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

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Abstract

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 facilitators 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.

Keywords: female genital mutilation, migration, youth health care professionals, child protection, prevention, The Netherlands.

Background

Female genital mutilation or cutting (FGM/C) is a serious health problem[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]. The World Health Organization, together with a wide range of international organizations, shows opposition to FGM/C[2].

With an increase in migration, FGM/C has become an issue of serious concern in West-European 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, FGM/C has been prohibited and policies have been developed to prevent it by encouraging detection and taking cases to criminal court. This task of detection and prevention has been delegated to health care professionals. However, this prevention policy leads to a dilemma 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 4000 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]. The policy regarding FGM/C is part of the youth prevention policy of combatting child abuse. Youth health care professionals (YHCPs) play a central role in the prevention of FGM/C as they have to regularly examine all girls from birth until the age of 18, discuss all aspects of FGM/C with the parents, assess the risks of FGM/C, act when FGM/C is suspected and offer help if there are problems resulting from FGM/C[13]. In case of a high risk estimation, the YHCP can 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]. The topic of FGM/C is discussed by the YHCPs at several contact moments: with the parents when the girl is at a young age (0-12 years) and with the girl herself at secondary school (between 13-15 years). Some public health care organisations have digitally arranged that the task of discussing FGM/C pops up automatically in the girl's file when she comes from a risk country. A protocol has been developed as a guidance to support YHCPs in conducting the conversation with the mother or the adolescent girl[15].

Despite the protocol, according to a Dutch study evaluating the FGM/C prevention policy in the Netherlands, the YHCPs experience difficulties in discussing this sensitive subject within their limited time[16]. Moreover, there are linguistic barriers, 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[16]. Although criminal law currently is an integral part of the approach to FGM/C, YHCPs are often not prepared to report suspicions and observations to the criminal authorities.

This study was carried out to explore factors that can shed light on the difficulty of effective implementation of the Dutch

policy towards FGM/C prevention. A more thorough understanding from the perspective of the YHCPs could lead to recommendations to support them in carrying out this task. The specific aim of this study is to explore the experiences, barriers and facilitators related to the prevention of FGM/C and detection of girls at risk from the perspective of YHCPs.

Method

Study design and recruitment

A 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.

Recruitment took place by sending an email to 15 YHCPs and in case of agreement, she was informed about the study by phone, explaining the purpose of the study. 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
2) Facilitators 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 focus group discussion (FGD) was organized with three health care managers to get feedback on the results of this study and the implications for practice.

Data analysis

Data analysis was oriented toward the development of themes[17]. 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 study participants

Table 1. Participant characteristics

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

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 seeker center, which led to being more familiar with the topic of FGM/C.

Four themes showed up 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 about FGM/C, but it is 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.

   'With FGM, I always consult the protocol to feel comfortable in discussing this topic with the girl. I regularly discuss FGM/C, about once every month, every time I need to update my knowledge.' (participant 3, a nurse)

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 do 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. All YHCPs are aware of the sensitivity in discussing FGM/C with the clients. They consider FGM/C to be a negative cultural practice because of its physical and psychological impact on the young girl and later adult woman.

   'Of course I am against FGM/C. It is horrible that someone's body is maltreated in that way. Also, there are severe physical and emotional implications of that unnecessary practice'. (participant 5, a nurse) YHCPs start the conversation with introducing the topic and by explaining why they ask questions about FGM/C. According to the YHCPs, mothers react to the discussion of this topic by saying that they will 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 deny knowing anything about FGM/C. Some YHCPs avoid the conversation about this issue with the girl in secondary school, when they notice in the girl's file that it was talked over with the parents at the time the girl was young. They also do not discuss it with the girl, when they estimate the risk for circumcision to be low since that time.

   Some YHCPs mention that they discuss the topic on the phone with the mother. This is contrary to the practice of other YHCPs, who express 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. **Facilitators and barriers to discuss FGM/C**

   According to the YHCPs several structural factors could be considered to be a facilitator in the 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. A second facilitator is the existence of the instructor protocol and a third the popping up of the contact moments in the file of the clients. A fourth facilitator is having sufficient time to discuss it.

'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 problems were mentioned and formal interpreters can be called in. A family member could help with the translation, but most YHC professionals prefer 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 is that YHCPs do not have a lot of knowledge about the issue and no insight into its context. Also, practical knowledge on FGM/C is lacking – in the sense of having experience with it in their own daily life or in their professional career. Therefore, some YHCPs feel less confident to discuss this topic.

'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, pediatrician)

Another barrier is 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 are not very aware of the protocol: they do not always consult it before the interview; they only pose the questions about FGM/C to the parents who come from a risk country, when it shows 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.

'Most parents 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 the timing of the appointment at school: it is often done in the morning during the morning break when it is noisy outside the classroom. Therefore, conditions to have a confidential conversation with the girl are lacking. 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 recommend to emphasize in the protocol that the

issue of FGM/C has to be discussed face to face, because of its sensitivity.

YHCPs also recommend to hand out information on paper to their clients on the risks of FGM/C and the regulations in the Netherlands. They also recommend this for the information for circumcised mothers about services that they can consult if they suffer from complications.

Another recommendation was to speak with the secondary school girls at another timeslot, for instance when it is quieter at school. It was also suggested to have the appointment out of sight of classmates, for example at the office of the public health organization.

The YHCPs also recommended to regularly discuss FGM/C in the team together with the difficulties that they encounter when discussing it with the target group. As an additional recommendation it was 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 FDG 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 to not 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 language and therefore cannot read or understand the written information. They may even throw it away as soon as they leave the building.

Discussion

Our study shows that most YHCPs only have 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 pops up in the files. It is not always discussed according to the protocol, because that is not considered necessary. 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 for 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 - cultural distance and stigma related to FGM/C among the risk group.

Comparison with other literature

YHCPs lack sufficient knowledge and awareness, on the one hand because FGM/C is not a very common practice and only occurs among some small migrant populations 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 seeker centre or other public health care institutions, 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 and healthcare professionals report having insufficient, inaccurate or partial knowledge and skills. It leads to uncertainty about how to discuss FGM/C[18][19]. Health care providers identified a need for practical skills development[20].

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[21][22][23]: migrant groups from risk countries give up the tradition once arrived in the host country. Therefore, the answers of the mothers and girls in secondary school can be considered as valid. On the other hand, since FGM/C is a sensitive topic and surrounded by taboo due to its association with sexuality and private parts[24][25][26], 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 will carry out the procedure by sometimes travelling to countries, where it is practised[27].

The current prevention policy of FGM/C is delegated to YHCPs, who have the task to monitor the health and care for their clients. However, YHCPs are not trained as police officers. The task of referring to an institution that could lead to a prosecution could interfere with the task of caring for others[10]. YHCP may also struggle with the necessary breach of trust and the violation of professional confidentiality.

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[28][29]. Fourthly, the managers suggested the use of videos, which could be made available on the official website of the public health organization.

Strengths and limitations of the research

The data for this study have been collected in only one public health institution, situated in one of the four main large cities in The Netherlands. It is unclear whether these results reflect the practice of discussing FGM/C in other public health organisations in the Netherlands. However, 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. Furthermore, this study, because of its qualitative design, does not give any indication of the frequency of facilitators and barriers related to the conversation on FGM/C, but instead gives an indication of the type of facilitators and barriers which YHCPs have mentioned in a public health care organization.

Conclusion

YHCPs are burdened with the difficult task to discuss a topic that is not familiar to them and surrounded by secrets. Sharing information about it on team level can contribute to prevent its continuation. Further training and research are required to develop measures that support YHCP's 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, as was confirmed in writing by the medical ethical committee of the AMC, 28 October 2010. 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.

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