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Chapter

Experiences of Sexual and Reproductive Healthcare Professionals Working with Migrant Women Living with Female Genital Cutting in Western Australia

Darlene Ndasi and Kwadwo Adusei-Asante

Abstract

Female genital mutilation or cutting (FGM/C) is a global public health problem. The practice is particularly prevalent amongst people of African, Middle East and South East Asian descent. FGM/C creates a permanent change to the body of women. When such women migrate to other countries, they bring the associated social and health problems of FGM/C with them. As a multicultural society, Australia has many residents who come from settings in which FGM/C is prevalent. This qualitative study investigated whether healthcare professionals in Western Australia are prepared and able to provide adequate healthcare to women living with FGM/C. We found that there is a paucity of literature in Australia generally, and Western Australia more specifically, about FGM/C and the associated experiences of healthcare providers. Healthcare professionals were found to experience challenges when working with women living with FGM/C, mainly because of poor cultural sensitivity and poor levels of communication, and lacked appropriate education and training for working with women living with FGM/C. This study identified a need for empirical studies on how women living with FGM/C experience sexual and reproductive health services in Western Australia.

Keywords: female genital cutting, FGM/C, gender, phenomenology, women

1. Introduction

Female genital mutilation/cutting (FGM/C) is practised beyond the borders of countries where it is traditionally reported. Through the influx of asylum seekers and refugees to host countries such as Australia, FGM/C is increasingly creating challenges for healthcare professionals, who may have no or few culturally specific skills to work with its presentation in migrant women [1]. The sexual and reproductive needs of migrant women living with FGM/C are unique, and without culturally specific healthcare frameworks, meeting the healthcare needs of these women may be inhibited by cultural, environmental, and language barriers [2].

The World Health Organisation (WHO) classifies FGM/C into four categories: Type I, Type II, Type III and Type IV. Type III is described as the most severe, whilst Type IV is described as only symbolic and not a ritual [3]. There are two forms of Type I. Type Ia involves the intentional removal of the hood of the clitoris and seldomly occurs on its own [4, 5]. Type Ib results in clitoridectomy—a procedure requiring the removal of the clitoral hood. Type Ib is more common and may also include the partial or complete removal of the clitoris together with that of the prepuce [6]. In Type II (excision), the clitoris and labia minora are partially removed with sharp objects, although some cultures partially cut out the labia majora and may apply ashes or herbs to stop the ensuing bleeding [5, 7]. FGM/C Type III (infibulation) involves the removal of all external genitalia, after which the wound is fused with cat gut, thorns or surgical threads (see [8, 9]). The clitoris may be pricked, pierced and scrapped to let blood in FGM/C Type IV. The practice represents the ritual of FGM/C in communities where FGM/C is outlawed ([10, 11]; for other forms of the practice, see [12, 13]).

An estimated 200 million women and girls globally have undergone the FGM/C procedure, with populations with the highest percentages residing in Africa, including 1% in Cameroon, 4% in Ghana and Togo, and above 91% in Egypt and 98% in Somalia UNICEF [5]. In Europe, it is estimated that half a million women and girls are living with FGM/C [14], mostly due to the mobility of women and girls from countries that practice FGM/C [15, 16].

The prevalence of FGM/C in Australia is difficult to determine, although some speculate that it has been around since 1994 [17]. Whilst there appears to be a lack of research and literature around FGM/C in Australia, the increase of migrants into the country from nations where FGM/C is practised may be an indication that FGM/C prevalence is increasing in Australia [18]. It is believed that women who have experienced FGM/C arrive in Australia after the procedure has been done [19]. Tellingly, statistical analysis shows that Australia received 38,299 migrants from 11 African countries where FGM/C is highly prevalent such as Sudan (24,082), Egypt (6258), Somalia (2736) and Ethiopia (5223), with the remainder from other African nations, as reported by Bourke [20, 21]. In 2010, the Melbourne Royal Hospital reported that it had seen 600–700 women living with FGM/C [20, 21]. Mathews [18] argues that the challenge of accurately establishing the prevalence and occurrence of FGM/C in Australia also stems from secrecy of the practice when compared to how it is symbolically portrayed in public ceremonies in countries that observe FGM/C (see also [16]).

A 2010 US survey revealed that sexual and reproductive healthcare professionals (SRHPs) may have knowledge about the presentation of FGM/C amongst migrants, but lacked culturally competent skills and adequate information to provide competent healthcare for women living with FGM/C [22]. Hess et al. [22] also found that negative attitudes and cultural insensitivity in SRHPs reinforce stigmatisation and isolation, resulting in poor sexual health amongst migrant women. Further, Berggren et al. [23] conducted a study in Sweden revealing that midwives attending to women living with FGM/C did not have adequate knowledge, which was evident during labour of women with infibulation. They also revealed that cultural insensitivity by healthcare professionals, poor cross-cultural communication and poor management of the labour process resulted in caesarean sections in women with FGM/C more often than was necessary.

Zaidi et al. [24] found that there is a need for healthcare professionals working with women living with FGM/C to be aware of their own cultural prejudices that may affect the wellbeing of their patients. Other researchers investigating healthcare professionals' knowledge and management of FGM/C revealed that cross-cultural training of healthcare professionals working with migrant women is imperative to

address the knowledge gaps that hinder efficient service delivery to women living with FGM/C [25, 26]. Widmark et al. [27] suggested that the systematic involvement of infibulated women in pregnancy and birth planning frameworks could ultimately establish efficient service delivery and address knowledge gaps.

Cultural competence amongst healthcare professionals working with women living with FGM/C can also decrease stigmatisation towards these women, ultimately leading to better health outcomes for them and their families [22]. Further, Zaidi [24] cited communication between the healthcare professionals and women living with FGM/C as a major drawback to the achievement of better health outcomes for women living with FGM/C in host countries. This study aimed to investigate the experiences of healthcare professionals providing sexual and reproductive healthcare to women living with FGM/C in Western Australia. A secondary aim of this study was to contribute to the wider body of knowledge regarding healthcare professionals working with women living with FGM/C in Western Australia.

2. Literature review

The WHO defines FGM/C to include ‘all procedures that involve partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons’ ([3], p. 3). FGM/C is performed on children between 0 and 15 years [28]. Traditionally, it is performed at 8 years of age on average but can occur at any age. Kolawole [29] argued that FGM/C is infused with cultural, legal and medical implications, making it difficult to adequately define. Debates regarding terminology and definitions continue across all societies, social groups and cultures. Almroth et al. [30, 31] pointed to concerns amongst scholars regarding the use of terminology and the ritual of FGM/C; in particular, some scholars consider ‘mutilation’ (p. 457) a medically acceptable term for the practice, as it involves the removal of healthy tissue and organs without medical indication, whilst others have argued that this term denotes negative connotations and attitudes towards the procedure, and may be offensive to some cultural groups [31, 32].

We have argued elsewhere [33] that the term ‘female circumcision’ implies an analogy with male circumcision, which is misleading from an anatomical aspect as male circumcision only involves the removal of the glans, which by no means corresponds to the cutting of female genitalia (see also [31, 34])—FGM/C could only be compared with male circumcision if the penis were completely amputated and the surrounding tissue removed, as the cutting experienced by girls is severe, with irreversible effects that inhibit both sexual and reproductive capacities [29].

According to Bibbings [35], ‘female genital mutilation’ (p. 139–149) suggests torture and violent bodily injury forced on children and unwilling women by men and women from their cultural groups for the benefit of men and their communities or groups. This study shares this viewpoint, and both the term female genital mutilation and cutting (FGM/C) have been used concurrently to take a strong stand against the procedure, whilst acknowledging the theoretical debates on the definition of FGM/C as well as cultural, social and health implications of the procedure (see [36]).

Several scholars have argued that FGM/C is a strategy that exploits female sexuality for the sexual pleasures of men [37–39]. Some authors have postulated different reasons for the occurrence of FGM/C, including marriage [39], religion [26], cultural reasons [40], ethnicity [41], maternalism [23], patriarchy, and social pressures [37]. Additionally, community attitudes towards the continuance of the practice are reported to slow and frustrate measures designed to address and potentially end the practice [11, 42].

According to Almroth et al. [30, 31], there seems to be no known clinical studies that have documented the consequences of FGM/C, and the body of available literature only documents results of survey-based studies [30]. Anecdotal evidence and accounts of the consequences of FGM/C report a correlation between the procedure and adverse sexual and reproductive health outcomes [43]. Immediate and long-term sexual and reproductive health conditions have been reported in women living with FGM/C, although the severity of these conditions is believed to be dependent on the extent or the type of the procedure performed.

Diouf and Nour [44] argued that the adverse effects of Type I, Type II and Type III FGM/C can be short and long term, and possibly increase the risk factors for an HIV transmission due to the use of non-sterile instruments during the procedure. Wakabi [45] documented how surgical equipment is traditionally used numerous times on more than one initiate during the FGM/C procedure without being sterilised, increasing the risk of HIV and other blood-borne viruses (BBVs) being transmitted. Additionally, [46] argued that excessive bleeding is a complication of the FGM/C procedure, which can increase the need for medical attention (i.e., a blood transfusion); this may again increase the risk of potential HIV transmission. Although untraditional, it is based on adverse medical complications of FGM/C that the procedure came to into existence by emulating western medical practices of male genital cutting/circumcision (MGC/M).

The medicalisation of FGM/C refers to any form of FGM/C being performed by healthcare providers, whether in private or public facilities, in the home or any other place where it may occur, in contrast to the traditional circumcision ceremony, which is usually ritualised and surrounded by public celebrations of the procedure [47]. In Kenya, for example, the medicalisation of FGM/C has become common amongst holidaymakers living in Western countries who originate from this country. Therefore, it is common amongst the Bagusii and the Kuria in the west of the country, where FGM/C is highly prevalent, and Njue and Askew [48, 49] reported that it has become common amongst nurses, midwives and even medical doctors to perform the procedure after consultations with a child's parents.

However, we opine that the medicalisation of FGM/C raises moral questions pertaining to whether it is a measure to protect the sexual and reproductive health of girls and women or an imperialistic promotion of a dangerous practice [50, 51]. Furthermore, the minimisation of complications during and after the procedure raises questions as to whether the medicalisation of FGM/C reduces harm or perpetuates an extremely dangerous practice [38].

A decade ago, the WHO delivered a joint statement against the medicalisation of FGM/C on the basis that it excuses and perpetuates a harmful practice, and further stated that the medicalisation of FGM/C is a dangerous and criminal practice, requiring strategies to stop healthcare providers from carrying out the procedure [52].

3. Methods

This project was designed as a qualitative study. According to Morse [53] and Sandellowski [54], qualitative research is particularly useful when collecting information about unknown topics, as it has the potential to provide rich and detailed descriptions of a phenomenon. The descriptive phenomenological approach in qualitative research was used as it can provide deep insights, as discussed by Liamputong [55, 56]. Phenomenology is an approach to qualitative

research that seeks descriptions of phenomena and how they are experienced by the actors and is effective in bringing to the fore the perceptions and experiences of individuals from their own perspectives [57]. Phenomenology allows researchers to unearth lived experiences of individuals through narratives, whilst the research takes a neutral position with no preconceived ideas of what the outcome might be (see [58–60]). Lopez and Willis [61] also suggested that the phenomenological approach in qualitative studies can examine subjective human experiences by making enquiry efficient without bias and preconceived knowledge, attitudes and values, which must be shed by the researchers prior to conducting interviews.

Purposive sampling was applied as a time-saving technique, to avoid the process of searching for specific information in a potentially broad group of possible informants. Coyne [62] suggested that purposive sampling is the most appropriate method when detailed and abundant data are required to investigate a specific phenomenon [62]. Therefore, participants were chosen based on their experiences working with patients living with FGM/C who were seeking sexual and reproductive healthcare services. The research sample was drawn from different healthcare organisations across the Perth metropolitan area, all of whom worked in various sexual and reproductive healthcare organisations.

The researchers also applied snowball sampling; six participants who met all the inclusion criteria were interviewed. The number of participants in this study was appropriate, as qualitative research does not seek to generalise but to seek and report on phenomena [63]. They ranged in age from approximately 25–60 years, with mean age of 39 years. The participants comprised four midwives, one nurse and one doctor. All worked for the government public health departments of both government and private sectors.

Face-to-face in-depth interviews were conducted at the participants' place of employment. Interviews took 30–60 minutes and were conducted using semi-structured questions to guide the process and ensure relevant topics were covered. Participants were provided with a Participant Information Sheet and signed an Informed Consent Form before the interviews commenced. Signing the Informed Consent Form provided permission for the interview to be audio recorded. One joint group interview of four midwives and two individual interviews, one with a doctor and the other with a community nurse, were conducted. The joint interview was facilitated as participants had extreme time restrictions and the only available time could accommodate a joint interview comprising team members of the maternity ward department of a public hospital.

The audio-recorded interviews were transcribed within 2 weeks of collecting the data, each line being numbered and printed to allow easy examination of the content. Data reduction was conducted after the transcribing and the data coded afterwards, allowing for the categorisation of emerging themes. The printed transcriptions were examined and constantly compared with the field notes to identify emerging themes. The initial analysis was open, allowing the researchers to develop hierarchal categories across all data sets, including the field notes, to find repeated patterns of meaning. This was followed by axial coding, which allowed the researchers to connect codes, thereby establishing the relationship between all codes [63].

Open coding was initiated at the beginning of data analysis, with the researchers examining and colour-coding field notes to identify themes and then sequentially numbering all the lines in the transcribed interviews. In coding the data, Nvivo 10 and Microsoft Word were used. This study was approved by the Curtin University Research Ethics Committee.

4. Findings

4.1 Communication difficulties

Anis et al. [64] argued that placing patients at ease in an environment so they are able to speak about their FGM/C is a key to provide consistent care and positive outcomes. Participants expressed concerns regarding poor communication between their patients and themselves. The difficulties in communication were both verbal and non-verbal, which included the refusal by patients to respond to questions when asked if they lived with FGM/C. Participants reported that they also refused examinations when they presented at the sexual and prenatal clinics. This led to the late discovery of the presence of FGM/C in women who had presented with pregnancy and labour. The following excerpts are from the interviews conducted with the SRHPs:

They don't talk about it ... but they don't talk about it ... they know what is happening to them ... the very first one that I saw I was really shocked, because there was only an opening you could only let a finger in ... she knew she had a problem ... but she didn't talk of what had happened to her ...

Another midwife made the following statement: 'they would refuse all vaginal exams ... they don't tell anyone that it has been done to them ... and they just arrive ... here!' Another participant commented:

Well ... hopefully, that should be identified at the antenatal clinic ... but as it goes ... don't tell us ... if they refuse examination at the antenatal, which a lot of them do, we don't find out until they are in labour ...

The professional health workers expressed how some of the patients were not aware of the FGM/C themselves, that it had been done when they were too young and that they may not have even known that they had it. One of them reported that she saw no need to talk about FGM/C with these patients. She also expressed her view that it was not her place to talk about FGM/C as she feared there could be implications in speaking about it with her patients. She expressed a deep lack of confidence in communication with her patients living with FGM/C:

I wonder if it is helpful for me to point out to them that they have a problem which is not in one of my problem categories ... yeah ... They would be as how they have always been ... they won't actually know any difference ... I don't know what intervention is of benefit ... Maybe that is what I need to learn more about ... what evidence is there towards intervention? ... asking those questions is important but I don't know how ... but I do feel that even if someone says that, this is ok to talk about it ... I can still get myself into a lot of trouble ... and I think I ... bring up a subject that is very sensitive and very difficult ... that I actually don't have very much skill to help with ... then I would cause harm ... and so often I won't mention whether they may or may not perceive they have a problem is sometimes more harmful than good ... and yet I recognise that I may be missing an opportunity ... to discuss ... but they may not have the courage to discuss ...

Participants reported that they felt inadequately equipped to communicate effectively with women living with FGM/C and suggested that healthcare professionals with the same cultural background as their patients would be appropriate to provide services to women living with FGM/C. It was also suggested that

culturally specific healthcare to women living with FGM/C would promote efficient communication between healthcare professionals and their patients. A doctor made this statement:

I guess my thinking is that someone who is from the same culture or background would understand that background and would have more ability to ... perhaps ask the right questions ... so it is that sense of someone who understand me ... so I won't go to a man for a pap smear ... someone who understands women's health ... I think the similar would be the case ... to talk to someone who thinks this is barbaric ... to do that to my daughter ... how can I go to that person for help? I need to speak to someone who understands the background and the pressure ...

Additionally, participants reported that they were concerned about their patient's capacity to comprehend the medical information and advice provided. One midwife expressed concern about the ability of the patients to clearly understand what was being communicated to them during service delivery:

I'm not 100% sure women will know what we are asking them ... you know ... have you been cut? ... they may not understand what we are asking ... and they may not have knowledge of what has been done ... a youth worker ... had FGM ... and she didn't know because she didn't know how a normal vagina would look like ... She didn't know she had been cut ... a doctor had to examine her to see if she had been cut.

Another participant strongly emphasised the importance of efficient communication between patients and healthcare professionals: 'Yes. Communication is the key.'

Communication difficulties between participants and their patients were discussed by participants as barriers to efficient sexual and reproductive health service delivery. The reasons for these communication barriers were reported to stem from cultural conflict between healthcare professionals and their patients.

4.2 Cultural conflict

Several of the participants reported that they viewed the procedure of FGM/C in their patients as barbaric, incomprehensible, oppressive and dangerous and expressed sadness and anger at the pain that women with FGM/C have to endure during delivery. However, despite these feelings of sympathy, they experienced frustration, shock and anger that these women do not speak about FGM/C even when they are asked. A doctor made this statement:

it makes me sad that that happens ... to people who don't have the ability to step out of their culture ... they don't go, 'Oh my God, we are cutting a baby on a sensitive area! That can't be right!' And yet, I have days I reflect on tradition and things that have been done for a long time ... then there must be some reason behind it even though to my ... outsider position I am looking at it, and it is completely wrong.

Another participant stated:

The sensitivity is of course related to sexuality; it is related to cultural identity and that whole sensitivity is multiplied by the fact that we are medical professionals from the other culture ... And I think if it was my culture, I would feel I have the

right to ask ... in the same way a woman can ask a woman about periods and talk about sex in a way that a man doctor can't ask that question ... But I come from a different culture and I am asked questions about a practice that people from that culture, which is new to this country, they realise that the practice is forbidden and that there is overriding condemnation of it. And they may even feel that me asking a neutral question could sound like condemnation.

A midwife described with profound sadness how she witnessed a woman suffer during childbirth: 'Oh, I was upset ... when I saw the poor girl ... I told you she had an opening only one centimetre. We couldn't even find her urethra ... It is very sad.'

Another midwife was clearly psychologically disturbed by FGM/C in her patients:

It makes me mad ... it makes me very sad that the woman has had to endure it ... especially if it was done in countries with basic tools ... knives, and I think, that is a small child that it was done to and I ... the pain and why you do it?

4.3 Re-infibulation and the medicalisation of FGM/C

Re-infibulation occurs after childbirth and returns de-infibulated women back to the previous state of infibulation; it is argued to have no benefits (e.g., [51, 65]). Statements were made by participants that women requested re-infibulation after childbirth. One midwife described how a doctor carried out re-infibulations after birth, giving him a large clientele of patients who preferred his services, which is in contrast to the typical cultural practice of women who are living with FGM/C, who usually have a preference for female healthcare providers [22, 66]. This midwife said:

I know ... when I worked at XXXX hospital, one of the doctors used to look after a number of Middle Eastern ladies because he spoke their language, and there was a high proportion of FGM/C in these ladies ... and at one stage, I know he was sewing them back as they were ... because they were requesting it ... before he was talked to about all the legalities ...

In non-traditional rituals, as occurred in Western societies, clinicians who support the practice of FGM/C often perform re-infibulation, creating a situation where FGM/C is medicalised [18]. This has been highly controversial within the WHO [52], which has called for prosecutions of clinicians who perform FGM/C, in line with the rationale that there is no excuse whatsoever for the facilitation of any form of FGM/C by medical practitioners [52]. Whilst the campaign against FGM/C has been highly visible within the traditional locations where FGM/C is practised (e.g., sub-Saharan Africa), in Western countries, clinicians are still faced with poor training. A lack of access to and knowledge of clear clinical guidelines for the treatment of women living with FGM/C is evident, which may increase the likelihood of re-infibulation occurring [67, 68].

Participants in this study described how some women would travel for long overseas holidays to perform re-infibulation and also have their newborn daughters circumcised. The following statements were made by participants:

XXXX hospital now refer women, any women who have had daughters, to social workers to ensure they don't disappear for long to circumcise their daughters ... and they are trying to introduce it here: any woman that has a female baby is followed up ... they have training for social workers ... because they have specific training ... to ensure these women do not disappear for long periods of time so the same thing is not done on them.

Another midwife made the following statement: ‘she had previous Type III FGM ... and the social worker sent me an email saying, “Can you talk to her about it, she has got two daughters and we want to make sure she doesn’t cut them?”’

Some of the statements made by the participants identify the need for culturally specific sexual and reproductive healthcare to meet the needs of women living with FGM/C.

4.4 Culturally specific healthcare

The participants expressed the need for women living with FGM/C to have access to culturally specific healthcare, reporting that this was lacking in the public health system in Western Australia. Participants described how healthcare professionals find it difficult to understand the culture of FGM/C and therefore feel inadequate in their capacity to provide sexual and reproductive health services in an efficient manner to women living with FGM/C. A doctor expressed how culturally specific healthcare would minimise conflict in the relationship between women living with FGM/C and healthcare professionals by training professionals with a similar cultural background as the patients to provide efficient healthcare:

it is a specialised area and accessing specialised services is important by those people who are fairly trained to help ... even within gynaecology, you wouldn’t refer them to any gynaecologist ... just those who are more experienced, those who are more able to help. Psychologists would have very little experience within that area, counselling and some would be very well experienced ... I think there needs to be more conversations about it, and probably more training by people who are very much from that culture and understand all the in’s and out’s. And then give good advice as to how someone who is not from that culture might approach the issue. Because within our own culture we have many ideas of healthcare, even within one culture every person is different. It isn’t helpful if doctors are trained to provide the wrong approach.

It appears therefore that clinicians with experience and backgrounds where FGM/C is traditionally practised can offer invaluable support to women presenting with FGM/C at sexual and reproductive health services in Western Australia. These clinicians could be targeted for specialised training in numbers that can appropriately cater for sexual and reproductive health needs of women living with FGM/C.

5. Complications of FGM/C in sexual and reproductive health provisions

All participants stressed the importance of consistently screening pregnant women for FGM/C and clearly recording the information at the antenatal care stage before women go into labour. The participants stated that this could help prevent complications during childbirth, such as prolonged labour and unplanned caesarean sections and episiotomies. Routine screening and the correct use of information were reported to facilitate appropriate planning and the prevention of trauma during childbirth. However, it was reported that this was often hindered by women’s refusal to be physically examined and by the poor recording of information. This is exemplified in this excerpt from one midwife:

One of the doctors is the one who usually do ... the anterior cuts ... they actually do cut where they have been stitched ... the registrar would decide where the cut’s gonna

[sic] be ... exactly where they will be placed ... someone came in labour and no one knew the woman had FGM ... and then it is bit of panic, and what can we do ... Type III – a baby is not gonna [sic] come out ... normally, if it is Type III, you would do one cut up, and then two up that way, and then afterwards sew the edges ... so that it is not bleeding ... and then do construction work afterwards.

Another midwife concurred, adding the following:

and this poor girl had to have three episiotomies ... one anterior and two posterior, to get her baby out. Because the baby was pressing against her vaginal wall I guess ... and it started opening that diameter ... a centimetre ... the baby was never going to come out, so she had three cuts! And we had to get one of our consultants to come and do the delivery, because she needed a lot of work, and repair work done ... so she had to go to theatre to get everything repaired, and hopefully, next time she'd have another baby, she should've been ok.

These experiences were also reported to affect other important medical procedures. A doctor expressed difficulties when conducting pap smear examinations on infibulated women:

so the first lady that I ever met ... I was quite convinced that ... that was what I was seeing ... she had a very severe form of uterine prolapse ... which sounds like shouldn't have happened ... cause she had been stitched all up ... and when this lady came, I could see that she had been ... eh ... I am actually sure whether it would have been Type II or Type III, but certainly stitched together for the large part. So the pap smear was difficult ... so I didn't know whether to tell her that's the reason or I didn't know whether to tell her whether it is due to menopause ... so it is not really not relevant to say why ... so say sorry it hurts and I just do what I need to do.

Cross-cultural training as evidenced in this data is a key to efficient services to women presenting to sexual and reproductive health services with FGM/C. SRHPs' experiences of caring for women with FGM/C in Western Australia reveal many frustrations and difficulties of providing care for these women. Appropriate training and policy framework and clear clinical guidelines for the care of women living with FGM/C are imperative in meeting the special needs of these women. The value of adequate experience, knowledge and skills in this area cannot be overstated.

5.1 Training needs

The participants reported their concerns regarding the inadequate training available for working with women living with FGM/C. All of the participants stated that the existing training was inadequate and, additionally, that they were not provided with adequate time or support from their employers to participate. They also commented on the lack of an adequate curriculum. One participant said:

more training would be useful ... I know there is some training based in XXXX hospital ... and I had an opportunity to do some of that training yesterday ... and ... I mean ... it is important to do more training ... sometimes I think training would make me understand this is Type II ...

It was also suggested by the participants that professionals who have backgrounds working with women living with FGM/C would be ideal if trained as

peer educators for women living with FGM/C, improving the processes of service delivery. A doctor made this statement:

probably more training by people who are very much from that culture and understand all the in's and out's ... And then give good advice as to how someone who is not from that culture might approach the issue. Because within our own culture, we have many ideas of healthcare, even within one culture every person is different. It isn't helpful if doctors are trained to provide the wrong approach ...

Other participants stated the need for integrated curricula in tertiary and professional training courses for doctors and midwives to enable them to acquire adequate skills for addressing FGM/C in their practice. One participant commented that the training is extremely basic and only provides limited information on FGM/C:

I think focusing less on the types and pictures ... and focusing more on the effects that it has on the women's lives ... and how we can talk to people about it, and how we can educate people ... but it is more about what can we do ... educating ourselves than rather just analysis of FGM ... But the fact that a child is screaming ... it makes me sad that they are living with it and the effects it has on people. It makes me want to know more and what can I do ... I used to examine women but in this role I am currently doing antenatal care ... which is why I need to know how to ask these questions.

Another concern was expressed regarding the content of the existing training. It was reported that, for a long time, the same content has been delivered yearly, with nothing new incorporated. A midwife stated:

she [the trainer] would come and talk to our staff, she would literally take you through the types ... the medical side, and same thing every year ... same PowerPoint presentation, every year. And you knew you were never gaining anything from it ... every year, but the same thing ... quite a number of years ... probably five years ... listening to the same thing ... being delivered.

A midwife agreed and stated that, 'It's usually the same information ... it hasn't changed.' Some of the participants also expressed the need to be provided with training opportunities and supported by their employers if they were to be well equipped to deal with FGM/C in their patients. One midwife said:

I used to be a staff development officer at XXXX hospital, and the staff are inundated with 'you have to do this, you have to do that' ... (lack time for training), and plus you have to do your work ...

There is a need for healthcare policies to integrate appropriate modules in curricula for training healthcare professionals to facilitate efficient and appropriate service delivery to women with FGM/C. This has to be based on the cultural diversity in Western Australia and the larger Australian society.

6. Conclusion

This study focused on the experiences of healthcare professionals providing sexual and reproductive healthcare to women living with FGM/C in Western Australia and aimed to contribute to the wider body of knowledge regarding healthcare professionals working with women living with FGM/C in Western

Australia. Individuals reported both unique experiences and commonalities within the context of their interviews. SRHPs providing services to women living with FGM/C in Western Australia identified a gross lack of adequate training services capable of equipping SRHPs to expertly meet the needs of women living with FGM/C. Significant changes are required to provide adequate care for women living with FGM/C in Western Australia.

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Author details

Darlene Ndasi and Kwadwo Adusei-Asante*
School of Arts and Humanities, Edith Cowan University, Western Australia

*Address all correspondence to: k.adusei@ecu.edu.au

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