

1 **Midwives' experiences of caring for women with female genital mutilation: insights**
2 **and ways forward for practice in Australia**

3

4 **ABSTRACT**

5 **Background:** Female genital mutilation (FGM) has serious health consequences, including
6 adverse obstetric outcomes and significant physical, sexual and psychosocial complications
7 for girls and women. Migration to Australia of women with FGM from high-prevalence
8 countries requires relevant expertise to provide women and girls with FGM with specialised
9 health care. Midwives, as the primary providers of women during pregnancy and childbirth,
10 are critical to the provision of this high quality care.

11 **Aim:** To provide insight into midwives' views of and experiences working with women
12 affected by FGM.

13 **Methods:** A descriptive qualitative study was undertaken using focus group discussions with
14 midwives from four purposively selected antenatal clinics and birthing units in three hospitals
15 in urban New South Wales. The transcripts were analysed thematically.

16 **Findings:** Midwives demonstrated knowledge and recalled skills in caring for women with
17 FGM. However, many lacked confidence in these areas. Participants expressed fear and a
18 lack of experience caring for women with FGM. Midwives described practice issues,
19 including the development of rapport with women, working with interpreters,
20 misunderstandings about the culture of women, inexperience with associated clinical
21 procedures and a lack of knowledge about FGM types and data collection.

22 **Conclusion:** Midwives require education, training and supportive supervision to improve
23 their skills and confidence when caring for women with FGM. Community outreach through
24 improved antenatal and postnatal home visitation can improve the continuity of care
25 provided to women with FGM.

26 **Keywords:** female genital mutilation; midwifery practice

27

1 **INTRODUCTION**

2 Female genital mutilation (FGM) is an ancient practice performed on infants and young girls
3 that involves the partial or total removal of the external female genitalia or other injury to the
4 genitalia for non-therapeutic reasons (1). The United Nations estimates that more than 130
5 million girls and women in 29 countries of Africa and the Middle East (e.g. Yemen, Iraq) have
6 undergone FGM, with three million at risk each year (2). It is also prevalent in some
7 countries of Asia (e.g. India, Malaysia and Indonesia) and migrant communities from these
8 countries in Australia, New Zealand, United States and Europe. (3) Hence in Australia,
9 increasingly, health professionals, especially midwives, are caring for women with FGM and
10 therefore need appropriate expertise (4, 5).

11 There are four types of FGM (6). The most common procedure entails the excision of the
12 prepuce with, or without excision of part or the entire clitoris (Type 2). The most extreme
13 form, known as type 3 or infibulation, involves the removal of all or part of the external
14 genitalia and the stitching of the two cut sides, narrowing the vagina to varying degrees.
15 Infibulation comprises leaving a small opening for the passage of urine and menstrual blood
16 (6).

17 Following the procedure, girls are at risk of death from haemorrhage or infection. If they
18 survive, transmission of infections and injury to adjacent organs during the cutting, such as
19 rectum and urinary tract, can occur. There are many other physical, obstetric, sexual and
20 psychosocial complications of FGM. It is estimated that an additional 10 to 20 babies die per
21 1,000 births as a result of women having had FGM (7, 8).

22

23 In some communities globally, FGM has become a self-enforcing social norm, a socially
24 upheld behavioural rule (2). The sense of social obligation to cut one's daughter is so
25 entrenched that it overrides any potentially positive influence from moral and legal norms.

26 Reasons to inflict FGM on girls can vary in different communities and include preservation of

1 premarital virginity, marital fidelity, family honour, rite of passage and perceived religious
2 requirement. Christians, Muslims and people of traditional African religions carry out FGM,
3 even though no religion condones it. Mothers subject their daughters to FGM to protect
4 them, to secure good prospects of marriage, to ensure acceptance in the community and for
5 economic security (2, 9).

6

7 The prevalence of FGM in Australia is unknown, as there is no state, territory or national
8 data collection, but specialist hospital teams have been established in some centres in
9 response to increased presentations (10, 11) to enhance the health outcomes for mothers
10 and their babies. Midwives, as the primary providers of women during pregnancy and
11 childbirth, are critical members of such specialist teams. However, there is a lack of research
12 focusing on the practice and needs of midwives in Australia (12). The need for educational
13 resources was responded to by the Australian College of Midwives who have collated
14 materials on a national website (13). There is however, still a gap in the understanding of the
15 educational and practice needs of midwives. Research to gain insight into midwifery practice
16 and perceptions towards the practice of FGM will assist the development of appropriate
17 education and training curricula and best support midwives to provide quality care for women
18 with FGM.

19 The purpose of this study is to provide insight into midwives' views of, and experiences
20 working with, women affected by FGM. In particular, the research aims to describe how
21 midwives define FGM, the populations they believe to be affected, and their knowledge of
22 the health implications, as well as their clinical practice experiences and suggestions for
23 improving the quality of care delivered to women.

24

25 **A BRIEF ANALYSIS OF THE LITERATURE**

1 With the exception of Aboriginal and Torres Strait Island peoples, Australia is a country
2 comprised of migrants, with many arriving as refugees from countries having experienced
3 war, disasters and persecution. Migrants and refugees bring with them their rich cultural
4 heritage and traditions. The anxiety of the many unknown and new ways of life in the country
5 of migration, coupled with a lack or poor command of the new language, may result in
6 migrant communities strongly adhering to their own traditions. There may also be anxieties
7 about job opportunities, and a sense of loss of control about raising their children according
8 to their cultural values (14). Hence, traditions –beneficial or harmful – may continue into the
9 next generation.

10

11 Cultural practices of some communities, such as remaining at home until married, or
12 marriage partner or career selection according to the advice of elders, may be discarded or
13 modified, and new practices adopted in their new country of migration, according to what is
14 valued by the new society and considered more personally beneficial (15). The practice of
15 FGM has been shown to be affected by migration (16). A Norwegian study reported that
16 70% of Somali migrants supported the discontinuation of all forms of FGM and 81% did not
17 intend to subject their daughters to it. The majority of those who supported FGM, had been
18 living in Norway for less than four years (17). This low rate of support in Norway is in
19 contrast with the FGM rate of 98% in Somalia (18), suggesting that change can probably be
20 brought about within a generation, if the benefit of a tradition declines.

21

22 According to the latest Australian census, there are more than 165,000 migrants who were
23 born in countries that make up 29 nations in the Middle East, North and Sub-Saharan Africa
24 where FGM is identified as prevalent (2, 3). In addition, there are approximately 140,000
25 people who identify having ancestry from these 29 countries. This equates to migrants from
26 these countries comprising approximately 1.5% of the total Australian population of 21.5
27 million people. However, there are a large number of Australians who were born in other

1 countries where FGM is reported to be practised but there is no national prevalence data.
2 These countries include Thailand (19), Indonesia (20), Malaysia (21), India and Pakistan
3 (22). There are approximately 550,000 migrants born in these countries in Australia (23).
4 Some of the fastest growing migrant groups are from countries where there is a medium to
5 high prevalence of FGM, including Guinea, Nigeria, Liberia, Cote d'Ivoire, Senegal and
6 Sierra Leone (23). These migration data and trends highlight the need to address FGM.

7

8 In Australia, FGM is illegal with laws prohibiting a person or assisting another person from
9 performing any type of FGM with or without consent (24). It is prosecutable by imprisonment
10 of up to 21 years. Research shows that some health professionals have performed FGM in
11 Australia (5). Two cases of FGM involving young girls are before the courts in New South
12 Wales (NSW). The first involves four people, including a retired nurse and a sheik. The
13 second involves parents who took their child overseas to have FGM performed (25, 26).

14

15 There are significant health issues associated with FGM that require girls and women to
16 have special care. FGM can result in haemorrhage and death, chronic pain, injury of
17 neighbouring organs, recurrent genital abscesses and infections, incontinence, clitoral
18 malformations and painful menstruation (27, 28). Scarring of the vulva and vagina can lead
19 to painful sex and bleeding that can expose women to further infection. Women with FGM
20 can experience prolonged labour, tearing of their perineum during birth and obstetric fistulas
21 (29). In African countries where FGM is commonly practised, FGM is significantly associated
22 with adverse maternal health outcomes, requiring emergency treatment that increases
23 according to severity of the type. For example, compared with women without FGM, women
24 with FGM type 3 have been found to have 1.7 times the risk of severe bleeding during
25 childbirth, and 1.3 times the risk of a caesarean section. Twenty-two percent of perinatal
26 deaths in infants born to women with FGM can be attributed to the FGM (7). FGM means
27 health professionals, especially midwives, often need to perform de-infibulation, or the
28 opening of the scar, to reverse the FGM procedure in preparation for childbirth. FGM is

1 associated with infant problems and extended hospital stays (7). FGM also affects women's
2 mental health. A study in the Netherlands found that one in six respondents suffered from
3 FGM related post-traumatic stress disorder and one-third reported symptoms related to
4 depression or anxiety that became more prominent during childbirth (30).

5
6 The particular issues that women with FGM face around pregnancy and the birth of their
7 baby require midwives to have additional knowledge, skills and workplace support. However,
8 there are very few research studies in Australia that focus on FGM and none that specifically
9 investigate the perspectives and needs of midwives. Of the four published studies from
10 Australia that include research related to FGM, the first examines African women's
11 experiences of giving birth in a hospital in Brisbane. It found that women were often
12 "surprised" that midwives were not experienced in managing FGM (31). In a study of hospital
13 staff (professions unspecified) and African women, clinicians reported trying to discuss FGM
14 sensitively, while women viewed their efforts as intrusive and inappropriate (32). Two other
15 Australian studies examined health professional and hospital experience of women with
16 FGM. A survey of Royal Australian College of Obstetricians and Gynaecologists
17 (RANZCOG) Fellows, Trainees and Diplomates, and FGM education and prevention
18 program workers found anecdotal evidence for requests for FGM to be performed in
19 Australia and New Zealand (5). The only available study of antenatal outpatient records in
20 Australia is from the Royal Women's Hospital in Melbourne between October, 1995, and
21 January, 1997, which identified complications of FGM, including dyspareunia, apareunia and
22 urinary tract infections (4).

23
24 Despite a lack of research examining midwives' experiences of FGM in Australia, there are a
25 small number of studies involving midwives from other Organisation for Economic
26 Cooperation and Development countries where there has been migration from nations where
27 FGM is practised. These include the USA (33, 34), Sweden (35, 36) and the UK (37). The

1 findings of this research have been examined elsewhere in a systematic review, showing the
2 need for professional education and training, and a supportive working environment (12).

3

4 **METHODS**

5 A descriptive-interpretive qualitative research method was used to understand complex
6 phenomena of the provision of midwifery care to women with FGM in urban Australian
7 hospital settings (38). The focus of the study was on the comprehension of the multiple
8 realities or experiences of midwives relayed in focus group discussions (FGD) (39). The
9 focus group was selected to obtain accounts in participants' own words and enable
10 participants to build on one another's responses. The focus groups also enabled participants
11 to act as censors of one another, so that factual errors or extreme views could be identified
12 in the course of the discussion.

13 Ethical approval was gained from The NSW Ministry of Health Human Research Ethics
14 Committee (LRN WMEAD 14/19) and ratified by the University of Technology, Sydney
15 Human Research Ethics (2014000289).

16

17 *Study site*

18 Four antenatal clinics and birthing units in three hospitals in urban New South Wales were
19 purposively selected for inclusion. These are situated in a principal referral hospital with
20 more than 5,000 births per year, and two metropolitan hospitals with 3,000 and almost 1,500
21 births per year, respectively. We used the list of prevalent countries outlined in the recent
22 UNICEF report (2) and selected hospitals in areas where there were large communities of
23 migrants based upon Australian Bureau of Statistics census data (3). Midwives were invited
24 to provide their insights into their experiences of caring for women in these hospitals, as they
25 served populations of women from countries where FGM is prevalent.

26

27 *Participant selection*

1 The Clinical Nurse Midwifery Unit Manager and their midwives in each hospital were
2 provided with information about the study and invited to participate in a FGD at a mutually
3 agreed time and day. We asked the Clinical Nurse Midwifery Unit Manager to distribute the
4 invitation to registered midwives working in the hospital with a range of skills and experience.
5

6 *Data collection*

7 Focus groups provided the opportunity to engage 10-12 participants per group for
8 approximately one hour to share their thoughts, attitudes and ideas on FGM. Four FGDs
9 were conducted using an interview guide. The guide included questions such as, “How
10 would you describe FGM?”, “How are women affected by FGM?”, “What is your experience
11 working with women with FGM?”, “What is your experience collecting and recording data
12 about FGM?”, “What professional development needs do you have in relation to FGM?”.

13 One researcher (AD) moderated the focus group, while another (ST) observed and took
14 notes to assist with the clarification of participant contributions during the analysis. The
15 groups were held in meeting rooms in the hospitals in which midwives worked during time
16 allocated for professional educational development.
17

18 *Data analysis*

19 After consent from participants, the discussions were audio recorded and transcribed
20 verbatim. All identifying features were removed, including names of participants and
21 hospitals. A thematic analysis was undertaken by two authors (AD and ST), which involved
22 comprehending, synthesising, theorising and re-contextualising the data (40). The transcripts
23 were read several times and subjected to intensive review by the two primary researchers
24 through questioning, comparing and then synthesising to identify issues, topics and patterns.
25 Categories were created, some of which were collapsed into themes. During the theorising
26 process, data were challenged by alternative explanations until a fit with the data was
27 identified (41). Data saturation was achieved during this analysis process when it became

1 clear that the data collected provided strong support for the emergent categories and themes
2 and that no further relevant information was necessary to further support these. The process
3 of re-contextualisation involved situating the findings in the context of other research and
4 demonstrating how the research made a new contribution (40). This was undertaken in
5 consultation with all authors. The findings were collated in a report and sent to the contact
6 Clinical Nurse Midwifery Unit Manager in each hospital to be distributed for comment and to
7 inform in-service training if required. No requests to emend the analysis were received and
8 no midwives asked for further data to be included in the findings report.

9

10 **FINDINGS**

11 Forty-eight midwives participated in the study. Five themes emerged from the analysis: (1)
12 knowledge of FGM, (2) perceptions and experiences of caring for women, (3) influences on
13 midwifery practice, (4) FGM data collection and (5) education and training. The findings are
14 described below according to these major themes.

15

16 *Midwives' knowledge of FGM*

17 Midwives in all groups knew that FGM involved "cutting", "circumcision" and "mutilation" and
18 noted different types, including "pricking of the area", "surgical excision of some degree"
19 (FGD 4). One midwife stated, "*I know there are different grades based on the amount of*
20 *tissue that's there or has been removed*" (FGD 2). Midwives in two FGDs noted four types,
21 with greatest severity attributed to type three. "*The really bad ones have a really small*
22 *opening to allow menstrual blood and urine to flow*" (FGD 2). Another midwife knew the three
23 types as "*the good, the bad and the ugly*" (FGD 2), while others were able to describe the
24 procedure in detail, i.e. "*It's the removal of any or all parts of the clitoris and the labia minora*
25 *and then suturing together the skins that's left over*" (FGM 3).

26

27 Several midwives were unsure about FGM types, i.e. "*I'm usually asking the doctors what's*
28 *that classification. I really don't know*" (FGD 2). All participants knew that FGM was practised

1 in some Arab states and North and Sub-Saharan African countries. One midwife (FGD 1)
2 was aware that it was prevalent in Malaysia. There was no mention of other Asian nations or
3 ethnic groups. A participant believed the “*worst*” type or “*infibulation*” to be practised in
4 Somalia. One midwife attributed the name “*chop chop*” to the practice in Malaysia (FGD 2),
5 while another said that an “*Arab ethnic group*” called it “*nos nossos*” and described a specific
6 type of damage to the clitoris (FGD 3).

7

8 Participants’ knowledge included an understanding that the practice was “*tribal*” (FGD 3),
9 “*very old*” (FGD 1), “*cultural*”, “*matriarchal*” (FGD 4) and that it was usually “*done by the*
10 *women*”, “*not in a hospital setting and (with) no anaesthetic*” (FGD 2). One participant felt
11 that FGM was “*about men telling women what to do*”, whilst another midwife emphasised
12 that practice was a form of “*power*” and “*control*” (FGD 1). Midwives described the practice
13 as “*barbaric*”, a form of “*sexual assault*” and that it involved “*taking away your rights*” (FGD
14 2). Some understood that women regarded it as a “*rite of passage*” (FGD 3), or an “*honour*”
15 and often saw it as “*normal*” (FGD 4) and were “*proud to have this done*” (FGD 3).

16

17 The purpose of FGM was regarded by midwives to “*make the women remain chaste*” (FGD
18 4), “*faithful*”, “*satisfy men*” and “*clean*” (FGD 2) and that it would enable women to “*get a*
19 *good barter or trade at their wedding*” (FGD 4). One midwife stated that “*religion was used to*
20 *justify the practice*” (FGD 4). Several participants mentioned piercing and one asked, “*What*
21 *is the difference between what we do to our bodies and what they do to theirs?*” The answer
22 provided by another midwife was the lack of consent in the case of FGM (FGD 3).

23

24 Participants knew that the practice was illegal in Australia, the United Kingdom and the
25 United States (FGD1, 2, 3, 4), but several midwives said that they were unclear about the
26 legality of an anterior episiotomy (FGD 3). Midwives knew about the health issues
27 associated with FGM, including urinary tract infections, wound infections, dyspareunia,
28 dysmenorrhea and incontinence. They also understood obstetric complications, such as

1 perineal tears, fistula and prolonged labour requiring episiotomy (FGD 4). One midwife
2 stated that women may needed a caesarean section if de-infibulation was not performed
3 before labour (FGD 1), while another noted that, “*As regards to the pregnancy itself and the*
4 *development of the fetus, it doesn’t impact upon the fetus at all*” (FGD 4). Many midwives
5 were unsure of the current policy to guide midwifery practice with respect to FGM. Several
6 participants suggested where it could be found; while another said that she had seen the
7 new revised version (FGD 2).

8

9 *Midwives’ perceptions of women with FGM and experiences of caring for them*

10 Midwives described a range of perceptions of women with FGM and experiences working
11 with FGM in Australia, the UK and the Middle East. Many perceived that women did not
12 always disclose or admit to having FGM (FGD 4, 2), saying that they were “*ashamed*” (FGD
13 3, 4), and expressed “*horror*” at the practice to avoid questions (FGD 4). One midwife
14 perceived that “*It is us who see them as mutilated*”, which affected how women interact with
15 health professionals (FGD 3). Some midwives reported that many women were
16 embarrassed; they indicated they wanted privacy during care and that some women were
17 not very knowledgeable regarding their type of FGM or aware that FGM was not practised in
18 Australia (FGD 4). Other midwives stated that, in their experience, women with FGM were
19 very “*open*” and “*clued up [aware]*” in terms of the practice being illegal in Australia (FGD 4)
20 and that many women were educated (FGD 2).

21

22 Other midwives perceived women to be confident when faced with issues while in hospital.
23 One midwife described how a woman with FGM type 3 offered to assist a doctor to
24 undertake her transvaginal ultrasound by inserting the probe herself (FGD 3). Another
25 midwife recalled an incident when a woman with FGM had visited her friend in hospital who
26 has just had a baby and heard her urinate. The woman was reportedly shocked to hear the
27 loud noise that her friend had made. Upon receiving the explanation of de-infibulation, she
28 asked if she could also be “*booked in*” for the same procedure (FGD 4). However, midwives

1 perceived that many women did not want clinical interventions, generalising that “*African*
2 *women hate epidurals*” and were reportedly “*fearful of having a spinal anaesthetic for a*
3 *caesarean section*”, as they felt that the process was “*in the hands of God*” (FGD 2).

4 Midwives stated that women were not keen to be de-infibulated during pregnancy, preferring
5 instead to wait until the birth, as they believed that they were going to receive an episiotomy
6 at this time anyway (FGD 3). One midwife described the influence of an older woman on the
7 decision to have a de-infibulation prior to birth, citing that “*their mother or aunty said no*”.

8 One midwife wondered if the fact that women were not re-infibulated, meant that they were
9 ostracised for being de-infibulated (FGD 2). However, one participant recalled the reaction of
10 the partner of one woman to re-infibulation who said, “*There’s no way you’re going to do that*
11 *to my wife, I don’t want her sewn up again*” (FGD 3).

12

13 Midwives referred to women as “*traumatised, physically and psychologically*” (FGD 3, 2) as
14 a result of FGM. One participant recounted a story told to her by a woman’s birth companion.
15 She described a young girl who was so affected by seeing the procedure carried out on her
16 sister in her country of origin, that she tried to drown herself but was prevented and forcefully
17 mutilated against her wishes (FGD 3). However, other midwives felt that women did not have
18 a memory of having FGM because they were too young when it was performed (FGD 3).

19

20 Concerns about the perpetuation of the practice were described by several midwives who
21 recalled women asking how FGM could be arranged for their daughters (FGD 1, 2). The
22 changing views of women were noted by one midwife participant. She recalled a woman
23 describing how she “*looked forward*” to having FGM performed until she “*realised the impact*
24 *that it had*” and that “*there was often a lot of fear for the children if they went on holiday back*
25 *to Africa, if they’re going to be subjected to it as well*” (FGD 2).

26

27 Midwives expressed particular views about women with FGM and their culture. The pain and
28 suffering that women endured, led one midwife to say she “*felt sorry for them*” (FGD 4).

1 Several midwives did not believe that women from countries where FGM was performed
2 could speak openly about sex (FGD 3). Midwives said that women were very accepting of
3 the pain during childbirth (FGD 2), while others stated that women did not really want to talk
4 with midwives. One participant agreed that women became quiet and did not want to share
5 their feelings and perceived this to be disrespectful and impolite behaviour (FGD 2). Several
6 participants shared their opinions about the countries women with FGM came from and
7 ascribed certain characteristics to them. One midwife felt that the “*incidence is rising*” (FDG
8 4) but a midwife at another hospital claimed that they did not see “*a lot any more*” (FGD 2).

9

10 *Influences on midwifery practice*

11 The importance of a mutually respectful rapport between midwives and women with FGM
12 was seen as a critical part of midwifery practice. There was discussion about appropriate
13 and sensitive terminology regarding FGM in the FGDs. Midwives commented that “*Mutilation*
14 *is such a horrible term*”, “*Circumcision is widely accepted*”, “*Female cutting is actually a little*
15 *bit softer*” (FGD 3). Other terms were noted by participants as appropriate, including the use
16 of “*traditional practice*” as compared to “*genital surgery*” (FGD 3).

17

18 Midwives spoke about the importance of interacting in appropriate ways to put women at
19 ease and elicit information, especially at the antenatal booking visit. One participant said “*It's*
20 *the way we approach these women whether they're going to feel shame. ...when we come*
21 *up and discuss it with them, and depending on how we discuss it that they're forthcoming*
22 *with information*” (FGD 3). One midwife highlighted the importance of not judging women
23 with FGM (FGD 2). “*So I'm not treating them as like this is bad*”, emphasizing the need to be
24 polite and careful not to “*offend*” by stating your “*opinions*” (FGD 4).

25

26 A major impact on the delivery of antenatal services was the additional time needed to
27 sensitively understand a woman's context and needs. One midwife explained that it might
28 involve a vaginal examination and consent needed to be obtained. She felt that midwives

1 must be careful not to reveal their shock when they see a woman with FGM, as “*faces tell a*
2 *thousand (words)...*” (FGD 3) and the midwife’s reaction may upset the women. Another
3 participant highlighted the need to be respectful, acknowledging past trauma and the need to
4 seek continuing permission when undertaking vaginal examinations on women because the
5 “*touching of their genitalia causes a spiral of events*” (FGD 3). One midwife expressed her
6 concern, as she did not want to “*do any further damage to what's left*” (FGD 2). Building
7 rapport with women was seen as essential midwifery practice in order to obtain a complete
8 history to inform their care. According to one midwife, “*Once you've built up a rapport, the*
9 *information that you get from these women is amazing and you talk about sex with them and*
10 *they answer the questions easily*” (FGD 3). In one hospital “*very enthusiastic and very client-*
11 *focused*” medical liaison officers were described as an important part of developing rapport
12 with women (FGD 3). However, midwives described barriers to providing continuity of care
13 for these women over the course of their pregnancy and birth of their babies (FGD 3).
14 Despite this, one midwife said that women in the community were familiar with the service
15 and were self-referring.

16 “*I can tell when women turn up at my clinic and I've never met them before but they*
17 *know me, and they know where I'm from and they know it's because they've been*
18 *recommended by somebody, or we've been recommended by somebody. Word of*
19 *mouth is a really powerful recommendation.*” (FGD 3)

20

21 Midwives discussed counselling as an important part of midwifery practice for these women.
22 Time constraints were seen as problematic but the importance of the antenatal counselling
23 was highlighted:

24 “*It is hugely dreadful when you have to do an anterior episiotomy with somebody*
25 *who's transitional [late first stage of labour], who's just walked in in that state; there's*
26 *no counselling around that. So you are actually doing a procedure that is very*
27 *uncomfortable because you cannot rationalise with the woman in that state. So that is*
28 *the key, antenatal counselling is all I can say.*” (FGD 3)

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The need for postpartum counselling was also noted:

“Also, if you do that at the last minute, what about the postnatal care when they pass urine and it's noisy and they're going to freak out because they're not used to this because we just put a drip in? If that's the case, then we need to have really, really good postnatal counselling as well.” (FGD 3)

Communication was sometimes challenging due to language barriers, the lack of available, culturally acceptable interpreters and the particularly sensitive nature of the topic of FGM. Phone interpreters were said to be available if required (FGD 2) and family members were often called to interpret but this was described as *“difficult”* (FGD 2). A midwife described feeling uncomfortable and that women were embarrassed when male interpreters were assigned, as female interpreters were often unavailable (FGD 3). Working successfully with interpreters was noted by midwives as a skill requiring experience and training (FDG 3).

Many midwives described a lack of skill and experience in caring for women with FGM and the potentially negative impact it had on their practice. Midwives described feeling *“fearful”* because they did not want to cause any pain or further harm to the women. A midwife said, *“Having done the anterior episiotomy, my biggest fear is having to do a lateral episiotomy as well. We've had one occasion where we did have to do that. It felt like we'd mutilated that woman even further”* (FDG 2). Other participants were worried about undertaking clinical procedures that they were not confident with. One midwife described her experience carrying out one such procedure:

“I had to actually do an anterior episiotomy on her. I found that very unnerving to actually have to cut upwards, which is against everything that we normally do. Having the fear of how (to do it) when it's going to stop because you don't technically use the scissors on that. You just - well, we didn't. We put the blade behind it and it just gave. The fear is how far is it going to extend and what it's going to do.” (FGD 2)

1 Other participants outlined the challenging nature of caring for women with FGM. *“It’s*
2 *emotionally confronting”* (FDG 2) and *“shocking”* (FDG 1). One midwife said, *“My biggest*
3 *fear is when that head is crowning. You’re just looking and thinking: I don’t know what to do”*
4 *(FGD 2)*. Another recalled an experience of being left alone with a labouring woman with
5 FGM as *“terrifying”*. She said, *“They were all deciding she was going to have a caesarean*
6 *section because of FGM. But they’d all gone out to decide this, and left me alone in the*
7 *room... and yeah, they came back - never leave me alone again.”* (FGD 1). Two midwives
8 also described having *“mini panic attacks”* when they saw the sticker on the women’s notes
9 indicating that they had FGM (FGD 4), as they felt that their practice was inadequate.
10 Midwives also stated that they did not have enough experience to identify FGM, saying it
11 was not always *“clear-cut”* to classify (FGD 2).

12

13 Midwives described ways to improve their ability to care for women. In one hospital,
14 midwives said they received referrals from a midwife with specialist training with the
15 women’s history and suggestions for care (FDG 4). A unique care plan was seen by several
16 midwives to be a useful way forward (FGD 4). Without this information, they admitted they
17 felt very unprepared. Moreover, they maintained that because of their lack of experience,
18 FGM was not something they immediately considered as a possible cause for obstructed
19 labour. It was noted that this lack of consideration could impact on care. One participant
20 recounted a story where an un-booked woman presented with an intrauterine death. It took
21 the midwives a long time to realise that the reason for the length of time it was taking for the
22 woman to give birth, was that she was infibulated (FDG 4).

23

24 Midwives discussed the importance of professional development regarding pregnancy and
25 FGM, allowing them to gain experience and confidence in caring for women with FGM.

26 *“You’ve got to be comfortable with and have the knowledge base and feel confident.*
27 *And then, of course, there is that person that’s sitting opposite you, they’re very*
28 *nervous when they first come in for a first book-in, they have no idea what’s going to*

1 *happen. They've heard tidbits from their friends. You can see them relax as you*
2 *proceed. (FGD 3)*

4 *Collecting data about FGM*

5 The routine collection of information about women with FGM was discussed in relation to a
6 women's history at the antenatal booking, the initial vaginal examination and following birth
7 in the obstetric information system. Time pressures and lack of experience were seen as
8 barriers to data collection. One participant explained that a skilled midwife was able to frame
9 questions in a logical, sequential manner rather than as individual data points (FGD 3). In
10 one hospital, labels were placed on women's files to indicate FGM. This was entered onto
11 the computer under an alert function. However, one midwife admitted that these were not
12 properly assessed by staff (FGD 3).

13
14 Some midwives were aware of where they could record FGM on the database under "*other*
15 *surgeries*" but felt that it was often missed and that FGM needed its own indicator, or a
16 "direct question" for clarity. Participants were not supportive of additional forms, as there
17 were too many already (FGD 4). Several midwives said they did not know where to add
18 information about FGM and had not done so before (FGD 1), thus reflecting the current lack
19 of agreed data collection on FGM at a hospital level. One midwife said "*If they have been de-*
20 *infibulated during pregnancy, is that in Obstetrixs?*" (A hospital database)

22 *Training and education needs*

23 Most midwives spoke about gaining knowledge and skills about FGM "*on-the-job*", with a few
24 recalling intermittent in-service training. Most participants called for more continuing
25 professional development in the area. Gaining experience from senior midwives through
26 mentoring and training was regarded as important to participants, particularly during history
27 taking at the antenatal booking (FGD 3). The importance of quality up-to-date resources was
28 also cited as useful, including photographs depicting types of FGM and videos of de-

1 infibulation processes and lateral episiotomies (FGD 1, 2). Midwives called for training for
2 general practitioners to be involved in prevention programs for FGM. *“So I think here our GP*
3 *program - our doctors that are involved in the GP share program - have ongoing training and*
4 *education to help women and prevent it”*(FGD 1).

5

6 Midwives also called for the need to educate men and women in the community in order to
7 protect girls from being taken overseas to undergo FGM (FGD 2, 3). Participants highlighted
8 the need for health professionals to partner with the community to *“build trust”* to deliver
9 health education to prevent FGM (FGD 3).

10

11 **DISCUSSION**

12 Midwives who participated in four focus groups from three Australian urban hospitals
13 described their challenges in providing care to women from countries where FGM is
14 prevalent. They demonstrated their knowledge and recalled skills in caring for them. This
15 study underlined the fact that many midwives require additional opportunities to build their
16 confidence, knowledge and skills to care for women with FGM. Midwives described practice
17 issues, including the need to quickly develop rapport with women, the importance of working
18 with interpreters, addressing misunderstandings about the culture of women, being
19 inexperienced with associated clinical procedures and a lack of knowledge about FGM types
20 and data collection. This confirms findings in other studies for the need for more professional
21 development around FGM (12). Midwives in our study suggested useful strategies to
22 improve care, including continuity of care, the use of medical liaison officers and community
23 outreach programs. Practice was exemplary when there was midwifery continuity of care,
24 especially where women had sought out midwives who had provided care to them on
25 previous occasions, or who had been referred by other women in their community.

26

27 Quality care requires involving women’s partners in the counselling process. FGM is no
28 longer considered an issue affecting women only. There is evidence that male partners of

1 women with FGM can have complications as well. Interviews of 59 men in Sudan revealed
2 that the majority had difficulty in vaginal penetration, wounds and infections on the penis and
3 psychological problems. Of particular importance was the fact that the men experienced their
4 wives' suffering as their own problem (42). Husbands may be the decision makers to have
5 their newborn daughter cut, or their wife re-infibulated after delivery (43). The midwives'
6 counselling skills are therefore skills very important so they are confidently able to discuss
7 the meaning and complications of FGM and the benefits of de-infibulation with women and
8 their husbands together.

9

10 Underlining training and education, is the need for hospitals in Australia to develop and
11 implement protocols and guidelines for midwives and doctors to provide the specialised care
12 that women and girls with FGM require. Currently there are only four hospitals in Australia
13 that have specialised units that offer holistic care programs of counselling, antenatal de-
14 infibulation procedures and continuity of care for these women and their babies. Community-
15 based continuity of maternity care provided by midwives and obstetricians has been found to
16 significantly improve maternal clinical outcomes (44). Effective collaboration and referral
17 systems between hospitals and these units are also very important.

18

19 *Supportive supervision and mentoring*

20 This study highlighted the need for supportive supervision and mentoring of inexperienced
21 midwives by peers who had worked with women with FGM. Midwives requested mentoring
22 during the antenatal booking to assist them with building rapport with women to enable them
23 to learn about FGM in non-threatening ways that would encourage disclosure. In addition,
24 midwives expressed the need to improve professional skills to work with interpreters and
25 develop confidence and feel more comfortable talking with women. Clinical mentoring may
26 also be useful during vaginal examinations and during births. Mentorship, preceptorship and
27 clinical supervision have been highlighted as important processes for supporting midwives
28 (45). In New Zealand, for example, it has been suggested that professional supervision

1 should be viewed as a competency requirement (46). A focus on mentoring and supportive
2 supervision for midwives in contexts where they are involved in delivering care to women of
3 diverse culture groups, may be particularly helpful in improving the quality of care women
4 receive and the satisfaction of midwives in their roles (47).

5

6 *Midwifery education and training*

7 Midwives in this study had had a range of education and training experience but most
8 expressed the need for more. Regular in-service training is clearly needed in contexts where
9 midwives are delivering care to communities that have a high prevalence of women with
10 FGM. This training should include activities to help midwives develop knowledge and skills,
11 so they are able to accurately classify FGM types and record this data appropriately in the
12 allocated space in the database system. Such efforts would help improve the collection of
13 accurate data on FGM that is essential to evidence-based decision-making. Training is also
14 required to raise awareness of the possibility that women from particular countries may have
15 FGM. Whilst a firm knowledge of appropriate policy and protocols for care of women with
16 FGM is required, these have not been developed in most hospitals in Australia. Developing
17 midwives' capacity to perform clinical procedures, such as anterior episiotomies, would also
18 help to build skills and confidence. Midwives may also benefit from pre service education in
19 Bachelor and Postgraduate programs that emphasise caring for new immigrant mothers, as
20 noted in a study of maternity care culture of immigrant and refugee new mothers in Finland
21 (48) and Afghan mothers in Australia (49).

22

23 *Cultural safety*

24 While several midwives in this research demonstrated understanding of the reasons for the
25 practice of FGM and appropriate ways to interact with women, many expressed cultural
26 stereotypes and did not acknowledge the need to reflect upon and respond appropriately to
27 the woman's cultural expectations. This is not a new phenomenon, with women in other
28 research noting that health providers lacked communication skills and understanding of their

1 culture. A study of the experiences and knowledge of reproductive health and contraception
2 for Sudanese and Eritrean mothers and daughters described poor cultural competency as a
3 key barrier to positive health care seeking attitudes and the attainment of contraception and
4 sexual and reproductive health knowledge (50). Culturally safe midwifery practice requires
5 awareness of cultural difference and the legitimisation of this difference in planning midwifery
6 care, as well as the provision of a space for a woman to express her cultural needs (51).
7 Several midwives provided examples of this in practice, including the use of appropriate
8 terminology, refraining from being judgemental and working to develop rapport with the
9 woman in the community to provide antenatal and postnatal care, as well as in the hospital
10 at the antenatal booking, during and after delivery. The importance of midwifery continuity of
11 care and cultural competency has also been highlighted in an Australian study with pregnant
12 women born in African countries where FGM is practised (52). Cultural safety could be
13 improved through in-service training for midwives and the provision of appropriately trained
14 female interpreters. This could not only improve cultural competence but also help to reduce
15 the anxiety expressed by midwives when caring for women with FGM.

16

17 *Prevention opportunities in the community*

18 Community outreach programs can be pivotal in improving the care of women with FGM, as
19 well as preventing this harmful practice. Examples are midwifery continuity of care models,
20 health professional engagement in community activities and the involvement of other health
21 professionals, such as general practitioners (GP). Prevention efforts could be facilitated by
22 the delivery of health promotion into homes through initiatives such as the community-based
23 midwifery program in NSW (44), midwife and GP Shared Care (53), Midwifery Group
24 Practice (54) and the Sustaining NSW Families home visiting program that involves a visit
25 from a child and family health nurse two weeks after the birth of a child (55). Building rapport
26 with women and their families through home visiting, community midwifery and general
27 practice is in line with the service co-ordination called for by Family Planning Victoria to
28 prevent FGM (56). Investment in prevention has been found to be cost effective with one

1 study estimating that the cost of government efforts to prevent FGM will be offset by savings
2 from preventing obstetric complications (57). Other long term effects of prevention could
3 involve reduction in the costs of policing, prosecutions, alleviate the psychosocial
4 complications, as well as the cost of health interventions to perform surgery for
5 complications to the female genital tract and to repair the mutilation that had been inflicted
6 on these women, treat infections and counsel women.

7

8 Some inroads into working with the community to prevent FGM in Australian have been
9 noted (58, 59). Research is required in Australia to assess effectiveness of intervention
10 programs in communities. We also need to know how best to deliver education programs to
11 women and their families by front line health care providers, such as midwives. Insights may
12 be gained from experiences in other high income countries, such as the Ethiopian and
13 Bedouin migrants to Israel, where acceptance of changing cultural identity and behaviour
14 was related to the eventual discontinuation of FGFM (60).

15

16 **CONCLUSION**

17 When migrants' cultural practices are challenged in their adopted countries, and they lose
18 their benefit, harmful traditions can be discarded. In Australia, as in other countries of
19 migration of women with FGM, we have the opportunity for women and their partners to
20 discuss this sensitive and private issue through their health professionals, especially
21 midwives. Effective education, communication, and counselling by midwives, who are often
22 the first point of contact in the health sector, can help transform the lives of women with FGM
23 who suffer in silence from this injustice and human rights abuse that was perpetrated when
24 they were children.

25

26 **ACKNOWLEDGMENTS AND DISCLOSURES**

27 The authors would like to acknowledge funding from the Australian Commonwealth
28 Department of Health and Aging Health System Capacity Development Fund Female Genital

1 Mutilation Support Targeted Round that supported this study. The authors do not declare
2 any conflicts of interest.

3

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