A survey of Australian midwives’ knowledge, experience, and training needs in relation to female genital mutilation

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Abstract

Background

Female genital mutilation (FGM) involves partial or total removal of the external female genitalia or any other injury for non-medical reasons. Due to international migration patterns, health professionals in high income countries are increasingly caring for women with FGM. Few studies explored the knowledge and skills of midwives in high income countries.

Aim

To explore the knowledge, experience and needs of midwives in relation to the care of women with FGM.

Methods

An online self-administered descriptive survey was designed and advertised through the Australian College of Midwives’ website.

Results

Of the 198 midwives (24%) did not know the correct classification of FGM. Almost half of the respondents (48%) reported they had not received FGM training during their midwifery education. Midwives (8%) had been asked, or knew of others who had been asked to perform FGM in Australia. Many midwives were not clear about the law or health data related to FGM and were not aware of referral paths for affected women.

Conclusion

As frontline providers, midwives must have appropriate up-to-date clinical skills and knowledge to ensure they are able to provide women with FGM the care they need and deserve. Midwives have a critical role to play in the collection of FGM related data to assist with health service planning and to
prevent FGM by working closely with women and communities they serve to educate and advocate
for its abandonment. Therefore, addressing educational gaps and training needs are key strategies to
deliver optimal quality of care.

**Key words**

Female Genital Mutilation, Midwives, Training needs, Experiences, Women, Australia, High Income
Countries.
Introduction:

Female genital mutilation (FGM) involves partial or total removal of the external female genitalia or any other injury of the female genital organs for non-medical reasons (1). This practice is deeply rooted in culture, with social obligation and marriageability considered to be two of the most important reasons for its continuation(2). It has also been linked with a girl’s transition from childhood to womanhood (3, 4), perceived religious requirement, family honour through premarital virginity and marital fidelity, aesthetics, and fear of exclusion from resources and opportunities as a young woman (5). There are no health benefits associated with FGM and the practice has many short and long term consequences, which significantly impact on women’s lives (1). The World Health Organization (WHO) and other international and national agencies and governments have been advocating for the abandonment of FGM for many decades (1, 2). FGM is banned by law in 26 African and Middle Eastern countries plus 33 countries with migrant populations from high prevalent FGM practicing countries (6).

Despite the serious and often long-term adverse consequences of FGM, the practice remains prevalent (1, 2). It is estimated that 200 million women and girls have undergone FGM worldwide and another three million women and girls are at risk annually (1, 7). FGM is practised in 30 African and Middle Eastern countries, and in some parts of Asia (7). Recently it has been reported in Russia (8). However, in recent years there has been an increasing number of women with FGM residing across Europe, the United States, Australia, New Zealand and Canada as a result of demographic change due to widespread global migration (9-12). Although, FGM prevalence data is not collected in Australia the number of women with FGM who have migrated from high FGM-prevalent countries is estimated to be 83,000 of which 44% are women of childbearing age (13). Given the international migration patterns, healthcare professionals in high income countries (HIC) are increasingly caring for
women with FGM (11, 14-20). This highlights the need for up to date data on FGM to inform
maternity health service planning (17).

Studies of healthcare professionals, including midwives, providing care for women who have
undergone FGM in HIC, have indicated major gaps in the technical knowledge and skills of providers
(19, 21-24). A study in Sweden found a lack of hospital policy in relation to FGM that resulted in
inconsistent care for women with FGM (25). The research found that doctors and midwives were
unclear about their professional roles and responsibilities with regard to the clinical care and referral
of women with FGM. This situation affected the monitoring of pregnant women and communication
between women and clinical staff. There is evidence from some HIC that health care professionals
are largely unaware of legal issues related to FGM. For example, in a survey of Belgium
gynaecologists more than half did not know that FGM was illegal (26). In contrast, in the United
Kingdom (UK) (27) the majority of doctors in a survey knew that FGM was illegal but they were
unable to provide details about the relevant Act.

Australia, like many other countries, has endorsed legislation against FGM (28). However, there have
been reports of FGM offences in Australia (29-31). A small number of health care professionals in
Australia have also reported that they have been asked by their patients to perform FGM (19, 32).

There are only two small qualitative studies in New South Wales, Australia that have explored the
knowledge and experiences of a midwives (17, 33). These studies found that midwives lack
knowledge, experience, and competency in providing care for women with FGM. Midwives
expressed their lack of confidence about interacting with women from different cultures where FGM
is practised and perceive this as a barrier to providing quality care to women (17).

The aim of this study therefore was to explore the knowledge, experience and needs of a larger
number of midwives working in a range of contexts in relation to the care of women in Australia with
FGM. With the scarcity of data in this area, this paper provides further evidence to inform midwifery
education and training in order to improve the quality of maternity care.
Method

A self-administered online survey was designed to explore the knowledge and experience of midwives in caring for women with FGM across all states and territories of Australia. The survey comprised 19 multiple choice and open ended questions, containing demographic data (i.e. age, country of midwifery training, qualifications, experience and speciality areas including years of experience as midwife), knowledge of FGM types based on WHO classification (see Table1), means for access to technical updates, personal experiences (including their challenges in caring for women with FGM and problems with data collection) and training needs. We also ascertained whether midwives had been asked or knew someone who had been asked to perform FGM. The questionnaire evaluated by AD and CH to ensure the questions does not contain common errors such as leading or unclear as well as successfully captured aim of the study.

Following approval by university’s Human Research Ethics Committee, the questionnaire was piloted among midwives who had clinical experience, and their inputs were incorporated into the final version. The survey was conducted between October 2014 and February 2015.

The online survey was posted on the Australian College of Midwives’ (ACM) website and midwives were invited to take part in the study. It was also advertised through the ACM e-bulletin and social media. In addition, hard copies of the questionnaire were distributed during the ACM conferences in Queensland and New South Wales in late 2014. Consent was obtained from respondents and the data was collected anonymously. The quantitative and qualitative data were analysed using descriptive statistics and content analysis, respectively.
Findings

Two hundred midwives responded to the survey. Two surveys were returned blank and were excluded. A total of 198 surveys were included in the study. However, not all midwives responded to every question so that the denominators were different for some questions.

The majority of the respondents were midwives from New South Wales (NSW) (74%, n=147), followed by Queensland (10.1%, n=20), Victoria (6.6 %, n=13), South Australia (3.6%, n=7), Western Australia (3%, n=6), Australian Capital Territory (ACT) (1.6%, n=3), and the Northern Territory (1.1%, n=2)(see Table1).

The midwives’ years of clinical experience ranged between 0-42 years. Of the respondents, 89% (n=177) were educated in Australia, 10% (n=20) in Europe and 1% (n=2) in Asia.

Of the 198 midwives, 86.5% (n=173) were practising in public facilities and the remainder were either employed as academics (n=22) or practised privately (n=6) or independently (n=7). Few midwives (n=6) reported not working as midwives at the time of the survey.

All 198 midwives responded to the question regarding awareness of FGM and indicated that were familiar with the issue. However, in response to the question on classification of FGM types, 53% (106/198) were able to answer correctly, 24% (47/198) did not know the correct classification and 23% (45/198) provided an incorrect answer to the types of FGM (Table 1).

Among the 196 midwives who answered the question on training about FGM during their midwifery pre-service education, less than half (43%, n=84) said they learnt about FGM during their midwifery education (pre-service). Almost half of the respondents (48%) reported they had not received any type of training during that time and 9% did not recall any training related to FGM over the course of their midwifery education (see Figure 1).
All midwives responded to the question related to legal knowledge (n=198). Ninety-one percent (n=180) reported that there was an Act against FGM in their state/territory, while around 8% (n=15) were not aware of such a law, and less than 2% (n=3) believed there was no law in place in their state. Some of the midwives indicated that they wanted more information related to the legal aspects of FGM in Australia as demonstrated in the quotation below:

‘It would be very helpful to know relevant legislation specific to FGM in Australia.’

Most midwives (74%, n=146) knew how and where to get information on FGM. The internet was the most popular source of information about FGM.

Of the 198 respondents, 105 (52%) indicated they were aware of guidelines on the care of women with FGM. Government documents such as the NSW Health guidelines on FGM, hospital policies, and documents from the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) were the most quoted sources.

Eighty-six percent of the respondents (n=171) answered the question on care for women with FGM. Half of them (n=85) indicated they had provided direct care during pregnancy and childbirth for women who had undergone FGM.

Midwives were asked if they had cared for women with FGM in other reproductive health settings rather than childbirth in which they have been able to select more than one option of choices provided. Of the 171 respondents to this question, 74 (43%) reported experience of care for women with FGM in health settings such as performing a Pap smear or pelvic examination outside of pregnancy or obtaining history for other medical reasons.

Of 171 respondents, 166 (97%) reported that there was a need to collect specific information in relation to the women’s FGM status and type during maternity care. The majority of these (42%) reported they did not have access to any system or form to collect this data during maternity care.
Twenty-eight percent of respondents reported having a form/database to gather data about FGM.

Another 27% did not know if they had a system of data collection (see Figure 2).

Most midwives (46%; 76/165) did not know the referral path for a pregnant woman with FGM. The midwives who indicated a referral route reported they would refer women to an obstetrician, specialist, a general practitioner (GP), or other clinics and hospitals (46%; 41/89). Some respondents emphasised the importance of a clear referral pathway in the open questions where they stated that clear paths were necessary as they felt they did not have enough knowledge and skills to effectively care for women with FGM. For example, one midwife wrote:

'I am from small rural community who had only one case where woman had FGM and referral is the only option as I have no any knowledge and experience.'

'Clear referral pathways need to be initiated and all midwives should be aware of these.'

Eight percent (16/193) of respondents reported they had been asked or knew of other midwives who had been asked by their patients to perform FGM in Australia. However, no further details concerning these requests were provided.

Most midwives (91%; 173/190) requested specific in-service training on FGM. Sixty-eight percent requested e-learning, followed by study days and seminars (45% and 38%, respectively) (see Figure 3).

Discussion

The findings of this survey suggest that despite Australian midwives being well informed about FGM as a public health issue, there are gaps in their knowledge. This is supported by the findings of earlier qualitative studies among midwives by Dawson et al. (17) and Ogunsiji (33). The survey demonstrated gaps in the technical knowledge of midwives despite 43% of our respondents reporting clinical experience of caring for women with FGM.
There are other studies from high income countries which also indicate the lack of knowledge among health professionals in different settings (14). In the UK, a study among obstetricians and midwives found that less than 5% of participants were able to list FGM types correctly and that FGM was not included in the midwifery curriculum. However, approximately 80% of the study participants had encountered and cared for women with FGM during their practice (24). Similarly, studies in Italy (34, 35), Sweden (20), the United States of America (USA) (18) and Spain (36) have also reported poor of health provider knowledge of FGM.

In recent years, several learning resources and guidelines have been developed by different organisations in Australia to address the educational needs of healthcare professionals (37-46). Our survey suggests that many midwives were not aware of the availability of such resources were not able to access them. Other studies have also noted a lack of health professional access and uptake of FGM resources. For example, Leye et al. (26) in Belgium reported that just 1% of participants in their study were aware of available FGM guidelines and information due to the little attention to the area in training curricula and poor communication between providers and women.

Many midwives in our study had a poor understanding of the legal aspects of FGM that concurs with the findings of other research in Australia (17, 33). In a study in the US, almost 45% of healthcare professionals did not know that FGM was illegal in their country. Similarly, in the UK around 60% of respondents were not aware of FGM legislation. One way forward would be to raise awareness of existing FGM laws, policies and guidelines by sharing these through networks in the health and legal systems in a corporative and continuous manner as recommended by Australia’s FGM Legal Framework (47).

Women with FGM may require specialised counselling and procedure such as de infibulation prior to child birth (15) therefore clear referral pathways and inter professional collaboration are an integral part of care for these women (15). However, the midwives in our survey were unclear about referral pathways for such women. In Australia, referral pathways are outlined in a number of existing
guidelines (39-42). The Royal Women’s Hospital, Victoria clearly elaborates the appropriate services that a women may require during pregnancy and childbirth (43). Effective and collaborative referral arrangements between health professionals are also articulated in clinical guidelines in Australia and other countries such as the UK (17, 24, 48).

The majority of respondents in this survey claimed that they did not have a system of data collection for FGM in their clinical workplace or they were unaware of such information system. The challenges associated with data collection have previously been identified by midwives and they admitted FGM issues were often not properly recorded as they had no adequate experience and knowledge (17). While, collecting information about FGM is critical for health service planning, such information can also support policy development, awareness-raising and improve the evidence base around the care of affected women (49).

As found in other Australian studies of obstetricians, gynaecologists and paediatricians (19, 32), our survey also indicates that a small number of midwives (n=16) had been asked by their patients, or knew of other midwives who had been asked to perform FGM. Evidence from other high income countries such as Belgium, Switzerland , the UK and Sweden also show that health providers have been asked to perform FGM either in adult women or girls (20, 26, 27, 50). This highlights evidence that FGM is being sought by migrants and refugees hence the practice appears to be continuing.

While this is concerning, there is evidence from studies in Norway that migrant communities that practise FGM do not support the practice in their adopted country that may result in a trend towards it being abandoned (51, 52). Health professionals, including midwives, can play a crucial role in primary prevention activities to facilitate behavioural change in migrant communities from FGM prevalent countries (17, 53).

Many midwives who responded to our survey undertook their pre-registration education prior to the current wave of migration to Australia from FGM prevalent countries. Therefore, it is not surprising that most of them had poor knowledge on the clinical, legal and data related issues as they might not
have had the opportunities to access recent educational and training or resources. This highlights the need for FGM to be incorporated into basic midwifery education that includes the early identification of resources. Kaplan et al. (36) has argued that such strategies are associated with better outcomes for women as many women with FGM present to health services in an ad hoc way when they have clinical concerns or complications (22, 54). A national approach to training and education for Australian healthcare providers might be the key solution in order to deliver optimal quality of care (47).

The findings of this survey underline the increased need for further training on FGM as it has been suggested by other studies in Australia (17, 33). Likewise, other HIC such as the UK (24, 27), US (18), Sweden (20) and Italy (34, 35) also emphasised the need for specialised skills for healthcare professionals who care for women with FGM during pregnancy and childbirth. Australian midwives expressed the need for more comprehensive and specialised training as part of pre-service and in-service midwifery training (33). FGM is not a defined compulsory part of the midwifery curriculum content in many courses. In our previous study, Australian midwives could not recall the topic as part of their midwifery training (17).

Midwives in our survey identified a preference for education in the form of e-learning or online resources. Australian midwives stated that most of the education programs were some distance from their hospital so they were not able to attend the training offerings (33). Education should reflect all the barriers faced by midwives in providing care for women with FGM. Further study in collaboration with relevant experts in this area might provide a better understanding of the required skills and knowledge at a specialised level to be included as part of a professional development package for midwives in the future.

**Limitations**

We tried to involve many Australian midwives as possible and to this end, advertised the online survey through the ACM website. We could not exclude non-Australian midwives although the
instructions at the beginning made it clear that this was the inclusion criteria. Our study sample is small in relation to the potential total number of midwives in Australia and may not represent the knowledge and experience of Australian midwives as a whole. Moreover, the majority of the respondents are midwives from NSW therefore our study mostly reflect the knowledge and experience and training needs of NSW midwives. The low response rate may be because few midwives have had experience with caring for women with FGM. Midwives who had not had the experience were unlikely to contribute. However, even though the response rate is small, this is still the largest survey of midwives in relation to FGM in high income countries. We developed the survey specifically for this purpose and as such, we may not have captured all the expected aspects of midwives’ experiences and knowledge in relation to FGM. Despite these limitations, this study provides a useful snapshot on the experiences and educational needs of these midwives.

Conclusion

This study indicates that Australian midwives encountering women with FGM while there are gaps in technical and legal knowledge. The need for specialised training programs as a compulsory part of professional development and pre-service education is important particularly for midwives who are caring for women in hospitals, health centres and home who are from communities where FGM is a traditional practice.

Addressing underlying issues such as poor communication and lack of collaboration between states and territories in Australia should be discussed in order to develop a uniform approach within health systems involving all stakeholders.

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References


41. NSW MoH. Maternity-Pregnancy and Birthing Care for Women Affected by Female Genital Mutilation / Cutting. In: Families NKa, editor. NSW, Australia: Ministry of Health NSW; 2014.


**Table 1 FGM classification (WHO 2016b)**

<table>
<thead>
<tr>
<th>Type</th>
<th>Classification of each type</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Type I:</strong></td>
<td></td>
</tr>
<tr>
<td>Partial or</td>
<td>Ia: removal of the prepuce/clitoral hood</td>
</tr>
<tr>
<td>total removal</td>
<td>Ib: removal of the clitoris with the prepuce (clitoridectomy)</td>
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<tr>
<td>of the clitoris</td>
<td>(clitoridectomy) and/or the prepuce</td>
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<tr>
<td>and/or the</td>
<td></td>
</tr>
<tr>
<td>prepuce</td>
<td></td>
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<tr>
<td><strong>Type II:</strong></td>
<td></td>
</tr>
<tr>
<td>Partial or</td>
<td>Ila: removal of the labia minora only</td>
</tr>
<tr>
<td>total removal</td>
<td>Ilb: partial or total removal of the clitoris and the labia minora</td>
</tr>
<tr>
<td>of the clitoris</td>
<td>IIC: partial or total removal of the clitoris, the labia minora and the labia majora</td>
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<tr>
<td>and the labia</td>
<td></td>
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<tr>
<td>minora, with</td>
<td></td>
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<tr>
<td>or without</td>
<td></td>
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<tr>
<td>excision of</td>
<td></td>
</tr>
<tr>
<td>the labia</td>
<td></td>
</tr>
<tr>
<td>majora (excision)</td>
<td></td>
</tr>
<tr>
<td><strong>Type III:</strong></td>
<td></td>
</tr>
<tr>
<td>Narrowing of</td>
<td>IIIa: removal and appositioning the labia minora with or without excision of the clitoris</td>
</tr>
<tr>
<td>the vaginal</td>
<td></td>
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<tr>
<td>orifice with</td>
<td></td>
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<tr>
<td>the creation</td>
<td></td>
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<tr>
<td>of a covering</td>
<td></td>
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<tr>
<td>seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation)</td>
<td></td>
</tr>
<tr>
<td>Note: Re-infibulation is the procedure to narrow the vaginal opening in a woman after she has been deinfibulated (i.e. after childbirth); also known as re-suturing</td>
<td></td>
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<tr>
<td><strong>Type IV:</strong></td>
<td></td>
</tr>
<tr>
<td>All other</td>
<td>Practices include pricking, pulling, piercing, incising, scraping and cauterization</td>
</tr>
<tr>
<td>harmful</td>
<td></td>
</tr>
<tr>
<td>procedures</td>
<td></td>
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<tr>
<td>to the female</td>
<td></td>
</tr>
<tr>
<td>genitalia for non-medical purposes</td>
<td></td>
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</table>
Table 2 Demographic characteristics of midwives who responded to the survey

<table>
<thead>
<tr>
<th>Variable</th>
<th>N = 198</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>State or territory of practice:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>New South Wales</td>
<td>147</td>
<td>74</td>
</tr>
<tr>
<td>Queensland</td>
<td>20</td>
<td>10.1</td>
</tr>
<tr>
<td>Victoria</td>
<td>13</td>
<td>6.6</td>
</tr>
<tr>
<td>South Australia</td>
<td>7</td>
<td>3.6</td>
</tr>
<tr>
<td>Western Australia</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>Australian Capital Territory</td>
<td>3</td>
<td>1.6</td>
</tr>
<tr>
<td>Northern Territory</td>
<td>2</td>
<td>1.1</td>
</tr>
<tr>
<td><strong>Years of experience (median=16)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;5</td>
<td>53</td>
<td>26.5</td>
</tr>
<tr>
<td>5-10</td>
<td>20</td>
<td>10</td>
</tr>
<tr>
<td>11-15</td>
<td>25</td>
<td>12.5</td>
</tr>
<tr>
<td>16-20</td>
<td>29</td>
<td>14.5</td>
</tr>
<tr>
<td>21-25</td>
<td>12</td>
<td>6</td>
</tr>
<tr>
<td>26-30</td>
<td>40</td>
<td>20</td>
</tr>
<tr>
<td>Type of practice/ role</td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>------------------------------------------------------------</td>
<td>-------</td>
<td>------</td>
</tr>
<tr>
<td>Public Health Facility (clinical)</td>
<td>173</td>
<td>86.5</td>
</tr>
<tr>
<td>Private Health Facility(clinical)</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>Independent practice(clinical)</td>
<td>7</td>
<td>3.5</td>
</tr>
<tr>
<td>Not currently working as midwife or academic</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>Academic, PhD students</td>
<td>22</td>
<td>11</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Country of initial midwifery education</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australia</td>
<td>177</td>
<td>89</td>
</tr>
<tr>
<td>Europe</td>
<td>20</td>
<td>10</td>
</tr>
<tr>
<td>Asia</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>
Figures

Figure 1 FGM training

Learnt about FGM During Midwifery Education

- **Yes**: 47.5%
- **No**: 43.4%
- **Don't remember**: 9.1%
Do you have a form/database to record information about FGM?

- No: 42%
- Yes: 27.5%
- Don’t know: 27%
- Not applicable: 3.5%
What type of training would you like to have about FGM?

- Printed information
- E-learning modules
- Workshops with community groups
- Network with colleagues who work in this...
- Professional/Multi-Agency conferences
- Study days
- Seminars