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REPORT



Women who have undergone female genital mutilation/cutting's perceptions and experiences with healthcare providers in Paris

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ABSTRACT

Female genital mutilation/cutting (FGM/C) is a health and human rights issue and a dangerous form of gender-based violence. Given migratory flows from the countries in which it is practised, FGM/C concerns a substantial number of women living in Western countries. In this study, we looked at women who had undergone FGM/C experiences with French medical practitioners. We also discussed with them the desirability of screening for, and prevention of, FGM/C in international travel medicine centres. A qualitative approach was used to collect and analyse the data. Focus groups and semi-structured interviews were held with 26 women (24 participants in focus groups and 2 individual interviews). Transcriptions were coded and analysed thematically. All the participants came from sub-Saharan Africa. Their median age was 32.9 years. Persistent silence about FGM/C in the host society following immigration resulted in dissatisfaction with healthcare providers. Participants expected professionals to address the subject of FGM/C, feeling professionals should bring up the subject first so as to put women at ease. International travel medicine centres were discussed by some as a possible means of prevention.

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Introduction

Female genital mutilation/cutting (FGM/C), is a threatening expression of gender-based violence for non-therapeutic reasons and refers to all actions that involve injury to, or the partial or total removal of, the external female genitalia. The World Health Organization (WHO) has classified FGM/C into four types (WHO 2008): type I, or clitoridectomy, involving the partial or total removal of the clitoris or the clitoral prepuce; type II, which involves the partial or total removal of the clitoris and the labia minora, with or without the excision of the labia majora; type III or infibulation, which involves the narrowing of the vaginal opening, sometimes by stitching the labia, with or without the removal of the clitoris; type IV, which includes all other harmful procedures to the female external genitalia, like pricking and piercing for example. It should be

noted that these typologies represent biomedical categories and that different communities may have their own nomenclature.

More than 200 million women and girls have undergone FGM/C globally, with an additional 3 million girls under the age of 18 estimated as being 'at risk' each year (WHO 2008, 2020). Different forms of the procedure are present in over 92 countries (End FGM European Network 2020). However, with increasing international migration, FGM/C exists globally and not only in the countries that traditionally practise it. Despite the fact that such procedures are illegal in all Western countries and in 29 countries in Africa, there is inadequate discussion about to what extent these practices are supported within immigrant communities (Johnsdotter and Mestre I Mestre 2017). In 2009, the European Parliament Committee on Women's Right and Gender Equality estimated that over half a million women and girls living in European Union countries were FGM/C survivors and 180,000 girls and women were at risk of undergoing FGM/C every year (Van Baelen, Ortensi, and Leye 2016). More recent studies show that due to the COVID-19 pandemic, efforts to eliminate FGM by 2030, will be disrupted - sixty-eight million girls being expected to face FGM between 2015 and 2030, and an estimated two million additional cases of FGM needing to be averted (UNFPA 2018, 2020, April).

In France, an initial indirect estimate suggested that about 60,000 adult women had undergone some form of FGM/C in the mid-2000s (Andro and Lesclingand 2007). According to the most recent update using the same extrapolation method, 125,000 adult women with FGM/C were living in France in the early 2010s. Despite migration and the transmission of the practice to Western countries, the views of excised women, women who suffer the complications of FGM/C, and women who are indirectly concerned because of their country of origin, have not been well documented. Most previous studies have focused on the gynaecologic and obstetric healthcare experience of women with FGM/C, and little is known about women's experiences of primary healthcare workers (Kawous et al. 2020).

The sensitive and taboo nature of FGM/C means that talking about it is problematic both for concerned women and healthcare providers. Consequently, there is a need for additional training, practice guidelines for qualified healthcare professionals, and good quality care plans for the outcomes of FGM/C (UNICEF 2013). Only 13 migrant host countries (in which FGM/C survivors reside) have a designated medical code for FGM/C, and only two countries, the UK and the Netherlands, report the systematic use of these codes (Johansen et al. 2018).

Even where training has been given and clear care pathways and protocols exist, problems may endure. For example, a recent study of FGM/C management in a large London maternity unit found that, despite of the existence of guidelines and training, clinical care for women/girls with FGM/C was sub-standard (Zenner et al. 2013). The reason for this lack of adherence to protocols was unclear, so there is a need to explore in more depth how organisational and personal factors may influence health professionals' views and behaviours in this area (Cappon et al. 2015; Dawson et al. 2015; Kaplan-Marcusan et al. 2009; Widmark, Tishelman, and Ahlberg 2002).

The first French national survey on the long-term consequences of FGM ($n = 2882$) based on a case-control comparison of self-reported health highlights the need for a

careful approach to the health of women with FGM/C, even in favourable healthcare contexts, and for the training of health professionals to engage with the consequences of FGM/C in different respects (Andro, Cambois, and Lesclingand (2014). A recent study in France revealed varying risk according to the neighbourhood and healthcare setting, particularly concerning maternal and perinatal morbidity (Sylla and Andro 2020).

Healthcare professionals can play a key role in FGM/C screening and prevention (Johansen et al. 2013; University of Nairobi 2008; WHO 2008). Studies show that health professionals report that they are concerned about the subject, but their lack of training and knowledge hinders discussion with women who have undergone FGM/C and may lead to cultural misunderstanding and lack of communication (Dawson et al. 2015; Evans et al. 2019). In this regard, FGM/C is seen as a 'difficult' subject to address both ethically and culturally. As a result, many identification opportunities are missed, probably due to lack of training and support (Abdulcadir, Rodriguez, and Say 2015; Dawson et al. 2015). Despite repeated gynaecological follow-up of women during gynaecological or maternity consultations, studies report that the women concerned regret not addressing this issue with their physicians.

Many families, including women and girls, undergo a consultation at travel medicine centres before leaving for a foreign country. In view of this, travel medicine centres could therefore be places in which to identify women at risk of having undergone FGM/C or children at risk of undergoing FGM/C. In a 2015 study which compared 52 travel medicine specialists and 60 generalist practitioners working in travel clinics in France, only 24% of health professionals of these clinics reported having received university education about FGM/C, while nearly 43% of professionals surveyed reported that they had ever been confronted with an FGM/C situation or the risk of FGM/C for a child. Only one-third of professionals, mostly general practitioners, said that they examined children going to a country at risk. There are currently no recommended procedures for screening for FGM/C in travel medicine in France and professionals are not trained to initiate dialogue about FGM/C. On the other hand, Canada, the USA, Switzerland, Belgium, and the UK have published such recommended procedures (Tantet et al. 2018; Abdulcadir, Rodriguez, and Say 2015; Chiodini 2017; Royal College of Obstetricians & Gynaecologists 2018; Royal College of Nursing 2016).

As part of our ongoing work, we aim to create professional training for this population of healthcare professionals. In order to develop this training, we studied women's experiences of health professionals in France and how, according to them, dialogue could take place more easily and be more satisfying for women concerned. Based on participants' experience, we aimed to identify women's needs and make suggestions for improving healthcare consultations regarding FGM/C. Additionally, we asked about travel medicine centres as possible venues for FGM/C screening and prevention.

Methods

We used a socio-anthropological approach to allow to FGM/C to be sensitively addressed in a culturally relevant way during medical consultations and to encourage

dialogue with immigrant women from sub-Saharan Africa about FGM/C. Focus groups or group interviews seemed to us the most relevant way to elicit women's feelings about their experiences of health professionals by providing a group dynamic favourable to exchange. Focus groups in particular make it possible to compare points of view and differences of opinion, which are frequent when it comes to the subject of FGM/C. They also allow an exploration of people's perceptions dependent on their life history (Kitzinger 1994).

Our focus in this research was on the interaction between health professionals and women on the topic of FGM/C. Women who have undergone FGM/C often feel discriminated against or unwelcome in healthcare settings and seek a woman-centred approach (Scamell and Ghumman 2019), making the use of single sex focus groups particularly acceptable. Compared to individual interviews, focus groups also reduce the feeling of being under the control of the interviewer. However, two women preferred individual interviews for talking about their feelings and sharing their stories with us.

Three focus groups were held with 24 participants and 2 semi-structured interviews were held with two women who preferred to participate in the study separately. Interviews and focus groups were held in French. Data were collected between January and March 2020. All data were anonymised, and recordings were transcribed verbatim by a professional transcription agency and the audio recordings destroyed. No identifiers of individual participants were retained. Transcripts were coded and analysed thematically. The study was approved by the Research Ethics and Deontology committee of Sorbonne University.

Recruitment and study population

The study population consisted of women older than 18 years living in France who had undergone FGM/C. Sampling was purposeful, aiming for variation in age, country of origin, duration and residence status in France, marital status and giving birth in France or not. Our non-profit organisation partners¹ working on sexual health in the infectious disease departments of two hospitals in Paris and its suburbs (Bichat Hospital in the north of Paris and Avicenna Hospital in Bobigny), assisted in the creation of three focus groups. Six to eight women participated in each focus group, with care being taken to ensure the inclusion of participants from different geographical regions (East/West Africa) and age groups.

Focus group process

A focus group guide was developed in line with a focus on the three study themes: women's experience of medical consultations; what participating women would like professionals to do and the behaviour they would like them adopt when addressing FGM/C in a consultation; and the potential role of travel medicine centres as a location for identifying FGM/C.

Each theme consisted of five to six questions. Participants' responses and feedback provided the opportunity to explore certain themes in greater depth or to prompt follow-up. Participants received a study information note and signed a consent form.

Each focus group lasted approximately three hours. At the end of the focus group, the facilitators made sure that any additional support needs were met.

Analysis

A phenomenological approach was used for the qualitative data analysis. The focus group transcripts were initially coded by three coders² to identify key themes and sub-themes. All coders worked independently of one another to allow inter-rater reliability to be assessed. Initial codes were then discussed with other members of the research team to finalise the coding framework. Such an approach helps ensure both consistency and efficiency during this stage of data analysis. The two individual semi-structured interviews were also coded and analysed separately.

Findings

Of the 24 participants in the focus groups, 10 were women living with HIV. All of the participants came from sub-Saharan Africa, mostly Côte D'Ivoire, Guinea and Mali. The median age of the participants was 32.9 years. Eight participants were single, and of the 16 who were married with children, 5 had given birth in France.

The first subject raised to facilitate dialogue in the focus group was women's reasons for participating in the study. These reasons were: to make progress, to be informed and fight back against lack of information; to break the taboo and try to stop excision; and to prevent and save their daughters from the practice. One of the participants told us about her reasons for participation:

We talk about excision, yes, we talk and it's good, everyone is aware of it, but in fact, no, we are never fully aware of it, we are never informed enough about the subject. (23 years, Guinea)

Some participants described how they found out about having been excised in the past. Some only realised they had been excised after watching documentaries or talking with their friends and finding themselves different to other women. The majority of participants however had known their FGM/C status before arriving in France, but some found out they had been excised only after arrival, and in an unexpected situation. As one participant said:

I visited a gynaecologist to remove my IUD. So, I explained to her that I was coming to remove my IUD. I talked about the pain I experienced during sex and she told me to lubricate well, etc. Then she said to me: 'Well, it's also a bit because of your excision'. And that was the time I actually discovered FGM. And suddenly, I said to her: 'How's that?' And she closed the topic. But actually, when I got out of her office, well I sat down in the street, because in fact what she said to me was like someone had slapped me, I didn't know how to handle it, I didn't know where to go. So, I made an appointment with another gynaecologist. (32 years, Côte d'Ivoire)

Two other participants also discovered their FGM/C status for the first time by learning about it unexpectedly in a medical consultation. Several participants believed that FGM/C could be a cause of infertility, and most believed that it eliminated their desire and their pleasure when having sex. Three of them believed that their HIV infection could be related to their FGM/C.

Recent experience with medical professionals

Thirteen participants had initiated talk about FGM/C with medical professionals; the rest had never done so. The professionals talked with included an infectious disease specialist, gynaecologists, a midwife, general practitioners (three participants) a paediatrician and practitioners in maternal and child protection and family planning centres (PMI in France).

Some of the professionals talked to had asked about complications such as lack of sexual desire and pleasure or obstetric complications. Three professionals had suggested reconstructive surgery. Other professionals had simply noted the bodily evidence of FGM/C without giving any explanation.

For seven participants, discussion had taken place in the context of a request for help in connection with an application for asylum.³ The certificate had then become a tool to open up dialogue about FGM/C and provided five participants with confirmation that they had been cut. One of these participants told us about her experience and the practitioner's failure to explain anything about FGM/C to her:

When I told her I need an FGM/C certificate she said: 'Oh really! I'm going to examine you'. She only put it on my file that I'm cut; she said nothing. (20 years, Mali)

Another participant described her experience asking for a certificate stating that she had been excised:

The doctor told me 'This (certificate) is not going to get you anything madam!' She (the doctor) said, 'it's not an important document, because you are already excised, so it doesn't matter'. It is not important in the French system. In fact, here in France, they prefer to protect someone who is eight years old, if I may say so... and they prefer to protect minors instead of offering support to a girl who is 19 years old and [already] excised. (19 years, Guinea)

Experiences and feelings about medical consultation

She told me it was a clean cut. But for me, I said to myself: 'what is clean excision, unclean excision or just excision? I don't see why we say clean and not clean'. And this was when she advised me that there is the possibility of corrective surgery. (26, Senegal)

Many participants expressed confusion after a medical consultation. For some, there were still informational issues to be addressed. The following questions were asked during the focus group discussion: was FGM/C a cause of infertility; was FGM/C the reason for a lack of pleasure in sexual relationships; and for those hesitant about surgical repair, what reasons might there be for applying for the surgery? Most participants felt that medical practitioners were the best individuals to help them with these concerns.

Reasons for bad experiences and for dissatisfaction with medical practitioners

To measure satisfaction, we studied whether women's expectations regarding healthcare providers had been met by asking about their bad or good experiences with healthcare providers.

Silence: persistent taboo about FGM/C

Most participants expressed feeling sad and confused because healthcare providers kept silent about FGM/C in France, or because of the way they neglected to talk about the subject. One participant told us that during a medical consultation the doctor observed that she has been cut but had never talked about it with her:

Frankly, if he sees something, he has to talk about it. It's like he sees a woman, he examines a woman, he sees that she's got bruises and marks on her body and he's not going to say anything about it. He should at least say: 'Are you okay at home? 'I see you've got marks, what's going on?' (34, Côte d'Ivoire)

Most of the participants had been informed about the consequences of FGM/C outside their country of origin. However, two participants reported having been activists against FGM/C in their country of origin. Participants who were already aware of FGM/C's physical and mental toll were particularly sensitive about the way health professionals in France had responded to their needs.

Rapid examination

Some women reported bad experiences with medical professionals in relation to FGM/C. One of the main reasons for these bad experiences was the fact that the medical examination was cursory. One participant described her experience with a gynaecologist as follows:

He said, 'get undressed, take off your panties and everything, spread your legs, do this'. Then he touched me. But when I told him that I was a virgin, he actually didn't touch me. He just said to me, 'It's okay. He just looked and said, "There's no clitoral hood, that's fine"'. (26 years, Mali)

The indifference of the gynaecologist and the manner in which he reacted to this subject made this woman feel uncomfortable. For other participants being a virgin was also important and was something participants felt the doctor should know about before the examination. Some participants said that they had wanted to talk about FGM/C during consultations, in particular in relation to the trauma suffered, and sometimes regretted the fact that the subject was not discussed.

For a few survivors of FGM/C any examination of their sexual organs was an experience that they would have preferred not to have. Two participants had never visited a gynaecologist, or had any examination related to FGM/C. One of them expressed her feelings as follows:

No, this part... never again, retouching this zone again, it's not possible for me, it's enough. (38 years, Congo)

Physical pain and lack of sympathy/indifference

For some participants, feeling physical pain led to a general dissatisfaction with medical care. Rapid examination without prior explanation of how things would proceed could lead to bad feelings about medical care.

But here (in France) it happened, she did it like that... She spread well, it hurt a lot. It really, really hurt me. Actually, I've been to the hospital, but when you go there, even if you have nothing, you get sick. Instead of treating you, it looks like they don't want you there! I don't know. (28 years, Guinea)

Racism and discrimination

Some participants' bad feelings were linked to experiences of discrimination and racism. Several participants had experienced discrimination or stigmatisation

He said to me, 'What did you come to do in France?' 'You have to go back home. Can't you go home? Because I believe that the same treatments exist there [so] what did you come for?' (23 years, Guinea)

Other doctors seemed to discuss HIV but not FGM/C

The doctor said to my face, 'Ah, you don't have HIV ... no, you don't have AIDS '. It shocked me so much and when I thought about it I said to myself: 'Yes, he told me because I came from another country or because...' I don't know... I don't know why he actually said it suddenly, and never asked me about if I've been cut. (28 years, Côte d'Ivoire)

Lack of explanation

One woman described her experience during childbirth where the midwife, during the consultation, explained the topic of excision to her students, who were present, using her body as an example but without talking to her directly.

I was shocked, and I said to myself: 'The first time she tells me was on the delivery table while I'm giving birth!' And she was with two students. And she said to me, "You are excised". And then, she explained to her students, 'Well there you go, she doesn't have her labia minora and everything'. I actually heard that, but I was in another world. So immediately after giving birth, I actually forgot about it. It was in 2019 that I actually remembered the events, fully one year later. (34 years, Côte d'Ivoire)

Good experiences and satisfaction

Most participants believed that the way they were treated by the doctor played an important role in making them feel (un)comfortable. One of the participants said she liked the fact that her gynaecologist took the time to ask her questions about her sexuality and that made her feel relaxed. Another participant appreciated the caring and welcoming attitude of the general practitioner she visited.

He is welcoming. It's good. When you go to ask him something, he welcomes you very well. There you are, he doesn't show you that below you, excised, no, he doesn't talk about that, but he only does his work. (29 years, Mali)

The fact that FGM/C was spoken of simply among other ordinary questions about her daily life also put the woman at ease.

I came to talk about excision, of course, but we talked. He talked to me about the rain and the good weather, he was talking to me about what I did yesterday, my children, where are they ... interested in my daily life. I became relaxed and I was ready to talk about anything to do with excision. (30 years, Guinea)

Participants' recommendations regarding professionals' attitudes

Most participants expected medical professionals to take the initiative in talking about FGM/C because doing so would put them at ease. They were afraid to 'disturb'

professionals by talking about it themselves. Some were embarrassed to do so, especially when the professional themselves was not comfortable. The embarrassment was especially present the first time they discussed it and then afterwards it was easier.

And that's too bad actually if the doctor doesn't talk about it. There are people who just wait for the doctor or the professional to talk about it first, or there are people who don't even know it, and in fact it's the doctors who can explain to them. He can simply start like this: 'Ah, listen. I see you have a scar, have you been cut?' In fact, it's actually important to us women that the doctors too can speak out about it. (31 years, Côte d'Ivoire)

Asking for consent and talking gently

Ideally, the professional should seek consent and approach the subject gently. They should take time in bringing up the topic of FGM/C and approach the subject gently and not with direct questions.

The doctor might apologise to the lady first and ask if he can ask her a question about the excision. 'Can I ask you some questions about FGM/C? Me, I think that's the way it is, it has to go. So, going from there, now it's up to the lady to answer, 'Yes', or 'No'. So, if it's affirmative, I think the doctor can ask her [more]. (41 years, Côte d'Ivoire)

Other women considered that FGM/C should be approached by asking indirect questions.

You don't say bluntly to her, 'Have you had FGM/C?' The doctor should start by asking 'What do you think about FGM/C?' From there, you open a window. Maybe the doctor will say, 'Ah, this is a practice that must be abandoned'. And there is a[another] front door. (29 years, Senegal)

Being welcoming and available

Women stressed how the professional should be available, benevolent and welcoming.

'Go ahead, have a seat. What can I do for you?' All of this allows you to open up to him. But if he says to you like that, as the lady just said, 'Why are you here?' 'What is ...' you see? Or 'You came again' ... [then that's a different matter] (27 years, Guinea)

Some participants stated that even if the doctor talks directly about FGM/C, it is always better to be welcoming first.

'Listen, are you feeling all right?' and then, 'What do you think about FGM/C?' (26 years, Mali)

Avoiding the use of certain words

Women could not agree on the best vocabulary to use. For some, this did not matter. So long as the topic was discussed, the terms 'sewn', 'cut', 'excised' could be used interchangeably. A participant in an individual said, however,

I find 'mutilation' very strong, and it was created by white feminists, while the term 'excision' is more neutral and scientific. (21 years, Guinea)

Most participants objected to the use of terms such ‘barbarians’ to describe those who imposed FGM/C on others, saying they should not be used for fear of creating conflict between the woman and her family. They considered that FGM/C was a violent practice but did not want their families to feel insulted.

[it’s] as if the doctor thinks we are barbarians. Yeah, there you go, that’s it, barbarians, monkeys, people who can’t live that’s what, when it’s not at all. It is the practice that is barbaric, but not necessarily the people. We have to talk about that. (20 years, Côte d’Ivoire)

Doctors should inform us about the health consequences, but also the law

Participants felt it imperative that women were informed that FGM/C could be a reason for seeking asylum. It was also important to them that society in general knows about the law and that FGM/C is a crime. Women and other being informed will help to prevent the practice. Participants also wanted professionals to educate families and raise awareness among men so the practice would stop. They also wanted information to be made available in the media.

If the doctor is not a specialist themselves, then they should refer the woman to a specialised centre.

Doctors should also talk about the law and religion

Women expected doctors not only to provide information and medical explanations about FGM/C, but also to know where FGM/C is practised and why, and to be able to discuss with their patients the relationship between FGM/C and religion as well as the consequences of FGM/C.

Travel medicine consultation

Only three participants had consulted doctors working in international travel medicine centres, but others had participated in discussion about such centres offering the opportunity for screening or prevention. One reason why participants had little experience of these centres was because they were predominantly new arrivals. Most were asylum seekers and had not had the opportunity to travel or return to their country of origin.

Participants varied in their views about the value of travel medicine consultations providing an opportunity for FGM/C screening or prevention. Some thought that travel medicine centres were just for vaccinations and had nothing to do with FGM/C. Others felt that talking about FGM/C with other family members possibly present was inappropriate. One woman felt that it was none of the doctors’ business to offer advice within this context and that it was up to her to decide whether or not to cut her daughter:

It’s your decision now to cut the child or not. Now there is another problem. When you deal with the child, and this problem arises, it is up to you to decide, and what comes after is up to you. (44 years, Côte d’Ivoire)

In contrast, some other women expected the doctor to inform them about the risks before a trip back to their home country if they had daughters. It could then be

valuable to discuss with issue with their husband present so that he too was informed about the risks and the fact that FGM/C is prohibited in France.

I think that can be good, because we often speak directly to women, but the men are not there, are not introduced into this subject. And the fact that he is going to hear it, even though the woman is uncomfortable, at least he has heard it. And he knows that when he comes back, he's going to ... if he practices it, if he intended to practice it, well he might have problems if he does. So, maybe hearing that from the professional talking to them about it, it'll actually slow down the decision of cutting the girl. (35 years, Guinea)

Discussion

The experiences and perceptions regarding healthcare professionals of women with FGM/C illustrate the primary need for members of this population to be more informed by medical practitioners about FGM/C, its physical consequences and potential complications, the law, and specialised centres of care. Women expected professionals to address the subject of FGM/C, because it was difficult for them to talk about it spontaneously and they had a hard time with the fact that the subject is not discussed. This finding is consistent with those of other studies (e.g. Guillot et al. 2018; Norman et al. 2009). A recent meta-analysis (Evans et al. 2019) revealed that women's experiences of FGM/C are often marked by silence and stigma and which hinders care-seeking and access to care, particularly for non-pregnant women. In all the countries involved in the study, women reported emotionally distressing care-seeking experiences and their knowledge of specialised services was limited.

Participants believed that to facilitate dialogue between women with FGM/C and health professionals, the general population needed to be better informed, and some participants signalled the role of the school in warning the family about the consequences of FGM/C. The use of posters in health centres encouraging the eradication of the practice was described as necessary and beneficial. Travel medicine consultations were seen as one opportunity for prevention and for informing the family about the consequences of FGM/C.

The quality of care depends on having a trusting relationship with a professional who is able to engage with relevant cultural issues in addition to having acquired competence in the subject. Women in this study reported having a sense of being heard and listened to when the caregiver adopted such a cultural approach, using words carefully, having an appropriate attitude and respecting cultural traditions such as virginity before marriage, while understanding that some women might find it difficult to undergo a gynaecological examination.

Limitations

One important limitation of this study derived from the fact that the focus groups were conducted on the premises of non-profit organisations, two of which provide support to women living with HIV who are foreign nationals or who were born in a foreign country, most usually on the African continent. French African women born in France, who had perhaps been cut during holidays to their parents' country of origin,

were less well represented in the focus groups. In future work it is important to find opportunities for dialogue with such women in community centres not related to the subject of FGM/C. This would likely result in a more inclusive sample.

Conclusion

The host society's persistent silence regarding FGM/C means that following immigration, women who have undergone FGM/C may find themselves dissatisfied with healthcare providers. This is a key message to convey to professionals, who are often reluctant to bring up the subject spontaneously during a consultation. However, the expectations and satisfaction of women depends not only on the medical practitioner's approach and attitude towards FGM/C, but also the context in which discussion occurs. Expectations and attitudes toward medical professionals may differ between women seeking an FGM/C medical certificate for an asylum application and women attending FGM/C consultations with obstetricians and gynaecologists. For women applying for asylum, an FGM/C medical certificate is an important document to have, and practitioners are there to provide it. For women attending specialist FGM/C consultations, medical practitioners must not only be aware of FGM/C and able to provide appropriate information, they should also be able to talk easily and sensitively about this subject. While views differed in this study, there was some support for consultations at travel medicine centres undertaking FGM/C prevention, informing families about relevant law in France, and providing guidance to those who had undergone FGM.

Notes

1. These were the Unité de réflexion et d'action des communautés africaines (URACA), the Maison des Femmes, and Ikambéré in Saint-Denis, which works with women living with and affected by HIV.
2. These were Claire Tantet, an infectious disease practitioner, Fatoumata Sylla a doctoral fellow in epistemology, and Bahar Azadi a post-doctoral fellow in sociology.
3. FGM/C has been a criminal offence in France since 1983. Any girl or woman at risk of FGM/C can apply for asylum. Applications may be made by adult women who have not undergone FGM/C, women who have undergone only partial mutilation, as well as women who have undergone reconstructive surgery in France, who fear that they may be victims of a new mutilation.

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