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Evidence to inform education, training and supportive work environments for midwives involved in the care of women with female genital mutilation: A review of global experience

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ABSTRACT

Objective: to identify how midwives in low and middle income countries (LMIC) and high income countries (HIC) care for women with female genital mutilation (FGM), their perceived challenges and what professional development and workplace strategies might better support midwives to provide appropriate quality care.
Design: an integrative review involving a narrative synthesis of the literature was undertaken to include peer reviewed research literature published between 2004 and 2014.
Findings: 10 papers were included in the review, two from LMIC and eight from HIC. A lack of technical knowledge and limited cultural competency was identified, as well as socio-cultural challenges in the abandonment process of the practice, particularly in LMIC settings. Training in the area of FGM was limited. One study reported the outcomes of an education initiative that was found to be beneficial.
Key conclusions: professional education and training, a working environment supported by guidelines and responsive policy and community education, are necessary to enable midwives to improve the care of women with FGM and advocate against the practice.
Implications for practice: improved opportunities for midwives to learn about FGM and receive advice and support, alongside opportunities for collaborative practice in contexts that enable the effective reporting of FGM to authorities, may be beneficial and require further investigation.

Background/introduction

Female genital mutilation (FGM), also known as female cutting or female circumcision, is a practice that is carried out on young girls and women in 29 countries in Africa and the Middle East, as well as some Asian countries (WHO, 2008). Although the practice is more prevalent in African countries, changing patterns of migration have led to health professionals encountering women with FGM in high income countries (HIC) including Sweden (Lundberg and Gerezgiher, 2008), Norway (Johansen, 2006), Belgium (Leye et al., 2008), Switzerland (Wuest et al., 2009), Greece (Vrachnis et al., 2012), Italy (Bonessio et al., 2001), Spain (Kaplan-Marcusan et al., 2010), the United States (Johnson-Agbakwu et al., 2013), the United Kingdom (Dorkenoo et al., 2008) and Australia (Moeed and Grover, 2012).It is estimated that 130 million girls and women have undergone FGM and that 30 million girls are at risk of undergoing some form of the procedure over the next decade (UNICEF, 2013; WHO, 2001e). In some countries (Kenya, Mali, and Tanzania), girls are being cut at a younger age, while in others the percentage of women and girls who have undergone FGM is slowly declining, indicating generational trends (UNICEF, 2013).

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FGM is a deeply culturally entrenched social norm within certain communities with different meaning and importance attached to the practice. Families may feel that if they do not conform they may be socially excluded, or subject to criticism or stigma. Parents may also believe that non-adherence could affect the ability of young women to find marriage partners which may have negative economic consequences (UNICEF, 2013). The practice is regarded by some communities as a rite of passage marking a girl's transition to womanhood, or it can been seen as maintaining girls' chastity, hygiene, beauty, preserving fertility, and enhancing sexual pleasure for men (WHO, 2001e).

FGM is illegal in many countries of the world (Rahman and Toubia, 2000; Rasheed et al., 2011). However, the highly entrenched sense of social obligation overrides any potentially positively modifying influence of legal and moral norms, thereby fuelling the continuation of this practice (UNICEF, 2013). The eradication of FGM has been prioritised as a key issue by the African Union (AU, 2011) and global community (UNFPA/UNICEF, 2011).

FGM involves procedures that comprise partial or complete removal of the external female genitalia or other injury to the female genital organs for non-therapeutic reasons (WHO, 1997). There are four different types of FGM. The most common type entails the excision of all or part of the clitoris and the labia minora and the most extreme form is known as type 3 or infibulation (removal of all or part of the external genitalia and the stitching of the two cut sides, closing the vagina to varying degrees). Infibulation involves leaving a small for the passage of urine and menstrual blood. De-infibulation or the opening of the scar to reverse the FGM procedure may be performed to allow intercourse, or in preparation for childbirth. Re-infibulation involves stitching the raw edges together again to create a small posterior opening. Type 4 includes unclassified procedures that include, but are not restricted to pricking, piercing or incision of clitoris and/or labia; stretching of clitoris and/or labia.

FGM procedures are associated with adverse obstetric outcomes (WHO, 2006), and serious immediate and long-term physical and psychosocial complications for girls and women (Magied and Musa, 2004; Vloeberghs et al., 2012) as well as men (Almroth et al., 2001). Although usually carried out by traditional practitioners in lower and middle income countries (LMIC), an increasing trend has been noted in the number of health professionals performing FGM in some countries, particularly Egypt and Kenya (UNICEF, 2013). In some countries such as Sudan and Kenya, midwives may perform the procedure (UNICEF, 2013).

Many communities understand the complications of FGM. Hence parents seek out health care professionals to perform the cutting to minimise the harm to their children. This is justified using the concept of harm reduction, which argues that carrying out FGM in controlled hygienic conditions will result in a reduction of infection and other adverse conditions (Shell-Duncan, 2001). As health care professionals are highly respected in communities, their performance of FGM signals endorsement of this practice and can serve to prolong and legitimise the practice (WHO, 2010, p. 9). The medicalisation of FGM has prompted the development of a global plan to stop health-care providers from performing FGM (WHO, 2010). Many United Nations (UN) human rights treaty monitoring bodies address FGM (CEDAW, 1990, 1992; UNOCHR, 1989) and have been active in condemning the practice and recommending measures to combat it.

The need for professional education and supportive environments for midwives

Midwives (ICM, 2005) are often the first providers women will see for their maternal health needs and therefore play a critical role in providing quality care and preventing the practice. Midwives develop trust with women, carry out de-infibulation (a surgical procedure to open up the closed vagina after FGM type 3), and refer women to obstetricians and gynaecologists when needed. Midwives perform routine examinations of the newborn and, as such, document the genitalia of newborn girls. This initial assessment may provide grounds for legal proceedings if FGM is subsequently performed. In addition, midwives play a critical role in child protection and preventing FGM through the education and counselling of families from communities where the practice is known to occur (Ball, 2008).

Training on FGM is critical and has been shown to be successful in improving clinical practice and increasing advocacy efforts, as shown in Kenya (Population Council, 2008). Data from 88 agencies and five country assessments in Burkina Faso, Egypt, Ethiopia, Mali and Uganda found that training for health care professionals in treating physical and psychological FGM complications was poor (WHO, 2011). Eighteen per cent of health professionals (including midwives) surveyed in Spain reported that they had no interest in learning about FGM. Less than half could correctly identify the different types despite approximately 30% of the population whom these professionals served were immigrants from North African and nearly 14% from Sub-Saharan African countries where FGM is practiced (Kaplan-Marcusan et al., 2009). In Australia, a survey of health care practitioners revealed they had little knowledge or experience of the cultural and health issues relevant to FGM (Moeed and Grover, 2012). Significant gaps have also been identified in the provision of appropriate and safe antenatal care for women with FGM and their daughters (Zenner et al., 2013).

The World Health Organization (WHO) has declared FGM training of health workers a priority strategy (WHO, 2001d) and has produced a number of guidelines (WHO, 2001b) and curriculum for nurses and midwives (WHO, 2001a). Professional midwifery bodies in many HIC have developed education materials, including Australia (ACM, 2013) and the UK (RCN, 2006), while other materials are generic for all health care professionals (Ministry of Health Kenya, 2010; New Zealand Ministry of Health, 2009). There is a need in many countries for FGM education specific for midwives (Calleja, 2013; Nursing Times.net, 2012) and a supportive working environment to enable midwives to carry out counselling and feel empowered to refuse to undertake re-infibulation or re-closure of the vagina after a women has given birth (WHO, 2001c, p. 12). A supportive workplace can involve policies, guidelines, protocols and supervision that enable midwives to develop knowledge, skills and cultural competence to deliver appropriate clinical and psychosocial interventions, gather accurate data on FGM presentations, report suspected or actual instances of FGM and requests from women or families to carry out FGM or re-infibulations.

Need for a narrative synthesis

A first step in developing educational programs on FGM would be gathering knowledge of the needs of the health professionals, in this case, midwives. It seems that little is known about the knowledge, experiences and needs of midwives with respect to FGM. Moreover there is no synthesis of current research to inform the design of midwifery education programs or supportive workplace practice in both LMIC and HIC settings. Reviews to date have focused on nursing care (Terry and Harris, 2013), health professional training in Africa (Berg and Denison, 2012, 2013), or have provided a broad discussion of peer reviewed and grey literature on health professional training (Johansen et al., 2013). To address the gap in the literature, we undertook a review of the peer reviewed literature to examine the experiences and needs of