

## Medical Defibulation as a Possibility—the Experiences of Young Swedish-Somali Women

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### ABSTRACT

**Purpose:** Infibulation is the most pervasive form of female genital cutting. Infibulated women face difficulties such as obstruction of urine and menstrual blood flow, sexual problems, and birth complications, and may therefore need medical defibulation. This study explores the lived experiences of young migrant women from Somalia and their views on undergoing medical defibulation in Sweden.

**Methods:** A qualitative study was conducted using phenomenological lifeworld research. Data were collected through in-depth interviews with nine young women originating from Somalia, now resident in Sweden. The interviews were analysed to reveal the meaning of the phenomenon of infibulation.

**Results:** The essential meaning of the phenomenon is characterized by a limbo regarding both infibulation and defibulation. There is a strong desire both to handle the Swedish perspective on infibulation and to stay with the Somali cultural values. These women are being exposed to a tacit tradition that makes it hard to relate to the possibility of medical defibulation. As a result, the women perceive the possibility to undergo medical defibulation as limited or non-existent.

**Conclusions:** Healthcare professionals can be a support to encourage women in need of medical defibulation to reflect on traditional ideals concerning infibulation and defibulation.

### ARTICLE HISTORY

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### KEYWORDS

Infibulation; female circumcision; female genital mutilation; female genital cutting; defibulation; deinfibulation; phenomenology; life world research

## Background

Female genital cutting (FGC) is a practice that is prevalent in a cluster of countries in Africa, from the Atlantic coast to the horn of Africa, but also in some countries in the Middle East and Asia (UNICEF, 2016). Due to migration from countries where FGC is practised, it has become an issue in Western countries such as Sweden, and for Western healthcare systems such as the Swedish healthcare system (Socialstyrelsen, 2016). The National Swedish Board of Health and Services estimates that 40 000 girls and women in Sweden have been exposed to FGC (Socialstyrelsen, 2016), usually before coming to Sweden, as the procedure has been prohibited in Sweden under the Act Prohibiting the Circumcision of Women (SFS, 1982:316). Women and girls from Somalia account for half of this number (Socialstyrelsen, 2016). In Somalia, as to the most updated Multiple Indicator Cluster Surveys (MICS), almost 100% of girls and women between 15 – 49 years are exposed to FGC (UNICEF, 2006, 2014), and approximately 80% of these women reported being infibulated (UNICEF, 2006, 2014).

FGC is performed due to socially constructed norms and traditions. A frequently reported reason for performing FGC is to sexually control women, by

cutting external genitalia as the labia and clitoris and/or by closing the vulva as in infibulation (Van der Kwaak, 1992). Infibulation is considered the most extensive type of FGC. During infibulation, the inner or outer labia is cut and sewn together over the urethra and to a greater or lesser extent covering the vaginal orifice, leaving a constricted opening for urine and menstrual blood. The clitoris can be cut or left intact underneath the infibulation. Infibulation is categorized as type III FGC by the World Health Organization (WHO) (WHO, 2018). In cultures where infibulation is performed, it is perceived as an act to provide a woman with the means to prove her virginity at the time of marriage. At marriage the closed vulva is opened up by the husband, a circumciser or by medical staff, giving the woman status as respectable and virtuous (Johnsdotter, 2002; Van der Kwaak, 1992).

Effects on FGC are serious and complications can be acute or chronic. As the procedure is usually performed by a traditional circumciser with no medical education and under unhygienic circumstances, acute complications include bleeding, shock, difficulty urinating, and infections. Chronic complications from the procedure may involve difficulties in emptying urine

and menstrual blood, pain, repeated urinary tract infections, incontinence, dyspareunia and other sexual difficulties, psychological problems such as post-traumatic stress disorder, and increased risk of birth complications (Berg et al., 2010, 2014). The chronic symptoms are considered more prevalent in cases of infibulation than with other types of FGC (Makhlouf Obermeyer, 2005).

Both the WHO and the National Swedish Board of Health and Welfare recommend medical defibulation to relieve problems caused by infibulation (WHO, 2016; Socialstyrelsen, 2016). Medical defibulation is a simple procedure where the infibulation is opened surgically, to relieve the passage of urine, menstrual blood, and make vaginal intercourse and vaginal birth possible (WHO, 2016). However, although a simple medical procedure, medical defibulation may be difficult to perform due to cultural values (Johansen, 2017a, 2017b; Safari, 2013). In Johansen it was concluded that to have medical defibulation done may be difficult for a woman as it can be an act opposing the meaning of infibulation; to prove that she is virtuous and has not engaged in premarital sex (Johansen, 2017a), and that it may be equally important for men, proving their virility by being able to penetrate the infibulation with their penis on the wedding night (Johansen, 2017b).

National Swedish guidelines on female genital cutting comment on the fact that the decision to undergo medical defibulation can be hard to make. However, the guidelines do not explain or mention the difficulties involved, leaving the question as to which difficulties unanswered, and in the long run also leaving healthcare professionals responsible for counselling infibulated women without guidance. Instead, and equally important, they focus on supporting healthcare professionals in how the question of FGC can be addressed and how girls and women who may have been subjected to the practice can be approached, as there has been a fear among healthcare professionals that a girl or woman may feel hurt or offended by the question (Länsstyrelsen Östergötland, 2015; Socialstyrelsen, 2016).

The lack of guidance concerning the difficulties involved in medical defibulation may be explained by the fact that research on the subject is scarce. A search in PubMed on “defibulation” gives 30 articles on the subject. Most of these focus on medical issues as maternity care and obstetric outcome (Essén et al., 2005; Paliwal et al., 2014; Wuest et al., 2009), or evaluate and describe medical defibulation and the effects of it from a medical point of view (Abdulcadir et al., 2016; Effa et al., 2017; Jacoby & Smith, 2013), while 3 articles focus on the women’s views on medical defibulation (Johansen, 2017a, 2017b; Safari, 2013). The limited number of articles signals a research gap on medical defibulation in general,

and on the women’s views especially. The need for research is obvious and, concerning the women’s views, highlighted in two reviews (Abdulcadir et al., 2015; Evans et al., 2019).

In societies where infibulation is practised and ideals of virginity are strong, younger women are usually more affected by these ideals as potential marriage partners (Van der Kwaak, 1992). As previous qualitative studies on the women’s views on medical defibulation have interviewed mostly middle-aged women, most of them who were married, there is an urgent need to investigate how younger women perceive medical defibulation. Evans et al. (Evans et al., 2019) also remark on a need to explore issues on FGC from a life course perspective, especially concerning younger and older women, as they have found no studies concerning these groups. Against this background, the purpose of this study was to investigate what it means to have the possibility to undergo medical defibulation in Sweden, from the perspective of young Swedish-Somali women.

## Methods

To gain a deeper understanding of the opportunity for young Swedish-Somali women to undergo medical defibulation, reflective lifeworld research was used (Dahlberg et al., 2008). The overall aim in reflective lifeworld research is to describe and elucidate the lived world in a way that expands our understanding of human being and human experience (Dahlberg et al., 2008). The lifeworld is a core concept in phenomenology, referring to the concrete and immediately lived existence—our everyday actions and relations—into which we are immersed. We have access to the world through our bodies, which can never be understood as purely biological: it is through our subjective and lived bodies that the world becomes meaningful. In other words, this research approach rests on an understanding that meaning is created in the interaction between humans and our surrounding world (Dahlberg et al., 2008).

Meaning is also created between the researcher and the phenomenon. For this reason, the researcher’s understanding of the phenomenon being investigated is of great importance, as is the fact that the researcher should not come to an understanding too quickly or without reflection. Therefore, openness towards the phenomenon being investigated is emphasized and is called a “bridled attitude” characterized by awareness and presence (Dahlberg & Dahlberg, 2020; Dahlberg et al., 2008). Such open and perceptive attitude can be understood as a deliberate reflective process which is achieved by the researcher reflecting consistently on her/his own understanding of the phenomenon, thus not taking for granted what is understood, but remaining

present during the research process, allowing for the phenomenon to present itself in order to explore all possible understandings (Dahlberg & Dahlberg, 2020, 2019). A bridled attitude is useful throughout the whole research process, from project planning to method selection, data collection, analysis, and presentation of the project.

### Settings and participants

Inclusion criteria for this study were that the Swedish-Somali women were young and infibulated. The women reported being infibulated themselves, and there was no gynaecological examination prior to interviewing as this was considered unethical. We used the age span of patients who are allowed to seek healthcare at youth clinics.<sup>1</sup> In the region where the study was conducted, youth between 13 and 25 years are welcome. Adolescents younger than 15 years of age were excluded as their participation would have required parental consent, and defibulation was assumed to be a sensitive issue to raise with parents. The women's length of stay in Sweden ranged from 9 months to 6 years, and they were either working or conducting studies at compulsory school or upper secondary school. Former education in Somalia or other countries before coming to Sweden ranged from a couple of months to 8 years, either in Quran schools or public schools. Two of the women had a fiancé, one had a boyfriend, and one was recently married (2 months prior to interviewing), and five were unmarried/single. For an overview of the women, see Table I.

As prior studies reported difficulties recruiting participants (Safari, 2013), the recruitment was spread out to different health institutions meeting women affected by FGC on a daily or weekly basis. A total of 28 women were asked via a gynaecological clinic, a youth clinic, and the health

facility at an upper secondary school in a larger city in Sweden, and then agreed to participate in the study. The women were informed orally about the study at their regular visits to their doctor or midwife at the participating clinics or during a health class at the upper secondary school. The women who participated in the health class were first asked by school nurses and teachers at the school, on the basis that they had reported an interest in participating in the study. For all those who agreed to participate in the study, an appointment was made with the first author. During the appointment, further information was provided. The interviews took place immediately after written consent was performed. During one of the appointments with the first author, it was revealed that one of the women was not infibulated, and this woman was therefore not included.

The first author, who conducted the interviews, worked as a midwife at one of the participating clinics. As part of the youth healthcare team, she had encountered some of the participating women coming for a regular visit to the clinic. At the time of the interviews, she was not a treating midwife to any of the participants. The other two researchers had no relationship with the participants.

### Data generation

The interviews were conducted in the autumn of 2018. The interviews began with a question about when the interviewees had heard about FGC for the first time. The initial question was also seen as an opportunity to open up for lifeworld experiences and facilitate conversations about more personal experiences, as the subject matter was assumed to be sensitive and difficult to talk about. When the women touched on the subject of defibulation, open questions were asked, such as "What do you think of the possibility to have medical defibulation done" and "Could you tell me more about that". Further supplementary questions, such as "Could you tell me more about wanting/not wanting to go through with medical defibulation" were also asked. As suggested when interviewing participants who are less articulate or, as in this case, communicates through an interpreter (Dahlberg et al., 2008) the story was sometimes repeated back to the woman to make sure that it had been understood correctly. The women were then given the opportunity to clarify their experience of the phenomenon, and the interviewer had an opportunity to bridle her own understanding according to the phenomenological approach (Dahlberg et al., 2008).

Five interviews were conducted in Swedish. In four of the interviews, different interpreters in Somali were engaged (see Table I). The first interview with an

**Table I.** Overview of the interviewees.

Interview	Age (years)	Marital status	Length of stay in Sweden (years)	Language spoken at the interview
1	19	Unmarried/single	4	Swedish
2	22	Unmarried/boyfriend	6	Swedish
3	19	Divorced/fiancé	4	Swedish
4	17	Unmarried/single	3/4	Somali/IR
5	21	Unmarried/fiancé	3	Swedish
6	20	Unmarried/single	3	Somali/IP
7	20	Married	5	Swedish
8	16	Unmarried/single	1	Somali/IP
9	19	Unmarried/single	2	Somali/IP

IP = interpreter on the phone, IR = interpreter in the room.

interpreter was conducted with the interpreter present in the interview room. This is recommended practice when working with interpreters (Björk Brämberg & Dahlberg, 2013), but in the remaining interviews, an interpreter on the phone was used instead, using an external speaker for improved sound quality. For a further discussion on this; see limitations.

The interpreters had completed the required language tests and had started or completed training in interpreting (Tolkförmedling Väst, 2020). They were also selected based on their having completed sexual and reproductive health and rights (SRHR) training. The training ensures that interpreters can handle conversations about sexuality and use appropriate terms on the subject. It also ensures that the interpreter has a non-discriminatory approach (Västra Götalandsregionen, 2019). The interpreters chosen were women as this was expected to facilitate conversations about sexuality.

The interviews lasted between 45 and 90 min. Seven interviews were carried out at the interviewer's workplace and two were carried out in group rooms at a public library. Eight of the interviews were recorded digitally and then transcribed verbatim. One woman did not want the interview to be recorded and therefore notes were taken instead. The interviews were coded (interview 1, interview 2, etc.).

### **Data analysis**

The transcribed interviews were analysed in line with reflective lifeworld research (Dahlberg et al., 2008). The interviews were read and reread several times to get a sense of the whole. Next, preliminary meaning units responding to the aim of the study were extracted from the text. These meaning units were related to each other and the text as a whole to form a larger pattern of meaning, called a cluster. From this cluster, meanings emerged, particular as well as essential meanings. The essence of the phenomenon and its further constituents are clarified below and the constituents are exemplified with excerpts from the interviews.

Throughout the analysis, the following questions were posed to find the meaning of what was expressed and to bridge the process of understanding: "What do the women express, and what does it mean?" "Why do we understand it like this?" and "Can it be understood differently?" All authors participated actively in the analysis and a critical discussion took place between all authors to increase the credibility of the analysis. The meaning constituents and the essence were worked out collaboratively by the researchers. In the final stage of reporting the study,

an expert on phenomenological research was consulted.

### **Ethical considerations**

The procedures performed in this study were in accordance with the ethical standards of the institutional research committee and with the 1964 Helsinki declaration and its later amendments (World Medical Association, 1964). The study was approved by the local Swedish research ethics committee (No. 490–18). Before the interviews began, an appointment was made with the first author where detail information was handed out and participants had given their informed written consent. The women were assured that participation was voluntary and could be withdrawn at any time. They were also informed that anonymity and confidentiality were guaranteed. To ensure that the women understood the purpose of the study and what informed consent meant, an interpreter was used where necessary.

As the interviews dealt with a sensitive subject, the women also had the opportunity to meet with a counsellor, but all declined. Some of them were already in contact with a counsellor. The women were also offered help with medical issues related to their infibulation. As all participants had already been to a gynaecologist or were already referred to one, this help was also declined.

### **Results**

In line with the chosen research approach, the essence is presented first, and thereafter the meaning constituents. The essence can be understood as a background to the following constituents. The meaning constituents are not exclusive but overlap to some extent.

#### ***Being exposed to a tacit and unreflected tradition***

The results show that the women's approach to and decision to undergo medical defibulation are strongly influenced by their previous experience of infibulation and the values and symbolism surrounding both infibulation and defibulation. The participating women had left their homeland, where the tradition of FGC was strong and obvious, and had arrived in a new country where these traditions are judged as wrong and harmful. Since they do not have the ability to reflect on or verbalize the context and values of infibulation, an existential gap has arisen between these different value systems. The women have, in different ways, adopted both value systems, but without being able to reconcile them. Although the women express that they sympathize with Swedish norms, and that

they think that FGC is wrong in principle, they are still bound by values of chastity and virginity. The women are thus in a state of limbo, caught between the values expressed by the new home country (FGC is wrong) and the tacit and unreflected values of the old home country (a valuable woman is a virgin when she marries, and infibulation provides the woman with the means to prove her virginity). Because of this limbo, medical defibulation is perceived as a limited possibility or as no possibility at all. Below, we further reveal the constituting meanings of the studied phenomenon.

### ***Infibulation is a significant expression of being valuable***

The women distance themselves from the tradition of circumcision, but it is still important for them to be able to show, at the time of their marriage, that they are virgins. Being accused of having had sex before marriage would, according to the women, lead to social exclusion, meaning both exclusion by friends and family and exclusion from future partners. Unmarried women with an infibulated (closed) vulva have greater value compared to unmarried women with an open vulva, as the closure was a proof of virginity.

But those who are ..., everything closed so it's 100% she has not done sex. That's how it is. [...] Open means, if you're not married, it means something a little, eh, it means someone who is not, who has not so much value [...]. (Interview 5)

The importance of being a virgin strongly influence how they perceive the possibility of medical defibulation, because they are afraid that after such an intervention they will no longer be able to prove their virginity. The women describe a social environment where medical defibulation could lead to suspicions that they had had premarital sex and that they might even be suspected of having had medical defibulation to hide sexual activity. One woman described that it is important for her to have friends that she could meet after school, but that medical defibulation could lead to a rumour that she is a whore and then nobody would want to socialize with her, not even her best friend.

The women believe that Somali men prefer women who can prove their virginity by means of infibulation. They also believe that their virginity will be decided on their wedding night as, at vaginal penetration, a man would notice the difference between an infibulated woman who had or hadn't had sexual relationships. One interviewee is a victim of a rape and because of it, her infibulation was, as she believed, opened. She expressed a strong fear for her wedding night, and this fear is omnipresent

in her life. She described that she would say to her future husband that she had never been married, but she knew that this, for him, would mean being a virgin. She was afraid to be exposed as "already opened" at the wedding night, as vaginal intercourse would be too easy to perform, and this in turn would dissolve the marriage generating gossip about her and shame.

I'm so worried, so worried. [...] every night sometimes I think [...]. Sometimes I can faint when I think [about] this [...]. I say I'm unmarried, I have not been married, it's the first time I marry. [...] You can see that I have [been] sewn together, and it enters, what's it called, his willie, it enters [...] Then he will notice someone else has been there. The first intercourse is not so easy. (Interview 6)

### ***Hover between two value systems***

The women's stories are characterized by ambiguity, as they both express their disgust for practices such as FGC, and are positive to medical defibulation at a general level, and at the same time see it as important to follow the traditional values of their homeland. This ambiguity is evident when they expressed that infibulation was an abominable intervention, stating problems they themselves related to their infibulation as menstrual pains, but at the same time wished to follow the tradition and maintain their own infibulated state in order to prove their virginity at the time of marriage. Some women, however, expressed that the need to prove virginity is seen as a serious obstacle to medical defibulation, but one that could be bridged, as living in Sweden gave other opportunities for them. They described that in Sweden they would have the opportunity to find a man who may accept medical defibulation.

Well, it does not matter if he says, a man coming from my home country, if he says [...] you're open, I will not marry you. It does not matter to me. There are lots of people living here that I can marry, who have good culture, who don't think so much this crap culture. [...]. (Interview 5)

The ambiguity described above is also present when they described the values surrounding marriage and a pending sexual debut. The women know how vaginal intercourse could be for them, because they had heard stories from others who were infibulated or had their own experiences. They said that, according to the tradition, the man was supposed to defibulate the infibulation with his penis on the wedding night. This "traditional defibulation" was described as very painful. One woman remembered her traditional defibulation in Somalia:

When I got married it became difficult for me, really [...] You can ... [sighs] oh my God, it really hurts.

Actually, I had a small hole, you know the men they have, it cannot enter really, so it hurts really. So there is blood and blood, I could not go to the toilet [...]. One week I must be in bed. Or walk slowly, slowly [...]. (Interview 3)

The women's attitude to the tradition is negative, and they would call out loud that the tradition was a disaster, or that people in their homeland who did that to women were mad; and they questioned why women should have to have so much pain. Some women expressed shame over the tradition and one said that, today, you could be defibulated by healthcare professionals even in Somalia. The women pronounced that they were positive to medical defibulation at a general level.

The women were asked about what they thought about medical defibulation for themselves at the time of marriage. While women involved in a sexual relationship explained the difficulties they had conducting vaginal intercourse, realizing their need for medical defibulation, women not involved in a sexual relationship expressed astonishment, laughed, expressed shame, and made evasive statements as solely stating that as far as they were concerned the future was unknown to them. They explained that they did not know what position they would take in the future, and that they didn't think about medical defibulation. Traditional defibulation, on the other hand, seemed an option they could imagine. One woman described how a doctor offered her to undergo medical defibulation if she wished to do so. As the woman turned the offer down, the doctor offered her to come back and have the procedure done when she married. She knows from the stories of others that traditional defibulation would be painful, but at the same time, being uncertain what position she would take in the future, she also explained that the pain could be a good thing, because it meant that she could get pregnant, and that's what she wishes for in the future.

Another woman describes that when her fiancé gave her the opportunity to get married, she broke up the relationship. She was afraid of having to perform vaginal intercourse and the pain she thought it would mean. Her answer to why she did not consider medical defibulation to get relief from the fear, was that at the time of the break-up she simply did not consider it and that she forgot about it.

### **Confronting fear**

The women expressed fear of defibulation, both the medical and the traditional type. The fear derived from the painful and traumatic experience of

infibulation in Somalia, which was described by them as a trauma including extreme pain. For example, they described that they had been restrained by several adults, and that someone had cut their flesh while they were fully awake. After the infibulation was done, they had had to lie still for weeks with their legs tied for the cut labia to grow together. During the convalescence, they had had strong pains.

They negotiated and finally agreed to perform the procedure. They pushed me down. And then they put a piece of cloth over my eyes, they tied my eyes. They used a piece of cloth so that I would not see anything. Then she used anaesthesia [...]. And then she started [with] something sharp. And then she cut. [...] I bled a lot. After a while, I was very sick [...]. It was very, very painful. [...] It took weeks before I could walk. [...] As for circumcision, my experience was that way. (Interview 9)

This fear of pain affects how the women regard the possibility of medical defibulation and could lead both to a positive and to a negative attitude towards medical defibulation. Some women said they were afraid of medical defibulation as they knew from their experience of infibulation how painful it was when their genitals were cut. They described a fear of being cut with a knife again in a part of the body that had been sewn closed a long time ago, and that it would be painful to open it up. One woman who was pregnant associated defibulation with something that had to be done when giving birth. She described her own fear of the pain that awaited as she believed the midwife would have to defibulate her on delivering her child. As a child, she had experienced infibulation twice as her cut and sewn labia after her first infibulation had opened up, and therefore the procedure had been repeated. She had also experienced the death of her first child a few days after giving birth. She had had to go to a hospital to give birth as she was infibulated and the child could not come out, and the delivery had been long and difficult. Knowing what it meant to lose a child, and knowing the pain of infibulation, she explained that only a strong sense of wanting to save her child could give her the courage to be defibulated ("cut") during her second delivery.

[...] it [being cut] really hurts, we actually know! Really, you're afraid to do it again! But if you give birth, absolutely—because you need to give the child a chance to come out. You must save your child. So you need cutting. Otherwise, really, you don't dare! It hurts, really, you don't want to. (Interview 3)

There are also women who, by contrast, described how the fear of traditional defibulation after marriage, and the pain this would entail made them consider medical defibulation, as this provides the possibility for them to avoid pain. One woman who recently

married expressed how her thoughts had gone before her wedding. She thought she would die the first time she would have vaginal intercourse. She also thought that there would be a lot of blood and that she would not be able to walk because of the pain she would feel. She had heard stories from others telling her about their pains, and expressed that she was terrified, because she understood that she would have severe pain as well.

[...] Before we [the woman and her husband] met, I thought like this: [...] maybe I will die. I also think there will be lots and lots of blood, maybe. I also think I will not be able to walk. [...]. It's really hard if I tried with my husband, it will be really, really, really hard. Extremely, extremely painful. [...] I listened to adults and youth talking about girls, pain, this and that. I listened so very much. I am terrified, I feel like them, me, like them [...] (Interview 7)

Despite her fears, the woman did not undergo medical defibulation before marriage and agreed to face traditional defibulation with her husband. However, she described during the interview that she could not cope with the pain, and would now undergo medical defibulation.

I must open. [...] Yes, I don't want pain! (Interview 7)

### ***Being surrounded by silence***

The women described being in an environment where they did not have anyone with whom to discuss medical defibulation. In fact, women who did show an interest in having medical defibulation done, and raised it with their family, were usually advised to postpone the discussion until they were married. Even where a family member was positive about medical defibulation, the matter was not discussed at home, as described by one woman. She knew her mother would allow her to undergo medical defibulation as she had severe pains while menstruating, but firmly stated that while she sometimes overheard her mother discuss with friends the importance of stopping FGC and infibulation, they never discussed the issue of medical defibulation at home.

Another aspect of silence surrounding the women is that they do not speak of medical defibulation freely, out of fear of being slandered or that someone would stop them from having it done. They described the importance of keeping the thoughts or plans about the intervention to themselves. One woman described her fear of rumours. She believed she might be accused of having had premarital sex if anyone would know she had decided to undergo medical defibulation, and that her acquaintances and family would think she had used medical defibulation to cover up the fact that she was sexually

active. She thought they would think she only pretended to be a girl (i.e. a virgin).

Why tell others? They are slandering. They say, "She is fucking liar girl. Her husband, he knows nothing, she did several times sexually and when she married her husband she said I'm a girl, I did nothing, I'm the first time. And she told her husband I'll go to the doctor and open [...] because I feel [...] pain, but she doesn't mean that. She had sex, she is lying [...]" (Interview 7)

Neither did the women have the opportunity to talk to others who had made an active decision to go through medical defibulation. Since it was a taboo subject, they did not know if others had had it done. However, they did know of the need for infibulated women to be "opened" during labour as a necessity for the baby to come out, and know of others having this procedure done on delivering their first child in Sweden. One woman mentioned a friend of hers who endured the pains vaginal intercourse caused her until she got pregnant, and eventually medically defibulated in Sweden while in labour.

### ***Breaking the silence***

There are examples of where a woman had broken the silence and talked to a family member about a desire to undergo medical defibulation, but where this person had reacted negatively. In some cases, the woman had been forbidden to have the medical procedure done, and in others, the woman's wish had resulted in a lengthy process of fear to bring the subject up or negotiations.

One woman who wished to undergo medical defibulation expressed a fear of addressing the issue with her fiancé. She described a process in which she postponed her wedding, month after month, as she was afraid of having vaginal intercourse when she got married. In her case, the solution to avoid the pain was to undergo medical defibulation. Nevertheless, she did not want to raise the issue with her fiancé because she was afraid that he would forbid her to have medical defibulation and instead would want to defibulate her traditionally. After postponing the wedding for more than a year, she was forced to confront her fiancé with her fear as he was beginning to wonder why she kept postponing the wedding. She told her fiancé that she wanted to undergo medical defibulation and was surprised that he said yes to her wish, without questioning.

Another woman described the discussions she had had with her fiancé regarding her need for medical defibulation. She explained how her fiancé understood her need as she had difficulties urinating and could not engage in sports or vaginal intercourse due to her infibulation, but at the same time, he was afraid that the procedure could be seen as a wish from her

to hide that she had had sex with others. Having medical defibulation done would mean that she would be “opened.” In addition, he would not be able to carry out the task of defibulating her traditionally. To confront her fiancé’s fears, she told him that she could get her journals from the doctor, stating that she had been opened at the hospital, and not by someone else. The woman had an appointment at the doctor to go through with the procedure and was looking forward to the day when it was to be done.

## Discussion

This study shows that the women find it difficult to relate to, and reconcile, the two different value systems they find themselves in—on the one hand, the Somali way that promotes infibulation and traditional defibulation; on the other, the Swedish values and law that prohibit and condemn infibulation. The values borne by the women concerning infibulation and sexuality are tacit and thus unreflected, and they have had few opportunities to reflect on them, which limit, or even prevent, the possibility of medical defibulation.

One of the tacit values the women continue to hold in exile in Sweden is that it may be important to have their infibulation intact when marrying for the first time, and although opposing traditional defibulation, they don’t explicitly pronounce they will choose medical defibulation instead. This picture is confirmed in studies of Somalis in exile in Norway and the UK (Johansen, 2017a, 2017b; Safari, 2013), also concluding that traditional defibulation (in contrast to medical defibulation where the tissue is opened up to a larger extent), among other things, is perceived as a way to preserve a tight vagina for male sexual pleasure (Johansen, 2017b).

Other studies have reached different conclusions concerning the meaning of FGC in exile, and in Gele et al. (Gele et al., 2012), young Norwegian-Somali men expressed a preference for women who had not been exposed to FGC, believing that cut women could not have the same sexual feelings as uncut women. In the Norwegian study, then, there was a risk for women exposed to FGC to be rejected on the marriage market, which is in contrast to how the women in the present study reasoned. Another study, by Johnsdotter, reached the conclusion that infibulation in Sweden is not a must, as Swedish-Somali women in exile not exposed to FGC can prove their virginity through chaste behaviour. Johnsdotter argues that, for Somalis in exile, there are alternative marriage markets, where virginity is still important for a woman, but where infibulation is no longer needed to prove this (Johnsdotter, 2002). The present study has reached a different conclusion regarding the significance of infibulation in relation to marriage in

exile, where the women were reluctant to undergo medical defibulation as the alternative marriage markets were not obvious to them. For the women in the present study, the symbolism or experience of infibulation still had a strong influence on their attitude to medical defibulation, making it difficult or out of the question.

Another aspect for the infibulated women is the experience and memory of pain. The experience of pain from infibulation was described in a Norwegian study where the interviewees described the pain as so strong that its associated cultural values (e.g., as a cleansing or adulthood initiation ritual) could not be a strong enough motive for them to justify the pain. The interviewees described a feeling of wanting to die during and after the procedure to get relief from the pain they felt. The pain was embodied and the trauma could be re-experienced, for example, during pregnancy and childbirth (Johansen, 2002). The findings of the present study show, in a similar way, that the traumatic experience from infibulation influences how women perceive defibulation, both the medical and the traditional kind.

That women choose not to undergo medical defibulation because of the memory of pain or the symbolic values of infibulation, may cause additional suffering, for example, during childbirth, or problems such as menstrual cramps or painful vaginal intercourse. Traditional defibulation strongly contradicts how Swedish society recognizes the importance of young people’s sexuality and the importance of it being enjoyable. Sweden also has clear guidelines to protect and help young people against sexual violence (Helmius, 1990; Olovsson, 2013). However, guidelines concerning FGC in Sweden do not discuss traditional defibulation, nor do they give any recommendations on how to approach women affected by this. Instead, they focus on medical defibulation in obstetric care or in cases where women may have urinary or menstrual problems (Socialstyrelsen, 2016). As healthcare professionals have expressed insecurity on how to address sexual issues with infibulated women, to develop strategies in Swedish healthcare for these women is of great concern (Larsson & Johnsdotter, 2015).

Today, Sweden is a multicultural society where different norms concerning sexuality meet and collide. The Swedish society’s views on youth sexuality are often described as liberal, where young people are allowed to explore their sexuality (Olovsson, 2013). This liberal view is in sharp contrast to the view some immigrant groups in Sweden live with, where chastity and sexual abstinence and restraint before marriage are important ideals, especially for girls and women (Flodström, 2012; Larsson & Johnsdotter, 2015). Forsberg (Forsberg, 2008) has studied young people in Sweden living with these conflicting ideals



and notes that young people need opportunities to reflect on how they themselves wish to relate to the different views. In Forsberg, and also in Larsson and Johnsdotter (Larsson & Johnsdotter, 2015), it is clear, however, that young women with a more restrictive approach to sexuality may have difficulties to adopt other approaches to sexuality. The difficulties stem from a desire to earn respect and value by not showing interest in sex. Suspicions of engaging in sex can have great social consequences as exclusion and losing value (Forsberg, 2008; Larsson & Johnsdotter, 2015). Forsberg (Forsberg, 2008) describes this as part of a system built to control women's sexuality in societies where a woman's chastity is invaluable to a family's honour and states that this control is also practised in Sweden. The fear of losing value by breaking sexual norms and the control from other people is evident in the present study, but our results also show another aspect of the difficulty of relating to sexuality. Whereas the values of the homeland, concerning both the procedure of infibulation and the symbolism surrounding infibulation and sexuality, are tacit and unreflected, the values concerning the prohibition of FGC (and infibulation) in Sweden are explicit and firmly pronounced. The women do have the opportunity to receive, and agree with, the message that FGC and infibulation are wrong (and they are exposed to this message on their arrival in Sweden) (Wahlberg et al., 2017); however, it is harder for them to reflect on the sexual norms concerning infibulation. This makes it difficult for them to relate the different value systems to each other. Therefore, they can place great emphasis on being a virgin before marriage, for example, and on the fact that their infibulation is a proof of this, not actively turning traditional defibulation down for themselves, while at the same time they can also condemn the practice of infibulation and traditional defibulation. This ambiguity can be explained by the fact that the women are surrounded by silence, where issues of sexuality and defibulation are not discussed. This silence may be further pronounced as neither the traditional Somali society nor the Swedish society (through healthcare institutions) talks about medical defibulation as a sexual issue.

The silence is difficult to break because there is a fear of losing respect, family, and friends, but also because of difficulties of talking about sexuality. Similar feelings of shame are described in Larsson and Johnsdotter (Larsson & Johnsdotter, 2015), who interviewed young Swedish-Somali women. The shame felt was in this study linked to the fact that the youth were anchored in a different value system concerning sexuality, where religion was important and where it was perceived as illegitimate to show an interest in sexual matters. Breaking chastity norms could have major consequences such as social

exclusion. This fear is confirmed by Safari (Safari, 2013), who reports that women undergoing medical defibulation emphasized the importance of keeping the procedure a secret in order not to have rumours spread. According to two studies from Sweden and Finland, the spreading of rumours built on chastity norms seems to be a part of the life of young immigrant women from Somalia (Isotalo, 2007; Larsson & Johnsdotter, 2015). This censorship also applies to the women in this study and means that women cannot have someone who has undergone medical defibulation as a role model, and neither can they talk about the medical procedure themselves. As a consequence, the women in our study perceive medical defibulation as a very limited possibility or as no possibility at all.

### ***Methodological considerations and limitations***

Using interpreters in qualitative interviews is connected with methodological challenges. At the same time, there is no other way of doing research with interviewees speaking a different language than the interviewer. Moreover, since interpreters were not needed or wanted by five participants, the researcher was able to explore the phenomenon in direct communication with these women. In phenomenological research, the researcher also has the possibility to grasp meaning outside the spoken word (Dahlberg et al., 2008).

However, using an interpreter does challenge the ability to stretch the researcher's understanding, a matter of great importance in reflective lifeworld research. Translating an interview is more complex than simply finding the right word and forward this to the researcher and informant, respectively. The interpreter has to grasp the meaning of the researcher's question and then echo the informant's response in accordance with the researcher's language and understanding. In this way, the interpreter bridges a gap between different horizons of understanding and the interview can thus be viewed as a three-way co-construction of data (Björk Brämberg & Dahlberg, 2013).

The usual recommendation for using interpreters is that they are present in the same room (Björk Brämberg & Dahlberg, 2013). For this study, interpreters on the phone were chosen in three of the interviews as interpretation in the room was perceived as an obstacle, inhibiting the woman to speak freely. To reduce the risk of misunderstandings, only authorized interpreters were used. The interpreters were prepared before the interview about the subject and aim of the study (Björk Brämberg & Dahlberg, 2013). During the interviews, interruptions for translation were made and were compensated for by the interviewer according to recommendations for working with an interpreter in qualitative studies (Björk Brämberg & Dahlberg, 2013).

Thus, the interviewer formulated new questions based on the translation, keeping in contact with the woman during the translation by humming or otherwise showing that she was involved in what was being translated. If the interviewer became uncertain about the content or how it would be interpreted, she asked questions to confirm that the interpretation was correct. The interviewer did note that the interpreters were strictly concerned with translating everything that was said, and that everyone in the room would understand what was said.

The time of stay in Sweden for the women ranged from 9 months to 6 years. In previous studies concerning FGC, the participants were divided into groups of newly arrived and settled. The concept of being newly arrived ranges from being in the new country for less than a year (Johansen, 2017a, 2017b) up to 4 years (Wahlberg et al., 2017). This study should be read having in mind that (using the same definition of settled as in Wahlberg et al.) the majority of the women were newly arrived, which may have effect on results concerning the ability to reflect on different value systems. However, in Johansen, although including participants where the majority were settled (according to her definition of settled), ideals of virginity and traditional defibulation remained (Johansen, 2017a, 2017b).

Prior studies on FGC have used snowball sampling or recruitment through Somalis closely connected with the Somali diaspora (Isman et al., 2013; Johansen, 2017a, 2017b). As the issue concerning medical defibulation was something the women wanted to keep to themselves, this recruitment method was not used. However, as 18 women declined participating in the study, one needs to take into account that there may be something unusual about the women who did participate. Sixteen of the women declining participation did so after receiving group information about the study at the health class in upper secondary school, while two women declined participation after receiving individual information about the study at the youth centre, where the first author worked. No explanation to declining participation was given or demanded.

## Conclusions and clinical implications

In guidelines for healthcare professionals, it is necessary to emphasize that infibulated women need opportunities to reflect on their own experience of infibulation, as well as on traditional and tacit values. Without such a reflection, medical defibulation cannot be perceived as a real possibility. Healthcare professionals who come into contact with women who are infibulated can be an important resource to provide this opportunity. It is therefore important to give infibulated women

the opportunity to process any traumatic experiences from their own infibulation, but also to include the problems with chastity norms and traditional defibulation when counselling them. These are questions that healthcare institutions need to be aware of in order to give proper care to women in need of medical defibulation. If healthcare professionals can be supportive in this, they can provide an opportunity for the silence surrounding medical defibulation to be broken.

Based on the results of this study, further research focusing on the attitude of Somali women and men to vaginal intercourse when the woman is infibulated is needed. Also, research should be done on healthcare professionals' experiences of addressing the need for medical defibulation with Somali couples where the woman is infibulated. Further research could also include studies exploring the attitudes to medical defibulation among close relatives or friends of women in need of the procedure, as these individuals are important resources for women who wish to undergo medical defibulation. How healthcare can facilitate medical defibulation, when this is wanted, and at the same time consider the trauma infibulated women may have experienced, should also be researched.

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## Note

1. Youth centres are part of the primary health care system in Sweden, where trained midwives and counsellors offers health care on issues concerning sexual and reproductive health and physical and mental health to young people aged 13 and over (Västra Götalandsregionen/Väst Kom, 2018).

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