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FEMALE GENITAL MUTILATION

AND THE SWISS HEALTH CARE SYSTEM

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List of abbreviations

ANTAGEM	Anthropologists against genital mutilation
CAR	Central African Republic
DRC	Democratic Republic of Congo
EU	European Union
FGM	Female genital mutilation
HCP	Health care provider
IC	Ivory Coast
GAMS	Groupement d`Abolition des Mutilations Sexuelles
ICRH	International Centre for Reproductive Health
NGO	Non-governmental Organisation
SDC	Swiss Development Cooperation
SL	Sierra Leone
UK	United Kingdom
UN	United Nations
UNICEF	United Nations Children's Fund
UNFPA	United Nations Development Programme
WHO	World Health Organisation

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Summary

World-wide, more than 120 million girls and women are estimated to have undergone female genital mutilation (FGM), and each year 2 million more are subjected to these practices in the name of traditional culture. FGM is practised mainly in 28 African countries with a wide range of variation in prevalence rates between and within the countries concerned. Increasing international migration from regions where FGM is traditional has brought the practice to Europe. Receiving countries have been unfamiliar with these traditional practices, and health care providers face multiple questions in connection with FGM. Compared to other European countries, in Switzerland official attention to the subject of FGM has been a very recent phenomenon.

Previous studies referring to FGM and health care in Switzerland only presented the issue from the health care provider's side. Objectives of this study were to analyse how immigrant women with FGM experience gynaecological/obstetrical care in the Swiss health care system, and to investigate if gynaecologists/obstetricians and midwives, those health care professionals most directly concerned, are apt to treat and counsel FGM related complications adequately. Based on these findings the aim was to generate recommendations for the Swiss health care system. The quantitative part of the study aimed to estimate the prevalence rate of girls and women concerned in Switzerland, and to examine their distribution by country of origin, place of residence, and age group in the host country.

The quantitative part of the study consisted of data analyses concerning the current number of women from 28 FGM practising countries living in Switzerland, as provided by the Federal Office for Foreigners (2001) and the Federal Office for Refugees (2001). This study's emphasis was placed on the qualitative part that consisted of focus group discussions and in-depth interviews with women (n=29) and men (n=3) of the migrant communities from Somalia and Eritrea. Furthermore, in-depth interviews (n=37) with Swiss health care providers (20 physicians and 17 midwives) were carried out.

In 2001, there were more than 10,500 women and girls from FGM practising countries officially living in Switzerland. A prevalence rate of 4,051/10,501 women (≥ 16 years old) concerned has been estimated. More than 2/3 of the women living in Switzerland estimated to have undergone FGM are from Somalia, Ethiopia and Eritrea. 70% of the women concerned live in the large metropolitan areas, predominantly in the French speaking part of Switzerland.

The main FGM-related health complications that women from Somalia and Eritrea suffered from were a painful and prolonged menstruation, pain and reduced feelings during sexual intercourse. In Switzerland obstetric complications play a smaller role than in their countries of origin. Therefore, psychosexual complications become more prominent consequences of FGM. The concern of being different from women of the host society as FGM interferes with sexual pleasure, is a consequence that the migrant women face particularly. However, participants who had undergone FGM expressed a strong inter-individual variability with respect to sexual response. Generalisations that having undergone FGM leads to sexual indifference, are not based on evidence and might contribute to stigmatise women concerned.

Consequently, the aspect of gynaecological/obstetrical care was found to be more challenging in terms of a culturally sensitive interpersonal interaction between women concerned and health care providers, than in relation to technical management of FGM. The following aspects of the consultation concluded to be critical: the reactions of several health care providers when first facing a mutilated vulva (FGM type III) ranged from disclosing shock in front of the patient to totally ignoring the condition of FGM. A complete medical history related to FGM, including probing for FGM related complications, was not performed in most cases. Particularly, the sexual and social complications were rarely discussed. Regarding prevention, only 8% of the participating health care providers systematically addressed the future of concerned women's daughters. The issue of reinfibulation (re-establishment of infibulation or re-suturing the vulva after delivery to the antepartum state), a question specifically linked to obstetrical care of women with FGM type III, presents an ethical conflict for the gynaecologists/obstetricians and midwives. Ultimately all interviewed health care providers give priority to the wish of an adult patient and support partially re-suturing the vulva after delivery if requested. However, in respecting the interests of their clients, some Health care providers clearly violated the patient's rights by performing the intervention without thoroughly informing the patient. While other European countries ban reinfibulation (UK, Belgium) or clearly define degree and conditions concerning this intervention (Denmark), partial reinfibulation without existing guidelines is carried out at the obstetric services of all Swiss university hospitals participating in this study.

A striking lack of communication is a prominent finding in this study. This lack of discussing FGM is obvious between women concerned and health care providers, the women and their husbands/partners and even between the women of the same migrant community. As to the gynaecological/obstetrical consultation, main obstacles

were the language barrier, the general delicacy of the subject and the fact that FGM is a highly gender sensitive issue, which was a problem particularly for the male health care providers perceiving the women's reluctance to discuss FGM with a man. Among the couple it is the taboo of talking about FGM that contributes to maintaining the women's unconfirmed assumption that men of their cultural background generally prefer those women having undergone FGM. However, the young men of the migrant communities included in this study opposed FGM. Finally, there is a striking lack of exchange among the women concerned. This causes a difficult situation particularly for the adolescent women who are often not able to talk with their mothers about physical and social problems linked to FGM and thus carry the burden of secretly seeking for medical help without any support of their families. Yet, even for several women of the same generation and cultural background it was the first time they shared FGM related complications with each other in the context of this study.

Difficulties with FGM related gynaecological/obstetrical management were greatest in the first half of the 1990s, the time when most Somali immigrants entered Switzerland. Meanwhile, several gynaecologists/obstetricians and midwives at the university hospitals developed a certain experience in the management of FGM. In the regional hospitals however, where Health care providers are much less exposed to such cases, the lack of experience is much more obvious. Thus, at several regional hospitals in Switzerland to avoid vaginal deliveries in women with FGM type III, caesarean sections have been carried out. FGM type III as such is no medical indication for caesarean section. Moreover, with the perspective of migrant women to return eventually to their home countries where subsequent caesarean sections may be difficult to realise in resource poor areas, a previous caesarean section can then present a risk. Furthermore, the majority of participating women opposed caesarean section as they wished to maintain the option of many deliveries.

Migrants from Sub-Saharan Africa are one of the most vulnerable populations in the Swiss health care system. FGM means an additional burden for women from these communities. This study reveals that gynaecological/obstetrical care in Switzerland often does not meet the women's specific needs with respect to FGM. This is not due to lack of empathy or good will on the side of the Health care providers, but rather due to the fact that most Health care providers in Switzerland lack exposure, experience and guidance on how to care for such women. However, considering that FGM is a subject of great delicacy, inappropriate health care can even increase the women's burden by making them feel stigmatised.

Gynaecological/obstetrical care for clients who have undergone FGM needs to be adapted to a culturally more appropriate care and to a better management. Thus, FGM should be included in pre-and postgraduate education for gynaecologists/obstetricians and midwives in Switzerland. In order to improve the situation characterised by a multilateral lack of communication, possibilities of networking should be initiated. Exchange should be fostered between health care providers of different institutions in the country, harmonising experiences and making use of resource persons. Moreover, existing experience and instruments from other European countries should be included in the elaboration of further measures in Switzerland. Finally, it is a priority to offer the women concerned opportunities to share and discuss among each other their experiences related to FGM, integrating thematic subjects about delivery, sexuality and genital anatomy of a woman.

Women concerned are geographically concentrated in the large metropolitan areas of Switzerland and predominantly consult in the large canton hospitals for gynaecological/obstetrical care. Therefore, focussed efforts could make a great improvement for the women from Sub-Saharan Africa and for their health care providers in the Swiss health care system.

Resumé

Selon une estimation publiée par l'Organisation Mondiale de la Santé en 2001, plus que 120 millions de filles et de femmes dans 28 pays africaines ont subi une forme de mutilation génitale féminine (MGF). On estime à plus de 2 millions le nombre de jeunes filles exposées à des mutilations sexuelles chaque année. La migration internationale a augmentée pendant les dernières années et en Europe on trouve de plus en plus la MGF parmi la population immigrée. Les pays hôtes ne sont pas accoutumés à cette tradition. Des questions par rapport à la MGF se posent donc pour les professionnels de santé.

Des études précédents sur la MGF dans le système Suisse de santé ont démontrés uniquement la perspective des gynécologues face à la MGF. L'objectif de cette étude était d'analyser les perspectives des femmes atteintes en mettant l'accent sur leur perception du système de santé Suisse et de rechercher si les professionelles les plus concernés, comme les gynécologues/obstétriciens et les sages-femmes, sont en mesure de traiter et de conseiller les femmes au sujet de la MGF. Basé sur ces données, le but était de formuler des recommandations pour le système de santé Suisse. La partie quantitative de l'étude avait le but d'estimer le taux de prévalence des femmes touchées, résidant en Suisse et d'examiner leur répartition selon le pays d'origine et le lieu de résidence ainsi que le groupe d'âge dans le pays hôte.

Pour la partie quantitative, le nombre actuel des femmes résidant en Suisse et des femmes réfugiées de 28 pays Africains, où la MGF se pratique, était fourni par l'Office Fédérale des Réfugiés (2001) et par l`Office Fédérale des Etrangères (2001). Un taux de prévalence estimé des femmes ayant subit la MGF était calculé. L'accent de cette étude était mis spécialement sur la partie qualitative. 29 femmes de la Somalie (n=24) et de l'Erythrée (n=5) ayant subit la MGF participaient aux discussions de groupes focaux et d'entretiens approfondis. De même trois hommes de la communauté somalienne étaient interviewés. 37 entretiens approfondis avec des médecins (n=20) et avec des sages-femmes (n=17) étaient effectués.

Il y a plus que 10'500 de femmes et de filles des pays pratiquant la MGF qui vivent officiellement en Suisse. 72 % des femmes ont 16 ans et plus que 16 ans et 28 % sont des filles ayant 15 ans ou moins que 15 ans. Nous estimons à 4'051/10'501 ($\geq$ 16 ans) des femmes concernées. Par rapport à la répartition selon les nationalités, plus que 2/3 des femmes résidant en Suisse ayant subit la MGF viennent de la Somalie, de

l'Ethiopie de l'Erythrée. 70 % vivent dans les grandes villes de la Suisse. La répartition cantonale comparée avec la densité de la population Suisse montre que la majorité vit dans la partie francophone.

La plupart des femmes ayant participé à cette étude évoquaient des menstruations douloureuses et prolongées et des difficultés lors des rapports sexuels. Le degré des complications de santé était lié au type de la MGF. Elles ne sont pas uniquement d'origine médicale, elles peuvent aussi bien être d'origine sociale. L'inquiétude d'être différente des femmes du pays hôte (due au faite que la MGF interfère avec la faculté sexuelle) est une conséquence spécifique à laquelle les femmes immigrées sont confrontées. Les participantes à cette étude exprimaient une forte variabilité individuelle par rapport à la réponse sexuelle. Ainsi, l'idée que toutes les femmes ayant subi de la MGF souffrent d'indifférence sexuelle n'est pas fondée et pourrait contribuer à la stigmatisation des femmes concernées.

Lors de la consultation gynécologique/obstétricale, il est moins l'aspect technique de la MGF que l'interaction culturelle sensible qui relève le véritable défi entre le professionnel de santé et la femme concernée. Surtout les points suivantes sont critiques: Souvent les professionnels de santé interviewés n'ont pas établi de dossier médical complet sur la MGF. Les complications psychosociales et sexuelles ont rarement été abordées. Plusieurs professionnels de santé interviewés étaient conscients qu'ils jouaient un rôle important par rapport à la prévention de la MGF. Cependant concernant le futur des filles des femmes concernées, le sujet de la MGF a été négligé lors de la majorité des consultations. Pour les professionnels de santé le sujet de la réinfibulation (recoudre la vulve après l`accouchement à l`état prépartal) présente un conflit éthique. Tous les professionnels de santé déclaraient de donner la priorité au souhait de la femme d'être réinfibulée partiellement, si elle le désirait. Toutefois il y a défauts en informant les patientes sur la procédure et les possibilités des alternatives. Différent des autres pays européens qui s'opposent strictement à la reinfibulation (le Royaume Uni, la Belgique) ou bien définissent le degré et les conditions de l`intervention (le Danemark), il n'existe pas de directives sur la réinfibulation en Suisse et des réinfibulation partielles sont effectués dans tous les hôpitaux universitaires participant à cet enquete.

Un manque de communication général des communautés concernés par rapport à la MGF est imminent à plusieurs niveaux: entre patient et professionnel de santé, entre mari et femme, entre fille et mère, et même entre les femmes immigrées de la même génération. Lors de la consultation gynéco-obstétricale, un obstacle majeur était la bar-

rière de la langue. Toutefois d'autres raisons, comme le caractère intime du sujet et la question délicate du genre contribuaient de ne pas aborder la MGF lors de la consultation. Pendant les consultations médicales il était particulièrement difficile pour des professionnels de santé masculins d'aborder le sujet de la MGF avec les femmes concernées. A travers de la non-communication entre femme et son partenaire les arguments appliqués de continuer la pratique de la MGF laissent demeurer des suppositions et des inquiétudes non confirmées. Contrairement aux prévisions, les jeunes hommes des communautés immigrées s`opposaient à la MGF. Les immigrées adolescentes sont particulièrement vulnérables par rapport aux complications de la MGF. Souvent il est impossible pour elles de régler les problèmes avec leurs mères et le degré de la souffrance les motive d'échanger leurs expériences avec les professionnels de santé sans l`assistance de leurs familles. En plus, la majorité des femmes ayant participé à l'étude disaient qu'elles n'ont jamais discuté sur la MGF et les complications de la santé avec d'autres femmes avant cette étude.

Les difficultés liées au « management » de la MGF etaient les plus grandes au début des années 1990 quand la majorité des immigrantes Somaliennes sont arrivées en Suisse. Aujourd'hui, plusieurs gynécologues et sages femmes aux hôpitaux universitaires ont acquit de l'expérience. Cependant, dans les hôpitaux régionaux qui rencontrent ces cas très rarement, la manque d'expérience et beaucoup plus évident. La section césarienne chez les femmes infibulées ne présente pas de justification médicale, s'il n y a pas d'autres complications demandant l'intervention. Mais, dans trois-quart des hôpitaux régionaux participant à l`étude la section césarienne a été effectuée pour éviter l'accouchement vaginal des femmes ayant subit la MGF de Type III. De plus, avec la perspective des femmes immigrées de retourner un jour dans leur pays d'origine, où d'autres sections césariennes seraient difficile à réaliser, une section césarienne préalable peut présenter un risqué.

Les migrantes de l`Afrique Sub-Saharienne représentent une des populations les plus vulnérables dans le système Suisse de santé. Le fardeau lié à la MGF préoccupe particulièrement ces femmes. L`étude montre que le traitement gynéco-obstétricale souvent ne répond pas aux besoins des femmes concernées. Ceci n`est pas du à un manque d`empathie de la part des professionnelles, mais plutôt à cause d`un manque d`exposition, d`expérience et de conseil par rapport à la MGF. Cependant, en considérant que la MGF est un sujet de grande délicatesse, des soins inappropriés peuvent meme augmenter les difficultés de ces femmes en les faire sentir stigmatisées.

Le traitement gynéco-obstetricale pour les patientes ayant subi la MGF doit être adapté à une meilleure gestion de soins médicalement et culturellement appropriés. Les gynécologues/obstétriciens et les sages-femmes devraient être préparés et formés aux niveaux pré- et postgradués. Un réseau d`information devrait etre créé entre les professionnelles de santé et les différentes institutions en Suisse, en profitant des expériences des personnes clefs. De plus, l'expérience et les instruments utilisés dans d'autres pays européens devraient être inclus. Dans le contexte du manque de communication et de transparence il est impératif d'offrir aux femmes immigrées l'opportunité de s'informer et d'échanger les expériences liées à la MGF. Lié à cela, du matériel pédagogique sur la grossesse, la sexualité et la structure des organes génitaux féminins permettrait une meilleure compréhension. Cependant, l'information ne devrait pas être réduite uniquement à l'anatomie et la physiologie des organes génitaux féminins. La dimension sociale a besoin d'être inclue en considérant entièrement l'être humain.
En Suisse les femmes concernées vivent principalement concentrées dans les grandes villes. Elles consultent surtout les grands hôpitaux cantonaux pour le traitement gynéco-obstétricale. Donc, les efforts focalisés pourraient permettre des grandes améliorations pour les femmes concernées et pour les professionelles de santé qui les soignent.

Zusammenfassung

Weltweit sind Schätzungen der Weltgesundheitsorganisation zufolge mehr als 120 Millionen Mädchen und Frauen Opfer der weiblichen Genitalverstümmelung (female genital mutilation [FGM]). Jährlich sind davon weitere 2 Millionen Mädchen betroffen. FGM wird überwiegend in 28 Afrikanischen Ländern praktiziert. Die Zunahme der weltweiten Migration hat dazu geführt, dass FGM von den ursprünglichen Verbreitungsgebieten ausgehend nach Europa gekommen ist. Die Gastgeberländer sind mit diesen traditionellen Bräuchen nicht vertraut und im Gesundheitswesen Tätige sehen sich mit verschiedenen Fragen in Bezug auf FGM konfrontiert.

Die bisher im Schweizerischen Gesundheitswesen zu FGM durchgeführten Studien untersuchten das Thema ausschließlich aus Sicht der Gynäkologen. Um zu analysieren, wie von FGM betroffene Frauen die gynäkologisch-geburtshilfliche Behandlung in der Schweiz wahrnehmen, wählte diese Studie einen qualitativen Ansatz. Hierfür wurden Fokusgruppendiskussion und strukturierte Tiefeninterviews mit betroffenen Frauen aus Somalia (n=24) und Eritrea (n=5) durchgeführt. In 37 Tiefeninterviews mit Ärzten (n=20) und Hebammen (n=17) wurde der Frage nachgegangen, ob FGM und assoziierte Komplikationen angemessen behandelt werden. Basierend auf diesen Ergebnissen war es ein Ziel, Empfehlungen an das Schweizerische Gesundheitssystem zu formulieren. Der quantitative Teil der Studie umfasste eine Analyse von Daten des Bundesamtes für Ausländerfragen und des Bundesamtes für Flüchtlingsfragen bezüglich der aktuell in der Schweiz lebenden Nationalitäten aus 28 afrikanischen Ländern, in denen FGM praktiziert wird.

Es wurde ermittelt, dass derzeit in der Schweiz 10501 Ausländerinnen aus den 28 afrikanischen Ländern, in denen FGM praktiziert wird, leben. Davon sind unseren Schätzungen zufolge 4051 Frauen (>16 Jahre alt) von FGM betroffen (Prävalenzrate: 386/1000). Mehr als 2/3 dieser Frauen stammen aus Somalia, Äthiopien und Eritrea. 70% leben in den städtischen Regionen der Schweiz. Die auf die Bevölkerungsdichte berechnete kantonale Verteilung der betroffenen Frauen zeigt, dass sie überwiegend im Französisch- sprachigen Teil der Schweiz leben.

Als Hauptkomplikation von FGM gaben die Frauen eine schmerzhafte und verlängerte Menstruationsblutung und Sexualitätsstörungen an. Das Ausmaß der Symptomatik korrelierte mit dem Schweregrad der Beschneidung. Geburtshilfliche Komplikationen spielen in der Schweiz eine wesentlich geringere Rolle als in den Heimatländern. Dafür tre-

ten jedoch die psychosexuellen Probleme in den Vordergrund. Eine Folge von FGM, welche speziell die betroffenen Migrantinnen tragen, ist die Sorge, in Bezug auf die Sexualität anders zu sein als die Frauen des Gastlandes. Dabei war gerade das interindividuelle Erleben der Studienteilnehmerinnen im Hinblick auf die Sexualität sehr unterschiedlich. Verallgemeinerungen über sexuelle Indifferenz bei Frauen mit FGM sind wissenschaftlich nicht belegt und können dazu führen, dass sich betroffene Migrantinnen stigmatisiert fühlen.

Während der gynäkologischen Untersuchung waren somit weniger die technischen Aspekte in der Handhabung von FGM sondern vielmehr die einfühlsame Interaktion zwischen dem medizinischen Personal und der betroffenen Migrantin das größte Problem. Insbesondere folgende Punkte sind kritisch zu bewerten: Das ärztliche Gespräch in Bezug auf FGM war häufig unvollständig; besonders die psychosozialen und sexuellen Komplikationen von FGM sind selten angesprochen worden. Hinsichtlich der Prävention gaben lediglich 8% der befragten Ärzte und Hebammen an, mit den Müttern über die Zukunft der Töchter in Bezug auf FGM zu sprechen. Das Thema der Reinfibulation stellt für Gynäkologen und Hebammen einen ethischen Konflikt dar. Alle interviewten Ärzte und Hebammen befürworteten jedoch letztlich die Haltung, dem Wunsch der Patientin zu dienen und eine partielle Reinfibulation auszuführen. Dabei fehlten jedoch häufig Aufklärungsgespräche, in denen Alternativen zur Reinfibulation aufgezeichnet wurden. Während andere europäische Länder die Reinfibulation verbieten (Großbritannien, Belgien) oder Ausmaß und Kondition der Intervention klar definieren (Dänemark), wird die partielle Reinfibulation ohne vorhandene Richtlinien an allen Schweizer Universitätsspitälern, die an dieser Studie teilnahmen, durchgeführt.

Der Kommunikationsmangel in Bezug auf FGM betrifft verschiedene Ebenen. Er war offenkundig zwischen Gesundheitspersonal und Klientin, den betroffenen Frauen und ihren Partnern und sogar zwischen Frauen derselben Migrantennationalitäten. In der gynäkologisch-geburtshilflichen Behandlung waren die Sprachbarriere, die Intimität des Themas und die Geschlechterrollen ein Haupthindernis. Insbesondere für die männlichen Ärzte war es schwer, mit den betroffenen Frauen über das Thema FGM zu sprechen. Durch das zwischen den Frauen und ihren Partnern bestehende Kommunikations-Tabu, bleiben die stark internalisierten kulturellen Argumente, die den Brauch aufrechterhalten, bestehen. Die mangelhafte Kommunikation zwischen Müttern und Töchtern führt besonders bei den jugendlichen Frauen dazu, dass sie die körperlichen und sozialen Komplikationen von FGM alleine tragen und oft ohne das Wissen ihrer Familien ärztliche Hilfe suchen. Darüber hinaus gab die Mehrheit der Frauen an, sich im

Rahmen dieser Studie zum ersten Mal mit anderen Betroffenen einer Generation über FGM und damit einhergehende Komplikationen ausgetauscht zu haben.

Die größten Schwierigkeiten mit dem gynäkologisch-geburtshilflichen Management von FGM bestanden während der Immigrationswelle aus Somalia Anfang der 1990er Jahre. Mittlerweile hat eine Reihe der an den Universitätsspitälern tätigen Gynäkologen und Hebammen Erfahrungen im Management von FGM erworben. Dagegen ist der Mangel an Erfahrung deutlicher bei den Ärzten in der Facharztausbildung, die über weniger klinische Erfahrung verfügen, und in den nur marginal von FGM betroffenen Regionalspitälern. Obwohl FGM Typ III keine medizinische Indikation für eine Geburt per Kaiserschnitt darstellt, wurde diese Geburtsform zur Vermeidung vaginaler Geburten in ¾ der einbezogenen regionalen Krankenhäuser bei Betroffenen praktiziert. Unter der Perspektive, dass Migrantinnen wieder in ihre Heimatländer zurückkehren, wo Kaiserschnitte oft nicht realisiert werden können, stellt diese Form der Geburt ein Risiko dar.

Migrantinnen aus Sub-Sahara Afrika sind eine der verwundbarsten Gruppierungen im Schweizerischen Gesundheitssystem. Die Komplikationen durch FGM stellen eine zusätzliche Belastung für diese Frauen dar. Die Studie zeigt, dass die gynäkologisch-geburtshilfliche Betreuung in der Schweiz vielfach nicht die Bedürfnisse der betroffenen Frauen trifft. Grund dafür ist nicht die fehlende Empathie auf Seiten der Ärzte und Hebammen, sondern vielmehr der Magel an Erfahrung und Führung in der Betreuung betroffener Frauen. Eine unangemessene Betreuung kann jedoch dazu führen, dass die Belastung der betroffenen Frauen durch die Behandlung verstärkt wird, indem sie sich zusätzlich aufgrund von FGM stigmatisiert fühlen.

Die gynäkologisch-geburtshilfliche Betreuung betroffener Migrantinnen in der Schweiz muss verbessert werden. Gynäkologen und Hebammen sollten in ihrer prä-und postgraduierten Ausbildung in das Thema FGM und die wichtigen Aspekte einer kulturell sensiblen, spezifischen Behandlung dieser Frauen eingeführt werden. Um die Situation, die charakterisiert ist durch einen Mangel an Kommunikation und Transparenz, zu verändern, müssen Möglichkeiten der Vernetzung auf mehreren Ebenen geschaffen werden. Erfahrungsaustausch zwischen den verschieden klinischen Zentren und Regionen der Schweiz sollte unter Einbeziehung von Ressource-Personen aufgebaut werden. Bereits in anderen europäischen Ländern existierende Instrumente sollten mit einbezogen werden in die Entscheidung über das Erarbeiten von Richtlinien für die Schweiz.

Es ist eine Priorität, den betroffenen Frauen das anzubieten, ihre Erfahrungen und Probleme in Bezug auf FGM integriert in die Themenkreise Geburt, Sexualität und weibliche Anatomie untereinander auszutauschen. Die Frauen leben in der Schweiz geographisch konzentriert und konsultieren für die gynäkologisch-geburtshilfliche Behandlung bevorzugt die großen Kantonsspitäler. Gezielte Maßnahmen könnten daher eine Verbesserung der bestehenden Situation, sowohl für die Frauen als auch für die sie betreuenden Ärzte und Hebammen des Schweizerischen Gesundheitswesens bedeuten.

1. Introduction

1.1. Background

Over the last decade the practice of Female Genital Mutilation (FGM) has become a global concern. Increasing international migration from regions where FGM is traditional to Europe, the United States, Australia and New Zealand has contributed to bringing the issue to the attention of the public in these countries. Yet, while African women in the countries of origin have become increasingly active advocates for the abolition of FGM in their own countries, there has been little activity in the migrant communities dispersed in the different regions of the world. Being unfamiliar with these traditional practices and facing multiple questions in connection with FGM in various professional fields was a problem all host countries had in common. However, depending on what country women concerned migrated to, the issue of FGM again became a local problem with a different regional public health, legal and political response to it. This thesis will analyse the specific situation for immigrant women who have undergone FGM and the health care providers (HCPs) meeting them in the health care system of Switzerland.

Prevalence and distribution

World-wide more than 120 million girls and women have undergone FGM and each year 2 million more are subjected to these practices in the name of traditional culture (WHO, 2001, 1998). FGM is practised in 28 African countries and a few in the Middle East and Asia with a wide range of variation in prevalence rates between and also within the countries concerned. Whereas in the Democratic Republic of Congo only 5% of all women are estimated to be concerned, in Somalia the practice is almost universal with a prevalence rate of 98%. FGM is particularly wide-spread in the North-eastern African countries of Egypt, Sudan, Somalia, Djibouti, Eritrea, and Ethiopia with prevalence rates of 85% and above. Also, in some countries of Western Africa the practice is frequently carried out. In Mali and Sierra Leone and Guinea more than 90% of all women, and in Burkina Faso and Liberia 60% and more of all women are estimated to have undergone the practice of FGM (*Appendix 1*). There can be a wide range of variation within countries: In the northern region Yatenga of Burkina Faso FGM is almost universal whereas most ethnic groups of the southern part of the country do not at all practice FGM.

For the European countries, the prevalence rate and distribution of female immigrants, refugees and asylum seekers from FGM practising countries is not very well known. A compilation carried out in an EU funded research project remained incomplete. However, the estimates of 148,291 in the UK (1997), of 46,389 in Italy (1996) and 25,651 in Germany (1997) indicate the large numbers of women who have undergone FGM in European host countries (Leye et al., 1998).

Terminology

FGM comprises all procedures involving partial or total removal of the external female genitalia or the injury to the female genital organs whether for cultural and/or other non-therapeutic reasons (WHO, 1998). This internationally accepted definition applies the term “FGM” which has been increasingly used since the 1990s on international conferences and in the majority of publications. However, particularly in the field of anthropology, there has been some controversy about the terminology. In the early writings, including the 1980s, “female circumcision” was the most frequently used term, a term that is not only imprecise but also seems to put it at the same level with male circumcision (Smith Oboler, 2001). Some anthropologists have criticised the change of terminology because they considered the term “FGM“ to be a “clearly disapproving powerfully evocative and value-laden expression“(Obermeyer, 1996). However, much of this research only based on extensive literature review and is far away from the reality of the girls and women who have been mutilated in the name of traditional culture. A variety of alternative terms such as female genital cutting, female genital modification, female genital operations (Obermeyer, 1996; Shweder 2000, Smith Oboler, 2001) have been proposed by anthropologists. The main reason for doing so was the concern that the expression FGM might be viewed as unfairly judgmental by members of communities that traditionally modified women’s genitals in these ways (Gruenbaum, 2001). In Canada, Somali immigrants disapproved of the expression “FGM”, because they felt victimised by being labelled as belonging to a community that is barbaric and ignorant. Thus, when directly addressing women of a migrant community in a culturally sensitive approach it is suggested to not directly apply the term “FGM”, but instead the local terms of the practice in the language of the particular nationality or ethnic group (Toubia, 1994 a). Yet, throughout this thesis the term “female genital mutilation“, abbreviated as “FGM” will be used. This term is not only in accordance with the internationally accepted dialogue, but also does not disguise the harmfulness of a practice that damages healthy, functioning body organs of minors.

Literature review

Particularly, for a literature search the terminology is of importance. FGM is an interdisciplinary subject that comprises research in the fields of anthropology, medical science, law political sciences and ethics. An extensive search was performed on the terms of "FGM" and "female circumcision" in the databanks of Medline, Embase-Psychiatry, CINAHL[1], PsychInfo, FRANCIS[2], Web of Sciences. The Web of Sciences data bank was found especially suitable for the needs of this study because it includes medical and social sciences sources. Searching this databank by topic on the terms "FGM" and "female circumcision" on all sources in all available languages between January 1980 and August 2002 revealed the following:

Time frame	"Female circumcision" (Number of contributions)	"Female genital mutilation" (Number of contributions)
1/1980 - 12/1989	43	3
1/1990 - 12/1999	117	95
1/2000 - 7/2002	41	58

Table 1: Terminological shift from "Female circumcision" to "Female Genital Mutilation"

This table illustrates the terminological shift from "Female Circumcision" to "Female genital mutilation". More important however, it shows the enormous increase of contributions within the last years. Whereas in the first decade from 1980 to 1989 46 overall contributions were listed, from 1990-1999 more than four times as much overall contributions were produced and in the last 31 months about half of the overall listed publications of the previous decade were done! Searching the search engine "Google" for "Female Genital Mutilation" on August 4, 2002 there are 51,200 responses. Huge amounts of public contributions have been done by various "advocacy"-groups with respect to human rights and feminist issues.

Compared to the overall amount of available information, the number of scientific contributions is small. Searching the databank Medline for "Female Genital Mutilation and Switzerland" covering all entries, only one contribution was available. Thus, aiming to capture as much as possible of the reception in Switzerland and other European countries with respect to FGM it was of interest to include the Grey Literature.

[1] CINAHL: Citation Index Nursing and Allied Health Literature

[2] FRANCIS: French Retrieval Automated Network for Current Information in Social and Human Sciences

Different types of FGM and their complications on women's health

There are several forms of FGM that vary according to ethnic group and region where they are performed. The WHO issued the following classification of FGM:

Type I: Excision of the prepuce, with or without excision of part or the entire clitoris.

Type II: Excision oft the prepuce and clitoris together with partial or total excision of the labia minora.

Type III: Excision of part of all of the external genitalia and stitching/narrowing of the vaginal opening (infibulation).

Type IV: unclassified: prickling, piercing or incision of the clitoris and/or labia; cauterisation, scraping or introduction of corrosive substances into the vagina or any other procedure falling under the definition of FGM.

FGM is a major contributor to childhood and maternal mortality and morbidity in communities with poor health services (Toubia, 1994 b). The seriousness of physical complications depends on the degree of mutilation and the hygienic standard of the surgical operation. Immediate and late complications have been distinguished. Immediate complications can consist of haemorrhage, urinary retention, and injury of neighbouring organs, local and general infection (Dirie and Lindmark, 1992). Haemorrhage might be due to the rupture of the clitoral artery during the amputation of the clitoris which can lead to shock and death. As the procedure is often performed under non-hygienic conditions with the same surgical instruments on several girls, it has been postulated that FGM may also contribute to the HIV pandemic in Africa (Brady, 1999). FGM is generally performed on girls between several days of age and about 10 years old, only few ethnic groups such as the Masai and few tribes in Guinea perform the practice on adult women. In Somalia, girls are usually between 3 and 10 years old when the act of genital mutilation is carried out. In Eritrea, FGM is performed on baby girls who are about 8 days old (Bayoudh et al., 1995).

Long term complications are more often associated with FGM type III than with clitoridectomy alone (Toubia, 1994 b). The following long-term complications have been described: Dysmenorrhoea (painful menstruation), dyspareunea (pain and disability dur-

ing sexual intercourse), and chronic urinary tract obstruction with slow urinary stream leading to frequent urinary tract infections, urinary calculi and damage of the kidneys. Local long-term complications of the scar tissue such as dermoid cysts have been described to be the most common complications in the countries of origin (Dirie and Lindmark, 1992; Hanly and Ojeda, 1995). Other local long-term complications are the formation of keloids and neuromas. If defibulation[1] is not performed, obstetrical complications for the mother are described to consist of perineal lacerations, injury to neighbouring organs and creation of fistulas which lead to urinary of faecal incontinence. Prolonged second stage of labour has been reported to lead to increase morbidity and mortality of the child (Dörflinger and Dreher, 2000). A further long-term complication consists of an increased risk of infertility due to chronic inflammatory pelvic disease (Inhorn, 1993), which has socially adverse consequences in societies, which derive their statues from their ability to have children (Van der Kwaak, 1992).

Long term complications are relevant for HCPs of the host countries in the industrialised world who receive adult and adolescent migrant women, who have undergone the practice of FGM in their home countries. However, the anthology of complications presented above is derived from studies uniquely of the African context. So far, few studies on long-term health complications in the concerned migrant communities of the industrialised countries have been carried out. In all of these studies the large majority of women had undergone FGM type III. In these studies, the main reason for seeking gynaecological/obstetrical services were pregnancy (Momoh et al., 2001), or the request for defibulation, in the large majority due to painful or impossible sexual intercourse (Gordon, 1995; Huismann, 1997; Knight et al., 1999; Pok Lundquist and Haller, 2001). Two recent studies analysing the elevated perinatal mortality among children of immigrant women from the Horn of Africa found no direct association between FGM and perinatal death in countries with high standards of obstetric care (Vangen et al., 2002; Essén et al. 2002).

There is little evidence on psycho-sexual complications of FGM. This rather reflects the lack of attention by the research community to document these problems than the rarity of the condition (WHO, 1998). Also, stigmatising effects of FGM affecting the minority groups of migrant women concerned in the industrialised countries have only been marginally addressed by research.

[1] Defibulation: reversal of infibulation; incision of the scar tissue in the midline in order to open up vagina and urethra (WHO, 2001).

Cultural background

Why do people carry out a practice associated with pain which may result in morbidity, disability and even mortality? Every African ethnic group and society has particular and often multiple reasons to carry out FGM. This passage summarises the most commonly cited. In addition there are various beliefs that are rooted in mythology, e.g. that the clitoris is an aggressive organ that wounds a man during intercourse and kills the baby during childbirth (Lightfoot-Klein, 1989). The majority of sources used for this subchapter are of North-eastern African origin (Somalia, Sudan), where FGM type III is most prevalent, to provide a better understanding of the cultural background of the concerned migrant population in Switzerland who in majority comes from North-eastern Africa as will be shown in chapter 3. However, all of below presented motives were also relevant in qualitative studies from Senegal, West Africa (Kessler Bodiang, 2000).

Religion: Evidence of FGM can be traced back to genitally mutilated mummies from 200 BC that have been found in Egypt and are now object of further investigation to understand the roots of the ancient custom (Knight 2000). The practise thus predates Islam and Christianity and is not bound to any particular religion. FGM is practiced by Moslems, Catholics, Protestants, Copts, animists and unbelievers in the various countries were the custom occurs (Smith, 1995). Yet, the custom is frequently propagated in the sincere, but incorrect conviction that it was a duty imposed by Islam. In a study on 290 women in Somalia, the majority (70%) believed that Islam orders them to adhere to FGM (Dirie, 1991). However, Islam does not request for FGM, which is reflected by the fact that some of the most pious countries do not practice FGM.

Marrigeability and virginity: The fear that a girl who has not undergone FGM will not find a husband remains one of the strongest motivations to maintain the practise inherent in different African societies from Senegal (Kessler Bodiang, 2000) to Somalia (Bayoudh, 1995). Virginity at marriage is vitally important in many of the FGM practising cultures. Also anthropological research carried out in Sudan showed that FGM III has been carried out with the aim to protect a girl's virginity (Gruenbaum, 2001).

Sexuality: With respect to FGM type III, men are expected to prefer the tightness oft their partner's opening as the increased friction of a tight opening is said to be sexually more stimulating for men and thus is believed to enhance male sexual pleasure (Gruenbaum, 2001)

Hygiene and beauty: Particularly, in the North-eastern regions of Africa where FGM occurs, the female genitalia are seen as dirty and ugly. The objective of infibulation is to attain smooth, clean skin at the genitals and thus to enhance a more beautiful body. This aesthetic consideration also is linked to the culturally defined male sexual preferences. Women share this aesthetic preference and fear that a husband may find one's body distasteful if the vulva is not smooth (Gruenbaum, 2001).

Tradition: Considering a traditional practise that has been carried out for centuries and generations, informants asked about origin and justification of the practise; often say "it has always been so" (Smith, 1995).

Initiation ritual: The story of Anab from Somalia has been frequently quoted: "Anab was not circumcised. She felt very ashamed and impure and eventually took a knife and tried to circumcise herself. She was officially circumcised later and said that she felt very proud" (Van der Kwaak, 1992). Many young girls look forward to the day of infibulation because this is a special day often celebrated in the community on which a girl changes her female status from being a child to become part of the women's world. Yet, increasingly, the festive ceremonies are tending to disappear as the practice is carried out at a younger age (Smith, 1995).

Reasons why FGM are carried out are heterogeneous. Neither are they bound to a specific religion, nor are they bound to a certain nationality. Yet, what is common to these mutilating practices is the fact that they are deeply rooted in the cultural values of the societies that perform them. The gender identity of a woman of concerned societies has been defined for centuries by above mentioned motives such as initiation to womanhood, marriage, and guarantee for the descendants. Thus, it is not surprising that people have attributed such importance to maintaining the practice. These old traditions linked to FGM make it difficult to abolish it by a merely symptomatic treatment on individual level. Knowing about the local motives for the practice is a first step for discussing and eventually challenging it (Deutsche Gesellschaft für Technische Zusammenarbeit, 2001).

Those women who have joined the societies of the North, often due to wars, political and legal suppression in their countries of origin, carry their cultural background with them. Deeply internalised cultural traditions are not expected to disappear immediately only by a change of the outer setting. Eventually, they might become modified by the influence of the host country. However, approaching immigrant women concerned with respect to FGM in a sensitive manner implies to know about their cultural background.

1.2. Female Genital Mutilation and Switzerland

In 1991 it was estimated that there were about 1900 genitally mutilated women living in Switzerland at that time (Nyfeler and Beguin Stöckli, 1994). The number of concerned migrant women was estimated at 4344 in 1995 and expected to further increase (Beck Karrer, 1995).

Swiss initiatives

In 1990, the group Antagem (Anthropologists Against Mutilation) was founded at the Ethnological Institute of the University of Berne. In the beginning theoretical interest predominated. Participating students produced scientific studies and compiled a bibliography on FGM. One of the members who had been in dialogue for several months with Somalian immigrants in a refugee centre in the canton of Berne, contributed to rising awareness about FGM in the migrant community of Switzerland by sharing her experiences in midwifery and nursing schools. In 1993, Antagem produced an information brochure about FGM at its own expense, which was updated in 2001. Over the years Anatagem had become the unofficial information provider on FGM in Switzerland. However, efforts to receive more official support have not been successful.

In 2000, the first Swiss branch of the German organisation Terre des Femmes was opened in Biel. This NGO specifically fighting for the abolition of FGM supports projects in Africa but also does campaigns for the prevention of FGM in Europe. An art exhibition of Nigerian painters illustrating the cruelty of FGM organised by Terre des Femmes and co-funded by other German based NGOs contributed to raise public awareness on the subject in Switzerland in 2002.

The increasing international attention to FGM ultimately fostered a Swiss national initiative. In spring 2001, a workshop on FGM was organised by the Federal Office for Refugees, the Swiss Agency of Development and Cooperation, PLANeS, a Swiss foundation for sexual and reproductive health, and UNICEF. This seminary aimed to raise public awareness in Switzerland concerning FGM in different professional fields at national level and to initiate a networking process. Results of the meeting suggested that especially in the field of health care there was a need for professionals of different disciplines to receive background information on FGM, its health related consequences and how to provide adequate care. To develop the basis for a network on FGM in Switzerland, 4 working groups dealing with medical, social, political and research related aspects of

FGM were created. A first central meeting of the working groups was organised by UNICEF and PLANeS in winter 2001. Continuous, independent meetings of the different groups are currently taking place throughout 2002. For the group dealing with medical aspects of FGM, the objective to elaborate national Swiss guidelines remains a priority, but is still pending. The increasing relevance that professional groups see in the subject of FGM is also reflected by the fact that in 2002 the national journal of midwives ("Schweizer Hebamme") devoted an entire issue to FGM.

Political concern

In 1992, Caspar Hutter, a Swiss parliamentarian, asked the government to analyse the prevalence of FGM in Switzerland and to examine the possibility of FGM becoming subject to registration by Swiss doctors and hospitals (Interpellation Caspar Hutter, 7-10-1992). The government replied that existing information on that subject in Switzerland was sufficient. Emphasis was to be placed on local development projects in the countries of origin. Referring to the study of Nyfeler and Beguin Stöckli (1994) it was pointed out: "The government is willing to examine the possibility of target group oriented information in Switzerland." No such action, however, followed.

In 2000, the government was asked by a member of parliament to oppose FGM by supporting programs and organisations that fight for its abolition. (Motion Brigitta M. Gadient 23-06-01). The Swiss government emphasised that its position against the practice of FGM was in accordance with the international debate. The Swiss ministry of foreign affairs promised to increase funding through the Swiss Agency for Development and Cooperation to multi-and bilateral international interventions. As far as women in Switzerland are concerned, the governmental statement only said it should be investigated whether FGM was also practised in Switzerland. In the affirmative case, measures would have to be developed.
So far the governmental response of Switzerland with respect to subject of FGM has been weak. The majority of initiatives were organised by private people and NGOs.

Legal aspects

a.FGM in the context of penal law

There is no law explicitly condemning FGM in Switzerland. However, performing FGM in Switzerland is legally forbidden by article 122 of the Penal code.

(Art.122, Ziffer1, Alinea 2, Schweizerisches Strafgesetzbuch): “Anyone who intentionally has mutilated a body of another person, limbs or one of the important organs or has diminished the function of that organ or has caused infirmity, or (..) anyone who intentionally has done serious harm to another person’s bodily integrity or mental health, will be punished with a detention of 10 years or an imprisonment from six months to five years.“ Thus, a health care professional performing FGM in Switzerland would be subject to criminal persecution. Already in 1983 the central medical ethics commission of the Swiss Academy of Medical Sciences stated clearly that in its view FGM violated the bodily integrity of a human being and that a health care professional performing FGM was committing a very severe offence against medical ethical principles.

b.FGM in the context of the law of asylum

In 1996, the governmental position was inquired by a parliamentarian (“Postulat Jan Ziegler”, 4-10-1996). This time, FGM was placed in the context of the right of asylum. Jan Ziegler asked whether a woman under threat of being circumcised in her own country had the right to be given refugee status in Switzerland.

People who can receive asylum according to Swiss law are those who are exposed to serious disadvantage and persecution due to their:

- ethnicity
- religion
- nationality
- social group
- political opinion.

Traditional harmful practices are not explicitly mentioned as a reason to grant asylum in Switzerland. In the case of FGM, according to Swiss law, the definition of the “social group” could be asserted. However, this has not been applied as a legal practice in CH. Instead, FGM in combination with other plausible threats were considered as a threat of “inhuman treatment” (European convention of human rights, art.3.) By this law temporary admission has been granted. This status is held, for example, by many of the Somalian women currently living in Switzerland. In 1998 a new law of asylum passed the Swiss parliament making an amendment to the refugee defining art. 3: “Women specific

reasons for flight are taken into account." However, this additional statement has not had any legal consequence. So far, in Switzerland, asylum status has not yet been granted to a woman exclusively on the grounds of the threat that she may be genitally mutilated in the country of origin (Ganter Sonderegger, 2001). Two applications to grant asylum in Switzerland because of the threat of FGM have not been decided (one of them is pending since 1996).

Previous studies on FGM in Switzerland

In 1991, Nyfeler and Béguin Stöckli, two anthropologists, conducted a study on FGM focussing on the Swiss gynaecologists/obstetricians. They interviewed leading gynaecologists/obstetricians of the public hospitals of Switzerland as well as physicians working in refugee centres and gynaecologists in private practice in the canton of Berne. The study revealed that doctors in private practice or in refugee centres had encountered few women presenting with FGM. In the public hospitals, however, 19% of the gynaecologists interviewed had been in contact with women who had undergone FGM (Nyfeler and Berguin Stöckli, 1994).

In 1995, Beck Karrer concluded an ethnological M.A.-thesis at the University of Berne. She interviewed 36 women and men from Somalia, the majority of them at a refugee centre in Switzerland. Beck emphasised that prevention in the Somali migrant community was necessary because the majority of interviewed women declared to be in favour of continuing the practice on their daughters (Beck Karrer, 1995).

In 2000, a thesis on FGM in the field of social science ("Höhere Fachschule für soziale Arbeit") was concluded in Basel (Hinnen and Wohlgemut, 2000). Questionnaires were sent to all gynaecologists in private practice in Basel. The study, similar to that of Nyfeler and Béguin Stöckli, revealed that only 6 out of the 67 gynaecologists questioned had had contact with affected women and only an estimated 10-15 genitally mutilated women had been treated in Basel within "the last years".

Also in 2000, Conelli of the Faculty of Social and Political Sciences of the University of Lausanne concluded a sociological M.A.-thesis with the title "FGM in the Canton of Vaud." He mainly discussed anthropological, ethical and political aspects of FGM. Referring to the health care system he performed interviews with key informants (gynaecologists, anthropologists) at the Gynaecological University Hospital of Lausanne. This clinic receives 25%foreign patients with a high percentage of African origin. Although an

anthropologist is employed there, general guidelines for doctors facing ethically sensitive decisions in the specific treatment of affected women are missing (Conelli, 1999).

In 2001, the Swiss Association of Gynaecology and Obstetrics and UNICEF Switzerland conducted another quantitative study (Jaeger et al., 2002). They sent 1162 questionnaires to Swiss gynaecologists/obstetricians, trying to quantify contact with genitally mutilated women, and asking whether they thought that FGM was carried out in Switzerland. The study revealed that 20% of asked gynaecologists/obstetricians had treated women with FGM. 8% had been asked by a patient to perform reinfibulation. Only two physicians had been asked to carry out FGM. However, from the study, there was no indication that the procedure had been ever carried out on Swiss territory.

All of the studies with respect to the health care system focused on the health care provider's side. Even this population has not been thoroughly investigated, as only members of one profession, the gynaecologists, have been interviewed. With respect to the health care system, the research mentioned above has emphasised quantitative research questions. No study, has been performed using qualitative research methodology to let concerned women speak for themselves about the Swiss health care system and to find out what key health care providers of different professions think about the situation and to compare the two.

1.3. Female Genital Mutilation and Europe

Female Genital Mutilation and the EU

France and the UK with previous colonial ties to Africa have received many African immigrants and have been aware of FGM and its performance in their territory for about 20 years. In the 1990s as consequence of the political crisis in the county Somalian refugees immigrated to different European countries. A 98% prevalence of FGM in Somalia contributed to increasing prevalence of FGM in Europe. In many European countries NGOs and committed individuals have begun to develop initiatives against FGM. For some years there where mainly uncoordinated activities at grassroots level. Then, activists in different EU member states realised that this migration related cultural problem was one they all faced in common. An expert meeting in 1998 led to the creation of an European network in December 1999. Its aims included to exchange experiences and information, to share data and to avoid duplication of effort. The networking project was co-ordinated by the International network for Reproductive Health (Ghent University, Belgium) and was carried out in partnership with the former Immigration Services Administration for the City of Gothenburg, Sweden. The network was financed by funds of the European Commission. Explicit goals of the project were: 1) exchanging information and experiences and disseminating practices at community level; 2) harmonising various training and management guidelines currently available for health care professionals; 3) harmonising research efforts in Europe. Between December 1999 and December 2000 the EU network carried out 4 workshops, two on “Exchanging experiences at community level”, one on “Developing frameworks for the health care sector” and one on “Setting a research agenda” (Leye, 2000 a; Leye and Githaiga, 2000; Leye, 2000 b). Participants compared different approaches and developed ideas how to transfer further prevention strategies to national level. In May 2001 a “Joint Agenda for Action to Prevent and Eliminate FGM” was drafted. This declaration became the basis for the European Parliament resolution on FGM approved in September 2001. In this declaration the EU “strongly condemns FGM as a violation of fundamental human rights”. Moreover the EU Commission was called on to further establish “preventive, educational and social mechanisms to enable women who are likely to be victims to obtain real protection”. The European member states are called to “draw up guidelines for health professionals, teachers and social workers (...)”. Already at the expert meeting in 1998 in Ghent, training and sensitisation of health care providers had been found crucial. As a first reaction NGOs and members of caring professions had produced guidelines on their own initiatives. After creating a European framework to develop guidelines

concerning the training of health care professionals on the issue of FGM there has been an increase of initiatives at national level. In the Netherlands the Chief Medical Inspection of the Department of Public Health developed a guideline. In Denmark the National Board of Health published a book containing general and specialised information specific for different professionals dealing with FGM. Sweden served as model for other EU member states. The Swedish Ministry of Health subsidised a project named “Mother and Child Health Care-FGM.” In the framework of this project several guidelines for medical and health care staff were developed. These include specific guidelines for different medical professions and for the school health care system. In 2000, the German Ministry for Senior Citizens, Women and Youth published an information brochure for physicians and other health care providers referring to the situation in Germany, taking newest WHO information into consideration. In August 2001, the British Medical Association published an updated information brochure for doctors providing them with legal background, possible steps of action and information about supporting organisations in the UK to provide further help and advice in protecting girls from genital mutilation. (For an overview of direct comparison on information brochures about FGM of 9 different EU countries and Switzerland, see *Appendix 2*).

Legislation concerning FGM and the EU

Of all EU member states, specific laws explicitly prohibiting FGM only exist in the UK, in Sweden, and in Belgium. In the remainder of the EU-countries FGM is prohibited by the national penal code as “severe bodily harm” or “physical damage”. Performing FGM in the member states is punished by imprisonment for different periods according to national legislation. (For an overview of direct comparison on legal aspects about FGM of 9 different EU countries and Switzerland, see *Appendix 2*).

Relevance of networking in Europe

Common networking activities of EU member countries contributed to the progress of nonofficial and official awareness of FGM in Europe. Not only public interest in the topic but also specific professional sensitisation and advice in the care of genitally mutilated girls and women has increased. The rising number of guidelines and information brochures in the EU member countries proves that well. However, questions on precise mapping of women from FGM practising countries in Europe and the existence and extent of the practice of FGM in the member states remain open. FGM in the context of

the asylum policy of the EU will have to be further analysed. Also, the effectiveness of the interventions undertaken has to be evaluated.

In the EU, the problems to be solved and tasks to be done have at least been defined. In Switzerland, not having been part of the European networking, official attention to FGM concerning migrant women within the country is a recent phenomenon. To date, there have been no public initiatives at federal and cantonal level (e.g. contributions of the Federal Office of Health) to support focused measures for care and prevention of FGM in Switzerland. There is no Swiss data included in the EU-database. No official information brochure or guidelines for HCPs have been produced so far.

1.4. Justification for the study

Few studies have dealt with the fact of FGM in the migrant communities of industrialised countries. Previous studies were predominantly quantitative studies. The majority of those studies related to medical aspects of FGM and aimed at assessing the extent of complications.

Research priorities given by experts of the EU networking process suggested to specifically emphasise on mapping FGM in Europe, behavioural determinants related to a migration context and research on European professionals confronted with FGM (Leye, 2000 b).

Official Switzerland has not given much attention to affected women living in the country. In the health sector no co-ordinated preventive measures have been launched and no official recommendations for special care in the Swiss health care system have been created. However, in the last two years networking on national level has been initiated. Also, there have been increasingly diploma and thesis works created in different disciplines with respect to FGM and Switzerland. Yet, studies that referred to the health care system only approached the health HCP's views. Thus, there was a need for qualitative information that would include the perspective of women concerned.

2. Study Objectives

2.1. Estimate the prevalence rate of genitally mutilated females in Switzerland and examine their distribution by country of origin, place of residence and age group.

How prevalent is FGM in Switzerland? How is the distribution of affected women according to country of origin? How is the age group (0-15, ≥16) distribution of affected women in Switzerland? Are the concerned women distributed equally over Swiss territory?

2.2. Assess the specific objective and subjective health care problems of genitally circumcised African immigrant women living in Switzerland.

a) Does the fact of being genitally mutilated contribute to more frequent and more specific health care interventions?

b) Do circumcised women living in Switzerland themselves define special health care needs and do those correlate with above objectively defined needs?

2.3. Analyse the information needs of Swiss health care providers to treat genitally mutilated women according to the best given standards.

Are the Swiss health care providers adequately prepared to treat circumcised immigrant women, taking physical, psychological and intercultural aspects into consideration? What attitude do Swiss health care providers have regarding affected women? Is there an adverse social judgement of health care professionals about circumcised African women?

2.4 Analyse the demands of genitally mutilated women in CH with regards to the Swiss health care system.

What are their experiences with gynaecological consultation and delivery in Switzerland especially with the health care professionals (physicians and midwifes) involved. What expectations do affected women have of the Swiss health care system, and what improvements do they suggest?

2.5. Generate recommendations to the Swiss health care system based on the findings of 2.1. - 2.4.

If HCPs and circumcised women express information and behavioural deficiencies how can those be abolished?

The aim of the present study is to analyse the specific situation of genitally mutilated African immigrant women, and the health care providers who encounter them in the Swiss health care system. The study has two strategies: a) it will analyse the perspective of the affected women, emphasising their perceptions of the Swiss health care system. b) it will investigate whether gynaecologists/obstetricians and midwives, those professionals most directly concerned, treat and counsel FGM related complications adequately.

3. Methodology

It was seen as particularly important to include the perspective of women concerned. A qualitative design was chosen in order to compare directly the position of health care seekers and health care providers with respect to attitudes, knowledge, and behaviour concerning FGM. The quantitative part aimed at showing to what extent FGM is a problem in Switzerland. Knowing the distribution of women with FGM according to Swiss cantons served as a basis to decide in which region of Switzerland to localise this study.

3.1. Study population

The demographic characteristics will be presented separately for each study population.

a) Women

The total sample comprised 29 women who participated in focus group discussions and 3 in-depth interviewees. 24 of all women were of Somali origin. 5 women were from Eritrea by origin. All Somali sample women were Moslems. 2 of 5 women from Eritrea were orthodox Christians, whereas the other 3 were Catholic. All sample women had undergone FGM during their childhood in their country of origin. Three women had undergone FGM type II; all remaining women had undergone FGM type III. The age of female study participants, depicted in *Figure 1*, ranged from 17 to 64 years (average 34 years). One woman had less than 20 years and one woman was above 55 years. The largest group was that of ages 36-45 years old.

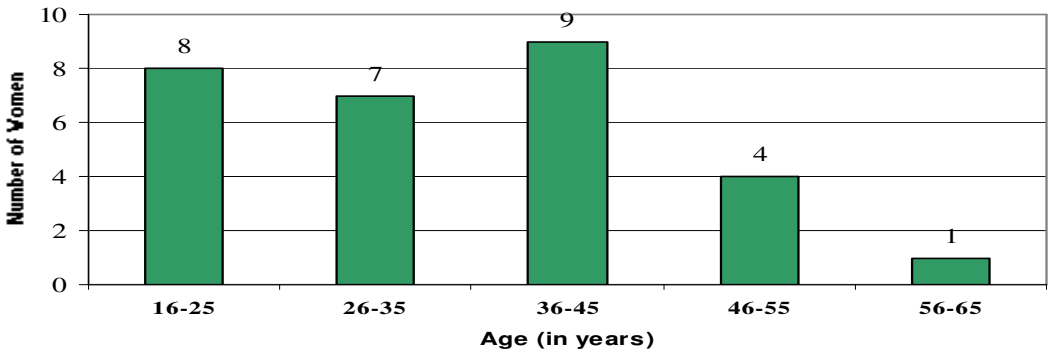

Figure 1: Age distribution of interviewed women

The different educational levels are presented in *Figure 2.* The majority of women (n=13) had attended elementary school (8 years of school). The second largest group (n=7) of sample women-almost a third- had not attended school. 7 women finished secondary school (12 years) and 2 women studied at university level. In one case there was no data available.

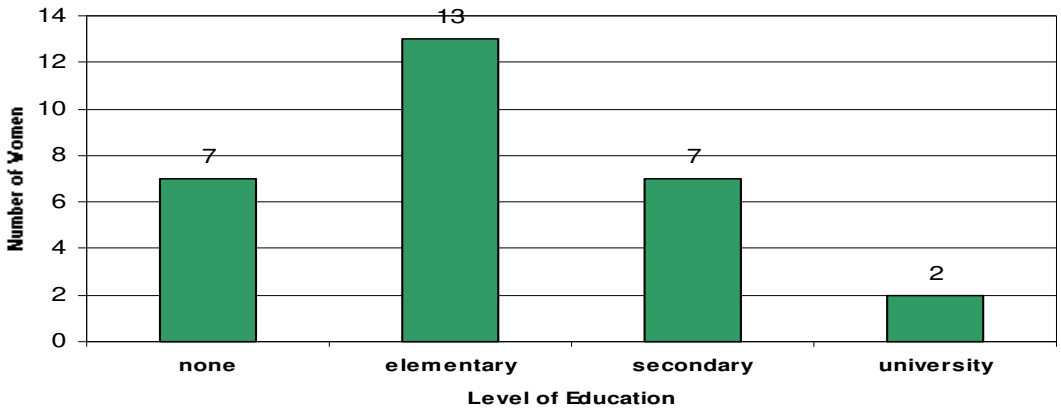

Figure 2: Educational level of women

The frequency of different categories of occupation is reflected in *Figure 3.* Striking is the large number of women (n=20) who had no occupation in Switzerland. The women with a formal employment worked as cleaning lady, in sales, as teacher, nurse, social worker and translator.

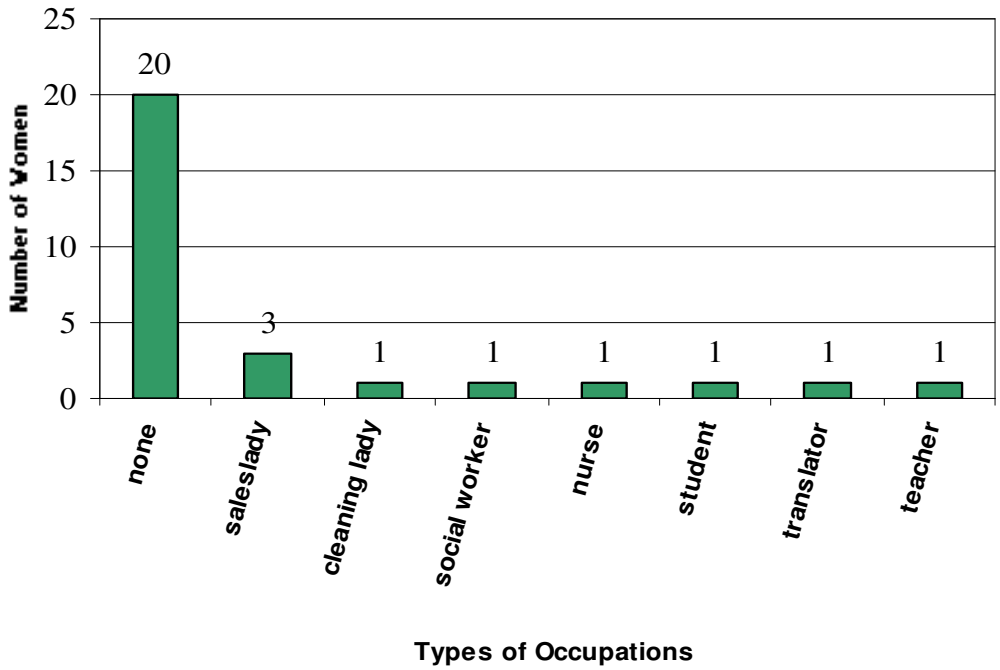

Figure3: Occupation of women

The marital status is depicted in *Figure 4*. The majority of women were married (n=19). 7 women were single and 3 women were divorced.

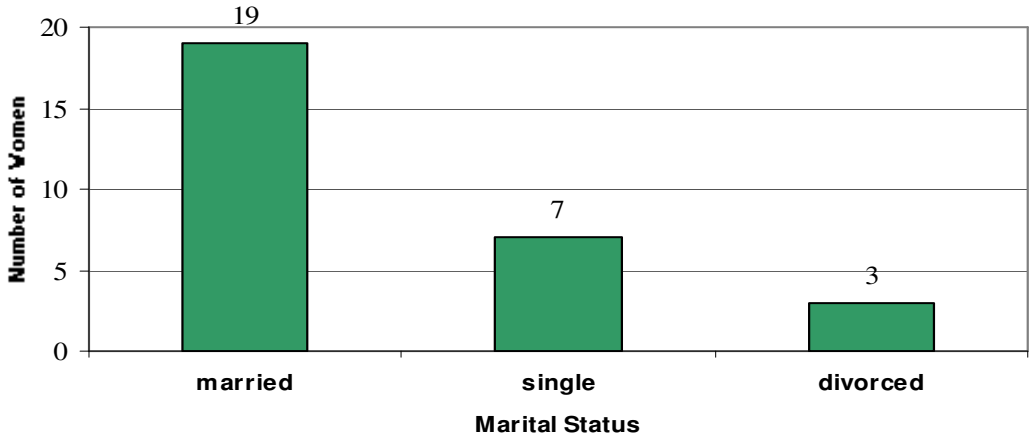

Figure 4: Marital status of women

Interestingly, about half of the women had only 1-2 children born (*Figure 5*). As in the countries of origin women usually have many children (Total fertility rate in Somalia according to the population reference bureau in 2001: 7.3), this finding might suggest the impact of civil war, migration and life in the industrialised world. The category of women who had not yet given birth accounts for the young, still unmarried women of the sample.

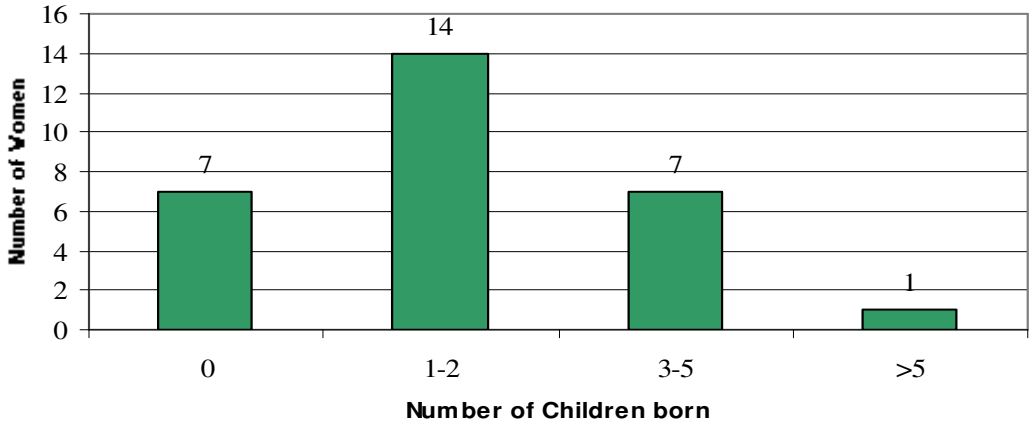

Figure 5: Number of children born to women

The majority of concerned women had been living between 8 and 11 years in Switzerland, which is depicted in *Figure 6*. The majority of them had originally come as asylum seekers and now has preliminary residency status (statues F).

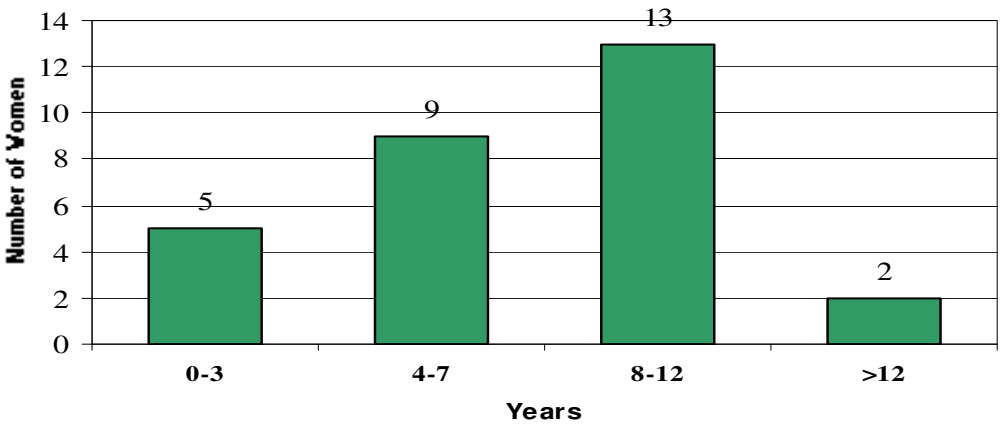

Figure 6: Number of years participants have spent in Switzerland

b) Health care providers:

The total sample comprised 37 in-depth interviews with physicians and midwives. The subgroup of the physicians consisted of 20 interviewees, 17 of them were gynaecologists/obstetricians, and 3 of them were general practitioners. 55% of the physicians and all midwives interviewed were women. The subgroup of the midwives consisted of 17 interviewees. The cantonal distribution of all health care providers, divided into the subgroups of the two different professions is presented in *Figure 7.* Besides the cantons of Geneva, Vaud, Zurich and Berne selected interviews (n=5) were conducted in the cantons of Basel, Solothurn and Appenzell, depicted as “others”.

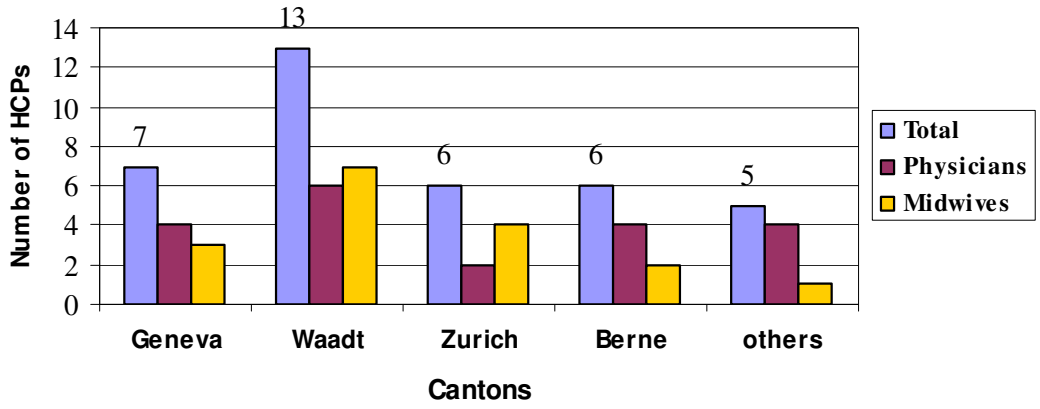

Figure 7: Distribution of sample health care providers according to Swiss cantons

The institutional distribution of health care providers is shown in *Figure 8.* The majority of HCPs included in the study were chosen from selected cantonal hospitals as they were thought to be the institutions predominately confronted with FGM. To verify this fact, health care providers of selected regional hospitals were also included in the study. A selected number of midwives and physicians in private praxis, who were recommended to have some experience with concerned migrants, were recruited. Finally, physicians and midwives working in the family planning centres of Berne and Lausanne were purposefully chosen because of expected experience of counselling concerned women.

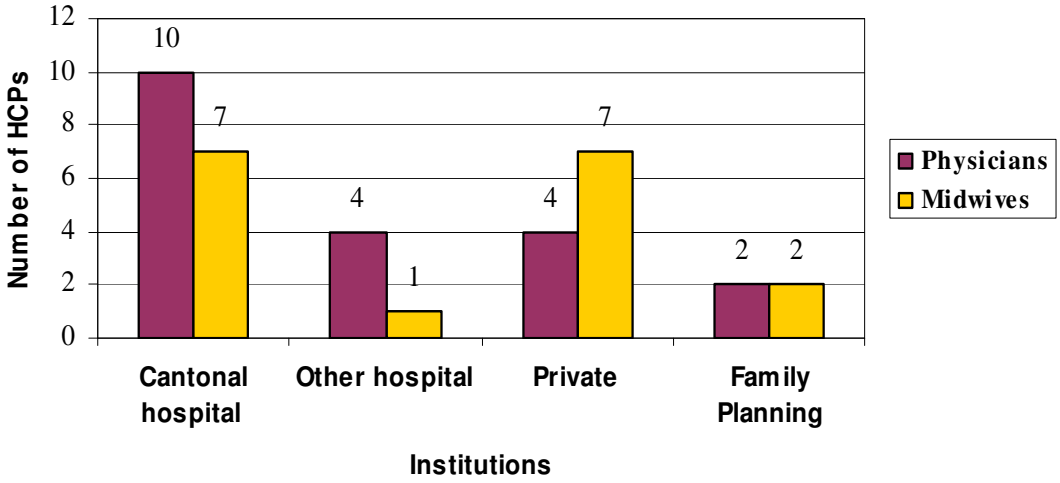

Figure 8: Institutional distribution of sample health care providers

3.2. Sampling

In order to select information rich cases, purposeful sampling (Patton, 1990) was done in this study. More specifically, sampling by criterion, snowball sampling, and sampling according to confirming/disconfirming assumptions were carried out.

Recruiting concerned migrant women

The criterion for participants to have undergone FGM could by no means be approached in a direct way. First of all, contacts to the African community had to be established. Addresses of 5 African migrant groups available from a previous pilot study were used for a first contact. Anticipation of the study was made in writing. Subsequently, the addressed migrant groups were called. When possible a personal meeting with a responsible of each group was aimed to arrange with the idea to enhance confidence, to further clarify questions related to the study and to include inputs of members of the migrant communities in the study design. Three issues made the process of recruitment especially difficult:

a) Logistics: Limited official working hours of volunteer work of the migrant organisations and long, often irregular working hours of private contacts complicated access to the migrant communities.
b) Gender issues: When contacting the organisations, often African men were reached. They declared the subject of interest as a women's topic. Sometimes it was promised to transfer the information concerning the study to women of the group and have them call back, which did not result in any response.
c) Criterion of FGM: Several times African informants from ethnic groups that do not practice FGM showed large interest in the study, however could not be of any help in recruiting concerned women.

After three months of intense efforts in trying to establish direct contacts to concerned women via migrant groups, this approach seemed almost impossible. Alternative ways of recruiting were tried by asking women in African restaurants, African import markets and African hair and cosmetic stores. However, also those individual approaches did not help to get in contact with women who were willing to participate in a group discussion. If women who had undergone FGM were contacted, often they were willing to help in the study and to become mediators or translators. However, they refused to

personally testify. In addition, as recent immigrants some had only limited contacts to other women of those ethnic groups/nationalities that perform FGM.

At a point of the study when it already seemed impossible to include women concerned, two chains of snowball sampling showed to be successful.

- Contacting Swiss centres for the integration of migrants in the cantons of Vaud and Geneva: Several African women who were not able to directly participate as informants recommended the centres “Camarada” in Geneva and “Appartenances” in Lausanne. “Camarada” is an only women’s centre, where migrant women from 57 nationalities are currently inscribed. “Appartenances” has a multicultural women’s department. Both centres offer education (languages classes and classes of alphabetisation on various levels), social contacts and intercultural exchange adapted to the needs of migrant women. Both centres were visited. After having discussed the study with the co-ordinators of the centres, they provided contacts with mediators of FGM practising ethnic groups/nationalities. In personal meetings confidence was established and the process of recruitment was explained. Criteria for recruitment were: women in their reproductive age who had undergone FGM, and had delivered in Switzerland. Recruitment was done by telephone and in personal meetings. Also, for the recruiters as women, mediators and members of the same ethnic group recruitment was a difficult process. Of nine women who had after various reconfirmation phone calls agreed to participate in the discussion group in Lausanne, only 3 women appeared on the arranged date to participate. Because of the difficulties of recruitment it was decided to also include younger participants who had not delivered (n=3) and participants who had not delivered in Switzerland (n=7).

- Using personal contacts of a previous study: After a lengthy chain of recruitment a mediator from Somalia who was recommended by a Somali mediator and translator of a previous study, agreed to participate in this project. She organised 8 Somali women to participate in a group discussion which meant series of phone calls for about a month, establishing trust, explaining several times in detail the goal of the discussion and finally arranging a meeting date and place suitable to the majority of the asked women. She was not only recruiter but also translator and co-moderator in this particular discussion.

With the help of the mediators women from Somalia and Eritrea could be recruited for the study. Originally, it had been foreseen to also include West African migrants with a less severe degree of genital mutilation than the concerned women from Eastern Africa. However, the number of women with origin from West Africa inscribed in the migrant centres was too small to realise this plan. Using personal contacts, it was not possible to motivate Senegalese women in Geneva to participate in the study. This could be due to the fact that women from West Africa with a less severe degree of genital mutilation which causes less medical complications and sometimes is not even recognised by Swiss health care providers might not be willing to disclose their state of genital mutilation by participating in the study.

Health care professionals

Gynaecologists/obstetricians and midwives, the professions most directly confronted with the phenomenon of FGM in Switzerland, were chosen to be the target group.

- Sampling by criterion (Patton, 1990)

In aiming to perform in-depth interviews with health care professionals about experiences in treating concerned women, those health care providers were aimed to address who had been confronted with the phenomenon of FGM in Switzerland. Knowing from previous studies that concerned women predominately consult in the large cantonal hospitals of the countries, gynaecologists and midwives working in the university hospital of Geneva, Lausanne, Zurich and Berne were defined to be the target group.

- Snowball sampling (Krueger, 1994)

Two senior female medical doctors were chosen as first contacts. These contacts were known from a publication and a previous study to be key persons in counselling and treatment of concerned women in the University Hospitals of Lausanne and Zurich. By asking them to provide further interview partners at the same and/or other institutions, snowball sampling started. The chain of recommended informants diverged initially and finally converged as a few key names were mentioned repeatedly. To begin with, staff at the university hospital was included for interviews. In the course of the recruitment, however, also physicians and midwives in private practice, who had been recommended by colleagues and women concerned to be health care providers of reference for the migrant community were also included in the study. Though the main target group were gynaecologists and midwives, two general practitioners were included in the study, one in private praxis and one working for an association particularly dealing

with the health care of migrants in the canton of Vaud. Because the family planning centres were recommended by several informants to be those locations were counselling for women with specific gynaecological, obstetrical and social problems in a culturally sensitive way would be performed, gynaecologists and midwives in family planning centres in the French and German speaking part oft the country were recruited for interviews.

- Confirming and disconfirming assumptions (Patton, 1990)

The so identified and interviewed gynaecologists and midwives predominately worked at large university hospitals, assuming that they are most confronted with concerned women and thus able to provide the most in-depth information/reflections. To confirm/disconfirm this idea, gynaecologists/obstetricians at 5 regional hospitals in rural areas of Switzerland were questioned, designing a short version of the questionnaire containing essential points of the original questionnaires.

3.3. Methods applied

Triangulation of data sources and methods was used to gain comprehensive insight in the nature of problems and to enhance internal validity of the study.
The following methods were applied in the study:

Samples	Methods applied		
Categories of samples	Focus group discussion	In-depth interviews	Observation
Concerned women	+	+	+
HCPs	not done	+	not done

Table 2: Triangulation of methods applied

Structured, in-depth interviews with categories of health care professionals

The questionnaire for health care professionals was formulated in an open ended manner so that respondents were free to express experiences, thoughts, attitudes and recommendations. It contained 29 questions, arranged in a structured way into seven sections *(Appendix 3)*. Few modifications were made between the questionnaires designed for the two health professions, gynaecologists and midwives. In the questionnaire for midwives a question referring to gynaecological complications of FGM was left out, whereas an obstetrical question relating to postnatal care of concerned women was added. Structure and length of the questionnaires remained identical.

Structuring the questionnaire served the following goals:

a) To lead the interviewees to focus on the research areas of interest.
b) To ensure exhaustiveness that all questions were covered by the researcher
c) To facilitate comparability of the interviews.

Questionnaires were originally phrased in the English language. For interviews in different regions of Switzerland, French and German versions were prepared.

With the exception of two interviews, all in-depth-interviews with health care professionals were performed as telephone interviews. Visiting all interviewees in different institutions and in various parts of the country would have been logistically impossible. Usually, health care professionals were contacted twice. First, they were approached in writing or via the telephone. During this first contact, the aim of the study was explained, informed oral consent was received and an appointment for the date of the interview was made. Some of the contacts needed several approaches before the individual could be reached, and some of the interviews were postponed several times due to professional obligations of clinicians. The interviews were prepared for a duration of 30 minutes. Depending on the amount of information the interviewees were able to provide, the interview time ranged between twenty minutes and 1.5 hours.

Focus group discussions with concerned women

To facilitate discussions with women concerned focus group discussions were considered the most appropriate methodology. The focus group methodology is an established tool in qualitative research (Krueger, 1994). The hallmark of focus groups is the explicit use of group interaction to produce data and insights that would be less accessible without the interaction found in a group, (Morgan, 1988). Focus group discussions have been described as a data collection technique particularly sensitive to cultural variables-and is therefore a particularly suitable tool in cross-cultural research and work with minority groups (Kitzinger, 1995).

Considering the sensitive topic of FGM and the perspective of a minority population, there are several advantages of the focus group approach:

- Informants reluctant to be interviewed on their own can be encouraged to participate in a group. Moreover, it has been stated that group work can actively facilitate the discussion of taboo topics because less inhibited members of the group break the ice for shyer participants (Kitzinger, 1995).

- Participants can provide mutual support in expressing feelings that are common to their group but which they consider to deviate from mainstream culture (or the culture of the researcher) (Kitzinger, 1995).

- Through analysing the operation of humour, dissent and consent within the group the cultural peculiarities of FGM transferred in a western health care system will be better understood.

- Women who cannot read or write will not be excluded from discussions.

Four focus group discussions were conducted in the cantons of Geneva, Vaud and Zurich. Three of these groups consisted of women from Somalia. One group consisted of women from Eritrea *(Table 3).*

Table 3: Overview Focus group discussions carried out

Focus group discussions (I-IV)	**Lausanne (I)**	**Zurich (II)**	**Geneva (III)**	**Geneva (IV)**
Date	06-02-02	23-03-02	25-03-02	26-03-02
Number of women	3	8	11	4
Nationality of women	Somalia	Somalia	Somalia	Eritrea
Type of FGM	III	III	III	50% II, 50% III
Discussion moderator	Researcher	Researcher	Researcher	Researcher
Mediator	Somali woman	Somali woman	Somali woman	Swiss woman
Occupation mediator	Intercultural mediator, translator	Social worker, translator	Teacher, translator	Teacher, mediator
Note taker	STI female research colleague	STI female research colleague	Female co-ordinator migrant centre	Female teacher migrant centre
Languages	Somali, French	Somali, German	Somali, French	Tigrinya, French

The researcher of this study moderated the discussions. One additional person was responsible for taking notes, twice STI research colleagues and twice teachers and mediators from the migrant centre “Camarada” took this responsibility. A second focus of this additional staff was to do **observation**. The observed non-verbal communication such as facial expressions and gestures reflecting the emotional state of participants were discussed in the debriefing between mediator, moderator and observer after each discussion.

For the focus group discussion a question guide was developed (*Appendix 4*) and translated into French and German to be suitable for the French and German speaking parts of the country. Questions were phrased in a clear, simple manner. Concerning the subject of FGM, questions were phrased in a neutral manner to avoid embarrassment and shame in the participants. Also, the questions were focussed on FGM with respect to the present situation in Switzerland in order to avoid flashbacks of the possibly traumatic excision procedure remaining from childhood, of civil war and of migration. On the other hand, often individuals felt the need to share memories of the past with other groups participants. Room was given for this exchange of experiences.

Semi-structured, in-depth interviews with members of the migrant population

In addition to the focus group discussions few women were interviewed individually. One woman who was ill at the time, one woman unwilling to participate in a group discussion and one woman who had unsuccessfully tried to organise a group but remained the only informant, were interviewed individually. To allow comparability, the question guide of the focus group discussion was used to structure the interview.

In the group discussions the absence of communication between women and men was a strong finding. Moreover, various not proven assumptions of concerned women related to male’s attitude towards FGM, seemed interesting to be verified by asking men directly. Though it had not been aimed to include men of the concerned migrant population initially, the idea arose to perform a male group discussion. Despite many attempts and support of key informants of the migrant sample, however, it proved impossible to organise a men’s group. This difficulty was determined by various reasons, such as: the sensitive character of the subject associated with the intimate topic of sexuality, the gender specificity and the unwillingness of men to participate in women’s business, political reasons, fear to damage the whole family’s reputation and finally the difficult social situation in the host country, where voluntary unpaid participation in a

study was felt to be a waste of strength and time. Also, it showed to be difficult to approach male informants individually. Considering the overall limited time frame of one year for the entire study and the progressed time at that particular point of the study, just three in-depth interviews with men of the Somali community in Switzerland could be performed. For this purpose a questionnaire was formulated in an open ended manner so that respondents were free to express experiences, thoughts, attitudes and recommendations. It contained 18 questions, arranged in a structured way into four sections *(Appendix 5).*

3.4. Use of tapes

All of the focus group discussions were recorded on tape as recommended in the literature (Dawson et al., 1995). Beforehand, the participants were informed about the aim of the study and the nature of a group discussion. Also, the reason for the tape recording was explained. In the first moment there were participants who showed to be reluctant or who had not decided to accept the tape recording. However, after ensuring that confidentiality would be guaranteed and after other group members had declared that they would not mind at all, all group members consented to the recording. The women were told that they could at any time of the discussion withdraw from the recording or interrupt it. One group member in one of the discussions, when telling the group about a subject especially intimate to her, asked for the recording to be stopped and then allowed continuation after she had finished. In-depth interviews with health care professionals were tape recorded after asking for informed consent. Also, with oral informed consent, 3 out of 5 in depth-interviews with women and men of the concerned migrant population were tape recorded, whereas two women did not allow tape-recording.

3.5. Transcription/Translation

The researcher transcribed all recorded in-depth interviews and focus group discussions. Written notes made taken during interviews and group discussion served for verification and to focus on sections of special interest. All in-depth interviews had been conducted either in German, French or English and each interview was transcribed in the languages applied. The focus group discussion with women from Eritrea was held in French and was consequently transcribed in French. The three other focus group discussions were performed in Somali and translated either in German or French, depending on the region of Switzerland the discussion took place. However, the majority

of the participants understood and spoke some German or French. Thus, large parts of the discussions were held in the languages of the host country. So, the translator only translated some sections in which participants preferred to speak their native language and statements of participants who were less fluent in the host country's language. All translated passages of the discussions were transcribed. To verify the translation, the recording of one entire group discussion was additionally transcribed and translated by an official Somali translator from Somali into German. In two discussions, this was not seen necessary because German or French prevailed and translated statements were testified and often verified or commented by other group members.

3.6. Analyses

Quantitative Analysis

For the quantitative part, the current number of female residents and female refugees from 28 FGM practising African countries that are officially living in Switzerland was obtained through the Federal Office for Foreigners (2001) and the Federal Office for Refugees (2001). An estimated prevalence rate of women having undergone FGM was calculated by applying the national prevalence rate of FGM of the countries of origin (*Appendix 1*) to the number of these nationals residing in Switzerland. The distribution of women and girls from FGM practicing countries according to nationalities, age groups (≥ 16 years and ≤15 years) and place of residence within Switzerland (cantonal distribution) was established. Also, the distribution of women (≥ 16 years) estimated to have undergone FGM related to nationalities and Swiss cantons was shown.

Qualitative Analysis

Content analysis was applied, which means the process of identifying, coding and categorising patterns in the data (Schensul and LeCompte, 1999). After having transcribed the whole data set, an in-depth analysis was carried out, which implied careful reading of the data several times. First, transcripts were rearranged and structured according to the predetermined paragraphs, containing broader thematic fields of interest. Then, for more detailed and exhaustive analysis, computerised data analysis was carried out. The transcribed data was formatted differently and entered into the MAXQDA-program, a software designed for qualitative data analysis (VERBI software, 2002; Berlin, Germany). Two "projects" were defined: one for the data of health care profession-

als and one for the data of the concerned population. Before starting the process of coding, limited categories of thematic priority were defined to set a focus for analytical emphasis. Coding was carried out in form of axial coding. For presentation and discussion of the areas of analytical emphasis, the coded segments of the transcribed texts of each project were retrieved according to the specific code. Then, retrieved segments were transferred into Microsoft Word, printed out, rearranged and embedded into the presentation and discussion of findings in this thesis.

3.7. Ethics

According to the key points of the protocol to the Ethical Committee of the Cantons of Basel, the eligible female participants were informed about the study by a introductory text "*information for participants of focus group discussion*". In the process of planning the group discussion this text was modified by including the recommendations of the Somali mediators on how to best approach women of the concerned population. The introduction to the group discussion was read out load by the moderator before the group discussion and was then translated to the whole group. In three of the discussions which were held at migrant centres, one of the female staff at the migrant centre known and accepted by the women was present to enhance trust in the project. All of these staff members, one of them an ethno-psychologist[1], the others teachers and mediators had longstanding experience with work in migrant populations. So in case that one of the focus group discussion-participants had experienced, reactivated by the topic of discussion, intense psychological distress at exposure to internal cues that symbolised or resembled the traumatic event of circumcision or other traumatic events before or in the course of migration, the study could have provided counselling during and/or after the discussion. However, no critical situation of emotional stress occurred in any participant. As the mediators recruited participants by phone, group participants gave their written consent immediately before the group discussion. Every study participant was guaranteed that he could withdraw from the study at any time. As scepticism of participants towards tape recording was evident, the purpose of using tapes was explained in depth. Also, the fact was emphasised that tapes would be destroyed two years after completion of the study. Before the interviewing started, the study protocol was submitted to the Ethical Committee of the Cantons of Basel. On January 22, 2002, the study received ethical clearance.

[1] Delphine Bercher, see acknowledgements

4. Findings

4.1. Prevalence and distribution

10,501 women from 28 African countries where FGM is practised are officially living in Switzerland (150/100,000 inhabitants). 6,100 of these women are registered as foreign residents (Federal Office for Foreigners, 2001) and 4,401 are registered as refugees (Federal Office for Refugees, 2001). The real number of women from 28 African countries residing in Switzerland is expected to be higher taking the unregistered migrants without a legal state into consideration. 7,596 (72%) of the women are 16 years old and older. 2,905 (28%) are girls who are 15 years old and younger. As illustrated in *Figure 9* the largest group of female migrant women from FGM practising countries residing in Switzerland comes from Somalia (2,564 women; 24% of the total residents from FGM practising countries), followed by the women from the Democratic Republic of Congo (2,161 women; 21% of the total residents from FGM practising countries), Cameroon (1,145 women; 11% of the total residents from FGM practising countries), Ethiopia (1,040 women; 10% of the total residents from FGM practising countries) and Eritrea (629 women; 6% of the total residents from FGM practising countries).

An estimated prevalence rate of women having undergone FGM was calculated by applying the national prevalence rates of FGM of the countries of origin (WHO, 2001) to the number of these nationals residing in Switzerland. The total estimated prevalence rate of female immigrants having undergone FGM is 5,718/10,501 (545 of 1,000 female immigrants from FGM practising countries), assuming that the migrant population has undergone FGM to the same extent as in the home country. The estimated prevalence rate of women (≥ 16 years old) having undergone FGM who officially reside in Switzerland is 4,051/10,501 (386 of 1,000 female immigrants from FGM practising countries).

Figure 10 illustrates that by far the largest group (38%) of all women (≥ 16 years old) in Switzerland who are estimated to have undergone FGM comes from Somalia. The high estimated prevalence rate is due to the high prevalence rate (98%) of all women in the home country. Contrary to this, the prevalence rate of FGM in the Democratic Republic of Congo is only 5%. Thus, though the total number of women from this country accounts for 21% of all women from 28 Sub-Saharan countries, only 2% of the women estimated to have undergone FGM come from the Democratic Republic of Congo. Also, the estimated prevalence rate of Cameroon, the third strongest group in terms of the

total frequency, remains low (5%). However, considering the high prevalence rate of FGM in Ethiopia (85%) and Eritrea (95%), these nationalities present the second (19%) and respectively third (11%) most concerned national group of women residing in Switzerland.

A further objective of this study was to question whether concerned women are distributed equally over Swiss territory. In *Figure 11* it is shown that there are strong regional differences. The majority of women concerned live in the large metropolitan areas of the country. More than 70% of all women estimated to have undergone FGM are living in the cantons of Geneva, Vaud, Zurich and Berne. In the rural cantons of Appenzell Inner-Rhoden, Obwalden and Uri there are living no women concerned at all. Based on this distribution of women concerned, it was decided that the cantons of Geneva, Vaud, Zurich and Berne would become the main study cantons. *Figure 12* shows the cantonal distribution relative to the total number of inhabitants per canton (Swiss Federal Statistical Office, 2001). The cantonal distribution adjusted to the number of inhabitants illustrates the fact that women concerned predominantly live in the French speaking part of the country, particularly in the canton of Geneva.

a) Frequency and distribution according to nationalities

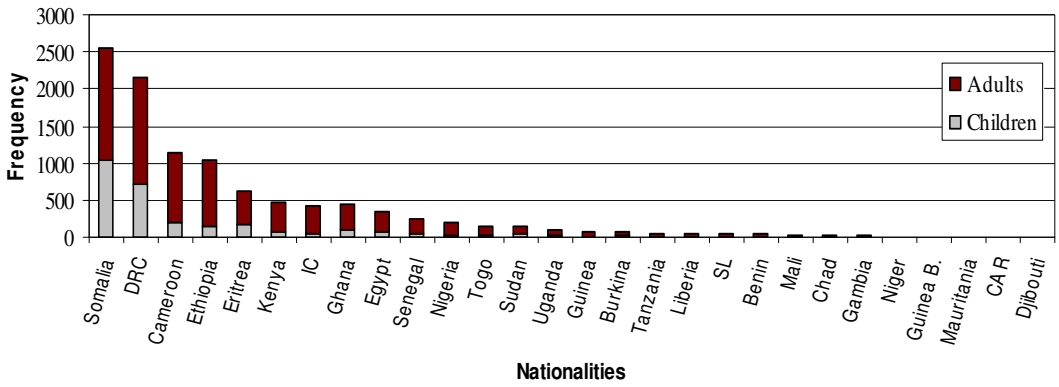

Figure 9: Female migrants from FGM practising countries who reside in Switzerland according to nationalities

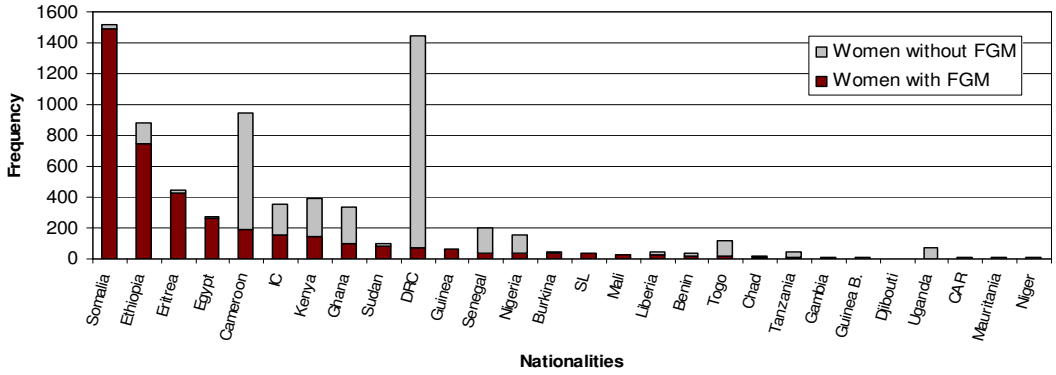

Figure 10: Estimated frequency of women (≥ 16 years old) concerned living in Switzerland

b) Cantonal distribution

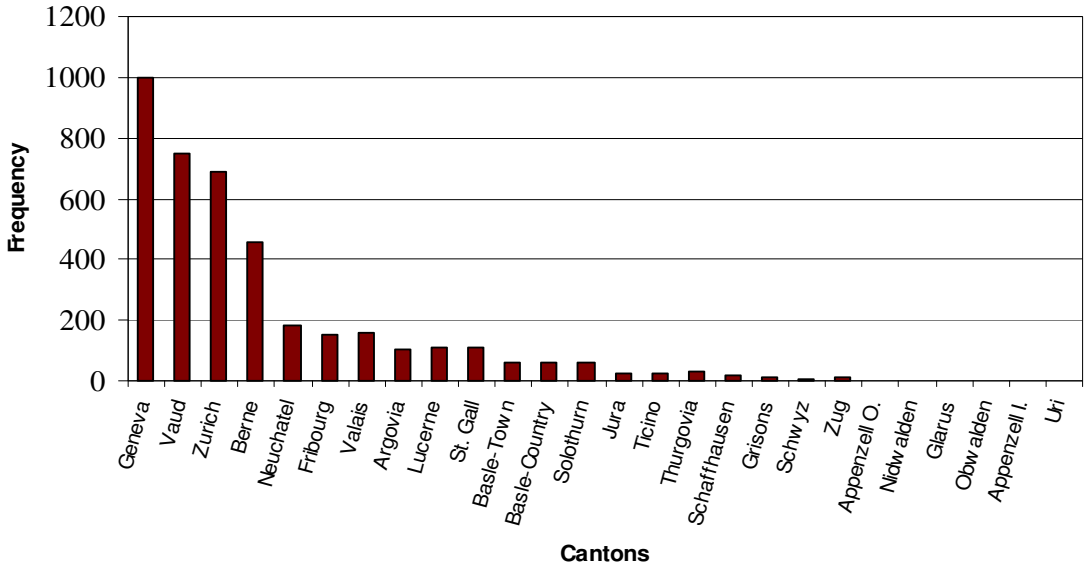

Figure 11: Distribution of women (>16 years old) concerned according to Swiss cantons.

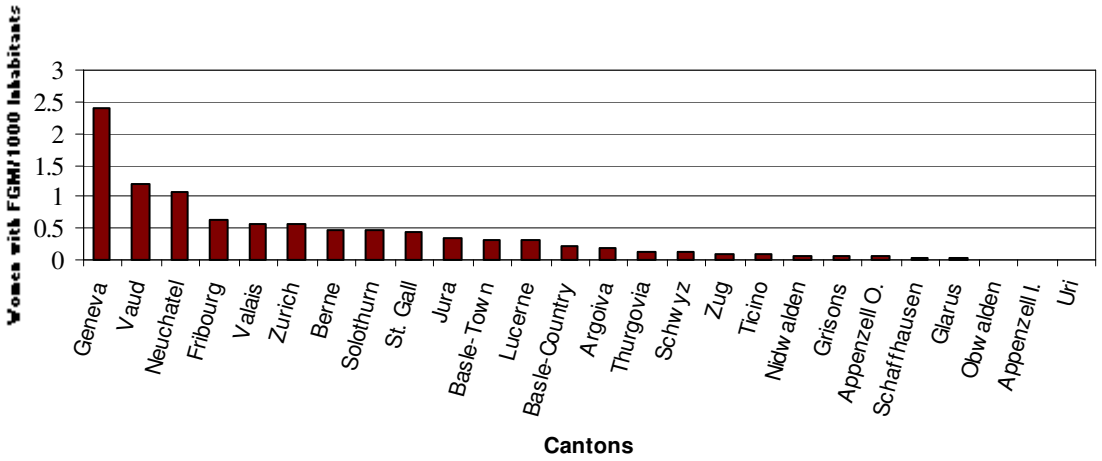

Figure 12: Distribution of women concerned related to 1000 inhabitants per canton

4.2. Complications of Female Genital Mutilation in Switzerland

Perspective of the women concerned

The health complications of FGM which women have experienced will be presented in the following paragraphs. Leading complications were related to sexuality and menstruation. *Table 4* presents FGM related health complications according to their frequency mentioned by women. The complications presented in the table are complications which were spontaneously mentioned and after general probing for FGM related gynaecological and obstetrical complications. However, no systematic prompting on each group participant and each FGM related complication was done.

Category	Complications	Frequency mentioned
sexuality	reduced sensation during sexual intercourse	5
	pain during sexual intercourse	4
menstruation	pain during menstruation	10
urinary tract	burning during urination	2
	prolonged urination	2
obstetrics	lesion of sphincter ani	1
Total:		24

Table 4: Frequency of health complications given by the women (Multiple response).

Sexuality related complications

a) Reduced feelings during sexual intercourse

As presented in the chapter on demographic characteristics, the majority of the women of the group discussion were married women who had delivered children. A central intimate issue that was frequently mentioned by this group of women with type II and FGM type III was the effect FGM has on feelings during sexuality. The majority of women commented to have reduced feelings during sexual intercourse.

- *"I am seeing my husband every evening. If for some months I wasn't with my husband every evening, it would not make a difference to me. The woman is unable to make love. For the woman it is a sort of labour to make love."* (Woman from Somalia, 37 years)

- *"A woman who has been excised as a girl at the age of 7 years does not know her feelings during sexual intercourse. The husband needs to make some efforts. If he does not do so, then she will never have an idea about her feelings."* (Woman from Somalia, 39 years)

- *"But it is clear that people say that we have difficulties with our feelings, that we enjoy less when having sex."* (Woman from Somalia, 38 years)

- *"FGM makes women cold*." (Woman from Eritrea, 36 years)

This woman from Eritrea continued that she cried and suffered during sexuality because she felt no pleasure. Her first husband just used her sexually whenever he felt the desire.

However, not all women expressed reduced feelings during sexuality. One interviewee felt a strong need to express that even without a clitoris, without labia minora and without parts of labia majora, she was able to reach an orgasm. She wanted to tell the researcher that she is not an asexual creature and stated:

- *"I need affection five time as much as the 'other' women. I feel tenderness on my whole body."* (Woman from Somalia, 23 years)

b) Pain during sexual intercourse

Pain was mentioned by a Somali woman with FGM type III who had not delivered a child so far. She revealed individually that she has had several sexual relationships though still being infibulated. To facilitate sexual intercourse, she used a great amount of lubricants. Still, every time she felt pain during intercourse. However, she chose to not undergo deinfibulation before delivery because she wanted to avoid in any case to be reminded of the traumatic act of FGM, which she underwent at the age of nine years. Several older women, having already a wider vaginal opening caused by delivery, recalled retrospectively the pain they had experienced. One woman explained:

- "*A Somali woman suffers from the beginning of her sexual activity till her first delivery."* (Woman from Somalia, 37 years)

Complications related to menstruation

Problems with menstruation were the most frequently mentioned complications and pain was the leading symptom *(Table 4).* Particularly, the young participants of the groups, who have not had a sexual experience, complained about severe pain. The majority of group participants showed strong compassion with them as they retrospectively recalled similar difficulties from the time when they were still tightly infibulated.
Eight women mentioned pain during their period, one woman reported dribbling "*the blood does not drain well*"(Woman from Somalia, 17 years) and one woman mentioned to have a hypermenorrhea "*lots of bleeding for 7 days every month*." (Woman from Eritrea, 33 years) In one group the following interaction between group members occurred when the youngest, not married participant (P1, woman from Somalia, 20 years) mentioned hesitatingly the pain she experienced. One of the older women (P3, Woman from Somalia, 38 years) showed understanding for this difficult situation. Another participant however, aimed to motivate her to choose for a surgical intervention to get relief from the suffering. (P2, Woman from Somalia, 31 years)

- *P1 (very hesitatingly):" I have difficulties with my menstruation. It is painful."*
- *P2: Then, go to have it opened!!*
- *P3: P1 is not yet married and is afraid. Maybe, she prefers to wait with the opening until she finds a husband.*
- *P2: Just go to the doctor, if you have problems! Have it opened! Nowadays it is not fashionable anymore to be so narrow."*

Another non-married woman described severe dysmenorrhoea in the following way*:*

- *"I have problems during my menstruation. It is very difficult; there is no place for the blood to leave. It is very painful. Every time I am suffering."* (Woman from Somalia, 23 years)

Complications related to micturition

Burning during urination, indicating a urinary tract infection or a local irritation of the urethra was mentioned as memory of immediate complications after the procedure of FGM in the home country and not in context of recurrent urinary tract infections. Prolonged micturition was recalled by some of the women to have been related to the statues of tight infibulation due to the covered urethral opening. This symptom was illustrated in a vivid manner:

- *"Passing water takes a long time: schschschschschschschschschsch(…), slowly, slowly*." (Woman from Somalia, 38 years)

Obstetric complications

Complications related to delivery were less common, but expressed to be of strong impact for those women concerned. A group participant from Eritrea mentioned that she had to stay several weeks in the hospital after delivery because her vulva had been torn to the anal sphincter. The week after the group discussion she was scheduled to undergo the third surgery within a year, aiming to reconstruct the lesion of the anal sphincter. Another Somalian group participant suspected the fact that she had delivered by means of caesarean section to be a complication of FGM. The doctors had not been patient and she immediately had received caesarean.

The different periods of suffering during the life time of a woman who has undergone FGM type III were summarised by one of the participants:

- *"If you are not married, you have problems with your menstruation. If you are married and you want to have sex with your husband, you suffer from pain. If you want to deliver your baby, it is difficult. This is terrible, this is hard."* (Woman from Somalia, 30 years)

Perspective of the health care providers

The most frequent pathological long term complications of FGM which health care providers reported about were related to sexual intercourse and menstruation. Patients had complained about very painful sexual intercourse. In some cases it had not at all possible due to the scar tissue barrier of the vaginal opening. With respect to menstruation, the leading symptom was pain. *Table 5* presents FGM related health complications according to their frequency mentioned by HCPs after probing for gynaecological, obstetrical complications of FGM.

Category	Complications	Frequency mentioned
sexuality	dyspareunia/apareunia	7
	reduced sexual arousal	0
menstruation	dysmenorrhea	4
urinary tract	prolonged micturition	2
	urinary tract infection	1
infibulation scar tissue	lesions of the scar tissue	2
	cysts and/or foreign bodies	1
obstetrics	lesion of sphincter ani	1
	wound infection after reinfibulation	1
Total:		19

Table 5: Frequency of health complications given by the HCPs (Multiple response)

Lesions of the infibulation scar were explained as a consequence of attempts to have sexual intercourse.

Physicians and midwives found it difficult to differentiate FGM from other possible causes of disease. Below, one general practitioner experienced in the care of migrant women phrased it in the following way:

- *"Gynaecological complications? Pain during menstruation is the only symptom, which I experienced often in women concerned. Other complications of infibula-*

tion? No, I have not diagnosed that. Recently, I had a Somali woman with a urinary tract infection. However, this woman just had married and probably the infection was related to sexual intercourse." (General practitioner, Geneva)

Thus, she could not clearly differentiate between the urinary tract infection due to frequent sexual intercourse of the recently married woman (honeymoon cystitis) and between a long term complication of FGM.

As to obstetric complications, there were several physicians working in the field of obstetrics, reporting that they had not been faced with specific complications of women with FGM type III. One of the gynaecologists/obstetricians stated:

- "*No, I cannot distinguish any obstetric complication related to FGM type III*. (Gynaecologist, Geneva)

One midwife however, recalled a perineal lesion that leads to rupture of the anal sphincter. To avoid faecal incontinence, several reconstructing surgeries followed delivery. However, also in this case the midwife could not tell if the complication was a consequence of FGM or if a large baby was the reason.

HCPs working at the large university hospital in the Cantons Geneva, Vaud, Zurich and Berne, mentioned vaginal deliveries of women concerned and denied to carry out more caesarean sections in these patients. However, in three of five regional hospitals included, that have been extremely rarely confronted, caesarean sections had been carried out or were considered to carry out, because health care providers were not familiar with the obstetrical management of patients with FGM type III

Also, only few gynaecological complications were mentioned by HCPs. One of them having treated a substantial number of concerned women during the last decade explained the occurrence of only few gynaecological complications by the fact that the large majority of concerned patients she had been treating were adult women. These patients had a lesser degree of infibulation because they had already gone through the painful widening of a tight infibulation in their past.

- *"After all, they do not have too many problems. I cannot say that they present with more infections. The concerned women whom I treat are predominantly married women who have already had sexual intercourse. I cannot say that I treat them more than the general population. I had two to three women who were really tightly closed and they had problems. They had pain during sexual intercourse and during menstruation The majority however, had the size of the vaginal opening which*

did allow for the menstrual blood flow. I have not diagnosed cysts and acute inflammatory syndromes. But this was an adult population who already had their problems in their countries of origin." (Gynaecologist, Geneva)

Two other gynaecologists/obstetricians interviewed, explicitly stated never to have faced inflammatory syndromes and local consequences of FGM such as cysts, consequences that are frequently described in the literature.

None of the asked gynaecologists/obstetricians, reported about increased infertility rates in concerned women. Also, the special clinic on sterility at the university hospital of Geneva does not see an increased percentage of women from Somalia/Ethiopia/Eritrea in the consultations.

4.3. The medical consultation

This section starts with the memory of the first consultation and describes how women and providers recall the first encounter. The following subsection describes the health seeking behaviour of concerned women. In the last subsection a response is given to the question in what way FGM explicitly becomes part of the medical consultation.

The first encounter

Perspective of the women concerned

The first gynaecological/obstetrical consultation in Switzerland is of importance for the migrant patients with FGM as it sets the basis of trust and determines further health care seeking in the host country.

The majority of women asked in the group discussion or in the in depth-interview had vivid memories of this experience, which in some cases dated back to the time when they had arrived in Switzerland several years ago. The following statements of different women show strong emotional reactions to FGM by the health care professionals faced with it. The inability to diagnose FGM and the difficulty to perform the gynaecological examination in the presence of FGM type III become obvious. Women who recalled those reactions were aware of the fact that gynaecologists/obstetricians reacting in this way, were indeed confronted for the first time with FGM.

- *"At the first visit of the gynaecologist. the doctor asked me: What happened to you? A burn? There was also a midwife, she had been in Africa. She started to talk about the subject and with her I spoke. The physician however, asked me-and I keep remembering it-if I had a burn."* (Woman from Somalia, 30 years)

- *"The physician said: Have you had an accident? He was very surprised. For him it was the first time."* (Woman from Somalia, 47 years)

- *"The first time, when I consulted the gynaecologist, it was a male physician. My husband was also present. He explained the doctor, who was really shocked, that you do not have to be shocked. That I am a woman as I am. In our country this is culture, even after delivery you resuture. He, the physician, was really shocked when he saw this."* (Woman from Somalia, 37 years)

Several women mentioned that the HCPs had difficulties to start the gynaecological examinations and to verify anatomical structures.

- *"I was in the maternity [women's hospital] in Zurich. It was difficult. The physician could not examine me properly because the hole was too small. Then, he asked, if his students could observe the examination. He was really shocked/frightened. Then, he said he was not informed, but he knew a physician from Sudan, with whom he would discuss."* (Woman from Somalia, 38 years)

This finding is also expressed in the following group interaction concerning the doctor's reaction:

- P1: *"The doctor was very surprised when he realised that the clitoris is missing."* (Woman from Somalia, 34 years)
  P2: "The physicians notice that something is missing, that flesh is missing, and they search." (Woman from Somalia, 31 years)
  P3: "With the instrument the doctor always viewed from above and searched a lot." (Woman from Somalia, 22 years)
  P4: "The doctor searched because the hole is just so small " (Woman from Somalia, 20 years)

The reaction of the doctor can provoke feelings of shame and fear, as the following quotes show.

- *"Beforehand I have been proud. But through the medical consultation my pride has been hurt. The physician was very shocked, when he realised that I am sutured. He did not want to ask. He did not at all want to talk about it."* (Woman from Somalia 38 years)

Perspective of the health care providers

In accordance with what concerned women perceived, health care professionals recall the first encounter as a moment of shock and astonishment. Most professionals who commented on their experience date it back to the beginning of the 1990s when the large wave of Somali immigration occurred. Some of the providers were still young and inexperienced midwives or physicians at that time.

A midwife described the first time she was confronted with FGM. At that time she was still in her training as midwife. In her testimony she especially emphasised the bilateral situation of distress. She was able to critically self reflect her reaction and asked herself if the distress and fear of the patient would also be a consequence of her own shock.

- *"The first confrontation with FGM I remember very well. It was in cantonal hospital in Fribourg: a very young woman from Somalia with infibulation who delivered for the first time. This was in 1991. It was very impressive. The day before we had listened to a presentation about the subject at the midwifery school. It was still very present to me and then I just saw it in reality. I was shocked. It was really terrible to me. To feel the fear of the woman was even worse for me. This is why I remember it that well. And still I asked myself: wasn't it maybe also my personal fear to hurt the woman and to make her feel my insecurity. Only from the features of this patient, I concluded that she suffered from pain. Yet, there was no verbal communication possible. She could not speak a language which I also understood (...)."* (Midwife, Berne)

Another midwife also commented explicitly on how difficult the situation was for both sides, for the concerned woman and for herself. As verbal communication was not possible due to the language barrier, she rather perceived the physical pain the concerned women experienced:

- "*I think what was really terrible for every woman concerned, this was the vaginal examination. I always experienced this to be extremely terrible. Some of them felt really strong pain. Or the examination did not work out at all. This was also very difficult to me. Fear of the women concerned? Verbally I do not recall it. I think it was also a problem of verbal communication. Mainly the body language was more legible."* (Midwife, Zurich)

She continued that when she was still younger she did not at all address the issue of FGM as she did not dare to do so. Later, being more experienced in terms of information on the subject and patient care, she was able to deal more actively with the situation.

- *"Talking about FGM? In those days I did not conduct anamnesis talks with respect to FGM. Often, the women arrived in the maternity when they had already begun*

labour. Often, there were difficulties of communication due to the language barrier. To address something in this situation was very difficult. Also, I would not have dared to talk about FGM in those days. I started to deal with this later." (Midwife, Berne)

One gynaecologist, who has accumulated a certain experience concerning FGM, while having treated a large number of concerned migrant women in her private practice during the last ten years, reported the change in her reaction between the first experience and facing FGM today. Yet, this statement comes from a gynaecologist who is amongst those practitioners in Switzerland that have developed the most experience with concerned migrants as she is the unofficial gynaecologist of reference in the Somali community of Geneva.

- "*When I started to be confronted I always initiated to talk about FGM because I was so shocked. However by now, after many women concerned had been referred to us, I know before examining them, that I will face FGM. I have never treated a Somali woman who was without FGM except the young children who were born here."* (Gynaecologist, Geneva)

Patterns of health seeking behaviour

Perspective of the women concerned

It is important to understand the health seeking behaviour of the women. Somalian and Eritrean women reported in the group discussions that they usually consult a gynaecologist/obstetrician for the first time when they become pregnant. For some women, pregnancy is the first and the only contact to the health care system in the host country. On the other hand, several discussion group participants said that they had undergone regular gynaecological check-ups since pregnancy.

- *"I consulted the gynaecologist for the first time when I was pregnant. I believe, we Somali women mostly go to see the doctor for the first time when we are pregnant and not before. Also now, I only consult a gynaecologist when I am pregnant, otherwise never."*(Woman from Somalia, 38 years)

- *"I saw the gynaecologist for the first time in the beginning of my pregnancy in Switzerland and after the delivery several times because I had complications."* (Woman from Eritrea, 36 years)

In the groups it was expressed that in the countries of origin gynaecological consultations before pregnancy are avoided, because they are associated with sexual intercourse before marriage.

- *"In the beginning I felt very ashamed during gynaecological consultation. Before I had my daughter, I had problems with my menstruation. The physician told me that I need to see a specialist for gynaecology. In our home country, in Somalia, it is not seen as reputable to consult a gynaecologist before marriage. Thus, I said: no, I am not going to see this specialist*." (Woman from Somalia, 30 years)

- *"Before my first pregnancy, I did not do regular check-ups, neither in Eritrea nor in Switzerland. The first time I consulted the gynaecologist was during the beginning of my pregnancy in Switzerland. In Eritrea, life is different. I had never touched a man over there. As a woman you await the marriage. Because I was never in contact with a man in Eritrea I was also not in contact with a gynaecologist over there. I did not have any problems in Eritrea."* (Woman from Eritrea, 36 years)

Concerning regular check-ups after pregnancy, the health seeking behaviour was variable: Some women only consult when they are pregnant, others go for gynaecological routine check-ups.

- *"When I become pregnant I will go to the gynaecologist. Otherwise I do not consult. I lost a child 3 times."* (Woman from Somalia, 34 years)

- *"I also consulted the first time when I was pregnant. Now I am consulting once per year."* (Woman from Somalia, 41 years)

- *"In the past it was strange. Now it is not strange any more. I have a private gynaecologist where I am consulting once per year. However, the first time was different."* (Woman from Somalia, 39 years)

- *"Once per year. That is normal for the controls. I did not have any problems."* (Woman from Eritrea, 30 years)

- *"When I was pregnant I did not consult the gynaecologist. I just consulted for the delivery at the maternity in Geneva. Afterwards I have done neither control nor consultations at the gynaecologist. I was in a real good state of health, 100% of health. Thus, it was never necessary for me to return to the gynaecologist."* (Woman from Somalia, 47 years)

Perspective of the health care providers

As to the health seeking behaviour, emphasis has been placed on the obstetric services. Health care providers clearly distinguish between the group of more recently arrived migrants who have the status of asylum seekers and live in asylum homes and those migrants who have been living in Switzerland for a longer period of time with residence permits or even having Swiss nationality. When asked about the health seeking behaviour of sub-Saharan women with FGM, health care providers generally referred to those women coming from Asylum homes: If a pregnancy is suspected, women are sent by the personnel of the foyers or by members of mediating organisations such as the CARITAS to health services which offer the adequate services. For the pregnancy test and further control check-ups during the course of pregnancy, women are usually sent to the gynaecological policlinics of the large cantonal hospitals. Various HCPs in the cantons of Vaud, Geneva, Berne, Zurich, where the study was conducted, reconfirmed that this system functions in a reliable way. These two physicians commented on the conditions in Geneva:

- *"If they avoid the consultation? No, generally they are quite well taken care of by the social frame, by the asylum centres, sent by people who are knowledgeable. No, I don't have the impression that they consult too late. This is not the case in a town as Geneva where there is a well established net of social support*." (Gynaecologist, Geneva)

- *"In Geneva there is this system of the nurses with respect to the asylum seekers. Thus, in the asylum homes they have the first consultations and then they are further oriented towards the medical system. For those who are living in the centres, I would say that they do no consult too late."* (General Practitioner, Geneva)

However, the stay in the foyers is limited and migrants are distributed to apartments in different Swiss cantons where a more independent life in the host country begins. A large number of Somali women has been living in Switzerland for at least ten years. Asked, whether those women regularly consult during pregnancy, health care providers expressed doubts with respect to regular controls and check-ups of that group of women. These women often remain at home taking care of their children. Not having sufficient contact with the culture of the host country, there are some who still do not speak the local language after having lived in Switzerland for several years.

- *"It is more difficult for those who find themselves later in independent apartments where they are much more isolated. Predominantly for the women who left the system of the asylum homes, who left the community life, who often do not speak well the local language, it is more complicated to consult the gynaecologist."* (Midwife, Vaud)

Yet, it is not necessarily always social distress which causes concerned women to consult late. It is also their cultural background that plays an important role. One of the midwives who had spent some years working in Africa said:

- *"It happens that the African women consult late, but this is a way of behaving what they know. To have regular annual controls as here is not very African". Thus, I do no t know if the reason for their delayed consultations is linked to FGM. They consult when they know that they are pregnant. When they feel the baby...."* (Midwife, Lausanne)

Addressing FGM during the consultation

Perspective of the women concerned

The majority of women in all of the focus group discussions and in depth interviews said that FGM had not at all been addressed during the gynaecological/obstetric consultation. Few of the women recalled that they had talked about medical or social consequences related to FGM during the medical consultation. The particular occasions when the subject of FGM was raised explicitly, were when women themselves requested either to become defibulated or to become reinfibulated.

Some women complained about the lack of addressing the issue during the consultation. The quote below shows a woman's disappointment that the doctor seemed to have noticed and understood everything, but she herself was the person who had to raise the topic.

- *"The doctor did not talk. That is why I did not find him friendly. He did not explain me anything. It was me who started to talk. The doctor understood everything but he did not talk."* (Woman from Eritrea, 36 years)

Again, the limited time during the consultation did not allow addressing questions related to FGM.

The below quoted woman felt that there was neither a physician nor a midwife in Switzerland who answered all the questions she had in relation to pregnancy and delivery. She missed the traditional birth attendant she was familiar with from Somalia.

- *"I always asked a lot of questions during my pregnancy. How should I deliver? How should I be opened to give birth? I had the feeling that there was nobody whom I could have really asked. A traditional midwife as we have in Somalia was missing."* (Woman from Somalia, 30 years)

Also, even when suffering from complications due to FGM, concerned women do not always manage to address their difficulties. One of the women mentioned that she accompanied another woman from Somalia to translate for her during the consultation. This woman had mentioned to the translator before the consultation that she suffered from severe pain during sexual intercourse. However, when the physician asked her about medical difficulties she did not dare mention this problem.

In the group of Eritrean women, the two participants who had a less severe degree of FGM, showed to be pleased that FGM was not addressed at all. The doctor seemed to have noticed it, but did not comment anything. From their perspective, he did not have to comment anything, as the form of FGM they had does not impede delivery. They were very aware of their difference in comparison with to the two more severely mutilated women of the group.

The only woman of the sample who was determined to remain "open" after delivery having taken the initiative herself, had never spoken with a heath care provider about FGM and had not even wanted to do so:

- *"I have not spoken with the doctor about it in detail. I myself wished to remain open after my first delivery in Switzerland. And it was done so. The doctor did not ask me and I also did not want to be asked. During the pregnancy controls I never addressed this topic with the physician."* (Woman from Somalia, 37 years)

Perspective of the health care providers

One of the physicians included in the study reported to always ask the women from Somalia about difficulties related to menstruation, knowing that this is a common FGM related complication of Somali women. Yet, she never asked Ethiopian or Eritrean women about this complication because she thought that FGM was not common in those countries and was surprised to hear that FGM and even the severe form of FGM type III, also was of relevance in Ethiopia and Eritrea.

The majority of HCPs stated that they did not systematically address FGM during the medical consultation, if the concerned woman did not mention medical problems or concerns related to FGM.

- "*So far I have not addressed FGM during the consultation. Also none of the patients has addressed the subject. My or our position is such that we are closely oriented by the wish of the woman concerned. The consultation is not meant for to speak with the patient about my feelings. If she herself does not address FGM and if I also do not have the feeling that the patient has a question related to this subject, then I do not prompt for it."* (Gynaecologist, Basle)

Carrying it a step further to a more in depth level of the discussion by addressing the psychosexual aspect of FGM, just one of 38 interview partners reported to have gone that far. The particular midwife doing so, had been relatively often in contact with the phenomenon of FGM within the last ten years, had spent some time in Africa, is open

to feminist concepts and has done teaching on FGM in a migrant centre. Yet, the general reaction of Swiss health care professionals related to psychosexual issues is depicted with the following statements. In this below case the difficulty of communication was presented as obstacle for not doing so:

- *"Psychosexual symptoms? Did you address those complications? Less so. It certainly was a problem of communication due to the language barrier. Thus, the midwives called me, because some Somali women understand Arabic a bit, which I also speak a very little. No, the more profound problems we could not talk about."* (Gynaecologist, Berne)

A gynaecologist expressed that the time of consultation is just too short to discuss the subject of sexuality affected through FGM.

- *"I do not know if they reach orgasm. This is very difficult to discuss with them during the consultation. I have never spoken in depth with them about the subject of sexuality. The Somali women, they never feel desire and they never feel no desire. For them it is like washing the dishes and preparing the meals. Yes, it is true, I would like to address the subject with them. However, the consultations are too short to do so."* (Gynaecologist, Geneva)

One of the senior doctors at a university hospital stated that he did not speak with concerned women about FGM because he felt they were uncomfortable being asked by a male doctor and preferred a female doctor.

- *"I believe that women who have undergone FGM feel restrained to talk about the subject. I do not actively address the topic of FGM because I think that women concerned prefer to talk with a female physician about it."* (Gynaecologist, Vaud)

FGM is more commonly addressed by gynaecologists/obstetricians in relation to delivery of an infibulated woman. Concerning infibulation, this issue is of direct importance to delivery. Without opening the vulva in a surgical intervention, delivery presents a risk of mortality for mother and baby. Furthermore, the question to which degree the woman should be closed after delivery is of particular relevance. Below physician said that he always addresses this aspect:

- *"With respect to delivery I always address FGM. The question if it needs to be repaired. If yes, as before or a bit less, is a discussion that we have every time with these patients and if possible without the presence of the husband."* (Gynaecologist, Vaud)

However, counselling is not always done before delivery. In some cases, the question which post-delivery state the woman would prefer was asked only in the delivery room.

In other cases, the woman concerned had not at all been involved in the decision.

This lead to the question of how actively concerned women address this issue: From the perspective of HCPs asked, concerned women play a rather passive role in the consultation. According to them, a woman, who comes for delivery, does not usually ask questions related to FGM. One physician assumes that concerned women do not actively raise the issue, because they know that they are "different" from Swiss women and do not know how the Swiss doctor would react to their concerns. Though especially the women from Somalia are described as proud personalities, their means of dialoguing appeared to be passive in the majority of the described situations of consultation.

- *"I think they do not ask a lot, because they feel their difference. They know that in Switzerland there is certain astonishment. I think that they do not ask because they feel that they are different."* (Gynaecologist, Berne)

The physicians of the family planning centres however, who predominantly see adolescent women, report a different role of the women they counsel. According to them, those young women actively comment on their problems related to FGM and ask for help in problem solving. Often, they complain about painful and/or impossible intercourse and ask for direct help with this disabling condition. The responsible physician speaks about a young lady who twice consulted on her own initiative.

- *"She had class with a colleague of mine. Then, after class she approached the colleague and addressed that subject in a very, very timid way. The colleague encouraged her to consult a physician. So, she was with us twice. I had the impression that she was already very mature and active. She has a boyfriend with whom she wants to have sexual intercourse and was not able to do so."* (Gynaecologist, Berne)

Addressing the intention to continue FGM on the daughters

Perspective of the women concerned

The great majority of concerned women reported never to have spoken with a doctor in Switzerland about the future of their daughters.

- *"Privately, I have spoken about the subject, but not with the physician. Never! I took my two daughters to the gynaecologist two years ago when the menstruation began. But talking about FGM during the consultation? Forget about it! I have not at all addressed it with the doctor."* (Woman from Somalia, 39 years)

Two women mentioned that the doctor warned shortly after delivery not to have FGM performed on their daughters.

- *"I recall that after the delivery it was commented: Oh, this is a beautiful baby girl. Do not do with your daughter what happened to yourself! Twice I made this experience when I accompanied a woman for translation*". (Woman from Somalia, 38 years)

- *"They also told me not to cut my daughter."* (Woman from Somalia, 29 years)

Interestingly, concerned women remembered the comments very clearly though it was just a short statement within the whole stressful experience of delivery. As they do not even speak with other women and with family members about FGM, women surly seemed not to expect to talk with the health care professionals about what they plan for their daughters. Yet, they actively remembered it, if a HCP had asked them to not perform FGM on their daughters.

Perspective of the health care providers

The great majority of interviewed gynaecologists and midwives reported not to have addressed the question of the women's intention regarding FGM of her daughters. Only 3 of 38 HCPs systematically refereed to the issue of prevention FGM. However, gynaecologists and midwives predominately attributed great importance to this issue.

- *"On contrary, I think that the physicians have a great role to play with respect to prevention. That is true particularly because the arguments are medical arguments".* (Gynaecologist, Vaud)

- *"For me, the whole act is prevention. Here in Switzerland but also in Africa. The*

problem is less important with respect to those women who are already excised or infibulated. The problem is not there." (Midwife, Geneva)

- *"The target group, in my opinion, is not the group of women who has already undergone FGM years ago, but the prevention of FGM on the daughters."* (Gynaecologist, Zurich)

One gynaecologist very much regretted not having addressed the future of the daughters of a concerned woman up to the date of the interview.

- *"Prevention talks? This is true; I did not consider this enough. I have not thought about it. It is good that you are addressing this issue. We should lead prevention talks, absolutely. I think with respect to this we, the health care providers, are demanded."* (Gynaecologist, Berne)

Of the very few HCPs who said that they systematically address prevention, one midwife especially emphasised her impression that with her approach she would reach the patient. Even in the direct peri-natal situation, characterised by the dynamic and stress of the delivery, she considered it to be worth addressing the future of the baby girl, not in a long conversation with the mother, but in a short demonstrative sentence:

- *"Prevention? I never forget about this aspect. I always consider it if a girl from Somalia has been born. It I speak to them or if I say good-bye I always say:*
  Keep your daughter in the same way she has been born!! I always have the impression that the women understand this very well (..).My impression is that immediately after the delivery they are very open and thus I am addressing this issue in my responsibility as midwife. I am not asking an open question but I am making a request. I have the impression that this is a good way to reach the women's souls." (Midwife, Zurich)

A large variety of reasons for not addressing the issue of prevention were given by HCPs interviewed (*Table 6*).

Table 6: Reported reasons of HCPs for not addressing the question of prevention

Lack of the right place	• *"The sea of emotions of the maternity hall is not the right place for such a conversation."* (Midwife, Vaud)
Lack of the appropriate moment	• *"Often there was no opportunity for such a conversation, e.g. if the apartment was full of visitors and family members."* (Midwife, Vaud)
Shortness of time	• *"No, the future of the daughter I have not yet addressed. In terms of time this presents a problem. In the maternity hall the procedure goes real fast. Openly spoken, I have not heard that the issue of FGM was addressed with a woman concerned."* (Midwife, Geneva)
Language barrier	• *"Often there have been problems due to the language barrier, which complicates addressing FGM."* (Midwife, Zurich)
Other more urgent demands	• *"Then, these women do have other, more immediate problems, e.g. concerning lactation or child care."* (Midwife, Vaud)
Limited personal contact to concerned patients	• *"No, we have not addressed the issue with women concerned. This is sure my mistake because this is a good occasion. But, often we do not know these women. They just come to deliver and then they leave. We are not their real physicians."* (Gynaecologist, Vaud)
Respect for the client's own culture	• *"Do I have the right to advice them what to do? Wouldn't it be better if another woman of the same nationality did the talk on prevention?!" (Midwife, Berne)*
Taboo topic	• *"No, unfortunately, I do not do this regularly. The subject of FGM is too much a taboo topic."* (Midwife, Vaud)
Assumption: in general, mothers do not want FGM for their children	• *"But they are not inclined to the same to their daughters. I think that they are content that FGM is not legal in Switzerland. Thus, they protect their children. No mother wants to perform FGM on her daughter if she is not pressured to do so. I think it is the maternal instinct, which wants to abandon FGM."* (Gynaecologist, Geneva)
Saturation	• *"The future of the Somalian daughters? It has been a while that I have not discussed this anymore. The women who I treat have been living in Switzerland for some time by now."* (Gynaecologist, Geneva)
Not having thought about it	• *"Prevention? No, I have not at all thought of this issue. I also do not remember if the women I had treated delivered a girl." (Gynaecologist, Berne)*
Not considering the relevance when treating adolescent women	• *"I mainly see the adolescent women. It is true that I have not addressed prevention of FGM among them. That is true."* (Gynaecologist, Vaud)
Not having been approached by concerned women regarding that subject	• *"A prevention talk I have so far never initiated. But, there also has never been a mother who approached me with her daughter inquiring about the possibilities of performing FGM on their daughter."* (Gynaecologist, Berne)

4.4. The controversial issue of reinfibulation[1]

For delivery, a woman who has undergone FGM type III needs to be defibulated*:* the mechanic broader of the scar tissue has to be actively removed in order to gain passage to deliver the child. If this is not performed, severe complications may affect mother and child: tearing of scar tissue and haemorrhage leading to shock of the mother, prolonged delivery with different degrees of complications such as asphyxia for the baby. In Somalia, the defibulation-procedure is performed most commonly by traditional birth attendants, followed by a nurse and by a physician. In Switzerland, in all of the hospitals that were included in the study, defibulation was performed by a specialist in gynaecology/obstetrics. All midwives asked on this issue, explicitly stated that in the hospital they work in, the defibulation-intervention was the duty of the physician. In the obstetric services of all hospitals included in the study, the intervention is performed during delivery. Usually, it is performed during the second stage of labour, immediately before passage of the child, when the head can be already seen. Once the scar-tissue has been removed and the baby has been born, the question arises of how to proceed with the opened vulva.

Perspective of the women concerned

Of twelve women who were defibulated for delivery in Switzerland, 8 women were re-infibulated, 1 woman remained defibulated, and 3 women did not comment on this issue.

The majority of participants seemed to agree with reinfibulation. Half of those women who had been reinfibulated (4/8) stated that they had explicitly requested it. The remaining 4 reported that they were not asked by the physician or the midwife if they wanted to become reinfibulated. Three of those women did not complain as they had not expected to be asked about their opinion. Also, they mentioned to be satisfied with the result of reinfibultation. One of them mentioned that she had suggested to remain open, but that the doctor had explained her that she could get an infection if the vagina remained “open”, because she had no protection by the labia. Thus, in her opinion, the physicians would be obliged to re-suture parts of the vaginal entry. One woman however, who developed a postoperative wound infection and a rupture of the sphincter ani, complained that she had not been asked before the intervention. Nobody had

[1] Reinfibulation: re-establishment of infibulation or re-suturing the vulva after delivery to the antepartum state.

taken time to counsel her. Moreover, she felt that the intervention was performed in a unsatisfactory way.

One of all participants who had been defibulated for delivery explicitly wished to stay "open" and was very determined about it.

With respect to the degree of reinfibulation women showed a homogeneous view. They also wished to actively comment on the degree of the reinfibulation they would like to be performed. The majority preferred partial reinfibulation to be less "closed" than before delivery, because they had memories of painful experiences due to tight infibulation before the first delivery.

- *"We prefer not to become too closed. It has to remain some space. It should only be resutured that part that had been a little bit supplementary, impeding the child to gain passage. We do not want to return to the status of a virgin. This is mortal, this is painful."* (Woman from Somalia, 53 years)

However, one of the women, who had delivered in Somalia, felt that her vaginal opening had been left too open. She stated:

- *"It has not been re-sutured enough. Now it is too open. I would like to go to the doctor again because it looks terrible."* (Woman from Somalia, 22 years)

*A*nother woman who had not delivered and was expecting her first child, was concerned that the vaginal opening would be too much of a gaping wound after delivery. Though actively opposing FGM and reinfibulation, she wondered, whether some structures which had been opened for delivery would not have to be closed again.

Perspective of the health care providers

It is a challenge for HCPs to respond to the question of how to react to the wish of concerned women who want to be "closed" again to the pre-delivery state. When asked for the main difficulty in the treatment of migrant women with FGM in Switzerland, this physician answered:

- *"It is the ethical question of how to respond to the real or assumed will of a woman who wants to become reinfibulated. As physician it is my main duty to serve the will of the patient. However, at the same time I consider it to be of great importance to model the vaginal opening of the patient after delivery to such width that the patient does not suffer from pain during delivery and that the menstrual flow is unrestricted."* (Gynaecologist, Vaud)

It is the dilemma to decide between a surgical intervention that has no medical indication and may even lead to adverse physical consequences and the request of a client, determined by social and cultural reasons. The Socratic oath states that a physician: "first, should do no harm". Yet, social consequences can deeply affect an individual's life, harming the well being of a person. How should a HCP react if the rejection of reinfibulation leads to severe adverse consequences such as social exclusion in form of being abandoned by the husband and ostracised from society in the perspective of returning to the country of origin? Even if it is a proven threat in some countries of origin as in Somalia, the question remains if it also presents a real threat to the immigrant population of Switzerland. Is it really always the aspect of social pressure that causes the woman to request for reinfibulation or is it maybe the lack of knowledge or education on the adverse effect of infibulation? Gynaecologists/obstetricians have different possible options for closing the episiotomy: Reconstitution of the pre-delivery state (reinfibulation), leaving the area of the former scar tissue open by re-suturing only the wound edges, performing reconstructive surgery, aiming to create complete anatomic conditions in form of labia minora/labia majora.

It is therefore of interest to know the individual attitudes and the institutional practices of HCPs confronted with the problem and health care institutions in Switzerland. On this issue a diverse picture of answers was expected. HCPs were asked about the clinical practice concerning reinfibulation in the institution they worked in and their personal attitude towards reinfibulation. Not all HCPs were able to comment on the current practice on reinfibulation as part of them works with outpatients only and does not perform deliveries. Surprisingly, in the obstetric services of all of the university hospitals questioned on this issue, reinfibulation is carried out. The intervention is performed, if the patient requests for it. On contrary, in the obstetric services of the regional hospi-

tals, where deliveries of concerned women are extremely rare, reinfibulation is not performed. Either it had been avoided by performing caesarean section, or only the wound edges were restored and no consecutive resuturing of the vulva was performed. In one of the regional obstetrical services, due to the vicinity of the airport, sub-Saharan migrants were mostly seen as rejected asylum seekers on transition back to their home countries. Thus, deliveries were performed ad hoc. Concerned women were not asked for their desires concerning reinfibulation. The scar tissue was removed and the vulva was left open.

Even those HCPs not directly concerned with the decision, when questioned on their personal opinion towards reinfibulation, the majority of the interviewees gave long comments reflecting doubts and ambiguity on the subject. Interestingly, all health care professionals who commented on reinfibulation (n=25) stated that they ultimately would decide in favour of reinfibulation if it was the wish of the patient. The majority of all HCPs who chose to accept the request for reinfibulation aimed to spare the women from the pressure of their husbands.

- *"If the husband says: I do not accept that my wife will be opened (..) If the wife only has disadvantages as consequence of the intervention, e.g. if the husband would not accept her anymore telling to other people of the community that she is a slut, because she is different than before -they attach values to it-then it does not make any sense."* (Midwife, Vaud)

Another view expressed that women or men are not to be seen isolated with respect to this decision but emphasising that the decision being in favour or against reinfibulation is a decision of the couple, in which the degree of education not only of the woman but also of the man and the quality of their relation accounts for the decision. If the woman takes the decision without the consent of her husband it could have adverse social consequences to her:

- *"Defibulation versus reinfibulation depends on the quality of the relation of the couple concerned. Certainly, the women should have the freedom to decide what they want. However, this also depends from the discussion we can have with her. Also her fears, the bond to her husband and the level of education of her husband present important factors. Those women who cannot write, who have not studied and who contribute to live here just as in Africa, those are the ones who request to become re-sutured after delivery. In my opinion you do not have the right to refuse this request. It is her relation to her husband and to her milieu. If she opposes her husbands view and her husband rejects her as consequence, the husband has won."* (Midwife, Vaud)

As a practical consequence of the perceived importance of the male part, a physician

recommends to include the husband at a point as early as possible in the course of pregnancy to enhance a decision of both partners.

- *"For the patient concerned the counselling during the pregnancy is crucial. Together with the husband it should be discussed at a moment as early as possible how the woman's genital anatomy should look like after delivery."* (Gynaecologist, Vaud)

Commonly, adverse social effects from "a bad reputation" to as dramatic as "cultural death" were mentioned as motivation to accept a request for reinfibulation. One gynaecologist, however, literally mentioned the threat of death, which an Ethiopian woman in Lausanne had expressed with respect to her planned return to the home country. Thus, the physician decided to accept the request for reinfibulation.

A further point was raised by several interviewees who commented on reinfibulation: The mutilation which concerned women suffered years ago as young girls in their countries of origin cannot be revised by a reconstructive surgery. The surgical creation of the clitoris organ is medically impossible. External plastic surgery of labia minora and majora would only be of superficial meaning. Why would a woman without severe complications who has been used to her specific genital anatomy for two decades and more, wish to have the anatomic conditions similar to a woman from Europe? One of the midwife commented:

- *"For example: there has been a tooth missing right here for very, very long-time, - since about 25 years- and I have never replaced this tooth for several reasons and I am with the dentist for a control who tells me: wouldn't you want to have an implant? I`m telling myself: well, I could chose the implant, but I should have done this years ago when I was young and beautiful….I am 100% in favour of this approach that health care providers perform reinifbulation according to the patients will."* (Midwife, Geneva)

A gynaecologist/obstetrician carried the controversy even a step further. She viewed the option of leaving the defibulated vulva entirely open after delivery as another form of mutilating the woman concerned.

Another point raised was that concerned women, who request reinfibulation after delivery, are usually adult women and not girls. It was assumed that those adult women know why they chose in favour of reinfibulation, even if the main cause for reinfibulation is to avoid pressure of the partner and of society.

In the discussion amongst HCPs on reinfibulation the degree of reinfibulation which was seen to be important. Especially, the physicians who performed the intervention of reinfibulation emphasised that the type of reinfibulation performed, is a partial reinfibu-

lation. It was stressed that the degree of reinfibulation should guarantee for normal urinary flow and painless sexual intercourse. A difficult issue is how far to go with reinfibulation. According to the interviewed physicians, the reinfibulation seems not to be performed according to standardised procedures and there are no medical guidelines on which they could base their decision.

4.5. Female Genital Mutilation and the role of men

This part of the research has not been anticipated, but developed in the course of the research. When being asked if there was a point of interest still missing in the interview, several gynaecologists/obstetricians and midwives independently from each other suggested the male part of the subject. After having introduced this aspect to the questionnaires of the health care providers, when preparing the focus group discussions, two open-ended questions on the role of men were also included in the discussion guide. In the group discussions the lack of communication between women and men showed to be striking. Views on men's attitudes primarily based on general assumptions. So, it seemed interesting to directly verify statements made by concerned women by asking men of the concerned migrant population. As pointed out in the chapter on methodology, even with contacts already made through the study, through the female mediators and also by knowing men of influence in the Somali community, recruitment of men turned out to be very difficult. Thus, in-depth interviews were performed with just three men. The findings of this chapter base on in depth-interviews with health-care professionals, focus group discussions with concerned women and in depth-interviews with men of the community.

Attitudes of men towards FGM

Perspective of women and men concerned

Especially striking from a western perspective is the lack of communication between concerned women and their partners with respect to the subject of FGM, which has been expressed in all focus group discussions. This absence of communication is especially true in the first generation of migrant women who experienced childhood and adolescence in the country of origin.

- *"No, I do not at all speak with my husband about FGM. To raise girls is a woman's business."* (Woman from Somalia, 29 years)
- *"You do not speak with the men about it. This is out of question. It is like being in prison if speaking with men about it. Even among the family you do not speak about it. It is the woman who is responsible. It is she who organises all this."* (Woman from Somalia, 53 years)
- *"I have not spoken with my boyfriend about it. I have not explained him the subject. I have not asked about it."* (Woman from Somalia, 34 years)

Though the issue of FGM is not discussed with the partner, the assumptions of male expectations are very strong. This refers especially to marrigeability, virginity and sexual pleasure. One woman says in relation to marrigeability:

- *"In Somalia, if a Miss is not closed, she does not have any chance to marry. She has to undergo this, otherwise she has no chance."* (Woman from Somalia, 39 years)

Another woman refers to the importance of virginity:

- *"Just because virginity is very important for the man. Most men realise it anyway if the woman has already done it."* (Woman from Somalia, 31 years)

One of the groups discussed the man's expectations with respect to sexuality. Interestingly, comments were increasingly sceptical.

- *"They do not agree, the men, if the opening it too wide. On the one hand he wants children; on the other hand he wants the opening always to be tight and small again. Maybe because he himself has such a small one! (the penis)."*
  (Woman from Somalia, 38 years)

Rising criticism of the male position was especially obvious in one of the group discussions. In a process of emancipation, women express that the husbands have to accept their wives as they are. The women felt that men have to accept that women do not stay that tight when having had children and that generally ageing affects women.

- *"The husband has to accept, that, if I have children from him, the opening becomes wider. Or are men looking for young women?"* (Woman from Somalia, 38 years)
- *"He has to accept that or he has to leave if he cannot accept that she is not as narrow anymore."* (Woman from Somalia, 29 years)
- *"After all she delivered children because of him. Women with 20 years of age and women with 40 years of age are not the same."* (Woman from Somalia, 39 years)

There were also voices of women who saw changing attitudes also in men. There was a distinction made by concerned women between Somali men in general and between modern Somali men. It was explicitly expressed that living abroad as a migrant in the western society, influences male's attitudes towards FGM. In Somalia, men would still continue to silently support FGM. In Switzerland, on contrary, men would change their "opinions":

- *"In Somalia, the husband does not change his opinion. When I decided to excise*

my daughters in Somalia, my husband agreed. Whereas here in Switzerland he changes his opinion. The problem is over there. Even if you stop here."
(Woman from Somalia, 37 years)

One of the group participants feels that not only men living abroad, but also travelling and seeing others people' s customs would widen their horizons and contribute to enhance opposition against FGM.

- *"The Somali men who live abroad and who have been travelling and who have observed how it functions in other countries, they rather tend to oppose excision."*
(Woman from Somalia, 30 years)

Also, the direct experience of pain and suffering of the woman and the consequent difficulties of sexual intercourse of both partners would provoke opposition against FGM by the husband.

- *"The modern men, they also suffer. They really prefer a woman who has already been opened. Because the suffering is not right for the women and it is also not right for the men".* (Woman from Somalia, 22 years)

This view was reflected by a family father, living in CH for 9 years. After his wife had delivered in Switzerland, he decided against re-infibulation. His wife had suffered from adverse consequences of FGM, especially pain and bleeding during sexual intercourse. But she still was in favour of FGM. He reported that he pressured her to remain defibulated and explained:

- *"I say it is not needed to close again, it is just somehow tedious. You do not have to do it again. You should not create the problem a second time. My wife, she did not like to leave it like that (*defibulated*). She was not happy, but I said: no, for what do you need it?! You know, she has her own culture and she cannot take another culture in 5 minutes. The problem is the culture, not the pain, but the culture."*
*(*Man from Somalia, 30 years)

Though opposing FGM, because of the pain his wife had to suffer from, the young man very much supported the aspect of FGM to preserve virginity and maintain the woman's dignity. In case of an adolescent daughter, he felt it was absolutely important to protect her against the influences of western promiscuity.

- *"I believe that circumcision in one way is bad, but in the other way it is good. For a woman it is bad, but for the family it is good. It protects the family; it protects the dignity of the woman. If she lives in Switzerland, circumcision is 100% good for her. The woman has 100% danger here in Switzerland, because they do not have our culture. Without the health problems, I would do it. I do not like my daughter will go to another man when she is 15 of 16 years old (..). But when I see that a 12*

years old lady is sleeping with another boy…This is the way it goes in Switzerland today. But to her health I think she has a very big problem. I do not do it to my lady. My daughter, I will not do it. But it remains you will always have a problem." (Man from Somalia, 30 years)

His reason for his opposition to FGM he explained as not to be influenced by the media or by prevention campaigns. He just could not continue to endure the pain his wife suffered from during sexual intercourse and described his decision against FGM to be a very personal decision:

- *"I respect the other ladies and what they want, they are not my wives, but this is my wife. Why do you want to have the same pain a hundred times? For what do you need it to have always the pain again*?" (Man from Somalia, 30 years)

Perspective of the health care providers

One strong position that various health care professionals perceived is the male attitude of indifference towards FGM. This indifference is seen as a reflection of the strong gender-separation in the cultures from which concerned women originate from.

- *"I consider the Somalian society to be a society where the man has the absolute right over the woman. I have the impression that there is no love. There always is a strong separation. As consequence of this, if you ask the men: What do you think about excision? They answer: this is not my business." (Midwife, Geneva)*

Leaving it to that, one could ask why it is so important to include the male part, if he is the neutral outsider. However, there are strong assumptions, concerning social pressure from the male part, which women expressed to the HCPs. This gynaecologist emphasised the external pressure that is especially related to marrigeability. A woman who has not undergone FGM is not a "correct woman" and thus will not be able to marry, a fact that has severe adverse social consequences. The gynaecologist concludes that the decision to excise should not be left only to the women's responsibility. On contrary, the strong outer social influence needed to be taken into consideration.

- *"So, the women tell me: I could not have given my daughter into marriage if she had not undergone excision. It is also necessary that the husbands ask themselves why there has to be excision and what it means. One cannot just leave the responsibility to the women. There is also this desire that the women have to be excised. Those who are not excised are no correct women." (General Practitioner, Geneva)*

However, it is not only the aspect of marrigeability, it is also a male expectation related to sexuality that concerned women expressed to one of the health care providers. The wish to undergo reinfibulation is bound to the assumption that the man enjoys sexuality more if the female partner has a tight vaginal opening that is sewn together, which was perceived by one of the HCPs interviewed.

- *"The Somalian man, what he likes is a tonic, firm and young sexual intercourse. The women say that to keep the husband you have to re-suture the vagina. Thus, the man will have more pleasure."* (Midwife, Geneva)

Another gynaecologist expressed how rigid she considered the position of the husband with respect to FGM in concerned cultures. This culturally determined bodily condition she sees to be out of any reach of a discussion with men.

- *"With the husband I have never discussed the subject of infibulation. I think this would be a long time investment without many results. To be infibulated is as having two eyes and two ears. It is part of the normal bodily condition."* (Gynaecologist, Geneva)

However, when commenting individual anecdotes of patients, one doctor described a far less rigid position:

- *"I have had a patient, who told me: my father is much more open-minded than my mother. The father had decided that in his family excision will not be practised. As long as her father was present, the girl was not touched. However, when the father left for a while, the mother excised her daughter. Now she feels very angry towards her mother because of this."* (Gynaecologist, Berne)

Also, on the level of the medical experience, a physician remembered two cases in which the husband was against reinfibulation of his wife.

- *"In both cases that I remember, the husband decided against infibulation and requested the vagina to be opened. I do not know for what reason. Only, he was not the one, who wanted that it remains closed."* (Gynaecologist,Berne)

The role of the husband/partner role during the consultation

When analysing the medical consultation, it was of interest who else-besides the woman-was present. If the husband/partner was present, the question was what kind of presence, what role, he had during the consultation. Furthermore, it was inquired how the presence of the husband influences the health care provider's decision to address the subject of FGM with the patient.

The majority of the HCPs, who commented on the role of men, stated that the husband/partner was rarely present during the consultation. HCPs said that women predominantly enter the consultation in company of a friend or other member of her ethnic group.

- *"No, the husband is very rarely present. Often, the women's girl friends from the centre accompany her. If the husband has come with her, he usually waits outside."* (Midwife, Vaud)

When present, his main task is to translate. L. from Somalia mentioned he had accompanied his wife for translation in the pregnancy controls. She had been in Switzerland for a much shorter time than he, had been much less in contact with the Swiss society than her husband and thus hardly spoke any German.

When referring to the issue of FGM there were health care professionals who categorically said that they would never address the subject in the presence of the husband. This midwife generalised the patriarchal character of men of concerned cultures. She reported that domestic violence is common.

- *"The role of the husband? Often the husband is present and often there is a problem with the husbands from these countries…There are many women of these countries who are beaten by their husbands. It is extremely patriarchal. If the husband was present I would not address the problem of FGM, because most women are under the thumb of their husband with means of bodily violence."* (Midwife, Berne)

Other HCPs however, explicitly stated that they do not perceive men to be dominant during the consultation. The presence of the husband is appreciated to facilitate communication, if it is not possible to guarantee for professional translation.

- *"The husbands sometimes accompany their women, but this is rare. More commonly they come with a friend (..). Sometimes if she does not speak French or Italian he accompanies her to translate. No, the husband is not too dominant."* (Midwife, Vaud)

However, in some institutions the double function of the man as husband and as translator is avoided. In one of the family planning centres participating in this study it is always possible to call for a female translator. Thus, the woman is allowed a free space to express personal issues. She has the choice to express herself without the presence of her partner, if she wishes to do so.

- *"Here in this department we categorically chose a woman for the translation because we think that the treatment should be sensitive to the female gender. The woman may express herself. Even if she does not use this offer, she sees that she could speak among women if she wanted to."* (Gynaecologist, Berne)

Also, one of the attending doctors in the obstetric department of a university hospital decided to give concerned women the possibility to also express themselves without the presence of their husband.

- *" They appreciate the offer to think for themselves when one takes them apart to discuss the intimate problem only between them and us, particularly with respect to the subject of reinfibulation. It is a dialogue between 4 eyes of patient and health care provider to express things in a more open manner. At this point the husbands are not present. However, I think that indeed also the husband plays an important role in the whole story."* (Gynaecologist, Geneva)

One of the senior physicians at a department specialised for migrant health described the positive effect of a gender sensitive approach for the consultation. For a first consultation the husband is more present. If he notices, however, that there is a female interpreter, that physician and nurse are also women, the husband accepts a position more in the background.

- *"The role of the husband? In our department he does not accompany her very often. For the first consultation the husband is more commonly present. If he learns however that the physician is a woman, that the nurse is a woman, that the interpreter is a woman, he comes less common. There is not too much of the problem that the husband is always behind his wife."* (General practitioner, Geneva)

However, one adverse experience was given. A young physician stated that one night when she was on duty, a woman with type III presented for delivery without anticipation. After the baby had been born, the husband pressured the doctor to re-suture the vulva, which the doctor agreed upon.

4.6. Information needs of interviewees and theirs suggestions

Both, health providers and health care seekers were directly asked if they had needs of additional information and if they could give recommendations with respect to FGM and more specifically with respect to obstetrical/gynaecological care under the condition of FGM in Switzerland. In addition, the women concerned asked questions and gave spontaneous recommendations.

Information needs and suggestions for women concerned

Perspective of the women concerned

In the focus group discussions and the in-depth interviews with Somali and Eritrean women, it was remarkable that it seemed easier for them to comment on their personal experiences made during delivery in Switzerland than to express their needs of information and further suggestions. Still, there were needs of information and further suggestions expressed.

a) The following questions were raised by the women:

- *"Does FGM provoke infertility?"* (Woman from Somalia, 32 years)

- *"Swiss women, do they deliver a child without being cut open?"* (Woman from Somalia, 22 years)

- *"Now a question for you, Clara. What do you prefer? Excision or no excision? Forget about health, reply from the perspective of the emotions! Do you think that we do not have any feelings?"* (Woman from Somalia, 39 years)

This question was asked by a mother of two adolescent girls, a strong personality, very clearly and directly sharing her personal experiences and attitudes with other group participants and thus directly and personally addressing the researcher. The woman addressed the subject of sexuality that showed to be of concern to some of the women concerned. With her question, she did not refer to a medical aspect. The question aimed at a social aspect of FGM. Her concern was that women having undergone FGM are different from the women of the host country, worrying if women concerned were less complete with respect to emotional experience than the "other" women.

b) Recommendations of the women:

With respect to gynaecological/obstetrical treatment, recommendations that the women expressed fall into two categories: Technical aspects of care and social aspects of care.

Concerning technical aspects, women of different groups stressed three issues to be relevant to them:

1. Defibulation should be performed during delivery and not as an additional traumatic event during pregnancy. One woman also said that she wanted to avoid being reminded in any form of this terrible pain she had experienced during the act of female circumcision as a child. Thus, it would seem really better to her, to get over all pain accumulated at moment of delivery. Another interviewee stated that Swiss women also would not be cut open during their pregnancy. If they had to be widened by cutting, this would be done during the delivery. Thus, why should Somali women be cut twice?
2. Following the wish of the women, defibulation should be performed with great care to avoid any lesion of the anal area. From memories in their home countries some women remember the adverse effect of a rupture of the anal sphincter which could not easily be restored. Being incontinent and thus smelling of faeces has traumatic social consequences for a woman.
3. Some women felt strongly that Caesarean section should be avoided to allow for multiple deliveries. One woman stated that in Switzerland caesarean section was performed much more frequently and could be avoided when being more patient. The women knew that it is not possible to have an unlimited number of children when having to undergo an operation every time.

   Concerning the social aspects of care, the women suggested the following:

1. The caregiver should be more cordial and express more warmth. One interviewee underlined that migrants often have left most members of their large families in their country of origin. Often, they miss the support by their relatives. When feeling lonesome it would be very helpful to receive empathic care.
2. The care giver should invest more time in the consultation. They made the experience especially with the doctors that they have never time. Thus, personal issues related to FGM could not be addressed. One 23 years old Somali women, pregnant

with her first child, had lots of questions to ask to the doctor. She had decided to stay "open" after delivery and wanted to know how much of the opened vulva would be re-sutured and how it would feel to be "open" after delivery. However, the doctor seemed so pressured in time that she did not dare to address the issue.

3. The caregiver should communicate and explain more in detail about the act of delivery, instead of only providing information on the baby.
4. The care provider should be a woman by preference. Women expressed how difficult it was for them to speak about FGM as it is a sensitive issue. However, with a man talking about such things seemed impossible to them.
5. The preferable care giver related to delivery is the midwife. A participant of a focus group discussion stated the following:

    - *"Particularly towards the midwives we feel a lot of confidence. If you are really in bed with severe pain, the only person that can soothe you down and that gives you confidence is the midwife. The physician, he will come and comment: she is going to deliver normally and if not we are going to carry out a caesarean section. However, the midwife will come and soothe you till the baby will be born. In Somalia, if a woman is pregnant she prefers just one midwife till the end. Also, from the first pregnancy up to 7-8 children you can rely on the midwife."* (Woman from Somalia, 30 years)

6. Remembering the first consultation in the beginning of the stay in Switzerland, women said that it is especially good to be assisted by a translator.
7. The women wished that there should not be so many doctors and assistant doctors caring for just one woman. Some women recalled the "crowds" of doctors in teaching hospitals eager to see their specific anatomy. They felt further intimated and hurt by such behaviour.

Perspective of the health care providers

Suggested information to be given to women concerned

The majority of gynaecologists/obstetricians felt that migrants who had undergone FGM needed more information on the subject. Health care professionals suggested informing concerned women about the normal female anatomy as is was questioned if women knew how an unchanged vulva looks like and if they were conscious about the fact that they had undergone FGM. One gynaecologist mentioned that one of her patients, unaware of the normal female genitalia presented with her daughter because she was concerned that the daughter had some pathological tissue between her legs that maybe needed to be eradicated by surgery.

Another gynaecologist stated that is was essential to inform concerned women about the changes to expect after deifibulation. She suggested explaining to the woman, illustrating with drawings and with the help of a mirror about the anatomical changes she had to expect. One of the midwives suggested that having more knowledge on the effect of FGM, the tendency to request for reinfibulation would disappear. Other health care providers questioned whether concerned women knew the fact that FGM is illegal in Switzerland. One gynaecologist, specialist in adolescent gynaecology, experienced that young women have the tendency to think that they are alone with the condition of FGM in Switzerland. Thus, she suggested an initiation of self-help groups.

Suggested channels to reach concerned communities

Informants suggested that women need to be reached in those structures that they frequent. Thus, information would need to be disseminated in the policlinics of the university hospitals, in the family planning centres and in the cultural centres for migrants in Switzerland. Also, it was suggested to reach concerned women through the federal refuge administration at the earliest possible moment when entering the country in the reception camp. When thinking about the form in which information should be provided, some health providers emphasised on guidelines which should be prepared by the help of women of the relevant ethnic groups in the languages of the home countries. The majority gynaecologists/obstetricians and midwives, however, preferred to pass information via discussion groups with concerned women. By this approach, the oral culture of transmitting information in concerned cultures would be made use of. A midwife or a physician with special knowledge on the subject of FGM should counsel the group. Especially, the aspect of prevention should be taken into consideration. With respect to prevention it was also seen as important to include men and boys in preventive measures:

- *"Prevention should be done among girls and mothers, but also among boys and fathers. One should also talk to the boys to find out what they know about that genital mutilation in their culture. I believe that FGM is an educational problem of both sides, not only of the women but also of the men."* (General practitioner, Geneva)

In abolishing FGM one of the asked midwives clearly states that she sees a priority in the role of man, taking his power and dominance in the concerned societies into consideration.

- *"I think if men in Somalia of Sudan said: we do not want to continue with the tradition of FGM, we do not marry infibulated women any more. If the men had the courage, I think it would take one more year and then all would be over with FGM. It is not true that you cannot do anything."* (Midwife, Geneva)

It was seen essential to include women who have undergone the practice themselves in the dissemination of information.

Further needs of information for health care professionals

The health care providers were also asked if as professionals they needed further information and training concerning FGM. The majority of health care professionals showed were in favour of getting further information. A survey carried out in a block course for speciality qualification in gynaecology/obstetrics at the university hospital of Lausanne held in June 2002 showed that 85% of the participating young physicians said to be in favour of guidelines. Particularly, a strong demand on cultural background information on FGM and on the migrant groups concerned was expressed. Only 3 percent of the participants did not feel that guidelines were needed.

The HCPs were asked what sources they preferred to receive further information and training from.

Guidelines

80% of the HCPs who commented on guidelines showed to be in favour of guidelines. Stating that the wheel had not to be invented a second time several HCPs suggested to review already existing guidelines in other industrialise host countries as a basis for the creation of Swiss guidelines. Cultural context and technical recommendations should be part of the guidelines. Also, the issue of child protection was suggested to be included. As the main confronted professions are the gynaecologists/obstetricians and the midwives, members of both professions suggested that common guidelines for both professional groups should be developed. Opinions varied on whether other professionals such as general practitioners and paediatricians should be included. It remained an open question if more in-depth guidelines with a large technical focus or rather broadly designed guidelines were needed. Another suggestion was to design a brochure of contacts and links of interest for further focused information at national and

international level. The majority of the HCPs suggested that guidelines should be developed at national and not cantonal level. The Swiss gynaecological association and the Swiss midwife association were felt to be best placed to develop guidelines. The national working group of psychosomatic medicine was also suggested. Some providers emphasised that the guidelines should be approved by the WHO. However, there were also voices against guidelines, expressing the following concerns:

- Medical professionals can easily receive information from other sources.
- There are already enough guidelines on FGM by WHO.
- Physicians do not read such guidelines.
- The professionals interested in the subject do not need guidelines; the professionals not interested in the subject will not read those guidelines.

Centres of reference

A regional centre of reference as a form of special clinic was suggested by several informants. Located in a central position, in this centre information and expertise could be collected. Health care providers with specific questions with regards to FGM and also concerned women could consult this centre. For the German speaking part of Switzerland, a physician suggested Berne to be the right location. In Geneva gynaecologist had a similar idea. This informant suggested in addition that a special clinic could be attached to the department of travel and migrant medicine at the medical policlinic in Geneva.

Workshops

Several midwives and gynaecologists of various background mentioned that a one day workshop concerning cultural and gynaecological/obstetrical knowledge on FGM would be very interesting.

Other sources of information

The national journal of Swiss midwives was suggested several times as a channel to provide information. This well read journal has already reported on FGM and thus could continue to do so. For the canton of Geneva it was suggested to reach general practitioners by the cantonal medical journal. Also, the creation of a website informing health

care providers with respect to FGM in Switzerland was suggested. On this website links to institutions and organisation with expertise on national and international level and to relevant literature on FGM could be provided.

5. Discussion

5.1. Limitations of the study design

This study comprises a quantitative and a qualitative part. For the quantitative part an estimated prevalence rate of women having undergone FGM was calculated. The researcher is aware of the fact that the prevalence rate of 5,718/10,051 female immigrants living with FGM in Switzerland is an estimation only. It is questionable if the migrant population is representative of the population in the home country with respect to the FGM prevalence rate. It can be expected that those women with a socio-economic and educational level higher than the general population and therefore less likely to have undergone the practice of FGM were the ones who had the possibility for migration. However, in the nationalities of the Horn of Africa, where FGM is almost universal it is not necessarily linked to the level of education (Allam and Irala-Estévez, 2001), the estimated prevalence rate of the adult migrant population might reflect that of the general population. Thus the estimated number of women from Somalia, who are by far the largest national group of women with FGM in Switzerland (40%), is a reliable estimate. There is uncertainty about how many girls living in Switzerland have undergone FGM. In Somalia, FGM is performed on girls between the age of 6 and 10 years (Bayoudh et al., 1995). FGM is not known to have been carried out in the migrant population of Switzerland, thus, girls who emigrated before that age might have escaped the procedure. However, there are families who have travelled to other European host countries and to their countries of origin to have the procedure performed on their girls.

The overall study design focussed on qualitative aspects. 29 women who had undergone FGM could be included. The fact that the topic of FGM is a very sensitive and intimate one particularly within in the concerned immigrant communities, made the recruitment of women extremely difficult. Considering constraints on the side of the investigator in terms of time and resources, mainly women from Somalia (n=24) and predominantly women with FGM type III (n=26) were recruited. Furthermore, the composition of the sample is not representative of the immigrant population in Switzerland, as it can be assumed that those women more open to discuss the sensitive issue and probably more ready to question FGM voluntarily decided to participate in the study. Despite not being planned in the original study design it was of interest to include male respondents of the relevant migrant communities when the opportunity was given. Only a limited number of 3 Somali men was interviewed. These results only allowed for a

first inquiry of men's attitudes towards FGM. Thus, particularly this part of the research is exploratory.

Even taking the above weaknesses into consideration, this study captures the situation of the most important migrant groups living in Switzerland in terms of the number of women and the severity of FGM. It was not the aim of this qualitative study to generalise results to other settings. However, internal validity of the data in this study is high. Different interviewing techniques were used (in depth-interviews and focus group discussions) to increase the validity (triangulation). Emphasis was placed on as much orginal data as possible, while still respecting the views of the women concerned and their health providers. Comparison of the women's and HCP`s perspectives was systematically performed and showed to be consistent in many aspects. The data was thouroughly analysed, using a standardized computer program for qualitative research to ensure that the conclusions were as objective as possible.

5.2. Health complications related to female genital mutilation

Both groups, the women concerned and the health care providers, reported about FGM related health problems. The migrant women interviewed had been submitted to FGM years ago in their countries of origin. This explains why only long-term complications of the procedure will be discussed in this chapter. The large majority of female participants had undergone FGM type III. Thus, most complications relate to this type accompanied by infibulation. *Table 7* summarises the complications concerned women said to have suffered from and their frequency in a direct comparison between women and the HCPs. Symptoms were mentioned by women after general prompting for FGM related health consequences.

Category of complications	Women	HCPs
Complications related to sexuality	9 (37%)	7 (37%)
Complications related to menstruation	10 (42%)	4 (21%)
Urinary tract complications	4 (17%)	3 (16%)
Local complications at the infibulation scar tissue	0	3 (16%)
Obstetric complications	1 (4 %)	2 (10%)
Total:	24	19

Table 7: Frequency of FGM related complications mentioned by women and HCPs (Multiple response).

Complications related to sexuality

Dyspareunia is a finding specifically related to FGM type III. Penetration into a narrow scarred introitus is obviously extremely painful. With 39% of all complications, it is the most frequently mentioned complication by HCPs, whereas dyspareunia presents 15% of the complications mentioned by the women concerned. Pain during sexual intercourse and/or even the inability to have sexual intercourse linked to FGM III is a relevant reason for consultation. At the university hospital of Zurich during eighteen months, 6 women from Somalia requested for defibulation (Pok Lundquist and Haller, 2001) for that reason. However, dyspareunia does not always lead to consulting a physician. It has been shown in our study that there are also women in a stable relationship or marriage who have regular sexual intercourse and rather endure suffering during sexual intercourse than undergo the intervention of defibulaton because they fear to be re-exposed to the trauma suffered during the act of FGM.

For the women having undergone FGM type III, reduced feelings during sexual intercourse were a relevant complication. This problem was raised in all focus group discussions and in depth interviews. The HCPs not addressing this issue leads to the conclusion that psychosexual aspects of FGM have not been adequately discussed during the medical consultation. What showed to be of particular concern to some migrant women was perceiving themselves labelled as asexual beings different from women of the host county- a concern resulting from personal interactions, newspaper articles, brochures and TV shows. Yet, the opposite experiences expressed in two of the in-depth interviews were striking. Both women had undergone FGM type III, so both were expected to have similar anatomic conditions. One of them expressed the lack of sexual satisfaction. She had no pleasure and suffered during intercourse. The other woman, however, strongly emphasised that she enjoyed sexual intercourse and experienced orgasm. As has been shown in several studies (Shandall, 1967; El-Defrawi et al., 2001), cutting part or all of the clitoris and labia minora undoubtedly interferes with the female sexual response. Yet, in accordance with our findings, other studies showed that the effect of FGM on sexual functioning is not uniform. Gruenbaum (2001) notes from her study in Sudan that there are midwives, fearing haemorrhage, who leave much of the clitoral tissue intact beneath the infibulation when they perform surgeries. Huismann (1997) of the Netherlands identified a clitoris underneath the thick scar tissue barrier in all 7 young Somali women who requested defibulation. This could explain how some women have orgasmic responses, despite infibulation. Furthermore, sexual satisfaction is a complex phenomenon that cannot be seen as monocausally

linked to the existence of primary female genital organs. Thus, generalisations that all women concerned feel sexual indifference or terrible pain, as often declared by advocacy groups in the international fight against FGM, are not based on evidence.
Sexuality related complications of FGM clearly are a burden for the immigrant women. However, psychological consequences may not only result from the inability to enjoy sexual relations fully but also from the fact that women feel stigmatised by the societies of their host countries.

Complications related to menstruation

Dysmenorrhea was the most frequently mentioned complication of the women (39%) and also was relevant to HCPs (22%). This is consistent with other studies as one of the main long-term consequences of FGM type III. In a sample (n=108) of migrant women in the UK, Momoh et al. (2001) found that 67% of the participants reported about dysmenorrhea. Knight et al. (1999) in Australia presents dysmenorrhea as the third most commonly mentioned syndrome after dyspareunia and urinary tract infections in a sample (n=51) of mostly infibulated migrant women. The type of dysmenorrhea characteristic of infibulation (FGM type III) has been described as “similar to that of spasmodic dysmenorrhea but starting with the flow, continuing throughout the cycle and only getting gradually milder until it disappears with the end of the period“ (Shandall, 1967). Concerned sample women in this study related the pain to the fact that the blood could not pass through the narrowed opening. The exact mechanism why this obstructed flow causes a painful menstruation is not known (Brown et al., 1989). It is suggested that increased pelvic congestion might be a consequence of infections. Also, a psychosomatic element, the increased anxiety over the state of the genitals could be a reason (WHO, 1998). Though presenting a consistent finding in the literature in association with FGM type III, dysmenorrhoea is particularly problematic to be discussed as it is an unspecific symptom of various gynaecological diseases, such as endometriosis, hormonal imbalances, infections of the uterus, etc. This might be a reason why the symptom was less frequently mentioned by HCPs than by the women concerned. Furthermore, there is a general difficulty when analysing suspected long-term complications because the exposure-the operation- and the outcome- the suspected complication- are not simultaneously assessed and it cannot be ascertained that the outcome in fact followed the exposure and was caused by it (Hennekens, 1987). Symptoms that are mentioned, years after the procedure of FGM was carried out, can be the result of many other factors. Yet, the women concerned linked dysmenorrhoea to their being excised and often felt disabled by it in their daily life.

Urinary tract complications

In this study, complications of the urinary tract were less often mentioned than other complications (by women and HCPs with 15% and 11% respectively). In the literature, recurrent urinary tract infections have been stated to be a common complication by various authors (El Dareer, 1983, Arbesman et al., 1993, Momoh et al., 2001). However, also a urinary tract infection presents a common and unspecific diagnosis for women. The fact that it has not been more frequently mentioned by the HCPs again suggests that it is seen as a diagnosis not specifically related to FGM type III.

Complications related to the infibulation scar tissue

These local complications were only mentioned by 17% of the HCPs. Small lesions of the scar tissue were seen as a consequence of attempts to carry out sexual intercourse on a tightly infibulated vulva. Women were not probed on these complications. Cysts in the scar tissue are described as very common long-term complications in the literature (El Darreer, 1983; Toubia, 1994 b). Physicians diagnose these complications during the clinical examination. As the focus group discussions and interviews were not held in a clinical setting, women might not have found it appropriate to address these local complications of the genital area. Also, as the scar tissue is not densely innervated and does not contribute to severe pain, women, even if concerned, might not have perceived the existence of cysts to be of priority.

Obstetric complications

The large majority of those HCPs who have carried out deliveries of women with type III FGM in Switzerland did not report obstetric complications. It cannot be established by this study, whether those obstetric complications mentioned by women and HCPs *(Table 7)* are more frequent than in the general population. Striking, however, is the difference in obstetric complications linked to FGM reported in industrialised countries as compared to the countries of origin. While in African countries, FGM is major cause of morbidity and mortality during pregnancy and delivery (Dörflinger and Dreher, 2000), in two recent studies from Norway and Sweden, no direct causal link to FGM could be found to explain the higher rate of obstetric complications observed in women from Somalia (Vangen et al.,2002; Essén et al.; 2002). In Switzerland and other European countries obstetric complications play a smaller role than in the countries of origin.

Therefore, attention has to be devoted to the psychosexual complications that become more prominent problems related to FGM in the industrialised host countries.

5.3. The gynaecological/obstetrical consultation

The first encounter

The first encounter is a crucial moment to establishing a relationship between patient and health care provider. Several women and HCPs have described a moment of “shock” when a HCP faced an infibulated vagina (FGM type III) for the first time. Negative surprise has been displayed by HCPs in front of several women in a very emotional way and also resulted in misdiagnoses such as a “burn scar” or as the sequelae of an “accident”. Apparently, these HCPs had never seen the condition of FGM before. Yet, it was not only a one-sided experience, but a bilateral reaction of distress: “shock“ on one side and “sweat and fear” on the other side. While the women felt shame and fear when presenting themselves for gynaecological examination, in some cases they also had to experience the strong, adverse reaction of the health care professional. Women particularly remembered the fact that in some cases in the teaching hospitals additional staff such as students or interested colleagues have been called for demonstration of the “curious case” of a mutilated vulva. This situation of being exposed publicly presented a further stress factor to the women concerned. These experiences reflect unpreparedness and lack of information and expertise with such cases on the part of some HCPs. However, not all HCPs face similar difficulties. Others have quite extensive experience with such cases and have established procedures-more on individual bases than following any institutional guidelines.

The HCPs also seemed to have technical difficulties to perform gynaecological examination when facing anatomical structures of mutilated women. The gynaecological/obstetrical examinations have been described by different women as a ”searching procedure.“ Indeed, the gynaecological examination in a woman with FGM type III can be difficult and vaginal examination with means of a speculum might be impossible due to a pinpoint opening (Pok Lundquist and Haller, 2001). Also, the difficulty to place a Foley catheter which is necessary when carrying out caesarean section has been described by sample HCPs. Baker et al. (1993) reports that a catheterisation could ultimately be performed after local pain management with application of Lidocain. Several midwives interviewed in this study reported to avoid routine vaginal examinations on women with FGM type III whenever possible to avoid pain to their patients. In the litera-

ture it is described that epidural anaesthesia was performed to facilitate vaginal examination in a woman with FGM type III (McCaffrey et al., 1995).

Most of the difficulties described date back to consultations in the early 1990s, when many of the concerned women first arrived in Switzerland and HCPs had not been previously exposed to the issue. A rather unprofessional reaction can also not be surprising, as the management of a patient with FGM is not dealt with during the training of medical students in Switzerland. Thus, an experience as illustrated above may still occur with young, less experienced HCPs, unless education will be provided.

Health seeking behaviour

From the interviews with HCPs it became obvious that the legal status of migrants influences health care delivered to them. Asylum seekers are offered medical care by the host country, including routine pregnancy controls. The staff of the asylum homes organise care for them. Thus, this group of migrant women does not need to actively initiate health seeking behaviour. However, migrants who already have a residence permit in Switzerland are more vulnerable to lack of treatment and counselling as they depend more on their own initiatives. Particularly, those women who are not well integrated in the host country's culture, were seen as more vulnerable to delay health care. The large majority of study participants belonged to residential migrants who had been living in Switzerland for several years, most of them between 7-11 years. In accordance with the cultural background of the country of origin, the majority of women had consulted a gynaecologist/obstetrician for the first time only when they were pregnant. This health seeking behaviour is in strong disagreement with medical recommendations of the industrialised world where gynaecological routine check-ups for women of reproductive age are recommended at least once in two years. After pregnancy, participants showed a variable behaviour concerning gynaecological routine controls. Several women reported to have found "their" gynaecologist whom they consult on a regular basis. Yet, a considerable number of women do not attend preventive controls. Reasons for that were the lack of knowledge and understanding of the need to see a doctor without feeling ill or without being in the special condition of pregnancy and keeping up the tradition of the country of origin. Though women did not directly express fear to disclose the condition of FGM as a reason to avoid regular gynaecological controls, it still might be a factor that unconsciously contributes to reduced controls. The health seeking behaviour of concerned women cannot be associated only to the state of FGM, but is linked to the generally low social status of migrants in the host country. Also, in other European countries access to and use of health promotion services and disease prevention information are low and existing offers sometimes totally ignored by the migrant communities, which has been shown in two studies on African communities in Germany and Finland (Edubio, 2001; Sabanadesan, 2001). Thus, there is a need to improve the health services for migrants from Sub-Saharan Africa living in Switzerland, women with FGM presenting one of the most vulnerable populations among them.

Addressing FGM

How FGM is being addressed during the medical consultation has been an important issue discussed during this study. In most cases no complete medical history on FGM has been taken by HCPs. Psychosexual aspects of FGM were systematically addressed by only one of all HCPs. The issue of prevention was only addressed by three HCPs. Moreover, various testimonies of women mention that FGM has not been addressed at all. Not speaking about FGM during the consultation can be seen as a professional shortcoming. However, the women also contributed to this situation. On the one hand, women expressed certain regret that FGM had not been addressed; on the other hand there was a sense of relief because in their daily life, even between women of the same ethnic background, talking about FGM and related subjects such as sexuality is a matter of taboo. Also, some HCPs assumed that if concerned women did not express difficulties or did not seem to have problems related to FGM, there was no need to address the subject. One of the main reasons for not addressing FGM given by HCPs was the language barrier. Blöchliger (1997) studied the health services provided to refugees and asylum seekers by the Swiss national health system. In her study most of the communication problems were related to not speaking a common language and the lack of professional interpreters. With respect to FGM, an in depth history inquiring about related health complications and addressing the cultural background and personal history related to FGM, is very important. Salis Gross et al. (1997) mentioned the inclusion of biographical and life conditions to be important preconditions for responding to medical and social demands of the patient. Moreover, psychosexual aspects should be addressed when dealing with FGM. Blöchliger (1997) showed in her study that interpreters were significantly more often present in consultations of patients with psychological/psychosocial diagnoses. However, with respect to FGM, this aspect might not have been considered or expected by HCPs who are drawn mainly to the striking physical appearance and immediate delivery related interventions than to the psychological and sexual problems. In this study translation services offered varied from institution to institution. Some departments could rely on professional translation and trained cultural mediators for migrants, while others applied the help of family members and friends. Yet, there was no specific policy of using the service of professional translation when treating or counselling a patient with FGM.

One specific aspect of FGM is the issue of prevention. The large majority of HCPs had not addressed the mother's intention to continue the practice on her daughters, although several of them declared the aspect of prevention to be of priority. The impor-

tance of preventive talks, particularly in the obstetrics services is further emphasised by the fact that pregnancy in some women is the first and possibly only contact to the health care system of the host country, as has been discussed above. Though the majority of women opposed FGM, some ambiguity and the inclination of few participants to carry out the less severe forms of the practice in their daughters, further emphasises the importance of prevention. Alltag et al. (2000) showed in a qualitative study carried out among the African migrant population in France that the majority of those women who opposed FGM still had their daughters undergo the practice. A finding which led to the recommendation to set up information campaigns, not only in various branches of the health care system, but also in other areas of the social life such as schools and universities. A large variety of reasons for not addressing FGM were given by HCPs interviewed in this study. Communication difficulties, not only directly related to the language barrier but also on a semantic level, have been discussed with respect to the patient-doctor interaction in a cross-cultural setting with Turkish patients in Switzerland (Obrist van Eeuwijk, 1992). Yet, the issue of FGM is suggested to present an additional challenge. HCPs stated not to have found the appropriate moment to address the sensitive issue of FGM. FGM and its prevention presented a subject of taboo to some of them, provoked also by the behaviour of the women concerned. Also, HCPs felt reluctant to tell women of a different cultural background how to proceed with their daughters regarding this traditional practice. Depending on the experience of HCPs in treatment and care of women concerned, there was a different approach on prevention. For those HCPs more experienced in treating patients with FGM, there were some doubts on how relevant the aspect of prevention still is in the migrant community of Switzerland, as most women have been living in the country for several years. Especially when dealing with adolescent women, some HCPs had not considered the aspect of prevention, because pregnancy and childbirth seemed still so distant. Yet, other HCPs having been less exposed, admitted they just had not considered the aspect of prevention at all. Thus, independent of the degree of experience, it is an educational priority to sensitise HCPs to systematically address the future of the women's daughters with respect to FGM.

5.4. The controversial issue of reinfibulation

All HCPs participating in the study shared strong opposition against FGM and rejected to perform any genitally mutilating procedure on a child. The subject of reinfibulation (re-establishment of infibulation or re-suturing the vulva after delivery to the antepartum state), however, was much more a point of debate. In the immense amount of literature on FGM the controversial issue of reinfibulation is only devoted a small sub-passage. Yet, for health care providers in industrialised countries who are confronted with concerned migrant women, reinfibulation presents an issue of major concern and ambiguity. This was strongly reflected in in-depth interviews with health care providers in often long answers sometimes offering aspects comparable to inner monologues. The discussion on reinfibulation reflects particularly the intercultural and social dimension of the discussion on FGM. On one hand the physician is devoted to the physical well being of the patient; on the other hand the HCP also tries to respect the social and cultural aspects that strongly influence the personal wellbeing of the patient.

Reinfibulation is performed in all of the sample university hospitals in Switzerland. Interestingly, all health care professionals in this study asked on reinfibulation, even if it was not their duty to carry out the procedure, supported the act if it was done according to the wish of the concerned woman. Few of those health care providers had actually been faced with the request of a concerned woman to have reinfibulation performed. From this more theoretical than practical point of view, the inclination to support infibulation to a certain degree was based on assumptions health care professionals drew from caring for women of non-western cultures, from personal experiences while having spent some time overseas and from the image the media presents concerning life in Africa and the practice of FGM. This tendency to reason in favour of reinfibulation was justified by the strong adverse social consequences the woman not undergoing the procedure would suffer from, such as becoming an outcast of society. It particularly was linked to the picture of the husband portrayed as an authoritarian partner inclined towards the practice of FGM. All but one woman who had delivered in Switzerland had undergone reinfibulation. Though the majority of concerned women said to agree with the procedure, there were also ambiguous views. Strikingly, half of the women who were partly reinfibulated said that the procedure was performed without them requesting it, nor was it addressed by the health care provider. Moreover, one woman even expressed that the physician had recommended her a certain degree of reinfibulation in order to avoid vaginal infection. Generally, gynaecologists/obstetricians and concerned women were in agreement with their opinion on partial reinfibulation, thus carrying it out

to a degree less severe than before delivery. Those gynaecologists/obstetricians performing the procedure emphasised the need to still allow for unimpeded sexual intercourse, urinary and menstrual flow. However, there are no official national and/or institutional guidelines that regulate reinfibulation and the degree of the procedure in Switzerland. The decision to perform reinfibulation remains an individual one for which each physician who carries out the procedure takes the responsibility. In the UK, however, reinfibulation is considered illegal by the Prohibition of Female Circumcision Act of 1995, the declaration of the Royal College of Obstetricians and Gynaecologists of 1997, and in the guidance on FGM published by the British Medical Association in 2001. The Prohibition of Female Circumcision Act states that "surgical operations on the vulva are legal if performed for the physical or mental health of the women (e.g. medical reasons, such as malignancy)" but makes it clear that "any operation cannot be performed if only for the purpose of custom or ritual." This led to the recommendation that "the obstetrician should do no more than the minimal amount of reparative surgery which will allow the cut edges of the labia to heal but which leaves the vaginal introitus open so that intercourse is not impeded" (Jordan, 1994).Thus, in both specialist clinics for treatment and counselling of women concerned in the UK, reinfibulation is not carried out (Mc Caffrey et al.; Momoh et al., 2001). Also, in other national and international recommendations on FGM, reinfibulation is banned. In the Belgian official technical guidelines for health care professionals of 2001, reinfibulation is considered just like carrying out FGM as a mutilation which will be prosecuted by penal law. The WHO (2001) states in its technical report: "The incision should not be closed to recreate a barrier at the introitus (...). Demands for re-suturing to recreate a small opening (reinfibulation) should be resisted and the potential future health problems of such procedure should be explained (…). Every effort should be made to discourage the practice."

Thus, clinical practice and attitudes of HCPs in Switzerland and of the majority of concerned women are in discordance with international guidelines and established best practices elsewhere. Yet, there are different approaches on the issue of reinfibulation. In Denmark, the procedure is not declared t illegal. The Danish National board of health stated the following: "There is no medical indication for this procedure (..). In the exceptional case where re-suturing is chosen, then this should only be done following an overall assessment of the woman's situation and the problems she would experience if she remains open. Re-suturing in terms of reinfibulation should only be performed after the woman has been informed about the risks involved. Only a re-establishment of the antepartum state is allowed and only in a way to allow vaginal examination." These

guidelines allow for a less categorical, individual decision. However, they request to thoroughly asses the patient's situation and to inform about risks.
Yet, the majority of Swiss HCPs supporting reinfibulation based their decision on assumptions about the patient without having inquired about the real situation. Moreover, several women reported they had not at all been informed about reinfibulation. This practice can even be less supported when knowing that some women are not determined to be reinfibulated, a finding which is supported by a study on Somali women in Canada. 20% of this 432 women declared it was the obstetrician's responsibility to take the decision on reinfibulation (Chalmers and Hashi, 2000). In Denmark, experience has shown that most women want to remain open if they have been thoroughly informed during their pregnancy about health consequences of re-suturing (National Board of Health, 2000). These findings underline how essential it is to include the women in the decision on reinfibulation.

5.5. The adolescent woman

Those adolescent migrants who have undergone the practice of FGM as young girls in their home countries and now have been living in Switzerland for several years are facing a specific situation in the host country. In chapter 4.3, it has been shown that the health complications of FGM type III are particularly severe in the adolescent women. This is due to the fact that if the vaginal opening has not been further opened through sexual intercourse and/or delivery, the vaginal passage is severely obstructed through the scar tissue barrier. The young women not only suffer from physical problems during menstruation or sexual intercourse, they also face social problems. Usually, adolescent women are, through school and peers, in much closer contact to Swiss society than their mothers. Some of them have spent large parts of their childhood and adolescence in Switzerland. The statement "I feel like a Swiss woman, but I have the body (meaning genital mutilation) of a Somali woman", illustrated a physically engraved difference this young woman suffered from. Especially, when having a Swiss boyfriend, the difficulty of how to disclose FGM arises. How should a young migrant woman during her first sexual encounter find the courage in this most sensitive, intimate moment to confront her boyfriend with a vagina which is closed? Addressing the health care provider for help often arises from the wish to have premarital intercourse. To disclose sexual complications to health professionals one needs the ability to talk about sexuality. The taboo of concerned populations to talk about sexuality is deeply routed in their traditions (Bayoudh et al., 1995). Moreover, there is a great importance attributed to virginity (Van der Kwaak, 1992; Gruenbaum 2001). Yet, the need for professional help was

expressed by young participants in two of the group discussions, who asked the researcher for the address of female gynaecologist that could help them. While the majority of adult women had not actively addressed the subject of FGM during medical consultations, the physicians of family planning centres where mainly adolescent women are treated often reported discussing about FGM related complications with young women. It is likely that it is the degree of immediate suffering that motivates adolescents to share their experiences. The decision for defibulation is taken in many cases without the knowledge of the parents. Moreover, several adolescents and mediators confirmed being the young woman's strongest fear, that this might be disclosed to the Somali population in Switzerland. In such a case adolescents fear that their reputation would be forever destroyed. One gynaecologist/obstetrician reported the case of one adolescent woman who finally seemed to have decided to undergo the procedure of widening her vaginal opening. However, the young woman did not respect the scheduled appointment. Similarly, a meeting between a concerned woman who suffered from strong physical complications and the researcher was arranged to prepare a visit to the gynaecologist. Though this meeting had been reconfirmed by phone the day before and the young woman seemed quite determined to follow this plan, she did not come to the meeting. These experiences illustrate how difficult it is for adolescents to approach Swiss health care workers for help. Concerning the physical and the social dimension of FGM type III, young women concerned clearly have a great need of sensitive counselling.

5.6. Female genital mutilation and gender

FGM and gender-interaction in the migrant communities

The question whether to undergo de- or reinfibulation concerns both partners. But in the communities concerned communication between wife and husband on important decisions concerning FGM is by no means common. The large majority of women questionned in the study, said that they had never spoken with their husband/partner about FGM. This non-interaction has been reconfirmed in the interviews with men of the concerned community. It is consistent with another qualitative study on FGM in the African context (Kouyat et al, 1998). The main arguments women mentioned to justify FGM in this study, are consistent with the literature. The practice is carried out to guarantee marrigeability, to enhance sexual pleasure in men, to maintain virginity which determines a woman's dignity, and reflects the social quality of the entire family (Van der Kwaak, 1992; Almroth et al., 2001). All of those arguments express strong male expectations which are traditionally not questioned. The women do not discuss them with their husbands and thus remain unconfirmed. The arguments have been internalised by women as strong social and cultural values. Especially, the ideal of beauty linked to the state of FGM was repeatedly expressed during a group discussion. Combined with the intensified sexual arousal of men caused by the tighter vaginal introitus, the aspect of a smooth and pure vulva is believed to please men more and to enhance the feeling to be a beautiful wife, a finding also reported by Smith (1995). Yet, in listening to the voices of migrant women there were changes to be observed. Rising criticism and opposition was uttered by some group participants on contradicting expectations of the husbands. On one hand, the husband wants lots of children, and on the other hand he wants the opening to be small and tight again. Two women said to have spoken with their partners about FGM and had told the partner that they planned not to have the daughter undergo FGM. Also, the notion of the "modern men" has been mentioned. These are men of the young generation who have been influenced by travelling and by life in Switzerland. All three men of the young generation interviewed in this study opposed FGM. Reasons varied from rather unemotional lack of understanding for a mutilating practice, influenced by the perspective of life in Switzerland, to a personal adverse experience with FGM. Also, there was some ambiguity on this view. Though FGM was acknowledged to have adverse physical consequences for a woman, the positive aspect of protecting an adolescent daughter against the bad influence of western life, seen to be strongly influenced by promiscuity and moral decline was also mentioned. This finding is consistent with a qualitative study among concerned migrant

women in New York City (Eyega and Conneely, 1997). One of the interviewees on our study actively decided against FGM and influenced his wife to become defibulated, because her suffering during sexual intercourse turned out to be a traumatic experience also for him. This finding is in accordance with the study of Almroth et al. 2001. In this study, strikingly different from what would have been expected from the literature, the majority of men of the young generation reported that they would have preferred to marry a woman without FGM. Though carried out under entirely different conditions (Sudanese villagers) as in our study, one of the main reasons for men to question FGM was the suffering and pain FGM causes for girls and women. Thus, men of the concerned communities might be less in favour of FGM than expected by their wives. Increasing communication between the couples will contribute to eradicate unconfirmed assumptions and help abolishing the practice of FGM.

The influence of gender in the medical consultation

a) The gender of the health care provider

During the medical consultation, the sex of the health care provider is attributed a great importance. The grand majority of concerned women mentioned that it was impossible for them to speak about personal subjects such as gynaecological problems and/or the subject of FGM with a male professional. This concern was especially strong in young women who have not had intimate contact with a man. Several participants expressed that it is seen disreputable to consult a gynaecologist/obstetrician before pregnancy, emphasising the high value of chastity of the woman: the first man a woman exposes herself to has to be her husband. Also in older women, the preference for a female gynaecologists prevailed when undergoing the first gynaecological examination in Switzerland. Clinical case studies elsewhere with immigrant patients from Sudan and Somalia who had undergone FGM type III also reflect this anxiety towards a male physician (Baker et al.,1993; Mc Cleary,1994). One author suggests that in case the examiner is a male physician, permission for examination should be obtained and the woman should be kept covered as much as possible to maintain intimacy (Mc Cleary, 1994). In our study, the obvious difficulty of concerned women to entrust themselves to a male doctor, led a male gynaecologist to conclude that he would not discuss FGM and related problems with concerned women because they would want and need a female gynaecologist/obstetrician. It is not surprising that the key health care providers, who are more experienced in care for concerned women in Switzerland, are all women.

In order to serve the women's needs those HCPs involved in the gynaecological/obstetrical consultation also should be female.

b) The role of men in the medical consultation

Health care professionals confirmed that the lack of communication between men and women also was a problem during the medical consultation. If women were accompanied by another member of the community, they were more commonly accompanied by a female translator/mediator and/or friend than by the husband. If the husband was present, most commonly he functioned as translator. Some husbands apparently had accompanied their wives to control the first consultation, however when a gender sensitive approach was used, such as a female doctor and female nurses, the next consultation occurred without the husband. Generally, the husbands/partners were perceived to have a rather passive role. Moreover, in some cases it was mentioned that the husband had opposed reinfibulation or wanted the wife to be less closed than before delivery. However, contrary to this finding, most health care providers portray the husbands of concerned women to be autocratic and wishing to control the sexuality of their wives. This assumption has caused some HCPs to not address FGM when the husband was present. The majority of HCPs, however, felt that it is essential to include the husband in the decision on defibulation or reinfibulation, because wife and husband, both, are affected by the consequences. The findings of this study, strengthened by a triangulation of perspectives, suggest that men might be less in favour of FGM than assumed by a large number of HCPs. Due to the adverse effect of FGM, men might even question FGM themselves and thus would agree to a decision for defibulation, if they were only included in the medical dialogue. Moreover, including men further in the medical consultation, and promoting the dialogue among the couple, would allow HCPs to decide about defibulation or reinfibulation in a more informed way together with the couple, instead of feeling the unverified duty to carry out reinfibulation to protect women from the threat of male suppression. Furthermore, including men in preventive measures could be a further step in abolishing FGM not only in the migrant communities but also in the countries of origin.

5.7. Information needs of interviewees and their suggestions

Information needs and suggestions of women concerned

In focus group discussions and in-depth interviews with Somali and Eritrean women, it was remarkable that it was easier for concerned women to tell about their experiences made during delivery in Switzerland rather than to formulate their needs and to give recommendations on what could be improved. It is likely that determined by gender and cultural characteristics of the countries of origin where patients are often not asked for their views and preferences, women may not feel at ease to formulate any requests or recommendations. Women, however, actively raised questions with respect to episiotomies and defibulation. It was not clear to the women, if not all women have to be defibulated for delivery. Concerned women compared themselves to the ”other” women of the host country who have not undergone FGM, not knowing how a normal female genital anatomy looks like as they only knew about their own anatomy. Also, effects of FGM on women’s sexuality and fertility were of interest. Educational material should thus include female anatomy and physiology of sexuality, pregnancy and delivery.

Participants of different group discussions raised concern over the number of caesarean sections performed. Caesarean section is not commonly performed in the countries of origin and is seen to impede further deliveries. Though the interviewed women had on average just 1-2 children, the option of giving birth to as many children as possible seemed important to some participants. Furthermore, avoiding caesarean sections in migrant women concerned is especially important with the perspective that they eventually might return to the home country, where caesarean sections often cannot be carried out in areas with limited resources. Results from health care providers working at regional hospitals showed that several times caesarean sections have been carried out to avoid vaginal delivery, because health care providers were not informed about the obstetric management of FGM type III. This finding is in accordance with experiences made in other European host countries: In Germany, caesarean section routinely had been carried out on women with FGM type III in some hospitals (Becker-Inglau, 1998). This tendency should be even further questioned, knowing that the majority of women concerned opposed caesarean section. If there is no other complication that requires a caesarean section, there is no medical justification for doing so in an infibulated woman.

The majority of women who commented on defibulation, preferred to have it done during delivery to avoid flashbacks of the act of excision and to avoid undergoing another painful intervention in addition to delivery. This view is in accordance with the obstetrical practice at the sample university hospitals. Furthermore, none of the gynaecologists/obstetricians and midwives included in the study saw a medical justification for having the woman concerned undergo an additional stressful intervention during pregnancy. However, in various international recommendations, including both of the UK specialist clinics, it is recommended to perform defibulation during the second trimester of pregnancy to guarantee that at the onset of labour the introitus is adequate for vaginal examinations and any intervention procedures necessary, and to avoid dependency on experienced personnel at delivery (McCaffrey et al.,1995; Momoh et al., 2001). Interestingly, the view of concerned women in the UK was consistent with recommendations given by women in our study. In the London specialist clinic, though antenatal defibulation had been recommended by staff, only 3 of 39 women agreed to have the procedure performed antenatally, whereas the large majority preferred to be defibulated during the second stage of labour, because they would ”rather go through a painful procedure once” (Momoh et al., 2001). Moreover, not all national guidelines are categorically in favour of antenatal defibulation. The technical guidelines from Belgium state that antenatal defibulation should be proposed to concerned women only in those severe cases of infibulation which do not allow vaginal examination because the introitus is too narrow (Richard et al., 2001). Swedish guidelines recommend a similar procedure (Immigration Services Administration Göteborg, 1998). However, the ultimate decision if to undergo the procedure during pregnancy or during delivery is left to the couple. WHO defines the issue of defibulation to be a priority for research: “Studies are needed to establish the timing (antenatal, during labour or at delivery) and safe techniques for the opening up of FGM type III, placing emphasis on reduction of perineal trauma, especially for use in the resource-poor areas” (WHO, 2001 b). The interviewed women worried about the way in which defibulation is carried out, fearing lesions of the anal sphincter, an adverse consequence of FGM known from the home country. As in the countries of origin plastic surgery in many cases is not available, resulting faecal incontinence and the constant smell of faeces means a terrible social stigma to every woman concerned. However, complications of defibulation are extremely rare in clinical settings of industrialised countries. Not all women concerned were aware of this. Therefore, not only the timing of defibulation but also the technical steps of the procedure should be discussed with the concerned patient, preferably with the help of anatomical drawings.

Finally, several general recommendations were given by the women concerned. The majority of these recommendations are not specifically linked to having undergone FGM, but reflect the general challenge for a HCP to treat and counsel immigrant woman. A majority of patients would prefer the health care provider to take more time during the medical consultation. Also, the wish to receive more empathic care was expressed by recommending more intense care by the midwives. Some women missed the intimate, more personal care of the traditional birth attendant which they are used to in the home country. Also, they asked for privacy during the consultation instead of having ”crowds” of medical students look at them. Particularly, when recalling their first consultation, some participants felt that they could have had a chance to ask more and to understand better what the doctor suggested if a translator had been present. During this study women expressed important specific and unspecific needs with regard to the gynaecological/obstetrical consultation in Switzerland. These questions and recommendations should be known and considered by Swiss gynaecologists/obstetricians and midwives.

Information needs and suggestions of health care providers

The majority of HCPs showed to be in favour of getting further information and training concerning FGM. There were also interviewees who questioned a need for further information because they felt that FGM is not a public health priority in Switzerland. Others, however, emphasised that they needed further information, as FGM is a rather rare phenomenon that does not allow acquiring clinical routine of treatment and counselling of women concerned. Most HCPs suggested that the women needed to be better informed, rather than questioning their own services provided. The support for the HCPs needed depends on their exposure to FGM. The more experienced gynaecologists/obstetricians in practice for at least ten years, working at university hospitals, and having experienced the wave of Somali immigrants in the beginning and mid 1990s felt confident in technically managing women concerned. Yet, expertise in caring for women with FGM is limited to a small number of gynaecologists/obstetricians and midwives who developed special interest in this area. These professionals are called on by colleagues as resource persons.

However, senior gynaecologists/ obstetricians in regional centres or in large centres in parts of the country that are less exposed to FGM felt that they are not well prepared to counsel and treat concerned women. Moreover, it is the group of young gynaecologists, who can neither rely on experience in clinical experience, acquired during the

1990s, nor has been trained on FGM at medical school, who expressed a strong demand on further information. A survey carried out by the author in a block course for speciality qualification in gynaecology/obstetrics at the university hospital of Lausanne in June 2002 showed that 85% of the participating young physicians said to be in favour of guidelines. Particularly, a strong demand on cultural background information on FGM and on the migrant groups concerned was expressed.

Various ways how HCPs could be provided with information were mentioned and discussed during the interviews. HCPs suggested the following sources of information: guidelines, centres of reference, workshops, and articles in professional journals on cantonal and/or national level and the creation of a national website. The journal ”Schweizer Hebamme” (“Swiss Midwife”) issued on a monthly basis devoted an entire issue to FGM in January 2002 and thus initiated a platform of exchange of experiences for midwives on national level. Several midwives suggested continuing dealing with the topic in future issues. A need for guidelines was mentioned by most of the interviewees. However, there were also HCPs who expressed scepticism about guidelines. To avoid duplications of effort guidelines already published elsewhere should be considered. There was a variety of views on which professional groups these guidelines should target, to what degree of depth they should be designed and by whom they should be produced. The majority of asked HCPs however, wished gynaecologists/obstetricians and midwives to be target groups and both professions should be involved in the elaboration of guidelines. With respect to the content of guidelines, it was generally suggested that they should include technical and cultural issues. Centres of reference were encouraged to become associated to those institutions where already knowledge on intercultural care and care for migrants would be available. Those centres could provide advice for women concerned and health care providers. HCPs of different private and public institutions would welcome workshops on FGM. Differently from other European countries, there have been no concerted initiatives in Switzerland to improve and harmonize the specific care for immigrant women with FGM. Women and HCPs participating in this study provided valuable suggestions. These suggestions will initiate further discussions and help decide on which measures to opt for.

6. Conclusions

There are currently about 10,500 women and girls from FGM practising countries living in Switzerland. In relative terms Switzerland hosts a similar rate of female migrants from FGM practising countries as other European countries, where much more official measures have been taken. This study shows that there clearly is a potential for improving the gynaecological/obstetrical care for women with FGM in the Swiss health care system.
With respect to the distribution according to nationalities, more than 2/3 of the women living in Switzerland who are estimated to have undergone FGM come from Somalia, Ethiopia and Eritrea where the severest form of FGM (FGM type III) with relevant long term complications is commonly practised. 70% of the women concerned live in the large metropolitan areas of Switzerland, predominantly in the French speaking part of the country. They consult mostly in hospital settings rather than in private practice.

The main FGM related health complications that women from Somalia and Eritrea suffered from were a painful and prolonged menstruation, pain and reduced feelings during sexual intercourse. In Switzerland obstetric complications play a smaller role than in their countries of origin. Therefore, psychosexual complications become more prominent consequences of FGM. The concern of being different from women of the host society as FGM interferes with sexual pleasure, is a consequence that the migrant women face particularly. Yet, participants who had undergone FGM expressed a strong inter-individual variability with respect to sexual response. Thus, the generalisation that having undergone FGM leads to sexual indifference, is not based on evidence and might contribute to stigmatise women concerned.

Consequently, the gynaecological/obstetrical care showed to be more challenging in terms of a culturally sensitive interpersonal interaction between the women concerned and the HCPs rather than in relation to technical management of FGM. The following aspects of the consultation were critical: the reactions of several HCPs when first facing the mutilated vulva (FGM type III) ranged from disclosing shock in front of the patient to totally ignoring the state of FGM. A complete medical history related to FGM including to probe for FGM related complications, was not performed in most cases. Particularly, the sexual and social complications were rarely addressed. As pregnancy in some women is the first and possibly only contact with the health care system of the host country, preventive talks are crucial in these services. Yet, only 8% of the participating HCPs systematically address the future of concerned women's daughters. The

issue of reinfibulation, a question specifically linked to obstetrical care of women with FGM type III presents an ethical conflict for the HCPs. Ultimately all interviewed HCPs support partially re-suturing the vulva after delivery, if requested. However, in respecting the interests of their clients, some HCPs clearly violated the patient's rights by performing the intervention without thoroughly informing the patient. While other European countries ban reinfibulation (UK, Belgium) or clearly define degree and conditions concerning this intervention (Denmark), partial reinfibulation without existing guidelines is carried out at the obstetric services of all Swiss university hospitals participating in this study.

A striking lack of communication is a prominent finding in this study. This lack of discussing FGM is obvious between the women concerned and HCPs, the women and their husbands/partners and even between the women of the same migrant community. As to the gynaecological/obstetrical consultation, main obstacles were the language barrier, the general delicacy of the subject, and the fact that FGM is a highly gender sensitive problem, particularly for the male HCPs feeling the women's reluctance to discuss FGM with a man. In a couple, it is the taboo of talking about FGM that contributes to maintaining the women's unconfirmed assumptions that men of their cultural background generally support FGM. On contrary, the young men included in this study opposed the practice due to personal adverse experiences with FGM. Finally, there is a striking lack of exchange among the women concerned. This causes a difficult situation, particularly for the adolescent women who are often not able to talk about physical and social problems linked to FGM with their mothers, and thus carry the burden of secretly seeking medical help without any support from their families. Yet, even for several women of the same generation and cultural background, this study was the first time they shared FGM related complications with each other.

Difficulties with FGM related gynaecological/obstetrical management were greatest in the first half of the 1990s, the time when most Somali immigrants entered Switzerland. Meanwhile, several gynaecologists/obstetricians and midwives at the university hospitals developed a certain experience in the management of FGM. In the regional hospitals however, where HCPs are much less exposed to such cases, the lack of experience is much more obvious. Thus, at several regional hospitals in Switzerland to avoid vaginal deliveries in women with FGM type III, caesarean sections have been carried out. FGM type III as such is no medical indication for caesarean section. Moreover, with the perspective of migrant women to return eventually to their home countries where subsequent caesarean sections may be difficult to realise in resource poor ar-

eas, a previous caesarean section can then present a risk. Furthermore, the majority of participating women opposed caesarean section as they wished to maintain the option of many deliveries. HCP`s needs for information about the treatment of concerned women depend on the extent of their experience, determined by the frequency of exposure to such cases. As the subject of FGM is not integrated in the training at medical schools in Switzerland, those young gynaecologists/obstetricians still receiving their speciality training and therefore with less clinical experience are not as prepared for FGM specific treatment and counselling.

Migrants from Sub-Saharan Africa present one of the most vulnerable populations in the Swiss health care system. FGM means an additional burden for women from these communities. This study reveals that gynaecological/obstetrical care in Switzerland often does not meet the women's specific needs with respect to FGM. This is not due to lack of empathy or good will on the side of the HCPs, but rather due to the fact that most HCPs in Switzerland lack exposure, experience and guidance as how to care for such women. However, considering that FGM is a subject of great delicacy, inappropriate health care can even increase the women's burden by making them feel stigmatised. Gynaecological/obstetrical care needs to be adapted to culturally more appropriate and sensitive care, taking the specific needs of the women with FGM into consideration. In order to improve the situation characterised by a multilateral lack of communication, further education and possibilities of networking need to reach the women and the HCPs. As women concerned are geographically concentrated and consult mostly in hospital settings, rather than in private practise, services could be improved with comparatively small additional efforts and resources. Both groups participating in the study gave valuable suggestions that were included in the recommendations of this study.

FGM is a public health issue in Switzerland. Moreover, in the era of globalisation, FGM presents a migration-related international problem that all industrialised host countries have in common. Switzerland, as a country hosting immigrants who have undergone FGM, should participate in international networking, an important process in which experiences can be exchanged and expertise can be further developed. With the perspective of rising migration from Sub-Saharan Africa to Europe, knowledge on FGM specific gynaecological/obstetrical care is increasingly important for heath care providers in Switzerland.

7. Recommendations

7.1. Recommendations for further research

This research has raised further questions. Following are the most important suggestions for further research aimed at improving the situation of migrant women with FGM in Switzerland. Some of these issues, such as the role of the husband/partner and the role of the adolescent woman have already been introduced in this research, as they showed to be of great relevance. However, this was only done in an exploratory way. Thus, they should be investigated more thoroughly.

- **FGM and the teenage women**
  The adolescent migrant women showed to be particularly to the physical and social complications of FGM.
  What are specific problems of the adolescents with respect to FGM?
  Implication: improving the situation of the adolescent woman.

- **FGM and the role of the husband/partner**
  What are men's attitudes towards FGM and their personal experiences with the practice in the migrant communities of Switzerland? Do men in the migrant communities have a different position/authority with respect to FGM than in the host country?
  Implication: involving the husband/partner in fostering communication on FGM and related complications within the couple. Involve men in preventing FGM in the next generation.

- **FGM and the influence of mass media**
  What influence has increasing publications of best-sellers, tabloid press contributions and internet publications on the migrant women's self esteem? Do women with FGM feel supported or stigmatised by the influence of mass media?
  Implication: avoid humiliation and stigmatisation of women concerned. Enhance further integration of these women into the host society.

- **FGM and the Swiss health care system compared to FGM and the Belgian health care system**

  What are differences in health care, infrastructure and information concerning FGM from the perspective of FGM practicing communities in two host countries of similar size?

  Implication: empowerment of concerned migrant communities by exchanging best practices and enhancing a networking process between the migrant communities on international level.

- **FGM and the influence of migration**

  Do length of stay and degree of integration in the host society have an influence on the tendency to abolish FGM?

  Implication: improve the understanding of factors contributing to abandon FGM in the immigrant communities; prevention of FGM in the migrant communities.

7.2. Recommendations to the Swiss health care system

One objective of this dissertation has been to generate recommendations to the Swiss health care system. These recommendations are directed to health care providers in Switzerland, more specifically to the interviewed professions of gynaecologists/obstetricians and midwives. The recommendations elaborated present a basis which hopefully will stimulate HCPs to discuss further steps of action among each other and to eventually lead to concrete measures aiming to improve the care of women concerned in the Swiss health care system. As the results and recommendations of this study root to a large degree in the experiences and suggestions of the women, members of the concerned migrant communities should also be included in all further steps of action.

- Gynaecologists and midwives in Switzerland should be better aware of the phenomenon of FGM in the sub-Saharan migrant population in Switzerland. Expecting the presence of FGM will avoid for both parties the “shock” of the first confrontation. Knowledge about the different types of FGM and their distribution among the main migrant nationalities will further prepare for the consultation. Anticipating the relevant long-term complications linked the degree of FGM, will allow taking a complete medical history.

- Adequate and sensitive sexual counselling is of great importance when dealing with concerned women in the context of migration, especially if they are afraid of being labelled as “asexual” beings when compared to women of the host country. Sexual complications of FGM might not be actively addressed by women concerned, but they should be probed by the gynaecologist/obstetrician and midwife, because they present one of the main health complications of FGM, and also prove to be of social concern to the women. Empathy for the subjective perception of the woman’s own sexuality will help to improve the caregiver-patient relationship. Knowing about the variability of sexual response, comprehension should be achieved on an individual basis, avoiding generalisations and stigmatisation of women concerned.

- In order to provide care in a culturally sensitive manner, it is important to have some information on the socio-cultural background of the practice of FGM. Equally important is to develop an understanding of the patient’s current life situation as a migrant in Switzerland and of the social dimension FGM has with respect to this

situation. Particularly, the potential social conflicts of the adolescent woman who might ask for defibulation, but at the same time fears for her reputation in the migrant community, should be treated with confidentiality, empathy and patience.

- The issue of defibulation needs to be discussed with each pregnant woman presenting with FGM type III and possibly involving her partner. It is recommendable to include her in the decision about time management of defibulation. The defibulation procedure and the expected outcome should be explained to her with the help of a mirror and/or anatomical drawings. An infibulated woman, who consults for a reason other than pregnancy, should be informed about the possibility of defibulation.

- While discussing defibulation, the woman and her partner should be asked about their position on reinfibulation. The HCP should assess their personal situation, and if there are problems the woman would experience if she remained defibulated. The fact that reinfibulation is medically unwarranted and might include health risks should be explained to the couple. This informative talk should be held in advance to allowing enough time before delivery to make a responsible decision. If reinfibulation is performed to avoid adverse social effects for the women, it only may be carried out to a partial extent to guarantee for gynaecological examination, sexual intercourse, and unrestricted urinary and menstrual flow**.**

- It is most recommendable to include the husband/partner in all discussions aiming at accomplishing an informed decision on defibulation/reinfibulation by the couple, and facilitating communication between both partners.

- Knowing that many women concerned feel great shame during a gynaecological examination by a male physician and feel that it is impossible to talk to a male HCP about FGM, a gender sensitive medical consultation should be offered to women concerned. Thus, all health care providers involved in the gynaecological/obstetrical consultation, including the translator, should be guaranteed for to be women. Because FGM presents an intimate subject for women concerned, privacy should be respected during the history taking and the examination.

- A professional translation should be offered that allows the woman concerned to freely express herself. Though the husband needs to be included as closely as

possible, the woman should have the opportunity to openly speak with the HCP without the presence of her partner if necessary.

- The role of the midwife should be strengthened with respect to obstetrical care of women concerned. As most midwives are women, it would help to guarantee for a gender sensitive approach. Due to their cultural background, women concerned feel more confident with the midwife than with the physician. Thus, the midwife should help to realise one of the women's explicit recommendations: to create a more empathic, individual and patient care with less time-constraint. She could also assist the physician in some of his responsibilities such as taking a thorough medical history related to FGM.

- Health care providers in Switzerland providing gynaecological and obstetric services to women concerned need to become more active in the prevention of FGM in the migrant community. Considering the fact that some women participating in this study were in favour of carrying out FGM on their daughters-even if it was the least severe form-and several were ambiguous about potential adverse consequences their daughters would suffer from if not undergoing FGM; addressing the daughter's future with respect to FGM is a priority for HCPs during the consultation. The woman's partner should be present during the preventive talk to ensure that both partners guarantee the bodily integrity of their child. Actively including men of concerned migrant communities in prevention initiatives would mean an important step towards abolishing FGM.

- Concerned migrant women should be offered opportunities to network, share and discuss among each other about matters related to sexuality and reproductive health, including FGM. Teaching materials should be provided and specific aspects of FGM should be discussed. However, information should not be reduced to the mere anatomy and physiology of the female genitals. By including the broad social dimension of FGM, the full human being will be respected. Also, for adolescent women and men of the concerned communities, they should have special opportunities to inform themselves about sexuality and reproductive health.

- Training on medical, social and cultural aspects of FGM should be included in the curricula of medical schools in Switzerland to prepare young doctors and advanced medical students during clinical rotations. Further education on FGM for

midwives and gynaecologists/obstetricians should be offered by HCPs of both professions who have the most experience in treatment and counselling of concerned women as well as representatives of the women's community. To further foster an exchange of experiences and to avoid the duplication of efforts, interdepartmental linkages of different institutions in different regions of the country should be established.

- Further measures that improve treatment and counselling of concerned migrant women should be elaborated in Switzerland. Particularly, the specific issues of defibulation and reinfibulation should be explicitly included. Key individuals of the concerned migrant community and key HCPs in treatment and counselling of FGM should be involved. The existing experience and instruments in other European countries should used as well. The recommendations of this study could be valuable for the elaboration of further measures in the Swiss health care system.

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8. Further steps of action

This study was initiated aiming to generate recommendations that could help improve the situation for both migrant women with FGM and HCPs receiving them. The following activities are planned to foster dissemination of the study results:

- A summery of the results will be created in a French and German version and will be sent as feedback to all informants and interviewees who participated in the study.

- The results of this study will be shared during various meetings with key informants and associations of the migrant community who participated in this study.

- Relevant stakeholders (Federal Office of Health, Swiss Association of Gynaecologists and Obstetricians, Swiss Association of Midwifery) will be contacted. The organisation of a workshop will be proposed in order to present the results of the dissertation and to discuss further steps of action.

- A publication of this study will be submitted to an international journal in order to make the study results available to interested stakeholders outside of Switzerland.

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10. Appendices

Appendix 1:

Prevalence rates of FGM in 28 African countries, updated in 2001, WHO

Country	Female population	Prevalence[1]	Number
Benin	2 730 000	50	1 365 000
Burkina Faso	5 224 000	72	3 761 280
Cameroon	6 684 000	20	1 336 800
Central African Rep.	1 767 000	43	759 810
Chad	3 220 000	60	1 932 000
Cote d'Ivoire	7 089 000	43	3 048 270
DRC	22 158 000	5	1 107 900
Djibouti	254 000	98	248 920
Egypt	28 769 000	97	27 905 930
Eritrea	1 777 000	95	1 688 150
Ethiopia	2 087 000	85	24 723 950
Gambia	496 000	80	396 800
Ghana	8 784 000	30	2 635 200
Guinea	3 333 000	99	3 299 670
Guinea-Bissau	545 000	50	272 500
Kenya	13 935 000	38	5295 300
Liberia	1 504 000	60	902 400
Mali	5 485 000	94	5 155 900
Mauritania	1 181 000	25	295 250
Niger	4 606 000	5	230 300
Nigeria	64 003 000	25	16 000750
Senegal	4 190 000	20	838 000
Sierra Leone	2 408 000	90	2 167 200
Somalia	5 137 000	98	5 034 260
Sudan	14 400 000	89	12 816 000
Togo	2 089 000	12	250 680
Uganda	10 261 000	5	513 050
Tanzania	15 520 000	18	2 793 600
Total			**126 774 870**

[1] Prevalence expressed as a percentage. Prevalences for Burkina Faso, Central African Republic, Côte d'Ivoire, Egypt, Eritrea, Guinea, Kenya, Mali, Niger, Nigeria, Sudan, Tanzania from National Demographic and Health Surveys (DHS).

Appendix 2:

Overview of existing guidelines and the legal situation in Switzerland and 10 European countries[1]

Country	Guidelines	Legislation
Switzerland	No official or federal guidelines, general information brochure "Circumcision of girls " by Antagem, Berne, 5/2001	*No specific law.* According to national penal code FGM is punishable as "serious harm to another person's bodily integrity."
United Kingdom	"Female Genital Mutilation: Caring for patients and child protection", published by the BMA; 8/2001	*Specific law* Circumcision Act: entered into force in 1986. Children Act of 1989: guarantees for measures of child protection.
Germany	"Genital Mutilation on girls and women", information brochure for physicians and advisers, published by the Ministry of Family, Women and Youth, 2000	*No specific law.* FGM is prohibited as physical damage according to article 23 of the penal code.
Netherlands	Guidelines developed by the Ministry of Public Health, 1994 and by Pharos Foundation-Refugee Health Care Centre	*No specific law.* According to the national penal code FGM is punishable as physical Abuse
Belgium	Technical guidelines for HCPs produced by (GAMS),distributed by the Belgian Ministry of Public Health (Richard, 2000).	*Specific law* FGM explicitly prohibited by a law for the protection of minors.
France	Leaflets: "Nous protégeons nos petites filles, Agir face aux mutilations sexuelles féminines", developed by GAMS in collaboration with the government.	*No specific law.* FGM falls under the national penal code as "mutilation". Approximately 10 cases have been brought to court within the last ten years.
Denmark	Information brochure on FGM containing general and specific information intended for different professions, published by the National Board of Health in 2000.	*No specific law.* Paragraph 145 of the national penal code prohibits FGM as bodily harm.
Sweden	Several specific guidelines for different HCPs, including the school health care system, published by a Gothenburg community project, subsidised by the Swedish Ministry of Health.	*Specific law* Prohibiting FGM came into force in 1982 and was amended in1998. Not only performing the act but also the failure to report its performance is punishable.
Norway	"Guidelines on Circumcision for Health Personnel in Norway", published by the Norwegian Board of Health, 2000.	*Specific law* Prohibiting FGM; entered into force in 1998
Spain	No reported guidelines.	*No specific law:* Article 147 of the penal code prohibits serious bodily harm. Specific bills have been introduced Spain considers changing the National law (The Lancet, 2001)
Italy	Manual "Mutilazioni dei genitali femminili: conoscerle, prevenirle, curare si le ha subite" for social and health workers, published by AIDOS (Associazione Italiana Donne per lo Sviluppo) in 2000.	*No specific law.* FGM is punishable according to Article 582 of the penal code.

[1]Sources for the Netherlands, Belgium, France, Spain, Italy , Denmark, Sweden provided by the European Network on FGM, Els Leye, Ghent: 1998 and 2000

Appendix 3:

Question guide for interviews with gynaecologists and midwives

I. Introduction

When did you treat a circumcised woman for the first time in Switzerland?

Can you comment on how many circumcised women you have seen since then?

Are the numbers of these patients increasing in your clinic?

Can you recall the percentage of different types of FGM (WHO classification) you have seen in your institution in Switzerland?

- Type 1 (Excision of the prepuce, with or without excision of a part or all of the clitoris):
- Type 2 (Excision of the clitoris, with partial and total excision of the labia minora):
- Type 3 (Infibulation: complete removal of clitoris, labia minora, inner surface of the labia majora with subsequent fusion of the labia majora leaving an opening with a diameter of about 2 cm to allow for the flow of urine and menstrual blood.):
- Type 4 (any other form):

Do you address circumcision if a woman of Sub-Saharan Africa consults? In what cases don't you ask?

Do you register circumcision in the patient's chart?

II. Gynaecological treatment (Questions particularly for gynaecologists/obstetricians)

What are the gynaecological problems concerned women suffer from when they come to see you? Which ones do you see as a consequence to the state of FGM?
Where do you see problems in the management of above complications?

Did you ever perform reconstruction surgery?
If yes, for what reason did you perform such surgery?

III. Psycho-social aspects of the consultation

Did affected women you have treated express psychosocial and sexual problems related to FGM? How often? Comment on the psychosocial and sexual problems:

Do you try to identify psychosocial and sexual complications of FGM by actively asking African women about those?

In your opinion do you think that a circumcised woman avoids or delays consulting the gynaecologist because she feels ashamed or embarrassed to disclose her circumcision?

If a concerned woman comes to see you for a gynaecological problem what do you do to make her feel at ease during the consultation?

Does the husband/male partner often accompany concerned women to the consultation? What role does he play?

IV. Obstetrical treatment

FGM during pregnancy: at what stage of pregnancy do you recommend your infibulated patient to become defibulated?

FGM during delivery: how does the treatment of excised/infibulated women differ from that of a normal delivery?

Do you discuss the delivery procedure with the woman concerned?

Do you feel at ease when having such women in your practice? Comment:

After defibulation due to delivery: What is your opinion in the discussion of total perineal reconstruction or limited reconstruction as a compromise respecting an African woman's wish who does not want to be completely "open" as a western woman?

How often have you been asked to perform a reinfibulation?
How often have you performed a reinfibulation?

IV a) Questions particularly for midwives:

After delivery:
How does the postpartal treatment of a woman who has been defibulated differ from that after a normal delivery? How does the postpartal treatment of a woman who has been reinfibulated differ from that after a normal delivery? Is there a need for a specific postpartal treatment for women who have been defibulated? Is there need for a specific postpartal treatment for women who have been reinfibulated?

V. Performing FGM

Have you ever been asked to circumcise an African girl in Switzerland?
If yes, how often? What was your reaction to the question?

What do you think about the "medicalisation"? (Allowing professionals to perform the circumcision to avoid that the act will be carried out by non-professionals in a non-hygienic manner which leads more frequently to acute medical complications of FGM.)

VI. Prevention

Do you lead preventive talks with a circumcised African woman concerning her daughters?

How is your experience concerning the impact the husbands/partners
of circumcised African women living in Switzerland have towards condoning/abolishing the practice of FGM?

VII. Professional Education

Does your institution provide further training for gynaecologists and obstetricians concerning the treatment of circumcised women?

Do you have recommendations in your department on special issues relating to the treatment of circumcised women?

VIII. Recommendations

In caring for circumcised women, do you feel the demand to get further information/ training? I yes, what source would you like to get this information/ training from?

Do you think that concerned migrant women in Switzerland need further information/raining with respect to FGM? Which source would you suggest?

Do you think that official government institutions (Swiss Federal Office of Health, cantonal health services, please name others) would need to be more concerned about the topic?

Appendix 4:

Question guide for focus group discussions with migrant women concerned

I. Experience with health care professionals in Switzerland

1. Did you ever consult a gynaecologist (the doctor who treats a woman's health problems) in Switzerland? Have you had a baby in Switzerland?
(Introductory questions)

2. How do you feel about seeing a gynaecologist/midwife in Switzerland? When you had a female health problem or when you suspected to be pregnant how long did you wait till you went to see the doctor/the midwife? Why did you wait? (If not already mentioned, ask: Do you rather avoid/ delay seeing a gynaecologist/midwife in Switzerland because you have undergone "Sunna/Pharaonic" and might feel ashamed/embarrassed when the doctor/the midwife sees it?)
(Investigation of the social aspects of health seeking behaviour)

3. Did the doctor/the midwife you saw in Switzerland notice that you were excised? How did he/she react when he/she saw you having undergone "Sunna" or "Pharaonic"? (the precise term which will be used still needs to be discussed with a Somalian moderator before the group discussion starts.)
(Preparedness of the gynaecologist to deal with FGM)

4. Did you and the doctor/the midwife talk about excision (the situation in Africa, the situation in Switzerland)? Did you also ask a question related to your personal situation? Did he ask you a question related to your personal situation? Who brought up the subject?
(Bilateral general approach to the subject in the situation of consulting)

II. Obstetrical Care

1. Some of you mentioned before that you had children in Switzerland? How many times of these pregnancies did you give birth in Switzerland? Tell us about your delivery in Switzerland!
(Anecdotal documentation of experiences concerning delivery in CH)

2. During your pregnancy did you ever discuss with the doctor in Switzerland that you would have to become "open" for delivery. What did he say would have to be done to you? Do you remember at what time in the course of pregnancy you discussed it for the first time?
(Adequate preparation of delivery)

3. Did you also talk about different possibilities after your delivery?
(If not mentioned by the participants address the following: remaining completely open, receiving some form of reconstruction (creation of labia minora), becoming partly closed, (adult woman size, however less closed than before), becoming completely closed again)
(Discussion of defibulation versus reinfibulation in the perspective of concerned women)

4. Did you and the doctor/midwife agree in that subject? Did you feel the doctor/midwife respected you in your opinion? What did you think about the doctor's views?
(Analysis of dialogue/possible controversial views)

III. Gynaecological complications of circumcision

1. Among others we also want to discuss the effect excision has on girl's and women's health. Do you know about any health consequences of excision/infibulation for girls/for women? Please comment!
(Knowledge and level of education about FGM, general introductory question preparing more focused questions)

2. Is there a difference between excision ("Sunna") and infibulation ("Pharaonic") as procedures? Is there a difference between them, when talking about their health effects? *(Leads to think about health consequences in a more differentiated manner.)*

3. Did you ever see a gynaecologist in Switzerland before being pregnant? Why?
(Inquiry of the variety of FGM and Non FGM-related gynaecological problems.)

4. Do you think there might be a relation between your just mentioned problems and "Sunna"/"Pharaonic"?
(Perception of personal health consequences of FGM)

IV. Prevention

1. In case you have a daughter, what would you prefer for her? "Sunna"? "Pharaonic"? No circumcision at all? Why? Did you talk to the doctor/midwife in Switzerland about it? Who addressed this question?
(Support of FGM, prevention talks included in the consultation?)

2. Has living in Switzerland influenced your decision? Do you think you would decide the same if still residing in your home country?
(Influence of migration.)

3. What does your husband/partner think about excision? Have you discussed with you husband/partner your decision in favour or against "Sunna"/"Pharaonic"? How does his voice count when you think about excising your girl*?*
(Male influence in the process of condoning/abandoning the practice of FGM)

4. Have you already talked to another Somali woman (for example a friend of yours) about "Sunna"/"Pharaonic" in Switzerland/Africa? If you yourself have a question/a problem related to "Sunna"/"Pharaonic" do you feel you could talk to one of your Somali female friends about it? How do you think you could influence another woman living in Switzerland/Africa who has undergone "Sunna"/"Pharaonic"?
(To what extent is FGM a topic of taboo? Female influence in the process of condoning/abandoning the practice)

V. Suggestions

In the last section of this discussion it is very important to hear your recommendations! They will be useful for doctors/midwifes to know if their treatment should be changed/optimised or not. More than that your suggestions will be very helpful for other African women living in Switzerland/ Africa who have undergone "Sunna"/"Pharaonic."

1. When you think about the ideal delivery for your child: how do you imagine it to be? What suggestions would you make to Swiss gynaecologists/midwifes concerning your treatment? How could they improve your treatment in order to help you feel more comfortable during the consultations? *(Suggestions specific to health care professionals in Switzerland)*

2. Would you like to get further information about the body of a woman, the legal aspects of excision in Switzerland (maybe also in comparison to the African situation) and the advantages and disadvantages of the excision of your girls? Comment! Show your priorities!
(Analysis of information demands related to health aspects, legal aspects and political aspects of FGM in Switzerland/in Africa. Establishment of educational priorities)

3. Where would you want to get this information? What would be the easiest, most direct way for you to receive it? Who do you suggest should provide it to you?
(Suggested source of information)

Appendix 5:

Question guide for men of concerned community

I. Experiences with obstetric/gynaecological care in Switzerland

Are you a father? If yes, how many children do you have?

Did your wife consult the gynaecologist for check-ups during her pregnancy? If yes, did you accompany her? Only for the first control, or every time? Why did you accompany her? (In case he did not accompany her: Why didn't you accompany her?)

Did your wife see a gynaecologist apart from pregnancy? If yes, did you accompany her? Why did you accompany her? (In case he did not accompany her: Why didn't you accompany her?)

How did you as husband/partner the obstetrical/gynaecological consultation in Switzerland? Please elaborate!

How was the delivery of your child/children in Switzerland? Were you present during the delivery?

Does female excision influence the course of the delivery?

Does female excision influence a woman's health?

Do you have an opinion to the question of woman who has undergone excision should be re-sutured after delivery? If yes: To what degree? Why?

II. General gender related attitude towards FGM

What do you think about a woman of your community/ethnic group who has not undergone excision? Does she face consequences if she has not undergone excision?

How do men of your community/ethnic group in your home country think about excision? How do men of your community/ethnic group living in Switzerland think about excision? Are there differences? Does life in Switzerland have an influence with respect to attitudes towards excision?

III. Personal attitude towards FGM

Imagine you are planning to marry: would you prefer to marry a woman who has undergone excision or would you prefer a woman who has not undergone excision? Explain your preferences!

What do you plan for your daughter with respect to excision? Have you spoken with your wife about this issue?

IV. Communication, need of information

Have ever discussed with your wife/girl-friend the issue of female excision? Have discussed with a friend about this topic?

Excision is generally rather seen to be a woman's subject. How do you feel during this

interview, talking about the issue?

Are men able to influence the discussion concerning the subject of female excision? What position could men take in the discussion? Should they play a more active role?

Would you be interested about more information related to excision? If yes, what aspects would you desire to focus on: Medical aspects, legal aspects, social aspects?

Where should this information come from? Which would be the best channel?

11. Curriculum Vitae

Name:	Clara Thierfelder
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1. Education

Education in Germany

1979-1985	Primary School	Gotenschule, Bonn-Bad Godesberg
1985-1989	Secondary School	Heinrich-Hertz Gymnasium, Bonn-Bad Godesberg
1990-1992	Secondary School/Abitur	Beethovengymnasium, Bonn
1992-1994	Undergraduate School	Otto v. Guericke University, Magdeburg
1994-1999	Medical School	Humboldt University, Berlin

International Education

1989-1990	Sandia High School	Albuquerque, NM, USA
1995-1996	Medical Externships:	
	• Emergency Room	University Hospital van Buren, Valparaiso, Chile
	• Neurology	Hospital Hanga Roa, Easter Island, Chile
	• Family Practice	Centro Medico, Isla del Sol, Bolivia
1998	Medical Externship:	
	• Internal Medicine	University of New Mexico Hospital Albuquerque, NM, USA

2. Diploma

1999	Graduation from Medical School: Diploma as physician	Humboldt University, Berlin, Germany

3. Degree

2001-2002	Medical Dissertation: “Female Genital Mutilation and the Swiss health care system”	Swiss Tropical Institute, Swiss Centre for International Health, Basel, Switzerland

4. Work Experience

1/2000-7/2001	Residency in Neurology	Neurological Rehabilitation Center, Greifswald, Germany
Since 12/2002	Residency in Internal Medicine	Medical Policlinic, University Hospital, Basel, Switzerland

5. Extracurricular activities

Problem Based Learning (PBL) in medical education. Tutor-experience	University of New Mexico, Albuquerque, USA
2002/2003 Public health initiative for female sexworkers: vaccination against hepatitis B.	AIDS-Hilfe, Basel, Switzerland

6. Language skills

Language	*Capacity*
German	mother tongue
English	fluent
Spanish	fluent
French	intermediate
Russian	intermediate

7. Publications

Concha G, de la Barra P, Thierfelder C, Klein N. Traditional Medicine on Easter Island. Easter Island in Pacific Context. California, USA: Easter Island Foundation, 1998.

Thierfelder C, Hatz Ch, Kessler C. Migrantinnen mit genitaler Verstümmelung in der Schweiz. Schweizerische Rundschau für Medizin 2003;31/32.