# Female Genital Mutilation (FGM)

## Knowledge and Attitudes of Regional Western Health Professionals

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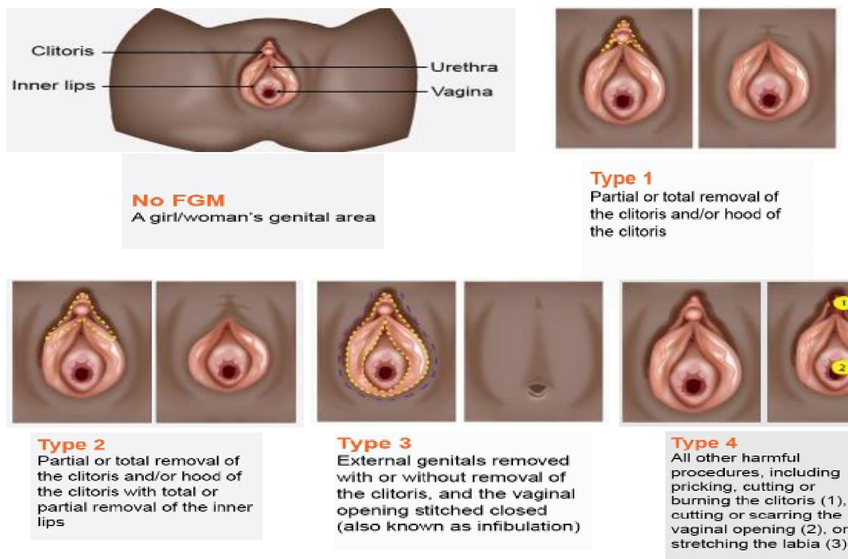
## BACKGROUND AND AIM

Figure 1: World Health Organisation Classification of FGM[6]




Female Genital Mutilation (FGM) is a practice that intentionally alters or causes injury to external female genitalia. The World Health Organisation (WHO) classifies FGM into four types, as shown in Figure 1.[1] It is estimated that 200 million girls and women alive today have undergone FGM and 3 million girls are at risk every year.[2] FGM is a practice with no benefits, and it is a violation of human rights. There are far reaching health consequences, including pain, infections, shock and even death. Long term consequences include gynaecological, obstetric and psychosocial issues.[1]

With increasing immigration and refugee populations from countries where FGM is practiced, there is an increase in FGM seen in Western countries, such as Australia.[1] In fact, the first Australian conviction for FGM was overturned this year, due to ambiguity of diagnosis. This highlights the need for further research. Current research shows women with FGM have negative experiences with western health professionals. There is perceived discrimination and marginalisation as well as poor trust and communication.[3] Gaps exist in qualitative research in regional settings. Furthermore, paediatricians and general practitioners (GPs) remain under-represented in research about this topic. Thus, the aim of this research was to explore the knowledge, attitudes and practices of health professionals in a regional setting.

## METHODOLOGY

A descriptive qualitative study was conducted using individual semi-structured interviews. General Practitioners, obstetricians, paediatricians and midwives working in a regional setting participated in the study. The interviews included the topics; knowledge, attitudes and practices regarding FGM. The study design was iterative and the interview guide was updated as themes emerged in concurrent analysis. Data analysis software, NVivo11, was used for coding. Data was coded into categories, and emerging themes were identified.

## RESULTS

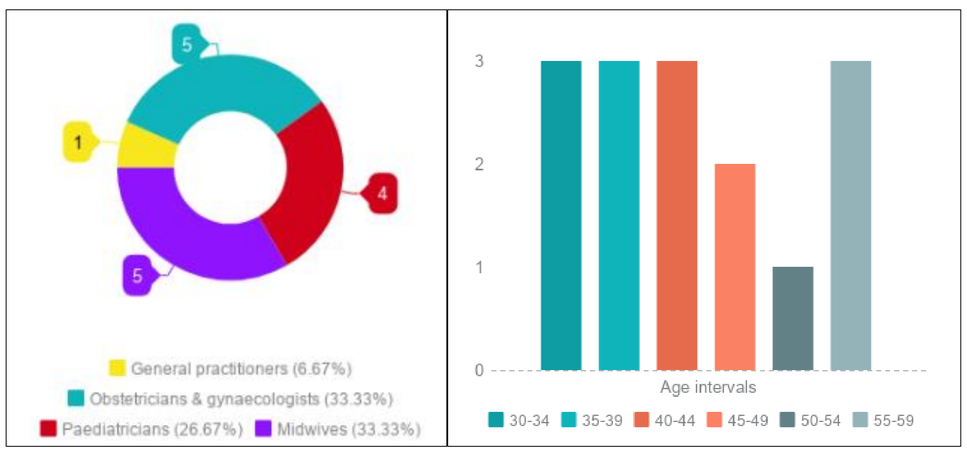



Figure 2: Participant demographics; (left) by speciality, (right) by age.

Fifteen participants were interviewed at a single regional centre in North Queensland. Three were conducted via phone, and 12 interviews were face to face. The interviews lasted 30-50 minutes. The participant demographics are summarised in Figure 2. Four major themes emerged from the data, with subthemes for further distinction of perceptions.

### Knowing the broad strokes of FGM

- 'Reasonable' level of knowledge – familiarity plus moderate depth
  - Listing some cultural reasons, health consequences & countries of incidence, plus awareness of legislation and guidelines
- Sources of knowledge largely informal – experience, self-directed study plus colleagues
- Experience poor in a regional setting
- Poor guideline awareness – resources poorly disseminated
- Acknowledged need for improved knowledge

### Practices: the what, when and how

- Only seven of the 15 had any experience with FGM
  - Of these, only two had managed > five cases
- **What**: providing woman centred care which can be complex due to cultural reasons
- **When**: importance of communication in the antenatal period
- **How**: culturally sensitive care is important in the context of FGM management

### Conflicted, complicated, complex

- Attitudes described with strong negative connotations
  - Abhorrent, inhumane, gruesome, cruel, child abuse, distressing
- Reasons cited: lack of consent, brutality of practice
- Difficulty labelling FGM as a harmful practice due to cultural connotations – 'complex issue'
- Conflict regarding medicalisation of FGM
  - Seen as favourable option with harm minimisation

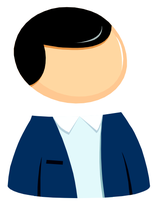
### Self-efficacy

- When asked "would you feel comfortable managing a woman with FGM" – majority replied yes.
- Large focus on refreshing knowledge, seeking advice from colleagues and referral
- Only one participant with specific management plan

I know there's other midwives that I've spoken to who've worked in places like Sydney where they had quite a high population of people who did it, and they talked about it.
Midwife 04
We have to study it ourselves, no one is teaching us.
OBGYN 04
And that kind of knowledge comes from extensive dissemination of resources, which doesn't happen.
OBGYN 05

I would hope those conversations have occurred in the antenatal period, so that they would have had some counselling and discussion
Midwife 2
I think cultural sensitivity comes in around anything to do with birth and female. Some of them very much would only have females looking after them and I think there is absolutely no reason why we shouldn't be able to facilitate that.
Midwife 3
We can't have it our way entirely, and then call it woman centred care. At the end of the day this is a woman who has to go back to her community, and live in that community. OBGYN 4

If someone has it done as adult, and wants to have it done because of beliefs. It's fine. But if someone is forced as a child and is forced because of the culture or background, that is not right. OBGYN 4
If it's becoming more medicalised and there's some safety guarding around that - then it makes me a bit more comfortable.
Paeds 1
I think it's complicated and I don't think that I have the right to judge anyone who has or hasn't had it. I think it's far more complex. Midwife 1



Increase my knowledge on the condition. I would…discuss it with a colleague who had more information… I would then go to the bigger centres…to seek advice in preparation.
Paeds 2
I'd feel confident in examining and I'd know where to refer.
GP 1
Yes, I'd be madly refreshing on the types and stuff as we go. I'd be like 'look I know that exists but I want to refresh'.
Midwife 5

## DISCUSSION

Health professionals in this regional area have a broad level of knowledge regarding FGM. There are conflicting attitudes when denouncing the practice due to perceived harm minimisation through medicalisation of FGM. Concerns lie in 'how' the FGM was carried out, rather than 'if' the procedure was done. This is despite a clear stance from WHO deeming medicalised FGM a violation of human rights. This suggests that knowledge may be superficial, with a lack of deeper understanding. Several researchers agree that communication remains an important aspect of management.[4,5] Our study adds new data regarding self-efficacy of health professionals. While health professionals have confidence in their abilities, practices centre around help-seeking. While this is appropriate management, it further demonstrates a lack of deep knowledge. Low exposure to FGM in regional settings translates to lower experience and poorer knowledge as sources of knowledge remain informal. Practices in regional areas are affected by lack of culturally appropriate resources such as liaison positions, and poorer interpreter availability and quality. The results from this study have implications for improved practice in regional areas by improving resource availability for staff, and by providing forums for discussions. The field would benefit from further research into the effects of regionality on FGM management.

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