The role of the midwife in supporting women with FGM (female genital mutilation)

ABSTRACT

Aim: The aim of this study is to understand the role of midwives in supporting women with FGM (Female Genital Mutilation).

Background: Around 200 million women presently have undergone some type of cut, change or removal of the outer part of their genitals. FGM causes physical and mental health problems that often affect victims for the rest of their lives. Considering the statistics of the UK, it has been identified that approximately 137,000 girls and women have been affected by FGM in Wales and England. Midwives play a central role in recognising and providing support to the women who have suffered from FGM. Majority of such females meet or interact with health services when they are presented to a midwife.

Method: Systematic review is the methodology used to address the research aim, in which both qualitative and quantitative research evidence has been reviewed. By using appropriate keywords and inclusion and exclusion criteria, pertinent research publications were retrieved from electronic databases. Nine articles were considered to be highly relevant to the research aim and are discussed.

Discussion: The key themes that are drawn from the selected pieces of evidence are; (1) Midwives knowledge, (2) Midwives training, and (3) Women's experiences.

Conclusion: FGM is a global issue and a serious public health concern, while midwives play a central role in recognising and providing support to the women who have suffered from FGM. The knowledge and awareness of midwives is a significant factor with respect to the care provided to the FGM. A midwife should have knowledge about the perpetrators of practice, prevalence rate within the country, legal practices of the country, and FGM centred typology.

TABLE OF CONTENTS

CHAPTER 1: INTRODUCTION

Research Background and Rationale

Female Genital Mutilation (FGM) is a symbol of gender identity in women's body, associated with the mandate of purity, virginity, chastity, and cleanliness (symbolic and physical); a social norm whose fulfilment is necessary to be part of the community (Feldman-Jacobs and Clifton, 2014; Momoh, 2017). In many communities, they constitute a rite of passage to adulthood (from girl to woman), which approves their femininity and permits them to sufficiently fulfil their role as daughter, wife, and mother certifying the honour of the family (WHO, 2018). There are three main types of FGM named as Type I, II, III. In type I, all or part of the clitoris is removed, whereas removal of all or part of clitoris as well as the inner labia, along with labia majora sometimes is referred to as type II FGM. On the contrary, vaginal opening narrowing or tapering through a seal created by repositioning or cutting the labia is termed as type III FGM, as presented in Appendix A (Paliwal et al., 2014; NHS, 2016; WHO, 2018).

Women who suffer from FGM are often mutilated in childhood, in some cases even when they are babies or during adolescence (Goldenstein, 2014). Like other forms of gender violence, Female Genital Mutilations contribute to the maintenance of the power and inequality relationships of men over women in the patriarchal social order. In this case through the control and domination over women’s bodies and their sexuality (Jewkes, Flood, and Lang, 2015; Haylock et al., 2016). FGM is not linked specifically to any religion; it is practised by people of Muslim, Christian, Jewish, animist religion (Andro and Lesclingand, 2017). They are carried out in the name of tradition (the UN considers them Harmful Traditional Practices) (Reig Alcaraz et al., 2014).

The practice of genital mutilation is considered by the communities that practice it as beneficial for women and girls since it is an essential requirement of belonging to the community (Varol et al., 2014). It grants them the status of respectable women and ensures that their body will be healthier that is cleaner, healthier, greater sexual satisfaction for the husband, healthier daughters and sons (Jiménez Ruiz, Almansa Martínez, and Alcón Belchí, 2017; Wahlberg et al., 2017). Even more so, when in

general, women and the community do not relate to the health problems of women and girls derived from female genital mutilation with their practice (Momoh, 2017).

Furthermore, FGM is a procedure in which the tissues of a woman's genital organs are deliberately cut, injured or partially or totally eliminated (Momoh, Olufade, and Redman-Pinard, 2016). According to the World Health Organisation, it can be described as a process that hurts the female genitalia for reasons that are not medical (Baillot et al., 2018). Usually, labia is removed in this procedure. One in 20 women and girls have suffered some form of female genital mutilation (FGM), which is supported by the statistics of the United Nations. It means that 200 million women presently have undergone some type of cut, change or removal of the outer part of their genitals (WHO, 2018; UNICEF, 2018). FGM causes physical and mental health problems that often affect victims for the rest of their lives.

Female genital mutilation or cutting is a practice carried out in 28 countries, most of them African (see Appendix B), endangering the health of millions of girls every year. It has been estimated that three million girls are at the risk of undergoing FGM each year (UNICEF, 2013). From the figure in Appendix B, it can be seen that Egypt has highest number of cases of FGM with 91% cases being recorded there (UNICEF, 2013). It is estimated that FGM is currently practised in Asia, some parts of the Middle East, and Africa (Sauer and Neubauer. 2014), but also in immigrant and refugee communities in Australia, North America, and Europe, as well as among the Embera indigenous community in South America. It has been estimated by the UN that FGM is also practiced in countries other than the Middle East and Africa where it is concentrated (WHO, 2019). Other countries include Latin America and Asia, along with some immigrants residing in Australia, New Zealand, North America, and Europe (Johnsdotter and Essén, 2016). It has been revealed by UNICEF through a report that twenty-four countries in the Middle East and Africa have developed decrees or laws against FGM, but still, FGM is prevalent in these countries (WHO, 2019).

About 168,000 women in the United States (Nour, 2015), more than 96% of women in some African countries (e.g. Somalia) have experienced genital mutilation (Muthumbi et al., 2015). The procedure usually performed during the beginning of adolescence (48,000 in children under 18). Considering the statistics of the UK, it has

been identified that approximately 137,000 girls and women have been affected by FGM in Wales and England (Macfarlane and Dorkenoo, 2015). Around 205 orders of protection have been made since 2015 to protect women and girls from FGM (Ministry of Justice, 2018). In addition to that, approximately more than a hundred girls have been recognised for having treatment or being treated for FGM in England in 2015-16 (Health and Social Care Information Centre, 2017; Macfarlane and Dorkenoo, 2015). Furthermore, in England and Wales, nearly 60,000 girls aged 0-14 were born to women having genital mutilation (Macfarlane and Dorkenoo, 2015).

FGM is a global issue and a serious public health concern. It is interference to one of the most intimate facets of the life of a woman, which is a primary violation of human rights (Abdulcadir, Rodriguez, and Say, 2015; WHO, 2018). In this regard, healthcare practitioners, particularly midwives in the UK and other countries have the responsibility to provide care and support to women who have suffered from FGM as a result of increased migration from regions where it is a cultural tradition (Bick, 2014). Midwives are the practitioners who meet the females for different needs and in distinctive phases during their reproductive age.

Midwives play a central role in recognising and providing support to the women who have suffered from FGM. Majority of such females meet or interact with health services when they are presented to a midwife (Midirs.org, 2015). Hence, it is important that these healthcare professionals have appropriate knowledge and training about the services needed by these women (Abdulcadir et al., 2014). It is one of the responsibilities of midwives to record the cases of FGM in order to ensure the provision of healthcare and support to the women who are affected. In 2015, according to Nursing and Midwifery Council (NMC), the code of nursing stated that it is mandatory for nurses or midwives to report cases of FGM to police (NMC, 2019)

In addition to that, midwives also have to provide counselling related to the negative health consequences to the families who want FGM to be performed on their daughters (Kimani et al., 2018). Considering the statistics of FGM, it can be said that there are numerous cases of FGM in the UK through the practice of FGM is not prevalent in this country. Therefore, healthcare practitioners must have the knowledge

and training to provide support to such women. Hence, this study aims to discuss and explore the role of midwives in providing support to women when have undergone FGM.

Research Significance

Women who have undergone FGM can have long-term complications (Andro, A., Cambois, E. and Lesclingand, M., 2014), which include during childbirth increased risk of HIV transmission, hypersensitivity of the genital area, sexual dysfunction, dyspareunia, damage to the urethra leading to urinary incontinence, keloid scar formation, formation of cysts and abscesses, anaemia, complication during childbirth, and psychological issues as well (Biglu et al., 2016; Reisel and Creighton, 2015). Hence, midwives play a significant role in providing support to these women. For this purpose, they need to have appropriate knowledge and training. This study explores the role of midwives in supporting women who have undergone FGM. Therefore, the outcomes of this study inform the practice and provide recommendations to effectively assist these women.

Aims and Objectives

Research Aim

The aim of this study is to understand the role of midwives in supporting women with FGM (Female Genital Mutilation).

Research Objectives

This systematic review has been conducted to achieve the following objectives;

- To understand the issues related to women with FGM
- To explore the role of midwives while dealing with women having genital mutilation
- To propose recommendations to be included in the practice for ensuring appropriate support and help to females with genital mutilations.

CHAPTER 2: METHODOLOGY

Review Context

The purpose of the systematic review is to recognise, evaluate, and collectively review the results of the research evidence associated with a specific health problem. In systematic reviews, previous researches are reviewed to provide an integrated summary of the outcomes of different researches, which inform the public, conserved health care authorities, and policy-making bodies (Gough, Oliver, and Thomas, 2017; Weed, 2018). With the help of systematic literature review, the gaps present in the existing literature can be identified, which improve the body of knowledge of the research community (Poojary and Bagadia, 2014). In these reviews, a search strategy is an important part as the articles extracted are based on it. In this study, the purpose is to understand the role of midwives in providing support to females with FGM.

Search Strategy

In order to fulfil the aim of the study, previous research evidence addressing the role of the midwife in supporting women with FGM has been searched in a systematic way. With the help of authentic electronic databases, the relevant research articles have been extracted, along with the utilisation of particular keywords and search terms. In this systematic review, the evidence was searched, screened, synthesised, and then analysed to attain the research aim.

Data Sources

With the help of electronic databases, relevant research publications have been extracted. Electronic databases are used due to their easy accessibility and authenticity (Grewal, Kataria, and Dhawan, 2016).Google Scholar, CINAHL, and Medline are used to retrieve pertinent literature. By applying the inclusion and exclusion criteria on the database, research evidence has been extracted. According to Grewal, Kataria, and Dhawan (2016), several electronic databases assist in identification of evidence, which is homologous to the research area. In addition to that, Wild et al. (2016) also

highlighted a strength of database that high-quality databases provides potential information sources to conduct a research at a considerably low cost.

Inclusion and Exclusion Criteria

To extract relevant information, specific criteria have been set in accordance with the research aim. According to Stern, Jordan, and McArthur (2014), the creation of inclusion and exclusion criteria ensure the relevancy of the literature obtained from different databases. In order to narrow down the search results, the following inclusion criteria are used.

- Literature published between the year 2009 and 2019
- Pieces of evidence published in the English language
- Primary research articles
- Include midwives as the target population
- Research publications addressing the role of midwives in supporting women with FGM.

On the contrary, research has been eliminated on the basis of the criteria given below;

- Literature published before the year 2009
- Pieces of evidence published in languages other than English
- Secondary research articles
- Articles that do not include midwives as the target population
- Research publications that did not discuss the role of midwives in supporting women with FGM.

Search Terms

To extract relevant information, specific key terms are used while considering the research aim. Search terms are extracted from the research aim, which ensures the relevancy of the generated publications (Grewal, Kataria, and Dhawan, 2016). The key terms are a significant aspect of search strategy, as provide the base to the research (Faggion et al., 2016). In this study, several search terms were used, to yield pertinent

evidence, including “Female Genital Mutilation”, “female circumcision”, “midwives”, “role”, “aid FGM women”, and “assessed FGM women”, presented in the table below.

Consequently, hundreds of research publications were generated as a result of using these keywords.it is quite difficult and time taking process to sort out relevant evidences. Hence, in addition to the inclusion criteria, a further limitation is applied with the help of Boolean expressions to reduce the number of results. Boolean expressions, for instance, “AND” and “OR” have the tendency to refine the results (Aromataris and Riitano, 2014). Both of these expressions are employed in this search strategy. However, there is a risk of elimination of relevant literature when such strict limiters are used.

Female Genital Mutilation		Midwives		Assessed FGM women
OR	**AND**	**OR**	**AND**	**OR**
Female circumcision		Healthcare practitioners		Aid FGM women

Table 1: Key terms

Search Outcomes

The initial research on the online databases resulted in the retrieval of one hundred and fourteen articles. In this initial phase, duplicate studies were eliminated, and the titles of the research publications were screened in order to eliminate irrelevant articles. Consequently, screening of the abstracts is performed to identify the publication that is in line with the research aim. By screening the abstract, more than half of the articles were eliminated, leaving 39 articles only to be assessed fully. Full-text analysis of the remaining publications was perfumed due to which 9 of the 39 articles were selected to be included in this review. The data collection process has been presented in the PRISMA diagram (Figure 1).

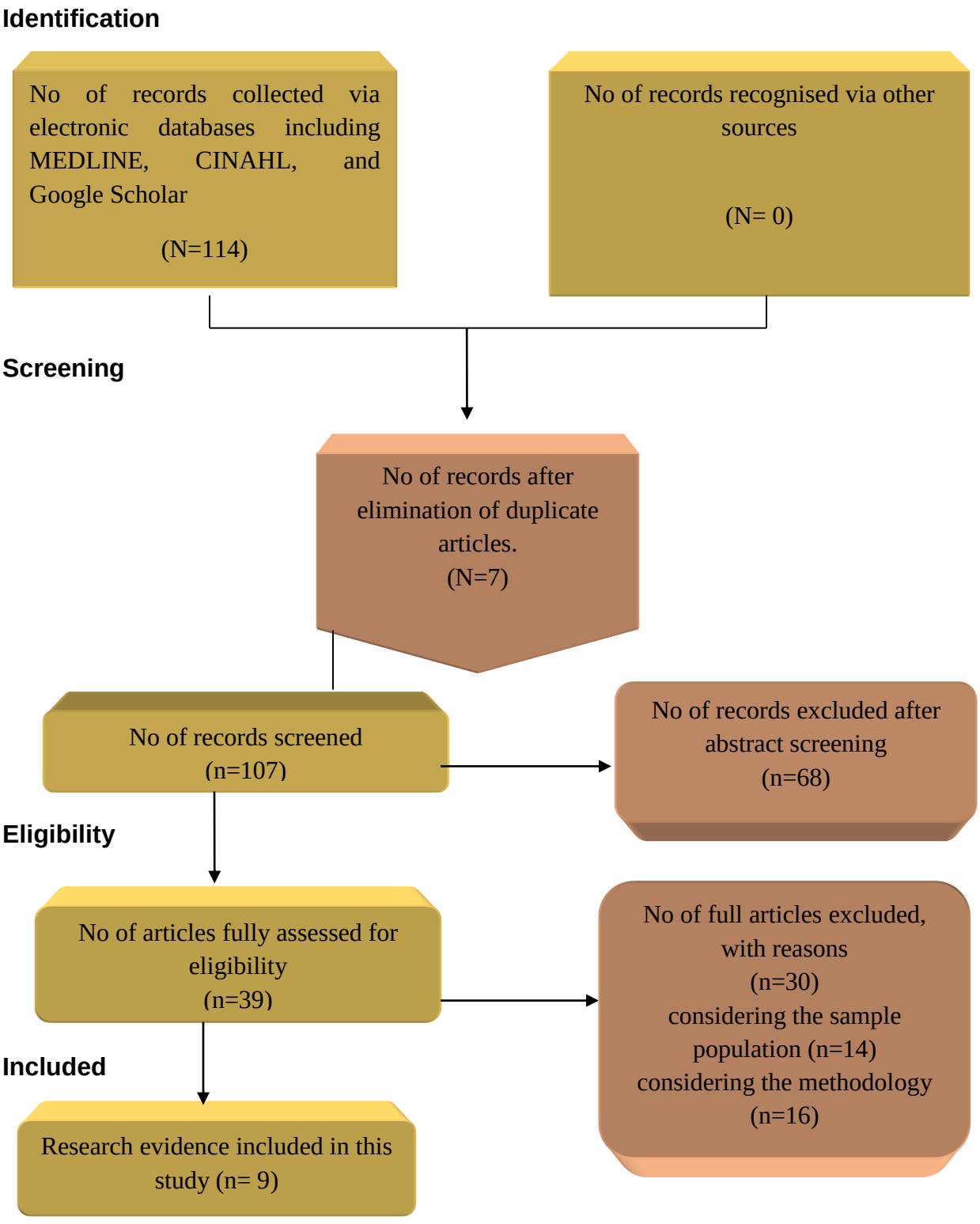

Figure 1: PRISMA diagram explaining the process of search outcomes

Quality Measurement

In the healthcare sector, it is important to ensure that the research evidence provides accurate and unbiased information. Wirth continuous addition in the scientific evidence, the probability of an increase in presenting biased information also increased. Regarding this, Umesh, Karippacheril, and Magazine (2016) suggested that critical appraisal of the evidences assist in recognising the flawed and valuable researches. If false research evidence is utilised to guide clinical decision-making process, then the health outcomes of the patient can be affected in a harmful way.

Therefore, the researches which include pertinent studies must assess the articles in a critical manner understanding the appropriateness of the methodology, sample size and other several factors. The process of quality appraisal evaluates the quality of the selected research evidence with the help of a critical appraisal tool in which certain questions are answered. In this study, the quality appraisal of the selected (N=9) studies were conducted with the help of Caldwell Framework. This framework allows the interpretation of the evidence by means of a specific framework identifying their weaknesses and strength. In addition to that, Caldwell Framework helps in understanding the methodological approach, rationale, research design, sampling, generalisability, and transferability of the publications.

Data Analysis

The articles used in this review were conducted by different research strategies. therefore, the likelihood is high that the researches focused on different aspects of the role of midwives to support women with FGM. Considering this, thematic analysis has been employed to evaluate and discuss the findings of the researches. According to Braun et al. (2019) and Maguire and Delahunt (2017), thematic analysis is a descriptive type of approach in which themes are identified and reported present in the evidence under consideration. The selected evidences have addressed different aspects of the role of midwives in providing support to the female with genital mutilation. After a comprehensive reading of the research evidences, again and again, the themes have been developed and the findings are discussed accordingly.

Ethical Considerations

There are certain ethical protocols that must be followed while conducting a research study (Bell, 2014). While conducting a research, it is important to consider the ethical issues beforehand and take appropriate actions to fulfil the ethical protocols. When human subjects are involved in a research, the first step is to take consent form them to participate in the research (Quinlan et al., 2019). Moreover, their anonymity, privacy and confidentiality will be ensured by the researcher with the help of different strategies, for instance, pseudonyms and passwords. However, this study does not have substantial ethical issues such as confidentiality, anonymity, or privacy as human subjects are not involved. The investigator has to ensure appropriate citation of the evidence used.

CHAPTER 3: LITERATURE REVIEW

Caldwell's Framework

In the field of nursing, a general method of evaluating the research evidences and its methodologies to identify the quality of the evidence is the critical analysis of the research publication (Mill, Allen, and Morrow, 2016). For this purpose, an appropriate framework is used to assess the evidence. Caldwell, Henshaw, and Taylor (2011) developed a framework which is used in this study to critically appraise the selected research articles.

With the help of this critical framework, the primary research publications can be appraised by identifying the weaknesses and strengths of the pieces of evidence, which will aid in judging the overall applicability and quality of the paper. This framework has certain questions, as presented in the Appendix D, which helps in evaluating the quality (Caldwell, Henshaw, and Taylor, 2011). Some of the questions are different for quantitative and qualitative research methodologies due to differences in their design process. Hence, the research papers used in this research are appraised in two different sections.

Appraisal of the Selected Quantitative Papers

A quantitative research conducted by Ali (2012) aimed to evaluate the attitude and knowledge of the midwives related to FGM. In this research, the title of the authors clearly addresses the research aim in addition to the research setting. Furthermore, the abstract of the research provides a comprehensive summary of the paper, presenting the statistical findings also in addition to aim, background, the methodology adopted, and conclusion (Grech, 2017). Considering the research design, the justification and the information regarding the research design has not been mentioned in the research. However, one of the strengths is that random sampling has been performed to reduce the bias in the sampling process.

Random sampling increases the reliability of the results as a random selection of participants from a larger population gives a sample which is representative of the understudied group (Meeker and Escobar, 2014). Another weakness of the study

conducted by Ali (2012) is that pertinent literature has not been reviewed in a separate section; rather a brief background has covered a few related studies. Nevertheless, the rationale of the research has been presented in a clear manner. The discussion comprehensively addresses the findings and relates it to the pertinent literature. However, the conclusion is quite brief and do not give a summary of the findings.

Similar to Ali (2012), Adekanle, Isawumi, and Adeyemi (2011) also described the research aim clearly with the help of the title. The investigators have the expertise to conduct the research as they belong to the department of the obstetrics and gynaecology. This suggests that they have the knowledge and understanding related to FGM and the role of midwives in it. Regarding this, the research aim is to evaluate the experience and knowledge the healthcare practitioners in different facilities where there is a high probability of presentation of patients with FGM.

Furthermore, the abstract provides a summary but did not present the abstract in different headings. Presentation of an abstract in separate headings increases the clarity and understanding of it (Mack, 2018). In the study Adekanle, Isawumi, and Adeyemi (2011), the rationale is clearly mentioned; however, the literature discussed is not comprehensive. Nevertheless, one of the important strength of this evidence is that the study design is presented in detail explaining the research setting. On the other hand, the investigator failed to address the justification of the research methodology adopted.

Adekanle, Isawumi, and Adeyemi (2011) used descriptive cross-sectional research methodology whose advantage is the collection of data related to multiple variables at once, measuring the prevalence of all the factors under consideration (Gilmartin-Thomas, Liew, and Hopper, 2018). In this research design, the sample size should be larger to approximate the prevalence of the issue under consideration with appropriate precision. This condition has been fulfilled by the investigators increasing the precision of the research outcomes. The authors described the conclusion in the discussion section and failed to address the limitations of this research. However, recommendations are provided to inform practice and policy-making governmental organisations (Appendix D).

The investigator of the research conducted by Cappon et al. (2015) have the credentials and the knowledge to perform it, as the investigator belongs to a well-reputed university and relevant departments. Similar to Ali (2012) and Adekanle, Isawumi, and Adeyemi (2011), the aim of this study is to assess the attitude and knowledge of the midwives. However, in contrast, another attribute is included in this research, which is the practice of the Flemish midwives. The research title explains the aim while presenting the research setting. In addition to that, the abstract also systematically and clearly summarise the study. The research aim has been presented in the abstract of the paper; however, the Cappon et al. (2015) failed to explain the research aim in the content of the paper. In contrast to the afore-mentioned researches, this study covers up-to-date and pertinent literature in the introduction section.

Moreover, the literature review is synthesised in a manner, which directs towards the significance and rationale of the study by Cappon et al. (2015). In the methodology section, one of the weakness is the absence of justification and identification of the study design used. However, the explanation of the key variables to be focused in the research has been clearly stated. Cappon et al. (2015) employed an appropriate data collection method along with consideration of the ethical issues. However, ethical considerations were not mentioned clearly. The results are discussed and presented quite effectively in the form of different themes. The variables are presented in a different section with the statistics of the results and tabular information. In addition to that, the discussion section also evaluates the outcomes with the help of thematic analysis contrasting the outcomes with previous findings.

The aim of the research study conducted by Relph et al. (2013) has been stated in the title of the research article, which is an assessment of attitude, training, and training of midwives and related professionals related to FGM. The strengths of this study include clear identification of the research aim, target key variables, identification of the targeted population, reliable and valid data collection and analysis method. However, considering the sample size of 79 midwives from a specific area, the findings of the study cannot be generalised to the entire population in the UK.

On the contrary, there are numerous weaknesses in the study by Relph et al. (2013), which includes lack of comprehensive literature to outline the rationale for the

research, absence of hypothesis, and no explanation or justification was provided related to the design and methodology (Appendix D). Nonetheless, the results were presented clearly in the form of tables and pictures. The authors discuss the results ion a section named as “comment”, in which pertinent literature was not used to support the findings. In the end, limitation and weaknesses of the research were addressed but the conclusion was not presented in this paper.

Similar to Relph et al. (2013), Hess, Weinland, and Saalinger (2010) investigator failed to mention the hypothesis clearly; however, key variables have been identified. The selection of methodology was not discussed but the investigator provides a detailed explanation of the sampling and data collection and analysis method.

Appraisal of the Selected Qualitative Papers

Hess, Weinland, and Saalinger (2010) used both quantitative as well as quantitative research design. The Caldwell Framework presented in the Appendix E addresses both types of questions for this research. Considering the general questions, the title and abstract adequately summarise the research evidence, reflecting the aim and the methodology used. The sample size of this study is quite large which increases the generalisability of the results and reduces bias in the study, as the random sampling has been done.

Hence, the philosophical background to conduct qualitative research has not been demonstrated. However, the collected data has been appropriately analysed with the help of themes. In addition to that, the results are presented clearly with the help of tables for quantitative data and themes for qualitative data. Furthermore, a considerable comprehensive discussion of the findings has been performed, highlighting the research outcomes. Moreover, the authors also address the implication and limitation of the study.

As per the above-appraised researches, the research conducted by Dawson et al. (2015) also has a clear research title directing towards the research aim. The authors mentioned the study setting also in the title of the study. This researcher discusses the previous literature similar to the context of this study in a separate section. Approximately 30 articles were discussed in this section covering the significance of this

study, from which most of the studies were conducted in recent years. This suggests that up-to-date information was discussed highlighting the need for the conduction of this research. There are few weaknesses in this publication which include lack of information related to ethical issues that have been considered, the absence of justification why qualitative research design has been adopted. Other than that, all the aspects have been covered by Dawson et al. (2015). With regard to the research methodology, the sample size was appropriate. In addition, the collected data has been transcribed verbatim, which means that the data collection method was auditable.

In the research Moxey and Jones (2016), though the title clearly described the research aim, it can be considered a bit lengthy. In detail explanation of the sampling strategy was given by the researcher in text form as well as tabular form. In addition to that, the interview findings were also summarised in the form of a table, which increases its readability (Slutsky, 2014). Moxey and Jones (2016) did not discuss the findings of the research in the form of themes, unlike Hess, Weinland, and Saalinger (2010). However, they presented a quite comprehensive discussion supporting their results with pertinent literature and summarising the findings (Höfler et al., 2018), as presented in the Appendix E.

Since audio recording has been utilised by Moxey and Jones (2016) to save the data received from participants, the data analysis is credible and confirmable as NVivo software was used to developed themes from the transcribed recordings. One of the strengths of this study is that the limitations and strengths were identified by Moxey and Jones (2016) in detail, which provides a suggestion to conduct future research more appropriately. The investigators did not conclude the research in a separate section; nonetheless, an ample summary of the outcomes was presented along with recommendations.

Isman et al. (2013) conducted research to demonstrate the experiences of midwives in providing support, care, and counselling to the women who have undergone FGM or experienced problems related to it. It is a qualitative, inductive study, which is mentioned clearly notified by the authors in the abstract and the research context as well. With regard to ethical issues of the respondents, the investigators did notify or address the privacy, anonymity and confidentiality issues (Novak, 2014). Isman

et al. (2013) used pertinent researches that have been published within the last ten years, ensuring the inclusion of new information. The data was analysed with the help of qualitative content analysis, in which the transcriptions were reviewed by team members independently to identify the main points discussed in it.

In order to increase the credibility and trustworthiness of the findings, quotations are presented in each theme to present the narratives of the participants by Isman et al. (2013), similar to Moxey and Jones (2016), Dawson et al. (2015), and Hess, Weinland, and Saalinger (2010). The presentation of the themes in the form of a table and the information of the participants can be considered as a strength of this research. This is because of data presented in tabular is easier to understand and read (Duquia et al., 2014). The authors failed to present the philosophical background of the study. Furthermore, in the discussion section, the outcomes were synthesised thoroughly, but the findings were not supported by research pieces of evidence (Appendix E).

The title of the research conducted by Ogunsiji (2015) addresses the aim of the research. On the contrary, the abstract does not reflect a comprehensive summary of the article. The abstract must be brief but covers important aspects fop as study such as aim, background, methodological approaches and findings (Jha, 2014). Moreover, another weakness of this research is the absence of a rationale to conduct the research. On the other hand, the literature review was presented in a comprehensive manner, including both past and present studies. NVivo is used to develop themes and analyse the data, which means that the information discussed can be considered as credible. Conclusion and recommendations have been provided in a separate section, ensuring a broad review of the findings of the research.

CHAPTER 4: DISCUSSION

The primary findings of the selected research articles are discussed in this section. Based on the findings of these publications, the chosen pieces of evidence have been evaluated by means of thematic analysis. Given the role of midwives in supporting women with FGM, there are numerous perceptions or aspects discussed in the selected articles that are drawn in three different themes presented below. The summary table of the selected papers is presented in Appendix C.

Theme 1: Midwives Knowledge

The knowledge and awareness of midwives is a significant factor with respect to the care provided to the FGM. According to Moxey and Jones (2016), the improved relationship among the midwives and patient could produce positive outcomes. Most of the Somali women shared their experience indicated that treatment by an experienced and knowledged midwife increases the satisfaction level of the patient. A midwife should have knowledge about the perpetrators of practice, prevalence rate within the country, legal practices of the country, and FGM centred typology. For instance, in South Wales FGM is strictly illegal for girls. Therefore, should know this and must not provide any illegal service to any patent.

The study of Dawson et al. (2015) explained that a midwife must develop her knowledge about the FGM associated health issues such as dysmenorrhea, urinary tract infections (UTIs), incontinence, wound infections, and obstetric complications. Following the aforementioned scenario, the Moxey and Jones (2016) study demonstrate that for the preventive role of midwives, a midwife should have effective communication skills and techniques, knowledge for general practices, FGM legal status, and clinical management tactics. The same study also considers effective knowledge with respect to FGM as the primary midwife competency. Additionally, another study by Hess, Weinland, and Saalinger (2010), emphasis on midwives and healthcare professionals to develop their cultural and region based knowledge so that they could better deal with the culture-sensitive patient and provide them adequate cultural sensitive care.

The study of Cappon et al. (2015) suggested that midwife under the age of 30 or young midwives usually have effective knowledge and skills. A satisfactory explanation

is that these midwives are freshly graduated from their university and have learnt about FGM in details. Another significant reason is that FGM is increasingly discussed among midwives throughout their educational era. Although Ogunsiji (2015) and Dawson et al. (2015) indicated that midwives often do not have effective knowledge about the types of FGM. In the research by Ali (2012), the number of participant midwives are not well-aware about all four types of FGM and they need to ask for FGM classification (Appendix C).

The study of Cappon et al. (2015) highlighted that midwives play a significant role in counselling. However, a midwife could only do effective and successful counselling, if she has significant knowledge about consequences, legal and ethical issues, typology, and rights of the patients about FGM. Relph et al. (2013) stated that the knowledge and practice of healthcare professionals and midwife are primarily based on their experience level and associated country. For instance, in contrast to UK healthcare professionals, African healthcare professionals are quite confident about their FGM diagnosis because FGM is quite prevalent in the continent of Africa.

In contrast to the aforementioned studies, the research of Moxey and Jones (2016) suggest that lacking FGM associated understanding and knowledge of midwives leads to trust issues in English healthcare system and undermine the confidence of midwives as well. A midwife with lack of knowledge exacerbate the inadequacy feelings of affected women and they feel hesitate in discussing about their FGM associated issue. Additionally, this study also emphasis on midwife on the development of effective FGM associated knowledge to serve quality antenatal care. This is because the mismanagement of midwives in dealing with pregnant women could lead to patient dissatisfaction, barriers in future services, and most significant labour and birth issues. In this respective, Hess, Weinland, and Saalinger (2010) claimed that lack of healthcare worker’s knowledge increases the number of unnecessary caesarean.

The study of Ogunsiji (2015), the midwives claimed various reasons lacking appropriate knowledge such as they did not receive the right education in their educational years. Moreover, midwives claimed that they were not exposed to FGM before in their practices, or they did not receive any information through books or services in a professional career. The study participants also revealed that the

educational workshops arranged for midwives raining are quite far distant to their working and residential areas and the workshops are not provided on a continuous basis. Therefore, the study of Ogunsiji (2015) stated to address this issue the working laces of midwives must provide appropriate education and training sessions with continuity with the accessibility of informative booklets and brochures associated with FGM care and practices.

Theme 2: Midwives Training

To overcome the FGM associated issue of lack of knowledge, communication, and similar other as discussed is the aforementioned section, midwives appropriate training is quite essential and need of healthcare. According to Dawson et al. (2015), the training of the midwives should include effective knowledge with appropriate understanding about FGM so midwives could better classify the types of FGM and record data within the database accurately. Moreover, their training must increase their knowledge about FGM prevalence globally. Ogunsiji (2015) argued that there was limited consideration put FGM in the pieces of training of midwives, which causes lack of midwives' knowledge about FGM. The outcomes of Cappon et al. (2015) suggest that the education of FGM must be increasing discussed in the education of the midwives, especially young midwives so they could better serve their services for the improvement of FGM care.

Isman et al. (2013) claimed that communication-based training of midwives is an effective way to increase the FGM patient's satisfaction. Improved communication improves the counselling session with progressed care quality (Appendix C). Another study of Cappon et al. (2015) also recommends that the provision of communication tools will better prevent FGM through midwives' empowerment. Moreover, other training tools are also quite effective in improving the care quality for FGM affected women. Additionally, Cappon et al. (2015) also suggested to arrange campaigns for improved FGM associated training of midwives. These campaigns based on significant cases, common issues, cultural variations, and possible concerns of FGM associated patients. These campaigns would help midwives in improving their knowledge and practical working which leads to improved quality of care.

The research of Dawson et al. (2015) highlighted various ways of improving midwives awareness and training for FGM patients. These approaches include taking special training about the patient's history with respective care suggestions, gaining knowledge and training through assisting senior midwives in care provision to FGM patients, and development of a unique care plan. In addition, Isman et al. (2013) observed that most of the midwives scared of counselling and do not feel themselves eligible for counselling. Therefore, this study commend that women counselling and caregiving training for FGM patients should be provided to each midwife, including both experienced and non-experienced. These training would boost up the counselling confidence of midwives and they could themselves ask for more training wherever they needed.

There is a number of service and training are arranged for midwives but there is still a need for increased training for better outcomes and increased patient's satisfaction. Therefore, the findings of Dawson et al. (2015) emphasis on the routine in-service training sessions for the women communities that have increased the prevalence of FGM. Though gynaecologists and obstetrics handled the long-term complications of FGM; however, some patients feel uncomfortable with the male specialist. Therefore, the study of Adekanle, Isawumi, and Adeyemi (2011) requested to promote education and practices of FGC services specifically female circumcision only for specified midwives. With respect to Dawson et al. (2015), a midwife must also maintain appropriate knowledge about the policy and protocols for FGM associated women, which lacks in the midwives of the most Australian healthcare organisation.

Apart from the ongoing practices and training, there is still a need to increase the education and pieces of training of midwives, which requires advanced health curriculum and health promotional training and campaigns (Ogunsiji, 2015). This is because the prevalence of FGM women is increasing every day and it could only be controlled from active and quality healthcare services. The midwives had developed improved concepts about labour, delivery, and antenatal care in their pre-service education. Therefore, Dawson et al. (2015) suggest that the graduate or post-graduate pre-service education of midwives is quite effective in providing care for the new immigrant mothers. Similarly, if midwives attain knowledge about FGM patients, attend

training sessions appropriately, and practice in a safer and open environment, they would serve quality care to FGM patients with reduced complications.

The training needs of midwives will be fulfilled through setting advanced guidelines focusing on the needs of patients (Cappon et al., 2015). Furthermore, Dawson et al. (2015) prefer in-service training as it promotes cultural safety and reduces the FGM women anxiety level, which eventually ease and give confidence to midwives in providing their services. In contrast to Dawson et al. (2015), Moxey and Jones (2016) focus on the feelings of midwives emotion and suggest that the training sessions and campaigns will be arranged, whenever midwives feel the need of training (Appendix C).

Theme 3: Women's Experiences

The articles discussed throughout this study reveals the personal experience of various FGM women. In the selected articles for this paper, the women displayed their different knowledge level and midwifery care experience about FGM. However, it does not discuss in enough details. Research of Moxey and Jones (2016) highlighted that most of the women with FGM have strong beliefs about midwifery care. Moreover, this study indicated that few women are well-aware about the legal and ethical parameters of the FMG. Ogunsiji (2015) demonstrate in their research study that the experience of women. The women had gone through the FMG and after then she was feeling ashamed as she developed different genitalia.

The experience and statements of these women explained that the common cause of FMG associated with the cultures of these patients. In most of the cultures, FMG considered as the major constituent of women's sexuality and the women are considered ready for the marriage. Dawson et al. (2015) indicated that most of the women were feeling unsatisfied and embarrassed when are treated by the male service provider (Appendix C). This leads to the cultural issue for the affected women and the satisfaction level of the women also affected. The study of Hess, Weinland, and Saalinger (2010) recommends that most of the Muslim and Christians women do not undergo FGM; however, few who lacks knowledge about their religion undergo FMG.

Although FMG is not ethically right, in different countries, its prevalence is increased due to the cultural and religious belief of people.

The outcomes of Moxey and Jones (2016) shed some light on further experiences of FGM women. These women experienced psychological issues such as being worried or embarrassment. Moreover, women also experienced physiological issues as well as difficulty in sexual intercourse. These women also experienced painful menstruation with difficulty. Dawson et al. (2015) discussed in their research article the initial examination experience of an African woman, while she gives birth. The women were surprised to know that the attending midwife is not experienced and do not have sufficient management skills. In this case, the clinician deals the FMG sensitively; however, the women were not satisfied and felt it inappropriate.

CHAPTER 5: RECOMMENDATION AND CONCLUSION

Recommendations

European countries are increasingly affected by FGM practice due to the presence of the immigrant communities from countries where FGM is a traditional practice. Indeed, trying to maintain their traditions associated with the origin country to reinforce their cultural identity, many immigrants practice FGM in other countries. Aware of the need to take measures to counteract the evolution of this practice and eradicate it, several European States have passed particular laws (the United Kingdom, Sweden, and Norway) or have altered their regulations (Spain, Denmark, Belgium, and Austria) to categorise FGM as a crime. Female genital mutilation or cutting is a practice carried out in 28 countries, most of them African, endangering the health of millions of girls every year. It is a deeply rooted and difficult to combat tradition. Some of the recommendations to reduce the prevalence of FGM and to improve practice on the basis of the findings are discussed.

It has been identified that it is important to give sessions and workshops aimed at local health professionals so that they know the physical and psychological consequences that ablation has on these girls and women. The consequences that ablation has on girls range from abdominal pain, infections, problems during delivery to the risk of dying from bleeding. It is difficult to convince families that these health problems in women are related to the removal of part of the genitals suffered during childhood or adolescence, so the training of health professionals to inform families is essential. Moreover, it is necessary that all paramedical and midwifery personnel as well as general public in the country are warned of the harm caused by female genital mutilation.

Additionally, the formation and sensitisation of mothers is a fundamental point in fight against ablation, since most of the time they are unaware of the physical and psychological consequences of ablation. Mothers consider that their daughters must go through this ritual because it is good and necessary for them based on a series of prejudices that keep this tradition rooted. It is the responsibility of midwives and other healthcare processionals to educate these mothers and young women to destroy these

false myths, show them the alternatives that exist and help them to take the complicated step of refusing to be practiced ablation**.** The support to families and women who have not decided not to undergo ablation is a key element that also serves as an example for other women. From the findings, it can also be recommended that midwives require training, education and support from supervisors to develop and enhance their knowledge, confidence, and skills to provide care to women who have undergone FGM (Dawson et al., 2015).

In addition, midwives must have a deeper knowledge and understanding to provide counselling to the families. Apart from counselling from healthcare practitioners, it has been recommended that awareness campaigns must be created, and information can be disseminated in different ways such as use of media, door-to-door teaching to reach housewives, and reaching girls through school to inform them about the negative consequences of FGM. These campaigns can aid in changing the perception of such communities and families about the myths linked to FGM and the health implications (Okofo, 2017; Isman et al., 2013).

Conclusion

In conclusion, it can be said that the knowledge and awareness of midwives is a significant factor with respect to the care provided to the FGM. A midwife should have knowledge about the perpetrators of practice, prevalence rate within the country, legal practices of the country, and FGM centred typology. For the preventive role of midwives, a midwife should have effective communication skills and techniques, knowledge for general practices, FGM legal status, and clinical management tactics. Furthermore, lacking FGM associated understanding and knowledge of midwives leads to trust issues in English healthcare system and undermine the confidence of midwives as well. To overcome the FGM associated issue of lack of knowledge, communication, and similar other midwives appropriate training is quite essential and need of healthcare.

The training of the midwives should include effective knowledge with appropriate understanding about FGM so midwives could better classify the types of FGM and record data within the database accurately. It is suggested to arrange campaigns for

improved FGM associated training of midwives which improves the care quality for FGM affected women. It has been identified that most of the midwives scared of counselling and do not feel themselves eligible for counselling. Therefore, women counselling and caregiving training for FGM patients should be provided to each midwife, including both experienced and non-experienced.

From the perspective of women who have undergone FGM, the common cause of FMG has been found to be associated with the cultures of these patients. In most of the cultures, FMG is considered as a major constituent of women's sexuality and the women are considered ready for the marriage after this procedure. FGM is a global issue and a serious public health concern, while midwives play a central role in recognising and providing support to the women who have suffered from FGM.

REFERENCES

Abdulcadir, J., Dugerdil, A., Boulvain, M., Yaron, M., Margairaz, C., Irion, O. and Petignat, P., 2014. Missed opportunities for diagnosis of female genital mutilation. *International Journal of Gynecology & Obstetrics*, *125*(3), pp.256-260.

Abdulcadir, J., Rodriguez, M.I. and Say, L., 2015. A systematic review of the evidence on clitoral reconstruction after female genital mutilation/cutting. *International Journal of Gynecology & Obstetrics*, *129*(2), pp.93-97.

Adekanle, A.D., Isawumi, A.I. and Adeyemi, A.S., 2011. Health Workers' Knowledge of and Experience with Female Genital Cutting in Southwestern, Nigeria. *Sierra Leone Journal of Biomedical Research*, *3*(2), pp.84-88.

Ali, A.A.A., 2012. Knowledge and attitudes of female genital mutilation among midwives in Eastern Sudan. *Reproductive health*, *9*(1), p.23.

Andro, A. and Lesclingand, M., 2017. Female genital mutilation around the world. *Population & Societies*, (543), p.1.

Andro, A., Cambois, E. and Lesclingand, M., 2014. Long-term consequences of female genital mutilation in a European context: Self-perceived health of FGM women compared to non-FGM women. *Social science & medicine*, *106*, pp.177-184.

Aromataris, E. and Riitano, D., 2014. Constructing a search strategy and searching for evidence. *Am J Nurs*, *114*(5), pp.49-56.

Baillot, H., Murray, N., Connelly, E. and Howard, N., 2018. Addressing female genital mutilation in Europe: a scoping review of approaches to participation, prevention, protection, and provision of services. *International journal for equity in health*, *17*(1), p.21.

Bell, J., 2014. *Doing Your Research Project: A guide for first-time researchers*. McGraw-Hill Education (UK).

Bick, D., 2014. Female genital mutilation: The abuse has to stop. *Midwifery*, *30*(3), pp.277-278.

Biglu, M.H., Farnam, A., Abotalebi, P., Biglu, S. and Ghavami, M., 2016. Effect of female genital mutilation/cutting on sexual functions. *Sexual & Reproductive Healthcare*, *10*, pp.3-8.

Braun, V., Clarke, V., Hayfield, N. and Terry, G., 2019. Thematic analysis. *Handbook of Research Methods in Health Social Sciences*, pp.843-860.

Cappon, S., L'Ecluse, C., Clays, E., Tency, I. and Leye, E., 2015. Female genital mutilation: knowledge, attitude and practices of Flemish midwives. *Midwifery*, *31*(3), pp.e29-e35.

Dawson, A.J., Turkmani, S., Varol, N., Nanayakkara, S., Sullivan, E. and Homer, C.S.E., 2015. Midwives' experiences of caring for women with female genital mutilation: insights and ways forward for practice in Australia. *Women and Birth*, *28*(3), pp.207-214.

Duquia, R.P., Bastos, J.L., Bonamigo, R.R., González-Chica, D.A. and Martínez-Mesa, J., 2014. Presenting data in tables and charts. *Anais brasileiros de dermatologia*, *89*(2), pp.280-285.

End FGM, 2015. *What is FGM.* [online] Available at: http://www.endfgm.eu/female-genital-mutilation/what-is-fgm/ [Accessed 11 Apr. 2019].

Faggion Jr, C.M., Wu, Y.C., Tu, Y.K. and Wasiak, J., 2016. Quality of search strategies reported in systematic reviews published in stereotactic radiosurgery. *The British journal of radiology*, *89*(1062), p.20150878.

Feldman-Jacobs, C. and Clifton, D., 2014. Female genital mutilation/cutting: data and trends. Update 2014.

Gilmartin-Thomas, J.F., Liew, D. and Hopper, I., 2018. Observational studies and their utility for practice. *Australian Prescriber*, *41*(3), p.82.

Goldenstein, R.A., 2014. Female genital cutting: Nursing implications. *Journal of Transcultural Nursing*, *25*(1), pp.95-101.

Gough, D., Oliver, S. and Thomas, J. eds., 2017. *An introduction to systematic reviews*. Sage.

Grech, V., 2017. WASP–Write a Scientific Paper course: why and how. *Journal of visual communication in medicine*, *40*(3), pp.130-134.

Grewal, A., Kataria, H. and Dhawan, I., 2016. Literature search for research planning and identification of research problem. *Indian journal of anaesthesia*, *60*(9), p.635.

Haylock, L., Cornelius, R., Malunga, A. and Mbandazayo, K., 2016. Shifting negative social norms rooted in unequal gender and power relationships to prevent violence against women and girls. *Gender & Development*, *24*(2), pp.231-244.

Health and Social Care Information Centre, 2017. *Female genital mutilation (FGM) enhanced dataset: April 2016 to March 2017, England, experimental statistics.* [online] Available at: https://files.digital.nhs.uk/publication/g/c/fgm-apr-2016-mar-2017-exp-rep.pdf [Accessed 5 Apr. 2019].

Hess, R.F., Weinland, J. and Saalinger, N.M., 2010. Knowledge of female genital cutting and experience with women who are circumcised: a survey of nurse-midwives in the United States. *Journal of midwifery & women's health*, *55*(1), pp.46-54.

Isman, E., Mahmoud Warsame, A., Johansson, A., Fried, S. and Berggren, V., 2013. Midwives' experiences in providing care and counselling to women with female genital mutilation (fgm) related problems. *Obstetrics and gynecology international*, *2013*.

Jewkes, R., Flood, M. and Lang, J., 2015. From work with men and boys to changes of social norms and reduction of inequities in gender relations: a conceptual shift in prevention of violence against women and girls. *The Lancet*, *385*(9977), pp.1580-1589.

Jha, K.N., 2014. How to write articles that get published. *Journal of clinical and diagnostic research: JCDR*, *8*(9), p.XG01.

Jiménez Ruiz, I., Almansa Martínez, P. and Alcón Belchí, C., 2017. Dismantling the man-made myths upholding female genital mutilation. *Health care for women international*, *38*(5), pp.478-491.

Johnsdotter, S. and Essén, B., 2016. Cultural change after migration: circumcision of girls in Western migrant communities. *Best Practice & Research Clinical Obstetrics & Gynaecology*, *32*, pp.15-25.

Kimani, S., Esho, T., Kimani, V., Muniu, S., Kamau, J., Kigondu, C., Karanja, J. and Guyo, J., 2018. Female Genital Mutilation/Cutting: Innovative Training Approach for Nurse-Midwives in High Prevalent Settings. *Obstetrics and gynecology international*, *2018*.

Macfarlane, A.J. and Dorkenoo, E., 2015. *Prevalence of female genital mutilation in England and Wales: National and local estimates*. City University London in association with Equality Now.

Mack, C.A., 2018, January. How to write a good scientific paper. SPIE.

Maguire, M. and Delahunt, B., 2017. Doing a thematic analysis: A practical, step-by-step guide for learning and teaching scholars. *AISHE-J: The All Ireland Journal of Teaching and Learning in Higher Education*, *9*(3).

Meeker, W.Q. and Escobar, L.A., 2014. *Statistical methods for reliability data*. John Wiley & Sons.

Midirs.org, 2015. *FGM guidance introduced for midwives.* [online] Available at: https://www.midirs.org/news-guidance-for-midwives-fgm/ [Accessed 5 Apr. 2019].

Mill, J.E., Allen, M.N. and Morrow, R.A., 2016. Critical theory: Critical methodology to disciplinary foundations in nursing. *Canadian Journal of Nursing Research Archive*, *33*(2).

Ministry of Justice, 2018. *Family court statistics quarterly, England and Wales: annual 2017 including October to December 2017*. [online] Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/695363/family-court-stats-oct-dec-2017.pdf [Accessed 5 Apr. 2019].

Momoh, C., 2017. Female genital mutilation. In *The Social Context of Birth* (pp. 143-158). Routledge.

Momoh, C., Olufade, O. and Redman-Pinard, P., 2016. What nurses need to know about female genital mutilation. *British Journal of Nursing*, *25*(9), pp.S30-S34.

Moxey, J.M. and Jones, L.L., 2016. A qualitative study exploring how Somali women exposed to female genital mutilation experience and perceive antenatal and intrapartum care in England. *BMJ open*, *6*(1), p.e009846.

Muthumbi, J., Svanemyr, J., Scolaro, E., Temmerman, M. and Say, L., 2015. Female genital mutilation: a literature review of the current status of legislation and policies in 27 African countries and Yemen. *African journal of reproductive health*, *19*(3), pp.32-40.

NHS, 2016. *Female genital mutilation (FGM).* [online] Available at: https://www.nhs.uk/conditions/female-genital-mutilation-fgm/ [Accessed 11 Apr. 2019].

NMC, 2015. *Nurses and midwives will have to report cases of FGM.* [online] Available at: https://www.nmc.org.uk/news/news-and-updates/nurses-and-midwives-will-have-to-report-cases-of-fgm/ [Accessed 11 Apr. 2019].

NMC, 2019. *Additional information on female genital mutilation cases New duty in force from 31 October 2015.* [online] Available at: https://www.nmc.org.uk/standards/code/female-genital-mutilation-cases/ [Accessed 11 Apr. 2019].

Nour, N.M., 2015, January. Female genital cutting: impact on women's health. In *Seminars in reproductive medicine* (Vol. 33, No. 01, pp. 041-046). Thieme Medical Publishers.

Novak, A., 2014. Anonymity, confidentiality, privacy, and identity: The ties that bind and break in communication research. *Review of communication*, *14*(1), pp.36-48.

Ogunsiji, O., 2015. Female genital mutilation (FGM): Australian midwives' knowledge and attitudes. *Health care for women international*, *36*(11), pp.1179-1193.

Okofo, L.K., 2017. *The influence of media campaign in the eradication of female genital mutilation practice in selected communities of South-South Nigeria* (Doctoral dissertation).

Paliwal, P., Ali, S., Bradshaw, S., Hughes, A. and Jolly, K., 2014. Management of type III female genital mutilation in Birmingham, UK: a retrospective audit. *Midwifery*, *30*(3), pp.282-288.

Poojary, S.A. and Bagadia, J.D., 2014. Reviewing literature for research: Doing it the right way. *Indian Journal of Sexually Transmitted Diseases and AIDS*, *35*(2), p.85.

Quinlan, C., Babin, B., Carr, J. and Griffin, M., 2019. *Business research methods*. South Western Cengage.

Reig Alcaraz, M., Siles González, J. and Solano Ruiz, C., 2014. Attitudes towards female genital mutilation: an integrative review. *International nursing review*, *61*(1), pp.25-34.

Reisel, D. and Creighton, S.M., 2015. Long term health consequences of Female Genital Mutilation (FGM). *Maturitas*, *80*(1), pp.48-51.

Relph, S., Inamdar, R., Singh, H. and Yoong, W., 2013. Female genital mutilation/cutting: knowledge, attitude and training of health professionals in inner city London. *European Journal of Obstetrics & Gynecology and Reproductive Biology*, *168*(2), pp.195-198.

Sauer, P.J. and Neubauer, D., 2014. Female genital mutilation: a hidden epidemic (statement from the European Academy of Paediatrics). *European journal of pediatrics*, *173*(2), pp.237-238.

Slutsky, D. (2014). The Use of Tables. *Journal of Wrist Surgery*, *3*(4), pp.219-219.

Stern, C., Jordan, Z. and McArthur, A., 2014. Developing the review question and inclusion criteria. *AJN The American Journal of Nursing*, *114*(4), pp.53-56.

Umesh, G., Karippacheril, J.G., and Magazine, R., 2016. Critical appraisal of the published literature. Indian journal of anaesthesia, 60(9), p.670.

UNICEF, 2013*. Female Genital Mutilation/Cutting: A statistical overview and exploration of the dynamics of change*. [online] Available at: https://www.unicef.org/cbsc/files/UNICEF_FGM_report_July_2013_Hi_res.pdf [Accessed 11 Apr. 2019].

UNICEF, 2016. UNICEF'S Data Work On FGM/C. [online] Available at: https://www.unicef.org/media/files/FGMC_2016_brochure_final_UNICEF_SPREAD.pdf [Accessed 11 Apr. 2019].

United Nations International Children's Emergency Fund [UNICEF], 2018. *Female genital mutilation*. [online] Available at: https://data.unicef.org/topic/child-protection/female-genital-mutilation/ [Accessed 5 Apr. 2019].

Varol, N., Fraser, I.S., Ng, C.H., Jaldesa, G. and Hall, J., 2014. Female genital mutilation/cutting–towards abandonment of a harmful cultural practice. *Australian and New Zealand Journal of Obstetrics and Gynaecology*, *54*(5), pp.400-405.

Wahlberg, A., Johnsdotter, S., Selling, K.E., Källestål, C. and Essén, B., 2017. Factors associated with the support of pricking (female genital cutting type IV) among Somali immigrants–a cross-sectional study in Sweden. *Reproductive health*, *14*(1), p.92.

Weed, D.L., 2018. The need for systematic reviews in oncology. *JNCI: Journal of the National Cancer Institute*, *110*(8), pp.812-814.

WHO, 2018. *Female genital mutilation.* [online] Available at: https://www.who.int/news-room/fact-sheets/detail/female-genital-mutilation [Accessed 11 Apr. 2019].

Wild, S., Fischbacher, C., McKnight, J. and Scottish Diabetes Research Network Epidemiology Group, 2016. Using Large Diabetes Databases for Research. *Journal of diabetes science and technology*, *10*(5), pp.1073-1078.

World Health Organisation [WHO], 2019. *Female genital mutilation (FGM).* [online] Available at: https://www.who.int/reproductivehealth/topics/fgm/prevalence/en/ [Accessed 5 Apr. 2019].

APPENDICES

Appendix A: Types of FGM

Figure 1: Types of FGM (End FGM, 2015)

Appendix B: Prevalence of FMG

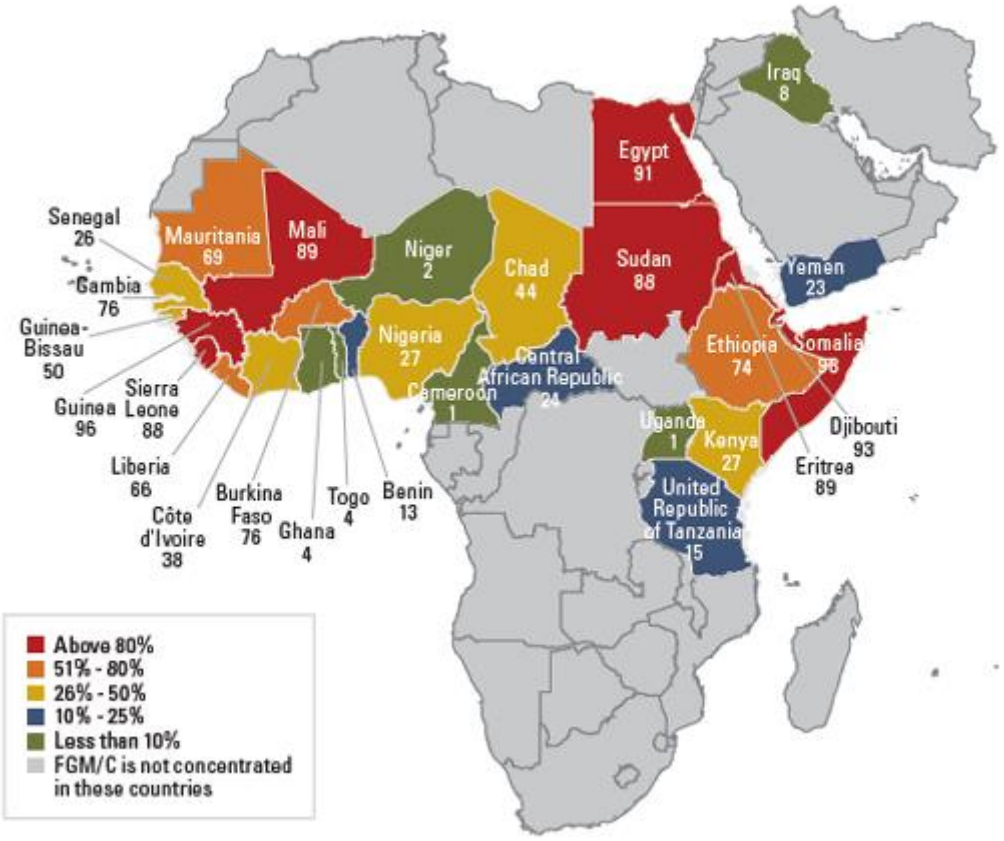

Figure 2: Prevalence of FGM in Africa (UNICEF, 2013)

Appendix C: Summary of the Articles

Author, Date	Ogunsiji (2015)
Title	Female genital mutilation (FGM): Australian midwives' knowledge and attitudes
Location	Australia
Aims	The aim of this article is to provide insight into the knowledge and attitude of Australian midwives toward FMG.
Methodology/Design	qualitative study
Sample size	11
Participant characteristics	Participants with sickle cell status
Outcomes/finding	The outcome of the study suggested that midwives often do not have effective knowledge about the types of FGM. Moreover, midwives claimed that they were not exposed to FGM before in their practices, or they did not receive any information through books or services in a professional career.

Author, Date	Isman et al. (2013)
Title	Midwives' experiences in providing care and counselling to women with female genital mutilation (fgm) related problems
Location	Somaliland
Aims	The aim of this study was to elucidate midwives experiences in providing care and counselling to women with FGM related problems
Methodology/Design	qualitative, inductive study
Sample size	8
Participant characteristics	midwives living in Somaliland

Outcomes/finding	The outcomes of the study revealed that communication-based training of midwives is an effective way to increase the FGM patient's satisfaction. Improved communication improves the counselling session with progressed care quality.

Author, Date	Moxey and Jones (2016)
Title	A qualitative study exploring how Somali women exposed to female genital mutilation experience and perceive antenatal and intrapartum care in England
Location	England
Aims	The aim of this study therefore was to explore how Somali women exposed to FGM, experience and perceive antenatal and intrapartum care in England
Methodology/Design	descriptive, exploratory qualitative study
Sample size	10
Participant characteristics	Convenience and snowball sample of Somali women residing in Birmingham
Outcomes/finding	The outcome of the research highlighted the improved relationship among the midwives and patient could produce positive outcomes. Most of the women with FGM have strong beliefs about midwifery care.

Author, Date	Dawson et al. (2015)
Title	Midwives' experiences of caring for women with female genital mutilation: insights and ways forward for practice in Australia
Location	Australia
Aims	To provide insight into midwives' views of, and

	experiences working with, women affected by FGM
Methodology/Design	descriptive-interpretive qualitative research
Sample size	48
Participant characteristics	focus group discussions with midwives
Outcomes/finding	The findings emphasised that a midwife must develop her knowledge about the FGM associated health issues such as dysmenorrhea, urinary tract infections (UTIs), incontinence, wound infections, and obstetric complications. Most of the women were feeling unsatisfied and embarrassed when are treated by the male service provider.

Author, Date	Hess, Weinland, and Saalinger (2010)
Title	Knowledge of female genital cutting and experience with women who are circumcised: a survey of nurse-midwives in the United States
Location	United States
Aims	The purpose of this study was to assess certified nurse-midwives' (CNMs') knowledge of FGC and to explore their experiences caring for African immigrant women with a history of genital cutting
Methodology/Design	survey design with qualitative and quantitative descriptions
Sample size	600
Participant characteristics	certified nurse-midwives (CNMs) from the member list of the American College of Nurse-Midwives
Outcomes/finding	Midwives and healthcare professionals must develop their cultural and region based knowledge so that they could better deal with the culture-sensitive patient and provide them adequate cultural sensitive

	care.

Author, Date	Ali (2012)
Title	Knowledge and attitudes of female genital mutilation among midwives in Eastern Sudan
Location	Eastern Sudan
Aims	The aim of this research is to assess knowledge and attitudes of the midwives towards FGM in Eastern Sudan
Methodology/Design	Quantitative
Sample size	154
Participant characteristics	midwives
Outcomes/finding	Midwives are not well-aware about all four types of FGM and they need to ask for FGM classification.

Author, Date	Adekanle, Isawumi, and Adeyemi (2011)
Title	Health Workers' Knowledge of and Experience with Female Genital Cutting in Southwestern, Nigeria
Location	Southwestern, Nigeria
Aims	The aim of this study is to assess the experience and the knowledge of the health workers practicing in our environment on Female genital cutting (FGC)
Methodology/Design	descriptive cross-sectional study, using structured questionnaires
Sample size	250
Participant characteristics	consenting health workers available in tertiary health facility, secondary health facility and convenient sample for private health facilities.
Outcomes/finding	There is a need for promotion of education and practices of FGC services specifically female

	circumcision only for specified midwives.

Author, Date	Cappon et al. (2015)
Title	Female genital mutilation: knowledge, attitude and practices of Flemish midwives
Location	Flemish region of Belgium
Aims	The objective of this study was to assess the knowledge, attitude and practices of Flemish midwives regarding female genital mutilation (FGM)
Methodology/Design	a quantitative design
Sample size	820
Participant characteristics	Midwives actively working in labour wards, maternity wards and maternal intensive care units (MIC)
Outcomes/finding	The findings revealed that midwife under the age of 30 or young midwives usually have effective knowledge and skills as they are freshly graduated from their university and have learnt about FGM in details. The education of FGM must be increasing discussed in the education of the midwives, especially young midwives so they could better serve their services for the improvement of FGM care.

Author, Date	Relph et al. (2013)
Title	Female genital mutilation/cutting: knowledge, attitude and training of health professionals in inner city London
Location	London, England
Aims	To assess the knowledge, attitude and training on female genital mutilation/cutting (FGM/C) amongst medical and midwifery professionals working in an

	area of high prevalence of the condition
Methodology/Design	Prospective observational study using a questionnaire
Sample size	79
Participant characteristics	Health care professionals working in North East London boroughs
Outcomes/finding	Knowledge and practice of healthcare professionals and midwife are primarily based on their experience level and associated country.

Appendix D: Appraisal of the Selected Qualitative Papers

Ogunsiji, O., 2015. Female genital mutilation (FGM): Australian midwives' knowledge and attitudes. *Health care for women international*, *36*(11), pp.1179-1193.

Questions	Yes	No	Can't Tell
Does the title reflect the content?	✓		
Are the authors credible?	✓		
Does the abstract summarize the key components?		✓	
Is the rationale for undertaking the research clearly outlined?		✓	
Is the literature review comprehensive and up-to-date?	✓		
Is the aim of the research clearly stated?	✓		
Are all ethical issues identified and addressed?	✓		
Is the methodology identified and justified?		✓	
Are the philosophical background and study design identified and the rationale for choice evident?			✓
Are the major concepts identified?	✓		
Is the context of the study outlined?			✓
Is the selection of participants described and sampling method identified?	✓		
Is the method of data collection auditable?	✓		
Is the method of data analysis credible and confirmable?	✓		
Are the results presented in a way that is appropriate and clear?	✓		
Is the discussion comprehensive?	✓		

Is the conclusion comprehensive?	✓		

Isman, E., Mahmoud Warsame, A., Johansson, A., Fried, S. and Berggren, V., 2013. Midwives' experiences in providing care and counselling to women with female genital mutilation (fgm) related problems. *Obstetrics and gynecology international*, *2013*.

Questions	**Yes**	**No**	**Can't Tell**
Does the title reflect the content?	✓		
Are the authors credible?	✓		
Does the abstract summarize the key components?	✓		
Is the rationale for undertaking the research clearly outlined?	✓		
Is the literature review comprehensive and up-to-date?	✓		
Is the aim of the research clearly stated?	✓		
Are all ethical issues identified and addressed?		✓	
Is the methodology identified and justified?	✓		
Are the philosophical background and study design identified and the rationale for choice evident?		✓	
Are the major concepts identified?	✓		
Is the context of the study outlined?			✓
Is the selection of participants described and sampling method identified?	✓		
Is the method of data collection auditable?	✓		
Is the method of data analysis credible and confirmable?	✓		
Are the results presented in a way that is appropriate and clear?	✓		

Is the discussion comprehensive?		✓	
Is the conclusion comprehensive?	✓		

Moxey, J.M. and Jones, L.L., 2016. A qualitative study exploring how Somali women exposed to female genital mutilation experience and perceive antenatal and intrapartum care in England. *BMJ open*, *6*(1), p.e009846.

Questions	**Yes**	**No**	**Can't Tell**
Does the title reflect the content?	✓		
Are the authors credible?	✓		
Does the abstract summarize the key components?	✓		
Is the rationale for undertaking the research clearly outlined?	✓		
Is the literature review comprehensive and up-to-date?	✓		
Is the aim of the research clearly stated?	✓		
Are all ethical issues identified and addressed?	✓		
Is the methodology identified and justified?	✓		
Are the philosophical background and study design identified and the rationale for choice evident?	✓		
Are the major concepts identified?			✓
Is the context of the study outlined?			✓
Is the selection of participants described and sampling method identified?	✓		
Is the method of data collection auditable?	✓		
Is the method of data analysis credible and confirmable?	✓		

Are the results presented in a way that is appropriate and clear?	✓		
Is the discussion comprehensive?	✓		
Is the conclusion comprehensive?	✓		

Dawson, A.J., Turkmani, S., Varol, N., Nanayakkara, S., Sullivan, E. and Homer, C.S.E., 2015. Midwives' experiences of caring for women with female genital mutilation: insights and ways forward for practice in Australia. *Women and Birth*, *28*(3), pp.207-214.

Questions	**Yes**	**No**	**Can't Tell**
Does the title reflect the content?	✓		
Are the authors credible?	✓		
Does the abstract summarize the key components?	✓		
Is the rationale for undertaking the research clearly outlined?	✓		
Is the literature review comprehensive and up-to-date?	✓		
Is the aim of the research clearly stated?	✓		
Are all ethical issues identified and addressed?		✓	
Is the methodology identified and justified?		✓	
Are the philosophical background and study design identified and the rationale for choice evident?	✓		
Are the major concepts identified?	✓		
Is the context of the study outlined?	✓		
Is the selection of participants described and sampling method identified?	✓		

Is the method of data collection auditable?	✓		
Is the method of data analysis credible and confirmable?	✓		
Are the results presented in a way that is appropriate and clear?	✓		
Is the discussion comprehensive?	✓		
Is the conclusion comprehensive?	✓		

Hess, R.F., Weinland, J. and Saalinger, N.M., 2010. Knowledge of female genital cutting and experience with women who are circumcised: a survey of nurse-midwives in the United States. *Journal of midwifery & women's health*, *55*(1), pp.46-54.

Questions	**Yes**	**No**	**Can't Tell**
Does the title reflect the content?	✓		
Are the authors credible?	✓		
Does the abstract summarize the key components?	✓		
Is the rationale for undertaking the research clearly outlined?	✓		
Is the literature review comprehensive and up-to-date?	✓		
Is the aim of the research clearly stated?	✓		
Are all ethical issues identified and addressed?	✓		
Is the methodology identified and justified?	✓		
Are the philosophical background and study design identified and the rationale for choice evident?		✓	
Are the major concepts identified?	✓		
Is the context of the study outlined?	✓		

Is the selection of participants described and sampling method identified?	✓		
Is the method of data collection auditable?	✓		
Is the method of data analysis credible and confirmable?	✓		
Are the results presented in a way that is appropriate and clear?	✓		
Is the discussion comprehensive?	✓		
Is the conclusion comprehensive?	✓		

Appendix E: Appraisal of the Selected Quantitative Papers

Hess, R.F., Weinland, J. and Saalinger, N.M., 2010. Knowledge of female genital cutting and experience with women who are circumcised: a survey of nurse-midwives in the United States. *Journal of midwifery & women's health*, *55*(1), pp.46-54.

Questions	Yes	No	Can't Tell
Does the title reflect the content?	✓		
Are the authors credible?	✓		
Does the abstract summarize the key components?	✓		
Is the rationale for undertaking the research clearly outlined?	✓		
Is the literature review comprehensive and up-to-date?	✓		
Is the aim of the research clearly stated?	✓		
Are all ethical issues identified and addressed?	✓		
Is the methodology identified and justified?	✓		
Is the design clearly identified and a rationale provided?	✓		
Is there an experimental hypothesis clearly stated and are the key variable identified?	✓		
Is the population identified?	✓		
Is the sample adequately described and reflective of the population?	✓		
Is the method of data collection valid and reliable?	✓		
Is the method of data analysis valid and reliable?	✓		
Are the results presented in a way that is appropriate and clear?	✓		

Is the discussion comprehensive?	✓		
Is the conclusion comprehensive?	✓		

Ali, A.A.A., 2012. Knowledge and attitudes of female genital mutilation among midwives in Eastern Sudan. *Reproductive health*, *9*(1), p.23.

Questions	**Yes**	**No**	**Can't Tell**
Does the title reflect the content?	✓		
Are the authors credible?	✓		
Does the abstract summarize the key components?	✓		
Is the rationale for undertaking the research clearly outlined?	✓		
Is the literature review comprehensive and up-to-date?		✓	
Is the aim of the research clearly stated?	✓		
Are all ethical issues identified and addressed?	✓		
Is the methodology identified and justified?		✓	
Is the design clearly identified and a rationale provided?		✓	
Is there an experimental hypothesis clearly stated and are the key variable identified?	✓		
Is the population identified?	✓		
Is the sample adequately described and reflective of the population?	✓		
Is the method of data collection valid and reliable?	✓		
Is the method of data analysis valid and reliable?	✓		
Are the results presented in a way that is appropriate	✓		

and clear?			
Is the discussion comprehensive?	✓		
Is the conclusion comprehensive?		✓	

Adekanle, A.D., Isawumi, A.I. and Adeyemi, A.S., 2011. Health Workers' Knowledge of and Experience with Female Genital Cutting in Southwestern, Nigeria. *Sierra Leone Journal of Biomedical Research*, *3*(2), pp.84-88.

Questions	**Yes**	**No**	**Can't Tell**
Does the title reflect the content?	✓		
Are the authors credible?	✓		
Does the abstract summarize the key components?	✓		
Is the rationale for undertaking the research clearly outlined?	✓		
Is the literature review comprehensive and up-to-date?		✓	
Is the aim of the research clearly stated?	✓		
Are all ethical issues identified and addressed?	✓		
Is the methodology identified and justified?		✓	
Is the design clearly identified and a rationale provided?		✓	
Is there an experimental hypothesis clearly stated and are the key variable identified?		✓	
Is the population identified?	✓		
Is the sample adequately described and reflective of the population?	✓		
Is the method of data collection valid and reliable?	✓		

Is the method of data analysis valid and reliable?	✓		
Are the results presented in a way that is appropriate and clear?	✓		
Is the discussion comprehensive?	✓		
Is the conclusion comprehensive?	✓		

Cappon, S., L'Ecluse, C., Clays, E., Tency, I. and Leye, E., 2015. Female genital mutilation: knowledge, attitude and practices of Flemish midwives. *Midwifery*, *31*(3), pp.e29-e35.

Questions	**Yes**	**No**	**Can't Tell**
Does the title reflect the content?	✓		
Are the authors credible?	✓		
Does the abstract summarize the key components?	✓		
Is the rationale for undertaking the research clearly outlined?	✓		
Is the literature review comprehensive and up-to-date?	✓		
Is the aim of the research clearly stated?		✓	
Are all ethical issues identified and addressed?		✓	
Is the methodology identified and justified?		✓	
Is the design clearly identified and a rationale provided?		✓	
Is there an experimental hypothesis clearly stated and are the key variable identified?	✓		
Is the population identified?	✓		
Is the sample adequately described and reflective of the population?	✓		

Is the method of data collection valid and reliable?	✓		
Is the method of data analysis valid and reliable?	✓		
Are the results presented in a way that is appropriate and clear?	✓		
Is the discussion comprehensive?	✓		
Is the conclusion comprehensive?	✓		

Relph, S., Inamdar, R., Singh, H. and Yoong, W., 2013. Female genital mutilation/cutting: knowledge, attitude and training of health professionals in inner city London. *European Journal of Obstetrics & Gynecology and Reproductive Biology*, *168*(2), pp.195-198.

Questions	**Yes**	**No**	**Can't Tell**
Does the title reflect the content?	✓		
Are the authors credible?	✓		
Does the abstract summarize the key components?	✓		
Is the rationale for undertaking the research clearly outlined?		✓	
Is the literature review comprehensive and up-to-date?		✓	
Is the aim of the research clearly stated?	✓		
Are all ethical issues identified and addressed?		✓	
Is the methodology identified and justified?		✓	
Is the design clearly identified and a rationale provided?		✓	
Is there an experimental hypothesis clearly stated and are the key variable identified?	✓		
Is the population identified?	✓		

Is the sample adequately described and reflective of the population?		✓	
Is the method of data collection valid and reliable?	✓		
Is the method of data analysis valid and reliable?	✓		
Are the results presented in a way that is appropriate and clear?	✓		
Is the discussion comprehensive?		✓	
Is the conclusion comprehensive?		✓	