The Royal College of Midwives

Female Genital Mutilation: Report of a survey on midwives' views and knowledge

Abstract

Between June and October 2010, the RCM conducted a survey of practising midwife members to elicit their views and opinions on a range of issues relating to Female Genital Mutilation (FGM) using a self-completion on-line questionnaire.

The results suggested that an overwhelming majority of midwives reported a view that FGM should never be carried out, over two-thirds (70.5%) of midwives reported an awareness of the UK Law, 21.2% of midwives also stated that it was illegal for midwives or doctors in the UK to re-suture following birth. Almost a quarter (24%) reported that their Trust did not collect data on FGM and 47.7% were unaware if their Trust collected data.

Few had knowledge of the source of evidence available to them with some reporting that they had to practise without FGM guidelines at times.

A large majority of midwives in the survey reported having no knowledge of where to refer women for specialist FGM services and only 15.3% reported having attended a training session. The majority of midwives who responded would like further support from the RCM and reiterated that they wanted more training to be able to care for women with FGM.

Given the fact that midwives are the primary care givers for pregnant women, it is important to urgently address the issues identified in this survey, including training and awareness raising, the availability of evidence based guidelines, systems for data collection and clear referral pathways for women with FGM.

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Introduction

It is estimated by the World Health Organisation, that around three million girls each year will undergo a Female Genital Mutilation (FGM) procedure. The practice of FGM is widespread and is reported to be carried out in some 28 countries, including African, Asian and Middle Eastern countries. The practice of FGM is also found amongst migrant communities in the UK from countries where FGM is practised; the countries include Somalia, Sudan, Kenya, Nigeria and Kurdish, Indonesian and Yemeni from FGM *(McCaffrey, 1995, WHO, 2011).* Girls under the age of 15 in communities where FGM is practised are most at risk. It is estimated that 66,000 women in the UK are affected by Female Genital Mutilation and that up to 24,000 girls in practising communities in the UK are at risk from FGM *(Dorkenoo et al, Forward, 2007).*

There are no health benefits associated with FGM and the practice has no religious basis in either Christianity or Islam; but some communities may use religion to justify the practice. FGM is deeply rooted in cultural norms, traditions and patriarchal attitudes towards women about their social roles and identities. This is tied to marriageability of daughters and 'respectability' and justification by some communities that FGM attenuates the sexual desire of girls, ensures marital fidelity and prevents sexual promiscuity *(Forward, 2009).* These underlying beliefs serve to maintain the practice of FGM, which is a violation of the human rights of girls and women and constitutes an extreme form of discrimination against women. These rights are clearly set out in the Universal Declaration of Human Rights and its associated United Nations Conventions including the Convention on the Elimination of All Forms of Discrimination against Women *(CEDAW),* the Convention on the Rights of the Child (CRC) and the Convention against Torture, and other Cruel, Inhuman or Degrading Treatment or Punishments.

FGM constitutes a serious threat to the health and well-being of girls and women. This is why the UN Commission on the Status of Women in its resolution of 2010 and 2011, urged countries to put in place and enforce legislation which makes Female Genital Mutilation illegal. The same resolution called for strengthened advocacy and raising awareness in the practising communities, including the development of policies to eliminate FGM *(WHO, 2011).*

Rising to the challenge set down by the UN Commission, much has been done in the UK by way of raising awareness and includes laws to protect girls from FGM. In England, Wales and Northern Ireland, the practice is illegal under the Female Genital Mutilation Act 2003 and in Scotland; the practice is illegal under the Prohibition of Female Genital Mutilation (Scotland) Act 2005. It should be noted that FGM is prohibited by law, whether it is committed against a UK national or permanent resident in the UK or abroad. The penalty for a person found guilty of an offence under the Female Genital Mutilation Act 2003 is a prison sentence of up to 14 years. This is in addition to provisions within the legal framework *(Section 11 of Children Act, 2004)* for Safeguarding children. Yet, despite these legal safeguards, there is anecdotal evidence, that some British girls are having FGM performed illegally in the UK or overseas.

The practice of FGM exerts an intolerable physical and psychological burden on girls and women and has long term consequences for their reproductive health, including sexual discomfort, chronic pain, infection, infertility, HIV and in some cases death. The psychological effect can range from severe psychological trauma, including flashbacks, anxiety, and depression and in some cases post traumatic stress disorder (PTSD). More information is emerging from research that girls and women who have undergone FGM are likely to have high levels of anxiety and levels of post traumatic stress disorder similar to adults who suffered abuse as children *(Lockhart H, 2004, Behrendt, A. et al 2005).* A recent study into the mental health status of young girls after FGM in Northern Iraq showed, that girls who have undergone FGM had a significantly higher prevalence of Post traumatic stress disorder(PTSD), depression, anxiety and somatic disturbance when compared to girls who did not have FGM *(Ilhan Kizilhan, 2011).*

FGM also has a financial impact on obstetric services. A study carried out in six African countries to estimate the cost to the health system from obstetric complications, due to FGM, estimated that in a population of 2.8 million 15-year olds in the six African countries, a loss of 130 000 life years is expected; an equivalent of losing a half month of each lifespan. The financial costs of FGM-related obstetric complications were estimated to be between

0.1% and 1% of government spending on health for women aged 15-45 years (Bathija, H, et. al, 2010). The drive to fully eliminate the practice and protect girls has become urgent not only in terms of the physical and psychological health of those affected, but in relation to the financial costs to the nation.

Background

Over the last five years**,** renewed efforts have been made by the UK government to identify and support women who have had Female Genital Mutilation (FGM) and to educate the communities who practise FGM about the health implications of this practice. In *2010*, the government set up a Task Force on Violence Against Women and Girls. The Report of Department of Health Taskforce on Violence against Women and Children (2010) *-A Place of Greater Safety: Violence against women and children- the role of the NHS -* acknowledges that the violence and abuse experienced by women and children every day is an urgent problem that must be addressed by all of us, and by all institutions- including the NHS. It recommended that targeted routine questioning is justified in those communities where there is evidence of prevalence of FGM. In 2010 the government published its plans to bring about long-term cultural change which focusses on tackling the social and cultural acceptance of Violence Against Women and Girls; the prevention of FGM has therefore become an important aspect of that strategy. Further in 2011, the Foreign and Commonwealth Office published the *Multi-Agency Guidelines* which clearly states that FGM is a **form of child abuse.** These Guidelines provide advice and support to front line practitioners to safeguard children and protect adults from the abuses associated with FGM. It also clarified that health professionals have a responsibility to save girls from harm and ensure that families know that FGM is illegal in the UK (HM Government, 2011). In relation to reproduction and birth, midwives are often the primary carer of women who have experienced FGM; it therefore follows that their level of understanding of the practice of FGM, the law surrounding it and the communities where it is practiced is paramount. This summary report, describes a UK wide survey that explored midwives knowledge and understanding of FGM.

Aim of the RCM Study

The aim of this study was to elicit the views and opinions of practising midwife members of the RCM on a range of issues relating to Female Genital Mutilation, including their understanding of the law, the practice, knowledge of the communities they work with and their response to FGM, with the purpose of identifying educational, training and support needs relevant to the prevention of FGM and care of women with FGM.

Design and Method

The study design was exploratory and descriptive. The objectives were considered to be best achieved through a survey approach using a self-completion on-line questionnaire. The questionnaire was developed and comprised of 13 questions that explored midwives' knowledge of and attitudes towards FGM (including the provision of guidelines within their maternity units). The participants were not asked to disclose any identifying information about themselves or that of any women that they cared for. Following approval from the Royal College of Midwives Ethics Committee, an email invitation was sent to midwife members currently registered as a 'practising midwife' giving them the option to participate in the survey. These were midwives who had given permission for the RCM to send them information via email. The questionnaire was also posted on-line between June and October 2011.

The investigators had no access to any of the personal or identifiable details of the membership database; administration of the survey was facilitated through the RCM's membership services.

To encourage participation, an email of invitation was sent at the time of the survey postings; This email included additional information concerning the purpose and background of the study. In anticipation of the sensitivities surrounding FGM, a confidential support number was also provided in the participant information letter. Assurances regarding anonymity was provided and full control over the decision to complete the questionnaire or not remained with the midwife member. Informed consent to participate was therefore implied on the completion of the on-line questionnaire.

Analysis

A total of 1, 756 questionnaires were completed. Access to the data generated by the study was restricted to the investigators and stored on a password protected computer. Analysis of the data was undertaken using SPSS® Version 18.0; descriptive statistics including frequency tables, percentages and cross tabulations were compiled. Content analysis for free response qualitative data was also undertaken using Microsoft Word® software. A number of respondents did not complete individual questions; a Missing Value Analysis however confirmed that there was no emerging pattern.

Results

Results focused on the demographical information, knowledge, attitudes of midwives concerning FGM and the availability and use referral services.

Demographical information, as reported in the following frequency table (Table 1), revealed that the majority of participants were English (82%; n=1,444). Midwives in Northern Ireland were least likely to respond (n=36).

Table 1: Frequency and Cumulative Percentage of Participants by Country

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	England	1444	82.2	82.3	82.3
	Scotland	189	10.8	10.8	93.0
	Wales	53	3.0	3.0	96.1
	N Ireland	36	2.1	2.1	98.1
	Other	33	1.9	1.9	100.0
	Total	1755	99.9	100.0	
Missing	System	1	.1		
Total		1756	100.0		

A breakdown of England by region revealed that the majority of respondents worked in the London area (21%) compared with the North West region which accounted for 3.7% of the

Table 2: Frequency and Cumulative Percentage of Participants in England by Region

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	London	299	17.0	21.0	21.0
	West Midlands	161	9.2	11.3	32.3
	Yorkshire and Humber	119	6.8	8.4	40.7
	North East	52	3.0	3.7	44.3
	East of England	138	7.9	9.7	54.0
	North West	144	8.2	10.1	64.2
	South Central	120	6.8	8.4	72.6
	South West	113	6.4	7.9	80.5
	South East Coast	119	6.8	8.4	88.9
	South West	158	9.0	11.1	100.0
	Total	1423	81.0	100.0	
Missing	System	333	19.0		
Total		1756	100.0		

overall response (See Table 2).

Analysis of an open-ended response where midwives in England were asked to report which Trust they worked for, resulted in a varied response. Midwives from across the UK reported having the experience of providing care for women with FGM. When asked how many women they had cared for while working in maternity services, the majority of participants (n=941, 59.7%) reported that they not cared for any women with FGM. As illustrated in Table 3, only a small number of midwives (n= 19, 1.1%) reported caring for more than 50 women with FGM.

Table 3: The Number of Women with FGM that Midwives Reported Caring For

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	None	941	53.6	59.7	59.7
	1-10	526	30.0	33.4	93.0
	11-20	51	2.9	3.2	96.3
	21-30	28	1.6	1.8	98.0
	31-50	12	.7	.8	98.8
	51 and greater	19	1.1	1.2	100.0
	Total	1577	89.8	100.0	
Missing	System	179	10.2		
Total		**1756**	**100.0**		

Cross-tabulating the number of women that midwives cared for with whether or not midwives had access to clinical guidelines revealed that on occasion midwives practised without knowledge of whether relevant clinical guidelines existed.

Table 4: Cross-Tabulations of Trust Monitoring Activity with Provision of Clinical Guidelines

How many * Clinical Guide Cross Tabulation

Count

		Clinical Guide			Total
		Yes	No	Don't know	
How many	None	235	220	395	850
	1-10	275	78	107	460
	11-20	30	6	7	43
	21-30	20	1	3	24
	31-50	6	2	3	11
	51 and greater	15	1	0	16
Total		581	308	515	1404

When midwives were asked to identify which guidelines were used, few had knowledge of the source of evidence available to them. A total of 86 respondents reported that practice was guided by a specialist team made up of obstetricians, midwives, specialist midwives and on some occasions, women groups. Twenty two participants referred to the role of a Lead Midwife including the research midwife, consultant midwife, delivery suite midwife and safeguarding midwife. A further 79 participants reported that the FGM specialist midwife provided guidance. Reference to written guidance included NICE (n=39), RCOG (n=23), WHO (n=26), RCM (n=16), RCN (n=6), UNICEF (n=6) and FORWARD (n=3). Eight midwives reported using guidelines from the Intranet but did not define their source of knowledge. The majority of midwives either stated they did not know about guidelines or they failed to respond to the question.

Of the number of midwives who responded to whether or not the Trust monitored the incidence of FGM (n=1576), a total of 752 (47.7%) stated they did not know if data was recorded. A further 378 (24%) indicated information was not collected while 25.4% (n=446) stated that the trust did monitor the incidence of FGM.

Further analysis of an open-ended question that invited midwives to briefly describe the different types of FGM, demonstrated that the majority of midwives who respond to the question (n= 827 of 929) reported aware of the classification associated with FGM.

Defining Female Genital Mutilation as "*all procedures involving partial or total removal of the female external genitalia or other injury to the female genital organs whether for cultural or other non-therapeutic reasons*" (WHO 1997) the data was compared to the four point classification employed by the WHO (1996); that is:

Type 1 - Clitoridectomy: partial or total removal of the clitoris (a small, sensitive and erectile part of the female genitals) and, in very rare cases, only the prepuce (the fold of skin surrounding the clitoris).

Type 2 - Excision: partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (the labia are "the lips" that surround the vagina).

Type 3 - Infibulation: narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the inner, or outer, labia, with or without removal of the clitoris.

Type 4 - Other: all other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterizing the genital area.

The following response rate indicates that midwives understood that FGM involved a degree of 'cutting' or 'excision' to the vaginal area:

- 29% (n=242) of midwives were able to identify that there were four (4) types of FGM i.e. Type 1-4. There was an understanding of the correct terminology for the different types such as, Clitoridectomy, Excision, Infibulation and Other.

- 49% (n=403) were able to identify FGM to three (3) types i.e. Type 1-3

- 16% (n=135) managed to identify FGM to two (2) types i.e. type 1 and 2 or type 3 and 4.(AOD-any other definition)

- 6% (n=50) respondents said they did not know the different classifications

Likewise, when asked to identify which communities practiced FGM, midwives provided the following responses (Table 5).

Table 5 Midwives Identification of Countries where FGM is practised

Please select which of the following communities you think practice FGM? (Please tick as appropriate)		
Answer Options	**Response Percent**	**Response Count**
Somali	90.6%	1431
Pakistani	12.3%	194
Burkina Farso	30.5%	482
Ethiopian	69.1%	1091
Indian	8.1%	128
Nigerian	50.4%	796
Ghanaian	43.2%	682
Egyptian	30.1%	475
Saudi Arabian	27.5%	434
Moroccan	17.0%	269
Sudanese	65.8%	1040
Yemeni	42.7%	675
Bangladeshi	9.1%	144
Don't know	8.1%	128
	Responses	**1580**
	Missing Values	**179**

When viewed same data diagrammatically, it becomes evident that Somali was most frequently cited by midwives as a country where FGM is practised. (Figure 6).

Figure 1 Diagrammatical View of Midwives Identification of Countries that Practice FGM

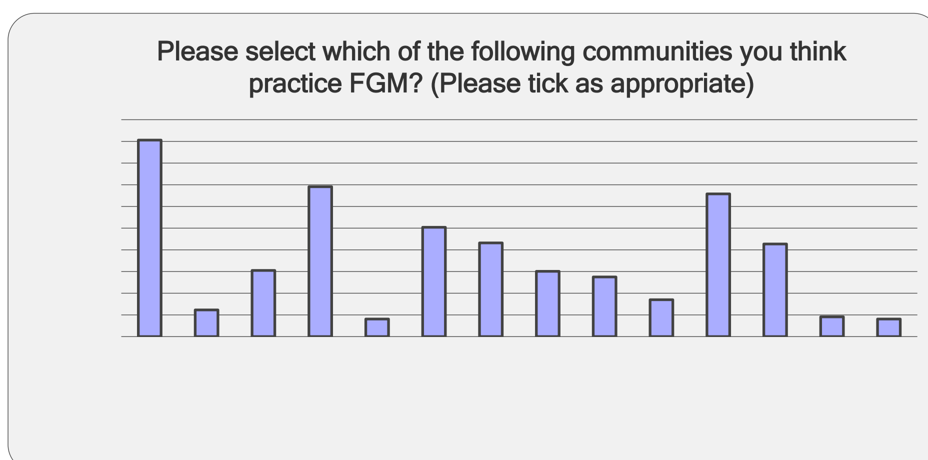


Table 7: Midwives Attitudes to FGM Being Performed Within the UK

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	12	.7	.9	.9
	No	1353	77.1	96.6	97.4
	Don't know	36	2.1	2.6	100.0
	Total	1401	79.8	100.0	
Missing	System	355	20.2		
Total		1756	100.0		

Table 8: Midwives Attitudes to FGM Being Performed Outside the UK

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	15	.9	1.1	1.1
	no	1330	75.7	95.6	96.7
	Don't know	46	2.6	3.3	100.0
	Total	1391	79.2	100.0	
Missing	System	365	20.8		
Total		1756	100.0		

When midwives were asked to state whether or not FGM should be carried out within and outside the UK, the overwhelming majority reported an attitude that it should not be carried out either in (Table 7) or outside the UK (Table 8). When asked to respond ‘Yes’ or ‘No’ to whether or not they knew what the UK Law said about FGM, the majority of participating midwives (n=1020, 58.1%) reported that they were aware of the law surrounding FGM.

Analysis of the open-ended question “What type of FGM can be carried out without harm to the girl” demonstrated that midwives felt strongly that FGM was not permitted in the UK (92.8%). A further 29.2% also stated that it was illegal for parents to take their children abroad to have the procedure carried out. Interestingly, 8.2% of midwives responding stated that there was a 15 year prison sentence associated with performing this procedure.

A small percentage of participants pointed out that it was the responsibility of the midwife to report a history of FGM in women they cared for. In relation to caring for women in the UK, 21.2% of midwives also stated that it was illegal for midwives or doctors in the UK to re-suture following birth.

A cross-tabulation of midwives attitudes towards the performing of FGM illustrated the overlap between those that believed FGM should be carried out within and outside the UK.

Table 9: A Cross-Tabulation of Midwives Attitudes to Performing FGM within and Outside the UK

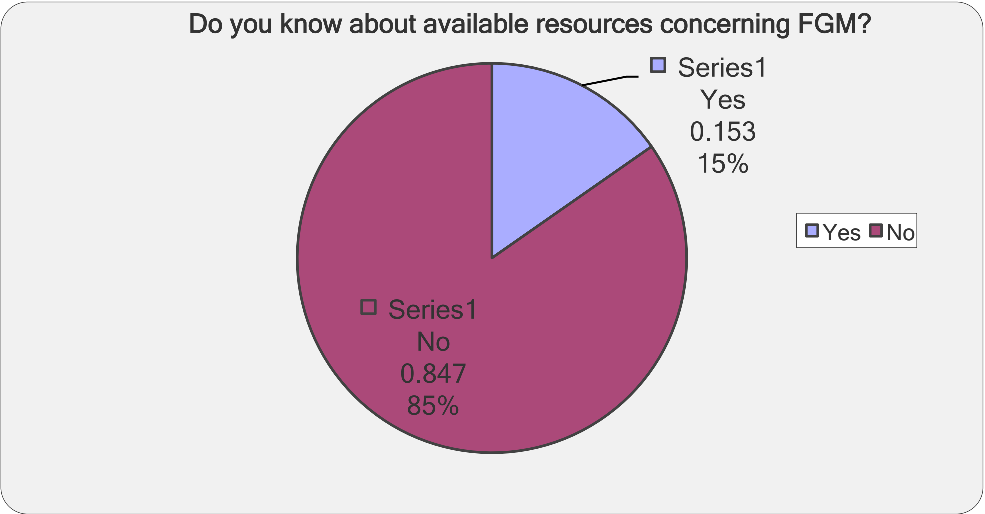
Agree UK Do It * Agree Outside Cross tabulation

Count

		Agree Outside			Total
		Yes	no	don't know	
Agree UK Do It	Yes	3	8	1	12
	No	8	1300	26	1334
	Don't know	3	14	19	36
Total		14	1322	46	1382

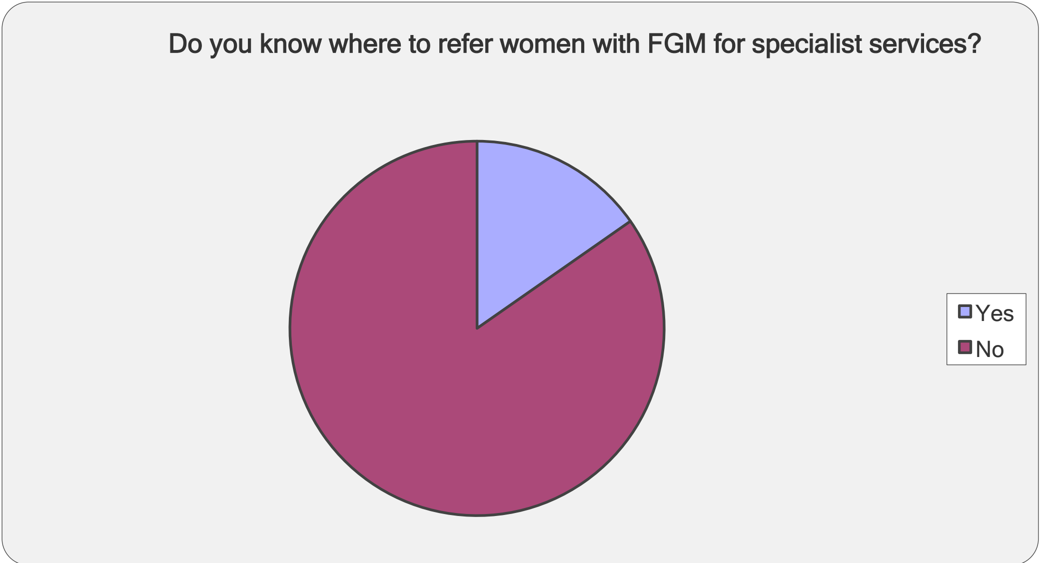
Midwives were asked about the availability and use of referral resources for caring for women with FGM. As the following figure indicates, the majority of participants reported that they were unaware of the available resources related to FGM:

Figure 2. The percentage of midwives who know about the available resources related to FGM



A similar picture was presented when midwives were asked if they knew where to refer women with FGM for specialist services.

Figure 3. Midwives knowledge of where to refer women with FGM for specialist services



In relation to professional training, 15.3% (n=215) midwives reported that they had attended a training session related to FGM. Exploration of the nature of this training revealed a strong reliance on mandatory, in-house training that was facilitated by FGM specialist midwives (n=97). Other training sessions included attendance of Study days (n=14); Supervisor of Midwives Conference (n=10); Health Conference Workshop (n=9); University Module (n=7) and ICM (n=2). In each of the following only one participant reported using this training resource: RCM video, RCN fringe session, on-line study, HEFT study day, GBV workshop, HOPE training and FORWARD training.

When asked what further support midwives would like the RCM to offer, the following responses were provided (Table 10). In addition to the specific requests for support, over half of participants reiterated that they wished the RCM to provide '*more training'* in relation to caring for women with FGM.

Table 10. Midwife members request for further RCM support when caring for women following FGM

What would you like the RCM to do to support you in working with women and girls affected by FGM? (Please tick as many that apply)		
Answer Options	*Response Percent*	*Response Count*
Further training	56.8%	786
Seminars	34.5%	477
Study days	57.9%	801
Multi professional/Multi-Agency conferences	36.1%	499
Network with colleagues who work in this area/have experience	46.4%	642
Workshops with community groups	28.7%	397
E-learning modules	64.1%	887
Printed information	56.1%	776
Other (please specify)	6.8%	94
	Responses	**1383**
	Missing values	**376**

Discussion

The overwhelming message from midwives who took part in this survey was the need for support when dealing with issues relating to FGM. Midwives clearly expressed the need for further training and awareness through a variety of methods so that they can respond appropriately to the issue. Maternity services need to take steps to become aware of local minority ethnic communities which support FGM, and of the special needs of the women in those communities (RCM 1998, 2011). Midwives cannot assume that because a woman is from a practising community or has a resulting problem from FGM that she is in favour of or against the practice. Often, it is the women themselves who are proponents of the practice. Conversely, some of the women may be against the practice and need midwives to discuss their current situation with them.

As much as members were or were not able to define FGM, it might have been useful to have had an opportunity to probe whether they knew what to do if they were presented with a woman in labour who has under gone FGM. Many midwives were not aware of what resources were available to them, despite the fact that the RCOG has developed clinical guidelines as well as the Multi-Agency Guidelines published in 2011 by the government. This is worrying, as it supports some of the communities' assertion that professionals are not always aware of what to do in these circumstances.

Another point would have been to ascertain whether or not their units had a policy on FGM, especially in relation to the information needs of women who have given birth to girls. In its first position statement in 1998 and subsequent revision, the RCM recommended that maternity services should forge links with the relevant communities in their area, particularly with women in practising communities, in order to keep informed of their needs and how best to meet those needs.

Conclusion

FGM is an intolerable practice that violates the rights of girls and has the potential to compromise their long term physical and psychological well-being. It is important that midwives do not see FGM as something that happens in certain groups or that it is difficult to raise a discussion about the practice. *The Department of Health Task Force Report (2010)* acknowledges that the NHS response to women and children who can be isolated and fearful as a result of their experience is critical to their future well-being. This is why it is important for midwives to develop their knowledge of FGM, its resulting effect and the law and respond appropriately, be it within a safeguarding or legal context.

Recommendations

Using the findings in the study, matched with policy and legislation, the following recommendations are made:

- It is important that there are systems and structures in place to support midwives in their work with women in FGM practising communities; these include a clear referral pathway for deinfibulation and psychological therapy.

- Midwives need to be familiar with the relevant clinical guidelines to enable them to deal appropriately with cases of FGM or suspected FGM.

- Clinical guidelines must be explicit, regularly updated and clearly state the expectations of practitioners in the antenatal period and during labour.

- Maternity units develop information for parents with infant girls which unequivocally explains the law on FGM – that it is against the law to take a child outside the UK for the purpose of FGM or to carry out the procedure in the UK.

- That maternity units should develop systems for data collection and audit of services and use local population data for service planning and delivery

- The provision of regular education, and evidence based updates on safeguarding of children in respect of FGM and an emphasis on the midwife's role in protecting children from harm.

- Midwives should appraise themselves of the legal framework on FGM in respect of Child protection.

- Training and educational resources for both pre and post registration education and training programmes should be developed within a multi-professional context with active involvement of the communities themselves.

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