Zurich University
of Applied Sciences

School of
Health Professions

# Surgical interventions for women with female genital mutilation/ cutting

*A) How successful are the most common types of surgical interventions for FGM/C available in industrialized countries, and B) which factors influence whether the results are considered satisfactory by the women receiving them?*

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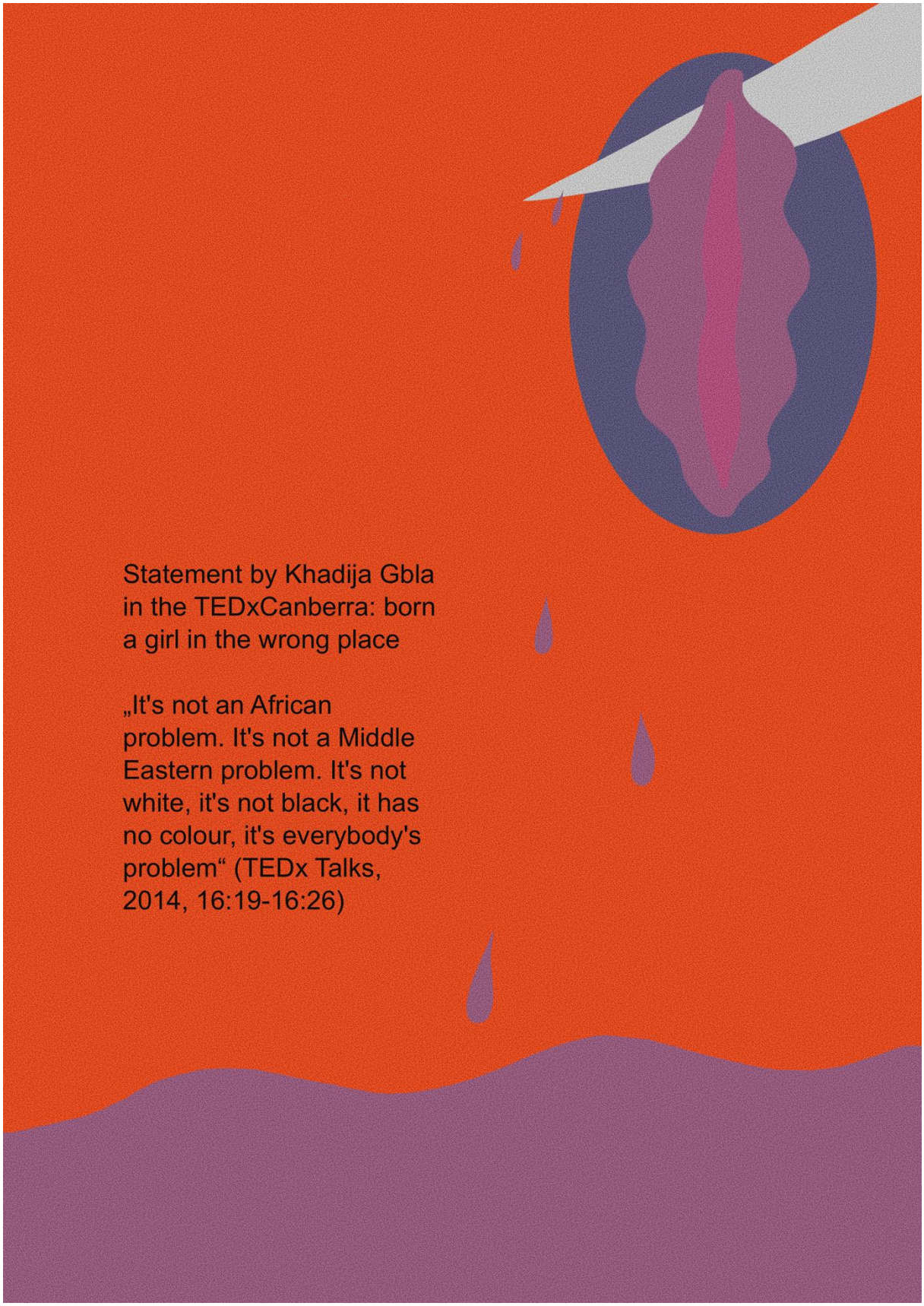
**Bachelor Thesis
Health Promotion
and Prevention**



Statement by Khadija Gbla in the TEDxCanberra: born a girl in the wrong place

„It's not an African problem. It's not a Middle Eastern problem. It's not white, it's not black, it has no colour, it's everybody's problem“ (TEDx Talks, 2014, 16:19-16:26)

## Abstract

Female genital mutilation and/or cutting (FGM/C) is classified into four types and leads to various health consequences for girls and women. Surgical interventions can be successful in alleviating or reversing physical consequences of FGM/C. The three most commonly performed procedures are defibulation, clitoral reconstruction and cyst removal.

Through critical examination of the available research on the subject, this thesis aims to provide insight into how successfully surgical interventions in industrialized countries are presently applied to women who have undergone FGM/C. Special attention will be paid to what factors result in being perceived as satisfactory by the women who underwent these interventions. Furthermore, the findings will be used to create a practice transfer and recommendations for midwives providing care to affected women.

The results show women with FGM/C require adequate information about surgical possibilities in order to ensure an informed decision. Thus, an appropriate intervention for the woman can be chosen together with the healthcare professional. The majority of women with FGM/C are pleased with the outcome after the surgical intervention.

There is a need for further investigation into the long-term outcomes of the different procedures.

**Keywords:** FGM/C, surgical intervention, therapy, midwife, guidelines

# Preface

As FGM/C is a global concern, the decision to write this bachelor thesis in English was made in order to increase understanding, reach and accessibility of this issue for a larger audience. When referring to midwifes, all genders working in this profession are referred to. In the bachelor thesis, the frequently used term healthcare professionals includes people from various healthcare sectors, such as nurses, midwives, paediatrics, obstetric-gynaecologists, physiotherapists, psychiatrists, psychologists and others. When mentioning the term industrialized countries the authors refer to countries that have a similar socio-economic-status to Switzerland. The word authors refers to the two writers of this bachelor thesis. The authors of the various sources are referred to as researchers.

This paper aims to be understandable and readable for laypersons, professionals in the healthcare sectors, midwives in education and with degrees. Therefore, technical terms are described clearly and straightforwardly in the glossary in the following chapter. When appearing for the first time, the technical terms are in italics. Abbreviations are described when mentioned first.
The bachelor thesis is citated and referenced to APA 7$^{th}$ edition.

## Glossary

| | |
|---|---|
| Antibiotics | A medicine that inhibits the growth of or destroys microorganisms |
| Asymptomatic | When the person does not show any signs, even though there is an illness or injury |
| Atony of the uterus | When the uterus does not contract after birth, which can lead to strong bleeding |
| Benign tumors | A mass of cells that is noncancerous |
| Caesarean Section | A surgical procedure by which a baby is delivered through an incision in the mothers abdomen (belly) |
| Circumcision | Cutting of genitalia (female and male) |
| Clitoridectomy | In association with FGM/C it is a partial removal of the clitoris glans and/or the prepuce |
| Code of practice | Guideline |
| Cyst | Sac-like pocket of tissue that contains fluid, air or other substances |
| Defibulation | Is the opening of the infibulation (FGM/C Type III) |
| Dyspareunia | Painful sexual intercourse |
| Epidural anesthesia | A locoregional anesthesia in the epidural space in the spine |
| Episiotomy | Is an incision made in the tissue between the vaginal opening and the anus (perineum) during delivery |
| Expulsive phase | The second stage of labour, when the cervix is completely dilated until the child is born |

| | |
|---|---|
| Gender | Is the non-biologic difference between men and women. It refers to social, economic, political and more other reasons that demonstrate inequality between men and women according to social, cultural and economic factors |
| Gynaecologist | Is a doctor specialized in the health of the female reproductive system |
| Hymen | Is the membrane that separates the external genital from the internal genital. The appearance of the membrane differs between individuals |
| Hypertonic uterus | The tone of the uterus is extremely contracted |
| Immigrant | A person who has to come to live to a country from some other country |
| Incision | Cut or opening (surgically) |
| Infection | A disease in a part of the body that is caused by bacteria or a virus |
| Labia majora | Limit the pubic cleft of the vulva |
| Labia minora | Under the labia majora and below the clitoris |
| Micturition | The action of urinating |
| Morbidity | The number of people in a particular population who have a disease |
| Mortality | Synonym for death rate |
| Myth | A widely held but false idea |
| Obstetrician | A gynaecologist who specializes in pregnancy, childbirth and female reproductive system |
| Opening phase | Also called first stage of labour. From the start of contraction until the cervix is fully dilated |

| | |
|---|---|
| Papilloma virus | Is a sexually transmittable virus |
| Peri-clitoral fibrosis | Thickening or scarring of the clitoral tissue |
| Perinatal | Before giving birth |
| Perineal tear | Vaginal tear during birth |
| Prenatal | Is the period before birth, during or relating to pregnancy |
| Prepuce | Is the skin around the clitoris (is also on the male genital) |
| Qualitative study | Involves collecting and analyzing non-numerical data to understand concepts, opinions or experiences |
| Quantitative study | Is the process of collecting and analyzing numerical data to find patterns and averages for example |
| Reinfibulation | Two sides of the labia are re-sutured after delivery |
| Symptomatic | When the person shows signs of illness or injury (for example: pain, fever, cough etc.) |
| Unsterile | Non-sterile, therefore not free of germs |
| Urethra | The tube through urine leaves the body |
| Urethral meatus | Opening of the urethra |
| Vaginal introitus | The vaginal opening |
| (Vaginal) seal | Closure of the external genital by stitching the labia majora |
| Virginity | When the woman has not been sexually penetrated and usually the hymen has not been ruptured |
| Virility | Masculinity |
| Vulva | Is a definition for the external female genitalia |

# Table of Contents

# 1. Thematic Foundation

## 1.1. Description of the Problem

FGM/C stands for female genital mutilation or female genital cutting, which is a traditional method of partially or totally removing the external genitalia of girls and young women for non-medical social and cultural motives and reasons but instead with social and cultural motives such as a believed increase in fertility, among many others (Amman et al., 2013, p. 4). Some of these beliefs are described in more detail in subchapter 2.2.1. Cultural Reasons.

According to *obstetrician* and *gynaecologist* Jasmine Abdulcadir, there are many *myths* and taboos regarding female sexuality among both women and men, for example "…women that are not cut are hypersexual" (TEDx Talks, 2019, 8:13–8:16). J. Abdulcadir mentions that even among healthcare professionals, there is a lack of knowledge about the history, biology and anatomy of the female genitalia (TEDx Talks, 2019). Therefore, inaccurate statements or myths such as "…the clitoris is a small organ that is removed during cutting" (TEDx Talks, 2019, 6:40–6:44) or "…women that have been cut share all the same experience" (TEDx Talks, 2019, 5:16–5:19), can be regarded as a result of lack of knowledge. On the basis of conversation, misconceptions and myths around female sexuality and FGM/C have therefore to be addressed in order to open our minds, and create an equal, inclusive and non-violent society (De Koster et al., 2019).

## 1.2. Relevance and Importance of the Subject

As *immigrant*s are coming to countries where FGM/C was previously unknown, female genital mutilation/cutting has become a global concern. According to Vorburger et al., it is estimated that in Switzerland approximately 15,000 girls and women are affected or in danger of FGM/C (Vorburger et al., 2019, p. 21). Both midwives and other healthcare professionals are faced with this problematic issue. FGM/C is not only a medical issue for healthcare professionals to whom this issue is culturally unfamiliar but also a legal and ethical problem (Amman et al., 2013, p. 8). Healthcare professionals in Switzerland are mostly confronted with FGM/C Type III (infibulation), especially obstetricians and midwives (Amman et al., 2013, p. 6). The infibulation of the female genital is a problematic procedure in many ways, not least because it results in an increased risk of complications during vaginal birth for both

the mother and the child. In countries where FGM/C is practiced, the *mortality* risk of a mother with Type III is doubled compared to a mother who has not undergone FGM/C Type III, and the risk of perinatal death is even three to four times higher (Amman et al., 2013, p. 11). With infibulation, the most detrimental long-term health consequences are expected compared to FGM/C Type I and II. Therefore, a surgical intervention such as defibulation, where the narrowing of the vaginal orifice is surgically reopened, can be considered an effective option (Vorburger, Denis et al., 2019, p. 21). Owing to medical interventions, midwifes have a much better chance to support healthy pregnancies and conduct safe births, which underlines the relevance of this issue to the field of work of midwifes and leads to the following research question.

## 1.3. Research Question

Medical interventions for women with FGM/C can be beneficial on various levels. Therefore, we aim to answer the following research question – A) How successful are the most common types of surgical interventions for FGM/C available in industrialized countries, and B) which factors influence whether the results are considered satisfactory by the women receiving them?

## 1.4. Objective

Based on evidence-based literature and expert interviews, the aim of this bachelor thesis is to investigate and analyze both how successful surgical interventions for women who have undergone FGM/C are, and which factors influence this process. Moreover, the experience of women and healthcare professionals regarding this subject is described in more detail.

## 1.5. Overview of the Bachelor Thesis Structure

At the beginning of the paper, a glossary with technical terms and acronyms is provided. This thesis is structured as follows: In chapter two, the theoretical background provides a general understanding of the anatomy of female genitalia, a concrete description of FGM/C and an overview of the surgical interventions. Chapter three clarifies the methodical approach in more detail. In the fourth chapter (Results and Discussion of Results) the results of the main studies are analyzed. Following that, the results are critically appraised and compared with each other, and the research question is answered by the authors. In chapter five, the results of the

bachelor thesis are brought in relation to practice, especially for midwives. In order to achieve that, two expert point of views are integrated. In the final chapter, a conclusion is drawn and limitations as well as future options and recommendations are presented.

### 1.6. Clarification of the Scope

The authors of this bachelor thesis decided to put their focal point on how current surgical interventions for women with FGM/C have proven successfully for women and healthcare professionals. The research conducted for the bachelor thesis comprises the findings and results of the last 10 years. Due to medical progress and social changes, this timeline seems appropriate to answer the research question. The focus is put on Switzerland concerning the state of research, recommendations, and interventions in order to have a realistic theory practice transfer. The authors aim to distinguish this paper from the previous Bachelor theses about FGM/C written at the ZHAW, Mulamba-Kuucha (2011) and Schreiber (2012), by focussing on surgical interventions for women with FGM/C. Both Mulamba-Kuucha and Schreiber state the need for further research on guidelines for healthcare professionals concerning FGM/C management and the use of them in Swiss hospitals.

## 2. Theoretical Background

This chapter provides an overview of various topics concerning the research question. Theoretical background and facts about the female genitalia, female genital mutilation/ cutting, surgical interventions and legal aspects regarding FGM/C are presented.

### 2.1. Female Genitalia

As previously mentioned in chapter 1.1. Description of the Problem, female genitalia have not always been discussed and taught precisely and extensively. “An accurate drawing of the clitoris is missing in many student and medical text books. It will be only in 2019, when we will update the drawing used in the biology lessons of the Swiss French speaking schools introducing the accurate drawings of the clitoris…” (TEDx Talks, 2019, 9:26–9:46), says Jasmine Abdulcadir, adding in the same talk that: “…and it was only in 2017 that we introduced at the faculty of medicine of Geneva University the first course on the history, biology and anatomy of the female genitals” (TEDx Talks, 2019, 9:47–10:00).

These statements illustrate that the female genitalia were underrepresented or even misrepresented in the medical curriculum in Switzerland until the late 2010s. Outside of medical academia, accurate education about the female genitalia is even more sparse, which contributes to the various myths and misconceptions common in the Western world, regarding both the structure and function of the genitalia in general as well as FGM/C specifically.

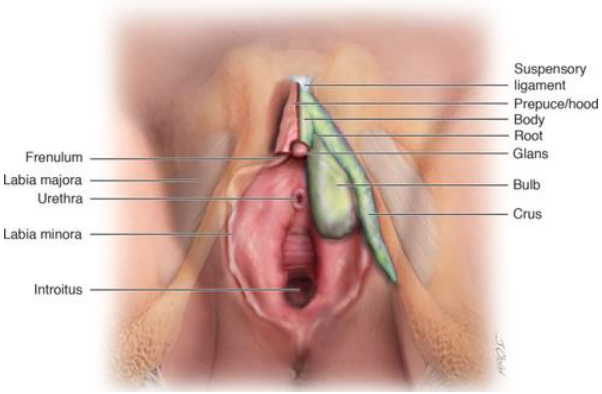
## 2.1.1. Anatomy

### 2.1.1.1. The External Genital Organs

The external female genital organs, also called *vulva* as collective term, consists of the clitoris, *labia minora* and *majora*, the bulbs, *urethra* and *introitus vaginae* (vaginal opening). At birth, the *hymen*, a thin piece of tissue is visible as it partly covers the vaginal opening (Campbell et al., 2021, p. 1058). The labia majora enclose and protect the rest of the vulva, they consist of a pair of thick, fatty ridges (Campbell et al., 2021, p. 1058). The labia minora are slender skin folds, which fringe the vaginal opening and the urethra opening as shown in Figure 1. As there are widespread misconceptions when it comes to the clitoris and bulbs, these two organs will be explained in more detail in the next subchapters. Indeed, it is important to be well informed about these erectile organs in order to be able to understand the misconceptions and possible surgical interventions regarding FGM/C.

*Figure 1*

*The External Female Genitalia*



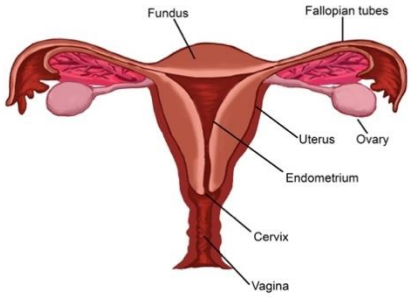

*Note.* From “Anatomy of the clitoris and the female sexual response” by R. N. Pauls, 2015, *Clinical Anatomy,* 28 (3), p.377, https://doi.org/10.1002/ca.22524. Copyright 2015 Wiley Periodicals, Inc.

### 2.1.1.2. The Internal Genital Organs

The internal female genital organs consist of the fallopian tubes, uterus, ovaries and the vagina as it is shown in Figure 2 (Huch & Jürgens, 2015, p. 398).

*Figure 2*

*The Internal Female Genitalia*




*Note.* From *Female reproductive anatomy – True.* (https://www.true.org.au/Health-information/womens-health). Copyright 2019 by True Relationships & Reproductive Health.

### 2.1.1.3. Clitoris and Bulbs

Liv Strömquist, a Swedish artist and feminist calls attention to the false description of the clitoris in a biology book that was published in 2006 and is still in use. There, the clitoris is described as an organ with a length of one centimeter, which is located at the tip of the point of intersection of the labia minora (Strömquist, 2017, p. 80). In this context, Helen O'Conell an urologist of the Royal Melbourne Hospital, discovered the actual length, which is about seven to ten centimeters and encircles the vaginal wall from behind. If the clitoris is stimulated, the whole organ bulges (Strömquist, 2017, p. 79).

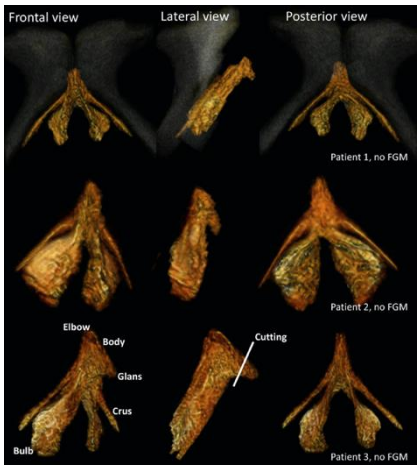
The clitoris contains the glans, the body and the crura. Whereas the glans is the only part that is visible, the two other parts are internal and therefore not visible (Abdulcadir, Botsikas, et al., 2016, p. 227). While doing research, it became apparent that the bulbs are rarely mentioned in the examined literature. The bulbs are two female erectile tissues that are located underneath the labia minora, where they swell during sexual arousal (Abdulcadir, Botsikas, et al., 2016, p. 227).

In some reports, the World Health Organization [WHO] classification of FGM/C states that some forms of female genital mutilation or cutting consist of the total removal of the clitoris (Abdulcadir, Botsikas, et al., 2016, p. 277). However, Jasmine Abdulcadir et al. (2016) demonstrate that only the visible part of the clitoris (the glans) is cut.

Therefore, the body and crura stay intact. For their research, a three-dimensional reconstruction of volumetric Magnetic Resonance Imaging [MRI] of the clitoris and the bulbs on three women without FGM/C and three women with FGM/C Type II or III was made, which involved the cutting of the clitoris (Abdulcadir, Botsikas, et al., 2016, pp. 233–234). This means that the WHO classification stating that the “total” clitoris is removed is anatomically incorrect.

*Figure 3*

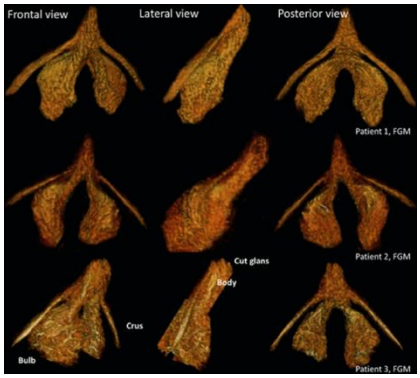
*3D Clitoris and Bulbs*




*Note.* Three-dimensional reconstruction of the clitoris and bulbs on women without FGM/C. From “Sexual Anatomy and Function in Women With and Without Genital Mutilation: A Cross-Sectional Study”, by J. Abdulcadir et al., 2016, *The Journal of Sexual Medicine, 13* (2), p.233 (10.1016/j.jsxm.2015.12.023). Copyright 2016 by *International Society for Sexual Medicine.*

*Figure 4*

*3D Clitoris and Bulbs*




*Note.* Three-dimensional reconstruction of the clitoris and bulbs on women with FGM/C. From “Sexual Anatomy and Function in Women With and Without Genital Mutilation: A Cross-Sectional Study”, by J. Abdulcadir et al., 2016, *The Journal of Sexual Medicine, 13* (2), p.234 (10.1016/j.jsxm.2015.12.023). Copyright 2016 by *International Society for Sexual Medicine.*

The figures above show that women with FGM/C have a smaller clitoral glans than women without FGM/C, which is due to FGM/C involving cutting the glans. Mean measurements of clitoral body length and glans showed only small differences between women with or without FGM/C (Abdulcadir, Botsikas, et al., 2016, p. 234). Jasmine Abdulcadir et al. (2016) conclude that the erectile organs responsible for sexual function are still present in women with FGM/C. As a consequence, the classifications and the incorrect notion that women with FGM/C do not have a clitoris, should be revised (Abdulcadir, Botsikas, et al., 2016, p. 236). The fact that the clitoris is larger than it appears outwardly allows for potential surgical reconstruction of the damaged and cut clitoris. Further information on this surgical option is provided in the subchapter 2.3.2. Clitoral Reconstruction.

### 2.1.2. Sexuality

One of the most common reasons for FGM/C is to suppress sexual pleasure, arousal and orgasm by cutting the clitoris. These beliefs about the clitoral glans in relation to women sexuality do not only subsist in countries practicing FGM/C but also in the West (Abdulcadir, Botsikas, et al., 2016, p. 227).

Even though women who experience FGM/C tend to have problems during sex or with their sexuality, this does not generally apply to every woman with FGM/C. Sexual difficulties can affect anybody, no matter what sex or whether they have undergone FGM/C or not (De Koster et al., 2019, p. 27). In fact, there are both women with FGM/C who are satisfied with their sex life and women who have difficulties in their sexuality following FGM/C. Indeed, sexuality is not only a physical concern but also an emotional one. Hence, it is important to address issues surrounding sexuality from a multidisciplinary angle, where medical, sexological and psychological care is offered to women and their partners (De Koster et al., 2019, pp. 27 & 31). In this context, the sexologist Cendrine Vanderhoeven states: “Sexuality is all encompassing, women have to know their bodies to find pleasure and to guide partners” (De Koster et al., 2019, p. 31).

## 2.2. Female Genital Mutilation/Cutting

Female genital mutilation/cutting includes a total or partial removal of the external female genitalia or other injury to the female genital organs for non-medical reasons (Stein et al., 2016a, p. 1). Although the origin of FGM/C is not determined, several

hypotheses claim that the custom originated in Egypt (Internationales Institut der Rechte des Kindes, 2012, p. 24).

The practice of FGM/C is over 2,000 years old, based on social and cultural traditions, and has no apparent medical benefits according to the WHO guidelines of 2016 (Stein et al., 2016a, p. 1). Thus, it is not the object of the practice to be harmful but for instance to maintain the perceived purity and *virginity* of the girl or woman for marriageability reasons in more than 30 countries where FGM/C is a traditional practice (Vorburger, Denis et al., 2019, p. 21). Female genital mutilation/cutting is justified by those practicing it as a means to preserve a completely pure female appearance since the female genitalia are considered masculinized in their original form. This is why FGM/C is for example called “getting pure” in the mother tongues of many countries where FGM/C is practiced (Vorburger, Denis et al., 2019, p. 21).

In half of the countries[1] where FGM/C is practiced, the majority of girls who undergo FGM/C are younger than five years, while they are between 5 and 12 years old in the other countries (Vorburger, Denis et al., 2019, p. 21).

### 2.2.1. Cultural Reasons for FGM/C

The initiation rite of female genital mutilation/cutting often marks the transition from being a girl to an adult woman. The motifs for the practice are tradition, medical myths, economic reasons and religion (Wohlfarth & Brucker, 2018, p. 4). Historically, the custom of FGM/C has its origin before Christianity and Islam and is not based on religious reasons even if it is often justified as such (Amman et al., 2013, p. 4). The historian Omar Ba mentions that after people converted to these religions, certain traditions were integrated and over time tradition was fused with religion (De Koster et al., 2019, p. 14). Overall, FGM/C is practiced in different cultural and religious communities for complex reasons (Birri et al., 2020, p. 10). The Swiss recommendation for doctors, midwives and healthcare professionals has listed some of the social and cultural reasons that vary from countries and regions, which are:

- Tradition, initiation rite;
- Purity law;
- Aesthetic reasons;
- Preservation of the virginity;
- Preservation of the matrimonial faithfulness;

[1] (https://www.unicef.org/media/files/FGMC_2016_brochure_final_UNICEF_SPREAD.pdf)

- Hygienic reasons;
- Condition of marriageability;
- Promotion of fertility;
- Preservation of the family honor;
- Strengthening of the togetherness of a group;
- Increase of the sexual satisfaction of the man;
- Fear of male impotence caused by the clitoris;
- Fear of the continuous growth of the labia minora;
- Fear of the oversized growth of the clitoris;
- Fear of the death of the newborn by touching the clitoris during birth;
- Necessity to remove the male characteristics of the newborn girl so that the child becomes a real woman in the future (Amman et al., 2013, p. 4).

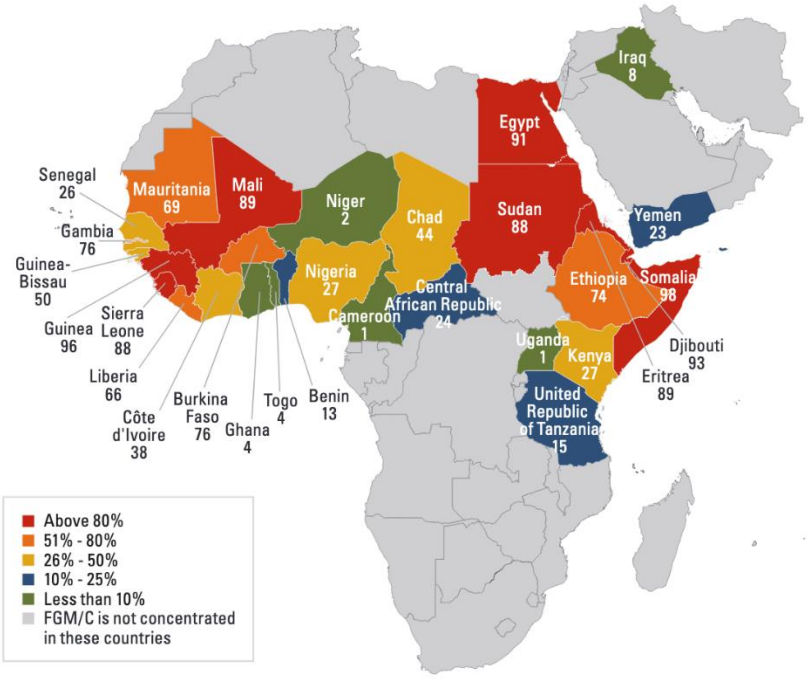
The practice of FGM/C is of great importance to young girls, women and their families regarding social integration in communities where it is considered a sociocultural norm. This is why parents let their daughters be mutilated/circumcised with no intention to harm them (Birri et al., 2020, p. 10). According to these communities, girls and women who are mutilated/circumcised have better marriage prospects, and therefore better chances for an economically stable and socially respected life (Wohlfarth & Brucker, 2018, p. 4).
In the 18th and 19th century *clitoridectomy* was a common medical practice in Europe (Internationales Institut der Rechte des Kindes, 2012, p. 26). The reason for that procedure was to prevent women from masturbation, as supposedly masturbation could lead to illnesses such as hysteria and epilepsy.

### 2.2.2. Prevalence of FGM/C All over the World

According to the WHO, the practice of FGM/C is prevalent in 30 countries in Africa and in a few countries in Asia and the Middle East. “Some forms of FGM have also been reported in other countries, including among certain ethnic groups in Central and South America” (Stein et al., 2016a, p. 1). In fact, it is estimated that around 200 million girls and women have undergone FGM/C worldwide and that every year, around three million girls are at risk of the practice and its medical implications (Stein et al., 2016a, p. 1).

*Figure 5*

*Infographic of FGM/C Prevalence*




*Note.* Percentage of girls and women aged 15 to 49 years who have undergone FGM/C, by country. Reprinted from *Female genital mutilation/cutting: a statistical overview and exploration of the dynamics of change* (p.34), by UNICEF, 2013. Copyright 2013 by United Nations Children's Fund (UNICEF).

*Note. UNICEF continue updating their data. Updated data available at: https://data.unicef.org/topic/child-protection/female-genital-mutilation/*

The incidence of Type I to IV varies, depending on the geographical location. The Swiss guideline of FGM/C shows that Type I and II are mostly practiced in countries like: "Benin, Burkina Faso, Democratic Republic Congo, Ivory Coast, Eritrea, Gambia, Ghana, Guinea, Guinea-Bissau, Indonesia, Yemen, Cameroon, Kenya, Liberia, Malaysia, Mali, Mauritanian, Niger, Nigeria, Senegal, Sierra Leone, Tanzania, Togo, Chad, Uganda and the Central African Republic" (Amman et al., 2013, p. 6).

Infibulation, or FGM/C Type III, is mainly practiced in Djibouti, Egypt, Ethiopia, Eritrea, Somalia and in the North of Sudan. In addition to infibulation, FGM/C Type I and II are also prevalent in these countries. In Somalia, 98% of the girls and women are affected by FGM/C Type I and II, and out of these 80% underwent an infibulation (Amman et al., 2013, p. 6).

In Switzerland, it is estimated that around 15,000 girls and women are affected by or at risk of FGM/C (Vorburger, Denis et al., 2019, p. 21).

*Figure 6*

*Prevalence Rate*

FGM – Prävalenzraten in den Herkunftsländern und geschätzte Prävalenzraten für die Schweiz

| Ursprungsland | FGM – Prävalenz (WHO) | Geschätzte Anzahl gefährdeter Mädchen und betroffener Frauen in der Schweiz* |
|---|---|---|
| Ägypten | 97% | 528 |
| Äthiopien | 85% | 981 |
| Benin | 50% | 27 |
| Burkina Faso | 72% | 55 |
| Demokr. Rep. Kongo | 5% | 113 |
| Djibuti | 98% | 7 |
| Elfenbeinküste | 43% | 208 |
| Eritrea | 95% | 613 |
| Gambia | 80% | 15 |
| Ghana | 30% | 173 |
| Guinea | 99% | 91 |
| Guinea-Bissau | 50% | 7 |
| Jemen | 23% | 28 |
| Kamerun | 20% | 249 |
| Kenia | 38% | 206 |
| Liberia | 60% | 37 |
| Mali | 94% | 41 |
| Mauretanien | 25% | 4 |
| Niger | 5% | 1 |
| Nigeria | 25% | 86 |
| Senegal | 20% | 67 |
| Sierra Leone | 90% | 66 |
| Somalia | 98% | 2828 |
| Sudan | 89% | 206 |
| Tansania | 18% | 22 |
| Togo | 12% | 21 |
| Tschad | 60% | 17 |
| Uganda | 5% | 8 |
| Zentralafrikanische Republik | 43% | 6 |
| **Total** | | **6711** |

*Note*. Prevalence rate in the countries of origin and guessed prevalence rate in Switzerland. From “Patientinnen mit genitaler Beschneidung. Schweizerische Empfehlungen für Ärztinnen und Ärzte, Hebammen und Pflegefachkräfte”, (by Amman et al., 2013, p. 13)

### 2.2.3. Classification of the Types

According to Stein et al., (2016), there are four types of female genital mutilation/ cutting, which have been classified by the WHO as follows:

**Type I**: Partial or total removal of the clitoris (clitoridectomy) and/or the *prepuce*

**Type II**: Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision)

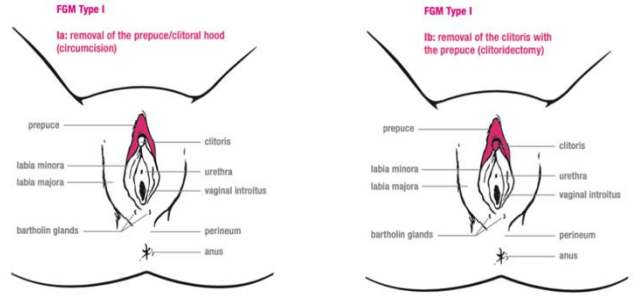
**Type III**: Narrowing of the vaginal orifice with the creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation)

[…]

**Type IV**: All other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, pulling, piercing, incising, scarping and cauterization (pp. 2–4)

*Figure 7*

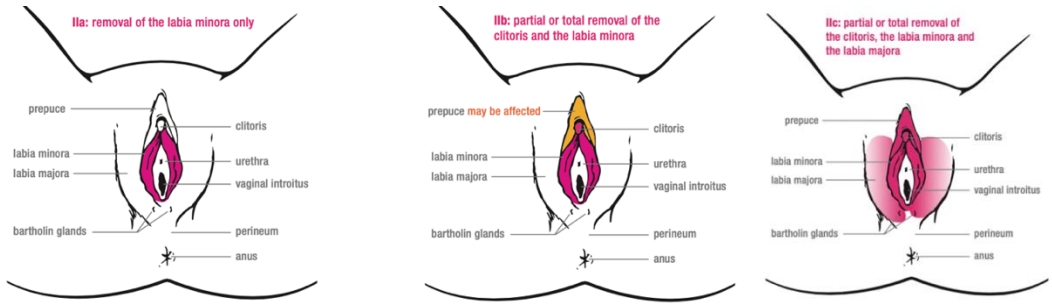
*FGM/C Type I*




*Note*. FGM/C Type Ia and Ib. From "Female Genital Mutilation: A Visual Reference and Learning Tool for Health Care Professionals", by J. Abdulcadir et al., 2016, *Obstetrics & Gynecology, 128* (5), p. 958-963 (10.1097/AOG.0000000000001686). Copyright 2016 by *The American College of Obstetricians and Gynecologists.*

*Figure 8*

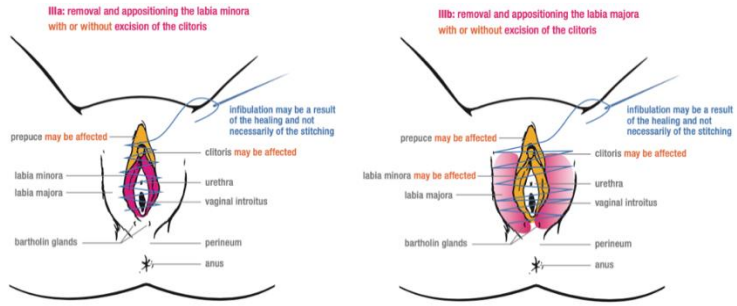
*FGM/C Type II*




*Note*. FGM/C Type IIa, IIb and IIc. From "Female Genital Mutilation: A Visual Reference and Learning Tool for Health Care Professionals", by J. Abdulcadir et al., 2016, *Obstetrics & Gynecology, 128* (5), p. 958-963 (10.1097/AOG.0000000000001686). Copyright 2016 by *The American College of Obstetricians and Gynecologists.*

*Figure 9*

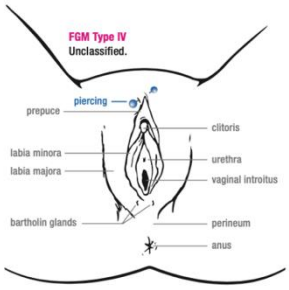
*FGM/C Type III*




*Note.* FGM/C Type IIIa and IIIb - Infibulation. From "Female Genital Mutilation: A Visual Reference and Learning Tool for Health Care Professionals", by J. Abdulcadir et al., 2016, *Obstetrics & Gynecology, 128* (5), p. 958-963 (10.1097/AOG.0000000000001686). Copyright 2016 by *The American College of Obstetricians and Gynecologists.*

*Figure 10*

*FGM/C Type IV*




*Note.* FGM/C Type IV. From "Female Genital Mutilation: A Visual Reference and Learning Tool for Health Care Professionals", by J. Abdulcadir et al., 2016, *Obstetrics & Gynecology, 128* (5), p. 958-963 (10.1097/AOG.0000000000001686). Copyright 2016 by *The American College of Obstetricians and Gynecologists.*

In Somalia and Sudan, FGM/C is classified as "pharaonic" or "Sunna". Pharaonic stands for FGM/C Type III or infibulation since the origin of the practice is associated with Egypt. Sunna symbolizes any type of FGM/C and is described as a minor cut and less damaging, although from a medical perspective it is not less harmful, as it can include infibulation (Johansen, 2017, p. 3). There are discrepancies between the definitions of those two terms, however, as some sources define Sunna as FGM/C Type I (Internationales Institut der Rechte des Kindes, 2012).

### 2.2.4. Pregnancy and Birth with FGM/C

Female genital mutilation/cutting can lead to difficulties during pregnancy and birth. Pregnant women who underwent an infibulation are the ones who are most affected

during pregnancy and birth. As a consequence of narrowing the vaginal orifice, it can be challenging to perform certain medical checkups. This includes for example the *papilloma virus* smear or the manual vaginal checkup, which are performed to prevent complications and risks for the mother and child. Depending on the *unsterile* circumstances of the FGM/C procedures, there is a high risk of *Human Immunodeficiency Virus* [HIV] infection as well as the risk of urinary tract infection (Amman et al., 2013, p. 11). Furthermore, pregnancy can evocate psychological burdens for affected pregnant women, such as fear of the reaction of healthcare professionals, fear of the pain during and after birth and fear of a *caesarean section*. Births without medical help can lead to complications such as a *hypertonic uterus*, postpartum *atony of the uterus*, delayed progression of delivery and therefore poor outcome of the newborn, cerebral damages up to *prenatal* death, *perineal tear* or additional complications for the mother, which can even lead to death (Amman et al., 2013, p. 11). As mentioned in subchapter 1.2. Relevance and Importance of the Subject, the *morbidity* and mortality risk for mother and child is higher due to complications caused by infibulation.

However, in Switzerland a well-assisted delivery should not involve risk for child and mother. Through recruiting staff like doctors or midwives who are specialized in women with FGM/C, risks during birth can be reduced. If the woman underwent infibulation, the first stage of labour proceeds without any intervention. For the second stage of labour an *incision* with an *epidural* or local anesthesia should be conducted. For women who already are defibulated before giving birth, no additional intervention is indicated (Amman et al., 2013, p. 11). According to the Swiss recommendation for the management for women with FGM/C, women should only undergo defibulation during pregnancy when vaginal checkups are not possible due to the infibulation. Even if the surgical intervention is beneficial for mother and child, it is still a painful procedure that needs to be properly discussed during pregnancy. Therefore, it is important to address women and their partners at the beginning of pregnancy since there is no high acceptance in relation to medicalized defibulation due to traditions (Amman et al., 2013, p. 11).

### 2.2.5. Health Risks for Girls and Women who Underwent FGM/C

To conduct FGM/C, tools such as knives, razor blades, scissors, glass shards and scalpels are used (Amman et al., 2013, p. 6). Since FGM/C is mostly performed by a

traditional practitioner with no profound medical knowledge, sterile instruments or any anesthesia, there is a high chance of health consequences which can be life-threatening for the woman (Stein et al., 2016a, p. 8). It is estimated that in Sudan, every third girl dies due to infections and the unavailability of *antibiotics* after the traditional procedure (Vorburger, Denis et al., 2019, p. 21). In 70% of all cases, FGM/C is practiced during childhood. While in some regions, the rite occurs straight after birth, the procedure is performed during puberty or right before marriage in other areas. According to the Swiss recommendation for doctors, midwives and nurses, the procedure of female genital mutilation is increasingly performed on young girls. This happens in some countries of origin and within some groups of immigrants because young children will not defend themselves unlike older girls and women might (Amman et al., 2013, p. 6).

FGM/C can have a lifelong negative impact on the physical and/or mental health of a girl or woman, such as trauma and pain. The WHO guideline mentions that there might be greater risks of immediate harm when Type III is performed and that these events are significantly underreported (Stein et al., 2016b, p. 5).

Several health risks that are related to FGM/C are starting to get acknowledged by communities. However, healthcare providers often do not know the risks and therefore do not recognize them (Stein et al., 2016b, p. 5).

*Figure 11*

*Health Risks of FGM/C*

| Risk | Remarks |
|---|---|
| **IMMEDIATE RISKS *(6, 8)*** | |
| Haemorrhage | |
| Pain | |
| Shock | Haemorrhagic, neurogenic or septic |
| Genital tissue swelling | Due to inflammatory response or local infection |
| Infections | Acute local infections; abscess formation; septicaemia; genital and reproductive tract infections; urinary tract infections<br>The direct association between FGM and HIV remains unclear, although the disruption of genital tissues may increase the risk of HIV transmission. |
| Urination problems | Acute urine retention; pain passing urine; injury to the urethra |
| Wound healing problems | |
| Death | Due to severe bleeding or septicaemia |
| **OBSTETRIC RISKS *(9, 10)*** | |
| Caesarean section | |
| Postpartum haemorrhage | Postpartum blood loss of 500 ml or more |
| Episiotomy | |
| Prolonged labour | |
| Obstetric tears/lacerations | |
| Instrumental delivery | |
| Difficult labour/dystocia | |
| Extended maternal hospital stay | |
| Stillbirth and early neonatal death | |
| Infant resuscitation at delivery | |
| **SEXUAL FUNCTIONING RISKS *(6, 11)*** | |
| Dyspareunia (pain during sexual intercourse) | There is a higher risk of dyspareunia with type III FGM relative to types I and II *(6)*. |
| Decreased sexual satisfaction | |
| Reduced sexual desire and arousal | |
| Decreased lubrication during sexual intercourse | |
| Reduced frequency of orgasm or anorgasmia | |
| **PSYCHOLOGICAL RISKS *(12)*** | |
| Post-traumatic stress disorder (PTSD) | |
| Anxiety disorders | |
| Depression | |
| **LONG-TERM-RISKS *(6, 8)*** | |
| Genital tissue damage | With consequent chronic vulvar and clitoral pain |
| Vaginal discharge | Due to chronic genital tract infections |
| Vaginal itching | |
| Menstrual problems | Dysmenorrhea, irregular menses and difficulty in passing menstrual blood |
| Reproductive tract infections | Can cause chronic pelvic pain |
| Chronic genital infections | Including increased risk of bacterial vaginosis |
| Urinary tract infections | Often recurrent |
| Painful urination | Due to obstruction and recurrent urinary tract infections |

*Note*. Reprinted from *WHO guidelines on the management of health complications from female genital mutilation* (p.6-7), by K.Stein et al., 2016. World Health Organization. Copyright 2016 by World Health Organization.

### 2.2.6. Legal Aspects

#### 2.2.6.1. Human Rights

The WHO has published a guideline on the management of health complications of female genital mutilation/cutting. Their intention is to demonstrate that the practice is a violation of a person's right to the highest attainable standard of health and therefore against human rights (Stein et al., 2016b, p. 5). To be more precise, FGM/C violates equality and non-discrimination on the basis of sex as well as the right of life when girls or women die because of the aftermath. Moreover, the procedure is against the right to freedom from torture or cruelty and against children's right by being inhuman and degrading (Stein et al., 2016b, p. 5).

Various United Nations [UN] conventions on the rights of humans' lives have stated obligations to respect, fulfil and protect the rights of girls and women and to ensure that no human has to undergo harmful practices such as FGM/C. With this action, states are obligated to ensure the best possible health conditions for everyone. However, the countries are often faced with challenging discrepancies between the UN obligations and the national laws and policies about FGM/C (Stein et al., 2016b, p. 7). In Europe, only four countries (Sweden, Great Britain, Belgium and Norway) have FGM/C-specific laws. In other European countries, including Switzerland, FGM/C is a criminal offence whereby the legal situation is noted in a criminal code (Amman et al., 2013, p. 7).

#### 2.2.6.2. Legal Situation in Switzerland Concerning FGM/C

The Swiss criminal code (Art. 124 des Schweizerischen Strafgesetzbuches [StGB]) states that any type of female genital mutilation/cutting, regardless of the degree of severity of the mutilation/cutting, the affection of body function or the hygienic conditions of the procedure, is forbidden. Additionally, the reason for the procedure receives no consideration (Birri et al., 2020). The person who performs FGM/C in Switzerland, as well as any involved person apart from the victim, is punished with a fine or imprisonment of up to 10 years. Being involved includes any person who arranges, agrees or instigates the procedure or organizes a trip to a country where FGM/C is performed. In addition to that, the criminal law fines the act of performances even if occurs abroad. In this case, it is irrelevant whether the Swiss law does not correspond to the one of the concerned countries: It does not matter if

the person involved in FGM/C is a Swiss resident or not. Through these laws, FGM/C on girls and women can be stalled in foreign countries (Birri et al., 2020, pp. 11–12). Furthermore, there is a child protection system in Switzerland for the purpose of preventing threat and injuries to the child's wellbeing, as well as to avoid further damage (Birri et al., 2020, p. 15). Thus, according to Art.320 and Art.321 StGB, healthcare workers are allowed to report child abuse despite professional secrecy (Amman et al., 2013, p. 7).

## 2.3. Surgical Intervention

In this subchapter, various interventions will be presented. As explained in subchapter 2.2.5. Health Risks for Girls and Women who Underwent FGM/C, there is a number of risks concerning FGM/C. This is where surgical interventions come to the fore. Healthcare providers should be able and confident to discuss FGM/C with women. This can be by providing evidence-based information concerning benefits and harms in a way that these women understand, thereby enabling them to make informed decisions and feel taken care of during health service encounters (Smith & Stein, 2017, p. 79).

### 2.3.1. Defibulation

Defibulation is an important topic concerning FGM/C Type III. As explained, with infibulation only a small opening is left for the urine or menstrual bleeding to drain away (Internationales Institut der Rechte des Kindes, 2012, p. 15). One possible indication for defibulation is to decrease *dyspareunia* and improve sexual functioning, as defibulation can make vaginal penetration easier (Abdulcadir et al., 2018, p. 602). Physiological *micturition* and menstrual outflow are also facilitated by defibulation. In order to give birth, either a surgical or traditional defibulation is needed to decrease obstetrical risks of cesarean section, *episiotomy*, and perineal tears (Abdulcadir et al., 2018, p. 602).

#### 2.3.1.1. Surgical Defibulation

Psychological support should be offered to women with FGM/C who undergo a surgical intervention since operative and post-operative pain can recall memories of post-traumatic stress (Abdulcadir et al., 2018, p. 603).

Surgical defibulation can be considered a minor surgical procedure. The intervention can be done under local anesthesia, or, depending on the patient's choice, also under locoregional or general anesthesia (Wohlfarth & Brucker, 2018, p. 7). The

purpose of this surgical intervention is to re-open the *vaginal introitus* of women living with infibulation (Stein et al., 2016b, p. 16). Defibulation can be performed on non-pregnant and pregnant women. In literature, there are discrepancies regarding the ideal timing of defibulation on a pregnant woman with FGM/C Type III. Wolfarth and Brucker (2018) recommend performing defibulation around the 20th week of pregnancy, or during birth in the *opening phase* or *expulsive phase* while Abdulcadir et al. (2018) state that surgical defibulation during delivery should be performed during the first stage of labour. Whereas the Deutsche Gesellschaft für Gynäkologie und Geburtshilfe [DGGG] recommends performing defibulation during delivery to prevent two surgical procedures (Utz-Billing, 2007), the WHO states that the timing of defibulation depends on various factors such as preference of the woman, access to healthcare facilities, place of delivery and healthcare providers' skills level (Stein et al., 2016b, p. 19). The medical procedure is as follows: the midline scar covering the vaginal introitus is incised (Stein et al., 2016b, p. 16). Depending on what the woman undergoing defibulation decided, the opening goes until up to one centimeter of the external *urethral meatus* (partial defibulation) or until uncovering the clitoris (total defibulation) (Abdulcadir et al., 2018, p. 605). Finally, the cut edges are sutured in order to keep the introitus open (Stein et al., 2016b, p. 16). Before performing the surgery, there are various issues to consider. It needs to be ensured that a certified interpreter is present if there are language barriers and that the girl/woman has been given enough time to thoroughly consider her decision beforehand and that a detailed pre-operative briefing with or without partner/company has occurred (Abdulcadir et al., 2018, p. 604). After the surgical intervention it is important to conduct post-operative checkups around the 7th and the 30th day to avoid post-operative complications (Abdulcadir et al., 2018, p. 608).

#### 2.3.1.2. Traditional Defibulation

The small opening left after infibulation impedes sexual intercourse by penile penetration, and therefore guarantees preservation of virginity as mentioned in subchapter 3.2.1. Cultural Reasons for FGM/C as virginity is part of social values in different communities. Eventually, the small opening has to be widened and reopened to conform to cultural values related to marriage and motherhood. In the opinion of her community, the girl becomes a mature woman in that process (Johansen, 2017, p. 3). Depending on the setting and the expectations and cultural

values of the setting, there are two different ways to perform traditional defibulation. In some places, the groom has to defibulate the bride by pure force through penile penetration, thereby causing the seal to tear and ensuring a sufficiently wide opening (Johansen, 2017, p. 3). Defibulation by sexual intercourse can involve pain on both sides, male and female, and the duration to achieve defibulation depends on a variety of factors. Johansen (2017) mentions the amount of force used, the orifice's size, the seal's thickness and scarring as some of those factors. There are men who even resort to more radical methods when penile penetration is insufficient, such as knives or razor blades (Johansen, 2017, p. 3).

In Northern Somalia, an excisor (circumciser) is requested to reopen the infibulation. Either way the couple has to practice repeated sexual intercourse in the following weeks to keep the wounds from resealing. This can cause the woman to experience strong pain due to the open wounds. Often this "maintenance" as Johansen (2017) calls it, can cause infections and bleedings in the female genitalia. For many women, the whole process of defibulation is comparable to the pain experienced during infibulation (Johansen, 2017, p. 3).

#### 2.3.1.3. Reinfibulation

After delivery has taken place, there are different ways that women deal with the reopening of the female genitalia. In some cultures, it is customary to re-suture the labia and additionally to cut or scrape new tissue so that the vaginal orifice resembles the one of an unmarried woman. *Reinfibulation* means that women have to endure the process of repeated closure and opening for as long as they are giving birth to children. There is no evidence that reinfibulation occurs in every culture that practices FGM/C (Johansen, 2017, p. 4). Although women sometimes wish to be reinfibulated, it is very important to be aware of the fact that there is absolutely no medical indication for refinfibulation (Amman et al., 2013, p. 12).

### 2.3.2. Clitoral Reconstruction

Clitoral reconstruction is a surgical technique where the internal part of the clitoris is externalized and repositioned with the aim to reinstate its nerve function (De Koster et al., 2019, p. 30). According to Sharif Mohamed et al. (2020), clitoral reconstruction is described as follows: "CR [clitoral reconstruction] involves removal and dissection of the scarred tissue covering the clitoral body that remains after FGM/C…" (p.532).

The intention of this surgical intervention is on one hand to improve problems associated with FGM/C such as chronic pain or dyspareunia and on the other hand to improve sexual function, genital and/or body image and to strengthen self-body image by reconstructing what was taken away without any permission (Sharif Mohamed et al., 2020, p. 534).

### 2.3.3. Cyst Removal

*Cyst* removal is a surgical procedure that is performed in order to remove a neuroma. Neuromas are *benign tumors* that develop after resection or injury to a nerve. Post-traumatic neuromas are an uncommon consequence of female genital mutilation/cutting (Abdulcadir et al., 2017). Clitoral neuromas can cause strong pain or be *asymptomatic*. The only therapy method is by removing the neuroma/cyst.

# 3. Methodical Approach

In the following chapter, the methodical approach of the bachelor thesis is exposed in more detail. It is demonstrated how literature sources were searched and selected and how research was conducted.

## 3.1. Database Research

The research question is addressed by means of a literature review. Therefore, only primary and secondary literature is used. The literature for the review is searched for in the following databases: PubMed, CINAHL Complete, MEDLINE and ELSEVIER. Further literature is perused in the NEBIS-catalogue as well as in the search engine Google Scholar, where most of the over 4,500 results have been obtained though they proved to be the least suitable. While searching in the databases, Boolean operators such as ‘AND’ and ‘OR’ are used. The keywords are used in combination with synonyms like ‘FGM’, ‘female genital mutilation’, ‘female cutting’, ‘female *circumcision*’, as shown in the table below, and are linked with the Boolean operator ‘OR’. When searching in the databases, the different keywords are also linked with the Boolean operator ‘AND’. Several combinations are applied with the keywords listed in the table below. Depending on the applied combination, between zero and 86 results are obtained. The same keyword combinations are used in the different databases.

## 3.2. Table of Keywords

**Table 1**

*Keywords and Synonyms*

| Keywords | Synonyms |
|---|---|
| FGM | female genital mutilation, female cutting, female circumcision, FGM Type I-IV |
| midwife | midwifery, midwives, midwifery practice, healthcare provider |
| *defibulation* | defibulate |
| guidelines | recommendation |
| therapy | treatment, intervention, therapy possibilities, surgical interventions |

With the keyword combination FGM OR female genital mutilation OR female cutting OR female circumcision AND defibulation, the most useful literature is found even though it is not the combination that generates most of the results. The keyword "guidelines" has helped to find the current guidelines regarding FGM/C in Switzerland, although it is not rewarding in relation to the research done in the databases. As the research question is not principally related to midwives only but rather to healthcare professionals in general, it has proven difficult to find useful literature containing the keyword "midwife".

## 3.3. State of Research

As a result of the delicacy with which the topic is still approached, most of the selected studies are *qualitative* rather than *quantitative*. In spite of this fact, however, there are current guidelines for healthcare professionals.

Letts and Law is a critical review form for qualitative studies. It is applied for the critical appraisal of the chosen studies as is recommended for bachelor theses which are written in English.

## 3.4. Limitations

In comparison to earlier bachelor theses by Schreiber (2012) and Mulamba-Kuucha (2011), the focus of this thesis is on women with FGM/C who have had surgical

interventions, and their experiences in this context. The research question does not include women with FGM/C who had no kind of intervention or therapy. The thesis does not refer to all countries because there might be different technical possibilities and status quos for surgical interventions. Moreover, it is not possible to review surgical interventions on all four types of FGM/C. Since the research question refers to different health-related professions, little literature that focuses exclusively on midwifery was found.

## 3.5. In- and Exclusion Criteria

**Table 2**

*Inclusion Criteria for the Literature Research*

| *Criteria* | *Inclusion Criteria* |
|---|---|
| time period | 2010-2020 |
| place | guidelines from industrialized countries (with similar cultural background as Switzerland) |
| population | Women with FGM/C who had surgical interventions |
| relational | midwives |
| setting | no exclusion referred to the setting |

## 3.6. Interviews

Female genital mutilation/cutting is of worldwide concern as explained in chapter 1. Thematic Foundation. To gain an understanding of the surgical approach on women with FGM/C and the prevalence of surgical interventions, expert interviews were conducted. Several gynaecologists and other people who are involved with the topic female genital mutilation/cutting in Switzerland, and one doctor from Kenya were contacted by Email. To gain an insight into a country where FGM/C is still traditionally practiced, a doctor from Kenya was interviewed. The interviewees were found on different websites concerning FGM/C and by the interviewees' referring to other experts. Two interviews took place during the months of January and February 2021. With those who responded, interviews were conducted by video call or by Email depending on the workload of the person and on the Corona pandemic. For those interviews, 10 questions were prepared in German and English and the interview

form was semi-structured or structured depending on the way it took place. The video call was in Swiss German and recorded by phone after the informed consent of the interviewee and lasted around 35 minutes. The responses were transcribed in German and are included in the theory practice transfer part of the thesis. The Kenyan doctor answered the questionary in English by Email. The interviews are attached at the end in the appendix. The interviewees were informed about the purpose of the collected data and the fact it was going to be anonymised.

# 4. Results and Discussion of Results

In this chapter, the results of two qualitative studies, a case study and a systematic review as well as the conclusions of the chosen literature are presented, discussed and compared to each other. The studies as well as the systematic review are critically appraised with appropriate grids.
The sources refer to female genital mutilation/cutting although they focus on different aspects. With the findings of the studies and literature, the research question: *A) How successful are the most common types of surgical interventions for FGM/C available in industrialized countries, and B) which factors influence whether the results are considered satisfactory by the women receiving them?,* can be answered, and a prediction for the future can be made regarding the current state of research.
Within this chapter, the limitations of the used literature are presented after the critical analysis of each source.

## 4.1 Research Result

The qualitative study from Spain was published in 2020 and is the latest source used in this bachelor thesis (Ugarte-Gurrutxaga et al., 2020a). The study's objective is "…to learn about the factors that healthcare professionals consider as facilitators for prevention and action when faced with female genital mutilation" (Ugarte-Gurrutxaga et al., 2020a, p. 1). According to the participants of the study, there are various shortcomings in the healthcare system regarding FGM/C, which will be referred to in subchapter 4.1.1. Healthcare Professionals.

The Norwegian qualitative study, which took place in 2017, aimed to investigate the acceptance of surgical defibulation among Somali and Sudanese women and men and how the procedure is perceived (Johansen, 2017). Even though traditional defibulation through penile penetration is painful for women as well as for men, the

study results show: “… also in these contexts, the medicalization of defibulation was commonly resisted” (Johansen, 2017, p. 8).

The purpose of the Swiss case study from 2015 is to present a specific multidisciplinary care issue and its clinical outcome after clitoral reconstruction performed at the Geneva University Hospital in Switzerland based on the cases of two African women (Abdulcadir et al., 2015a, p. 275). An additional purpose is to examine the link between clitoral neuromata and clitoral pain within the *peri-clitoral fibrosis*. “The cases reported a positive outcome with respect to pain, sexual function, self body image, and *gender* after multidisciplinary care, including clitoral reconstruction” (Abdulcadir et al., 2015b, pp. 278–279) .

To briefly look into surgical interventions for women with FGM/C, the systematic review from Norway was analyzed. In 2017, there were no current systematic reviews concentrating on the surgical interventions and their effectiveness (Berg et al., 2017). One of the specific aims of Berg et al. (2017) is “…to identify and summarize research on the range of reparative interventions for women with FGM/C-related concern” (Berg et al., 2017, p. 978). The systematic review by Berg et al. (2017) concludes that defibulation is the simplest and most accessible procedure, whereas reconstructive interventions are less accessible. An approximate range of 50-100% of the women who undergo defibulation are pleased with the result of the surgical intervention (Berg et al., 2017). However, there are women who are not contented as they dislike the new appearance of their genitalia. Berg et al. (2017) state that the genitalia even become “abnormal” for many women who undergo defibulation (p.985). The results by Berg et al. (2017) shows clitoral reconstruction producing a positive outcome in two thirds of the women, while one third seem to be dissatisfied with or perceive a worsening in the esthetic appearance (p.985). Additionally, Berg et al. (2017) states “…however, follow-up beyond 1 year is missing and women’s satisfaction could improve over time” (p.985). No numbers are referred to regarding cyst removal, though it is to assume that the outcomes are included in the two other surgical interventions. This assumption can be made as Berg et al. (2017) mention cyst removal usually being combined with some form of reconstruction.

It is outlined that further research should be encouraged, especially in countries were FGM/C is practiced.

> There is need for studies that investigate the most acceptable reparative interventions for women living with FGM/C, what women are seeking when requesting repair, and what their experiences with the interventions are, including whether their expectations are met through the care they receive. (Berg et al., 2017, p. 986)

### 4.1.1. Care

The case study by Abdulcadir et al. shows that by providing multidisciplinary care including experts in gynaecology, obstetrics, paediatrics, forensic science, violence against women, medical anthropology, law, sexual therapy, psychiatry and psychology, and clitoral reconstruction, positive outcomes were achieved. By providing information and sexual therapy over a period of 18 months, 6 out of 11 women did not need surgery anymore as the education was sufficient (Abdulcadir et al., 2015b, p. 280). This observation of women opting out of surgical reconstruction after receiving multidisciplinary counselling is also made by Berg et al. (2017). The women who underwent clitoral reconstruction reported improvement with respect to pain, sexual function, self-body image and gender after having had clitoral reconstruction (Abdulcadir et al., 2015b). According to Abdulcadir et al. (2015), the reason for undergoing surgery is often associated with the feeling that the women regain back what was taken from them.

It should be noted that the systematic review states that there is still insufficient evidence about the success of non-surgical interventions for women with FGM/C. As a result, there is not ample evidence whether multidisciplinary treatment should be offered to every woman with FGM/C instead of, before or combined with surgical reconstruction (Berg et al., 2017). There are a number of additional factors which have to be considered, when it comes to health education in society. The Norwegian qualitative study for example mentions different sexual concerns with regard to why some women and men resist medicalized defibulation. “First, penile defibulation was considered important for men to prove their *virility* and masculinity; second, full defibulation threatened to create a large vaginal orifice that was regarded as an obstacle to male sexual pleasure” (Johansen, 2017, p. 6). The second stated reason is that defibulation undermines the prove of virginity from the women. In that context,

Johansen (2017) shows how important medical counselling and preventive interventions are.

### 4.1.2. Healthcare Professionals

In several sources, the researchers point out the lack of training of healthcare professionals as part of the issue, such as lack of knowledge about guidelines, surgical interventions, management and prevention and lack of education regarding female genitalia and female genital mutilation/cutting. Ugarte-Gurrutxaga et al. (2020) state that there is a lack of training regarding FGM/C among healthcare professionals. The interviewees report this deficiency not only during the academic education but also when joining the workforce. A midwife interviewed in the study by Ugarte-Gurrutxaga et al. (2020) said in this context:

> Personally, I think that we midwives are lacking training in this sense, in this specific issue… [...] (laughs gently) we have loads of training, but there's a lack of knowledge about this… to the extent that we don't know if it's frequent or not, how frequent it is, whether there are… prevention programmes (emphasising), if there's a moment when we can act, if… how we have to deal with it; I've already seen myself at the moment of childbirth when you discover there's a mutilation… If there's any way we can intervene… there's a lack of knowledge, I think, where… we don't know what to do (9:39 E2). (p. 8)

In addition, the researchers note that other countries which are confronted with FGM/C reveal the same results. According to the WHO, healthcare professionals in different countries are often unaware of the negative health risks occurring with FGM/C (Stein et al., 2016b). The Swiss recommendations for doctors and midwives affirm this observation and underline that FGM/C should be part of the medical education for midwives, nurses and doctors, since FGM/C has many health consequences (Amman et al., 2013, p.12). As there is this lack of knowledge, women at risk of FGM/C as well as mutilated/cut women are overlooked, which in turn impedes the prevention of the procedure.

Berg et al. (2017) describe that in France, only a handful of surgeons are trained in clitoral reconstruction technique and that less than 10 doctors perform the surgery. According to this, Ugarte-Gurrutxaga et al., (2020) state:

> Related training should provide skills regarding how to control the twofold discomfort produced when providing care: that of the women (due to the

> “stigma”, matters related to sexism, cultural differences and customs) and that experienced by the person treating them (such as the fact that it is “a delicate topic”, which is uncomfortable and difficult to deal with, with psychological repercussions for the professional, among other aspects). (p. 11)

Due to the lack of training, healthcare professionals mention discomfort and lack of confidence, which leads to the dilemma whether to talk to women about FGM/C or not (Ugarte-Gurrutxaga et al., 2020a). The Swiss recommendations state that healthcare providers should not hesitate addressing women with FGM/C but treat it with sensibility. Furthermore, one has to be cognizant of the fact that some women do not know the anatomy of the female genitalia (Amman et al., 2013, p.8–9).

### 4.1.3. Costs

According to Johansen (2017), medicalized defibulation is offered as part of public health in Norway, therefore the costs at approximately 34 Euro are low.
Berg et al. (2017) indicates that besides the other two surgical interventions, clitoral reconstruction is considered inaccessible for most women, as the high costs and limited provision can be an obstacle. Reconstructive surgery is not covered financially by the healthcare system in most of the developed and in all developing countries as it is seen as cosmetic surgery and therefore not a basic need (Berg et al., 2017). However, Berg et al. (2015) state that the clitoral reconstruction in France: “…is considered a therapeutic procedure and the cost is covered by the national health care system” (p. 985). In their research about clitoral reconstruction, Abdulcadir et al. (2015) do not refer to the financial aspects.

## 4.2 Limitations of the Studies

In this subchapter, the authors of the bachelor thesis point out some limitations of the chosen literature regarding the answering of the research question. The qualitative study by Johansen (2017) has no clearly stated limitations but concludes “As these values remain strong, they limit the acceptance of medicalized defibulation…” (p. 10). However, Johansen (2017) does not state any concrete numbers concerning the low acceptance among Somali and Sudanese migrants.
The systematic review by Berg et al. (2017) does not include many studies concerning the satisfaction of women with FGM/C who underwent surgery. This limitation is relevant to the bachelor thesis, since the objective is to analyse how satisfactory current surgical interventions for women with FGM/C are.

Additionally, the systematic review has another relevant restriction. While the review was being compiled, new studies were being published regularly so that the systematic review might have missed some of them. This fact is meaningful because the findings do not include all of the most recent data, even though 71 studies were included in the systematic review. While the case study by Abdulcadir et al. (2015) analyses the satisfaction of women with FGM/C after having had clitoral reconstruction, the research is not representative in a global context as the two women live in a setting where Western mentality and values are prevalent. Another obvious limitation is the sample size of two participants. However, the concept of the case study gives relevant insights about the satisfaction of the two women after having had clitoral reconstruction. This outcome leads to the assumption that clitoral reconstruction might be a positive option for women with FGM/C. Therefore, the detailed evaluation of the case study is significant to the research question of the bachelor thesis. The research in the Spanish qualitative study by Ugarte-Gurrutxaga et al. (2020) has a sample size of 43 healthcare professionals. Even though it is stated that their aim is not quantity of data but quality, it is not expressed whether the collected data is adequate. Despite this fact, the study results are appropriate for the research question, since healthcare professionals from different fields, including midwives, are stating what would facilitate treatment for women with FGM/C in their experience.

## 4.3 Answering of the Research Question

The chosen studies and literatures show that in order to answer the research question: *A) How successful are the most common types of surgical interventions for FGM/C available in industrialized countries and B) which factors influence whether the results are considered satisfactory by the women receiving them?*, various aspects need to be considered.

A) Three different surgical interventions have been referred to different sources and researched more closely, namely: defibulation, cyst removal and repair, and clitoral reconstruction. As stated in subchapter 4.1. Research Results, Berg et al. (2017) conclude that an approximate range of 50-100% of the women who experience defibulation are pleased with the result. The majority of women with FGM/C undergoing clitoral reconstruction expressed satisfaction with the outcome. However,

it has to be considered that there are women who are not pleased after surgical interventions for different reasons.
Depending on what the main goal for women is, different surgical interventions could help to achieve this goal. Berg et al. (2017) state that women wanting to recover sexuality and getting their identity back are more likely to decide for clitoral reconstruction. On the contrary, women seeking to improve sexual pleasure, vaginal functioning and appearance, could have their needs met through defibulation. It is therefore important to provide complete information on the various possibilities so that women can make an informed decision.

B) Several sources state that good care by a multidisciplinary team, before and after surgery, should always be offered. The research of Abdulcadir et al. (2015) shows a new highly relevant perspective of treatment for women who suffer from the consequences of FGM/C. It can be observed that information and sexual therapy are often sufficient to improve a woman's relation to her own sexuality. As a result of that, more than half of the women opt out of surgery, which can be seen as a leading factor for the coming times since it is not an invasive therapy method and might be cost-efficient.
To provide adequate training, there is a need to more thoroughly inform healthcare professionals about female sexuality in general and the anatomy of female genitalia. As stated in the theoretical background subchapter 2.1. Female Genitalia, Jasmine Abdulcadir emphasizes the importance of accurate education on female genitalia as well as the correct appearance of the clitoris in biology books. This knowledge is essential for healthcare professionals in order to explain it to women with FGM/C and to treat them as well as possible. Abdulcadir et al. (2015) stated that the two women of the case report thought that the exposed clitoris was much bigger like a small penis in its natural state. Johansen (2017) also shows that female and male informants thought that infibulation ensures vaginal tightness, which is considered important for male sexual pleasure. To help change these cultural values, it is significant to address the issue and to clarify wrong perceptions.

# 5. Theory Practice Transfer

This chapter is focusing on the theory practice transfer. In addition to that, it will elaborate on recommendations for midwives when taking care of women with

FGM/C. For that reason, this will be discussed in more detail, and recommendations for the practice as midwife when treating women with FGM/C will be provided. These recommendations are based on what the authors have learned from different sources and the expert interviews with two doctors from different countries. Through this chapter, the authors of this study want to spread more awareness to their midwife colleagues concerning FGM/C and indicate ways how therapy possibilities can be successful.

Through the study from Ugarte-Gurrutxaga et al. (2020) and other sources, the authors of the thesis noticed the importance of education in order to recognize FGM/C and the classification of the type. The midwife should be aware of guidelines and/or recommendations where the midwife can find these and use them when taking care of women with FGM/C. Education and the knowledge of guidelines and/or recommendations can help when addressing women about their FGM/C condition and prevent stigmatisation.
While addressing vaginal birth with FGM/C, conditions in which vaginal birth can be considered and risks that can occur, for example increased bleeding, prolonged labour and others, need to be mentioned. Midwives need to know that FGM/C is not an indication for a caesarean section. The Swiss gynaecologist the authors interviewed stated that it is important to consider the fact that wound care after vaginal birth through stitching can lead to traumatisation by giving flashbacks to the moment of the procedure of FGM/C. Therefore, midwives and other healthcare professionals should inform women with FGM/C that vaginal tissue can tear and might need stitches in order to heal adequately. If it comes to traumatisation, the midwife should know where women can get psychological care. Since FGM/C is a delicate topic, the midwife should take time to explain the information around FGM/C and the resulting health consequences as well as the legal situation depending on the country. If there is a language barrier, an interpreter should be organized by the hospital or the woman. The translator has to be a neutral person to guarantee that the information provided by the healthcare providers is transmitted correctly in the best interest of the woman. When taking care of a woman from a country where FGM/C is common, FGM/C has to be addressed as soon as possible. Therefore, communication should be unbiased, and the caregiver’s personal attitude should be neutral. The interviewed gynaecologist recommends visualizing the mutilation/cut

with a mirror so that the women understand what their vulva looks like. According to her, a model of an intact female genitalia can be displayed and explained simultaneously. In addition to that, the midwife should explain the changes that will occur to the woman prior to a defibulation, for example that urine as well as the menstruation blood will be discharged in a flow and not in drops.
As mentioned previously, there are many myths and taboos about FGM/C. Therefore, midwives have an excellent opportunity to correct misinformation and myths through open conversation with the women in their care. This enables the women to make informed decisions about whether surgical interventions should be performed or not. Moreover, by breaking the taboos, prevention of further female genital mutilations/cuttings is provided as informed women and men might not want mutilate/cut their daughters.

The Kenyan interviewee explains that the focus on the medicalization of FGM/C differentiates from the focus in Switzerland. In Kenya, the focus is primarily on health consequences and on counseling rather than medical surgeries. As recommendation for midwives, the Kenyan doctor advises: “They should acquire advanced knowledge through seminars, workshops etc.” (see Appendix C).

## 6. Conclusion

Surgical interventions convey a lot of chances for women with FGM/C. In Western countries, three reparative interventions are practiced: defibulation, clitoral reconstruction, and cyst removal. As the study by Berg et al. (2017) demonstrates, the majority of women with FGM/C are satisfied with the results of the surgical interventions. Nevertheless, there are women who do not like the new appearance of the reconstructed external female genitalia. Women with FGM/C have different motives for choosing an intervention depending on the issues they are dealing with. For example, a woman struggling with her female identity because of mutilation/cutting can obtain great benefit out of clitoral reconstruction. On the other hand, a pregnant woman might want to consider surgical defibulation to reduce the risks of complications during vaginal delivery. It is important to inform the women that surgical interventions can help but do not erase what they experienced. Therefore, sexual therapy, physiotherapy and psychotherapy should be included in the treatment when seeking an intervention. Additionally, information about the anatomy

and physiology of uncircumcised female genitalia and sexuality should be provided. As Abdulcadir et al. (2015) and Berg et al. (2017) show in their studies, when administering such an extensive treatment, some women do not desire a surgical reconstruction anymore. However, as mentioned in subchapter 1.1. Description of the Problem, there are still many culturally ingrained misconceptions or myths about women with FGM/C. In this context, in her TEDx Talk from 2019, Jasmin Abdulcadir stated:

> But before we do surgery, we have to counter myths. Before we do defibulation we have to counter myths around the opened vulva or closed vulva. If we don't do this, women will refuse treatment, even when they suffer from very severe complications. (11:18–11:37)

The research of Johansen (2017) about virility and pleasure and female genital mutilation/cutting concluded that the influence of social norms and cultural values must be targeted in order to change the negative attitudes towards surgical interventions.

Midwives have the possibility to provide women with FGM/C evidence-based information and therefore ensure that they can make an informed decision when it comes to surgical intervention. As the results show, the majority of women with FGM/C after undergoing surgical interventions, such as defibulation, cyst removal and clitoral reconstruction, are satisfied with the outcome.

## 6.1. Limitations of the Bachelor Thesis

Even though the research about women with FGM/C in Western countries is ongoing, there is still little research into the success of medicalized therapy for women with FGM/C. In addition to that, only a few studies refer to midwives' perspectives on this issue. However, it is not often clearly stated whether midwives are included in the term healthcare professionals.

As a matter of fact, the official guidelines regarding FGM/C have had the same content for about the last 15 years, meaning that no new significant findings have been added to them since 2005. Indeed, the authors of this bachelor thesis have realized that even in the most recent studies about the topic, the same old sources are used. Another limitation is that there are considerably more qualitative than quantitative studies. The authors estimate that it is much easier to find participants for qualitative studies about FGM/C and surgical interventions than to find a high

number of women with FGM/C who are willing to participate in a quantitative survey. As a result of this, there is still not much data about the evaluation of women with FGM/C that underwent a medicalized intervention. The authors therefore suggest that further research on how and which therapy possibilities prove successful for women with FGM/C should be conducted.

## 6.2. Outlook into the Future

The authors of this bachelor thesis notice that for surgical interventions for women with FGM/C to succeed, different aspects need to be considered.
Healthcare professionals need to be more extensively educated and trained on FGM/C and the respective health consequences so that they can provide appropriate care to women with FGM/C. Especially midwives need to be able to recognize when a woman has experienced FGM/C and discuss the procedure for vaginal birth with her.
The WHO currently states that some types of FGM/C include a total removal of the clitoris, which is inaccurate (Stein et al., 2016b). Therefore, the worldwide guideline is not sufficiently precise and contributes to misinformation. In order to offer accurate education, guidelines need to be revised based on the latest evidence. These guidelines can then be used as a *code of practice*.

Another aspect that requires improvement in the future is the multidisciplinary connection in the healthcare sectors when it comes to FGM/C. For example, that midwives should inform the paediatricians when a woman with FGM/C gave birth to a female new-born. Thus, paediatricians can raise awareness of the legal situation in the respective country and possibly prevent the girl from being mutilated/cut.
Furthermore, the authors realized that there is need to do more research into the satisfaction of women with FGM/C who underwent a surgical intervention. This might ameliorate the care for women who suffer from FGM/C consequences. Moreover, the health condition of women with FGM/C might improve and accordingly have a positive impact on cultural values.

In the last couple of years, a lot of attentiveness to FGM/C has been paid on media. Only in March 2021, a video about a testimonial of a woman who went through FGM/C was published by Watson, a Swiss journal (Bloch, n.d.). It would be

interesting to examine the role of media when it comes to raising awareness of the issue and changing the attitudes of future generations.

As Khadija Gbla who underwent FGM/C, said during a TEDx Talk in 2014: “It’s not an African problem. It’s not a Middle Eastern problem. It’s not white, it’s not black, it has no color, it’s everybody’s problem” (16:19–16:26).

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## List of Figures



## List of Tables



## List of Abbreviations

| | |
|---|---|
| DGGG | Deutsche Gesellschaft für Gynäkologie und Geburtshilfe (German Society for Gynaecolgy and Obstetrics) |
| FGM/C | Female Genital Mutilation/ Cutting |
| HIV | Human Immunodeficiency Virus |
| MRI | Magnetic Resonance Imaging |
| StGB | Schweizerisches Strafgesetzbuch (Swiss criminal code) |
| UN | United Nations |
| WHO | World Health Organization |

## Number of Words

Abstract: 185

(without the keywords)

Number of Words: 10286

(excluding the two front pages, the abstract, the tables and their labels, the figures and their labels, the bibliography, the acknowledgement and the appendix)

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Thank you!

## Declaration of Originality

Luna Macher and Milena Raoult hereby assure that the following thesis has been written independently and without someone else's help. All the sources that have been used in the thesis are listed in the bibliography.

If the bachelor thesis or parts of it should be published, it is ensured that the published piece is referred to as a bachelor thesis written by two students of the ZHAW School of Health Professions.

Location, date: Zurich, 30th of April 2021

Signature Macher Luna:

Location, date: Zurich, 30th of April 2021

Signature Raoult Milena:

# Appendix

## Appendix A: Critical Appraisal by Letts and Law

Critical Review Form - Qualitative Studies (Version 2.0)
**© Letts, L., Wilkins, S., Law, M., Stewart, D., Bosch, J., & Westmorland, M., 2007**
**McMaster University**

**CITATION:**

Ugarte-Gurrutxaga, M. I., Molina-Gallego, B., Mordillo-Mateos, L., Gómez-Cantarino, S., Solano-Ruiz, M. C., & Melgar de Corral, G. (2020a). Facilitating Factors of Professional Health Practice Regarding Female Genital Mutilation: A Qualitative Study. *International Journal of Environmental Research and Public Health*, *17*(21), 8244. https://doi.org/10.3390/ijerph17218244

| | **Comments** |
|---|---|
| **STUDY PURPOSE:**<br><br>Was the purpose and/or research question stated clearly?<br>❁ yes<br>❁ no | Outline the purpose of the study and/or research question.<br><br>The purpose of the study is to analyze facilitating factors in prevention and action for healthcare providers when faced with female genital mutilation (Ugarte-Gurrutxaga et al., 2020b, p. 2). |
| **LITERATURE:**<br><br>Was relevant background literature reviewed?<br>❁ yes<br>❁ no | Describe the justification of the need for this study. Was it clear and compelling?<br><br>Women with FGM/C have reported negative experiences with the provision of healthcare providers. Due to a lack of cultural skills and structural adaptations by the healthcare system, women felt discriminated and vulnerable. This issue justifies the purpose of the study (Ugarte-Gurrutxaga et al., 2020, S. 2). |

| | |
|---|---|
| | How does the study apply to your practice and/or to your research question? Is it worth continuing this review?[2]<br><br>Yes, it is worth continuing the review of the selected study. The results show that it is necessary to adapt the healthcare system in order to facilitate treatment and prevention of FGM/C (Ugarte-Gurrutxaga et al., 2020, S. 2).<br>It is important to clearify women as soon as possible in order to achieve a successful treatment. Moreover prevention for girls can be given with social education and prevention services (Ugarte-Gurrutxaga et al., 2020, p.11). |
| **STUDY DESIGN:**<br><br>What was the design?<br>❀ phenomenology<br>❀ ethnography<br>❀ grounded theory<br>❀ participatory action research<br>❀ other<br>_____ | Was the design appropriate for the study question? (i.e., rationale) Explain.<br><br>It is a qualitative study which used the phenomenological design as they conduct semi-structured in-depth interviews.<br>This approach is appropriate, because with this design it is possible to understand and describe the meaning and essence of experiences. It is exactly the aim of the study, since the experiences of healthcare professionals were analyzed in order to improve and facilitate treatment. |

| | |
|---|---|
| Was a theoretical perspective identified?<br>❀ yes<br>❀ no | Describe the theoretical or philosophical perspective for this study e.g., researcher's perspective.<br><br>A qualitative methodological perspective is included to learn about discourses, opinions and underlying ideas. The |

[2] When doing critical reviews, there are strategic points in the process at which you may decide the research is not applicable to your practice and question. You may decide then that it is not worthwhile to continue with the review.

| | |
|---|---|
| | perspective contained everything that was said and how it was said. (Ugarte-Gurrutxaga et al., 2020, p.3) |
| Method(s) used:<br>❁ participant observation<br>❁ interviews<br>❁ document review<br>❁ focus groups<br>❁ other: discussion groups | Describe the method(s) used to answer the research question. Are the methods congruent with the philosophical underpinnings and purpose?<br><br>The used methods were 20 semi-structured in-depth interviews which were carried out by telephone (duration sixty minutes) and<br>three discussion groups, in which 43 healthcare professionals with various profiles participated. The discussion groups were held in person at the participants work center. |
| **SAMPLING:**<br><br>Was the process of purposeful selection described?<br>❁ yes<br>❁ no | Describe sampling methods used. Was the sampling method appropriate to the study purpose or research question?<br><br>The sampling method is not properly described since it is only mentioned what professional profile and sex the participants have. It is not mentioned how the participants have been selected and for what purpose. Therefore, the origin of the sampling is not traceable.<br>It cannot be said whether the sampling method was appropriate as the study does not show how the sampling was conducted. |
| Was sampling done until redundancy in data was reached?[3]<br>❁ yes<br>❁ no<br>❁ not addressed | Are the participants described in adequate detail? How is the sample applicable to your practice or research question? Is it worth continuing?<br><br>Yes, 43 healthcare professionals participated, both from primary care and hospital care, such as nurses, midwives, |

[3] Throughout the form, "no" means the authors explicitly state reasons for not doing it; "not addressed" should be ticked if there is no mention of the issue.

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| | family medicine, paediatrics and obstetrics-gynaecology (Ugarte-Gurrutxaga et al., 2020, p.4). The sampling can be seen in Table 2 page three.<br>As it is a qualitative study the sampling size is adequate, however it is not said whether enough data has been collected or not. |
| Was informed consent obtained?<br>❀ yes<br>❀ no<br>❀ not addressed | A signed informed consent for the interviewee was sent by e-mail (Ugarte-Gurrutxaga et al., 2020, p.2).<br>Before starting the interview and the discussion groups the participants were informed that it was possible to withdraw from the study at any time (Ugarte-Gurrutxaga et al., 2020, p.5). |
| **DATA COLLECTION:**<br><br>**Descriptive Clarity**<br>Clear & complete description of site:<br>{ yes { no<br>participants:<br>{ yes { no<br><br>Role of researcher & relationship with participants:<br>{ yes { no<br>Identification of assumptions and biases of researcher:<br>{ yes { no | Describe the context of the study. Was it sufficient for understanding of the "whole" picture?<br><br>Table 2 gives detailed information about the number of participating women and men including their professional profiles. Also, it is understandable from what field of work they come from (primary sector or hospital) (Ugarte-Gurrutxaga et al., 2020, p.4).<br>The researcher provided information about the study and its goals. The researcher did a transcription of the records, (interviews and discussions) along with the records of the non-verbal information collected by observers (Ugarte-Gurrutxaga et al., 2020, p.4).<br>The gathering of the data in conjunction with the analysis such as the used instruments, is clearly mentioned. The answers of the interviews are presented.<br><br>What was missing and how does that influence your understanding of the research?<br>The site of the interviews and group discussions is not explicitly stated. |

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| **Procedural Rigour**<br>Procedural rigor was used in data collection strategies?<br>❀ yes<br>❀ no<br>❀ not addressed | Do the researchers provide adequate information about data collection procedures e.g., gaining access to the site, field notes, training data gatherers? Describe any flexibility in the design & data collection methods.<br><br>The procedure of data collection is described in detail. Even the contents, the script of the interviews and the discussion groups are presented. |
| **DATA ANALYSES:**<br><br>**Analytical Rigour**<br>Data analyses were inductive?<br>{ yes { no { not addressed<br><br>Findings were consistent with & reflective of data? { yes { no | Describe method(s) of data analysis. Were the methods appropriate? What were the findings?<br><br>The information has been read and encoded with an Atlas-Ti programm. As a result, main dimensions were identified, and the most relevant aspects were distinct. The emerged categories are related to the objectives of the study.<br>The encoding and the categorization were verified by all members of the research team and by an external reviewer with experience (Ugarte-Gurrutxaga et al., 2020a, p. 4).<br>The various categories are distinguished and allocated with quotes. |
| **Auditability**<br>Decision trail developed?<br>❀ yes { no { not addressed<br><br>Process of analyzing the data was described adequately?<br>❀ yes { no { not addressed | Describe the decisions of the researcher re: transformation of data to codes/themes. Outline the rationale given for development of themes.<br><br>The decision trail is auditable, since the information about participants and the contents of the questions (interview/discussion group) is provided.<br>The results show the obtained information of the participants which leads to the conclusion. |

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| **Theoretical Connections**<br>Did a meaningful picture of the phenomenon under study emerge?<br>֍ yes<br>֍ no | How were concepts under study clarified & refined, and relationships made clear? Describe any conceptual frameworks that emerged.<br><br>The study refers to previous studies which have found similar results and are in concordance with each other (Ugarte-Gurrutxaga et al., 2020, p.10).<br>They all mention a lack of cultural skills training for healthcare professionals and the awareness of protocols relating to the subject. Moreover, the discomfort with FGM/C leads to the consequences that identifications of cases at risk of FGM/C, the identification of women who have already been mutilated and the prevention of FGM/C among daughters of these women are limited. |
| **OVERALL RIGOUR**<br>Was there evidence of the four components of trustworthiness?<br>Credibility<br>{ yes { no<br>Transferability<br>{ yes { no<br>Dependability<br>{ yes { no<br>Confirmability<br>{ yes { no | For each of the components of trustworthiness, identify what the researcher used to ensure each.<br><br>• Credibility: is given, as the results show similar aspects as previous studies.<br>• Transferability: various profession profiles are covered and previous studies have shown similar findings(Ugarte-Gurrutxaga et al., 2020b).<br>• Dependability: the analysis and method of the study are transparent therefore the results are plausible.<br>• Confirmability: among the researcher team a consent was achieved. Moreover, an external reviewer with experience verified the data in coding process, interpretation and categorization (Ugarte-Gurrutxaga et al., 2020, p.4)<br><br>What meaning and relevance does this study have for your practice or research question? |

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| | As the study is considerably recent, (published in 2020) the bottom line proves that during the last couple of years there was little development regarding the provision for women with FGM/C. This is meaningful and relevant for the healthcare section, and the research question. |
| **CONCLUSIONS & IMPLICATIONS**<br><br>Conclusions were appropriate given the study findings?<br>❁ yes { no<br><br>The findings contributed to theory development & future OT practice/ research?<br>❁ yes { no | What did the study conclude? What were the implications of the findings for occupational therapy (practice & research)? What were the main limitations in the study?<br><br>The study demonstrates the importance of guidelines that can be used at any time and are available for everybody that is confronted with the issue. Additionally, it is important to educate healthcare providers not to stigmatize and to address women directly instead of feeling uncomfortable and not providing the appropriate care (Ugarte-Gurrutxaga et al., 2020, p.11).<br>An important aspect is that midwives were part of the study. By that they informed about their skills, knowledge and lack of information concerning FGM/C.<br>The main limitation of the study is that the site is not clearly stated.<br>An aspect which is missing is that no school nurse was involved who could have had important impacts regarding prevention through education. |

# Critical Review Form – Qualitative Studies (Version 2.0)



**McMaster University**

**CITATION:**

Johansen, R. E. B. (2017). Virility, pleasure and female genital mutilation/cutting. A qualitative study of perceptions and experiences of medicalized defibulation among Somali and Sudanese migrants in Norway. *Reproductive Health*, *14*(25). https://doi.org/10.1186/s12978-017-0287-4

| | **Comments** |
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| **STUDY PURPOSE:**<br><br>Was the purpose and/or research question stated clearly?<br>❀ yes<br>❀ no | Outline the purpose of the study and/or research question.<br><br>Even though there is not a specific chapter indicating the aim of the study several times it was mentioned. The study focuses on how Sudanese and Somali migrants in Norway refer to medicalized defibulation (Johansen, 2017, p. 2). Furthermore to explore the factors that encourage and hinder them (Johansen, 2017, p. 4). |
| **LITERATURE:**<br><br>Was relevant background literature reviewed?<br>❀ yes<br>❀ no | Describe the justification of the need for this study. Was it clear and compelling?<br><br>The justification was clear as the researcher stated that a deeper confrontation with the issue can improve the understanding of health-seeking behavior from the affected population concerning medicalized defibulation (Johansen, 2017, p. 4). |

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| | How does the study apply to your practice and/or to your research question? Is it worth continuing this review?<br><br>The study gives an insight on the behavior among those who are affected. It might improve the knowledge of healthcare professionals concerning FGM/C, thereby adequate education/ information about medicalized defibulation can be provided.<br>It shows the benefits of surgical defibulation and helps to comprehend what it needs that the intervention can be more successful concerning the request. |
| **STUDY DESIGN:**<br><br>What was the design?<br>❁ phenomenology<br>❁ ethnography<br>❁ grounded theory<br>❁ participatory action research<br>❁ other_____ | Was the design appropriate for the study question? (i.e., rationale) Explain.<br><br>Yes, the approach is appropriate because it is a qualitative study and the aim is to find out the individual's lived experience in relation to defibulation. The researcher tries to build a theory through its study probably through a phenomenological approach. |

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| Was a theoretical perspective identified?<br>❁ yes<br>❁ no | Describe the theoretical or philosophical perspective for this study e.g., researcher's perspective.<br><br>The theoretical or philosophical perspective is not stated in the study. By assessing in-depth interviews with open questions it can be said that the researcher is trying to build a theory by the insight of the participants. Therefore, demonstrate why the medical intervention of surgical defibulation has not |

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| | proven successful yet among Somali and Sudanese migrants. |
| Method(s) used:<br>❁ participant observation<br>❁ interviews<br>❁ document review<br>❁ focus groups<br>❁ other<br>_____ | Describe the method(s) used to answer the research question. Are the methods congruent with the philosophical underpinnings and purpose?<br><br>In-depth interviews were conducted with Sudanese and Somali men (13) and women (23). Participant observations were conducted in several settings including homogenous and mixed groups (Johansen, 2017, p. 5). Various informal conversations and sessions took place where 30 to 40 supplementary men and women participated. At the end, two validation seminars with Sudanese and Somali men and women were carried out in two cities. |
| **SAMPLING:**<br><br>Was the process of purposeful selection described?<br>❁ yes<br>❁ no | Describe sampling methods used. Was the sampling method appropriate to the study purpose or research question?<br><br>According to Johansen (2017):<br>> Snowball sampling through different starting points was used to recruit 24 informants who had lived more than a year in Norway, and four key informants were recruited through the services in which they worked. In addition, eight newly arrived Somali quota refugees were included in the study. These refugees were recruited through the immigration authorities. (p.4)<br>Yes, the sampling method was appropriate because it is estimated that approximately nine thousand one hundred women and girls in Norway have undergone |

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| | infibulation pre-migration and are mostly of Somali and Sudanese origin. |
| Was sampling done until redundancy in data was reached?[4]<br>❀ yes<br>❀ no<br>❀ not addressed | Are the participants described in adequate detail? How is the sample applicable to your practice or research question? Is it worth continuing?<br><br>The study shows the gender, the country of origin, the age, length of stay in Norway and marital status of the 36 key informants (Johansen, 2017, p. 5). About the 30 to 40 additional men and women participating in the conversation and sessions, no information is provided.<br>The sampling is largely appropriate for the research question. Since also men could be important for the decision making concerning medicalized defibulation. |
| Was informed consent obtained?<br>❀ yes<br>❀ no<br>❀ not addressed | Ethical procedures were followed and informed consent in relevant languages was obtained from all participants (Johansen, 2017, p. 5). |
| **DATA COLLECTION:**<br><br>**Descriptive Clarity**<br>Clear & complete description of<br>site: { yes { no<br>participants: { yes { no | Describe the context of the study. Was it sufficient for understanding of the "whole" picture?<br><br>The role of the author/ researcher is explained extensively. She clarifies what relation she has to the African culture and that she has been studying FGM/C for almost 20 years (Johansen, 2017, p. 6). Further to this the role of the interpreter who assisted in interviews was also described in detail. In her explanation the researcher shows why there is no |

[4] Throughout the form, "no" means the authors explicitly state reasons for not doing it; "not addressed" should be ticked if there is no mention of the issue.

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| Role of researcher & relationship with participants:<br>{ yes { no<br>Identification of assumptions and biases of researcher:<br>{ yes { no | deliberate bias but how the appearance of the researcher along with the interpreter could possibly influence the key informants.<br><br>What was missing and how does that influence your understanding of the research?<br><br>There is no much information about the 30 to 40 additional men and women participating at the conversations. 30 public servants from various professions and with FGM/C experience were recruited but no additional information on how they were part of the research was given. It could be that they were doing the observations in the conversation groups but it is not stated. Apart from that data collection is described explicitly.<br>Through those information gaps it is not possible to comprehend completely their role in the study. |

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| **Procedural Rigour**<br>Procedural rigor was used in data collection strategies?<br>❀ yes<br>❀ no<br>❀ not addressed | Do the researchers provide adequate information about data collection procedures e.g., gaining access to the site, field notes, training data gatherers? Describe any flexibility in the design & data collection methods.<br><br>It is explained how the sampling was done, where the in-depth interviews took place, how the data was collected and analyzed. During the result chapter some of the participants responses are quoted. The researcher explains that to ensure anonymity information about the informants was kept to a minimum (Johansen, 2017, p. 5). |

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| **DATA ANALYSES:**<br><br>**Analytical Rigour**<br>Data analyses were inductive?<br>{ yes { no { not addressed<br><br>Findings were consistent with & reflective of data? { yes { no | Describe method(s) of data analysis. Were the methods appropriate? What were the findings?<br><br>Data was analyzed at the end of data collection while identifying recurrent themes and patterns as well as exceptions. The gathered data was coded by manual and electronic procedures with HyperResearch (Johansen, 2017, p. 6).<br><br>Even if the analyses is done rigorously it might have been appropriate to consider an extern expert to examine the data and to improve quality. |
| **Auditability**<br>Decision trail developed?<br>❀ yes { no { not addressed<br><br>Process of analyzing the data was described adequately?<br>❀ yes { no { not addressed | Describe the decisions of the researcher re: transformation of data to codes/themes. Outline the rationale given for development of themes.<br><br>As explained before the data was coded with HyperResearch. However, there is no concrete demonstration of the realization of the data. |
| **Theoretical Connections**<br>Did a meaningful picture of the phenomenon under study emerge?<br>❀ yes<br>❀ no | How were concepts under study clarified & refined, and relationships made clear? Describe any conceptual frameworks that emerged.<br><br>The researcher showed several patterns and differences that occurred in the analyses and pointed out that some results are congruent to other studies or theories. |

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| | "Therefore, the study explores a new avenue for understanding cultural change" (Johansen, 2017, p. 2). |
| **OVERALL RIGOUR**<br>Was there evidence of the four components of trustworthiness?<br>Credibility { yes { no<br>Transferability { yes { no<br>Dependability { yes { no<br>Comfirmability { yes { no | For each of the components of trustworthiness, identify what the researcher used to ensure each.<br><br>• Credibility: Is given even though it is quite a new field of research.<br>• Transferability: Infibulation is also practiced all over the world so the data can probably be transferred to not only Somali and Sudanese women in Norway. Virility of the man and virginity of the women might be a holistic issue in several countries practicing FGM/C and that is why the gathered information is transmittable.<br>• Dependability: The research process is demonstrated mostly rigorously and lucid.<br>• Confirmability: It cannot really be confirmed as there was no external review.<br><br>What meaning and relevance does this study have for your practice or research question?<br><br>Medicalized defibulation can be beneficial to minimize health risks. The results of the study visualize the maintaining influence of traditional defibulation, even if the surgical intervention is better for an infibulated woman. This is a significant finding for the healthcare sector in order to raise awareness of the benefits of medicalized defibulation and change cultural values. |

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| **CONCLUSIONS & IMPLICATIONS**<br><br>Conclusions were appropriate given the study findings?<br>۞ yes { no<br><br>The findings contributed to theory development & future OT practice/ research?<br>۞ yes { no | What did the study conclude? What were the implications of the findings for occupational therapy (practice & research)? What were the main limitations in the study?<br><br>The conclusion of the study is that most of Sudanese and Somali migrants suffer from the side effects of infibulation and traditional defibulation. There is still a reluctance regarding surgical defibulation due to the cultural values. In order to ensure adequate health for girls and women the cultural values must be addressed.<br><br>The main limitation of the study is that no own limitations were stated. However, Johansen does not state any concrete numbers concerning the low acceptance among Somali and Sudanese migrants. |

# Critical Review Form - Qualitative Studies (Version 2.0)


**McMaster University**

**CITATION:**

Abdulcadir, J., Rodriguez, M. I., Petignat, P., & Say, L. (2015a). Clitoral Reconstruction after Female Genital Mutilation/Cutting: Case Studies. *The Journal of Sexual Medicine*, *12*(1), 274–281. https://doi.org/10.1111/jsm.12737

| | **Comments** |
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| **STUDY PURPOSE:**<br><br>Was the purpose and/or research question stated clearly?<br>yes<br>no | Outline the purpose of the study and/or research question.<br><br>The purpose of this study is to present a specific multidisciplinary care and its clinical outcome after clitoral reconstruction performed at the Geneva University Hospital in Switzerland based on the cases of two African women (Abdulcadir et al., 2015a, p. 275). A further purpose is to research the link between clitoral neuromata and clitoral pain within the peri-clitoral fibrosis. |
| **LITERATURE:**<br><br>Was relevant background literature reviewed?<br>yes<br>no | Describe the justification of the need for this study. Was it clear and compelling?<br><br>There is not much evidence about the impact of all types of FGM/C on sexual function and chronic pain, in particular, the multidisciplinary range and the long-term follow-up after surgery. There has not been any research investigating the removed clitoral tissue and its relevance on the pain (Abdulcadir et al., 2015a, p. 275). |

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| | There is a need to conduct research in that field in order to be able to improve the treatment provided to women with FGM/C. |
| | How does the study apply to your practice and/or to your research question? Is it worth continuing this review?[5]<br><br>Yes, it is worth continuing this review because the case study shows that women who have undergone FGM/C can experience a clear improvement in their physical and mental well-being through surgical intervention. |
| **STUDY DESIGN:**<br><br>What was the design?<br>❀ phenomenology<br>❀ ethnography<br>❀ grounded theory<br>❀ participatory action research<br>❀ other<br>_____ | Was the design appropriate for the study question? (i.e., rationale) Explain.<br><br>As study design, two case studies were chosen with the purpose to develop a theory that could be applied to similar cases. This study design is time consuming, as the researchers goal is to expand their knowledge in a specific field of research and work, which is why often just a small number of participants are involved.<br>As the in-depth study focuses on a particular research topic, it can be classified as a phenomenological case study design.<br>However, it is not clearly mentioned what type of design the study has been referred to. |

[5] When doing critical reviews, there are strategic points in the process at which you may decide the research is not applicable to your practice and question. You may decide then that it is not worthwhile to continue with the review.

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| Was a theoretical perspective identified?<br>❁ yes<br>❁ no | Describe the theoretical or philosophical perspective for this study e.g., researcher's perspective.<br><br>As previously mentioned, the study does not exactly define what perspective was used. However, as there were only two participants and the results are limited to those two cases, it can be classified best as a phenomenological case study. |
| Method(s) used:<br>❁ participant observation<br>❁ interviews<br>❁ document review<br>❁ focus groups<br>❁ other<br>evaluation of the doctor's visits and consultations<br>_____ | Describe the method(s) used to answer the research question. Are the methods congruent with the philosophical underpinnings and purpose?<br><br>The psychosexual evaluation, therapy and surgery with a one year follow-up of the two cases was a good method to examine the issue more thoroughly. This multidisciplinary perspective can help in different areas to improve the understanding of the problem and be used for other similar cases. The study states that the two women were fully informed and describes the positive results the women experienced. However, it is not clearly stated how that information was supplied. In addition, it is not clearly revealed how and what kind of interviews were used. |
| **SAMPLING:**<br><br>Was the process of purposeful selection described?<br>❁ yes<br>❁ no | Describe sampling methods used. Was the sampling method appropriate to the study purpose or research question?<br><br>Only women with the types of FGM/C that involve the cutting of the clitoris were included. However, the exact reason for selecting those two women over other women who meet that criteria is not stated. This leads to the conclusion that the two participants were randomly selected. They must have been chosen from the patients |

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| | consulting the Geneva University Hospital for clitoral reconstruction after experiencing FGM/C. |
| Was sampling done until redundancy in data was reached?[6]<br>❁ yes<br>❁ no<br>❁ not addressed | Are the participants described in adequate detail? How is the sample applicable to your practice or research question? Is it worth continuing?<br><br>As there are only two participants, their background, their reasons for the surgery and what benefit of the surgical intervention they hope for is shown.<br>The sample is suitable for answering the research question in various ways. First of all, it describes a possible surgical intervention that can be done, and second, it also provides important information on the outcome from the perspective of the women. Therefore, this information is extremely useful considering our reason for conducting research into that specific issue. |
| Was informed consent obtained?<br>❁ yes<br>❁ no<br>❁ not addressed | Yes, both participants gave their informed consent before the study was published (Abdulcadir et al., 2015a, p. 280). |

[6] Throughout the form, "no" means the authors explicitly state reasons for not doing it; "not addressed" should be ticked if there is no mention of the issue.

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| **DATA COLLECTION:**<br><br>**Descriptive Clarity**<br>Clear & complete description of<br>site: { yes { no<br>participants: { yes { no<br><br>Role of researcher & relationship with participants:<br>{ {yes<br>{ { no<br><br>Identification of assumptions and biases of researcher:<br>{ {yes<br>{ { no | Describe the context of the study. Was it sufficient for understanding of the "whole" picture?<br><br>The site where research was conducted was the Geneva University Hospital, which is described at the beginning (Abdulcadir et al., 2015, p. 280).<br>Information about the participants is provided throughout the study which enables readers to understand their perspective and what kind of participants they are.<br>Although the relationship between participants and researcher is not mentioned, it can be assumed that the researcher was part of the multidisciplinary team as they are healthcare professionals as well.<br>The only bias mentioned, reveales that two of the authors are members of the WHO and that the conclusions do not necessarily represent those of the WHO (Abdulcadir et al., 2015a, p. 280).<br><br>What was missing and how does that influence your understanding of the research?<br><br>The study does not clearly mention how the participants were interviewed. However, the different treatments provided are described without supplying further information on how they took place, how many people talked to the women or how they collected all the information supplied by them. In a global context, the research is not representative as the women live in a context where Western mentality and values are present. |

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| **Procedural Rigour**<br>Procedural rigor was used in data collection strategies?<br>❀ yes<br>❀ no<br>❀ not addressed | Do the researchers provide adequate information about data collection procedures e.g., gaining access to the site, field notes, training data gatherers? Describe any flexibility in the design & data collection methods.<br><br>The data collection procedure is only mentioned by referring to three to four follow-up meetings. However, it does not really state how often healthcare professionals met the participants before surgery was performed except how much time the meetings took until they did the surgery. The data treatment process is not clearly described. |
| **DATA ANALYSES:**<br><br>**Analytical Rigour**<br>Data analyses were inductive?<br>{ yes { no { not addressed<br><br>Findings were consistent with & reflective of data?<br>{ yes { no | Describe method(s) of data analysis. Were the methods appropriate? What were the findings?<br><br>As mentioned in the procedural rigour, there is no specific method mentioned in the gathering of information. The information provided is that there are two case studies and what kind of procedure the participants underwent. As there are only two participants and the study admits that the results cannot be generalised, there is need for further studies in order to provide an evidence-based statement. |
| **Auditability**<br>Decision trail developed?<br>❀ yes { no { not addressed<br><br>Process of analyzing the data was described adequately? | Describe the decisions of the researcher re: transformation of data to codes/themes. Outline the rationale given for development of themes.<br><br>No information about data transformation is provided. |

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| ֍ yes { no { not addressed | |
| **Theoretical Connections**<br>Did a meaningful picture of the phenomenon under study emerge?<br>֍ yes<br>֍ no | How were concepts under study clarified & refined, and relationships made clear? Describe any conceptual frameworks that emerged.<br><br>Distinction to previous studies or case reports are made. No contrary perspectives are shown. Overall, reference is made to the lack of evidence in that area. |
| **OVERALL RIGOUR**<br>Was there evidence of the four components of trustworthiness?<br>Credibility { yes { no<br>Transferability { yes { no<br>Dependability { yes { no<br>Confirmability { yes { no | For each of the components of trustworthiness, identify what the researcher used to ensure each.<br><br>• Credibility: Data has been collected by revealing the experience of two women who have undergone FGM/C where the clitoris has been cut. Based on the conclusion that is provided at the end of the case study it is credible that the surgical intervention has a positive impact on women with FGM/C.<br>• Transferability: The research issue of the case study is clearly supplied. It is described in detail how the two women will be treated and which interventions will be performed in order to analyse the condition before and after the surgical intervention. This treatment procedure can be transferred to other industrialized countries with women seeking for clitoral reconstruction.<br>• Dependability: It is not clearly described how the process of research has been conducted. What is the reason for evaluating the condition after one year? Are two women sufficiently reliable? |

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| | • Confirmability: No, as it is not mentioned how data was transferred and collected.<br><br>What meaning and relevance does this study have for your practice or research question?<br><br>The conclusion of the case study is meaningful for the research because both the benefits of surgical intervention are described by the patients and new perspectives for better outcomes are discussed. In addition, the positive effects of multidisciplinary care is shown. |
| **CONCLUSIONS & IMPLICATIONS**<br><br>Conclusions were appropriate given the study findings?<br>❁ yes { no<br><br>The findings contributed to theory development & future OT practice/ research?<br>❁ yes { no | What did the study conclude? What were the implications of the findings for occupational therapy (practice & research)? What were the main limitations in the study?<br><br>The case study supplies a positive outcome in pain reduction and improved sexual function, self-body image, and gender after psychosexual therapy and clitoral reconstruction. Results of clitoral reconstruction indicate, for example: “At 1 year, she had complete disappearance of vulvar pain, pleasure with vulvar touch, and orgasm during sexual intercourse and masturbation.” (Abdulcadir et al., 2015b, p. 277). Additionally, the feeling of increased sexual desire, lubrication, vulvar pleasure and sensitiveness can be gained. Even improvement of self-body image could be verified after the procedure. The above-mentioned limitations were the female mutilation including clitoral cutting. |

## Appendix B: Critical Appraisal by CASP

CASP - Paper for appraisal and reference:

Berg, R. C., Taraldsen, S., Said, M. A., Krarup Sørbye, I., & Vangen, S. (2017). Reasons for and Experiences With Surgical Interventions for Female Genital Mutilation/Cutting (FGM/C): A Systematic Review. *The Journal of Sexual Medicine*, *14*(8), 14. https://doi.org/10.1016/j.jsxm.2017.05.016

Section A: Are the results of the review valid?

1. Did the review address a clearly focused question?

Yes Can't Tell No

There was no clear research question defined. The researchers aimed to identify and summarize research on the range of reparative interventions for women with FGM/C-related concern (Berg et al., 2017, p. 978).

2. Did the authors look for the right Type of papers?

Yes Can't Tell No

For the review the researchers followed the guidelines in the Cochrane Handbook for Systematic Reviews of Interventions. Design-specific checklists based on the user's guide framework were used. 132 full texts were assessed for eligibility and narrowed down to 71 studies. "There where two eligible conference abstracts and one book chapter and the rest were articles published in 45 different peer-reviewed journals" (Berg et al., 2017, p. 979). The majority were case reports and case series, but also qualitative studies were included.

Is it worth continuing?

3. Do you think all the important, relevant studies were included?

Yes Can't Tell No

Even though 71 studies between 1980 to 2016 were included of sixteen international databases, the researchers pointed out that one of their limitations was, that while assessing the review there were new studies published regularly. The systematic review might have missed some of the new studies (Berg et al., 2017, p. 986). To maximize the sensitivity no methodology search filters as well as no language delimiters were applied (Berg et al., 2017, p. 979). Studies in English, French, Dutch, German, Italian and Spanish were included. The literature search focused on a broad scope. “Little is known about whether women are satisfied with the surgery, and experiences appear mixed. Further research in this area of inquiry is needed” (Berg et al., 2017, p. 986).

4. Did the review’s authors do enough to assess quality of the included studies?

Yes Can’t Tell No

Screening and quality appraisal were independently undertaken by two researchers, with discrepancies resolved by re-examination of the study record and discussion. The two researchers confirmed the eligibility of the titles and abstracts and then the complete texts. Quantitative studies were assessed on their quality using the recommended design-specific checklists of the Cochrane Handbook. For qualitative studies an assessment tool, designed by the Critical appraisal Skill Programme, was used (Berg et al., 2017, p. 979).

5. If the results of the review have been combined, was it reasonable to do so?

Yes Can’t Tell No

The results that are similar were pointed out. If there had been deviations or other results the researchers would have noted it. The results were always referenced to the according study. Results are shown depending on the type of reparative intervention (defibulation or surgical separation of labia, surgery due to a cyst with or without some form of reconstruction and clitoral or clitoral labial reconstruction), motivation for seeking interventions and experiences with surgical interventions.

Section B: What are the results?

6. What are the overall results of the review?

“However, despite a rapidly expanding number of studies, methodologically valid investigations of reparative interventions for FGM/C-related problems are sparse” (Berg et al., 2017, p. 986). Of the three named intervention types the researcher found out that defibulation is the simplest and most accessible procedure. Whereas clitoral reconstruction is limited as it is expensive and there are not many trained surgeons. Some limitations and research gaps are shown. It is outlined that further research should be encouraged specially in countries were FGM/C is practiced (Berg et al., 2017, p. 985).

7. How precise are the results?

The results appear precise, as the researcher present numbers concerning the satisfaction of women with FGM/C after undergoing medical surgery. “Our findings also suggested that most women were satisfied with defibulation (overall satisfaction = 50-100%)” (Berg et al., 2017, p. 977). However, further research is needed to confirm the findings.

Section C: Will the results help locally?

8. Can the results be applied to the local population?

Yes Can’t Tell No

The population was put together of 7291 women, from infants to women in their seventies with any types of FGM/C (Berg et al., 2017, p. 980). 69% had FGM/C Type III. Even though FGM/C is not a traditional ritual in Switzerland, most of the studies included, were from Western countries. Thereby it can be applied to some of the local population. The review was done in Norway but studies all over the world were used, thus validates it for many settings. Table 2 shows 20 countries or settings where the studies took place (Berg et al., 2017, p. 983).

9. Were all important outcomes considered?

Yes Can’t Tell No

As the study also observed there are no studies concerning the effectiveness of non-surgical interventions for women with FGM/C-related problems (Berg et al., 2017, p. 986). This would have been an interesting point of view, as the study says that reconstructive surgery is quite expensive and therefore not available for everybody.

10. Are the benefits worth the harms and costs?

Yes Can't Tell No

Berg et al. (2017) quote:

> Currently, the Royal College of Obstetricians and Gynaecologists guideline on FGM/C recommends that "reconstruction should not be performed because current evidence suggests unacceptable complication rates without conclusive evidence of benefit" and calls for trials to examine its safety and effectiveness. (p.985)

There is need for further studies to evaluate and compare the different surgical, as well as non-surgical interventions in order to say if the benefits are worth the harms and costs.

## Appendix C: Transcription Expert Interview with Kenyan Doctor

1. How often do women with FGM/C contact you? And within what kind of situation does this happen?
- Annually. Since this is a cultural practice in the communities that I work with, it's inevitable to have women who have gone through FGM/C coming.

2. How do you inform these women about the circumcision and the therapy possibilities?
-Through outreaches, seminars and workshop, and mass media and social media platforms.

3. What should be looked out for when it comes to therapy for women with FGM/C?
-The timeframe over which they might have undergone the practice
-The extent of severity of the practice and injuries/or and infections.
-Any underlying medical conditions which may be life threatening e.g. sickle cell trait, anaemia, leukaemia, hepatitis A and B, HIV/AIDS etc.

4. Which problems do often occur during the care of women with FGM/C?
-Severe bleeding, (haemorrhage), infections, trauma and shock etc

5. How successful is defibulation as a medical intervention for these women?
-To a greater extent, some have been held to undergo defibulation successfully, anyway in some cases some victims have experienced complications such as difficulty in urination, dysmenorrhea, dyspareunia, apareunia etc

6. Are there other medical interventions that are used or that you are aware of?
-There is the use of herbal medicine, but to severe cases there have been need to seek clinical medication.

7. What other therapy possibilities are promising in addition to medical interventions?
-Counselling
-Bring these women together for team building.

-Engaging them in self-sustaining incoming generating projects etc.

8. How can female genital mutilation be a problem for pregnancy or birth?
-It has often led to complicated pregnancies leading to emergency caesarean sections, postpartum haemorrhage, prolonged maternal hospitalization due to the fear of unexpected complications etc

9. What are your experiences in collaboration with midwives regarding this problem?
-Occasionally I have witnessed foetal deaths due to maternal distress during labour, postpartum maternal death due to prolonged labour, postpartum haemorrhage, infections transfer etc.

10. What would you recommend midwives concerning the care of women with FGM/C?
-They should acquire advanced knowledge through seminars, workshops etc
-They should observe hygiene.

## Appendix D: Transcription Expert Interview with Swiss Gynaecologist

Interview partner: Mrs. Dr. Allen[7], a Swiss gynaecologist
Date: 28th of January 2021
Place: Zoom call
Interview duration: 16:30: - 17:05 (00:00:00 – 00:27:03)
I: Interviewee
A: Mrs. Dr. Allen

Mrs. Allen has given us the permission to record the interview. She has been informed that the record will be only used for the transcription of the interview and that no other person will have access to or hear the record. The person will be addressed anonymously in the transcribed interview as well as in the bachelor thesis. The interview is in Swiss German and is transcribed in German.

Interview situation: Due to the Covid pandemic, the authors do the interview with Mrs. Dr. Allen via Zoom Call. The interview is recorded by one of the authors' iPhone.

#00:00#
I: «GUT, also (.) ich möchte gerne mit der Frage beginnen, wie häufig nehmen Frauen mit genital/mit weiblicher Genitalverstümmelung Kontakt zu Ihnen auf? Oder in welchem Rahmen geschieht dies?»

#00:19#
A: « […] (seufzt), wie soll ich sagen, also (seufzt) wie häufig ist immer ein bisschen relativ […], es ist eigentlich wenig der Fall, dass eine Frau KOMMT […] und mit diesem Problem kommt. (.) also, dass eine Frau kommt und sagt ich bin/ich komme wegen meiner Beschneidung, das ist selten(..). Weil die meisten KOMMEN im Rahmen von einer Jahreskontrolle, oder was ganz häuf/was eigentlich ganz häufig ist, sie kommen im Rahmen der Schwangerschaft, also sie sind schwanger, (seufzt) und kommen dann zuerst mal zu einer Gynäkologin und dann […] wird es zum Thema oder auch nicht. Also es ist DANN wenig der Fall, dass die Frau das selbst

[7] Invented name in order to keep the privacy of the doctor

von sich aus anspricht, aber wenn man dann die Frau DARAUF anspricht, ein paar verharmlosen es, also für die ist das gar nicht so ein Thema und andere sind dann einfach […], sind dann schon so «aha da fragt mich mal jemanden zu dem Thema» und sagt dann schon «ja ich habe und doch und es nicht gut, ja».»

#01:34#
I: « Okay.»

#01:36#
A: « So ein bisschen in diesem (Stil?)  ja (..)»

#01:40#
I: « Danke.»

#01:42#
A: « Und es ist schon auch nicht so, dass es zum Beispiel, also was ich jetzt eigentlich eher auch gedacht hätte, dass vielleicht eine HAUSÄRZTIN sich dann an uns wendet (.) weil sie vielleicht eine Patientin hat mit dem Problem und sich Hausärztinnen natürlich noch weniger […] dann vielleicht mit dem Thema auskennen und durch das (..) ja noch eher noch sich meldet aber […]  das ist eigentlich nicht so der Fall ja.»

#02:13#
I: «[…] okay (seufzt) (.) und wie klären Sie dann die Frauen in Bezug auf die Beschneidung (.) auf und (über?) die möglichen Behandlungsformen?»

#02:24#
A: «[…] JA also dort geht es ein bisschen darum (.), also muss die Frau überhaupt darüber aufmerksam gemacht werden, dass da etwas ist wo man wahrnimmt oder wo auch mögliche Behandlungsformen sind. Frauen setzen dies manchmal dann auch nicht unbedingt […] so in Zusammenhang mit gewissen Beschwerden. (..) UND merken dann erst wenn man sie darauf anspricht, dass das ein Problem sein könnte und dort ist dann wirklich, also was (ganz?) GANZ VIEL der grosse Unterschied ist,

[…] sind beschnittene (unverständlich), ich weiss nicht kennt ihr euch mit den verschiedenen Typen der Beschneidung aus?»

#03:07#
I: « Ja»

#03:09#
A: «Also Typ eins, zwei und DREI und […] genau, Typ drei ist ja das […] wo die Frauen wieder zugenäht werden, also die […] die Frauen sagen selber, pharaonische Beschneidung. (..) oder […] dann genau Infibulation und das ist dann natürlich schon etwas wo die Frauen schon wirklich Beschwerden haben. Und was wir bei uns in der Zentralschweiz viele haben, das ist in anderen Regionen auch noch ein bisschen unterschiedlich, wir haben ganz viele Frauen aus Eritrea. Und Frauen aus Eritrea sind eher Typ EINS beschnitten oder vielleicht Typ zwei, also das heisst ihnen ist etwas weggeschnitten worden (seufzt) aber sie haben eigentlich die FUNKTION so. (.) und also die haben häufig keine BESCHWERDEN, wegen denen sie kommen oder ja. (..) genau […] (seufzt) genau und (unverständlich) und AUFKLÄREN […] also wie ich sie aufkläre ich […] wenn jetzt ich eine Frau aus einem Gebiet wo ich weiss (.) die könnte von Beschneidung betroffen SEIN, dann bereite ich mich eigentlich darauf vor, dass sie beschnitten sein könnte. Also […] ich weiss jetzt auch nicht von welchem Land wie viele betroffen sind und welche Typen, sondern, wenn ich jetzt vielleicht einen Namen habe wo mich ein bisschen erahnen lässt, dass sie aus einen ostafrikanischen Land kommen könnte, oder eben aus einem Land wo möglicherweise betroffen sein könnte (seufzt), dann würde ich mich vorher ein bisschen informieren und sobald ich weiss woher das sie kommt, dass ich mich kurz informiere, dass ich dann wie die Frau schon darauf ANSPRECHEN kann bevor ich sie untersuche. Und das ist für die Frauen eigentlich manchmal noch gut, dass ich dann […] einfach sage: “Ja ich sehe sie kommen aus SOMALIA, ich weiss in Somalia sind ganz viele Frauen von Beschneidung betroffen sind sie auch davon betroffen?“ So. Es ist […] manchmal häufig sprachlich nicht so ganz einfach aber wenn das irgendwie geht, dann würde ich das vorher ansprechen. Genau und dann kann ich beim Untersuch, manchmal ist es dann […] doch erst beim Untersuch, dann sagt man […]: «Ich sehe, Sie sind beschnitten worden als Kind. Wollen Sie es einmal anschauen?» und wenn sie bereit, ist dann gebe ich ihr einen Spiegel in die Hand,

dass sie selber schauen kann. (seufzt) und dann würde ich ihr dann auch anhand von einer Skizze (.) erklären was jetzt bei ihr anders ist, was bei ihr beschnitten worden ist , (.) was weggeschnitten worden ist und was noch vorhanden und so weiter. Genau ja und […] die möglichen Behandlungsformen, also bei einer infibulierten Frau […] bei einer Typ drei Beschneidung, dann würde ich schon ganz klar sagen, das kann man aufschneiden und das ist keine Sache und das können wir ambulant und in einer kurzen Operation machen. (seufzt) und dann […] gibt es vielleicht die, wo so (unverständlich) also eben jetzt bei einer […] sagen wir Typ eins oder zwei Beschneidung wo […] vielleicht die Vorhaut weggeschnitten ist und es dann einfach irgendwie ein HAUT/wieder Hautlappen über der Klitoris zugewachsen ist […] also in so einer Situation ist eigentlich die OP nicht das, wo man einer Frau anbietet. Es könnte schon sein, dass sie dann das Gefühl hat JA und eben und sowieso und die Beschneidung und es gefalle ihr nicht und sie wolle das wieder operieren und das nicht mehr so und dann muss man mal ein bisschen Tempo rausnehmen und sagen, das löst wahrscheinlich ihr PROBLEM NICHT. Also dort sind dann andere Aspekte WICHTIGER.»

#07:21#
I: « also und jetzt gerade in diesem Zusammenhang also auf was schaut man bei einer Behandlung von Frauen mit FGM also auf was sollte man BESONDERS Acht geben?»

#07:33#
A: « JA, was ist das Problem also hat sie (.) geht es ihr darum, dass sie aussehen will wie eine nicht beschnittene Frau? […] hat sie Schmerzen beim Sex? hat sie Probleme beim Wasser lösen? Hat sie Probleme (unverständlich) mit der Mens? Hat sie Schmerzen an DIESEM Ort wo sie beschnitten worden ist? Und anhand von dem muss man […] eine Therapie gestalten. Also häufig […] ist es dann […] auch so ein wenig|/die Sexualität ist sehr ein grosses Thema dann. Was aber auch wieder schwierig ist will die Frauen häufig selber nicht so gut den Zugang haben zu ihrer Sexualität, aber dann ist es eigentlich eher eine Herangehensweise über eine Sexualtherapie oder manchmal auch Physiotherapie. (..) So, dass sie […] ihren Beckenboden […] anfangen zu SPÜREN und anfangen wahrzunehmen und wo sind überhaupt welche Strukturen in meinem Beckenboden oder an meiner Vulva (seufzt)

aber es müssen dann natürlich Physiotherapeutinnen sein wo so ein wenig spezialisiert sind auf Vulva und auf Beckenboden (..) genau.»

#08:47#
I: «Super, danke. (.) Und was haben Sie so das Gefühl sind so die Probleme welche manchmal häufig auftauchen bei der BETREUNG von Frauen mit FGM und FGC?»

#09:02#
A: « […] also, es ist (unverständlich)/die offensichtlichen Probleme sind die sprachliche Barriere, also es ist […] manchmal schon ganz/es ist schon eher schwierig sich richtig ausdrücken zu können, dass die Frauen sich richtig ausdrücken können was jetzt ist. Meistens ist es ja dann die Sprache, eine interkulturelle Barriere, wo es dann nochmals schwieriger macht. Wenn du die Herangehensweise, die Sicht auf die Sexualität/auf die eigene Sexualität ist […] vielleicht von einer Frau aus Afrika viel schwieriger oder viel anders als bei uns. (.) und […] wenn dann noch mit der sprachlichen Barriere, dann ist es schon sehr schwierig sich dort anzunähern und zu fragen wo liegt dort das Problem, weil es ist ja nicht so, dass jede Frau die beschnitten ist man irgendwie etwas MACHEN muss. ALSO man kann durchaus das auch einfach wahrnehmen und sein lassen.»

#10:10#
I: « Mhm (..) und so mit der Sprache schaltet man dort dann manchmal wie noch jemanden mit ein, wo die Sprache spricht oder versucht man mit (unverständlich)»

#10:18#
A: « JAA (eigentlich?) (seufzt) idealerweise schon. Also ich habe ja […]  also genau ich bin jetzt eigentlich in der Privatpraxis und habe früher also als Angestellte im Kantonsspital gearbeitet. Das ist aber immer schwierig gewesen also es GIBT/von der Caritas gibt es interkulturelle Dolmetscherinnen welche […] ein bisschen auf diese Themen sensibilisiert werden, dass sie eben auch […]/so können sie ÜBERSETZEN. […]  genau und […]  zum Teil arbeiten wir auch mit denen zusammen, aber das ist […] immer eine Kostenfrage, weil das zahlt die behandelnde Ärztin das zahlt sonst niemand und das ist natürlich sehr teuer (..). Genau also dann ist es eigentlich ideal […] wenn jetzt die Patientin selbst jemanden hat der/die für sie

übersetzen KÖNNTE. Und das wäre ja schon/wobei man dort halt auch nicht wieder weiss, wie sind dann deren ihre Interessen oder ihre Meinungen, ihre Herangehensweisen. Genau.»

#11:23#
I: «Ja. […] (.) die nächste Frage wäre, inwiefern (unverständlich) bewährt sich Defibulation als medizinische Intervention?»

#11:33#
A: «Also das ist ganz klar zu befürworten. Also das IST eindeutig. Also ich glaube da gibt es nichts […] das dagegen spricht. (.) Weil es ist ja/Defibulation ist immer auch/man muss ja nicht […] eine Anatomie unbedingt wieder herstellen. Also man muss nicht […] die Klitoris jetzt unbedingt […] wieder hervorholen und ein schönes Präputium machen und so. Sondern es geht ja einfach darum, dass die normalen Funktionen möglich sind. Also ich habe auch schon (eine?) Patientin gehabt, die hatte eine überaktive Blase, die hatte […] Schmerzen, die Mens ist nicht richtig gelaufen und dann haben wir die defibuliert und die ist/die hatte ein neues Leben quasi also weil die kann normal pieseln und ihre Mens ist wieder normal. Das ist natürlich in einem Extremfall. Also das ist ja unterschiedlich wie stark ausgeprägt das ist. Und es muss auch durchaus nicht sein, dass man das eben bis zur Klitoris rauf eröffnet sondern man kann auch einfach die Urethra frei legen, den Introitus frei legen, genau. Und im Rahmen von Schwangerschaft und GEBURT ist das ja sehr wünschenswert.»

#12:52#
I: Ja. […] gibt es dazu noch weitere medizinische Interventionen, die sie anwenden oder kennen welche sich bewährt haben?»

#13:01#
A: « JA es gibt eben noch so, das habe ich jetzt selber […] nicht so Erfahrung damit, weil es so auch nicht/weil es noch so ein bisschen umstritten ist. Also es ist wohl schon GUT […], gute Ergebnisse ist dass man so eine Klitoris rekonstruiert (..)/hervorholt, weil es ist ja nicht/weil wenn man den Klitoriskopf […] beschneidet […] das ist ja nicht der einzige Punkt von der Klitoris, die Klitoris hat ja so zwei

Schenkel. Ich weiss nicht wie viel Sie über die Anatomie wissen und […] dort kann man schon das wie wieder hervorholen und das Präputium schaffen (..) ob das jetzt/das kann für gewisse Frauen wahrscheinlich wirklich SUPER sein aber es ist ja wahrscheinlich nicht das wo dann die Schmerzen beim Sex […] mindern oder […] ja eine bessere Sexualität gibt. Ja, sondern dort ist es dann wahrscheinlich eher/also schon so, Sexualtherapie oder Physiotherapie wo […] man mehr hervorholen kann. Und es ist ja wie, auch Defibulation, ZAGG ein Schnitt *blöd* gesagt, nichts Grossartiges und so eine Klitorisrekonstruktion das ist dann schon etwas wo dann auch eine längere […] postoperative […] also wie sagt man (lacht) also»

#14:36#
I: «Mhh ja Heilungsprozess (unverständlich).»

#15:37#
A: «Ja Heilungsprozess, genau. Und (unverständlich) Teile liegen dann offen und müssen dann sekundär heilen und so also das ist schon nicht so ganz OHNE.»

#14:47#
I: «Dementsprechend gibt es dann mit dieser Intervention auch mehr Risiken?»

#14:55#
A: « Ja, ja (..)»

#14:56#
I: «Okay und jetzt haben Sie das gerade schon ein bisschen angesprochen wegen weiteren Therapiemöglichkeiten, also so Sexualtherapie, das ist ja dann keine medizinische Intervention in dem Sinne?»

#15:08#
A: «Mhm.»

#15:09#
I: « Und Physiotherapie haben Sie gesagt. Gibt es da sonst noch etwas, irgendwie […] das man kennt und sich bewährt?»

#15:20#
A: « Nee (lacht) das ist glaube ich schon so ein bisschen das. (Seufzt), ja also Sexualtherapie, dann kommt dann natürlich auch noch Psychotherapie […] psychosexuelle Therapie. Also wir in Luzern […], also zum Beispiel durch die ELBE, das ist so eine Beratungsstelle bei Lebensfragen, die bietet psychosexuelle Therapie oder Beratung an und die beraten auch so Frauen (..) genau.»

#15:49#
I: «Okay, spannend (..) und jetzt natürlich für uns Hebammen auch spannend […] inwiefern ist so eine weibliche Beschneidung ein Problem für die Schwangerschaft und dann auch die Geburt?»

#16:07#
A: « JAA also grundsätzlich ist es kein PROBLEM aber DIESE Frauen sind häufig […] sehr empfindlich im Genitalbereich, im Vulvabereich also so vaginale Untersuchungen sind häufig schwierig […] und tolerieren es halt schlecht. Es ist aber nicht ein Grund für eine Sectio. Auch eine Infibulation ist kein Grund für eine Sectio. Es könnte/es kann sich […] vielleicht unter der Geburt die Austreibungsphase verzögern, einfach auch weil die Frau selbst auch Angst und Respekt hat. […] vor was da unten passiert. Es kann natürlich, unter Umständen im Bereich der Vulva, ziemlich narbiges Gewebe sein, was vielleicht noch zu schlimmeren Rissen führen könnte. Oder vielleicht auch zu vermehrter Blutung, zu schlechter Wundheilung, nachher wenn man bei Rissen hätte nähen müssen. Genau, das ist eigentlich so ein bisschen das und was halt sicher […] ich weiss nicht, ob das so zu dieser Frage gehört, […]  die Frage nach dem Kind wenn sie jetzt ein Mädchen gebiert also […] im Sinne einer Prävention.»

#17:27#
I: « Ja und gibt es in diesem Sinn nicht ein Ausmass von einer Infibulation wo also wo quasi der Scheideneingang ein bisschen so ist, dass man […] ein kleiner Schnitt machen müsste dass der kindliche Kopf durchkommt oder das Gesäss oder was auch immer?»

#17:45#

A: «Ja. (.) also Entschuldigung das WAS? Das der Kopf durchkommt?»

#17:49#
I: « JA (.) GENAU.»

#17:51#
A: « Ja das ist sicher so, dass man unter der Geburt aufschneiden muss. Und das ist was wir am Kantonsspital auch versucht haben […] die Leute zu sensibilisieren. Das wir Frauen sehen vor der Geburt […] weil ich glaube das ist manchmal ein Thema gerade zum Beispiel sagen wir es geht alles gut aber die Frau muss genäht werden, einfach weil sie einen banalen Dammriss hat […] dann kann das für die Frau halt schon […] ja vielleicht auch so eine Retraumatisierung […] beinhalten. Es ist oder/sie hat dann irgendwie das Gefühl sie werde jetzt zugenäht da muss man die Frau schon sensibilisieren und das ist auch/das wäre einfach/gerade die Defibulation/EIGENTLICH IDEALERWEISE macht man die Defibulation irgendwie zwischen der sechzehnten oder vierundzwanzigsten Woche. (.) Weil dann ist die (.) JA dann ist es sicher gut verheilt bis zur Geburt und […]  es ist nicht irgendwie in der Nacht bei jemandem wo keine Ahnung hat von Defibulation und […] von FGC und dann muss mit dem umgegangen werden. Und das ist natürlich für die Frau auch nicht so angenehmem. Genau (.) aber ist JA genau zu deiner Frage (lacht) man muss es aufschneiden. Genau man muss es häufig aufschneiden und sonst reisst es einfach, das ist (.) JA das geht ja auch es reisst ja auch. JA»

#19:36#
I: «Also das würde man zulassen, auch wenn die Frau jetzt nicht einwilligt das man aufschneidet?»

#19:43#
A: «Ja.»

#19:44#
I: «Okay. Und gibt es das, dass manchmal Frauen kurz nach dem […] sich wünschen, dass es wieder zugemacht wird?»

#19:54#
A: « Ja, das habe ich, also ich habe das selbst nie erlebt (lacht), dass sie das […] gewünscht haben, aber ich habe es auch schon gehört von Kolleginnen, wo dies der Fall gewesen ist […], dass dann irgendjemand gesagt hat sie soll zunähen. Aber das JA, ja das wird nicht gemacht.»

#20:13#
I: «Das ist verboten.»

#20:15#
A: «JA (.) es ist so ein bisschen eine Grauzone […] scheinbar rechtlich aber […] ich glaube ja. Darf man, soll man, JA nicht machen.»

#20:30#
I: «Ja, und was ist Ihre Erfahrung im Zusammenhang mit Hebammen? Haben Sie einmal mit Hebammen/»

#20:28#
A: «Ja eigentlich *mega* gut würde ich jetzt sagen, mit denen wo ich jetzt zu tun gehabt habe. ALSO ich glaube es […] es ist mehr dann manchmal das Problem die unerfahrenen ASSISTENTINNEN wahrscheinlich. Aber das wandelt sich glaube ich schon recht. Also ich glaube das Thema ist so ein bisschen/als ich angefangen habe, war es noch fast kein Thema und dann wird es immer mehr es THEMA. […] also das man sich dessen bewusst ist UND ich glaube […] dass sich […] die Hebamme dann […] auch nicht findet ja nein die Frau muss ich jetzt ständig untersuchen […] die braucht das nicht. Uns so das finde ich, ja das habe ich bis jetzt immer gute Erfahrungen gemacht, dass das schon sensibel behandelt wird. (Seufzt) und ich finde es […] einfach wichtig, dass […] vor der Geburt (.) ihr Hebammen auch darauf schaut also dass IHR euch bewusst seid wenn ihr eine ich weiss ja nicht, ihr habt ja auch/eine Hebamme kann zu ganz unterschiedlichen Phasen von der Schwangerschaft die Frau sehen und […] das ihr euch dessen auch bewusst seid. Ich meine es ist tatsächlich so, dass manchmal Ärztinnen entweder das gar nicht auffällt oder sie haben SOGAR nie vaginal untersucht und dann kommt eine Frau zur Geburt über und dann ist das einfach so. Also, dass ihr das selbst auch ein bisschen

wenn ihr mal eine Frau vor der Geburt habt euch dessen bewusst seid und dass dann selbst auch ansprecht und euch es dann so anschaut und dokumentiert wird, dass man das mit der Frau besprechen kann. Zum Beispiel besprechen, dass man sie aufschneidet vor der Geburt oder einfach nur schon wenn sie […] dass es sein könnte, dass es REISST und dass man sie nähen muss und dass sie ein bisschen Bescheid weiss und dann auch dass man ihr sagt, dass es in der Schweiz verboten ist und, dass wenn sie ein Mädchen gebären würde (..), dass sie […] das nicht beschneiden lassen darf.»

#22:47#
I: «Was würden Sie, also jetzt haben Sie es bereits schon gesagt, aber was würden Sie uns sonst noch so angehenden Hebammen bezüglich dem Thema empfehlen? Nebst der Beratung und das frühzeitige Abholen von diesen Frauen?»

#22:03#
A: «[…] ja ich glaube auch ein bisschen einen lockereren (Umgang?) also nicht […], sich nicht so vor diesem Thema scheuen also das es nicht so (erschrecken) jesses die ist beschnitten und oh die könnte beschnitten sein und so sondern ich meine für sie, für die Frauen ist das die NORMALITÄT (.), ist das normal und dann […] dass man das […] einfach, das man […] keine Angst davor hat und es einfach thematisiert und also ich habe eigentlich immer gute Erfahrungen wenn ich das thematisiere und es sagt vielleicht schon einmal eine ja nein ich bin als Kind beschnitten worden aber das ist […] normal bei uns und dann ist es aber auch klar, dann ist das für den Moment auch okay (.) genau (seufzt) aber nicht das JA.»

#23:52#
I: « Also sind sie tendenziell eher offen in diesem Thema?»

#23:56#
A: «JAHA scheint mir schon so, eigentlich schon ja. Sie sind das Ja (.) […] genau vielleicht das so ein bisschen versuchen einen unverkrampften Umgang mit dem zu finden und das […] wirklich ANZUSPRECHEN. Und wenn es ja, wenn dann die Hebamme unsicher ist oder es so/was eine Hebamme ja sicher auch machen kann einer Frau zu sagen: «Haben Sie das schon einmal mit einem Arzt angeschaut?».

Dann, also die Frau fragen: «Hat das ihre Ärztin gesehen?» und nachher kann ja die Frau sagen: «Ja nein, sie hat mich ja nie untersucht» oder so und dann kann ja die Ärztin rückmelden und sagen […] (.) wie JA können sie das mit der Frau besprechen (?) und vielleicht sagt ja die Ärztin: «Ja macht ihr das», aber das ihr das […] genau auch ein bisschen euch bewusst seid was […] was das […] für eine Geburt bedeuten kann und in den meisten Fällen macht es keinen Unterschied. (.) Aber was (.)/ich weiss nicht habt ihr auch ein bisschen Literatur gelesen zu dem Thema? Publikationen?»

#25:03#
I: «Mhm.»

#25:05#
A: «Genau, dann seid ihr ja sicher auf den Namen Abdulcadir gestossen?»

#25:08#
I: « Genau, ja.»

#25:10#
A: «Ja (.) weil sie hat ja ganz viel Publikationen, auch zum Beispiel, oder es gibt auch schon viel […] Publikationen zum Thema […] WIE Defi/[…] (unverständlich) wie […] FGC einen Geburtsverlauf (unverständlich) […] beeinflusst oder […] genau […] und wichtig: es ist keine Indikation für eine Sectio. ALSO ich glaube das ist manchmal zum Teil auch noch ein bisschen in den Köpfen. UND aber wenn sie jetzt zum Beispiel sagt, sie will ich der Schwangerschaft aber nicht defibuliert werden (.) und dies dann […] einfach bei der Geburt soll passieren so by the way das man das […] auch mit ihr anspricht und wenn es zur Sectio kommt. Und das ist dann auch, das wär dann auch so eine Gelegenheit wo man könnte […], klar das ist dann eigentlich Ärztinnenaufgabe, aber JA ich glaube dort seid ihr wahrscheinlich auch nahe bei der Patientin. UND noch das Andere zur Hebamme […] das Wochenbett, also gerade wenn ihr zum Beispiel eine Patientin habt, die defibuliert wird unter der Geburt und nicht wieder zugenäht wird, dass ihr das auch ein bisschen in die Wochenbettbetreuung auch auf der Station oder in der ambulanten Wochenbettbetreuung […] das mit der Frau neu weiter thematisiert, weil das kann

unter Umständen ihr Körpergefühl schon sehr verändern. Jetzt auch zum Beispiel […] mit dem Wasser lösen, also es gibt Frauen mit einer Infibulation, die haben tröpfchenweise […] können die nur pieseln und nachher haben sie plötzlich so einen richtigen Harnstrahl das ist ganz komisch für die. Das man das […] auch anspricht […] (.) auf dem Wochenbett. Das man das das mit den Frauen auch thematisiert und […] anspricht genau (.). Ja.»

#27:03#
I: «Super.»