: when you knock on the door and enter the exam room, what do you do?, will you interact as you would with any other patient?, how will you greet them?, and finally, how will you elicit their health history and furthermore bring up the sensitive topic of FGM?

Relative to cultural sensitivities unique to both Somalis and or Muslims, this author would infer that when entering the exam room, eye contact be made. In addition, if the male partner is present with the female, he should be greeted with a handshake only if the provider is male while a verbal greeting should be given to the female. Per previous discussion, keep in mind that it is acceptable for males to answer for their female partners. Thus, questions should be directed toward both parties or if the female is alone, “discussion with the husband or even other family members” may be necessary as “without this precaution, a Somali woman is likely to default” (Lee, 2007). Understanding the family component, reviewing the Health Insurance Portability and Accountability Act (HIPAA), and the legalities of living wills and durable power of attorney for health care should be reviewed by the practitioner and carefully explained to the patient and family. Even though the focus of this paper revolves around genital exams and assessments, family members may inquire regarding assessment findings.

In the context of FGM, this author implores the use of the initiating questions as presented by the Royal College of Midwives (1998), Fuller (2001) and Horowitz and Jackson

(1997). However, the culturally competent questions that Miller (1995) mentions should also be reflected on when the FGM initiating questions are proposed; thinking of Miller's questions may give the provider an added sincerity when posing the concept of FGM to the patient.

With regard to language barriers, this author, like the authors cited in the text agrees with the use of professional and culturally versed interpreters who are able to translate medical terminology and indigenous language and reveal in a cultural context, the patient's symptoms. However, this author urges the provider not to assume that these services are automatically needed. Instead, when the initial appointment is made, office staff should inquire if these services are needed by the patient.

Recommendations

In the context of the physical exam, Nour's (2004) methods seem just. Per her recommendations, the exam should be explained and tools shown. Additionally, this author feels that provider should keep patient modesty in the forefront while performing the physical exam; remember it is culturally sanctioned that these females be covered at all times. Also, it is worth mentioning "touch" during the physical exam. As the provider would with any patient during the exam, these females in particular should not only be given the details of what will be done during the exam as a whole but also what is about to occur in a step by step process. Not performing this act, may subject the female to psychological warfare and reliving her FGM experience.

Not only does the provider have to be knowledgeable in the patient encounter, but more so be able to engage trust and promote health seeking behavior in these women. Nour (2004) feels that in order to accomplish this, "providers must first address patients' concerns and fears." However, one participant in Carroll's Rochester N.Y. study implies this is not enough. To her "a positive healthcare experience included the practitioner smiling and showing kindness, being

available to talk, showing patience, and demonstrating interest and/or understanding about Somali culture or language” (Carroll, Epstein, Fiscella, Gipson et al., 2007). Keeping this in mind, with perceptions and excerpts presented earlier, healthcare providers must also keep these women from being the center of medical phenomena. Furthermore, patient education is an integral part of the patient/provider encounter as it was explored both by an actual Somali patient and as the key treatment challenge.

In terms of guiding the history and physical exam and furthermore documenting, the use of the tools presented by Daley (2004), Campbell (2004) and Adams (2007) are uniform in accurately covering the initial topics that a provider should address when first encountering an FGM patient. More so, the worksheet presented by Campbell serves as a reference tool for subsequent patient encounters as it outlines key points from her FGM experience that should be addressed at each visit. With this tool in its entirety, the provider has a document dictating all the vital information so that the provider whether new or previously met by the patient does not have to have the patient reveal/relive her experience more than necessary.

In further review of the work performed by Horowitz and Jackson (1997) a list of recommendations and clinical pearls for the healthcare provider were given. (See Table 6 & 7). Some mimic the recommendations for this author while others shed light to tactics unmentioned. Nevertheless, this guide is adequate in its existence and solidifies the implications that FGM adds to the patient/provider relationship.

Limitations

Although these recommendations/thinking points when combined with current practice models are ideal, it is however important to reveal that there are limitations to implicating these practice suggestions; limiting these recommendations are policy, research, documentation and

social justice issues. Without belaboring the topic, in order to fully submit to these suggestions, one may have to overcome generalized attitudes of powerlessness and other preconceptions by providers in regard to FGM. More so, one would have to detect and refute any bias toward the word “immigrant;” as removing the stigma of second class citizens is a crucial element in obtaining/performing a comprehensive health assessment.

Also, the medical world is mostly based on the concept of evidence based medicine. With that, it may be years before these suggestions can be implemented globally, seeing that several trials with in-depth analysis will have to be performed to convince medical providers on the validity behind this proposed practice model. Without attacking cultural practices, this proposed model may be seen as empowering to Muslim women thus leading to family, marital, and religious discourse. Nonetheless, the proposed recommendations as least in the context of this literature review are meant to serve as a guide for both the current and future provider in an attempt to ease anxiety when one has not had previous experience in rendering care to patients who have undergone FGM. Keeping in line with reducing anxiety, the proposed recommendations should also ease patient apprehension when seeking Western medical care. Through the suggestions presented, in combination with a review of current practice models and exploration of FGM treatment obstacles, the provider is fully equipped to tackle the initial question in the introduction: as soon as you knock on the door and enter the exam room, what do you do?

Conclusion

Overall, from this literature review one has been presented with the current state regarding clinical practice guidelines in the context of the questions this author wanted to answer. Remember, this author sought after to find documentation that would support the inexperienced healthcare practitioner's efforts in providing culturally competent care to Somali women who had female genital surgery in the context of initiating the sensitive topic of FGM during the patient encounter and furthermore, providing a physical exam (pelvic exam).

Given the literature, it appears that the provider has several universal questions that can be used to initiate discussion regarding this sensitive topic. However, keep in mind that even though questions are already in existence, the provider must reveal and display a caring demeanor toward the patient; otherwise, information regarding any part of her health history will not be revealed. Through excerpts and patient suggestion, we have seen that provider demeanor, educating one's self as well as providing patient education during the encounter are paramount to ensure a positive Somali healthcare experience. More so, it has also been revealed that having a firm understanding of cultural and religious practices is essential in rendering care to these women.

With regard to the physical exam, ensuring privacy but yet recognizing the importance and inclusiveness of family involvement is paramount to providing culturally sensitive care to Moslem women; plus, being cognizant of patient comfort through draping and procedure explanation are also crucial. Lacking however is a step-by-step procedure for the inexperienced healthcare provider in performing a pelvic exam. Presented although are general documentation guidelines encompassing an FGM patient encounter, insight into the tools utilized during the exam and a worksheet mimicking a checklist approach that lists physical findings that may have

resulted from the genital surgery that the provider should be looking for during the exam. Given this, this writer would still suggest continued research and increasing one's awareness in regard to completing a pelvic exam on patients who have had genital surgery. Yet, with the information provided, this writer feels that a complete pelvic exam could be performed by a provider who lacks experience with these females.

Nonetheless with all that has been presented in combination with the recommendations from this writer, the inexperienced provider mentioned in the introduction should now be able to enter the exam room, greet the patient, elicit the health history and perform a physical exam (pelvic exam) without hesitation; and additionally, if these guidelines are implemented tactfully, then not only will provider apprehension be minimized but that of the patient's will too.

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Tables

Table 1.

Persons Becoming Legal Permanent Residents during Fiscal Years 2003-2006 in Minnesota.

Year	2003	2004	2005	2006
Minnesota's Total Immigrant Population Male & Female from any country	8,406	11,708	15,456	18,254
Minnesota's Total Immigrant Somali Population	786	1,445	2,223	2,844
Percentage of Minnesota's Total Immigrant Population from Somalia	9.350%	12.341%	14.382%	15.580%
Minnesota's Somali Male Immigrant Population	414	741	1,045	1,333
Minnesota's Somali Female Immigrant Population	370	700	1,177	1,511
Minnesota's Somali Unknown Immigrant Population	2	4	1	0

Note. The fourth row of this table was calculated by this writer. From “Profiles on Legal Permanent Residents,” by U.S. Department of Homeland Security, 2007.

Table 2.

Projected State Populations (Minnesota), by Sex, Race, and Hispanic Origin: 1995-2025.

Year	1995	2000	2005	2015	2025
Total White Population	4318	4469	4580	4740	4855
Total White Female Population	2195	2269	2323	2400	2454
Total Black Population	127	158	185	233	279
Total Black Female Population	62	78	92	118	143
Total American Indian, Eskimo, Aleut Population	56	64	71	88	104
Total American Indian, Eskimo, Aleut Female Population	28	32	36	45	53
Total Asian & Pacific Islander Population	106	139	170	221	274
Total Asian & Pacific Islander Female Population	55	72	88	114	141
Total Hispanic Population	73	95	114	150	193
Total Female Hispanic Population	35	46	55	74	96
Total Non-Hispanic White Population	4254	4387	4480	4607	4684
Total Non-Hispanic White Female Population	2164	2229	2274	2334	2369

Note. Numbers are rounded to the nearest thousand and are projected for July 1st of the corresponding year. From “State projections consistent with the 1900 census,” by U.S. Census Bureau, 2004 & 2005.

Table 3.

Sample Questions to ask Circumcised Women.

- Many women from your country have been circumcised or “closed” as children. I ask my patients about this because some women have some questions about this part of their body, and others may have problems from the circumcision. If you do not mind telling me, were you circumcised or closed?
- Do you have any problems passing urine; does it take you a long time to urinate? (Note that women with obstruction may take several minutes to pass urine.)
- Do you have any pain with menstruation? Does your menstrual blood get stuck?
- Do you have any itching or burning from your pelvic area?
- (If sexually active) Do you have any pain or difficulty with having relations?

*If working with interpreters practice this first question with them and elicit feedback on an appropriate way to branch the subject and a culturally appropriate name for circumcision or infibulation.

From “Female ‘Circumcision’: African Women confront American medicine,” by C.

Horowitz and J. Jackson, 1997, *Journal of General Internal Medicine*, 12, p.498. 1997.

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Table 4.

Summarization of Treatment Challenges as Presented in the Literature Review

Patient Focused	Healthcare Provider Focused
Being the Center of Medical Phenomena	Inexperienced in FGM
Patient Emotions	Lacking cultural understanding
Language Barriers	Role of Male Providers
Not Understanding Preventive Health Efforts	Personal beliefs/bias
Being rushed in an office visit	Ignoring FGM during patient encounter
Not Understanding Medical Terminology	Being rushed in an office visit
FGM Terminology Choice: FGM vs. circumcision	Language Barriers
Opinion of Western Healthcare Providers	Inexperience with pelvic exams on FGM patients

Table 5.

Summarization of Practice Guideline Recommendations as Presented in the Literature Review.

Healthcare Provider Focused
Educate oneself in regard to FGM
Gain Insight to Patient's Cultural Practices and Religion Keep in mind the importance and implication of: Same Sex Hand Shaking, additional touch Male Influence in Decision Making Ability Holidays
Utilize a universal question style in the patient encounter
Utilize Professional Interpreters who are not related to the patient
Explain and show tools utilized in the physical exam; ensure proper draping at all times
Establish trust with the patient; display a friendly demeanor; provide patient education
Ensure patient privacy; be cognizant of provider touch
Provide adequate FGM documentation

Table 6.

Recommendations for Working African Communities

- Provide female clinicians and interpreters when possible.
- Work closely with professional medical interpreters; avoid using family members as interpreters.
- Have a brief previsit consultation with an interpreter to summarize issues expected for the encounter, become informed about traditional practices, and elicit suggestions for how to proceed, especially with sensitive issues.
- Encourage interpreters to discuss potentially offensive questions with you before interpreting them to the patient.
- Make confidentiality explicit.
- Develop collaborations between communities and your institution (i.e., invite community groups to educate staff about their culture and encourage students and residents to learn from community groups).
- Understand medical and social aspects of traditional surgery, and become comfortable with your own opinions and emotions before seeing patients.

From “Female ‘Circumcision’: African Women Confront American Medicine,” by C. Horowitz and J. Jackson, 1997, *Journal of General Internal Medicine*, 12, p.497. Reprinted with permission.

Table 7.

Clinical Pearls for Treating Circumcised Women

- Address patient-centered expectations for the medical encounter (do not prioritize circumcision above patient's own needs and concerns).
- Ask about circumcision as part of a reproductive history after establishing rapport with the patients, and explain the necessity of questions about it.
- Women who have complications often do not attribute them to the procedure. Therefore, ask women specifically if they have urinary, menstrual, or gynecologic difficulties, rather than if they have problems due to circumcision.
- Ask general, nonthreatening questions about circumcision so women who choose to may discuss related concerns.
- Assess the patient's knowledge of her reproductive system and inform her about anatomy and function before performing an examination.
- Respect the woman's modesty during the examination.
- As circumcision does not guarantee "chastity," teach women about contraception.
- Inform women they can be defibulated electively for problems, or prior to intercourse or delivery.
- Women with obstructive scar tissue may want to be defibulated prior to first intercourse to avoid traumatic tears on penetration.
- Pregnant women who have obstructive scar tissue should be defibulated before their second stage of labor.

From "Female 'Circumcision': African Women Confront American Medicine," by C. Horowitz and J. Jackson, 1997, *Journal of General Internal Medicine*, 12, p.497. Reprinted with permission.

Figures



Figure 1. A knife used in genital surgery.

From “Australian Islamist Monitor,” unknown, 2008, <http://www.islammonitor.org>, accessed on January 18, 2008. Copyright 2008 by Australian Islamist Monitor. Reprinted with permission.

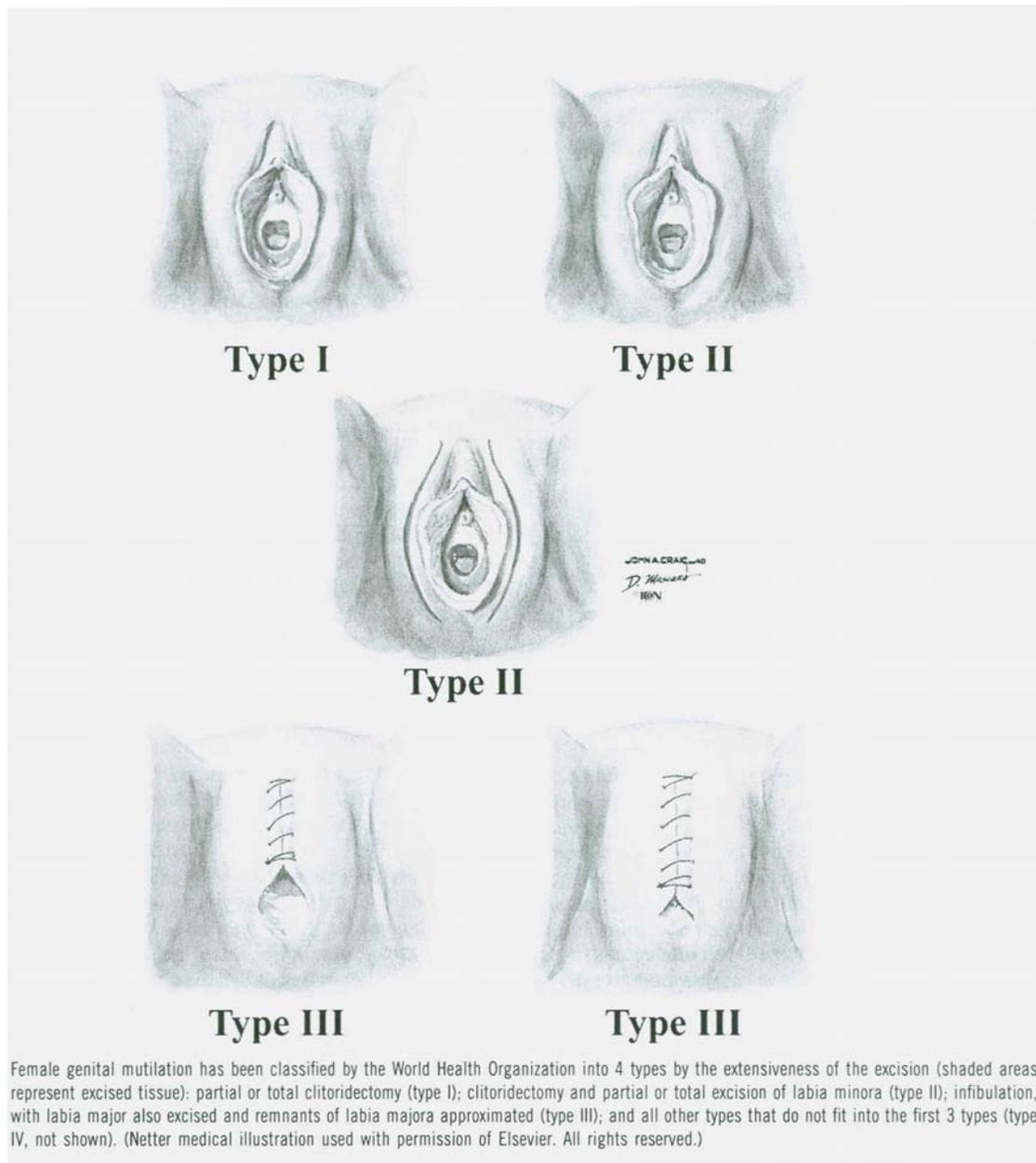


Figure 2. Types of female genital mutilation.

From “Female Genital Mutilation: Cultural Awareness and Clinical Considerations,” by C.

Braddy and J. Files, 2007, *Journal of Midwifery & Women’s Health*, 52, p.159. Copyright 2007

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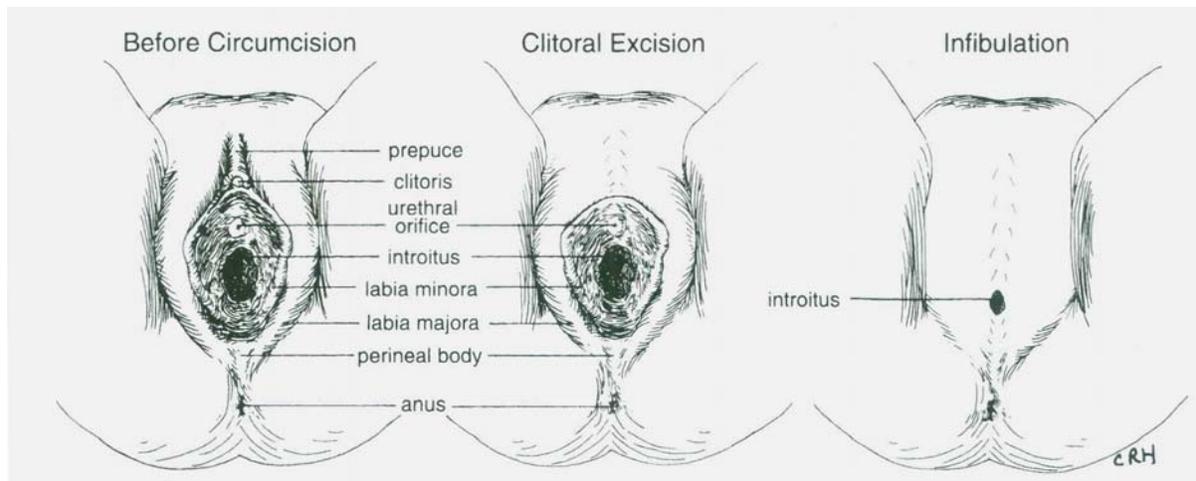


Figure 3. Types of female genital mutilation.

From “Female ‘Circumcision’: African Women Confront American Medicine,” by C. Horowitz and J. Jackson, 1997, *Journal of General Internal Medicine*, 12, p.492. Copyright 1997 by Springer Link. Reprinted with permission.

Box 1: Medical history*	
<p>Life story</p> <ul style="list-style-type: none"> • Pre-flight: <ul style="list-style-type: none"> ○ Country of origin and reason for escape ○ Life and employment before immigration ○ Medical problems or stress in home country • Path to host country: <ul style="list-style-type: none"> ○ Time spent in refugee camps, locations of the camps ○ Physical separation from loved ones ○ Losses of family members or friends and reasons for death 	<p>Sexual history and genital surgery</p> <ul style="list-style-type: none"> • Reproductive history: <ul style="list-style-type: none"> ○ Gravity, parity, outcome of previous childbirths ○ Sexual activity, desire for testing for sexually transmitted infections, contraception or pregnancy • Ritual female genital surgery: <ul style="list-style-type: none"> ○ Ability to have intercourse, dyspareunia ○ Chronic urinary tract infections, pelvic pain, scar abscesses ○ Desire for revision of circumcision (defibulation)
<p>Infectious diseases</p> <ul style="list-style-type: none"> • History of disease or exposure: tuberculosis, malaria, parasites, hepatitis, and sexually transmitted infections • Review of systems: <ul style="list-style-type: none"> ○ Recurrent fevers, night sweats, weight loss ○ Cough, haemoptysis ○ Diarrhoea, visible parasites in stool ○ Jaundice ○ Vaccine status: previous records and history of infections or vaccination 	<p>Trauma history **</p> <ul style="list-style-type: none"> • Deprivation of food, water, or shelter • Being lost, kidnapped, or imprisoned • Enforced isolation • Undergoing torture or serious injury • Being brainwashed • Being raped or sexually molested • Witnessing a murder or violent acts • Feeling close to death • Being in a combat situation
<p>Traditional medicine and substance misuse</p> <ul style="list-style-type: none"> • Use of herbal medicines • Acupuncture, moxibustion, coining, other modalities • Use of substances other than tobacco and alcohol 	<p>*Contents of the box are based on clinical expertise as guided by limited scientific evidence ** Components of the trauma history are adapted from Harvard trauma questionnaire.</p>

Figure 4. Tool utilized in obtaining a refugee's life history.

From "Healthcare Challenges from the Developing World: Post-Immigration Refugee Medicine," by K. Adams, L. Gardiner and N. Assefi, 2004, *BMJ-Clinical Research Edition*, 238, p.1549. Reprinted with permission.

<p>Box 2: Screening *</p> <p>*Screening items are in addition to recommended tests for healthcare maintenance (pap smear, mammogram, cholesterol testing)</p>	
<p>General</p> <ul style="list-style-type: none"> • Complete blood count with differential • Rubella IgG (women of reproductive age) • Hepatitis B and C • Syphilis, gonorrhoea, Chlamydia, and HIV-1 • PPD, chest radiography is > 10mm • Stool ova and parasitic examination (three morning specimens, different days) • Oral examination and dental referral • Vision and hearing screen 	<p>Optional</p> <ul style="list-style-type: none"> • Varicella IgG • HIV-2 (West Africa) • Urinalysis (if concern about schistosomiasis) • Peripheral blood smear (if concern about malaria) • PPD= purified protein derivative as used with Mantoux testing (tuberculosis)

Figure 5. Physical assessment and diagnostic screening tool utilized when rendering medical care to a refugee.

From “Healthcare Challenges from the Developing World: Post-Immigration Refugee Medicine,” by K. Adams, L. Gardiner and N. Assefi, 2004, *BMJ-Clinical Research Edition*, 238, p.1549. Reprinted with permission.

FEMALE CIRCUMCISION WORKSHEET

Patient Name: _____ EDD: _____

Date Completed: _____ Sent to HCH: _____

HISTORY

Age at circumcision: _____ Age now: _____ Country: _____

Painful intercourse? _____

Difficulty urinating? _____ Describe: _____

Hx of bladder infections? _____ Frequency: _____

Prior speculum exam? _____ Previous vaginal deliveries? _____

Episiotomy? _____ What kind? _____ Painful scar? _____

Wishes or concerns for next delivery: _____

DELIVERY ISSUES

Is anterior episiotomy acceptable? _____ Posterior episiotomy? _____

Would she want reapproximation of an anterior episiotomy? _____

Is cesarean section acceptable for fetal distress? _____ FTP/CPD? _____

Additional comments: _____

EXAM

Length of anterior vulvar hood/scar line: _____

Labia minora present? _____ Labia majora fad pad present? _____

Urethra visible? _____ Visible with retraction? _____

Could a urinary catheter be placed? _____ Keloid? _____

Dermal inclusion cyst? _____ Rectovaginal fistula? _____

Diameter of introitus: _____ Number of fingers fitting introitus: _____

Speculum exam difficulty? _____ Cervix visualized? _____

Figure 6. Female circumcision worksheet.

From "Care of Women with Female Circumcision," by C. Campbell, 2004, *Journal of Midwifery & Women's Health*, 49, p.365. Copyright 2004 by Elsevier Inc. Reprinted with permission.

Consideration	Relevance To Practice
Terminology & Phrasing	<ul style="list-style-type: none"> • The woman may not think of FGM as an operation • The word ‘mutilation’ may cause offence • Find out how the woman refers to FGM herself • Rephrase questions, such as: ‘Have you been closed?’ or ‘Do you have any problems passing urine?’ An alternative approach could be: ‘I know that they practice female circumcision in your country, have you been cut or had circumcision performed? (RCM, 1998)
Speaking English & Interpreters	<ul style="list-style-type: none"> • If the woman does not speak English an interpreter should be provided • The interpreter should be female, have good language skills with some knowledge of translation of medical terms and ensure the woman’s confidentiality. • Make sure the woman, not the interpreter, is in control and makes the decisions. • It is preferable if the woman and interpreter do not know each other socially. • The interpreter should not let personal beliefs influence the way she translates. • Relatives and children should be not used as interpreters. • Visual aids and leaflets in the appropriate language will improve communication and give the woman and family a clearer understanding of the health care services and benefits available to them.
Cultural Sensitivity & Privacy	<ul style="list-style-type: none"> • Ideally only female health professionals should care for women with FGM as care by men can be seen as degrading or sexually abusive and may be refused, even, if the woman is dangerously ill. All male health care professionals should be chaperoned. • Birth partners are likely to be female as traditionally men do not attend births. • It is usual for men to make all decisions regarding the care of their wives and they must be included in this process. • Keep the number of people in a delivery room to a minimum. • Do not leave the woman’s legs or vulva exposed or uncovered for longer than necessary. • Always obtain informed consent from the woman for those people present and for the procedures to be performed.

Figure 7. Nursing and midwifery care for women with genital mutilation.

From “Caring for Women who have Undergone Genital Mutilation,” by A. Daley, 2004, *Nursing Times*, 100, p.33. Reprinted with permission.

Appendix

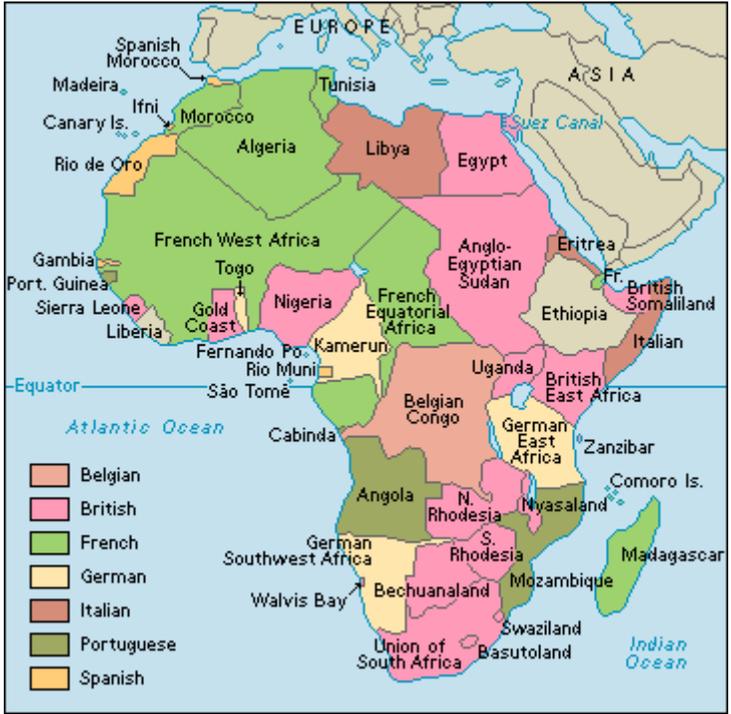


Diagram 1. 1914 African land claims.

From “History of Africa,” by unknown, 2008, <http://history.howstuffworks.com/african-history/history-of-africa.htm>, accessed May 18, 2008.” Copyright by howstuffworks.com.

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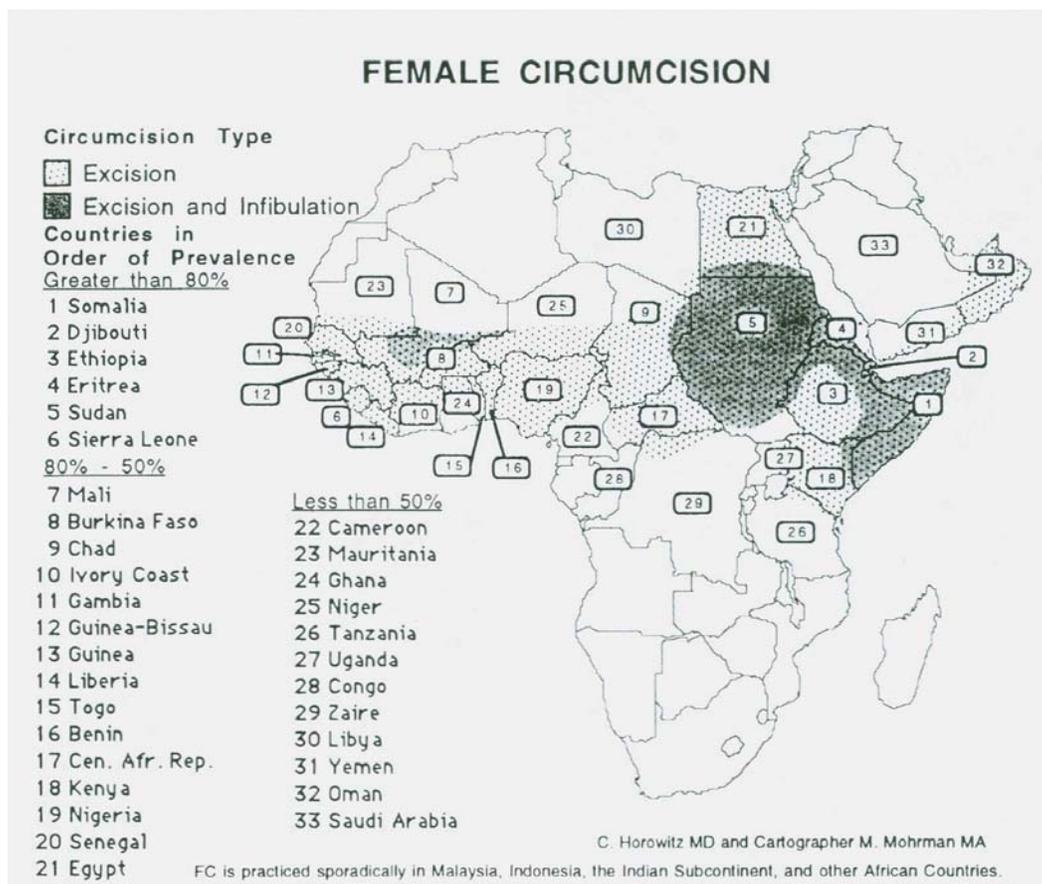


Diagram 2. Estimated prevalence of female circumcision in Africa, by country.

From “Female ‘Circumcision’: African Women Confront American Medicine,” by C. Horowitz and J. Jackson, 1997, *Journal of General Internal Medicine*, 12, p.494. Copyright 1997 by Springer Link. Reprinted with permission.



Diagram 3. A female forcibly held while FGM is performed.

From “Middle-East-Info.org,” unknown, n.d., <http://www.middle-east-info.org/league/somalia/fmgpictures.htm>, accessed on January 18, 2008. Copyright by Middle-East-Info.org. Reprinted with permission.

Abstract

Objective: To determine the current state of the literature with regard to eliciting a culturally sensitive health history and performing a pelvic exam on a female who has had female genital mutilation. *Methods:* Databases searched include: OhioLINK, MEDLINE, Social Work Abstracts, Health Source: Nursing/Academic, Women's Studies International, Pub Med, CINAHL and Social Science Citation Index. Terms utilized include: FGM, female circumcision, culture competence/sensitivity and infibulation. *Results:* Since the Somalian civil war in the late 80s, many women have been displaced to the US. Culturally rooted, FGM among female Somalians is becoming a phenomenon in Western medicine. Literature guides the inexperienced practitioner in eliciting the FGM experience, but falls short in giving explicit instructions for assessment and performing pelvic exams; however, general practice considerations are given. *Conclusion:* FGM will increasingly be seen in Western medicine and continued research by the practitioner is paramount in rendering culturally competent care.