Is Female Genital Mutilation discussed by general practitioners in The Netherlands?

Underlying factors revealed

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Is Female Genital Mutilation discussed by general practitioners in The Netherlands? Underlying factors revealed.

A thesis submitted in partial fulfilment of the requirement for the degree of
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by
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Abbreviations

GP	General Practitioner
FGM/C	Female Genital Mutilation and/or Cutting
NVOG	Dutch Society of Obstetrics and Gynecology
WHO	World Health Organization

Abstract

Introduction

The GP in the Netherlands might often be the first to be confronted with patients who have undergone Female Genital Mutilation and/ or Cutting (FGM/C), and - as a result - experience health problems. However, it is unknown if GPs in The Netherlands discuss FGM/C with patients and women (at risk) of FGM/C, and whether they experience challenges. Unravelling these challenges, needs and underlying mechanisms will give us important understanding on how to improve the services of GPs in The Netherlands towards these women. Therefore, the first aim of this study was to describe if and how often GPs discuss FGM/C during consultations. Secondly, we aimed to analyze the self-reported knowledge about FGM/C. Thirdly, we aimed to explore specific self-reported factors that can enable or hamper discussing FGM/C during the GP consultation.

Methods

This study was part of a bigger ZonMw project, of which this questionnaire for GPs was a sub study. The other sub-studies are a Vignette Study and Focus Group discussions with both professionals and patients. In the current study, an online survey was performed in two regions; Amsterdam-Amstelland and Gelderland-Zuid. We aimed to reach all GPs in the two regions (n=483) via e-mail and other media channels. The participants were GPs, or other medical professionals working in general practice. The questionnaire contained both closed and open questions. The answers on the open questions were coded manually and analyzed thematically.

Results

Almost half (49%) of all the participants (n=51) had experience with discussing FGM/C, and more GPs with experience of addressing FGM/C worked in region Amsterdam-Amstelland as compared to Gelderland-Zuid. Various underlying factors were identified that were associated with whether or not GPs discuss FGM/C, such as patient characteristics, self-reported knowledge and skills of GPs, awareness of the risk of FGM/C for family members, and use of external help from key persons or interpreters.

Conclusion

There is room for improvement for GPs to discuss FGM/C. Investing in knowledge and skills of GPs to discuss FGM/C will help discussing this important subject. Involving key persons in the

training of GP(registrars) on cultural competence and FGM/C in general will be useful. Furthermore, promoting an appointment for an intake for new patients (originating from FGM/C risk countries) by GPs will improve the relationship between the two and thereby enhance the possibilities of discussing FGM/C. These issues will be further deepened in the other sub studies (Vignette Study and Focus Group discussions) of the ZonMw project.

Keywords: Female Genital Mutilation, General Practitioners, Primary Health Care

Word Count: 11.360

Introduction

As a medical doctor, I have always had a broad interest in patients with other cultural backgrounds. This was one of the reasons I specialized in tropical medicine. After my specialization, I worked in a rural hospital in Southern Tanzania for 2.5 years. Both during my training in The Netherlands, as during my work in Tanzania, I saw patients who underwent FGM/C. I still recall the consequences of this procedure for these women (physically, psychologically, and sexually) which made a deep impression.

I came back to The Netherlands and started my specialization in General Practice. Also in this different setting (less tropical!) I still have a big interest in patients with other cultural backgrounds, and I enjoy this combination of working in The Netherlands in primary healthcare with my own background in tropical medicine. During my specialization as a GP, I also continued my Master International Health. I had the desire to focus my research on a subject that would link to international health, but would also be relevant for GPs in their (daily) practice. Via old (tropical doctor) colleagues I came in contact with a research team investigating the efficiency of the Dutch policy for FGM/C also focusing on GPs. I was immediately hooked to the subject, and eager to find out the experiences of GPs in discussing FGM/C with patient from risk countries. As I became a GP in May 2022, I hope my future work will link the primary healthcare with important international health challenges in The Netherlands, such as FGM/C.

Background

Female Genital Mutilation or cutting (FGM/C) comprises all procedures involving (partial or total) removal of the external female genitalia or other injury to the female genital organs for non-medical reasons[1] . FGM/C is associated with a risk of health complications, such as obstetric complications [2], urinary tract infections [3], and psychological complaints [4]. On top of that, there are significant more often sexual complaints as compared to women who did not undergo FGM/C, such as reduced sexual desire and satisfaction, and dyspareunia [5,6] All forms of FGM/C are seen as a violation of human rights by the World Health Organization (WHO)[1] .

Exact number of girls and women who have undergone FGM/C around the globe are not known, but it is estimated that at least 200 million girls and women experienced FGM/C [7]. These numbers are still very high, despite many attempts worldwide to end FGM/C via various routes, such as education, change of (inter)national policies, and juridical measurements [3,4].

Why is FGM/C still practiced?

As FGM/C is practiced in various continents and regions, the reasons why FGM/C is still carried out is also vary diverse [1]. Firstly, in most places, FGM/C is considered to be part of a cultural tradition, and this is thought to be the most important argument to continue the practice nowadays. Secondly, it is seen as a ' rite de passage', and making girls ready for adulthood. Thirdly, other beliefs, such as an increased change of marriage after FGM/C, or associations with what is considered as acceptable sexual behavior. Lastly, social pressure is an important factor, as this procedure contributes to the feeling that you belong to the community, as (all) other women do it and have underwent the same. [1].

Types of FGM/C

FGM/C had been classified by the WHO into four types as shown in Figure 1 [7]:

Type 1: Removal of the prepuce (also known as the clitoral hood, covering the clitoris) and, or (partial) removal of the clitoris.

Type 2: Excision: the clitoris is removed and parts or all of the labia minora. In some cases parts or all of the labia majora are removed as well.

Type 3: This type is also known as infibulation. A small opening is formed after removal (of big parts of the) labia minora and labia majora, and the remaining's are sewn together. Via the opening, menstrual blood or urine can leave the body.

Type 4: All other forms of mutilation for non-medical purposes of the female genitals, such as scraping or piercing fall in this category.

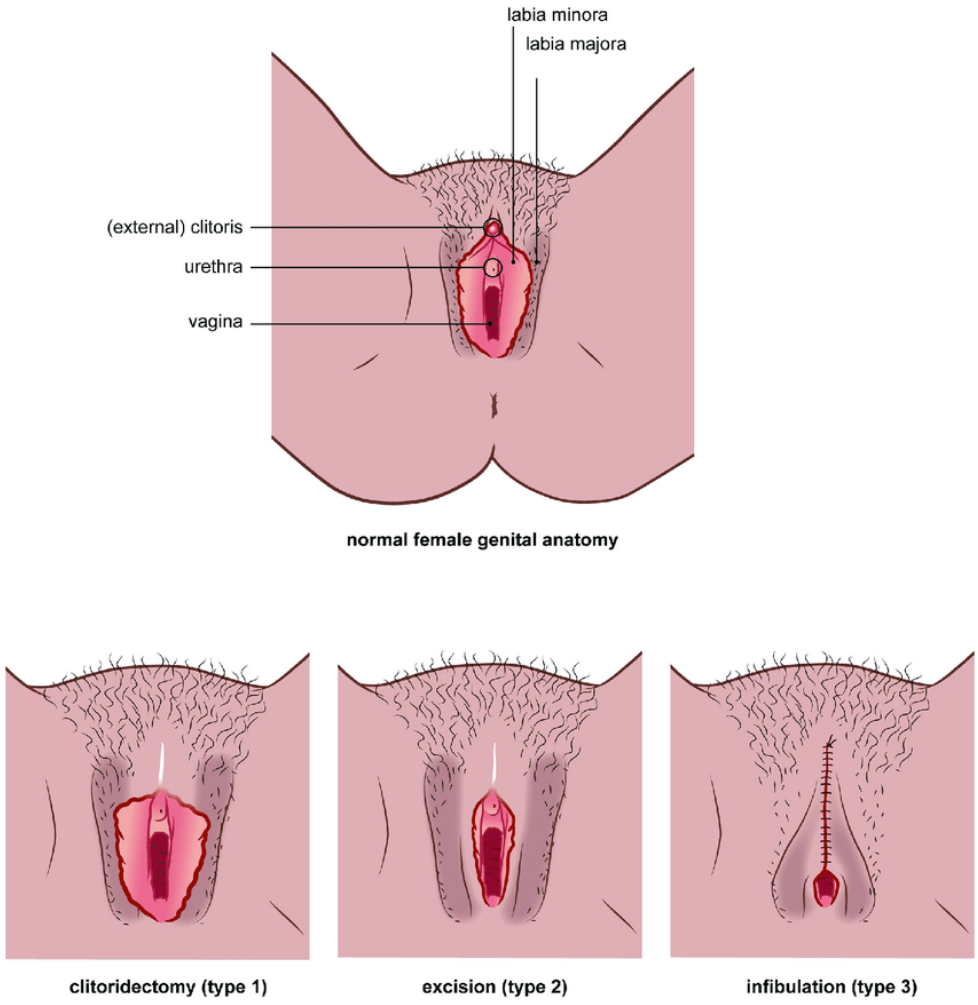

Figure 1: WHO classification of FGM/C [1,8]. Type 1: Removal of the prepuce or (partial) removal of the clitoris. Type 2: Excision of the clitoris and parts or all of the labia minora. Type 3: Infibulation. A small opening is formed after removal (of big parts of the) labia minora and labia majora, and the remaining's are sewn together. Type 4: This is all other forms of mutilation for non-medical purposes of the female genitals, such as scraping or piercing.

FGM/C in The Netherlands

In The Netherlands, 41.000 women have undergone FGM/C as estimated on 1st of January 2018 [9]. This estimation was calculated in a study in which Pharos, together with the Erasmus

University in Rotterdam, The University of Gent, Radboudumc, the Ministry of Health of The Netherlands, and the Royal Tropical Institute of Amsterdam, collaborated [9]. To investigate the prevalence of FGM/C in The Netherlands, data derived from the Dutch Central Statistical Office and data from Asylum Centers in The Netherlands was used. Of the 41.000 women who are estimated to have undergone FGM/C, 82% originates from Somalia, Egypt, Sudan, Ethiopia, Eritrea and Iraq [9]. In the same study, the estimation was made that around 4.200 girls in The Netherlands are at risk of undergoing FGM/C in the coming twenty years [9]. These girls originate mainly (82%) from Somalia, Egypt, Ethiopia, Sierra Leone and Guinee. Although some overlap is seen with the countries of the women that have undergone FGM/C, Sierra Leone and Guinee are ' new on the list'.

These numbers of women who have undergone FGM/C are significant and the Dutch Society of Obstetrics and Gynecology (NVOG) has recently developed a guideline for the management of FGM/C for all healthcare professionals in The Netherlands, including general practitioners (GP) [10]. The aim of this guideline is to provide all healthcare providers who may come into contact with women and girls with (or who might undergo) FGM/C with a national guideline. The guideline is supported by the relevant professional associations, and provides information on the prevention and treatment of girls and women with genital mutilation. This guidance provides the most recent evidence-based information on the subject of female genital mutilation. The purpose of the guideline is to increase knowledge about FGM/C and to provide tools for the guidance and treatment of these women in The Netherlands [10]. Clearly, the implementation of the guideline and making sure all professionals are familiar with the guideline is crucial for its success.

The Dutch Chain approach

In the early nineties, the Dutch were confronted for the first time with FGM/C, as the first women - from FGM/C prevalent countries - arrived in the Netherlands [11].

In 1993, when a substantial number of women who had undergone FGM/C arrived in the Netherlands, the Dutch Government took its official position that all forms of FGM/C are prohibited [12]. The Dutch policy focuses on one side on preventing that girls and women residing in The Netherlands, are being circumcised, and on the other side providing good (health) care to girls and women who have been circumcised in the past. So, the policy aims to target legal measures, health care and prevention [12].

In this light, the ' Dutch Chain Approach' was introduced, which describes the policy on FGM/C in The Netherlands, which was put into practice in 2006 [9]. This 'chain' is a collaboration of stakeholders from governmental and non-governmental organizations on prevention, care and law enforcement [9,12]. More particular, the chain of institutions involved in addressing FGM/C in The Netherlands consists of municipal public and youth health services (GGD), medical professionals (such as GPs, midwifes, gynecologists, nurses providing FGM/C aftercare). But also civil society and non-governmental organizations like the Federation of Somali Associations in the Netherlands (FSAN), Pharos, child-protection institutions, but also Immigration and Nationalization Service (IND) and the juridical system play an important role. This collaboration aims to prevent FGM/C, but in a wider sense provide services around FGM/C and intents for prosecution when possible [9,12]. The Ministry of Health, Welfare and Sports is responsible for the policy and coordinates this collaboration [9]. Since 2012, the municipalities were made responsible for the implementation of the policy to fight FGM/C, and especially the Public and Youth Health Services play a crucial role in this. The National GGD is still responsible for the national coordination and the initiation of the preventive approach for FGM/C within the Youth Health Care System [12]. The Youth Health Services provide regular medical and social check-ups for newborns (and older children) and their mothers, and probably in many cases, they therefore are the ones that will be – among other primary health care providers - the first to observe FGM/C related issues. To reach asylum seekers and refugees, they also provide health education on FGM/C in refugee centers [12].

An important role in the Dutch Chain Approach is assigned to the so called ' key persons' [13]. These key persons are men and women - mostly refugees and migrants - originating from countries where FGM/C is practiced, and often they have experienced FGM/C themselves. IN addition, key persons often have some knowledge on health care, for example because he or she was a doctor or nurse in their country of origin [13].

A key-person can have different roles, which are defined as following: educator, mediator, advisor, pathfinder, and role model. All key-persons have in common that they function as a 'bridge' between persons with a migration background and Dutch (healthcare) professionals such as GPs [14].

Pharos (the Dutch Centre of Expertise on Health Disparities), together with FSAN, provide training to potential key persons on FGM/C. After a three-day course, key-persons start to work with local organizations throughout the country, such as the municipalities, Youth Health Services, or a Language School [13].

The key persons discuss FGM/C with and within (their) risk communities, with the goal to provide support and refer to proper care and with the final goal to end FGM/C [13]. Furthermore, key persons support trainings of healthcare professionals – such as GPs – on the subject of FGM/C.

Juridical system

Law enforcement and in particular legislation on FGM/C is a another crucial component of the chain approach. Worldwide, there is a commitment to end FGM/C in all countries [1]. However, it has proven challenging to develop specific legislation with regard to FGM/C. Illustratively, in Europe, there is currently no specific legislation on FGM/C. However, the Istanbul Convention of 2011 is very promising as the countries that signed the Convention are willing to prevent violence against women, including FGM/C [15]. The Netherlands ratified the Convention in 2015.

In The Netherlands, there is no specific legislation for FGM/C. These practices fall under the general code intended for (child) abuse, and the main law criminalizing FGM/C is the Dutch Penal Code under Articles 300-304, 307 and 308 [16]. This is in line with other countries like Spain and France, where FGM/C is also forbidden under the general code [17]. On the contrary, other countries such as Belgium, Sweden and the UK, do have specific legislation on FGM/C [18]. In a Belgian research project [17], the difficulties of implementing the laws regarding FGM/C were compared between countries with specific legislation (Belgium, Sweden and the UK), with countries without specific legislation on FGM/C (Spain and France). The authors investigated the different legal approaches and their judicial outcomes. They concluded that no evidence was found that specific legislation is not more successful to assure punishment of FGM/C as compared to general criminal law provisions. In general, the study showed that criminal laws itself are not sufficient in preventing FGM/C, due to the difficulty in identification of cases and finding enough evidence. Finding enough evidence and identification of cases is complicated due to lack knowledge of professionals on FGM/C and the legal rules, and the difficulty that FGM/C is mostly committed within a family (or at least with their knowledge) and by other people belonging to their community [17,19].

Unsurprisingly, in line with the aforementioned observations, in the Netherlands, there have not been any convictions on planning or carrying out FGM/C. This is interesting, as the Penal Code was modified in 2013, to increase the possibilities of prosecution of FGM/C. Before 2013, it was possible to prosecute someone who carried out FGM/C abroad, but only if the suspect was either a permanent resident of The Netherlands or had the Dutch nationality [16]. But since 2013, the law was changed to include the possibility to prosecute 'everyone' who performed FGM/C abroad, as

long as the victim is a permanent resident of The Netherlands or is a Dutch citizen. However, up to date, there have not been any convictions on planning of carrying out FGM/C in The Netherlands.

Primary health care in The Netherlands

The Netherlands has a population of 17 million inhabitants [20]. The health insurance system in the Netherlands is referred to as a 'universal social health insurance approach' [21]. It is obligatory to have a health insurance, and insurers are obliged to accept all applicants. This insurance covers a standard package of care without extra payments, which also includes primary care provided by GPs. In the Dutch health system, the GP is often referred to as the 'gatekeeper' for specialist- and hospital care [22]. Patients therefore will have to get in contact with their GP first, and after a potential referral, patients may access specialist- or hospital care.

All Dutch inhabitants can choose their own GP within their neighborhood. Although it is officially not mandatory to register at a GP practice, the majority of the residents is registered. When registered, patients (or GPs) can initiate an intake with their GP to get to know their GP, although this is not obligatory. The purpose of an intake is to get to know the patient, their medical history and their general background [23,24]. Besides an intake, there are 'regular' consultations, usually concerning a specific complaints or subject.

Role of GP in discussing sensitive topics

During encounters of patients and their doctors, there is an interesting interaction and delicate balance, between what the patient asks and regarding which subjects the doctor initiates during a consultation [25]. From the literature, it appears that most GPs find certain subjects harder to discuss than others, as illustrated by the fact that GPs find it more challenging to start a conversation on certain subjects, some examples are sexually related issues or obesity [25,26,27]. For obesity, although GPs do try to engage in discussions about weight, they feel the conversation is challenging [27]. Due to moral judgment and blame, GPs said to be reluctant to discuss weight loss [26]. For sexually related issues, GPs experience sensitivity and complexity to discuss the subject [25]. These barriers were experienced to be even higher with patients from opposite gender, with patients from Black and ethnic minority groups, non-heterosexual patients, and older patients [25]. To improve communication about sexual related issues, training on communication skills seems to be helpful [25]. Apparently, improving communication helps to overcome (natural?) barriers to start these types of conversations.

General practitioners and FGM/C in The Netherlands

As illustrated in the sections above, the GP, being the first entry point in the healthcare system in The Netherlands, might often be the first to be confronted with patients who have undergone FGM/C and - as a result - experience health problems. The role of GPs is to provide healthcare, including to girls and women who have been circumcised in the past. The question is if they are aware if the patient has undergone FGM, do patient tell them about it or does the doctor actively ask about it? Furthermore, the GP could be involved in preventing that girls and women residing in The Netherlands are being circumcised, by signaling who might be at risk. However, it has been shown that FGM/C may be a blind spot for GPs in The Netherlands as illustrated in a recent study [28]. In this study, 16.700 anonymized patient records from five GP practices in The Netherlands were screened trying to identify records of patients with nationalities where FGM/C is prevalent [28]. From the total of 16.700 patient records, the country of origin from FGM/C prevalent countries was cited in 68 cases. From these 68 cases, the FGM/C status of the women was mentioned in 12 cases. Of the 12 cases, 11 had undergone FGM/C, but for none of these women the type of FGM/C was documented [28]. These numbers are low, and the authors therefore conclude that (the documentation of) FGM/C might be a blind spot for GPs in The Netherlands [28]. This observation is very problematic as this means women who have undergone FGM/C might lack care and the opportunity is missed to start the conversation about the risk for daughters and the potentiality that they will undergo FGM/C. According to another recent qualitative study in the Netherlands - most women would like their GP to proactively start the conversation about health problems related to FGM/C [8]. The authors of this study interviewed 16 women who had undergone FGM/C and asked them about their experiences with their Dutch GP [8]. Besides the wish of the women for their GP to actively start the conversation on FGM/C, they also felt that the consultations were too short [8]. These observations imply an important task for GPs to improve the detection FGM/C and start the conversation. Furthermore, a study in England shows an inability of GPs to address FGM/C [29]. Also in this study, semi-structured interviews were held, but instead of patients with FGM/C, in this study 17 GPs were interviewed working in English primary health care [29]. The GPs stated they were unsure when and with whom to discuss FGM/C and were concerned on imposing cultural sensitivities or offending women [29]. Furthermore, they found it challenging to balance the needs of the patient, and to estimate risks of FGM/C to family members and their needs [29].

For other professionals in the Netherlands, such as staff members at Youth Health Care involved in FGM/C, recent research shows that lack of knowledge and competence in communication on FGM/C resulted in an inability to address the topic [30]. In the Dutch setting, it is unknown

whether GPs experience challenges, and if so, which challenges, to discuss and act appropriately when encountering women (at risk of or) with FGM/C in their consultation rooms.

Problem statement and Justification

As illustrated in the Background section, tackling FGM/C related issues in The Netherlands is a complex task, divided over various actors in different sectors, all represented in the Dutch Chain Approach. Research regarding the effectiveness of the Dutch Chain Approach is currently limited. Nevertheless, it is essential to check whether the Dutch Chain Approach works in practice. Earlier research did focus on one element of the chain instead of the entire chain [30].

This is also in line with one of the recommendations from the Pharos prevalence study on FGM/C in the Netherlands, namely that evaluation and monitoring of the Dutch policy on FGM/C is recommended [12]. Therefore, there is a need to evaluate and focus on all chain partners involved in the prevention and care of FGM/C, and on perception of the patients about the care received.

In 2021, A ZonMw subsidy was granted to a project to evaluate the Dutch Chain Approach. This project consists of several sub-studies using quantitative and qualitative methods.

1. *Chain partners:* In chronologic order: these are a survey, a vignette study and focus groups with chain partners involved in prevention (follow-up) care and law enforcement. Providers to be approached during the study include general practitioners, Youth Health Care employees, obstetricians, gynecologists, employees of the FGM/C aftercare consultation hours, Safe at Home (In Dutch *Veilig Thuis*) employees, key persons, Child Protection Board, schools, police and the National Expertise Center for Honor Related Violence.

2. *Target group*: In addition, focus groups will be held with women and girls who have undergone FGM/C (or originate from the FGM/C risk countries) and an inventory is made of their needs and wishes have with regard to care and assistance.

In this way, the Chain collaboration will be evaluated, and success factors, barriers and possible points for improvements will be revealed. For the ZonMw study, two regions in The Netherlands were selected to conduct the research project, which are Amsterdam-Amstelland and Gelderland-Zuid.

In this thesis, I will focus on the first phase of the study, the questionnaire research. We will solely look at GPs. GPs are a key part of the chain approach and therefore can play a key role in the prevention and management of FGM/C cases. In parallel, the other questionaries filled in by

other chain partners will be evaluated by the research group involved in the ZonMw project. The later phases of the study (vignette study and focus groups) will take place consecutively.

As shown in the above section, it is largely unknown whether GPs in The Netherlands experience challenges, and if so, which challenges, to discuss and act appropriately when encountering women (at risk of or) with FGM/C in their consultation rooms. Unravelling these challenges, needs and underlying mechanisms that play a role will give us important understanding on how to improve the services of GPs in The Netherlands towards these women.

Objectives

The main objective is to described the perceived knowledge and experiences of GPs in regions Amsterdam-Amstelland and Gelderland-Zuid in The Netherlands while discussing FGM/C in their consultation rooms. As explained in the 'Problem Statement', this study is part of a larger study, which aim is to review the current Dutch policy on FGM/C. Therefore, this thesis is addressed to policy makers involved in FGM/C in The Netherlands, and particularly the GPs involved in policy making for the Dutch Organization of GPs (NHG). Furthermore, it can give important insights for individual GPs.

The following objectives would facilitate the achievement of this main objective:

1. To describe if and how often GPs in regions Amsterdam-Amstelland and Gelderland-Zuid discuss FGM/C during consultations.
2. To analyze the self-reported knowledge about FGM/C.
3. To explore specific self-reported factors that can enable or hamper discussing FGM/C during the GP consultation.
4. To formulate recommendations for modifying the other sub-studies (vignette study and focus group discussions) of the bigger ZonMw study.

Methods

Design

As described in the Problem Statement, A ZonMw subsidy was granted to a project to evaluate the Dutch Chain Approach. This project consists of several sub-studies. In this thesis, one of these sub-studies will be described. We will focus on the analysis of the questionnaire research of GPs. In parallel, the other questionaries filled in by other chain partners will be evaluated by the research group involved in the ZonMw project. This evaluation is still in progress, and no results have been released yet.

In this thesis, a survey was performed, in which participants filled in an online questionnaires with closed and open questions.

Participants and sampling

General practitioners from the regions 'Amsterdam-Amstelland' and ' Gelderland-Zuid' participated in this project. These two regions were selected for the bigger ZonMW project as they were considered representative areas for more urban (Amsterdam-Amstelland) and non-urban (Gelderland-Zuid) populations. In addition, the selection of these two regions was also pragmatic, as members of the 'action research group' (explained in the next section) themselves were working in these two regions as GPs. Therefore, they hoped to enhance the enrollment of participants in the study, as the project duration of the ZonMw study would be only 20 months. The questionnaire was aimed primarily at general practitioners, but also at general practitioners in training, medical assistants, and nurse practitioners working in general practice. The questionnaire contained open and closed questions (so both quantitative and qualitative data).

The total estimated number of GPs working in regions Amsterdam-Amstelland and Gelderland-Zuid is 320, and 163 respectively [31]. The intention was to estimate the proportion of GPs with experience of addressing FGM/C. As this study has an exploratory character, we strived for an as high response as possible. However, when keeping the total number of 483 GPs in the two regions in mind, the ideal sample size representing our population would be 122 respondents [32]. We estimated this number of participants with a power of 80% and significance level of 5% [32].

Recruitment of Participants

This research project is part of a bigger ZonMw subsidy project called ' The practical implementation of the policy on female genital mutilation and the needs and wishes of the target group'.[1] The project is executed through a collaboration with involved professionals and so called 'action research groups'. For the total research protocol of the ZonMw project and the involved professionals, please see the separate document available through KIT.

Through these groups and investigators, invitations were sent by e-mail to their colleagues (fellow GPs) in regions Amsterdam-Amstelland and Gelderland-Zuid in May 2021.
In this e-mail potential participants were informed on the project and invited to fill out the questionnaire about discussing FGM/C, which was available through a hyperlink. There was no email database of all GPS working in the two regions. Therefore, we aimed to recruit participants via various other channels, such as social media or regional GP collaboration websites. In this way, we strived to reach all GPs working in the two regions.

Data collection

A study-specific questionnaire was developed based on a former questionnaire on the subject of FGM/C policy developed by the Verwey-Jonker Institute [30]. This former questionnaire aimed to evaluate the experience of discussing FGM/C by Youth Health Care employees [30]. That questionnaire was developed by the Verwey-Jonker Institute, based on *'Standpunt Preventie van Vrouwelijke Genitale Verminking (VGV) door de Jeugdgezondheidszorg',* which served as a starting point for their questionnaire. The questionnaire was validated in that study [30]. In this thesis, the questionnaire was modified for its target group: the GPs. A pre-test was performed by members of the aforementioned 'action research groups' to identify possible difficulties and bugs.

The questionnaire contained open and closed questions (so both quantitative and qualitative data). We included the following topics: if and when GPs discuss FGM/C, factors possibly influencing whether or not GPs discuss FGM/C (such as self-perceived knowledge and competence on discussing FGM/C), knowledge on the policy of FGM/C. For an overview of the questions that were included in the questionnaire, please see Annex 1.

[1] In Dutch: ' *De praktische uitvoering van het beleid ten aanzien van vrouwelijke genitale verminking en de behoeften en wensen van de doelgroep'*

Data analysis

The respondent's characteristics and other information collected via closed questions were presented using descriptive statistics. The open questions were analyzed using thematic analysis [33] focusing on the objectives. The answers were independently analyzed manually by two researchers (MP and VS), using open coding. After coding the first 10 questionnaires, researchers came together to compare the coding they applied and to come to agreement on a set of codes which was then used for the subsequent questionnaires. After coding all questionnaires, another meeting was conducted between the two researchers to agree on the coding, and if needed, recode. This was a for- and backward process, which was finished after the last questionnaire was analyzed. Codes were then organized into categories, and the categories were organized into themes and overarching themes. To identify factors associated with discussing FGM/C, the outcomes on closed questions were compared between the participants with and without experience with discussing FGM/C. After analyzing both the open and closed questions, underlying factors associated with whether or not participants discuss FGM/C were identified.

Ethics and data management/ protection

We acquired ethical approval for the ZonMW project from Amsterdam University Medical Center, location AMC. Therefore - in consultation with the KIT Ethics Committee – no ethical waiver was needed from KIT, and clearance was provided. Participants gave their online approval for participation. All data was anonymized, treated confidentially and digitally stored on the secure server of the GGD Amsterdam.

Results

In total, 72 professionals working in primary health care setting of general practitioners filled in the questionnaire. However, the questionnaire was not completed in 21 cases in which participants only filled in the basic characteristics and seemed to have prematurely closed the questionnaire. Therefore, we have excluded them, remaining with 51 who filled in questionnaires. Of the 51 professionals, the majority (68.6%) worked in region 'Amsterdam-Amstelland'. Overall, the majority of the professionals was of female gender (76.5%). Furthermore, 92.2% (n=47) of all participants was general practitioner, the others (n=4) were either general practitioner in training, assistant or nurse practitioner. All respondents estimated the percentage of patients originating from risk countries for FGM/C in their practice to be between 0-25%.

The basis characteristics of the respondents are shown in Table 1, also for respondents with and without self-reported experience of addressing FGM/C. This self-reported experience in addressing FGM/C is defined as ever having conversation with a patient about FGM/C or related issues.

Table 1: Basic characteristics for respondents classified according to self-reported experience addressing FGM/C

CHARACTERISTICS	TOTAL (N = 51)	WITH EXPERIENCE OF ADDRESSING FGM/C (N=25)	WITHOUT EXPERIENCE OF ADDRESSING FGM/C (N=26)
REGION			
AMSTERDAM- AMSTELLAND	35 (68.6%)	21 (41.2%)	14 (27.4%)
GELDERLAND-ZUID	16 (31.4%)	4 (7.8%)	12 (23.6%)
SEX			
MALE	12 (23.5%)	4 (7.8%)	8 (15.7%)
FEMALE	39 (76.5%)	21 (41.2%)	18 (35.3%)
AGE (YEARS, MEAN AND STANDARD DEVIATION)	45.6 (10.2)	47.2 (8.7)	43.9 (11.4)
PROFESSION			
GENERAL PRACTITIONERS (GP)	47 (92.2%)	24 (47.1%)	23 (45.1%)
GP IN TRAINING	2 (3.9%)	0 (0%)	2 (3.9%)

ASSISTANT	1 (2%)	0 (0%)	1 (2%)
NURSE PRACTITIONER; MENTAL HEALTH	1 (2%)	1 (2%)	0 (0%)
TYPE OF GP (N=47)			
OWN PRACTICE	29 (56.9)	12 (23.5%)	17 (33.4%)
INDEPENDENT	3 (5.9%)	2 (3.9%)	1 (2%)
' HIDHA' #	1 (2%)	0 (0%)	1 (2%)
OTHER	14 (27.5%)	10 (19.6%)	4 (7.9%)
YEARS OF EXPERIENCE AS PROFESSIONAL (MEAN AND STANDARD DEVATION)	13.8 (8.9)	14.1 (8.4)	13.6 (9.7)
PERCENTAGE OF PATIENTS ORIGINATING FROM RISK COUNTRIES FOR FGM/C ESTIMATED BY GP			
0-25%	51 (100%)	25 (49%)	26 (51%)
25-50%	0 (0%)	0 (0%)	0 (0%)
50-75%	0 (0%)	0 (0%)	0 (0%)
25-100%	0 (0%)	0 (0%)	0 (0%)
RECENT TRAINING ON FGM/C?			
YES	5 (9.8%)	2 (3.9%)	3 (5.9%)
NO	46 (90.2%)	23 (45.1%)	23 (45.1%)

#HIDHA: is a GP working on a contract at another GPs practice.

For the basic characteristics, more respondents with experience of addressing FGM/C worked in region Amsterdam-Amstelland as compared to Gelderland-Zuid. Other characteristics, such as age, number of years of experience as a professional, type of practice or recent training on FGM/C did not differ between the two groups of respondents either with or without experience of addressing FGM/C.

As calculated in the Methods section, we aimed to have 122 respondents, which was not reached. To examine whether the 51 participants in this study were a representative sample of the total number of GPs in the two regions, characteristics of the groups were explored.

From the total GPs in Amsterdam-Amstelland,10 % (35/320) participated in this study, which was comparable with Gelderland-Zuid, where 9.8% (16/163) filled in the questionnaire. Other specific characteristics were not known for the GPs in region Amsterdam-Amstelland and Gelderland-Zuid. However, characteristics such as gender and age are known for all Dutch GPs and could be compared with the current study. For example, a higher percentage of the

participants in this study were women (76.5%) as compared to 58.1% of all GPs in The Netherlands [31]. The mean age of the participants in this study was 45.6 years of age. Although no mean age is known of the Dutch GPs in general, a large proportion of the GPs (44.8%) is aged between 35-50 years [31].(CBS)

The outcomes of the quantitative and qualitative data will be described according to the first two objectives that were described in the Methods section.

1. To describe if and how often GPs in regions Amsterdam-Amstelland and Gelderland-Zuid discuss FGM/C during consultations

Forty-nine percent of the participants (N=25) ever started a conversation with a patient on FGM/C, the remaining half of the participants did not have any experience with starting such a conversation. The number of times participants started the conversation on FGM/C varied from 1 to 20 times.

The participants that had experience with discussing FGM/C, mainly did that during regular visits, a few participants (n=5) used an intake with a patient to discuss the issue. The majority of the participants with experience of discussing FGM/C did that during consultation that was linked with FGM/C (n=16), and others started the conversation during consultation that was not linked with FGM/C (n=4), or stated to use ' other consultations' (n=5).

In Table 2, two statements are shown regarding starting the conversation on FGM/C, filled in by all participants (n=51). The majority of the participants indicated that they partly disagree with the statement, that they discuss FGM/C with patients from risk countries in practice one, at minimal. If the complains is related to FGM/C, then they discuss the matter several times.

Table 2: Statements about FGM/C and starting the conversation

	TOTALLY DISAGREE	PARTLY DISAGREE	NEUTRAL	AGREE	TOTALLY AGREE
I TALK ABOUT FGM/C, IN PRACTICE, WITH PATIENTS FROM RISK COUNTRIES AT LEAST ONCE					
WITH EXPERIENCE OF ADDRESSING FGM/C (N=25)	1 (4%)	10 (40%)	7 (28%)	6 (24%)	1 (4%)
WITHOUT EXPERIENCE OF ADDRESSING FGM/C (N=26)	4 (15.4%)	16 (61.5%)	5 (19.2%)	1 (3.8%)	0 (0%)
I DISCUSS FGM/C SEVERAL TIMES IF THE COMPLAINT IS RELATED TO FGM/C					
WITH EXPERIENCE OF ADDRESSING FGM/C (N=25)	0 (0%)	2 (4%)	2 (4%)	17 (68%)	4 (16%)
WITHOUT EXPERIENCE OF ADDRESSING FGM/C (N=26)	2 (7.7%)	7 (26.9%)	4 (15.4%)	11 (42.3)	2 (7.7%)

2. To analyze the self-reported knowledge about FGM/C

Knowledge

More than half of all the participants (n=34 (66.7%)) indicated they lack or have insufficient knowledge on the Dutch policy focusing on FGM/C. No differences were identified when comparing participants with or without experience of discussing FGM/C. Knowledge on cultural sensitive work in general was also experienced as lacking or insufficient by a considerable percentage of all participants (n=14 (27.4%)). Again, no differences were identified when comparing participants with or without experience of discussing FGM/C. However, regarding knowledge about the cultural background of FGM/C, when comparing the participants with and without experience of addressing FGM/C, participants without experience with addressing FGM/C more often stated to have no or insufficient knowledge as compared to participants with experience of addressing FGM/C (n=5 (25%), and n=18 (69.2%) respectively). The various percentages are shown in Table 3.

Table 3: Statements about FGM/C and knowledge

	(ALMOST) NO KNOWLEDGE	INSUFFICIENT KNOWLEDGE	AVERAGE KNOWLEDGE	SUFFICIENT KNOWLEDGE	MORE THAN SUFFICIENT KNOWLEDGE
I HAVE KNOWLEDGE OF THE DUTCH FGM/C POLICY					
WITH EXPERIENCE OF ADDRESSING FGM/C (N=25)	4 (16%)	10 (40%)	7 (28%)	2 (4%)	2 (4%)
WITHOUT EXPERIENCE OF ADDRESSING FGM/C (N=26)	6 (23.1%)	14 (53.8%)	5 (19.2%)	1 (3.8%)	0 (0%)
I HAVE KNOWLEDGE ABOUT THE CULTURAL BACKGROUND OF FGM/C					
WITH EXPERIENCE OF ADDRESSING FGM/C (N=25)	1 (4%)	4 (16%)	15 (60%)	4 (16%)	1 (4%)
WITHOUT EXPERIENCE OF ADDRESSING FGM/C (N=26)	5 (19.2%)	13 (50%)	7(26.9%)	1 (3.8%)	0 (0%)
I HAVE KNOWLEDGE ON CULTURE SENSITIVE WORK					
WITH EXPERIENCE OF ADDRESSING FGM/C (N=25)	0 (0%)	3 (12%)	12 (48%)	7 (28%)	3 (12%)
WITHOUT EXPERIENCE OF ADDRESSING FGM/C (N=26)	1 (3.8%)	10 (38%)	10 (38%)	4 (15.4%)	1 (3,8%)

The majority (n=42 (80.7%)) of the participants stated to have no knowledge on the guidelines and the guidelines' recommendations (being the ' Leidraad 2019' and the ' Model Protocol 2010'). Two participants (3.9%) stated to know about both the guidelines and the recommendations. Seven participants (13.7%) stated to know about the guidelines only. Two participants (3.9%) stated to regularly use the recommendations in daily practice, the others answered negative.

3. To explore specific self-reported factors that can enable or hamper discussing FGM/C during the GP consultation

In Table 4, various reasons for not starting the conversation on FGM/C are shown as indicated by the participants with and without experience of addressing FGM/C (n=51). Participants could select more than one answer. The three options mostly selected were *' Not enough time'*, *' I don't know who the population of interest is* , and *' I don't know how to start the conversation'* .

Table 4: Reasons for not addressing FGM/C

REASONS*	
I DON'T KNOW WHO THE POPULATION OF INTEREST IS	16
NOT ENOUGH TIME	15
I DON'T KNOW HOW TO ADDRESS FGM/C	12
I ASSUME A COLLEAGUE ALREADY DISCUSSED FGM/C	5
I ASSUME THE PATIENTS' COMPLAINT IS NOT RELATED TO FGM/C	5
I ASSUME THERE IS NO RISK OF FGM/C FOR FAMILY MEMBERS	5
DISCUSSING FGM/C WILL INFLUENCE THE RELATIONSHIP WITH THE PATIENT/PARENTS	3
THERE ARE MORE URGENT MATTERS TO BE DISCUSSED	8

*Participants could choose multiple reasons

We created the themes and categories (as seen in Figure 2) based on the qualitative data (according to the process of thematic analysis as described in the Methods section) derived from questions in which participants were asked to clarify what reasons were for (not) addressing FGM/C. The questions were filled in by both participants with and without experience of addressing FGM/C, and since no differences were identified in the type of answers, the analysis was done with both groups of participants taken together. The three overarching themes we identified are: '*Patients' factors', 'Doctors' factors'* and '*External factors'*.

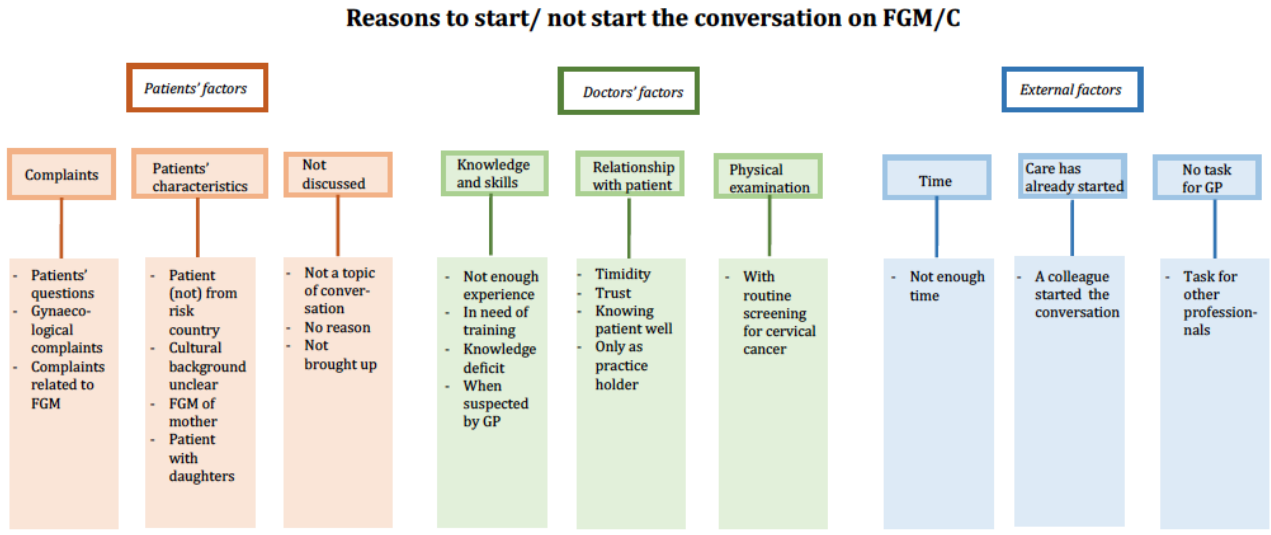

Figure 2: Reasons to (not) discuss FGM/C

Patients' factors

The first theme we identified was *'Patients' factors'* as a reason to (not) start the conversation on FGM/C. We divided this theme into three subthemes – ' Complaints', ' Patients' characteristics', and ' Not discussed' – as shown in Figure 1. The first subtheme, ' Complaints' of the patient, was a reason for (not) starting the conversation om FGM/C, as illustrated by the following quote (GP, 35 years):

> *' I discuss it with vaginal complaints. I should probably also discuss it with unrelated complaints, I'm not doing that now.'*

Or for example (GP, 44 years):

> *'If obvious complaints related to FGM/C, then I always start the conversation, and when a patient has questions about it or wants to talk about it then of course also.'*

The second subtheme we identified, ' Patients' characteristics', contained characteristics of the patient that were reason(s) for participants to (not) discuss FGM/C. Participants for example questioned how many women with possible FGM/C were present in their practice, as illustrated by the following quote (GP, 59 years):

' *As far as I know, the target group is not visibly represented in my current practice.'*

Depending on if FGM/C was present, participants also mentioned that this was a reason to as about the risk for daughters, as seen in the following quote (GP, 49 years):

'I only discuss it when I see it (FGM/C) with the mother and then extend it to FGM/C on her daughter(s)'

The third and last subtheme we identified was 'Not discussed'. Participants elaborated that the subject of FGM/C was not discussed or not brought up during consultations, for example (GP, 59 years):

' *I never had a reason to discuss this*'

And as illustrated by the following quote (Assistant, 24 years):

'Usually, such complaints are not discussed with us'

<u>Doctors' factors</u>

The second theme we identified was *'Doctors' factors'* as a reason to (not) start the conversation on FGM/C. We divided this theme into three subthemes – ' Knowledge and Skills', ' Relationship with patient', and ' Physical Examination' – as shown in Figure 1. The first subtheme, ' Knowledge and Skills' of the doctor, was a reason for (not) starting the conversation om FGM/C, as illustrated by the following quote (GP, 37 years):

'Difficult to speak up if you have no idea whether it (FGM/C) is the case.'

Or, as seen in the following quote (GP, 38 years):

' *During a consultation with a patient from a risk country, it does not immediately occur to me that this subject requires attention, due to insufficient knowledge about the incidence of the problem*'

The second subtheme we identified, ' Relationship with patient', in which participants indicated the importance of their relationship with the patient as a reason to (not) discuss FGM/C. For example shown in the two following quotes from the same participant (GP, 61 years):

'It is only possible (to discuss FGM/C) when you know them well'

'You will have to win some trust'

And (GP 56 years):

'First get in contact, then deepen the relationship'

The third and last subtheme was ' Physical Examination'. The observations during physical examination was a reason to (not) discuss FGM/C, as illustrated by the following quote (GP, 49 years):

'I honestly only discuss it during a gynecological examination if the woman has already been circumcised earlier, not with young girls, I will then talk to the mother about whether or not to circumcise young girls.'

Routine cervical smear (for screening of cervical cancer) was another distinct moment mentioned by general practitioners, to start the conversation on FGM/C, as shown this citation (GP, 34 years)

'With a cervix smear I discuss FGM/C when needed'

Or (GP, 38 years):

' I see it during the examination for a Pap smear or other gynecological consultation. Then I discuss it.'

External factors

The third theme we identified was *'External factors'* as a reason to (not) start the conversation on FGM/C. We divided this theme into three subthemes – ' Time', 'Care has already started', and 'No task for GP'– as shown in Figure 1.

The first subtheme, ' Time' was a reason for (not) starting the conversation om FGM/C, as shown by the next quote (GP, 38 years):

> *'If I would have all the time of the world…'*

The second subtheme we identified was 'Care has already started', in which participants indicated the importance of other professionals that already were involved, such as (GP, 55 years):

> *'I have only been indirectly involved in patients with FGM/C. I only have seen that this (i.e. FGM/C) was the case with patients who were already being helped for this (i.e. FGM/C.'*

The third and last subtheme we extracted from the data was 'No task for GP', in which participants marked they were not sure if they found it their 'task' to discuss FGM/C, as illustrated in the following citation (GP, 57 years):

> *'And I think it is an important task for the Youth health services (GGD) and not for the GP'*

Skills and competence

The majority of the general practitioners indicated they know FGM/C should be talked about with patients from risk countries, preferably several times, and that the type of FGM/C needs to be registered. When comparing the participants with and without experience of addressing FGM/C, participants without experience with addressing FGM/C more often stated to lack skills to start the conversation on FGM/C as compared to participants with experience of addressing FGM/C. The various numbers and percentages are shown in Table 5.

Table 5: Statements about FGM/C and skills

	TOTALLY DISAGREE	PARTLY DISAGREE	NEUTRAL	AGREE	TOTALLY AGREE
I KNOW FGM/C SHOULD BE TALKED ABOUT WITH PATIENTS FROM RISK COUNTRIES					
WITH EXPERIENCE OF ADDRESSING FGM/C (N=25)	0 (0%)	1 (4%)	3 (12%)	16 (64%)	5 (20%)
WITHOUT EXPERIENCE OF ADDRESSING FGM/C (N=26)	1 (3.8%)	2 (7.6%)	9 (34.2%)	13 (49.4%)	1 (3.8%)
I KNOW FGM/C SHOULD BE TALKED ABOUT MULTIPLE TIMES					
WITH EXPERIENCE OF ADDRESSING FGM/C (N=25)	0 (0%)	1 (4%)	5 (20%)	15 (60%)	4 (16%)
WITHOUT EXPERIENCE OF ADDRESSING FGM/C (N=26)	1 (3.8%)	3 (11.4%)	13 (49.4%)	9 (34.2%)	1 (3.8%)
I KNOW THE TYPE OF FGM/C NEEDS TO BE REGISTERED					
WITH EXPERIENCE OF ADDRESSING FGM/C (N=25)	0 (0%)	10 (40%)	5 (20%)	9 (36%)	1 (4%)
WITHOUT EXPERIENCE OF ADDRESSING FGM/C (N=26)	2 (7.7%)	5 (19.2%)	12 (46.1%)	7 (26.9%)	0 (0%)
I HAVE ENOUGH SKILLS TO START THE CONVERSATION ABOUT FGM/C					
WITH EXPERIENCE OF ADDRESSING FGM/C (N=25)	0 (0%)	7 (28%)	9 (36%)	9 (36%)	0 (0%)
WITHOUT EXPERIENCE OF ADDRESSING FGM/C (N=26)	6 (22.8%)	14 (53.2%)	4 (15.2%)	2 (7.6%)	0 (0%)

Figure 3 shows the themes and subthemes on *skills and competence* from the open questions in which participants were asked to clarify what influences their skills and competence to discuss FGM/C. Questions were filled in by both participants with and without experience of addressing FGM/C, and since no differences were identified in the type of answers, the analysis was done for both groups of participants taken together. The three overarching themes we identified are: '*Patients' factors', 'Doctors' factors'* and '*External factors'*.

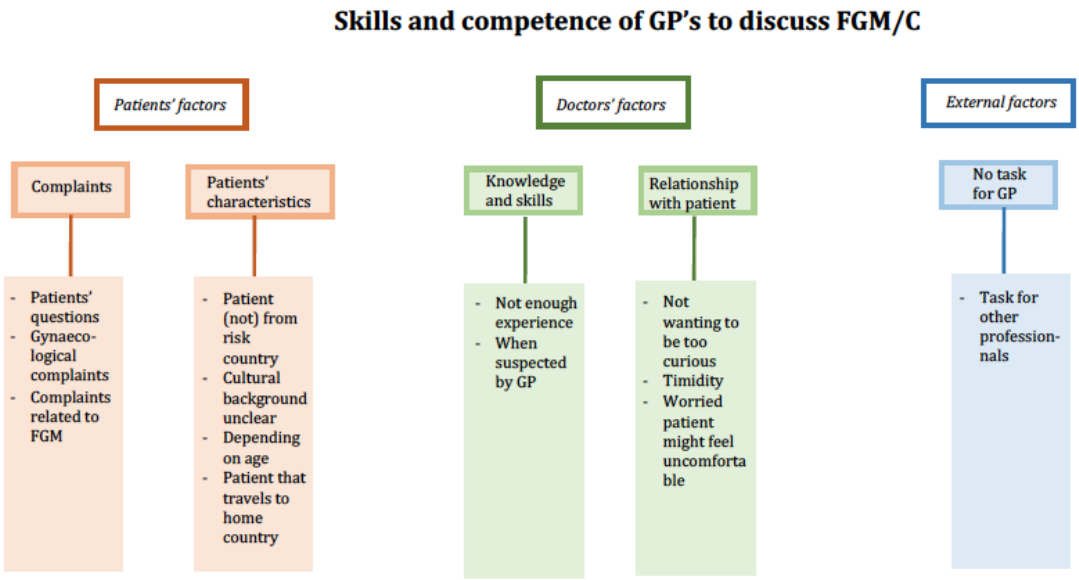

Figure 3: Skills and competence of GPs to start the conversation on FGM/C

Patients' factors

The first theme we identified was *'Patients' factors'*. We divided this theme into two subthemes – ' Complaints', and ' Patients' characteristics', as shown in Figure 2.

The first subtheme, 'Complaints' of the patient, was mentioned by participants as important for their skills and feeling of competence to start the conversation on FGM/C, as illustrated by the following quote (GP, 46 years):

> *'There were no questions or complaints about it or that I came across it during a physical examination'*

The second subtheme we identified, ' Patients' characteristics', contained characteristics of the patient that were of importance for the skills and competence of the participants to discuss FGM/C. For example, whether patients traveled back to their home country was mentioned by GPs as an important indicator to feel competent to discuss FGM/C, as shown in the following quote (GP, 53 years):

' *I have very few patients from high-risk countries. I discussed it once when a family with 3 daughters went back to Somalia for family visit.'*

Doctors' factors

The second theme we identified was *'Doctors' factors'.* We divided this theme into two subthemes – 'Knowledge and Skills', and ' Relationship with patient' as shown in Figure 2. The first subtheme, 'Knowledge and Skills' of the doctor, in which participants stated to not have enough experience on starting the conversation. For instance, in the following quote (GP 53 years):

'I never started the conversation (on FGM/C) because it never came across, but actually I also just never thought'

The second subtheme we identified, was ' Relationship with patient'. Participants mentioned the importance of trust, and knowing their patient well. For example, one participant stated (GP, 57 years):

' *I am concerned a patient will feel uncomfortable. I don't want to be curious'*

And (GP, 61 years)

' *It's only possible to start the conversation when you know the patient well'*

External factors

The third theme we identified was *'External factors'*, as shown in Figure 2. Participants indicated that their skills and competence on discussing FGM/C was also depending on whether they knew if other professionals already discussed the subject with a patient, as illustrated by the this citation (GP, 59 years):

'I worked with 2 female colleagues, if they had concerns they talked to the patient or the parents.'

Prevention of FGM/C

The majority of the participants (n=31 (60.7%) indicated they (totally or partly) disagree with the statement that they discuss the risk for FGM/C for family members. More participants without experience disagreed with this statement compared with participants with experience. The various percentages are shown in Table 6.

Table 6: Prevention; discussing the risk of FGM/C

	TOTALLY DISAGREE	PARTLY DISAGREE	NEUTRAL	AGREE	TOTALLY AGREE
I DISCUSS THE RISK FOR FGM/C FOR FAMILY MEMBERS, IF NECESSARY					
WITH EXPERIENCE OF ADDRESSING FGM/C (N=25)	1 (4%)	9 (36%)	8 (32%)	6 (24%)	1 (4%)
WITHOUT EXPERIENCE OF ADDRESSING FGM/C (N=26)	5 (19.2%)	16 (61.6%)	5 (19.2)	0 (0%)	0 (0%)
I DISCUSS FGM/C SEVERAL TIMES IF ATTENTION NEEDS TO BE GIVEN TO A RISK OF FGM/C FOR FAMILY MEMBERS					
WITH EXPERIENCE OF ADDRESSING FGM/C (N=25)	1 (4%)	1 (4%)	8 (32%)	11 (44%)	1 (4%)
WITHOUT EXPERIENCE OF ADDRESSING FGM/C (N=26)	3 (11.5%)	9 (34.6%)	6 (23.1%)	7 (26.9%)	1 (3.9%)

Support from other service professional cadres

Participants were also asked if they use interpreters and/ or key persons to discuss FGM/C. The majority of the general practitioners indicated to never use key persons (80.4%) as well as interpreters (59.6%).
Participants illustrated what their experiences were with interpreters, for example (GP, 44 years):

> *'Reasonably good but also time consuming and difficult if patient does not show up. As soon as good contact, it's very nice'*

And (GP, 40 years):

> ‘ *I also find the conversation with an interpreter difficult because of confidentiality, timidity with patients*’

Participants also explained why they did not use key-persons during consultations associated with FGM/C. For example (GP, 35 years):

> ‘ *I did not know about the existence of key-persons*’

And (GP, 57 years):

> ‘ *For me it is not clear who a key-persons is and how they can help*’

Discussion

It is unknown if and when GPs in the Netherlands discuss FGM/C, and whether they experience challenges to discuss and act appropriately when encountering women (at risk of or) with FGM/C in their consultation rooms. We aimed to unravel these challenges, needs and underlying mechanisms to give us important understanding on how to improve the services of GPs for these women. Here, we report that (almost) half (49%) of the GPs that participated in this study ever started a conversation to discuss FGM/C.

Taken together, our findings suggest that there is room for improvement for GPs in discussing FGM/C with their patients. We identified various underlying factors - such as patient factors, knowledge, skills and competence and use of other partners - playing a role in whether GPs discuss FGM/C or not, and by addressing these factors we might be able to improve the care provided by GPs for women with FGM/C in the Netherlands.

Knowledge

'Knowledge' was a recurrent theme in the survey, and a considerable percentage of all participants stated that knowledge on cultural background of FGM/C - and on culture sensitive work in general – was perceived as insufficient. In the open questions, participants stated to not have enough experience while starting the conversation, having a knowledge deficit and being in need of training on the subject as reasons for not addressing FGM/C. It would be interesting to know where this ' knowledge deficit' comes from. Has the GP ever had knowledge on the subject and is it just too long ago they were trained on the subject? Or has there never been a thorough training on FGM/C? When asking around the eight universities (providing GP-training) in The Netherlands whether they provide education on FGM/C, only one (Amsterdam UMC) stated to provide specific courses for GPs in training on the subject (own assessment done by the author). It therefore seems already a lack of knowledge that starts early in the career of GPs, and one could argue that this subject could be more prominently educated during the GP training curriculum.

To make sure all health care professionals in The Netherlands work according to the same protocol, the NVOG developed a guideline for the management of FGM/C in 2019 [10]. Our study however implies that these guidelines are not well known by GPs in the two regions where the survey was held and we can only hypothesize what the reason for that might be. In what way did

communication take place to inform GPs about this new guideline? Has it drawn their attention in the first place? Are GPs ' just' too busy to read all new guidelines, and should there be another way of bringing new guidelines to their attention?

Knowledge on culture sensitive work was another important factor and experienced insufficient by the majority of the GPs in this study. This observation is in line with other research, as a review on 'cultural competence' implied a few years ago [34]. This systematic literature review analyzed 50 studies describing cultural competence for GPs across the globe (including The Netherlands) and defined 'cultural competence' as requiring ' knowledge', 'awareness/ attitudes' and 'skills/ behavior' [34]. Cultural competence training appeared to take place informally 'on the job', and GP registrars wished for more formal training programs through cultural mentors [34]. Cultural mentors are described in this review as representatives of their community, being able to function between their community and health care providers [34]. In this light 'cultural mentors' seems to have a similar definition as the Dutch key persons. To our knowledge they are not involved in training of GPs on cultural competence (with focus on FGM/C), but regarding to the abovementioned literature review [34] this could be very beneficial to improve cultural competence of GP (registrars).

Skills and competence: call for help?

The participants without experience with addressing FGM/C often stated to lack skills to start the conversation on FGM/C as compared to participants with experience of addressing FGM/C. This might therefore be one of the reasons for the GPs to not discuss FGM/C with women that are at risk. This is unfortunate, especially because we know from a qualitative study performed in The Netherlands, that most women would like their GP to discuss health problems related to FGM/C [8].

When considering the competence and skills to start the conversation as a GP, this also involves the use of other partners, such as key persons and interpreters. The majority of the GPs in this study - both with and without experience of discussing FGM/C - indicated to never use key persons, as well as interpreters.

Key-persons were less frequently asked for advice as compared to interpreters. It remains uncertain what the reason for that is. Do GPs not know of their existence? If this is the case, the abovementioned training of GP registrars on cultural competence by key-persons (or cultural mentors) would 'kill two birds with one stone' [35]. Firstly, they would benefit from improved

cultural competence as registrars, and secondly, the GP would know about their existence and how to involve them in the future when needed.

The use of (professional) interpreters by healthcare professionals has been subject of debate in The Netherlands last decades. From 2005, there was an active policy of the Dutch Government to advocate for the use of interpreters by healthcare professionals in case of a language barrier [36]. This policy was probably fed by a calamity investigated by the Health Care Inspectorate (IGZ) in 2003, of an abortion against the wishes of the mother, in which an informal interpreter (for example a friend or family member) was involved [37]. Since then, the Ministry of Health – together with health care professionals – advocated actively to often (and when needed) use professional interpreters with language barriers [36]. Unfortunately, Dutch government terminated the free use of interpreters in healthcare in 2012 despite that many professionals and scientists have spoken out against the measure [37]. They were afraid that the accessibility and quality of care will be in danger, and warned for their fear that professional interpreters would be less frequently used. This was in the years that followed indeed the case, with a decrease of 75% of using professional interpreters in primary health care. Hopefully, this will change again now that in some deprived neighborhoods the costs for using professional interpreters is covered by regional Deprivation Funds (In Dutch ' Armoede Fonds) [37].

Prevention of FGM/C

The estimation is that around 4.200 girls in The Netherlands are at risk of being circumcised in the coming twenty years [9]. These girls originate mainly (82%) from Somalia, Egypt, Ethiopia, Sierra Leone and Guinee [9]. In the current study, participants with experience of discussing FGM/C, often agreed to the statement (as compared to participants without experience of discussing FGM/C) that GPs should start the conversation on the risk of FGM/C for family members. It is a good sign that the participants with experience are at least aware of the importance of discussing the risk of FGM/C for family members. But, at the same time, there is room for improvement for a large number of participants to be aware of the risk and discuss it with the patient and its family. These observations are – unfortunately – in line with a qualitative study performed in England in which GPs were interviewed about discussing FGM/C [29]. They – just as the findings in this study – found it challenging to balance the needs of the patient, and to estimate risks of FGM/C to family members and their needs [29].

Timing

Of the participants that had experience with discussing FGM/C, the minority (6 of 26) stated to discuss the subject during an intake, the others used individual consultations. Having an intake as ' new patient' with your GP is quite common in The Netherlands, although it might be questioned if patients with a language barrier/ other cultural background are aware of that possibility [23,24]. One could argue what the responsibility of the GP is in getting to know new patients – especially from risk countries – and that it might be very useful to actively invite new patients. This will not only improve the patient-doctor relationship, but will also create the possibility to actively ask about a patients' (migrant) background and all issues that might be related to that.

The majority of the participants with experience of discussing FGM/C did that during consultation that was linked with FGM/C (18/26). These observations are in line with another study performed in England [29]. The GPs in that study stated they found it easier to discuss FGM/C in relation to a possible related clinical complaint such as urinary tract infections or obstetrical problems [29]. We may hypothesize that both the English GPs and the Dutch GPs in the current study, it felt more easy to start the conversation on a subject as FGM/C when there is a clear reason to discuss FGM/C.

Cultural barriers

As mentioned in the section on ' knowledge', cultural sensitive work might be improved among GPs and the question remains what cultural barriers GPs and patients experience during consultation. As seen in earlier cited studies cultural barriers might play an important role in whether or not discussing FGM/C, probably from both the patients' as well as from the professionals' side [8,29]. This cultural (mis)understanding was also a theme that emerged in a review which included 30 papers from nine countries. In this study, the researchers investigated factors that influenced care of FGM/C [38]. Cultural (mis) understanding was one of the 6 themes that was identified from all these papers [38]. These observations are in line with our findings, as some participants also stated not wanting to 'be curious' and they did not want to make patients ' uncomfortable'. For sexually related issues, we know that GPs experience sensitivity and complexity to discuss the subject [25]. Although the comments in our study give some insight in how GPs might experience conversations on FGM/C, more information on this subject would have been very useful. It would have been very interesting to have been able to deepen the comments further. Why are the GPs not wanting to be curious? What are they ' afraid' of? In the

next sub studies (Vignette Study and Focus groups discussions) these observations will be used to deepen these aspects of discussing a sensitive topics – as FGM/C – further.

Design of the study: strengths and limitations

With a total of 51 participants, this study describes the experiences of a small proportion of the total number of GPs in The Netherlands, which was 13.429 in 2021 [39]. Although the numbers in this study are relatively small, it shows insight in the experiences of the participants in discussing the issue of FGM/C.

This study was carried out in two regions: 'Amsterdam-Amstelland' and 'Gelderland-Zuid,' and more GPs from Amsterdam-Amstelland had experience with discussing FGM/C as compared to GPs from ' Gelderland-Zuid'. From the GPs perspective, they estimated in both regions, the percentage of patients originating from risk countries for FGM/C between 0-25%, and not higher. Given the wide range between 0% and 25%, the category is wide and therefore the finding is not very precise. It is a drawback that we chose the answers for this multiple choice question with 'steps' of 25%. Probably, it may have been more useful to ask the GPs in an open question what the estimated prevalence of patients with FGM/C in their practice would have been. However – as in all questions in the survey – recall bias might influence the results. One way to address the issue of recall bias would have been to ask the question within a limited time-frame.

From earlier studies, it is estimated that 41.000 women have undergone FGM/C in The Netherlands [9]. It could be hypothesized, that significantly more women that have undergone FGM/C live in region 'Amsterdam-Amstelland' as compared to region 'Gelderland-Zuid.' It is not exactly known, where these women live throughout The Netherlands, however, we might be able to make an estimation of this number. In region Amsterdam-Amstelland it is estimated that 15.000 girls and women reside from 29 countries where FGM/C is practiced, as compared to 3.000 girls and women from 29 countries where FGM/C is practiced living in region Gelderland-Zuid. These numbers are unpublished and were provided by Pharos [40]. With this difference in number of girls and women originating from ' FGM/C risk countries', one could imagine a GP working in region Amsterdam-Amstelland is much more likely to meet a woman from a risk country as compared to a GP working in region Gelderland-Zuid.

We aimed to convince as much GPs to fill in the questionnaire as possible, but hoped to get at least 121 participants. Unfortunately, we did not reach this number, and that might have several

reasons. First, we had not one email-address list to reach all GPs easily and directly. We tried to reach them via email-addresses that were known, and via GP collaboration websites. Probably, more GPs would have participated if they would have been invited directly by email. As a result with the current methods, there may likely have been selection bias. You may hypothesize that the GPs that filled in the questionnaire are 'different' from the ones that did not fill in the questionnaire. From the general characteristics that we could compare, we noticed more female GPs filled in this questionnaire as compared to the average percentage of female doctors in The Netherlands [31]. Secondly, 21 participants did not complete the questionnaire. Since the questionnaire was anonymous, we may only guess what the reason for that might have been. Were the questions not clear enough? Did it take too much time?

In general, using a questionnaire can be an effective method, with relatively 'easy' useful information. Especially to estimate the prevalence or find differences a survey is a good approach. However, the method also has important drawbacks. The most important drawback is that there is no possibility to ask further questions and to explore unknown factors further. For certain answers that were given in the open questions, that would have been very useful. However, the following components of the larger research project will follow, and will fill in these gaps.

For the ZonMw project, two regions in The Netherlands were selected to conduct the research studies, as described in the Methods Section. Certainly, including more regions and participants throughout the Netherlands would have been very useful for the study results. Although the regions were selected to a representative 'sample' of the Dutch GPs, the results in this study describe the results in these two regions. We should therefore be careful with interpreting these results for national guidance.

For analyzing the open questions, we used the method of 'thematic analysis' with open coding. Therefore, purposefully, no conceptual/thematical framework was designed on forehand. However, looking back on the results we collected, in a next study it might have been useful to use a thematical framework. For instance, the themes identified in a qualitative systematic review (30 studies included over nine countries) might be interesting [38]. In this review [38] the researchers explored factors that influenced care provided by professionals on FGM/C and identified the following six themes: 1. Knowledge and training, 2. Communication is key, 3. Encountering the 'other' in clinical practice: Negotiating cultural dissonance and achieving cultural understanding within healthcare relationships, 4. Identifying FGM/C: Hit and miss. 5. Clinical management practices: Inconsistent and variable. 6. Optimal service development. Retrospectively, it could have been useful to use these (or related) themes to analyze the data

from the open questions. For the other sub studies of the ZonMw project, these themes might be striking as well. Lessons learned from this study will be passed on to the teams in charge of the following sub-studies of the ZonMw project (Vignette Study and Focus group discussions) to address the identified challenges.

Future perspectives

If GPs decide to discuss FGM/C with women, it is good to be aware of the possibilities of care afterwards. Depending on the complaints women experience, there are various possibilities. For example, there are specific 'After Care' consultations available in certain Dutch cities via the Public and Youth Health services (GGD) for women (at risk of or) with FGM/C [41]. From these consultations, they can be referred to other professionals who can help with certain complaints, such as physiotherapists, sexologists or gynecologists [41]. One of the recent developments playing a role in this issue is reconstructive surgery. There are attempts being done to make it possible to start reconstructive surgery after FGM/C which should be covered by health insurance in The Netherlands, which is currently not always the case [42]. In other European countries, such as France, Belgium, or Switzerland, this procedure is covered by the national health insurance [43]. Currently, the Dutch government decided to cover the costs of reconstructive surgery in certain situations to relieve certain complaints which resulted from FGM/C [44].

Conclusion and recommendations

Conclusion

In this study, we aimed to unravel if and when GPs in the Netherlands discuss FGM/C, and whether they experience challenges to discuss and act appropriately when encountering women (at risk of or) with FGM/C in their consultation rooms. We showed that (almost) half (49%) of the GPs that participated in this study ever started a conversation to discuss FGM/C.

First, patient characteristics and their complaints were a reason for GPs to (not) discuss FGM/C. The cultural background and the (psychical) complaints of patients was a factor influencing whether or not GPs discussed FGM/C. Besides 'patients' factors' played a role, various 'doctors' factors' also were identified. So, secondly, half of all participants stated that lack of knowledge was an important factor influencing whether or not they discuss FGM/C. Participants without experience with addressing FGM/C often stated to have no or insufficient knowledge about the cultural background of FGM/C as compared to participants with experience of addressing FGM/C. In addition, knowledge on culture sensitive work and lack of knowledge on guidelines regarding FGM/C was mentioned by the majority of the participants. Thirdly, in line with these findings, more than half of all participants stated to have lack of skills to start the conversation to discuss FGM/C. Fourthly, whether or not GPs started a conversation on the risk of FGM/C for family members– either in their home country or the Netherlands – participants with experience of discussing FGM/C more often agreed to discuss this issue. Lastly, during consultations, only a minor proportion of the GPs made us of external partners such as interpreters or key-persons.

To our knowledge, we are the first to present data about if/ and when GPs in The Netherlands – in regions Amsterdam-Amstelland and Gelderland-Zuid - discuss FGM/C. We explored underlying factors which are associated with whether or not they discuss this important issue in their consultation rooms. These observations give us important insight on how to improve the services of GPs in The Netherlands towards these women.

Recommendations

The following recommendations are suggested to enhance the services of GPs towards women (at risk of or) with FGM/C, by improving various underlying factors playing a role in discussing FGM/C by GPs in the Netherlands. Lessons learned from this study will be passed on to the teams in charge of the following sub-studies of the ZonMw project (Vignette Study and Focus group discussions) to address the identified challenges.

1. Invest in knowledge of FGM/C of GPs

GPs could benefit from more knowledge on FGM/C, either as separate trainings on the subject, as well as during the training of GP registrars. The specific needs for type of training can be explored during the focus group study, as well as the Vignette study. Improvement of knowledge on FGM/C will hopefully lead to more confidence of GPs to discuss FGM/C when necessary.

2. Make the national guidelines on FGM/C common knowledge

Make sure that the GPs in The Netherlands are familiar with the national guidelines and recommendations from the Dutch Society of Obstetrics and Gynecology as published in 2019. This could be done by publishing the guidelines on the website of the Dutch College of General Practitioners (NHG). Knowing the guidelines and the other partner in the Dutch Chain will improve their collaboration and thereby the care provided for women (at risk of or) with FGM/C.

3. Involve key persons in the training of GP (registrars) on cultural competence and FGM/C in general

Involvement of key persons in the training of GP (registrars), with a focus on cultural competence and FGM/C in particular, will improve the skills of (future) GPs. GPs in training would benefit from improved cultural competence as registrars, and secondly, the GP would know about their existence and how to involve them in the future when needed. During the focus group discussions with professionals, it would be recommended to involve GPs in training to explore their needs on this subject.

4. Promote an appointment for intake for all patients by GPs

Knowing your patient and her (or his) background – either cultural, medical and general – will improve the relationship of the patient with their doctor. The need for the use of an interpreter can then already be assessed. An improved relationship will then hopefully lead to discussing FGM/C more often when necessary, and not only when there is a physical complaint. The specific needs for patients during this intake can be explored in the sub study with focus groups discussion with patients.

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Annex 1

The questionnaire: an overview of all questions in Dutch.

Achtergrondvragen

1. Wat is uw leeftijd?

….jaar

2. Wat is uw geslacht?

- man
- vrouw
- anders

3. Wat is uw beroep?

- huisarts
- (huis)arts in opleiding-> ga naar 3a.
- doktersassistente
- praktijkondersteuner Somatiek
- praktijkondersteuner GGZ
- anders, namelijk...

3a. In welk jaar van uw opleiding bevindt u zich nu?

…….. jaar

4. Op welke manier bent u als huisarts werkzaam?

- praktijkhouder
- waarnemend
- HIDHA
- anders, namelijk

5. Hoeveel jaar werkervaring heeft u in het beroep dat u nu uitoefent?

…. jaar

6. In welke regio bent u werkzaam?

- Amsterdam-Amstelland-> ga naar vraag 6a.
- Gelderland-Zuid-> ga naar vraag 6c.

6a. Waar in Amsterdam- Amstelland bent u werkzaam?

- Aalsmeer
- Amstelveen
- Amsterdam -> ga naar vraag 6b.
- Diemen
- Ouder-Amstel

- Uithoorn
- Wisselende locaties
- Ik ben niet in Amsterdam-Amstelland werkzaam.

6b. In welk stadsdeel bent u werkzaam?

- Centrum
- Nieuw-West
- Noord
- Oost
- West
- Zuid
- Zuid-Oost
- Wisselende locaties
- Niet van toepassing

6c. Waar in Gelderland-Zuid bent u werkzaam?

- Beuningen
- Buren
- Culemborg
- Druten
- Berg en Dal
- Heumen
- Maasdriel
- Neder-Betuwe
- Nijmegen
- Tiel
- West Maas en Waal
- West Betuwe
- Wijchen
- Zaltbommel
- Wisselende locaties
- Ik ben niet werkzaam in de regio Gelderland-Zuid

7. Hoe groot schat u het percentage patiënten afkomstig uit risicolanden in uw praktijk?

Risicogebieden/landen waar meisjesbesnijdenis/vrouwelijke genitale verminking voorkomt, zijn Afrika (Egypte, Soedan en de zuidelijke Sahel, inclusief Somalië), het Midden-Oosten (delen van Jemen en Oman) en Azië (Maleisië, Indonesië).

- 0%-25%
- 25%-50%
- 50%-75%
- 75%-100

Bespreken van meisjesbesnijdenis/vrouwelijke genitale verminking

We zijn benieuwd hoe in uw praktijk invulling wordt gegeven aan het bespreekbaar maken van meisjesbesnijdenis/vrouwelijke genitale verminking bij vrouwen uit risicolanden. Ook zijn we benieuwd of er aandacht wordt besteed aan het risico op besnijdenis bij eventuele andere gezinsleden of familieleden. De volgende vragen gaan hierover:

8. Bent u ooit een gesprek over meisjesbesnijdenis/vrouwelijke genitale verminking aangegaan? = objective 1

- ja -> ga naar vraag 8b.
- nee -> ga naar vraag 8a.

8a. Kunt u uw antwoord toelichten?

- -
- -

8b. Hoe vaak, naar schatting, heeft u meisjesbesnijdenis/vrouwelijke genitale verminking met (de) direct betrokkene(n) besproken?

Ongeveer ………. keer

9. Geef aan in hoeverre u het eens bent met de volgende stellingen

	(Bijna) geen kennis	Onvoldoende kennis	Gemiddelde kennis	Voldoende kennis	Ruim voldoende kennis
a. Ik heb kennis van het Nederlandse VGV-beleid 2					
b. Ik heb kennis over de culturele achtergrond van meisjesbesnijdenis/vrouwelijke genitale verminking 2					
c. Ik heb kennis over cultuursensitief werken 2					

10. Geef aan in hoeverre de stelling op u van toepassing is

	Helemaal mee oneens	Mee oneens	Noch oneens, noch eens	Mee eens	Helemaal mee eens

a. Ik weet dat meisjesbesnijdenis/vrouwelijke genitale verminking bij patiënten/cliënten/ouders en/of verzorgers uit risicolanden besproken moet worden. 2					
b. Ik weet dat meisjesbesnijdenis/vrouwelijke genitale verminking met de patiënt/cliënt/ouder(s) en/of verzorger(s) meerdere keren besproken moet worden. 2					
c. Ik weet dat bij besneden vrouwen de type-VGV geregistreerd moet worden. 2					
d. Ik bespreek meisjesbesnijdenis/vrouwelijke genitale verminking met de patiënt/cliënt/ouder(s) en/of verzorger(s) uit risicolanden minimaal één keer in de praktijk. 1 = (vraag 8)					
e. Ik bespreek het risico op besnijdenis bij eventuele andere gezinsleden of familieleden. 1b					
f. Ik bespreek meisjesbesnijdenis/vrouwelijke genitale verminking meerdere keren als de klachten (mogelijk) gerelateerd zijn aan meisjesbesnijdenis/vrouwelijke genitale verminking. 1a					
g. Ik bespreek meisjesbesnijdenis/vrouwelijke genitale verminking meerdere keren als er aandacht aan het risico op besnijdenis bij eventuele andere gezinsleden of familieleden besteed moet worden. 1b					
h. Ik heb voldoende vaardigheden om meisjesbesnijdenis/vrouwelijke genitale verminking bespreekbaar te maken. 2					

11. Indien u meisjesbesnijdenis/vrouwelijke genitale verminking bespreekt, kunt u aangeven wanneer dit met name gebeurt? 1

Er zijn meerdere antwoorden mogelijk

- ☐ Intakegesprek
- ☐ Individueel consult
- ☐ Meisjesbesnijdenis/vrouwelijke genitale verminking wordt niet of nauwelijks besproken
- ☐ Anders, namelijk...

12. Indien u meisjesbesnijdenis/vrouwelijke genitale verminking bespreekt, kunt u aangeven bij welk type consult/gesprek dit met name gebeurt? 1

Er zijn meerdere antwoorden mogelijk

- ☐ Bij een consult/gesprek dat met meisjesbesnijdenis/vrouwelijke genitale verminking te maken heeft
- ☐ Bij een consult/gesprek dat niet met meisjesbesnijdenis/vrouwelijke genitale verminking te maken heeft
- ☐ Anders, namelijk…

13. Wat zijn redenen voor u om meisjesbesnijdenis/vrouwelijke genitale verminking niet bespreekbaar te maken? 1

Er zijn meerdere antwoorden mogelijk

- ☐ Onvoldoende tijd
- ☐ Ik weet niet wat de doelgroep is
- ☐ Ik weet niet hoe meisjesbesnijdenis/vrouwelijke genitale verminking bespreekbaar gemaakt moet worden
- ☐ Ik ga er vanuit dat meisjesbesnijdenis/vrouwelijke genitale verminking reeds door een collega-huisarts of een andere zorgverlener besproken is
- ☐ Ik ga er vanuit dat meisjesbesnijdenis/vrouwelijke genitale verminking niet gerelateerd is aan de klachten van de vrouw
- ☐ Ik ga er vanuit dat meisjesbesnijdenis/vrouwelijke genitale verminking geen risico vormt bij eventuele andere gezinsleden of familieleden
- ☐ Bespreken gaat ten koste van de relatie met de patiënt/cliënt/ouder(s) en/of verzorger(s)
- ☐ Er zijn urgentere kwesties die moeten worden besproken
- ☐ Anders, namelijk...

14. Kunt u uw antwoord(en) toelichten?

- -

- -

- -

- -

Voor medische zorgprofessionals, onder wie huisartsen, is in 2019 de 'Leidraad Medische zorg voor vrouwen en meisjes met vrouwelijke genitale verminking (VGV) ontwikkeld. Deze leidraad vervangt het 'Modelprotocol medische zorg voor vrouwen en meisjes met vrouwelijke genitale verminking (VGV)' uit 2010'.

15. Bent u op de hoogte van de leidraad uit 2019 en/of het modelprotocol uit 2010? 2

- ☐ Ja, van beide-> ga naar 16.
- ☐ Ja, van de leidraad-> ga naar 15a.
- ☐ Ja, van het modelprotocol-> ga naar 15a.
- ☐ Nee, geen van beide -> ga naar 15a.

- **15a. Kunt u uw antwoord toelichten?**

- -

- -
- -

-> afhankelijk van het antwoord op vraag 15, ga naar vraag 16 of 17.

In de 'Leidraad Medische zorg voor vrouwen en meisjes met vrouwelijke genitale verminking (VGV)' is een overzicht opgenomen van aanbevelingen ter <u>ondersteuning</u> van dagelijkse praktijk aangaande het onderwerp: medische zorg voor vrouwen en meisjes na meisjesbesnijdenis/vrouwelijke genitale verminking.

16. Bent u op de hoogte van de aanbevelingen? 2

- ☐ Ja -> ga naar 16b.
- ☐ nee -> ga naar vraag 16a.
- ☐ enigszins -> ga naar vraag 16a.

•

16a. Kunt u uw antwoord toelichten?

- -
- -
- -
- -

-> ga naar vraag 17

16b. Gebruikt u deze aanbevelingen in de praktijk? 2

- ☐ Altijd
- ☐ Meestal wel
- ☐ Meestal niet
- ☐ Nooit

16c. Kunt u uw antwoord toelichten?

- -
- -
- -
- -

17. Wordt er door u bij een individueel consult gebruik gemaakt van een professionele tolk om meisjesbesnijdenis/vrouwelijke genitale verminking bespreekbaar te maken? 2

- ☐ Altijd
- ☐ Meestal wel
- ☐ Meestal niet
- ☐ Nooit

17a. Kunt u uw antwoord toelichten?

- -

-> afhankelijk van het antwoord op vraag 17, ga naar vraag 17b of 18.

17b. Wat zijn uw ervaringen met een professionele tolk geweest?

- -

18. Wordt er door u bij een individueel consult gebruik gemaakt van een sleutelpersoon om meisjesbesnijdenis/vrouwelijke genitale verminking bespreekbaar te maken? 2

Sleutelpersonen zijn afkomstig uit de eigen gemeenschap en speciaal getraind in het bespreekbaar maken van meisjesbesnijdenis/vrouwelijke genitale verminking. Zij hebben een rol in de preventie van meisjesbesnijdenis/vrouwelijke genitale verminking, het informeren over strafbaarheid en in de toeleiding naar zorg. Professionals kunnen deze sleutelpersonen via een GGD inzetten.

- ☐ Altijd
- ☐ Meestal wel
- ☐ Meestal niet
- ☐ Nooit

18a. Kunt u uw antwoord toelichten?

- -

-> afhankelijk van het antwoord op vraag 18, ga naar vraag 18b of 19.

18b. Wat zijn uw ervaringen met sleutelpersonen geweest?

- -

Tot slot

19. Wilt u:

1. **Geïnformeerd over de uitkomsten van dit onderzoek?**
   - Ja
   - Nee

2. **Benaderd worden voor deelname aan andere onderzoeken binnen het ZonMw-project over VGV?**
   - Ja
   - Nee

3. **Geïnformeerd worden over de voortgang van het ZonMw-project, waarvan dit onderzoek onderdeel is?**
   - Ja
   - Nee

Vul hieronder (eventueel) uw e-mailadres in:

- -