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Female genital mutilation in the context of migration: experience of African women with the Swiss health care system

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Background: In contrast to other European countries, the Swiss health care system does not deal with the specific needs of women with female genital mutilation (FGM) in a consistent manner, though migrants from countries where FGM is commonly practised are living in Switzerland. **Methods:** For this study, the interaction of women who had undergone FGM, with the Swiss health services was analysed both from the perspective of the women concerned and that of health care professionals (doctors and midwives). The methods used were mainly qualitative, including focus group discussions with 29 women from Somalia and Eritrea and telephone interviews with 37 health care professionals. **Results:** It is estimated that some 6000 girls and women with FGM could be living in Switzerland. The fact that health care providers rarely see such patients and the absence of professional guidelines give rise to misunderstandings. Counselling of the women is often inadequate, and there is a striking lack of communication about FGM between health care providers and users, as well as within the women's communities. As a surprising finding, reinfibulation is carried out in Switzerland when requested by the patient. **Conclusions:** This study shows that at present the specific gynaecological and obstetric health care needs of migrant women who have undergone FGM are not adequately addressed in the Swiss health system. The situation could be easily improved by taking into consideration the fairly simple measures suggested by the women and the health care providers taking part in this study.

Key points

- Due to international migration, female genital mutilation (FGM) has become an issue of increasing concern in host countries such as Switzerland.
- Objectives of this study were to analyze how immigrant women with FGM experience gynaecological/obstetrical care in the Swiss health care system, and to investigate if gynaecologists/obstetricians and midwives treat and counsel FGM related complications adequately.
- Specific health care needs of women with FGM should—and easily could—be better considered by the Swiss health care system.
- Recommended measures include capacity building and professional guidelines on FGM for health care providers; and access to culturally appropriate information and self-help groups for the communities concerned.

Keywords: female genital mutilation, FGM, health care, migration, reinfibulation, Switzerland

According to the World Health Organization, world-wide more than 120 million girls and women from mostly sub-Saharan African countries have undergone female genital mutilation (FGM).[1] As a result of important migration flows from such countries in the 1990s, FGM has become an issue of increasing concern in host countries such as Switzerland.

Female genital mutilation, the term currently used by the World Health Organization, comprises all procedures involving partial or total removal of the external female genitalia for cultural or other non-therapeutic reasons.[1] The World Health Organization differentiates four forms of FGM. Type II involves excision of the prepuce and clitoris together with partial or total excision of the labia minora. Type III involves excision of part or all of the external genitalia and stitching/narrowing of the vaginal opening (infibulation).[1]

The practice and its harmful effects in terms of physical, sexual and psychological short-term and long-term complications for the girls and women subjected to it have received growing international attention over the past years. Several European countries that are hosting large numbers of people from countries where FGM is practised have addressed the issue of FGM in relation to their health care systems. The European Commission has provided funding support for a European network on this issue.[2] A number of countries, such as the UK, Germany, Belgium and Sweden, have established guidelines on FGM for medical providers.[3–6]

In Switzerland there is not yet a similar official commitment to addressing FGM-specific needs of immigrant women or the health care providers confronted with them, and a wide interest in the subject is a very recent phenomenon. The few studies carried out on FGM in Switzerland to date approached the issue either from an anthropological or sociological perspective[7,8] or looked mainly at quantitative aspects related to one of the provider groups. One recent study concluded that

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obstetricians and gynaecologists all over Switzerland had been confronted with patients presenting with FGM, with a regional concentration in francophone cantons.[9] As yet, no guidelines have been elaborated in Switzerland addressing FGM in relation to gynaecological/obstetrical care.

Objectives of this study were to analyse how immigrant women with FGM experience gynaecological/obstetrical care in the Swiss health care system, and to investigate if physicians and midwives treat and counsel FGM related complications adequately. Based on these findings, recommendations for the Swiss health care system were to be generated. In addition, the study aimed to estimate the prevalence rate of girls and women concerned in Switzerland, and to examine their distribution by country of origin, place of residence, and age group in the host country.

As the voices of the sub-Saharan African women themselves have received little attention in the European literature published so far, this article will focus primarily on their perspective, contrasting their views with findings from the Swiss health care providers when this is appropriate.

Methods

For the quantitative analysis, data provided by the Swiss Federal Office for Foreigners and the Federal Office for Refugees was analysed in terms of the number of women from countries where FGM is practised, country of origin, age classification and distribution between the Swiss cantons in 2001.

Qualitative methods were used to collect the perceptions and experiences of the main stakeholders. The range of views and perceptions and the exploration of unexpected findings were of greater interest than generalizing the results obtained. To facilitate the exchange with the women concerned, focus group discussions were considered the most appropriate methodology. This method is known to be a particularly suitable tool in cross-cultural research and work with minority groups.[10] The sensitive topic of FGM could be explored using this method for several reasons: group work can actively facilitate discussions as shyer participants are encouraged by others breaking the ice. Women can provide mutual support and empathy during and following the discussions, facilitated by a member of their community. Alternatively, women who did not want to participate in the group discussion had the option to be interviewed individually. Both the group discussions and the interviews were based on semistructured, open-ended questions to help focus on the areas of research interest, ensure exhaustiveness and facilitate comparability.

The study obtained ethical clearance from the Ethics Committee of Basel.

Purposeful sampling was used to select women of reproductive age who had undergone FGM before migrating to Switzerland, and health care providers who had received such patients. Identifying women who were ready to talk about their experiences proved difficult. Contacts with migrant associations, Swiss centres working with immigrant women and key individuals from the African communities, and visits to African restaurants, markets and shops were used to recruit women for group discussions.

A total of four focus group discussions including 29 women (24 from Somalia and five from Eritrea) could be organized with the help of mediators from the migrant communities in the cities of Zurich, Lausanne and Geneva. Informed consent was obtained from participants. The discussions were facilitated by the principle investigator as moderator and a female co-moderator of the same country as the participants who also served as translator. To create a gender-sensitive atmosphere all staff was female. The background of the participating women is shown in table 1.

Health care professionals from six Swiss cantons underwent an in-depth interview by telephone. For logistic reasons individual telephone interviews were chosen for this study group. A structured questionnaire with open-ended questions was used. Health care professionals were identified using a snowball approach. Professionals known to be often exposed and migrant organisations proposed other health service providers that could be interviewed. In all, 37 health care professionals were interviewed: 17 gynaecologists/obstetricians, three general practitioners and 17 midwives. The majority were from reference and other hospitals and some from private practice and family planning centres.

All discussions and interviews were tape recorded, transcribed and analysed with the help of the software MAXQDA (VERBI software, 2002; Berlin, Germany).

Results

Estimated distribution of women with FGM in Switzerland

In the year 2001, a total of 10,501 women from the 28 African countries where FGM is practised were officially living in Switzerland. More than two-thirds (72%) of that population is older than 15 years. When applying the rates of FGM prevalence in the country of origin (WHO 2001) to the number of these nationals in Switzerland, an estimated 5,718 girls and women with FGM could be living in Switzerland. Most of them originate from countries with extremely high prevalence rates, namely Somalia, Ethiopia and Eritrea. It should be noted that in these countries the severest forms of FGM, Types II and III, are practised. In Switzerland the majority of these women live in urban centres, mostly Geneva and Lausanne, followed by Zurich and Berne.

Reported long-term physical complications related to FGM

Both the interviewed women and the health care providers portrayed a similar situation as to long-term complications linked to having undergone FGM. Difficulties with sexual intercourse and menstruation were mentioned most often, followed by urinary tract, local and obstetric complications

Table 1 Demographic characteristics of participating women

Country of origin	N	FGM		Age in years			Education			Years in Switzerland		
		Type II	Type III	16–25	26–35	$\geqq 36$	none	primary school	secondary school	<3	3–10	>10
Somalia	24	1	23	8	4	12	5	12	7	4	15	5
Eritrea	5	2	3	0	3	2	2	1	2	0	4	1
Total	29	3	26	8	7	14	7	13	9	4	19	6

Table 2 Reported long-term physical complications of FGM by respondent group and frequency of mention (multiple answers possible)

Category of complications	Women concerned	Health care providers
Difficulties with sexual intercourse and dyspareunia	9	7
Difficulties with menstruation and dysmenorrhoea	10	4
Prolonged micturition, urinary tract infection and dysuria	4	3
Local complications (lesions of scar tissue, cysts)	0	3
Obstetric complications (lesion of sphincter ani, wound infection after reinfibulation)	1	2
Total	24	19

(table 2). While the description and the ranking of the complications according to their importance was very similar for most conditions, a notable difference was observed in terms of 'reduced sensation during sexual intercourse.' Hardly any of the health care providers actively mentioned this complication. For the women involved it was of major concern and extensively discussed during all focus group discussions. One woman stressed the fact that she is able to reach orgasm even though she has been 'circumcised', but the majority of participants described their sexual difficulties in vivid terms. 'For the woman it is a sort of labour to make love'. This compares to the statement of two physicians to whom it seemed that 'having sex was for some of the infibulated women just another duty like washing dishes'. Many women also compared themselves to the women of the host country who have not undergone FGM. In relation to sexuality some of the Somali and Eritrean women interviewed said they suffer from 'being different'. In summary, the following quotation well reflects the lifelong suffering of many of these women: 'If you are not married, you have problems with your menstruation. If you are married and you want to have sex with your husband, you suffer from pain. If you want to deliver your baby, it is difficult. This is terrible!'

The medical consultation

Both the women and the Swiss health care providers very clearly remembered the first encounter with each other, often dating back to the early 1990s, when most of these migrants arrived in Switzerland. Many women recalled the reaction of the doctors treating them as one of shock or surprise. Some women were asked by the doctor whether they had suffered an accident or a burn. Many reported the difficulties doctors and midwives had had in performing vaginal examination, making the procedure prolonged and painful. Others had been asked whether students could observe the examination, as their genitalia were seen as something of medical interest. This provoked feelings of shame and fear, reflected in the following statement: 'Beforehand I was proud. But the medical consultation hurt my pride. The physician was very shocked when he realised that I was sutured'.

The majority of the women participating in the study said that the issue of FGM had not been talked about during consultation and most gynaecologists/obstetricians confirmed they did not address the issue of FGM systematically when caring for a woman from a country where FGM is practised. Health care providers and the women concerned agreed that the main reasons for avoiding the subject were the language barrier, cultural, gender related and social reasons, as well as an inappropriate setting and time constraints. Some women felt disappointed and badly supported by the Swiss health care providers. 'I had a lot of questions during my pregnancy. I had the feeling there was nobody whom I could have really asked. I missed a traditional midwife as we have in Somalia'. Other women were quite relieved that FGM was not addressed during the consultation, as they did not want to be asked about it. Also the important question of whether the women as mothers intended to have FGM carried out on their daughters was neglected. Only 8% of the interviewed health care professionals said that they addressed the prevention of FGM during relevant consultations. Just as during the consultation, FGM and related complications are not commonly talked about in the private life of these women. Many of them had never spoken with their husbands about the subject and even among women themselves FGM was said to be a taboo topic.

Reinfibulation

For delivery, most women who have undergone FGM type III need to be defibulated (opened) to prevent complications. In all Swiss hospitals contacted, defibulation is performed only by physicians. The time chosen is during delivery (usually the second stage of labour), rather than during pregnancy. Once the scar tissue has been removed and the baby has been born, the question arises how to proceed with the opened vulva. The obstetricians are faced with the options of restoring the pre-delivery vaginal opening (reinfibulation) or closing the wound to restore a physiological opening as is done after episiotomy.

There were 12 women in the study who had been defibulated for delivery in Swiss hospitals. Of these, eight had been reinfibulated, one remained 'opened', and three did not comment on this issue. Surprisingly, half of the women who had been reinfibulated stated they had not been previously informed about it. One woman who developed a postoperative wound infection complained that she had not been adequately told about risks before the intervention, but the majority of women were satisfied with the result, not expecting to be asked about their views.

For the health care professionals confronted with it, the question of reinfibulation poses a great ethical challenge. On the one hand, there is no medical justification for closing the vaginal opening more than necessary. On the other hand a number of arguments could be used to justify reinfibulation: patients' rights, the fear of exposing women to social exclusion or rejection by the husband if they were left 'open', and the fact that the women taking the decision were of a mature age. One gynaecologist went as far as saying 'leaving the defibulated vulva open after delivery is another form of mutilating the woman'. In the obstetric services of all university hospitals taking part in this study, partial reinfibulation is carried out when requested by the patient. In doing the operation, physicians basically rely on their own judgement in deciding what would be appropriate, as no standardised procedures or medical guidelines exist in Switzerland.

Women's suggestions about how to improve services by the Swiss health care providers

Several women said they would like to get more information on what to expect during delivery, not only information concerning the baby. The women showed great interest in discussing the advantages and disadvantages of being excised and/or infibulated and learning about what is 'normal' in Swiss women. In addition, they wished for more empathic care, and especially that doctors would take more time to allow for discussions during consultations. The care provider should preferably be a woman. Discussing this issue with a man was said to be

extremely difficult. Generally, the women said they felt more confident when receiving care from a midwife rather than a doctor. Recalling teaching hospitals with 'crowds of doctors' eager to see their specific anatomy, the women wished for more privacy and intimacy during examinations.

As to the more medical aspects, all women participating in the discussions stressed that defibulation should be performed during delivery, as episiotomy is done on Swiss women, rather than adding an additional traumatic event during pregnancy. 'Why should a Somali woman be cut twice?'

Some women felt that in Switzerland Caesarean section was performed too often. In several small Swiss hospitals which rarely encounter women with FGM the health care providers reported that Caesarean section was the routine method for delivering such women. This was not the case in the larger Swiss university hospitals with more relevant experience.

Discussion

In comparison to other European countries, such as the UK or France, Switzerland hosts a small number of women from countries where FGM is practised. However, in relative terms compared to population size, Switzerland shows a similar proportion of women from these countries (150/100,000) to, for example, Germany (100/100,000). In Switzerland, these women live in concentrated geographical areas, which can help to target the response measures.

When estimating the number of women potentially affected in Switzerland, the researchers are aware that the migrant population may not be representative of the population in the home country with respect to FGM. However, in Somalia, Ethiopia and Eritrea, where most of the migrant women concerned are from, FGM is practised almost universally, usually before the age of 12 years. The majority of asylum seekers from the countries concerned were above 15 years old when they entered Switzerland (*source: statistics of the Swiss Federal Office for Refugees*), and can be expected to have undergone FGM at a similar rate to that of the home country. Nothing is known about how many of the girls born in Switzerland to migrant parents have undergone the practice.

Most of the physical long-term complications of FGM mentioned by the two study groups are similar to those described in the literature.[11] It should be noted that this study covered only women who have undergone the severest forms of FGM (type III and II). The results and conclusions drawn cannot be generalized to women who have undergone other types of FGM.

This study confirms the difference of obstetric complications linked to FGM in industrialized countries compared to the countries of origin. In African countries FGM causes major morbidity and mortality during pregnancy and delivery.[12] In a recent study from Europe no direct causal link to FGM could be found to explain the slightly higher rate of obstetric complications observed in women from Somalia than in local women.[13] Since obstetric complications play a smaller role in the European context, psychosexual complications, such as reduced sensation and pain during sexual intercourse, become more prominent as problems related to FGM. The present study shows that health care providers in Switzerland do not adequately address these psychosexual concerns.

The obstetric/gynaecological examination and related counselling of women who have undergone FGM type II or III needs particular knowledge and experience on the part of the health care professional. Not only vaginal examination, but also history-taking, need to be adapted to the needs of such patients in a sensitive and culturally appropriate way. The consultation should also address the question of whether or not a mother intends to have the operation carried out on her daughters—especially when she has given birth to a girl. Health care providers should not take a judgmental position in condemning traditional values and practices, but rather offer an informed discussion on the harmful effects of FGM and alternative options.

In terms of medical interventions, the frequency of Caesarean sections was of particular concern to the women who participated in the study. Reports from other countries indicate that Caesarean section is carried out more often on women with FGM. In Germany Caesarean section had routinely been performed on women with type III FGM in some hospitals.[14] A recent cross-sectional study from Norway with a large sample size found that rates of emergency Caesarean sections among Somali women were significantly higher than in the Norwegian population.[15] This confirms findings of this study from smaller Swiss hospitals. Skilled care for a woman with FGM during labour delivering does, however, not imply routine Caesarean section. Unless there are foetal indications, Caesarean section can be avoided by carrying out defibulation.

In order to avoid unnecessary trauma for the women, we support the practice of the Swiss health care professionals who perform defibulation during delivery and not during pregnancy.

The question of whether reinfibulation should be carried out is complex. Though they generally try to respect the interests of their clients, some Swiss health care providers seem to have violated the basic patients' right of informed consent before undertaking reinfibulation. In addition, Swiss health care providers who perform reinfibulation after delivery are not acting in line with recommendations of WHO, which condemns FGM and discourages reinfibulation beyond the normal closing of an episiotomy.[16] In some European countries, such as the UK and Belgium, reinfibulation is clearly condemned.[17,18] The Danish Board of Health presents a less categorical solution allowing for partial reinfibulation if wished by the client. However, experience showed that most women wanted to remain open if they had been thoroughly informed during their pregnancy about the health consequences of re-suturing.[19] These findings underline those of our study. Informing the women about the options and related consequences and including them in the decision on how to proceed after delivery is essential.

Finally, there is a great need for opportunities for the women concerned to share their experiences with each other, facilitated by an outsider. Sensitization efforts should give access to information about sexuality, pregnancy and delivery, with specific reference to women who have undergone FGM. They should include information about the normal female anatomy and the need for preventive check-ups outside pregnancy. Also, taking into consideration the lack of communication on FGM between sexual partners, it is crucial for health providers to involve men and to facilitate discussions within the couple. A further study with a representative group of men that analyses the position of immigrant men in the communities concerned would be of interest.

Conclusion

This study shows that the specific gynaecological and obstetric health care needs of women with FGM living in Switzerland are not being adequately addressed at present. This is not due to a lack of good will on the part of health care providers, but rather to the fact that, as with other culturally linked health issues that are seen rarely in Europe, most Swiss health professionals lack experience and guidance on how to care for such women. Clinical decisions are often based on assumptions rather than on evidence or on established guidelines.

Even though women with FGM are not very numerous in Switzerland, their specific health care needs should—and easily could—be better considered by the Swiss health care system. As they live in a geographically limited area and seek health care

mostly in hospitals, rather than in private practice, services could be improved with comparatively little additional effort and resources. Capacity building for health care providers and providing evidence-based professional guidelines on FGM should be priorities in Switzerland. It is equally important to provide access for women and men of these communities to culturally appropriate and sensitive information and to create opportunities for exchange, for example through self-help groups. These measures could lead to a much more positive encounter for both the women and the health care providers involved.

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