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“The task for the health care professional is to be curious.”

Researching barriers and facilitators to discussing female genital mutilation/cutting in a health care setting

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Abstract

Discussing female genital mutilation/cutting (FGM/C) in health care is of paramount importance to provide high-quality care and prevent (young) women from undergoing the practice. Despite this, research suggests that the topic is often avoided in consultation rooms. This study aimed to review which barriers and facilitators influence the lack of discussing FGM/C in health care. The study is two-fold in that findings derived from both a scoping review of published research, and 20 in-depth interviews with Dutch (health) professionals involved in FGM/C care or prevention practices and cultural mediators. Some major barriers to discussing FGM/C were a lack of general knowledge regarding FGM/C and FGM/C management, language barriers, the sensitive nature of the topic, and time constraints. Facilitators included building a professional-patient relationship based on mutual trust and respect, enhanced collaboration between institutions involved in FGM/C prevention and care, and adequate education and training on FGM/C for professionals.

To improve the experiences of FGM/C-affected women and/or (prospected) parents from practicing countries, and increase the likelihood of girls at risk being identified, the findings of this study imply the need for more training opportunities for (health) professionals to gain confidence in discussing FGM/C. Next to that, respect and acceptance were emphasized to bridge barriers between professionals and women with FGM/C or (prospected) parents.

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Introduction

Conflicts due to migration, and the way one ought to deal with conflict situations, are everyday occurrences and dilemmas in rising pluralistic migration societies (Foroutan, 2019). Where different cultures encounter one another, conflict seems to be inevitable. Within the health care setting, cultural conflicts become highly visible as it is a place where such intercultural contact moments occur on a daily basis. Migrants and refugees, at one point in time, all experience an encounter with the Dutch healthcare system. The healthcare setting is therefore a unique place to study intercultural communication. Pinto (2007) introduced the notion of intercultural communication in the Netherlands in 1990. He claimed that everything surrounding communication and management is culturally determined. During intercultural contacts, misunderstanding are more likely to happen (ibid). Miscommunications are inevitable (Cui, 2020). Nevertheless, the quality of healthcare is dependent on communication and misunderstandings in healthcare provision can potentially be harmful to one's health (Buller & Street, 1992; Kreps & Kunimoto, 2014; Ulrey & Amason, 2001). Thus, aiming to diminish miscommunication in health care is crucial.

The case of FGM/C

Female Genital Mutilation or Cutting (FGM/C) is a specific concern in global health that, due to migration from countries where it is concentrated, primarily countries in Africa, the Middle East and Asia, has grown to become a global concern (Jordal & Wahlberg, 2018). The World Health Organisation (WHO) defines FGM/C as a practice "comprising all procedures involving the partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons" (WHO et al., 2008). As of 2016, an estimated 200 million women and girls have undergone FGM/C and 3 million girls are predicted to be at risk of undergoing the practice every year, according to the United Nations (UN) (UNICEF, 2016). The WHO distinguishes four types of FGM/C, with type III, also referred to as infibulation, being the most severe (see fig. 1). Both short- and long-term physical, mental and sexual health issues, such as infections, anxiety disorders, and impaired sexual function, have been associated with female circumcision (WHO et al., 2008). Reasons for the practice vary across cultures

and communities, but range from religious requirements to marital fidelity, and enhanced beauty and cleanliness (Dawson et al., 2015). FGM/C (in Western literature) is often depicted as an example of violence against women. Not only is violence against women "a multifaceted global public health problem" (p. 2), the gender-based violence is also considered a violation of human rights (Byrskog et al., 2015), and a "reflection of unequal power relationship between men and women" (Schmuel & Schenker, 1998, p. 239). The practice is deeply rooted in many countries, primarily in Africa, the Middle East and Asia, such as Sierra Leone, Iran and Indonesia (WHO et al., 2008).

As a consequence of global migration, health care workers from all over the globe are confronted with the native custom of female circumcision and are expected to work across cultures to provide high quality care (Evans et al., 2019). There is increasing evidence that women with FGM/C receive lower quality of care (e.g. Evans et al., 2019; Jordal & Wahlberg, 2018). One of the main reasons for the low quality of care affected women receive, is the lack of discussing FGM/C (Andersson Elffers Felix, 2021; Evans et al., 2019). Studies have found that (health) professionals experience a certain discomfort or fear when FGM/C needs to be discussed (Drost et al., 2018). Proper treatment for FGM/C affected women and timely interventions for girls at risk, are impossible if FGM/C is withheld and remains under the radar.

Zero Tolerance

The Netherlands hosts approximately 41,000 FGM/C affected women (Kawous, Van Den Muijsenbergh, et al., 2020). Research has estimated that in the next 20 years, 2100 girls are at risk of undergoing the practice (ibid). The Netherlands has a so-called zero-tolerance approach to FGM/C. This means all types of FGM/C, as described by the WHO, whether executed in the Netherlands or abroad on Dutch citizens or permanent Dutch residents, are prohibited (Government of the Netherlands, n.d.). There is no specific law against FGM/C in the Netherlands, but the procedure is categorized as 'assault' or 'severe assault' (Pharos, 2018). According to the Dutch Criminal Code, articles 300 to 304 of the Criminal Code apply (Phao, 2002).

The zero-tolerance approach remains a debated topic when comparing the Dutch approach to male circumcision. This is, namely, not prosecutable. The Dutch government does not consider male circumcision a form of (severe) assault as it deems the procedure non-harmful to the physical or mental well-being of (young) men (Wahedi, 2017). Given that some forms of FGM/C can be considered less prone to medical complications than male circumcision, this harsh line between the prosecution of the two customs remains a topic of discussion (Dekkers & Hoffer, 2008). Furthermore, in countries where governments successfully imprisoned parents for exposing their daughters to FGM/C, scholars have questioned whether this victimizes a child twice for being deprived from its parents after the impermissible procedure (Middelburg, 2016). Hence, the zero-tolerance approach sounds promising, but does not go without question.

To prevent and combat female circumcision, the Netherlands is one of the few European countries to have developed a national chain approach. In this chain approach prevention, care, law enforcement and information-sharing are combined and reinforce each other (Pharos, 2018). According to the Dutch action plan against the practice of FGM/C, (health) professionals have the responsibility to provide quality care for women with FGM/C and identify and prevent girls from undergoing the practice. Youth Health Care centres monitor children's health at various stages of their development and as such play an important role in identifying and assessing a risk of FGM/C (Rechel et al., 2018). Besides, youth healthcare professionals are required to inform parents from countries where FGM/C is practiced that FGM/C is prohibited and prosecutable by law (Pijpers et al., 2010). If doctors- and nurses working in youth healthcare are concerned that a girl may be at risk of FGM/C they have a legal obligation to report this to the Support Centre for Domestic Violence and Child Abuse in the Netherlands (in Dutch: Veilig Thuis) (ibid).

Despite these rules, regulations and guidelines to prevent FGM/C and care for women who have undergone it, research suggests that patients are still experiencing distressing interactions with healthcare workers (Evans et al., 2019). The barriers and facilitators to discussing FGM/C between (health) professionals and women with FGM/C or (prospected) parents from practicing countries, will be extensively studied in this thesis.

Internship

Pharos is a Dutch expertise center that aims to decrease health disparities in the Netherlands by means of acquiring knowledge through academic research, and sharing this knowledge with stakeholders, such as physicians or policymakers (*Missie En Visie - Pharos*, n.d.). Health inequalities or health disparities can be defined as "*a difference in which disadvantaged social groups—such as the poor, racial/ethnic minorities, women, or other groups who have persistently experienced social disadvantage or discrimination—systematically experience worse health or greater health risks than more advantaged social groups*" (Braveman, 2006, p.167).

Reducing health inequalities can be considered a 'wicked problem' according to Pharos (Pharos expertisecentrum gezondheidsverschillen, 2020). Wicked problems are extremely complex policy-related issues, with many interrelated factors contributing to that complexity (Rittel & Webber, 1973). Although one might have to accept that 'solving' such problems may not be attainable, the aim should be to enhance benefiting methods and diminish harmful ones (ibid). Pharos attempts to do this by picking specific health related issues that various social groups experience in the Netherlands. The social groups are, for instance, low-literate people, groups with lower educational status, migrants, and refugees. The latter group commonly faces health disparities, because the negative consequences of violence and traumatic experiences are often detrimental to their physical and mental health (Pharos, 2018). Pharos specifically concentrates on the topic of FGM/C as it exacerbates issues migrants or refugees might encounter (Evans et al., 2019). As the focal point for creating awareness on FGM/C in the Netherlands, Pharos serves an important role in the prevention of FGM/C and the care for women affected by circumcision who currently reside in the Netherlands. During my internship at this organization, Pharos served as a case study organization from within which the research question on discussing FGM/C was investigated. This contextualizes the results of this study, which is further explained in the section on my positionality as a researcher.

This thesis was simultaneously written with two journal articles on the same study in collaboration with Pharos. Therefore, some of the passages are verbatim with yet to be published articles. However, the text is my own original writing.

Societal relevance

Research from the professional's perspective indicates that (health) professionals sometimes find themselves uncomfortable in caring for FGM/C affected women (d'Entremont et al., 2014). The uncertainty and insecurity experienced by professionals, play a large role in avoiding the topic during consultations, and since affected women often do not disclose their FGM/C by themselves, the topic remains unspoken about (Dawson et al., 2015; Vaughan et al., 2014) A lack of discussing FGM/C as well as the miscommunications between patients and professionals show to be one of the main barriers to high-quality health care (Evans et al., 2019). If FGM/C is not broad up during consultations with health professionals or professionals involved in the prevention of FGM/C, proper care cannot be provided and girls will remain at risk of undergoing the practice. As mentioned earlier, the physical, mental and psychosocial consequences of female circumcision can be detrimental (WHO et al., 2008) and it is therefore paramount that professionals do not refrain from discussing FGM/C with affected women or (prospected) parents from practicing countries. Knowing what hinders and facilitates professionals in discussing FGM/C is thus fundamental to combatting this practice.

Scientific relevance

The first part of this study is a scoping review of the literature on discussing female circumcision. This study will add to the existing literature on FGM/C care and prevention by including articles from both the (health) professional's perspective as well as the patients' perspective. This was deemed important to create a more holistic view of the apparent barriers and facilitators to discussing FGM/C.

Furthermore, authors often recommend enhancing cross-cultural or intercultural communication skills to be able to address and discuss FGM/C in a culturally sensitive manner (e.g., Lazar et al., 2013; Ogunsiji, 2016; C. Widmark et al., 2010). Research suggests that a structural implementation of discussing FGM/C during consultations with women from practicing countries, significantly improves the quality of care and decreases the likelihood of daughters undergoing the practice (Evans et al., 2019). However, there seems to be no further explanation what this ought to look like in practice. Next to that, expert consultations on professional's knowledge, attitudes and confidence in the care for women with

FGM/C, show that there is a need for a thorough understanding of what actually works in practice with regard to discussing FGM/C (ZonMw, 2019; Drost et al., 2018). Therefore, the scoping review is complemented by in-depth interviews with Dutch healthcare professionals, professionals involved in the prevention of FGM/C, and so-called cultural mediators, whose task is further described in the methods section. This type of research had not yet been conducted in the Netherlands and because FGM/C is a very culturally sensitive topic, the results might differ in the Netherlands compared to other countries as described in the findings from the scoping review. The objective is therefore to test the results from the scoping review in practice by means of interviews.

The aim of this thesis is to provide an overview of the barriers and facilitators to discussing FGM/C between FGM/C affected women, or (prospected) parents from practicing communities, and (health) professionals. Hence, it aims to contribute recommendations for 'tools' to optimize discussing FGM/C and consequently the care and prevention of the practice.

The main research question reads: *What are the barriers and facilitators to discussing Female Genital Mutilation/Cutting in a health care setting between health professionals or professionals involved in the prevention of FGM/C, and women with FGM/C or (prospected) parents from practicing countries?*

The first research objective was to conduct a scoping review of scientific articles on discussing FGM/C, to identify the barriers and facilitators to discussing FGM/C found in previous studies. The review was conducted in a systematic manner to be able to map the existing knowledge. The Social Ecological Model was used to layer the findings according to the 5 levels of influence it distinguishes: *individual, interpersonal, organizational, community, and policy/enabling environment*. This model can help map and identify the interaction of environmental and personal factors on individual behaviour and as such has often served as a guide for (public) health practice and decision-making (Chynoweth et al., 2020; Golden & Earp, 2012). This part of the research is connected to the first sub-question: *What are the barriers and facilitators to discussing FGM/C in a health care setting according to (health) professionals and women with FGM/C?*

The findings from the scoping review served as the topic guide for semi-structured in-depth interviews. Three different groups of individuals have been interviewed for this research: 1) healthcare professionals such as midwives or FGM/C physicians, 2) professionals involved in the prevention of FGM/C, 3) and individuals from practicing countries currently residing in the Netherlands who are active as so-called cultural mediators. These interviews aided the process of gathering data on the professional's and patient's ideas of what 'tools' can help to discuss FGM/C. Besides, the wishes and needs to diminish shyness of action (in Dutch handelingsverlegenheid) were investigated. Shyness of action can be defined as being unsure whether to act, not knowing how to act, or not acting in certain situations even if the situation calls for action. Drost and colleagues (2018) have found that the majority of Dutch (health) professionals indicate that 'shyness of action' is the main reason for them to refrain from discussing FGM/C. It is therefore key to understand how to reduce this among professionals and what professionals wish or need to be able to overcome shyness of action when discussing FGM/C. The second sub-question thus reads: *What are the wishes and needs of (health) professionals and cultural mediators with regard to reducing shyness of action in discussing FGM/C?*

Outline chapters

The overall structure of this thesis takes the form of 5 chapters. The following chapter (2) starts with a discussion on the different labels for FGM/C and is followed by the global debate regarding intervention on FGM/C. Next, to illustrate why communities practice FGM/C and the extent to which the practice can vary across cultures, the significance of FGM/C for communities in Nigeria and Indonesia is presented. The next section of the theoretical framework describes the importance of communication in health care settings and specifically why discussing FGM/C is paramount for affected women and girls at risk. The Social Ecological Model (SEM) and Seeleman's (2009) Cultural Competence (CC) framework are presented afterwards. The latter presents three main competencies which are linked to effective intercultural communication (Deardorff, 2016). This is followed by the limitations of communication in general and of the CC framework. Lastly, my positionality as a researcher and the extent to which this influenced the research process is described.

Chapter 3 presents the methods for both the scoping review as well as the in-depth interviews in which each step of the research process is carefully described, and the justifications for the CC framework and the SEM, are given.

The analysis of the results are presented in chapter 4. All the barriers and facilitators to discussing FGM/C found during the scoping review are layered according to the SEM. The barriers and facilitators, and the wishes and needs for tools to diminish shyness of action, which came to light during the interviews are presented according to the CC framework.

Chapter 5 starts with a comparison of the barriers and facilitators from the scoping review with those of the in-depth interviews. Next the barriers and facilitators according to the (health) professionals are compared to those mentioned by women with FGM/C or the cultural mediators. Then, the differences between health care and prevention services are pointed out. Afterwards, a reflection on the SEM and the CC framework is given. The next sections focus on the limitations of the study and the policy and practice recommendations for discussing FGM/C. To finish, an overall conclusion is presented.

Theoretical framework

To further understand the factors that play a role in discussing FGM/C between professionals and affected women or parents from practicing countries, it is important to first give an overview of what female circumcision entails and to what extent discussing the practice in a health care setting is key to combatting it.

Labelling FGM/C

The highly sensitive and normative nature of the topic of FGM/C generates a need to carefully define each step of this study and to continuously remind myself as well as the reader of my positionality in this debate, beginning with labelling the practice. It is important to note that a variety of terms can be identified to describe female circumcision. Naming the practice is controversial in itself as labelling things immediately ties certain connotations to it (Lewis, 1995; Walley, 1997). The term circumcision was the more generic term in the 1990s before the issue slowly gained more attention and popularity in academic research (Ibid). With this increased attention in the Western world, the realisation that labelling FGM/C as circumcision equalizes male and female circumcision and thus nullifies the unique complications that are connected to female circumcision, grew larger. According to the WHO any type of female circumcision is a way of mutilating a woman's body (WHO et al., 2008). Therefore, they have decided to use the term female genital mutilation. This term addresses the practice as not merely a health issue, but also a human rights issue. Some authors, on the other hand, claim that by using the word 'mutilation' to describe female circumcision, women are subjected to thinking they are mutilated. Next to that it gives the impression that parents would deliberately intend to harm their daughters (Walley, 1997). Moreover, circumcision continued, and still is, the most used term in practicing countries. Therefore, some believe that the West should likewise use female circumcision and refrain from labelling the practice as female genital mutilation.

Even though I do not want to underplay the importance of referring to the practice as indefinitely hurting women's bodies and violating human rights, I likewise wish to refrain from describing any woman as mutilated, or claiming each parent is deliberately aiming to hurt their child. Therefore, I chose to include

‘cutting’ in the notion and as such use the acronym FGM/C rather than merely FGM, and alternate this acronym with ‘female circumcision’ throughout this thesis. Furthermore, during the interviews, the terms used were adapted according to the different interviewees, using female circumcision with cultural mediators, and FGM/C with health professionals.

A global debate

The aim of this thesis is to research how discussing FGM/C between women with FGM/C or (prospected) parents from practicing communities and (health) professionals can become more fruitful to provide higher quality care and aid the prevention of the practice. There are, however, differing opinions on whether or not the current approach to combatting FGM/C stems from the right reasonings. These two perspectives are fleshed out below in an attempt to enhance understanding of what it entails to try to interfere in culturally traditional practices.

The reasons for condemning FGM/C are widely known and accepted in high-resource countries. FGM/C is considered a human rights issue and a gender equality issue. Furthermore, anthropological and feminist studies show how women in most practicing countries are confined to patriarchal cultural norms (Bennett, 2005). The WHO and the United Nations demonstrate the inherent violation of women’s rights and of child’s rights in FGM/C practices, “including the principles of equality and non-discrimination on the basis of sex, the right to life when the procedure results in death, and the right to freedom from torture or cruel, inhuman or degrading treatment or punishment” (WHO et al., 2008, p.9). The list of potential harmful consequences is long. Pain, bleeding, infections, decreased sexual pleasure, childbirth issues, post-traumatic stress disorder and so on. In general, the more severe the procedure, the more significant the potential complications (ibid). All of these significations makes FGM/C a global issue the WHO, most high-resource countries, and many practice countries themselves, wish to combat and prevent.

Some scholars, however, do argue that one could ask themselves whether intervening to combat FGM/C can be regarded as imperialism. Is it our place, or duty, to tell women, who have undergone it themselves, to not subject their daughters to it? Walley (1997) demonstrates the importance of the influence of high-

resource countries on the debate of FGM/C. According to him (1997), these countries sensationalized the topic of FGM/C and adopted the “us” versus “them” discourse to reaffirm the notion of cultural superiority over practicing countries. ‘Us’ being the superior ones condemning FGM/C, ‘them’ being the inferior ones practicing it. FGM/C, as mentioned above, is viewed as a gendered issue in which patriarchal norms and ‘male domination’ play a role in the continuation of the practice. Walley (1997) argues that this description of ‘male’ domination in traditional societies has long been used as a justification for colonialism, with the idea that Western countries would civilize other countries and bring them the notion of gender equality. According to Walley (1997), this neglects the facts that colonial rule was oppressive to both men and women, and that gender equality was not at all reached in the ruling countries. In the same vein, Njambi and her colleagues (2000) argue that anti-FGM/C activists have imperialist tendencies which they do not always recognize. “The anti-FGM discourse is subject to contradictory meanings, images and practices that carry legacies of colonial representations of “Third World” societies as “savage” and “barbaric,” even while claiming to be pursuing their collective well-being” (ibid, p. 7). They critique these said imperialist tendencies in the discourse used to combat the practice. Besides that, they denounce the “universalising meta-narratives” (p. 115) such as condemning each and every type of FGM/C, and the underlying idea that ‘Western’ human rights are universal human rights. Palm and her colleagues (2019) describe in their research on the attitudes of midwives towards female circumcision how “policy documents guide their obligations, yet they are also influenced by culture-specific notions about bodies and sexuality and what can be called "the FGM standard tale".” (p.1). Their study showed how most midwives react in horror or sorrowful when they encounter a circumcised woman. Many midwives believed that their ability to enjoy sex was distorted or even destroyed saying things such as “[with cutting] you take away all sexual pleasure for the woman” (Respondent as cited in Palm et al., 2019). The authors describe this particular clitoris-centred view on women’s sexuality as typically Western. Any alteration to the bodily aspect gives the impression of impaired sexual functioning. Most types of FGM/C indeed have been linked to impaired sexual functioning, but it must be noted that this is not necessarily true for all procedures (Palm et al., 2019) Moreover, in some practicing cultures, the focus is less on the clitoris and more on the thoughts and the mind in relation to sexual pleasure.

The goal of these scholars is not to condone or justify the practice, but to shift the attention towards the imperialist and universalistic tendencies in the discourse surrounding it. *"What might appear as defensiveness on the part of "Third World" voices, which seem to shout protests whenever cultural values are questioned, is better viewed as an acknowledgement of the history which has made this Western gaze and interventionist stance a normal part of this "globalized" world"* (Njambi et al., 2000, p. 182). Together, the various stances on combatting FGM/C reinforce the importance of being aware of the historical and cultural background that is inherent to the topic of female circumcision.

The significance of FGM/C

Nigeria and Indonesia are both countries where female circumcision is still deeply rooted in some communities. An empirical explanation of these two countries is given, to understand the variations in the type of FGM/C and the procedure around it, in varying countries. Nigeria has been chosen because of its recent proportion in Dutch migration (Vluchtelingenwerk, 2020). Indonesia is considered interesting, since it is the fourth largest migration group in the Netherlands, indicating back to Dutch colonial history (CBS, 2021).

The Nigerian case

According to UNICEF, 28 countries in Africa practice FGM/C. The highest prevalence can be found in Somalia (98%) and Djibouti (93%) where FGM/C is virtually universal (WHO et al., 2008). It must be noted that all numbers and statistics regarding the prevalence of each country are estimates. In 2019, Nigerian refugees were the second largest group, next to Syrians, fleeing to the Netherlands. About 2100 Nigerians applied for asylum (Vluchtelingenwerk, 2020). The prevalence in Nigeria is not as high as in Somalia or Djibouti. Nevertheless, 24,8% of the women aged 15-49 have undergone the practice. This adds up to approximately 20 million Nigerian women being circumcised, accounting for roughly 10% of the total number of FGM/C affected women worldwide. Because of the higher influx of Nigerian refugees, the likelihood of cross-cultural encounters with Nigerian circumcised women and Dutch health professionals has presumably increased. Reviewing the Nigerian case is therefore valuable for this thesis.

As mentioned earlier, different communities practice different types of FGM/C and have various reasons for doing so. Within Nigeria, the type and prevalence varies greatly per region. In the South of Nigeria type I (partial or total removal of the visible part of the clitoris) is most prevalent, whereas more severe types of FGM/C, type IV (infibulation), are mostly present in the North. Female circumcisions occurs almost in all cases (82%) before the first birthday (Unicef Nigeria, 2011). The consequence of this is that most adult women cannot recall the event, and do not remember it being painful and traumatic (Budiharsana et al., 2016). This might have an influence on the likelihood of mothers wanting their daughters to undergo FGM/C as well (ibid).

Even though the practice does not have a direct relationship with religion, in Nigeria the prevalence is higher in regions, primarily in the South, where Christianity is dominant (Gayawan & Lateef, 2019; Okeke et al., 2012). Most of the procedures (64%) are executed by traditional circumcisers (Unicef Nigeria, 2011). Nearly all regions have legislations in place prohibiting FGM/C. However, the actual implementation and execution of the legislations is said to have been deficient (Sedletzki, 2007).

As in most high-risk countries, FGM/C in Nigeria is often routinely performed "as an integral part of social conformity and in line with community identity" (Okeke et al., 2012, p. 71). The most common reasons for female circumcision in Nigeria is the preservation of chastity and purification, and for the protection of a woman's virginity. Snails are sometimes used to smear the external genitalia with, in order to 'slow down' a women's sexual desire or activity (ibid). Next to that, marital reasons, family honour, or the fact that in some regions uncircumcised women are legally prohibited from inheriting property, remain driving forces behind the continuation of the practice. Daughters are being circumcised to prevent them from being banished or shunned. All in all, the practice remains deeply rooted within the Nigerian society and is thus difficult to combat (ibid).

The Indonesian case

Colonialism and imperialism is argued to play a role in FGM/C (Njambi et al., 2000; Walley, 1997). Indonesia was a Dutch colony from the late sixteenth century until the end of World War II in 1945 and therefore serves as an interesting second case to explore. Moreover, its geographically different position from Nigeria makes it intriguing to analyse.

Indonesia has a prevalence rate of 49% of women between the ages of 15-49, accounting for 60 million affected (young) women. In Indonesia, the procedure is referred to as female *khitan* or *sunat perempuan.* Here too, does the majority of the procedures take place before the first birthday (82%) (*Ending Female Genital Mutilation in Indonesia - BORGEN*, n.d.).

The Indonesian government has quite often changed its position on the legality of the practice in the past two decades. In 2006, a complete ban on the practice was put in place, but by 2010 FGM/C was legalized once again. With the aim of ensuring that the procedure would be executed in a safer and more sterile way, it was now "instituted in every hospital in the country and carried out by medical personnel" (Subzwari, 2020, p.1). Although the legislation was repealed in 2014, most circumcisions are still executed by medical personnel nowadays (Budiharsana et al., 2003.). In some regions FGM/C is offered in a so-called 'birth package'. Hospitals offer to execute the procedure along with vaccinating a baby girl and piercing her ears (Budiharsana et al., 2003). Medicalization of FGM/C remains a thorny issue in which morals, values and beliefs are involved. The reason why the Indonesian government has chosen for medicalization is because they belief it is better "to have trained medical personnel perform the procedure than risking severe infections if performed by traditional circumcisers" (Budiharsana, 2003. p.1). Moreover, the type of female circumcision executed in most Indonesian communities is quite 'mild' in comparison to other (African) countries. Mass circumcision ceremonies are also quite popular because these are usually free of charge. Boys and girls are all circumcised at the same time during these ceremonies (ibid).

The Islam is often used as a justification for FGM/C in Indonesia. In 2008 a fatwa was issued by the Indonesian Ulema Council, "an influential quasi-government body of Muslim scholars" (Dhumieres, n.d.). A fatwa is a legal opinion on a matter of Islamic law (Chishti, 2016). The 2008 fatwa recommends female Muslims to undergo the procedure, claiming FGM/C to be a rule or symbol of the Islam (Unicef, 2019). The most prevalent type, in line with the recommendations by this fatwa, is the removal of the skin that covers the clitoris (the clitoral hood). Scraping, light cutting and incising of the clitoral hood are the most common procedures. Removing of the clitoris or stitching hardly ever occurs (ibid). Symbolic circumcisions are also quite common in Indonesia. These are ceremonies where actual

‘cutting’ does not occur, but in which (baby) girls are symbolically cleansed and purified. The most common reason for executing FGM/C in Indonesia is that uncircumcised women will be ‘oversexed’. FGM/C is strongly recommended following some interpretations of the Islamic law, because it would guarantee a healthier and purer life for women by avoiding infections, and stabilizing ones libido (Ida & Saud, 2020).

As these two examples show, the signification, and procedures of FGM/C vary tremendously. Taking this into account is important when discussing FGM/C. The following section will describe how discussing FGM/C can aid FGM/C affected women and girls at risk of undergoing the practice.

Communication is key

Although the debate is ongoing, the law is clear. FGM/C is not allowed in the Netherlands nor when practiced abroad on Dutch citizens. Professionals have to obey the law, provide high quality care, and reinforce the prevention strategy as part of the zero-tolerance approach (Government of the Netherlands, n.d.). This starts with opening up the conversation on FGM/C with affected women and with parents who migrated from practicing countries (Evans et al., 2019). Yet, this type of intercultural communication can be quite complicated according to cultural studies scholars (e.g. Barna. Laray, 1994; Ulrey & Amason, 2001; Watson, 2008) According to Ulrey and Amason (2001), “There are many barriers to intercultural communication in health care” (p.452), such as assumptions, language differences, held stereotypes and the stress or anxiety that comes along with such encounters (Barna. Laray, 1994).

In practicing communities it is frowned upon to speak up about FGM/C and discussing it usually goes hand in hand with feelings of shame and a fear of stigmatization (Colver et al., 2012). Moreover, sometimes women themselves do not know their health complications are related to FGM/C (Dawson et al., 2015). As a consequence women refrain from disclosing their FGM/C and seeking care when needed.

Since affected women will most likely not initiate discussing FGM/C, professionals have the responsibility introduce the topic in their consultations. According to Perron and colleagues (2013),

discussing FGM/C will ensure that women have access to the right information to make informed decision about their health care, and elevates the overall care experience. Next to that, Welch (2000) argues that it could positively influence affected women's "perceptions of themselves, their bodies and their decision to seek future health care." As Small (2015) put it, "talking about FGM opens up doors to wider discussions and can be a catalyst for change". Studies on intercultural communication in healthcare often focus on the enhancement of intercultural communication skills, as with that, they argue, cultural competence will follow (Watson, 2008). Next to that, research has found that improving intercultural communication skills is not only in the best interest of a patient but aids health professionals as well, since it reduces experiences of stress and anxiety during intercultural contact moments (Ulrey & Amason, 2001).

Even though the group of circumcised women may be relatively small in the Netherlands, the impact on individuals is severe and lasting (Allwood, 2021). Allwood (2021) shows how most physical, mental, and sexual issues related to FGM/C can be resolved with the right treatment. This simply cannot occur if professionals do not recognize and discuss FGM/C. Unfortunately, FGM/C remains a complex topic and is therefore rarely discussed (Evans et al., 2019). D'Entremont and colleagues (2014) illustrate the silence that surrounds the encounters between health professionals and FGM/C affected women. This is a silence that needs to be broken in order to provide the care that they need and deserve, but likewise to prevent girls from undergoing the practice in the future.

Cultural Competence framework and the Social Ecological model

Two frameworks are taken into account to analyse the barriers and facilitators to discussing FGM/C in a health care setting. For the scoping review the Social Ecological model (SEM) guides the identification and coding process. This framework can help map the interaction of environmental and personal factors on individual behaviour and as such has often served as a guide for (public) health practice and decision-making (Chynoweth et al., 2020; Golden & Earp, 2012). Individuals are positioned at various levels of hierarchical influence (Mcleroy et al., 1988). Taking a social ecological approach to identifying barriers and facilitators in previous studies allows to go beyond traditional motivational and behavioural theory and analyse components on the individual, interpersonal, community, and policy/environmental level

(Fleury & Lee, 2006). This framework has often guided scoping reviews in the past that aimed to unfold a complex social issue such as FGM/C (e.g. Anderson et al., 2018; Garney et al., 2021; Loewenstein, 2018).

For the interviews Seeleman's (2009) Cultural Competence Framework is considered best to layer the findings, as the focus in the interviews is on individual experiences as well as wishes and needs for discussing FGM/C rather than an overall view of influencing factors as in the scoping review. To be able to provide high quality care for patients and clients from diverse ethnic backgrounds, Seeleman and her colleagues (2009) created a cultural competence framework which indicates the competencies that are most desirable for working cross-culturally in a medical setting.

Although much progress has been made through the years to define and measure cultural competence, a consensus on which competencies result in more effective intercultural communication, has not yet been reached. Some authors believe cultural competence manifests itself in a person's characteristics (Lonner, 2013), whereas others associate competence with skills (Wilson et al., 2013), "that is, behavioural displays or performance" (Chiu et al., 2013, p. 844). In Seeleman's framework, cultural competence is the combination of knowledge and abilities, as well as a welcoming and respectful attitude (Saha et al., 2008; Seeleman et al., 2009). When faced with a language barrier, culturally competent (health) professionals should, for example, be able to work with an interpreter and simultaneously be mindful of their own preconceptions and stereotypes. Previous research has found that "the ability to communicate effectively and appropriately in intercultural situations is based on one's intercultural knowledge, skills, and attitudes" (Deardorff, 2016, p. 247-248). The central notion of this study regards discussing FGM/C in an intercultural setting. Therefore the current research focuses on these three main cultural competencies.

The competencies (see table 1) might be regarded as general competencies all professionals ought to possess, but Seeleman (2009) argues that the competencies are of extra importance when working with patients from different ethnic groups. Moreover, the successfulness of the competencies depends on the degree to which they are interactively used. Each competency is reinforced by the other ones (ibid).

Table 1. Cultural competence framework

Competencies	Definition
Knowledge	Knowledge of epidemiology and the differential effects of treatment in various groups
Attitude	Awareness of how culture shapes individual behavior and thinking
	Awareness of the social context in which specific groups live
	Awareness of one's own prejudices and tendency to stereotype
Skills	Ability to transfer information in a way the patient/client can understand and to use external help (e.g., interpreters) when needed
	Ability to adapt to new situations flexibly and creatively

Table 2. The Social Ecological Model

Levels	Definition
Individual	Individual factors such as, knowledge, skills, attitudes, beliefs and values that facilitate or hinder discussing FGM/C
Interpersonal	Social networks, social connections and interactions that hinder or facilitate discussing FGM/C
Organizational	Rules, regulations, and (in)formal organizational structures that facilitate or hinder discussing FGM/C
Community	Relationships or collaborations between groups and organizations that facilitate or hinder discussing FGM/C
Policy/enabling environment	Policies, laws and cultural conditions that facilitate or hinder discussing FGM/C

What if communication is not the key?

The Cultural Competence framework provides an ideal combination of knowledge, attitudes and skills when working in an intercultural setting, such as discussing FGM/C with people from practicing countries. Nevertheless, Seeleman (2009) acknowledges that simply acquiring the competencies and using them interactively does not mean that a cross-cultural encounter will indeed be fruitful and conflict free. Rather she claims that "sometimes there may be no solution other than to accept an unsolvable or unsatisfactory situation" (Seeleman et al., 2009, p. 235). In line with her and her colleagues, this thesis

argues that not all interactions will become satisfactory once all of the barriers to discussing FGM/C are lifted and all the facilitators are implemented. These discussions will remain a two-way interaction, for which the outcome is depended on both the professional as well as the patient or client. Furthermore, assessing cultural competencies and knowing when a professional possess these competencies remains complex and is most likely not a binary conclusion in practice. Striving towards diminishing miscommunications and enhancing adequate care for women affected by FGM/C is a necessary aim, but completely overcoming all barriers is beyond the bounds of possibilities. Besides, according to the interactionist view, no conflict might even be undesirable as a certain degree of it is often related to change and improvements (Verma, 1998).

Positionality as a researcher

According to Scharp and Thomas (2019), it is important to assess one's own positionality in critical social science research, to shed light on where and when your positionality might have influenced the research process. The fact that I am a Dutch, white, and (I would say) privileged individual who identifies herself as a woman, most likely has had a large impact on why I condemn FGM/C. The research internship at Pharos further fuelled this position and this was therefore the (unchallenged) starting point of this research, which contextualized my findings. I do recognize and acknowledge the imperialistic ideas and influences that are inherent to the Euro-American side of the debate and the aim to eradicate the practice as argued above. Besides, I believe the debate with the comparison to male circumcision does tend to create a slippery slope sometimes for the zero-tolerance approach. Nevertheless, I simultaneously believe that drawing a line between various types of FGM/C is ultimately impossible due to the extremely wide variation in FGM/C practices that exist. Therefore, the zero-tolerance approach seems to me the best possible solution to try to combat the practice. Although this might imply the idea of a perpetrator and a victim, I realize that this cultural practice is in the main something parents do out of love or due to immense pressure. Hence, I condemn the practice, but do not condemn those affected by it. I believe one can only shift their cultural view (on FGM/C) once it becomes clear it is a cultured view. Therefore, I wish to refrain from the perpetrator-victim narrative. The question remains whether the above-mentioned acknowledgement is enough. Is it merely a question

of recognition, or does one have to act on this revelation? And if so, how? These questions remain unanswered for me.

Lastly, my positionality and the access to the data through Pharos' network, might limit the scope of what can be said about how to discuss FGM/C with people from affected communities, as most, if not all, participants had the same starting point condemning the practice. The barriers and facilitators to discussing FGM/C are potentially different for advocates of FGM/C.

Methods

Scoping review

A scoping review was conducted to identify factors that hinder or facilitate discussing FGM/C. Scoping reviews can be used to summarise and disseminate research findings on topics that have not yet been extensively researched (Antman et al., 1992) and to identify varying factors related to a concept (Munn et al., 2018). Communicating FGM/C in the healthcare setting can be considered such a relatively under-researched topic. Systematic reviews aim to provide an answer to clear policy or practice related research questions whereas scoping reviews have a broader approach in aiming to identify the 'scope' of the literature written and the concepts related to a topic thus far (ibid). As the aim of this part of the research was to identify and map facilitators and barriers through which a comparison can be made between a professional's perspective and affected women's perspective, this methodology was deemed more appropriate for synthesizing the body of existing evidence.

Data sources and search strategy

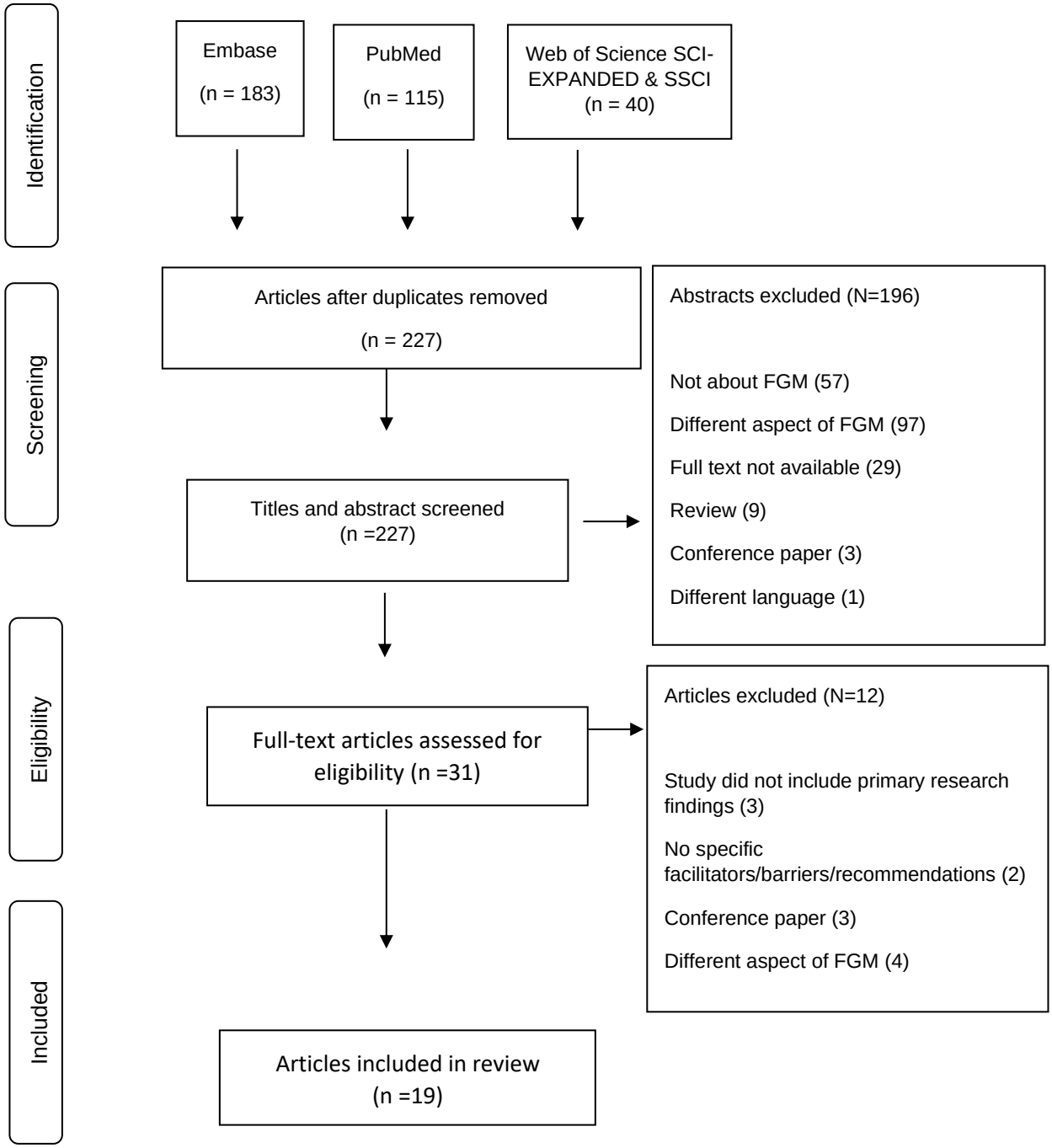
A literature search was undertaken on the databases PubMed, Embase, Medline, SCI-EXPANDED, and Cochrane. Key terms were identified and a search string was created based on these. The search string included key terms, such as *female genital mutilation, professional-patient relationship, interpersonal communication*. The search was limited to the English language. No limitation was in place for the publication date of articles. Studies from both the professionals' perspective and the perspective of women with FGM/C in any healthcare setting, care and prevention, were taken into account. Reviews and conference papers were excluded. The reference lists of relevant review articles were checked to see if any articles had been missed that needed to be included. Grey literature was not included, because the quality of the content cannot be guaranteed.

Data selection

After the duplicates were removed, a total of 227 articles remained. First, abstracts and titles were reviewed. The remaining articles were fully read and reviewed on the following inclusion criteria: 1)

relevancy to the research aim. Hence, whether the topic of the article was indeed on discussing FGM/C in light of prevention and care, 2) the study had to provide primary research findings, 3) articles had to include facilitators and barriers to discussing FGM/C. Articles were excluded if: 1) the article did not cover FGM/C, 2) the focus of the article was on a different aspect of FGM/C (e.g. the prevalence, physical care, or the existing laws), 3) articles for which the full-text was unavailable. If it was unclear, based on the title and abstract, whether an article had to be included, the full-text was reviewed. The process was iteratively executed. After all full-texts were read and reviewed a total of 19 articles were left to be included in the review. The flowchart below illustrates this data selection process.

Flowchart scoping review



Charting of data

To map the barriers and facilitators to discussing FGM/C, the data from the articles were chartered. Charting is the extraction of the data through a preconstructed data charter form (see appendix) that indicates which variables ought to be extracted. Through this, it was possible to indicate structure on each level of influence. Barriers were defined as any factor hindering discussing FGM/C between professionals and women with FGM/C. Facilitators were defined as any factors easing or enhancing discussing FGM/C between professionals and women who have undergone FGM/C.

For the purpose of charting the included articles, the computer assisted qualitative data analysis program Atlas.ti was used. Open coding initially took take place, in which codes derived directly from the content being analysed (Bryman, 2012). This was done to gain an overall idea of the different factors the literature had touched upon so far. Secondly, all barriers and facilitators to discussing FGM/C were coded. Any overlapping codes were merged. All barriers and facilitators were classified into overarching themes and categorised based on the Social Ecological Framework. The social ecological framework distinguishes 5 levels of influence*: individual, interpersonal, organizational, community, policy/enabling environment.* Layering the insights within the framework provided clearer insight in the interdependencies of each barrier and facilitator and in what areas certain interventions could be undertaken in the future. The framework guided the charting and synthesis of the data, but was not taken into account for the data collection process.

In-depth interviews

Study design

This scoping review was complemented by 20 semi-structured in-depth interviews with FGM/C professionals, and target group individuals active as so-called cultural mediators in the Netherlands. Conducting semi-structured in-depth interviews made it possible to understand the various perspectives, experiences and opinions those involved had when discussing FGM/C in a health care setting. Moreover, it provided a deeper understanding of the needs and wishes participants had to ease this conversation.

Participants and recruitment

Through purposeful and snowball sampling professionals were recruited from the network that Pharos has built over the years. Sampling was purposive, aiming to enhance variation in the practice setting and experience of professionals from both the prevention side of FGM/C as well as the care for women affected by FGM/C. Via emailing various Municipal Health services (in Dutch: GGD) and Support Centre for Domestic Violence and Child Abuse in the Netherlands (in Dutch: Veilig Thuis) locations, employees outside of Pharos' network were recruited. An attempt was made to recruit general practitioners with less experience on discussing FGM/C by means of contacting general practices with a high migrant population. This, unfortunately, without success. The cultural mediators were recruited through Pharos' network as well as through recommendations or references of professionals. Variation in gender, ethnic and geographical background, age was education level was sought. Nevertheless, all participants identified as women. Cultural mediators are adult men and women who originate from countries where FGM/C occurs. They are trained to discuss FGM/C with people from the target group. With their experience with the Dutch health sector they guide other migrants or refugees through instances such as doctor's appointments (Pharos, 2021). Table 3 provides an overview of all the participants, their occupation and the region in the Netherlands in which they work.

Table .3 Participant overview

Group	**Profession**	**Region in NL**							**Total**	**Of which experts**
		AMS	GRO	UTR	DH	IJS	TIL	NIJ		
Professionals	Midwife			1					**1**	**1**
	doctor/paediatrician			3					**3**	**1**
	Gynaecologist						1		**1**	**1**
	Forensic doctor	1							**1**	**0**
	General Practitioner							1	**1**	**1**
	Nurse			1	1				**2**	**0**
	Veilig Thuis employee				2	1			**3**	**0**
	Additional GGD employees		1		1	1			**3**	**3**
Target group	Cultural mediators				1	4			**5**	**0**
Total		**1**	**1**	**5**	**5**	**5**	**1**	**1**	**20**	**7**

Data collection and setting

Two topic guides for professionals and target group individuals were created. Overall themes for both groups were equal, however, specific topics or questions sometimes differed. The topic guides for the interviews directly derived from the initial results of the scoping review and covered the following themes: 1) knowledge, training and individual competencies on FGM/C, 2) professional's attitude, 3) talking about a taboo/sensitive topic, 4) professional-patient/client relationship, 5) cultural barriers, 6) language barriers, and 7) organisational barriers. Interviews started with the overall question of which barriers and facilitators to discussing FGM/C the participant experienced or believed to play a role. Through this, it was possible to indicate if the found barriers and facilitators in the scoping review were equal to those experienced in practice. The last questions asked related to their wishes and needs regarding 'tools' aimed at reducing shyness of action in discussing FGM/C. The interviews were conducted in Dutch with all participants. During the interviews with cultural mediators, the term 'meisjesbesnijdenis' (female circumcision) was used as it is often the more acceptable term within most practicing communities. The interviews were held online through videocalls. All interviews were recorded with the approval of each participant. The recordings were transcribed in Dutch.

Data analysis

The transcripts were coded using ATLAS.ti as a data analysis program. Most codes derived from the topic guide, but any additional data, not covered in the topic guide, was depicted with a new code. The codes were then categorised according to the three components of Seeleman's (2014) Cultural Competence framework. This framework shows how cultural competence can be used as an instrument to overcome diversity issues and enhance intercultural communication skills. It is important to note that this framework merely guided the data analysis and not the data collection process. The cultural competencies in this framework are: 1) knowledge, 2) awareness, 3) ability. Table 1 further defines the three competencies. The codes from the theme 'organizational barriers' did not fit the cultural competence framework and the component 'organizational- and system related barriers and facilitators'

was thus added. All codes were grouped according to the four themes to see in which area most barriers and facilitators could be found, and to identify where most wishes and needs lie.

Results

The result section is divided in two parts. The first part presents the results of the scoping review and the second part of the interviews.

Scoping review

The themes that derived from the findings from the 19 articles were layered according to the Social Ecological Model. Each overarching theme presents the found barriers and facilitators to discussing FGM/C. A distinction is made between the articles from the professionals' perspectives and those from the perspective of women with FGM/C. Although the aim was to differentiate between care and prevention, articles on the facilitators and barriers to discussing the prevention of FGM/C with people from practicing countries were not found during the literature search.

Barriers

Individual

Lack of knowledge or skills

A lack of knowledge and skills was reported in a large number of studies from the professional's perspective (Byrskog et al., 2015; Dawson et al., 2015; Lazar et al., 2013; Ogunsiji, 2016; Ugarte-Gurrutxaga et al., 2020; Vaughan et al., 2014; Widmark et al., 2010). Besides an insufficient understanding of the medical side of FGM/C (Widmark et al., 2010), the unawareness of the needs of women from a different cultural background (Byrskog et al., 2015; Lazar et al., 2013) and a lack of skills regarding discussing culturally sensitive topics came to light (Ugarte-Gurrutxaga et al., 2020). Additionally, being unaware of the countries where FGM/C is practiced, and an insufficient understanding of women's cultural backgrounds or the significance of FGM/C for them, were reported as barriers to discussing FGM/C (Byrskog et al., 2015; Ugarte-Gurrutxaga et al., 2020). Insufficient knowledge about FGM/C frequently resulted in not discussing the topic. Moreover, the lack of knowledge and skills made professionals feel scared or insecure and thus undecided on whether or not to address FGM/C (Ugarte-Gurrutxaga et al., 2020; Vaughan et al., 2014).

The lack of knowledge and skills was partly contributed to the low number of FGM/C cases professional encountered during their careers, as well as the absence or insufficient education and training they received (Dawson et al., 2015; Lazar et al., 2013; Mbanya et al., 2020; Ogunsiji, 2016; Ugarte-Gurrutxaga et al., 2020). Education on FGM/C was in many cases not part of the curriculum, nor did professionals receive adequate training after joining the workforce (Ugarte-Gurrutxaga et al., 2020).

Studies focusing on the perspective of women with FGM/C indicated that women often believe professionals do not have sufficient knowledge about FGM/C-related care nor about how to discuss the topic with them, resulting in them feeling less comfortable discussing FGM/C with professionals (Harper Bulman et al., 2002; Kawous, Allwood, et al., 2020; Mbanya et al., 2020; Vaughan et al., 2014).

Attitudes and emotions

A perceived poor attitude of professionals towards women with FGM/C or the practice itself, was pointed out by studies from the women's perspective (Harper Bulman et al., 2002; Mbanya et al., 2020). The type of questions asked were sometimes considered rather intrusive and inappropriate, making the women feel uncomfortable in discussing the matter (Mbanya et al., 2020). A strong emotional response towards FGM/C by professionals was also reported in studies on the women's experiences. However, the result of this differed as for one study the women said this felt unsettling (Vaughan et al., 2014), whereas in another article they did not experience it as something negative (Kawous, Allwood, et al., 2020).

The poor attitude of professionals was not mentioned as a barrier in studies from the professional's perspective. Nevertheless, the strong emotional responses professional had towards FGM/C were indeed described as possibly inhibiting communication (Dawson et al., 2015; Horowitz & Jackson, 1997; Koukoui, 2017; Ugarte-Gurrutxaga et al., 2020; Vaughan et al., 2014; Widmark et al., 2002). Strong emotional responses were especially linked to assumptions and stereotypes professionals held regarding the male dominance in the practicing cultures (Lazar et al., 2013; Widmark et al., 2002). Anger, but most of all sorrow and sadness could overwhelm professionals which sometimes impeded clear and culturally sensitive discussions (Lazar et al., 2013; Vaughan et al., 2014). Even though studies reported

on professionals trying to hide these emotions, they did admit that their body language might speak for itself (Widmark et al., 2002).

Lack of trust

A perceived sense of mistrust by affected women towards the health professionals in host countries was only reported in studies from the professional's perspective (Lazar et al., 2013; Ogunsiji, 2016). Professionals had the idea that women trusted family members more than professionals, which they linked to an unwillingness to follow health professional's recommendations. This both led to frustration and worry (Lazar et al., 2013).

Interpersonal

Language barriers

Problems stemming from a language barrier, were the most recurring interpersonal factors in the included literature. Professionals linked the issue of a language barrier to other factors such as elongated consults, the specialist vocabulary that was needed to transfer information, or the culturally appropriate terms needed to discuss female circumcision (Byrskog et al., 2015; Dawson et al., 2015; Lazar et al., 2013; Straus et al., 2009; Thierfelder et al., 2005; Vaughan et al., 2014; Widmark et al., 2002, 2010). Problems with interpreters was most often mentioned as aggravating in terms of the language barrier. The availability and quality variations between interpreters made working with them difficult according to the studies from professional's perspective. The use of interpreters was often inconsistent with protocols stating when interpreters should be used, and professionals were sometimes unsure about the correctness of translations or worried about women's confidentiality in the presence of interpreters, especially with informal interpreters such as family or friends. Professionals had the idea that women lost their agency when family or friends would take over the conversation. (Byrskog et al., 2015; Dawson et al., 2015; Dixon et al., 2020; Harper Bulman et al., 2002; Lazar et al., 2013; Simpson et al., 2012; Straus et al., 2009; Vaughan et al., 2014; Widmark et al., 2010).

Articles pertaining to the experience of women with FGM/C likewise discussed the language barrier (d'Entremont et al., 2014; Harper Bulman et al., 2002; Mbanya et al., 2020; Moxey & Jones, 2016; Thierfelder et al., 2005; Vaughan et al., 2014). According to Bulman (Bulman et al., 2002), problems with language provision underpinned or exacerbated all other barriers to discussing FGM/C that women affected by it experienced. Women would feel unsupported or frightened due to the language barrier, since they were unable to understand information (Bulman et al., 2002) .

One study reported on the importance of non-verbal communication for Somali women (Straus et al., 2009). UK health care professionals did not propagate a lot of non-verbal communication, which the Somali women considered as hampering the relationship with their professional.

Involvement of family

According to some studies, women from practicing countries are generally speaking more community or family focused. Family or community thus have a large influence on their healthcare (Lazar et al., 2013; Widmark et al., 2002, 2010). As mentioned above, problems sometimes arose when family members were used as interpreters or interfered in the woman's care (Byrskog et al., 2015; Dawson et al., 2015; Lazar et al., 2013). Widmark (Widmark et al., 2002) found that midwives often felt the pressure to "negotiate decisions with family members" (p. 119). This was often frustrating and time consuming. The involvement of family as a barrier to discussing FGM/C was not found in the articles from the women's perspective.

Organizational

Time constraints

Time constraints was one of the main reasons why the topic would be avoided, and therefore, negatively impacted the data collection and registration process of women affected by FGM/C, as well as women's overall health care experience (Evans et al., 2019; Kawous et al., 2020). Discussing FGM/C was considered a time consuming act by professionals due to, for instance, the use of an interpreter. Moreover, professionals indicated that understanding the cultural context or communicating in a

culturally sensitive manner, often in an indirect way, elongated consultations (Dawson et al., 2015; Dixon et al., 2020; Lazar et al., 2013; Thierfelder et al., 2005; Widmark et al., 2010).

Studies from the women's perspective confirm the negative impact of time constraints (Kawous, Allwood, et al., 2020; Thierfelder et al., 2005). Women would feel rushed during consults which made them dissatisfied with the care they received (Kawous, Allwood, et al., 2020).

Lack of guidelines, procedures and routines

The lack of guidelines, procedures or routines for discussing FGM/C with women from practicing countries further impeded discussing the practice according to studies with professionals (Lazar et al., 2013; Widmark et al., 2002, 2010). Many clinical sites did not have formal protocols in place for discussing FGM/C, or the knowledge of existing protocols was low (Bulman et al., 2002; Lazar et al., 2013).

Role Ambiguity

The review revealed that some healthcare professionals could be unaware of the fact that it is their role to open up a conversation on FGM/C (Ugarte-Gurrutxaga et al., 2020; Widmark et al., 2010). Due to role ambiguity, female circumcision would not be discussed during consultations. In one study, professional's said FGM/C "is associated with a cultural tradition and that addressing it is beyond the remit of healthcare professionals" (Ugarte-Gurrutxaga et al., 2020).

Community

Collaboration, registration and information sharing

With regard to the collaboration between different organisations, the inadequate integration of language services in the structures of hospitals was clearly a barrier for the women with FGM/C according to one study (Bulman et al., 2002).

Furthermore, information sharing between primary and secondary healthcare on FGM/C cases was defective and insufficient as was the actual recording of FGM/C cases, making it difficult to know whether FGM/C had been discussed or not (Dixon et al., 2020; Ugarte-Gurrutxaga et al., 2020).

Policy/enabling environment

Law

Simpson (2012) stated that legislation prohibiting FGM/C can be a barrier for affected women to discuss it, since disclosure about their FGM/C might negatively affect their family if they were the ones who exposed her to the practice. Moreover, misunderstandings about legislation (e.g. that being circumcised is a crime in itself) could make women in the asylum process fear deportation if they disclosed their FGM/C.

Sensitive topic

The sensitive nature of FGM/C is a dominant barrier to discussing the topic for both professionals and women with FGM/C. A certain discomfort with discussing FGM/C was found in the majority of the articles (d'Entremont et al., 2014; Dawson et al., 2015; Dixon et al., 2020; Kawous, Allwood, et al., 2020; Koukoui, 2017; Lazar et al., 2013; Thierfelder et al., 2005; Ugarte-Gurrutxaga et al., 2020; Vaughan et al., 2014; Widmark et al., 2002). The topic was said to be a taboo and thus avoided among the women themselves and between them and their husbands (Koukoui, 2017; Thierfelder et al., 2005). Studies from the professional's perspective show how professionals assume that the topic is a taboo for the women as well and therefore avoided the topic out of respect to women with FGM/C, or because they were afraid that it would offend them, or potentially bring up a traumatic experience (d'Entremont et al., 2014; Dixon et al., 2020).

Stereotypical assumptions

A reliance on stereotypes or assumptions is not unusual for some professionals according to the literature from the perspective of professionals (Dawson et al., 2015; Horowitz & Jackson, 1997; Simpson et al.,

2012; Straus et al., 2009; Vaughan et al., 2014; Widmark et al., 2010). Negative or positive stereotypes guided their judgement in various ways. To illustrate, Bulman and colleagues (2002) describe how midwives had the stereotypical assumption about Somali women with FGM/C "that they prefer to be instructed rather than receive information and choices concerning their care" (p. 347).

Cases of experienced racism or prejudice regarding African-refugees were found in an Australian based study (Vaughan et al., 2014). The women felt as if health professionals viewed them as different, "were put 'on show' to colleagues" (p. 4), and talked to them as if they were deaf (ibid). Generalisations regarding FGM/C can be harmful as group-level explanations, may lead to individual experiences going unnoticed (Dawson et al., 2015). Women may feel patronised by such encounters, lowering the chances that a fruitful conversation on their experience with FGM/C will occur (ibid).

Quality care and gender professional

An additional barrier that hampered smooth conversations on FGM/C was the lack of consensus between health professionals on what constituted good quality care for women affected by FGM/C (Widmark et al., 2002, 2010). Furthermore, a clear preference for female professionals came to light. Talking with male professionals about FGM/C was seen as more uncomfortable and difficult in the studies from the women's perspective (Kawous, Allwood, et al., 2020; Ogunsiji, 2016; Thierfelder et al., 2005).

Facilitators

Individual

Understanding cultural values

A common mentioned facilitator to discussing FGM/C for professionals was to enhance their social and cultural understanding of FGM/C for various groups. Understanding the significance of the practice for communities could help to communicate in a cultural sensitive manner (Horowitz & Jackson, 1997; Mbanya et al., 2020; Moxey & Jones, 2016; Straus et al., 2009; Vaughan et al., 2014; Widmark et al., 2002). Both were key to fostering a good relationship between women with FGM/C and professionals,

which was one of the core elements needed for discussing a sensitive topic such as FGM/C (Mbanya et al., 2020; Moxey & Jones, 2016).

Besides understanding what FGM/C means for the practicing communities, authors also pointed out the importance of understanding your own views towards FGM/C and the women affected by it. When one knew their own standpoint and had a better understanding of the other's reasonings, communication could flow more easily according to these authors (Byrskog et al., 2015; Horowitz & Jackson, 1997; Straus et al., 2009).

Interpersonal

Mutual respect and trust

The majority of the articles reported on the need for mutual trust and respect to discussing FGM/C (Byrskog et al., 2015; d'Entremont et al., 2014; Dawson et al., 2015; Dixon et al., 2020; Horowitz & Jackson, 1997; Kawous, Allwood, et al., 2020; Lazar et al., 2013; Mbanya et al., 2020; Moxey & Jones, 2016; Ogunsiji, 2016; Vaughan et al., 2014). This was especially evident in the articles on the perspective of affected women To create this trust, a cultural sensitive approach was considered best (Dawson et al., 2015; Horowitz & Jackson, 1997; Kawous, Allwood, et al., 2020; Lazar et al., 2013; Mbanya et al., 2020; Ogunsiji, 2016; Ugarte-Gurrutxaga et al., 2020; Vaughan et al., 2014). This was often connected to the abovementioned enhancement of social and cultural understanding of FGM/C and of your own values and opinion regarding the practice. Some authors advised against using the term 'mutilation' to talk about the practice with women from practicing countries. Terms such as circumcision or cutting were deemed more appropriate since women themselves did not regard their bodies as mutilated and wished not to be described as such (Dawson et al., 2015; Vaughan et al., 2014).

Direct communication

In terms of the ownership of the topic, most studies mentioned that professionals ought to initiate the conversation on FGM/C. Communication initiated by professionals themselves was most successful in trying to bring the topic to light according to studies from both perspectives (Byrskog et al., 2015;

d'Entremont et al., 2014; Kawous, Allwood, et al., 2020; Lazar et al., 2013; Mbanya et al., 2020; Moxey & Jones, 2016; Straus et al., 2009). Once the conversation was initiated, authors from the professional's perspective also recommended explaining the reasoning for asking about it (Dixon et al., 2020; Simpson et al., 2012). Women would be more likely to answer openly if a professional explained why they asked certain questions.

Involve family

Community and family ties are considered stronger for women from practicing countries. As such including the family, and especially the men or husbands, in the care for women with FGM/C was important to foster the relationship and enhance compliance to doctor's orders (Dawson et al., 2015; Lazar et al., 2013; Ogunsiji, 2016; Thierfelder et al., 2005; Widmark et al., 2002, 2010). It is important to note, however, that no articles from the women's perspective mentioned involving their family in discussing FGM/C as a facilitator.

Organizational

Adequate education and training

The most recurring need for improving the care for FGM/C affected women and the prevention for girls at risk, was greater and ongoing training opportunities for professionals (Byrskog et al., 2015; d'Entremont et al., 2014; Dixon et al., 2020; Harper Bulman et al., 2002; Koukoui, 2017; Lazar et al., 2013; Mbanya et al., 2020; Moxey & Jones, 2016; Simpson et al., 2012; Ugarte-Gurrutxaga et al., 2020; Vaughan et al., 2014; Widmark et al., 2010). Technical knowledge on FGM/C had to be enhanced, as well as cross-cultural communication skills. Some studies even pointed out that FGM/C should be part of the curriculum of education programs such as, midwifery or medicine (d'Entremont et al., 2014; Simpson et al., 2012; Widmark et al., 2002). Lastly, adequate knowledge about the 'at risk' signs had to be spread more widely to all health professionals (d'Entremont et al., 2014).

Sufficient time

An obvious facilitator, in extension of the barrier, was the need for sufficient time while discussing FGM/C, as feeling rushed during a consult was a clear obstacle for discussing female circumcision (Byrskog et al., 2015; Kawous, Allwood, et al., 2020; Simpson et al., 2012; Thierfelder et al., 2005).

Routine process and clear guidelines

Two studies recommended a routine process to discussing FGM/C (Moxey & Jones, 2016; Simpson et al., 2012). Routine questioning had to become a part of each consult if a woman originated from a practicing country (ibid).

Trained interpreters

Interpreters were supposed to overcome language barriers, but experiences with interpreters were not always positive. A need for more highly qualified and trained interpreters became apparent especially for the professionals (Byrskog et al., 2015; Dawson et al., 2015; Bulman et al., 2002; Lazar et al., 2013; Simpson et al., 2012; Widmark et al., 2010). Better trained interpreters were key to a more fruitful conversation with women who do not master the language of their host countries. These interpreters were preferably female interpreters according to the literature from the affected women's perspective.

Continuity and person-centred care

Continuity of care was another facilitator important for creating a more trusting relationship between the professional and the women with FGM/C (Byrskog et al., 2015; d'Entremont et al., 2014; Dawson et al., 2015; Bulman et al., 2002; Straus et al., 2009).. Moreover, d'Entrement (2014) mentioned that seeing the same professional during most consultations would be beneficial in safeguarding the women's confidentiality. As the topic is already privacy sensitive, multiple professionals working on one case can feel intruding and decrease a woman's willingness to discuss FGM/C (d'Entremont et al., 2014).

Moreover, articles emphasized person-centred care. Going beyond social, cultural or ethnic background when encountering a woman with FGM/C and seeing them as individuals with agency was paramount

for providing high quality care. (Byrskog et al., 2015; Dawson et al., 2015; Dixon et al., 2020; Harper Bulman et al., 2002; Lazar et al., 2013).

Community

Collaboration

Collaborating within the same organisation even as with external organisations working with women affected by FGM/C, was another facilitator to discussing FGM/C and the provision of high quality care (Byrskog et al., 2015; d'Entremont et al., 2014; Dawson et al., 2015; Dixon et al., 2020; Ogunsiji, 2016; Straus et al., 2009; Ugarte-Gurrutxaga et al., 2020; Vaughan et al., 2014). The sharing of patient data between different professionals, such as the general practitioner and the midwifery, should be executed more thoroughly and on a regular basis (Ugarte-Gurrutxaga et al., 2020; Vaughan et al., 2014). On the prevention side, social and educational services had to be included in the collaboration as these can be the first ones noticing signs and spreading awareness and information (d'Entremont et al., 2014; Ugarte-Gurrutxaga et al., 2020).

Policy and enabling environment

Clarity on laws

Two studies identified the need for further clarity on the laws regarding FGM/C. Ogunsiji (2016) shows how Australian health care workers had to be more aware of the national legislation, as it became clear they did not all know what was allowed regarding reinfibulation in their region specifically. Simpson (2012), on the other hand, pointed out how the communities themselves needed to gain more knowledge on the regulations to avoid misinterpretation of the law, as women sometimes avoided seeking health care, because they believed they were prosecutable for having undergone a circumcision.

Clear guidelines

The need for a protocol or clear guidelines on the healthcare provision for women with FGM/C, is recognized by some of the included literature (Byrskog et al., 2015; Dawson et al., 2015; Koukoui, 2017;

Lazar et al., 2013; Ugarte-Gurrutxaga et al., 2020). Noteworthy, this need did not decrease according to the year of the article. A protocol would not only ensure more quality healthcare provision, but would simultaneously protect the professional, whom "by being able to adhere to what is established in specific protocols, would for all purposes be carrying out a task considered to be correct" (Ugarte-Gurrutxaga et al., 2020) (p. 11).

Some studies identified a lack of compliance to the already existing protocols or guidelines. This was mainly due to professionals being unaware of their existence. Therefore studies recommended increasing awareness among professionals of these protocols and the importance of following them when encountering a woman with FGM/C (Koukoui, 2017; Ugarte-Gurrutxaga et al., 2020).

Community engagement

Community engagement was reported by both studies from the professional's perspective as well as from the affected women's perspective as important for building a relationship with practicing communities to ensure more disclosure and to enhance prevention of the practice (Dawson et al., 2015; Horowitz & Jackson, 1997; Lazar et al., 2013; Moxey & Jones, 2016; Simpson et al., 2012; Vaughan et al., 2014). "It is well established that interventions are most effective if driven by, and involving, whole communities" (Vaughan et al., 2014) (p. 30). One study did mention, however, that the way in which communities are approached is of paramount importance. A non-judgemental approach in which the community kept their agency is important to ensure their willingness to contribute (Vaughan et al., 2014).

Table 4. Barriers and facilitators to discussing FGM/C based on the scoping review

The Social-Ecological Model levels	**Factors**	**Number of articles mentioning factor**		
Levels	**Barriers**	**Prof (N=12)**	**Women (N=8)**	**Total (N=19)**
Individual	Lack of knowledge and skills regarding FGM/C and cultural sensitive communication due to a lack of education and training	7	4	10
	Poor perceived attitude by professionals	0	2	2
	Strong emotional reactions when encountering women with FGM/C	7	3	9
	Scepticism towards host country's health care system	2	0	2

Interpersonal	Language barriers including issues with interpreters, the usage of specialist vocabulary and culturally appropriate terms, and lack of non-verbal communication	9	6	13
	Involvement of family or community in discussing FGM/C with the professional	3	0	3
Organizational	Time constraints during consults	5	2	6
	Lack of guidelines, procedures or routine processes for discussing FGM/C	5	0	5
	Role ambiguity regarding discussing FGM/C	2	0	2
Community	Inadequate integration of language services in hospitals	0	1	1
	Inadequate registration of FGM/C cases	2	0	2
	Inadequate information transfer of FGM/C cases	2	0	2
Policy/Enabling environment	Misunderstandings and fear of the laws on FGM/C in host country	0	1	1
	Sensitivity of FGM/C	7	4	10
	Stereotypical assumptions held by professionals of practicing communities	6	3	8
	No consensus of what constitutes high quality care for women with FGM/C	2	0	2
Levels	**Facilitators**			
Individual	Understanding your own and others' values and beliefs about FGM/C	4	3	7
Interpersonal	Cultural sensitive approach to foster trusting relationship	6	4	8
	Direct communication preferably initiated by the professional	3	4	7
	Involving the families of women affected by FGM/C	6	0	6
Organizational	Adequate education and in-job trainings about FGM/C and cultural sensitive communication	9	4	13
	Sufficient time during consults	3	1	4
	Routine process and clear guidelines for discussing FGM/C	6	1	7
	Better trained interpreters	5	1	6
	Continuity of care and person-centred care	3	2	5
Community	Enhanced collaboration with other institutions focusing on FGM/C	7	2	8
Policy/enabling environment	Clarity on the laws and legislations for professionals and especially practicing communities	1	1	2
	Engaging communities in the care for affected women and the prevention of FGM/C	5	3	6

In-depth interviews

Twenty participants took part in semi-structured in-depth-interviews: five health professionals, five cultural mediators and ten professionals involved in the prevention of FGM/C (e.g., doctors- and nurses working in youth healthcare, professionals working at Support Centre for Domestic Violence and Child Abuse in the Netherlands). The cultural competence framework (knowledge, attitude and skills) by Seeleman and colleagues (2009), served as the basis for ordering and presenting the results.

Knowledge

Similar to the scoping review one of the most recurring factors that hindered discussing FGM/C for both professionals and cultural mediators was a lack of knowledge. This lack of knowledge was identified in relation to two main areas. First, several professionals and cultural mediators indicated that both health professionals and professionals involved in the prevention of FGM/C most likely lack general knowledge about FGM/C, including the types of FGM/C, prevalence in countries of origin, health risks or complications related to female circumcision, and reasons for performing FGM/C for practicing communities.

"But I do not believe that they all know about the prevalence countries, what countries it is practiced in or who they should discuss it with." (Project manager FGM/C at Sense GGD)

Second, in terms of prevention- and care pathways and protocols for FGM/C cases, participants mentioned a lack of knowledge of existing guidelines or protocols for both identifying girls at risk and caring for women with FGM/C. Specifically general practitioners (GPs), as the gatekeeper of the healthcare system in the Netherlands, were mentioned as lacking knowledge with regard to FGM/C. One interviewed GP believed that this mostly had to do with the wide variety of topics a GP needs to know about and the relatively low number of FGM/C cases in the Netherlands.

"The GP knows nothing about Africa or about Asia or about that tradition. Absolutely nothing."(Cultural mediator)

Additionally, participants mentioned that this lack of knowledge may be due to the fact that FGM/C is not embedded within the curriculum of most medical, midwifery, and public health training programmes

in the Netherlands. A number of professionals wished FGM/C would be included in curricula of various education programmes in the future.

"I think the next step is that you also ensure that it is included in the curricula" (Forensic doctor)

In the Netherlands a series of training initiatives for the health providers do exist, however these are not obligatory. Nonetheless, although these initiatives are not obligatory, professionals are required to know what to do when they encounter a women with FGM/C, or sense a risk of female circumcision.

"Every professional has to know that. So, you just can't get away with the excuse that you don't know. For the disciplinary judge I mean." (Gynaecologist)

Also similar to the literature, a common view amongst the participants was the need to improve training opportunities for professionals to enhance their knowledge regarding FGM/C and its protocols and guidelines. E-learning was considered an easy and affordable means for professionals to gain more medical technical knowledge. Some professionals suggested that a training should include a personal story from someone who experienced FGM/C, since personal stories had the potential to make an impact on professionals.

"I went to a gathering, where affected women and cultural mediators (..) told their story. That will stick very well, if you hear it that way." (Doctor at the Support Centre for Domestic Violence and Child Abuse)

There were concerns about the number of health professionals, especially GP's, who would join training opportunities. Therefore, some suggested that FGM/C should be made part of a broader topic such as upbringing, cultural sensitivity, or sexual violence to increase the likelihood professionals would sign up for those training opportunities. Enhancing knowledge by providing training and education would facilitate discussing FGM/C. Nevertheless, many professionals and cultural mediators indicated that increasing knowledge was not the ultimate solution to the lack of discussing female circumcision, since knowledge on FGM/C quickly seemed to fade. According to those who touched upon this, knowledge faded because they often no longer see cases after they have had a training and therefore do not have to activate that specific knowledge.

Furthermore, professionals and cultural mediators believed that group information sessions on FGM/C for affected communities in the Netherlands should be given more often in various communities and cities. Other suggestions included having two or more spokespersons from an organisation actively working on combatting FGM/C, who can become known to the public as the ones who do have knowledge regarding female circumcision. One participant mentioned to include the topic in a tv show to raise awareness of the practice in the Netherlands.

Attitude

Barriers and facilitators to discussing FGM/C laid additionally in a professionals' and patient's attitude when approaching one another. Professionals explained that discussing FGM/C could bring about a certain discomfort or fear which often negatively influenced the conversation. This fear derived from being afraid of offending or stigmatizing women or girls, or jeopardizing the professional-patient/client relationship, and was mostly related to the sensitive nature of the topic.

Cultural mediators all mentioned that FGM/C is a taboo in their communities which you ought not to talk about. This was especially true for recently migrated women. Professionals likewise believed the topic to be a taboo, although more experienced health providers indicated that most women with FGM/C were usually relieved to discuss it with them.

"She does want to discuss it, but you have to see how you get all that information from the woman" (Nurse)

Additionally, the discomfort derived from difficulties professionals experienced in coping with cultural barriers. More experienced professionals indicated that professionals still have the tendency to approach migrants in a Dutch or Western manner. Two cultural mediators both shared a similar experience in which a professional inspected their daughters' genitals during a consult without any introduction. When asked what she thought of the professional's attitude, she responded *"cold, no real contact. (...) work had to be done like chop chop chop and finished."* And following that as a response to the question what that did to her she said: *"Fear. You are immediately afraid, because it is your child and it's in his hands".*

Feeling rushed and not really seen by professionals was experienced as quite distressing. Cultural mediators believed that these types of interactions could lead to people not returning to that professional or closing up completely.

"Two women said to me; 'No on Tuesdays I don't go to the Youth Health centre.' 'Why?[I said]' 'The older lady is there. She is always curt or busy with other things. I'm not going. She doesn't even say hello to me. She doesn't even look at me." (Cultural mediator)

The majority of the professionals indicated that (stereotypical) assumptions could hinder discussing FGM/C. Specifically stereotyping the culture and the practice of FGM/C as barbaric and wrong. Interestingly, professionals said that colleagues sometimes assumed that people would feel stereotyped if professionals asked them about FGM/C, and therefore avoided discussing it. This did not, however, devalue the importance of being aware of stereotyping. Rather it showed how assuming someone's reaction or feelings towards your actions can in practice be quite harmful. To overcome this fear of stigmatizing or stereotyping women with FGM/C or (prospected) parents from practicing countries, professionals mentioned to emphasize your professionality and that it is your task as a professional to discuss FGM/C with them.

The topic of discrimination came across a few times during the interviews. Some professionals mentioned that discrimination occasionally ensues between professionals in the form of discriminatory comments, such as 'why should we clean their mess'. Cultural mediators did not indicate that they had experienced discrimination, but one cultural mediator did mention that professionals had expressed negative thoughts about female circumcision to her during an FGM/C training session.

The desired attitude when discussing FGM/C according to participants were an open, accepting and simply friendly attitude. The importance of integrity and confidentiality likewise came to light. Furthermore, participants said that discussing FGM/C should embark on the notion of empathy and refraining from speaking in a so-called technical and distant manner. In a number of interviews, participants mentioned the term 'genuine curiosity'. Genuine curiosity meant that a professional asked questions that might not directly granted them the specific information needed, but that allowed the

patient or client to tell their story. By being genuinely curious a professional created a safe environment in which eventually there would be space for the needed information to be gathered.

"So the task for the health care professional is to be curious. Be curious about who is sitting in front of you, about the background of that person and how they experience things, because that too is not black and white." (Gynaecologist)

The preferred attitude was mostly linked to building a professional-patient/client relationship. Due to the taboo that surrounds FGM/C, a trusting relationship was considered rather crucial for discussing the topic. A number of professionals and cultural mediators indicated that, for the sake of building the relationship, the first conversation should be about becoming acquainted with one another. Unfortunately, it was not always possible to build a relationship with someone before FGM/C had to be discussed. For instance, professionals involved in the prevention of FGM/C often have not seen the (prospected) parents before they have to discuss the prevention of FGM/C. Multiple professionals and cultural mediators mentioned that this was quite complicated for them due to the sensitive nature of the topic. As a solution they mentioned that showing interest in the person in front of you was the easiest way to quickly make others feel at ease to open up.

More experienced professionals emphasized the importance of realizing that FGM/C is normal to the affected women. Next to that, one should be aware of their own thoughts and ideas towards FGM/C and how these are shaped by Western culture.

"You may think it is a weird tradition. That is okay, but be conscious of the fact that you think that, and that for those women it is completely different. For those women its actually weird that we think it is weird."(FGM/C liaison employee and midwife)

Participants explained that some professionals have a more natural tendency to work in a culturally sensitive manner. Affinity with- or an interest in the target group or people with a distinct cultural background was an important asset to being able to discuss FGM/C. An interest in cultural differences often came from international experiences (e.g. working in a foreign country), or the cultural background

of the professionals themselves. Hence, a few professionals also pointed towards the benefits of a diverse workforce.

"I also think there is something to be said for colleagues from a certain cultural backgrounds seeing parents from certain cultural backgrounds. They match more quickly"(Doctor, GGD)

According to the participants, affinity was mostly attributable to a professional's personality. However, they believed that certain communication techniques, such as how to introduce the topic or dive into depth about FGM/C, could be taught during training opportunities especially through in-person role-play practices.

Skills

Language barriers

A language barrier was for most professionals a complicating factor in discussing FGM/C. Language barriers not only lengthened the consultation time, but also made it difficult to talk about emotions and traumas and were mentioned as obstacles to building a professional-patient/client relationship.

To overcome the language barrier, both professional interpreters (in the room and via the phone), as well as informal interpreters, family members including children, are used by Dutch professionals. Experienced professionals pleaded for working with interpreters or cultural mediator to dive deeper into the topic of FGM/C. Nevertheless, the interviews revealed that in practice interpreters or cultural mediators are not being utilized as often.

Some professionals experienced no issues with working with interpreters. To them, using interpreters was the obvious solution to problems that arose due to language barriers. Others, on the other hand, were hesitant to work with interpreters or cultural mediators due to the additional time it cost to call and converse with an interpreter, their feelings of uncertainty about how things are translated, and the quality difference between interpreters.

"We currently have a real problem with the interpreter phoning service (…) because if I, nowadays, want to reserve an interpreter, I first have to wait half an hour (…) to get an interpreter on the phone" (Gynaecologist)

Especially cultural mediators emphasized the importance of working with interpreters or cultural mediators. As such, the need for practicing on how to converse when external help was involved, was recommended.

"I think it is a pity that a cultural mediator who is trained is not being used. We are real bridging people. (…). We can make a lot of things go smoothly because of the language and the knowledge we have."(Cultural mediator)

Informal interpreters, such as friends or family, were considered a convenient way to overcome language barriers by some professionals. According to them, discussing FGM/C with an informal interpreters saved them time, as they did not have to go through all the steps of arranging a formal interpreter. Downsides were more uncertainty about whether things are translated properly, and concerns about confidentiality, since informal interpreters do not have professional secrecy. All respondents who touched upon children as interpreters, agreed that using children was to be avoided, but unfortunately still happened. *"Because if you are going to talk about her having intercourse with her husband then it is very awkward if there is a 12-year-old child of course."(FGM/C liaison employee, midwife)*

Cultural sensitivity skills

Most professionals addressed a lack of skills about how to talk about FGM/C in a cultural sensitive manner. The majority of them expressed the need to enhance intercultural communication skills and provide more cultural sensitivity training opportunities for various professionals who have to discuss FGM/C. They argued that practicing the conversation in a role-play type of approach would be most valuable to being able to discuss FGM/C in a cultural sensitive manner.

"I think that the chances of something going wrong are smaller for someone who is properly trained in cultural sensitivity, but doesn't know anything about FGM/C, than for someone who has had a training

on the medical technical aspect of FGM/C, but who does not work in a culturally sensitive manner." (Gynaecologist)

Organizational- and system related barriers and facilitators

Beyond the scope of the cultural competence framework participants mentioned multiple organizational and collaborative barriers and facilitators to discussing FGM/C.

Task trigger

Some professionals worked with a task trigger for discussing FGM/C that popped up on their screen based on the country of origin of a woman or (prospected) parents. For instance, if a woman from Somalia, comes in for a consultation at a youth health care clinic with her newborn girl, the professional gets a task trigger on their computer screen as a reminder that FGM/C should be discussed since the woman is originally from a practicing country. This task trigger pops up at each consultation with this person. Some professionals who had not such an automatic trigger in their system, indicated that they would prefer working with one to keep them from forgetting or avoiding the topic. Nevertheless, those working with the trigger in youth care, mentioned that it could get frustrating to continuously have to bring up the topic at each consultation when, for instance, the parent in question had already been there with other daughters. Next to that, since a professional had the possibility to ignore the task trigger, it was unclear whether FGM/C was discussed or a risk assessment was performed. Although professional's agreed this could negatively affect the recording of female circumcision, they simultaneously believed a certain degree of freedom for- and trust in colleagues was desirable. All in all, the task trigger was viewed as a helpful reminder to discuss FGM/C by the majority of the participants.

Time and funding

A lack of time during consultations was a structural barrier to discussing FGM/C for professionals working in health care (e.g. GP's and midwifes) and youth health care. Participants mentioned that the heavy workload of professionals and the additional time needed for consultations when language barriers played a role, all fueled the hesitation to discuss FGM/C. Professionals working at the Support

Centre for Domestic Violence and Child Abuse did not experience time as a barrier, since they were usually granted as much time as they needed to indicate a risk for FGM/C.

Funding for training opportunities and using cultural mediators varied greatly per region. For some, the funding was thus a barrier, whereas others were more so frustrated that some professionals did not use cultural mediators or joined training opportunities when there was indeed funding for that in their region. One professional had a pressing wish that the funding of the FGM/C chain approach, would go to executors such as midwifes, pediatricians or Support Centre for Domestic Violence and Child Abuse employees.

"My cry from the heart since I have been purely or mainly working in implementation is, let's allocate funds to the people who have to do the work. I'm definitely a big proponent of research like you do, (…), but above all let's make sure that the money we get for this also goes to the executors who have to do the work."(Doctor, Support Centre for Domestic Violence and Child Abuse)

Gender of professional

All professionals and cultural mediators, who touched upon the gender of professionals, indicated that it would be preferable and easier to discuss FGM/C with female professionals and interpreters due to its sensitive and gender-related nature.

"Interviewer: And does it matter whether you talk to a female or male doctor?

Participant: Yes always rather with women.

Interviewer: What happens when a man talks about this?

Participant: She will be really ashamed and cannot really talk normally about it." (Cultural mediator)

Internal and external collaboration

A frequently recurring facilitator for discussing FGM/C was the collaboration between the various partner institutions. Some experienced professionals mentioned that unfortunately not all colleagues know exactly who to contact or refer to when encountering a woman with FGM/C. Professionals

indicated that guidelines do exist, but that it is unsure if professionals are aware of them and if so, whether actions undertaken by professionals are in line with the guidelines in place. Some regions had alleged FGM/C working groups in which one employee of each partner institution, worked together to regularly meet and discuss their collaboration.

"We have it and it just works like a charm. Because you are very close to everything. You know each other well. You can just call each other, even outside the meetings." (Project manager for Harmful practices, GGD)

Staying in close contact with one another by meeting regularly was beneficial for the rapidness with which FGM/C cases could be tackled and solved. For instance, if parents were planning a trip to their country of origin with a young girl who might be at risk of FGM/C there, close ties between schools and the Support Centre for Domestic Violence and Child Abuse (Veilig Thuis), made it easier to quickly take action and have a discussion with the parents about FGM/C. Nevertheless, this had to be properly coordinated. It became clear how quickly fruitful collaborations can fade away when proper coordination is lacking. One participant said about a coordinator retiring: *"Then you notice that it becomes more fragmented and that it doesn't really belong anywhere. Who is responsible for the cultural mediators, who is responsible for the aftercare consultation hours? (…) We do keep each other informed a bit, but there is not really one designated person or one designated department where it is very clear: this is the subject." (Forensic Doctor)*

Professionals mentioned that specifically GPs are hard to reach when it comes to collaborating on the topic of FGM/C.

The lack of collaboration and information sharing between primary and secondary care was a thorn in side for most professionals. According to one participant, patient data sometimes disappeared when a patient record would be uploaded in her electronic system due to the differing systems for the various organizations. A nurse mentioned that at multiple times she saw FGM/C affected women who were in labour and had not yet discussed their FGM/C with for example a midwife or GP.

Fogginess surrounding the internal and external collaboration was especially tangible for the less experienced professionals. They mentioned that they would benefit from a, what they called, roadmap that indicates who to contact in different situations, such as who they could contact to help them in discussing the topic or when to contact the Support Centre for Domestic Violence and Child Abuse (Veilig Thuis). Cultural mediators emphasized their wish for professionals to know who to refer affected women to who, for instance, need specialist care due to the complications.

Templates, visual aids and information material

Professionals indicated a need for a template or document which they could employ for discussing FGM/C. Templates could include example sentences, do's and don'ts, and specific sentences that professionals can use as inspiration when women or (prospected) parents claimed they would not subject their daughter to FGM/C, but the professional was still unsure whether there was indeed no risk of female circumcision.

"Maybe just on an A4 size paper: How do you start such a conversation? What should you do and what not? Do's and don'ts. Something like that." (Project manager Harmful practices, GGD)

Furthermore, professionals wished to use visual aids during consultations such as images of the types of FGM/C or the deinfibulaiton process. Professionals said the visual aids had to be subtle to avoid a shocking effect. Some professionals already worked with visual aids. One of them reported that the captions of images were in Dutch and that it would be helpful if these would be written in a variety of languages. Professionals also expressed the need for brochures, posters or internet links with general information on FGM/C and its health consequences, for girls and women to review outside of the consultation. One professionals said this would also help to continue discussing female circumcision the next consultation, since she could then ask the women or girls what they thought about the information.

Due to the fact that cultural mediators play a large role in educating people from their own communities on FGM/C and the Dutch health care system in general, they too wished to have information material with general information on female circumcision as well as the Dutch FGM/C legislation in various languages which they could distribute among their communities.

Professionals working on prevention of FGM/C pointed out that they were sometimes unsure what indicators point to a risk of FGM/C. Hence, they mentioned the need for a more standardized list with basic information of the at-risk signs to better inform their future actions.

Impact of Covid-19

An additional overarching challenge that a small number of participants touched upon was dealing with covid-19 restrictions in the health care sector. Creatively adapting to new situations is a competency that, due to the global pandemic, has become more paramount. The COVID-19 crisis had created multiple challenges for discussing FGM/C. Professionals mentioned that consultations had or have to take place on the phone even though this was far from ideal.

"In this covid year it was also difficult because a lot of things had to be done over the phone and this is not really a topic that lends itself to be discussed over the phone" (Youth care nurse)

One professional indicated that the overview of the prevalence of FGM/C in the Netherlands had worsened due to COVID-19. According to her, it had become more complicated to know how people from practicing countries view FGM/C, or, in other words, whether they are pro or against practicing female circumcision, since professionals did not physically meet the women or (prospected) parents anymore. Next to that, a youth health care professional said she had missed extra schooling or training opportunities in the field of FGM/C, as they were put on hold. Hence, new professionals were not being trained to discuss the topic.

Table 5. Facilitators and barriers to discussing FGM/C based on interviews

Barriers	Facilitators, wishes and needs
Knowledge	
Lack of general knowledge regarding FGM/C	Training initiatives to enhance general medical technical knowledge regarding FGM/C (incl. personal story of an affected woman)
Lack of knowledge regarding discussing FGM/C in a cultural sensitive manner	FGM/C embedded in curricula
Lack of knowledge regarding guidelines and protocols on FGM/C management	Group information sessions about FGM/C for target groups
Attitude	
Sensitive nature of FGM/C as a topic to discuss	Being curious, integer and accepting towards patient/client
Cultural differences between professional and patient/client	Awareness of own and patient's/client's cultural background, values and beliefs
Stereotypical assumptions/discriminatory thoughts held against target group	Affinity with target group/getting acquainted/building rapport through showing interest and making contact Emphasize discussing FGM/C is professional's job
Skills	
Language barriers (incl. lack of using interpreters due to additional time/effort and uncertainty about translations)	Deploying interpreters and cultural mediators (incl. training on how to converse with an interpreter/cultural mediator)
Lack of intercultural communication skills/cultural sensitivity	Intercultural communication/ cultural sensitivity training (incl. role- play practicing approach)
Organizational- and system related barriers and facilitators	
Lack of time during consults	Automatic task trigger to discuss FGM/C based on the country of origin of the patient/client
Lack of funding for training initiatives	Frequent collaboration meetings with partner institutions
Heavy workload for professionals	Seamless exchange of patient data
Flaws in patient data exchange	Clear guidelines, protocols and roadmaps for contacting the chain approach actors as well as referring affected women Female professionals and interpreters/cultural mediators
	Collaborating with schools on FGM/C
	Templates including example sentences to introduce FGM/C or keep conversation going after a social desirable answer
	Non-shocking visual aids (e.g. images) with captions in a variety of languages
	Information material (e.g. folders, posters, internet links) for target group
	List with basic information needed for risk assessment

Discussion

This study described the barriers and facilitators to discussing FGM/C in an intercultural setting. The aims were to compare barriers and facilitators between professionals and women with FGM/C or (prospected) parents from practicing countries, in both health care settings as well as prevention services. With regard to the scoping review, studies in the latter setting were unfortunately not found during the literature search and those results thus merely pertain to the health care setting. That gap in the literature was to a certain extend covered during the in-depth interviews, but further research on discussing the prevention of FGM/C should be undertaken more rigorously to explore the barriers and facilitators in prevention services.

The main barriers to discussing FGM/C found in the review, included a lack of general knowledge regarding FGM/C, difficulties with language barriers, the sensitivity of the topic, and held stereotypes towards the target group. The most common facilitators were building a professional-patient relationship based on mutual trust and respect, enhanced collaboration between institutions involved in FGM/C management, and adequate education and training on FGM/C for health care professionals.

The results from the interviews show that, in practice, it remains a difficult task for Dutch (health) professionals to discuss female circumcision in depth, to work with interpreters or cultural mediators to overcome linguistic and/or cultural barriers, or to report cases to the Support Centre for Domestic Violence and Child Abuse (Veilig Thuis). The findings suggest that knowledge- and skills enhancement, awareness about cultural divides, strong collaboration between partners involved in FGM/C care or prevention, and organizational support, are all factors contributing to discussing FGM/C.

Comparison scoping review and in-depth interviews

Most barriers and facilitators described in the interviews resemble those from the scoping review. Language and cultural barriers, time constraints and the sensitivity of the topic were likewise the most mentioned barriers as in the articles reviewed. A couple of minor differences particular to the Dutch context were, first, the focus on working with cultural mediators. Both more experienced professionals and cultural mediators themselves emphasized the utility of working with cultural mediators and

simultaneously the need to do this more frequently in various regions. Second, the task trigger that reminded (health) professionals to discuss FGM/C when a patient or client had migrated from an FGM/C affected community, was often mentioned as a facilitator in the interviews. A more prominent difference was the fact that professionals involved in prevention indicated that most (health) professionals believe that it was more complicated to assess a risk and keep the discussion going once the conversation died down when women or (prospected) parents said they will not have their daughter(s) cut, compared to bringing up the topic and starting the conversation as was the main obstacle in the literature. The question that some professionals raised in regard of this was whether the need to go discuss FGM/C in more depth after such an answer was given, stemmed from the feeling that the parent(s) are not telling the truth. Implicit bias might play a role in this. In retrospect, this would have been valuable to have fleshed out during the interviews. The influence of implicit bias when discussing the prevention of FGM/C is an important issue for future research to study.

Comparison of professionals and women with FGM/C

For the scoping review a distinction was made between studies from the professional's perspective and those from FGM/C affected women. Most barriers and facilitators were equal for both professionals and affected women. Nevertheless, a number of barriers and facilitators were merely mentioned in studies from one perspective. It must be noted that this does not necessarily mean a facilitator or barrier is not a contributing factor according to the opposite group, as it is possible the topic was simply not covered in the studies. Further research is necessary to draw conclusions on the reasons for these discrepancies. First of all, studies on the women's perspective indicated that women experience a professional's poor attitude as a barrier to discussing FGM/C. This barrier did not come across in any of the studies with professionals. This might be because professionals' attitude could be influenced by subconscious ideas and values and as such professionals do not perceive their attitude as poor. Second, professional's mentioned in a number of studies that they feel as though women are sometimes skeptical towards the health care provision in host countries, which negatively influenced their adherence to health professional's advice. Nevertheless, skepticism towards host countries' health care systems was not a found barrier in the studies on women's perspective. It may be the case that women are not skeptical

even though professionals experience is as such, but as mentioned above, further research is needed to determine this. Third, both a barrier and facilitator for professional's was the involvement of family in women's care. Again, these were not touched upon by any of the articles from the women's perspective. Lastly, barriers and facilitators on the organizational level were, as can be expected, mostly mentioned in the literature from the professional's perspective. Factors on the individual and interpersonal level, on the other hand, were relatively more emphasized in studies from the perspective of women with FGM/C. For example, the majority of the studies with professional's focused on guidelines and collaboration to overcome barriers, whereas the literature on women with FGM/C was more so focused on respect and cultural awareness.

Comparison health care and prevention services

The barriers and facilitators for health professionals were to a large extend similar for the professionals working in the prevention of FGM/C. The main differences were that professionals working for the Support Centre for Domestic Violence and Child Abuse (Veilig Thuis) did not experience time constraints, whereas health professionals usually had to adhere to the 10/15 minute consultation time. Moreover, experienced health professionals indicated that women were relieved once the professional brought up FGM/C, while this was not mentioned as something that occurred for professionals working in prevention services. This might be because discussing the prevention of FGM/C, hence whether one will subject their daughter to the practice, could feel more intrusive compared to talking about a woman's health in relation to their FGM/C. It would be interesting for future research to investigate if women affected by female circumcision are indeed relieved to discuss FGM/C when a professional initiates the conversation and to what extend this differs between health care and prevention services.

Reflection on the Social Ecological Model and the Cultural Competence Framework

For the scoping review, the varied ways that the barriers and facilitators function and reinforce one another was better grasped by placing the data within the Social Ecological model. However, despite the categorized presentation of the barriers and facilitators according to the Social Ecological Model, it is important to acknowledge the interconnectedness between the various factors and avoid viewing them as merely affecting one level of influence. For instance, language barriers are exacerbated by time

constraints and vice versa. In like manner, the success of the cultural competencies described by Seeleman (2009), depends on the degree to which they are interactively used. Each competency is reinforced by the other ones. This was reflected in the interviews as most participants indicated that there is not one ultimate solution to discussing FGM/C. When it comes to discussing FGM/C, I personally believe that knowledge is the most important competency to bring up the topic. If a professional simply does not possess basic general knowledge on FGM/C, the chances are very rare that it will be discussed. However, in terms of during the conversation, the right attitude is paramount to ensure it is a fruitful conversation and that affected women or (prospected) parents from practicing countries will share more and return to that professional.

The interviews revealed that professionals not only believed it was important to be aware of how culture shaped the behavior of a patient or client, as described in the framework, but simultaneously how it shapes you as a professional. Emphasizing this as well would be a valuable asset to the attitude competency described by Seeleman (2009) and his colleagues. Furthermore, the barriers and facilitators in the organization and collaboration theme suggest that knowledge, skills, and attitude are not all there is to working with migrant populations. The systems and guidelines in place, the workload, and the time available in the organization one works for, as well as the extent to which collaborations are successful, additionally play a major role in discussing FGM/C. Balcazar and his colleagues (2009) argue that the Cultural Competence framework excludes organizational support, because of the strong influence of a clinical model that focuses on the individual. However, as also came from this study, an individual can have the best intentions to improve their intercultural communication skills and cross-cultural competencies, if the organization does not support them, their efforts might not succeed (ibid). The Social Ecological Model thus shows a more holistic picture of the various factors that influence discussing FGM/C, whereas the Cultural Competencies Framework focuses more on the professional itself, which provides a more limited view on the barriers and facilitators. Therefore, I believe the CC framework should not be used as a stand-alone framework, since one will miss important aspects (e.g. organizational support) that influence to what extent cultural competencies can be attained. Moreover, it neglects the interaction between professionals and patients or clients, while the interviews with

cultural mediators also revealed that sometimes the women with FGM/C or (prospected) parents have a negative attitude or hold assumptions about professionals, such as Dutch professionals not knowing anything about their culture and/or the tradition. Of course it is important for a professional to have the competencies to be able to respond to these situations, but I would argue that the other party and their contribution to the conversation should not be neglected.

All in all, I would argue that the Social Ecological Model has great potential for creating a clear overview of barriers and facilitators in the healthcare setting, specifically when focusing on policy and practice recommendations as are described below. In retrospect it would have been valuable to layer the findings of the interviews in this framework as well, to see the (dis)similarities between the two methods used. The SEM, however, lacks guidance for the improvement of certain individual and interpersonal level aspects. This is where the Cultural Competence Framework provides clarity, since the cultural competencies described by Seeleman (2009) are indeed clear examples of how knowledge, skills and attitude can be further developed when it comes to working with migrant populations. Nonetheless, as the SEM showed, more than merely training opportunities for the professional's knowledge, skills and attitude is necessary to open up the conversation on female circumcision. In my regard, this should start with more awareness among (health) professionals of the fact that FGM/C is an issue that indeed affects Dutch citizens and refraining from viewing it as a 'them' problem. Hence, taking responsibility in the fact that it also is their task to combat this practice in the Netherlands.

Limitations

Both the scoping review and the in-depth interviews were subjected to certain limitations. For the scoping review the following limitations could have influenced the results: first, the distribution of articles on professional's perspectives and FGM/C affected women's perspectives, was uneven with the majority of the studies referring to the former group. Second, due to time restrictions, screening studies beyond the search strategy was limited to examining reference lists of eligible articles. Third, as merely English written articles were include in the review, the generalizability to global contexts is limited. Fourth, no limitation was put on the date of the articles. As such, some barriers or facilitators might

already be outdated. However, the likelihood of this is small, since factors were found across multiple studies from various dates.

In terms of the interviews, all interviewees, both professionals and cultural mediators, indicated to oppose FGM/C. The barriers and facilitators to discussing FGM/C might have varied if some participants had differing views towards the practice. Secondly, although all cultural mediators were also FGM/C affected women and could thus express themselves from personal experience, women with FGM/C who were not active as cultural mediators were not interviewed. This group likewise could have given different answers and thus results. Thirdly, the distribution between health care professionals and professionals active in the prevention of FGM/C was uneven, as the majority of the professionals were part of the latter. Lastly, the gender of the participants may have introduced some bias as all participants identified as women. Future research could aim to include the groups that were underrepresented in the sample.

Policy recommendations

The findings of this study suggest several courses of action for both policy and practice. With regards to policy, the scoping review, specifically the findings on the policy/environmental level revealed that there is much to be gained in terms of engaging affected communities in FGM/C care and prevention. With the introduction of cultural mediators in the health care sector, the Netherlands seems to be working on the idea that policies and practices should be created in collaboration with affected communities. However, due to the variation in the extent to which cultural mediators are being used across different regions, a need for a more nationalized approach to tackling FGM/C comes to light. The regional differences made it difficult for professionals to understand what to do when encountering a woman with FGM/C or a risk of circumcision. Therefore, guidelines and protocols should provide a clear roadmap for whom to collaborate with for the regions individually and likewise on a national level if cases have to go beyond the regional approach (e.g. an affected woman needs specialized care only provided in another region). This goes hand in hand with a more national approach to the allocation of funds for the usage of cultural mediators. In the region of Utrecht, cultural mediators were not being

employed, since funds were allocated differently, while the findings suggest a positive impact of cultural mediators on discussing FGM/C.

Practice recommendations

The organizational facilitators mentioned in both the review as well as the interviews, can be regarded as practice recommendations for discussing FGM/C and thus its care and prevention in the Netherlands. The most important ones that could be implemented are described. First, the automatic task trigger to discuss female circumcision when a patient or client is originally from a practicing country, should be employed in all health care and prevention services, to make sure that if an affected woman comes in with symptoms, the health professional is made aware of the fact that these could be related to her FGM/C, diminishing the chances a woman has to go through multiple consultations and medical treatments before the cause of her symptoms is detected. For both health care and prevention, the task trigger is helpful to remind the professional it should be discussed if they are not aware of all the prevalence countries. Second, the language barrier was one of the most recurring and pressing barriers for both professionals and women. Interpreters are to overcome this, however both the review and the interviews, showed how professionals are not always comfortable working with interpreters, mainly due to a lack of trust in their translations. This finding raises the need for investigating how interpreters can facilitate discussing in a way the professional feels confident in the process, and how professionals might be trained to work with qualified interpreters. Besides, increasing diversity within the medical staff (e.g. more health professionals originally from practicing countries), could also be a solution to said linguistic and cultural barriers. Third, the exchange of patient data between various health and prevention institutions has to be more seamless. This means that, next to consistent information sharing, the systems institutions work with should match one another, so no data is lost during the transfer. Fourth, templates are to be made easily available and accessible for all professionals. These templates should include example sentences for discussing FGM/C and, specifically for the prevention services, how to answer when (prospected) parents say they will not subject their daughter to FGM/C, but you do not feel completely confident in their answer. Fifth, specifically recently migrated women with FGM/C often did not know they had been circumcised, and/or that their FGM/C is the cause of many physical or

psychosocial symptoms they experience. Therefore, it would be best if information regarding FGM/C and the Dutch legislation (with an emphasis on the fact that being circumcised is not considered a crime), is given to women from practicing countries, early upon their arrival in the Netherlands.

Conclusion

In spite of the limitations, the current study offers valuable insights into the barriers and facilitators to discussing FGM/C in an intercultural setting. A gap in the literature on discussing the prevention of FGM/C in host countries with people from practicing communities, revealed itself during the literature search. Discrepancies between barriers and facilitators found in studies on professional's perspective and the perspective of FGM/C affected women, highlight the need for further in-depth research in this field. To improve the experiences of affected women and/or parents from practicing countries, the findings of this study imply the need for more training opportunities for (health) professionals to gain confidence in discussing female circumcision. Respect and acceptance were emphasized to bridge barriers between professionals and women with FGM/C or (prospected) parents from practicing countries. This will most likely contribute to discussing female circumcision more frequently and in a culturally sensitive manner. If FGM/C is not discussed and remains under the radar, the provision of high-quality cross-cultural care and the protection of (young) women is unattainable. In order to overcome this, the abovementioned practice recommendations ideally are to be implemented on a national level. However, raising awareness among (health) professionals about the already existing tools or training opportunities available to them seems likewise essential, as it became clear not all professionals are aware of this. Ultimately, discussing FGM/C should be higher on the agenda of (health) professionals and health care institutions to improve the care experience of women with FGM/C and increase the likelihood that girls and women at risk are being identified and protected.

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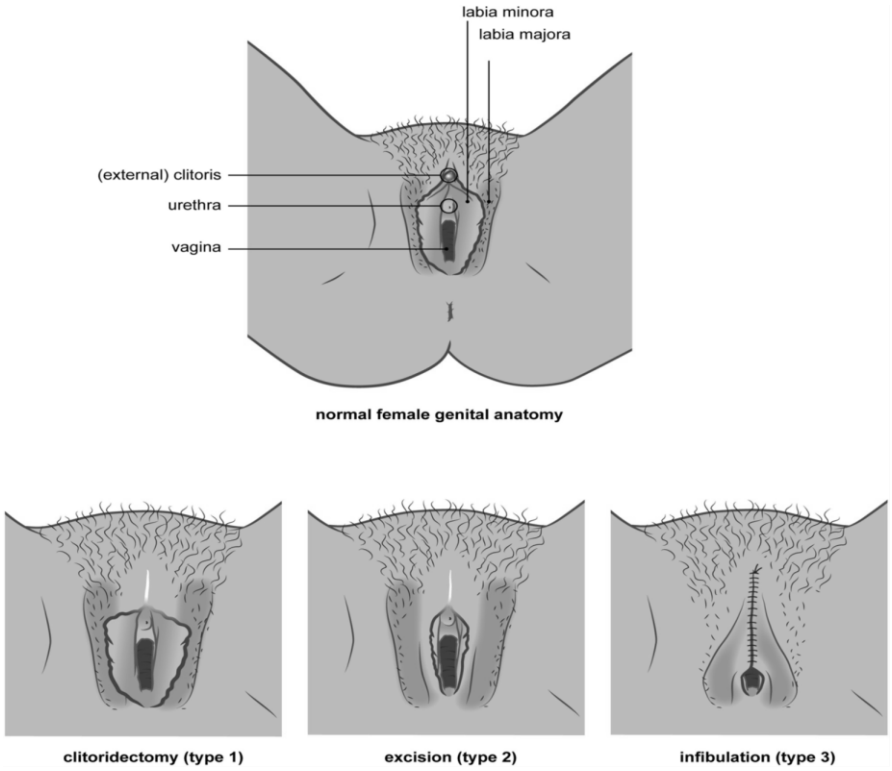
Appendix

Fig 1. World Health Organization classification of female genital mutilation or cutting. Type I refers to excision of the prepuce, with or without excision of part or all of the clitoris. Type II refers to excision of the clitoris with partial or total removal of the labia minora. Type III refers to excision of part or all of the external genitalia and stitching or narrowing of the vaginal opening (infibulation). Type IV includes all other harmful procedures to the female genitalia for nonmedical purposes, e.g., pricking, piercing, incising, scraping and cauterizing the genital area (WHO, 1998, 2020)



Literature Search

Embase.com	183	183
Medline ALL Ovid	115	39
Web of Science SCI-EXPANDED & SSCI	40	5
Total	**338**	**227**

Embase.com 183
('female genital mutilation'/exp OR (((female OR girl* OR women OR woman) NEAR/6 genital* NEAR/3 (mutilat* OR cutting*)) OR fgm OR fgc OR infibulat* OR deinfibulat* OR reinfibulat* OR ((female OR girl* OR women OR woman OR pharaon*) NEAR/3 circumcis*) OR clitorectom* OR clitoridectom*):ab,ti) AND ('professional-patient relationship'/exp OR ('interpersonal communication'/exp AND ('health care personnel'/exp OR 'health personnel attitude'/exp)) OR (((physician* OR doctor* OR provider* OR professional* OR personnel* OR worker* OR GP OR gps OR practitioner* OR gynecologist* OR gynaecologist* OR midwife* OR midwive*) NEAR/6 (relationship* OR discuss* OR barrier* OR facilitator* OR communicat* OR mention* OR address* OR talking OR taboo*))):ab,ti)

Medline ALL Ovid 115
(Circumcision, Female/ OR (((female OR girl* OR women OR woman) ADJ6 genital* ADJ3 (mutilat* OR cutting*)) OR fgm OR fgc OR infibulat* OR deinfibulat* OR reinfibulat* OR ((female OR girl* OR women OR woman OR pharaon*) ADJ3 circumcis*) OR clitorectom* OR clitoridectom*).ab,ti.) AND (exp Professional-Patient Relations/ OR (Communication/ AND (exp Health Personnel/ OR exp Attitude of Health Personnel/)) OR (((physician* OR doctor* OR provider* OR professional* OR personnel* OR worker* OR GP OR gps OR practitioner* OR gynecologist* OR gynaecologist* OR midwife* OR midwive*) ADJ6 (relationship* OR discuss* OR barrier* OR facilitator* OR communicat* OR mention* OR address* OR talking OR taboo*))).ab,ti.)

Web of Science SCI-EXPANDED & SSCI 40
TS=(((((female OR girl* OR women OR woman) NEAR/5 genital* NEAR/2 (mutilat* OR cutting*)) OR fgm OR fgc OR infibulat* OR deinfibulat* OR reinfibulat* OR ((female OR girl* OR women OR woman OR pharaon*) NEAR/2 circumcis*) OR clitorectom* OR clitoridectom*)) AND ((((physician* OR doctor* OR provider* OR professional* OR personnel* OR worker* OR GP OR gps OR practitioner* OR gynecologist* OR gynaecologist* OR midwife* OR midwive*) NEAR/5 (relationship* OR discuss* OR barrier* OR facilitator* OR communicat* OR mention* OR address* OR talking OR taboo*)))))

Data charter form

Article number	Publication year	Author(s)	Title	Purpose/objective	Design	Method	Country of origin: Host country:	Study population
1	1997	C.R. Horowitz, J.C. Jackson	Female "Circumcision" African Women Confront American Medicine	To understand and adress conflicts that occur when clinicians provide care to patients whose beliefs and practices differ from their own.	Qualitative study	informal discussion and interviews	Ethiopia, Eritrea and Somalia United States and Canada	clinicians and FGM/c affected women
2	2002	K. Bulma, C. McCourt	Somali refugee women's experiences of maternity care in west London: A case study	To develop an understanding of the reality faced by Somali women in their contacts with the maternity services in the UK	Qualitative study	interviews and focusgroups	Somalia United Kingdom	FGM/C affected women
3	2002	C. Widmark, C. Tishelman, B. Ahlberg	A study of Swedish midwives' encounters with infibulated African women in Sweden	To investigate Swedish midwives' perceptions and attitudes towards infibulation and infibulated women	Qualitative study	focus group discussions and interviews	Sweden	Midwives
4	2005	C. Thierfelder, M. Tanner, C. Bodiang	Female genital mutilation in the context of migration: Experience of African women with the Swiss health care system	To analyse how immigrant women with FGM experience gynaecological/obstetrical care in the Swiss health care system, and to investigate if physicians and midwives treat and	Qualitative study	focusgroups, interviews	Somalia and Eritrea Switzerland	Health care professionals and FGM/C affected women

				counsel FGM related complications adequately.				
5	2009	L. Straus, A. McEwen, F. Hussein	Somali women's experience of childbirth in the UK: Perspectives from Somali health workers	To conduct a qualitative study of perceptions of experiences of childbirth from Somali health workers in the UK	Ethnopgraphic qualitative study	interviews	Somalia United Kingdom	Somali female healthcare professionals
6	2010	C. Widmark, A. Levál, C. Tishelman et al.	Obstetric care at the intersection of science and culture: Swedish doctors' perspectives on obstetric care of women who have undergone female genital cutting	To explore obstetrician's perspectives on caring for women with FGC in Sweden	Qualitative study	interviews	Sweden	Obstetricians
7	2013	J. Lazar, C. Johnson-Agbakwu, O. Davis et al.	Providers' Perceptions of Challenges in Obstetrical Care for Somali Women	To obtain information about providers' experiences, training, practices and attitudes surrounding the prenatal care, delivery, and management of women with Female Genital Cutting (FGC)	Qualitative study	interviews	Somalia United States	Obstetricians/gynecologists and midwives
8	2014	M. d'Entremont, L. Smythe, J.	The Sounds of Silence-A Hermeneutic Interpretation of	To more fully understand circumcised women experiences of childbirth	Hermeneutic phenomenology	interviews	France	FGM/C affected women

		McAra-Couper	Childbirth Post Excision					
9	2015	U. Byrskog, P. Olsson, B. Essén et al.	Being a bridge: Swedish antenatal care midwives' encounters with Somali-born women and questions of violence; a qualitative study	To explore ways ANC midwives in Sweden work with Somali born women and the questions of exposure to violence	Qualitative study	interviews	Somalia Sweden	Midwives
10	2015	A. Dawson, S. Turkmani, N. Varol et al.	Midwives' experiences of caring for women with female genital mutilation: Insights and ways forward for practice in Australia	To provide insight into midwives' views of, and experiences working with, women affected by FGM	Descriptive qualitative study	focus group discussions	Australia	Midwives
11	2016	O. Ogunsiji	Australian midwives' perspectives on managing obstetric care of women living with female genital circumcision/mutilation	To report Australian midwives' stories about how they manage obstetric care of women living with FGM	Qualitative Heideggerian phenomenology	interviews	Australia	Midwives
12	2016	J. Moxey, L. Jones	A qualitative study exploring how Somali women exposed to female genital mutilation	To explore how Somali women exposed to female genital mutilation experience and	Descriptive, exploratory qualitative study	interviews	Somalia United Kingdom	FGM/C affected women

			experience and perceive antenatal and intrapartum care in England	perceive antenatal and intrapartum care in England				
13	2017	S. Koukoui	Female Genital Cutting/Mutilation: a Challenge for Patients and Clinicians	To shed some light on the perspectives of both health care providers and women with FGC/M on the clinical encounter	n/a	commentary	n/a	
14	2020	S. Dixon, L. Jinton, S. Ziebland	Supporting patients with female genital mutilation in primary care: A qualitative study exploring the perspectives of GPS' working in England	To explore the perspectives of GPs working in England on potential challenges and resource needs when supporting women and families affected by FGM	Qualitative study	interviews	United Kingdom	General practitioners
15	2020	V. Mbanya, L. Terragni, A. Gele et al.	Barriers to access to the Norwegian healthcare system among sub-Saharan African immigrant women exposed to female genital cutting	To explore the experiences and perceptions hindering access and use of the Norwegian healthcare system among sub-Saharan African (SSA) immigrant women exposed to FGC	Qualitative study	interviews	Norway	SSA immigrant women
16	2020	R. Kawous, E. Allwood, E. Norbart et al.	Female genital mutilation and women' s healthcare experiences with general practitioners	To look into the experiences of women with FGM/C in Dutch general practice	Qualitative study	interviews	the Netherlands	FGM/C affected women

			in the Netherlands: A qualitative study					
17	2020	M. Ugarte-Gurrutxage, B. Molina-Gallego, L. Modillo-Mateos et al.	Facilitating factors of professional health practice regarding female genital mutilation: A qualitative study	To learn about the factors that healthcareprofessionals consider as facilitators for prevention and action when faced with female genital mutilation	Cross-sectional descriptive study	interviews and discussion groups	Spain	health professionals
18	2014	C. Vaughan, N. White, L. Keogh et al.	Listening to Victorian communities about female genital cutting	To investigate the local impact of FGC in order to better design, deliver and evaluate appropriate responses.	Qualitative study	focus group discussions, small group discussions, interviews	Australia	North Yarra community members and health professionals
19	2012	Simpson, J, K. Robinson, S. Creighton et al.	Female genital mutilation: The role of health professionals in prevention, assessment, and management	To provide health professionals with a practical approach to the assessmentand management of women and girls with FGM, coupled with strategies aimed at prevention.	N/A	grey literature search, clinical experiences, personal communications	United Kingdom	N/A