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Original Research – Quantitative

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.
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Statement of significance

Problem or issue

Due to international migration patterns, health professionals in high income countries including Australia are increasingly caring for women with FGM. There are few studies around the world that explore the knowledge and skills of midwives in high income countries who provide care for migrant and refugee women with FGM.

What is already known

Midwives as frontline health providers need to be well equipped with the required knowledge and skills and cultural competence in order to optimise the quality health care for women affected by FGM during pregnancy and childbirth. However, just two small scale studies looked at Australian midwives Knowledge, experience and training needs.

What this paper adds

This is still the largest survey of midwives in relation to FGM in high income countries. This survey specifically to capture different expected aspects of midwives' experiences and knowledge in relation to FGM and provides a useful snapshot on the experiences and educational needs of these midwives.

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1. 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] 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.[11,14–18] This highlights the need for up to date data on FGM to inform maternity health service planning.[15]

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.[17,19–21] A study in Sweden found a lack of hospital policy in relation to FGM that resulted in inconsistent care for women with FGM.[22] 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.[23] In contrast, in the United Kingdom (UK)[24] 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.[25] However, there have been reports of FGM offences in Australia.[26,27] A small number of health care professionals in Australia have also reported that they have been asked by their patients to perform FGM.[17,28]

There are only two small qualitative studies in New South Wales, Australia that have explored the knowledge and experiences of a midwives.[15,29] 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.[15]

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.

2. Method

A self-administrated 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 Table 1), 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 a group of 8 midwives with clinical expertise. The survey was conducted between October 2014 and February 2015. The inclusion criteria were registered midwives who had clinical experience in Australia and had worked in public sector.

The survey was distributed through the Australian College of Midwives (ACM), the leading professional body for midwives in Australia.[30] Around 5000 midwives are members of ACM[30] however, not all of the ACM members are directly involved in midwifery clinical practice and midwifery students also members.

The online survey was posted on the Australian College of Midwives' (ACM) website and registered 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

Table 1
FGM classification (WHO[1]).

Type	Classification of each type
Type I: Partial or total removal of the clitoris (clitoridectomy) and/or the prepuce	Ia: removal of the prepuce/clitoral hood Ib: removal of the clitoris with the prepuce (clitoridectomy)
Type II: Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision)	IIa: removal of the labia minora only IIb: partial or total removal of the clitoris and the labia minora IIc: partial or total removal of the clitoris, the labia minora and the labia majora
Type III: Narrowing of the vaginal orifice with the creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation) 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	IIIa: removal and appositioning the labia minora with or without excision of the clitoris IIIb: removal and appositioning the labia majora with or without excision of the clitoris
Type IV: All other harmful procedures to the female genitalia for non-medical purposes	Practices include pricking, pulling, piercing, incising, scraping and cauterization

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