Are Health Care Professionals Prepared to Provide Care for Patients Who Have Experienced Female Genital Cutting? A Cross-Sectional Survey of Canadian Health Care Providers

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ABSTRACT

Health care professionals may be underprepared to address the unique needs of patients who have experienced female genital cutting. This cross-sectional survey found that health care professionals in a large Canadian city report an overall lack of knowledge and preparedness to provide care for these patients and to address issues of defibulation, reinfibulation, child safeguarding, and legalities surrounding female genital cutting. Barriers to providing quality care include lack of training and clinical exposure. Health care professionals have indicated strong interest in further training, and consolidated efforts should be made to implement culturally informed care into health professional education.

RÉSUMÉ

Il arrive que les professionnels de la santé ne soient pas adéquatement préparés à répondre aux besoins particuliers des patientes qui ont subi une excision génitale féminine. Cette étude transversale a révélé que les professionnels de la santé d'une grande ville canadienne signalent un manque global de connaissances et de préparation pour prodiguer des soins à ces patientes et pour aborder les questions de désinfibulation et réinfibulation, la protection des enfants et les aspects juridiques entourant l'excision génitale féminine. Le manque de formation et d'exposition clinique est un obstacle à la prestation de soins de qualité. Les professionnels de la santé ont indiqué avoir un fort intérêt à pousser leur formation. Il y a lieu de consolider les efforts pour intégrer les soins de santé respectueux de la culture dans la formation des professionnels de la santé.

Keywords: women's health; female genital cutting; female genital mutilation; circumcision; female, education; medical, health knowledge; attitudes; practice

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INTRODUCTION

Female genital mutilation/cutting (FGM/C) is defined by the World Health Organization (WHO) as "all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons." Over 200 million girls and women worldwide have experienced FGM/C,[1] and international migration has resulted in an increased prevalence of women with FGM/C living in Canada.[2]

FGM/C can have significant health consequences, including immediate complications such as urinary retention, genital swelling, hemorrhage, infection, and even death.[3] Long-term complications include recurrent urinary tract infection, chronic pain, obstetrical difficulties, sexual dysfunction, and psychological consequences.[3] Surgical treatments

offered to those affected by FGM/C include defibulation (releasing the scar of infibulation to allow penetrative intercourse, urinary flow, menstruation, and vaginal delivery) and clitoral reconstruction to decrease pain, improve sexual response, and restore vulvar anatomy.[4]

Health care professionals (HCPs) play an important role in caring for patients with FGM/C but often receive little to no training on how to provide high-quality, culturally competent care.[5] Providers often do not clinically recognize FGM/C, face difficulties initiating conversations about the practice, and are often unfamiliar with treatment options.[6] Furthermore, patients themselves who have experienced FGM/C have reported a lack of cultural sensitivity from Canadian HCPs and inadequate treatment during pregnancy and birth care.[7]

This is the first empirical assessment of Canadian HCP knowledge and attitudes and the experiences of patients with FGM/C. Our study sought to examine how HCP perceive their knowledge and preparedness to provide care to patients who have experienced FGM/C, with the intent of using this information to further develop educational resources and support for practitioners to provide higher quality, culturally informed care for these patients.

METHODS

A cross-sectional survey of practicing HCPs in Calgary, Alberta, was conducted between May 14 and July 4, 2019. The survey contained 25 items developed de novo and included both scaled and open-ended questions to elicit both quantitative and qualitative data surrounding exposure to FGM/C in practice and self-perceptions of practitioner knowledge, skills, and attitudes for providing care to patients with FGM/C. The initial survey underwent pilot testing with 5 individuals to assess wording and comprehensibility and was revised to improve items and usability. The survey was distributed electronically to HCPs involved in women's health who may encounter patients with FGM/C, including midwives, nurses, and physicians from family medicine (FM), obstetrics and gynaecology (OBGYN), and plastic surgery. Residents from OBGYN were also surveyed.

Data Analysis

Data were entered into IBM SPSS and analyzed using descriptive statistics. Data were stratified by provider group to explore group differences. For questions with scaled responses, Cronbach's alpha was computed to assess internal consistency to examine the reliability of evidence.

Ethics

This study was approved by the University of Calgary Conjoint Health Research Ethics Board (File #19-0498). Department heads or managers provided consent for distribution of the survey to the providers affiliated with their discipline.

RESULTS

Two-hundred seven individuals completed the survey, for a response rate of 30% (207/688). Participants included nurses (n = 85), FM physicians (n = 47), OBGYN physicians (n = 23), midwives (n = 23), OBGYN residents (n = 22), and plastic surgeons (n = 7) (Table).

Level of Preparedness to Provide Care

Twenty-one percent of HCPs reported having no exposure to patients with FGM/C in the last 5 years, and most participants (43%) had seen fewer than 5 cases (Table). Less than 10% of HCPs believed they were very prepared to care for patients with FGM/C. The majority of OBGYN (82%) and FM physicians (90%) felt either somewhat or very prepared, whereas the majority of OBGYN residents (64%) and midwives (52%) reported not being prepared to care for these patients.

Most (58%) reported they could identify risk factors associated with FGM/C and were aware of the short- and long-term complications of FGM/C (49% and 46%, respectively); however, fewer (24%) agreed they knew which questions were pertinent to ask when taking a history from a patient with FGM/C or that they could diagnose FGM/C based on the WHO classification system (16%) (Figure).

Obstetrical Care

Only 5% of participants who provide obstetrical care felt very confident developing an obstetrical delivery plan for a patient with infibulation (WHO Type III FGM). A quarter of participants had experience with providing defibulation, most commonly during labour (39, 18%). Forty-eight percent of physicians (49) reported requests for reinfibulation. The timing of the request varied, including outside of pregnancy and in the antenatal, intrapartum, and postpartum period.

Medicolegal Implications

Almost all respondents (194, 94%) agreed that the practice of FGM/C is illegal in Canada; however, only 28% (58) of HCP felt prepared to discuss with patients the legalities of FGM/C as it relates to any children deemed at risk.

Resources and Training

Sixty-three percent (n =130) did not know whom to refer a patient to if they had clinical concerns. Ninety percent

Table. Participant demographics and exposure to FGM/C (n = 207)

Description	No. (%)
Type of health care professional	
Physician: family medicine	47 (22.7)
Physician: obstetrician–gynaecologist	23 (11.1)
Physician: plastic surgeon	7 (3.4)
Resident: obstetrics and gynaecology	22 (10.6)
Nurse	85 (41.1)
Midwife	23 (11.1)
Gender	
Woman	181 (87.4)
Man	21 (10.1)
Nonbinary	2 (1.0)
Prefer not to say	3 (1.4)
Years in clinical practice[a]	
≤5	51 (24.6)
6–20	114 (55.1)
≥21	42 (20.3)
How many cases of FGM/C have you seen in the last 5 years?	
None	45 (21.7)
<5	88 (42.5)
5–20	55 (26.6)
21–99	18 (8.7)
≥100	1 (0.5)
When caring for patients who have undergone FGM/C, I am:	
Very prepared	20 (9.7)
Somewhat prepared	116 (56.0)
Not prepared	70 (33.8)
Prefer not to respond	1 (0.5)

[a]Includes postgraduate training

FGM/C: female genital mutilation/cutting.

(186) agreed they would benefit from more knowledge and training to provide high-quality care for women with FGM/C.

DISCUSSION

Current practitioners may lack the knowledge and skills required to provide high-quality, culturally competent care for patients who have experienced FGM/C, particularly regarding methods to elicit a health history, diagnostic criteria, and clitoral reconstruction procedures and referral pathways. The lack of training and exposure to FGM/C are identified barriers to optimizing care.

The under-recognition or misclassification of FGM/C poses an increased risk in pregnancy, especially as it relates to delivery planning and obstetrical outcomes.[6] FGM/C can increase obstetrical complications, particularly in the setting of infibulation, with increased risks of prolonged labour, episiotomy, and complex perineal tears without proper defibulation.[3] Obstetrical care providers should be confident in identifying a person at risk of FGM/C, performing a vulvar examination early in prenatal care and making appropriate obstetrical care plans, including timing of defibulation if necessary.

Reinfibulation, the "resuturing" and narrowing of the vulvar opening that has undergone defibulation (often at time of childbirth), is not a recommended practice because it is considered medically unnecessary, causes further vulvar scaring, and is considered a violation of human rights.[2,8] Requests for reinfibulation can pose a difficult dilemma for providers who have reported a lack of an approach to addressing the request. Further training is warranted for HCPs on how to address requests for reinfibulation.

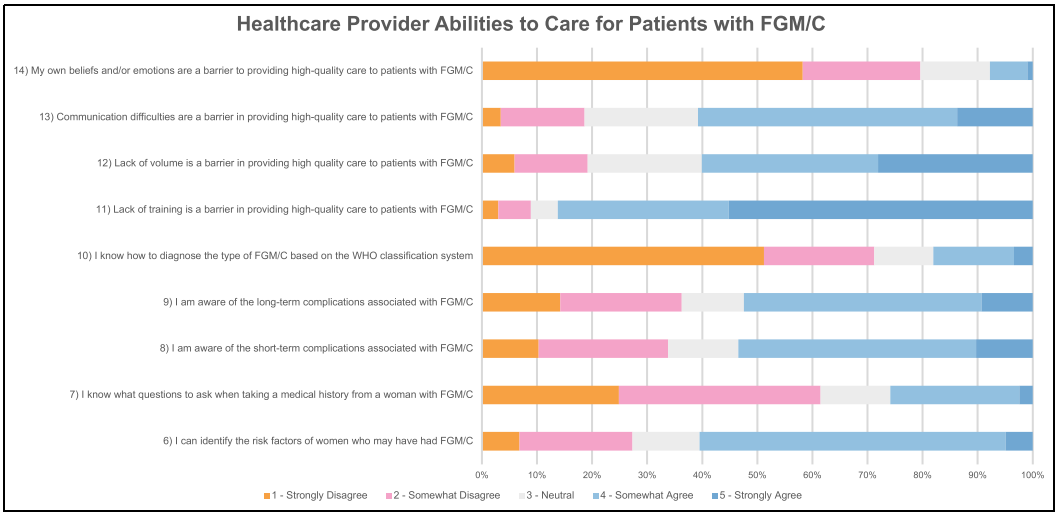
Globally, an increasing number of HCPs offer clitoral reconstruction procedures to women who have experienced FGM/C; however, more research is needed to determine the efficacy of the procedures.[4] It is strongly recommended that women who have undergone FGM/C who are considering clitoral reconstruction surgery have a robust assessment in a multidisciplinary setting with extensive counselling.[4]

The Ontario Human Rights Commission has identified evidence to indicate that FGM/C is practiced in Canada, and daughters have been sent outside of Canada to have the procedure performed.[9] Performing FGM/C is considered aggravated assault and is illegal in Canada under the criminal code. If a parent agrees to have FGM/C performed by another party, the parent can be convicted as a party to the offence. Additionally, the code prohibits the transport of a child outside of Canada for the purpose of FGM/C (see criminal code R.S.C., 1985, c. C-46., sections 268[3], 273.3[1], 21[1]).[10]

Safeguarding children at risk of FGM/C is a responsibility of providers and includes educating parents on the illegality of the practice and the harmful effects FGM/C can have on a child. Additionally, HCP have a *duty to report* should they have suspicions that a child may be at risk. Not all HCPs may be aware of the legal implications of FGM/C within Canada and may be underprepared to discuss with patients the legalities of FGM/C as it relates to any children deemed at risk.

The gap in HCP knowledge and skill could be addressed by incorporating FGM/C content in the health

Figure. Health care provider abilities to care for patients with FGM/C.



FGM/C: female genital mutilation/cutting.

profession's core curriculum and having readily available continuing medical education and professional development opportunities. There are a growing number of resources designed for education of HCP in regard to caring for women with FGM/C,[8] including Canadian guidelines.[2] Although this is valuable and encouraging, further efforts should integrate these resources into health profession education, include cultural competency training, and provide experienced content experts and community liaison workers to bolster the teaching and training of our HCPs. A review of the FGM/C content currently being taught in medical, nursing, and midwifery school curricula across Canada may be an important step in addressing an improved HCP education.

Limitations

This research is limited in that the study sample was voluntary, from a single city in one country, and had a response rate of 30%. The results therefore may reflect a selection bias towards the opinions of those with more interest in or knowledge of FGM/C.

CONCLUSIONS

This survey has identified major gaps in HCP knowledge and awareness of and training in FGM/C within a major Canadian city. Our results highlight the need for further education around obstetrical care in the setting of infibulation, requests for reinfibulation, and child safeguarding. Consolidated efforts are recommended to implement high-quality, culturally informed training for the multidisciplinary providers who care for women with FGM/C.

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