

WHEN AUTONOMY HAS A COLOUR

A VIDEO VIGNETTE STUDY OF CULTURAL AND RACIAL BIAS IN BELGIAN
HEALTHCARE REGARDING FEMALE GENITAL MODIFICATION.

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II. Abstract

This thesis examines whether cultural and racial biases influence how Belgian healthcare professionals respond to women's requests for female genital modification. The study addresses two research questions: (1) Does the perceived racial, or cultural identity of a patient affect the clinical decision-making process? (2) Should a genital modification still be classified as 'mutilation' when it is voluntarily requested by an informed adult?

A qualitative, deductive experimental design combining scripted video vignettes with semi-structured elite interviews was employed. Twenty Belgian gynecologists and plastic surgeons each viewed one of three video vignettes depicting the same request, a reduction of labial tissue, presented by a white woman, a black woman, and a black woman wearing a headscarf. The script, setting, and delivery were similar across the vignettes, to isolate the effect of perceived identity.

The findings reveal a consistent three-step consultation process, but with thresholds that shifted according to the patient's profile. Requests from white and black women were more often accepted as a personal choice, whereas requests from culturally racialized women more often prompted questions about cultural or familial coercion. Many doctors rejected the term 'mutilation' for procedures voluntarily requested by competent adults, particularly when framed as personal, aesthetic, or functional choices. However, the label was more often retained when requests were linked to cultural or religious motives from non-Western contexts, showing that the term's application remains selective and culturally mediated.

The study concludes that Belgian medical professionals apply autonomy and harm criteria selectively, thereby reinforcing cultural and racial double standards.

Keywords: Female genital modification, FGM/C, FGCS, medical decision-making, cultural bias, racial bias, Belgium

Table of contents

I.	Acknowledgements	2
II.	Abstract	3
1.	Research Introduction.....	7
1.1.	<i>Rational of the study.....</i>	7
1.2.	<i>Research aims and questions.....</i>	8
1.3.	<i>Terminology</i>	8
1.4.	<i>Structure of the report.....</i>	9
2.	Literature review	10
2.1.	<i>Conceptualizing FGM/C and FGCS</i>	10
2.1.1.	Definition, scope, and prevalence.....	10
2.1.2.	Anatomical overlap	11
2.2.	<i>Socio-cultural motivations behind FGM/C and FGCS.....</i>	11
2.2.1.	Cultural significance, purity, and tradition in FGM/C	11
2.2.2.	Western beauty ideals and the rise of FGCS.....	12
2.2.2.	Gender norms, social pressure, and perceived agency	12
2.3.	<i>Legal and policy frameworks</i>	13
2.3.1.	Criminalization versus personal choice	13
2.3.2.	Policy debates about double standards.....	14
2.4.	<i>Health implications and medicalization</i>	14
2.4.1.	Immediate and long-term health consequences of FGM/C	14
2.4.2.	Clinical complications of FGCS	15
2.4.3.	The Role of medicalization	15
3.	Contextual framework.....	17
3.1.	<i>FGM/C in Belgium.....</i>	17
3.1.1.	Geographical and demographic aspects.....	17
3.2.	<i>FGCS in Belgium</i>	18
4.	Theoretical/conceptual framework	19
4.1.	<i>The coloniality of gender</i>	19
4.2.	<i>Foucault on knowledge, power, and medical discourse.....</i>	19
4.3.	<i>Relational autonomy and intersectionality</i>	20
5.	Methodology.....	22
5.1.	<i>Research design</i>	22
5.2.	<i>Data collection methods.....</i>	22
5.2.1.	Video vignettes	22
5.2.1.1.	Definition and background.....	22
5.2.1.2.	Script and video development	23
	Phase I: Deciding whether video vignettes are appropriate	23
	Phase II: Script development	24
	Phase III: Experimental manipulations	24
	Phase IV: Filming.....	24
	Phase V: Administration	25

5.2.2.	Semi-structured interviews.....	25
5.2.2.1.	Definition and background of elite interviews.....	25
5.2.2.2.	Interview procedure.....	26
5.3.	<i>Sampling strategy</i>	26
5.4.	<i>Ethical considerations</i>	28
5.5.	<i>Data analysis</i>	28
5.6.	<i>Expected outcomes</i>	28
5.7.	<i>Personal reflection</i>	29
6.	Results	30
6.1.	<i>Interpretations of the video vignettes</i>	31
6.1.1.	Understanding the nature of the request.....	31
6.1.2.	Clinical approach and diagnostic framing.....	32
6.1.3.	Influence of perceived identity.....	33
6.2.	<i>Conditional autonomy</i>	34
6.2.1.	Presumed autonomy within normative Western frameworks.....	34
6.2.2.	Autonomy affirmed, but tested through clarity and confidence.....	35
6.2.3.	Cultural markers as triggers for heightened scrutiny.....	36
6.2.4.	Cross-case patterns of conditional trust.....	37
6.3.	<i>The borderland between FGM/C and FGCS</i>	38
6.3.1.	Framing the request: formal distinctions and underlying tensions.....	38
6.3.2.	Consent, culture and conditional autonomy.....	39
6.3.3.	Terminology, moral frameworks, and implicit hierarchies.....	39
6.3.4.	Professional scope, legal boundaries, and evolving positions.....	40
6.3.5.	Legal uncertainty, proposed reforms and a shifting boundary.....	41
6.4.	<i>Conclusion of the results</i>	41
7.	Discussion and conclusion	43
7.1.	<i>Summary of key findings</i>	43
7.2.	<i>The interpretation of the results</i>	44
7.3.	<i>Strenghts and limitations</i>	46
7.4.	<i>Recommendations for further research and practice</i>	47
7.5.	<i>Conclusion</i>	48
	References	50
	Appendix	66
	<i>Appendix 1: The video vignettes of three patients with varying backgrounds</i>	66
	<i>Appendix 2: Flowchart of medical decision-making for female genital modifications</i>	67
	<i>Appendix 3: Final script used for video vignettes</i>	68
	<i>Appendix 4: Semi-structured interview guide</i>	70
	<i>Appendix 5: Informed consent template respondents</i>	74
		75
		81
	<i>Appendix 7: Data management and ethics form</i>	82
		84

.....	87
<i>Appendix 8: Sociodemographic characteristics of the medical professionals interviewed</i>	<i>88</i>

1. Research Introduction

1.1. Rational of the study

What if a white woman, a black woman, and a black woman wearing a headscarf, all adults and fluent in Dutch, walk into a doctor's office with the same request: a reduction of their labia? Would the doctor respond to them all in the same way? Would their motivations be judged equally? Would their autonomy be interpreted in the same way?

This thesis begins with that simple but unsettling question: does the body in front of the doctor shape the way a request is understood, not because of what is asked, but because of who is asking? While all three women may be adults, capable of informed consent and bodily autonomy, the ways in which their requests are received may differ depending on the racial, or cultural assumptions projected onto them.

This question becomes particularly urgent in the context of female genital mutilation/cutting (FGM/C), a field marked by profound legal, ethical, and cultural contradictions. The term FGM/C generally refers to cutting practices performed on girls, most often in non-Western settings and without medical justification (Palm, 2024). Within the communities where these practices are carried out, FGM/C is frequently understood as a meaningful and socially embedded intervention, tied to cultural identity and values, sexual morality, and ideals of femininity or womanhood (Abathun et al., 2016; Abusharaf, 2001; Ahmadu, 2000; Bennett, 2012; Earp & Johnsdotter, 2021; Jirovsky, 2014; Njambi, 2004, 2007; Powell et al., 2020). However, Western societies overwhelmingly condemn FGM/C, framing it as a form of gender-based violence and a violation of fundamental human rights (WHO & UN, 2008). At the same time, female genital cosmetic surgery (FGCS), including procedures such as labiaplasty and vaginal rejuvenation, is widely accepted in the West. These procedures, often pursued for aesthetic or medical reasons, are legal, normalized, and commercialized, with over 210,633 labiaplasty procedures performed globally in 2024 alone (ISAPS, 2024).

Despite the anatomical overlap between some types of FGM/C and FGCS, their legal and moral treatment diverges significantly. This discrepancy has been noted by several scholars, who argue that such distinctions reveal deeper cultural and colonial biases (Boddy, 2020; Earp & Johnsdotter, 2021). FGM/C is typically portrayed as a violent tradition imposed by patriarchal, non-Western cultures, where women are cast as passive victims of oppression (Ball, 2018; Boddy, 2016; Florquin & Richard, 2020; Shahvisi, 2021). In contrast, FGCS is framed as a rational, autonomous decision made by free Western women seeking personal or aesthetic improvement.

This binary reinforces a colonial gaze: one that positions white Western women as capable subjects of informed choice, and racialized or culturalized women as victims of cultural coercion (Ball, 2018; Van Bavel et al., 2024; Van Eekert et al., 2024). Yet both practices, as scholars have shown, are deeply embedded in social expectations, aesthetic ideals, and structural pressures (Abathun et al., 2016; Abusharaf, 2001; Ahmadu, 2000; Bennett, 2012; Earp & Johnsdotter, 2021; Jirovsky, 2014; Njambi, 2004, 2007; Powell et al., 2020). Recognizing these shared foundations challenges the simplistic dichotomy that separates mutilation from modification, or coercion from choice. This raises crucial questions about whose bodies are protected, whose desires are validated, and whose autonomy is recognized.

While theoretical critiques have thoroughly exposed these inconsistencies, there remains a significant empirical gap. There is missing literature that examines how these biases play out in practice, particularly in clinical interactions where medical professionals must decide whether to grant or deny a request for genital modification. As noted by Florquin and Richard (2020), much

of the debate has proceeded in abstract, without data on how these biases manifest in real clinical decision-making. We know what the laws dictate and what scholars argue, but we have limited research on how front-line healthcare providers actually navigate genital modification requests in multicultural settings. Do Belgian gynecologists and plastic surgeons apply a double standard when patients of different backgrounds request similar procedures? Are women's motives and consent evaluated through a racialized lens? These questions are largely unanswered in the literature. By structuring the literature review around the dual themes of FGM/C and FGCS, we have set up the key debates and contradictions that frame our study.

This thesis will respond to those debates by providing empirical evidence from the Belgian context. In doing so, it aims to contribute to a more nuanced and equitable understanding of female genital modifications. Rather than treating FGM/C and FGCS as utterly disconnected phenomena, this research, guided by the literature, approaches them as points on a continuum of bodily interventions on women, mediated by culture, power, and agency.

At its core, this research critiques the racialized and gendered double standards in healthcare, and challenges the narratives underlying the divide between the civilized/uncivilized divide. It advocates for a more nuanced and equitable approach that recognises complexity without resorting to cultural essentialism or legal absolutism. In doing so, it makes a valuable contribution to the ongoing debate around autonomy, consent, embodiment, and the politics of care in a multicultural European context.

1.2. Research aims and questions

This thesis aims to explore how cultural and racial biases influence Belgian doctors' decision-making in response to requests for female genital modifications. Specifically, it examines whether the doctor's clinical judgment, interpretation, and classification of the requests are affected by the perceived identity of the patient, particularly with regard to their race or cultural background.

Additionally, the study investigates whether a genital modification should still be classified as 'mutilation' when it is voluntarily requested by an adult woman, in a context of full informed consent and bodily autonomy.

These two guiding research questions shape this study:

1. How do cultural and racial biases influence medical professionals' decisions regarding requests for female genital modifications in Belgium?
2. To what extent does the classification of female genital modifications as 'mutilation' hold when the procedure is voluntarily requested by an adult woman in the context of informed consent and bodily autonomy?

1.3. Terminology

Due to the politicized nature of terminology in this field, it is important to reflect on how language is used. A range of terms, such as female genital cutting (FGC), female genital mutilation (FGM), and the hybrid female genital mutilation/cutting (FGM/C), attest to the complexity and contested meanings surrounding these procedures (Iguchi et al., 2023). This thesis adopts the combined term 'female genital cutting/mutilation' (FGM/C) as a general descriptor. The introduction of this hybrid term by UNICEF and other UN agencies responded to the need to balance the condemnation of harmful practices with the avoidance of cultural stigmatization or moral superiority (UNICEF, 2013). While 'FGC' is often regarded as more neutral and descriptive,

‘FGM’ conveys the recognition of harm and human rights violations associated with the practice (Palm, 2024). Rather than favouring one perspective, this thesis adopts the hybrid form to acknowledge the spectrum of experiences, motivations, and discursive framings that surround these practices (Johansen, 2022).

As Palm (2024) argues, using a hybrid term can help researchers to navigate the tension between acknowledging the serious consequences of these procedures and avoiding cultural essentialism or moral superiority. The aim of this thesis is not to minimize harm or deny the seriousness of FGC/M, but rather to critically reflect on how such labels are applied differently depending on the cultural, racial, or religious background of the women involved.

1.4. Structure of the report

This first chapter introduced the research topic, presented the central research questions, and outlined the terminology. The second chapter provides a review of the relevant literature, followed by an overview of the Belgian context in which female genital modifications are regulated. Chapter four sets out the theoretical framework that guides the analysis, drawing on feminist theory, postcolonial critique, and discourse analysis. Chapter five details the research design and methodology. The sixth chapter presents the empirical findings, structured around recurring themes in how medical professionals responded to the vignettes and framed concepts such as autonomy, consent, and the distinction between FGM/C and FGCS. The final chapter offers a critical discussion of these findings in light of the research questions and existing literature and concludes with reflections on policy implications and suggestions for future research.

2. Literature review

2.1. Conceptualizing FGM/C and FGCS

2.1.1. Definition, scope, and prevalence

The WHO (2025a) defines FGM/C as “all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons” (p.1). This definition highlights the non-medical nature of the practice, distinguishing it from interventions performed for therapeutic purposes. However, scholars have highlighted that this definition is not neutral, the classification and understanding of FGM/C are shaped by cultural and political sensitivities. Media and popular discourse often frame FGM/C in alarmist terms and dehumanizing language, referring to “barbaric procedures” performed by “backwards people” (Abdulcadir et al., 2020; Bader, 2019; Boddy, 2020; Earp, 2022; Shahvisi, 2021). Such representations oversimplify the practice’s diverse cultural meanings and contexts, contributing to stereotypes and obscuring its complexity.

According to UNICEF (2024), over 230 million girls and women worldwide have undergone FGM/C, an increase of roughly 15.0 % (around 30 million additional cases) since 2016. This rise is driven by population growth in high-prevalence regions rather than a geographic spread of the practice. FGM/C remains most common in parts of Africa (over 144 million cases), Asia (over 80 million), and the Middle East (over 6 million), and continues within diaspora communities in Europe, North America, and Australia (Chen, 2022; Gómez, 2017; UNICEF, 2024; WHO, 2025a).

FGM/C encompasses a spectrum of procedures, ranging from pricking or symbolic cutting to more extensive forms such as the removal of the clitoral glans or labia, and infibulation (the narrowing of the vaginal opening by sealing it) (UNICEF, 2024). It is typically performed on girls between infancy and age 15 (Gaffney-Rhys, 2021), with considerable variation in form, meaning, and social significance across cultural contexts (Eshraghi et al., 2024). The WHO (2025a) categorizes FGM/C into four main types, with subcategories reflecting specific variations (see **Table 1**). Most documented cases (approximately 90.0 %) involve Types I, II, or IV, which are less extensive, while about 10.0 % are the most extensive form, Type III (Gómez, 2017). This typology is relevant to legal and health debates, as harm and risk profiles differ between types.

Table 1.

WHO classification system for FGM/C

Type	Description
Type 1: Clitoridectomy	-The partial or total removal of the clitoral glans and/or the prepuce/clitoral hood. -Including: I. type 1a: circumcision - removal of the prepuce/clitoral hood II. type 1b: clitoridectomy - removal of the clitoral glans with the prepuce.
Type 2: Excision	-The partial or total removal of the clitoral glans and the labia minora, with or without removal of the labia majora. -Including: I. type 2a: removal of the labia minora only II. type 2b: partial or total removal of the clitoral glans and the labia minora III. type 2c: partial or total removal of the clitoral glans, the labia minora and the labia majora.
Type 3: Infibulation	-Narrowing of the vaginal opening with the creation of a covering seal. The seal is formed by cutting and repositioning the labia minora or labia majora. The covering of the vaginal opening is done with or without removal of the clitoral prepuce/clitoral hood and glans (Type 1 FGM/C). -Including: I. type 3a: appositioning of the labia minora II. type 3b: appositioning of the labia majora. This classification also includes re-infibulation following childbirth.
Type 4	All other harmful procedures to the female genitalia for non-medical purposes, for example nicking, pricking, piercing, incising, scraping, stretching, and cauterization.

Note: Adapted from “Rethinking the Definition of Medicalized Female Genital Mutilation/Cutting,” 2024, by N. Van Eekert, H. Barrett, S. Kimani, I. Hidayana, & E. Leye, Archives of Sexual Behavior, 53(2), p. 441–453 (<https://doi.org/10.1007/s10508-023-027>)

In contrast, FGCS refers to a broad range of legal permitted surgical procedures intended to alter the appearance or function of the female genitalia, with or without medical necessity (Goodman, 2009; Kalampalikis & Michala, 2021). There is no universally accepted definition, as FGCS encompasses diverse practices categorized differently across medical, legal, and cultural contexts (Shaw et al., 2022; Zwier, 2014). Unlike FGM/C, FGCS is typically performed in regulated medical settings on consenting adults, and is framed as elective, often for functional, sexual, or aesthetic reasons (Braun, 2005; Giarenis & Cardozo, 2014; Goodman, 2009; Kalampalikis & Michala, 2021; Zwier, 2014).

FGCS has become increasingly prominent in high-income Western societies, integrated into the lucrative global cosmetic surgery industry (Boddy, 2020). Motivations vary but tend to fall into functional (e.g., discomfort during sexual activity or exercise), sexual (e.g., enhancing pleasure or confidence), and cosmetic (e.g., dissatisfaction with appearance) categories (Veale et al., 2013; Zwier, 2014). The most common procedures include labiaplasty, clitoral hood reduction, and vaginal tightening. According to the International Society of Aesthetic Plastic Surgery (ISAPS, 2024), 210.633 labiaplasties were performed worldwide in 2024, making it the 21st most common cosmetic operation. Although the number of labiaplasties declined slightly in 2024 (by 3.7 % from 2023), the procedure has seen a 48.2 % global increase since 2020. Vaginal tightening procedures ranked 28th in 2024, with 75.719 operations performed. The demand also varies by region: Brazil, the United States, and France report some of the highest labiaplasty rates, likely reflecting robust cosmetic surgery markets, whereas countries such as Belgium show lower numbers, perhaps due to smaller market penetration (ISAPS, 2023).

Although procedural scope and motivations differ, certain FGCS interventions, such as labiaplasty or clitoral hood reduction, are anatomically similar to some forms of FGM/C, particularly WHO Types I and II (Boddy, 2016, 2020; Earp, 2022; Florquin & Richard, 2020; Gaffney-Rhys, 2021; O'Neill et al., 2020; Shahvisi, 2021; Shahvisi & Earp, 2019; Van Eekert et al., 2024). For example, a labiaplasty, which involves a partial removal of the labia minora (or majora), is anatomically similar to what the WHO classifies as Type II FGM/C, which entails excision of the labia minora (and/or the clitoral glans or prepuce). Similarly, a clitoral hood reduction entails the excision of part of the clitoral prepuce, mirroring the tissue removal that defines Type Ia FGM/C. The implications of these overlaps, and how they are framed discursively and legally, are explored in the next section.

2.2. Socio-cultural motivations behind FGM/C and FGCS

2.2.1. Cultural significance, purity, and tradition in FGM/C

FGM/C is embedded in the cultural and social fabric of many practicing communities, where it is linked to locally defined ideals of feminine purity, modesty, and maturity (Abusharaf, 2001; Ahmadu, 2000; Boddy, 2020; Gómez, 2017; Nakamura et al., 2023; Njambi, 2004; Palm, 2024; Shell-Duncan et al., 2021). In such contexts, altered genitalia may signify proper womanhood, full social membership, readiness for marriage, and moral virtue, in accordance with communal norms. The practice can also be associated with hygiene or aesthetics, aiming to achieve what is locally perceived as cleanliness or beauty (WHO, 2025a).

Within these societies, women may view the practice as a proud cultural or (religious¹) tradition rather than as ‘mutilation’. It connects them to shared values, rite-of-passage rituals, and communal ideas of honor and decency. In these societies, FGM/C is often upheld by women (e.g., mothers, grandmothers, and other elder female excisers) who see it as essential for a girl’s social acceptance and proper upbringing (Eshraghi et al., 2024; Garcés De Marcilla Musté, 2023; Gómez, 2017; Palm, 2024). From this perspective, it is not solely an act of patriarchal imposition but rather a female-led transmission of cultural values. Advocates of the practice may view it as marking the transition to respected womanhood, ensuring controlled sexuality, and affirming communal honor (Abathun et al., 2016; Ahmadu, 2000; Palm, 2024). The underlying motivation is to align with community-prescribed ideals of femininity and virtue, thereby securing a girl’s place as a ‘respectable’ woman.

2.2.2. Western beauty ideals and the rise of FGCS

FGCS, by contrast, has emerged in Western societies under a different set of gender norms and beauty ideals. The growing demand of labiaplasty and related procedures reflects intense societal ideals of the ‘perfect’ vulva (e.g., petite, symmetrical, hairless, and with minimal labial protrusion) features that align with prepubescent or highly Eurocentric norms (Kirkman et al., 2023; Ortega-Sánchez et al., 2025; Sharp et al., 2016; Nurka & Jones, 2013). These standards are reinforced by media, pornography, advertisements, and even anatomy textbooks, which overwhelmingly depict vulvas with hidden or small inner labia, reinforcing the notion that any visible labial tissue is ‘abnormal’ or ‘unattractive’ (Bennett, 2012; Kalampalikis & Michala, 2021; Kirkman et al., 2023; Nurka & Jones, 2013; Sharp et al., 2016). Women who perceive their own anatomy as deviating from these ideals often report shame, insecurity, or dissatisfaction, sometimes amplified by comments from partners.

Cosmetic surgery marketing further normalizes the pursuit of these ideals, framing FGCS as a route to empowerment, (sexual) confidence, and self-improvement (Bennett, 2012; Kalampalikis & Michala, 2021). However, critical literature links these aesthetics to colonial histories (Boddy, 2020). In the 19th century, European pseudoscience and colonial discourse pathologized the elongated labia of certain African women, infamously described as the “Hottentot apron”, and framing them as primitive or hypersexual (Boddy, 2020; Nurka & Jones, 2013). While contemporary FGCS discourse rarely makes explicit racial references, it perpetuates an implicitly Eurocentric ‘normal’ that marginalizes anatomical diversity. As Boddy (2020) observes, the logic of the village elder who views uncut genitalia as less acceptable and the cosmetic surgeon who regards ‘excess’ labial tissue as something that can be reduced is structurally similar, both reinforce aesthetic norms that favor minimal, hidden labia.

2.2.2. Gender norms, social pressure, and perceived agency

Despite their different cultural settings, both FGM/C and FGCS are shaped by gendered social expectations rather than being purely individual choices (Wrenn, 2015). In FGM/C-practicing contexts, families (particularly mothers and grandmothers) may feel compelled to ensure girls undergo cutting to secure their social future, marriage prospects, and community acceptance (Ahmadu, 2000; Gruenbaum et al., 2022; Eshraghi et al., 2024; Florquin & Richard, 2020; Shell-Duncan et al., 2011). Refusal can lead to stigma or ostracism for both the girl and her family.

¹ Although some communities consider FGM/C to be religious, the practice is not prescribed in major religious texts such as the Quran or the Bible (WHO, 2025a). In fact, historical evidence indicates that FGM/C predates both Islam and Christianity. Its association with religion is therefore based on interpretation rather than scriptural instruction.

While the act is externally condemned as coercive, it is internally framed as responsible parenting and moral duty (Ahmadu, 2000; Gruenbaum, 2022; Shweder, 2000; Wellsch, 2019).

In Western contexts, women who pursue FGCS also navigate strong social conditioning. Many cite discomfort, irritation, or functional concerns (Giarenis & Cardozo, 2014; Sharp et al., 2016), yet health professionals note that such reasons can mask primarily aesthetic motivations shaped by cultural norms. Even with formal consent, choices occur within environments that define certain anatomies as undesirable, making the decision a negotiation with societal ideals of femininity.

The consequences of both practices further reflect the power of these expectations. FGCS can alleviate body-image distress and increase confidence (Kirkman et al., 2023; Ortega-Sánchez et al., 2025), but some women remain dissatisfied, suggesting that deeper issues of self-image persist (Mironica et al., 2024). Similarly, women's experiences of FGM/C vary, some express pride in fulfilling a cultural rite, while others, particularly in diaspora contexts, report trauma or a sense of loss when confronted with conflicting value systems (Boisen et al., 2021; Eshraghi et al., 2024; O'Neill et al., 2020, 2021; Salah et al., 2024).

Understanding these practices through the lens of gendered social conditioning, albeit articulated in different cultural languages, allows us to move beyond simplistic binaries of 'oppression' versus 'choice'. It situates women's decisions within the intersecting pressures of culture, community, and body politics, revealing that the social forces underpinning genital modification are global in scope, though differently articulated.

2.3. Legal and policy frameworks

2.3.1. Criminalization versus personal choice

Since the late twentieth century, international human rights law has framed FGM/C as a violation of bodily integrity and dignity (Alié, 2014). Early instruments such as the Universal Declaration of Human Rights (1948) protect the right to dignity and the right to freedom from cruel, inhuman or degrading treatment (Articles 1 and 5), which have served as a basis for anti-FGM/C advocacy (Alié, 2014; FOD Volksgezondheid et al., 2011). Building on these general principles, later treaties explicitly call for the elimination of 'traditional practices' that harm women or children. The Convention on the Elimination of All Forms of Discrimination Against Women (1979) and the Convention on the Rights of the Child (1989) both require states to abolish customs prejudicial to women's and children's health (Article 24) (Alié, 2014). The UN Declaration on the Elimination of Violence Against Women (1993) goes further by identifying FGM/C as a form of violence against women, providing a direct mandate for criminalization. More recently, UN General Assembly resolutions in 2012 and 2014 have reaffirmed this global consensus by urging member states to enact laws and programmes that eradicate FGM/C (Alié, 2014).

At the European level, the Council of Europe's Istanbul Convention (2011) became the first binding treaty to require criminalization of FGM/C (Alié, 2014; FOD Volksgezondheid et al., 2011). Article 38 obliges signatories to criminalize performing, aiding, or inciting FGM/C, and its broader provisions on prevention, protection, and prosecution have influenced national strategies. The EU has further integrated FGM/C into gender-equality and victims' rights frameworks. For example, Directive 2012/29/EU recognizes victims of FGM/C as requiring special protection (Alié, 2014).

Belgium's legal approach reflects this robust criminalization framework. Since 2001, Article 409 of the Belgian Criminal Code has prohibited all forms of FGM/C, regardless of age or consent,

imposing prison sentences of three to five years, and higher if the victim is a minor or suffers aggravated injury (Artikel 409 Van Het Belgisch Strafwetboek, 2001; FOD Volksgezondheid et al., 2011). Consent is explicitly excluded as a legal defense (Artikel 409 van het Belgisch Strafwetboek, 2001; Florquin & Richard, 2020). This reflects a policy position that FGM/C is inherently harmful, placing the state under an obligation to prevent it, even in cases involving adult consent.

In contrast, FGCS is legal across most Western jurisdictions and regulated as a standard medical service (Chen, 2021; Shahvisi, 2021). Procedures that surgically alter the labia or clitoral hood, technically similar to some forms of FGM/C, are permissible when framed as elective cosmetic interventions. In Belgium, such surgeries are lawful and may even be performed on minors with parental consent if justified by claims of physical or psychological discomfort (GAMS, 2024).

2.3.2. Policy debates about double standards

This legal divergence has prompted sustained scholarly critique (Boddy, 2016; Shahvisi, 2021; Shell-Duncan, 2022). Critics note that, while FGM/C is universally criminalized as gender-based violence and child abuse, similar procedures are permitted, and sometimes promoted, when performed as aesthetic enhancements on women and girls from Western cultures (Ball, 2018; Bennett, 2012; Florquin & Richard, 2020; Shahvisi, 2021). Scholars argue that this discrepancy reflects an implicit racial and cultural double standard (Ball, 2018; Bennett, 2012; Florquin & Richard, 2020; Gaffney-Rhys, 2021; Shahvisi, 2021). Practices associated with non-Western minority communities are prohibited outright, regardless of adult consent, whereas comparable surgeries within Western contexts are legitimized through discourses of personal choice, self-improvement, and bodily autonomy (Boddy, 2016; Shahvisi, 2021).

This selective application of autonomy raises questions about whether current legal frameworks genuinely uphold the principle of self-determination, or whether they apply it selectively according to cultural and racial boundaries. For some scholars, such inconsistencies undermine the universality of human rights norms and reveal how legal interpretations of harm and consent are mediated by cultural bias (Boddy, 2016; Gaffney-Rhys, 2021; Florquin & Richard, 2020; Shell-Duncan, 2022).

2.4. Health implications and medicalization

2.4.1. Immediate and long-term health consequences of FGM/C

FGM/C provides no physical health benefits and deliberately injures normal genital tissue, disrupting natural bodily functions, and is widely recognized as a serious threat to women's physical, sexual and psychological well-being (WHO, 2025b). Acute complications commonly reported include excessive bleeding, severe pain, shock, tissue swelling, infection (e.g., fever) and urinary problems (Berg et al., 2014; Pallitto et al., 2025; WHO, 2025b). A systematic review by Berg et al. (2014) estimates that over 10.0 % of girls and women experience these immediate complications. Furthermore, the non-clinical settings in which FGM/C is often performed, with shared and unsterilized instruments, heightens the risks of infections, such as tetanus, hepatitis, and HIV, though precise infection rates remain difficult to determine (Reisel & Creighton, 2014).

Beyond immediate injuries, FGM/C has long-lasting health repercussions. Multiple studies (Berg et al., 2014; Pallitto et al., 2025; WHO, 2025b) have identified higher risks of obstetric

complications (e.g., prolonged labor, obstetric tears, caesarean birth, postpartum hemorrhage, neonatal distress), Chronic gynecological and urological problems (e.g., scarring, keloid formation, dysmenorrhea, recurrent urinary infections, general urinary difficulties), sexual dysfunction (e.g., dyspareunia, decreased libido, anorgasmia), and mental health impacts (e.g., PTSD, anxiety, or depression) (Mulongo et al., 2014; Pallitto et al., 2025; WHO, 2025b).

In response to health awareness campaigns, some communities have shifted towards less invasive types of cutting, such as symbolic pricking (Type IV), but these practices remain condemned as violations of bodily integrity (Kimani & Kabiru, 2018).

2.4.2. Clinical complications of FGCS

FGCS also injures normal genital tissue, but is usually carried out in a clinical setting under anesthesia and with sterile instruments and post-operative care, which reduces, but does not eliminate, the risks (Boddy, 2020). Complications include infection, wound breakdown, allodynia, hematoma, nerve damage, reduced lubrication, dyspareunia, adhesions, urinary symptoms and pelvic floor dysfunction (Boddy, 2020; Schnatz & Boardman, 2020). Goodman et al. (2009) conducted a retrospective analysis of women undergoing FGCS and reported complication rates ranging from 8.5% to 18.2%. While many patients seek FGCS in the hope of improving their sexual function or body confidence, negative outcomes such as genital numbness, sexual pain or psychological distress have also been reported (Boddy, 2020; Goodman et al., 2009; Schnatz & Boardman, 2020). Furthermore, a lack of empirical evidence exists to support claims that FGCS enhances sexual pleasure (Braun, 2005; Cain et al., 2013; Wellsch, 2019), thereby highlighting the uncertainty surrounding the safety and efficacy of FGCS in general (Shahvisi, 2021; Shaw et al., 2022; Wellsch, 2019).

The absence of long-term safety data, coupled with the increasing commercialisation of FGCS, raises further concerns (Azmoode et al., 2024; Shaw et al., 2022; Wellsch, 2019). This is particularly concerning given the discrepancy between surgeons' reported satisfaction rates and women's accounts of ongoing pain, scarring or sexual dysfunction (Goodman et al., 2009; Wells, 2019). Psychological outcomes also vary widely. Some women report feelings of empowerment or increased confidence, while others experience dissatisfaction and refocus on other perceived bodily imperfections, which is consistent with the pattern of body dysmorphic disorder (Boddy, 2020; Braun, 2005).

2.4.3. The Role of medicalization

Thus, a key distinction between FGM/C and FGCS lies in their relationship to medicalization. FGCS is fully embedded in modern healthcare systems, often framed in therapeutic language, such as correcting 'abnormal' anatomy or improving self-esteem, thereby normalizing it as a legitimate medical option. This framing, coupled with access to anesthesia and antibiotics, reduces certain risks but can obscure the socio-cultural pressures, rooted in media-driven beauty norms, that generate the demand (Boddy, 2020; Braun, 2005; Cain et al., 2013).

Global health policy, by contrast, has aimed to de-medicalize FGM/C to prevent its normalization. Nonetheless, medicalized FGM/C, performed by trained professionals, is on the rise in some countries, with families viewing it as a safer alternative (Shell-Duncan, 2001; Kimani & Shell-Duncan, 2018). The WHO (2018) strongly opposes medicalized FGM/C, arguing that it

legitimizes a rights-violating practice regardless of the reduced physical harm (Earp & Johnsdotter, 2020).

The divergence in public health messaging is stark. A symbolic nick under FGM/C is condemned globally, while surgical removal of labial tissue in a cosmetic context is legally and socially accepted. Anatomically, both can involve excision of sensitive tissue, scarring, and potential loss of erotic sensation, as well as infection risks and long-term discomfort (Shahvisi, 2021). FGCS is generally less extensive than severe forms of FGM/C and more often performed in safer conditions, but not all FGM/C results in catastrophic harm, particularly in its less invasive forms. Portraying one as inherently ‘safe’ and the other as universally ‘dangerous’ oversimplifies the reality (Boddy, 2020; Shahvisi, 2021).

3. Contextual framework

Belgium presents a unique case study for examining the paradoxes surrounding female genital modifications. As a Western liberal democracy, Belgium enforces strict legal prohibitions against FGM/C, while simultaneously offering FGCS through both public and private healthcare systems. This contradiction underscores the broader socio-legal disparities discussed in previous sections. This chapter provides a contextual overview of how FGM/C and FGCS are embedded in Belgian society.

3.1. FGM/C in Belgium

In recent years, Belgium has seen an increase in the number of women and girls affected by or at risk of FGM/C (see [Figure 1](#)). Updated prevalence studies by Dubourg and Richard (2022a) offer insights into these trends. Their research, conducted every four years and using demographic and migration data, estimates the scale of FGM/C across the country and identifies groups at elevated risk.

As of 31 December 2020, it was estimated that approximately 23,395 women and girls had already been subjected to the practice, while 12,064 were considered to be at high risk. This totalled around 35,000 affected individuals (Dubourg & Richard, 2022a). This marks a rise from the 2016 figures (25,900 combined cases).

This increase is largely explained by migration patterns. Between 2016 and 2020, citizens of Guinea, Somalia and Eritrea made the most notable contributions, accounting for 30.0%, 27.0% and 14.0% of the increase each (Dubourg & Richard, 2022a). Importantly, the rise is not only attributable to first-generation migrants, but also to children born in Belgium of mothers originating from these high-prevalence countries. Around 40.0% of these Belgian-born girls were of Guinean heritage, 23.0% were Somali, and 6.0% were Eritrean.

This demographic shift is also reflected in the asylum system. The number of female international protection applicants affected by FGM/C rose from 1,155 in 2016 to 1,428 in 2020 (Dubourg & Richard, 2022a).

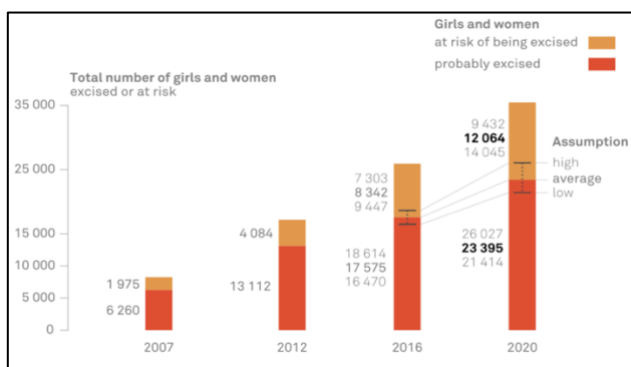
As noted in Section 2.3.1., Belgium criminalized FGM/C in 2001 under Article 409 of the Penal Code, adopting a zero-tolerance policy that prohibits the practice regardless of consent or age, with enhanced penalties for minors (Artikel 409 Van Het Belgisch Strafwetboek, 2001; FOD Volksgezondheid et al., 2011).

3.1.1. Geographical and demographic aspects

The communities most affected by FGM/C in Belgium originate primarily from Guinea, Somalia, Egypt, Ethiopia, and Ivory Coast (see [Table 2](#)) (Dubourg & Richard, 2022a). These communities

Figure 1

Estimated number of girls and women in Belgium who had undergone or were at risk of undergoing excision between 2007 and 2020.



Note. Adapted from "Estimation of the Prevalence of Girls and Women who have undergone or are at Risk of Undergoing Female Genital Mutilation in Belgium, 2022", by D. Dubourg, & F. Richard

are predominantly situated in the Flemish region, where healthcare systems report that over half of the childbirths by women from these backgrounds are by those who have undergone FGM/C.

The affected population is relatively young. Of the estimated 35.459 women and girls involved in the 2020 prevalence study, 12.730 were under the age of 18. Each year, approximately 1.700 circumcised women give birth in Belgian hospitals, highlighting the ongoing intergenerational presence of FGM/C within the country's maternity care system (Dubourg & Richard, 2022a).

Table 2.

Age and regional breakdown of women who had been circumcised as of 31 December 2020

Age group	Flanders	Wallonia	Brussels-Capital	Fedasil	In an undocumented situation	Total Belgium	Of whom, born in an FGM/C country
< 5 years	2,013	867	877	112	-	3,869	310
5-19 years	4,471	2,337	2,679	319	20	9,826	4,735
20-49 years	8,433	4,255	5,386	966	144	19,183	18,472
>50 years	1,173	531	842	31	4	2,581	2,510
Total	16,089	7,989	9,784	1,428	168	35,459	26,027

Note. Adapted from "Estimation of the Prevalence of Girls and Women who have undergone or are at Risk of Undergoing Female Genital Mutilation in Belgium, 2022", by D. Dubourg, & F. Richard

3.2. FGCS in Belgium

In recent decades, FGCS has garnered growing attention across Western societies, driven by broader developments within the global cosmetic surgery industry (Gonzales-Alabastro et al., 2019). While its popularity continues to rise internationally, the scale of FGCS in Belgium remains relatively modest.

Despite its relatively low prevalence, FGCS is legal and practiced in Belgium as part of the broader domain of cosmetic medicine (Florquin & Richard, 2020; GAMS, 2024). The most recent data from the ISAPS (2023) show that in 2023, Belgium recorded 1.374 labiaplasty procedures and 235 vaginal rejuvenation surgeries, numbers that represent only a fraction of global totals.

Most of these procedures are offered in private or public settings by either plastic surgeons or, to a lesser extent, gynecologists. Importantly, they are generally not reimbursed by public health insurance unless there is a clear medical indication (Senn et al., 2008). As outlined in the report by the Belgian Federal Knowledge Center for Health Care, reconstructive surgery is traditionally defined as a medical specialty aimed at correcting congenital anomalies or physical defects resulting from accidents, disease, or surgery (Senn et al., 2008). In contrast, aesthetic or cosmetic surgery seeks to alter or enhance variations of normal anatomy, such as signs of ageing, and is not medically necessary. These procedures are performed at the patient's request and are typically not justified by clinical indications.

A notable regulatory gap in Belgium lies in the absence of clear, nationally specific medical guidelines on FGCS, leading to variability in clinical practices across providers (Senn et al., 2008). Compounding this regulatory gap is the lack of empirical research on FGCS in the Belgian context (Senn et al., 2008). This absence of academic and clinical studies limits the availability of data on key factors such as patient demographics, regional distribution, and the motivations driving these procedures, making it difficult to assess the full scope and implications of FGCS in Belgium.

4. Theoretical/conceptual framework

4.1. The coloniality of gender

In order to analyze the different discursive and legal classifications of female genital modification practices, this study draws on María Lugones' (2007, 2010) decolonial feminist concept of the 'coloniality of gender', which is based on Aníbal Quijano's (2000) concept of the 'coloniality of power'. Lugones (2010) argues that colonialism not only exploited resources, sex, collective authority and labor, but also imposed a Eurocentric, binary, and hierarchical gender system that combined race, gender and sexuality into a matrix of domination. According to this theory, gender is not a universal category, but rather a colonial construct imposed on colonized populations. This transforms fluid or plural gender practices into rigid binaries that align with Western-Christian ideals (Lugones, 2010).

When applied to contemporary debates on FGM/C and FGCS, this lens reveals how colonial logics continue to determine which gendered practices are legitimized or condemned. Historically, colonizers positioned themselves as civilizing authorities, framing the customs of colonized persons, particularly those concerning women's bodies, as primitive and hypersexual, and in need of reform (Lugones, 2010; Shahvisi, 2021; Van Bavel et al., 2024). These narratives are still present in the global discourse. For example, African and Middle Eastern women are often portrayed as passive victims of oppressive cultures, whereas comparable bodily alterations among white Western women are often reframed as acts of autonomy, modernity, or empowerment (Shahvisi, 2021; Van Eekert et al., 2024).

This dichotomy reflects what decolonial feminists such as Mohanty (1988), Nnaemeka (2005), and Lugones (2010) have critiqued as a colonial gaze, a way of seeing and knowing that positions Western norms as universal and rational, while Othering non-Western norms as backward and oppressive (Shahvisi, 2021; Van Eekert et al., 2024). In this framework, Western women's body modifications, such as labiaplasty or vaginal rejuvenation, are generally medicalized and normalized as personal choices, whereas similar practices undertaken by racialized women are pathologized and criminalized (Bennett, 2012; Shahvisi, 2021). This double standard exemplifies the coloniality of gender: the unequal capacity of different subjects to exercise recognized autonomy over their bodies, shaped by intersecting systems of race, gender, and colonial history (Boddy, 2020; Nurka & Jones, 2013).

Through this framework, the unequal classification of genital modifications is understood as an exercise of power: determining whose bodily practices are criminalized, whose desires are validated, and whose autonomy is respected (Shahvisi, 2021). This study uses the coloniality of gender to unpack the normative assumptions that underpin medical and legal responses to identical requests from women perceived as belonging to different racial or cultural groups.

4.2. Foucault on knowledge, power, and medical discourse

The second theoretical pillar is based on Michel Foucault's analysis of the relationship between power, knowledge and discourse, particularly in medical contexts. Foucault (1976, 1980) argued that power is everywhere and operates through the production and circulation of knowledge. He introduced the concept of power/knowledge (1980) to demonstrate that what is accepted as 'truth' in any given society is not neutral or universal, but is instead constructed through power relations. Importantly, Foucault emphasized that such truths are historically contingent, they change with context and are upheld by institutions such as universities, governments and professional bodies, which act as gatekeepers of legitimacy (Foucault, 1976).

In *The Birth of the Clinic* (1963), Foucault introduces the concept of the ‘medical gaze’, which describes how modern clinical practices and medical knowledge have control over the patient’s body. He also shows how different ways of perceiving are related to historically developed structures of scientific discourse. Through this gaze, doctors acquire epistemic authority to define normality and pathology. Medical discourse, as Foucault (1963) shows, produces categories such as healthy/unhealthy and normal/abnormal, which become internalized. He later conceptualized this as ‘biopower’ (1976), a form of power exercised through institutions, such as medicine and public health, which governs life by defining what is acceptable, healthy or dangerous.

Foucault’s (1981) ideas stem from post-structuralist theories and challenge the assumptions of the Enlightenment about objective knowledge. His framework is instrumental in examining the discourses and power relations surrounding female genital modification. From a Foucauldian standpoint, the discourse of ‘FGM/C = mutilation’ is a product of the power/knowledge networks of global health organizations, laws and medical ethics committees. These networks have produced the near-universal truth that any cutting of female genitals (if the culture is considered ‘other’) is illicit and harmful (Earp & Johnsdotter, 2021). Undoubtedly, colonial governments saw the practice of FGM/C as a symbol of illness in colonies (Iguchi et al., 2023), and this colonial medical gaze continues to echo in contemporary global health frameworks. This regime of truth is enforced by institutions such as the WHO and national laws, and it carries real power: for example, doctors in Belgium are legally and normatively bound to reject requests for FGM/C because it is categorically defined as immoral. In contrast, the discourse surrounding FGCS in the West portrays it as a legitimate medical procedure or personal choice. This is supported by a substantial cosmetic surgery industry and is normalized in medical textbooks and training. This stark difference in classification (mutilation versus surgery; victimhood versus choice) reflects what Foucault would call ‘politics of truth’ (1980).

By applying Foucault’s framework, the research methodology will pay attention to the language doctors use and the justifications they provide in interviews or case analyses, revealing the tacit ‘rules’ by which they separate acceptable from unacceptable requests.

4.3. Relational autonomy and intersectionality

The third pillar draws on feminist critiques of liberal autonomy and incorporates the concept of relational autonomy developed in feminist bioethics (Mackenzie & Stoljar, 2000). A key point of departure is the ‘principlist framework’ of Beauchamp and Childress (2012), which has long dominated the field of biomedical ethics. This framework is based on four principles: autonomy, beneficence, non-maleficence and justice. These principles are intended to guide ethical decision-making in clinical practice. Within this model, autonomy is generally defined as an individual’s right and ability to make informed and voluntary decisions, and respecting this autonomy is fundamental to ethical medical care (Beauchamp and Childress, 2012).

Beauchamp and Childress (2012) propose a three-condition theory to determine whether someone is acting autonomously. This theory is based on intentionality, understanding, and non-control. According to this theory, actions are considered autonomous when they are performed intentionally, with sufficient understanding of the relevant information, and without coercion or manipulation.

This is where feminist and relational theories intervene. Mackenzie and Stoljar (2000) propose the term ‘relational autonomy’, challenging the idea of the autonomous subject as being isolated, rational and unaffected by social, cultural and religious structures (Christman, 2014; Mackenzie & Stoljar, 2000). Instead, it emphasizes that autonomy is always exercised within relational and

sociocultural contexts, such as by power dynamics, welfare, interpersonal relationships, environments and structural inequalities (Christman, 2014; Donchin, 2001; Friedman, 2003; Mackenzie & Stoljar, 2000). This approach is particularly important when considering medical decisions related to the body, such as genital modifications. While Western frameworks often presume that white, secular, middle-class women choose procedures like labiaplasty freely, women from racialized or religious backgrounds are frequently presumed to lack agency, even when expressing similar motivations (Shahvisi, 2016; Van Bavel et al., 2024). This asymmetry calls for an intersectional understanding of autonomy.

Here, the work of Kimberlé Crenshaw (1989) is indispensable. Crenshaw (1989, 1991) introduced intersectionality as a framework to examine how multiple social categories, such as race, gender, class, and language background, interact to create overlapping systems of disadvantage and privilege. Drawing from black feminist thought, Crenshaw demonstrated that treating race and gender as separate categories in anti-discrimination law rendered the specific experiences of black women invisible. Intersectionality emphasizes that these identities are interconnected and mutually constitutive, operating within complex structures of inequality and power that shape individuals' lived experiences (Collins & Bilge, 2020; Shields, 2008; McCormick-Huhn et al., 2019). It highlights how multiple systems of oppression, such as racism, sexism, and classism, function simultaneously to structure social realities (Papp, 2024; Schlesinger et al., 2017). Beyond describing these dynamics, intersectionality serves as a heuristic tool for identifying emerging structures of power and mobilizing solidarity across diverse groups (Carbado et al., 2013). Since its introduction, intersectionality has been applied across disciplines to analyze how positions in social hierarchies are shaped by the overlapping and interdependent nature of social identities (Mooney & Becker, 2020).

This perspective is central to the thesis, as it illuminates how cultural, racial, and gendered biases may converge to influence medical professionals' interpretations of, and responses to, women's requests for genital modifications.

5. Methodology

5.1. Research design

This study employs a small-scale, deductive experimental design to investigate how racial and cultural biases may influence the clinical decision-making processes of healthcare professionals in Belgium regarding requests for female genital modification. To achieve this, a qualitative methodology consisting of two sequential components will be employed. Participants will first watch a video vignette, after which they will be interviewed in a semi-structured manner.

The qualitative data will offer insight into the social and cultural assumptions that may inform clinical judgments, elements that are not always apparent in quantitative outcomes alone. Combining these methods enables the study to generate both measurable findings and a deeper contextual understanding of how perceptions of ethnicity, culture and gender influence professional responses in sensitive healthcare encounters.

This research design is inspired by the methodology used by Delaruelle et al. (2021) in their study ‘Mind the gate’. In that study, video vignettes were employed to examine how Flemish general practitioners (GP’s) responded to patients of different migration statuses (specifically native Belgian patients, patients of foreign descent, and asylum seekers) who all exhibited symptoms of major depression. The findings revealed a provider bias: GPs viewed patients of foreign descent as less trustworthy and less likely to adhere to treatment, and they held particularly pessimistic views regarding the recovery prospects of asylum seekers. Inspired by this methodologically approach, this study also employs video vignettes to explore how racial and cultural cues shape healthcare professionals’ decision-making regarding female genital modifications. By adapting this established approach, this research builds on prior insights into provider bias, while shifting focus to a new medical and sociocultural domain within the Belgian healthcare context.

5.2. Data collection methods

5.2.1. Video vignettes

5.2.1.1. Definition and background

Vignettes are a methodological tool in social sciences for studying how individuals make decisions in specific, controlled contexts (Atzmüller & Steiner, 2010; Ceuterick et al., 2020; Evans et al., 2015). They consist of short, systematically constructed descriptions of situations, people, or objects that combine selected characteristics to simulate realistic scenarios. While vignette studies have traditionally relied on written descriptions to investigate professional judgment and behaviour, recent years have seen the growing use of video vignettes, scripted scenarios performed by actors, particularly in healthcare research (Ceuterick et al., 2020; Evans et al., 2015; Hillen et al., 2013). By incorporating visual and auditory cues, video vignettes enhance immersion and realism, making them especially suitable for simulating complex interpersonal interactions, such as doctor–patient consultations.

This methodological evolution has proven valuable for examining clinical decision-making and discriminatory bias among healthcare professionals (Evans et al., 2015; Hillen et al., 2013; Wets et al., 2023). Scripted video vignette experiments, as highlighted by Wets et al. (2023), represent a relatively recent innovation in discrimination research. They allow for the simulation of patient–provider encounters in a highly standardized yet lifelike way, enabling researchers to assess how variables such as ethnicity, language, or gender influence professional judgments. Compared to other approaches, video vignettes capture non-verbal cues and social signals that are essential for understanding bias in real-world contexts (Ceuterick et al., 2020).

A key strength of vignette designs lies in their ability to combine experimental control with realism (Ceuterick et al., 2020). Controlled elements remain constant across all versions, while selected variables are deliberately manipulated to assess their effect on participant responses (Ceuterick et al., 2020; Hillen et al., 2013). This structure allows researchers to isolate the impact of specific factors while holding all other conditions stable, thereby increasing the internal validity of the study.

Video vignettes also offer advantages in terms of external validity. Their realistic format enables participants to engage with scenarios that closely mirror real-life situations (Ceuterick et al., 2020; Hillen et al., 2013). In clinical settings, information is conveyed not only through words but also via gestures, facial expressions, and tone, elements that a video can capture far more effectively than text (Ceuterick et al., 2020). This quality tends to elicit more authentic responses, enhancing the ecological relevance of the findings.

Nonetheless, this methodology is not without limitations. Because vignettes are pre-recorded, participants cannot actively engage with the scenario, ask follow-up questions, or seek clarification, interactions that often shape decision-making in real consultations (Ceuterick et al., 2020). This lack of dynamic exchange may limit the authenticity of diagnostic reasoning. Furthermore, despite their realism, vignettes remain simulations, and responses given in a controlled research setting may differ from those in actual practice (Cox et al., 2023).

5.2.1.2. Script and video development

Creating valid and reliable video vignettes requires a systematic and transparent process to ensure internal consistency, interpretive clarity, and ecological validity. This study followed the five-phase framework proposed by Hillen et al. (2013), widely recognized as a methodological benchmark in video vignette research.

Phase I: Deciding whether video vignettes are appropriate

Video vignettes were selected as the most suitable method due to both the ethical sensitivity of the topic and the need for experimental control. Female genital modification lies at the intersection of culture, medicine, and law, making real-life clinical observations or direct patient-provider recordings ethically problematic. Simulated encounters allow for a realistic yet ethically sound alternative.

Methodologically, video vignettes are an effective tool for identifying implicit biases in clinical decision-making processes, as they enable the isolation of specific variables (Evans et al., 2015; Hillen et al., 2013; Wets et al., 2023). In this case, visible identity markers, such as skin colour and cultural features, can be isolated while all other elements remain constant. Unlike written vignettes, which lack paralinguistic and visual cues, video vignettes enable the capture of non-verbal communication, tone of voice and facial expressions. These factors have been shown to influence healthcare judgements (Ceuterick et al., 2020; McKinlay et al., 2013).

Additionally, video vignettes offer a rare combination of realism and standardization (Ceuterick et al., 2020). Each participant is exposed to the exact same clinical script and behavioral delivery, with the only variation being the manipulated characteristic(s) of the patient. This control enhances the validity of conclusions regarding the impact of patient identity (Cox et al., 2023). The close-up framing further directs attention to facial expressions, tone, and body language,

subtle cues that often shape unconscious perceptions in real consultations (Ceuterick et al., 2020; McKinlay et al., 2013).

Finally, the use of video vignettes is especially appropriate for this topic given the inherent ambiguity of labiaplasty consultations, where motivations may be framed in terms of medical necessity, cultural norms, aesthetics, or personal autonomy. This interpretive grey zone mirrors the diagnostic and ethical uncertainties of actual practice, making video vignettes an ideal tool for examining how such complexities are navigated in relation to perceived patient identity.

Phase II: Script development

The script was developed through multiple stages to ensure realism and contextual accuracy. Initial input came from a consultation in November (2024) with a co-author of the study ‘Mind the Gate’ (Delaruelle et al., 2021), who provided sample scripts and methodological advice. A second meeting in January 2025 with anthropologist Dr. Hannelore Van Bavel, an expert in female genital modification, offered detailed insights into real-life consultation dynamics. Both sessions took place under the guidance of Professor Dr. Newman.

Drawing on this expert feedback and relevant literature on clinical communication, a preliminary script was drafted and refined in consultation with Dr. Van Bavel and Professor Dr. Newman. The final version, provided in [Appendix 3](#), simulated the agenda-setting and information-gathering stages of a first consultation, as outlined in the Calgary–Cambridge Guide (Manalastas et al., 2020). These phases were chosen because first impressions and the framing of patient requests are particularly likely to reveal implicit bias.

The patient’s stated reasons (aesthetic discomfort, social insecurity and, partner expectations) were selected based on both expert recommendations (Dr. Van Bavel and Professor Dr. Newman) and their prevalence in discussions of FGM/C and FGCS (Earp & Johnsdotter, 2021; Boddy, 2020). Clinical terminology, such as ‘labiaplasty’ or ‘FGM/C’, was intentionally avoided. Instead, the patient referred to wanting ‘a change’ or ‘a reduction’. This preserved diagnostic ambiguity and allowed for observation of how meaning was constructed based on the patient’s identity.

Phase III: Experimental manipulations

A between-subjects factorial design manipulated two variables, (1) skin colour and (2) cultural appearance, while holding all other elements constant (e.g., script, tone of voice, setting, posture). Three versions were created:

- 1) A white woman of European decent (Flemish-speaking).
- 2) A black woman of African descent (Flemish-speaking).
- 3) A black woman of African descent, wearing a headscarf (Flemish-speaking).

The second and third version were portrayed by the same actress, with the headscarf as the only difference. The white Flemish woman was portrayed by a second actress matched for age, tone, and demeanor. Both actresses were in their early twenties, wore similar clothing, and were coached to maintain consistent delivery. Minor differences, such as speech rhythm or micro-expressions, were minimized through rehearsal but acknowledged as limitations.

Phase IV: Filming

Filming took place in a controlled setting designed to resemble a medical consultation room. All vignettes were recorded from the physician’s perspective, with the patient facing the camera, a format shown to enhance realism and focus (Ceuterick et al., 2020; McKinlay et al., 2013).

Due to limited resources, filming did not employ a professional filming and editing team. The same seating position, background, and camera settings were used for each take. Filming occurred on the same day to maintain environmental consistency. The patients wore similar clothing (plain black t-shirt) and were coached on consistent facial expressions, posture, pauses, and tone of voice.

Two amateur actresses played the roles of the patients, due to budget constraints. They received the final script in advance and participated in a preparatory session in which they practiced their delivery and watched each other's performances to ensure consistency. A third voice actor (unseen) provided the physician's standardized questions. This created the sense of a consultation without adding uncontrolled visual variables. The vignettes were reviewed by Professor Dr. Newman and Dr. Van Bavel for clarity and realism. Minor improvements were suggested but not implemented due to time constraints, both experts confirmed the adequacy of the final videos.

Phase V: Administration

The participants, who were Belgian gynaecologists and plastic surgeons, were randomly assigned to watch one of three video vignettes. Recruitment took place via official physician registers, hospital websites and professional networks. Eligibility was limited to licensed gynaecologists and plastic surgeons, including those who had recently retired. Showing each participant only one vignette prevented learning or comparison effects and reduced the risk of social desirability bias, which could occur if participants viewed multiple videos and identified the study's focus. The sampling strategy is discussed in greater detail in Section 5.3.

Each video was viewed individually in a quiet setting to minimize distraction and simulate the attentiveness of a real consultation. Immediately afterwards, participants completed a semi-structured elite interview exploring their interpretations, ethical considerations, and intended clinical actions. While participants were informed that the study examined the decision-making regarding genital modifications, the focus on cultural and racial bias was not disclosed, reducing priming effects and preserving authentic responses. The YouTube links to the three patient video vignettes are provided in [Appendix 1](#).

5.2.2. Semi-structured interviews

5.2.2.1. Definition and background of elite interviews

Interviews remain one of the most used research methods in the social and political sciences, offering in-depth insights into decision-making processes, perceptions, and reasoning (McClure & McNaughtan, 2021; Morris, 2009; Holstein & Gubrium, 1995). When interviewees occupy positions of authority or hold specialist expertise, commonly referred to as 'elites', additional methodological considerations are required (Morris, 2009). Elites may include political figures, corporate executives, or professionals such as healthcare providers, whose expertise is coupled with institutional authority and proximity to decision-making structures (Becker, 1995; Burnham et al., 2004; Lilleker, 2003).

Unlike standard interviews, elite interviews often shift the balance of power towards the respondent (Burnham et al., 2004; Morris, 2009). Such individuals may be more selective in what they disclose, more adept at steering the conversation, and more inclined to present themselves in a favourable light. While these dynamics can limit access to certain factual details, they also provide insight into how authority is performed and how narratives are strategically constructed.

Gaining access can be challenging, as elites may direct researchers to public relations staff or administrative gatekeepers. These factors necessitate careful preparation, non-leading questioning, and adaptive follow-up techniques to maintain both depth and direction.

In this study, healthcare professionals are approached as professional elites given their authoritative role in clinical decision-making and their capacity to shape medical practice. The elite interview format offers the flexibility to investigate how such professionals interpret patient cues, navigate ethical dilemmas, and justify recommendations in contexts involving contested procedures such as female genital modifications. As McClure and McNaughtan (2021) note, this approach is particularly valuable in research addressing sensitive topics such as discrimination, where nuanced experiences and perceptions are central to understanding the phenomenon.

Elite interviews in this context can generate insights with direct practical implications, beyond academic relevance. Understanding how influential clinicians make decisions could inform institutional practices, training and policy development. Although challenges regarding access and power imbalances must be recognized, this approach remains effective in revealing how structural authority intersects with personal judgement in real-world healthcare settings.

5.2.2.2. Interview procedure

Each interview followed a structured sequence designed to maintain consistency while allowing flexibility for probing and clarification. Before the interview commenced, participants were asked to read and sign the information and consent form, and asked explicitly verbal consent for the audio recording.

The interview began with open-ended questions designed to elicit the participant's general impressions of the video vignette they had just viewed. This was followed by more targeted prompts exploring clinical reasoning, ethical considerations, and potential cultural or racial influences on their decision-making. The semi-structured format allowed the interviewer to follow the prepared guide while also pursuing relevant lines of inquiry emerging from the participant's responses. The full interview guide is provided in [Appendix 4](#).

At the end of each interview, the interviewer orally asked a brief set of demographic questions, such as the participant's gender, professional specialization, and years of clinical experience. This final step provided contextual background information to help situate the findings within the broader medical landscape.

5.3. Sampling strategy

This study focused on licensed healthcare professionals in Flanders, specifically gynaecologists and plastic surgeons, with direct experience performing female genital modification procedures. To ensure linguistic consistency, participants were required to be fluent in Dutch, as both the video vignettes and interviews were conducted in that language. Exclusion criteria included being in training, lacking relevant clinical experience, or practicing outside Belgium. Recently retired specialists (within the past five years) were eligible.

A multi-method, non-probabilistic sampling approach combining purposive (theoretical), and snowball sampling techniques was adopted (Roose & Meuleman, 2023). Initial recruitment followed a purposive sampling approach, selecting individuals whose expertise aligned with the study's core theme of female genital modification surgery, and who had direct experience of

performing such procedures. This approach prioritizes analytical depth over statistical representativeness, making it especially appropriate for sensitive, under-researched topics.

The recruitment began with a systematic online search on the official registry of the Belgian Order of Physicians, focusing on specialists located in East Flanders. This region was selected for practical reasons, such as the researcher's place of residence and the limited travel funding available. Using the registry, a preliminary list of certified gynaecologists and plastic surgeons was compiled. Professionals were approached individually when direct contact details (e.g., email) were available. Where contact information was not listed in the registry, the researcher conducted targeted online searches to find it. This included consulting clinic websites, hospital staff pages and institutional contact forms. Professionals were then contacted via email.

Recognizing that the Order's registry does not capture all practicing specialists, supplementary recruitment steps were taken. All major hospitals and private clinics in East Flanders were mapped by municipality and relevant practitioners were manually identified through institutional staff pages. The national professional association for gynaecologists and plastic surgeons was also contacted to circulate the participation call internally.

Given the relatively small and often hard-to-reach nature of this professional group, snowball sampling was used during the fieldwork phase. Participants were invited to refer colleagues, meeting the inclusion criteria.

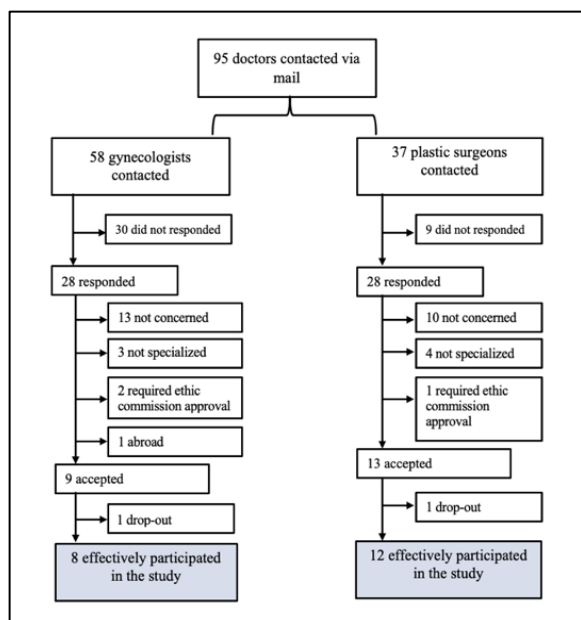
The interviews took place between April and August 2025. They were conducted face-to-face in Dutch, with one interview held via Microsoft Teams. Each participant was interviewed once and

the interviews varied in length, ranging from 25 to 120 minutes. To accommodate the busy schedules of the medical experts involved, the scheduling platform Calendly was used. This allowed participants to select a time slot that suited them best from a list of options provided by the researcher. As well as choosing a convenient time, participants could indicate their preferred interview location, usually their own consultation room or home office, to ensure comfort and minimal disruption to their workflow.

A total of 95 healthcare professionals were contacted via email, 58 gynaecologists and 37 plastic surgeons. Non-respondents received up to three reminder emails at spaced intervals (e.g., two weeks) to maximize response rates. Ultimately, 56 responded. After accounting for exclusions and drop-outs, 20 healthcare professionals effectively participated in the study. [Figure 2](#) provides a detailed overview of the recruitment and participation process.

Figure 2.

Flowchart of the recruitment and participation process



5.4. Ethical considerations

Participation was based on informed consent, both the actresses in the video vignettes ([Appendix 5](#)) and the participating doctors ([Appendix 6](#)) signed before taking part. The actresses were fully briefed on the study's aims, scope, analytical focus, use of the video material, and all relevant ethical considerations, including voluntary participation and data handling procedures.

For the doctors, the informed consent process was intentionally not fully transparent regarding the study's specific analytical focus. The following information was provided to them: an outline of the interview procedure, the voluntary nature of participation, the right to withdraw at any stage without consequence, the procedures for data collection, storage, and anonymization, and the notice that they would view a vignette depicting a patient requesting a genital modification. The study was presented to them as an exploration of clinical decision-making.

The specific focus on cultural and racialized perceptions, as well as the existence of multiple vignette versions, was deliberately withheld. This approach, often used in research on discriminatory biases, helps minimize priming effects, prevents participants from tailoring their responses to explicit cues, and reduces the likelihood of socially desirable answers, thereby preserving the authenticity of their reasoning (Gaddis, 2022; Riach & Rich, 2004). The full research focus was disclosed only at the end of the interview, and only if participants asked about it.

5.5. Data analysis

The interview recordings were transcribed in Dutch and an open coding approach was used for the initial coding to identify meaningful units of text that captured the participants' interpretations, reasoning processes and reflections on the vignette (Corbin & Strauss, 2008). Codes were continually compared across interviews to detect recurring patterns as well as differences in how the same clinical situation was understood.

From this process, three overarching themes were developed for the results chapter, applied separately to each video vignette: (1) interpretations of the video vignette, (2) autonomy and consent, and (3) the borderland between FGM/C and FGCS

Subthemes within each category were refined through axial coding (Roose & Meuleman, 2023), which allowed related codes to be merged into broader conceptual groupings. Translated quotations are included in the thesis to illustrate key points. Similar statements were consolidated, and contrasting viewpoints were placed side-by-side to highlight variation while avoiding redundancy.

At the end of each interview, a brief oral demographic survey was conducted to gather background information such as gender, years of professional experience, and type of clinical setting. These sociodemographic data, summarized in [Table 3](#), were not coded thematically, they informed the interpretation of qualitative findings. This strategy ensured that the analysis stayed firmly anchored in participants' own words while directly engaging with the study's research questions on cultural bias and the classification of female genital modifications.

5.6. Expected outcomes

This study aims to provide detailed insight into how Belgian medical professionals approach requests from patients for female genital modification. By analyzing responses to standardized video vignettes depicting patients of different ethnicities and cultures, the research aims to reveal

possible differences in the assessment of autonomy, legitimacy and clinical necessity. It is expected that patients identifying as Western may be more readily perceived as independent decision-makers acting out of personal preference, whereas patients from ethnic minorities may be perceived as subject to cultural or patriarchal pressures, even when motivations are comparable (Florquin and Richard, 2020; Shahvisi, 2021).

The findings are also likely to shed light on how existing legal provisions and professional ethical codes are applied and whether these interpretations change depending on the patient's perceived background. Such results would contribute to broader discussions on cultural bias, the unequal regulation of health and cosmetic procedures, and the potential for medical paternalism (Boddy, 2016; Florquin and Richard, 2020; Shahvisi, 2021).

5.7. Personal reflection

As a white, Western woman with a background in social and political sciences, I was aware that my positionality could influence both the design and interpretation of this study. My commitments to gender equality and bodily autonomy informed my interest in exploring healthcare professionals' perspectives on adult women's requests for genital modifications, but I aimed to do so without imposing my own moral stance. Maintaining this openness required conscious reflexivity, especially when participants expressed views that diverged from my own.

The video vignettes used in the study were created by me, each depicting the same patient request but varying in racial, cultural, or religious presentation. This design reflected the core aim of investigating whether these identity markers influenced medical decision-making. Taking on the dual role of stimulus designer and interviewer made it essential to remain aware of my own assumptions and to guard against letting them influence data collection or analysis.

To reduce interpretive bias, the analysis began with inductive coding grounded in participants' words before introducing relevant theoretical perspectives. In conducting interviews, I paid close attention to my phrasing, tone, and reactions when addressing sensitive topics such as religion, cultural norms, and gender expectations, with the aim of avoiding reinforcement of stereotypes or alienating participants.

Interviews were approached as opportunities for open, two-way dialogue rather than as a means to confirm pre-existing assumptions. By actively reflecting on my role throughout the research process, I sought to ensure that my positionality functioned as an asset, enhancing the ethical integrity, fairness, and analytical depth of the study, rather than as a source of bias.

6. Results

A total of 20 Belgian doctors participated in this study (see [Table 4](#)). The sample included 12 plastic surgeons and 8 gynecologists, with a mix of 11 men and 9 women. The participants' ages ranged from their early-thirties to their mid-seventies (mean ≈ 49 years), and their clinical experience ranged from 1 to 50 years (mean ≈ 18 years). Almost all interviewees were Belgian nationals (18/20), two doctors (one plastic surgeon and one gynecologist) came from neighboring countries.

The doctors were, at random, evenly distributed across the vignettes, and the specializations were also proportionally represented within each vignette. Among the plastic surgeons, four viewed vignette A, four viewed vignette B, and four viewed vignette C. Among the gynecologists, three viewed vignette A, three viewed vignette B, and two viewed vignette C. Overall, the video-vignette allocation was balanced: seven participants viewed vignette A, seven vignette B, and six vignette C, ensuring that each scenario received comparable discussion.

To protect confidentiality, each doctor has been assigned an anonymized code. Codes beginning with 'G' denote gynecologists (G1 – G8) and codes beginning with 'PS' denote plastic surgeons (PS1 – PS12). These codes are used throughout the results chapter when quoting or paraphrasing individual interviewees.

Table 4.

Sociodemographic characteristics of the medical professionals interviewed (N = 20)

Code	Specialty	Gender	Age (approx.in years)	Years in practice	Vignette viewed	Workplace Setting
PS1	Plastic surgeon	Female	35	1	B	Private and public
G1	Gynecologist	Female	34	7	A	Private and public
PS2	Plastic surgeon	Male	40	7½	A	Public hospital
G2	Gynecologist	Male	76	50	A	Public hospital
G3	Gynecologist	Male	57	23	B	Public hospital
PS3	Plastic surgeon	Male	61	29	C	Private and public
G4	Gynecologist	Female	58	33	A	Private and public
G5	Gynecologist	Female	34	4	B	Private and public
PS4	Plastic surgeon	Male	61	30	A	Private and public
PS5	Plastic surgeon	Male	54	18	C	Private and public
PS6	Plastic surgeon	Male	70	35	B	Public hospital
PS7	Plastic surgeon	Male	49	16	B	Private and public
G6	Gynecologist	Male	69	32	C	Private and public
PS8	Plastic surgeon	Male	38	5	A	Private and public
G7	Gynecologist	Male	46	21	C	Private and public
PS9	Plastic surgeon	Female	31	1	A	Private and public
PS10	Plastic surgeon	Female	41	10	C	Private and public
PS11	Plastic surgeon	Female	34	3	C	Private and public
G8	Gynecologist	Female	57	25	B	Public hospital
PS12	Plastic surgeon	Female	40	8	B	Private and public

The central aim of these interviews was to explore how the perceived racial or cultural background of patients influenced the diagnostic reasoning, terminology and ethical responses of medical professionals, and to what extent. Particular focus was given to whether physicians interpreted the request as labiaplasty or as FGM/C.

The following sections present the results of each video vignette in three thematic categories, highlighting recurring patterns, differences and tensions across the interviews. The themes are: (1) interpretations of the video, (2) autonomy and consent, and (3) the perceived boundary between FGCS and FGM/C. Within each theme, sub-themes are explored and contrasted across the three video conditions.

6.1. Interpretations of the video vignettes

6.1.1. Understanding the nature of the request

Across all three video vignettes, most clinicians appeared to interpret the scenario as a request for labiaplasty, perceiving it as a realistic portrayal of routine clinical consultations. However, the subtle variations in the patient's perceived identity seemed to shape how clinicians evaluated the underlying motives and credibility of the request.

In Video A (a white, Flemish-speaking woman), the request was generally described as familiar and plausible. However, several clinicians observed that the patient's wording was sometimes vague and hesitant, and that she did not provide a clear medical indication. They interpreted her hesitation as uncertainty, embarrassment, or difficulty in articulating her concerns. Some doctors said that their patients tend to be more explicit in their requests.

This perceived vagueness, however, was not treated as a direct reason to reject the request. Instead, it was by some physicians interpreted as an understandable emotional discomfort. A few doctors even saw it as a sign of courage. One clinician described: "She was nervous, making little eye contact and looking left and right. That showed that it took her a big step to come here" (PS9). Others speculated that the patient's concerns stemmed from social comparison or exposure to idealized genital images, expressing caution about approving surgery based solely on these pressures. Nevertheless, in most cases, her legitimacy appeared to be presumed and her autonomy was not actively questioned.

In Video B (a black, Flemish-speaking woman without a headscarf), doctors seemed to interpret the request in a similar way to Video A, particularly when the patient referred to physical discomfort. As one noted, "The majority of women who come to me mention pain or discomfort, especially with tight clothing or during sex. That is usually the core of the issue" (PS7).

However, as the vignette progressed and the patient started to mention aesthetic concerns and fear of social judgement, some doctors' views shifted. They increasingly saw the motivation as driven by appearance rather than function, which raised doubts about the medical necessity of the request. As one respondent remarked: "Later on, we are pushed in a certain direction, towards someone who is extremely anxious about how she looks and afraid of being judged" (PS7).

Some doctors remarked that the patient's delivery felt hesitant or 'bizarre' compared to real-life consultations (PS1, PS3). While some attributed this to the artificiality of the vignette, others seemed to view it as a possible sign of indecision, immaturity, or diminished autonomy. Although the patient's racial identity was not explicitly cited as a factor (during their first interpretation of the video), her perceived youth and hesitance appeared to lower confidence in the credibility of her request.

In Video C (a black, Flemish-speaking woman with a headscarf), skepticism among some doctors intensified. While almost all doctors again identified the request as a labiaplasty, several questioned the authenticity of the stated complaints. Some noted again that the patient expressed herself vaguely and emotionally hesitant, but some linked this behavior to a new impression. Two surgeons noted that the patient may have framed her request using acceptable medical narratives, such as discomfort during sports or intercourse, to mask an underlying aesthetic concern. As one surgeon explained, "They often say it bothers them during sports or intercourse, but those are stories they have learned to tell, deep down, it is about how it looks" (PS3).

Another noted that we should be more cautious and not believe everything right away, and that the consultation could also be a form of performance, remarking that “women use the reasons they know we find acceptable” (PS5), suggesting the patient could be navigating medical expectations strategically. One clinician even dismissed the notion of physical pain entirely, stating, “I have never had someone complain about pain in the labia. That does not exist. If it occurs, it is psychosomatic” (PS3), and acknowledged tending to take pain expressed by non-Western women less seriously due to perceived communication or interpretation barriers.

Despite these critical reflections, there were also more neutral or nuanced assessments. Even, some directly expressed a greater openness to the legitimacy of the woman’s psychological concerns, even if the physical indications were unclear (G7 and PS5). One physician remarked, “I see that she is truly struggling. She feels ashamed and uncomfortable in her body. That can be a valid reason for such a request” (G7). Another noted, “If a woman says, I feel ashamed. I do not want to have sex because of how I look, that is a real concern too. It does not have to be ‘medical’ in the traditional sense to be valid” (G6).

Across the vignettes, the interpreted request generally remained within the boundaries of standard labiaplasty consultations. However, the vagueness of the patients’ narratives appeared to be interpreted differently depending on their perceived identities: as an understandable embarrassment in Video A, a possible ambivalence in Video B, and a potential concealment or external influence in Video C. This suggests that similar communicative styles may be interpreted very differently when filtered through identity-based expectations.

6.1.2. Clinical approach and diagnostic framing

Despite differences in how patient motivations were interpreted, physicians across all three vignettes described a consistent consultation structure. As shown in [Figure 3](#), this process could be understood in three stages, each acting as a gatekeeping mechanism through which the legitimacy of the request was evaluated.

1. **Anamnesis**

In the first stage, most clinicians aimed to gain an in-depth understanding of the patient’s background and the underlying motivations. This often involved a detailed exploration of both physical symptoms and contextual factors, such as when the condition first appeared and life events that may have contributed to it.

Beyond physical health, psychological and social dimensions were sometimes also addressed. Some doctors mentioned that they would probe into the patient’s body image, levels of self-confidence, perceived or real reactions from intimate partners, and possible cultural or societal pressures influencing the request. As one doctor mentioned: “You treat the whole patient. Not just what you see, but what is going on in their mind too” (G6). The aim was to evaluate the full spectrum of factors, biomedical, psychological, and sociocultural, that may shape the patient’s experience and expectations. Although, it is important to note that not all medical professionals would adopt this psychological and social approach of probing. Some saying that they would have a quicker look down there, after the anamnesis. While no decisions are made at this point, this step helps doctors form a first impression of the request and its context.

They remain open and listen carefully, without yet directly assessing whether the request is legitimate or acceptable.

2. **Clinical examination**

A physical examination followed in all cases, functioning as a second filter. Doctors emphasized that they should not act solely based on complaints, but that they should also examine the anatomy and determine whether it deviated from what they considered normal. Even when symptoms seemed plausible, physical findings were used to confirm indications for surgery. Some felt that hypertrophy, asymmetry, or abnormalities had to be visually identified or confirmed by irritation in order to justify surgical intervention. For others, the examination was also an educational tool, used to reassure the patient that her anatomy was within a normal range or to explain the potential benefits and risks of surgery. In some cases, doctors described how they would use a mirror during the examination with the patient, to establish a shared vocabulary, as one states: “I let her look in the mirror with me. It is important that she sees what I see, so we are speaking the same language” (PS7).

3. **Case-by-case decision-making**

After collecting motivational and clinical information, doctors made individual judgements about the acceptability of each request. In the absence of standardized medical guidelines, these judgements relied instead on each practitioner’s professional boundaries and ethical frameworks.

Some doctors followed a strict medical approach, only accepting patients with persistent physical complaints and rejecting those seeking purely aesthetic procedures. Others were open to aesthetic or mixed motives if the procedure was considered safe and beneficial. As one surgeon explained: “People have their own body, so they may choose what to do with it. if I believe it will bring benefit and I can perform it safely, then yes, I consider it” (PS9). Another doctor stated, “Even if it does not look extreme, that does not mean the patient is not struggling. But I still need objective evidence before considering surgery” (PS10). Several also emphasized on the importance of a cooling off period, “I always ask them to come back after at least two weeks. It is a surgical procedure, it has to be thought through” (PS10). This is to guard against impulsive decisions and detect external pressure.

These positions formed a spectrum: physicians who were open to aesthetic motives generally accepted functional and mixed cases, whereas those who required medical necessity rejected aesthetic requests outright. The categories were cumulative rather than fixed, creating a gradient of clinical acceptability.

Throughout this process, doctors’ subjective views of normalcy and suffering shaped the determination of what constituted a ‘legitimate’ request. Decisions were guided by physical findings and interpretations of the patient’s social and cultural context.

6.1.3. Influence of perceived identity

Although anamnesis and examination followed a comparable structure across all vignettes, the focus and intensity of the questioning often shifted based on the patient’s perceived identity. Several physicians acknowledged that cues such as age, race, religion, clothing, and mannerisms shaped their clinical vigilance.

In Video A and B, multiple doctors assumed the patient was a minor based on her youthful appearance and stated they would involve parents or refer her to a psychologist. In Video C, the presence of a headscarf led many to associate the request with religious or cultural conservatism. As one explained: “The headscarf stood out. It made me think of religion or conservatism. That definitely played a role in how I approached her story” (PS5). Another (PS6) indicated that he would probe more thoroughly for trauma, familial expectations, or symbolic procedures like hymen repair when treating patients with non-Western features.

While such vigilance may be motivated by past experience, it risks reinforcing stereotypes and subjecting certain groups to disproportionate scrutiny. More than half of the doctors (G5, G6, G8, PS5, PS6, PS8–PS12) admitted that the possibility of FGM/C “might come to mind more quickly” with a black patient of African heritage than with a white patient (G5). While some explained this as experience-based vigilance, it risks reinforcing stereotypes and subjecting certain groups to disproportionate scrutiny.

Not all identity-based considerations were linked to concerns about cultural coercion. Some doctors introduced additional medical precautions based on racial characteristics. Half of the practitioners, who saw video B or C, mentioned that they would warn patients with darker skin about the increased risk of hypertrophic scarring, which is more prevalent among people of African descent.

In conclusion, while the clinical pathways capture a common clinical structure, they also reveal the discretionary space in which individual, cultural and normative judgments intersect. In the absence of a universally accepted set of diagnostic criteria, medical professionals are compelled to rely on personal thresholds that are shaped by their personal values, life experiences, and professional assumptions. This variability has concrete implications for the evaluation of patient requests and the decision to either legitimize or deny them. These variations highlight the necessity for critical reflection on the construction of autonomy, harm and bodily normalcy, and the groups to whom they are made available. The following section will examine these dynamics in depth.

6.2. Conditional autonomy

Across all three vignettes, medical professionals emphasized that adult women have the right to make decisions about their own bodies. In practice, however, the assessment of autonomy was not simply a matter of age or legal competence, but rather a situational judgment shaped by perceived motivation. Before proceeding to any physical examination, doctors primarily evaluated whether the request appeared internally motivated, socially conditioned, or culturally imposed. The degree to which a woman’s decision was seen as autonomous depended on how her narrative, identity, and background were interpreted.

6.2.1. Presumed autonomy within normative Western frameworks

In Video A, most doctors assumed the patient to be bodily autonomous. Her request was often interpreted as self-initiated, rational, and grounded in personal discomfort or aesthetic preference. As one stated: “If it is her own wish and not imposed by someone else, then that is nobody else’s business” (PS9), reflecting a liberal framework of autonomy applied to patients who align with normative Western expectations.

However, this presumption of autonomy was not unconditional. Doubts emerged when the woman appeared young, lacked sexual experience, or struggled to articulate her motivations. Rather than being framed in cultural terms, these concerns were framed in developmental terms, leading to more cautious approaches such as extended consultations, additional education, or advice to postpone surgery. “With someone who is young, insecure or inexperienced, I spend more time explaining things and often send them home to think about it” (PS2). Others stressed that older women possess more bodily awareness and life experience, and can therefore “give consent” more easily (G1). Thus, autonomy was assessed relationally, through indicators of maturity, emotional stability, and self-knowledge, rather than simply assumed.

Even when autonomy was granted, clinicians continued to evaluate patients’ motivations. Those linked to insecurity, beauty ideals, social media trends, or a partner’s preferences were met with caution. However, these factors (except for the partner factor) were generally understood as lifestyle influences rather than coercive forces, and were rarely considered problematic unless they dominated the decision-making process. If such influences were present but not seen as dominant, the procedure was often still deemed acceptable. Several physicians noted that Western beauty standards were largely internalized and normalized, rather than recognized as threats to autonomy.

As a result, explicit coercion or overt social pressure was largely absent from discussions of Video A. While some acknowledged the possibility of influence from partners or family, these concerns were rarely raised. Only when prompted directly did some doctors consider that Western women might also be influenced by external norms. As one doctor explained, “Many women worry their partner might find it ugly, that is still one of the main reasons they come to us” (PS2). Another commented, “Today, there is more comparison, more talk, and a stronger drive toward the ideal image. Social media plays a big role in this” (G2). However, such pressures were generally described as diffuse and culturally embedded rather than as coercive or morally problematic.

Several doctors later admitted that they might have exercised more caution if the patient’s identity had been more clearly marked by culture or religion. When presented with a hypothetical scenario involving a veiled woman of a non-European background, they acknowledged that they would have exercised more caution. “If a woman wears a headscarf, we are more likely to assume the request is religiously motivated”, one respondent acknowledged (PS2). Another added, “If there is a dominant man involved, I want to talk to him too. Because then the question becomes: is she doing this freely, or to avoid rejection?” (G2). These reflections suggest that trust in autonomy is not applied uniformly, but is instead shaped by implicit assumptions about race, religion, and culture.

6.2.2. Autonomy affirmed, but tested through clarity and confidence

In Video B, most physicians initially presumed the patient to be autonomous. The fact that she was able to articulate her request independently, without the presence of a partner or family member, was often seen as a sign of informed agency. Several noted that women requesting labiaplasty usually think about it for a long time before consulting a doctor. However, as in Video A, those who appeared hesitant or emotionally conflicted prompted some to probe further into their underlying motivations.

These decisions were based on the degree of emotional clarity and perceived confidence. Physicians sought to determine whether the request stemmed from an internal desire or external pressure. Follow-up questions often explored peer influence, body image concerns and potential partner expectations. While Western cultural pressures, such as beauty ideals and media influence,

were acknowledged, they were generally discussed in the context of background influences rather than as direct coercion. By contrast, non-Western cultural influences were more likely to be framed as potential sites of concern.

These concerns became more pronounced when the doctors perceived the patient as being from a racial or ethnic minority background. Several participants then speculated, sometimes implicitly, that she might have African origins, occasionally linking this perception to practices such as genital mutilation. This assumption could result in more structured questioning about family expectations, relationship dynamics and symbolic or ritual practices. Previous clinical experiences involving hymen repair or ritual cutting often informed this cautious approach.

Such heightened vigilance was not without ambivalence. Some clinicians acknowledged the risk of reproducing bias and explicitly warned against cultural pathologizing. As one remarked, “Women here do it for the same reasons: porn, social media, peer pressure. That is a form of cultural pressure too” (G5). Another cautioned that assuming cultural or religious markers, such as a headscarf, automatically signal coercion would be prejudiced in itself (PS1). These perspectives argued for recognizing that Western norms are equally capable of exerting social pressure.

Nevertheless, some participants admitted that patients who did not fit the dominant white, Western profile were often subject to greater scrutiny, whether this was framed as bias or as a precaution to safeguard consent. “Maybe it is a form of bias”, one doctor reflected, “but I want to believe I approach it mindfully” (PS6). Interestingly, such reflections tended to emerge during hypothetical discussions rather than in direct responses to the vignette itself. While few suspected coercion in the video scenario, many admitted that a patient’s racial background could influence the rigor with which they would assess her motivations in a real consultation.

Overall, the principle that adult women can make autonomous choices about their bodies was widely upheld. However, this principle appeared to be more widely accepted when it aligned with dominant Western norms, such as doing it ‘for herself’. When a patient was perceived as being outside these norms, her motivations were more likely to be questioned, either subtly or explicitly, through additional diagnostic and ethical enquiries. While racial background did not formally prevent consent, it often triggered deeper scrutiny, suggesting that trust in autonomy is not applied uniformly, but is influenced by perceptions of race, culture and vulnerability.

6.2.3. Cultural markers as triggers for heightened scrutiny

In Video C, the patient’s autonomy was both affirmed and questioned. While most doctors stated that they treated all patients equally, “I treat every patient the same, whether Chinese, South American or African” (G6), several acknowledged that visible cultural or religious markers, such as the headscarf, led to additional scrutiny. These visual cues were often interpreted as potential signs of cultural or religious pressure, resulting in more cautious and thorough consultations.

Several participants admitted that the woman’s conservative appearance raised questions about the authenticity of her request. Some viewed it as a sign that her motivations might stem from collective (non-western) cultural expectations rather than personal choice. One plastic surgeon expressed this hesitation directly: “You cannot just treat that like any other case. There is a whole other world behind it” (PS11). While such caution was often framed as protective or preventive, several acknowledged the possibility that these assumptions reflected unconscious bias. In these cases, cultural difference was visible and thus more easily subject to suspicion. Some doctors also

linked her perceived background with mutilation. This dynamic illustrates how the presence of religious or ethnic markers can shift a medical encounter from neutral evaluation to heightened suspicion.

One doctor stood out among the participants for his explicitly racialized and exclusionary response. He dismissed the scenario as entirely implausible and alien, stating: “Why is there a veiled woman? A black, veiled woman? That is very atypical here. We are in Europe. Not Congo” (PS3). His immediate rejection of the request was not based on clinical criteria or the woman’s explanation, but on her identity. Unlike his peers, he did not provide a scenario in which he would consider the request legitimate, thereby denying the patient’s agency altogether. His concept of autonomy was firmly rooted in Eurocentric norms and excluded cultural others by default.

In contrast, some clinicians showed a certain degree of reflexivity regarding their own assumptions. One noted: “I try not to project what I think I know about a culture onto someone. But I cannot deny that it enters the room with me” (PS10). However, even when self-awareness was present, it often coexisted with precautionary measures, such as prolonging consultations or delaying decisions, which were less commonly applied to white or secular patients. Although these strategies were described as safeguarding consent, they also reflected the uneven application of suspicion based on perceived cultural identity.

Nevertheless, most doctors insisted that a patient’s cultural background alone was not sufficient to reject a patient’s request. Doubts were said to arise only when there was a mismatch between the patient’s narrative and the clinical findings. As one doctor clarified: “If everything looks normal and the patient insists, then yes, I start to wonder whether she is doing it for herself. But I do not assume that from the start” (G6). In cases where a visible aesthetic or functional irregularity was observed, the request was framed as a legitimate correction rather than mutilation, regardless of the woman’s ethnic or religious identity. This suggests that biomedical evidence could override cultural suspicion, but also reveals how normative ideas of bodily deviation mediate access to autonomy.

6.2.4. Cross-case patterns of conditional trust

Across all cases (A, B and C), the concept of patient autonomy was examined through an often unequal and layered lens. Women who appeared hesitant or uncertain, or who were visibly different due to their culture or religion, were more frequently required to justify their requests in greater depth. These patients encountered a higher threshold of credibility, suggesting that trust in their self-determination was conditional. Although some doctors did reflect critically on this imbalance, questioning why Western beauty norms were not regarded as equally culturally constructed, the dominant clinical discourse upheld a dichotomy between internal, individualized motivations (deemed legitimate) and external, culturally influenced ones (deemed suspect).

Although most doctors emphasized that they would not assume coercion outright and that each case would be assessed individually, the broader pattern revealed an uneven application of this ideal. Patients who were perceived as culturally ‘other’ were often presumed to be more vulnerable to external pressure, and their capacity for autonomous decision-making had to be demonstrated rather than presumed. By contrast, Western patients were more readily given the benefit of the doubt, even when their motivations aligned with prevailing social or aesthetic trends. This asymmetry reflects how structural bias can manifest in individualized care, under the guise of caution or professionalism.

A further dimension concerned the interplay between patient and physician autonomy. Several participants stressed that, even when a patient made a clear, informed and voluntary request, the clinician retained the right to refuse the procedure. Such refusals were not framed as denials of care, but rather as expressions of professional ethics and clinical judgement. In this way, physicians positioned themselves as both medical experts and moral gatekeepers, particularly in cases where the boundaries between cultural practice, aesthetic preference, and medical necessity were blurred.

Overall, these findings suggest that autonomy was treated less as a fixed legal status and more as an interpretive, relational process. It depended on how convincingly patients articulated their motivations, as well as on how clinicians judged the cultural legitimacy of those motivations. This subjectivity highlights the fragility of presumed neutrality in clinical encounters and foreshadows the critical discussion in the next chapter.

6.3. The borderland between FGM/C and FGCS

This third theme looks at how physicians told the difference between FGCS and FGM/C. While labiaplasty is legal in Belgium and is often framed as a matter of personal choice, FGM/C is criminalized regardless of consent. The anatomical overlap, particularly between labiaplasty and WHO Type II FGM/C, complicates this legal and ethical boundary. Interviews revealed varying and sometimes evolving views on whether requests from adult women for culturally meaningful genital modifications can ever be accommodated, and on how consent, cultural motivation, and professional scope interact in decision-making.

6.3.1. Framing the request: formal distinctions and underlying tensions

When first asked about the nature of the request in the video vignettes, almost all participants identified it as labiaplasty, regardless of the woman's ethnicity, religion, or appearance. None initially classified it as FGM/C. Later in the interviews, when the topic of FGM/C was explicitly raised, either by the interviewee or the interviewer, doctors offered strong moral and legal rejections of the practice, describing it as unethical, medically unnecessary, and culturally coercive. It was consistently associated with minors, non-Western traditions, and procedures carried out in non-medical settings.

By contrast, FGCS, particularly labiaplasty, was generally presented as a legitimate procedure when performed in clinical settings on consenting adults, often for aesthetic or functional purposes. As one surgeon put it: "FGM/C happens under coercion, it is a ritual that is often forced on children. What we do here is individual, voluntary and safe" (PS7). In this dominant narrative, FGCS was framed around autonomy, while FGM/C was framed around oppression.

However, several participants acknowledged that the anatomical results of some labiaplasties, particularly those involving a substantial reduction of the labia minora, can closely resemble with Type II FGM/C. For some, the patient's motivation was the decisive ethical factor, for others, this did not fully resolve the ambiguity. One gynecologist reflected: "If the result is the same, whether for aesthetic or symbolic reasons, why should we treat them differently?" (G5). Another surgeon remarked that "both practices alter nature", suggesting that cultural identity rather than anatomy often determines classification (PS1).

These reflections reveal that while a formal ethical and legal distinction between FGCS and FGM/C is widely upheld, its practical application can be less clear-cut, particularly when outcomes converge.

6.3.2. Consent, culture and conditional autonomy

When presented with hypothetical cases of adult women requesting genital modifications for non-Western cultural or symbolic reasons, many doctors' openness narrowed. Cultural motivations were frequently interpreted as evidence of coercion, reclassifying the request as FGM/C. Even those who stressed bodily autonomy in earlier parts of the interview qualified this by insisting that consent must be 'culturally free'. As one gynecologist explained: "If the psychological discomfort turns out to be culturally influenced, then it becomes a no-go" (G6).

This conditional understanding of autonomy stood in sharp contrast to the treatment of Western aesthetic motives, which were generally accepted as legitimate personal choices. Some doctors challenged this asymmetry. One surgeon argued: "The assumption is that they cannot possibly want it. But if they do, then it is discriminatory to deny them that choice" (PS5). Another accepted the possibility of performing a Type II procedure for an informed adult: "If an adult woman requests it, fully understands the risks and meaning, and the technique is safe, then it should definitely have a place in clinical practice" (G7). A third likened it to harm reduction: "It is like giving clean needles to drug addicts. You do not approve of the act, but you reduce the damage" (PS11).

These divergent views underline the central tension: whether non-Western cultural motivations should automatically invalidate a woman's request, or whether autonomy should be applied, regardless of cultural origin.

6.3.3. Terminology, moral frameworks, and implicit hierarchies

The term mutilation carried strong ethical weight for all participants and was unanimously applied to non-consensual procedures on minors. However, its use for adult-requested modifications was contested. Some felt the term implied unavoidable harm, which was not appropriate in cases where an informed adult sought the procedure. One surgeon stated: "It implies harm is being done, but in some cases, such as when an adult woman understands the risks, it becomes more of a choice" (PS1). Another criticized the binary framing of mutilation versus cosmetic surgery, arguing that it fails to account for the interplay between agency and cultural norms (G5). A different doctor emphasized that, while he would never perform FGM/C on minors, adult women's choices should not be dismissed outright: "No one is ever completely free of influence, but that does not mean they cannot make a real choice" (PS7).

A few spoke openly about contradictions in their own practice, sometimes without reflecting on them. One surgeon described FGM/C as "barbaric" but stated that he would perform an extreme labia amputation on a white woman if she requested it (PS3), adding: "The customer is king". However, similar procedures requested by non-Western women were classified as FGM/C and refused by that surgeon. Others noted the discrepancy: "We say, 'They do it because of their culture'. But do not women here also do it because of their culture?" (G5). Another added: "Cultural influences are everywhere. Pornography also promotes labiaplasty. Are we really sure that Western women are making free choices?" (PS10).

These comments point to implicit racial hierarchies in how autonomy is recognized: Western aesthetic procedures were rarely labelled mutilation, while similar non-Western requests were criminalized. Such contradictions highlight the inconsistent application of terminology based on the patient's identity.

6.3.4. Professional scope, legal boundaries, and evolving positions

Willingness to perform genital modifications was shaped by doctors' self-defined professional scope. As shown in [Figure 3](#), participants' baseline practice ranged from operating only for clear medical indications, to combining medical and aesthetic motives, to accepting purely aesthetic requests. These categories provide important context for understanding how attitudes shifted when the same request was framed as culturally non-Western.

Across all groups, the introduction of a non-Western cultural motivation frequently led to more restrictive decision-making, as shown in [Table 5](#). Even surgeons in the 'aesthetic' category, who would normally accept physical and appearance-related requests, sometimes refused or set stricter conditions, even in cases of physical or aesthetic abnormality. Some participants declined all such cases outright, regardless of medical need. A smaller group were only willing to proceed if there were clear functional problems, while others considered cases on a case-by-case basis provided the intervention was safe and technically feasible and aligned with their judgement. By contrast, for Western-motivated requests, these same doctors often operated without such constraints.

Table 5.

Professional scope and willingness to operate by cultural framing of request

Professional scope	Willingness for Western-motivated requests	Willingness for culturally non-Western requests
Medical-only	G5, G4, G1, PS2	Refuse regardless: G1, G5 Only if medical: PS2, G4
Combination	PS11, G8, G6, G3, G2	Refuse regardless: PS11, G6, G2 Only if medical: G3, G8
Aesthetic	PS12, PS10, PS9, PS8, PS7, PS6, PS5, PS4, PS1, G7	Refuse regardless: PS10, PS5, PS6 Case-by-case: PS12, PS9, PS8, PS7, PS4, PS1, G7
Outlier (Complete labial amputation if requested)	PS3	Refuse regardless: PS3

This pattern reflects the conditional nature of autonomy already noted in earlier sections: the same anatomical request could be reclassified from acceptable cosmetic surgery to unacceptable FGM/C purely based on its cultural framing. This shift was not determined by anatomy or medical risk but by the perceived legitimacy of the underlying motivation.

Interviews also revealed moments of reflection and change. Some participants reconsidered their assumptions during the conversation, acknowledging that ethical boundaries were less fixed than they had believed. Others confessed they became more cautious when the patient wore a

headscarf, but were uncertain whether this was justified or prejudiced. A few questioned why similar interventions could be celebrated as autonomy in some contexts but condemned in others.

Not all were open to such reconsideration. One surgeon dismissed academic debates entirely, insisting that FGM/C “happens in Africa” and that labiaplasty is a Western consumer choice. He categorically refused requests from black veiled women, stating they did not belong in a European clinic (PS3). This outlier illustrates how personal ideology can override ethical deliberation, but also underscores that, for most participants, the boundary between acceptable and unacceptable procedures was negotiated in more complex and reflective ways.

6.3.5. Legal uncertainty, proposed reforms and a shifting boundary

All participants endorsed the zero-tolerance legal framework for FGM/C, particularly regarding minors, but several questioned its rigidity when applied to fully informed adults. One described it as “a zero-tolerance framework that does not always reflect the complexity of real-world cases” (PS7). Another cautioned, “If you tighten the legal framework without thinking it through, you risk criminalizing women’s autonomy, and that is not justice either” (PS4).

While most participants did not advocate for legislative change, some proposed more nuanced approaches. These included harm-reduction strategies or narrowly defined case-by-case exceptions, subject to strict ethical oversight. Others suggested establishing multidisciplinary expertise centers, bringing together doctors, ethicists, and legal experts, to assess complex requests. Such centers, they argued, could minimize arbitrary refusals, prevent unsafe underground procedures, and ensure decision-making remains transparent and accountable. As one noted: “There are enough guidelines. The problem is how they are interpreted. That depends on the doctor” (PS6).

Overall, the FGCS–FGM/C divide emerged as a shifting borderland rather than a fixed line. At one end, non-consensual procedures on minors were uniformly condemned. At the other, purely aesthetic labiaplasties for Western women were accepted. Between these poles lies a continuum of cases, such as adult women requesting modifications for symbolic, aesthetic, or mixed reasons, where categories blur and views diverge.

Physicians who prioritized autonomy or harm reduction were more likely to acknowledge overlaps. In contrast, those with a strictly reconstructive focus or strong cultural stereotypes tended to maintain rigid distinctions. However, across these perspectives, the label ‘mutilation’ was more often applied when non-Western culture was involved. This reveals how legal and moral boundaries can reinforce unequal recognition of bodily autonomy.

6.4. Conclusion of the results

The three themes examined above demonstrate how Belgian doctors’ responses to requests for labia reduction are influenced by racial, cultural, and professional biases. The procedure in question, labiaplasty, was considered standard when requested by a white or black woman, with occasional reservations regarding the motivation, and was viewed with greater suspicion when requested by a veiled woman. Doctors followed similar diagnostic protocols in all cases, but differed in how they weighed the patient’s account, her autonomy, and the legitimacy of her motivations. Autonomy was not a static legal status, but rather a relational judgment influenced by factors such as age, self-confidence, identity, and the doctor’s personal biases. The impact of

cultural pressure on non-Western women has been the subject of extensive critical scrutiny, while this aspect has been somewhat overlooked in the case of Western women.

In conclusion, while the legal distinction between cosmetic surgery and mutilation was formally upheld, its moral validity was called into question. Some medical professionals recognized that labelling similar procedures differently based on the patient's cultural motivations was discriminatory. However, others regarded this differentiation as a necessary form of professional gatekeeping.

7. Discussion and conclusion

7.1. Summary of key findings

Throughout the interviews, almost all of the participating doctors recognized the scenarios depicted in the vignettes as requests for labiaplasty. This was consistent regardless of the patient's perceived identity, although subsequent interpretations of motivation and acceptability varied. Doctors described a consistent three-step consultation process when responding to the requests: anamnesis, clinical examination, and case-by-case decision-making.

Although this sequence of steps was consistent, the thresholds applied within each stage varied considerably. Two factors proved decisive in shaping these thresholds: (1) the professional scope of the doctor and (2) the perceived identity of the patient.

The professional scope determined the range of acceptable motivations. Doctors who limited their practice to medically indicated surgery typically agreed to operate only when clear physical symptoms (e.g., pain, wounds, or visible hypertrophy) could be reduced. Those who also performed aesthetic procedures accepted a wider set of motivations, which could include physical symptoms but also dissatisfaction with appearance or psychosocial distress. In some cases, a combination of physical, aesthetic, and social factors was considered valid, as long as the intervention could be performed safely, offered a realistic prospect of improvement, and fell within the doctor's scope of practice.

The patient's perceived identity, particularly her racial and cultural presentation, also influenced how motivations were interpreted and how autonomy was assessed. While many doctors stated that skin colour and culture 'should not matter', the interviews revealed that these factors often shaped the depth and nature of scrutiny. Both white and black women, when presenting what doctors perceived as a legitimate request, were generally likely to have their request accepted. However, while white patients who stated they wanted the procedure 'for themselves' were typically taken at their word and faced minimal probing, black patients, those without overt markers of non-Western culture, were often subject to slightly more questioning before their request was accepted. While Western-associated influences (e.g., pornography and prevailing beauty ideals) were acknowledged as shaping these personal choices, they were rarely problematized or viewed as undermining autonomy. In other words, 'doing it for herself' was often considered as sufficient evidence of self-determination, even when the reasoning closely aligned with socially constructed Western norms.

By contrast, when a woman wearing a headscarf, or otherwise perceived as non-Western, expressed the same motivation, claiming she wished to undergo the procedure 'for herself', doctors were more likely to probe further. In these cases, visible markers of religion or cultural difference appeared to trigger greater skepticism about whether the decision was genuinely autonomous or influenced by oppressive (non-Western) cultural norms. While some doctors would accept the request after additional questioning, a few would refuse, even when the patient's reasoning was rational, and the procedure was technically feasible.

This asymmetry reveals an uneven recognition of how cultural contexts influence the decision-making. Most doctors acknowledged that no choice is made in a vacuum, yet Western beauty ideals and sexual norms were rarely scrutinized with the same rigor as non-Western cultural references.

A similar pattern emerged when the request was explicitly framed in cultural or religious terms. Most participants adhered to the legal and discursive distinction between FGCS and FGM/C,

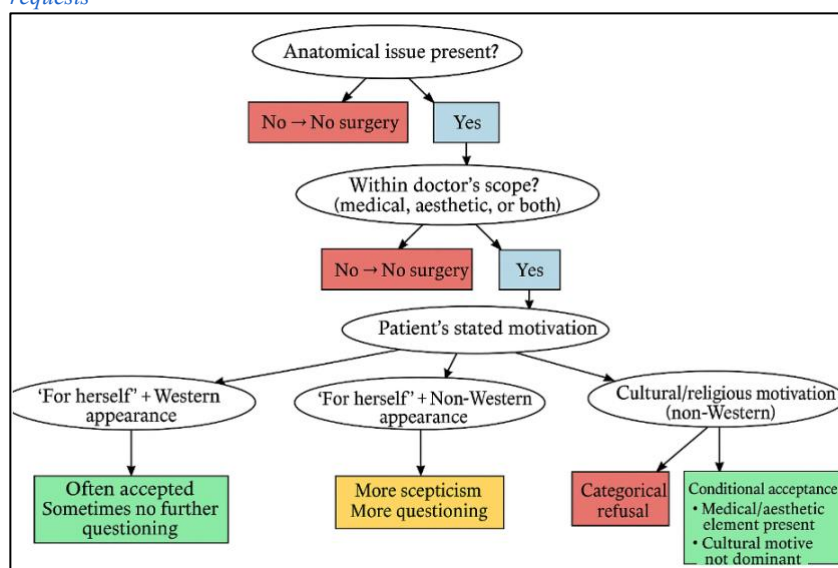
condemning the latter as inherently coercive. For many, the presence of a cultural or religious motivation, driven by non-Western contexts, was sufficient for refusal, regardless of whether they would have performed the same procedure in a different (Western) context. However, another group of doctors reconsidered their position when prompted to reflect on parallels between Western and non-Western cultural pressures. For these doctors, if the procedure could be performed safely, offered a genuine physical or aesthetic improvement, and was requested by a competent adult, they saw no reason to automatically reject it, even when the question was driven by non-Western cultural motives.

Overall, clinical judgments were shaped by the cultural meaning attributed to the request. The decision-making process followed the same broad structure for all patients, but the thresholds at which a request was accepted or refused varied according to professional scope and the patient's perceived identity. In practice, gatekeeping thresholds tightened for racialized and religiously coded patients, particularly when their motivations were interpreted as culturally driven.

This process, with its consistent stages but variable thresholds, is illustrated in [Figure 4](#). The diagram summarizes the main decision points observed in the interviews and highlights how different pathways emerged depending on the interplay between anatomical findings, professional scope, stated motivations, and perceived cultural background.

Figure 4.

Decision-making pathways described by doctors when responding to labiaplasty requests



Note: Figure 4 synthesizes the results with analytical insights from the discussion. Building on the procedural overview in Figure 3, this flowchart reflects an interpretive model highlighting potential points where patient background, appearance, or stated motivation may influence decision-making.

7.2. The interpretation of the results

The findings of this study reveal how Belgian doctors' decisions regarding labiaplasty requests are shaped by a combination of professional scope, perceived patient identity, and the cultural framing of motivations. The consultation process consistently followed a three-step structure that mirrors patterns reported in previous research (Veale et al., 2013; Zwier, 2014). However, the thresholds applied within each step varied markedly. This variation reflects deeper patterns identified in the

literature and aligns with theoretical perspectives on how race, culture, and gender intersect in medical decision-making.

The findings confirm and expand upon existing literature on the asymmetrical treatment of FGCS and FGM/C, as well as how they are classified and evaluated morally. Previous theoretical research has shown that anatomically similar procedures can be treated differently depending on their cultural and discursive context (Boddy, 2020; Florquin & Richard, 2020; Shahvisi, 2021; Van Bavel et al., 2024). In line with this, this study found that doctors were generally willing to approve labiaplasty for white and black women, particularly when the stated motivation was ‘for herself’, even though such reasoning is often shaped by Western beauty ideals and sexual norms (Braun, 2005; Sharp et al., 2016). These influences, as in prior research, were rarely problematized or seen as undermining autonomy. By contrast, when similar requests were made by women with visible markers of non-Western culture, such as wearing a headscarf, doctors were more likely to question whether the decision was genuinely self-determined, often probing for signs of coercion or cultural pressure. This finding echoes studies that have highlighted how visible racial and cultural markers can trigger assumptions about oppressive social norms, leading to a higher threshold for recognizing autonomy (Shahvisi, 2016; Florquin & Richard, 2020).

The interviews also revealed moments of friction with existing literature. While many doctors initially upheld the strict legal and normative prohibition on culturally motivated genital modifications, some did depart from that dominant discourse. When asked to compare Western and non-Western cultural influences, they agreed that all choices are made within a social context and never in a vacuum, echoing feminist bioethics’ view of autonomy as relational (Mackenzie & Stoljar, 2000). This reframing exposed the bias of accepting Western-influenced decisions as self-evidently autonomous while treating non-Western influences as suspect.

Another recurring discourse in the interviews was the assumption that FGM/C is primarily imposed by men upon women. While some doctors acknowledged other influences, many framed the practice as the product of patriarchal control, positioning women in FGM/C-practicing communities as passive recipients of male-dominated norms. This narrative, however, does not fully reflect the anthropological and sociological evidence. As numerous studies have shown, the decision to perform FGM/C is often driven by women (e.g., mothers, grandmothers, and other female relatives) who view it as a rite of passage, a prerequisite for adulthood, or a marker of beauty and hygiene within their community (Abusharaf, 2001; Ahmadu, 2000; Boddy, 2020; Gómez, 2017; WHO, 2025a). While coercion can occur, it is neither universal nor unique to non-Western contexts. Similar pressures to conform to partner preferences or societal ideals are also found in Western settings, particularly in relation to FGCS. This highlights those cultural motivations, whether Western or non-Western, can overlap, encompassing aesthetic, hygienic, social, and identity-related reasons. From a clinical perspective, the task is therefore not to categorically reject requests associated with a particular culture, but to assess on a case-by-case basis whether coercion is present, and to recognize that expressions of agency can take different forms across contexts. The tendency of world politics and global health discourses to frame non-Western women as passive victims in need of rescue (Shahvisi, 2021; Van Bavel et al., 2024) overlooks these nuances and risks reproducing the very colonial gaze that decolonial feminism seeks to dismantle.

The colonality of gender (Lugones, 2010) offers a structural explanation for this asymmetry. Colonial histories positioned Western women’s bodily practices as modern and self-directed, while framing similar practices among racialized women as primitive or harmful. The readiness to

accept white women's accounts with minimal interrogation, contrasted with deeper probing of culturalized women, reflects the persistence of these hierarchies in contemporary medicine.

Foucault's concept of power/knowledge further illuminates the mechanisms through which these distinctions are maintained. The legal and medical discourse framing FGM/C as 'mutilation' operates as a regime of truth, institutionalized through global health policies, national legislation, and professional norms (Foucault, 1980; Earp & Johnsdotter, 2021). This discourse produces categorical boundaries between legitimate and illegitimate bodily modifications, boundaries that doctors in this study navigated carefully. The willingness to accept certain requests, and the refusal of others, was not determined solely by anatomical or technical considerations, but by the dominant cultural meanings ascribed to those requests, echoing Foucault's (1980) concept of 'subjugated knowledge'. In this way, medical professionals acted as gatekeepers of legitimacy, reinforcing the discursive separation between FGCS and FGM/C while simultaneously revealing the fragility of that separation when pressed to consider adult autonomy in non-Western contexts.

An intersectional lens (Crenshaw, 1989, 1991) makes clear that these dynamics cannot be reduced to either race, culture, or gender alone. Instead, the interpretations of the requests in this study were shaped by the intersection of racialized identity, cultural background, gender norms, and medical authority. A white woman and a culturally racialized (non-Western) woman could articulate identical motivations, yet their requests were often met with subtly different levels of scrutiny. This reflects not only the interaction of multiple systems of oppression, but also the selective application of autonomy based on social positioning. By combining intersectionality with the concept of relational autonomy, these findings illustrate how assessments of consent and legitimacy are socially dependent, mediated by the doctor's perceptions of the patient's cultural identity and by the broader discursive frameworks that govern interpretations of female genital modification.

In sum, the results of this study both confirm and extend existing literature. They confirm prior observations of double standards in the treatment of FGCS and FGM/C, and they extend these by demonstrating how such distinctions are operationalized in everyday medical decision-making in Belgium. The findings further reveal that, overall, the white and black patients without overt non-Western markers were treated similarly, with only slightly more probing directed at the black patient before her request was accepted. In contrast, the patient perceived as black and visibly wearing a headscarf faced the greatest degree of skepticism and questioning. These findings illustrate how deeply embedded discursive frameworks, rooted in colonial histories, sustained by medical authority, and intersecting with racial and gender identities, shape not only whether a request is accepted, but how autonomy itself is recognized.

7.3. Strengths and limitations

This study has both strengths and limitations that should be considered when interpreting its findings. Firstly, the study's scope was limited both geographically and linguistically, as most participants were doctors from East Flanders and all interviews were conducted in Dutch. Consequently, only Dutch-speaking professionals were included, which may have excluded perspectives from French-speaking practitioners in other regions of Belgium. For example, in Brussels, where the medical workforce is more culturally and linguistically diverse, healthcare professionals may encounter a broader range of patient backgrounds and experiences, potentially influencing how they interpret and respond to requests for genital modification and how they weigh cultural, ethical, and legal considerations. The sample size was also limited to twenty doctors, and participation was voluntary, introducing the possibility of selection bias. Those who chose to take part may have had a particular interest in, or openness to, discussing female genital

modification, which could affect the range of views represented. This means that the results cannot be generalized to Belgian healthcare professionals or to other national contexts.

A major strength of this study was its use of video vignettes. By presenting all participants with the same recorded consultation, the method ensured a standardized stimulus, making it possible to systematically compare responses. At the same time, the vignettes were realistic and detailed enough to transcend a purely hypothetical scenario. Participants were able to observe not only the verbal content of the request, but also non-verbal cues such as tone, hesitation and body language. All of these factors can influence real-life decision-making. This visual and contextual detail anchored the discussion, enabling participants to engage with the patient as an individual rather than an abstract case. It also helped to surface implicit assumptions about identity, culture, and motivation that might not emerge in a verbal interview alone. In this sense, the vignettes acted as a bridge between structured comparability and the complexity of real consultations, adding both depth and analytical rigor to the study.

However, while the video vignette methodology used in the study was valuable for standardizing the stimulus across participants, it could not fully replicate the dynamics of real-life consultations. Doctors' responses in an interview setting may differ from those in their usual practice, particularly when faced with patient's emotions, time constraints, or institutional pressures. The absence of immediate clinical consequences may have encouraged more considered and idealized responses than would have been given in the situation itself. Additionally, social desirability bias may also have influenced interviewees to present themselves as more culturally sensitive or egalitarian than they are in practice. Conversely, while one doctor's overtly racist response may not be representative, it does highlight the spectrum of views.

Finally, the research focused exclusively on the perspectives of doctors. While this aligns with the aim of examining medical decision-making processes, it means that the views of patients were not considered. Consequently, the analysis is unable to capture how women experience these consultations, how they interpret questions about their motivations, or how they perceive the fairness of outcomes. Including patient perspectives would provide valuable additional insight into the real-life consequences of the asymmetries identified in this study. While these limitations do not undermine the validity of the findings, they do indicate that the findings should be understood as exploratory rather than definitive. Nevertheless, combining video vignettes with in-depth interviews offered a unique approach, providing valuable insights into how cultural and racial bias may influence decisions regarding female genital modification.

7.4. Recommendations for further research and practice

These findings have practical, ethical, and policy implications. Firstly, this study highlights the need for empirical research into how race, and culture interact with medical decision-making processes. Future research should examine larger and more diverse samples, including doctors from different regions, countries, and healthcare systems. Comparative studies could examine how legal frameworks, such as those that criminalize FGM/C while permitting FGCS, influence clinical practice. Secondly, investigations should also include the perspectives of patients, particularly those from racialized and religious minorities, in order to understand their experiences of navigating healthcare systems and encountering bias.

Furthermore, educational reforms and clinical guidelines are required. Medical training should include modules on cultural humility, implicit bias, and the historical context of genital modification. Guidelines should clarify how to assess requests for genital surgery, focusing on informed consent and physical indications rather than cultural assumptions. Interdisciplinary

ethics committees could provide support on a case-by-case basis, ensuring that decisions are consistent and transparent. If adult women seek culturally meaningful procedures, harm-reduction approaches warrant consideration; safe clinical options could minimize harm while respecting autonomy. Furthermore, lawmakers should reconsider policies that criminalize all forms of FGM/C requested by adults, while permitting analogous cosmetic surgeries for both minors and adults. While protecting minors and adults should remain essential, a more consistent, consent-based framework could help to avoid reinforcing racial hierarchies.

Finally, further research should also examine the role of media and pornography in shaping both patient demand and clinician perceptions. The BMC study links the ‘clean-slit’ ideal to pornographic depictions and identifies the internet and social media as drivers of demand (Kirkman et al., 2023). Understanding how these influences permeate clinical judgement could inform educational interventions that help doctors recognize and challenge normative biases.

7.5. Conclusion

This thesis began with a simple question: What if a white woman, a black woman, and a black woman wearing a headscarf, all adults and fluent in Dutch, walk into a doctor’s office with the same request: a modification of their genitals? Would the doctor respond to them in the same way? Would their motivations be judged equally? Would their autonomy be interpreted through the same lens?

The findings suggest that the answer is complex and dynamic, rather than fixed. While the consultation process itself is broadly consistent, the thresholds applied within it are not. Professional scope plays a significant role: functional surgeons restrict their acceptance to clear medical indications, while those who also perform aesthetic procedures are open to a wider range of motivations. Yet, the patient’s perceived identity and the cultural meaning attributed to her request also matter.

In principle, doctors stated that they would perform labiaplasties on any competent adult whose request fell within their scope of practice. However, when identical motivations were expressed by patients with different visible cultural markers, the level of scrutiny shifted. Requests from white or black patients who framed the decision ‘for themselves’ were often accepted with minimal questioning, even when the reasoning aligned closely with Western beauty ideals. In contrast, similar statements from religiously racialized patients, such as those wearing a headscarf, were more likely to trigger probing about possible cultural or familial coercion. This asymmetry, acknowledged by some participants, reflects deeper cultural assumptions about where autonomy resides and whose choices are considered genuinely self-determined.

Every form of fundamentalism and extremism carries the danger of injustice, and such discrimination is a serious matter. Yet, becoming entangled in the philosophical argument that if discrimination exists it must automatically be prohibited, risks oversimplifying a far more nuanced reality. That is why this thesis does not argue for the disappearance of the zero-tolerance policy on FGM/C, but rather for a critical re-examination of its scope and application, ensuring it protects where necessary while avoiding unnecessary restrictions on competent adults. This small-scale, pioneering study does not reveal explicit or uniform patterns of racial discrimination. Instead, it uncovers subtle but meaningful differences in interpretation, language, and frames of reference, differences that may, over time, contribute to unequal treatment. They emerge not from overt prejudice, but from deeply embedded discursive and cultural frameworks that shape how autonomy, consent, and legitimacy are assessed.

These findings reveal that the boundaries between FGCS and FGM/C are not solely defined by anatomy or technique, but by cultural meaning and the positionality of the patient. They highlight how Belgian doctors, consciously or not, navigate the intersection of law, medical ethics, and social norms in ways that can reinforce existing inequalities. In doing so, they confirm and extend existing literature on the coloniality of gender, the operation of power/knowledge in medical discourse, and the relational and intersectional nature of autonomy.

Addressing these asymmetries will require more than individual awareness. It calls for clearer clinical guidelines that address how to assess motivations without reproducing cultural bias, as well as a critical re-examination of legal frameworks that categorically prohibit certain procedures in some cultural contexts while permitting them in others. Such changes are essential if we are to ensure that all competent adults, regardless of background, have their bodily autonomy evaluated according to consistent and transparent standards.

Ultimately, this research shows that in the space between law, medicine, and culture, decisions about the body are never made in isolation. They are shaped by histories, discourses, and the visible and invisible markers that signal how a patient is perceived to be. As one surgeon succinctly put it during an interview: “Is a modification of your genitals at the request of an adult person still to be classified as genital mutilation?” (PS4).

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Appendix

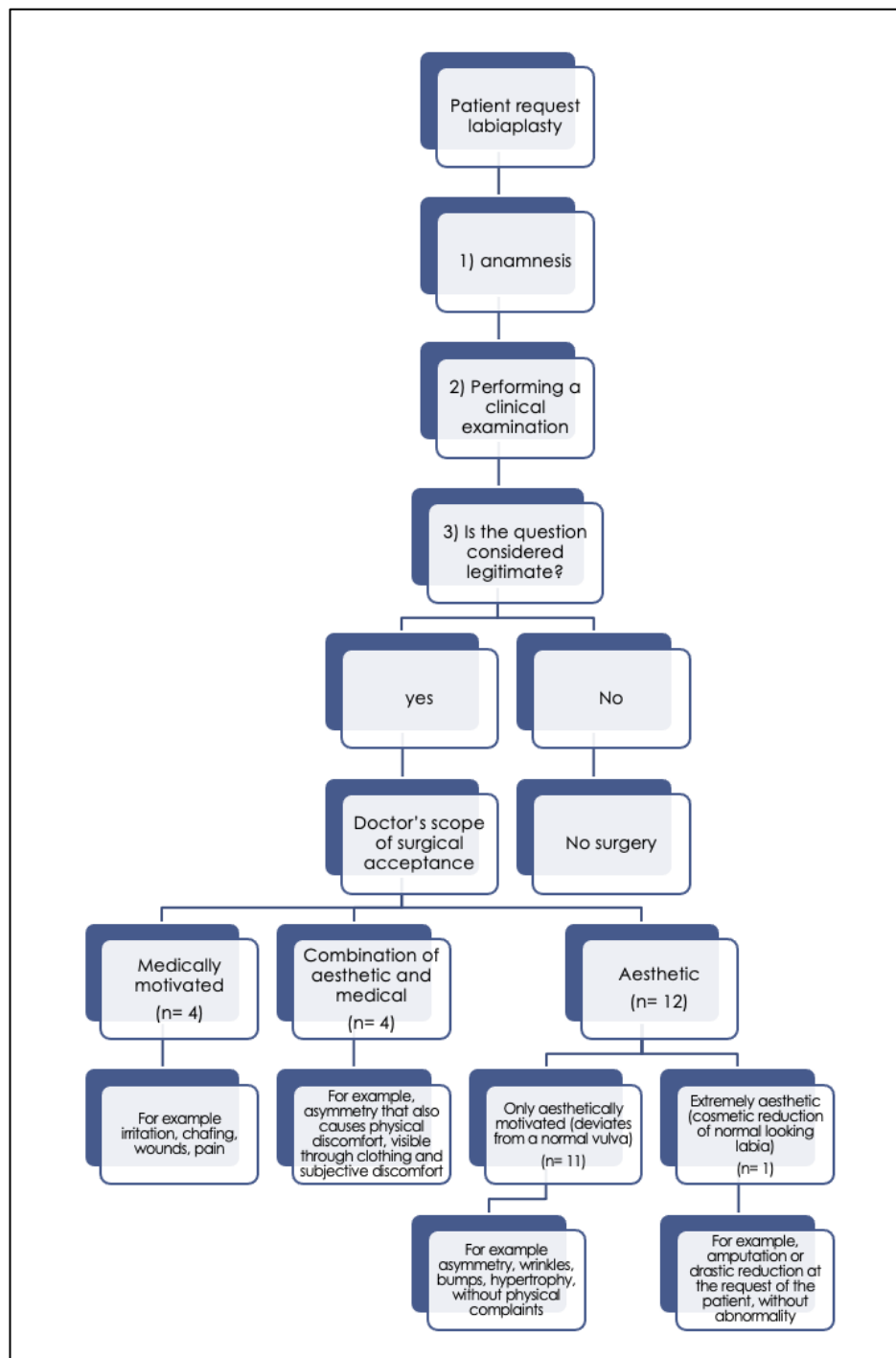
Appendix 1: The video vignettes of three patients with varying backgrounds

1. A white woman of European descent (Flemish-speaking): <https://youtu.be/VDuvVsQNocs>
2. A black woman of African descent (Flemish-speaking): <https://youtu.be/Y8f8gnjaZ2A>
3. A black woman of African descent wearing a hijab (Flemish-speaking):
<https://youtu.be/nMqEUr2h15c>

Appendix 2: Flowchart of medical decision-making for female genital modifications

Figure 3.

Flowchart of medical decision-making for female genital modifications



Note: Figure 3 visualizes the consultation process as described by participants during the interviews. The number of doctors in each category is indicated (n). These categories are not mutually exclusive but cumulative: doctors who perform labiaplasty for aesthetic reasons also accept medically or functionally motivated cases. The inverse, however, does not apply.

Appendix 3: Final script used for video vignettes

The following script was used for the video vignettes administered during the experiment. All participants received the same dialogue, with only visual attributes of the patient differing (e.g., ethnicity, or headscarf). The script is presented below in a bilingual format: English (left) and Dutch (right).

English

Dutch

Doctor:

Good afternoon, Miss Oewusu/Van de Velden.
How can I help you today?

Dokter:

Goedemiddag juffrouw Oewusu/Van de Velden.
Wat kan ik voor u doen?

Patient:

(Slightly hesitant, adjusts posture)

Uhm... I made this appointment because I have been having some discomfort around my vagina for a while. My labia often chafe, and it gets really irritating.

Patiënt:

(Schuift ongemakkelijk op stoel, aarzelt kort)

Uhm... Ik heb een afspraak gemaakt omdat ik al een tijdje last heb rond mijn vagina. Mijn schaamlippen schuren vaak waardoor ze geïrriteerd geraken.

Doctor:

I see. Could you describe the discomfort a bit more? What exactly do you feel?

Dokter:

Oké, kan u dat ongemak wat beter beschrijven?
Wat voelt u precies?

Patient:

(Hesitates, searching for the right words)

Well... they rub against my clothes sometimes, especially when I walk or exercise. Occasionally it feels like a pulling sensation, other times like a quick, sharp sting.

Patiënt:

(Aarzelent zoeken naar woorden)

Well... Ze wrijven tegen mijn kleren aan, vooral als ik wandel of sport. Dan heb ik soms een trekkend gevoel en af en toe een scherpe steek rond mijn schaamlippen.

(Pauses briefly)

It's not that it's painful all the time, but... I'm always aware of it. Like, even when I'm just sitting or moving around, I feel them. It's like they're just... there. Always.

(Korte stilte)

Het is niet dat het altijd pijn doet, maar... ik voel het gewoon altijd. Zelfs als ik gewoon zit of beweeg. Ze zijn er precies altijd.

Doctor:

When did you start feeling this way?

Dokter:

Sinds wanneer hebt u dat gevoel?

Patient:

(Pauses, fidgeting slightly)

I'm not sure. I guess I've always been aware of it, but lately... it's been on my mind a lot more.

Patiënt:

(Pauzeert, friemelt lichtjes met haar handen en ontwijkt oogcontact)

Ik weet het eigenlijk niet precies. Maar de laatste tijd... zit het meer in mijn hoofd.

I try not to compare, but... (hesitates) you know, when you see other girls, their labia just seem... smaller, tidier. It's not like I go looking for it, but I've seen enough to notice that mine look different.

Ik probeer er niet te veel over na te denken, maar... (aarzelt) ja, als je andere meisjes ziet, hun schaamlippen lijken gewoon... kleiner, straker. Niet dat ik dat bewust opzoek of zo, maar ik merk het wel.

(Raise the shoulders slightly) And I know that some girls get theirs done. It's not really talked about openly, but it happens. Some of my friends have mentioned it. And I think my older sister might have had it done too. We never spoke about it, but... (pauses) I saw hers once, and that's when I really noticed the difference.

(Haalt haar schouders op) En ik weet dat sommige meisjes er iets aan laten doen. Er wordt er niet echt over gepraat, maar het gebeurt wel. Sommige vriendinnen hebben het er weleens over gehad. En ik denk dat mijn oudere zus het misschien ook gedaan heeft. We hebben er eigenlijk nog nooit over gesproken, dat wordt

(Looks away briefly, then back)
And... it's not just about what I think. Some people expect it, you know. Or maybe it's just how society is... like, the way people talk about these things, it's almost like it's something you're supposed to do.

(Takes a deep breath, fidgets slightly)
I don't know. I just feel like mine... they're too long. And I just want them to be... normal.

Doctor:
Has anyone ever commented on how your labia looked?

Patient:
(Shakes head quickly, then hesitates)
No... not really. I mean, no one has said anything directly.

(Pauses, looks down)
But... I think about it a lot. Like, what if someone did see them?

Doctor:
Have you had sexual relations before and has it caused a problem?

Patient:
(Shakes her head)
No, I haven't.

(Takes a deep breath)
And honestly ... I don't think I could. Not like this.... Like, what would my partner think if they saw what it looked like?

(Fidgets slightly with hands, avoids direct eye contact, takes a deep breath, then looks up)
To be honest, I just want them removed. If they were smaller, I wouldn't have to worry about this anymore. I think I would feel a lot better about it.

-End of scene.

niet echt gedaan bij ons thuis. Maar...
(pauzeert) ik heb het al gezien bij haar. En toen viel het mij pas echt op.

(Kijkt even weg en dan terug)
En... het is niet alleen wat ik er zelf van vind. Sommige mensen verwachten het ook, snap je? Of misschien is het gewoon hoe het is... hoe erover gepraat wordt, hoe ernaar gekeken wordt. Alsof het iets is dat je eigenlijk hoort te laten doen.

(Haalt diep adem, friemelt met haar handen)
Ik weet het niet... Maar ik heb het gevoel dat die van mij... te lang zijn. En ik wil gewoon dat ze normaal zijn.

Dokter:
Heeft iemand ooit iets gezegd over hoe uw schaamlippen eruitzien?

Patiënt:
(Schudt snel haar hoofd, aarzelt dan)
Nee... niet echt. Ik bedoel, niemand heeft er ooit iets direct over gezegd.

(Pauzeert, kijkt naar beneden)
Maar... ik denk er veel over na. Wat als iemand ze zou zien?

Dokter:
Heeft u al seksuele ervaring gehad? Heeft dat ooit voor problemen gezorgd?

Patiënt:
(Schudt haar hoofd)
Nee, nog niet.

(Haalt diep adem)
En eerlijk? Ik denk niet dat ik dat zou kunnen. Niet zoals het nu is... Ik bedoel... wat zou mijn partner ervan denken als die het zou zien?

(Friemelt met handen, ontwijkt oogcontact, haalt diep adem en kijkt dan op) Eerlijk gezegd wil ik ze gewoon laten verkleinen. Als ze kleiner zouden zijn, zou ik me veel beter voelen, denk ik.

-Einde van de scène

Appendix 4: Semi-structured interview guide

INTERVIEW GUIDE

SECTION I: INTRODUCTION & INSTRUCTIONS (BEFORE THE VIDEO)

Interviewer:

- Thank you for taking the time to participate in this study.
- Before we begin, I'd like to provide some context about the research and explain how the information you share will be used.
- This study explores how medical professionals approach and respond to patient requests for genital modifications.
- Specifically, we are interested in understanding how such requests are assessed and discussed during clinical consultations.
- The interview consists of three parts. In the first part, you will watch a brief video vignette portraying a clinical consultation. The consultation is between the patient and the doctor, and the scene is presented from the doctor's point of view, so only the patient will appear on screen. Following the video, we will proceed with the interview. And at the end of the interview, a few demographic questions will be asked.
- Please respond as openly and honestly as you can.
- As outlined in the information sheet and consent form provided earlier, your participation is entirely voluntary. You may choose not to answer any question or withdraw from the interview at any time, without consequence.
- In a moment, I will show you the video vignette. It lasts approximately 2 to 3 minutes. We will begin the interview directly afterwards.
- There are no right or wrong answers, we are primarily interested in understanding your thought processes.
- As noted in the consent materials, this interview will be audio recorded for research purposes.
- All responses will be handled with strict confidentiality and anonymized during analysis and reporting.
- Do you have any questions before we begin?

→ **Play the video clip**

→ **Begin audio recording**

SECTION II: THE INTERVIEW TOPICS, QUESTIONS AND PROMPTS

1. OPENING & GENERAL IMPRESSIONS (2)

1. Can you describe any situations in your practice that reminded you of this? (Open question)
 - a. If yes, could you describe it?
2. How would you evaluate the way the doctor handled the patient's request? (Open question)
 - a. Did you find the questions appropriate or professional?

2. MEDICAL DECISION-MAKING PROCESS (5)

3. If you were the doctor in this situation, how would you treat this patient? (Open question)
 - a. Which factors do you consider when evaluating a patient's request to remove or reduce (part of) the labia?
 - i. (e.g., physical complaints, psychological distress, cultural or religious reasons...)
4. How do you determine whether this request to remove or reduce (part of) the labia is justified? (Open question)
 - a. Why or why not?
 - b. Can you elaborate on any medical or ethical considerations you take into account?
5. In this case, would you consider the request to be cosmetic, medical or something else? (Closed/Open question)
 - a. Which diagnose would you give the patient?
6. How would you describe the difference between a cosmetic request and a medical necessity in such cases? (Open question)
7. Do you rely on any guidelines when making decisions about this request to remove or reduce (part of) the labia? (Closed question)
 - a. If yes, which ones?

3. INFLUENCE OF PATIENT DEMOGRAPHICS (5)

8. Based on the video vignette, what assumptions did you make about the patient's age and background? (Open question)
9. Would your approach change in any of the following cases? (Closed question)
 - a. If the patient was under 18 or older?
 - b. If the patient was sexually experienced?
 - c. If the patient was of a different ethnic or cultural background?
 - d. If the patient's religion was different or visibly expressed (e.g., hijab)?
10. Do you think the patient's background in the vignette influenced your interpretation of the case? (Closed question)
 - a. Why or why not?
 - b. Do you think your interpretation would have changed if the patient had a different background (e.g., white/Black/Black Muslim)?
 - i. Why or why not?
11. Do you believe that patients of different ethnicities might receive different advice for these types of procedures? (The request to remove or reduce (part of) the labia) (Closed question)
 - a. Why or why not?
 - b. In your opinion, should a patient's cultural or ethnic background ever be taken into account when evaluating such a request?
 - i. Why or why not?

12. What factors, do you think, influence women to request a removal or reduction of (part of) their labia? (Open question)
- i. Which social or cultural factors do you believe play a role?

4. ETHICAL, LEGAL & AUTONOMY CONSIDERATIONS (4)

13. Do you see ethical concerns around requests for labial reduction or removal? (Closed question)
14. How do you view such procedures when they are requested for non-medical reasons? (Open question)
- a. Do you believe adult women should have full autonomy over decisions regarding the removal or reduction of (part of) their labia?
 - b. How do you balance patient autonomy with other ethical principles such as non-maleficence, beneficence and justice?
15. Can you describe a situation where a practitioner should refuse to perform such a procedure, even if the patient consents? (Open question)
16. Are you familiar with the concepts of Female Genital Mutilation (FGM) or Female Genital Cutting (FGC)? (Closed question)
- c. If yes: In your point of view, is there a difference between FGM/C and the type of request presented in this vignette?
 - i. Why or why not?
 - d. What is your stance on the circumcision of boys, here in Belgium?

5. PROFESSIONAL REFLECTION & SYSTEMIC ISSUES (2)

17. How do you ensure that your medical advice is free from unconscious bias? (Open question)
18. Based on your point of view, are such requests treated equally across all patients in Belgium regardless of ethnicity? (Closed question)
- a. Why or why not?
 - b. Do you think there are, unconsciously, systemic biases in Belgian healthcare regarding requests for the removal or reduction of (part of) the labia?

6. END OF THE INTERVIEW (3)

19. Do you have any additional comments or concerns about how these procedures are regulated in Belgium? (Open question)
20. How realistic did you find the consultation in the video vignette? (Closed question)
- a. What aspects felt accurate or unrealistic?
21. Would you like to add any final thoughts or reflections? (Open/Closed question)

SECTION III: PARTICIPANT BACKGROUND

PERSONAL INFORMATION

1. What is your gender?
 - a. Male
 - b. Female
 - c. Other: ...
2. What year were you born?
3. What is your ethnicity or nationality?

PROFESSIONAL INFORMATION

4. What is your specialization?
 - a. Gynecology
 - b. Plastic surgery
 - c. Other, namely: ...
5. Did you receive specific training in female genital cosmetic procedures (FGCP) during your education?
 - a. Yes
 - b. No
 - c. Not sure
6. Have you taken any additional courses or training in FGCP since then?
 - a. If so, where and what kind of training?
7. How many years have you been working in your specialization?
8. Where do you currently work?
 - a. A public hospital
 - b. A private practice
 - c. Both
 - d. Other, namely: ...
9. How many days do you work on average per week?
10. What types of female genital cosmetic procedures do you perform? (For example: labiaplasty, vaginoplasty, clitoral hood reduction, etc.)
11. Approximately what percentage of your total number of procedures are genital cosmetic procedures?
 - a. And what percentage of your total number of procedures are medical procedures?
12. How many of these procedures do you perform per year, approximately?
13. Have you ever received training on cultural sensitivity or ethics surrounding body modification?

Appendix 5: Informed consent template respondents

For supervisors and commissioners, signed informed consent forms of the respondents are available upon request.

 FACULTEIT POLITIEKE EN
SOCIALE WETENSCHAPPEN

INFORMATION LETTER AND
CONSENT FORM

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PART 1 – INFORMATION LETTER

Title of study: Factors in medical decision-making on female genital modifications in Belgium

This is a study conducted by Ghent University. The researchers responsible are:

Pauline Van de Walle	Dr. Anneke Newman	Dr. Hannelore Van Bavel
Department of Conflict & development studies	Department of Conflict & development studies	RHEA Research Centre Gender, Diversity & Intersectionality
Ghent University	Ghent University	Vrije Universiteit Brussel
E-mail: Pauline.vandewalle@ugent.be	E-mail: Anneke.Newman@ugent.be	E-mail: Hannelore.Van.Bavel@vub.be

Tel. nr.: +32 468 176 210

A. Information about the study

Dear Madam/Sir,

You are invited to participate in a study at Ghent University. Please take enough time to read this information letter carefully before you decide to participate in this study. Do not hesitate to ask questions to the researcher if there are any confusions or if you would like additional information. Make sure you understand everything. Once you have decided to participate in the study, you will be asked to sign the consent form at the end.

What is the purpose of the research?

This study aims to examine how healthcare professionals make decisions regarding requests for female genital modifications. By presenting a video vignette scenario of woman requesting this procedure, this research investigates the factors that influence medical decision-making in these cases.

B. Information regarding participation

What does taking part in this study involve?

Participation in this study involves watching a short video vignette depicting a woman requesting female genital modifications and responding to questions regarding the appropriateness of the medical intervention. The study will take approximately 60 minutes.

Participants may withdraw from the study at any time without providing a reason, and this will not impact their professional status or any affiliations with the university.

What are the risks and benefits of participating in this study?

There are no known permanent risks associated with this study. Some participants may find the subject matter sensitive, but efforts will be made to ensure a comfortable and professional environment.

This study contributes to understanding factors in medical decision-making, which can help inform future training and policy recommendations for equitable healthcare practices.

Is any compensation or reward provided for participation in this study?

The participation is voluntary and unpaid

C. Information on Privacy and Personal Data

The legal framework for the processing of personal data and confidential information in the context of this study is determined by:

- The European General Data Protection Regulation 2016/679 of 27 April 2016, effective since 25 May 2018 (this is the AVG or GDPR)
- The Belgian Law on the Protection of Natural Persons with regard to the Processing of Personal Data of 30 July 2018

Researchers must comply with the Ghent University generic code of conduct for processing personal data.

What personal data are collected?

The following personal data will be processed:

- Gender
- Education
- Age
- Nationality/ethnicity
- Medical specialty
- Number of years of experience
- Work setting
- Average number of working days per week

The following special categories of personal data will be processed:

- Voice recordings of the participant

- Professional opinions related to video vignette scenarios (pseudonymized)

Personal data will be collected using deep-interviews, and audio recordings of interviews.

Why are these personal data collected?

The personal data collected are necessary for analyzing trends in decision-making among healthcare professionals and understanding how they approach requests for female genital modifications.

On what legal ground will the data be processed?

To process your personal data, your explicit consent will be obtained. This is done by signing the 'consent form'. This consent can be withdrawn at all times by notifying the principal investigator.

Who has access to my (personal) data?

All collected data, including the video vignettes and interview recordings, will be safely stored in a password-protected folder, accessible only to myself, Pauline Van de Walle, and my research supervisors, Anneke Newman and Hannelore Van Bavel. To protect participants' identities, the data will be pseudonymized (unless explicitly requested otherwise) with unique codes assigned for confidentiality. Raw data will not be shared with external parties. Summarized findings and pseudonymized parts will be used only for academic purposes, such as this master's thesis and related research, assignments or presentations.

Reuse of data

The research data collected here may also still be useful in answering other research questions. Therefore, the possibility exists that the research data may be reused at a later date for another research. The reuse of the research data can be done both within the own research team and by external researchers within and outside the European Union. To this end, research data will be made available in a controlled manner via a dedicated research data sharing platform. In doing so, all necessary measures will be taken to guarantee the confidentiality of your personal data as prescribed in the Ghent University Generic Code of Conduct for handling personal data and confidential information. They will only receive access in a pseudonymized format to ensure confidentiality.

What rights do you have as a participant regarding your personal data?

In accordance with European and Belgian privacy legislation, your privacy is respected. As already indicated, you can withdraw your consent at any given moment and without giving any reason. This means that your data will not be further processed from the moment of withdrawal.

You have the right to inspect the data collected about you and you may also request a copy, provided this does not infringe the rights and freedoms of others, including those of Ghent University. Any inaccurate data about you can be corrected at your request. Furthermore, you have the right to be forgotten. This means that, after withdrawing your consent, you may ask for your personal data to be deleted.

To exercise any of the above rights, please contact the researcher(s) concerned at pauline.vandewalle@ugent.be.

If you have a complaint

If you would like to file a complaint about the way your personal data is handled or if you have any questions regarding your personal data in the context of this study, you may contact Ghent University's Data Protection Officer at privacy@ugent.be or T 09 264 95 17.

You may also file a complaint with the Data Protection Authority, Drukpersstraat 35, 1000 Brussels (e-mail: contact@apd-gba.be) and/or the Vlaamse Toezichtcommissie (e-mail: contact@toezichtcommissie.be).

PART 2 – CONSENT FORM

A. Consent regarding participation in the study

Please tick the appropriate bullet	Yes	No
I voluntarily participate in this scientific study.	☐	☐
I know that I may withdraw from the study at any time without giving a reason for this decision and that this will not in any way affect my further relationship with the researcher.	☐	☐
I have read the information form and received sufficient explanation about the nature, purpose, duration, and anticipated effects of the study.	☐	☐
I was given the opportunity to ask questions and I received satisfactory answers to all my questions.	☐	☐

B. Consent regarding the processing of personal data

Please tick the appropriate bullet	Yes	No
I know that I have rights to safeguard my privacy (including access, correction, deletion) and to whom I should turn to exercise these rights.	☐	☐
I give permission to the researchers to collect, process, store, analyse and report on my (personal) data for the purposes of this study.	☐	☐
I understand that my responses will be pseudonymized and used only for academic research.	☐	☐

C. Consent regarding re-use and sharing of data

Please tick the appropriate bullet	Yes	No
I give permission to researchers of the research group to reuse my data for further similar scientific research.	☐	☐
I give permission to the researchers to share my data for further similar scientific research and this within and outside the European Economic Area. In doing so, all necessary measures will be taken to protect the confidentiality of my personal data.	☐	☐

Name of participant	Name of researcher
Date:	Date:
Signature:	Signature:

Appendix 6: Informed consent template actors

For supervisors and commissioners, signed informed consent forms of the actors are available upon request.



FACULTEIT POLITIEKE EN
SOCIALE WETENSCHAPPEN

**INFORMATION LETTER AND
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FACULTEIT POLITIEKE EN
SOCIALE WETENSCHAPPEN

PART 1 – INFORMATION LETTER

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E-mail: Pauline.vandewalle@ugent.be	E-mail: Anneke.Newman@ugent.be	E-mail: Hannelore.Van.Bavel@vub.be

Tel. nr.: +32 468 176 210

A. Information about the study

Dear Madam/Sir,

You are invited to participate as an actress in a research study at Ghent University. Please take enough time to read this information letter carefully before you decide to participate in this study. Do not hesitate to ask questions to the researcher if there are any confusions or if you would like additional information. Make sure you understand everything. Once you have decided to participate in the study, you will be asked to sign the consent form at the end.

What is the purpose of the research?

This study aims to investigate how healthcare professionals make decisions regarding requests for female genital modifications. To achieve this, video vignettes featuring actresses portraying women requesting these procedures will be recorded and used in the study.

B. Information regarding participation

What does taking part in this study involve?

If you agree to participate, you will be acting in short video recordings where you portray a woman requesting female genital modifications. The recordings will take place in a controlled setting, with scripted dialogue based on the research objectives. The videos will then be



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2

shown to healthcare professionals, who will respond to questions regarding medical decision-making in these scenarios.

The filming process will take approximately 2 hours. Your participation is entirely voluntary, and you may withdraw at any time without consequences.

What are the risks and benefits of participating in this study?

There are no known permanent risks associated with participation. However, the subject matter may be sensitive. If you feel uncomfortable at any time, you may choose to withdraw from the study.

Your participation contributes to research on medical decision-making, which could help inform future training and policy recommendations for equitable healthcare practices.

Is any compensation or reward provided for participation in this study?

The participation is voluntary and unpaid

C. Information on Privacy and Personal Data

The legal framework for the processing of personal data and confidential information in the context of this study is determined by:

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- The Belgian Law on the Protection of Natural Persons with regard to the Processing of Personal Data of 30 July 2018

Researchers must comply with the Ghent University generic code of conduct for processing personal data.

What personal data are collected?

The following personal data will be processed:

- Gender
- Name (pseudonymized where applicable)
- Age
- Nationality/ethnicity
- Video recordings of your performance

Why are these personal data collected?

The data are necessary for creating realistic research scenarios that will be analyzed by healthcare professionals.

On what legal ground will the data be processed?

To process your personal data, your explicit consent will be obtained. This is done by signing the 'consent form'. This consent can be withdrawn at all times by notifying the principal investigator.

Who has access to my (personal) data?

All collected data, including video recordings, will be securely stored and accessible only to the research team. To protect your identity, your data will be pseudonymized. The recordings will be used exclusively for academic purposes, including this master's thesis and related presentations. Additionally, the data will be retained for further research related to this topic. These recordings may serve as additional information for other studies exploring similar themes in medical decision-making and cultural biases in healthcare.

Reuse of data

The research data may be useful for future studies. Thus, there is a possibility that your video recordings may be reused in similar research projects. If shared, they will be in a controlled manner that maintains confidentiality.

What rights do you have as a participant regarding your personal data?

In accordance with European and Belgian privacy legislation, your privacy is respected. As already indicated, you can withdraw your consent at any given moment and without giving any reason. This means that your data will not be further processed from the moment of withdrawal.

You have the right to inspect the data collected about you and you may also request a copy, provided this does not infringe the rights and freedoms of others, including those of Ghent University. Any inaccurate data about you can be corrected at your request. Furthermore, you have the right to be forgotten. This means that, after withdrawing your consent, you may ask for your personal data to be deleted.

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If you have a complaint

If you would like to file a complaint about the way your personal data is handled or if you have any questions regarding your personal data in the context of this study, you may contact Ghent University's Data Protection Officer at privacy@ugent.be or T 09 264 95 17.

You may also file a complaint with the Data Protection Authority, Drukpersstraat 35, 1000 Brussels (e-mail: contact@apd-gba.be) and/or the Vlaamse Toezichtcommissie (e-mail: contact@toezichtcommissie.be).

PART 2 – CONSENT FORM

A. Consent regarding participation in the study

Please tick the appropriate bullet	Yes	No
I voluntarily participate in this study as an actress.	☐	☐
I know that I may withdraw from the study at any time without giving a reason for this decision and that this will not in any way affect my further relationship with the researcher.	☐	☐
I have read the information form and received sufficient explanation about the nature, purpose, duration, and anticipated effects of the study.	☐	☐
I was given the opportunity to ask questions, and I received satisfactory answers to all my questions.	☐	☐

B. Consent regarding the processing of personal data

Please tick the appropriate bullet	Yes	No
I know that I have rights to safeguard my privacy (including access, correction, deletion) and to whom I should turn to exercise these rights.	☐	☐
I give permission to the researchers to collect, process, store, analyse and report on my (personal) data for the purposes of this study.	☐	☐
I understand my video recordings will be used solely for academic research.	☐	☐

C. Consent regarding re-use and sharing of data

Please tick the appropriate bullet	Yes	No
I give permission for my video recordings to be reused for similar academic research.	☐	☐
I give permission for my video recordings to be shared for further similar scientific research and this within and outside the European Economic Area. In doing so, all necessary measures will be taken to protect the confidentiality of my personal data.	☐	☐

Name of participant	Name of researcher
Date:	Date:
Signature:	Signature:

Appendix 7: Data management and ethics form

DATA MANAGEMENT AND ETHICS FORM

FOR STUDENT RESEARCH AT THE FACULTY OF POLITICAL AND
SOCIAL SCIENCES OF GHEENT UNIVERSITY

Title of the research project and date¹

Title	Cultural and racial bias in medical decision-making: A video vignette study on female genital modifications in Belgium
Date of first version DMP	11/08/2025
Date of last update (if applicable), please specify changes made	

Name of the researcher(s)

Name researcher(s):	Pauline Van de Walle
Name supervisor (s):	Anneke Newman
Department:	Department of Conflict & Development Studies
E-mail address contact person:	Pauline.vandewalle@ugent.be



DATA MANAGEMENT PLAN

WHAT

A Data Management Plan (DMP) entails all actions needed to ensure that data are secure, easy to find, understand, and (re)use; not only during a research project, but also in the longer term. In all cases, it is an excellent tool to manage your research project.

WHY

Research data constitute the evidence needed to verify and validate published claims.

All researchers, including Bachelor and Master students, carefully need to think through how data are organised, managed properly not only before but also during the research project and after the project has finished. This is done in a DMP.

A DMP shows that researchers adhere to the principles of responsible research. It will enable:

- Your data to be re-used for follow-up or new research
- Research findings to be reproducible (a fundamental principle of good research)
- The researcher(s) to safely store and find his/her data (a DMP will make you think about how to avoid the consequences of unexpected events, such as a stolen laptop or corrupted files)
- Compliance with legal and ethical guidelines (for this reason, most organisations and virtually all funding agencies require a DMP prior to approval or funding)

In other words, a DMP will help you to think carefully about your data management. For this reason, writing a DMP is a good practice. This document helps you to think through the data management process. You are asked to fill out the text boxes. Expand the boxes if needed.

1. Personal data or not

Please first indicate the type of data you will collect or create:

- ☐ No personal data (i.e., no information about an identified or identifiable natural person)
- ☒ Personal data (i.e., any information about an identified or identifiable natural person)

Please note: A natural person is considered to be identifiable if he or she can be identified directly or indirectly using the collected data. Information that at first sight doesn't appear to be traceable to a person can therefore still be personal data. This may be the case if the person in question can be identified by combining the collected data with additional information (cf. GDPR).

If you will collect or create personal data, please indicate what personal data you will collect (several options may apply)

- ☒ identifying information (e.g., name, address, email address, IP address, etc.)
- ☒ information revealing gender identity, ethnic origins, political views, or religious beliefs/practices
- ☐ information on a person's sexual behaviour or sexual orientation
- ☐ information related to criminal convictions and/or offences (e.g., forensic information or self-reported crime)
- ☐ genetic, biometric or health information

2. Data formats, contents, and modes of collection

What data will be collected and how? Describe:

- the contents (e.g., attitudes towards migrants, voting preferences, mental health, etc.)
- the types (e.g., numerical, textual, audio-visual, multimedia, etc.)
- the format (e.g., spreadsheets, databases, images, audio files, (un)structured texts, etc.)
- the mode(s) of data collection (e.g., surveys, interviews, experiments, derived/compiled from other sources, etc.)

1. Video vignette materials (stimuli)

- a. Contents: Pre-recorded (fictive) videos of actresses portraying a patient requesting a genital modification procedure.
- b. Type: Audio-visual.
- c. Format: .mp4.
- d. Purpose: Standardised stimulus in the experimental design, identical scripts with only racial/cultural/religious presentation varied.
- e. Source: Produced by researcher, actresses consented separately. In one case, an actress's last name was used in the vignette script, she provided oral consent for this inclusion.
- f. Processing: Used only as part of the interview, not linked to participant personal data.

2. Participant data (interview responses from doctors)

- a. Contents: Professional opinions, reasoning processes, and decision-making regarding the vignette scenario; demographic/professional background (gender, age, ethnicity, specialty, work setting, years of experience).
- b. Type: Audio (interview recordings) and text (transcripts, notes).
- c. Format: mp3 for audio, .docx/.pdf for transcripts.
- d. Mode of collection: Semi-structured interviews conducted face-to-face or online after viewing a randomly assigned vignette.

3. How will the data be documented?

- Describe how you will ensure that the data remain understandable or interpretable (after data collection), how the data are prepared – if relevant – for reuse, and how you will make the results from your research independently reproducible for others.
- Explain who will be responsible for the data documentation.

- interviews will be fully transcribed in Dutch.
- Transcripts will include anonymised identifiers (e.g., "Participant 1 of the plastic surgeons – PS1").
- A coding framework will be developed for thematic analysis.
- Metadata will be kept in a separate document linking anonymised identifiers to original recordings, stored securely and separately.
- Pauline Van de Walle will be responsible for documentation.

4. Explain how and where data will be safely stored and backed up

Describe how you will make sure that access to the data will be restricted for third parties (e.g., via passwords on documents, ...) and how you aim to avoid accidental loss of data (e.g., by making back-ups and by storing (electronic) documents in different places). Identify who or what parties will have access to the data (i.e., name and function/position).

- All digital files (audio, transcripts, coding notes) will be stored on the password-protected OneDrive of the university of Ghent and my personal OneDrive.
- Backups will be made weekly to Ghent University's secure storage server.
- Only the researcher (Pauline Van de Walle) and the supervisor (Anneke Newman) will have access.

5. Plans for sharing or providing access to data

In most cases, data are to be destroyed after the research project has finished and has been assessed. There may, however, be reasons to preserve the data for a longer period. If so, what are the plans for sharing or providing long-term access to the data? Will the whole dataset be preserved, and in what form?

Which data should be preserved? **Why** and for **how long**? Pay explicit attention to the preservation of non-anonymous data. Who will be responsible for data management and preservation in the future?

- Raw interview recordings and transcripts will not be publicly available due to sensitivity and GDPR.
- All data will be pseudonymized, identifiers stored separately in a secure, password-protected location.
- Reuse/sharing only with participant consent, for similar scientific research within the research group or by approved external researchers (including outside the EEA).
- Access via controlled research data platforms, only pseudonymised data shared.
- Anonymised excerpts may be used in the thesis, academic publications, and presentations.

ETHICAL AND LEGAL ISSUES

WHY

Research must comply with the highest ethical principles. Thus, the rights, dignity, and welfare of anyone involved must be protected, and the research must be conducted in a transparent and independent manner. Researchers play an active role in assuring participants (and broader society) that research is conducted in a responsible manner. Note that ethical issues relate to both issues of **legal protection** (e.g., anonymity, data storage and use) and issues related to a **professional attitude** (e.g., clearly explaining your research intentions to participants, considering how the research may potentially affect participants, etc.)

This implies that researchers, including Bachelor and Master students, carefully need to explain to anyone involved what the research objectives are, how the research is carried out, how research participants are protected, and what happens to the data.

If you are not working with personal data, ethical issues boil down to a thorough explanation of how you conducted the research in a transparent and independent manner.

6. Consent form (required when you work with personal data)

If you work with personal data¹, it is likely that you will use an informed consent form when carrying out a survey, interviews, focus groups, participant observations, etc.

In this form it is necessary to²:

- Explain the objectives of your research in a language understood by the participants (i.e., avoid academic jargon)
- Explain what you expect the participant to do and explain that they have the right to withdraw from the research project at any stage (e.g., even during or after an interview) without any formal explanation on their behalf
- Explain what you will do with the data
- Explain how personal information and details are protected (anonymisation, pseudonymisation)
- Explain – if applicable – whether participation may imply risks (discomfort, anxiety) and benefits (compensation for participation). If there are risks, provide the participant with contact details where they can ask for support
- Explain how data will be stored, for how long, and who is responsible for data storage
- Include your name and contact details

Please indicate whether you will use a consent form:

- ☒ I do make use of an informed consent form (please attach that form to this document).
- ☐ I do not make use of an informed consent form. Explain why you do not use an informed consent form.

¹ If you conduct research on participants that lack the legal age to make informed decisions, you need consent from parent(s) or guardian(s).

² Please note that this is a non-exhaustive list of elements of an informed consent form. Feel free to add issues to the form.

7. Other issues

The previous sections will likely cover 95% of the ethical issues that emerge in your research activities, but other ethical questions may (likely) arise in your project. Here are two *examples*.

First example: You intend to do research on discrimination in the housing market and – as an experimental design – you send letter to landlords which are signed with fictive names, some of these are clearly Flemish names, others suggest the senders are from another country. In fact, you are deceiving the landlords – but possibly this can be condoned. Nonetheless, it is necessary to explain *why* you take this approach.

Second example: You are observing youth gangs with the objective to understand why youngsters become members. During your observations you witness a criminal activity. From a legal perspective, you are supposed to report this to the police. From an ethical perspective, people may likewise say that your legal duty trumps the importance of your scientific work, but what if you suspect that the police officers in question are corrupt? How does this suspicion change your ethical assessment of the situation?

Please use this box to reflect on any ethical issues not covered above.

Doctors were informed that the research focused on decision-making around female genital modifications, but the specific emphasis on racial and cultural bias was withheld prior to participation to avoid priming. Using video vignettes in which only the patient's racial, or cultural presentation varied while all other factors remained constant, the study aimed to isolate potential bias in interpretation without explicitly signaling it, thereby reducing social desirability effects. Given the experimental design, this limited form of deception was considered minimal, ethically justified, and mitigated by participants' right to withdraw and the option of post-interview disclosure upon request.

Appendix 8: Sociodemographic characteristics of the medical professionals interviewed

Table 3.

Sociodemographic characteristics of the medical professionals interviewed (N = 20)

Characteristics	n (%) or mean (range; n)
<i>Gender</i>	
Male	11 (55.0)
Female	9 (45.0)
<i>Age</i>	
20–39 years	6 (30.0)
40–59 years	9 (45.0)
60+ years	5 (25.0)
<i>Nationality</i>	
Belgian	18 (90.0)
Other (specify)	2 (10.0)
<i>Medical specialty</i>	
Gynecology	8 (40.0)
Plastic surgery	12 (60.0)
<i>FGCS training during studies</i>	
Yes	10 (50.0)
No	10 (50.0)
<i>Additional FGCS training</i>	
Yes	8 (40.0)
No	12 (60.0)
<i>Years in practice</i>	
< 5 years	4 (20.0)
5–10 years	5 (25.0)
> 10 years	11 (55.0)
<i>Workplace</i>	
Public hospital	5 (25.0)
Private	0 (0.0)
Both	15 (75.0)
<i>Working days per week</i>	
Mean (range; n)	Mean: 5.0 (range: 3.0–6.0; n=20)
<i>Types of FGCS performed</i>	Mostly labiaplasty
<i>Type of genital surgeries (%)</i>	
Cosmetic genital surgeries	Mean: 25.8% (range: 0.0–100.0%; n=19)
Medical genital surgeries	Mean: 64.6% (range: 0.0–100.0%; n=18)
<i>Annual number of FGCS</i>	
Mean (range; n)	Mean: 20.7 (range: 2.0–100.0; n=17)
<i>Training in cultural sensitivity or ethics</i>	
Yes	6 (30.0)
No	14 (70.0)
Unknown / Not reported	1 (5.0)

Note: Mean values and ranges for 'Working days per week', '% Cosmetic genital surgeries', '% Medical genital surgeries', and 'Annual number of FGCS' are based on participants' self-reported estimates. Midpoints were used for ranges (e.g., 5–10 → 7.5), 'greater than' values were treated as the stated minimum (e.g., >100 → 100), and non-numeric responses (e.g., does not know, n/a) are shown as 'Unknown / Not reported' and excluded from calculations. The number of valid responses (n) for each variable is indicated in parentheses.