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Female Genital Mutilation

Studies on primary and repeat female genital cutting

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ABSTRACT

Background: Worldwide at least 130 million now living women and girls have undergone female genital mutilation (FGM), also called female genital cutting (FGC). Reinfibulation (RI) is a secondary form, mainly performed after delivery. In spite of documented complications, the procedures continue, and it seems essential to further reveal the underlying motives in order to increase the understanding of its persistency and to elucidate the encounter in maternity care after migration.

Objectives: To explore FGC and RI in a country of origin, Sudan, and after immigration to Sweden. More specifically the objectives were: (I) to describe the perceptions and practice of FGC among rural Sudanese women and men; (II) to describe the prevalence of RI in hospital settings; (III) to elucidate knowledge, attitude and practice of FGC and RI in a rural setting in Sudan; (IV) to explore the experiences and perceptions of RI after delivery among Sudanese midwives; (V) to investigate the experiences of FGC and RI among Sudanese women and men; and (VI) to explore the experiences of FGM and the encounter with Swedish maternity care among women immigrants from Sudan, Somalia and Eritrea.

Methods: These studies were conducted in El Gezira and in Khartoum State, Sudan, and in Sweden after immigration. The studies employed both qualitative and quantitative methods: (I) interview-administered questionnaires to 120 villagers; (II) participant observations and digital examination at 100 deliveries; (III) interview-administered questionnaires; (IV) non-participant observations and open-ended interviews; (V) focus groups and open-ended interviews; (VI) open-ended interviews.

Results: (I) A high prevalence of FGC (100%) was stated among the respondents. Tradition and social importance were the main motives. The younger generation stated a change in practice, preferring the least severe form of FGC for their daughters. (II) 61% of the women included had undergone tightening vulvar operations after delivery, at the delivery wards, including women who had not been subjected to primary FGC. (III) Reinfibulation after delivery was widely practised and the main motives were social reason/tradition and alleged male sexual satisfaction. The younger generation of women described the midwife and older female relatives as being behind the decision. (IV) The midwives' motives for RI were to respond to the social requests and to benefit the women by increasing their beauty and value. (V) Women and men explained both negative health implications and perceived benefits of the practices. Both men and women were seen as victims of the consequences of the practices and blamed each other and the midwives for its persistence. (VI) The immigrant women's experienced suffering from being abandoned and mutilated, feeling vulnerable in the encounter with Swedish healthcare personnel, which led them to avoid seeking maternity care.

Conclusion: This thesis indicates high prevalence of FGC and RI in settings in Sudan and health complications associated with the practices. The motives are not only social, sexual, traditional and economic, but also embrace normality, identity and power relations related to paternalism, maternalism and patriarchy. Deficient communication was demonstrated between women and men in Sudan and between women and midwives, both in Sudan and in Sweden. This thesis also shows that there is still a need of increased practical skills related to FGC among Swedish healthcare personnel and continuous training to meet culturally specific health needs.

Key words: female genital mutilation, female genital cutting, reinfibulation, vulva, sexuality, midwife, immigration, migration, Sudan, Sweden, Somalia, Eritrea.

LIST OF PUBLICATIONS

This thesis is based on the following papers, which are referred to by their Roman numerals:

- I Almroth, L., **Almroth-Berggren, V.**, Hassanein, O. M., El Hadi, N., Al-Said, S. S., Hasan, S. S., Lithell, U. B., Bergström, S. A community based study on the change of practice of female genital mutilation in a Sudanese village. *Int J Gynaecol Obstet*, 2001; 74: 179–85.
- II **Berggren, V.**, Elsiddig Yagoub, A., Mahmoud Satti, A., Abdel Khalifa, M., Bergström, S. The phenomenon of post-partum tightening operations at the delivery ward. The prevalence of reinfibulation after delivery in two hospital settings in Khartoum, Sudan. Submitted.
- III **Almroth-Berggren, V.**, Almroth, L., Hassanein, O.M., ElHadi, N., Lithell, U-B., Bergström, S. Re-infibulation among women in a rural area in central Sudan. *Health Care for Women International*, 2001; 22: 711-722.
- IV **Berggren, V.**, Abdel Salam, G., Bergström, S., Johansson, E., Edberg, A.-K. An explorative study of Sudanese midwives motives, perceptions and experiences of reinfibulation after delivery. *Midwifery*; 2004; 20: 299–311.
- V **Berggren, V.**, Ahmed Musa, S., Hernlund, Y., Johansson, E, Habbani, B., Edberg, A.-K. Being victims or beneficiaries? Sudanese women’s and men’s perceptions of female genital cutting with particular reference to reinfibulation. Submitted.
- VI **Berggren V.**, Bergström S., Edberg A.-K. Being different. Experiences of female genital mutilation after migration and in the encounter with the Swedish maternity care. Submitted.

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ABBREVIATIONS

ANC	Antenatal Care
DI	Deinfibulation
FC	Female Circumcision
FGC	Female Genital Cutting
FGD	Focus Group Discussion
FGM	Female Genital Mutilation
NGO	Non-Governmental Organisation
RI	Reinfibulation
SPSS	Statistical Package for the Social Sciences
SVCP	Sudan Village Concept Project
TBA	Traditional Birth Attendant
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organisation

DEFINITIONS

Deinfibulation	Splitting the vulvar scar after an infibulation to widen the vaginal orifice.
Episiotomy	Cutting performed in the perineum with the purpose of facilitating vaginal delivery.
Reinfibulation	The repair of an infibulated vulva after delivery, and in addition, re-suturing on the sides of the vaginal orifice to recreate the size of primary infibulation, often of a pinhole size.

LIST OF CONTENTS

ABSTRACT	iii
LIST OF PUBLICATIONS	v
ACKNOWLEDGEMENTS	vi
ABBREVIATIONS	viii
DEFINITIONS	viii
LIST OF CONTENTS	ix
1 INTRODUCTION	1
1.1 Terminology	1
1.2 The global aspect of female genital cutting	2
Reinfibulation	2
1.3 Rationale for the persistence of female genital cutting	3
1.4 Medical aspects of female genital cutting and reinfibulation	4
2 AIMS AND OBJECTIVES	5
2.1 General aim	5
2.2 Specific objectives	5
3 THE STUDY CONTEXT	5
3.1 Sudan	5
Female genital cutting in Sudan	7
The study settings	7
3.2 Sweden	9
Immigration to Sweden from Sudan, Somalia and Eritrea	9
4 METHODS	9
4.1 Study design, participants and data collection	10
Participants and data collection procedures	12
4.2 Data analysis	15
5 ETHICS	17
6 RESULTS	19
6.1 Attitudes, perceptions and practice of primary female genital cutting (I)	19
6.2 The prevalence of post-partum tightening operations (II)	20
6.3 Attitudes to, perceptions and practice of reinfibulation (III)	20
6.4 Midwives' reasoning about reinfibulation (IV)	22
6.5 Experiences of female genital cutting among women and men (V)	23
6.6 The experiences of female genital cutting and the encounter with maternity care after migration (VI)	25
7 DISCUSSION	26
7.1 Methodological considerations	26
7.2 Victimisation as a consequence of female genital mutilation	28
7.3 Balancing benefits and harm related to the practices	30
7.4 Paternalistic health professionals and suppressive maternalism	32
7.5 Individual men as victims in a patriarchal system	34
7.6 Striving for protection by female genital cutting and reinfibulation	36
7.7 Re-victimisation in the encounter with Swedish maternity care	38
8 CONCLUSIONS	40
REFERENCES	42
ORIGINAL PAPERS	49

1 INTRODUCTION

1.1 Terminology

The focus of this thesis is an important reproductive health issue, but it is also a sensitive topic. Attention should therefore be paid to the terminology chosen when approaching the issue. The term “female circumcision” has been used historically. As the harm that the practice causes became increasingly recognised, the term gave way to “female genital mutilation”. The term female genital mutilation (FGM) has been adopted by many women’s health organisations, such as the Inter African Committee on Traditional Practices Affecting the Health of Women and Children, and intergovernmental organisations, such as the World Health Organisation (WHO). More and more often the term “female genital cutting” is used, in an attempt to find a language that is value-neutral, but which adequately describes the nature of the procedures [1]. In a joint statement by WHO, UNICEF and UNFPA, it was described that FGC comprises all procedures involving partial or total removal of the external female genitalia or other injury to the female organs, whether for cultural or other non-therapeutic reasons [2]. The three agencies classified the different types in the table below.

Table 1. The types of female genital cutting according to WHO, UNICEF and UNFPA [2, 3].

Descriptions	
Type I	Excision of the prepuce, with or without excision of part or all of the clitoris.
Type II	Excision of the clitoris, with partial or total excision of the labia minora.
Type III	Excision of part or all of the external genitalia, with stitching/narrowing of the vaginal opening (infibulation).
Type IV	Unclassified: includes pricking, piercing or incising of the clitoris and/or labia; stretching of the clitoris and/or labia; cauterisation by burning of the clitoris and surrounding tissue; scraping of tissue surrounding the vaginal orifice or cutting of the vagina; introduction of corrosive substances or herbs into the vagina to cause bleeding or for the purposes of tightening or narrowing it; and any other procedure that falls under the definition of female genital mutilation.

1.2 The global aspect of female genital cutting

Worldwide above 130 million females, now living, have been subjected to some kind of genital cutting [3]. The origins of FGC are obscure, but some researchers [4-8] claim that FGC, particularly infibulation, originates from the time of the Pharaohs in ancient Egypt, and then diffused to the Red Sea coastal tribes with Arab traders, and from there into eastern Sudan. Others, like Abdalla al Tayib in Al Safi [9] claimed in 1964 that FGC in Sudan could have been derived from Arabia. The latter also describes how infibulation was practised by ancient Arabs before Islam to protect the shepherd girls against rape while they were out unescorted with their sheep. According to Seligman in 1913, quoted in Al Safi [9], infibulation represents a local elaboration of clitoridectomy in Neolithic times in an undifferentiated Hamito-Semitic culture. Concerning culture and religion, FGC is practised across socio-economic classes and among different ethnic and religious groups, including Christians, Jews and Muslims [10]. However, neither the Koran nor the Bible mentions any surgery of the female genitalia [5, 7, 11-13].

Today FGC is reportedly practised in 30 African countries in the Sub-Saharan and North-eastern regions [3, 14], in parts of the Middle East, in Indonesia and Malaysia [3, 15] and among some migrants in Europe [14, 16, 17]. It is most commonly practised in the African region, in a broad, triangular east–west band that stretches from Egypt in the north-east and Tanzania in the south-east and to Senegal in the west. However, not all women in the areas have been subjected to FGC, but only those of certain tribes [6]. For instance, it is reported that among the Ino, in Kenya, the second largest group, women have not been subjected to any form of FGC [6].

Reinfibulation

Reinfibulation (RI) has been defined as the re-stitching after delivery of the scar tissue resulting from infibulation [4] but is also described as additional tightening mimicking the narrow introitus of a virgin [4, 11, 18-20]. The definition of RI is not always clear in the literature. It should, however, be distinguished from episiotomy repair, which signifies the reconstruction of a normal vulvar anatomy after delivery. The need for a more extensive tightening beyond episiotomy repair is the basis of the practice of

tightening vulvar operations and RI. The English translation of the Arabic name, El Adel, literally means “putting right and improving” [21].

The origin of primary FGC, performed on the girl dates, as mentioned, back to ancient times, but RI is claimed by some authors [22] to be quite a new phenomenon, while others, like Hayes [23], believe that it is a practice with roots as old as the primary forms. Several studies have mentioned the phenomenon of RI in Sudan [19, 20, 22, 24], some question it (in Somalia) [25], but few have estimated its prevalence. Even in 1982, El Dareer [5] estimated that over 50% of Sudanese women underwent RI, one or more times postpartum. Reinfibulation is performed on women who have previously undergone infibulation or other severe forms of FGC and who have given birth, are widowed or divorced with the purpose of recreating the narrow vulvar introitus of a virgin [11, 19, 20, 26-30]. Because of the alleged male sexual satisfaction, the practice has been referred to as “Adlat El Rujal”, men’s circumcision [11]. Reinfibulation is also carried out in cases where the original infibulation of the girl was unsuccessful. Defibulation or Deinfibulation (DI) consists of an enlargement of the enclosed vulva [31].

1.3 Rationale for the persistence of female genital cutting

The persistence of FGC stems from deep-rooted traditions within the societies where these are practised, and reasons can vary according to ethnic group, type of FGC and the time when they are performed.

For some groups, FGC serves as a rite of passage into womanhood, without which a girl cannot marry or assume the responsibilities of a woman. It also ensures the preservation of a daughter’s virginity, which in turn protects the family’s honour and improves a daughter’s marriage prospects [4, 8, 25, 26, 30, 32]. Clitoridectomy is believed to attenuate female sexual desire, and therefore, protects a girl from sexual temptation. Hygiene, aesthetics, improved fertility, religion, female identity, tradition, social custom, marriageability and improved male sexual pleasure are other rationales described for the various forms of FGC [4, 6, 7, 25, 33-37]. The age at primary FGC varies, from infancy to just before marriage. In Sudan, the operation is usually performed between the ages of 4 and 8, or even 14 [3, 38].

In some settings, as in Sudan, the traditional birth attendant or the midwife has a recognised stake in FGC by performing the operations and gaining financially from it [17, 19, 25, 30, 39]. FGC is sometimes described as supported and encouraged by men, [17, 40, 41], for example Black puts it this way: “indeed the operation can be regarded as an exercise in male supremacy and the oppression of women” [17].

1.4 Medical aspects of female genital cutting and reinfibulation

The health risks and complications of FGC depend mainly upon the gravity of the mutilation [42]. According to El Dareer [5], there are difficulties in estimating the extent and the prevalence of complications, for many reasons. Since FGC is illegal in Sudan, many try to hide the complications, fearing enquiries about the operator and why they let it be performed. In addition, the health services are not within easy reach in rural and remote areas [5].

Several physical health complications following FGC have been documented through different studies, ranging from infections to severe bleeding, shock, infertility [6, 26, 43, 44], menstrual problems and complications at micturition [26, 45], prolonged labour [34, 42, 46] and maternal mortality [47]. Sexual and psychological problems have also been documented, related to the psychological trauma from the operation itself and from problems with sex life [4, 33, 48-51]. Previous research indicates that RI causes the same health hazards as primary infibulation, repeatedly putting the woman at risk of severe sequelae [5, 18, 20, 30, 44].

International campaigns have largely focused on the epidemiological status and health complications of FGC. In spite of all the documented complications, the procedures continue, and it seems essential to further reveal the underlying motives in order to increase the understanding of their persistency.

Patterns of migration now mean that women with FGC are likely to be encountered throughout the world. Immigration is in general associated with increased physical and psychological illness, which implies challenges for the health care system of the country that receives the new immigrants [52, 53].

2 AIMS AND OBJECTIVES

2.1 General aim

The overall aim of the thesis was to explore prevalence, perceptions, attitudes and experiences concerning primary and repeat female genital cutting in Sudan, and to explore experiences of FGC and the encounter in maternity health care in Sweden after immigration.

2.2 Specific objectives

The specific objectives of this thesis were:

To identify, at the community level, attitudes to and practice of female genital cutting and the decision-making process among Sudanese men and women from different generations (Paper I).

To elucidate the prevalence of tightening operations of the vulva post delivery in hospital settings in Sudan (Paper II),

To explore women's motives, attitudes and practice of reinfibulation after childbirth in a rural setting in Sudan (Paper III),

To explore Sudanese midwives' motives, experiences and perceptions of reinfibulation and to elucidate its context and determinants (Paper IV),

To elucidate perceptions, attitudes and experiences of female genital cutting and reinfibulation among Sudanese men and women (Paper V),

To describe experience of female genital cutting and the encounter with Swedish maternity care among immigrants from Sudan, Somalia and Eritrea (Paper VI).

3 THE STUDY CONTEXT

3.1 Sudan

Sudan is the largest country in Africa with 2.5 million square kilometres and nine neighbouring countries. It has a population of about 34 million, 60% of whom live in rural areas, including around two million nomads. The population is concentrated in the capital province, Khartoum, which is situated where the Blue and the White Nile merge

to form the Nile. In Sudan the Arabic and the African cultures meet. The state religion is Islam, and the majority of the Sudanese are Muslims (70%), 20–30% believe in traditional African religions and around 5–10% are Christians. There are about 600 ethnic groups and more than 400 languages are spoken in Sudan [54].

Because of the protracted wars and conflicts in the neighbouring countries as well as inside the country, Sudan is one of the countries in the world with the highest number of refugees [54]. The position of women in Sudan varies from region to region and from one ethnic group to another. Nonetheless, the importance of the family overrides these differences. It is the family that is the principal social unit of Sudanese society; above all, its honour and dignity must be preserved. Dignity and honour depend upon the behaviour of every family member, especially the moral conduct of its women [4]. As in many other African settings, the population under 15 years of age constitutes 45% in Sudan. The overall literacy rate is 40% for females and 66% for men. The life expectancy at birth is 52 years for males and 56 years for females [55].

In Sudan antenatal care has around 80% coverage and 57% of the deliveries are supervised by skilled attendants, most of them midwives. There are in total around 12,000 midwives in Sudan. The midwifery training has a duration of one year after 0–8 years of schooling (District Midwives). In Sudan maternity care is mainly provided by different types of midwives. Health visitors perform 64% of prenatal care, traditional birth attendants (TBA) 13% and nurse-midwives 9.5%. Physicians perform only 3.5% of prenatal care. The median number of visits per woman is 5.2. Most women receive prenatal care during 3–6 months of pregnancy (84%) and the median gestational age at first visit is 4.5 months. Most deliveries are performed at home (78%) or at governmental hospitals (20%). The deliveries are most often assisted by a health visitor, mother/female relative, TBA or nurse-midwife. In Sudan the crude birth rate is 33, which implies around one million births per year. The maternal mortality ratio for 2001 was 763 [55]. This implies 7,000–8,000 maternal deaths per year in the country. Maternal mortality rates vary from 541 to 2,270 deaths by region, the eastern, southern and western regions having higher rates than the central regions and Khartoum [47].

Female genital cutting in Sudan

Approximately 90% of the women in northern Sudan have experienced FGC in girlhood, infibulation being the predominant form [55-57]. Studies from Sudan, published both locally [58, 59] and internationally [8, 37, 38], report a change of practice from infibulation to clitoridectomy, at least among young educated urban people.

Efforts to combat FGC in Sudan have been going on since several decades before the Second World War. Religious leaders, politicians, activists and medical practitioners have been concerned with finding ways and means to abolish the practice of FGC. The Criminal Law of Sudan has prohibited infibulation since 1946 and Sudan was the first country in Africa to legislate against FGC [60, 61]. The law was ratified again in 1956, after Sudan became independent, and the punishment imposed for carrying out infibulation was five years imprisonment and/or a fine. However, with the introduction of the 1983 penal code, this law ceased to exist. FGC is illegal and punishable in Sudan by fines and imprisonment [14, 61], covered under the criminal codes provision on 'injury', since the 1991 Penal Code does not refer to FGC as such [61]. The current government of Sudan publicly opposes all forms of FGC and is working on enactment of a specific law against all forms of FGC [61, 62].

In Sudan, the search for ways to successfully confront FGC is going on through numerous local campaigns and NGO activities. Public statements in campaigns for social change on a participatory basis have recently proved to be successful [63]. Recently, the Ministry of Health in Sudan emphasised the importance of acknowledging the practice of RI in their recommendations for Public Health work against FGC [62]. Unlike primary FGC, RI has been shown to be widely practised irrespective of level of education and socio-economic status [19].

The study settings

The setting chosen for papers I and III was a village in the El Gezira scheme along the Blue Nile in central Sudan (Figure 1). Contacts with the village were initially made through an international development project, Sudan Village Concept Project (SVCP) that had been working in the village since 1994. According to the SVCP baseline survey

(1994) there were about 3,600 inhabitants in the village. It was estimated that 50% were below 15 years of age. Many of the male inhabitants did not live in the village at the time of the research. Lack of working possibilities made men move to cities to be able to earn enough money to support their families. This resulted in about 70% of the villagers being women. All inhabitants in the village were Muslims.

The setting for papers II, IV and V was Khartoum State, Khartoum/Omdurman, Sudan.



Figure 1: Map of Sudan.

3.2 Sweden

Immigration to Sweden from Sudan, Somalia and Eritrea

Since the end of World War II, Sweden has been an immigrant country. Around 20,000 women and men born in Eritrea, Somalia and Sudan, have migrated to Sweden, most of them as recently as the 1990s. The majority are from Somalia (14,809) in 2003 [64].

Studies have shown that in Sudan, Somalia and Eritrea more than 90% of the women of reproductive age have been subjected to FGC, and the majority of these women have experiences of the most severe form, infibulation [3, 14, 65]. Studies have shown that women from sub-Saharan Africa, living in Scandinavia, represent a high-risk group [66, 67]. Perinatal mortality among parturient sub-Saharan immigrant women was found to be four times higher than among native Swedish women [68]. There were also higher rates of foetal distress, emergency Caesarean section and low Apgar scores among these women than among native women [46, 68]. It has been discussed whether this fact is related to FGC or to other aspects. Other factors such as low social status, suboptimal antenatal and perinatal care, mental stress and larger burden of other diseases have also been presumed to interact with the poor health of the immigrant women [66, 67, 69]. Yet research on these women's encounter with Swedish maternity care is limited.

The settings for paper VI were three cities in Sweden. The cities varied in size, from 70,000 to 300,000 inhabitants.

4 METHODS

The research in this thesis applied both quantitative and qualitative methodologies.

All research needs to be questioned and evaluated. The term trustworthiness is an appropriate overall term for evaluation of both quantitative and qualitative research, while the terms credibility and transferability are used for qualitative research instead of the concepts internal validity and external validity [70-77]. Lincoln & Guba [70] describes several procedures, each of which enhances the trustworthiness of qualitative research. These approaches are prolonged engagement, persistent observations,

triangulation, peer review or debriefing, negative case analysis, member check and clarifying researchers' potential bias from the onset of the study, rich descriptions and external audit [70]. In triangulation an issue is evaluated with the help of perspectives that come from several different angles (compare with the determination of position in navigation). According to Polit et al: "*Triangulation provides a basis for convergence on the truth. By using multiple methods and perspectives, researchers strive to distinguish true information from information with errors*" [77].

Triangulation can occur in data sources, data collection methods, investigators and even research methodologies. Triangulation in data sources may entail collecting data from different people involved in an event, e.g., doctors and patients. Triangulation in data collection methods may include the combination of in-depth interviews with focus group discussions. Further, triangulation in investigators refers to the use of more than one investigator. Finally, triangulation in research methodologies refers to the combination of qualitative and quantitative methodologies for studying the same research topic [72]. In this thesis triangulation of data collection methods, investigators and research methodologies were used in order to strengthen the credibility and transferability.

4.1 Study design, participants and data collection

Table 2 summarises the study design, participants, data collection and the analysis used in the papers included in this thesis.

Table 2. Summary of study design, participants, data collection and analysis (I–VI)

Study	Sample	Study design, data collection and analysis
I Perceptions and practice of FGC in Sudan. (March–May 1997)	60 women and 59 men from different generations living in rural areas.	A descriptive Knowledge-Attitude-Practice (KAP) study with interview-administered questionnaires to investigate attitudes to and practice of FGC among women and men. Analysis through manifest content analysis and statistical analysis.
II The prevalence of RI after delivery in Sudan. (January–August 2004)	100 women from two hospital settings.	The study design was descriptive and explorative. A hospital-based study that measured the prevalence of repeat FGC after delivery through participatory observations and digital examination. Statistical analysis.
III Reinfibulation after delivery in a rural setting in central Sudan. (March–May 1997)	60 married women, including two generations.	Interview-administered questionnaires in a KAP design were used to elucidate perceptions and practice of RI among women. Analysis through manifest content analysis and statistical analysis.
IV Midwives' motives, perception and experiences of reinfibulation in a Sudanese hospital setting. (September 2001–May 2003)	17 midwives in two hospital settings in Khartoum/Omdurman.	An explorative study using observer-as-participant observations and open-ended tape-recorded interviews to elicit midwives perceptions and experiences of FGC and RI. Analysis through qualitative latent content analysis.
V Women's and men's experience of FGC and RI in Sudan. (September 2002–June 2003)	20 participants in the pilot and 22 in the main study.	Focus-group sessions and tape-recorded open-ended interviews were performed in order to investigate perceptions and experiences of FGC and RI. Analysis through qualitative latent content analysis.
VI Women's perceptions and experiences of FGC and the encounter with Swedish maternity care after migration. (January 2003–August 2004)	22 women living in Sweden, originally from Sudan, Somalia and Eritrea.	An explorative design with open-ended interviews focusing on experiences of FGC and RI and the encounter with Swedish maternity care. Analysis through qualitative latent content analysis.

Participants and data collection procedures

Paper I

A total of 119 participants were selected, representing two generations and both sexes. They were randomly selected from an updated election list from 1996. Four groups of villagers were interviewed: (1) married women 30 years of age and below; (2) grandmothers regardless of age; (3) married men 35 years of age and below, or older if their oldest daughter (or oldest son if they did not have a daughter) was less than four years; (4) grandfathers (regardless of age).

The sample consisted of 30 young mothers, 29 young fathers, 30 grandmothers, 30 grandfathers. Pre-tested questionnaires with fixed questions and open answer possibilities were used for the interviews. The interviews with group 1 and 2 were carried out at the respondents' home by the author (V.B.) and another female interviewer (N.E.-H.). The interviews with group 3 and 4 were carried out by three male interviewers (L.A., S.S.A.-S. and S.S.H.).

Paper II

The sample consisted of 100 women, 50 from each of the two hospital settings included in Khartoum State, Sudan. Both samples were selected systematically upon being admitted to the delivery ward, resulting in every tenth woman on the patient lists being selected during the observation shifts. Participatory observations with digital examinations before and after delivery were carried out. A pilot study was carried out in several steps. During the pilot, a form was developed for data on age, number of deliveries, type of FGC, estimated width of vaginal orifice before delivery, DI/anterior episiotomy, other episiotomies, type of delivery, midwife who performed the delivery, re-stitching after this delivery, and estimated width of the vaginal orifice after delivery. Then the form was piloted at 10 deliveries, evaluated and modified and then tested and re-modified at another 20 deliveries in the other hospital setting. The data collectors moved between two types of participant observation, *complete participation* and *participant-as-observer* [73]. The data collectors were two registrars in obstetrics and gynaecology, each of them working in the two hospital settings with data collection during their ordinary shifts in the wards. A tape measure was used to transversely

establish the dimensions of the digits (at the level of the second interphalangeal joint of the index and middle finger of the right hand) of the two registrars. The same registrar conducted the assessment of vaginal width before and after delivery for each case.

Paper III

Structured interviews were performed among 60 young mothers and grandmothers (same sample as in paper I). Two groups of villagers were interviewed: married women 30 years of age and below and grandmothers regardless of age. Thirty respondents in each group were randomly selected from the lists. Pre-tested questionnaires with fixed questions and open answer possibilities were used for the interviews. The interviews were carried out at the respondents' home by the author (V.B.) and another female interviewer (N. E.-H.). There was no other person present at the time of the interview, except for some of the grandmothers who had a few female friends with them. In order to avoid selection bias of respondents the election lists from 1996 were updated with the help of different villagers until no new individuals were added or withdrawn.

Paper IV

Triangulation of data collection methods was applied, using non-participant observational technique and explorative open-ended tape-recorded interviews with 17 Sudanese midwives. The settings were two government hospitals in Khartoum/Omdurman, Sudan. The midwives were selected among midwives working at the different wards, using purposive sampling in order to obtain maximum variation. The inclusion criteria for the participants were difference in age, education and professional experience. The interviews covered three main areas: the midwife's experience of her profession and her motives for and perceptions and experiences of RI. Follow-up questions were asked to deepen, further develop or clarify the answers. The interviews were performed by the author (V.B.) in close co-operation with a midwife, who was interpreting between Arabic and English. V.B. and the interpreting midwife discussed each interview and how to adjust focus, before the next interview. All interviews were tape-recorded with the consent of the interviewees. The tapes were coded to ensure confidentiality and transcribed verbatim in English and partly in Arabic.

The technique of *Observer-as-Participant* [73] was used, with the majority of the researcher's time spent observing and interviewing. The principal investigator (V.B.)

performed observations of the overall context and of 167 deliveries and made field notes about what she saw taking place in the delivery wards of two public hospital settings in the Khartoum area during regular visits, between September 2001 and May 2003. The field notes consisted of detailed and concrete descriptions of what was observed, quotations from the people observed, the observer's reactions, and field-generated insights and interpretations.

Paper V

The design was descriptive and explorative and based on interviews with men and women in Khartoum State, Sudan, between September 2002 and June 2003. A feasibility study was performed through two focus groups, one with men and one with women, and through ten interviews, with five women and five men. The analysis of the pilot interviews formed the basis for the final interview guide regarding perceptions and experiences of men and women towards the following themes: clarifying definitions of practices, attitudes to uncircumcised girls, attitudes and practice of FGC and RI, motives for, perceptions of and experiences of FGC and RI and the decision-making process. The main study comprised 22 open-ended interviews, including twelve women and ten men. The participants were selected by purposive sampling with variation in economic status and ethnic group. The inclusion criteria for the participants were: difference in age, education, ethnicity and geographical area. The data collection was performed by Sudanese female psychologists. The interviews were conducted in an isolated place to minimise interference and to maintain privacy. The participants were asked open-ended questions about their own experiences and their general perceptions, attitudes and practices of primary FGC and RI. Follow-up questions were asked to deepen, develop or clarify the answers.

The female participants were between 19 and 68 years old. Two women were illiterate, one woman had primary education, five had secondary education, two intermediate and two had university education. The female respondents were teachers, nurses or housewives. The male participants were between 28 and 47 years old. Five men had secondary education, two had intermediate education and three had university education. The male respondents were working as businessmen, physicians, nurses or gatekeepers.

Paper VI

The design was explorative. Tape-recorded open-ended interviews were performed with immigrant women living in three different cities in Sweden from January 2003 until September 2004. The cities varied in size, from 70,000 to 300,000 inhabitants. A pilot feasibility study [77] was carried out with explorative interviews of three women. The results were used to develop themes and questions for the main study. The women were selected using snowball sampling or network sampling with selection of subjects by means of nominations or referrals from earlier subjects. The inclusion criteria for the participants were coming from Eritrea, Somalia or Sudan and having experiences of delivery. Two different snowball samplings took place, one with women of Sudanese origin and one with women from Somalia and Eritrea. In both chains, efforts were made to obtain variation in the respondents' age, religion and time in Sweden. In all, 22 women, six from Eritrea, eleven from Somalia and five from Sudan, participated in the study. The interviews covered three main themes: the women's perceptions and experiences of FGM, the women's experiences of delivery and the experiences of the contact with Swedish maternity care. Follow-up questions were asked to deepen, further develop or clarify the answers

4.2 Data analysis

For this thesis both manifest content analysis and latent or interpretative content analysis were used to analyse the qualitative data. Content analysis originates from the analysis of propaganda during the Second World War [75]. According to Holsti [78], content analysis is defined as a research technique for the objective and systematic description of the manifest content of communication. From this kind of content analysis, summarising surface features of messages, a qualitative content analysis has been developed, aimed at interpreting the meaning of the content, which Baxter [79] called interpretative content analysis. In Weber [80] content analysis is described as a research method that uses a set of procedures to make valid inferences from text, with the following purposes: to code open-ended questions in surveys, to identify the intention and other characteristics of the communication and reflect cultural patterns of groups, institutions or societies. Berg [75] distinguishes between manifest and latent content analysis: "*manifest content is comparable to the surface structure present in the messages, and latent content is the deep structural meaning conveyed by the message.*"

Data analysis, papers I–III

The statistical software used for the quantitative material in papers I, II and III was the Statistical Package for the Social Sciences (SPSS), version 9.0. SPSS, version 11.0, was used for analysis of all data in paper II. Data were entered by two different operators. Significance testing of differences between proportions was conducted using the Chi-squared test where applicable. Fisher's exact test was used when numbers were equal to or less than five. A p-value of < 0.05 was considered statistically significant.

Manifest content analysis was used for the narrative text from the open questions in the interview-administrated questionnaires (I, II). The texts were analysed by colour-coded brackets to mark different topics [81]. After the coding process was completed, each piece of the coded material was sorted and all material relevant to a particular topic was placed together and thereafter used as quantitative data.

Data analysis, papers IV–VI

The analysis of the data embraced the qualitative integral processes of comprehending, synthesising (decontextualising), theorising and recontextualising or description, conceptual ordering and theorizing [73, 74, 82, 83]. The technique for analysis of the transcribed texts (IV–VI) was qualitative latent content analysis according to Berg [75]. Latent content analysis of the text moves from understanding to explanation and from explanation to comprehension [75]. The texts were read several times. In the first reading the authors of the papers read the transcribed notes independently of each other. The aim of the first reading was to provide a sense of the whole, while the aim of the second reading was to gain ideas for further analysis. During the third reading, text units appearing to deal with the same content were identified and sorted into topics relevant to the purpose of the study. The statements in each topic were critically analysed and questioned, read and compared in order to achieve reasonability. After each reading the authors came together and compared their analysis. The transcribed texts were then reflected on and organised into categories. In the final step, the authors reflected on the text as a whole and the aim was to reach a consensus on an overall understanding. Berg [75] and Sandelowski [84] recommend detailed excerpts from relevant statements to serve to document the researcher's interpretations.

5 ETHICS

Conflicts between ethical requirements and self-interest may produce practical dilemmas that give rise to questions about practical priorities instead of moral dilemmas or problems [85]. Methodical reflections in ethics necessarily involve two kinds of premises: those concerning facts and those concerning values. The factual premises involve information concerning, for example, decision-making ability, risk of harm and degree of suffering. Value premises involve ethical values such as obligations, rights, autonomy and justice. The value premises are based on ethical theories or principles. The ethical field contains several different theories that suggest different forms of value premises [1, 85, 86].

Most ethical guidelines assume some consensus that is considered to be based on common morality and that involves elements of various ethical theories. This system constitutes one of the modern theories and expresses obligations in terms of four ethical principles: autonomy, non-maleficence, beneficence and justice [1, 85-87]. Some researchers include the principle of non-maleficence (above all, do not harm) as one dimension of the principle of beneficence [77].

The principle of autonomy implies that we are obliged to respect people's right to decide about their own lives, as long as it does not intrude on other people's right to decide about their own lives. Respect in accordance with this principle means that we have an obligation to make it possible for people to act autonomously, i.e. well informed, with competence and out of free will. *The principle of beneficence* is the ethical duty to do good and maximise good and includes the obligation to prevent and reduce harm. *The principle of non-maleficence* means that we have an obligation not to harm people. Harm could involve physical or mental harm as well as disrespect for people's integrity or interference with someone's well-being. *The principle of justice* means that we ought to treat people with fairness, but it is also the principle that the law and legal institutions such as law courts aim to serve [1, 85, 86].

Respecting the principle of autonomy in research on human beings means that informed consent should be obtained before the subject/participant is included, and that the participant has the right to leave at any time without any obligation to explain why.

Informed consent means that it is ethically valid, implying given by a competent person with understanding and voluntarily, in accordance with the Ethical Principles for Medical Research Involving Human Subjects, World Medical Association Declaration of Helsinki [87], which were followed in conducting the research in the papers included in this thesis.

According to the principle of beneficence there is an obligation to gain knowledge to lessen the harm of FGC and RI. According to Olatunbosun [88], conducting research in the area of FGC could enhance the process of empowerment for both the investigators and the participants by combining perspectives from outsiders and insiders. The potential beneficence of research depends on several aspects, such as the ability of the investigator to balance the demands of research against the well-being of the study participants. It is difficult to gain knowledge in research in sensitive issues without the risk of interfering with the obligation to protect individuals. Therefore the principle of beneficence, which motivates the research, must be balanced against other principles. Polit et al. [77], recommends researchers to always balance the principles considering a risk/benefit ratio, counting potential benefits and costs of research to participants and potential humanitarian benefits of the knowledge to be gained.

The principle of non-maleficence was considered when conducting this research, assuming that asking about experiences of FGC might cause distress, anxiety and suffering. These issues were carefully discussed within the multidisciplinary research team, which included senior Sudanese psychologists and psychiatrist with experience in research about FGC in Sudan and in psychological counselling.

The studies in Sudan were approved ethically by the Research Directorate, Federal Ministry of Health, Khartoum, Sudan. The studies were also approved by the Ethics Committee at Karolinska Institutet, Stockholm, Sweden. Local ethical approvals were received from the hospital managers in Khartoum/Omdurman, Sudan (II; IV) and from Ahfad University for Women, Khartoum, Sudan (V).

6 RESULTS

6.1 Attitudes, perceptions and practice of primary female genital cutting (I)

All female respondents had undergone FGC, 59 of 60 were infibulated and one young woman had undergone clitoridectomy. All grandparents had let their first daughter undergo some form of FGC. Among the young parents, 50% of the women and 38% of the men had decided not to let their first daughter undergo FGC. Two of the young men and four of the young women had let their eldest daughter undergo FGC. This had been carried out between 4 and 7 years of age. There had been a significant shift from infibulation, preferred by previous generations, to clitoridectomy, preferred by the younger generation. The level of education played an important role in the young women's decisions. Significantly more of those with higher education did not want to let their daughters undergo FGC. Significantly more of those who believed in religious support for FGC would let their daughters undergo the procedures than of those who did not believe in this support. More men than women thought that there was religious support for FGC (56 and 33%, respectively). On the other hand 22% of all believed that FGC is against the teachings of Islam. This was not related to level of education.

A girl's mother was the major decision maker. According to the young men, the father of the girl was more involved when decisions were made not to perform FGC. On the general level, tradition and social importance were stated as the main motives for performing FGC. Sexuality was also an aspect mentioned frequently (the most frequent answer among the young mothers), specified as: to ensure virginity/decrease sexual desire or for the benefit of the future husband/to satisfy husband/because men prefer it. The reason "women's tradition/grandmothers' push" was mentioned as a motive for FGC, especially among the young women. On the personal level, the major answer of all respondents was that FGC is performed because it is socially important. Grandmothers and grandparents most frequently answered that tradition was the motive. All groups mentioned that FGC is important for the future husband, implying marriageability. The motive for those who did not want their daughter to undergo FGC was mostly that they wanted her to avoid the suffering that FGC causes.

6.2 The prevalence of post-partum tightening operations (II)

The younger group of women (15–25 years) had a primary FGC prevalence of 85% and the older group (26 and above), had a prevalence of 94%. No differences in age were found related to type of FGC. Out of all the women, 70% were deinfibulated before delivery, 83% had episiotomy before delivery, 10% had no FGC, 2% had type I, 7% had type II, 80% had type III and 1% had type IV.

Of the 80 women who had been subject to FGC type III, 69 (86%) had episiotomy. Among women with other forms of FGC this proportion was 56% ($p < 0.05$). A significantly higher proportion of nulliparous women underwent episiotomy than women with previous deliveries. Out of all deliveries, 90% were normal deliveries and 3% were performed with forceps and 7% were assisted because of breech presentation or shoulder dystocia. Midwives performed 92% of the deliveries and 8% were performed by registrars.

The prevalence of tightening vulvar operations after delivery was 61% among the 100 newly delivered women. Those women were >10 mm tighter after delivery through suturing than before delivery. In hospital A 66% and in hospital B 56% had undergone such tightening operations. Out of the 47 young women (15–25 years), 31 (64%) were tighter post-partum than before delivery. Out of the 53 older women (25–35 years), 31 (58%) had undergone a tightening after delivery, compared with before delivery.

Out of the women entering the delivery ward with FGC type III, 70% (56/80) had undergone a tightening operation after delivery, which was significantly more than was the case among women with types 0–II. It is noteworthy that 35% (7 out of 20) of the women who had not been subjected to a sutured type of FGC before delivery (no FGC or type I–II) had been subjected to a tightening operation post-delivery. Two women (out of 10) without any primary FGC had undergone a tightening operation after delivery.

6.3 Attitudes to, perceptions and practice of reinfibulation (III)

All the 60 women interviewed had undergone FGC and all were infibulated except one. All except one had been subjected to RI. Out of the 27 young women who had children,

4 had Caesarean sections and 23 had delivered vaginally. In the latter group 20 had been reinfibulated after delivery. None of the women who had Caesarean sections had been subjected to RI, but two expressed that they had been expected to have it performed.

A few young women had decided to break the pattern and not be subjected to RI after future deliveries, due to health complications such as pain, infections, bleedings, abscess formation, sexual problems, obstructed labour and difficult deliveries, but also religious reasons for not undergoing RI were mentioned. Several respondents also mentioned death being associated with the practices of deinfibulation and reinfibulation, repeated after every delivery.

Concerning the decision-making process, the young group of respondents stated that the midwife and female relatives were behind the decision about RI, rather than the woman herself. The group of grandmothers answered that reinfibulation was a decision of the woman herself (15 of 29), but some (8) answered that it was the decision of the woman's mother or other female relatives. According to the women, men were not involved in decisions to perform RI, but some young women said that men had played a supportive role in the few cases when decisions were taken not to perform RI. An example of the complex decision-making process related to RI after delivery, by a 21-year-old woman:

“I refused to be reinfibulated after the Caesarean section, though my mother wanted it. My husband supported me in my decision. He did not want me to go through such suffering again. I am very happy about it now. We are often told by older women that men want the tightening, but I have not heard it from men.”

The main motive for performing RI was for all respondents to satisfy the husband sexually (in all 24). Several (8 of 29) of the grandmothers answered “tradition/the normal thing to do/social reason” as a motive for RI, but only two out of the younger women answered this. Two old women answered that a motive was satisfaction for both the woman and the man, and one describes how RI was needed to heal and avoid infection.

6.4 Midwives' reasoning about reinfibulation (IV)

Most of the participating midwives had undergone infibulation and RI themselves, and 11 had daughters who had undergone different forms of FGC.

Concerning the context, 94 women were observed to have undergone infibulation, 36 women had been subjected to other forms of FGC and 37 women had no form of FGC. For women with infibulation or an intermediate form of FGC, DI was performed before every birth. DI involves the cutting of the scar of FGC to allow access, and splitting the scar to widen the opening for birth. A smaller cutting in the fused tissues was also observed in order to ease medical procedures or because of a request just after marriage. Re-suturing to the size as before delivery (Khiata) was considered necessary by the midwives to prevent bleedings and infections. The second type of re-suturing, RI/El Adel, was performed to recreate the size of the primary infibulation, a pinhole size.

Concerning the decision-making process, the midwives described different actors: the woman's mother, grandmother and other female relatives, the husband, the midwife and the woman herself. Their roles in turn seemed to be interrelated: the mother of the delivering woman as the one negotiating with the husband and the midwife, the husband as the one often paying for the procedure and sometimes also taking the initiative directly with the midwife. The woman was seldom described as being the one taking the initiative in performing RI herself. The midwives acknowledged themselves as having a role in motivating the women to undergo RI. One midwife tried to explain:

“Yes, it happens that the woman refuses – when you talk to the woman she will say: ‘I don't want this.’ You see, sometimes the woman has a different opinion – and sometimes it is a request from the husband. The husband will give his wife gold and a new traditional dress.”

On a personal level, the midwives used a multiple rationale for justifying their performance. They perceived it as meeting socio-cultural requests, striving for beautification and completion of the women, enhancing male sexual enjoyment to maintain marriage, and then their own economic motives. The primary FGC was not considered completed until RI had been performed. The midwives were trying to balance the demands of the family for the performance of RI, against a worry about

inflicting pain and suffering on the women. The midwives acknowledged that harmful health complication could be a consequence of the practice, but not personally for them. They reasoned that if they did not perform RI someone unskilled might perform it instead, entailing complications and worse suffering for the woman.

Socio-cultural motives emerged as central, including reasons related to normality, culture, nationality and religion. Reinfibulation (El Adel) was mentioned as the “normal” thing to do after delivery, a tradition and a necessity, which had to be performed for the husband’s sexual satisfaction. Some midwives even mentioned that the practice of re-tightening is a fashion and mentioned groups who had not formerly practised El Adel after delivery, but had recently taken up this practice. Narratives were told about women who had moved to Khartoum without any previous history of primary FGC, who requested El Adel after delivery.

6.5 Experiences of female genital cutting among women and men (V)

All the women interviewed had personal experience of infibulation, except one who had undergone an intermediate form of FGC. All the interviewed men had wives who had undergone infibulation, except one who had been subjected to clitoridectomy. A majority of the interviewed women had undergone RI after delivery and some also in between deliveries. Half of the men interviewed had wives who had undergone RI.

Concerning the decision-making process: men and women blamed each other for the continuation of the practices, but women also blamed the old women and the midwives. The younger women indicated that the older women were the ones with power and the ones who insist on FGC, preferably infibulation. The few older women interviewed admitted their interference and stressed that it is an important tradition. Some women blamed the silence of the male society for the lack of change in practice. They argued that it is the men who have the influential role in the family and thus can change the painful traditions. On the personal level, all women who decided to resist RI spoke of support from their husbands and some also had personal experience that the father’s role was important in the decision about the FGC for the daughter. A 65-year-old woman explained:

“I do not ask my sons and daughters, I will compel them to circumcise their daughters whether they agree or not as long as I am alive. After my death it is up to them.”

The overall understanding of the perceptions and experiences was that both the women and the men were victims of the consequences of FGC and RI. The female narratives could be understood in the categories: viewing oneself as being “normal” in having undergone FGC and RI; being caught between different perspectives; and having limited influence on the practices of FGC and RI. The male narratives could be understood in the categories: suffering from the consequences of FGC and RI, trying to counterbalance the negative sexual effects of FGC and striving in vain to change female traditions. Concerning RI, all participants were aware of the different repairs after delivery. The women stated that it is the midwife who performs the operation after delivery, or in between pregnancies. The women viewed themselves as being “normal” in having FGC/RI, expressed in relation to being purified and re-tightened and being sexually restrained. Being sexually restrained was only mentioned in relation to primary FGC, but being purified and re-tightened was mentioned in relation to both FGC and to RI. A 42-year-old woman who had been submitted to FGC herself, described women who had not undergone FGC in this way:

“I think she can’t control her sexual behaviour, because she has a very strong sexual urge. She has a nasty smell and she is not accepted by the men as the circumcised women are.”

Regarding social consequences, women described how families that decide not to let their daughters undergo FGC are perceived to be at risk of stigmatisation. In some of the interviews the uncircumcised girl/woman was described as hypersexual, considered undesirable for marriage, since a girl who is not circumcised could create problems for the family in getting her married, and marriageability was mentioned as important. On a personal level, concerning their own family, the men said that they had only limited influence. Almost all the men stated that they did not want their daughters to undergo FGC and no man answered that he wanted his daughters to undergo infibulation.

6.6 The experiences of female genital cutting and the encounter with maternity care after migration (VI)

All the interviewed women had personal experiences of some form of FGC, except one woman. The women's experiences were seen as three main categories: Suffering from being abandoned and mutilated, Experiencing being vulnerable in the encounter with Swedish healthcare personnel and Trying to adapt in a new cultural context. The overall understanding was *Being different*. The women would have felt different and shameful in the home countries if they not had submitted to FGC, but in the encounter with Swedish health care they felt different and vulnerable by having undergone FGC.

Women experienced vulnerability in the encounter with Swedish health care personnel. Memories of the primary FGC experience were reawakened in situations with gynaecological examination and delivery. In the category Being abandoned and mutilated the women narrated how they as girls were not only vulnerable, but also subjected to an often very painful outrage that had coloured their entire life. A 24-year-old woman remembered:

“She holds up the razor blade and she cuts me. She has some home-made analgesic, but it does not help. I feel the most terrible pain. I feel how she cuts in me, I felt the razor in me, and I felt as they cut away a part of myself, so painful was it. I thought I was going to die.”

When reasoning about their daughters, they referred to their own personal experiences, from which they wanted to protect their daughters. They also explained that because of migration, they had got rid of most of the female peer-pressure to continue all forms of FGC.

The women said that they had wanted to be re-sutured after delivery, as the practice is in the home countries, at least to the same size as before delivery. But this request was not fulfilled. Women referred to their own suffering by “being open”, and thought that the law forbidding health personnel to reinfibulate was too harsh, referring to their own health complications.

Concerning the delivery situation, the women felt that they were not asked beforehand about FGC, and therefore they took it for granted that the midwives already had the knowledge. In the delivery situation the women experienced helplessness being in the hands of midwives with lack of cutting skills. The interviewed women also expressed problems in the communication with the midwives. A 35-year-old woman described:

“There are many Somali women here in Sweden, so they must have the experience. This was what I thought. I remember the delivery as a long fight from my side. And then I mean not only fighting with the delivering of my baby, but fighting in order to get the staff to understand how I would like it. In Somalia the midwives know how to deal with us. We need to have help, because we are sutured. We can’t become like Swedes and we can’t deliver like Swedes. We are more afraid because we are sutured.”

The women described how they had perceived been stared at by several personnel at the same time, without being asked. They described that they understood from the facial expressions of the personnel that they saw something strange, even showing expressions of disgust. Women with high parity felt less well received than in the first two pregnancies and deliveries. The women also described perceived condescending attitudes and alleged insults from the nurses at the health centres that made them not to return to the regular pregnancy-related health controls.

The women’s narratives also expressed an eagerness to state how grateful they were to be in a peaceful country and to receive a high standard of clinical care.

7 DISCUSSION

7.1 Methodological considerations

The aim of this thesis was to explore FGC and RI in a country of origin, Sudan, and after emigration, in Sweden. The thesis covers FGC and RI with focus both on the victim and on the perpetrator, and its focus is also on the encounter between victims of primary FGC and the health care staff in Sweden, from a qualitative perspective.

Perhaps there is no value-free or bias-free research. Therefore, awareness of interaction with researchers' pre-understanding is important [71]. This knowledge is especially important in qualitative research, where the human being is the primary instrument for data collection and is used as a tool in the interpretation process. However, the pre-understanding is not easy to make explicit and capture as it is unconsciously adopted and taken for granted.

To accomplish this thesis, several procedures were performed with the aim of ensuring trustworthiness, in accordance with Lincoln and Guba [70]. Peer debriefing took place and there were ongoing discussions regarding interpretation and translation through all the studies. Also member checks were performed (IV, VI). Transferability, the extent to which results could be transferred to other populations and context, was established through sampling based on variation (I–V and partly VI). The so called dependability – the extent to which the results would be repeated if the study was to be replicated – was reflected through all the papers with by keeping field notes, notes on analysis and computers files of preliminary interpretations. Finally, confirmability, implying the extent to which the results are not due to bias by the researcher, was aimed for through self-reflection by the researcher to maintain awareness of risks of bias and through triangulation of researchers and data [71, 72, 76]. Triangulation of different points of views of FGC/RI are the results of this thesis; the women's and the men's perspective, the prevalence perspective and the midwives point of view.

The current legal situation, both in Sudan and in Sweden, complicates the issue of research about FGC and RI. The practices are illegal and punishable in both countries [14, 61, 89, 90]. Studying the prevalence of illegal actions suffers from the inherent risk of underestimation of the true prevalence [91]. Studying experiences of something that is illegal or perceived as illegal makes it more sensitive and people could withhold experiences because of fear of being reported.

Moving between cultural and language barriers implies a risk that some information might have been lost due to the procedures of translation and interpretation.

7.2 Victimisation as a consequence of female genital mutilation

From a research perspective, FGC is not only unethical, according to the four ethical principles, but also criminal, according to the Sudanese and the Swedish penal codes. Female genital cutting and RI cause harm to the individuals who become victims. The principle of autonomy is violated as girls become victims of a crime without possibilities to give informed consent. The victim perspective builds on the United Nations Crime Victim Declaration as follows:

“Victims means persons who, individually or collectively, have suffered harm, including physical or mental injury, emotional suffering, economic loss or substantial impairment of their fundamental rights, through acts or omissions that are in violation of criminal laws operative within Member States, including those laws proscribing criminal abuse of power” p. 3 [92].

It may be argued that the victim perspective is an expression of a western and outsiders’ interpretation. But respondents in the studies in this thesis (I, III–IV), described experiences of suffering of health complications related to FGC. Harmful health complications as direct consequences of the primary forms of FGC have been thoroughly documented in the local and in the international literature [3, 4, 18, 26, 93–95]. Even if FGC did not entail risk of physical and psychological harm, it would still constitute a violation of children’s and women’s human rights as innately sexual beings [96]. It is also a violation of the United Nations’ Convention on the Rights of the Child, which all countries except Somalia and the USA have ratified. Article 19 requires “measures to protect the child from all forms of physical or mental violence, injury or abuse”, Article 24 requires abolition of “traditional practices prejudicial to the health of the child” [97].

Victimisation in the decision-making process was seen through the papers in this thesis. The results of this thesis elucidate a complex decision-making process, in which the different agents blamed the persistence on each others. Female as well as male respondents blamed the older women and the midwives for the persistence of the practices (I, IV). Midwives blamed their performance of the operations on their wish to satisfy the demands of the community. The younger generation of women and the younger generation of men viewed themselves as unwilling to continue with either FGC

or RI (I) but neither of them saw themselves in a position to achieve a change (V). Both sexes blamed the other for the continuation of the practices (V). Both men and women mentioned suffering of health complications because of FGC/RI (III, V), but said that they did not communicate this between the sexes, because of the taboo (III, IV and V). A lack of communication between the sexes in this issue, in the Sudanese context, has previously been described by several authors [4, 30, 98]. The respondents also spoke of deficient communication concerning FGC and RI between women and midwives, both in Sudan (III, IV, V) and in Sweden after migration (VI).

A revictimisation through RI could be seen in the light of papers III and V and from previous research [5, 18, 20, 30, 44], describing how RI causes the same health hazards as primary infibulation. Our results indicate also that women experienced themselves as vulnerable in the decision-making process concerning RI, being under pressure from older female relatives and the midwives (III, V). In paper IV, the midwives described how it could happen that they sometimes try to convince the women to submit to RI and also that they sometimes even performed RI after delivery without asking the women personally.

Concerning the prevalence of RI (II), for 61% of the women, tightening vulvar operations had been carried out already at the delivery ward. Of the women who had not been subjected to FGC with suturing before delivery, 35% had such an operation after delivery. Also women without any primary FGC had been subjected to a tightening operation post-delivery (II). This means that the phenomenon of RI might be more prevalent and more complex than previously elucidated. Ahmed et al [19, 20] claimed recently that the majority of infibulated Sudanese women undergo RI after delivery, confirming El Dareer's study [5] that showed that over 50% of Sudanese women have RI performed after delivery. The findings of papers IV and V confirm recent research from Ahfad University in Sudan that tightening operations are performed not only after delivery, but also on other occasions. Among some ethnic groups in Sudan, RI additionally takes place up to several times every year, with the purpose of increased sexual pleasure for the man [19].

It might be argued that the mentioned conclusion in Paper II (concerning that 61% had been subjected to tightening vulvar operations post delivery) is vague, since two

practices are merged together, both reinfibulation and vaginal tightening following delivery for women without previous FGC. However, the relationship between type of FGC and extent of post-partum tightening is clearly described in the paper, as well as the number of women without any primary FGC that had undergone a tightening operation after delivery.

7.3 Balancing benefits and harm related to the practices

This thesis shows that FGC and RI could be perceived as resulting in both victimisation and benefits for women (including midwives) as well as men. A consistent pattern through the papers in this thesis was the balancing between conflicting attitudes related to motives for the practices of FGC and RI on the one hand and on the other hand awareness of harmful potential health complications. From an ethical perspective, this could be interpreted as ethical dilemmas between the principle of beneficence and the principle of non-maleficence. This kind of balancing was shown concerning the daughters among men and women (I, V, VI) and among midwives (IV) regarding the harm they might inflict on the newly delivered women in relation to their perceived demands from the family. This dilemma was also shown concerning the women's decision whether they should submit to RI or not (V). The midwives (IV) recognised that the women's physical well-being was at risk in the close perspective as the procedure caused pain and suffering, but perceived that in the long run the women's status would benefit.

Midwives also gained economic benefits from the performance of RI. However, it is a point in paper IV, that the economic incentives were not decisive for their motives, since previous research has mentioned economics as the only motive [19, 22, 30, 49, 99, 100]. That the midwives (IV) did not mention economic benefits spontaneously could also be interpreted as a reluctance to express the hidden context. Further concerning economic benefits, Black [17] described the material benefits from the family's point of view, describing how primary FGC ensures a satisfactory bride price; an eligible man would not consider marrying a girl without FGC. The issue of *Mahr*, the dowry in Muslim marriage, without which the marriage is not valid, has been previously discussed, and in Sudan the traditional bride price is paid to the wife alone [101].

It is sometimes hard for respondents to clarify their support for a practice so obviously “right” as FGC [4]. In this thesis, tradition and social custom were the most common (I, III) or most consistent (IV–VI) explanations given by respondents as reasons for the persistence of the practices. The older generation often answered “*that is the normal thing to do*” (I, III). This has previously been explained by Rushwan et al. as “*Conformity strengthens their collective identity*” [4]. According to Rushwan, the northern Sudanese claim it is incumbent upon them to observe the rules of their family, group or tribe. In a Sudanese study [4], including 1,804 females and 1,787 males, almost half of the women and one third of the men answered that FGC is a good tradition. The respondents said that FGC was performed on the girls and the women because “we are Sudanese”, or “we don’t want to be like ‘Felata’” (migrants from West Africa or southerners) [4]. This was also mentioned in the present papers (I, III, IV). On the other hand, rejection of FGC in both Rushwan’s study [4] and paper IV was frequently justified by appeal to tradition; that this is *not* the tradition of our family or tribe. According to Berger & Luckmann [102], shaping of what is considered normal is created gradually through the creation of so-called sub-universes of meaning. These meanings may be socially structured by various criteria such as sex and age, and the chances that they appear increases in a society with strong segregation between, for example, men and women [103]. This aspect of separation of the sexes should be acknowledged in the context concerning the previously mentioned deficits in communication about FGC and RI among women and men, in papers I and IV and also in other studies [4, 30, 98]. Some authors argue that the matter of sexual segregation is not perceived as repressing or denigrating to the position of women, nor is it associated with inequity [101]. The anthropologist Fluehr-Lobban puts it this way: “*Separation of the sexes is practiced in nearly every sphere of daily life, both in the household and in the public area... The matter of sexual segregation is a problem only with the Western perception of that social reality and its peculiar view of the poor condition of the Muslim women. There are a number of social improvements which women and men would like to see but an end to sexual segregation is not a high priority*” [101] . However, this context does not facilitate the problematic communication in such a sensitive matter as FGC and RI.

Concerning the matter of different perspectives, aspects of health and illness, culture and gender roles should be better elucidated to facilitate for outsiders to clarify how the perceived “benefits” of FGC often predominate. In the context where FGC persists, there are often other ways of understanding health, illness and disease than westerners are used to. In societies in which few women remain without FGC, medical problems arising from FGC are likely to be seen as normal part of a woman’s life and sometimes not even associated with FGC [104]. Instead health problems are related to the evil eye, witchcraft, spirits, God’s will, or just to the female fate of suffering, and might thus not be specifically reflected on [4, 93, 104-107]. In papers III–V, young and old women and midwives experienced personal suffering from FGC and RI, but viewed this as something belonging to the female fate. This has been described by Professor Amna Badri at Ahfad University for Women, Sudan, in this way: *“It is a custom which is considered by the majority of those who practice it as not only essential but a real part of female status, similar to the fact that a girl should be married. She should be ‘circumcised’ as well. It is considered to be a natural part of her life cycle which could not possibly be eliminated”* [108].

7.4 Paternalistic health professionals and suppressive maternalism

Women could be seen as being victimised due to the health professionals’ paternalistic view and even acts towards them (IV). Medical sociologists often emphasise that patients in general are victims of relation asymmetry and professional exploitation of power [109]. Sometimes the midwives (IV) were trying to convince the woman to undergo the procedure or even doing it without asking the woman, stating that their intention was to increase her value. Midwives performed RI with the intention of doing a good thing for the woman, adding to her beauty and restoring her sexual attraction after delivery. On the one hand, from an ethical point of view, these midwives were acting in a paternalistic way based on the concept of utility with the best intentions [110]. Actually, any action directed towards an individual with the aim of benefiting her, without the individual’s informed consent, is paternalistic, which always involves some form of interference with or refusal to conform to another person’s preference regarding their own good [85]. In ordinary English, the term *beneficence* connotes acts of mercy, kindness and charity. The principle of beneficence is a moral obligation to act

for the benefits of others. Utility is an extension of the principle of beneficence [86, 110].

On the other hand, from the principle of non-maleficence, it could be argued that the midwives violated the bodily integrity and informed consent of their patients in order to gain economic benefits. In addition, respect for autonomy and non-maleficence (not inflicting evil or harm) sets moral limits to the professionals' actions [110]. The mentality of paternalism is within the midwives' rationale for justifying their actions, through perceived socio-cultural requests striving for beautification and completeness and enhancing male sexual enjoyment in order to maintain marriage. The midwives (IV) stated that through these genital alterations the women's bodies improved and became more beautiful, smoother and more valuable. These insiders' views have previously been described in the literature [8, 32, 35, 111]. The midwives in paper IV experienced the performance of RI as an act of completion and beautification, completing the primary infibulation, thereby beautifying the woman as well as securing her honour. The completion argument has previously been described in the context of infibulation in Sudan by Boddy [32], but referring to it more as the enclosing of the female organs (used as a metaphor for fertility and femininity). In the latter study the completeness was linked to the concept of virginity or actual re-creation of virginity.

Other paternalistic aspects in this thesis were the encounter with health personnel after immigration to Sweden. The immigrant women (VI) experienced being vulnerable in the hands of the Swedish health personnel, who presumably acted with the best intentions. Paternalists would say that it is ethically right to act in someone's allegedly best interests, even if it is against that person's will. Some recent Swedish studies, viewing the encounter with infibulated women from the midwives' perspective, confirm our paternalistic interpretation, in that the Swedish midwives were reported to have ethnocentric attitudes, perceiving the immigrant women as powerless victims and holding condemnatory attitudes towards the infibulated women and their husbands [112, 113].

Another recurrent theme related to victimisation was that female respondents particularly complained about the strong peer pressure from the female hierarchy ruled by the older women (I, III-VI). This particular female social pressure and concern in the

issue of FGC has previously been described in several studies [4, 8, 22, 30, 33, 96]. This could be seen as women suffering from female peer pressure in the name of maternalism. Maternalism has diverse meanings; according to Sklar [114], historians have used it to denote the purely female version of paternalism, meaning some form of interference with another person's preference regarding their own good with the aim of benefiting her [110]. According to Weiner [115] maternalism is a way to explain variations in the social, political and cultural behaviour of women. Maternalism implies women aiming at doing good for other women, in a context of male domination. The role of maternalism in FGC (prolonged by RI) in Sudan could be understood in relation to both the overall patriarchal context and the subordination between older and younger women and between mothers and daughters. Al-Sa'dawi describes what it is like to grow up as an Arabic woman: "But my mother rules over my life, my future, and my body, even down to the locks of my hair" [116]. These unequal power relations embedded in the maternalistic relations might contribute to sustaining the traditions of FGC and RI. Especially the maternalistic relation between mother and daughter might promote the old attitudes to the coming generation, to the new generation of grandmothers who might be attracted by the power relationship that is linked to being the one deciding about FGC for the daughters, and as mothers of married women, being the one deciding about RI for the newly delivered woman. However, there might be a recent change in family patterns, especially in urban settings.

7.5 Individual men as victims in a patriarchal system

In spite of present patriarchal systems, individual men were also seen as victims, but on another level than the women, through the papers in this thesis. The men expressed suffering of the negative health consequences of FGC and RI and the perceived domination of females in the decision-making process (V). Men claimed that they were hardly involved at all in the decision to perform either FGC or RI (V). This makes the issue more complex than that FGC is supported and encouraged by men [17, 40, 41]. Olatunbosun [88] confirms that the ancient practices of FGC are sustained by collusion among women, within the existing patriarchal system. Other research has also acknowledged that RI and infibulation are performed in the context of a patriarchal system that emphasises virginity at marriage and marital fidelity in the interest of legitimate heirs and male honour [41, 117]. Another example of the complexity is that

the practice of polygamy in Sudan might affect the women's reception of the pressure from the female peers concerning RI. As expressed in the findings of paper V, women might fear that their husband will divorce them or take a co-wife if they do not subject themselves regularly to RI. This was also used as an argument by the midwives for the performance of RI (IV). However, no international or national study has been found where men, whether fathers, brothers or sons, have been shown to be involved in the decision for the girl to undergo FGC. The men (V) claimed that it is not until they are newly married that men get involved when meeting the irrevocable consequences of their wives' primary FGC. The midwives (IV) also said that sometimes husbands were unaware and disappointed by the fact that their wives had undergone El Adel and in other cases even refused the performance of El Adel. Several men expressed a wish that the wife had not undergone primary FGC, which they related both to their premarital sexual experiences with women without FGC and to the negative health consequences of FGC for both women and men (V). This has also been shown in previous research [4, 98, 118, 119]. Men explained that in general men might request RI after delivery because of the form of FGC (implying infibulation) needed this physically, because the damage of primary infibulation is already there (V). This actually secondary request might confirm women's alleged expectations that men want tight (infibulated) brides and influence the decision-making process for FGC for the daughters.

Men in both papers I and V described active male participation in the decision not to perform either primary FGC or RI. It should however be noted that the men in these papers were more educated than the women, and more than average Sudanese men. But the fact that men show attitudes contradictory to the expected ones has previously been shown in other studies [4, 30, 98, 118, 119]. Some men explained also in these papers that they leave their disapproval unspoken because FGC and RI are women's matters. Both "sexual pleasure" and "religion" were given as reasons in papers in this thesis (I, III, V) and in El Dareer's study [8] for both approval and disapproval of FGC. In the study by El Dareer, both sexes believed that FGC gave more sexual pleasure to the husband, and this view was particularly strong among men. This was in contrast to the results in our study (V) where the men described FGC and RI to have mainly negative consequences for their sexual life. However, the repeated infibulation through RI was perceived by the women in the papers in this thesis as a necessity for the husbands' sexual satisfaction (I, III-V). This attitude has been described before by several authors

[8, 11, 119]. Indirectly, according to the midwives (IV), RI/El Adel also helped keep the marriage intact, inhibiting the husband's desire for a second wife. This is also described by Wilson, who states that:

“Reinfibulation is also performed because it is believed that it will enhance the husband's penile pleasure and deflect him away, where polygamy is permitted, from searching sexual pleasure by taking a second wife.” [41].

Perhaps, too, as Rushwan et al [4] also mention, the men might be reluctant to deviate from the existing stereotypes of Sudanese males. Nonetheless, as both women and men stated, inaction and passive stances by males, who are the major decision-makers of the family, may be key factors in the perpetuation of the practice (V).

7.6 Striving for protection by female genital cutting and reinfibulation

A consistent aspect in the thesis was FGC and RI as a means for protection of the females. Primary FGC was often justified by invoking the importance of virginity and marriageability for daughters, in papers I and IV–VI. This is confirmed in several previous studies [8, 25, 30, 34, 41, 120, 121]. Papers in this thesis show that tightening operations sometimes take place also before marriage, after Caesarean section and post-abortion, post-menopause and in between deliveries (IV, V). In all cases the procedures seem to be linked to the concept of virginity. Divorced or widowed women may also undergo RI in anticipation of remarriage, thus renewing their “virginal” status. This has also been described by previous authors [4, 22, 30].

Female genital cutting and RI were viewed as protections against the alleged social stigma of not having FGC and RI (I, III–VI). This social argument/social pressure is frequently described in previous literature, but only considering primary FGC [4, 8, 22, 36, 96]. Primary FGC was also seen as protection against premarital sex and thus as a protection of the virtue of the girl and the honour of her family (IV, V). Paper IV showed that one of the reasons for the persistence of infibulation in Sudan is that it is considered to prevent premarital sexual acts, through the physical barrier created. Cook et al. [96] and others [4, 25, 30] have previously pointed out that the practice is common where premarital virginity is required, often as an indication of a family's honour, which is related to the association of FGC with personal and family purity.

The protection from social insult was also expressed in the study after migration to Sweden (VI). The women told that in their ethnic groups, before migration, FGC was traditionally practised because of culture in order to become normal, to be like the other girls and in order to protect the girl. The women explained that people perform FGC to reduce a girl's sexual desire, in order to preserve her virginity before marriage. They further explained that in their ethnic groups in Eritrea, Somalia and Sudan, everybody is still expected to undergo FGC, and mothers of girls without FGC are teased and insulted by other women. They were ashamed in the home countries if they had not undergone FGC, but in the encounter with Swedish health care, they felt ashamed because they had been subjected to FGC. Trying to adapt meant missing the female community and striving for the protection of their own daughters. They related their own FGC to an experience of an outrage with a horror and pain that they never could have imagined, that they wanted to protect their own daughters from.

After tradition, marriageability was the main motive for primary FGC in the papers in this thesis, while RI aimed at maintaining the marriage, alleged to reduce the risk that the husbands would want to divorce or marry a second wife (IV, V). In previous literature, the importance of marriageability [33] and the value of gender identity [32, 106] have also been described in relation to FGC. The marriageability aspects have previously been described as one of the major sustaining mechanisms of FGC [96], within the existing patriarchal systems, emphasising virginity at marriage and marital fidelity in the interest of legitimate heirs and male honour [40, 41, 88]. The practice of polygamy in Sudan also might affect the women's submission to the pressure from female peers concerning RI. Another aspect, rarely mentioned in previous literature, is the issue of being sexually restrained within marriage. The women in paper V viewed themselves as being "normal"; having been purified and re-tightened they considered themselves sexually restrained. Being sexually restrained was mentioned only in relation to primary FGC, but being purified and re-tightened was mentioned in relation to both FGC and RI.

Protection against FGC through the law was perceived after migration to Sweden (VI). Women explained that they felt that the Swedish law supported them in their decision to protect daughters from FGC. But the women also expressed worry about managing to

protect their daughters from FGC on vacation in the countries of origin and concerning the liberal Swedish attitudes on sexual matters. The Swedish law [90] makes all forms of FGC practice illegal, including re-suturing the anterior episiotomies postpartum. The intention of the law is to protect parturient women from such re-suturing of the vulva postpartum that is not indicated from a clinical/obstetric point of view. The justification for this professional ethical requirement may not be immediately clear or may even be unacceptable to the individual woman. This conflict between the preference of the patient and the professional preference dictated by medical ethics is a reality that ought to be addressed in antenatal care in a more profound way than is the case at present.

7.7 Re-victimisation in the encounter with Swedish maternity care

The principle of justice says that we ought to treat people with fairness, which implies that immigrating women with primary FGC have the right to just as good health care as anybody else, and even special attention, if needed, not to cause further harm.

The women in study VI had become victims of FGC in childhood. The encounter with Swedish maternity care caused the women a multiple victimisation in several respects. Firstly, in the encounter with antenatal care the immigrant women considered Swedish midwives to have good intentions to advise them about family planning, but at the same time they were encroaching on their integrity. Alleged attitudes and even the experience of insults from the midwives made the women avoid attending maternity care. This phenomenon has also been described in another study after migration to Western countries, where women reported being too afraid to attend antenatal care before the 20th week of gestation [122]. This fact might contribute to psychological consequences of FGC that might also interact with the delivery.

Secondly, concerning the delivery situation, the immigrant women expected that the midwives had the adequate knowledge to perform deinfibulation at birth, but found the contrary, which caused feelings of fear and panic. A recent study confirms the lack of practical knowledge, as perceived by immigrant birthing women, about FGC among Swedish midwives [123]. Also in studies about Swedish midwives' perceptions of the encounters with infibulated women, midwives admit a gap in knowledge concerning FGC in general and, in particular, how to handle infibulated women at delivery [112,

113]. From the results of these studies there seems to be a lack of systematic discussions about birth practices and care management for women who have undergone FGC. Caregivers have also expressed an unfulfilled need of training for work with people from different cultures [112, 113]. Previous research (Holmgren, unpublished) describes a failure to address FGC in the Swedish curricula of midwifery and medical schools. Black found that none of a number of well-known British obstetric and paediatric textbooks mentions FGC [17].

Thirdly, concerning communication, the interviewed immigrant women perceived that they were not asked about FGC. The women also said that they felt shy about this issue, which might affect mutual communication in antenatal care. The study by Widmark et al. [112] represents a mirror of our paper (VI), but from the midwives' point of view. In paper VI, the immigrant women found it impossible to say: "Hello, I'm circumcised...!" And in Widmark et al. [112], midwives said: "It feels very private that 'hello-'... It feels wrong to ask this woman straight off because then you'll lose the first important contact with her" [112]. In the same study, Swedish midwives were said to avoid asking the women if they had undergone FGC. "They wanted to treat all women equally in a professional and sensitive manner and seemed to reason that talking directly to a woman about FGC would point her out as different" [112]. Ismail [45] found that Swedish school nurses felt too embarrassed to talk about FGC with Somali girls, lacking confidence in how to approach the girls, and being afraid to offend them or their families. These studies indicate a need to facilitate communication for both the immigrant women and the midwives.

Finally, I give the word to Leininger, quoted in a commemorative edition of *Notes on Nursing by Nightingale* [124]. She summarises that we still have much to learn about human caring with respect to people, families, institutions, communities, and cultures. "It must continue to be studied as a transcultural phenomenon to understand human growth, development, wellness, health, and survival" [124].

8 CONCLUSIONS

This thesis confirms a high prevalence of FGC and RI in settings in Sudan and health complications associated with the practices. That also women without any primary FGC had been subjected to a tightening operation post-delivery means that the phenomenon of RI might be more prevalent and more complex than previously elucidated. This stresses the importance of recognising RI as a separate type of secondary FGC, which might have a role in perpetuating primary FGC. Reinfibulation is not yet included in the WHO definition of FGC, and should as such be further considered, not only in the local but also in the international ongoing work against the practices.

The practice of FGC aims at virtue and the social control of women's sexuality, in close association with preservation of virginity, marriageability and family honour. Reinfibulation could be seen as a re-creation of the primary virginity for both sexual purposes and sustained marriageability. The motives for both primary FGC and RI are likewise social, sexual, traditional and economic, but embrace also normality, identity and power relations. These perceived benefits interact in a complex paternalistic and maternalistic value system with physical harm inflicted on the girl or the woman.

Midwives are important stakeholders in perpetuating FGC and RI, but the issue is more complex than previously described. By recognising midwives for their important role in the community related to the whole well-being of the women, society ought to acknowledge the midwives to be the group most able to affect people in the prevention of both RI and primary FGC.

Deficient communication about primary FGC was shown between women and men in Sudan and between women and midwives, both in Sudan and in Sweden. Reinfibulation was perceived as a very intimate issue and both women and men in Sudan mentioned the silent culture between the genders as one of the major obstacles to change. This thesis shows that FGC and RI could be perceived as resulting in both victimisation and benefits for women as well as men. The women blamed the persistence of the practice on the domination of the older women as well as the men's passivity, while the men blamed the women. This thesis also provided some new information in the little-researched issue of men's experiences of FGC and RI. None the less, as both women

and men stated: inaction and passive stances by males, who are the major decision-makers of the family, may be one of the factors in the perpetuation of the practice. Overall, FGC and RI are much too complex to be understood as only subconscious patriarchal and maternalistic actions. FGC and RI are also too complex to be fully understood in relation to socially constructed concepts of normality, female identity, tradition and religion, in a culture of silence between women and men. In order to arrive at a deeper understanding of the persistence of these practices we have to go beyond these aspects.

This thesis indicates that greater attention needs to be paid to prepare health care personnel, in a setting after immigration, to meet both the psychological and the practical needs especially related to women with previous FGC. There is a need to handle FGC appropriately in Swedish maternity care by addressing it in the curricula of midwifery and medical schools. Guidelines and training material must be developed to inform providers about how to manage the health needs related to FGC and about appropriate ways to counsel patients when they request RI after delivery. Overall, the emphasis should be on the importance of a non-judgemental approach, and on the right of each woman to be treated sensitively and individually.

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