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REVIEW ARTICLE

A systematic review of doctors' experiences and needs to support the care of women with female genital mutilation

Angela Dawson [a,*], Caroline S.E. Homer [a], Sabera Turkmani [a], Kirsten Black [b], Nesrin Varol [c]

[a] Centre for Midwifery, Child and Family Health, Faculty of Health, University of Technology, Sydney, NSW, Australia
[b] Discipline of Obstetrics, Gynaecology and Neonatology, Sydney Medicine School, University of Sydney, Sydney, NSW, Australia
[c] Discipline of Obstetrics, Gynaecology and Neonatology, Central Clinical School, University of Sydney, Sydney, NSW, Australia

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ABSTRACT

Background: Female genital mutilation (FGM) involves partial or complete removal of the external female genitalia or other injury for non-therapeutic reasons. Little is known about the knowledge and skills of doctors who care for affected women and their practice in relation to FGM. *Objectives:* To examine the FGM experiences and educational needs of doctors. *Search strategy:* A structured search of five bibliographic databases was undertaken to identify peer-reviewed research literature published in English between 2004 and 2014 using the keywords "female genital mutilation," "medical," "doctors," "education," and "training." *Selection criteria:* Observational, quasi-experimental, and non-experimental descriptive studies were suitable for inclusion. *Data collection and analysis:* A narrative synthesis of the study findings was undertaken and themes were identified. *Main results:* Ten papers were included in the review, three of which were from low-income countries. The analysis identified three themes: knowledge and attitudes, FGM-related medical practices, and education and training. *Conclusions:* There is a need for improved education and training to build knowledge and skills, and to change attitudes concerning the medicalization of FGM and reinfibulation.

1. Introduction

Female genital mutilation (FGM)—also known as female genital cutting or female circumcision—is a practice that is performed on young girls and women in 29 countries in Africa and the Middle East, and in some Asian countries [1]. FGM has become more common as a result of migration: women with FGM live in Europe, Australia, New Zealand, and the USA. It is estimated that 130 million girls and women have undergone FGM, and that 30 million girls are at risk of undergoing FGM in the next decade [2]. Nevertheless, the incidence of women and girls with FGM is falling [2].

FGM is illegal in many countries [3]. Additionally, FGM is associated with adverse obstetric outcomes [4], and serious physical and psychosexual complications for girls and women [5]. However, the highly entrenched sense of social obligation is more powerful than any perceived legal, medical, or human rights arguments against the practice, thereby fuelling the continuation of FGM [2].

FGM involves partial or complete removal of the external female genitalia or other injury to the female genital organs for non-therapeutic reasons [6]. There are four different types of FGM described by WHO [1]. Infibulation—the most severe type, experienced by approximately 15% of all women with FGM [7]—involves leaving a small opening for the passage of urine and menstrual blood. Deinfibulation—or the opening of the scar to reverse the FGM procedure—can be performed to allow vaginal intercourse or in preparation for childbirth. Reinfibulation involves stitching the raw vulval edges together after childbirth or vaginal intercourse to create a neo-introitus.

Although usually performed by traditional practitioners in countries of low and lower-middle income (LMICs), an increasing trend toward the medicalization of FGM has been noted, with healthcare professionals including doctors undertaking the practice [2]. Many parents understand the complications of FGM and seek out healthcare professionals to perform the cutting to minimize the harm to their children. Harm reduction is based on the notion that by engaging skilled practitioners to perform FGM in controlled, sterile conditions, there will be a reduction in adverse conditions [8]. Because healthcare professionals are highly respected in communities, their involvement in FGM indicates an endorsement of this practice that could serve to prolong and legitimize it [9]. The medicalization of FGM has prompted the development of a global plan to stop healthcare providers from performing FGM [9].

Professional medical associations in countries such as the UK and Canada have issued statements opposing the practice and have produced practice guidelines [10,11]. Ministries of Health in countries including Kenya have contributed to the development of documents where FGM is noted as a harmful practice [12]. Nevertheless, doctors' involvement in FGM has been implicated in controversial news stories where doctors who have reportedly performed FGM are prosecuted

* Corresponding author at: Centre for Midwifery, Child and Family Health, Faculty of Health, University of Technology, PO Box 123, Sydney, NSW 2007, Australia. Tel.: +61 2 9514 4892; fax: +61 2 9514 4917.
E-mail address: angela.dawson@uts.edu.au (A. Dawson).

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[13]. Such stories could reflect only a small part of the larger picture whereby medical practitioners are not informed of the law or professional guidelines, do not understand the risks involved, or feel pressured by sociocultural obligations to perform FGM and reinfibulation after birth. Establishing the knowledge, attitudes, and practices of medical practitioners in relation to FGM is an important part of planning education and advocacy efforts, including targeting the dissemination of professional practice guidelines.

Previous reviews have focused on the role of medical providers in caring for women with FGM and discuss clinical management in high income countries (HICs) [14]. Little is known about the knowledge and skills of doctors and their current practice in relation to FGM. There do not seem to be any syntheses of research that could inform the design of education programs for doctors. Therefore, the aim of the present review was to examine the experiences and educational needs of doctors in LMICs and HICs with respect to FGM. The overall goal was to identify ways to improve the medical training and continuing professional development of doctors so that they can best care for women and advocate against the practice.

2. Materials and methods

A narrative synthesis method was employed to analyze the literature. This method was selected because of the varied methods used in the studies identified for the review, which did not allow for the synthesis of findings. A Population, Interventions, Comparators, Outcomes, Study design (PICOS) question was developed to guide the present review [15]. The question was: what are the experiences and education needs of medical practitioners and students in relation to FGM? Knowledge, attitudes, and skills were explored among doctors from contexts where FGM is a common social practice and where it is not. Observational, quasi-experimental, and non-experimental descriptive studies published in English were considered suitable for inclusion. The Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines [16] were used to report the review process.

A systematic search was undertaken of the primary research published from January 1, 2004, to December 31, 2014. Five bibliographic databases (Medline, PubMed, Scopus, ProQuest Health and Medical Complete, and Web of Science), manuscripts from African Journals Online, and the reference lists of relevant papers were searched by A.D. and S.T. to identify peer-reviewed primary research literature. The key words used in the search were “female circumcision,” “female genital mutilation,” "medical," "doctors," “education,” and “training”. Retrieved records were screened for their focus as per the PICOS question and duplicates were removed by A.D. Discursive papers, those older than 10 years, or whose focus was outside of the aim were excluded.

The full-text of identified papers was retrieved and screened by A.D. and S.T. for relevance in relation to the PICOS question. Papers deemed relevant were appraised by all authors using the Critical Appraisal Skills Programme tool for qualitative research [17] and the McMaster University Quality Assessment Tool for Quantitative Studies [18]. Any reports of survey results that were not disaggregated by profession were excluded.

The narrative synthesis was conducted as per guidelines outlined by Popay et al. [19], allowing for different types of data collected via various methods to be examined to provide critical insights. The results sections of the remaining papers were analyzed to identify doctors’ experiences and needs. A thematic analysis was undertaken by A.D. using tables, in discussion with other authors. The relationships within and between studies were explored and coded.

3. Results

3.1. Identified studies

Among 37 records screened, 10 were included in the qualitative synthesis (Fig. 1, Table 1). Eight were quantitative surveys [21–27,29] and two used qualitative interviews [20,28]. Three were undertaken in LMICs—two in Egypt [24,26], and one in Sudan [22]—and the remaining seven studies were done in HICs [20,21,23,25,27–29].

The papers from LMICs included medical students [24], doctors with range of specialties including obstetrics and gynecology [26], and doctors or those in training for whom the area of specialization was not provided [22]. The studies in HICs included obstetricians and gynecologists, registrars undertaking specialist training in obstetrics and gynecology, doctors working in obstetrics in their second and third years after qualification, and specialists from other disciplines [20,21,23,25,27–29].

The analysis of the findings sections of the papers revealed three key themes: knowledge and attitudes, FGM-related medical practices, and education and training (Table 2). Three areas emerged: lack of awareness, diverse practice, and communication issues.

3.2. Knowledge and attitudes

The three papers from LMICs where FGM is traditionally practiced [22,24,26] provided detailed information about participants’ knowledge and attitudes. In the study from Sudan [22], personal experiences of FGM were reported: over 80% of the 200 young, Sudanese trained female doctors reported that they had experienced FGM themselves. Overall, 71% stated they would not accept reinfibulation if asked by their spouse and 97.5% would prefer their daughters to not undergo FGM. Although personal experience of FGM was not described in the other two LMIC studies (from Egypt) [24,26], awareness of the procedure was high and nearly half the participants in both studies regarded it as a priority health issue.

Many medical students surveyed in Mostafa et al.’s study [24] held positive attitudes toward FGM. Nearly half the students surveyed believed that FGM prevented promiscuity, maintained a girl’s chastity, and helped to keep the genitalia clean. One-third felt that FGM was an essential part of culture and a religious requirement [24]. Despite not being able to list any medical reasons to perform FGM, half the medical students supported the continuation of FGM and most were in favor of its medicalization to reduce the pain and risks to health. One-third anticipated having their daughters cut [24].

Most doctors in Refaat’s study [26] stated that they did not approve of the practice because it was painful and not required by religion. The minority who supported the practice did so for religious and cosmetic reasons. However, 40% of surveyed individuals believed doctors were the most suitable people to practice FGM [26].

Participants in the LMIC studies demonstrated knowledge of the different types of FGM and associated complications. Mostafta et al. [24] reported that knowledge of legal aspects of FGM was low: only 17% of participants were aware that the Egyptian law did not permit FGM to be performed by non-physicians at the time of the study. Although only 23% considered that a specific law was enough to protect girls from the practice, 53% believed that laws needed to be accompanied by community education. Two-thirds of doctors in the other Egyptian study [26] approved of the law banning FGM that was passed in 2008; those against the ban felt that such restriction would result in FGM being undertaken secretly. Despite many students showing support for the practice, half the medical students in Mostafa et al.’s study [24] thought they could contribute to abolishing this practice. Doctors in the Sudanese study [22] considered culture and tradition as barriers to behavior change.

In the eight studies from HICs, doctors were aware of the types of FGM and related complications. In one study from Sweden [27], some doctors believed that they had adequate knowledge of FGM. However, knowledge gaps were identified among British doctors, including failure to correctly identify FGM types [29] and low awareness of the prevalence of related mental health issues [25]. Half the respondents in Purchase et al.’s UK study [25] did not know how to refer women with FGM to specialist services. Awareness of hospital guidelines was found to be very low among Flemish gynecologists [21]. Only 1% were