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Knowledge, attitudes and practices of Swiss reproductive health and paediatrics professionals regarding female genital mutilation/cutting: a cross-sectional study

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Summary

STUDY AIMS: Reproductive health and paediatrics professionals play a key role in the prevention and management of female genital mutilation/cutting (FGM/C) and its consequences. While global studies on knowledge, attitudes and practices regarding FGM/C exist, none have specifically focused on these professionals in Switzerland. This study addresses this gap by using a valid, theoretically informed measure to provide new insights into their knowledge and practices regarding FGM/C. The study aimed to identify gaps in knowledge, attitudes, practices and confidence regarding FGM/C among Swiss specialists, to inform training programmes and policy recommendations.

METHODS: We conducted a cross-sectional survey between August and October 2021. Physicians, nurses and midwives working in the reproductive health and paediatrics departments of the five Swiss University hospitals were invited to participate (convenience sampling). The questionnaire was administered in English, and all participants who had at least B1-level English proficiency and who had ever heard of FGM/C were eligible to participate. The primary outcome was knowledge score on FGM/C, and exploratory outcomes included attitudes, self-reported practices and confidence levels.

RESULTS: A total of 127 reproductive health workers and 76 paediatrics workers completed the survey. Mean knowledge scores were 25.7/31 for reproductive health and 19.5/27 for paediatrics workers; the differing denominators reflect the distinct number of knowledge items included in each group's specific questionnaire modules. Knowledge gaps common to both groups included correct identification of WHO FGM/C types (reproductive health: 35–68%; paediatrics: 9–18%), and awareness of surgical treatment options. Reproductive health workers demonstrated low knowledge regarding indications for caesarean in patients with infibulation (66%), while paediatrics workers were less familiar with the Swiss legal context and reporting regulations. While healthcare providers generally condemned the practice of FGM/C and recognised their responsibility to address it with patients, most perceived women with FGM/C as "victims" and the communities that practice it as oppressive. Confidence levels were particularly low regarding the visual identification of FGM/C in children and coding capacities.

CONCLUSIONS: This is the first study to assess specialists' knowledge, attitudes, practices and confidence regarding FGM/C at a national level. It highlights key gaps to address in future training programmes – including both biomedical skills and also bias awareness – with particular attention to inter-regional differences and underscores the need for accessible national and local guidelines to be actively implemented in all hospitals.

Introduction

An estimated 24,600 women and girls in Switzerland are living with or at risk of female genital mutilation/cutting (FGM/C), defined by WHO as all non-therapeutic procedures injuring or removing female external genitalia [1].

With more women with FGM/C living in diaspora-hosting countries, healthcare providers need evidence-based knowledge to offer respectful, bias-free care and follow clinical guidelines [2, 3]. Yet major gaps remain in prevention and management [4], and training on discussion, care and treatment is scarce [5, 6]. In Switzerland, only two studies (2012, 2016) have assessed general knowledge and practice, without examining legal knowledge, attitudes or confidence [7, 8].

All providers need baseline understanding of FGM/C, but reproductive health and paediatrics workers require even more specialised knowledge (e.g. managing complications and preventive counselling) [9-11]. Lack of specialised knowledge, unconscious bias, and discrimination can hinder access, support and treatment, leading to harmful practices.

This paper examines reproductive health and paediatrics specialists' gaps in knowledge, attitudes, practices and confidence across all five Swiss university hospitals. We compare German- and French-speaking regions, where exposure and resources differ. On the one hand, two thirds of women and girls at risk of FGM/C reside in the German-speaking region (Cottler and Abdulcadir, unpublished data). On the other hand, (French-speaking) Geneva hosts the country's only specialised FGM/C consultation with established training, protocols and documentation [12]. Based on these findings, the paper will guide the development of targeted training strategies and inform policy recommendations in Switzerland.

Methods

Study design and setting

This was a cross-sectional study conducted in 2021 among health professionals working in Gynaecology-Obstetrics and Paediatrics departments in all five Swiss university hospitals (located in the cities of Geneva and Lausanne, in the French-speaking part of Switzerland, and in Bern, Basel and Zürich, in the German-speaking part). The parent study assessed knowledge, attitudes and practices regarding FGM/C across eight departments (Gynaecology-Obstetrics, Urology, Paediatrics, Internal medicine, Primary care medicine, Psychiatry, Infectious diseases, Tropical/Travel medicine) [13]. The present study targets specialists at the forefront of FGM/C care, working in reproductive health and paediatrics departments, exploring additional items tailored to their scope of practice.

Questionnaire

An online, self-administered survey was created on REDCap (version 10.0.33) and sent to targeted departments in the five Swiss university hospitals between August and October 2021 (convenience sampling). The questionnaire was adapted, with permission, from an item bank developed in collaboration with the WHO and based on a conceptual framework informed by qualitative research [14]. The questionnaire included five sections: sociodemographics, knowledge, attitudes, practices and confidence. Items were reviewed by three FGM/C experts for relevance, Swiss applicability and evidence-based accuracy. We then pre-tested the questionnaire among five Swiss healthcare providers to ensure clarity, relevance and confirm acceptable completion time. Only sociodemographic questions were mandatory.

Participant recruitment

Participants were recruited via the medical directors of the five hospitals, who either forwarded the questionnaire or provided departmental contacts. In some hospitals, heads of medical and nursing staff were contacted separately to disseminate the survey. In all cases, different departmental and hospital contacts were willing to distribute the questionnaire, but none could provide exact distribution lists. The questionnaire was in English and was sent to a total of 2443 email addresses (1039 reproductive health and 1404 paediatrics), but inactive emails, duplicates and staff turnover limit the accuracy of this count, preventing reliable calculation of response rates. Reminders were sent after two and three weeks. Participants were eligible if they (1) were physicians, nurses or midwives; (2) worked at one of the five Swiss university hospitals; (3) had previously heard of FGM/C; and (4) self-reported "good" or "very good" English proficiency. Respondents who did not meet any of these criteria were automatically prevented from proceeding beyond the sociodemographic section of the questionnaire.

Variables and outcomes

The primary outcome was total knowledge score while attitudes, self-reported practices and confidence levels were treated as exploratory outcomes and reported at the item level.

Demographic

Our survey included 21 demographic questions including individual and clinical practice characteristics, and previous exposure to FGM/C. For analysis, responses of "No" and "I don't know" on prior exposure to FGM/C were combined into a single category.

Knowledge

The knowledge section included 27 items covering six key areas: general FGM/C knowledge, vulvar anatomy, ethical and legal aspects, communication, health complications and management approaches. Reproductive health workers had four additional items on defibulation and pelvic examination.

Each item had a single correct answer plus an "I don't know" option to reduce guessing; correct answers were scored 1 and incorrect 0. A total knowledge score, calculated only for participants completing all items, was created to facilitate comparisons across different groups, ranging from 0 to 27 for paediatrics and from 0 to 31 for reproductive health workers.

Attitudes

The attitudes section contained 23 items, plus an additional 5 items for reproductive health workers (concerning defibulation). Attitude items were scored on a Likert scale (from 0 "Strongly disagree" to 4 "Strongly agree") and are reported at the item level as each item measures a distinct aspect of attitudes rather than a single underlying construct.

Practices

There were 29 practice items in total, following a branching logic depending on specialty but also professionals' previous exposure to FGM/C or to minor patients. Five items targeted only practitioners who had ever performed defibulation. Items in this section had different response formats (multiple-choice question, Yes/No question or 5-point Likert scale), making it hard to calculate total scores.

Confidence

Four items assessed confidence regarding visual identification of FGM/C, management of health concerns of women with FGM/C and coding capacities. One additional item targeted only reproductive health workers and enquired about their confidence levels in defibulation.

Statistical analysis

Categorical variables are presented as counts and proportions/percentages. Continuous variables are reported as means and standard deviations (SD) or medians and interquartile ranges. We used chi-squared tests to compare proportions where applicable and report with p-values. We also ran t-tests, reported with p-values, to compare knowledge scores (primary outcome) between regions and professional titles. Data was analysed in STATA 16.0 (StataCorp LLC, College Station, TX, USA).

The initial protocol included plans for psychometric validation of the questionnaire and multivariable analyses to identify predictors of higher knowledge scores. However, due to heterogeneity across scale items, psychometric validation was not appropriate, and multivariable modelling was not performed. Analyses were therefore limited to descriptive and univariate approaches.

Ethics approval

The study has been approved by the Swiss ethics committee, as part of a larger study protocol (protocol number 2018-01851). The Institutional Review Board at Georgetown University also gave their approval for hosting the questionnaire on the local institutional REDCap software installation. The study poses minimal burden to participants, who self-administered the questionnaire voluntarily and gave online consent. Invitations to participate in the survey were distributed through department heads, and we did not have access to individual e-mail addresses. All responses were submitted anonymously via REDCap, and no personally identifying information was recorded.

Results

Demographics

Reproductive health workers

A total of 127 reproductive health workers completed the survey. Most were women and physicians, and the majority worked in the French-speaking region of Switzerland. Midwives accounted for just over one quarter of respondents, while only six nurses completed the form. Despite different scopes of practice, nurses and midwives working in the same department are likely exposed to similar reproductive and sexual health care and FGM/C-related training, so they were grouped together for analyses.

Paediatrics workers

In total, 76 paediatrics workers participated, the majority of whom were female physicians. Most worked in French-speaking hospitals. Additional demographic characteristics are shown in table 1.

Table 1: Demographic characteristics.

Characteristics		**Gynaecology-obstetrics (n = 127)**	**Paediatrics (n = 76)**
Sex, n (%)	Female	108 (85.0%)	58 (76.3%)
	Male	19 (15.0%)	18 (23.7%)
Religion, n (%)	None	56 (44.1%)	32 (42.1%)
	Christian	66 (51.9%)	39 (51.3%)
	Muslim	2 (1.6%)	0 (0%)
	Other	1 (0.8%)	1 (1.3%)
	Refused to answer	2 (1.6%)	3 (4.0%)
Professional title, n (%)	Physician	85 (66.9%)	69 (90.8%)
	Midwife	36 (28.4%)	NA
	Nurse	6 (4.7%)	7 (9.2%)
Hospital, n (%)	Lausanne	42 (33.1%)	27 (35.5%)
	Geneva	38 (29.9%)	30 (39.5%)
	Basel	19 (15.0%)	6 (7.9%)
	Zürich	17 (13.4%)	5 (6.6%)
	Bern	11 (8.6%)	8 (10.5%)
Age in years, median (IQR)		35 (31–44)	35 (30.5–42)
Working experience in years, median (IQR)		7 (4–13)	6.5 (4–12.5)

IQR: interquartile range; NA: not applicable.

Prior exposure to female genital mutilation/cutting

Reproductive health workers

Most reproductive health workers had cared for women and girls with FGM/C, with around a third having seen more than 20 cases. Despite this experience, only about half had received training, mainly via full lectures or independent reading. Familiarity with local regulations for reporting FGM/C in children was low. Nearly all reported at least some interest in learning more about FGM/C. Table 2 summarises prior exposure.

Table 2: Prior exposure to female genital mutilation/cutting.

Exposure		Gynaecology-obstetrics, n (%) (n = 127)	Paediatrics, n (%) (n = 76)
Have you ever seen a woman or girl with female mutilation/cutting in your clinical setting?	Yes	124 (97.6%)	25 (32.9%)
	No	2 (1.6%)	45 (59.2%)
	I'm not sure	1 (0.8%)	6 (7.9%)
If yes, how many patients?	<5	14 (11.0%)	13 (17.1%)
	5–20	61 (48.0%)	11 (14.5%)
	>20	49 (38.6%)	1 (1.3%)
Did you receive previous trainings about female mutilation/cutting?	Yes	65 (51.2%)	19 (25.0%)
	No	62 (48.8%)	57 (75.0%)
If yes, what kind of training did you follow?	Full class	31 (24.4%)	5 (6.6%)
	Brief mention in a class	20 (15.8%)	9 (11.8%)
	Independent article reading	28 (22.1%)	12 (15.8%)
	Trained with a specialist	23 (18.1%)	5 (6.6%)
	Other	6 (4.7%)	3 (4.0%)
Does your work setting have any written guidelines that help professionals know how to care for women/girls with female mutilation/cutting?	Yes	80 (63.0%)	13 (17.1%)
	No / I don't know	47 (37.0%)	63 (82.9%)
Have you ever read guidelines for the care of women and girls with female mutilation/cutting?	Yes	93 (73.2%)	21 (27.6%)
	No	20 (15.8%)	43 (56.6%)
	A little	14 (11.0%)	12 (15.8%)
Are you aware of the WHO Classification system for female mutilation/cutting?	Yes	112 (88.2%)	29 (38.2%)
	No	11 (8.7%)	41 (53.9%)
	I don't know	4 (3.1%)	6 (7.9%)
Are you interested in learning more about female mutilation/cutting?	Yes	106 (83.5%)	60 (79.0%)
	No	6 (4.7%)	4 (5.3%)
	A little	15 (11.8%)	12 (15.8%)
Are you familiar with local regulations about reporting of female mutilation/cutting in children?	Yes	48 (37.8%)	24 (31.6%)
	No	56 (44.1%)	39 (51.3%)
	A little	23 (18.1%)	13 (17.1%)
Has female mutilation/cutting been practiced within your family or close contacts?	Yes	5 (3.9%)	2 (2.6%)
	No	121 (95.3%)	74 (97.4%)
	I don't know / I don't want to answer	1 (0.8%)	0 (0%)

Regional comparisons of prior exposure and training among reproductive health professionals are presented in table 3. Overall, prior clinical exposure and interest in further training were high in both regions. Previous training and awareness of workplace guidelines were significantly higher in Swiss French reproductive health workers than in their Swiss German counterparts.

Table 3: Prior exposure to female genital mutilation/cutting by region.

Exposure	Reproductive health workers (n = 127)		Chi-squared p-value	Paediatrics workers (n = 76)		Chi-squared p-value
	French-speaking	German-speaking		French-speaking	German-speaking	
Total	n = 80	n = 47		n = 57	n = 19	
Prior clinical exposure to FGM/C, n (%)	78 (97.5%)	46 (97.9%)	0.89	20 (35.1%)	5 (26.3%)	0.48
Previous training on FGM/C, n (%)	47 (58.8%)	18 (38.3%)	0.026	15 (26.3%)	4 (21.1%)	0.65
Awareness of workplace guidelines, n (%)	55 (68.8%)	25 (53.2%)	0.08	13 (22.8%)	0 (0%)	NA
Interest in further training, n (%)	74 (92.5%)	47 (100%)	0.13	54 (94.7%)	18 (94.7%)	0.77

Paediatrics workers

Only a third of paediatrics workers had cared for a girl with FGM/C. Most lacked prior training, with independent learning and brief mention in a class being more common than full lectures. Nearly all expressed some interest in learning about FGM/C. Only a third were familiar with local regulations on reporting cases in children. Regional comparisons of prior exposure and training among paediatrics professionals are also presented in table 3. Prior clinical exposure, training and interest in further learning were similar across regions. The main regional difference was lower awareness of workplace guidelines among Swiss German paediatrics professionals as compared to their Swiss French colleagues.

Knowledge

Reproductive health workers

Overall, reproductive health workers knew the definition of FGM/C and its potential health consequences and answered anatomy questions adequately. The lowest scores were seen for identification of WHO FGM/C types, indication for caesarean in type 3 FGM/C, and clitoral reconstruction, with around three quarters mistakenly believing FGM/C could involve removal of the entire clitoris. Table 4 shows correct answer proportions, at the item level.

Table 4: Knowledge test about female genital mutilation/cutting.

Question		Correct answer, n (%)	
		Gynaecology-obstetrics, n = 127	Paediatrics, n = 76
Definition and types of FGM/C	What is the definition of FGM/C?	107 (84.3%)	66 (86.8%)
	Identification of FGM/C WHO type 1	86 (68.3%)	14 (18.4%)
	Identification of FGM/C WHO type 2	63 (49.6%)	7 (9.2%)
	Identification of FGM/C WHO type 3	77 (60.6%)	12 (15.8%)
	Identification of FGM/C WHO type 4	76 (59.8%)	10 (13.2%)
	FGM/C may include the removal of the entire clitoris	45 (35.4%)	7 (9.2%)
Health-seeking behaviour	Women with FGM/C may avoid coming to see some health professionals because they fear that they will be stigmatised	115 (90.6%)	73 (96.1%)
	Women with FGM/C may not know that FGM/C can cause health problems	120 (94.5%)	73 (96.1%)
	Women with FGM/C may not seek healthcare because they fear legal consequences	102 (80.9%)	66 (86.8%)
Health consequences	FGM/C type 3 may cause slowed urinary emptying	114 (89.8%)	48 (64.0%)
	FGM/C may be associated with recurrent urinary tract infections	123 (96.9%)	73 (97.3%)
	FGM/C may cause chronic pain at the site where the woman was cut	122 (96.1%)	72 (97.3%)
	FGM/C may make it difficult to perform pelvic examination, for example during labour	124 (99.2%)	NA
	Women with FGM/C may experience anxiety, depression or Post-Traumatic Stress Disorder (PTSD) related to their FGM/C	125 (99.2%)	72 (96.0%)
	Women with FGM/C may experience traumatic flashbacks to their FGM/C during genital examination	122 (96.8%)	72 (96.0%)
Defibulation (indications and consequences)	FGM/C type 3 is a sufficient indication to perform a caesarean birth	84 (66.1%)	12 (16.0%)
	After defibulation, the woman may have decreased pain with vaginal penetration	103 (81.1%)	40 (58.8%)
	Defibulation may reduce the incidence of recurrent urinary tract infections	117 (92.1%)	50 (73.5%)
	Defibulation can reduce the risks of severe vaginal lacerations during childbirth	111 (87.4%)	NA
	After defibulation, women may report faster urine flow	106 (83.5%)	48 (64.0%)
	After defibulation, women may report that the vagina feels more open	103 (81.8%)	44 (59.5%)
	Women have the right to refuse defibulation during childbirth even if the health professional thinks that the woman should be deinfibulated	106 (83.5%)	42 (56.8%)
Clitoral reconstruction	Clitoral reconstruction is a surgery that will reverse the FGM/C	75 (59.1%)	33 (43.4%)
	Clitoral reconstruction is a surgery that may decrease pain caused by scar tissue on or near the clitoris of a woman who has FGM/C	75 (59.1%)	36 (47.4%)
Knowledge of female anatomy	Identification of labium minus	126 (99.2%)	73 (96.1%)
	Identification of hymenal caruncle	125 (98.4%)	70 (92.1%)
	Identification of urethra	127 (100.0%)	73 (96.1%)
	Identification of clitoris	125 (98.4%)	69 (92.0%)
Sexual dysfunction treatments	Can FGM/C-related sexual problems be treated?	110 (86.6%)	53 (69.7%)
Knowledge of legal context	It is illegal to perform FGM/C in Switzerland	124 (97.6%)	66 (86.8%)
	It is illegal to transport a person outside Switzerland for FGM/C (vacation cutting)	111 (87.4%)	54 (71.1%)

FGM/C: female genital mutilation/cutting; NA: not applicable.

The mean knowledge score was 25.7 (SD: 4.0) out of 31 points. Physicians scored significantly higher than midwives and nurses. No differences were observed between French- and German-speaking hospitals (table 5).

Table 5: Female genital mutilation/cutting knowledge scores.

Reproductive health workers (n = 127)			**SD**	**t-test p-value**	**Paediatrics workers (n = 76)**	**SD**	**t-test p-value**
Total, n (%)		25.7 (31%)	4.0		19.5 (27%)	4.0	
By region	French-speaking, n (%)	25.8 (31%)	4.4	0.64	19.3 (27%)	3.8	0.29
	German-speaking, n (%)	25.5 (31%)	3.3		20.0 (27%)	4.7	
By professional title	Physician, n (%)	27.1 (31%)	3.1				
	Midwife/nurse , n (%)	22.9 (31%)	4.3	<0.001	NA	NA	NA
By training status	Trained, n (%)	26.8 (31%)	0.5		21.7 (27%)	0.9	
	Not trained , n (%)	24.7 (31%)	0.6	0.004	18.9 (27%)	0.6	0.02

NA: not applicable; SD: standard deviation.

Paediatrics workers

Paediatrics workers showed similar knowledge gaps to reproductive health workers, also scoring low in three additional areas: understanding defibulation, including its indications and consequences; awareness that FGM/C-related sexual issues are treatable; and knowledge of the Swiss legal context. While most participants correctly recognised that FGM/C is illegal in Switzerland, a small but meaningful proportion were unsure or believed it to be legal, with even higher uncertainty regarding vacation cutting. See table 5 for more details.

The mean knowledge score was 19.5 (SD: 4.0) out of 27 points, with no differences between German- and French-speaking hospitals. A comparison between physicians and nurses was not possible due to the absence of nurse data (none had completed the knowledge test entirely).

Attitudes

Common to both reproductive health workers and paediatrics workers

Overall, reproductive health and paediatrics workers shared similar attitudes and beliefs towards FGM/C and those who perform it (table 6).

Table 6: Female genital mutilation/cutting (FGM/C)-related attitudes and beliefs.

Attitudes and beliefs	Group	Strongly disagree	Disagree	Don't agree nor disagree	Agree	Strongly agree
Attitudes towards those who practice FGM/C, n (%)						
Parents have the right to have their daughter's genitals cut	RH	118 (92.9%)	8 (6.3%)	0 (0%)	1 (0.8%)	0 (0%)
	PED	72 (94.7%)	4 (5.3%)	0 (0%)	0 (0%)	0 (0%)
Parents who have their daughters' genitals cut should receive some punishment	RH	8 (6.3%)	10 (7.9%)	27 (21.3%)	40 (31.5%)	42 (33.1%)
	PED	4 (5.3%)	5 (6.6%)	24 (31.6%)	27 (35.5%)	16 (21.1%)
It is wrong to cut / surgically alter the genitals of any child (boy, girl or intersex)	RH[a]	14 (11.1%)	4 (3.2%)	19 (15.1%)	20 (15.9%)	69 (54.8%)
	PED	10 (13.2%)	6 (7.9%)	14 (18.4%)	13 (17.1%)	33 (43.4%)
Female mutilation/cutting is a religious practice	RH	43 (33.9%)	27 (21.3%)	32 (25.2%)	21 (16.5%)	4 (3.2%)
	PED[a]	15 (20.0%)	16 (21.3%)	23 (30.7%)	19 (25.3%)	2 (2.7%)
Communities that practice FGM/C are honouring an important cultural tradition	RH[a]	43 (34.1%)	24 (19.1%)	38 (30.2%)	20 (15.9%)	1 (0.8%)
	PED[b]	20 (38.2%)	19 (25.0%)	21 (27.6%)	6 (7.9%)	1 (1.3%)
Communities that practice FGM/C are oppressive towards women	RH[a]	1 (0.8%)	7 (5.6%)	28 (22.2%)	63 (50.0%)	27 (21.4%)
	PED	0 (0%)	1 (1.3%)	23 (30.3%)	30 (39.5%)	22 (29.0%)
The social benefits of FGM/C are more important than the health risks for some women	RH	74 (58.3%)	18 (14.2%)	16 (12.6%)	15 (11.8%)	4 (3.1%)
	PED	41 (54.0%)	13 (17.1%)	12 (15.8%)	7 (9.2%)	3 (4.0%)
Pricking (small puncture of) the clitoral hood, with a small needle, may be an alternative to more extensive FGM/C	RH	83 (65.4%)	20 (15.8%)	15 (11.8%)	4 (3.2%)	5 (3.9%)
	PED	57 (75.0%)	10 (13.2%)	6 (7.9%)	1 (1.3%)	2 (2.6%)
Attitudes and perceptions about women with FGM/C, n (%)						
Adult women should have the right to undergo FGM/C if they choose to	RH[c]	25 (20.0%)	28 (22.4%)	36 (28.8%)	29 (23.2%)	7 (5.6%)
	PED[a]	8 (10.7%)	17 (22.7%)	23 (30.7%)	20 (26.7%)	7 (9.3%)
Adult women should have the right to undergo genital cosmetic surgery	RH	2 (1.6%)	6 (4.7%)	26 (20.5%)	55 (43.3%)	38 (29.9%)
	PED[a]	1 (1.3%)	2 (2.7%)	9 (12.0%)	31 (41.3%)	32 (42.7%)
Women with FGM/C are less educated	RH	53 (41.7%)	43 (33.9%)	20 (15.8%)	10 (7.9%)	1 (0.8%)
	PED	24 (31.6%)	26 (34.2%)	17 (22.4%)	9 (11.8%)	0 (0%)
Women with FGM/C are victims	RH[a]	2 (1.6%)	6 (4.8%)	25 (19.8%)	46 (36.5%)	47 (37.3%)
	PED[a]	2 (2.7%)	0 (0%)	13 (17.3%)	32 (42.7%)	28 (37.3%)
Women with FGM/C do not frequently experience sexual pleasure	RH	8 (6.3%)	20 (15.8%)	52 (40.9%)	34 (26.8%)	13 (10.2%)
	PED	0 (0%)	2 (2.6%)	40 (52.6%)	28 (36.8%)	6 (7.9%)
FGM/C makes a woman less of a woman because her genitals have been altered	RH	82 (64.6%)	29 (22.8%)	7 (5.5%)	7 (5.5%)	2 (1.6%)
	PED	52 (68.4%)	12 (15.8%)	6 (7.9%)	5 (6.6%)	1 (1.3%)
Women with FGM/C deserve to feel that their genitals are attractive	RH	6 (4.7%)	6 (4.7%)	29 (22.8%)	56 (44.1%)	30 (23.6%)
	PED	0 (0%)	2 (2.6%)	27 (35.5%)	25 (32.9%)	22 (29.0%)
Women with FGM/C are more difficult to manage during childbirth than women without FGM/C	RH[a]	11 (8.7%)	24 (19.1%)	33 (26.2%)	52 (41.3%)	6 (4.8%)
Attitudes towards providing care for those with FGM/C, n (%)						
It is not my place to condemn FGM/C	RH	43 (33.9%)	42 (33.1%)	22 (17.3%)	15 (11.8%)	5 (3.9%)
	PED	23 (30.3%)	37 (48.7%)	6 (7.9%)	6 (7.9%)	4 (5.3%)
Health professionals should strongly condemn FGM/C when talking to patients	RH	26 (20.5%)	42 (33.1%)	30 (23.6%)	26 (20.5%)	3 (2.4%)
	PED	6 (7.9%)	20 (26.3%)	23 (30.3%)	19 (25.0%)	8 (10.5%)
It is not within my job responsibility to address FGM/C	RH[c]	72 (57.6%)	44 (35.2%)	5 (4.0%)	1 (0.8%)	3 (2.4%)
	PED[a]	38 (50.7%)	33 (44.0%)	3 (4.0%)	1 (1.3%)	0 (0%)
Women may be offended if the health professional discusses FGM/C with them	RH[a]	17 (13.5%)	45 (35.7%)	18 (14.3%)	41 (32.5%)	5 (4.0%)
	PED[a]	10 (13.3%)	23 (30.7%)	12 (16.0%)	26 (34.7%)	4 (5.3%)
During a clinical consultation, if a patient does not talk about FGM/C, the professional should not mention it either	RH	49 (38.6%)	67 (52.8%)	8 (6.3%)	2 (1.6%)	1 (0.8%)
	PED	31 (40.8%)	37 (48.7%)	7 (9.2%)	1 (1.3%)	0 (0%)
I feel distressed when I deal with a woman's or girl's experience of FGM/C	RH[c]	9 (7.2%)	48 (38.4%)	31 (24.8%)	33 (26.4%)	4 (3.2%)
	PED[a]	5 (6.7%)	15 (20.0%)	17 (22.7%)	33 (44.0%)	5 (6.7%)
It is difficult for me to hide my distress when caring for women with FGM/C	RH	32 (25.2%)	65 (51.2%)	23 (18.1%)	7 (5.5%)	0 (0%)
	PED[a]	7 (9.3%)	27 (36.0%)	29 (38.7%)	11 (14.7%)	1 (1.3%)
Health professionals who perform reinfibulation are violating their medical ethical responsibility of doing no harm	RH	14 (11.0%)	11 (8.7%)	28 (22.1%)	34 (26.8%)	40 (31.5%)
	PED[d]	5 (7.3%)	13 (18.8%)	21 (30.4%)	21 (30.4%)	9 (13.0%)
Health professionals should be able to perform reinfibulation if the woman requests it	RH	59 (46.5%)	21 (16.5%)	20 (15.8%)	14 (11.0%)	13 (10.2%)
Women who have been infibulated (FGM/C type 3) often want their scar to be re-closed	RH[d]	5 (7.3%)	13 (18.8%)	21 (30.4%)	21 (30.4%)	9 (13.0%)
It is important to include male partners in counselling for defibulation	RH	5 (3.9%)	11 (8.7%)	32 (25.2%)	46 (36.2%)	33 (26.0%)
Reinfibulation is less harmful than the original FGM/C	RH[a]	43 (34.1%)	33 (36.2%)	37 (29.4%)	11 (8.7%)	2 (1.6%)

a 1 missing; b 9 missing; c 2 missing; d 7 missing. PED: paediatrics worker; RH: reproductive health worker.

An overwhelming majority of respondents strongly disagreed that parents have the right to cut their daughters, while agreement that it is wrong to surgically alter the genitals of any child (boy, girl or intersex) was lower.

More than half of participants disagreed or strongly disagreed that performing FGM/C honours an important cultural tradition, and a similar proportion strongly disagreed that social benefits outweighed health risks for some women.

Additionally, most reproductive health and paediatrics workers agreed or strongly agreed that women with FGM/C are "victims". Most participants disagreed or strongly disagreed that women with FGM/C are less educated. Most disagreed or strongly disagreed that communities practicing FGM/C are not oppressive towards women.

Almost three quarters agreed or strongly agreed that adult women should have the right to undergo genital cosmetic surgery, but only a third believed in the right of adult women to undergo FGM/C.

Paediatrics workers were more likely to report distress when treating a patient with FGM/C and found it harder to hide this distress from patients, compared to reproductive health workers.

Reproductive health workers

Some attitude items were specific to the scope of practice of reproductive health workers. Almost half of reproductive health workers agreed or strongly agreed that women with FGM/C were more difficult to manage during childbirth. When asked about reinfibulation – defined in the survey as the "re-closure of the female mutilation/cutting type 3 scar (for example, after childbirth)" – almost half believed that women wanted their scars re-closed after childbirth and a fifth agreed or strongly agreed that they should be able to perform reinfibulation at the patient's request.

Practices

The term "consistent" practices in this paragraph refers to the combined responses of "frequently" and "always" on the Likert scale, with the percentages reflecting the total of these two categories. Table S1 in the appendix summarises the practices of reproductive health and paediatrics workers.

Reproductive health workers

Only about one fifth of reproductive health workers consistently ask all women about FGM/C, with even fewer limiting inquiries to those perceived as at risk. About half consistently recommend a genital examination when suspicion arises. When counselling women with FGM/C, workers address gynaecological health concerns more consistently than sexual and mental health issues.

Approximately one third of reproductive health professionals reported ever performing defibulation, most commonly during the second stage of labour. Routine episiotomy and postpartum repair were less frequent, and most providers offered follow-up care.

Interpreter use was generally high, but consistent interpreter use was significantly higher in French-speaking regions (95.0%) than in German-speaking regions (68.1%, $p < 0.001$).

Paediatrics workers

Only about half of paediatrics workers routinely examine female genitals during well-child visits, and fewer consistently document FGM/C status or record the WHO type. A notable proportion were uncertain about mandatory reporting to authorities.

Interpreter use was high and there was no significant difference in consistent interpreter use between Swiss German (84.2%) and Swiss French paediatrics workers (87.7%, $p = 0.70$).

Confidence

Table 7 describes confidence levels for both reproductive health and paediatrics workers. Percentages in this section refer to participants "somewhat" or "very" confident.

Table 7: Confidence levels related to female genital mutilation/cutting.

Question	Group	Not at all	Not really	Undecided	Somewhat	Very much
How confident are you that you are able to confirm if a woman has FGM/C on visual inspection of her genitalia?	RH[a]	3 (2.4%)	7 (5.7%)	13 (10.6%)	57 (46.3%)	43 (35.0%)
	PED[b]	11 (14.7%)	25 (33.3%)	18 (24.0%)	18 (24.0%)	3 (4.0%)
How confident are you that you can identify FGM/C in a paediatric patient?	RH[c]	21 (19.4%)	32 (29.6%)	31 (28.7%)	19 (17.6%)	5 (4.6%)
	PED[b]	8 (10.7%)	23 (30.7%)	13 (17.3%)	27 (36.0%)	4 (5.3%)
How confident are you that you can address the health concerns of women/girls affected by FGM/C?	RH[b]	6 (4.8%)	12 (9.5%)	19 (15.1%)	62 (49.2%)	27 (21.4%)
	PED[d]	8 (10.8%)	24 (32.4%)	13 (17.6%)	18 (24.3%)	11 (14.9%)
How confident are you that you can perform defibulation correctly?	RH[b]	45 (35.7%)	20 (15.9%)	12 (9.5%)	30 (23.8%)	19 (15.1%)
Among those who had ever seen a woman with FGM/C in their clinical setting, RH (n = 124), PED (n = 25): How confident are you that you can apply appropriate diagnosis codes (for example, ICD-10) to a patient with FGM/C?	RH[d]	24 (19.7%)	17 (13.9%)	25 (20.5%)	44 (36.1%)	12 (9.8%)
	PED	5 (20.0%)	11 (44.0%)	4 (16.0%)	5 (20.0%)	0 (0%)

a 4 missing; b 1 missing; c 19 missing; d 2 missing. FGM/C: female genital mutilation/cutting.

Reproductive health workers

A majority of reproductive health workers reported being somewhat or very confident in detecting FGM/C in adult women through visual inspection, yet only a third felt confident in identifying it in paediatric patients. A large majority was confident they could address the health concerns of patients with FGM/C. Over a third of respondents felt somewhat or very confident in performing defibulation, despite fewer than one third having prior experience with the procedure. Confidence levels were quite low for coding abilities.

Paediatrics workers

In general, paediatrics workers showed lower confidence levels than their reproductive health counterparts. Paediatrics workers were more confident in their ability to identify FGM/C visually in children compared to adult patients. However, only a third believed they could adequately address the health issues of patients with FGM/C. Confidence in coding capacities was similarly low.

Discussion

Women and girls with FGM/C living in Switzerland are entitled to high-quality care, yet, like other diaspora-hosting countries, we identified gaps in knowledge, attitudes, practices and low levels of confidence [15-17]. These gaps represent missed opportunities for appropriate support, care and prevention [6].

Interpretation of main findings

Prior exposure

Our sample of respondents was generally very exposed to women and girls with FGM/C in their clinical practice: 97.6% of reproductive health and 32.9% of paediatrics workers had already been in contact with a patient, numbers higher than a recent study in similar populations in France [15]. Despite this, only a quarter of paediatrics workers received any FGM/C training, and just 6% attended a full-class lecture, similar or slightly lower than previous paediatrician studies [17-19]. About half of reproductive health workers were trained, comparable or slightly higher than prior reports [20]. Comparisons should be cautious, as our survey included reproductive health and paediatrics professionals across disciplines (physicians, midwives, nurses), unlike multiple prior studies focusing mainly on physicians. Unlike earlier research [15, 17, 21], we did not find higher training rates among midwives, though the small number of midwife respondents limits interpretation.

Knowledge

Reflecting low formal training, notable knowledge gaps were observed, especially in clinical understanding of FGM/C types (WHO classification) and awareness of national or institutional guidelines, consistent with other studies [15, 21, 22]. Awareness of the illegality of FGM/C in Switzerland was high, but knowledge of regulations regarding vacation cutting was limited, similar to findings among UK participants who were aware that FGM/C is illegal domestically but less familiar with the Female Genital Mutilation Act's provisions covering vacation cutting [20, 22, 23]. Notably, neither

our 16-year clinical experience nor current literature documents confirmed cases of FGM/C occurring within Switzerland or during travel since the introduction of the national law prohibiting the practice in 2012 [24]. However, even in the absence of reported cases, misconceptions about the legal framework surrounding FGM/C represent critical missed opportunities for prevention, adequate parental counselling and early intervention, potentially allowing the practice to persist undetected.

In addition to these knowledge items, we explored other underexamined areas such as knowledge about defibulation and clitoral reconstruction. Paediatrics workers had very low knowledge about surgical treatments available for women and girls with FGM/C. To date, this aspect of paediatrics workers' knowledge has scarcely been studied. We believe it is necessary for paediatrics workers to be aware of existing available treatments and surgical techniques and indications to be able to inform their patients and refer them adequately [11].

Reproductive health workers had good self-reported *theoretical* knowledge of the effects of defibulation. Still, over a third believed that infibulation alone was a sufficient indication for a C-section. This suggests that many women may undergo unnecessary caesarean deliveries without discussion of the option for defibulation during pregnancy or labour, as recommended by national and international guidelines [3, 10, 25].

Among reproductive health workers who had ever performed defibulation, the majority reported doing so during the second stage of labour. This finding suggests that older protocols may still be in use and little discussion about possibilities of different timing of defibulation with patients at the beginning of their pregnancy. Current guidelines now recommend performing defibulation at any time considered most appropriate following discussion with the patient; therefore, other response options (except "on the day of consultation") were correct [25, 26]. However, if the patient opts for an intrapartum defibulation and not a second trimester procedure, defibulation is recommended during the first stage of labour to better monitor labour, have access to urinary catheterisation, operate on less swollen tissues and with adequate time [3, 25]. Our data is difficult to compare with previous studies, as clinical guidelines have changed over the past few years. For example, a knowledge, attitude and practices study conducted in London in 2013 expected professionals to perform defibulation either before pregnancy or during the second trimester only, considering defibulation during labour not ideal [21]. In addition, anaesthetists were not included in this study, although they may play an important role in shaping access to spinal anaesthesia for defibulation during the second trimester. Their perspectives, knowledge and clinical practices could act as either facilitators or barriers to the provision of this procedure.

Around 16% of reproductive health workers reported routinely performing episiotomies in infibulated women, consistent with a recent meta-analysis showing significantly higher odds of episiotomy among women with FGM/C type 3 compared to controls [27]. This unnecessary intervention reflects suboptimal care, highlighting the need for increased provider knowledge of appropriate management of FGM/C. Swiss and WHO guidelines recommend episiotomy only when clinically indicated, even in type 3 FGM/C with defibulation [25].

Both paediatrics and reproductive health workers showed limited knowledge of clitoral reconstruction, despite growing evidence of its efficacy, particularly for chronic clitoral pain [28]. This may reflect a broader lack of understanding of clitoral anatomy: 75% of reproductive health and 90% of paediatrics workers believed FGM/C could involve removal of the entire clitoris. Longstanding gender biases in Western medicine have historically hindered anatomical understanding and perpetuated misconceptions rooted in racist and misogynistic beliefs [29, 30]. Although the body, crura and bulbs of the clitoris are not removed during FGM/C [11], misconceptions regarding the complete excision of the clitoris during FGM/C may lead clinicians to overlook reconstructive options and underestimate preserved sexual function, limiting holistic discussions of sexual health, sex therapy or physiological rehabilitation.

Attitudes

Many negative attitudes and double standards regarding FGM/C persist, often reflecting discriminatory views towards women and their communities. Women and girls with FGM/C may experience intersecting forms of bias across race, gender, migration, religion and linguistic status [31].

Previous knowledge, attitude and practices studies have examined healthcare workers' attitudes, focusing on reasons for performing FGM/C, endorsement and medicalisation of the practice, and perspectives on reinfibulation [22]. In our study, we also investigated current controver-

sies, including genital cutting of boys and intersex children and cosmetic genital surgery. Despite ongoing debates on double standards and the similarities and differences between FGM/C and cosmetic genital procedures [32-34], a big portion of our sample seemed to adopt the mainstream view that an adult woman's consent is often seen as unquestionable when framed as "cosmetic surgery", but is met with suspicion when framed as "FGM/C".

Survey respondents also condemned FGM/C more strongly than the cutting of boys or intersex genitalia, highlighting a gender-based double standard in how genital cutting is judged as moral or not [35]. Finally, the failure of the majority of our sample to think of FGM/C also through a social lens, rather than solely through physical health risks, could limit culturally sensitive discussions and understandings during screening, care and prevention of FGM/C [36].

Most healthcare providers in our sample viewed women with FGM/C as "victims". Viewing and/or treating women with FGM/C as "victims" can reinforce their social stigmatisation in diaspora settings, such as Switzerland [29]. It could also reflect a perception that women with FGM/C lack agency, as evidenced by the high number of healthcare professionals (especially paediatrics workers in our sample) who did not support women's right to refuse defibulation during childbirth.

Similar to UK findings, where 18% of health professionals reported willingness to perform reinfibulation if legal [21], a small proportion of Swiss respondents were uncertain about reinfibulation. Most reproductive health and paediatrics workers opposed it, but nearly one third of reproductive health workers were neutral on whether it is less harmful than the original FGM/C. This ambiguity reflects both concern for women's wellbeing and the need for training on complex ethical and sociocultural considerations.

Practices and confidence

Health workers' confidence can reflect their ability to provide care, but it must be validated against actual practice. We observed inconsistencies between self-reported confidence and reported practices that may affect patient outcomes. Although many reproductive health specialists felt confident addressing FGM/C-related concerns, consultations primarily focused on gynaecological issues, with mental and sexual health often overlooked. This aligns with previous studies showing that reproductive health workers frequently lack sexual health training and rarely initiate such discussions, even though patients may expect them to [30].

Although most health workers had limited clinical experience with FGM/C, the majority believed they could identify affected patients through visual examination. This perception may stem from the assumption that FGM/C always produces obvious physical alterations. It may also reflect the Dunning-Kruger effect, a cognitive bias in which individuals with limited knowledge or experience overestimate their competence [37], leading clinicians to believe they can reliably identify FGM/C despite limited clinical exposure.

Similarly, over 40% of paediatrics workers felt confident identifying FGM/C in children, yet only half routinely examined genitals during well-child visits. Without regular examinations, clinicians may lack the experience to distinguish FGM/C from normal anatomical variations or conditions like lichen sclerosus or labial adhesions [38]. Given known gaps in paediatric gynaecology knowledge [11, 39, 40], clinicians unfamiliar with vulvar anatomy may over- or under-interpret FGM/C, expecting only severe forms or overlooking subtle cases, similar to challenges in child sexual abuse cases [41].

Overconfidence in visual identification may also lead to reporting in certain communities only, fostering stigma and undermining patient care.

Nearly 40% of paediatrics workers indicated they would report FGM/C in minors regardless of timing or context, raising concerns about unnecessary reporting. Under Swiss law (Article 124), FGM/C is criminalised if performed in Switzerland by a resident or abroad on a Swiss resident [42]. However, procedures carried out before migration, in the absence of ongoing risk, do not *usually* require reporting as doing so may fuel stigma and undermine trust in healthcare [43, 44]. The situation becomes more complex when FGM/C occurred pre-migration in a country where it was already illegal. In such cases, Swiss law allows for the possibility of prosecution under universal jurisdiction, a stance that differs from that of most European countries, as highlighted in the Boudry case [45]. This illustrates the legal ambiguities Swiss clinicians face and the resulting potential for inconsistent reporting. The broad application of the law, though protective, may not align with ethical or practical concerns, and universal prosecution may be inappropriate when there is no ongo-

ing risk. This mirrors concerns in Sweden, where aggressive legal measures led to invasive compulsory genital examinations, suggesting that a high-suspicion climate may lead to overreporting and marginalisation rather than effective protection [46, 47].

Over a third of reproductive health workers felt confident performing defibulation, but fewer than 30% had experience. This discrepancy suggests that self-reported confidence does not necessarily reflect actual clinical exposure, a gap partly driven by the limited identification of cases and the absence of proactive defibulation in routine practice. Currently, the procedure is often performed only upon explicit patient request, meaning it is offered to a minority of patients who truly need it. Our 16 years of clinical experience reveal critical failures in care. For example, we have managed infibulated women suffering from severe genitourinary conditions and dyspareunia who underwent multiple C-sections without ever being offered defibulation.

Furthermore, the perception that most women will request reinfibulation after childbirth may influence providers' expectations, potentially contributing to the underutilisation of defibulation services.

Finally, more than half did not consistently document FGM/C, reflecting low coding knowledge and aligning with prior Swiss hospital data [48]. Poor medical documentation limits the ability of the public health community to understand the scope and burden of FGM/C in Switzerland.

Policy recommendations

Our findings highlight the necessity of increasing training on FGM/C. On a national level, inter-regional differences should be considered. Although training should be strengthened across all of Switzerland, it should be specifically intensified in German-speaking regions, where prior training levels were significantly lower. This need is further underscored by the higher estimated indirect prevalence of women and girls living with FGM/C in this region compared with the French-speaking one. In addition, awareness of existing guidelines was particularly low in German-speaking hospitals, suggesting that either local workplace guidelines are lacking, or their dissemination and visibility are limited. This emphasises the need for all hospitals to ensure staff are familiar with both national guidelines and local protocols for the care of women and girls with FGM/C [23]. Internal protocols should be concise, regularly updated and made easily accessible for healthcare workers. At the very least, guidelines should include information about referral strategies and clinics [23].

Interest in learning more about FGM/C was similarly high in both regions, indicating that across Switzerland there is both a need and a willingness to improve knowledge and skills. Our results suggest that inter-regional differences are primarily driven by institutional factors, such as the presence of specialised consultations and robust multidisciplinary networks in the French-speaking region [12], rather than differences in individual motivation or baseline interest.

Training can take many forms, with interactive group workshops shown to be effective and well accepted [49]. Monitoring and evaluation programmes are essential to assess efficacy [50]. To reach less motivated practitioners, pre-graduate cross-disciplinary training should be included, as it is harder to mandate post-graduate programmes. Medical students have shown strong interest in learning about FGM/C too [51].

Technical training on biomedical and legal aspects remains insufficient. Since FGM/C predominantly affects women of colour and migrants, training must go beyond clinical skills to confront implicit biases, cultural assumptions, and the risk of perpetuating racial or cultural imperialism. Cultural humility and trauma-informed approaches, alongside respectful engagement with patients' values and beliefs, are essential to improve competence in transcultural care [9].

Finally, sustained improvement in knowledge likely depends on the amount of information provided [52]. Training programmes should therefore be concise, practical and tailored to each specialty and department. Table 8 summarises key gaps identified in Swiss university hospitals to guide future targeted trainings.

Table 8: Summary of identified gaps to inform targeted training programmes.

Knowledge		Attitudes	Practices	Confidence
Common to both	WHO types	Cultural sensitivity / humility; recognition of implicit biases and challenging double standards	Identification of patients with FGM/C; screening of health consequences, specifically mental and sexual	Coding capacity
Reproductive health	Surgical management of FGM/C including defibulation and clitoral reconstruction	Harm of reinfibulation	Screening of health consequences, specifically mental and sexual; reducing unnecessary routine episiotomy in infibulated women	Defibulation; identification of paediatric patients
Paediatrics	Swiss legal context including vacation cutting and reporting in children		Routine genital examination; documentation of FGM/C status in charts; reporting FGM/C to authorities when applicable (preventing under- and overreporting)	Identification of patients; addressing health concerns

Strengths and limitations

Study limitations include the small sample size likely due to the 20-minute questionnaire and the heavy workload during the COVID-19 pandemic. This may have led to self-selection bias, with participants more interested or knowledgeable about FGM/C responding more to the questionnaire, suggesting that actual knowledge gaps could be greater. The lower participation of nurses compared to physicians may be partly explained by differences in English proficiency between professional groups, as the questionnaire was only available in English. Finally, regions without university hospitals, such as Ticino, were not included, despite hosting important migrant populations from FGM/C-practicing countries.

Future studies should include paediatrics and reproductive health professionals working in other primary care centres and private surgeries who may also be "in the front-line of managing women with female genital mutilation" [23]. Future studies should also be designed with larger samples and validated scales to allow for more advanced statistical analyses, including multivariable modelling to control for potential confounders.

Strengths include use of a questionnaire with content and space validity, with item development following a thorough and strict process. Our study contributes methodologically by using a conceptually informed measure to assess knowledge, attitudes and practices, whereas most existing studies provide little or no theoretical grounding in the design of their assessment tools. To our knowledge, this is also the first study of this type to be conducted on a national level in Switzerland. Our study also contributes to the limited research specifically reporting on paediatricians, a group for which knowledge, attitude and practices data remain scarce [22]. Finally, our questionnaire was shared with teams from different countries, hopefully making our results comparable in the future.

Conclusion

Reproductive health and paediatrics professionals are on the front lines of caring for patients with FGM/C, requiring targeted training beyond mere referral strategies. Yet, as in other diaspora settings, training levels among Swiss specialised workers remain insufficient. Future programmes should aim to close knowledge gaps (e.g. vulvar and clitoral anatomy, WHO FGM/C types, surgical options and legal frameworks) and address biases. Enhanced knowledge and attitudes will hopefully lead to improved health outcomes for women and girls with FGM/C while reducing stigma and discrimination.

Data sharing statement

Deidentified data and data dictionaries may be shared with investigators upon reasonable request if they (1) have independent review committee approval, or (2) propose a meta-analysis. Data may be requested from the authors following publication. Proposals must include a data sharing agreement and be submitted within 36 months of publication. Due to lack of participant informed consent for public sharing, the dataset will not be posted in an open data repository.

Notes

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Use of AI: The authors declare that they used generative artificial intelligence (AI) solely for grammar and spelling review of this manuscript.

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Appendix

Table S1: FGM/C-related clinical practices

IDENTIFICATION OF FGM/C AND ITS COMPLICATIONS							
	Group	***Never***	***Rarely***	***Sometimes***	***Frequently***	***Always***	***Only women I consider at risk***
		N (%)	N (%)	N (%)	N (%)	N (%)	N (%)
How often do you ask women if they have experienced FGM/C?	RH	12 (9.5)	39 (31.0)	31 (24.6)	19 (15.1)	5 (4.0)	20 (15.9)
	PED[a]	37 (50.0)	16 (21.6)	5 (6.8)	5 (6.8)	0 (0)	11 (14.9)
							NA
If you suspect FGM/C in a woman/girl, do you recommend a genital examination to confirm the FGM/C?	RH	5 (3.9)	15 (11.8)	25 (19.7)	20 (22.8)	40 (31.5)	13 (10.2)
	PED	2 (2.9)	5 (7.2)	5 (7.2)	7 (10.1)	29 (42.0)	21 (30.4)
Among those who have ever cared for a woman or girl with FGM/C *RH (n=124), PED (n=25)*							
Do you screen for mental health concerns?	RH[b]	15 (12.2)	34 (27.6)	35 (28.5)	28 (22.8)	11 (8.9)	
	PED[b]	2 (8.3)	2 (8.3)	7 (29.2)	10 (41.7)	3 (12.5)	
Do you screen for gynaecological health concerns?	RH[b]**Erreur ! Signet non défini.**	6 (4.9)	9 (7.3)	22 (17.9)	49 (39.8)	37 (30.1)	
	PED[b]	1 (4.2)	0 (0)	3 (12.5)	13 (54.2)	7 (29.2)	
Do you screen for sexual health concerns?	RH[b]	8 (6.5)	16 (13.0)	29 (23.6)	42 (34.1)	28 (22.8)	
	PED[b]	1 (4.2)	2 (8.3)	4 (16.7)	12 (50.0)	5 (20.8)	
Do you provide information about sexual health?	RH	9 (7.3)	27 (21.8)	31 (25.0)	37 (29.8)	20 (16.1)	
	PED[b]	3 (12.5)	4 (16.7)	5 (20.8)	9 (37.5)	3 (12.5)	
Do you document FGM/C status in the chart?	RH[b]	7 (5.7)	13 (10.7)	21 (17.2)	34 (27.9)	47 (38.5)	
	PED[a]	4 (17.4)	4 (17.4)	4 (17.4)	3 (13.0)	8 (34.8)	
Do you document the WHO FGM/C type in the chart?	RH	13 (10.6)	17 (13.8)	14 (11.4)	34 (27.6)	45 (36.6)	
	PED[c]	8 (36.4)	6 (27.3)	2 (9.1)	0 (0)	6 (27.3)	
Do you counsel her against FGM/C for the daughter?	RH[b]	15 (12.2)	25 (20.3)	14 (11.4)	27 (22.0)	42 (34.2)	
	PED[b]	2 (8.3)	3 (12.5)	1 (4.2)	3 (12.5)	15 (62.5)	

When you identify a woman with FGM/C type 3, do you ask if the woman is satisfied with her sexual health?	RH[b] PED[b]	27 (22.0) 9 (37.5)	32 (26.0) 6 (25.0)	17 (13.8) 3 (12.5)	34 (27.6) 2 (8.3)	13 (10.6) 4 (16.7)
When you identify a woman with FGM/C type 3, do you screen for gynecological complications?	RH[a] PED[b]	12 (9.8) 6 (25.0)	13 (10.7) 4 (16.7)	27 (22.1) 3 (12.5)	42 (34.4) 6 (25.0)	28 (23.0) 5 (20.8)
When you identify a woman with FGM/C type 3, do you routinely cut an episiotomy during the second stage of labor?	RH[d]	35 (29.7)	27 (22.9)	37 (31.4)	15 (12.7)	4 (3.4)

a: 2 missing, b: 1 missing, c: 3 missing, d: 6 missing

INTERPRETER USE

	Group	***Never***	***Rarely***	***Sometimes***	***Frequently***	***Always***
How often do you use an interpreter if you and your patient do not speak the same language?	RH PED	0 (0) 0 (0)	2 (1.6) 3 (4.0)	17 (13.4) 7 (9.2)	59 (46.5) 37 (48.7)	49 (38.6) 29 (38.2)

Among those who do not always use an interpreter *RH (n=78), PED (n=47)*

	Group	***No interpreter was available***	***I do not have time to use an interpreter***	***I do not trust the quality of services***	***I do not know how to access them***	***It is too expensive***
For what reasons do you not always use an interpreter when needed	RH PED	61 (78.2) 36 (76.6)	24 (30.8) 21 (44.7)	1 (1.3) 1 (2.1)	4 (5.1) 3 (6.4)	5 (6.4) 2 (4.3)

CARE OF CHILDREN WITH FGM/C

Among those who have ever cared for patients < 18 years old *RH (n=115), PED (n=76)*

	Group	***Yes***	***No***	***NA***	***Only if I suspect FGM/C or abuse***	
Do you routinely examine the genitals of the girl child at routine well-child visits?	RH PED	2 (1.7) 38 (50.0)	23 (20.0) 15 (19.7)	78 (67.8) 14 (18.4)	12 (10.4) 9 (11.8)	
Do you routinely inspect the genitalia of the girl child for FGM/C?	RH PED	1 (0.9) 19 (25.0)	24 (20.9) 15 (19.7)	77 (67.0) 14 (18.4)	13 (11.3) 28 (36.8)	
	Group	***Never***	***Rarely***	***Sometimes***	***Frequently***	***Always***
Who do you screen for FGM/C?						
All pediatric patients	RH[e]	70 (78.7)	10 (11.2)	4 (4.5)	2 (2.3)	3 (3.4)

	PED[c]	28 (38.4)	24 (32.9)	8 (11.0)	7 (9.6)	6 (8.2)
Children from communities I consider at risk	RH[f]	50 (58.1)	8 (9.3)	8 (9.3)	12 (14.0)	8 (9.3)
	PED[b]	13 (17.3)	14 (18.7)	15 (20.0)	16 (21.3)	17 (22.7)
Infants (0-11 months)	RH[g]	67 (79.8)	5 (6.0)	5 (6.0)	3 (3.6)	4 (4.8)
	PED	22 (30.1)	12 (16.4)	10 (13.7)	11 (15.1)	18 (24.7)
Children (1-12 years)	RH[h]	63 (75.9)	9 (10.8)	3 (3.6)	3 (3.6)	5 (6.0)
	PED[i]	18 (25.0)	19 (26.4)	17 (23.6)	10 (13.9)	8 (11.1)
Adolescents (13-18 years)	RH[j]	35 (40.2)	13 (14.9)	23 (26.4)	8 (9.2)	8 (9.2)
	PED[c]	21 (28.8)	23 (31.5)	18 (24.7)	5 (6.9)	6 (8.2)
		Yes, no matter setting and timing of FGM/C	***Yes, depending on setting and timing of FGM/C***	***No***	***I don't know***	
If you were to identify a minor who had FGM/C, would you report it to the authorities?	RH[a]	27 (23.9)	36 (31.9)	7 (6.2)	43 (38.0)	
	PED	30 (39.5)	24 (31.6)	2 (2.6)	20 (26.3)	
		Yes	***No***	***NA***		
On identification of a child with FGM/C, do you ask the mother if she also has FGM/C	RH	10 (83.3)	0 (0)	2 (16.7)		
	PED	14 (100.0)	0 (0)	0 (0)		
		Yes	***No***	***I am not aware of any referral service***		
If yes, do you offer the mother referrals for FGM/C care?	RH	8 (80.0)	0 (0)	2 (20.0)		
	PED	13 (92.9)	1 (7.1)	0 (0)		

a: 2 missing, b: 1 missing, c: 3 missing, d: 6 missing, e: 26 missing, f: 29 missing, g: 31 missing, h: 32 missing, i: 4 missing, j: 28 missing

DEFIBULATION	
Among those who have ever performed defibulation *RH (n=38) PED (=0)*	
When do you perform defibulation?	
On the day of consultation	1 (2.6)
Before marriage	6 (15.8)
Before pregnancy	6 (15.8)
During pregnancy	8 (21.1)

During first stage of labour	14 (36.8)
During second stage of labour	28 (73.7)
During a cesarean birth	6 (15.8)
If you perform defibulation during labor, to what extent do you repair the defibulation postpartum?[b]	
I re-close completely	0 (0)
I re-close to the level of the urinary meatus	1 (2.7)
I re-close however patient requests	1 (2.7)
I do not re-close	33 (89.2)
I do not perform defibulation during labour	2 (5.4)
Did you provide follow-up support after defibulation?	
Yes	33 (86.8)
No	5 (13.2)
If yes, what follow-up support did you provide?	
Pelvic floor therapy	12 (36.4)
Counselling	22 (66.7)
Follow-up visit	29 (87.9)
If no, for what reasons did you not provide any follow-up support after defibulation?	
There was none available	2 (40.0)
I did not know it was needed or indicated	1 (20.0)
I do not trust referral professionals	0 (0)
Other	1 (20.0)

b: 1 missing