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par

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MUTILATIONS GÉNITALES FAITES AUX FEMMES : CONNAISSANCES, ATTITUDES ET PRATIQUES DES SOIGNANTS EN PREMIÈRE LIGNE, UNE ENQUÊTE NATIONALE.

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SERMENT D'HIPPOCRATE

En présence des enseignants et enseignantes
de cette Faculté,
de mes chers condisciples
et selon la tradition d'Hippocrate,
je promets et je jure d'être fidèle aux lois de l'honneur
et de la probité dans l'exercice de la Médecine.

Je donnerai mes soins gratuits aux indigents,
et n'exigerai jamais un salaire au-dessus de mon travail.

Admis(e) dans l'intérieur des maisons, mes yeux
ne verront pas ce qui s'y passe, ma langue taira
les secrets qui me seront confiés et mon état ne servira pas
à corrompre les mœurs ni à favoriser le crime.

Respectueux(euse) et reconnaissant(e) envers mes Maîtres,
je rendrai à leurs enfants
l'instruction que j'ai reçue de leurs parents.

Que les hommes et les femmes m'accordent leur estime
si je suis fidèle à mes promesses.
Que je sois couvert(e) d'opprobre
et méprisé(e) de mes confrères et consœurs
si j'y manque.

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Mutilations génitales faites aux femmes : connaissances, attitudes et pratiques des soignants en première ligne, une enquête nationale.

Introduction
Les mutilations génitales féminines (MGF) sont une pratique traditionnelle répandue. Plus de 200 millions de femmes seraient concernées actuellement dans le monde. En France, les MGF touchent des femmes migrantes ainsi que des femmes nées en France de parents originaires de pays où se pratiquent les MGF. Les gynécologues-obstétriciens (OB/GYN), sages-femmes (SF) et infectiologues rencontrent au quotidien des femmes potentiellement concernées. Avec cette enquête, nous avons souhaité évaluer les connaissances, attitudes et pratiques de ces soignants au sujet des MGF.
Matériels et méthodes
Le questionnaire élaboré par une équipe multidisciplinaire internationale comportait 30 questions divisées en 5 sections : données sociodémographiques, pratiques professionnelles, connaissances, attitude, formations. Il a été diffusé via Limesurvey de septembre 2021 à mars 2022. Tous les questionnaires complétés, même partiellement, ont été inclus dans l'analyse.
Résultats
Nous avons inclus 1142 questionnaires dont 963 étaient complets. Parmi les enquêtés, on décompte principalement des infectiologues (203; 18%), des OB/GYN (336;29%) et des SF (292; 26%).
Concernant les pratiques et attitudes, plus de la moitié des soignants (54%; 592) avait déjà accompagné une femme ayant vécu une MGF. Soixante-trois pourcent (63% ; 613) des soignants interrogés abordaient la question des MGF en consultation. Parmi ces derniers, 47% (n=286) avaient reçu une formation initiale contre 32% (110) de ceux qui ne l'abordaient pas. Lorsqu'ils évoquent le sujet, les enquêtés déclarent poser le cadre juridique (36% ; 220) et référer la patiente lorsque cela est nécessaire (44%; 250). *Au sujet des connaissances*, avoir reçu une formation au sujet des MGF dans son cursus initial, être un praticien expérimenté et être confiant dans ses compétences sont des facteurs significativement associés à de meilleures connaissances théoriques. *Concernant la formations*, 41% (446) des enquêtés déclarent avoir été formés dans leur cursus initial. Les SF ont reçu une meilleure formation que les autres spécialités (66%; 180, p< 0,001).
Conclusion
Le principal défi pour les soignants est probablement d'ouvrir le dialogue au sujet des MGF afin d'orienter au mieux les femmes concernées vers un parcours de soins adaptés. Dans cette étude, les soignants les plus confiants, les plus expérimentés et les mieux formés abordent plus souvent la question que les autres. Ces résultats nous invitent à concevoir une formation ciblée auprès des soignants en première ligne, portant notamment sur les aspects relationnels de la prise en soin des personnes.

Mots clés : Mutilations génitales féminines, réinfibulation, santé de la femme, pratiques professionnelles, formation professionnelle, soignants

Female genital mutilation/cutting: knowledge, attitudes and practices of front-line caregivers, a national survey.

Background
Female genital mutilation (FGM/C) is a widespread traditional practice. More than 200 million women are currently affected worldwide. In France, FGM/C affects migrant women and women born in France to parents from FGM/C practicing countries. Gynecologists and obstetricians (OB/GYNs), midwives and infectious diseases (ID) specialists meet affected women in their daily practice. With this survey, we aimed to assess the knowledge, attitudes and practices of these front-line caregivers regarding FGM/C
Materials
The questionnaire, designed by an international multidisciplinary team, included 30 questions divided into 5 sections (demographics, practices, knowledge, attitude and training). It was disseminated via Limesurvey from September 2021 to March 2022. All questionnaires completed, even partially, were included in the analysis.
Results
We included 1,142 questionnaires, of which 963 were completed. The respondents were mainly ID specialists (203; 18%), OB/GYNs (336; 29%) and midwives (292;26%).
Regarding practices and attitudes, more than half of the caregivers (54%; 592) had already cared for a woman who had undergone FGM/C. Sixty-three percent (63%; 613) of the caregivers surveyed raised the issue of FGM/C during consultation. Among them, 47% (n=286) had received initial training, compared with 32% (110) of those who do not approach the subject. When they raised the subject, the respondents often used the legal framework (36%; 220) and referred the patient when needed (44%; 250). *In terms of knowledge*, having received undergraduate training on the subject of FGM/C, being an experienced practitioner and being confident in their skills are factors significantly associated with better theoretical knowledge. *Regarding training*, 41% (446) of the caregivers had been trained during their medical studies. Midwives were better trained than other specialties (66%; 180, $p< 0.001$).
Conclusion
The main challenge for health-care providers is probably to raise the issue of FGM/C with the aim of meeting women's needs and to direct them to a tailored healthcare pathway. In this study, the most confident, experienced and well-trained caregivers raised the issue more often than others. These results highlight the need for targeted training for the caregivers concerned, with a special focus on the relational aspects of care.

Keywords: Female Genital Mutilation/Cutting, reinfibulation, Women's health, Healthcare professional practices, Healthcare professional training, Healthcare providers

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Female Genital Mutilation/Cutting: Knowledge, Attitudes and Practices of Front-Line Caregivers, a National Survey.

Female Genital Mutilation/Cutting: Knowledge, Attitudes and Practices of Front-Line Caregivers, a National Survey.

Abstract

Background

Female genital mutilation (FGM/C) is a widespread traditional practice. More than 200 million women are currently affected worldwide. In France, FGM/C affects migrant women and women born in France to parents from FGM/C practicing countries. Gynecologists and obstetricians (OB/GYNs), midwives and infectious diseases (ID) specialists meet affected women in their daily practice. With this survey, we aimed to assess the knowledge, attitudes and practices of these front-line caregivers regarding FGM/C.

Materials

The questionnaire, designed by an international multidisciplinary team, included 30 questions divided into 5 sections (demographics, practices, knowledge, attitude and training). It was disseminated via Limesurvey from September 2021 to March 2022. All questionnaires completed, even partially, were included in the analysis.

Results

We included 1,142 questionnaires, of which 963 were completed. The respondents were mainly ID specialists (203; 18%), OB/GYNs (336; 29%) and midwives (292; 26%). *Regarding practices and attitudes*, more than half of the caregivers (54%; 592) had already cared for a woman who had undergone FGM/C. Sixty-three percent (63%; 613) of the caregivers surveyed raised the issue of FGM/C during consultation. Among them, 47% (n=286) had received initial training, compared with 32% (110) of those who do not approach the subject. When they raised the subject, the respondents often used the legal framework (36%; 220) and referred the patient when needed (44%; 250). *In terms of knowledge*, having received undergraduate training on the subject of FGM/C, being an experienced practitioner and being confident in their skills are factors significantly associated with better theoretical knowledge. *Regarding training*, 41% (446) of the caregivers had been trained during their medical studies. Midwives were better trained than other specialties (66%; 180, p< 0.001).

Conclusion

The main challenge for health-care providers is probably to raise the issue of FGM/C with the aim of meeting women's needs and to direct them to a tailored healthcare pathway. In this study, the most confident, experienced and well-trained caregivers raised the issue more often than others. These results highlight the need for targeted training for the caregivers concerned, with a special focus on the relational aspects of care.

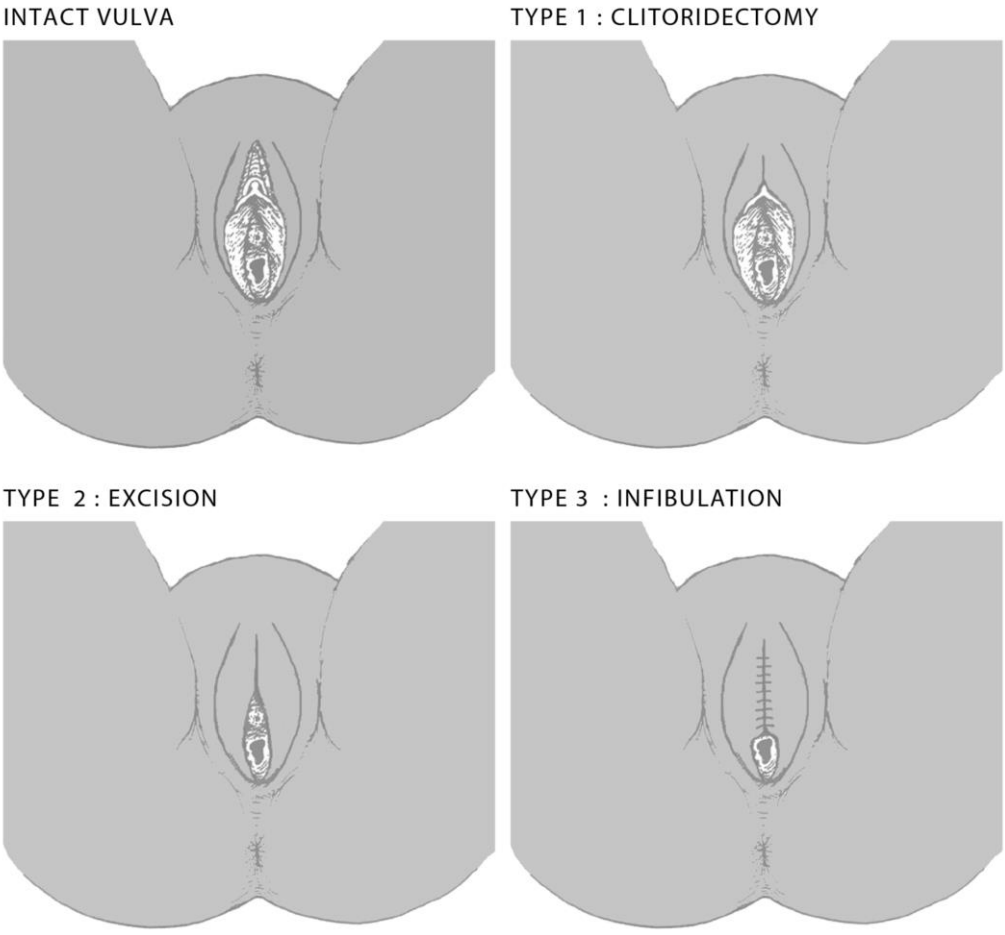
Introduction

Sexual and gender-based violence is a major public health issue. It is associated with multiple physical injuries, mental illness and compromises health in its holistic sense. According to the recent World Health Organization (WHO) report, more than 30% of women aged 15 years and older have been subjected to physical and/or sexual violence at least once in their lifetime (1). Eliminating gender-based violence is thus a universal priority and gender equality is one of the UNHCR's Sustainable Development Goals in the 2030 Agenda (2). Caregivers are well positioned to identify this type of violence especially during consultations that women attend alone (3). Unfortunately, these acts of violence are often under-detected by healthcare providers. Several obstacles have been identified: limited time during consultations to address this sensitive issue, lack of provider knowledge and education, inadequate support staff to give appropriate care to women and scarcity of available referral services. In addition, the provider's discomfort discussing the topic of violence and the fear of offending

care seekers may play a role as personal barriers: they may think that it is not their role to screen for violence during a medical follow-up (4–7).

Female genital mutilation/cutting (FGM/C) falls within the scope of gender-based violence. Due to migration flows and globalization, women affected by FGM/C live all over the world. Regardless of their specialties, caregivers are frequently in contact with these women. This cultural practice is deeply rooted in gender inequality and discrimination against women. Worldwide, FGM/C constitutes a fundamental violation of human rights of girls and women. According to the WHO, "Female genital mutilation encompasses all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons" (8). FGM/C is classified into 4 major types (described in Figure 1) (8).

Figure 1: Types of Female Genital Mutilation/Cutting



Source: milleparcours.org

Type I	This is the partial or total removal of the clitoral glans, and/or the prepuce/clitoral hood
Type II	This is the partial or total removal of the clitoral glans and the labia minora, with or without removal of the labia majora
Type III	Called "infibulation", this is the narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the labia minora, or labia majora, sometimes through stitching, with or without removal of the clitoral prepuce/clitoral hood and glans.
Type IV	All other harmful procedures to the female genitalia for non-medical purposes, *e.g.*, pricking, piercing, incising, scraping and cauterizing the genital area.

FGM/C mainly affects girls between the ages of 0 and 15 years. Although FGM/C is usually performed by traditional excisors, there is a tendency to medicalize the practice. This custom is a deeply ingrained cultural practice, the social norm and societal pressure are factors that enable its continuation (8–10). FGM/C is performed for several reasons, including rite of passage into womanhood, evidence of purity, marriageability, and way to control women sexuality (8–11). Finally, many women report that they consider it as a religious requirement (10,11).

Beyond the moral and cultural reasons for the practice, a number of factual aspects associated with FGM/C have been identified. A lower level of parental education, family history of FGM/C and low income increases the likelihood of being excised. However, living in an urban region, women's FGM/C literacy, and low community FGM/C prevalence are associated with a reduced likelihood of FGM/C (10–13).

Despite the fact that performing FGM/C is widely banned by law even in countries where the practice is prevalent (10–14) this issue remains a hot topic. Before 2019, the WHO estimated that more than 200 million girls and women had undergone FGM/C and during the COVID-19 pandemic, there was a worrying signal suggesting that FGM/C cases were increasing in countries where the practice is prevalent (15,16). This custom is spread across East and West Africa, in areas of the Middle East such as Iraq and Yemen and in some Asian countries such as Indonesia. With wide variations in prevalence, cases have been described in other ethnic groups in Malaysia, India, Israel, Colombia, the United Arab Emirates, Oman, and Saudi Arabia (9,17).

Existing research suggests that this practice is declining along with immigration (18,19). By migrating, many women who have themselves suffered from FGM/C have the opportunity to protect their own daughters. Every year, approximately 20,000 women and girls seek asylum from FGM-practicing countries of origin in the EU (20). In France, as in most hosting countries, very few cases of FGM/C occur (21). A recent national study estimated that 124,355 FGM/C affected women were living in France in the 2010's, making France the second most concerned country in the EU after the UK (22). However, the number of girls at risk remains difficult to evaluate (8,10). In France, FGM/C affected women come mainly from Guinea, Senegal, Côte d'Ivoire, Cameroon and Mali (22). The prevalence of these women is heterogeneous across the country and reaches 7.2 % in the Paris area (22,23).

All forms of FGM/C can be associated with short-term complications such as severe pain, hemorrhage by laceration to pudendal and/or clitoral arteries, sepsis due to non-sterile procedures, urinary problems, delayed wound healing and death (24). In a recent study, the authors estimated that 44,320 girls die each year due to FGM/C, making this practice one of the leading causes of death among girls and young women in countries where it is performed (25). FGM/C is also responsible for chronic complications including chronic pain, genitourinary problems, reproductive tract and genital infections, infertility and HIV (24). Type III FGM/C (and Type II in some cases) is associated with obstetric complications such as prolonged labor, caesarian section, postpartum hemorrhage and increased risk of childbirth issues (26). Mental health diseases may also occur. Depression, somatization, anxiety, Post-Traumatic Stress Disorder (PTSD) and sleep disorder are the main issues. Finally, FGM/C may also lead to sexological disorders including painful intercourse, lack of sexual satisfaction or desire and difficulties in lubrication (24,27).

Beyond the physical and psychological complications, well-being is frequently affected. A recent study explored the psychosocial well-being of cut women in high income countries (28). The available evidence shows that women are likely to feel stigmatized and shameful. This sense of difference may affect girls' socialization and their relationship with their peers. Moreover, immigrant families and mothers in particular may feel anxiety due to pressure from family members in their home country regarding female circumcision of the daughters. They fear that uncut girls would be rejected by the community when returning home.

Beyond these observations, we should note that some women report no complications and do not require any support from the healthcare providers.

Caregivers are often on the front line of the therapeutic management of complications, but also from a preventive medicine and global health perspective. Healthcare providers working in maternity health services

are on the front line for the detection of FGM/C related problems. Gynecological and pregnancy follow-up may be an opportunity to tackle the subject. Obstetricians and gynecologists (OB/GYN) and midwives may be involved in pain management, deinfibulation, episiotomy and cesarean birth (29). From a risk prevention perspective, we believe that traveler's consultations could be the right place to discuss the question and to detect children at risk. FGM/C rarely occurs in the hosting countries, but it may happen when families come back to their home country during holidays. In 2015, a French survey was conducted among 112 physicians including 52 travel specialists. Forty-three percent (43%) of them reported having been confronted with a situation of FGM/C or at risk of FGM/C for a child. However only half had already discussed FGM/C with patients and a third declared they examine children traveling to high-risk countries (30). Infectious diseases (ID) specialists who are the main ones to work in traveler's consultations in France are frequently in contact with migrants for screening purposes or tropical diseases. From this standpoint, we believe that ID specialists have a decisive role to play in the field of FGM/C (31).

Missed opportunities to diagnose FGM/C and to help women living with a FGM/C seem to be frequent, probably due to lack of training, confidence and competence of the professionals (32,33). Detecting women who may have undergone FGM/C opens up a space for dialogue to identify disorders and specify support needs. It helps to direct women who so wish towards specific and multidisciplinary global support, based on the identified needs. Reconstructive surgery is sometimes proposed (34). Finally, offering the best possible care to women who have undergone FGM/C is probably a means of preventing FGM/C in their daughters. The healthcare system in France is publicly funded, universal and supports all these services. Detecting cases at risk of excision and FGM/C affected women is therefore a real challenge for care providers (35).

In France, research into FGM/C and the knowledge and skills of professionals regarding this topic is scarce. As far as we know, only one previous study explored knowledge, attitude and practice (KAP)-related FGM/C in France (30). To fill this gap, we designed a survey supported by the GENDERNET-Plus consortium. GENDERNET-Plus is a European research network which aims to promote the integration of sex and gender analysis into research. RHCforFGC "Sharing Actions and Strategies for Respectful and Equitable Health Care for Women with FGM/C" belongs to GENDERNET Plus consortium. Focusing on the FGM/C issue, this program involved six teams based in migrant-hosting countries (France, Belgium, Canada, Spain, Switzerland and Sweden). The ambition was to cross-fertilize experiences and knowledge from the group's experts in order to improve FGM/C prevention and to better care for girls and women at risk of or affected by FMG/C. One of the objectives of this transnational collaboration was to assess KAP of healthcare workers with a special focus on attitudes and practices.

Thanks to this cross-sectional descriptive study, we aimed to assess the degree of knowledge, attitudes and practices of women's healthcare professionals working in clinics that at-risk women may attend. This survey was conducted both in France and Belgium. In France, we focused our survey on OB/GYN, midwives and ID specialists. The primary outcome of this study was to describe the FGM/C related KAP of caregivers concerned. The secondary outcome was to identify training gaps in order to determine the key elements to be integrated into future training for caregivers.

Materials and methods

Questionnaire

A self-administered online survey was designed to explore knowledge, attitudes and practices, and to identify training needs across France and Belgium (questionnaire in appendix). The questionnaire was developed by researchers from different fields: anthropology, demography, nursing, public health, infectious diseases, gynecology-obstetrics and maieutics. They summarized existing FGM/C KAP-related questionnaires and integrated results from previously conducted focus group analyses. The survey was pre-tested both in France and Belgium. It comprised 30 mandatory questions divided into 5 sections: sociodemographic data (age, gender, profession, specialty, place of work), professional experience (number of followed up FGM/C affected women

in the last 12 months), attitude toward women from countries where FGM/C is performed, training resources and needs, clinical and theoretical knowledge (FGM/C types based on WHO classification, number of women living with FGM/C today in France).

We used respondents' answers to the items above to create a theoretical knowledge score out of 3. FGM/C classification weighted for 2 (0.5 points attributed to each type named correctly), and FGM/C prevalence weighted for 1. We also evaluated perceived self-efficacy with two questions: Do you feel comfortable to recognize the different FGM/C types on clinical examination? How do you rate your skill level regarding FGM/C? Most of the questions were multiple choice and few of them were open ended. It took approximately fifteen minutes to complete the entire survey.

Distribution

Available on Limesurvey from September 2021 to March 2022, the questionnaire was distributed across the country through academic mailing lists and professional organizations. ID specialists, including medical doctors and residents, were approached through the French College of infectious diseases specialists, the pediatrician expert group in tropical medicine (Groupe de Pédiatrie Tropicale) and the learned society of travel medicine and international medicine (Société Francophone de Médecine Tropicale et de Santé Internationale). Both students and graduate professionals in midwifery, obstetrics and gynecology were contacted through the French College of Obstetricians/Gynecologists, the national mailing list of OB/GYN residents and local perinatal networks. A short educational slide presentation was available after completing the questionnaire (available in appendix).

Analyses

We identified several outcome variables: theoretical knowledge score as defined above, addressing or not the issue of FGM/C during consultations and exposure to training materials. The main explanatory variables were provider professions, providers' ages, medical status (resident /medical doctor), provider's initial training and perceived self-efficacy. Among the respondents, we defined an expert sub group as the sample of providers who cared for 6 FGM/C affected women or more during the past year and the self-confident respondents who estimated their skills as good or very good. Other variables included in the analysis were the provider's experience defined as number of followed-up FGM/C affected women over the last 12 months, the manner in which FGM/C topic is approached in consultation, gender, location of practice and practice setting.

The study was an online volunteer survey and a nominal ratio of the professionals surveyed was not available, therefore we used a non-probabilistic sampling procedure. All questionnaires were included as soon as the second survey question had been completed. No items were eliminated due to omission. Duplicates were identified using IP addresses and were not included in the analysis. For continuous variables, we used the mean and the median, categorical variables were described by the number of subjects and their percentage. For categorical variables, we used a Chi Square test with Fisher correction when necessary. To perform knowledge score comparisons, we used a Mann-Whitney test, a Krusskal Wallis and ANOVA test when appropriate. The threshold of statistical significance was 5%. All analyses were conducted using *pvalue.io*[1]. The map of France was created using the Free and Open Source QGIS.

Ethics

This research project was approved by the Human Research Ethics Committee of the University Hospital of Tours (project no. 2021 037). Informed consent was obtained from all study participants and no intervention was performed on them. To ensure the confidentiality and privacy of study participants in compliance with EU ethics guidelines, respondents could not be identified after data retrieval.

[1] Medistica., *pvalue.io, a graphic user interface to the R statistical analysis software for scientific medical publications.*, 2019-22. Available on: https://www.pvalue.io.

Results

Demographics

Among the solicited participants, 1,142 began the survey and 963 completed it entirely. All were included in the analysis. The demographics are detailed in Table 1. Most of the ID specialists worked in their hospital's infectious diseases department (85%, n= 173/203). Among ID specialists, 12% (n=24) worked in traveler consultation, 10% (n= 20) worked in CeGIDDs (sexually transmitted infections prevention center) and family planning clinic. Both OB/GYN and midwives practiced mainly in delivery rooms (64%, n= 214/336; 62%, n=180/292) and in postpartum care (34%, n=115; 54%, n= 158). Twenty eight percent (28%; n=95) of OB/GYN and 22% (n=63) of midwives worked in antenatal consultations. Approximately one tenth of OB/GYN and midwives had a private practice (10%, n=32; 13%, n=39). Forty-four percent (44%, n=147) of OB/GYN had a surgical practice (data shown in Figure 2).

Regarding geographical origin, the respondents came mostly from Pays-de-la-Loire (33%, n= 363/1103) and from the Paris area (Ile de France) (29%, n= 318). (Data shown in Figure 3).

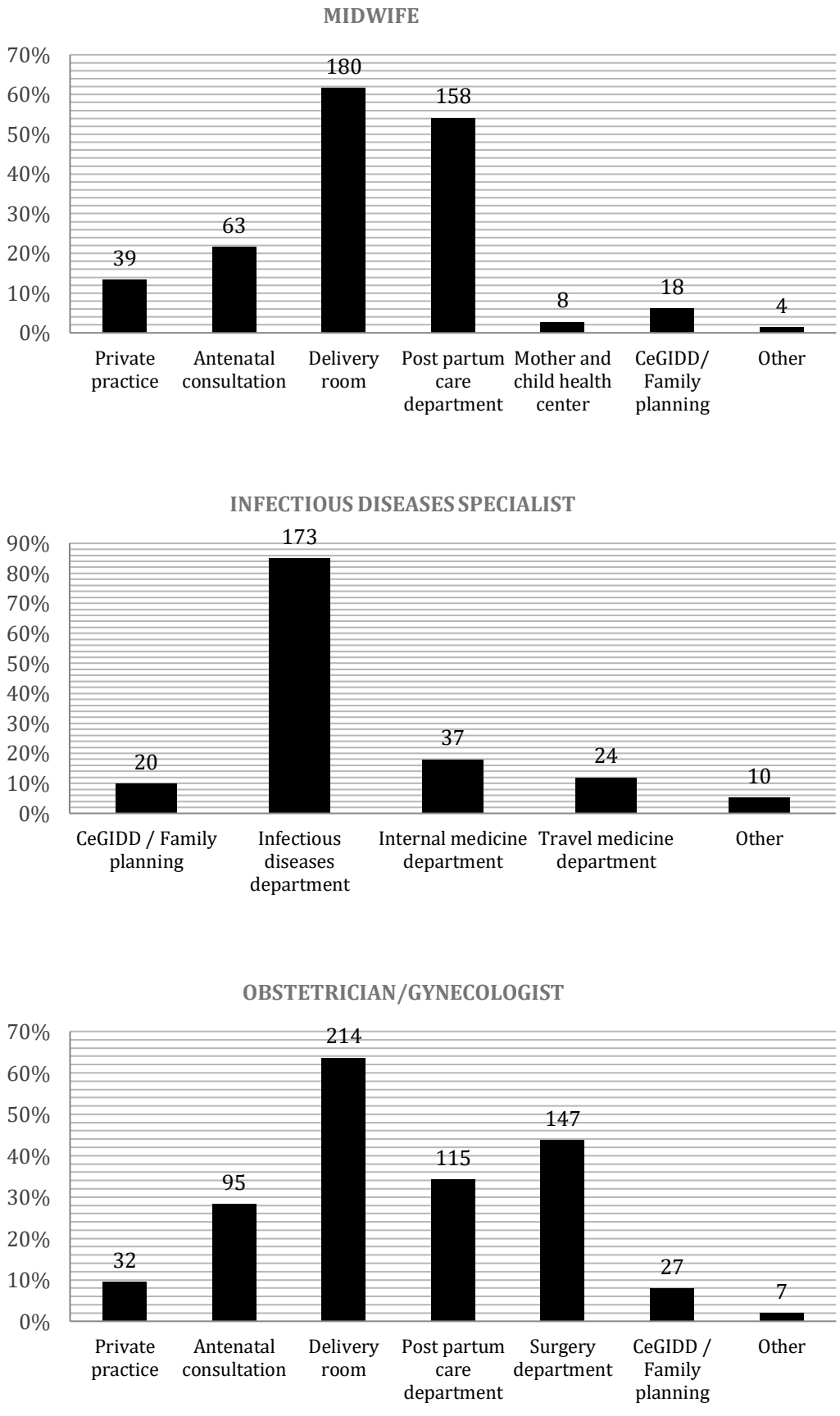
Table 1. Sociodemographic characteristics of survey participants

Characteristics of participants	Population n (%)
Gender n (%)	
Women	879 (78,1)
Men	245 (21,8)
Others	1 (0,089)
Age n (%)	
20 - 39 years old	673 (59,8)
40 - 54 years old	269 (23,9)
> 55 years old	183 (16,3)
Profession n (%)	
Infectious disease specialists	203 (17,8)
Obstetrician/Gynecologists	336 (29,4)
Midwives	292 (25,6)
Pediatricians	85 (7,4)
Nurses	45 (3,9)
General practitioners	92 (8,1)
Medical doctors (other specialties)*	63 (5,5)
Other professions**	26 (2,3)
Status n (%)	
Residents	203 (26,5)
Medical doctors	563 (73,5)

* "Medical doctors (other specialties)" included psychiatrists, neurologists, emergency physicians, public health doctors, anesthesiologists, pathologists, biologists, hematologists, occupational physicians, nephrologists.

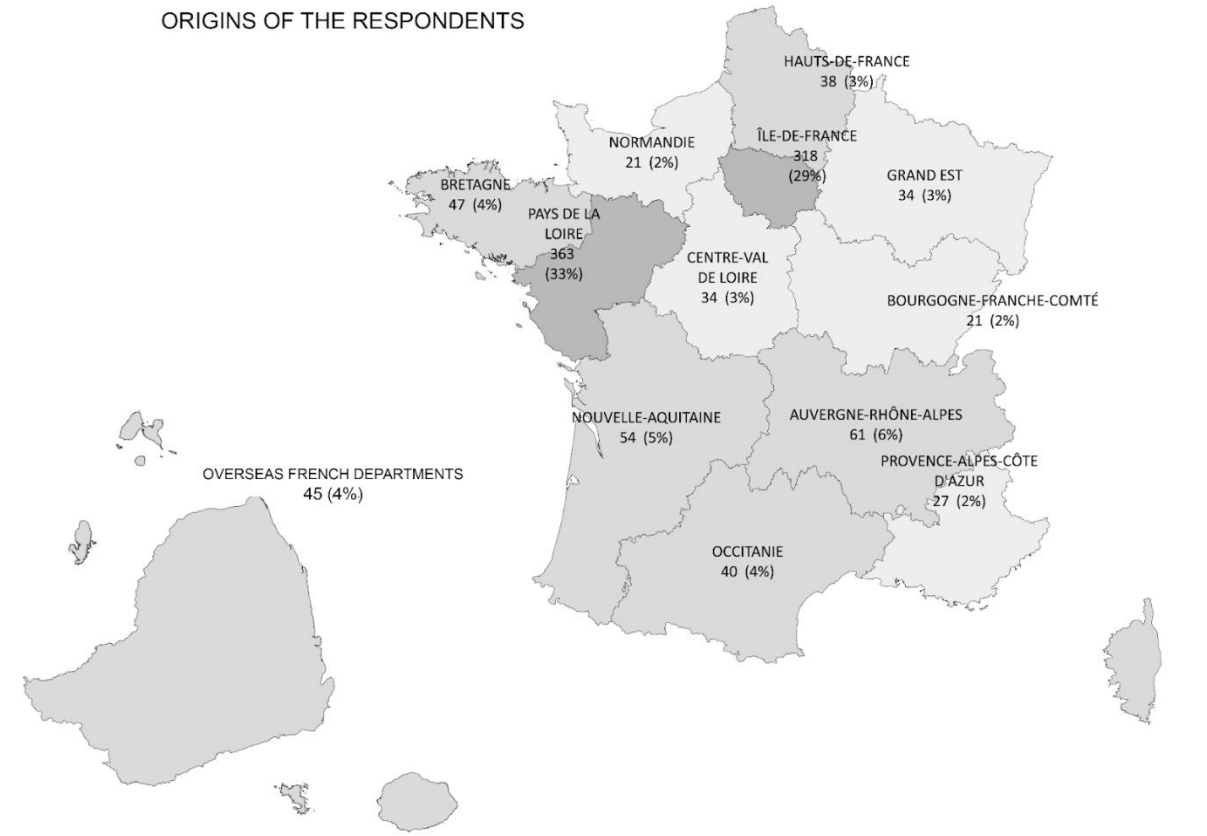
**"Other professions" included social workers, health mediators, psychologists, medical secretaries, one hospital director, sexologists and lawyers.

Figure 2: Distribution of Facility Structures



"Others" refers to asylum seeker centers, Tuberculosis centers (Centre de Lutte contre la Tuberculose), free medical centers (Permanence d'Accès Aux Soins de Santé), centers for social actions (Centre Communal d'Action Sociale), NGO and other non-profit organizations.

Figure 3: Geographical origins of the respondents



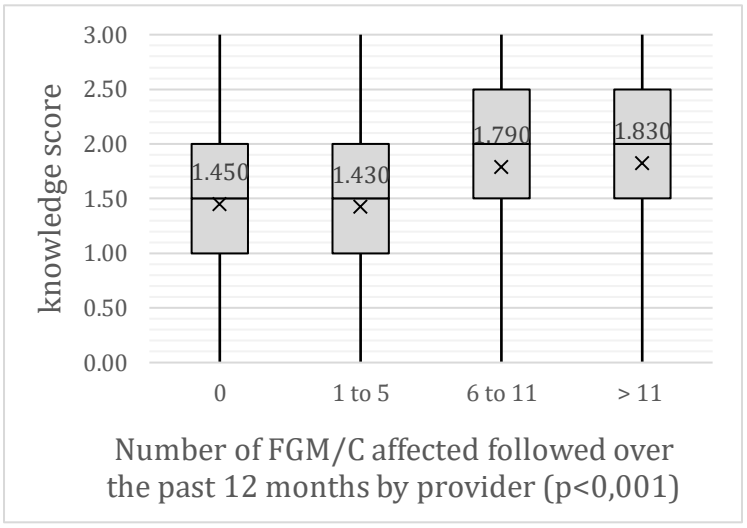
Knowledge

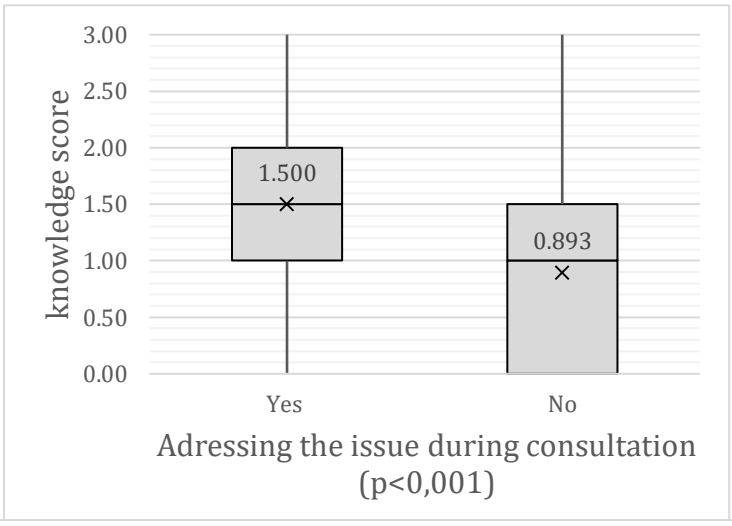
Regarding subjective clinical knowledge, 39% (n=354/909) of respondents felt confident in their ability to identify correctly the different types of FGM/C, among them, 61% (n= 169/275) of OB/GYN and 51% (n=119/234) of midwives felt confident.

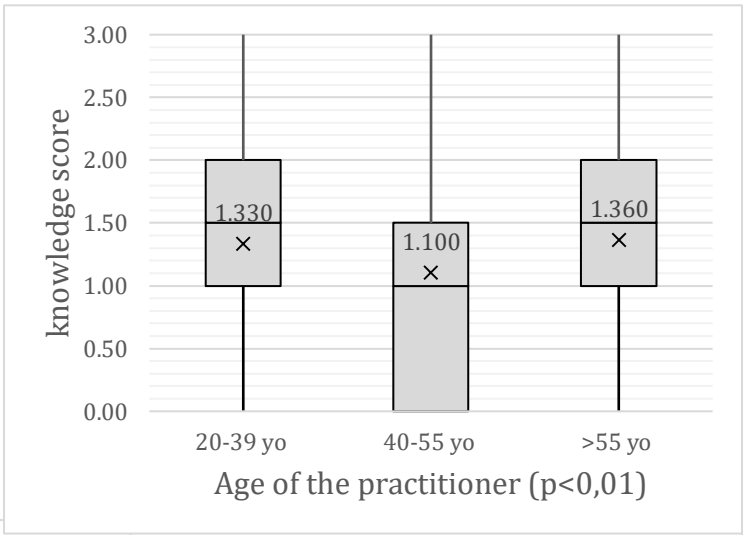
We evaluated theoretical knowledge thanks to a score out of 3 (Data shown in Figure 4). In response to the question on prevalence of FGM/C in France, 30% (n= 285/965) of providers were able to answer correctly, 25% (n=237) underestimated the prevalence, 19% (n=185) overestimated the prevalence and 28% (n=258) reported they did not know the answer. Among the respondents, 16 % (n=149/912) could correctly name the 4 types of FGM/C as defined by the WHO. We did not find any difference in clinical and theoretical knowledge between males and females.

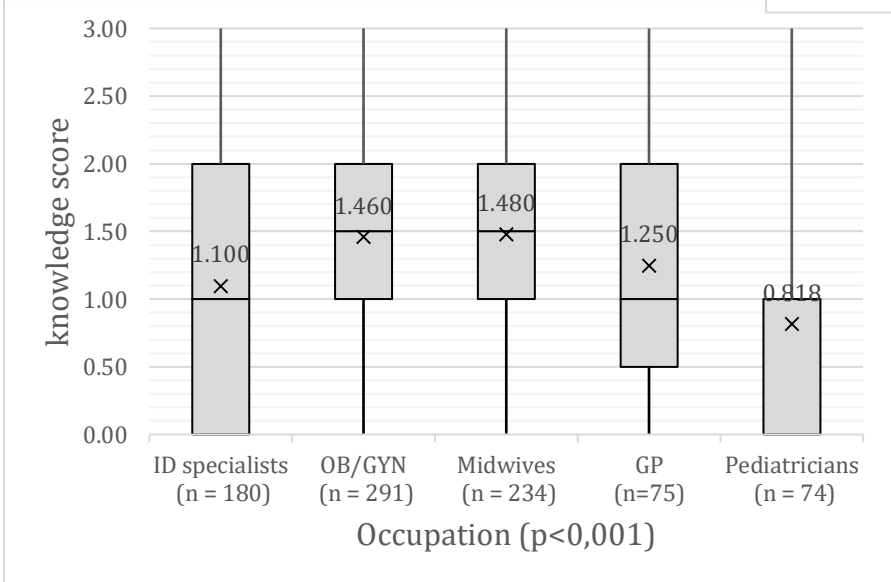
With respect to the risk factors of being mutilated during a journey, to the question: “which risk factors to identify during a consultation with a girl and her parents?” 88% (n=112/128) of the most experienced providers (as previously defined) and 86% (n= 96/111) of self-confident providers answered first the item “The fact that the mother or the sisters have had a FGM/C”. The second risk factor identified was the prevalence of FGM/C in the country of origin, 82% (n=105) of experienced providers answered this item while 86% (n= 96) of self-confident providers did.

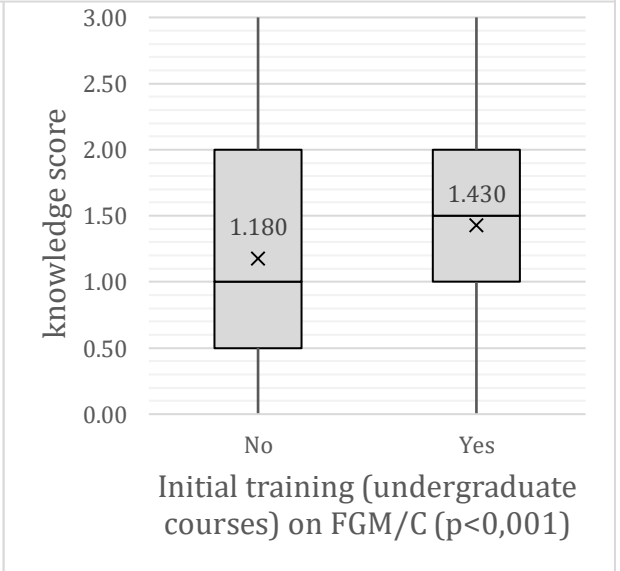
Figure 4: Objective knowledge score by experience, self-confidence, initial training, profession and age *(Score out of 3)*











FGM/C: Female Genital Mutilation/Cutting, OB/GYN: Obstetricians and Gynecologists, ID specialists: Infectious Disease specialists, GPs: General Practitioners

Practices

Of 1,093 respondents, 54% (n=592) had previously cared for a woman affected by a FGM/C. Approximately one quarter of them (24%, n=141/592) had cared for 6 or more women affected by a FGM/C in the past year (details shown in the appendix Figure A). Midwives were the most experienced providers, 78% of them (n= 213/274) had previously cared for a woman affected by a FGM/C (data shown in the appendix Figure B). Only 20% (n=224/1094) of the healthcare providers had previously cared for a girl at risk of FGM/C, and 16% of the respondents (n= 170), including pediatricians, did not know if they had ever met a girl at risk of being mutilated.

Sixteen percent (16%, n=94/577) of OB/GYN and midwives in our population had previously been asked to perform reinfibulation, a practice which consists in re-suturing completely or partially the vulva after defibulation for delivery or related to gynecological procedures. Very few caregivers had been asked to perform an excision (0.7%, n= 4/577). These items were limited to obstetric providers and midwives for whom these procedures are in their field of practice.

Attitudes toward Patients

Among all respondents, 63 % (n= 613/967) declared they address the issue of FGM/C during consultations. This rate reached 95% among the most experienced practitioners (who had seen 6 or more FGM/C affected women during the past 12 months) (n= 122/128). Among ID specialists, those working in tropical and travel medicine sectors were not more likely to raise the issue than the others.

Regardless of discipline, 88% (n= 307/349) of the providers who did not address the issue during a consultation consider themselves as under-qualified (feeling like having an insufficient or very insufficient skills level); on the contrary, providers who addressed the issue of FGM/C were less often feeling unconfident regarding FGM/C issue (50% n= 304/613)

Forty-seven percent (47%, n=286/611) of those who raised the issue of FGM/C had received undergraduate training, compared with 32% (n=110/348) of those who did not.

Providers who addressed the issue of FGM/C had a better objective knowledge score than those who did not (data shown in Figure 3). We did not find any difference between men and women in addressing the subject during a consultation.

Approximately one third of the providers who reported approaching the subject of FGM/C preferred to spend a time alone with the patient and when necessary, they asked the family to go out (34%, n=191/563). Moreover, they often had a talk based on the legal framework (39%, n=220/563) and referred patients toward qualified organizations when needed (44%, n=250/563). Very few providers asked a colleague for help and practical tools were rarely used (*i.e* silicon vulvas, prevalence world map, drawings of excised vulvas, flyers) (Data shown in the appendix Figure C). Among these latter tools, drawings of various types of mutilations were more often used by OB/GYN and midwives, while midwives were more likely to give flyers and information booklets.

Table 2: Characteristics of providers who reported to address the issue of FGM/C during consultation

Characteristics		Providers who address the issue of FGM/C	P-value
Age (years old)			p=0.24
	20-39 (n=591)	373 (63%)	
	40-54 (n=236)	146 (62%)	
	> 55 (n=140)	98 (70%)	
Status			p < 0.01
	Residents (n=180)	90 (50%)	
	Doctors (n=485)	307 (63%)	
Profession			p < 0.01
	ID specialists (n=180)	92 (51%)	
	OB/GYN (n=291)	201 (69%)	
	Midwives (n=234)	180 (77%)	
	GPs (n=76)	57 (75%)	
	Pediatricians (n=74)	34 (46%)	
Self-assessment of skills			p < 0.01
	Insufficient (n=611)	304 (50%)	
	Moderate (n=240)	204 (85%)	
	Good (n=111)	105 (95%)	

FGM/C: Female Genital Mutilation/Cutting, OB/GYN: Obstetricians and Gynecologists, ID specialists: Infectious Disease specialists, GPs: General Practitioners

Educational Past and Training Wishes

Providers 'educational past is detailed in Table 3. Overall, 41% (n=446/1085) of respondents received initial training (undergraduate courses). Regarding training organizations, providers reported in open ended questions that they had been trained mainly by NGOs and associations (*i.e* GAMS, Gynécologues Sans Frontières), local perinatal networks and learned societies, especially during their annual conferences.

Training wishes

Overall, 64% (n=611/962) of providers considered their skills towards FGM/C insufficient or very insufficient. Midwives and OB/GYN were more likely to feel self-confident regarding their skills than ID specialists and pediatricians. Overall, 75% (n= 722/963) of providers declared to wish specific FGM/C training. We found that even among practitioners who raised the issue of FGC/M in consultation, 78% (n=472/609) requested specific training.

Regarding wishes for further training, caregivers wanted to receive training courses related to their daily practice: 75% of OB/GYN (n=188/252) and 59% of midwives (n=125/211) would have liked to be trained in sexology, 84% (n=56/67) of pediatricians declared that they wanted to better know how to recognize children at risk of FGM/C. Overall, approximately 55 % (n= 473/854) of providers were asking for a legal education related to FGM/C, with no difference between professions. Moreover, most of the providers wanted to be trained in relational aspects (relationship component with patients) (64%, n=550) and on clinically identifying FGM/C (68%, n=581). No statistically significant differences were found between the different age groups, nor differences based on gender.

Table 3: In which context did you hear about FGM/C?

Characteristics of participants		Undergraduate courses	Media or social network training	Postgraduate courses (ongoing education, university degree, conference, academic MOOCs)	Personal training	Clinical training, Clinical experience
Status	Residents (n=195)	90 (46%)	104 (53%)	42 (22%)	92 (47%)	139 (71%)
	Medical doctors (n=537)	163 (30%)	220 (41%)	242 (45%)	169 (31%)	341 (64%)
Age	20-39 years old (n=654)	356 (54%)	333 (51%)	203 (31%)	239 (37%)	449 (69%)
	40-55 years old (n=260)	73 (28%)	105 (40%)	108 (42%)	86 (33%)	176 (68%)
	>55 years old (n=171)	17 (10%)	58 (34%)	98 (57%)	54 (32%)	114 (67%)
Profession	ID specialists (n=196)	78 (40%)	109 (56%)	81 (41%)	77 (39%)	91 (46%)
	OB/GYN (n=319)	124 (39%)	117 (37%)	124 (39%)	111 (35%)	273 (86%)
	Midwives (n=273)	180 (66%)	126 (46%)	98 (36%)	87 (32%)	211 (77%)
	GPs (n=89)	26 (29%)	33 (37%)	51 (57%)	27 (30%)	61 (69%)
	Pediatricians (n=83)	20 (24%)	43 (52%)	20 (24%)	24 (29%)	39 (47%)

FGM/C: Female Genital Mutilation/Cutting, OB/GYN: Obstetricians and Gynecologists, ID specialists: Infectious Disease specialists, GPs: General Practitioners, MOOCs: Massive Open Online Courses.

Discussion

Main findings

The findings of this survey show that in their daily practice, many providers take care of women who may have undergone FGM/C or are at risk of FGM/C. However, addressing the issue of FGM/C during a consultation remains a difficult issue. In our study, the providers who approach this question are more often self-confident, better trained, they have better knowledge and they are more experienced than others. When they initiate the dialogue during a consultation, they usually try to create a favorable setting being alone with the patient, they often use the legal framework and refer the patient when needed.

Regarding detection of cases at risk of being excised, especially when a family is traveling to their country of origin, two main risk factors were reported by the expert subgroup of our respondents: the fact that the mother or the sisters had undergone FGM/C and the prevalence of FGM/C in the country to which they are traveling.

Finally, we found that having received FGM/C training in health studies, being an experienced provider and being self-confident regarding FGM/C management are associated with good theoretical knowledge of FGM/C. Nonetheless, there are still gaps in the providers' knowledge and training. When questioned, they declared that they wanted to be trained in legal, clinical and relational aspects.

Strengths and limitations

As far as we know, this study is the largest survey of doctors and midwives in relation to FGM/C in high income countries. Moreover, we collected responses from a variety of diverse professionals rarely surveyed in this field, particularly ID specialists and pediatricians, representing the spectrum of providers who care for women affected by or at risk of FGM/C (30,36,37).

Another strength of our study lies in the multidisciplinary aspect of this project. To provide the best approach to this complex issue, this questionnaire was drawn up by an international, multidisciplinary team made up of researchers in the humanities, the social sciences, the health sector and field based caregivers. This design will allow later comparisons with Belgium. The results from Belgium's survey were recently published (38).

However, due to its design, this study suffered from some limitations. First, our sampling did not permit us to calculate a precise response rate. However, an excellent response rate was observed among ID specialists. Although not all of them were approached for this survey, we collected responses from approximately 30% of French ID specialists working in the country at that time (39). For other specialties, including OB/GYN and midwives, we observed a geographical heterogeneity, with over-representation of Western France and the Paris area, which could affect the extrinsic validation of our results. This heterogeneous distribution corresponds to the starting point of the questionnaires, where the authors are from.

Moreover, the findings are dependent on self-reporting, with a probable sampling bias. Providers who didn't know about FGM/C were less likely to complete the survey, our data might thus overestimate KAP among health professionals.

Discussion

We believe that opening up dialogue about FGM/C is the key to ensuring that women have a positive care experience. From a women's viewpoint, silence and taboo are the main barriers to high-quality support (35,40,41). A recent qualitative systematic review by Evans *et al* (33) highlighted that the first step to better care for women who underwent FGM/C is to communicate. In our study, almost two thirds of the professionals surveyed declared they addressed the issue of FGM/C during their consultations, which shows an improvement in caregivers' attitude compared with the last and only study available in France (30). Similar to previous studies, those who tackle the subject are more often experienced, more confident and better trained (33,42,43). In our population, the medical doctors were more likely to talk freely about FGM/C than the residents. As suggested by other researches (44,45) this confidence is probably due to the experience they acquired during their careers rather than their initial training, which is often lacking. To explain the difficulty in raising the topic, several barriers have been previously identified from the healthcare provider's perspective. The lack of awareness, the lack of cultural sensitivity and knowledge may be involved. Choosing the right time and the appropriate words to tackle the subject and dealing with language barriers may also be hard to handle. Addressing such a sensitive subject requiring an appropriate vocabulary during the short time available in a consultation may be seen as a major obstacle (29,33,46).

Furthermore, when it comes to addressing the question of FGM/C, most of the health professionals declared that they informed on the illegality of the practice in France, they tried to be alone with women and referred them to specialized organizations when needed. However, only 12% of respondents reported that they asked for help from a colleague during a consultation. We believe that this human support is under-used. Coordination with caregivers from other specialties (*i.e* psychologists, sexologists, nurses) and the help from cultural mediators are valuable for a trusting relationship, especially when several sociocultural factors and beliefs are involved (47–49). We also point out that the use of practical tools and teaching materials were unusual. This

may be due to the fact that some of these tools are not well known, such the world map of FGM/C prevalence and some of them are still expensive (silicone vulvas).

Similar to findings from other studies, in our survey midwives and OB/GYN are the providers the more often confronted to women who may have undergone FGM/C (data shown in the appendix Figure B) (29,36,47,50,51).

Reinfibulation, also known as resuturing, belongs to the medicalization field and consists in resuturing genital labia, most frequently after delivery, in women with previous FGM/C. It is regarded as mutilation and condemned by the WHO, although it is not an illegal practice worldwide (52). In our study population, approximately 16% of OB/GYN and midwives had been asked, once or more, to perform reinfibulation. This represents a lower proportion of participants than the findings from older surveys in other high income countries (47,51,53,54). According to the WHO, requests for reinfibulation are an indicator of the impact of health education surrounding surgical intervention (55). Thus, our findings may be explained by the fact that girls and women are better informed about the health benefits of deinfibulation and the implications of reinfibulation. However, reinfibulation requests still remain numerous and many caregivers are confronted with these demands, raising ethical concerns in their clinical practice, questioning the principles of non-maleficence, beneficence, justice and autonomy (56–58).

With respect to theoretical knowledge, regardless of discipline, the overall level is insufficient as in most hosting countries (33,40,50,59–61). A better theoretical level was observed among the most experienced and better trained providers, which is consistent with the literature (50,56,58,62). The knowledge gap may be harmful for women for several reasons. First, this lack of knowledge could lead to an under-detection of women who have undergone FGM/C and to a wrong way to manage complications related to a certain type of FGM/C. Second, the available evidence from the literature suggests that healthcare providers 'ignorance is associated with the avoidance of the subject of FGM/C (46) and with a feeling of shame and stigmatization for women when they are confronted to providers who are not familiar with this practice (63–65).

To improve knowledge and enhance skills related to FGM/C in healthcare settings at the public policy level, training caregivers in high income countries has been shown to be effective (66,67). In our study, we found that a minority of the medical practitioners had received undergraduate training in FGM/C, similar to the findings in other host countries (36,37,40). Midwives received better initial training than doctors, like in Spain (50) , and among doctors, the junior ones were more likely to have had formal training in FGM/C during their primary studies, which is in line with the results from previous European studies (44,53). The latest available data in France show that in 2015, less than 30% of the providers had been trained during their medical school and approximately 40% had received postgraduate training (30). Therefore, in our country, undergraduate training seems to be greater than before, reaching 66% for midwives, the best trained caregivers, whereas postgraduate training appears to be relatively constant. In addition to institutional teaching, associations and NGOs were involved in the health care providers' training (68,69).

The findings of our survey underline that, while residents are better trained, they are less likely to raise the issue of FGM/C during their daily practice than the older ones. This surprising result may be explained by a confounding factor which is experience itself. We assume that being experienced and self-confident helps to raise the FGM/C issue during a consultation (see results in Table 2).

In France available FGM/C training courses are based on theoretical aspects (70,71) and very few of them focus on communication and soft skills. How to manage one's own emotions, how to deal with the distress or discomfort of a woman who has experienced violence, how to speak with them about FGM/C are rarely taught. These soft skills are probably learned by providers through clinical experience (see data in Table 3). Nonetheless, theoretical knowledge remains essential. In our survey, we found that self-confident providers had a better knowledge score and that those who address the subject of FGM/C during consultations were better trained. We believe that both experience gained over the years and formal education concerning FGM/C are important factors to feel comfortable and legitimate in discussions about violence.

The need to improve knowledge and skills about FGM/C was shared by the survey participants. They claimed that they would like to be informed and trained on the relational aspects and on the juridical dimension. Interestingly, these requests are fairly consistent with the results of other surveys (37,40,42,47,53). We

hypothesize that this item is important for health providers for two reasons. First, we notice that the practitioners often use the legal framework to approach the subject of FGM/C (data shown in the appendix Figure C). We assume that it may be easier for them to use an external argument which is the law rather than dealing with their own feelings and emotions toward this practice. Second because in France, health professionals have a legal obligation to inform the judicial authority of the possible risk of FGM/C procedure, which is a crime whereas it happens in the territory or elsewhere.

A recent qualitative exploration of 31 experts' opinions highlighted that understanding risk factors for FGM/C was one of the key aspects of knowledge for providers to acquire (72). Risk assessment of FGM/C relies on identifying red flags that are not consensual in the literature (73,74). Even within our working group, we were unable to reach a consensus, we then decided to analyze the answers from the most experienced providers and the self-confident participants (as defined above). They identify two items, which corroborates our national guidelines (75) based on experts' opinions.

Conclusions and further prospects

Midwives, OB/GYN and ID specialists have a critical role to play in providing quality care to FGM/C affected women and preventing the practice. The main challenge for women's healthcare providers is probably to open up dialogue and to refer women who have undergone FGM/C to specialist structures when it is needed. Some difficulties remain in addressing the subject. Thus, for future research, it would be pertinent to explore the deep reasons underlying avoidance of the subject among healthcare providers, along with their attitude, using psychometrically validated tools (76).

The results of our study show that healthcare providers are not yet sufficiently prepared to meet patients' needs. We found that those healthcare workers most likely to raise this issue of FGM/C were the most experienced, the most confident and the most knowledgeable. We believe that to ensure adequate care for women who have experienced FGM/C, providers should have a high confidence in their ability to manage FGM/C related issues. Therefore, it is crucial to promote and develop teaching tools and specific training based on a holistic approach with a special focus on soft skills and relational aspects (76,77). Devoting dedicated time to listening, empathizing, using words carefully and using interpreters may be relevant notions to defend later on (35,63,78). Future training efforts should also provide ongoing training for the professionals concerned, a follow-up and supervision on emotional management facing violence.

Appendix

Figure A. Practitioners' practice

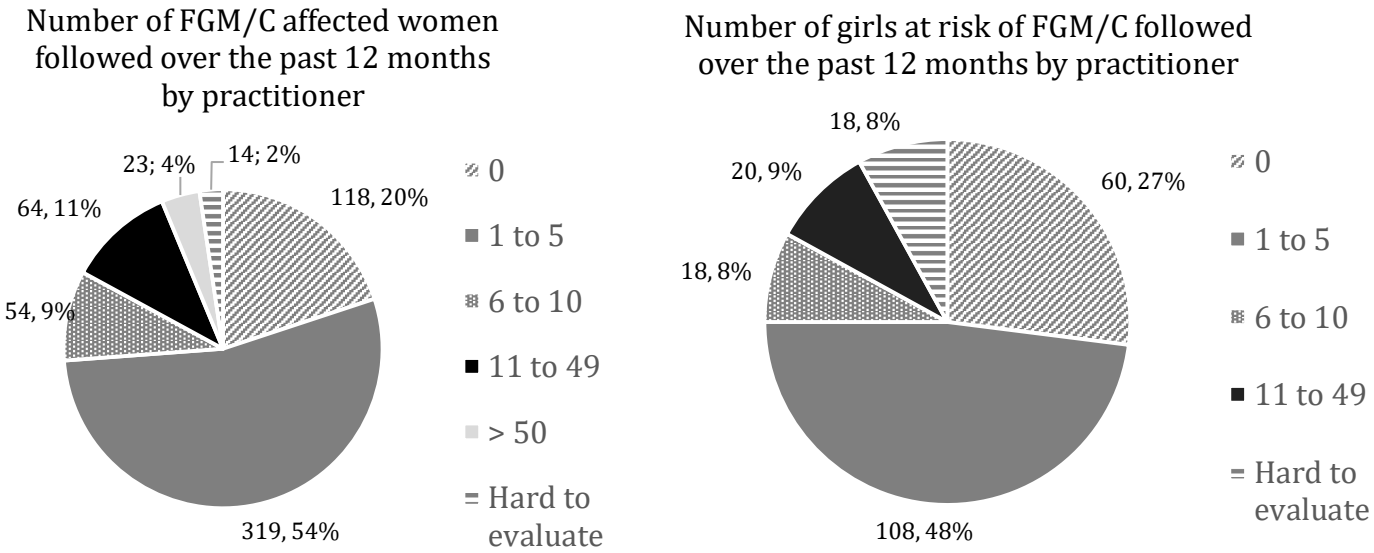
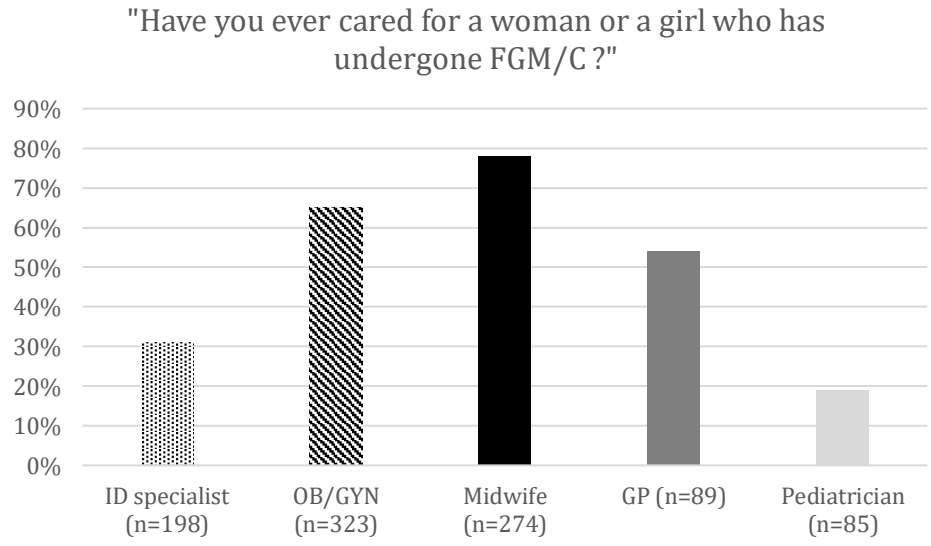
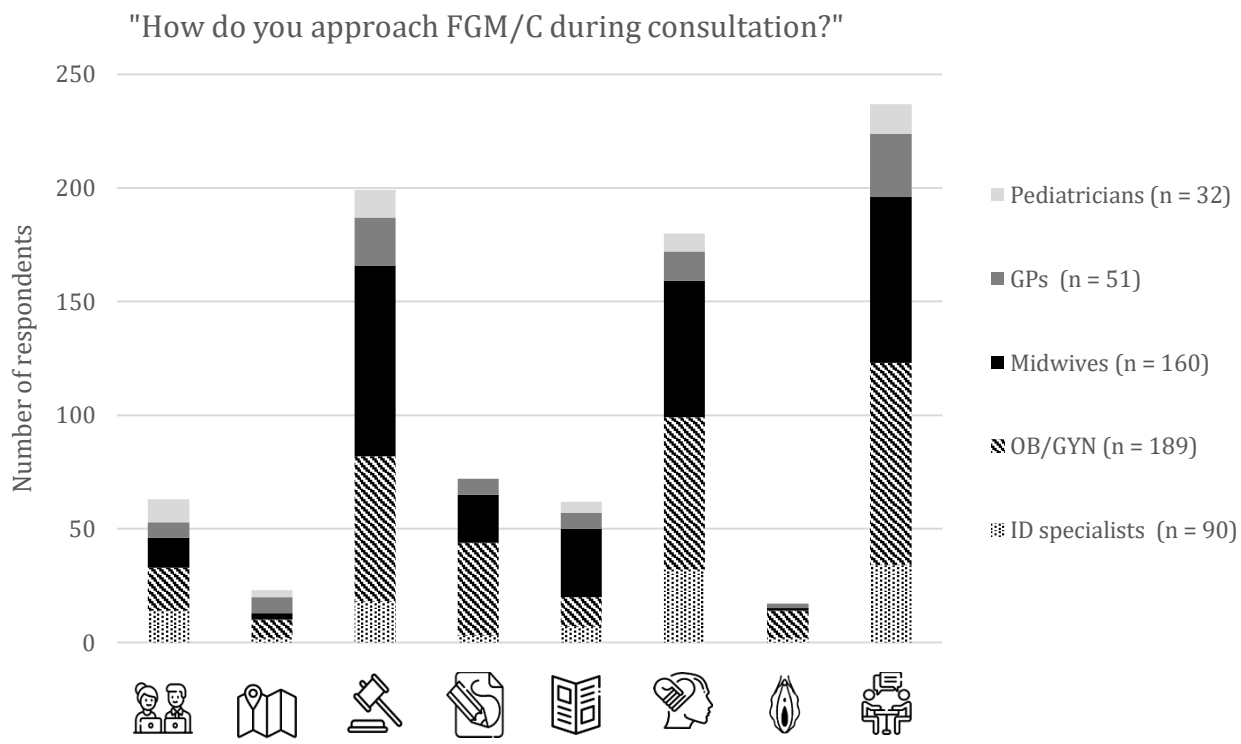


Figure B. Providers' experience



FGM/C: Female Genital Mutilation/Cutting, OB/GYN: Obstetricians and Gynecologists, ID specialists: Infectious Disease specialists, GPs: General Practitioners

Figure C. Human resources and practical tools



I ask a colleague for help

I use a map showing the prevalence of FGM/C by country

I ask the woman or the girl if she knows the French law on the subject

I show drawings of different types of FGM/C and ask the woman if she knows her type of FGM/C

I hand out flyers or information booklets

I organize a favorable environment by being alone with the patient, asking the accompanying persons to go out if needed

I use silicone vulva-type tools

I approach the subject spontaneously and give the woman addresses where she can consult if she wishes

FGM/C: Female Genital Mutilation/Cutting, OB/GYN: Obstetricians and Gynecologists, ID specialists: Infectious Disease specialists, GPs: General Practitioners

Questionnaire

Knowledge, Attitudes and Practice (KAP) - RHCforFGC - Gender Net, Version française

Prévenir, repérer et répondre aux besoins des filles et des femmes vivant avec une excision ou à risque d'excision

Texte présenté avant le début du questionnaire

« Bonjour !
Nous vous transmettons ce questionnaire afin d'étudier les connaissances, les attitudes et les pratiques des professionnel.les de santé au sujet de l'excision dans plusieurs pays.
A la fin du questionnaire, vous trouverez une formation sur le sujet sous forme de diapositives synthétiques.
Merci beaucoup pour votre précieuse participation qui nous permettra de mieux comprendre les besoins de formation et de recommandations sur ce sujet.
L'équipe France et GenderNet. »

1. Quelle est votre profession ? (Une seule proposition possible)
- □ Etudiant.e d'assistance sociale
- □ Etudiant.e infirmière
- □ Etudiant.e psychologue
- □ Etudiant.e sage femme
- □ Gynécologue/obstétricen.ne ou gynécologue médical
- □ Infirmièr.e
- □ Médecin autres spécialités
- □ Médiateur/trice en santé
- □ Psychologue
- □ Sage femme
- □ Sexologue (activité principale)
- □ Travailleur.se social.e
- □ Autre (merci de préciser), réponse libre : …

Si la réponse à la question « Quelle est votre profession ? » est « Médecin autres spécialités »
La question suivante s'affiche :

1.1 Merci de préciser votre spécialité : (Une seule proposition possible)
- □ Anesthésiste-réanimateur/trice
- □ Infectiologue
- □ Médecin de santé publique
- □ Médecin généraliste
- □ Pédiatre
- □ Psychiatre
- □ Urgentiste
- □ Autre (merci de préciser), réponse libre : …

Si la réponse à la question « Quelle est votre profession ? » est « Médecin autres spécialités » ou « Gynécologue/obstétricen.ne ou gynécologue médical »
La question suivante s'affiche :

1.2 Merci de préciser votre statut : (Une seule proposition possible)
- □ Interne
- □ Docteur.e en médecine

Si la réponse à la question « Merci de préciser votre statut » est « interne »
La question suivante s'affiche :

1.2.1 A quel niveau ? (Une seule proposition possible)
- □ Phase socle
- □ Phase d'approfondissement
- □ Phase de consolidation

Si la réponse à la question « Merci de préciser votre statut » est « Docteur.e en médecine »
La question suivante s'affiche :

1.2.2 Êtes-vous thésé.e depuis plus de 2 ans? (Une seule proposition possible)
- □ Oui
- □ Non

2. Dans quel(s) service(s) travaillez-vous ? (Plusieurs réponses possibles)
- □ Consultation pré-natale
- □ Salle d'accouchement
- □ Service de suites de couches/post-partum
- □ Maison de naissance
- □ Service de pédiatrie
- □ Service de médecine interne
- □ Service de chirurgie
- □ Service de médecine du voyage / Travel Clinic
- □ Maison médicale
- □ Centre de planning familial / Centre de santé spécifique à la santé des femmes
- □ Centre d'accueil pour demandeurs d'asile (Fedasil, Croix-Rouge, Caritas,…)
- □ Service de maladies infectieuses et/ou médecine tropicale
- □ Centre de dépistage des infections sexuellement transmissibles
- □ Centre de lutte contre la tuberculose
- □ Centre Public d'Action Sociale (CPAS)
- □ Organisation non gouvernementale (ONG)/ Association à but non lucratif
- □ Autre (merci de préciser), réponse libre : …

<u>Informations socio-démographiques</u>

3. Vous êtes ? (Une seule proposition possible)
- □ Un homme
- □ Une femme
- □ Autre

4. Quel âge avez-vous ? (Une seule proposition possible)
- □ 20-39 ans
- □ 40-54 ans
- □ 55 ans ou plus

5. Depuis combien d'années exercez-vous cette profession ? (En année)
Réponse libre : …

6. Dans quelle région exercez-vous ? (Code postal)
Réponse libre : …

<u>Pratique professionnelle</u>

7. Avez-vous déjà entendu parler de l'excision (tous types de sources) ? (Une seule proposition possible)
- □ Non
- □ Oui
- □ Je ne suis pas sûr.e

Si la réponse à la question « Avez-vous déjà entendu parler de l'excision (tous types de sources) ? » est « oui »
La question suivante s'affiche :

7.1 A quelle(s) occasion(s) ? (Plusieurs réponses possibles)
- □ Formation pendant le curriculum de base (universitaire ou haute école)
- □ Formation post-universitaire type DU ou DIU
- □ Situation clinique rencontrée dans ma pratique au sein du service dans lequel j'exerce
- □ Staff médicaux (revues de cas)
- □ Formation continue
- □ Publication dans un journal scientifique
- □ Auprès d'une femme ou d'une fille que j'ai reçue en consultation
- □ Média (TV, radio, podcast, film..)
- □ Réseaux sociaux
- □ Informations personnelles
- □ Je ne me souviens pas
- □ Autre (merci de préciser), réponse libre : …

Si la réponse à la question « A quelle(s) occasion(s) ? » est « Formation continue »
Deux questions s'affichent :

7.1.1 Quel(s) type(s) de formation : (Plusieurs réponses possibles)
- □ Mooc, e-learning
- □ Séances en présentiel
- □ Conférences
- □ Formations médicales continues (accréditées)
- □ Autre (merci de préciser), réponse libre : …

7.1.2 Par quel organisme ?
Réponse libre : …

8. Avez-vous déjà accompagné une femme ou une fille ayant subi une excision ? (Une seule proposition possible)
- □ Non
- □ Oui
- □ Je ne suis pas sûr.e

Si la réponse à la question « Avez-vous déjà accompagné une femme ou une fille ayant subi une excision ? » est « oui »
La question suivante s'affiche :

8.1 Si oui, combien de fois dans les 12 derniers mois (environ) ? (Une seule proposition possible)
- □ 0
- □ 1 à 5
- □ 6 à 10
- □ Entre 11 et 49
- □ Plus de 50
- □ Difficile à évaluer

9. Avez-vous déjà accompagné une femme ou une fille à risque de subir une excision ? (Une seule proposition possible)
- □ Non
- □ Oui
- □ Je ne suis pas sûr.e

Si la réponse à la question « Avez-vous déjà accompagné une femme ou une fille à risque de subir une excision ? » est « oui »
La question suivante s'affiche :

9.1 Si oui, combien de fois dans les 12 derniers mois (environ) ? (Une seule proposition possible)
- □ 0
- □ 1 à 5
- □ 6 à 10
- □ Entre 11 et 49
- □ Plus de 50
- □ Difficile à évaluer

Si la réponse à la question « « Quelle est votre profession ? » est « Etudiant.e sage femme » ou « Sage femme » ou « Gynécologue/obstétricen.ne ou gynécologue médical »
Deux questions s'affichent :

10. Vous a-t-on déjà demandé de pratiquer une excision sur une enfant mineure ? (Une seule proposition possible)
- □ Non jamais
- □ Oui très rarement (une ou deux fois)
- □ Oui plus souvent (plus que deux fois)

11. Vous a-t-on déjà demandé de pratiquer une réinfibulation après un accouchement ? (Une seule proposition possible)
- □ Non jamais
- □ Oui très rarement (une ou deux fois)
- □ Oui plus souvent (plus que deux fois)

Connaissances et formations

12. D'après vous, combien de femmes excisées vivent en France (approximativement) ? (Une seule proposition possible)
- □ Moins de 60 000
- □ 60 000
- □ 120 000
- □ 450 000
- □ 980 000
- □ Plus de 980 000
- □ Je ne sais pas

13. L'OMS a décrit plusieurs types de mutilation génitale féminine (MGF). Combien en connaissez-vous ?
Réponse libre : …

13.1 Nommez et décrivez brièvement les différents types de mutilation génitale féminine repris dans la définition de l'OMS (utilisez une ligne par type)
Réponse libre :

a…….
b…….
c…….
d…….
e…….

Si la réponse à la question « Quelle est votre profession ? » est « Médecin autres spécialités », « Sage femme », « Etudiant.e sage femme », « Sexologue (activité principale) », « Etudiant.e infirmière », « Infirmièr.e » ou « Gynécologue/obstétricen.ne ou gynécologue médical »
La question suivante s'affiche :

14. Vous sentez-vous capable de reconnaître les différents types selon la classification de l'OMS à l'examen clinique ? (Une seule proposition possible)
- □ Presque toujours
- □ Avec plus ou moins de certitude
- □ Avec peu de certitude
- □ Pas du tout
- □ Je ne sais pas, je n'ai jamais eu l'occasion de faire un tel examen

15. Abordez-vous le sujet de l'excision lors de votre pratique ? (Plusieurs réponses possibles)
- □ Non, jamais
- □ Oui, mais seulement si la femme/la famille en parle d'abord
- □ Oui mais seulement si je suspecte un risque d'excision chez l'enfant
- □ Oui, systématiquement quand une femme ou une fille est originaire d'un pays qui pratique (ou susceptible de pratiquer) l'excision
- □ Oui systématiquement sauf si la femme est accompagnée par un/des proche(s)
- □ Oui, pour une autre raison (merci de préciser), réponse libre : …

Si la réponse à la question « Abordez-vous le sujet de l'excision lors de votre pratique ? » est « oui »
La question suivante s'affiche :

15.1 Si oui, comment abordez-vous le sujet lors de la consultation ? (Plusieurs réponses possibles)
- □ J'utilise une carte présentant les prévalences des MGF par pays
- □ Je remets des flyers ou livrets d'information
- □ Je lui montre des dessins avec les différents types d'excision et lui demande si elle connaît le type de son excision.
- □ J'utilise des outils type vulve en silicone
- □ Je demande l'aide d'un.e collègue
- □ Je m'organise pour me trouver un moment seul.e avec la femme en faisant sortir si besoin les enfants, le mari ou d'autres accompagnant.e.s
- □ J'aborde le sujet spontanément et lui fournit des adresses afin de référer la femme si elle le souhaite
- □ Je lui demande si elle connaît la loi en France sur le sujet
- □ Autre (merci de préciser), réponse libre : …

16. Quels sont les facteurs de risque d'excision à repérer lors d'une consultation en présence d'un ou des deux parents et d'une petite fille ? (Plusieurs réponses possibles)
- □ La prévalence dans le pays d'origine des parents
- □ La prévalence dans le pays où le voyage est prévu
- □ Le groupe ethnique auquel elle appartient (groupe qui pratique les MGF)
- □ Le fait que la mère ou les sœurs soient excisées
- □ Les plans de voyage dans le pays d'origine, principalement si l'enfant est envoyée sans les parents
- □ La mauvaise qualité des échanges ou interactions avec les parents pendant la consultation
- □ La mauvaise compréhension du français (barrière linguistique)
- □ Les signes extérieurs religieux
- □ Le fait de résider en France depuis moins d'un an
- □ Quand dans une fratrie ce ne sont que les filles qui voyagent
- □ Quand les voyages sont prévus pour une longue période
- □ Le port d'habits traditionnels
- □ Le titre de séjour
- □ Autre (merci de préciser), réponse libre : …
- □ Je n'ai pas d'avis sur la question

17. Concernant les MGF, comment estimez-vous le niveau de vos compétences ? (Une seule proposition possible)
- □ Très bon
- □ Bon
- □ Moyen
- □ Insuffisant
- □ Très insuffisant

18. Souhaiteriez-vous suivre une formation ou une remise à niveau dans ce domaine ? (Une seule proposition possible)
- □ Non
- □ Oui
- □ Je ne suis pas sûr.e

Si la réponse à la question « Souhaiteriez-vous suivre une formation ou une remise à niveau dans ce domaine ? » est « oui » ou « Je ne suis pas sûr.e »
La question suivante s'affiche :

18.1 Si oui, sur quels aspects la formation devrait porter :
- □ Aspects juridiques
- □ Aspects relationnels (interaction avec les usager.e.s, attitudes)
- □ Accompagnement social
- □ Identification clinique des MGF
- □ Identification des enfants à risque de MGF
- □ Prise en charge si découverte d'une excision récente
- □ Prise en charge obstétricale
- □ Prise en charge sexologique
- □ Prise en charge chirurgicale
- □ Prévention de l'excision auprès des enfants
- □ Intégration de la question des MGF dans l'éducation à la sexualité
- □ Autre (merci de préciser), réponse libre : …
- □ Je n'ai pas d'avis sur la question

CHRU HÔPITAUX DE TOURS

GAMS BELGIQUE - BELGIË

CENTRE HOSPITALIER UNIVERSITAIRE DE NANTES

L'excision:

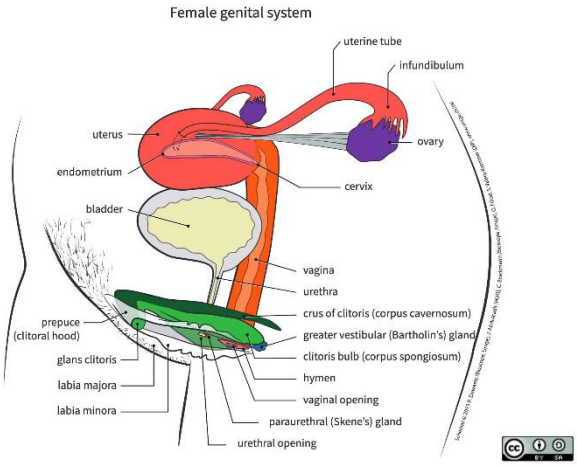
Identifier, prévenir et accompagner

GENDER NET Plus

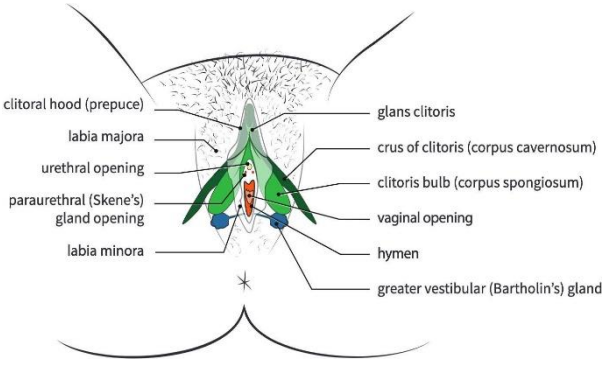
Horizon 2020 European Union Funding for Research & Innovation

ASSISTANCE PUBLIQUE HÔPITAUX DE PARIS

L'appareil génital féminin



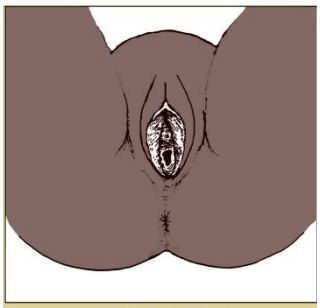
Le clitoris



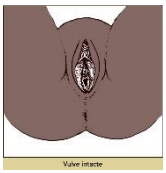
4 types définis parl'OMS:

Type 1:

Ablation totale ou partielle du gland clitoridien et/ou du prépuce



Type 1 : clitoridectomie



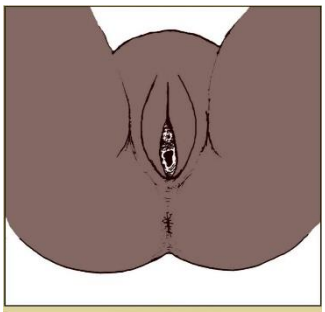
Vulve intacte

Sources : Dessins de l'illustratrice Clarice d'après des croquis de F. Richard
Référence : OHCHR, UNAIDS, UNDP, UNECA, UNESCO, UNFPA, UNHCR, UNICEF, UNIFEM, WHO. Eliminating female genital mutilation. An interagency statement. World Health Organization; 2008.

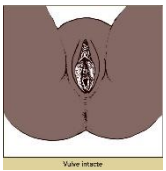
4 types définis parl'OMS:

Type 2:

Ablation totale ou partielle du gland clitoridien et des petites lèvres, associée ou non à celle des grandes lèvres (excision)



Type 2 : excision



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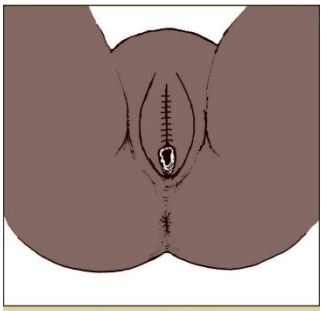
Sources : Dessins de l'illustratrice Clarice d'après des croquis de F. Richard
Référence : OHCHR, UNAIDS, UNDP, UNECA, UNESCO, UNFPA, UNHCR, UNICEF, UNIFEM, WHO. Eliminating female genital mutilation. An interagency statement. World Health Organization; 2008.

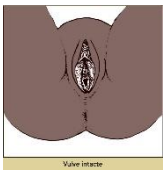
4 types définis parl'OMS:

Type 3:

Rétrécissement de l'orifice vaginal avec recouvrement par l'ablation et l'accolement des petites lèvres et/ou des grandes lèvres, avec ou sans excision du clitoris (infibulation)



Type 3 : infibulation



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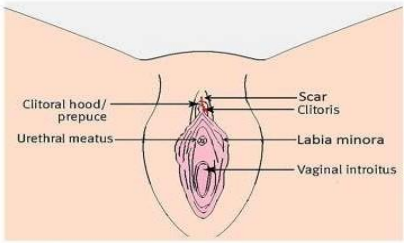
4 types définis par l'OMS:

Type 4:

Toutes les autres interventions nocives pratiquées sur les organes génitaux féminins à des fins non thérapeutiques, telles que la ponction, le percement, l'incision, la scarification et la cautérisation



Creighton *et al*. BMJ Open 2016

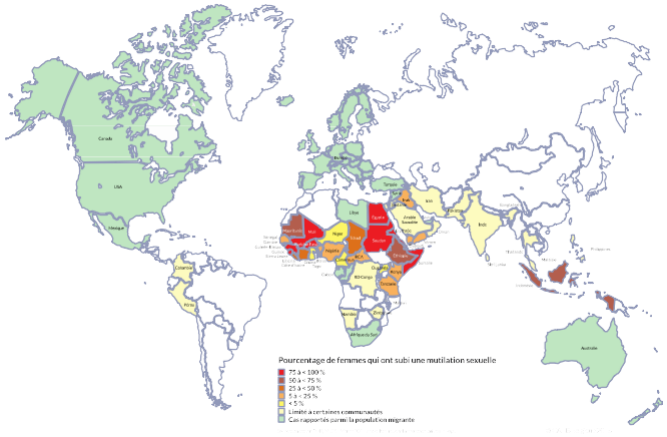
Complications

- **Somatiques**
  - Infections urinaires ou gynécologiques
  - Douleurs chroniques neuropathiques
  - Obstétricales (types 2 et 3: césarienne notamment))
- **Sexologiques**
  - Dyspareunie
  - Absence de plaisir
  - Absence de désir
- **Psychologiques**
  - PTSD
  - Troubles anxieux
  - Troubles dépressifs

Chaque femme a son histoire et son vécu

Certaines femmes souhaitent que l'excision soit reconnue et nommée, ne déclarent pas de complication et n'ont pas d'autre demande

PRÉVALENCE DES MUTILATIONS SEXUELLES FÉMININES DANS LE MONDE



En France

- Estimation en 2009: 60 000 femmes au milieu des années 2000
- Estimation en 2019: **125 000** au début des années 2010 (féminisation de la population migrante et vieillissement des « deuxièmes générations »)
- Moment du risque : Lors d'un départ au pays pour les vacances.
- L'excision est un crime : obligation de signalement par les médecins. Art. 223-6 du code pénal.
- Les parents peuvent être poursuivis en France même si l'excision a eu lieu à l'étranger (principe d'extraterritorialité)
- Possibilité d'obtenir une protection internationale (statut de réfugié.e) pour être protégé.e du risque d'excision

Estimation du nombre de femmes adultes ayant subi une mutilation génitale féminine vivant en France

Et dans le Monde?

- **Au niveau international**: Les textes reconnaissent l'excision comme violences faites aux femmes, et comme violation des droits de l'Homme et de l'enfant.
- **En Afrique:** 36 pays d'Afrique ont banni l'excision par un décret national ou une loi.

Ouvrir le dialogue

Comment repérer?

- Se sentir à l'aise pour mettre à l'aise la personne.
- *« Vous venez d'un pays où l'excision est pratiquée. Connaissez-vous cette pratique? Etes-vous concernée? Est-ce un problème pour vous? Savez-vous que l'on peut vous proposer un accompagnement en France? »*
- Pas de jugement sur la pratique ou sur la famille qui a pratiqué cela, bannir les termes « pratique barbare »
- Savoir où orienter à l'issue de la consultation

Accompagnement holistique

Selon la demande de la patiente

- Gynécologue, sage-femme
- Chirurgien.ne
- Infectiologue
- Consultation douleur
- Sexologue
- Psychologue
- Kinésithérapeute
- Travailleurs et travailleuses sociaux/sociales
- Thérapies complémentaires: danse, yoga, socio-esthétique, travail sur l'image de soi

Comment faire de la prévention?

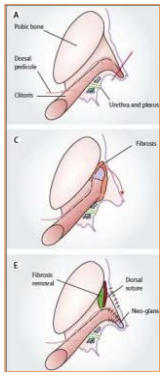
Ici, on peut en parler!

combattrelexcisi

- Affiches sur les murs
- Flyers d'informations
- Outils pédagogiques (vulves en silicone)
- Intégrer la question des MGF à l'interrogatoire, de façon systématique
- Se former

SEX-ED +
Outils pour l'éducation à la sexualité

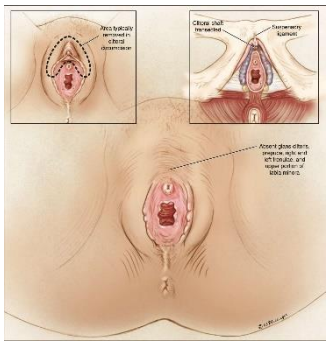
Chirurgie clitoridienne

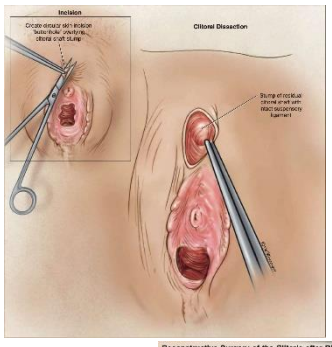


- Résection de la fibrose préclitoridienne
- Section du ligament suspenseur du clitoris
- Mobilisation du gland clitoridien

www.thelancet.com Vol 380 July 14, 2012

Chirurgie clitoridienne

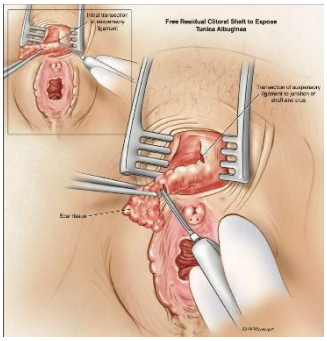


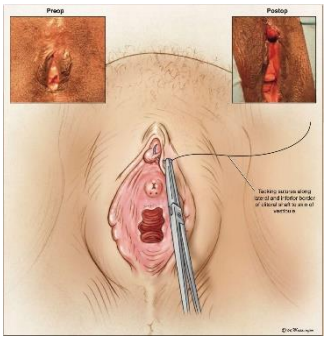


Reconstructive Surgery of the Clitoris after Ritual Excision

J Sex Med 2006;3:1091–1094

Chirurgie clitoridienne





Reconstructive Surgery of the Clitoris after Ritual Excision

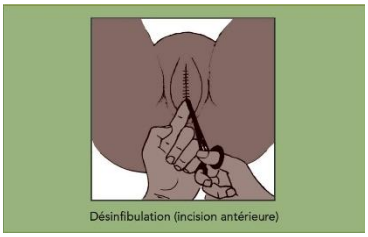
J Sex Med 2006;3:1091–1094

Désinfibulation

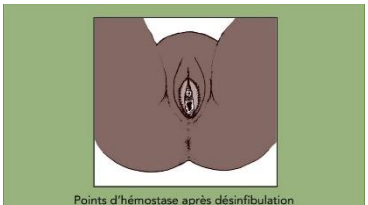
Opération recommandée par l'OMS

A proposer systématiquement chez les femmes infibulées pendant la grossesse:

- Au deuxième trimestre de la grossesse
- Au moment de l'accouchement



Désinfibulation (incision antérieure)



Points d'hémostase après désinfibulation

Sources : Dessins de l'illustratrice Clarice d'après des croquis de F. Richard

Référence : OHCHR, UNAIDS, UNDP, UNECA, UNESCO, UNFPA, UNHCR, UNICEF, UNIFEM, WHO. Eliminating female genital mutilation. An interagency statement. World Health Organization; 2008

Paroles de femmes envers les professionnel.les

« Mais déjà qu'il parle s'il le voit… Franchement, s'il voit quelque chose il faut qu'il en parle. C'est comme s'il voit une femme, il ausculte une femme, il voit qu'elle a des bleus, des marques et tout, il va pas venir et absolument rien dire sur ça. Il va forcément dire au moins un minimum : « Ça va à la maison ? Je vois que vous avez des marques, qu'est-ce qui se passe ? »

« Si on n'enlève pas ce tabou-là en parlant et en se disant réellement ce qu'il faut faire, c'est des pratiques qui vont jamais s'arrêter. »

« C'est pas comme si je me sentais pas à l'aise, mais j'étais un peu gênée. Lui s'est mis à l'aise, donc moi aussi, je me suis »

« Ça sert à rien de fermer les yeux parce que c'est être complice de… »

A parcourir

Recommandations HAS 2020:

https://www.has-sante.fr/upload/docs/application/pdf/202002/reco307recommandationsmutilationssexuellesfeminines.pdf

Annuaire et documents pour informer les personnes :
https://federationgams.org

Outils de consultation:
https://positivesexed.org/a-propos/
http://combattrelexcision.org/

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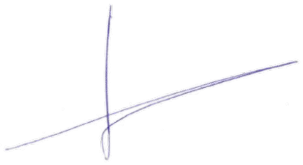
Vu, le 29/09/2023

Dr Lemaignen Adrien



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LE CŒUR Chemsa

46 pages – 3 tableaux – 7 figures

Résumé :

Introduction.
Les mutilations génitales féminines (MGF) sont une pratique traditionnelle répandue. Plus de 200 millions de femmes seraient concernées actuellement dans le monde. En France, les MGF touchent des femmes migrantes ainsi que des femmes nées en France de parents originaires de pays où se pratiquent les MGF. Les gynécologues-obstétriciens (OB/GYN), sages-femmes (SF) et infectiologues rencontrent au quotidien des femmes potentiellement concernées. Avec cette enquête, nous avons souhaité évaluer les connaissances, attitudes et pratiques de ces soignants au sujet des MGF.

Méthodes.
Le questionnaire élaboré par une équipe multidisciplinaire internationale comportait 30 questions divisées en 5 sections : données sociodémographiques, pratiques professionnelles, connaissances, attitude, formations. Il a été diffusé via Limesurvey de septembre 2021 à mars 2022. Tous les questionnaires complétés, même partiellement, ont été inclus dans l'analyse.

Résultats.
Nous avons inclus 1142 questionnaires dont 963 étaient complets. Parmi les enquêtés, on décompte principalement des infectiologues (203;18%), des OB/GYN (336;29%) et des SF (292;26%). *Concernant les pratiques et attitudes,* plus de la moitié des soignants (54%; 592) avait déjà accompagné une femme ayant vécu une MGF. Soixante-trois pourcent (63% ; 613) des soignants interrogés abordaient la question des MGF en consultation. Parmi ces derniers, 47% (n=286) avaient reçu une formation initiale contre 32% (110) de ceux qui ne l'abordaient pas. Lorsqu'ils évoquent le sujet, les enquêtés déclarent poser le cadre juridique (36% ; 220) et référer la patiente lorsque cela est nécessaire (44%; 250). *Au sujet des connaissances*, avoir reçu une formation au sujet des MGF dans son cursus initial, être un praticien expérimenté et être confiant dans ses compétences sont des facteurs significativement associés à de meilleures connaissances théoriques. *Concernant la formations*, 41% (446) des enquêtés déclarent avoir été formés dans leur cursus initial. Les SF ont reçu une meilleure formation que les autres spécialités (66%; 180, p< 0,001).

Conclusion.
Le principal défi pour les soignants est probablement d'ouvrir le dialogue au sujet des MGF afin d'orienter au mieux les femmes concernées vers un parcours de soins adaptés. Dans cette étude, les soignants les plus confiants, les plus expérimentés et les mieux formés abordent plus souvent la question que les autres. Ces résultats nous invitent à concevoir une formation ciblée auprès des soignants en première ligne, portant notamment sur les aspects relationnels de la prise en soin des personnes.

Mots clés : Mutilations génitales féminines, réinfibulation, santé de la femme, pratiques professionnelles, formation professionnelle, soignants

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