Facing the Issue of Cultural Sensitivity with Female Patients who have Undergone Circumcision: A Survey of Nursing Students’ Knowledge and Perceptions Concerning the Practice of Circumcision

Sarah Ahmann
Carroll College, Helena, MT

Follow this and additional works at: https://scholars.carroll.edu/nursing_theses
Part of the Nursing Commons

Recommended Citation
Ahmann, Sarah, "Facing the Issue of Cultural Sensitivity with Female Patients who have Undergone Circumcision: A Survey of Nursing Students’ Knowledge and Perceptions Concerning the Practice of Circumcision" (2004). Nursing Undergraduate Theses. 56. https://scholars.carroll.edu/nursing_theses/56

This Thesis is brought to you for free and open access by the Nursing at Carroll Scholars. It has been accepted for inclusion in Nursing Undergraduate Theses by an authorized administrator of Carroll Scholars. For more information, please contact tkratz@carroll.edu.
Facing the Issue of Cultural Sensitivity with Female Patients who have Undergone Circumcision: A Survey of Nursing Students’ Knowledge and Perceptions Concerning the Practice of Circumcision

by

Sarah A. Ahmann

Presented to

Office of the Vice-President for Academic Affairs

In partial fulfillment of the requirements of

NU 499: Senior Honors Thesis

Carroll College

Department of Nursing

April 5, 2004
This thesis for honors recognition has been approved for the
Department of Nursing.

Director: Jocie Waldron
Department of Nursing

Date: 4/5/2004

Reader: Joni Walton
Department of Nursing

Date: 4-5-2004

Reader: Murphy Fox
Department of Sociology

Date: 4-5-2004
Table of Contents

Abstract ................................................................. p. 4
Introduction ............................................................... p. 5
Background ................................................................. p. 7

Population Involved .................................................. p. 7
Types of FC .............................................................. p. 7
Culture and Custom ................................................... p. 8
Health Problems Related to FC ................................. p. 9

Social and Ethical Implications .................................. p. 11
Review of Literature .................................................. p. 13

Health Complications Resulting from Female Circumcision p. 13
Cultural Perceptions of Female Circumcision .................. p. 15
Culturally Sensitive Nursing Care ............................... p. 19
Importance of Transcultural Education ........................ p. 21

Methodology ............................................................. p. 24

Design ................................................................. p. 24
Participants ............................................................. p. 24
Instrument .............................................................. p. 25
Procedure .............................................................. p. 25

Results ................................................................. p. 27
Discussion ............................................................. p. 30

Nursing Implications ................................................ p. 30

Limitations ............................................................ p. 32
Abstract

With an influx of refugees coming to the United States, the need to be culturally sensitive has become increasingly important. Health care workers are now being exposed to what was once a relatively unknown issue in the Western world: the controversial practice of female circumcision. The aim of this research was two-fold: to determine the degree of knowledge nursing students have concerning female circumcision, and to ascertain if participating in an educational seminar on the practice of female circumcision might have an effect on how nursing students care for patients who have been circumcised. Data was collected from 25 nursing students who were enrolled in an upper-level nursing course. Seventy-six percent of the students had little or no knowledge of the practice. Data from this study may be considered for future curriculum development.
In the summer of 2002 I journeyed to West Africa with a group of six female students and a professor of chemistry. We spent two and a half weeks soaking in as much of the native culture as possible. Along the way we were introduced to an old comrade of the professor, a former Peace Corp volunteer still living in Togo, West Africa. She shared many of her experiences with our group of what it was like for her being a volunteer in a small rural Muslim village. This woman never imagined that she would be placed in a village where female circumcision was practiced. Most of us had little knowledge of the subject, and most felt sickened by the thought of men doing such an abominable act to women.

What the Peace Corp volunteer went on to say surprised us. She told of a conversation she had with her host father about female circumcision. She had asked her host father what he thought of the ritual in regards to his own daughter. He said he never felt more pride than the day his daughter was circumcised, but he didn’t agree with the practice at all. He thinks it’s wrong. His pride was felt for his daughter’s coming of age, not the circumcision.

Thus, with the volunteer’s story began my quest to discover more about female circumcision, its origin, why and where it is practiced, and how it can affect one’s health. But even beyond gaining personal knowledge on the subject, I desired to find what others knew about it, and educate those who knew little about female circumcision. I hypothesized that nursing students in particular would not have sufficient enough knowledge about female circumcision to be able to deliver culturally sensitive care. I also concluded that students would benefit from an educational seminar on the subject, with the premise that such topics are usually
not included in college nursing courses. With these insights in mind I developed
the rationale for this study.
Background

Population Involved

Female circumcision (FC), otherwise known as female genital mutilation (FGM), is practiced among Jews, Muslims, Christians, and followers of indigenous religions in 28 African nations, as well as communities in Asia and the Arab Peninsula, and among refugees and immigrants in Europe, North America, and Australia (Morris, 1999).

The origins of FC are unknown. Some scholars believe the practice may have originated in ancient Egypt, or perhaps in Africa and then spread to Egypt. It is generally accepted that FC was practiced in pre-Islamic Egypt, Arabia, and the Red Sea coasts (Morris, 1999). No justification can be given for the practice. It poses no health benefits, but rather strips a woman of her right to be a sexual being.

Types of FC

FC can be classified under four different categories: (a) Type 1. (Sunna) the removal of the clitoral prepuce and sometimes excision of the clitoris entirely or partially, (b) Type 2. (Intermediate Excision) involves the removal of the prepuce and clitoris as well as total or partial removal of the labia minora, (c) Type 3. (Infibulation/Pharaonic Circumcision) involves complete or partial excision of the external genitalia; the vaginal opening is usually stitched or narrowed; (d) Type 4. Rare FGM or manipulation that may include piercing the clitoris or labia, cauterizing the clitoris and surrounding tissue; scraping or cutting the vagina; stretching the labia minora and/ or using corrosive substances to cause
the vagina to bleed, tighten, and narrow (Morris 1999; Mwangi & Smith-Stoner, 2002).

Culture and Custom

A woman who is a traditional birth attendant, or an elderly woman, often performs the circumcision. On average, FC is performed on females 4 to 7 years of age. However, it is not uncommon to see it performed during infancy or adolescence. In most, if not all, instances, FC is a rite of passage into womanhood. As such, the practice is usually supported by the females in the community and is passed on from generation to generation to preserve culture.

In some cultures where FC is practiced, it is believed that women have a natural tendency to be promiscuous and circumcision is seen as a way to promote virginity before marriage and fidelity during marriage. Those who are uncircumcised are seen by society as being impure and unclean. Often a woman who has not been circumcised is an outcast, and her potential for marriage may be dramatically reduced. In her essay on FC, Elizabeth Oram, a Peace Corp volunteer, quotes a Maure African woman as saying, “No man would marry an uncircumcised woman” (Badran & Cooke, 1990). In the Mauritanian culture (where Type 1 FC is usually performed) it is believed that if the clitoris is kept intact it will cause a woman to be greatly aroused thus causing a woman’s thoughts to be constantly turning towards sex and could lead to infidelity. Also, the legend has been passed down through generations that if the clitoris is not removed it may grow to be the size of a full penis. Interestingly, the word for clitoris in the Arabic dialect (which Maures speak) means penis (Badran &
Cooke, 1990). Among some groups of people it is thought that if the head of an infant is to touch the clitoris during childbirth that newborn will die.

Ingrained into many cultures is the idea that FC enhances a man’s sexual performance and pleasure, as well as promoting a women’s fertility (Morris, 1999; Mwangi & Smith-Stoner, 2002). However, current research has found that men are not always in support of FC. In fact, women, not men, have been recognized as having a major influence on the continuation of FC. Women who choose to be circumcised, or to have their daughters circumcised, are attracted to it for many reasons: it assures the father a high bride price; tradition is kept; presents are given as a part of the rite of passage; grandmothers, mothers, and first born girls are very influential influencing the younger sister’s desire to be circumcised (Chugulu & Dixey, 1999-2000).

Botkin et al. (1998) cite Kopelman (1994) as saying, “FGM is endemic in poor societies where marriage is essential to the social and economic security for women” (p. 2). Also, the continuance of circumcision is beneficial for the women who perform the service, as it comes at a fee (Almroth-Berggren et al., 2001). Some of the research concerning males’ and females’ views about FC (who come from areas in which FC is practiced) will be discussed in the literature review.

Health Problems Related to FC

The tools used to perform the circumcision are usually razors, sharp glass, scissors, or a knife. Sterility is never guaranteed, and there is the potential for transmission of blood-borne pathogens (Brady, 1998). Circumcision can lead to serious reproductive and urinary tract complications, as well as psychological
strain. Immediate consequences of circumcision include tetanus, septicemia, hemorrhage, shock, and sometimes death. Other complications that may arise are chronic urinary and vaginal infections, obstructive uropathy, incontinence, fistulas, menstrual disorders, infertility, excessive scar tissue growth or cysts at the cutting site, pain during sexual intercourse and possible difficult and prolonged labor (Rahman & Toubia, 2000).

The urethra is often obstructed because of scar tissue formed as a result of FC. The opening that is left for menstrual and urinary flow is often very small. Urination can be painful and can take up to 15 minutes, as in some instances a woman with a drastically small opening must urinate drop by drop. These women are at high risk for urinary tract infections (UTI’s), pelvic inflammatory disease, and dehydration; urination is painful and time consuming, women may tend to decrease the amounts of fluids they consume (Brady, 1998). FC can lead to severe scarring, chronic vaginal infections, painful and prolonged menstruation (lasting up to 10-12 days), blood clot accumulation during menses, keloid formation, and possible infertility as a result of chronic infection (Brady, 1998; Morse, 1999).

The vaginal area of the circumcised woman may lose elasticity, and often deinifubulation must be performed before giving birth. During pregnancy, the mother is at risk for pre-term labor because of chronic UTI’s. During labor, the fetus is at risk for hypoxia as a result of birth canal obstruction. The birthing mother is at higher risk for bladder damage, perineal tears, fistulas, infection, and hemorrhage (Brady, 1998; Morris, 1999).
Social and Ethical Implications

In 1992, the Bureau of Refugee Programs worldwide published statistics stating 130 million women and girls had experienced FC to date, with 2 million circumcisions occurring annually (Morris 1999). Morris cites an article by Jones (1997) identifying populations at risk in the United States:


reported ancestry or place of birth as a country or region where

FGM is practiced. About one-fourth (77,000 females) were girls

under 18 years of age. In all, 65% of the estimated number of girls

under 18, with or potentially at risk for FGM/FC, live in 35

metropolitan areas in the United States; about 72% of these girls

were born in the United States. (p. 2)

Circumcision is a social norm for many refugees. But refugees are living in a society that sees their practice of FC as being a violation of human rights. It is not acceptable socially or ethically in the West as well as globally:

The most comprehensive international statement on women’s

rights is the Convention on the Elimination of All Forms of

Discrimination Against Women (CEDAW), adopted by the UN’s

General Assembly in 1979; as of October 1999, 165 countries had

ratified it. Several of its provisions can be interpreted to require

states to take action against the practice of female genital

mutilation. (Affara, 2000, p. 54)
Ultimately, a need exists to try and understand the cultural significance of FC, though we may not ethically agree with the practice, in order to reach out to the client and support her. Mwangi and Smith-Stoner (2002) emphasize that though our reactions to FC may be extremely negative, the health-care provider’s job is to support the client. They write:

[The] . . . nurse’s role is to support the patient; therefore, showing obvious signs of rejection of the FC practice increases the patient’s difficulty in describing her feelings. (p. 32)
Review of Literature

Health Complications Resulting from Female Circumcision

*Urinary tract problems.* Epstein, Graham, and Rimsza (2001) documented a case of obstructive uropathy related to FC. A 23-year-old Somali woman presented to a student health clinic with complaints of lower abdominal pain. She reported having severe dysmenorrhea and heavy bleeding with menses, dysuria and prolonged micturation. Upon inspection, the examiner found that she had a labial minora midline fusion that obscured any vision of the vagina. An ultrasound showed bladder enlargement and bilateral hydronephrosis. The authors write:

We discussed the results of the ultrasonography with the patient and recommended reconstruction of her perineal anatomy . . . . She declined to have the surgery. In her country, she explained, it is customary for the husband to “break” the scar during intercourse.

(p. 275)

She married weeks after the visit. Her attempts at intercourse were painful and unsuccessful. She and her husband later agreed to the surgery. The physicians had the following comments about the post-surgery exam:

. . . [The] examination revealed well-healed, reconstructed perineal anatomy, and the follow-up ultrasound of the kidneys and bladder 5 months after the surgery showed resolution of the calicectasis in both kidneys. The patient was quite pleased with the results of the corrective
procedure. Her micturation time was greatly reduced and she experienced no dysuria or dyspareunia. (p. 276)

Reproductive complications. Chalmers and Hashi (2000) interviewed 432 Somali women living in Canada, who had previously been circumcised, about the long-term health problems they have experienced as a result of circumcisions. A majority of the women (96.1%) had had infibulation (Pharaonic circumcision) performed, the most extreme form of FC. Out of the 432 women, 70.1% experienced immediate vaginal or urinary retention as a result. Long-term, 62.3% experienced perineal tears, 54.2% had perineal scarring, 21.7% reported pelvic infections, and 24.3% said they had perineal cysts. Sixty-eight percent of the women associated sex with pain, while 78.2% clearly stated sexual intercourse was painful.

Pregnancy and delivery problems. Interviews of 60 young women and grandmothers in central Sudan done by Almroth-Berggren et al. (2001) revealed there may be an association between FC (infibulation and re-infibulation after birth) and labor complications. A young woman whom they interviewed commented, “One month ago a friend of mine died at the city hospital due to her deinfibulation. She bled to death, while waiting for the blood transfusion” (p. 717). Another said, “I have heard that three women have died recently in the neighboring village because of obstructed labor related to female circumcision” (p. 718).

A study was conducted in Sweden by Bodker et al. (2002) concerning an association between FC and perinatal death given the disproportionate number of
perinatal deaths occurring in infants born to African immigrants as compared to those born to Swedish women. The researchers examined the records of 63 patients whose infants had experienced perinatal death. Relying on expert opinions from obstetricians who reviewed the cases, the researchers concluded there was no connection between FC and the perinatal deaths. However, this study relies on past medical records, without eyewitness observations or interviews. Also, the population of immigrants may have been unrepresentative of the majority of women who have been circumcised, as specific styles of FC are not identified in this study. Considering the lack of eyewitness accounts and the unknown factor of what kind of FC the women had, false inferences could have been made by the obstetricians and researchers into what caused the deaths.

*Psychological concerns.* Often in western medicine, cesarean section is performed instead of allowing the circumcised mother to go through the natural birthing process. Feelings of disappointment and anger are not uncommon in the post-partum mother. Chalmers and Hashi (2000) report that out of the 432 Somali women they interviewed in Canada, 216 (50%) delivered via c-section, while only 1% of them actually wanted this birth method. In Canada the cesarean rate is 17.6% of all births (Chalmers & Hashi, 2000). The reason why this particular study’s rates among Somali women were excessively higher than the national average could have been due to the caregivers’ concern that complications might arise during childbirth as a result of the woman’s circumcision.
Cultural Perceptions of Female Circumcision

In the same study done in Sudan on reinfibulation by Almroth-Berggren et al. (2001), 3 of the 60 women decided not to become reinfibulated following labor. These women cited menstrual and abdominal pain, and pain during sexual intercourse, as their main reasons not to be reinfibulated. Two women said it was their individual choice. The other woman stated that her husband supported her decision not to become reinfibulated. Among these women social pressure was cited as having a strong influence on the practice.

In a study done by Islam and Uddin (2001) on perceptions of FC in Haj-Yousif, Shendi, and Juba (Sudan, Africa), results showed that 67 % of the women in Haj-Yousif believe FC should be continued (87% of the women were circumcised, with 96% being Pharaonic circumcision), 56 % in Shendi (almost 100% of the women from this area were circumcised, with 69% being Pharaonic circumcision), and only 4 % in Juba (only 7% of the women in this area were circumcised, 31% being Pharaonic). Also, results showed that the percentage of women favoring FC continuation decreased with the increase in their level of education. Of those favoring the continuation of FC, most agreed that a lesser form of it should be done. The majority of women who support continuation cite custom as being the biggest reason why it should remain a practice (Haj-Yousif, 69 %; Shendi, 75 %). Among the women who believe FC should be stopped, most agreed FC causes medical complications (Haj-Yousif, 63%; Shendi, 88%). Data in their study also showed that women perceived men were less likely than they were to support FC.
Chugulu and Dixey (2000) interviewed 150 women, and some of their male counterparts, from two rural Roman Catholic villages in Tanzania about three topics: what FGM means to them, attitudes of men and women about FGM, and its importance in society and sexual relations. Type I, the least severe form of FC was practiced among these women. About 41% of the women had been circumcised and 59% had not been. Similar conclusions were drawn from this study compared to the studies previously discussed. Social pressure and tradition were some of the main reasons that FC is practiced.

As stated previously, reasons given for wanting to be circumcised included being given presents, being influenced by one’s first born sister, and being persuaded by one’s grandmother and mother.

Women (circumcised as well as uncircumcised) had varying feelings about their support of continuing the practice. As with previous studies, the more education a person had, the more he or she was in support of discontinuing the practice, citing medical complications as the number one reason to stop FC. Men in support of FC argued circumcision curbed females’ sexual desires and kept them faithful. One man interviewed said, “After all, (it) is done to cut off sexual desire of a woman so she cannot riot” (p. 111). Another said, “Its time has passed. Whether they are circumcised or not they all riot” (p. 112).

The men interviewed by Chugulu and Dixey (2000) did express that “after exposure to uncircumcised women, they found them more attractive . . . [and] that sex with circumcised women was not as satisfactory” (p. 112). Men or boys in this society marry circumcised women to fulfill traditional beliefs and will often
find an uncircumcised female counterpart after they are married, “to enjoy better sex” (p. 112).

Chugulu and Dixey (2000) found a great concern of the men was that there is a higher rate of mortality among babies born to uncircumcised women. This view shows a need for education pointed at such potentially false inferences, but it also gives light to a great fear held by males in this society:

Those who did not continue with the practice, their babies died.

Then, old men and women looked into the matter closely and found that it is because they have not been circumcised. After circumcision they have live babies. (p. 112)

In the Canadian study by Chalmers and Hashi (2000) women were interviewed about their feelings regarding FC. Sixty-six percent of the women report feelings of excitement in anticipation of their circumcision, 79% reported feeling special and 71.8% reported feeling happy the days following the circumcision. At the time the interview was conducted, 72.9% said they felt proud about their being circumcised, 52.6% felt more pure, and 30.1% felt more beautiful; a few (16.4%) were sorry it had been done (p. 230). The interviewers asked the women if they would prefer not to be stitched back up (reinfibulated) after childbirth. Sixty-nine percent would prefer being left open and 63.9% of the women said their husbands would prefer this as well (p. 231-232).

As has been illustrated in a few of these recent research studies, males are not always in favor of FC continuance, and females are many times advocates of the practice.
Culturally Sensitive Nursing Care

A lack of cultural sensitivity in general can be seen within the field of healthcare. In a qualitative study of the experiences of Mi’kmaq clients (members of a First Nation Community who have inhabited Eastern Canada for over 2000 years) in a New Brunswick hospital, researchers found “participants often felt misunderstood by caregiver in a way that made them feel lessened as persons” (p. 8). They felt like they were strangers in a hospital milieu that was difficult to understand (Baker, Biro, & Joe 2000).

Kirkham (1998) interviewed 8 recently graduated registered nurses (nurses who had graduated from a Canadian bachelor’s program or diploma school within the last 2 years) about their experience caring for culturally diverse patients. As a whole, the nurses expressed enthusiasm about their caring for patients from cultures other than their own. They enjoyed personal growth as a result of the care. However, the nurses spoke of several other nurses providing “resistant care”. Culturally insensitive nurses were seen as trying to block the culturally sensitive care of others. Kirkham (1998) comments that the most disturbing conclusion of this study is that racism is present in healthcare.

In a study utilizing the Cultural Self-Efficacy Scale (Bernal & Froman, 1987) to examine the cultural self-efficacy of community health nurses, Bernal and Froman (n.d.) concluded that, “The average rating of self-efficacy across all three culturally distinct groups show a rather low level of confidence in the nurses’ ability to care for the three culturally distinct population groups” (p. 28). African-Americans, Mexican-Americans, and Southeast Asians were the ethnic
groups the nurses listed as most frequently serving. Two hundred and six nurses of various educational, specialty, and racial/ethnic backgrounds completed the study’s questionnaires. The majority of the nurses were white female, average age 41.2, Bachelor in the Science of Nursing (BSN) trained, with an average of 16.5 years of experience. This survey was a nation-wide survey, and a random sampling procedure was used.

In Chalmers and Hashi’s interview of the Somali women, most of the women felt with overwhelming conviction that they were exposed to a lack of cultural sensitivity. Chalmers and Hashi stated:

Most (87.5%) reported hurtful comments being made by their caregivers...[Verbal] expressions of surprise (74.2%)... nonverbal expressions of surprise (78.0%)... being regarded with disgust (55.1%)... [and] having no respect shown for their cultural practice (57.4)... (p. 232)

In an interview of 9 women and 7 men from Somalia who had childbirth experiences in Sweden, most of the women felt healthcare professionals’ reactions to their circumcisions were “satisfactory and unproblematic” (Aden, Dahlgren, Wiklund, & Wikman, 2000). However, one woman said:

It was a bit strange. I met this doctor for the first time, during the first pregnancy here in Sweden. He was going to examine me. He saw and he wondered. He had never seen such a thing before, he said, ‘What is this? Is it an injury or what? Why do you do this?’

... It felt very odd. (p. 108)
Importance of Transcultural Education

Recent qualitative studies of nursing students and graduated nurses of BSN programs who were involved in immersion experiences show that cultural integration has had positive effects not only on their broad worldview, but also their cultural competence and personal insight. Bennett, Brigham, Ryan, and Twibell (2000), interviewed 9 BSN graduates who spent time abroad in one of 4 countries: India, Korea, Honduras, or Guyana. Interviewee’s made similar comments such as “learning to think differently creates an avenue for an open mind” (p. 405). One participant stated this experience enabled her to “[learn] to care for clients in their world, not mine” (p. 403). Another participant stated, “Something I’ve been able to incorporate into my nursing is that I realize I’m biased . . . . I have to nurse through my biases if I’m going to help them (patients) effectively” (p. 406). Although the study concluded that personal growth and cultural sensitivity came from the experience, the study may have been weakened by not having a comparison group of students who did not do an immersions experience. Thus, their level of cultural awareness and sensitivity can only be assumed.

A qualitative study by Haloburdo and Thompson (1998) of 14 BSN students who traveled to one of three countries—the Dominican Republic, Nicaragua, and the Netherlands—cited similar results. The students shared feelings of personal and professional growth, and they felt they gained “a greater appreciation for cultural differences, yet recognized the universal human
characteristics” (p. 19). However, again, no study was done to compare this group to a group of students who did not do a study abroad.

Napholz (1999) compared the experiences of nursing students, one group of which was exposed to extra cultural diversity education taught by a hired consultant, and the other group having the traditional method of cultural diversity as incorporated into a clinical course. The results of the study showed that the added cultural education did indeed have an effect on cultural competency when providing care to clients from different cultures. The researcher notes:

Having a consultant who was a member of a minority culture seemed to add face validity, depth, and meaning to information the students had previously learned regarding racial and ethnic differences in their cultural sensitivity lecture course. In addition, the open and frank sharing of the consultant’s own experiences facilitated greater realization and sensitivity of the clients’ ethnic minority reality. (p. 82)

In a significant study of transcultural nursing (TCN) curricula in 217 responding baccalaureate and higher degree National League for Nursing (NLN) schools of nursing around the United States, Ali, Carlton, and Ryan (2000) found that 67% of the undergraduate programs had TCN modules in courses, while only 51% of the graduate programs did. Also, cultural opportunities were available to 74% of the undergraduate programs in their geographical areas, but only 55% of the graduate schools provided experiences nearby. Of the schools included in the
survey, 57% said “students were guided or mentored by faculty members qualified in TCN for field experiences” (p. 303). And shockingly, of 163 participants responding to whether they have sufficient faculty prepared in TCN, 22% said yes and 78% said no. Of 617 schools contacted for the survey, only a third of the schools responded. This poor response rate may reflect the need to explore the incorporation of TCN into nursing programs more thoroughly.

A review of the literature shows that cultural education and encounters are important to the development of a more rounded, and culturally competent individual. A lack of experiences and a lack of qualified professionals to teach important content related to transcultural nursing may impede the nursing students’ development of critical interpersonal, professional, and competent nursing skills.
Methodology

Design

This non-experimental, non-random study consisted of collecting questionnaire data from upper-division nursing students at a small liberal arts college in the northwestern United States. Two different questionnaires were used during different parts of the study. The first questionnaire was used to gain perspective on basic knowledge regarding female circumcision. After an educational seminar was conducted on FC, a second questionnaire was used to assess the usefulness of having such a seminar.

Participants

The sample population was chosen in a non-random manner and consisted of nursing students in their 20’s to mid-40’s, including 4 males and 21 females (the majority of students were younger than 25). The sample was chosen based on current status as a nursing student enrolled in upper division courses. The students were invited to fill out a survey and be present during an in-class presentation on female circumcision. Each student signed a consent form and was assured that these surveys would remain anonymous and that participation in the study was voluntary. The consent form included information on the purpose of the study, the procedure to be used, as well as assurance that the information provided by the participant would be confidential. The consent form was approved for use by a professor acting as thesis director and individual ethics advisor in the Nursing Department. All students chose to participate. A copy of the consent form is included as Appendix A.
**Instrument**

Development of the survey questionnaire was guided by Fain’s (1999) textbook *Reading, Understanding, and Applying Nursing Research* (p. 101-111). The survey consisted of 14 questions that asked about student’s perception of his or her own knowledge regarding various aspects of FC (i.e., had he or she ever heard of FC, did he/she have any knowledge regarding the various forms of FC, where it is practiced, who practices it, etc.). The students rated themselves based on a four point Likert scale, with responses ranging from 1, no knowledge; 2, very little knowledge; 3, a moderate amount; to 4, a great deal. The last part of the survey consisted of 2 yes/no questions, in which the student identified whether or not they had any interest in, and would benefit from, learning more about the practice. The questionnaire was developed using care to avoid negatively worded items, which may have created a biased response. The thesis director, acting as ethics advisor in the Nursing Department, again approved the questionnaire for use. A copy of the questionnaire is included as Appendix B.

**Procedure**

The students were given class time to complete the survey one week before attending the educational seminar. The students then attended a one-hour lecture on circumcision in which the origin, types, complications, and some of the cultural implications of FC were discussed. Care was taken to remain objective in giving information to the students. The students had time at the end of the lecture to ask questions. After the seminar, each student filled out an open-ended questionnaire, again anonymously, about what they learned from the lecture and
whether or not the information presented was of use to them. This questionnaire was presented to and approved by the thesis director prior to administration. A copy of this questionnaire can be found as Appendix C.
Results

Numbers were calculated using a point scale, with the greatest number of points being 48 (a person marked 4’s for all 12 questions) and the least number of points being 12 (a person marked 1’s for all 12 questions). Of the 25 nursing students surveyed, an average of 8% reported having no knowledge of the subject area at all (scored at a 12), 68% reported having very little knowledge (scored between 13 and 24 points), 20% had a moderate amount of knowledge (scored between 25 and 36 points), and 4% reported having a great deal of knowledge (scored between 37 and 48 points). Those persons whose scores indicated they knew a moderate amount about FC were on the lower end of the scale, with an average number of points being 27.6. These results are presented in Table 1.
Table 1

Degree of Knowledge Concerning Female Circumcision

<table>
<thead>
<tr>
<th>Self Rating</th>
<th>Number of Persons</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>2</td>
</tr>
<tr>
<td>Very Little</td>
<td>18</td>
</tr>
<tr>
<td>Moderate Amount</td>
<td>4</td>
</tr>
<tr>
<td>Great Deal</td>
<td>2</td>
</tr>
</tbody>
</table>
Common themes emerged from the open-ended questionnaire. Twelve of the students commented on how they previously thought this act was solely male-dominated, or a "horrible thing done by males." One student wrote, "I always thought that this procedure was a male dominated act and that women were not accepting of the practice. I also thought that it was just done for no reason and now I know that it is more complex than that."

All 25 students found the lecture to be interesting and useful to their future practice as nurses. A student commented, "I never realized that as a nurse I might possibly have to deal with a patient who has been circumcised. Knowing a little bit of the background now already makes me feel like I could handle this situation better." Two students commented as future mid-wives it will especially be important to know about the FC; one person who plans on working in the emergency room after graduation shared in this belief. Twenty-two of the students said knowledge gained from the lecture will help them in becoming a good nurse—objective and culturally sensitive. As one student said, "In nursing, constant education is a key factor in becoming a good nurse." This student had never heard of FC before this study. Another student commented, "It (the knowledge gained from the lecture) will help me be more culturally sensitive and realize I need to be well educated before I push my beliefs on others."
Discussion

The results indicate that upper division nursing students feel that education regarding FC is useful and that a need exists for knowledge and understanding related to the practice of FC. It appears that FC is not a subject that is common knowledge and that upper division students in this study have a skewed perception of its practice. One student who had never heard of the practice stated, “I think if I would have encountered this (FC) I would have been ultimately surprised and probably outraged.” Horror stories about circumcision are abundant in our western culture. But as one student put it, “It is easy to sit back and judge something but it is better to try to learn the reasons why something happens.”

Nursing Implications

Females who have been circumcised run the risk of being stigmatized by western culture and the healthcare system. Women with FC may fear the response of caregivers to the knowledge that this cultural rite has been performed on them. An appropriate nursing diagnosis pertaining to this situation, whether it be in the doctor’s exam room, home care, or labor and delivery, would be anxiety related to a lack of recognition from others (Carpenito, 2002). Carpenito (2002) writes, “Individuals and families from different cultures may face many challenges when they seek healthcare in the dominant culture’s healthcare delivery systems” (p. 118). Mwangi and Smith-Stoner (2002) list several issues to consider when giving
care to females with FC. The following considerations on the part of the nurse may relieve the anxiety a client is feeling:

1. Choose wording carefully. Statements such as “Are you being abused?” may cause the patient to cease communication. In many countries this practice is not seen as abuse by either males or females.

2. Look for subtle signs of genital/urinary complications. Patients may not contribute such problems to FC or may be embarrassed to admit problems.

3. In the case of a woman who has just given birth, encourage the patient to verbalize concerns. Type 3 and 4 FC may cause reconstructive surgery to be extensive. The female is at a greater risk of infection and post-partum hemorrhage (remember the length of micturation can cause a woman to avoid going to the bathroom, hence a greater chance that the bladder will be distended causing decreased uterine contraction).

4. FC is a very private topic. The healthcare worker should establish trust before engaging in any kind of intimate discussion with the client.

5. FC should never be discussed with the patient’s family members without consent.

6. If language is a barrier, seek a proficient translator.

7. Help the patient to make independent decisions, especially with regards to reinfibulation.

8. Assist the client in learning more about the complications of FC and ways to correct the procedure.
9. A great way to gain trust is to visit with clients in the home and eat whatever food is offered as a sign of respect and acceptance toward their culture.

Ultimately, it is the job of the healthcare professional to give accurate information in a nonjudgmental way. The gaining of trust is key to the nurse’s role. The only way nurses are going to help transcend the practice of FC is to share dialogue with clients of other cultures. Baker (1997) emphasizes this point in her article concerning cultural relativism as it applies to nursing practice:

In cross-cultural encounters between a nurse and client, both are at the center of a hermeneutic circle. The nurse reads and interprets the client through the prejudices of one tradition, and the client reads and interprets the nurse through the prejudices of another. However, the possibility of understanding through dialogue exists.

(p. 10)

Thus, the importance of exposing nursing students to the practice of FC becomes clear. Armed with compassion, knowledge, and cultural sensitivity, nurses can do their part to effectively educate their clients and other healthcare professionals about the risks associated with FC in an effort to eradicate the practice.

Limitations

The sample size for this research project was not ideal. Though useful data was drawn from the questionnaires, and patterns did emerge, it would have been better to have had a larger group (at least 50 people). Also, the students go to school in an area where racial and ethnic diversity is not considerable. Perhaps
other schools of nursing—those within metropolitan areas where more refugees live—already invest time into teaching this subject. Thus, the sample population may not be representative of the greater population of student nurses in the United States.
Future Research

No study to date has been done on the possible impact of vaginal infection (as a complication of FC) in causing stillbirths, fetal malformations, intrauterine growth retardation, or placental abruption. Also, in general limited research has been done in the United States regarding FC as it pertains to healthcare and healthcare costs. Are there differences in nurses’ perceptions of patients who have undergone female circumcision? Do nurses care for these clients differently? These questions need to be asked. A qualitative study interviewing nurses on their views of FC has the potential for yielding useful information to guide healthcare practice.
Conclusion

Nurses and healthcare workers are entering an era where female circumcision cannot be ignored. The more we educate each other as to the effects of FC and its cultural implications the more successful we will be in eradicating its practice. This research study showed that a lack of understanding existed among this group of nursing students, and they felt the knowledge gained by participating in the educational seminar on FC will help them to be more culturally sensitive when caring for persons who have been circumcised.
Appendix A

Carroll College Department of Nursing

Consent to Participate in an Honor's Thesis Research Survey

Title: Assessment of Students' Knowledge and Understanding of Female Circumcision

Principal Investigator: Sarah A. Ahmann

Your Name (please print)

Purpose

You are invited to share in my Honor's Thesis Research Project. The purpose of the study is two-fold: Firstly, to assess how much knowledge and understanding individuals feel they have with regards to female circumcision. Secondly, to see if an educational seminar on female circumcision would be of benefit to you and future students.

It is important that you understand that your participation in this study is completely voluntary. You are not being graded, and your identity and responses will be held in strict confidence.

Procedure

You will be asked to participate in three components of this study. Initially, you will be given class time to complete a survey. You will be asked to answer several questions related to female circumcision. Please answer to the best of your ability, and know that there are no right or wrong answers.
The second component of the project will consist of a formal lecture, during your Professional Role class, on female circumcision. After the lecture I will ask you to participate in the third part of the study, which will entail a follow-up questionnaire concerning the usefulness of having an educational seminar on female circumcision.

Confidentiality

Your surveys will be confidential, and your name will not be used in any reports or publications of this study. Please feel free to ask any questions you may have regarding the study before, during, or after the survey and educational seminar are conducted.

Consent

I have read and understand the above information and agree to be a participant in this study. I understand that my participation in this study is completely voluntary.

__________________________________________  _______________
Signature                                      Date

__________________________________________
Witness Name (please print)

__________________________________________  _______________
Witness Signature                              Date
Appendix B

Survey of Students' Knowledge and Understanding of Female Circumcision

Below are some questions about the practice of female circumcision. Please read each question and circle the response that best describes how you feel. There is no right or wrong answer. Please note that Female Circumcision will be referred to as “FC.”

Respond by circling one of the following numbers that best represents your answer:

1= None
2= Very little
3= Moderate amount
4= A great deal

1. How often have you heard the term female circumcision (FC)? ............ 1 2 3 4
2. How often have you heard the term female genital mutilation? ............ 1 2 3 4
3. How knowledgeable are you with regards to where in the world FC is most often practiced? ................................................................. 1 2 3 4
4. How knowledgeable are you with regards to the origin of FC? .......... 1 2 3 4
5. How knowledgeable are you regarding the age at which females are circumcised? ................................................................. 1 2 3 4
6. How great is your understanding of who usually performs the act of incision and stitching involved in female circumcision? ............... 1 2 3 4
7. How great is your understanding of why female circumcision is performed? ................................................................. 1 2 3 4
8. How would you rate your knowledge of Sunna, the classification of FC Type 1? ................................................................. 1 2 3 4
9. How would you rate your knowledge of Intermediate excision,

   FC Type 2? ................................................................. 1 2 3 4

10. How would you rate your knowledge of pharaonic circumcision/infibulation,

    FC Type 3? ................................................................. 1 2 3 4

11. How would you rate your understanding of any secondary medical complications
    that might arise from female circumcision? ......................... 1 2 3 4

12. I would rate my overall understanding of female circumcision as ...... 1 2 3 4

Please answer yes or no to the following questions:

1. Would it be helpful to have an education seminar on Female Circumcision? .........

   .............................................................................................................. yes / no

2. Do you think knowing about female circumcision would help

   you in your profession as a nurse? ....................................................... yes / no
Appendix C

Post Questionnaire

Did you find this lecture to be of interest to you? Why or why not?

Please share any thought and feelings regarding what was discussed during the lecture. (Do you have any thoughts concerning, or questions about, female circumcision?)

Do you believe the knowledge gained from this lecture will be of value to you when practicing as a nurse? Please explain.

Please share any further comments or suggestions:
References


