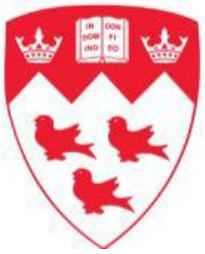

The Medicalization of FGM/C: Eradicating or Perpetuating the Tradition?

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Thesis Abstract (English)

Rationale: Female Genital Mutilation/Cutting (FGM/C) is a traditional gender-based violence practice involving the partial or total removal of the external female genitalia affecting over 230 million girls globally (Kimeu, 2024; UNICEF, 2024). In Guinea-Conakry, FGM/C is performed on 96-97% of girls/women, with 31% carried out by healthcare professionals, a practice known as the medicalization of FGM/C (Mareah et al., 2023; UNICEF, 2024; WHO 2022). Medicalization of FGM/C provides no medical benefits and involves long-term physical, mental, sexual, and reproductive health deleterious outcomes for their victims while violating the 'Hippocratic oath' of clinicians and women and girls' human rights. Guinea is the third African country with the highest rate of medicalization of FGM/C (WHO 2022). While solutions to stop the medicalization of FGM/C are still underway, educating healthcare providers and students in clinical professions has been recommended as a key strategy to prevent medicalization by leading international organizations (Kimeu, 2024; Mareah et al., 2023; WHO 2022; UNICEF, 2024). International training guidelines of the WHO, while suggesting relevant content to be addressed in such training programs, do not provide strategies to adapt their content to culture and the lived experience of students in health care professions. There is thus a need to better understand the complexity of the meaning clinical students and HCPS attribute to the medicalization of FGM/C and their own lived experience concerning the practice.

Objective: This research aims to understand the meaning and experience attributed to the medicalization of Female Genital Mutilation/Cutting (FGM/C) among midwives and nurses enrolled in a program of an anonymous University in Guinea. While research suggests that increased participation of HCPS in medicalization may stem from various motivations (Doucet, et al., 2017; Mareah et al., 2023), there is a gap in knowledge on the motivations of Guinean students in nursing and midwifery programs towards this practice.

Methods: The study conducted two focus groups with nursing and midwifery students to explore the meaning they attribute to medicalization of FGM/C and their lived experience on the subject. We used the innovative *RapForMe*© method to analyze the qualitative findings. The *RapForMe* is a participatory method that engages participants in developing interview questions, conducting group interviews, and co-analyzing qualitative data with the research team.

Results: Our study affirmed the understanding that traditional FGM/C is a deeply rooted cultural practice that has psychosocial implications within communities. Student midwives and nurses acknowledged its cultural roots, often justified by beliefs regulating women's sexuality. Discussions on medicalization revealed their adherence to the "harm reduction" philosophy, with unanimous agreement that it reduces physical harm to women and girls. Nursing students stressed biomedical standards and sterile environments with antiseptics, while midwifery students saw medicalization as a social and cultural obligation in needs to be addressed. However, both groups valued antiseptic use as a safety precaution. While midwifery views varied, nursing students universally advocated for medicalization as a means for reducing FGM/C physical health risks.

Conclusions: The medicalization of FGM/C reflects the clash between nursing and midwifery students' cultural and healthcare provider 'thought communities'. This intersubjective conflict highlights the need for nuanced, culturally sensitive intervention strategies. Healthcare providers' diverse backgrounds shape their perspectives, urging tailored approaches that delve into the intricate cultural dimensions of FGM/C. Our study on nursing and midwifery students emphasizes their distinct and different roles within the healthcare system and relationship to FGM/C. The medicalization of FGM/C among healthcare providers is likely to persist unless

effective intersubjective solutions are proposed and implemented to replace medicalization and HCPs are empowered to intervene at the community level.

Thesis Abstract (French)

Les mutilations génitales féminines/excision (E/MGF) constituent une pratique traditionnelle de violence basée sur le genre qui touche près de 230 millions de filles dans le monde et qui impliquent l'ablation partielle ou totale des organes génitaux féminins externes (Kimeu, 2024 ; UNICEF, 2024). En Guinée-Conakry, 96-97% des filles/femmes subissent l'E/MGF, et 31% d'entre elle ont été coupées par un professionnel de la santé, une pratique connue sous le nom de la médicalisation de l'E/MGF (Mareah et al., 2023 ; UNICEF, 2024; OMS 2022). La médicalisation de l'E/MGF ne présente aucun avantage médical et engendre des conséquences délétères à long terme sur la santé physique, mentale, sexuelle et reproductive des victimes, tout en violant les droits humains des femmes et des filles et le "serment d'Hippocrate" des cliniciens. La Guinée est le troisième pays en Afrique affichant le taux le plus élevé de médicalisation de l'E/MGF (OMS 2022). Cette recherche vise à explorer les perspectives et les expériences liées à la médicalisation des mutilations génitales féminines (E/MGF) chez les étudiants inscrits aux programmes de sage-femme et de soins infirmiers dans une université anonyme en Guinée. Alors que des recherches antérieures suggèrent que la participation accrue des professionnels de la santé à la médicalisation des MGF/E peut être motivée par divers facteurs (Doucet et al., 2017 ; Mareah et al., 2023), il existe un manque de connaissances sur les motivations des étudiants guinéens en soins infirmiers et en étude de sage-femme. Nous avons utilisé la méthode innovante RapForMe©, qui implique les participants dans l'élaboration des questions d'entrevue, la tenue des entrevues de groupe et l'analyse collaborative des données qualitatives avec l'équipe de recherche. Les résultats de notre étude ont confirmé que l'E/MGF est une pratique profondément ancrée dans la culture qui a des incidences psychosociales importantes au sein des communautés. Les étudiantes sage-femmes et infirmières ont reconnu l'importance de cette tradition justifiée par des croyances régulant la sexualité des femmes. Les discussions sur la médicalisation ont révélé une adhésion à la philosophie de "la réduction des méfaits", avec un accord unanime sur le fait que le rôle de la médicalisation est de réduire des dommages physiques de l'E/MGF sur les femmes et les filles. Les étudiants en soins infirmiers ont souligné l'importance des normes biomédicales et des environnements stériles, préconisant l'utilisation d'antiseptiques comme mesure de sécurité. De leur côté, les étudiantes en sage-femme ont plutôt perçu la médicalisation comme une obligation sociale et culturelle envers leur communauté.

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An agreement has been made that Felicia Gisondi will be the first author, with Dr. Alexandre Delamou (second) and Dr. Danielle Groleau (last) and as co-authors, for the manuscript titled *The Medicalization of FGM/C: Eradicating or Perpetuating the Tradition?*

Abbreviations

FGC: Female Genital Cutting

FGM/C: Female Genital Mutilation/Cutting

KAP: knowledge, attitudes, practices

HCP: Healthcare professional

UAE: United Arab Emirates

UNFPA: United Nations Population Fund

UNICEF: United Nations International Children's Emergency Fund

WHO: World Health Organization

An introduction (Traditional Thesis)

What is Female Genital Mutilation/Cutting?

The History of FGM/C

Female genital mutilation/cutting (FGM/C) is an ancient tradition, practiced in at least 30 countries in Africa, the Middle East, and Asia. In Guinea, it is estimated that 97% of women and girls ages 0-14 have undergone FGM/C in their life (Balde et al., 2021; Boun, et al., 2023). Globally, it is estimated that there are over 230 million women and girls are living with FGM/C and that more than 3 million girls are at risk of being cut every year (UNICEF, 2024). FGM/C is a traditional procedure that involves the partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons (UNFPA-UNICEF, 2023).

Different forms of FGM/C include partial or total removal of the clitoral glans *Type I* (the external and visible part of the clitoris, which is a sensitive part of the female genitals), and/or the prepuce/clitoral hood (the fold of skin surrounding the clitoral glans). *Type II* includes an excision (partial or total) removal of the clitoris and the labia minora, with or without excision of the labia majora. The most invasive form of FGM/C *Type III* also known as "infibulation" involves the removal of the clitoris and labia-minora, and the stitching closing off the labia majora (WHO, 2023). *Type III* (infibulation) FGM/C is achieved by narrowing the vaginal orifice by creating a covering seal, accomplished by cutting the labia minora and/or labia majora, with or without clitoral excision. Infibulation is responsible for significant urological, obstetrical, and psychosexual consequences that can be treated with defibulation/de-infibulation, an operation that opens the infibulation scar, exposing the vulvar vestibule, vaginal orifice, external urethral meatus, and eventually the clitoris (WHO, 2023). Other variations of FGM/C include pricking, piercing, incising, scraping and cauterizing the genitals, which are categorized

as *Type IV* FGM/C (WHO, 2023).

Complications related to FGM/C

FGM/C commonly presents women with deleterious immediate and long-term physical and psychological complications. Some common immediate physical risks include; severe pain, excessive bleeding (hemorrhage), genital tissue swelling, fever, HIV, infections, urinary problems, wound healing problems, and/or injury to the surrounding genitals (WHO, 2008; WHO, 2023).

Beyond the vast immediate risks, FGM/C can also give rise to long-term health problems, such as urinary problems (painful urination, urinary tract infections); vaginal problems (discharge, itching, bacterial vaginosis and other infections); menstrual problems (painful menstruations, difficulty in passing menstrual blood, etc.); scar tissue and keloid; various sexual problems (pain during intercourse, decreased satisfaction, etc.); increased risk of childbirth complications (challenging delivery, excessive bleeding, emergency cesarean, need to resuscitate the baby, etc.), need for later surgeries and newborn deaths (WHO, 2008; WHO, 2023). Death as a complication of FGM/C can also a result of the practice in some cases. Some girls and women do not survive the complications of FGM/C suffering from hemorrhage, infections (e.g., tetanus) and obstructed labor (Tammary, Manasi, 2023; WHO, 2023).

Additionally, psychological health problems such as anxiety, depression and post-traumatic stress disorder (PTSD) and experiences of memory loss around the experience of FGM/C may also occur (Tammary, Manasi, 2023; WHO, 2023). Victims of FGM/C may experience various psychopathological problems relating to negative self-image, sexual disempowerment, and even re-traumatization during childbirth or re-infibulation. The mental

health burden resulting from FGM/C can be furthered by feelings of incompleteness, fear, chronic irritability and nightmares, a sense of inferiority, and suppression of emotions (Tammary, Manasi, 2023; WHO, 2023). Women and girls who have undergone FGM/C are often at a higher risk for psychiatric and psychosomatic diseases (Tammary, Manasi, 2023; WHO, 2023). FGM/C is a global human rights violation and goes against women and girls human right to sexual and reproductive autonomy and freedom (Tammary, Manasi, 2023; WHO, 2023). However, the motivations of this practice are deeply intrenched within sociocultural norms upheld by communities (WHO, 2023).

Emic and Etic related to FGM/C

Motivations of FGM/C can be examined into five general categories; psychosexual reasons, sociological and cultural reasons, hygiene and aesthetic reasons, religious reasons and socio-economic factors (Leye et al., 2019; WHO, 2023). Psychosexual reasons commonly include the notion that a woman's sexuality must be tamed and stifled to adhere to social norms of purity, chastity, and marriageability (WHO, 2023). Sociological and cultural reasons often include myths that vary from region to region. They often include beliefs that an uncut clitoris will grow to the size of a penis, that FGM/C will increase a man's sexual pleasure, that FGM/C will enhance fertility or that FGM/C will promote child survival (WHO, 2023). In sub-Saharan Africa controlling a wife's sexuality is often seen as essential to maintaining the structure and stability of the marital unit. This control is believed to safeguard against infidelity and ensure the hierarchy within the relationships, emphasizing the traditional roles and expectations placed on women in monogamous and polygamous unions. Hygiene and aesthetic reasons beliefs that the external female genitalia are considered dirty and ugly and are to be removed, ostensibly to promote hygiene and aesthetic appeal (WHO, 2023). While Islam or Christianity, do not argue in favor of female circumcision, some supposed religious leaders may in some context, use

religion as a rational amongst their community to justify the practice (WHO, 2023). Various socioeconomic factors play a significant role in the perpetuation of FGM/C, with many arguing that FGM/C is deemed a prerequisite for respect, dowery, and marriage of a girl. Women who have undergone FGM/C are well respected by their community members as this practice upholds ancestorial traditions and meaning. In communities and cultures where women are largely dependent on men, the economic necessity of marriage for a woman can be a major contributor to the continuation of the procedure FGM/C and sometimes constitute a prerequisite for the right to inherit land or a dowery. However, beyond the vast sociocultural arguments presented, FGM/C has never been found to provide women and girls with any health benefits.

Refusal to practice FGM/C [Families]

In practicing communities, women who have undergone FGM/C are viewed by society as women of honor and status (Boun, et al., 2023). While uncut girls are perceived as promiscuous and often fall victims of social mockery, rejection, or exclusion by the community (Boun, et al., 2023). Therefore, the possibility of challenging norms within these communities becomes extremely daunting for families to endure in fear of social repercussions (Boun, et al., 2023). There have even been instances where women have experienced such extreme exclusion or shame due to not having been cut, that they forgo and requested to be cut, to end their psychological torture (Omigbodun et al., 2022). In a study done by Omigbodun et al., (2022), of Nigerian women who were not cut, eventually chose to undergo FGM/C to regain social capital. These women reported that undergoing FGM/C and experiencing significant pain/physical suffering from the procedure expressed the *"emotion[s] of relief from knowing their psychological torture would end and that they would gain social acceptance and total capital from being cut"* (Omigbodun et al., 2022, p.2). Displaying how significant social inclusion and acceptance are countries where FGM/C is practiced. Additionally, since excision ceremonies and

rituals are reserved for women, some women see this experience as an opportunity to free themselves from the rules of patriarchy and male domination that are omnipresent in the societies concerned (Boun, et al., 2023). Communities within Guinea, Nigeria, and Dijbouti will use traditional practices such as the use of witchcraft, gossip, and beliefs related to the supernatural power of the excisors (traditional cutters) who play a critical role in maintaining the practice. Suggesting, that many families are reluctant to challenge the cutters based on fear of social isolation (Omigbodun et al.,2022; Boun, et al., 2023).

What is the medicalization of FGM/C?

According to the WHO, the "medicalization" of FGM/C refers to situations in which FGM/C is practiced by any health professionals, whether in a public or a private clinic, at home or elsewhere, at any point in a woman's life (Doucet, et al., 2017, WHO 2022). Health professionals involved in medicalization include; physicians, assistant physicians, clinical officers, nurses, midwives, trained traditional birth attendants, gynecologists/ obstetricians, plastic surgeons, and other personnel providing health care to the population, in both private and public sectors. They may be undergoing medical training, working in the medical sector, or retired (Doucet, et al., 2017).

Healthcare Professionals Motivations and Rational related to FGM/C

In recent years, the medicalization of FGM/C has evolved to become increasingly common, even if it violates healthcare professionals' medical ethics and Hippocratic oaths (Doucet, et al., 2017). Globally, among 25 countries, the rates of medicalization among women aged 15–49 are highest in five countries. Guinea stands as the third highest African country, accounting for 31% of all FGM/C procedures performed with the assistance of healthcare

professionals (Kimani, Shell-Duncan, 2018). It is thus important to understand the social drivers of this recent emerging phenomenon to better guide policy and prevention. According to an integrative review of the literature done by Doucet, Pallitto & Groleau (2017), the researchers found that the main rationale regarding healthcare providers' motivations to practice FGM/C was; (1) the preconception that performing FGM/C on a girl within a medical setting would be less harmful for girls or women than the procedure being performed by a traditional practitioner in a nonsterile setting, with little medical knowledge of anatomy. The review also found that since medical professionals are a part of practicing communities their belief system surrounding the justification of FGM/C motivated their participation in the procedure. The review also revealed that financial gains associated with healthcare professionals, particularly nurses and midwives, may serve as an incentive for these individuals to perform the procedure. However, within this research, we did not corroborate this motivation. Finally, professionals may respond to requests of the community or feel pressured by the community members to perform FGM/C regardless of their opinion of the practice.

Risks of rejecting FGM/C for HCP

Many healthcare providers are aware of the health complications associated with FGM/C, which influences their decision to refuse to practice. Additionally, in countries where FGM/C is illegal such as Egypt, Sudan, and Guinea, some providers address legal constraints as a reason for refusal. Some healthcare providers consider FGM/C as a harmful practice, using this stance as their primary rationale for rejection (Doucet, et al., 2017, WHO 2022). However, there remains a need for more research to delve into the motivations behind medical professionals' refusals to understand healthcare motivations to reject the practice (Doucet, et al., 2017, WHO 2022).

Why is the Medicalization of FGM/C a New Phenomenon?

Within the last thirty years, some major public health organizations nationally and internationally campaigned against FGM/C and stressed the human rights violations of FGM/C and its adverse health consequences, assuming that this would help to raise social awareness of the health risks and in turn motivate people to abandon the practice (Aziz, Elgibaly, Ibrahim, 2022; Leye et al., 2019). However, it is speculated that the health approach focusing on the harms and human rights violations of FGM/C unintentionally motivated the medicalization of FGM/C, on both the demand and supply side. In 2009 the World Health Organization (WHO), the United Nations Children's Fund (UNICEF), and the United Nations Populations Fund (UNFPA) condemned the medicalization of FGM/C in any setting. However, the WHO had already raised this issue 30 years earlier (ref ,1979) at an international conference, stating *"it is unacceptable to suggest that performing less invasive forms of FGM/C within medical facilities will reduce health complications"* (WHO, 2016). However, 15 years later, in 1994, the Egyptian Minister of Health stated that physicians could perform FGM/C on girls in designated facilities at fixed times and prices, claiming that medicalization of the practice would reduce complications and eventually end the practice (Aziz, Elgibaly, Ibrahim, 2022). It has also been noted that the fear of health risks may have unintentionally motivated parents of young girls to seek out the medicalization of FGM/C to mitigate harm (Doucet, et al., 2017; Leye et al., 2019; Kimani & Shell-Duncan, 2018). Therefore, public health campaigns highlighting the physical complications related to FGM/C and its medicalization may not effectively prevent or educate practicing communities and health professionals (Aziz, Elgibaly, Ibrahim, 2022; Doucet, et al., 2017; Leye et al., 2019). The medicalization of FGM/C is notably prevalent among girls aged 0-14 and is increasing in countries like; Egypt (78%), Sudan (77%), Indonesia (62%), Guinea

(31%), Djibouti (21%), Kenya (20%), Iraq (14%), Yemen (13%), and Nigeria (12%) (Kimani & Shell-Duncan, 2018). It is crucial to clarify that these percentages represent the proportion of girls who have undergone the medicalization of FGM/C, not the prevalence of FGM/C in these countries. Traditional FGM/C rates remain higher in the mentioned countries, but the figures provided specifically address the prevalence of medicalized FGM/C practices (Kimani & Shell-Duncan, 2018; UNFPA-UNICEF, 2023).

Research rationale: Why do we need to evaluate and understand the meaning and experience of the medicalization of FGM/C?

The medicalization of FGM/C is deeply entrenched in social, psychological, financial, and cultural beliefs and myths that coexist within communities and systems that encourage this harmful practice. Understanding the motivations and rationality related to the medicalization of FGM/C is critical to help eradicate it. However, recent literature attributes the continuation of the practice to a variety of cultural determinants and to the "harm reduction" philosophy adopted by health care professionals (Aziz, Elgibaly, Ibrahim, 2022; Doucet, et al., 2017; Leye et al., 2019). Therefore, we must fully understand the meaning and experience of healthcare professionals' for adopting the practice to identify effective intervention strategies that will address the complexity of the phenomenon.

As of 2023, there remains an absence of a standardized healthcare training program(s) or culturally tailored educational intervention that can be applied to prevent or address the medicalization of FGM/C (Matanda et al., 2023). Although the World Health Organization introduced a guide in 2022 to develop such a training program, it only superficially addresses cultural motivations, the need for region-specific approaches, and ways to adapt the training to

local cultural contexts (Matanda et al., 2023; WHO, 2022). Culture permeates the perpetuation of FGM/C and its ongoing existence. Addressing local cultural motivations, meanings, and experiences related to the medicalization of FGM/C is the key strategy for creating effective educational intervention strategies moving forward. To effect changes towards abandoning FGM/C and its medicalization, there have been arguments made towards the notion that medical professionals can serve as agents of change within their community to abandon the medicalization of FGM/C (Matanda et al., 2023). However, this type of training has yet to be effectively developed, implemented, and evaluated to effectively address cultural contexts (Matanda et al., 2023). Culturally led interventions, driven by local healthcare expertise and experience, can play an impactful role in combating the medicalization of FGM/C (Leye et al., 2019; Matanda et al., 2023). These interventions address social and cultural motivations, while also avoiding potential complications associated with top-down approaches imposed by international and national organizations, which may inadvertently reproduce previous neocolonialist approaches and outcomes, like the medicalization of FGM/C (Leye et al., 2019; Matanda et al., 2023).

Research Objective:

Our research aim addressed in the manuscript of this thesis is to better understand the complexity of the meaning and lived experiences of medicalization of FGM/C amongst university students in midwifery and nursing training programs sat a unanimous University in Guinea. To better understand the meaning and experience of these future HCPs in training regarding medicalization is an important step towards understanding the recent (31%) and

growing phenomenon of medicalization that characterizes Guinea (Kimani & Shell-Duncan, 2018).

Literature Review (Traditional Thesis)

Literature Review:

A Rapid Review on healthcare professionals' meaning, and experience of the Medicalization of Female Genital Mutilation/Cutting in countries where FGM/C is a traditional practice.

Define the Review Objective and Questions

This chapter presents a rapid review of the published research regarding the meaning and experience of healthcare providers (HCP) concerning the medicalization of FGM/C. I chose to conduct a *rapid review* as this review method is an alternative to a systematic literature review which can speed up the analysis of newly published data (Smela, et al., 2023). Given that the medicalization of FGM/C is a recent and rapidly growing phenomenon and that this review is done in the context of an MSc thesis, it was appropriate and useful.

The following research questions thus arose to guide the research in attaining this objective: *What are the meaning and experiences relating to the medicalization of FGM/C among student's studying nursing and midwifery at a university in Conakry, Guinea?*

Search Strategy

A systematic search strategy was developed for PubMed and Google Scholar databases for peer-reviewed articles. Additional searches were also performed in the WHO Library, including grey literature to search for remaining peer-reviewed studies and other grey literature,

such as reports produced by non-governmental organizations. The keywords used for the WHO library included: f*emale genital mutilation, female genital mutilation/cutting, FGM, FGM/C, and medicalization.*

The following keywords were used for the search in Google Scholar and PubMed: f*emale genital mutilation, female genital mutilation/cutting, FGM, FGM/C, meaning, experience, prevention, education, understanding, culture, context, social, and medicalization.* The search strategy was conducted between September and December 2023, to include literature published between 2015 to 2023. French and English language restrictions were imposed.

Inclusion and exclusion criteria

The inclusion criteria incorporated qualitative, quantitative, and mixed-methods studies. All forms of FGM/C (type 1-4) and its medicalization were reviewed. All research results that focused on FGM/C and its relation to all types of healthcare professionals (doctors, midwives, nurses, public health professionals) were included. All papers, regardless of their country of origin, were included in the review, but only those written in French or English were reviewed.

Articles excluded were those relating to the "context of immigration or migration" OR the "country of immigration". This decision was made because my research specifically focuses on the cultural context of countries where FGM/C is traditionally practiced, with a particular emphasis on the Conakry-Guinean context.

Study selection:

The search strategy used yielded 3053 eligible studies from PubMed (January 2024). I imported these studies into *Covidence,* the world's leading software for managing and streamlining systematic reviews and removing duplicates. This resulted in 1072 studies after duplicate removal. These studies were screened via their titles and abstracts to assess the

relevancy of the subject matter relating to the objectives of my literature review, reducing the number of eligible studies to 351. Then, 187 were removed at this stage as they failed to satisfy inclusion criteria. After examining and annotating the screened literature, I extracted studies that pertained to the literature review objectives to inform the next steps of my research. For each potentially relevant publication, I retrieved and read the full-text article. 165 studies related to my literature review objectives were found (Appendix A). However, it is to be noted that out of these 165 publications, only (n=21) articles focused primarily on the medicalization of FGM/C. The remaining texts (n=144) predominantly centered on various aspects of FGM/C in its traditional form, cultural beliefs, and practices related to FGM/C, discussions on the harms and effects of traditional procedures, results of FGM/C including sexual dysfunction, as well as FGM/C within the global context. The literature on medicalization and the influence of HCP relating to the practice is still emerging and growing, hence the relatively smaller number of publications in this specific area.

Introduction

Our rapid review explores HCPs perspectives on the medicalization of FGM/C in high prevalence practicing countries, specifically the UAE, Egypt, and Sub-Sahara Africa. The literature reveals that HCP' lack general knowledge on the illegality of FGM/C and its

medicalization. Complex ethical perspectives emerge between HCP identity and cultural/communal experiences. The literature on medicalization uncovers HCP motivation related to the harm reduction philosophy and socio-economic influences concerning the medicalization of FGM/C.

The lack of knowledge of HCP on the illegality of FGM/C and its medicalization in their country

In Guinea, Egypt, and Sudan, as well as the United Arab Emirates (UAE), there are national laws prohibiting FGM/C whether it is practiced by a lay person or by an HCP. However, these laws do not seem to be well understood by healthcare professionals or even reinforced within the healthcare systems (Aziz, Elgibaly, Ibrahim, 2022; Balde et al., 2020; Bedri et al., 2018; Rashid, Iguchi, Afiqah, 2020; Yussuf, Matanda, Powell, 2020). Healthcare professionals in these 4 countries are aware of the practice of FGM/C and its medicalization and the complications attributed to the procedure. However, there are notable gaps in HCP knowledge regarding the laws in their respective countries (Djibouti, Egypt, Guinea, Iraq, Kenya, Nigeria, Sudan) prohibiting FGM/C, particularly in its medicalized form. (Aziz, Elgibaly, Ibrahim, 2022; Balde et al., 2020; Bedri et al., 2018; Rashid, Iguchi, Afiqah, 2020; Yussuf, Matanda, Powell., 2020). One study found that upon surveying 120 nurses and doctors practicing in the UAE, *"Only 26.7% of the medical practitioners were aware of UAE law banning FGM/C, while 50% had no knowledge concerning this issue"* of UAE law of FGM/C in a medicalized setting (Al Awar et al., 2023). While UAE medical law does not specify penalties for HCP performing FGM/C procedures, it does impose severe penalties on non-medical professionals who carry out these procedures. Traditional circumcisers of FGM/C are not authorized to perform FGM/C. Despite the threat of punishment, FGM/C procedures continue to be performed **(**A study

conducted by Al Awar et al., revealed that the prevalence of FGM/C in the UAE was 41.4%**)**. However, few healthcare professionals' motivations for rejecting the practice of medicalizing FGM/C relates to the fact it is a criminal or illegal act (Aziz, Elgibaly, Ibrahim, 2022; Balde et al., 2020; Bedri et al., 2018; Rashid, Iguchi, Afiqah, 2020; Yussuf, Matanda, Powell, 2020). This suggests that the lack of enforcement may be due to a lack of reports from medical professionals identifying harm from these procedures and a general lack of awareness about the law against FGM/C (Al Awar et al., 2023). However, within the same study 64% of HCPs understood the possibility of complications due to the medicalization, and approximately 83% of HCPs believed that FGM/C should be eradicated internationally. The lack of legal understanding underscores the need for accurate and relevant education of HCPs regarding FGM/C, its medicalization and relevant laws relative to the practice. A mixed methods study in Malaysia medical doctors were asked why they chose not to practice the medicalization of FGM/C, only 2% mentioning that they believed that practicing FGM/C was against the law (Rashid, Iguchi, Afiqah., 2020). Understanding the law on FGM/C is critical for medical professionals to protect patients, uphold medical standards, and advocate for FGM/C prevention. It ensures compliance with legal obligations and empowers healthcare professionals to build trust and communicate effectively with patients and families (Aziz, Elgibaly, Ibrahim, 2022; Balde et al., 2020; Bedri et al., 2018; Rashid, Iguchi, Afiqah, 2020; Yussuf, Matanda, Powell., 2020).

In Guinea, the third-highest African country practicing the medicalization FGM/C, there is limited information on healthcare providers' understanding of the legality of FGM/C in relation to their local laws (WHO, 2024). Despite existing literature on medical providers' knowledge regarding FGM/C laws and their motivations to practice the procedure, there are significant gaps in the context of medical professionals' understanding of their local laws related to the

medicalization of FGM/C in Guinea. These gaps highlight the need for further research and targeted interventions to address healthcare professionals' knowledge regarding the legal aspects of practicing FGM/C.

Ethical Conflict to one's profession and community.

While the medicalization of FGM/C is illegal in most practicing countries, healthcare professionals deal with a complex ethical dilemma when reporting incidences of the medicalization of FGM/C (Kimani, Shell-Duncan, 2018; Balde et al., 2020; El-Gibaly, Aziz, Abou Hussein, 2019). Healthcare providers have a "duty to report" when they believe a patient is at risk of FGM/C. The obligation to report emerges when a statute, regulation, by-law, or policy mandates that a physician can reveal confidential information if they believe their patient is at risk. In relation to FGM/C this duty is compulsory. This "duty to report" is effective in over 16 countries that practice FGM/C, while 18 other countries require formal action to be taken when health professionals suspect that FGM/C will be carried out by anyone, this is called a "duty to avert" (Kimani, Shell-Duncan, 2018). However, this "duty" raises a major ethical dilemma regarding healthcare professionals' identity and loyalty to their patients. Healthcare professionals must abide by their *Hippocratic oath* and medical ethics; however, these professional sanctions may directly conflict with their identity as a local community member (Kimani, Shell-Duncan, 2018; Balde et al., 2020; El-Gibaly, Aziz, Abou Hussein, 2019). Reporting these procedures in the UAE, Guinea, Egypt, Djibouti, Egypt, Iraq, Kenya, Nigeria, and Sudan, or even attempting to prevent them by reporting FGM/C may lead to the removal of a girl from the home or lead to the imprisonment of her parents (Kimani, Shell-Duncan, 2018). Since healthcare professionals are members of these communities this ethical dilemma weighs heavily on them are there are intrinsic conflicts between their professional responsibilities and personal identities.

The history of the harm reduction discourse

Public health campaigns have advocated vehemently against FGM/C and its continuation (Aziz, Elgibaly, Ibrahim, 2022). The rationale of these campaigns relied heavily on informing the population of the deleterious effects of FGM/C on the health, both physical and mental of girls and women. However, it has been speculated that the health-based rational use for supporting the importance of abandoning FGM/C furthered the practice's evolution towards its medicalization, at both the supply and the demand ends.

In 1994, the Egyptian Minister of Health stated that physicians could perform FGM/C on girls in designated facilities at fixed times and prices, claiming that medicalization of the practice would reduce complications and eventually end the practice (Aziz, Elgibaly, Ibrahim, 2022). However, this then unintentionally legitimized medicalizing FGM/C and created an impression amongst the population that the procedure may be performed safely, which in turn undermined all historical efforts for abandonment of FGM/C and resulted in increased medicalization rates. Since then, in 1995 fifty-five percent of FGM/C procedures have been done by a healthcare provider, and this percentage has since risen to seventy-eight percent across Egypt, regardless of

[1] Duty to Report when FGM/C has already taken place.
[2] Duty to Avert when there is a risk of FGM/C.
[3] Hippocratic oath is an oath stating the obligations and proper conduct of doctors, formerly taken by those beginning medical practice. Parts of the oath are still used in some medical schools.

campaigns attempting to support the abandonment of FGM/C globally (Aziz, lgibaly, Ibrahim, 2022; Balde et al., 2020; Leye et al. 2018., Van Eekert et al., 2022; Yussuf, Matanda, Powell, 2020). This predicament became increasingly critical in Egypt, which now presents as the country with the highest rate of medicalization in the world (Kimani, Shell-Duncan, 2018: UNFPA, 2018).

Within the last thirty to forty years, major public health organizations nationally and internationally have campaigned against FGM/C and stressed its human rights violations and its adverse health consequences. Assuming that this would help to raise social awareness of the health risks and in turn motivate people to abandon the practice (Aziz, Elgibaly, Ibrahim, 2022; Leye et al., 2019). However, it is speculated that this public health approach focusing on the harms and human rights violations of FGM/C unintentionally motivated the medicalization. The fear of health risks for their child may have motivated parents of young girls to seek out a medicalized form of FGM/C to mitigate harm (Doucet, et al., 2017; Leye et al., 2019; Kimani & Shell-Duncan, 2018). In 2009, public health agencies like the WHO, UNFPA and UNICEF condemned the medicalization of FGM/C in any setting, despite the WHO having raised this issue 30 years earlier (1979) at an international conference, stating *"it is unacceptable to suggest that performing less invasive forms of FGM/C within medical facilities will reduce health complications"* (WHO, 2016). However, 15 years later, in 1994, the Egyptian Minister of Health stated that physicians could perform FGM/C on girls in designated facilities at fixed times and prices, claiming that medicalizing the practice would reduce complications and eventually end FGM/C entirely (Aziz, Elgibaly, Ibrahim, 2022). Therefore, public health campaigns aiming to prevent FGM/C may have inadvertently contributed to enhancing the problem by stimulating the

uptake of a new form of FGM/C with its medicalization. Inadvertently creating a new and growing problem, the medicalization of FGM/C (Aziz, Elgibaly, Ibrahim, 2022; Doucet, et al., 2017; Leye et al., 2019).

Medicalization in the context of education, wealth and decision making

The practice of the medicalization of FGM/C is more common among women from a high socioeconomic, and educational background in Sub-Saharan Africa (Aziz, Elgibaly, Ibrahim, 2022; Van Eekert, Leye, Van de Velde, 2018; Morhason-Bello, et al., 2020)

Education

Historically, women with higher education who have previously undergone FGM/C have been more likely to reject the traditional practice in contrast to non-educated individuals (UNICEF, 2022). This was reinforced by a study that derived data from the 2005, 2008 and 2014 from the Egypt Demographic Health Surveys which sampled 11,455 women. Out of the sample 79% of women had their daughter cut by a trained health professional. The study aimed to better understand the relationship between a woman's social position and the decision to use a trained health professional to perform genital cutting. They found that *"the odds of medicalization were greater among women who had a primary education (odds ratio, 1.2) or a secondary or higher education (1.8) rather than no education*" (Van Eekert, Leye, Van de Velde, 2018). Therefore, education amongst mothers becomes increasingly important in understanding the perpetuation and continuation of the medicalization of FGM/C. The results suggests that education of women indirectly empowers them (e.g., by increasing their ability to earn income, control their fertility and participate in public life). This association can be attributed to the notion that educated women who want to continue the practice are willing to seek out medicalization to reduce the

risk of infections and problems related to the health complications associated with the practice. Some women may want their daughters to adhere to cultural norms but attempt to mitigate physical risks and complications. Therefore, within the context of the medicalization of FGM/C, this practice can be seen as a compromise between the abandonment of the historical harms while a means of continuing the traditional practice (Aziz, Elgibaly, Ibrahim, 2022; Morhason-Bello, et al., 2020).

Wealth

Financial motivations have been identified as a motivation why healthcare professionals continue performing FGM/C (Doucet, Pallitto, Groleau, 2017). Households with higher economic status can provide healthcare professionals with financial incentives to perform FGM/C on their daughters. Mothers from wealthier households had more than twice the odds of opting for a medicalized FGM/C compared to those from poorer households (Van Eekert, Leye, Van de Velde, 2018), suggesting that women with economic security and stability are more likely to make decisions and access healthcare professionals for FGM/C procedures. The medicalization of FGM/C involves a procedure that often requires payment (Aziz, Elgibaly, Ibrahim, 2022; Morhason-Bello et al., 2020), and having economic resources enables these women to afford the costs of the medical procedure.

Decision making

Women in educated and affluent households often engage in shared decision-making within their families, influencing choices regarding medical procedures. Research in Egypt suggests that women with shared decision-making authority, are more inclined to opt for

medicalizing their daughters' FGM/C. This inclination may stem from the perception of medicalization as a symbol of status, possibly indicating a woman's socioeconomic standing, with those having decision-making power often possessing higher social status (Van Eekert, Leye, Van de Velde, 2018).

Education of Medical Professionals

Education plays a crucial role in reducing FGM/C among women in affected communities. Many experts also recommend enhanced training for healthcare professionals to address the medicalization of FGM/C, aiming to challenge the social and cultural norms that perpetuate this practice.

Since 2010, there has been an international strategy aimed at ending the medicalization of FGM/C. The WHO guidelines outlined in the *Global Strategy to Stop Health-care Providers from Performing Female Genital Mutilation* (2010) state that health-care providers must not carry out any form of FGM/C in any setting. This includes refraining from performing re-infibulation after childbirth or in any other circumstance. According to the WHO strategy (2010), healthcare providers should provide care for girls and women suffering from complications associated with FGM/C, including special care during childbirth for women who have already undergone FGM/C. They should counsel women suffering consequences from FGM/C, and their families, and advise them to seek care for their complications and mental health consequences, advise them against re-infibulation, and counsel them to resist having FGM/C performed on their daughters or other family members. Health-care providers should also act as advocates for the abandonment of the practice in the community at large. Instead of performing procedures harmful to girls' and women's health, that violates their human rights. Healthcare providers

should use their competencies and authority to promote the health and human rights of girls and women, including their rights to information, physical integrity, freedom from violence, and health. The education for healthcare professionals must address social and cultural norms that uphold the practice of FGM/C within their practicing communities and the practice of the medicalization of FGM/C in the healthcare systems (Balde et al., 2020; Bedri et al., 2018; Morhason-Bello, et al., 2020; Yussuf, Matanda, Powell, 2020). Healthcare professionals play a crucial role in eliminating the medicalization of FGM/C; however, FGM/C education is frequently lacking within their professional training programs. This gap exists in Djibouti, Egypt, Guinea, Iraq, Kenya, Nigeria, Sudan, and Yemen, where the national prevalence of medicalized FGM/C exceeds 10%. Additionally, there is an absence of standardized training programs for healthcare professionals and students in these regions. This leaves healthcare professionals without essential knowledge of FGM/C, including its human rights violations and illegality in their countries (Balde et al., 2020; Bedri et al., 2018; Morhason-Bello, et al., 2020; Yussuf, Matanda, Powell, 2020). This lack of training contributes to the continuation of the practice, as healthcare professionals may find it difficult to refuse requests for the procedure. They might also struggle to advocate for the social rejection of the practice within clinical settings when interacting with patients and their families (Balde et al., 2020; Bedri et al., 2018; Leye et al, 2019; Morhason-Bello, et al., 2020; Yussuf, Matanda, Powell, 2020)

In line with the WHO's 2010 strategy to end the medicalization of FGM/C, the World Health Organization introduced a guide in 2022 of training programs and modules to assist educators in ending this harmful practice. However, within this training program, culture is addressed in a reductionist form. The need for region-specific approaches, and ways to adapt the training to local cultural contexts (Matanda et al., 2023; WHO, 2022). Culture permeates the

perpetuation of FGM/C and its ongoing existence. Addressing local cultural motivations, meanings, and experiences related to the medicalization of FGM/C is the key strategy for creating effective educational intervention and strategies moving forward. To effect changes towards abandoning FGM/C and its medicalization, there have been arguments made towards the notion that medical professionals can serve as agents of change within their community to abandon the medicalization of FGM/C (Matanda et al., 2023). However, this type of training has yet to be effectively developed to address cultural context (Matanda et al., 2023) and has yet to be effectively implemented and evaluated. Culturally led interventions, driven by local healthcare expertise and experience, can play an impactful role in combating the medicalization of FGM/C. These interventions address social and cultural motivations, while also avoiding potential complications associated with top-down approaches imposed by international and national organizations, which may historically inadvertently reproduce previous neocolonialist approaches and outcomes, like the medicalization of FGM/C (Leye et al., 2019; Matanda et al., 2023).

Gaps in Literature

Lack of Legal Knowledge

In various practicing countries such as the UAE, Malaysia, and Egypt, literature exists on healthcare providers' understanding of local and national laws regarding FGM/C. However, given the increasing trend of medicalized FGM/C, there is a clear need for more comprehensive literature to support the promotion of the social rejection of this practice within healthcare systems. As of 2024, there is a notable absence of literature on healthcare providers' knowledge

of the illegality of practicing medicalization of FGM/C. In Guinea, where 31% of FGM/C procedures are carried out by healthcare professionals, no study has been published focusing on HCPs knowledge of the illegality of FGM/C and its medicalization. While existing literature suggests that legislation alone has not led to a decline in FGM/C in many countries, healthcare professionals' understanding of their legal obligations remains a crucial element in the efforts to eliminate FGM/C. The lack of legal education and understanding among healthcare professionals may hinder various efforts to reject FGM/C within their communities.

Cultural Oversight

Socio-cultural factors are the primary contributors to the perpetuation and evolution of FGM/C. However, educational interventions and training programs developed by the WHO and other UN agencies often address culture in an overly rational way that underestimates potential reactions of the populations at stake, the recent and growing phenomenon of medicalization being an example of this. The socio-cultural beliefs influencing FGM/C, such as beliefs about vaginal cleanliness, purity, marriageability, myths surrounding the clitoris, beauty standards, and more, vary significantly from one community to another. Therefore, superficially addressing culture with a one-size-fits-all approach is unlikely to effectively address the unique communal and cultural belief systems that support and uphold FGM/C and its medicalization. This, in turn, hinders the main objective of these interventions, which is to promote the social rejection of FGM/C. A more nuanced, community driven, and locally tailored approach is needed to effectively reject FGM/C in all its forms.

For example, the WHO's toolkit on "*Integrating female genital mutilation content into nursing and midwifery curricula: a practical guide" (2022),* OR their manual for "*Person-centered communication for female genital mutilation prevention: a facilitator's guide for training health-care providers"* (WHO, 2022) lacked a clear cultural understanding concerning healthcare professionals and their relationship to FGM/C. The motivations behind the medicalization of FGM/C are continuously noted within the literature, the "harm reduction" philosophy has been serving as a consistent motivator among healthcare professions (Aziz, Elgibaly, Ibrahim, 2022; Balde et al., 2020; Leye et al. 2018., Van Eekert et al., 2022; Yussuf, Matanda, Powell, 2020). However, training programs often neglect to address this philosophy throughout their courses (WHO, 2022). This neglected area is concerning because it represents a key consistency highlighted in relevant literature regarding healthcare professionals' rationales for the medicalization of FGM/C. Effective education intervention strategies aimed at combating FGM/C often do not have culture at the core of their design. Additionally, these strategies are not consistently implemented on an international scale, which creates a significant gap in efforts to address and eliminate this harmful practice.

Transition

In recognition of these gaps within the healthcare training sector, there is a need to better understand the meaning and experiences of healthcare professionals and students related to the medicalization of FGM/C. Understanding the meaning and experiences of healthcare professionals (HCPs) and students regarding the medicalization of Female Genital Mutilation/Cutting (FGM/C) is crucial for a variety of reasons.

My Project

Firstly, this type of knowledge will support the advancement of effective intervention strategies to reject the practice in their communities. By addressing current gaps within the literature this will help us identify key components to address in educational interventions and training programs to support the eradication of the medicalization of FGM/C. This ensures that the HCPs training programs will resonate with the participants lived experiences, making training programs more effective and relevant to participants. This approach will also address previous faults of the "top-down" approach where public health agencies created health campaigns that stressed the adverse health consequences of the practice without cultural understanding which may have unintentionally motivated the phenomenon of the medicalization of FGM/C. Centering the voices and insights of healthcare professionals, can help us better address the complex sociocultural dynamics surrounding FGM/C. Further research in this area is essential to create meaningful interventions that align with the needs and realities of affected communities, advancing the critical goal of eradicating the harmful practice of FGM/C and its medicalization.

Manuscript: The Medicalization of FGM/C: *Eradicating or Perpetuating the Tradition?*

MANUSCRIPT: Abstract

Female Genital Mutilation/Cutting (FGM/C) is a traditional gender-based violence practice affecting over 230 million girls globally (Kimeu, 2024; UNICEF, 2024). In Guinea-Conakry, 96-97% of girls/women undergo FGM/C, with 31% of procedures performed by healthcare professionals, termed medicalization (Mareah et al., 2023; UNICEF, 2024; WHO 2022). This practice offers no medical benefits, leading to long-term physical, mental, sexual, and reproductive health issues, breaching the 'Hippocratic oath' and human rights (WHO 2022). Guinea ranks third in Africa for medicalization (WHO 2022). Educating healthcare providers is crucial to prevent this, recommended by leading organizations (Kimeu, 2024; Mareah et al., 2023; WHO 2022; UNICEF, 2024). However, current WHO training guidelines lack cultural adaptation strategies. This research explores the views of midwifery and nursing students in Guinea's university program on FGM/C medicalization motivations, using *RapForMe*© qualitative methodology (Doucet, et al., 2017; Mareah et al., 2023). Our study held focus groups, revealing diverse perspectives: nursing students emphasize harm reduction and biomedical standards, while midwifery students see it as a social obligation. The clash reflects differing cultural and healthcare perspectives, urging culturally sensitive interventions strategies moving forward. The medicalization of FGM/C among healthcare providers is likely to persist unless effective intersubjective solutions are proposed and implemented to replace medicalization and HCPs are empowered to intervene at the community level.

MANUSCRIPT: Introduction

According to the World Health Organization (WHO), the "medicalization" of Female Genital Mutilation/Cutting (FGM/C) refers to situations in which FGM/C is practiced by any health professionals, whether in a public or a private clinic, at home or elsewhere, at any point in a woman's life (Doucet, et al., 2017, WHO 2022). Health professionals involved in medicalization include physicians, assistant physicians, clinical officers, nurses, midwives, trained traditional birth attendants, gynecologists/ obstetricians, plastic surgeons, and other personnel providing health care to the population, in both private and public sectors. They may be undergoing medical training, working in the medical sector, or retired (Doucet, et al., 2017). In recent years, the medicalization of FGM/C has evolved to become increasingly common, even if it violates healthcare professionals' medical ethics and Hippocratic oaths (Doucet, et al., 2017). Globally, among 25 countries, the rates of medicalization among women aged 15–49 are highest in five countries. Guinea stands as the third highest African country, accounting for 31% of all FGM/C procedures performed with the assistance of healthcare professionals (Kimani, Shell-Duncan, 2018). It is thus important to understand the social drivers of this recent emerging phenomenon to better guide policy and prevention. According to an integrative review of the literature done by Doucet, Pallitto & Groleau (2017), the researchers found that the main rationale regarding healthcare providers' motivations to practice FGM/C was; (1) the preconception that performing FGM/C on a girl within a medical setting would be less harmful for girls or women than the procedure being performed by a traditional practitioner in a nonsterile setting, with little medical knowledge of anatomy. The review also found that since medical professionals are a part of practicing communities their belief system surrounding the justification of FGM/C motivated their participation in the procedure. The review also revealed that financial gains associated with the procedure by healthcare professionals, particularly nurses and midwives, may serve as an

incentive for these individuals to perform it. This is partly explained by the loss in income resulting from the introduction of maternal health fees exemption policies. However, within this research, we did not corroborate this motivation. Finally, professionals may respond to requests of the community or feel pressured by the community members to perform FGM/C regardless of their opinion of the practice. Many healthcare providers are aware of the health complications associated with FGM/C, which influences their decision to refuse to practice. Additionally, in countries where FGM/C is illegal such as Egypt, Sudan, and Guinea, some providers address legal constraints as a reason for refusal. Some healthcare providers consider FGM/C as a harmful practice, using this stance as their primary rationale for rejection (Doucet, et al., 2017, WHO 2022). However, there remains a need for more research to delve into the motivations behind medical professionals' refusals to understand healthcare motivations to reject the practice (Doucet, et al., 2017, WHO 2022).

Within the last thirty years, some major public health organizations nationally and internationally campaigned against FGM/C and stressed the human rights violations of FGM/C and its adverse health consequences, assuming that this would help to raise social awareness of the health risks and in turn motivate people to abandon the practice (Aziz, Elgibaly, Ibrahim, 2022; Leye et al., 2019). However, it is speculated that the health approach focusing on the harms and human rights violations of FGM/C unintentionally motivated the medicalization of FGM/C, on both the demand and supply side. In 2009 the WHO, the United Nations Children's Fund (UNICEF), and the United Nations Populations Fund (UNFPA) condemned the medicalization of FGM/C in any setting. However, the WHO had already raised this issue 30 years earlier (1979) at an international conference, stating *"it is unacceptable to suggest that performing less invasive forms of FGM/C within medical facilities will reduce health*

complications" (Aziz, Elgibaly, Ibrahim, 2022; WHO, 2016). However, 15

years later, in 1994, the Egyptian Minister of Health stated that physicians could perform FGM/C on girls in designated facilities at fixed times and prices, claiming that medicalization of the practice would reduce complications and eventually end the practice (Aziz, Elgibaly, Ibrahim, 2022). It has also been noted that the fear of health risks may have unintentionally motivated parents of young girls to seek out the medicalization of FGM/C to mitigate harm (Doucet, et al., 2017; Leye et al., 2019; Kimani & Shell-Duncan, 2018). Therefore, public health campaigns highlighting the physical complications related to FGM/C and its medicalization may not effectively prevent or educate practicing communities and health professionals (Aziz, Elgibaly, Ibrahim, 2022; Doucet, et al., 2017; Leye et al., 2019). The medicalization of FGM/C is notably prevalent among girls aged 0-14 and is increasing in countries like; Egypt (78%), Sudan (77%), Indonesia (62%), Guinea (31%), Djibouti (21%), Kenya (20%), Iraq (14%), Yemen (13%), and Nigeria (12%) (Kimani & Shell-Duncan, 2018). It is crucial to clarify that these percentages represent the proportion of girls who have undergone the medicalization of FGM/C, not the prevalence of FGM/C in these countries. Traditional FGM/C rates remain higher in the mentioned countries, but the figures provided specifically address the prevalence of medicalized FGM/C practices (Kimani & Shell-Duncan, 2018; UNFPA-UNICEF, 2023).

The medicalization of FGM/C is deeply entrenched in social, psychological, financial, and cultural beliefs and myths that coexist within communities and systems that encourage this harmful practice. Understanding the motivations and rationality related to the medicalization of FGM/C is critical to help eradicate it. However, recent literature attributes the continuation of the practice to a variety of cultural determinants and to the “harm reduction” philosophy adopted by health care professionals (Aziz, Elgibaly, Ibrahim, 2022; Doucet, et al., 2017; Leye et al., 2019). Therefore, we must fully understand the meaning and experience of healthcare professionals' for

adopting the practice to identify effective intervention strategies that will address the complexity of the phenomenon. As of 2023, there remains an absence of a standardized healthcare training program(s) or culturally tailored educational intervention that can be applied to prevent or address the medicalization of FGM/C (Matanda et al., 2023). Although the World Health Organization introduced a guide in 2022 to develop such a training program, it only superficially addresses cultural motivations, the need for region-specific approaches, and ways to adapt the training to local cultural contexts (Matanda et al., 2023; WHO, 2022). Culture permeates the perpetuation of FGM/C and its ongoing existence. Addressing local cultural motivations, meanings, and experiences related to the medicalization of FGM/C is the key strategy for creating effective educational intervention strategies moving forward. To effect changes towards abandoning FGM/C and its medicalization, there have been arguments made towards the notion that medical professionals can serve as agents of change within their community to abandon the medicalization of FGM/C (Matanda et al., 2023). However, this type of training has yet to be effectively developed, implemented, and evaluated to effectively address cultural contexts (Matanda et al., 2023). Culturally led interventions, driven by local healthcare expertise and experience, can play an impactful role in combating the medicalization of FGM/C (Leye et al., 2019; Matanda et al., 2023). These interventions address social and cultural motivations, while also avoiding potential complications associated with top-down approaches imposed by international and national organizations, which may inadvertently reproduce previous neocolonialist approaches and outcomes, like the medicalization of FGM/C (Leye et al., 2019; Matanda et al., 2023).

Our research aim addressed in the manuscript of this thesis is to better understand the complexity of the meaning and lived experiences of medicalization of FGM/C amongst university students in midwifery and nursing training programs at an anonymous University in Guinea. To better understand the meaning and experience of these future HCPs in training regarding medicalization is an important step towards understanding the recent (31%) and growing phenomenon of medicalization that characterizes Guinea (Kimani & Shell-Duncan, 2018).

MANUSCRIPT: Methods

Setting, recruitment and sampling:

Participants of this study were students in a class given by the co-author (DG) on 'Qualitative Health Research method' in January 2024 at an anonymous University in Guinea. This 35-hour class introduced students to qualitative health research methodologies and data collection techniques for research in healthcare. During the class, students were taught the *RapForMe*© method developed by the co-author (DG) (Groleau, submitted) that is a rapid group interview method that allows to plan and conduct a group interview and analyze the qualitative data in a participatory way. The data presented in this paper will pertain to two of the group interviews conducted and led by participating students registered in the programs of nursing and midwifery. The class participants were allowed to voluntarily participate in a research project on the medicalization of FGM/C. A total of 60 students were registered in the class of whom two students refused to participate in the study. The study was explained to all the students in class. Those who accepted to participate read and signed the informed consent form that was approved by the ethics review boards of the universities of the authors. Focus groups were conducted by health profession to promote candid discussions and gather detailed insights while acknowledging the unique dynamics within nursing and midwifery programs. This approach enhanced the research's ability to comprehensively understand the meaning and experiences related to FGM/C medicalization in the context of healthcare in Conakry, Guinea.

Recruitment:

Participants were emailed about the free qualitative health research class, receiving detailed information. They gave informed consent, understanding the study's purpose, procedures, risks, and benefits.

Data collection method: Sociodemographic Data

Sociodemographic data was collected through enrollment in the Qualitative Health Research course. Information on sex, religion, years of professional experience, and country of birth was gathered via a survey provided to students at the beginning of the course. This survey aimed to understand the diverse backgrounds of the participants (APPENDIX F & G).

Data collection method: Focus Groups & *RapForMe*© participatory method

In accordance with Krueger (2014), a focus group is a type of group interview that allows for discussion around planned themes or questions. It collects data from participants in a friendly non-threatening environment, with the hopes of strengthening the discussion's atmosphere as a catalyst for data collection. To conduct focus groups effectively, we planned to have two separate sessions, each with 8-10 participants—student nurses and midwives. This group setting encouraged discussions, allowing each member to express their thoughts thoroughly and clarify their positions regarding convergent and divergent ideas. Given the sensitivity of the topic, it was clarified from the beginning that consensual and divergent ideas were valued and important for the study and participants were encouraged to state their positions on discussed subjects whether they were in accordance with others or not.

For each focus group, one skilled moderator (a university midwifery or nursing student) led the discussions, while three student observers took detailed notes during the session. Two of the note-takers focused on the answers (including consensual and divergent positions) to each question by entering their notes under each of the Focus-Group questions in a laptop using a Microsoft Word document. The third note-taker also took note of the answers but focused on the non-verbal cues of participants linked to the discussed ideas (Gisondi). All note-takers needed to identify in their notes the convergent and divergent statements and ideas put forward during the discussions. The discussions were recorded and guided by a series of open-ended questions (Appendix D&E) designed by the two groups to elicit comprehensive responses and discussions between the participants (Krueger, 2014). The participants' responses were recorded with three recorders placed in different spaces to make sure all comments were well recorded during both focus groups. The midwives' focus group consisted of seven student midwives, with Student: Gisondi serving as the nonverbal user notetaker. The nursing student focus group comprised 19 participants.

Positionality of author

The first author, FG, served as a third note-taker in the midwife's focus group, responsible for noting non-verbal cues, and later assumed the role of the main note-taker in the post-focus group consensual meeting for the creation of the final *RapForMe*© rapport. FG's identity as a McGill graduate student and outsider to the community presented various implications. Her student status potentially made her relatable to participants, facilitating comfort in sharing experiences. Moreover, as an outsider, there might have been trust in FG's presence, which would not lead to breaches of confidentiality. This trust could have fostered a more open and honest discussion within the focus group. However, Felicia's outsider status could have

hindered participants' full disclosure of sensitive information, resulting in a superficial understanding of cultural contexts and potentially limiting the depth of participants' experiences. Her role might also have influenced group dynamics, leading some to be hesitant to share. Despite fostering relatability, challenges in representing diverse perspectives may have emerged due to her positionality.

Data analysis method; *RapForMe*© (Groleau, submitted)

Our qualitative design involves using the *RapForMe*© participatory method that serves to co-design, co-conduct and co-analyze the qualitative data from a focus-group. The unpublished participatory *RapForMe*© method was developed by Dr. Danielle Groleau.

The *RapForMe*© method involves the following steps:

Step 1: The initial stage entails the collective design of questions by the entire group of midwifery or nursing students, focusing on the attributed meanings and experiences, with a set of five questions per sub-topic for the upcoming focus group session. Following the formulation of questions, the group collectively assigns roles, including the selection of a moderator, focus group participants, observers, and note-takers. This participatory approach aims to foster inclusivity, shared responsibility, and a collective sense of ownership over the focus group process and its outcomes.

Step 2: The second phase involves conducting a recorded focus group session comprising 8-10 participants, facilitated by a single moderator and supported by three observers who act as note-takers. The note-takers are then tasked with synthesizing the themes of convergence and divergence for each question posed during the focus group discussion. Additionally, a third note-

taker is responsible for recording non-verbal observations and any potential issues of power dynamics that could silence certain participants.

Step 3: Following the focus group session, a qualitative analysis meeting is convened within one day, bringing together researchers, the moderator, and the three observers. This meeting's main objective is to delve into the responses provided to each question from the focus group and distill them into convergent and divergent ideas. Throughout these discussions, a designated note-taker collaboratively documents a summary of the convergent and divergent ideas expressed by the three note-takers.

Step 4: The subsequent day, one of the note-takers is assigned the task of independently revising, correcting, and validating the written summaries by thoroughly reviewing the complete recordings of the focus group session. This meticulous process ensures the accuracy and fidelity of the *RapForMe*© report, correcting any discrepancies or clarifying points as necessary.

RapForMe© method: Focus-group organization
[8-10] Focus-group Participants
[1] Moderator
[3] Notetakers
[3-6] Participants

Ethics: (include consent)

The present study was conducted according to ethical principles stated in the Declaration of Helsinki (2013). Ethical approval was granted by the Research Ethics Office (IRB) of the Faculty of Medicine and Health Sciences at McGill University (IRB Internal Study Number: A12-B50-23B) (Appendix B). Participants' confidentiality was protected throughout the project. Any personal information collected was kept confidential and stored securely. Quotations of

participants verbatim presented in this paper were changed slightly to avoid identification. Participants in the focus groups were asked to protect the confidentiality of others. The project considered power dynamics between researchers and participants, particularly in terms of gender, education, and professional backgrounds.

Participants Consent

We obtained informed consent from all participants, ensuring they had a clear understanding of the project's purpose, procedures, potential risks and benefits, and their rights as participants. The consent forms addressed sensitive topics such as FGM/C, with care and provided an opportunity for participants to ask questions and withdraw their consent at any time without negative consequences. A mitigation plan was developed to address reenactment of FGM/C related trauma and vicarious trauma among students & research team with counseling available on site if needed, which was not needed. The two researchers FG and DG who were on site during data collection were trained to recognize traumatic reactions and psychological distress and intervene accordingly (Appendix C).

MANUSCRIPT: Results

The Meaning of Traditional FGM/C

Participating students from the nursing and midwifery program noted that traditional FGM/C is a cultural practice deeply rooted in communities, justified by beliefs that it serves to control the sexual desire and behavior of women and girls. Participants noted these beliefs perpetuate social norms centered on preserving virginity, and sexual purity, as sexual desire and activity outside the institution of marriage are frowned upon in Guinea. These practices reflect larger societal ideals of modesty and family honor as low sexual desire in girls and women is a key cultural value that determines the respectability of the girl. This norm is upheld by the shaming behavior of community members towards girls who step outside these cultural norms. Participants noted traditional FGM/C is viewed as a crucial step in preserving a girl's purity until marriage, linking the practice to the maintenance of traditional values. Failure to undergo FGM/C can lead to social stigma, ostracization, and the rejection of individuals family, illustrating its deep-seated importance within these communities.

> *"Yes, it* [would] *allow my daughter* [to undergo traditional FGM/C] *to have less of a sexual desire and focus on her education... this will diminish her risks of participating in sexual acts"* (Midwifery Student, Female).

> *"In our society* [Conakry-Guinea]*, excision is seen as a necessary evil, it allows the reduction of sexual activity of a girl and reduces STIs & HIV"* (Nursing Student, Female).

While both nursing and midwifery students share the cultural belief that FGM/C reduces sexual appetite, their perspectives diverge. Nursing students emphasize the biomedical aspect,

citing its potential to prevent STIs and HIV. While midwifery students focus on social and community acceptance and obligation, viewing FGM/C to uphold cultural identity.

4

The meaning of the medicalization of FGM/C: Harm reduction philosophy

When discussing the medicalization of FGM/C the "harm reduction" philosophy permeated the discussions. Midwifery students unanimously agreed that the medicalization of FGM/C presents far fewer physical risks in comparison to traditional cutting. This was attributed to the use of antiseptiques, scientific and surgical tools to reduce the health complications and risks. Participants unanimously noted that the traditional cutting procedure poses major physical complications, as it is often carried out by a non-medical professional. However, when discussing motivations related to the medicalization of FGM/C, the obligation stems more from the integral respect for family, culture, and tradition. Even though participants expressed positive sentiments related to the medicalization, they were aware of potential infections that could occur following the procedure. Participants noted that the medicalized FGM/C would also cause physical harm. Among the consequences mentioned were lack of sexual desire, pain, complications during childbirth, hemorrhage, and painful periods. Psychological complications such as depression, and trauma, were only noted by one midwifery student.

> "[The] *Medicalization presents far fewer physical risks/complications...the use of anesthesia and scientific tools to reduce the risks of FGM/C...in comparison to*

[4] Maïeuticien has recently been introduced in some countries to name (male) midwives.

traditional cutting procedures which poses major physical problems and is often carried out by an elder in the forest". (Midwifery Student, Female)

Among the nursing students, discussions about the medicalization of FGM/C centered on the importance of biomedical adherence to antiseptic practices. The nursing students expressed a generally positive stance toward the medicalization of FGM/C.

"To my knowledge if all measures are taken in relation to this practice, it will have no negative consequences on the girls/women medicalized" (Nursing Student, Female).

However, within the nursing student group, there was only one divergent voice that firmly rejected FGM/C in all its forms. This was a stark comparison to the midwifery students who were much more conflicted when discussing whether the medicalization was a positive or negative practice for women and girls. While the harm reduction philosophy emerged as a common theme in both groups to justify practicing medicalization, conflicting opinions on medicalization being a positive practice or not were more present within the midwifery students' discussions.

Clinical Knowledge: Sterile environment & medical tools

Both nursing and midwifery students highlighted clinical understanding of antiseptic knowledge and usage as a motivating factor and potential favorable outcomes of the medicalization of FGM/C. Both groups expressed favorable perspectives on the use of antiseptics as a driving force and a potentially beneficial consequence of medicalizing FGM/C. None of the participants raised objections regarding the benefits of using antiseptics and sterile medical tools in the context of medicalized FGM/C.

"Complications at the hospital [medicalization] *are minimal compared to traditional cutting"* (Midwifery Student, Female)

"Medicalizing the practice considers the safety of the people being excised, which is why it is critical. As medical professionals with Western medical education, we can profit as health professionals to mitigate risks and help inform society" (Nursing Student, Male).

Both the nurses' and midwives' focus groups highlighted the use of antiseptics as a positive outcome of the medicalization of FGM/C. The participants emphasized the importance of clinical knowledge in antiseptic usage and understanding of anatomy as rationales for practice of the medicalization.

Eradication or Perpetuation?

When asked if the medicalization was a form of continuing FGM/C or eradicating the procedure the midwifery students were divided. The debate between medicalization contributing to the eradication of FGM/C or continuing the practice was the first major division within the student midwives focus group. Some midwives stated that medicalization was a means of eradicating FGM/C, because social perceptions cannot be changed abruptly, one must take a gradual approach. However, the opposing participants focused on medicalization as a means of

[5] excised: participants used the term "excised" concerning FGM/C as a synonym for being "cut".

perpetuating the practice but in a safer way. Firmly stating that cutting is continuing, regardless of the biomedical sanctions that can be put in place, people will continue to practice, even if it causes women harm.

> " [The medicalization] *It's a way of continuing the practice, because something that's forbidden shouldn't be done, but if the health workers do it, it's to continue by changing the method of excision...There is a difference between traditional excision and medicalization...but if we do this in a medical setting, in a new way, it's a way of avoiding complications from traditional FGM/C* [and] *If we do it [FGM/C] in a medical setting, it is not the same* [and] *They will always continue to cut"* (Midwifery Student, Male)

However, one participant pointed out that if he had to choose between traditional excision and medicalization, he would choose medicalization and the group unanimously agreed with this statement.

> *"If I had to choose between traditional excision and medicalization, I would choose the medicalization"* (Midwifery Student, Male).

Amongst the nursing student group, most participants advocated for the medicalization of FGM/C as a means of reducing infections and health risks to women and girls. Within this biomedical framework, many nursing students supported medicalization, with only one student rejecting any form of FGM/C.

> *"It's necessary evil, historically traditional cutting has killed girls, our death tolls are high, the medicalization will lower this death toll. This* [medicalization] *will contribute to the reduction of the risk of infection and risks"* (Nursing Student, Male).

While some midwifery students considered the practice of medicalization as a perpetuation of FGM/C others believed it was a necessary step in eradicating the practice. However, except for one student, nursing students were however unanimous in advocating for the medicalization of FGM/C as a means of reducing infections and health risks to women and girls.

Cultural identity vs the Biomedical Professional identity

Student midwives' express reluctance to end traditional FGM/C, fearing loss of Guinean cultural identity shaped by Western norms. The contrast between Western biomedical professional education and Guinean culture shaped the midwifery students' perspectives on their meaning of FGM/C.

> "*But if we do this in a medical setting, in a new way, it's a way of avoiding complications from traditional FGM/C... If we do it [FGM/C] in a medical setting, it is not the same"*
> (Midwifery Student, Female)

This conflicted sentiment was amplified by the nursing students. who expressed in the ongoing conflict between their professional identity, rooted in western medicine, and their understanding and experience of traditional and communal practices. Despite this conflict within their professional identity, they perceive their biomedical expertise and knowledge as a tool to minimize physical harm to women and girls. Nurses perceive their medical expertise as a means to resolve this internal conflict by leveraging the use of their Western medical education and tools to uphold a traditional procedure like FGM/C. They see the medicalization as a way to

integrate safety measures such as antiseptics and sterile environments, applying the insights from their medical education within the framework and honoring their tradition.

> *"As* [future] *medical professionals with Western medication education, we can profit as health professionals to mitigate risks and help inform society"* (Nursing Student, Female).

In addressing the complexities of cultural identity and professional identity, midwifery and nursing students alike find themselves at the intersection of traditional Guinean and western biomedical ethics, seeking to uphold women and girls' safety while preserving cultural traditions.

Lived Experience

Among midwifery students in Guinea, discussions on the medicalization of FGM/C revealed a central theme of culture and identity. Their perspectives were shaped by witnessing or experiencing traditional FGM/C practices within their communities. These experiences unveiled beliefs connected to identity, womanhood, sexuality, and societal norms. Cultural motivations such as sexual control, fidelity, purity, and the duty to uphold tradition were discussed, highlighting diverse views on FGM/C and its medicalization. The normalization of FGM/C in Guinea, where it is culturally obligatory, was evident in shared experiences of witnessing cutting ceremonies among the students. This cultural backdrop deeply influenced their perspectives on FGM/C, guiding their views on its continuation and medicalization.

> One participant said that when she was a little girl, *"I was happy to be circumcised...if I had known the outcome and the results, I would not have been so enthusiastic about undergoing FGM/*C" (Midwifery student, Female).

The nursing students approached FGM/C discussions from a professional and biomedical standpoint. While they acknowledged cultural factors, their reflections were less supported by their personal experience compared to the midwifery students. They discussed women's discontent with traditional FGM/C outcomes and mentioned community experiences with the practice. However, the nursing students did not delve into their own lived experiences of FGM/C throughout the focus group discussions, maintaining a more objective stance on the subject. This juxtaposition of personal and professional perspectives underscores the complexity and multifaceted nature of meaning surrounding FGM/C and its medicalization within these educational contexts.

> *"The image of excision has dual imagery, for educated people this practice has no advantage while in the community for non-literate or uneducated people they see it as a means of respect for their tradition. Excision has a dual image in our community, accepted by some and rejected by others"* (Nursing Student, Female).

The conflicting cultural prescriptions and professional identities were evident in both focus groups regarding the continuation of FGM/C and its medicalization. As participants reflected on their own experiences and encounters with traditional FGM/C, they simultaneously focused on the mission to reduce harm for women and girls through the medicalization of the practice.

MANUSCRIPT: Discussion

Importance of our results

Although numerous studies (Balde et al., 2022; ElMorally, 2024; Leye et al., 2019; Shell-Duncan et al., 2017; Van Eekert et al., 2024) have explored the determinants of FGM/C in Guinea, this study is the first to examine the meaning and experience of FGM/C and its medicalization among students completing a university program in nursing and midwifery. Our findings, which fill an important knowledge gap, are critical for two reasons. The primary step in understanding the uphill drivers of the recent phenomenon of medicalization is to understand how future practitioners perceive the traditional practice of FGM/C as a baseline for understanding the medicalization phenomenon. Secondly, Guinea is one of the countries in the world presenting with the highest rates of both FGM/C (97%; Balde et al., 2021; Boun, et al., 2023) and medicalization of FGM/C (31%; Kimani & Shell-Duncan, 2018; UNFPA-UNICEF, 2023). Our findings therefore become crucial in supporting the direction of national and likely international initiatives aimed at eradicating the medicalization of FGM/C (Boun, et al., 2023; UNFPA 2018).

Traditional FGM/C

Both groups noted the perpetuation of traditional FGM/C as a method of reducing women's libido and sexual desire, diminishing sexual pleasure and intimacy, which in turn positively affects marriage prospects due to cultural norms. Both Nurses and Midwives also mentioned that motivation to suppress women's sexuality contributes to the continuation of FGM/C practices, stating that FGM/C is not only a cultural tradition but is also perceived as a necessity for societal acceptance and marriageability of girls and women. This focus on the suppression of women's sexuality through FGM/C aligns with various other research on the social determinants of

FGM/C in Guinea (Balde et al., 2022; Boun, et al., 2023; ElMorally, 2024; Leye et al., 2019; Shell-Duncan et al., 2017; Van Eekert et al., 2024). Both nursing and midwifery students noted that the fear of social rejection is a significant factor in the perpetuation of FGM/C. Families and community members may continue these practices due to the potential for gossip, collective shaming, and ostracization. This source of fear towards the community was also present in the studies by Doucet et al. (2017; 2020; 2022) who found that some Guinean parents hid the fact that their daughter was not cut because of the same kind of fear. Our participants however also added how future husbands also might contribute to the perpetuation of FGM/C. If they discover a woman is uncut, it could lead to further social repercussions and potentially impact the woman's marriage prospects.

In the cultural context of Guinea, where identity is collective as opposed to individualist identity in the West (Akinsulure-Smith, Andjembe Etogho, & Genco, 2023; Doucet et al., 2020; Doucet et al., 2022), nursing and midwifery students navigate their lives within a web of interdependence with their families and communities (Akinsulure-Smith, Andjembe Etogho, & Genco, 2023; Doucet et al., 2020; Doucet et al., 2022). This collective dimension of identity means that acts of ridicule or mockery can reverberate widely, impacting not just the individual but also shaping perceptions of their entire familial and communal standing (Akinsulure-Smith, Andjembe Etogho, & Genco, 2023; Doucet et al., 2020; Doucet et al., 2022).

Through reflections and recollections, both nurses and midwives shed light on their experiences with traditional FGM/C ceremonies. Their accounts underscore the communal significance deeply ingrained in these rituals, emphasizing that these practices are viewed as communal affairs rather than solely individual. This understanding illuminates the intricate ways in which stigma and its severe impact operates within these cultural frameworks, offering insight

into the complex dynamics that perpetuate the practice of FGM/C within these communities. Research by Akinsulure-Smith, Andjembe Etogho, & Genco (2023) and Doucet et al. (2020, 2022) corroborates these findings, highlighting the deep-rooted stigma for those who reject FGM/C and its role in reinforcing community norms and expectations.

Healthcare students in nursing and midwifery programs are individuals who possess a complex understanding of FGM/C within their societies, having either undergone the practice themselves or witnessed it firsthand. Their lived experiences with the traditional practices of FGM/C serve as a foundational knowledge base in their complex understanding of the medicalization of FGM/C in Guinea. This means that their insights into the cultural significance and rituals surrounding FGM/C allow them to discern how these practices are evolving into medical settings, where they may be performed by themselves or another healthcare professionals.

The medicalization of FGM/C: Harm reduction philosophy

The result of this study emphasizes the importance and nuances relating to the harm reduction argument and ideology (Aziz, lgibaly, Ibrahim, 2022; Balde et al., 2020; Leye et al. 2018., Van Eekert et al., 2022; Yussuf, Matanda, Powell, 2020) which also presented as a strong motivation for practicing medicalization of FGM/C among both nursing and midwifery students. This result aligns with findings from previous academic studies among HCPs. We know that the harm reduction argument was a driver among HCPs in Guinea (Doucet et al., 2020; Doucet et al., 2022); however, prior to our research, the nuances surrounding this rationale were not adequately investigated or documented. This refers to the subtle or detailed aspects of the harm reduction philosophy addressing specific motivations upheld by HCPs, cultural beliefs that influence the approach, and nuances that present across HCP disciplines. Generalization relating

to the harm reduction philosophy have been well noted among HCPs in Egypt, Indonesia, Kenya, and Somalia, where it serves as a prominent biomedical rationale put forward within the public health discourse (Aziz, Igibaly, Ibrahim, 2022; Balde et al., 2020; Doucet et al., 2017; Leye et al., 2018; Van Eekert et al., 2022; Yussuf, Matanda, Powell, 2020).

Eradication or Perpetuation

While both groups adhered to the harm reduction rationale to justify medicalization, each group held their own emphasis. The difference in their discourse about harm reduction lies in the emphasis on a social versus a biomedical rationale. The student midwives discourse focused on the social aspect, aiming to shift the practice away from traditional cutters. They see the medicalization as a way to safeguard the health of girls and women by eliminating the risks associated with these traditional practices. Among midwifery students, however, there was a split in views on medicalizing FGM/C. Some students saw it as a potential means to reduce the severity of the practice, possibly leading to its abandonment. Others feared medicalization might legitimize and sustain FGM/C within healthcare systems. Some midwifery students rejected any form of FGM/C, viewing it as a violation of girls' rights. This diversity underscores the complexity of addressing FGM/C among healthcare professionals, reflecting broader societal debates and the need for sensitive approaches.

In contrast to the divided views among midwifery students, nursing students presented a more unified perspective on the medicalization of FGM/C. Among the latter, medicalization was regarded as a crucial step towards improving the lives of women and girls, with one participant even describing it as a notable *"necessary evil"*. The medicalization was seen to uphold traditional values while simultaneously safeguarding the well-being of women and girls. For student nurses, medicalization represents a means through which women can attain a higher

social status while ensuring their physical wellbeing. It was viewed as something beneficial for both healthcare professionals, women, and girls, offering a means to mitigate risks associated with the traditional practice of FGM/C while preserving cultural traditions. This unified support for medicalization among nursing students was based on a strong belief that medicalization was a way of bringing about positive change and improvements to the health outcomes and rights of women and girls.

However, viewing medicalization as a continuation of FGM/C opens the door to discuss its legal aspects in training programs for health care professionals: medicalization is still FGM/C and thus illegal in Guinea. This discussion aligns with the literature (Aziz, Elgibaly, Ibrahim, 2022; Balde et al., 2020; Bedri et al., 2018; Rashid, Iguchi, Afiqah, 2020; Yussuf, Matanda, Powell, 2020) which suggests that few healthcare professionals in Egypt, Guinea, Sudan, Somalia, Malasia are aware of the illegal nature of medicalization of FGM/C.

Biomedical vs social motivation

However, among healthcare students, there is a distinct difference in their motivations and rationale for practicing medicalization of FGM/C. Nursing students are motivated by a biomedical lens, while midwifery students are divided regarding the social consequences of medicalization as being either a means to perpetuate or gradually eradicate FGM/C. Literature suggests that medicalization of FGM/C is supported by various psychosocial and financial motivations (Doucet, et al., 2017). While the literature does not discuss variations in these motivations among and between different HCPs, our results, suggest that these differences can exist, and therefore should be considered and addressed in professional training programs that aim to prevent medicalization.

Midwifery students are concerned with a variety of contextual issues, including cultural, ethical, legal, and professional considerations, which they discuss and debate when addressing the medicalization of FGM/C. This understanding and complex approach could be attributed to the holistic nature of midwifery responsibilities compared to nursing (Dioubaté et al., 2024; Hyrkäs, & Mowitz, 2023). Midwives follow women and future mothers throughout and after their pregnancies, taking a holistic and contextual approach to healthcare (Hyrkäs, & Mowitz, 2023). Thus, when discussing the medicalization of FGM/C, they may consider a range of these factors to determine whether medicalization contributes or not to perpetuate or eradicate FGM/C.

The nursing students focused heavily on the deleterious physical health outcomes of FGM/C and how its medicalization could positively impact women's health, especially in Guinea, where they often practice in complex, unsanitary, and highly stressful environments. These conditions have only deteriorated, particularly prior to the COVID-19 pandemic, adding further challenges to the healthcare system (Dioubaté et al., 2024; Hyrkäs, & Mowitz, 2023). The assumption that physical complications are mitigated when FGM/C is performed by a medical professional may lead nurses to overlook or underestimate the mid and long term physical deleterious implications of medicalization, including difficulties during childbirth, a higher risk of HIV transmission and fistula, pain during sexual intercourse, and other associated health risks (Tammary, Manasi, 2023; WHO, 2023). This aspect of the practice is something nurses might not encounter, potentially limiting their understanding of the full scope of the impact of medicalized FGM/C on women's physical and mental health and well- being. Moreover, while medicalization is known to present women and girls with complex psychological issues such as depression, anxiety, and trauma (WHO, 2023), these psychological concerns related to FGM/C and its medicalization were mentioned only once by a single

participant from the midwifery students' group. Among the nursing student group, psychological ramifications were mentioned only twice in the context of the continued medicalization of FGM/C as a method of reducing mental health outcomes within the harm reduction philosophy. This highlights a limited acknowledgment of the psychological impacts of FGM/C within the discourse surrounding its medicalization. This lack of awareness or knowledge regarding the mental health risks of FGM/C and its medicalization is critical to address in training programs when discussing critically medicalization as a "harm-reduction" philosophy.

It highlights a significant gap in nursing and midwifery students understanding of the complex and profound impact of the practice. Hence, equal consideration should be given to the deleterious mental health outcomes of medicalization in training programs for HCPs. These programs should also provide a discussion of the deleterious impact of medicalization of FGM/C and how this practice does not align with healthcare professionals' Hippocratic oaths and medical ethics of “do no harm". It is not only crucial for promoting the overall well-being of women and girls but also serves as a motivation and rationale for providing comprehensive care. By addressing both the physical and mental health aspects of medicalization in healthcare professionals training programs, it can uphold their ethical duties and ensure that all their patients are receiving the best care possible.

Medicalization as an intersubjective solution to conflicting ‘communities of thought’

Intersubjectivity, a concept coined by the philosopher Edmund Husserl (1859–1938), refers to the sharing of subjective experiences, meanings, and interpretations between individuals or groups (Zerubavel, 1999). This concept can help identify and explain how the conflicting "thought communities" of nursing and midwifery students contribute to the growing phenomenon of the medicalization of FGM/C (Zerubavel, 1999). Zerubavel (1999) explains that

intersubjectivity emphasizes the unique social experiences held by different groups or "thought communities".

In our research, we have found that student nurses and midwives identify with two separate "thought communities" that present conflicting ideologies regarding the value of the traditional practice of FGM/C: a cultural ‘thought community’ that values FGM/C as a mandatory tradition, and an HCP "thought community" that cannot accept FGM/C due to the physical harms it inflicts on girls and women. This juxtaposition highlights the complex intersection of cultural beliefs and health concerns surrounding FGM/C. Our results suggest that belonging simultaneously to these two ‘thought communities’ creates a conflict regarding FGM/C, and that medicalization provides an available intersubjective solution to this conflict through the harm reduction rationale. This implies that the medicalization of FGM/C serves as a compromise between differing perspectives, offering a perceived solution to the complex ethical and cultural debates surrounding the practice. Nurses and midwives hence agree with the continuation of the medicalization of FGM/C because it serves as a practical resolution to the inherent intersubjective conflict they face between their roles as healthcare providers and community members. Nursing and Midwifery students are training to prioritize patient welfare, they inherently oppose FGM/C as a harmful practice, a stance that aligns with their HCP community of thought. However, originating from and belonging to cultures where FGM/C is entrenched and highly valued, they confront a contradiction or a clash of "thought communities". This internal discussion finds reconciliation through medicalization, given that the procedure is conducted under clinical conditions by skilled professionals. Nursing and midwifery students advocate for this approach, citing its ability to ensure safer outcomes for affected women and

girls while delicately balancing the duties of healthcare providers with the preservation of cultural practices.

The need for HCPs training to provide an alternative intersubjective solution to medicalization.

The medicalization of FGM/C represents an attempt at an intersubjective solution to the complex conflict faced by student nurses and midwives. In navigating the tension between biomedical principles and cultural identity, the practice of medicalizing FGM/C emerges as a means to reconcile these conflicting "thought communities" within healthcare settings.

Recognizing that medicalization constitutes an intersubjective solution to conflicting ‘communities of thoughts’ have implications for training programs that aim to eradicate this practice. Training programs should offer alternative intersubjective solutions to medicalization. Potential solutions should empower healthcare providers to act as "agents of change" within their cultural communities, emphasizing the illegality of FGM/C and its medicalization, and highlight the mid- and long-term deleterious health outcomes associated with it , including both physical and mental health (ElMorally, 2024; Leye et al., 2019; Shell-Duncan et al., 2017; Waigwa, Doos, Bradbury-Jones, & Taylor, 2018). Also, providing tools to engage with communities is essential to prevent stigma continuation linked to refusal to practice FGM/C, aiming towards comprehensive and culturally sensitive interventions. Our focus on nursing and midwifery students reveals their unique healthcare identities and roles, departing from the general approach of grouping healthcare professionals. By delving into the intricate cultural nuances of FGM/C, we move away from standardized approaches and acknowledge the complexity of cultural beliefs surrounding the practice (Balde et al., 2022; ElMorally, 2024; Leye et al., 2019; Shell-Duncan et al., 2017; Van Eekert et al., 2024; WHO, 2022a, WHO, 2022b, WHO 2022c).

This shift from a one-size-fits-all approach is essential for developing nuanced and effective strategies to address the medicalization of FGM/C, as highlighted in the broader landscape of research on the subject. Recognizing this diversity, training programs should delve into the complex cultural intricacies of FGM/C, moving beyond uniform or standardized approaches, as culture's multifaceted motivations cannot be singularly replaced by biomedical knowledge alone. (Abdulcadir et al., 2017; Doucet et al., 2017; Marea et al., 2023). This contrasts with the more generalized Knowledge, Attitudes, and Practices (KAP) studies often conducted, particularly in regions like Guinea (Balde et al., 2022; ElMorally, 2024; Leye et al., 2019; Shell-Duncan et al., 2017; Van Eekert et al., 2024).

The inherent contradiction among nurses and midwives discourse presents an opening for educational training within healthcare settings. Their endorsement of medicalization, coupled with proposals for eradicating FGM/C, underscores a thoughtful and nuanced approach to tackling the issue. This indicates a willingness among student healthcare professionals to embrace both biomedical and Guinean perspectives, potentially paving the way for more effective strategies for eradication efforts. It is important to note that all participants in the study are still in the process of studying, which suggests that their professional identities are still developing and thus, they may be flexible and open to alternative critical positions and discussions regarding the medicalization of FGM/C.

MANUSCRIPT: Limitations

Natural Group Setting

Firstly, the focus groups took place within the context of a qualitative health research class at an anonymous university in Guinea. The natural group among participants further supported engaging discussions as nurses and midwives were among their classmates (APPENDIX F & G). The natural group setting also enhanced the co-constructive qualitative analysis (*RapForMe*©) by involving participants in a 5-day class, ensuring consistent group settings and participant return. The participatory *RapForMe*© method allowed us to steer clear of a top-down approach during the data collection and analysis stages. This approach favored a thorough comprehension of the phenomenon of medicalization within a relatively short timeframe.

Lack of participants clinical experience

Secondly, participating nurses and midwifery student attending the university in Guinea lacked practical clinical experience, potentially resulting in a limited understanding of the medicalization of the FGM/C process (APPENDIX F & G). This lack of hands-on experience can hinder their ability to fully grasp the nuances and complexities involved in medicalization within healthcare systems and settings. The absence of practical exposure may lead to a superficial understanding of the medicalization process, potentially overlooking important details or implications. Due to their limited clinical experience, student nurses and midwives may struggle to comprehend the professional implications associated with both the practice and rejection of the medicalization of FGM/C. Their professional identity as student nurses and midwives may not be fully developed, further complicating their understanding of the implications of medicalization practices. This can affect their perspectives, understanding, and

decisions regarding FGM/C. During discussions about "harm reduction" the specific types of FGM/C (Types I, II, II) were neither mentioned nor discussed in either of the focus groups. This omission can be attributed to the absence of formal training on FGM/C within their educational programs, which means they were not familiar with the WHO guidelines and classifications of FGM/C. Consequently, the student midwives and nurses did not discuss the different forms of FGM/C related to their meaning and experiences related to the medicalization of FGM/C. Future research should involve a larger volume and more diverse group of medical professionals, and discussions surrounding the clitoris, the anatomy and physiology of the vulva deserved to be investigated and presented as their developed clinical expertise and established professional identities may present diverse and complex perspectives regarding the medicalization of FGM/C (APPENDIX F & G).

Limitations among Midwives Focus Group

Thirdly, the Midwives Focus Group, composed of seven participants, presents a limited sample size that may hinder the representation of perspectives within the study. During the focus group sessions, it was observed that a male participant actively dominated the discussions, often speaking at length and sometimes overtaking the conversations (APPENDIX F). This tendency to dominate the dialogue could have limited the contributions of other participants. Moving forward, it is suggested that more training for the moderator in conducting co-constructed qualitative analysis would be beneficial. This training could help ensure a more balanced and inclusive discussion environment, allowing all participants to contribute meaningfully to the conversations, especially for a taboo and challenging topic like FGM/C. Moreover, the participants in this group lack clinical experience, which could restrict the depth of insights into the nuances of medicalization of FGM/C. FG, a MSc student at McGill, took part in the student

midwives Focus Group as a non-verbal observer throughout the session and served as the primary *RapForMe*© rapporteur. Her inclusion might sway the dynamics of the conversations, potentially resulting in a biased view of the topics under discussion. Despite these limitations, there was noted high engagement among the midwives in the focus group discussions, suggesting a keen interest in the topic. These limitations emphasize the need for caution when interpreting the findings from the Midwives Focus Group and support the necessity for future research involving a more diverse and experienced sample size of healthcare professionals.

Limitations among Nurses Focus Group

Fourthly, the Nurses Focus Group, there was a considerable number of (n=12) student participants, presenting a challenge in facilitating in-depth discussions and ensuring all participants' viewpoints are adequately heard (APPENDIX G). The focus group's size might have led to difficulties in managing the flow of conversation and could result in some perspectives being overshadowed or unheard. However, despite these challenges, the notetakers engaged in effectiveness and detailed notetaking, displaying a strong commitment to documenting the insights shared. The nurses' enthusiasm and active participation in the focus group discussions indicate a genuine interest in medicalization. Nonetheless, the large group size and potential limitations in of having many student observers in presence should be considered when interpreting the findings from the Nurses Focus Group, highlighting the importance of future research that carefully considers these factors.

MANUSCRIPT: Conclusion

In Guinea, with rates of both traditional FGM/C (96%-97%) and its medicalization (31%) among the highest globally, urgent interventions are needed (Mareah et al., 2023; Kimani & Shell-Duncan, 2018). Over 20 million girls and women have undergone FGM/C by healthcare providers, with rates expected to rise (Kimeu, 2024; UNICEF, 2024). Yet, there are significant gaps in understanding nursing and midwifery perspectives on FGM/C medicalization. Our research emphasizes the need to explore the nuanced meanings of FGM/C among different healthcare professionals. Our findings underscore that relying solely on KAP questionnaires is insufficient to grasp the complex social experiences tied to FGM/C medicalization. Anatomical details and implications of FGM/C were absent from the students' discussions, highlighting a crucial area for future education and training programs. Incorporating comprehensive anatomical education and detailed information about FGM/C will better equip healthcare professionals to understand and address this critical issue. Neglecting individual perspectives risks superficial understanding and ineffective intervention strategies. These complex viewpoints among midwifery and nursing students regarding the role of medicalization in eradicating or perpetuating FGM/C further illustrates this issue. Distinct professional motivations among these students also emerge, with nurses focusing on biomedical outcomes while midwives consider broader social, ethical, and professional aspects. This highlights the holistic nature of midwifery practice and the need for comprehensive professionally tailored training modules moving forward. The intersections of culture and professional training become evident in Guinea, where students have firsthand experiences with FGM/C, both witnessing its practices and the social consequences of challenging it. Future research should delve deeper into how these intersections shape HCPs perceptions and practices. Intersubjectivity among healthcare professionals emerges as a key result. The clash between distinct 'thought communities' of nursing and midwifery

students suggests that medicalization arises as an intersubjective solution to FGM/C. Future training programs need to provide an alternative intersubjective solution to replace the one offered by ‘medicalization as harm reduction’. This can be achieved by informing HCPs about the lasting effects of FGM/C, even with the use of antiseptics, is crucial. Awareness of local and international laws, ethical conflicts, and individualized perspectives must also be emphasized. Transcending the KAPs approach and adopting a qualitative participatory method like *RapForMe*© can support in navigating these complexities. These efforts should aim to develop culturally sensitive, effective interventions that acknowledge the unique perspectives and diverse "thought communities" of healthcare professionals.

In conclusion, understanding the intersections of cultural beliefs, professional roles, anatomy, and personal experiences is essential in addressing FGM/C medicalization effectively. This research highlights the need for nuanced, intersubjective approaches that recognize the multifaceted identities of healthcare professionals. By doing so, we can develop tailored interventions that empower HCPs to provide sensitive, effective care within diverse communities.

Conclusion (Traditional Thesis):

The medicalization of FGM/C

In Guinea, where our study was conducted, the rates of both traditional FGM/C (97%) and its medicalization (31%) are among the highest in the world (Mareah et al., 2023; Kimani & Shell-Duncan, 2018). Health professionals involved in medicalization include physicians, assistant physicians, clinical officers, nurses, midwives, trained traditional birth attendants, gynecologists/obstetricians, plastic surgeons, and other personnel providing health care to the population, in both private and public sectors (UNICEF, 2018; WHO, 2022). A UNICEF report (2018) noted that over 20 million girls and women have undergone FGM/C at the hands of a healthcare provider. Both the rates of FGM/C and its medicalization are expected to grow, underscoring the urgent need for effective interventions and awareness campaigns (Kimeu, 2024; UNICEF, 2024). However, there are notable gaps in knowledge when it comes to nursing and midwifery perspectives on the medicalization of Female Genital Mutilation/Cutting (FGM/C) in high prevalence practicing countries like Guinea. The literature indicates that healthcare providers often lack general knowledge about the illegality of FGM/C and its medicalization (Aziz, Elgibaly, Ibrahim, 2022; Balde et al., 2020; Bedri et al., 2018; Rashid, Iguchi, Afiqah, 2020; Yussuf, Matanda, Powell, 2020). While our study revealed that some nursing and midwifery students recognized the illegality of FGM/C, their knowledge of the medicalization of FGM/C and the relevant law in Guinea has limitations. Our research sheds light on the complex ethical perspectives that emerge among nursing and midwifery students, particularly in the context of their professional identity and their experiences within Guinean cultural communities. Existing literature on the medicalization of FGM/C primarily examines the Knowledge, Attitudes, and Practices (KAP) of healthcare providers using questionnaires, yet there remains a gap in understanding the nuanced meanings and community experiences ofof healthcare provider

in relation to this issue. This gap hinders the development of effective intervention strategies, especially since current training programs only touch on cultural aspects superficially. By focusing on nursing and midwifery students in our study, we shed light on their unique healthcare roles, contrasting with the common of the tendency in the literature to lump health professionals together (Balde et al., 2022; ElMorally, 2024; Leye et al., 2019; Shell-Duncan et al., 2017; Van Eekert et al., 2024). Our study highlights the need to delve into the nuanced meanings and experiences of Female Genital Mutilation/Cutting (FGM/C) of different health care professions. Our results also contrast with the typical approach of Knowledge, Attitudes, and Practices (KAP) studies that reduce culture to a list of beliefs and practices. Our results underscore that questionnaires alone are insufficient to understand the nuanced complexity of meaning and corresponding social experiences linked to the medicalization practice. Neglecting to delve into the individual perspectives and experiences related to the medicalization of FGM/C can result in a superficial understanding of this complex sociocultural issue and unsuccessful interventions to eradicate FGM/C and its medicalization. Such understanding is crucial for addressing the impact on the sexual and reproductive rights of women and girls globally.

What we know about FGM/C needs to guide our training but not dictate it.

Our research confirms the emphasis in existing documented literature regarding FGM/C, highlighting social and cultural motivators as significant factors contributing to the continuation of FGM/C in all its forms. However, it is crucial to understand that this information should serve as a guide for training and prevention interventions rather than dictating them. Our findings fundamentally show that participants (midwifery and nursing students) hold individualized and distinct cultural perspectives concerning FGM/C, which are key components in its perpetuation within these healthcare and community settings.

The medicalization of FGM/C: Harm reduction philosophy

In exploring the harm reduction philosophy among nursing and midwifery students, our study highlights its profound impact on the medicalization of FGM/C in Conakry-Guinea. Through previously documented evidence (Aziz, lgibaly, Ibrahim, 2022; Balde et al., 2020; Leye et al., 2018; Van Eekert et al., 2022; Yussuf, Matanda, Powell, 2020), we recognize this philosophy as a powerful driver for the continuation of medicalized procedures, shedding light on the nuanced perspectives within the healthcare community.

Eradication or Perpetuation

However, among midwifery and nursing students, the discussion concerning if the medicalization of FGM/C is a means of Eradication or Perpetuation of FGM/C presented a complex viewpoint from both student groups. While student midwives debate its potential as both a means of eradication or perpetuation of FGM/C midwifery students' discussions revolved around introducing a less invasive form of medicalized cutting to change the cultural practice of excision. Yet some participants rejected any form of FGM/C as a violation of girls' rights. The nursing students unanimously view medicalization as a vital step towards improving women's physical health outcomes, highlighting that clinical sanctions surrounding the practice would support the physical health outcomes of women and girls. However, mental health complications

from the medicalization of FGM/C were only briefly noted by one participant, highlighting the gap in knowledge related to the deleterious mental health outcomes associated with the medicalization of FGM/C across both nursing and midwifery students.

Biomedical vs Social

Our findings present distinct motivations among nursing and midwifery students concerning the medicalization of FGM/C. While nurses focus on biomedical benefits and risk reduction, midwives navigate a broader spectrum of social, ethical, and professional considerations. This contrast highlights the holistic nature of midwifery practice, emphasizing the need for a comprehensive approach that addresses both physical and social well-being of women and girls. As we understand nursing and midwifery students meaning and experiences concerning the medicalization of FGM/C, it becomes evident that any strategy for harm reduction must equally highlight and educate healthcare students on the mental health outcomes associated with FGM/C including its medicalization alongside the mid and long term deleterious

outcomes for the physical health This ensures a more comprehensive and effective approach to tackling the challenges posed by this practice.

Negotiating conflicting professional and cultural identities

The discussions and insights presented by both nursing and midwifery focus groups shed light on the intricate intersections between their cultural backgrounds and professional training. In Conakry-Guinea, these students possess firsthand exposure to traditional FGM/C practices, often encountered through cultural ceremonies and for the most, experiencing traditional FGM/C themselves (96%-97% of women and girls experience FGM/C in Guinea). These students have also witnessed the social ostracization endured by those who challenge or reject FGM/C. Their cultural identities, shaped by intimate encounters with various forms of FGM/C, directly clash with their emerging professional roles as nurses and midwives. This internal conflict is profound, as it compels them to reconcile deeply ingrained cultural beliefs with the biomedical knowledge they acquire during their healthcare training. Training of health care professionals must acknowledge and address the complexity of these intertwined identities. These healthcare students are not passive observers to FGM/C; rather, they are deeply embedded in its cultural significance, even as they become informed about its deleterious health impacts. This clash between cultural experiences and professional responsibilities presents a significant challenge as they navigate their professional and clinical roles. While they acknowledge the health risks linked to performing FGM/C, nursing students find justification of practicing the medicalization of FGM/C with the "harm reduction" rational, aligning it with their cultural norms. They believe that given that FGM/C is unavoidable- in a context where 96-97% of girls are cut- it is preferable for it to take place in a hygienic biomedical setting. It is possible that the perception of FGM/C being unavoidable may be different in geographical areas where FGM/C is not so prevalent as in Guinea. Moreover, this ongoing challenge faced by midwifery and nursing students emphasizes

their lack of power within communities that severely stigmatize families and individuals who reject FGM/C, thus underscoring the need to provide community-based approaches that support HCPs that wish to reject medicalization and FGM/C altogether.

Future research; professional and cultural identities

Future research is crucial to deepen our understanding of the complex intersection between HCPs identities, their cultural beliefs, and their evolving professional roles. This understanding is essential for developing nuanced and effective interventions strategies that respect the uniquely complex perspectives and experiences of healthcare providers from FGM/C practicing countries. The intersection of personal and healthcare professional identities among nurses and midwives needs to be acknowledged and explored in greater depth. Delving into their lived experiences using a participatory approach provides valuable insights into how their cultural backgrounds shape their perceptions of healthcare practices, especially concerning FGM/C. This research sheds light on how these professionals navigate the tensions between cultural traditions and Western medical knowledge in their careers. By understanding this intersection, we can develop training programs that empower healthcare providers to navigate

the complexities of FGM/C with sensitivity, cultural competence, and effective communication with their patients and communities. Moreover, future studies should aim to humanize healthcare professionals within the healthcare system and during their training. This means recognizing their multifaceted identities, including their culture, personal beliefs, and the challenges they face in providing care within diverse communities. By understanding the human aspect of healthcare providers, interventions and training programs can be tailored to support them in delivering culturally sensitive and effective care.

Intersubjectivity “thought communities” of HCPs.

The research conducted in Conakry suggests that the medicalization of FGM/C is an outcome of the clash between the two distinct 'thought communities' to which nursing and midwifery students belong. Our findings suggest that the medicalization of FGM/C arises as an intersubjective solution to this conflict. Therefore, programs and training programs need to provide an alternative intersubjective solution to replace the one offered by ‘medicalization as harm reduction’. Healthcare providers bring diverse and community-shaped experiences to their practice. Recognizing this intersection, future intervention strategies should avoid standardized approaches. Instead, they should delve deeply into the nuanced cultural dimensions and address the intersubjective ‘thought communities’ related to their experiences and relationships with FGM/C and its medicalization. Our focus on nursing and midwifery students in the study sheds light on their unique roles within healthcare, emphasizing that they hold distinct professional views. This contrasts with the tendency in official policy documents, such as those from Guinea, to generalize all healthcare professionals (Balde et al., 2022; ElMorally, 2024; Leye et al., 2019; Shell-Duncan et al., 2017; Van Eekert et al., 2024). Our findings highlight the importance of recognizing the diverse perspectives and individualized "thought communities" among healthcare professionals, as revealed by our study results. This underscores the need for more

comprehensive approaches beyond Knowledge, Attitudes, and Practices (KAP) studies to address the complexities of FGM/C and its medicalization. (Balde et al., 2022; ElMorally, 2024; Leye et al., 2019; Shell-Duncan et al., 2017; Van Eekert et al., 2024). The medicalization of FGM/C among healthcare providers is likely to persist unless effective intersubjective solutions are proposed and implemented to replace medicalization.

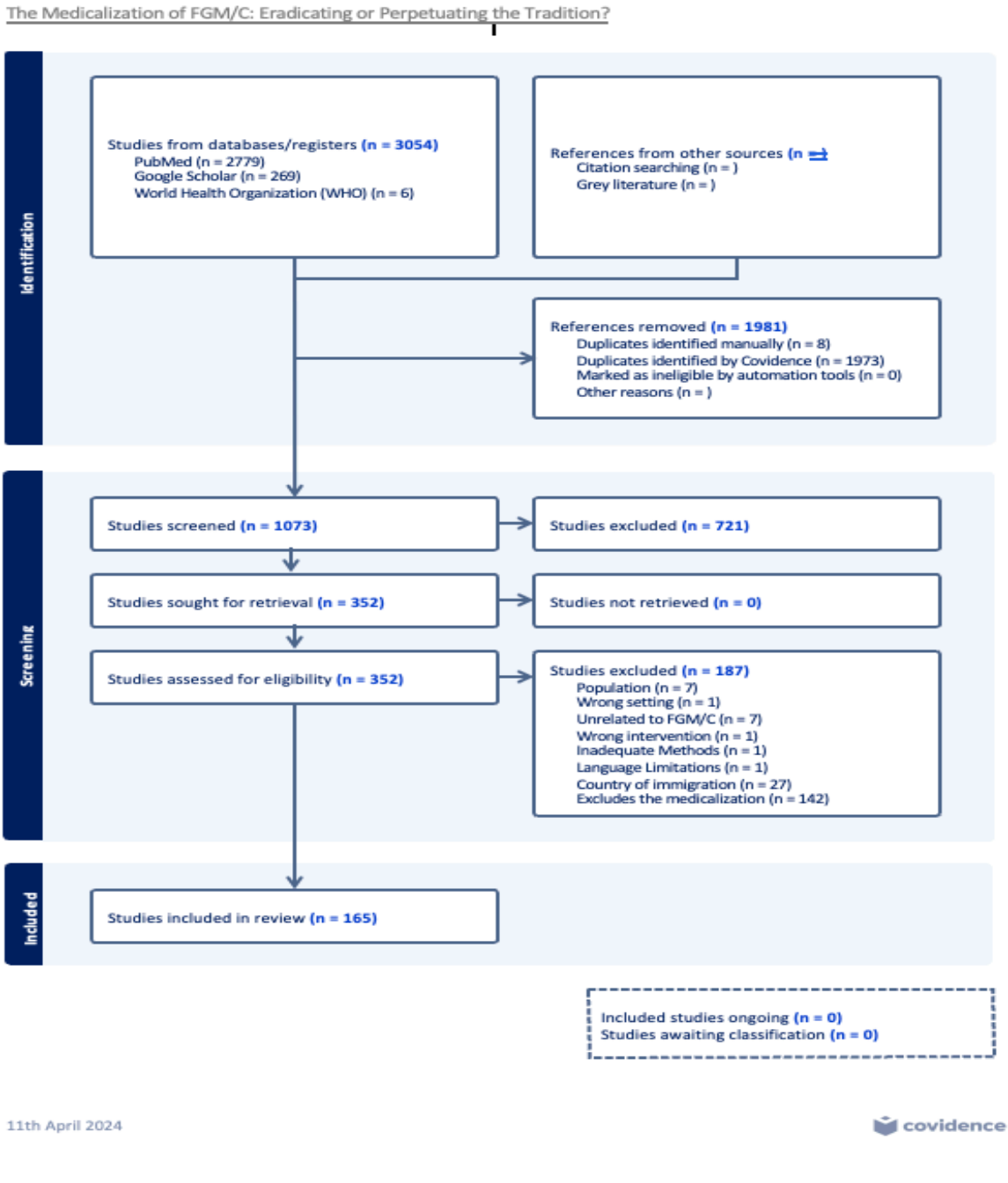
Key points to underscore for future training programs

Moving forward, future training programs need to integrate the following aspects regarding medicalized FGM/C. Firstly, healthcare professionals must be informed about the detrimental effects in the short, mid, and long term, acknowledging that even with the use of antiseptics, deleterious effects persist. This includes evidence-based insights into both physical and mental health outcomes. Secondly, HCPs should be aware of the local and international laws concerning medicalized FGM/C, and its conflict with medical ethics such as 'do no harm' and the Hippocratic oath. Thirdly, training programs must transcend the KAPs approach, recognizing that each HCP brings unique objectives and missions tied to patient care. To achieve this, programs should delve into the meaning and experience of FGM/C and its medicalization by healthcare professionals, avoiding a reduction of culture, identity, and community experiences to

mere beliefs. Fourthly, these programs should provide tailored, community-based solutions to medicalization, applying an intersubjective lens to address the issue effectively. To facilitate this lens, the integration of a qualitative participatory approach like the *RapForMe*© method is critical. This method assists in navigating the complexities, steering clear of a post-colonial top-down model, and aligning with a constructivist educational framework.

Appendices

APPENDIX A: Prisma Flow Chart



APPENDIX B: Research Ethics

McGill | Faculty of Medicine and Health Sciences | Faculté de médecine et des sciences de la santé

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December 4, 2023

Dr. Danielle Groleau
Institute of Community and Family Psychiatry
Jewish General Hospital
4333 Chemin de la Côte Ste Catherine
Montreal QC H3T 1E4

Info-Ed File Number: **23-09-073** **(IRB Internal Study Number: A12-B50-23B)**

Study/Protocol Title: *Scrubs and Scars: Unveiling Nurses and Midwives' Meaning and Experiences with the Medicalization of FGM/C in Conakry-Guinea*

Principal Investigator: Danielle Groleau

Dear Dr. Groleau,

Thank you for submitting the above-referenced study for an ethics review.

As this study involves no more than minimal risk, and in accordance with Articles 2.9 and 6.12 of the 2nd Edition of the Canadian Tri-Council Policy Statement of Ethical Conduct for Research Involving Humans (TCPS 2 2018) and U.S. Title 45 CFR 46, Section 110 (b), paragraph (1), we are pleased to inform you that approval for the study was provided by an expedited/delegated review on December 4, 2023 valid until **December 3, 2024**. The study proposal will be presented for corroborative approval at the next meeting of the Committee.

The following documents were reviewed and approved:

- Initial notification and summary, November 10, 2023
- Protocol, IRB dated November 10, 2023
- Focus group questions, IRB dated November 10, 2023
- Focus group posters, IRB dated November 10, 2023
- Consent form, IRB dated November 10, 2023

The Faculty of Medicine and Health Sciences Institutional Review Board (IRB) is a registered University IRB working under the published guidelines of the Tri-Council Policy Statement 2, in compliance with the Plan d'action ministériel en éthique de la recherche et en intégrité scientifique (MSSS, 1998), and the Food and Drugs Act (17 June 2001); and acts in accordance with the U.S. Code of Federal Regulations that govern research on human subjects (**FWA 00004545**). The IRB working procedures are consistent with internationally accepted principles of good clinical practice.

The Principal Investigator is required to immediately notify the Institutional Review Board Office, via amendment or progress report, of:

- Any significant changes to the research project and the reason for that change, including an indication of ethical implications (if any);
- Serious Adverse Effects experienced by participants and the action taken to address those effects;
- Any other unforeseen events or unanticipated developments that merit notification;
- The inability of the Principal Investigator to continue in her/his role, or any other change in research personnel involved in the project;
- A delay of more than 12 months in the commencement of the research project, and;
- Termination or closure of the research project.

The Principal Investigator is required to submit an annual progress report (continuing review application) on the anniversary of the date of the initial approval (or see the date of expiration).

The Faculty of Medicine and Health Sciences IRB may conduct an audit of the research project at any time.

If the research project involves multiple study sites, the Principal Investigator is required to report all IRB approvals and approved study documents to the appropriate Research Ethics Office (REO) or delegated authority for the participating study sites. Appropriate authorization from each study site must be obtained before the study recruitment and/or testing can begin at that site. Research funds linked to this research project may be withheld and/or the study data may be revoked if the Principal Investigator fails to comply with this requirement. A copy of the study site authorization should be submitted the IRB Office.

It is the Principal Investigator's responsibility to ensure that all researchers associated with this project are aware of the conditions of approval and which documents have been approved.

The McGill IRB wishes you and your colleagues every success in your research.

Kind regards,

Roberta M. Palmour

Roberta M. Palmour, PhD
Chair
Institutional Review Board

cc: Associate Dean, FMHS Research
A12-B50-23B (23-09-073)

APPENDIX C : Participant Consent Forms

Formulaire de consentement

Titre de l'étude : Révéler le Sens et les Expériences des Infirmières et des Sage-femmes face à la Médicalisation des Mutilations Génitales Féminines/Excision à Conakry, en Guinée.

Vous êtes invité(e) à participer à une étude volontaire. Veuillez prendre le temps de lire attentivement, de comprendre, d'examiner et de poser des questions sur les informations contenues dans ce formulaire de consentement.

Introduction : Le problème de santé étudié et la raison pour laquelle le sujet est approché. Cette recherche porte sur les mutilations génitales féminines/excisions (MGF/E), qui inclut des procédures impliquant l'ablation partielle ou totale des organes génitaux féminins externes, ou d'autres lésions faites aux organes génitaux féminins pour des raisons non médicales (OMS, 2023). L'objectif principal de la recherche sera d'étayer les connaissances sur la médicalisation de l'E/MGF, une procédure pratiquée par des professionnels de la santé, qui est apparue comme un phénomène récent motivé par les familles dans l'espoir de réduire les risques immédiats pour la santé des filles et des femmes. Il est important de noter que les prévalences de MGF/E et de sa médicalisation sont souvent motivées par des raisons communautaires et culturelles (Marea et al., 2023).

Avantages et risques : Les avantages escomptés de la participation à l'étude doivent être présentés de manière impartiale ; il convient d'éviter à la fois un pessimisme excessif et un optimisme exagéré. Par exemple, si le bénéfice escompté est une réduction de la probabilité d'une récidive locale, il convient de l'indiquer clairement. S'il n'y a pas de bénéfices pour le participant individuel, les bénéfices espérés pour d'autres personnes atteintes de la maladie peuvent être soulignés. Cette étude porte sur la participation d'étudiants en soins infirmiers et de sage-femmes à un groupe de discussion portant sur le thème de la médicalisation de MGF/E. En échange de leur participation à l'étude, les étudiants auront accès gratuitement à un atelier de formation sur les entretiens de groupe. Dans cet atelier, ils apprendront les méthodes de recherche qualitatives, en particulier comment animer des groupes de discussion et utiliser la méthode qualitative *RapForMe(c)* pour analyser les données des groupes de discussion (Focus Group en anglais). Les méthodes qualitatives seront enseignées par le Dr Danielle Groleau, experte internationalement reconnue en méthodes qualitatives. Les étudiants auront également un aperçu de la médicalisation des mutilations génitales féminines (MGF/E) et de ses implications pour la santé et les droits humains des filles/femmes. Dans le cadre de l'atelier, les étudiants participeront à leur propre groupe de discussion sur la médicalisation de MGF/E. Ils apprendront ensuite à utiliser la méthode *RapForMe(c)* pour analyser les données qualitatives produites pendant le groupe de discussion.

Les avantages pour les participants à l'étude sont multiples :
Les participants peuvent apporter des connaissances et une compréhension culturellement pertinente de la médicalisation de MGF/E, ce qui leur permet d'exprimer leurs idées et leurs expériences sur cette question cruciale. En participant à ces discussions, les participants pourront

améliorer leurs connaissances et leurs compétences professionnelles en matière de pratiques de soins de santé liées à MGF/E. Leur participation pourra contribuer à l'adéquation culturelle d'un programme de formation pour prévenir la médicalisation de MGF/E, ce qui pourrait conduire à une amélioration des pratiques de soins de santé et à une meilleure sauvegarde des droits humains des filles et des femmes. Des groupes de discussion plus restreints créent un espace sûr pour des discussions ouvertes et franches sur des sujets sensibles.

Risques : Les discussions sur MGF/E peuvent entraîner une détresse émotionnelle chez certains participants mais les animateurs sont formés pour identifier et soutenir les réactions émotives et potentiellement traumatiques. Les participants peuvent également être confrontés à la stigmatisation culturelle et professionnelle, ce qui peut avoir un impact sur leur vie, en particulier si leurs opinions relatives à la médicalisation de la médicalisation des mutilations génitales féminines s'opposent à la position d'autres participants. En outre, certains participants peuvent être confrontés à des dilemmes éthiques en raison de leur implication personnelle ou de leur soutien à la médicalisation, ce qui peut
entraîner des conflits moraux et un certain malaise au cours des discussions. Le modérateur abordera ces points dans le contexte du groupe de discussion afin de garantir que les discussions soient respectueuses des opinions de l'ensemble des participants et pour éviter la polarisation des points de vue.

Coût / Assurance : Aucun coût n'est associé à la recherche.

Rémunération : Les participants ne seront pas rémunérés. Toutefois, le déjeuner et les collations seront fournis gratuitement tout a long du projet de recherche et leur participation à l'atelier de formation en recherche qualitative sera offert gratuitement. Un certificat de participation à l'atelier sera également délivré à la fin de l'atelier.

Droits des participants :

- Vous avez le droit de participer à cette étude de votre plein gré. Votre décision de participer ou de vous retirer à tout moment n'aura pas de conséquences négatives.
- Confidentialité et anonymat : Vos informations personnelles et vos réponses resteront confidentielles et les données seront rendues anonymes afin de préserver votre identité.
- Droit de retrait : Vous conservez le droit de vous retirer de l'étude à tout moment, sans justification et sans encourir de pénalités. La procédure de retrait vous sera communiquée.
- Communication avec l'équipe de recherche : Vous avez le droit de contacter l'équipe de recherche à tout moment au cours du projet pour exprimer vos préoccupations, poser des questions ou faire des commentaires. Les coordonnées des personnes à contacter sont indiquées ci-dessous.
- Informations sur les résultats de la recherche : Si vous en exprimez le souhait, les participants peuvent avoir le droit de recevoir les conclusions générales ou les résultats du projet de recherche. Ces informations seront communiquées de manière à préserver la confidentialité et à ne pas divulguer les identités individuelles.

Confidentialité :Les participants peuvent être assurés que leurs données seront traitées avec le plus grand soin et gardé sous clés de façon confidentielle.

Stockage sécurisé des données : Toutes les données recueillies, y compris les questionnaires et les transcriptions, seront remisées en toute sécurité. Des fichiers électroniques protégés par un mot de passe et des solutions de stockage cryptées seront utilisés pour protéger les données numériques.

Accès limité : Seul le personnel de recherche autorisé et directement impliqué dans le projet de recherche
- Dr Alexandre Delamou, Dr Danielle Groleau, Felicia Gisondi et Kadiatou Sow - aura accès aux

données. L'accès sera accordé pour les fins de l’étude seulement, et tous les membres de l'équipe seront
bien informés des protocoles de confidentialité des données.

Transfert sécurisé des données : Lorsque des données sont transmises par voie électronique, des méthodes sécurisées et cryptées seront utilisées pour garantir leur sécurité. Les données sensibles ne seront pas envoyées par le biais de courriels ou de services en nuage (ex. : ICLOUD) non sécurisés.

Confidentialité des rapports : Lors du partage des résultats ou des données avec les parties prenantes, des mesures seront prises pour présenter des données agrégées ou dépersonnalisées afin de protéger l'anonymat des participants individuels.

Pseudonymes pour la publication : Lors de la compilation et de la soumission des résultats de recherche pour publication, des numéros associés aux participants seront utilisés pour garantir la confidentialité.

Contact : Si vous avez des questions sur l'étude ou si vous souhaitez vous retirer de l'étude, veuillez contacter :

- Alexandre Delamou, MD, MPH, PhD, Professeur Titulaire de santé publique (médecine préventive), Chef de la Chaire de santé publique et Directeur du Centre d'Excellence d'Afrique pour la Prévention et le Contrôle des Maladies Transmissibles (CEA-PCMT), de la Faculté des sciences et techniques de la santé (FSTS) de l'Université Gamal Abdel Nasser de Conakry (UGANC). Courriel : adelamou@gmail.com
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Signature : L'étude m'a été expliquée et j'ai obtenu des réponses satisfaisantes à mes questions. J'accepte de participer à cette étude. Je ne renonce à aucun de mes droits en signant ce formulaire de consentement. Je certifie les informations ci-dessus.

Nom : _____
Numéro de téléphone #1 :
Numéro de téléphone #2 :
Courriel :

Signature :_____

APPENDIX D: Focus Group Questions (Nurses)

French	English
1. Question d'introduction : *Nom, université, programme.*	1. Introduction Question: *Name, university, program.*
2. Que pensez vous de l'excision ?	2. What do you think of excision?
3. Que pensez de la médicalisation de l'excision ?	3. What do you think of the medicalization of excision?
4. Comment percevez-vous la médicalisation ?	4. How do you perceive medicalization?
5. Quelle valeur accordez-vous à la médicalisation dans notre société?	5. What value do you place on medicalization in our society?
6. La médicalisation des MGF impacte t-elle celle des MGF traditionnelles dans votre communauté ?	6. Does the medicalization of FGM have an impact on the medicalization of traditional FGM in your community?
7. Quelle est l'image de l'excision dans votre communauté de nos jours ?	7. What is the image of excision in your community today?
8. L'excision est-elle une obligation dans votre communauté ?	8. Is excision an obligation in your community?
9. Conseillez-vous votre communauté à pratiquer toujours l'excision ?	9. Do you advise your community to always practice excision?
10. Quels sont les principaux défis auxquels sont confrontés les professionnels de la santé face à une femme ayant subi l'excision?	10. What are the main challenges faced by health professionals when dealing with a woman who has undergone FGC?
11. Pouvez-vous nous partager votre expérience par rapport à la médicalisation ?	11. Can you share your experience of medicalization?
12. Quelles sont les réactions des femmes ayant subi l'excision traditionnelle à l'égard de la médicalisation de cette pratique ?	12. What are the reactions of women who have undergone traditional excision to the medicalization of this practice?
13. Le rejet de l'excision dans nos communautés serait-il une contradiction religieuse ?	13. Is the rejection of excision in our communities a religious contradiction?

14. Comment votre société se comporterait-elle face à un refus d'excision ?	14. How would your company react to a refusal of excision?
15. À votre avis, que fait-il pour prévenir la médicalisation des mutilations génitales féminines: • Dans le système éducatif ? • Avec les familles? • Dans la communauté ? • Avec les professionnels de la santé • Au sein du gouvernement	15. In your opinion, what is it doing to prevent the medicalization of female genital mutilation? • In the education system? • With families? • In the community? • With health professionals • Within the government

APPENDIX E: Focus Group Questions (Midwives)

French	English
1. Quel est votre nom, votre âge et le programme dans lequel vous êtes inscrit ?	2. Introduction Question: *Name, university, program.*
2. Pourquoi participez-vous à ce groupe de discussion sur la médicalisation de l'excision MGF ?	2. Why are you taking part in this discussion group on the medicalization of FGM?
3. Qu'est-ce qui incite les gens ou les parents à faire inciser leur enfant ?	3. What motivates people or parents to have their child cut?
4. Quelle place occupe l'excision dans votre région ?	4. Where does excision rank in your region?
5. Les agents de santé font-ils la médicalisation pour de l'argent ou pour ne pas être rejeté par leur communauté ?	5. Do health workers seek medical treatment for money or so as not to be rejected by their community?
6. Êtes-vous au courant que la médicalisation a des effets négatives ?	6. Are you aware that medicalization has negative effects?
7. Accepteriez-vous d'exciser vos filles sans aucune obligation culturelle ou familiale ?	7. Would you agree to have your daughters excised without any cultural or family obligation?
8. La médicalisation serait-elle un petit pas dans l'éradication de l'excision ou une manière de continuer la pratique ?	8. Is medicalization a small step towards eradicating excision or a way of continuing the practice?
9. Selon votre expérience personnelle ou professionnelle, la pratique de l'excision médicalisée comporterait-elle moins de risques que celle de l'excision non médicalisée ?	9. Does the medicalization of excision cause complications during childbirth?
10. Avez-vous une fois suivi la pratique de la médicalisation de l'excision ?	10. Have you ever followed the practice of medicalizing excision?

11. 11. Une fille non exciser est-elle rejetée dans votre communauté ?	11. Is an uncircumcised girl rejected in your community?
12. Pourquoi la médicalisation est-elle fréquente en Guinée ?	12. Why is female circumcision so common in Guinea?
13. Questions qui clôturent la discussion et cherchent à valider les perceptions et questions récapitulatives qui permettent à chacun de réfléchir aux commentaires et échanger sur les aspects les plus importants.	13. Questions that close the discussion and seek to validate perceptions and summary questions that allow everyone to reflect on the comments and discuss the most important aspects.
14. Comment est-que le focus-group aujourd'hui à vous aider à rééjecter le pratique de la médicalisation de L'excision ?	14. How has today's focus group helped you to rethink the practice of medicalising excision?
15. How can today's focus group help you to reject the practice of medical excision?	15. Comment le groupe de discussion d'aujourd'hui peut-il vous aider à rejeter la pratique de l'excision médicale ?

APPENDIX F: Demographic details (Midwives)

Age	Sex	Profession	Religion	How many years of professional experience?	Country at Birth
21	Femme	Midwives	Muslim	No experience	Guinée, Malinké
20	Femme	Midwives	Christian	No experience	Guinée, Ppèlè
20	Femme	Midwives	Christian	<5 years	N/A
23	Homme	Midwives	Christian	<5 years	Guinée
21	Femme	Midwives	Muslim	No experience	Guinée
20	Femme	Midwives	Christian	<5 years	Guinée

APPENDIX G: Demographic details (Nurses)

Age	Sex	Profession	Religion	How many years of professional experience?
33	Homme	Christian	5-10 years	Guinée
20	Femme	Muslim	No experience	Guinée
21	Homme	Muslim	No experience	Guinée
23	Femme	Muslim	No experience	Guinée
22	Homme	Christian	No experience	Guinée, Forestier
23	Homme	Muslim	<5 years	Guinee, Peulh
19	Homme	Muslim	No experience	Guinée, Malinké
22	Homme	Muslim	No experience	Guinée, Soussou
23	Femme	Muslim	No experience	Guinée
22	Femme	Muslim	No experience	Guinee, Peulh
22	Homme	Muslim	No experience	Guinee, Peulh
20	Femme	Muslim	No experience	Guinee, Peulh
22	Femme	Muslim	<5 years	Guinee, Peulh

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