Research Article

Discussing Female Genital Mutilation by youth health care professionals in the Netherlands: aids and barriers

Rima Alkirawan[1], Ramin Kawous[2], Jeanine Suurmond[3], Dorothea Touwen[4], Fijgje de Boer[5]

1. Vanderbilt University Medical Center, Nashville, Tennessee; 2. Pharos Centre of Expertise on Health Disparities, Utrecht, Netherlands; 3. Amsterdam UMC, Amsterdam, Netherlands; 4. Leiden University, Netherlands; 5. VU University Medical Center, Amsterdam, Netherlands

Introduction

In order to prevent child abuse, the care for women and girls at risk of Female Genital Mutilation/Cutting (FGM/C) in the Netherlands has been delegated to Youth Health Care Professionals (YHCPs). However, there is considerable evidence about sub-optimal care provided by YHCPs. This study aimed to explore the aids and barriers in providing FGM-related healthcare as perceived by YHCPs.

Method

A qualitative study was carried out in which 15 YHCPs were interviewed. Data analysis consisted of three steps and was oriented towards the development of themes.

Results

The results show insufficient knowledge and awareness of FGM/C and not sharing information about it among YHCPs. A facilitating factor is the existence of an instructor protocol together with a digital reminder of the contact moments to discuss FGM/C with a client; a main barrier was the difficulty to discuss the issue of FGM/C with the target group.

Conclusion

FGM/C is a complicated, culturally based tradition. There is a need for improvement of the conversation-related part of the protocol and for participative workshops to train Dutch YHCPs to work effectively across divides.

 doi.org/10.32388/9ZMNCK.2

Background

Female genital mutilation or cutting (FGM/C) is a serious public health concern as it causes health complications[1]. It refers to all procedures involving the partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons[2]. The practice is internationally recognized as harmful with an increased risk of immediate and long-term negative physical, psychological and sexual health consequences, as well as a violation of girls' and women's human rights[3][4][5]. FGM/C occurs predominantly in Africa, the Middle East and Asia[6].

With an increase in migration, FGM/C has become an issue of serious concern in high resource countries[7]. A study shows that an estimated 500.000 first generation girls and women in the EU, Norway and Switzerland had undergone FGM/C before their migration[8]. Since the nineties, several high resource countries have developed strategies and policies to prevent FGM/C to protect those at risk and to provide services for those affected by FGM/C. However, this prevention policy presents a challenge for health care professionals as they seem not equipped to discuss the practice with their clients[9].

FGM/C in The Netherlands

It is estimated that in The Netherlands about 41,000 girls and women are living with the effects of FGM/C and 4,200 are estimated to be at risk for undergoing it[10]. Since 1993, all forms of FGM/C are forbidden in the Netherlands; the aim is to prevent it and offer good quality care to girls and women who have been circumcised[11]. Currently, the Dutch government also claims jurisdiction with regard to genital mutilation of residents, who practise it elsewhere[12]. Youth health care professionals (YHCPs) play a central role in the prevention of FGM/C as they already have the task to regularly examine the health of all girls from birth until the age of 18. When a girl comes from an FGM/C risk country, the YHCPs have as additional task to discuss all aspects of FGM/C with the parents, assess the risks of FGM/C, and offer help if there are problems resulting from FGM/C[13]. In case of a high risk estimation, the YHCPs are required to report it to the child abuse organization Safe at Home, a governmental organization with legal rights to carry out a further investigation into a case[14]. A protocol has been developed as a guidance to support YHCPs in conducting the conversation with the mother or the adolescent girl[15].

The FGM/C protocol in the Netherlands is a guideline for YHCPs on how and when to conduct the conversation about FGM/C with the target group.

The protocol mentions multiple contact moments at which YHCPs discuss FGM/C with the parents when the girl is (0-12 years) and with the girl herself at secondary school (13-15 years).

As FGM/C prevention in the Netherlands is delegated to youth health care centres, the aim of this study is to explore the experiences of YHCPs in discussing FGM/C with their clients and barriers and aids related to the prevention of FGM/C. A more thorough understanding from the perspective of the YHCPs could lead to recommendations to support them in carrying out this task.

Method

Study design and recruitment

An exploratory qualitative study was conducted in 2021 using individual semi-structured interviews with YHCPs working in a public health care organization in a large city in the Netherlands. Purposeful sampling was carried out by sending an email to 15 YHCPs (nurses and pediatricians) of whom it was known that they discussed the topic of FGM/C with the risk group. All of them agreed to participate. After that, they were informed about the study by phone. After verbal consent, the reasons of the study were again explained orally during the face-to-face interview after which the participant signed the informed consent form.

Data collection

For the semi-structured interviews, an interview guide was developed based on existing literature and the topics in the research question (see box 1 for the topics).

The interviews were conducted and audiotaped in the office of the public health care organization and lasted between 50 and 115 minutes. All recordings were transcribed verbatim by the main researcher RA.

Topic guide

1) Knowledge and awareness of FGM/C
2) Aids and barriers in the communication with the target group
3) Attitudes towards FGM/C
4) Views on the quality of the guidelines/protocol
5) The conversation with the client

Box 1. Interview guide with topics for the interviews with the YHCPs

Afterwards, a small focus group discussion (FGD) was organized with three health care managers from the same organization to discuss the results and the implications for practice.

Data analysis

Data analysis was oriented toward the development of themes[16]. Firstly, the transcripts of the interviews were coded inductively using the software qualitative data analysis program MAXQDA by the first author (RA, female), who also conducted the interviews. The codes were double checked by another researcher (FdB, PhD and university teacher). Differences in coding and code clustering were discussed until agreement was reached. A framework with themes was set up representing the topics discussed in the data. Following interviews were coded according to this framework of themes. New codes were added and subthemes developed. The analysis resulted in the emergence of four main themes. Results were sent back by the first author to four participants with the question whether they recognized the results. No changes were suggested. As a last step, the data of the FGD was compared with the framework of themes.

Results

Characteristics of the participants

nr	Profession	Yrs work experience	Care for: age group children	Experience in Asylum Seeking Center
1	Nurse	6	12-18	No
2	Nurse	10	0-18	Yes
3	Nurse	15	0-12	Yes
4	Nurse	10	0-18	No
5	Nurse	5	0-12	No
6	Nurse	10	0-12	No
7	Nurse	4	12-18	No
8	Nurse	5	0-12	No
9	Nurse	4	12-18	No
10	Nurse	8	0-18	No
11	Pediatrician	7	0-12	No
12	Pediatrician	7	0-12	No
13	Pediatrician	6	0-12	No
14	Pediatrician	5	0-12	No
15	Pediatrician	4	0-12	No

Table 1. Participant characteristics

Fifteen female participants participated in the study: ten with a nursing degree and five with a medical degree. The nurses vary in their work experience related to target group: some have been working for more than 10 years as a public health nurse, others much less than that. Three nurses work with children from all age groups (from 0 -18 yrs.), four nurses and the five pediatricians work with

children from 0-12 and three nurses only visit girls who are at secondary school. Two nurses worked in an asylum seeking center, which led to being more familiar with the topic of FGM/C since the risk group consists mostly of refugees.

Four themes emerged during data analysis.

1. **Knowledge and awareness of FGM/C**

   YHCPs varied in their work experience and knowledge of FGM/C. Some professionals started only recently to work as a YHCP and were, therefore, not familiar with the topic of FGM/C. Other professionals had more experience, for instance had been working in an asylum seeking center.

   'FGM/C is a topic I am familiar with for many years. I followed a training and I have had many conversations about it with asylum seekers' (respondent2, a nurse).

   All YHCPs showed having basic knowledge of FGM/C, but it was not a topic that they often discussed with their colleagues. Few of the YHCPs had ever been confronted with cases of FGM/C in their professional practice. When having more long-term experience with FGM/C, a YHCP knew better how to prepare for the discussion on it with the client. All YHCPs experienced the discussion of FGM/C with the clients as a sensitive topic to which they felt a cultural distance. They considered it to be a negative cultural practice because of its physical and psychological impact on the young girl and later adult woman.

2. **The use of the protocol in the conversation with the client**

   Discussing FGM/C is facilitated by the protocol, which indicates the moments when it needs to be discussed and how the communication should take place. However, often YHCPs did not consult the protocol before the interview either with the parents or the girl.

   'I do not look at the protocol. I discuss FGM/C in my own way' (participant 4, a nurse).

   Training is offered on a voluntary basis to YHCPs. Therefore, some respondents lacked any training about FGM/C.

   YHCPs started the conversation with introducing the topic and by explaining why they asked questions about FGM/C. They confirmed that mothers rejected this practice for their daughters by saying that they would not carry out the procedure.

   'Especially when the mothers are mutilated, they really do not want that to happen to their daughters' (participant 6, a nurse).

   According to the YHCPs most girls in secondary school denied knowing anything about FGM/C.

Some YHCPs avoid the conversation about this issue with the girl in secondary school, when they noticed in the girl's file that it was discussed with the parents at the time the girl was young. They also did not discuss it with the girl when they estimated the risk for circumcision to be low since that time.

Some YHCPs mentioned that they discussed the topic on the phone with the mother. This was contrary to the practice of other YHCPs, who expressed a strong preference to discuss FGM/C face-to-face with the mother/parents and not by telephone, because of the sensitivity of the topic.

3. **Aids and barriers to discuss FGM/C**

According to the YHCPs several structural factors facilitate FGM/C prevention. One is that FGM/C is considered in the Netherlands to be a form of child abuse, which can be reported to the child abuse organization. Other aids are the existence of the instructor protocol, the appearing of the contact moments in the girl's digital file and having sufficient time to discuss FGM/C with the clients.

Timing is never a problem. We always could extend the appointment when I see that I need to discuss it further with the parents. Otherwise, we can arrange a meeting at another moment' (participant 8, a nurse).

No linguistic barriers were reported. In case of communication difficulties language interpreters could be called in. A family member could also help with the translation, but most YHCPs preferred to rely on formal interpreters who might accompany the parents/girl since the issue is not easily discussed within a family context. The YHCPs showed a preference for a female interpreter. In case of a male interpreter, there is often no possibility to elicit in-depth information from the mother.

'Because FGM/C is a sensitive topic, I prefer to call the translation centre. Sometimes we are lucky to have a female interpreter rather than a male one' (participant 4, a nurse).

YHCPs mentioned several barriers. An important barrier was that YHCPs did not have a lot of knowledge about the issue and no insight into its context. Also, practical knowledge on FGM/C was lacking – in the sense of having experience with it in their own daily life or in their professional career. Therefore, some YHCPs felt less confident to discuss this topic to which they felt culturally distanced.

'I am supposed to be capable to discuss FGM/C with my clients. However, I do not have the specific tools

to conduct a conversation about this delicate and culturally-related topic' (participant 13, paediatrician).

Another barrier was that FGM/C is hardly ever discussed in the team and some YHCPs did not have any training in discussing it. A third barrier is that the YHCPs were not very aware of the protocol: they did not always consult it before the interview; they only posed the questions about FGM/C to the parents who come from a risk country, when it showed up in the medical file.

According to the YHCPs, parents are aware that FGM/C is prohibited in the Netherlands; however, it is no guarantee that they will not carry it out when the girl has reached the age of three. No physical examination is carried out since then anymore unless there is a suspicion; so the practice could take place after that age.

'Parents usually reply that they know it is prohibited to do FGM/C in the Netherlands and they do not do it. I think if the parents are still willing to conduct FGM/C to their girl, they will not tell us' (participant 14, pediatrician).

A barrier to discuss FGM/C with the girls in secondary school is that it is often discussed at school during a break when it is noisy outside the classroom. Therefore, it is difficult to have a confidential conversation in such an environment. In addition, most girls in secondary school seem not to be aware of FGM/C or deny knowledge about the practice.

4. **Improving the FGM/C prevention policy**

The YCHPs gave several recommendations to improve the prevention policy related to FGM/C. It was pointed out that it is necessary to read the protocol and especially the conversation-related part before interviewing the clients. It was, therefore, suggested to further elaborate the conversation-related part in the protocol. Participants also mentioned that some colleagues discuss FGM/C through the phone. They strongly recommended to emphasize in the protocol that the issue of FGM/C has to be discussed face to face, because of its sensitivity.

YHCPs also recommended to hand out information on paper to their clients on the risks of FGM/C and the regulations in the Netherlands. Another recommendation was to speak with the secondary school girls at another timeslot, for instance when it is quieter at school or at the office of the public health organization.

YHCPs also recommended to regularly discuss the difficulties they encounter during the FGM/C discussion with the target group. It was also mentioned that learning about FGM/C should take place in an active participative manner, for instance by organizing workshops with theatre actors

to practice interview skills.

However, the FGD with the health care managers showed another view on these recommendations. They foresaw not much time for discussion of FGM/C in the team, because of the many other issues that have to be discussed as well. They also stressed not to hand out information on paper to their clients as written information is not always regarded to be the best manner to inform clients. People from the target group often lack proficiency in Dutch and therefore cannot read or understand the written information. They may even throw it away as soon as they leave the building. The managers suggested the use of videos, which could be made available on the official website of the public health organization.

Discussion

According to the participants, YHCPs have only basic knowledge and awareness of the occurrence of FGM/C among the risk population. They take up the discussion of this topic with the target group, because it appears automatically in the files. It is not always discussed according to the protocol. The conversation on the topic of FGM/C is perceived as delicate, the answers of the mothers/girl that they will not carry it out are accepted and taken as valid.

Recent measures to facilitate the conversation on FGM/C with the risk group, such as revising the protocol and adding a pop-up in the file, appear to be not sufficient to guarantee effective prevention of FGM/C. There seems to be a gap between discussing the topic of FGM/C and obtaining a valid answer to the question whether the parents/girls will carry it out. Absence of knowledge and awareness of FGM/C could be an explanation for the existence of this gap, but also – as the study results show – the cultural distance to FGM/C.

Comparison with other literature

YHCPs lack sufficient knowledge and awareness as FGM/C occurs among small migrant groups in the Netherlands. The professionals are rather infrequently confronted with this topic in their daily practice which makes it less possible to build up (practical) knowledge and awareness about it. YHCPs, who had been working in an asylum seeking centre, showed having more experience with the target group and showed preparedness for the conversation on this topic. However, this only applies for a minority of the YHCPs. Furthermore, the lack of practical experience and insufficient knowledge and awareness may lead to misunderstandings in the communication, to being insufficiently able to

recognize the occurrence of FGM/C in the family or to ignoring the topic. Many studies describe a lack of professional awareness around FGM/C which leads to uncertainty about how to discuss FGM/C[17][18]. Health care providers identified a need for practical skills development[19].

On the other hand, cultural distance toward FGM/C, which refers to cultural differences between YHCPs and the mothers/girls, and to cultural assumptions could be another factor that may affect the communication resulting in misunderstanding and distrust. The discussion on FGM/C is often not very extended and the YHCPs take the answers of mothers/girls that they will not carry it out at face value and do not elaborate on the answers. Studies describe a cultural change after migration to Western countries; migrant groups from risk countries give up the tradition once arrived in the host country[20][21][22]. Therefore, YHCPs can trust the answers of the mothers and adolescent girls. However, since FGM/C is a sensitive topic and surrounded by taboo due to its association with sexuality and private parts[23][24][25], YHCPs might encounter the silence around this issue when they receive the answer that FGM/C will not be practiced by the family or that the girl at secondary school is not familiar with this topic. There is some evidence that some families prefer to have their young daughters to be circumcised. Through their network contacts they find persons who carry out the procedure by sometimes travelling to countries, where it is practised[26].

Implications for practice

The YHCPs provided several recommendations to overcome barriers in discussing FGM/C with the target group. Firstly, the current protocol needs further elaboration on how to guide the conversation with the mother and the girls in order to be able to build up a confidential relationship and what to take into consideration. Secondly, knowledge and awareness of FGM/C can be improved by stimulating the use of the protocol, what could be accomplished by shared discussions about it in the team under the supervision of a health care professional who is familiar with the topic of FGM/C. Thirdly, there is an urgent need for more education and training on all aspects (cultural, clinical, legal) associated with the risk for FGM/C[27][28].

Strengths and limitations of the study

Although the sample size is small to make a valid generalization across the country, it is still greatly appreciated as this study would stimulate further research and the resultant improvement in current practices in detection and management of FGM/C. From another side, the results indicating that

YHCPs have difficulties discussing this topic with their clients correspond to other studies, also outside The Netherlands, which makes these results more credible. According to a Dutch study evaluating the FGM/C prevention policy in the Netherlands YHCPs experience difficulties in discussing this sensitive subject within their limited time[29]. Moreover, knowledge and skills related to FGM/C topics are lacking, such as background information, knowledge about the culture and how to discuss this sensitive issue[29].

Conclusion

YHCPs are burdened with the difficult task to discuss a topic that is not familiar to them. Sharing information about it on team level can contribute to prevent its continuation. Further training and research are required to develop measures that support YHCPs in their difficult task of preventing FGM/C as part of efforts to discontinue this practice.

Declarations

Ethics approval and consent to participate

According to the Dutch Medical Research Involving Human Subjects Act, this study did not require medical ethical approval. We followed the ethical principles for medical research involving human subjects as laid down in the Declaration of Helsinki and adopted by the World Medical Association (WMA Declaration of Helsinki, 2000). Codes were used to designate the participants to guarantee their anonymity. Each participant was adequately informed of the aim and methods of the study and a priori oral consent was obtained from the participants and audiotaped.

Consent for publication

Not applicable.

Availability of data and materials

The data consist of mainly transcripts of taped, in-depth interviews which cannot be shared because of privacy concerns and legal restrictions on data containing sensitive (health) information. Data are available from the corresponding author on reasonable request.

Competing interests

None.

Fundings

The first author was employed to conduct this project at the public health organization

Authors' contributions

RA contributed to the conception and design of the study, acquisition of the data, analyses, and interpretation of the data, drafting of the manuscript, and gave final approval for submission of the manuscript. FdB contributed to the design of the study, analyses, and interpretation of the data, drafting of the manuscript, and gave final approval for submission of the manuscript. RK, JS and DT have read, gave comments on and approved the submission of the manuscript.

Acknowledgments

We are grateful to all participants who agreed to participate in this study.

References

1. ^*Sauer PJ, Neubauer D. Female genital mutilation: a hidden epidemic (statement from the European Academy of Paediatrics). Eur J Pediatr. 2014;173(2):237-238.*
2. ^*World Health Organization. Eliminating female genital mutilation: an interagency statement. OHCHR, UNAIDS, UNDP, UNECA: UNESCO, UNFPA, UNHCR, UNICEF, UNIFEM, WHO. Geneva; 2008. Accessed 12 Jun 2019. Available: http://whqlibdoc.who.int/publications/2008/9789241596442_eng.pdf?ua=1.*
3. ^*Berg R, Underland V. Immediate health consequences of female genital mutilation/cutting (FGM/C). Nor Knowl Cent Heal Serv. Oslo; 2014. Available: http://accaf.uonbi.ac.ke/sites/default/files/chs/accaf/Berg_2014_Immediate health consequences of FGM.pdf*
4. ^*Berg RC, Underland V, Odgaard-Jensen J, Fretheim A, Vist GE. Effects of female genital cutting on physical health outcomes: A systematic review and meta-analysis. BMJ Open. 2014(4):1–12.*
5. ^*Berg RC, Underland V. The Obstetric Consequences of Female Genital Mutilation/Cutting: A Systematic Review and Meta-Analysis. Obstet Gynecol Int. 2013;2013:1–8.*

6. ^United Nations Children's Fund. Female Genital Cutting: A Global Concern. New York: Unicef; 2016. https://data.unicef.org/resources/female-genital-mutilationcutting-global-concern.
7. ^Korfker DG, Reis R, Rijnders MEB, Meijer-van Asperen S, Read L, Sanjuan M, Buitendijk SE. The lower prevalence of female genital mutilation in the Netherlands: a nationwide study in Dutch midwifery practices. Int J Pub Health. 2012.
8. ^Baelen L. van, Ortensi L, Leye E. Estimates of first-generation women and girls with female genital mutilation in the European Union, Norway and Switzerland. Eur J Contracept & Reprod Health Care.2016; 21(6):474-482.
9. ^Johnsdotter S. Meaning well while doing harm: compulsory genital examinations in Swedish African girls. Sex Reprod Health Matters.2019;27(2):87-99.
10. ^Kawous R, Van den Muijsenbergh METC, Geraci D. et al. (2020). The prevalence and risk of Female Genital Mutilation /Cutting among migrant women and girls in the Netherlands: an extrapolation method. PLoS One. 2020;15:1–16.
11. ^Pharos. The Dutch chain approach. Utrecht. Available at: https://www.pharos.nl/english/female-genital-mutilation/the-dutch-chain-approach.
12. ^Kool RS, Wahedi S. Criminal enforcement in the area of female genital mutilation in France, England and the Netherlands: a comparative law perspective. Int. Law Res.2014;3(1):1-15
13. ^Pijpers F, Exterkate M, Jager M. Standpunt Preventie van Vrouwelijke Genitale Verminking (VGV) door de Jeugdgezondheidszorg [View point of the Institute for Youth Health Care on the prevention of Female Genital Mutilation (FGM)]. Bilthoven: RIVM; 2010. Available at: https://www.rivm.nl/ bibliotheek/rapporten/295001017.pdf
14. ^Nederlandse Vereniging voor Obstetrie & Gyneacologie. Leidraad Medische zorg voor vrouwen en meisjes met vrouwelijke genitale verminking (VGV) [Dutch Association for Obstetrics and Gyneacology. Protocol Medical care for women and girls with female genital mutilation (FGM)]. Utrecht; 2019
15. ^Pharos. Handelingsprotocol Vrouwelijke Genitale Verminking bij minderjarigen Uitleg en handvatten bij aanpak VGV voor Veilig Thuis, Raad voor de Kinderbescherming en Politie. [Protocol for Female Genital Mutilation in minors. Explanation and guidelines for the approach to FGM for Safe at Home, the Child Protection Board and the Police]. Utrecht; 2016. Available at: https://www.pharos.nl/kennisbank/handelingsprotocol-vrouwelijke-genitale-verminking-bij-minderjarigen-uitleg-en-handvatten-bij-aanpak-vgv-voor-veilig-thuis-raad-voor-de-kinderbescherming-en-politie/
16. ^Braun V, Clarke V. Using thematic analysis in psychology, Qual Res Psychol. 2006;3(2):77-101.

17. ^ *Bulman KH, McCourt C. Somali refugee women's experiences of maternity care in west London: a case study. Crit Public Health. 2002;12(4):365–80.*

18. ^ *Lazar JN, Johnson-Agbakwu C, Davis OI, et al. Providers' perceptions of challenges in obstetrical care f or Somali women. Obstet Gynecol Int. 2013. Article ID 149640.*

19. ^ *Burchill J, Pevalin DJ. Demonstrating cultural competence within health-visiting practice: working wit h refugee and asylum-seeking families. Divers Equal Health Care. 2014;11(2):151–9.*

20. ^ *Johnsdotter S., Essén B. Cultural change after migration: circumcision of girls in Western migrant com munities. Best Pract Res Clin Obstet Gynaecol. 2016;32:15-25.*

21. ^ *Morison LA, Dirir A, Elmi S, et al. How experiences and attitudes relating to female circumcision vary a ccording to age on arrival in Britain: a study among young Somalis in London. Ethnicity & Health.2004; 9:(1):75-100.*

22. ^ *Agboli AA, Richard F, Aujoulet I. "When my mother called me to say that the time of cutting arrived, I j ust escaped to Belgium with my daughter": identifying turning points in the change of attitudes toward s the practice of female genital mutilation among migrant women in Belgium. BMC Womens Health. 20 20;20:107.*

23. ^ *Ziyada MM, Lien I-L, Johansen REB. Sexual norms and the intention to use healthcare services related to female genital cutting: A qualitative study among Somali and Sudanese women in Norway. PLoS On e. 2020;15(5):e0233440.*

24. ^ *Costello S. Female genital mutilation/cutting: risk management and strategies for social workers and h ealthcare professionals. Risk Management and Healthcare Policy. 2015;8:225-233.*

25. ^ *Evans C, Tweheyo R, McGarry J, Eldridge J, Albert J, Nkoyo V, et al. (2019). Crossing cultural divides: A q ualitative systematic review of factors influencing the provision of healthcare related to female genital mutilation from the perspective of health professionals. PLoS One. 2019;14(3):e0211829.*

26. ^ *Barre HS, Ressler M. 'Vakantie' in Kenia. Besnijdenis van Nederlandse meisjes in het buitenland. [On 'holiday' in Kenia. Genital mutilation of Dutch girls abroad] De Groene Amsterdammer. 2019. Available at: https://www.groene.nl/artikel/vakantie-in-kenia*

27. ^ *Kouta C, Kofou E, Kaili C. (2020) United to end female genital mutilation: an on line knowledge platfo rm for professionals and public. Eur J Contracept & Reprod Health Care. 2020;25(3):235-239.*

28. ^ *End FGM European Network. How to talk about female genital mutilation. Brussels 2019. Available a t: https://www.endfgm.eu/editor/files/2020/05/HTTAFGM_EndFGMEU.pdf*

29. [a], [b]*Drost LF, Hoefnagels C, van Esch S. Het Jeugdgezondheidszorgbeleid ter preventie van vrouwelijke g enitale verminking. Een Quick Scan naar de vraag hoe de JGZ-praktijk het beleid ter preventie van VGV uitvoert [The youth health care policy for the Prevention of Female Genital Mutilation. A Quick Scan int o the question of how the YHC practice implements the policy for the prevention of FGM]. Utrecht. 2018*

Declarations

Funding: The first author was employed to conduct this project at the public health organization

Potential competing interests: The author(s) declared that no potential competing interests exist.