Kenyan midwives experiences of female genital mutilation and of caring for genitally mutilated women in connection with childbirth.

Kenyanska barnmorskors erfarenheter av kvinnlig könsstypning samt av att vårda könsstypade kvinnor i samband med förlossning.

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**Key words:** Female Genital mutilation, Female Circumcision, Childbirth, Complications
Abstract

Female genital mutilation is defined by World Health Organization as a procedure in which part or all of the external genitalia is cut off for reasons that do not have medical purpose. Examples of reasons for genital mutilation is social acceptance, maintenance of family honor, beauty ideals and preservation of the woman's innocence. As a result of increased immigration from African countries to the West, female genital mutilation has become known in Sweden. Today, approximately 38,000 genitally mutilated girls and women live in Sweden.

The aim of the interview study was to describe Kenyan midwives’ experiences of female genital mutilation and their experiences of caring for genitally mutilated women in connection with childbirth. The study was based on eight interviews with midwives from hospitals and health facilities in different areas of Kenya. The study shows that Kenyan midwives experience FGM as a harmful procedure with negative consequences that risk women’s health, especially in connection with childbirth. By educating the entire community and abiding by the law against FGM, the procedure may eventually cease to exist.

Conclusions that can be drawn from the study is that FGM is experienced as an obsolete and harmful practice that cause severe complications, both directly adjacent to the procedure and later, in connection with childbirth.
It is what my grandmother called the three feminine sorrows. She said the day of circumcision, the wedding night and the birth of a baby are the triple feminine sorrows.

- Dahabo Ali Muse
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1. Introduction
Female genital mutilation (FGM) is an issue in many countries. Today, 140 million women and girls are estimated to be genitally mutilated at some point in their lives; with the majority of these occurring in 29 African countries as well as in the Middle East (World Health Organization [WHO], 2014) (See figure 1). WHO (2014) defines female genital mutilation, or female circumcision, as a procedure in which all or parts of the external genitalia are removed for reasons that have no medical purpose. FGM is usually performed on girls between infancy and age 15 but can even occur in adult women (ibid.).

![Figure 1](https://example.com/figure1.png)

*Figure 1: percentage of genitally mutilated girls and women aged 15-49 (United Nation Children’s Fund [UNICEF], 2013)*

As a result of increased immigration from Africa to western countries, FGM has become known in Europe. In 2008, the number of genitally mutilated women in Sweden was 28,000 (Lundberg & Gerezgiher, 2008). Today, approximately 38,000 mutilated women live in Sweden, 7000 of which are girls under 18 years of age. This represents an increase of 10,000 women over a period of seven years and has resulted in increased awareness of the subject. This places greater demands on Swedish medical staff who encounter genitally mutilated women (Socialstyrelsen, 2015).

2. Background

2.1 The origins of FGM

The motives behind FGM are often cultural. In some communities where it is practiced, the belief is that the female orgasm kills the sperm and that genital mutilation will improve fertility (Socialstyrelsen, 2002). Another belief is that the clitoris, if remained intact, can threaten the husband’s health during intercourse as well as a baby’s life in the uterus (Sala & Manara, 2001). The procedure of FGM is also seen as a guarantee for family honor, virginity and marriage...
ability. After being mutilated, the girl at puberty age enters adulthood and is then viewed as a woman ready for marriage (Mudege, Egondi, Beguy & Zulu, 2012). The procedure is also performed with the aim to maintain health, hygiene and for esthetic reasons (Sala & Manara, 2001). FGM exists among Protestants, Muslims, Catholics and animists. However, there is no religious affiliation with the practice (UNICEF, 2013). The origins of FGM can be traced back thousands of years, to as far as 500 B.C. Remains of mummified women who have been mutilated have been found in ancient Egypt, Rome, Arabia and tsarist Russia (Little, 2003). The hierarchical order of that time period is believed to be one of the original reasons for FGM. The woman was considered to be an important investment that, with strict control from the superior man, could strengthen his position of power in the community. The man was said to own the woman and thus the right to her body and offspring. Other causes of genital mutilation was considered to be the belief that women had a higher risk of becoming nymphomaniacs, lesbians or sexually overactive if the clitoris remained in its natural state. Genital mutilation was also used in 1930 century Europe, as a cure for mental conditions such as hysteria (Socialstyrelsen, 2002).

2.2 Different types of FGM

FGM is divided into four main types, based on the physical complications that arise as a result of the procedure (WHO, 2014).

- Type I, also called clitoridectomy, includes procedures where the foreskin of the clitoris and all or part of the clitoris is removed. Of the four types, this one results in the mildest complications.
- Type II, excision, includes the procedures in which the clitoris and all or parts of the labia minora are removed.
- Type III results in the most severe complications and is called infibulation. It includes procedures where all the external genital organs, i.e., the clitoris and the inner and outer labia, are removed. The infibulation also includes a narrowing of the vaginal opening through the creation of a seal. The seal is formed by repositioning the remaining parts of the outer labia. See figure 2.
- Type IV includes other interventions that go under the definition genital mutilation, such as scratching or pricking of the clitoris with a sharp object. In addition, other forms of injury to the genital area such as burning, cutting, caustic and scraping can occur (ibid.).

![Figure 2: Type I, II and III of FGM (WHO, 2001)](image-url)
2.3 FGM and childbirth

Childbirth is divided into three stages. The first stage occurs when the cervix expands from zero centimeters to ten centimeters, and eventually obliterates. Labor contractions, which will expel the baby, start during the second stage of labor. In this stage, the baby passes from the uterus, through the cervix, and further through the birth canal. The baby is then delivered. During the third stage of labor, the placenta is expelled (Lundberg & Gerezgiher, 2008).

During delivery of a child, complications such as prolonged labor and tearing of the pelvic floor can occur. Prolonged labor can, at worst, lead to asphyxia in the child and risk its life (ibid.). To prevent asphyxia, a vacuum extractor can be used to facilitate the delivery, for example if a mother is too tired to push the baby out. Tearing of the pelvic floor during childbirth is common and can vary in severity. To avoid complications that may occur from the tearing, an episiotomy can be performed. An episiotomy is a medial or medio-lateral incision in the perineum, i.e. the area between the vagina and anus, performed in order to widen the vaginal opening during delivery (Socialstyrelsen, 2013). In developed countries, an episiotomy is not a routine operation. However, in less developed countries where FGM is practiced, the use of episiotomy is a routine procedure (Liljestrand, 2003).

2.4 FGM in Kenya

The countries that still practice FGM are mainly found in Africa. Kenya has the seventeenth highest rate in Africa with 27% of the female population genitally mutilated. The most common type of FGM in Kenya is type two, excision (UNICEF, 2013). The Kenyan population consists of several indigenous tribes such as the Luo, the Kisii, the Maasai, the Somali and the Kuria (Socialstyrelsen, 2006). The prevalence of FGM in Kenya varies among the different tribes with the lowest mutilation rate being 0.1% in the Luo while the highest is 97.6 % in the Somali. The second highest rate belongs to the Kisii with 96.1% and the third highest rate belongs to the Maasai with 73.2% of the women being mutilated. See table 1.

<table>
<thead>
<tr>
<th>Tribe</th>
<th>Mutilation rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Somali</td>
<td>97.6</td>
</tr>
<tr>
<td>Kisii</td>
<td>96.1</td>
</tr>
<tr>
<td>Maasai</td>
<td>73.2</td>
</tr>
<tr>
<td>Luo</td>
<td>0.1</td>
</tr>
</tbody>
</table>

Out of all educated women in Kenya, 19% had undergone FGM compared to the 54% of uneducated women who had undergone FGM. There is also a higher prevalence of FGM in rural areas than in urban areas with a percentage difference of 14.1% (Kenya National Bureau of Statistics [KNBS] and ICF Macro, 2010).
A law against FGM was introduced in Kenya in 2011, which includes banning partial or total removal of the female genitalia or other injury which does not have medical purpose. According to the law, all forms of FGM are illegal. It is a criminal act to perform the mutilation despite the girl's consent. It is also an offense to provide room or materials, or in any way participate in the mutilation. If a girl dies under or directly adjacent to FGM, the offender is at risk of lifelong imprisonment. Trained health personnel may not perform genital mutilation and it is also a crime to bring a girl out of the country to undergo mutilation in another country (Kenya Law, Prohibition of Female Genital Mutilation 2011:62B).

2.5 FGM in Sweden

In 1982, Sweden became the first Scandinavian country to introduce a law against FGM. Conducting the procedure could lead to a maximum sentence of four years in prison. In 1999, a revision of the law was introduced, which made it an offence to send girls to undergo FGM in a country where it is not illegal. According to the law, all health care professionals are obligated to report in case of suspicion of a girl being mutilated or at risk of mutilation (Eriksson, 2009).

In the African countries that practice FGM, the majority of genitally mutilated women experience great pain and discomfort associated with visits to the midwife as a result of the mutilation. However, it is considered shameful among cultures that practice FGM to speak of pain and anxiety with health care professionals. As a result, the women suffer in silence (Lundberg & Gerezgher, 2008). Therefore, it is of great importance to help the patient to be able to talk about the pain and discomfort. This leaves the Swedish health care professional with a big responsibility, which includes responding to patients in a respectful manner that promotes women's autonomy and integrity (Franck, 2010). International council of nurses (ICN) took a stand against FGM in 1995, by actively educating and informing health personnel and the public about the risks with FGM (Affara, 2002).

In January of 2015, a new International Classification of Diseases (ICD-code) was presented. The aim of the code is to facilitate for health professionals to identify the need for care among women who have undergone FGM. ICD is a diagnostic tool for epidemiology and health management, which includes monitoring the incidence and prevalence of various health-related conditions (Socialstyrelsen, 2015).

2.6 Theoretical frame – humanism

FGM is contrary to numerous human rights principles, such as the principles of doing no harm, of bodily integrity and of human dignity (UNICEF, 2013). FGM affects women’s reproductive and sexual health and is therefore considered an abuse of women’s rights. A contributor to FGM and its continued existence is believed to be the attitudes against women in communities where it is practiced. Most of these communities have little or no respect for women since they lack value other than giving birth to sons. Women that are not mutilated in communities where the custom is practiced are seen as indecent and disgusting, and will have difficulties getting married (Sala & Manara, 2001).

Looking at professional health care through a humanistic perspective, all men and women should be treated with care and respect for oneself. That means that women should be given care on equal terms with men (McCabe & Holmes, 2007).
2.7 Rationale for the study
With increased immigration from African countries, the number of women in Sweden who have undergone FGM has increased by 10,000 over a period of seven years (Socialstyrelsen, 2015). As the healthcare system is well developed in Sweden, complications related to pregnancy and birth of these women are neither as common nor comprehensive as in less developed countries. By learning about Kenyan midwives’ experiences with female genital mutilation, the expectation of this study is to integrate knowledge and understanding among Swedish health care professionals. This also provides cultural competence in the meeting with patients of other ethnicities.

3. Aim
The aim of this study was to describe Kenyan midwives’ experiences of female genital mutilation and of caring for genitally mutilated women in connection with childbirth.

4. Method
The study was conducted as a qualitative interview study with descriptive design (Polit & Beck, 2012). Study participants were midwives working at health facilities and hospitals in Migori, Nkararo and Narok in Kenya. See figure 3.

![Figure 3: The three areas were the study was conducted (Google maps, 2015).](image)

4.1 Sampling strategy
The participants were selected through a maximum variation sampling, which is a purposive sampling strategy with the aim to get a wide range of study participants and therefore many different experiences on the subject. Since the types of FGM differs between regions and tribes, the participants were midwives selected from three health facilities and hospitals in different areas of Western Kenya (Polit & Beck, 2012).

Both male and female professionals were considered for the study. Experience in the profession was, however, of great importance for the study's credibility as the opportunities to respond to the questions in the interview guide increased. Therefore, the participants had to have actively practiced midwifery for at least two years to be included in the study. The participants were
selected by availability i.e. the midwives who was on duty the day of the interview and wanted to and had time to participate in the study were selected. If one of the surveyed participants could not participate in the study for some reason, the next available midwife at the hospital or health facility on duty that day was asked until the goal of eight midwives was achieved. If no interviews could be conducted during the day of the planned interviews, another attempt was made in the next few days (Polit & Beck, 2012). The day of the interviews were booked in advance since the authors of the present study had to travel long distances between their base and the location of the hospitals and health facilities.

The sample consisted of eight midwives, five of which were women and three were men. They were selected from two hospitals located in urban areas and one health center located in a rural area. The two hospitals in the urban areas were equipped with modern operating rooms, a maternity ward and several other wards for different treatments. The health center in the rural area was small and located approximately one hour away from the closest village. It was equipped with a small operating room but lacked equipment to provide care in emergency cases. Therefore, the majority of patients in need of further care were referred to bigger hospitals in neighboring cities.

Of 10 surveyed participants, two withdrew from the study due to staff- and time shortage. The participant with the least experience had practiced midwifery for two years, and the one with the most experience had 14 years in the profession.

4.2 Ethical approval and consent form letter

Contact with the different hospitals and health facilities was established through the supervisor in field. The consultant physician of Migori County Hospital, Dr Wafula Nalwa, the consultant physician of Nkararo Health facility, Dr Leshos Licharge and Clinic officer in charge in Narok health facility, Dr Moses Nkuto wrote ethical clearances which made it possible for the study to be conducted in the different areas. A doctor in charge at the different locations introduced the maternity ward and the midwives available on the day of the interview. The surveyed midwives chose the time and location of the interview. Before the interviews took place, the participants received an informed consent form and an information form about participation in the study. As a complement to the written information, they were also given oral information about the study and their participation. Directly adjacent to the interview, the participants were provided with a written version of the interview guide to facilitate language comprehension. See appendix 1, 2 and 3.

4.3 Data collection

The interviews were semi-structured, based on an interview guide with planned questions asked in a similar way at every interview opportunity. The questions in a semi-structured interview are open-ended with an opportunity for the participant to express personal opinions. This was expected to provide rich and detailed information about the subject. The questions did not need to be in the same order at all interview occasions, and there was an opportunity to ask follow-up questions (Polit & Beck, 2012).

One of the authors of the present study was assigned to lead the interview, and one author was assigned to observe and take notes. The same author led all interviews in order to maintain continuity. Directly adjacent to the interview, the participant was given the interview guide to read through. The questions were also read out loud during the interview. The author who observed and took notes was also involved in the conversation between the interviewer and the
participant. Follow-up questions were asked during the interview. Since the population in the areas where the study was conducted speaks Swahili as well as several indigenous languages, a female interpreter proficient in Swahili was available if needed. However, there was no need for her services since the participants spoke decent English. The interview was recorded with an Mp3-player and then transcribed verbatim. The Mp3-player was placed in between the participant and the interviewer for optimal sound recording. The author not in charge of asking questions managed the recording device and paid attention to the body language and reactions of the participant. If technical errors would have occurred during the data collection, alternatives were available in the form of a backup computer as well as a backup recording device.

The midwives' requests for time and location of the interview determined where it took place. There was a variety of locations in which the interviews were held. Some of them were conducted in a public, outdoor environment whilst others were conducted in a private area, indoors. The interview with the shortest duration took 12 minutes and 30 seconds, and the interview with the longest duration took 31 minutes and 17 seconds. See table 2. See appendix 1.

Table 2. Interview descriptions

<table>
<thead>
<tr>
<th>Interview nr</th>
<th>Place for the interview</th>
<th>Duration of the interview</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interview 1</td>
<td>Outdoor environment, public place</td>
<td>21:31 minutes</td>
<td>Considerable noise and distractions.</td>
</tr>
<tr>
<td>Interview 2</td>
<td>Outdoor environment, public place</td>
<td>12:52 minutes</td>
<td>Considerable noise and distractions.</td>
</tr>
<tr>
<td>Interview 3</td>
<td>Office environment, private place</td>
<td>22:04 minutes</td>
<td>Some distractions.</td>
</tr>
<tr>
<td>Interview 4</td>
<td>Outdoor environment, public place</td>
<td>20:05 minutes</td>
<td>Undisturbed environment</td>
</tr>
<tr>
<td>Interview 5</td>
<td>Adjacent to examination room, public place</td>
<td>31:17 minutes</td>
<td>Considerable noise and distractions.</td>
</tr>
<tr>
<td>Interview 6</td>
<td>Office environment, private place</td>
<td>12:30 minutes</td>
<td>Undisturbed environment</td>
</tr>
<tr>
<td>Interview 7</td>
<td>Office environment, private place</td>
<td>15:48 minutes</td>
<td>Undisturbed environment</td>
</tr>
<tr>
<td>Interview 8</td>
<td>Adjacent to examination room, public place</td>
<td>12:37 minutes</td>
<td>Some distractions.</td>
</tr>
</tbody>
</table>

4.4 Data processing and analysis

The result of the study was based on the recorded interviews. These were transcribed and analyzed using a qualitative content analysis. A qualitative content analysis is a type of analysis that categorizes narrative data into smaller units that are then coded and named according to similar content. In qualitative studies, analysis of collected data often occurs while the study is still being conducted. Since it is often a lot of material to process, there should be balance between identifying the most important content and keeping the data concise (Polit & Beck, 2012).
The interviews that were already implemented were transcribed verbatim, simultaneously with the continued collection of data. One of the authors listened to a recorded interview and then transcribed the content verbatim. The second author then listened to the same interview in order to reduce the risk of transcription errors in the text. The authors took turns to transcribe the interview and examine the text for errors, so that each author got the same amount of interviews to transcribe. Emotions and pauses were noted during the transcription. Participants, other people and places mentioned during the interviews were made confidential. Once all the interviews were transcribed, both authors read through the collected material several times, individually. By scrutinizing the data repeatedly, a deeper meaning and understanding could be achieved. Reading through the material individually and thoroughly is necessary for comprehension of the text (Polit & Beck, 2012).

During the text analysis, both authors matched the content of the text to the aim of the study. This process is termed meaning units. The parts of the text not related to the aim were erased from the material. The content was then organized into codes, which are conclusions of content in the material that corresponds to the aim of the study. The codes were divided into categories and subcategories that summarized the importance of the codes. The subcategories were then sorted by similar content to facilitate the analysis process. The codes, categories and subcategories were then read through by both authors in order to adjust the categorization. It was initially 18 categories and 13 subcategories, which were reduced to five categories and seven subcategories (Polit & Beck, 2012). See table 3.

Table 3. Examples of meaning units, codes, sub categories and categories

<table>
<thead>
<tr>
<th>Interview nr</th>
<th>Meaning unit</th>
<th>Code</th>
<th>Sub category</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Most of the one I deliver are being married when they are still young. And they are more likely to get complications because of their tender age, usually at 14 years of age</td>
<td>FGM results in early marriage and early childbirth.</td>
<td>Early marriage and childbirth in connection with FGM</td>
<td>Kenyan midwives experiences of FGM as a tradition</td>
</tr>
<tr>
<td>4</td>
<td>The vagina prepares for the childbirth by expanding, but when labia minora is chopped off, it cannot expand due to scar tissue.</td>
<td>During delivery, the vagina cannot expand due to scar tissue in that area.</td>
<td>Complications during childbirth.</td>
<td>Complications of FGM in connection with childbirth</td>
</tr>
<tr>
<td>5</td>
<td>Before the law, there were always ceremonies, but today it’s different. It’s done in secret. The statistics are wrong, they are wrong.</td>
<td>Before the law, FGM was followed by a ceremony. But after the law, it is done in secret.</td>
<td>Experiences of the law against FGM</td>
<td>Experiences of FGM in government and community</td>
</tr>
</tbody>
</table>

4.5 Ethical considerations

An ethical clearance was obtained through the director of each hospital, which made it possible for the study to be conducted in three different locations. Each surveyed participant was given
an information form about the study, the aim of the study and what the collected data was going to be used for. There were also a consent form for the participants to sign. The participants were given the opportunity to retain the information form in order to contact the authors if any questions arised. All participants received written- as well as spoken information from the authors. All documents were written in consideration to the Declaration of Helsinki. The declaration is international and contains four main ethical principles that exist to protect men and women participating in research studies considering medicine, nursing and health (World Medical Association, 2014).

As preparations for this study were done, it was vital to demonstrate consideration and respect, especially in the design of the interview questions. These should be professional and clearly worded to avoid misunderstandings. The content of the questions should be regarded as sensitive and potentially offensive if asked in an improper manner. It was also of great importance to inform the participants about confidentiality and that they were, in no way, forced to participate. The interviews were recorded by audio recording devices for use in data collection and analysis. The participants' identity was protected during the data collection and after the study. The recorded material was stored in two computers as well as on an external hard drive. The computers and the hard drive were kept locked up (Polit & Beck).

5. Result

Kenyan midwives' experiences of FGM and their experiences of caring for genitally mutilated women in connection with childbirth could be summarized in five main categories. These were further divided into seven sub-categories. See table 4.

Table 4. Categories and subcategories

<table>
<thead>
<tr>
<th>Categories</th>
<th>Subcategories</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kenyan midwives experiences of FGM as a tradition</td>
<td>FGM in different tribes and customs</td>
</tr>
<tr>
<td></td>
<td>The traditional procedure of FGM</td>
</tr>
<tr>
<td></td>
<td>Early marriage and childbirth in connection with FGM</td>
</tr>
<tr>
<td>Complications of FGM in connection with childbirth</td>
<td>Complications during childbirth</td>
</tr>
<tr>
<td></td>
<td>Complications after childbirth</td>
</tr>
<tr>
<td></td>
<td>Complications of home delivery caused by FGM</td>
</tr>
<tr>
<td>Preparations and materials needed when delivering babies from mutilated women</td>
<td></td>
</tr>
<tr>
<td>Experiences of FGM in government and community</td>
<td></td>
</tr>
<tr>
<td>Midwives opinions about measures that should be taken against FGM</td>
<td></td>
</tr>
</tbody>
</table>

5.1 Kenyan midwives experiences of FGM as a tradition

*FGM in different tribes and customs*

FGM is by Kenyan midwives described as a deeply-rooted tradition that has continued partly due to ignorance, and partly due to fear of change. It is mostly viewed as a rite of passage, after which the girl transitions from a child to a woman ready for marriage. FGM is performed for various reasons depending on tribal affiliation. One of the biggest fears among the parents of the girls in Maasai is that they cannot get married if they are not genitally mutilated. In other tribes such as Kuria and Somali, they also believe that FGM is a way to control the sexuality and the behavior of the woman.

```
Usually they say that a circumcised girl behaves well. She shows respect for elders and her husband. Usually they say that an uncircumcised girl is hard for the man to control. That’s how it is, especially here in Maasai. They usually say, that a girl that is circumcised, her libido is low and the respect is high. And an uncircumcised girl, her libido is high and her respect is low. And she will go to more than one man (Interview 7).
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According to the majority of participants, Kuria, Samburu and Somali are tribes that believe that an unmutilated woman is not a woman, but a child. If an unmutilated woman, after all, gets married, she will bring shame to her husband and will be banished from the family until she undergoes FGM. In case of pregnancy in an unmutilated woman, the mutilation will be conducted as a forced procedure directly adjacent to the delivery of the baby.

```
If somebody married a woman who is not cut and she is pregnant, during the delivery, the traditional birth attendant will perform the cut even if the mother is delivering the baby. Even if she’s still at home they will perform the cut. So when she’s coming to the hospital to have her baby, the first thing we see is a bleeding mother, from the cut. And then you need to start with the delivery process (Interview 5).
```

According to the participating midwives, the belief among Maasai is that women who are not genitally mutilated are the main cause of divorce in the community.

*The traditional procedure of FGM*

FGM is, according to all participants, performed locally by traditional birth attendees without any medical training. It is conducted under unhygienic conditions with long distance to hospitals, which can threaten the girl’s life if complications arise. Usually, a group of girls are mutilated at the same time with the same instrument which increases the risk of infectious diseases such as HIV. Materials used during the mutilation are razorblades, knifes, scissors and also sharp stones or pieces of glass. During the mutilation, the girl’s arms and legs are held down and sometimes, if the girl is not too small, a person sits on top of her chest to prevent her from moving and thereby obstruct the mutilation. Severe pain and excessive bleeding are by the midwives described as two complications that occur directly adjacent to the mutilation. After the mutilation, the wounds heal poorly with extensive scarring and, in some cases keloids, as a result. Since most of the genital area consists of scar tissue, complications will occur when the women are giving birth.
So what you can think is that one of the ladies is suffering from HIV and the rest who are clean and do not have HIV can end up getting HIV because the knife they use when cutting all the girls is the same, it’s not clean. So it can introduce some infectious diseases to the ones who have not been exposed to this diseases. So it is an unhygienic practice (Interview 2).

According to all participants, the procedure of FGM varies from tribe to tribe. The women in the Somali tribe undergo infibulation, which includes the removal of clitoris, labia minora and labia majora. Thereafter, they sew the wound edges together, leaving only a small opening. The Maasai and the Kuria tribes perform an extensive type of mutilation in which the clitoris, labia minora and labia majora are removed. Unlike the Somali, the wound is left open and the healing process takes a long time. This results in a lot of fibroses and scar tissue. Many girls die during or adjacent to the mutilation.

All participants described FGM as a public event, where everyone in the village is present. The ceremony is performed in a similar way among all tribes in Kenya. Men, women and children gather around the girl that is about to be mutilated and look when the procedure is performed. The girl is expected to show courage and bravery, and disgraces herself and her family if she screams or cries during the mutilation. A girl who cries will not be celebrated afterwards, and may also have difficulties getting married. A girl who stays silent is celebrated by the village, and goats are slaughtered in her honor. Since the law against FGM was introduced, the mutilation is nowadays done in secret rather than in public, according to the participants.

Early marriage and childbirth in connection with FGM

The Maasai community practice a marriage tradition in which the recently mutilated girl is abducted by a group of village men. She is then taken to a remote place where she is raped by all of the men in the group.

They just go to the girl while she still in the circumcision period… right after the circumcision. They snatch her and take her out in the bush. They come as a group, sometimes 10. They just go and look for her and then they tell the others in the group that they want to snatch her … immediately when they take her, they have sex with the girl (Interview 4).

Many parents among the Maasai community see FGM as a way to assure their daughters marriage and by that, an increased income. The parents are paid for their daughter with cattle, and it is one of the men that abducted her that will marry her. The girls have no say in the matter of marriage, according to the majority of the participants.

The majority of the girls in Maasai and Kuria go through FGM when they are 12, 13 and 14 years old, according to most of the participants. Since they are considered mature after being mutilated, they are mostly married immediately after the procedure is done. This means that a 12-year old girl, or one even younger, can be married off to a significantly older man. After the mutilation, the girl is expected to undertake upon a traditional wife’s duties, such as being attentive, giving the husband children and being a good mother. The participating midwives have also experienced that the girl will have to drop out of school immediately after the marriage.

Most of the participants experience that early marriage leads to early childbirth. Due to their tender age, the girls feel embarrassed and mostly want to deliver the baby unnoticed. That means
that a traditional birth attendee will help the girl to deliver the baby in the villages. Going through childbirth when being very young can cause complications since the girl is not yet developmentally mature.

According to all participants, the pelvis is too narrow for the baby’s head to pass which causes prolonged labor and, consequently, asphyxia of the child. Since the villages often are in remote areas, far from hospitals, complications that arise during childbirth can be devastating.

There is tearing. Especially when they deliver at home, in the villages. The young girls are shy and don’t come to the hospital to deliver. Most of them deliver in the villages where there is probably a village midwife. And that’s why you see a lot of infections because of the tears. And they can also bleed a lot, some even die. Most of them get infections because of the tearing (Interview 8).

According to the majority of the participants, the complications that occur when young girls deliver in the villages can be prevented. They believe that by presenting the benefits of giving birth in a hospital to the women, the number of complications and deaths among the girls and their babies could be reduced.

5.2 Complications of FGM in connection with childbirth

Complications during childbirth

According to all participants, the biggest complication when delivering a baby from a mutilated woman is severe tearing. When delivering babies from women who have undergone FGM, it is necessary to perform an episiotomy. A strong opinion among the participants was that without an episiotomy, genitally mutilated women cannot deliver normally without having multiple tears.

The vagina prepares for the childbirth by expanding but when labia minora is chopped off there is only scar tissue there, it cannot expand. When you tell that girl to push the baby it becomes a problem because the vagina is to stiff (Interview 4).

According to most of the participants, prolonged delivery often occurs in mutilated women. Due to the inelastic vagina, the second stage in delivery is delayed and can therefore cause asphyxia in the baby. Some of the participants experienced that more caesarean sections were performed on women that have undergone FGM than on women who have not. The reasons for that are believed to be prolonged labor due to the lack of elasticity in the vagina, and narrow pelvis due to the woman’s young age.

Some of them usually end up having a cesarean section because it is way too tight and they can’t deliver normally and even if it opens they end up with so many tears. It can go upwards and downwards during childbirth (Interview 3).

Delivery of babies from women who have undergone infibulation is described as difficult since the tearing tends to get a lot worse than on women who have undergone excision. The Somali tribe does not allow cesarean section due to their traditions, which can cause difficulties when a caesarian section is a woman’s last hope. That is a major problem, according to most of the participants.
Complications after childbirth

The tearing is described as the biggest complication when delivering a baby from a mutilated woman since it causes further complications, such as postpartum hemorrhage (PPH), infections and fistulas. The normal bleeding from giving birth along with the bleeding from the tearing can cause anemia and at worst, maternal death. Health facilities in remote areas do not have a blood bank, which means that a vehicle that can transport the woman to a bigger hospital needs to be available at all times. The healing of the tearing is slow, and can cause infections that lead to sepsis. One of the most severe complications is fistula formation due to the tearing. One participant shared a memory regarding fistula formation in a mutilated woman:

The scar tissue from the removed genitals covered almost half of the vagina so you can imagine there was a lot of fibroses, it’s like dead tissue. So it becomes extended and when it tries to extend it tears off, all of the vagina was really hurt. The head is trying to come out and the vagina tries to expand, there is no elasticity, and the mother is having contractions. You will have very severe tears. She ended up having a fistula. A fistula is actually just a hole that goes from the vagina to the urethra. Her urethra teared completely (Interview 5).

When delivering, a woman can get a tear that goes upwards to the urethra, or downwards to the rectum. This is described by all participating midwives. The tear can create a fistula formation that causes urinary- and fecal incontinence. According to all of the participants, these complications are common among mutilated women. They further describe that the incontinence causes difficulties in terms of exclusion and isolation. If a woman develops a fistula, her husband will divorce her and also terminate contact with their children. Even if the woman get surgically repaired at a hospital, the man will still not take her back. According to the majority of participants, the same applies to women who develop keloids due to scarring from mutilation or childbirth. These conditions are looked upon as curses and the woman becomes an outcast. The more births a mutilated woman goes through, the harder it gets since the scar tissue from the tearing in previous deliveries increases the risk of further tearing and fistula formation.

Complications of home delivery caused by FGM

The majority of the women in Maasai and Kuria deliver at home, partly due to remote areas with long distances to hospitals and partly due to their culture. According to all participants, the risk of complications increase when women who has undergone FGM deliver at home.

The general opinion among the participants is that women who come to seek help at hospitals or health facilities after a home delivery are in a very poor condition. Many need to be referred to larger hospitals to be repaired and possibly get blood and antibiotics. The number of babies who die when delivered from mutilated women at home is described as high, partly due to prolonged labor and partly due to long distance to hospitals if complications arise. There is also an increased maternal mortality due to the aforementioned complications. All participants emphasized the importance of informing women about the risks that occurs when delivering at home. They tried to persuade women to give birth in a hospital or health facility, but they found it difficult.

5.3 Preparations and materials needed when delivering babies from mutilated women

There was a strong opinion among the participants that special preparations and resources were needed when delivering babies from genitally mutilated women. A knife, razorblade and scissors
were described as the most important materials to have at hand during delivery. Due to the scarred and inelastic vagina and perineum, it is almost impossible for mutilated women to deliver a baby normally without having an episiotomy. If an episiotomy is not performed, she will have severe tearing which causes fistulas and infections. However, even though an episiotomy is performed, the women still tend to tear a lot. According to most participants, preparations for procedures to remedy blood loss were of great importance. To prevent PPH, it is of great importance to check the women’s blood type and hemoglobin levels before she is transferred to a bigger hospital to receive blood.

You give them the episiotomy but still they get so many tears and the bleeding is coming, the normal bleeding from the childbirth but also bleeding from the other cuts. So it becomes a lot of bleeding. And some of it can be really hard to suture. There so many tears so where am I going to suture (Interview 3)?

A vacuum extractor was described as a necessary means during deliver. However, delivering a baby from a mutilated woman with a vacuum extractor was also described as troublesome due to the non-expanding genital area. Some of the participants indicated that, in the majority of cases, it was too late for preparations to be done. The majority of the women about to give birth arrive to the health facilities late in second stage of labor, which can mean that there is no time for preparations other than explaining to the woman what is going to happen.

5.3 Experiences of FGM in government and community

Some participants believed that the law against FGM has slowly reduced the number of girls being mutilated. Before the law, it was a forced procedure. Girls who didn’t want to undergo FGM were abducted and forced to undergo the procedure. After the law was introduced, the girls could go to the chief in the villages and say no to FGM with the law on their side. If someone practices FGM, they will go to jail for three to six years or have to pay a bail of 2500 euros.

Statistically, the number of girls who have undergone FGM has reduced. However, according to some participants, there are still some tribes that practice FGM. The Maasai, the Samburu and the Kuria do not abide by the law and continue with the mutilation on the same scale as before.

Those girls that was really against FGM, who were educated, tried to go to the chief but they were forced. It was a forced procedure. She’s taken away and circumcised by force. Now, because of the law, they know there is somewhere they can go and they can report to the chiefs and therefore be saved (Interview 6).

Some participating midwives describes an increase in the number of girls being mutilated. The increased number of FGM can, according to some midwives, be attributed to a power shift among the security department in the government. People who had previously been arrested for practicing FGM were now suddenly defended by the security department and released without further penalty. Hospitals and doctors are responsible for checking that the young girls are not mutilated. According to most participants, it is common to get doctors to look the other way using bribes.
5.4 Midwives opinions of measures that should be taken against FGM

According to all participants, the main measure against the practice of FGM was education. By educating the entire community, FGM could cease to exist. The common opinion was that education should be held everywhere: in the schools, in the church, in the markets, and in the hospitals. The mothers and the fathers are the ones most in need of education. It could be held only for the parents, or for the parents together with their children. Schoolteachers should inform the children, both girls and boys, the benefits of not being mutilated and the risks that occurs during and after the procedure. Girls at immediate risk of FGM should be taught that they still can get married even though they are not mutilated. Sexual education should also be provided to these girls, in which the benefits of not being mutilated are described. Additionally, elders, traditional birth attendants and men need to be aware of the severe complications that often occur when a genitaly mutilated woman delivers a child.

The husband should also be present when his wife delivers a baby. It is by the midwives described as impossible for the man to be present during childbirth, since the belief is that he will be cursed. Witnessing the difficulties that the women goes through when delivering is, according to some participants, the first step in putting a stop to FGM.

Among several tribes, such as the Maasai, the fear of the law is strong. Therefore, it is of great importance to educate the communities about the meaning of the law against FGM and the penalties that are enforced upon anyone who breaks the law.

If they get enough education and show those the problems with FGM this thing can stop. And it must start with us, especially we mothers. I have a daughter and she is not circumcised. I didn’t circumcise her because of the problems you end up with. And she would never be able to continue her education (Interview 4).

Finally, the common opinion of the participating midwives is that by educating the leading figures in the community, FGM can come to an end. Since it is the leaders that have the power, the rest of the people will follow their lead. If the chief in a tribe is aware of the risk and complications of FGM, then he could forbid it in that area.

6. Discussion

6.1 Method discussion

Since the aim of this study was to describe Kenyan midwives' experiences and views, a qualitative method was used. When writing a study about people’s experiences and thoughts, a qualitative method is best suited. Credibility, dependability, transferability and conformability are four concepts that are used when conducting a qualitative study. Together, these four dimensions forms the basis of the study’s trustworthiness and were therefore considered during the data collection and analysis (Kristensson, 2014). The pool of interviews was small and the aim was not to describe the larger population, but to give a deeper understanding of midwives’ experiences of FGM and of caring for mutilated women in connection with childbirth. Despite
the small pool of participants, the transferability of the result is high and might be transferred to midwives and health professionals working with mutilated women (Polit & Beck, 2012).

**The sample strategy**

The sample of eight midwives was made with the aim to have as wide of a range of study participants as possible in regards to their gender, age, experience in the profession and knowledge of the subject FGM. Therefore, the participants were selected from three hospitals or health facilities in different areas of Kenya. However, there was only a small number of the staff that was available the day of the interview. Therefore, the options were limited, which may have affected the variation of the sample. Two participants withdrew from the study due to time- and staff shortages which resulted in some difficulties in finding replacements. This somewhat delayed the data collection, since the authors of the present study had to wait for new staff to become available in the next few days. The number of different hospitals or health facilities may be considered as low, and therefore have influenced the sample so that it was not as wide as expected.

**The data collection**

The interview situations were not optimal. Six of the interviews took place in a public environment with considerable noise and distractions. To increase the participants comfort and make them feel as relaxed as possible, they chose the time and location of the interviews. Some were held in a distracting outdoor environment with people continuously passing by, and some were held adjacent to an examination room. There was a considerable amount of interruption from colleagues and patients. Only two of the interviews were held in a private office environment and could be carried out undisturbed. Due to time- and staff shortages, the participants often felt stressed which resulted in shortened interviews. Although the interviews ended up being shorter than expected, the collected material was rich and the content of the interviews were highly relevant for the aim of the study.

Different tribes have different opinions regarding FGM. This is something that should be taken into consideration since the participant’s tribal affiliation may have influenced their responses. There is also a risk that the participants’ answers were angled in a way that agreed with the opinions of the authors of the present study or the general norms in society. Therefore, the credibility may be difficult to ensure because there is no opportunity for the authors of the present study to verify the veracity of the participants’ statements (Polit & Beck, 2012). The questions were asked objectively to increase the credibility of the study. Authors of the present study have a position of power during the interviews that can affect the participant’s answers in a negative way. Since the authors outnumbering the participant, it was of great importance to keep in mind that the participant may feel inferior. The authors of the present study paid attention to the placement during the interview to avoid the participant feeling cornered. They also tried to give a relaxed impression and to be sure to inform about the participants’ rights when taking part in the study (Polit & Beck, 2012).

**The interview guide**

The interview guide is attached as an appendix, which strengthens the study’s dependability since it might be helpful to future researchers conducting a similar study. See appendix 1.
The interview guide contained 13 main questions, which in retrospect could be seen as too many. However, not all questions were asked during all interviews since most participants preceded the questions in the interview guide and answered the questions before they were asked. There was then no need for the authors of the present study to repeat questions already asked. Some of the questions may have been perceived as angled when read in the order of the interview guide, for example “Do you think that FGM is a problem in Kenya?” The questions were however asked in a different order than the order of the interview guide, mainly due to the semistructured interview method which made it possible to ask the questions in a different order than the one in the interview guide (Polit & Beck, 2012). Also, as aforementioned, not all questions were asked during all interviews. Therefore, the credibility does not decrease since the participant’s opinions about FGM already had emerged.

The language barrier caused some minor difficulties during the interviews. Since English is both the participants’ and the authors’ second language, there were some misunderstandings. An interpreter was available but not used, which in retrospect may have been a mistake since a few of the participants spoke poor English. An interpreter can, however, affect the answers by including some of his or her own values, which was the main reason the authors of the present study chose not to use one (Polit & Beck, 2012).

The data analysis

The recording device was placed in between the author assigned to lead the interview and the participant, for best audio recording. There were, however, some disturbances in the sound recording due to disturbing surroundings, which contributed to some difficulties in the transcription. To avoid accidental- and deliberate alterations in the data, the authors of the present study listened through the recorded interviews several times, both individually and together. Accidental alterations consist of typos in the text, misinterpreting words and omissions such as commas or periods. There is also deliberate alterations and unavoidable alterations that can occur when processing data. Deliberate alterations of data could mean that the author intentionally made some changes to the text so that it better suits the aim of the study. Unavoidable alterations are alterations that transcriptions cannot capture during an interview, for example, those related to body language (Polit & Beck, 2012). The risk of deliberate alterations must be reduced in order to achieve high credibility in the study (Kristensson, 2014). To avoid unavoidable alterations as much as possible, the author that was assigned to observe and take notes during the interviews paid attention to the participant’s body language and emotions. These were written down and used as support to the recorded interviews during the transcription. During the analysis process, both authors of the present study listened and read through the collected data individually and together to strengthen the credibility of the study (Polit & Beck, 2012).

The ethical approach

An ethical approach was of great importance when conducting the study. The subject FGM arouses strong feelings and emotions among people, both those that are for and against the practice. It is a deeply-rooted tradition that still means a lot to some tribes. They have been performing FGM for as long as they can remember and cannot see any benefits that would come with ending it, but rather the opposite.
When conducting the interviews, it was of great importance for the study’s conformability not to put own values in the interview situation. The authors of the present study had to be objective in their way of looking at the subject and the participants’ answers to avoid an angled result (Polit & Beck, 2012).

6.2 Result discussion

FGM as a tradition

The result of the present study showed that Kenyan midwives experienced FGM as an obsolete, harmful practice that causes great difficulties, especially in connection with childbirth.

The study showed that FGM still exists due to ignorance and fear of change. Furthermore, Mudege et al (2012) emphasizes that the old traditions and social context behind FGM is the main reason for the procedure’s survival. Not undergoing mutilation can lead to exclusion, which is the main reason for women to voluntarily undergo the procedure. By having their daughters genitally mutilated, the women spare them the suffering of isolation and not being able to get married and have children. Imoh (2013) further describe the procedure as beneficial since the girls maintain their honor and get included in the life of the community. The procedure of FGM is a major part of a deeply-rooted tradition that should not be easily dismissed. After all, different communities all over the world have their specific traditional practices which characterize the society. Questioning a tradition, and thereby an entire society and its norms, may lead to strife and discord between communities of different opinions. A mutual respect should be taken into consideration when approaching traditions and different customs. However, the serious complications that arise following the procedure of FGM cannot be ignored. The result shows that the unhygienic environment, the contaminated instruments and lack of medical knowledge are the major causes of complications during and adjacent to the procedure. The complications may at worst lead to death, which is further emphasized in the study of Mudege et al. (2012). When looking at the traditional practice, both beneficial and disadvantageous outcomes should be taken into consideration. However, although the tradition is deeply-rooted and characterizes several communities, the consequences of FGM are hard to look upon in any other way but negative. By looking at the physical and physiological difficulties that occur as a result of the procedure of FGM, it is easy to interpret the practice as harmful and obsolete. This result can be implemented on Swedish health care and how the personnel behaves in the meeting with patients of different ethnicities. It is important for Swedish health care professionals to respond to genitally mutilated women with respect for their culture and tradition, and to be able to override their own opinions on the subject.

According to Swenurse (2012), health care is based on a holistic-existential approach with a humanistic view and focuses on understanding a person's life-world in relation to health, illness and suffering rather than focusing exclusively on problems and diagnoses. It is of great importance to see the woman and the reasons behind her mutilation rather than only the medical condition or the fact that she is mutilated. This applies in maternal health care as well as school health and community health care. A woman who have been genitally mutilated may be encountered anywhere within the health care system which places great demand on all health care professionals in Sweden. One finding in the result of the present study is that different tribes
practice different types of FGM. When working within health care in Sweden and meeting women with Kenyan origin, it could therefore be of significance to dialogue with the patient and inquire about her tribe affiliation. Knowing that could increase the personnel’s understanding for the women and therefore further promote a holistic person-centered care.

**Complications of FGM**

FGM causes lifelong problems besides the ones directly adjacent to the procedure. The result of the present study shows that the most severe long-term complications of FGM occur in connection with childbirth. Bleeding, extended delivery and severe tearing were some of the complications mentioned. These complications are also described in a study of Lundberg and Gerezgiher (2008). The result shows that special materials and preparations are needed when delivering women who has undergone FGM, in order to prevent more severe complications. It is described as a problem when women delivers at home since there is no material available. This problem ought to be easy to solve by educating the women and encouraging them to deliver at hospitals and health facilities instead of in the villages. By doing that, the opinions of the authors of the present study is that the rate of maternal- and infant deaths could be reduced.

When looking further into the complications in connection with childbirth, the major issue is suffering, pain and death of both mothers and babies. Women’s suffering might further increase since some of the complications such as fistula formation after childbirth leads to isolation. The authors of the present study find it upsetting that the lack of knowledge is so apparent. Ignorance is described as the major reason for the practice’s survival and also the beliefs that medical conditions are caused by curses. This result can be implemented in Swedish health care and the meeting with women from Kenya as well as other countries. Knowing that different cultures have different views on medical conditions and childbirth increases the understanding of the patient and her tribe’s or communities specific customs. It also promotes family centered care since, by educating and informing the father of the child, he could be involved in the pregnancy and present during the delivery of the child.

The result shows that an extensive type of FGM is performed in some tribes in Kenya, in which clitoris, labia minora and labia majora are removed and the wound is left open. This type is not mentioned in WHO’s definition of the four main types of FGM. The authors of the present study find it strange that this type of FGM has not been mentioned in any of the literature read or previous scientific studies. They further believe that it should be defined as an own, fifth type of female genital mutilation. The extensive type causes severe complications since it leaves an open flesh wound that takes long time to heal. When the wound is left open, it further increases the risk of bleeding and infections. According to the authors of the present study, the risk of complications ought to further increase with the warm and humid climate in Kenya. The extensive type of genital mutilation contributes, according to the result of the study, to severe scarring that sometimes covers large parts of the vaginal orifice. The authors of the present study believe that the extensive type causes greater difficulties than type I and type II in connection with childbirth, but also in the everyday life with difficulties urinating, menstruating and sexual intercourse. In comparison with type III, the extensive type may be seen as equally deleterious regarding the complications that arise during and after the procedure, especially in connection with childbirth.
**Education in the subject FGM**

According to the authors of the present study, the lack of knowledge is likely to be greatest in rural areas. KNBS and ICF Macro (2010) further emphasize that the prevalence of FGM is higher in rural areas than in urban areas. There are several reasons for this difference in statistics. One is the tribe affiliation and another is the level of education. The tribes with the highest prevalence of FGM, for example the Somali and the Maasai, are located in rural areas of Kenya whilst the tribes with the lowest prevalence, for example Luo, are located in more urban areas. The level of education is also of great importance considering the prevalence of FGM (ibid.). According to the authors of the present study, the importance of education is reflected in the result. All midwives participating in the study express a wish that FGM should be repealed. Since they are all educated, the conclusion that can be drawn is that with education comes knowledge and eventually an end to the practice of FGM.

To be able to enlighten the communities about the drawbacks of FGM, a deeper knowledge in the subject is of great importance. It is the authors of the present study’s opinion that it is easy to underestimate the difficulties of FGM in connection with childbirth, especially regarding the milder types. Before the study was conducted, the authors themselves believed that by removing “only” the labia minora or clitoris, there would be less severe complications during childbirth than for example after the infibulation. However, according to the result of the present study, that proved to be wrong. The result therefore demonstrates that not only the people of Kenya, but also other populations such as the one in Sweden, are in need of education in the subject of FGM. According to Swenurse (2012), it is of great importance for registered nurses to work with health promotion and education. To be considered as part of health care, the health education should be characterized by cooperation, dialogue, empowerment and respect for the individual. Working health promotion is particularly important when working within the school health and health facilities with girls who have been- or is at risk of being mutilated. The Swedish registered nurses who work within the school health or in health facilities have a great responsibility to educate not only the girls, but also their parents and families. This could be done by supportive dialogues and conversations with both the girls and their parents, either all of them together or individually.

Respect for the individual is as aforementioned of great importance, especially since FGM concerns intimate body parts that might be difficult to talk openly about. The result of the present study demonstrates that FGM is a deeply rooted practice that seems natural for individuals affected. This places great demands on Swedish health care professionals when it comes to encountering mutilated women with respect and understanding.

**Measures taken against FGM**

In Kenya, specifically men are in great need of knowledge regarding women’s suffering during childbirth due to FGM, to be able to fully understand what the women endure. By doing that, the men can hopefully contribute to the effort to make the practice cease to exist. In the study of Mudege et al. (2012), the importance of education and knowledge is emphasized in the pursuit of getting FGM to stop. The result further shows that the law against FGM is considered one of the major, and most important, measures taken against FGM. The importance of the law when fighting against female genital mutilation is also described in the study of Mudege et al. (2012). The result of the study shows that the law have decreased the number of girls being mutilated. However, the unreported cases are described as high since the practice is done in secret after the
implementation of the law. Mudege et al (2012) further emphasize that the practice of FGM is done in secret, mainly in rural areas. A finding in the present study was that the statistics that shows that the number of girls being mutilated has decreased, cannot be fully trusted. As a Swedish registered nurse, this is important to keep in mind when encountering women and girls with Kenyan origin, but also when looking at the statistics in Sweden. By working health promotion within school health care and health facilities, the number of girls being mutilated in Sweden can decrease. According to ICN (2012), promoting health and preventing illness is two of a registered nurses main responsibilities, which can be achieved by working health promotion.

Reasons for the continued existence of FGM

The result shows that the practice of FGM still exists partly due to ignorance. However, according to the authors of the present study, a major reason for the customs continued existence is the poor attitude against women. In the areas where FGM is practiced, a woman’s life is of little, or none, significance. This is also mentioned in the study by Sala and Manara (2001). This means that even if the procedure of FGM in some cases leads to the death of a girl, it does not affect the society substantially. The hierarchical order from 500 B. C is described by Socialstyrelsen (2002) as one of the main reasons for the genesis of performing FGM. According to the authors of the present study, this order still exists today. Women in some Kenyan tribes are inferior the man and looked upon as commodity and trade. This is further described in the study of Sala and Manara (2001), in which the women are defined as minors who do not own the rights to their own bodies and minds.

According to Swenurse (2012), a patient should be viewed as a free individual with the possibility to make choices of her own. In Sweden, health professionals strives to provide care from a humanistic perspective, which in a study by McCabe & Holmes (2007) is described as a person-centered care where each individual is looked upon as a unique human being. The result of the present study could provide suggestions to Swedish- as well as Kenyan health care professionals in how to respond to- and empower female, genitaly mutilated patients in a humanistic perspective. Also, some suggestions on how to encounter the views on women in different cultures is enlightened. The term gender is by Swenurse (2012) referred to as thoughts and descriptions of male and female, and are constructed by the society and possible to change. Gender is based on a cultural interpretation of biological differences between men and women, and varies by different societies. This study could provide some gender awareness among Swedish health care professionals, with the aim to clarify prejudices and preconceptions. If the personnel have knowledge of the cultural view of patients with different ethnicity, they can encounter them with respect for their tradition and culture.

7. Clinical implications

Female genital mutilation has become known in Sweden through increased immigration, mainly from African countries. In the present study, the authors have tried to describe Kenyan midwives experiences of FGM and their caring for genitaly mutilated women in connection with childbirth. By taking part of the Kenyan midwives knowledge and experiences, Swedish health care professionals such as registered nurses could gain a deeper understanding and knowledge in the subject FGM and how to care for women who have been genitaly mutilated. With a deeper understanding comes a deeper knowledge, not only in the subject FGM but also in the different cultures that perform the practice. By partaking of the reasons behind the practice of FGM, the opportunities to provide good, person-centered care with respect for the woman’s integrity and autonomy increases. This could promote integration in Sweden and contribute to a greater
cultural competence among Swedish health care professionals in the meeting with women of different ethnicity. The result of the present study can thus summarized be used by Swedish health care professionals to improve the person-centered care provided at health facilities and hospitals in Sweden. Since the research on the subject FGM may be lacking in substance, the result of the present study can be used as a support as well as to strengthen future studies. Finally, the results of the present study can enhance and develop the care provided to women whom have been genitaly mutilated. This with the aim to decrease the number of women in Sweden suffering from the drawbacks of female genital mutilation, as well as decrease the number of girls and women being mutilated in Kenya.

8. Conclusions

One conclusion to be drawn from the study is that Kenyan midwives experience FGM as an obsolete and harmful custom that should end with immediate effect. The result of the study shows that with education and knowledge follows awareness and enlightenment. The authors of the present study conclude that by educating the society about the negative consequences of FGM, the custom is one step closer to cease to exist. The education should be held for men, women and children in both rural and urban areas.

A second conclusion is that the traditional procedure of FGM is experienced as a threat to girls’ health and, in some cases, even their lives. An extensive type of FGM that is practiced among tribes in Kenya, are described in the result of the study. This type is not part of WHO’s definitions of the different types of FGM. According to the authors of the present study, there is not enough scientific literature about this extensive type of mutilation, and it should be looked into further. It should also constitute a separate type in WHO’s definitions of FGM.

A third conclusion is that FGM is experienced as problematic in connection with childbirth. It causes severe complications both directly adjacent to the delivery and long-term complications. Some special materials are needed when delivering babies from mutilated women in order to prevent more severe complications.

A final conclusion is that the introduction of an improved way of looking at other human beings among people in the Kenyan communities where FGM is practiced, is crucial for the cessation of the practice. It is upsetting that the attitudes against women are so poor. In order to make FGM cease to exist, it is of great importance to strengthen the humanistic view in Kenya. According to the authors of the present study, it is only when the people, especially the women, gets a higher value in the society and is provided with equal rights as men, that FGM can come to an end.
References


Appendix 1

Interview guide

Hi!

Our names are Anna Jerlström and Malin Johansson. Thank you for taking part of our study by answering the interview guide. We are conducting a study to describe African midwives' experiences of caring for genitally mutilated women before, during and after childbirth. We look to you to hear your opinions and experiences. Our conversation will be completely confidential and nothing you tell us can be traced back to you. We are grateful for your participation in the study!

What type of education do you have?

How long have you been working as a midwife?

Do you think that FGM is a problem in Kenya?
If so, why? If no, why not?

Do you believe that FGM causes problems before, during and after childbirth?
If so, why / what problems? If no, why not?

Do you think FGM increases the risk of complications during pregnancy and childbirth?  If yes, how and why? If no, why not?

What's the biggest difference when delivering a baby from a woman who has undergone FGM compared to a woman who has not?

Is there any special preparations needed before the delivering of a genitally mutilated woman? If so, what?

What kind of material is used when delivering a baby from a genitally mutilated woman?

Can you tell me about a delivery of a baby from a genitally mutilated woman who left a special imprint?

Are there any religious or superstitious opinions behind FGM since it still exist?

What do you think is required to make female genital mutilation cease to exist?

What is your personal opinion considering FGM?
Appendix 2

Hello participants!

Our names are Anna Jerlström and Malin Johansson and we are conducting a study to describe African midwives' experiences of caring for genitally mutilated women before, during and after childbirth. We are studying to become nurses at Örebro University in Sweden and are writing our thesis at spring term 2015. Both of us are interested in studying further to become midwives and meet Sweden’s multicultural population and different needs.

Participating in the study is optional and you as a participant does not need to fulfill the interview unless you want to. There will be no consequences for withdrawing without completing your participation. Your task as a participant is to answer an interview guide containing questions considering women who has undergone female genital mutilation, FGM. The interview is estimated to take approximately 30 minutes but if you have further things you would like to share with us we will have the possibility to extend the time schedule. The interview will be recorded and confidential, meaning no one can trace your answers back to you. The interview will be strictly confidential and your answers will be used only as material to our study. If there is anything you would like to know or ask about the participation in our study, do not hesitate to contact us by e-mail.

Best regards,

Anna Jerlström (anna.jerlstrom@gmail.com)
Malin Johansson (mallejohansson88@gmail.com)
Appendix 3

*Informed consent form*

To participate in this study a consent form needs to be signed. Please read the letter below and sign the paper if you agree with what is written. I fully understand that I am being a part of a research study, conducted by nursing students from Örebro University in Sweden. The study will describe Kenyan midwives experiences of caring for pregnant women who have undergone female genital mutilation.

My consent means that I agree to participate in this study by answering an interview guide. The questioning will take place where ever I decide and whatever time I choose. The interview will take approximately 30 minutes and will be recorded.

Everything I say is confidential and will only be used in the study. If I don’t feel like continuing my participation I can discontinue at any time, without consequences.

I realize that I need to have at least 2 years of experience from the work as a midwife. I also need to be able to implement the interview in English.

I realize that the information I share will be kept confidential, even though the compiled study data are going to be published in a thesis at Örebro University.

I can contact Anna and Malin any time during the participation in the study.

I have read and understand this consent form and I agree to participate in the study. I understand that I will be given a copy of this signed consent form.

*Signature of participant* ____________________________  *Date*

*Signature of interviewers* ____________________________  *Date*