



# **Health Care Personnel challenges encountering patients with Female Genital Mutilation**

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<p>Sammandrag:</p> <p>Problemställning: Människor flyttar allt mer och det kräver mera av hälsovården i länder som tar emot människor från kulturer och länder olik sin egen. Jag ville skriva detta examensarbete för att försöka svara på vad som är utmaningarna för hälsovårdspersonalen, och hur man kan lösa dom problemen när det kommer till kvinnlig könsstympning som är en utbredd praxis i Afrika och inom islam.</p> <p>Motivation: Kvinnlig könsstympning är en viktig fråga för det påverkar en kvinnas liv både psykiskt och fysiskt. Det är en tradition som är främmande för oss i västvärlden.</p> <p>Tillvägagångssätt: Fem personer inom sjukvården blev intervjuade. De jobbar eller har jobbat inom ämnet kvinnlig könsstympning i många år. Undersökningen var kvalitativ forskningsmetod och intervjuerna var fokuserade och semi strukturerade.</p> <p>Resultat: Resultaten visar att innan lagändringen kom i kraft i Norge i 1995 var det inga riktlinjer för sjukhusen att följa när det kom till kvinnlig könsstympning. Personalen fick jobba enligt samvete och vad de kunde hitta i böcker. På 2000-talet har Norge gjort stora steg inom vården av denna patientgrupp. Instituter blev skapade för att motverka könsstympningen och handlingsplan har lagts fram.</p> <p>Slutsats: Norge har kommit långt med att erbjuda rätt vård till denna patient grupp. Och utmaningarna idag verkar vara mera kulturella än medicinska. Kultur (Exempelvis att bli frågad om att ljuga om hur skadad en patient är så att patienten kan undslippa ett äktenskap) språk och finkänslighet (hur man tar upp ämnet utan att patienten känner sig stigmatiserad).</p>	
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<p>Abstract:</p> <p>Background: People are moving more and it demands more of health care in the countries receiving people from cultures and countries different from their own. I wanted to write this essay to try to answer what are the challenges for healthcare staff, and how to solve those problems when it comes to female genital-mutilation which is a widespread practice in Africa and in Islam.</p> <p>Aim: Female genital mutilation is an important issue because it affects a woman's life, both mentally and physically. It is a tradition that is alien to us in the Western world.</p> <p>Methods: Five people in the health care environment were interviewed. They are working or have worked in the subject of female genital mutilation for many years. The study was qualitative research and interviews were focused and semi-structured.</p> <p>Results: The results show that before the law came into effect in Norway in 1995, there were no guidelines for hospitals to follow when it came to female genital mutilation. The staff had to work according to their conscience and what they could find in books. In the 20th century, Norway has made great strides in the care of this patient group. Institutes were created to combat genital mutilation and action plan have been formed.</p> <p>Conclusions: Norway has come far with offering care to this patient group. Today, it seems that the challenges for health care personnel are culture related rather than medical. The main categories when it comes to challenges for health care workers are: Culture (for example being asked to lie to the patient's husband about being damaged to get out of a marriage), language and sensitivity (how to bring up the subject without the patient feeling stigmatized).</p>	
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# 1 INTRODUCTION

Norwegian law states that” *Anyone who intentionally performs an operation on a woman's genitalia that damages the genitalia or permanently changes it, will be punished for genital mutilation.*” (Kjønnslemlestelsesloven 1995, par.1).

It is unsure how many immigrated women or children have had female genital mutilation done since they moved to Norway but it is believed that most of them have experienced it before the move to Norway (NKVTS - Norge).

I wish to write about this topic because this is a foreign concept in the Nordic countries that a woman would be cut in their genitals for any reason that is not medical. Due to the special nature of these act's, there is an added pressure on Health Care Personnel to take care of this vulnerable group of people, who might have different beliefs and thought's on the subject. Norway accepts many immigrants which adds pressure to the health care system in Norway.

I feel very strongly about women's rights because I believe that in African societies they are the glue that holds the family together. If health care personnel at home learn how to optimize their care for women who have undergone female genital mutilation, they can help them that much better during a project or any field work during a disaster. I will concentrate on the current situation in the metropole Oslo since it is my area of employment.

An example of a woman who have undergone female genital mutilation is Waris Dirie, UN Ambassador and fashion model, who writes in her book “Desert Dawn” that she has undergone female genital mutilation (Dirie & D'haim 2002:12). She was circumcised when she was “*as tall as a goat*” (Dirie & Miller 2011:11-12). The woman who did it was an old woman who had done these types of procedures before (Dirie et al 2002:12). Waris Dirie was held down by her mother while this old woman cut off her clitoris, inner parts of her vagina and then continued to



stitch her up (Dirie et al 2002:12). When she was done she only had a tiny match-stick sized hole left for urinating and menstrual blood (Dirie 2002:12). This is called infibulation.

Sometime after this she left Somalia to go live with her Aunt in London (Dirie et al 2011:143). She had struggled with her period all her life and usually suffered from fainting, due to her menstrual blood only being able to drip one drop at a time (Dirie et al 2011:143). When she passed out in London, in front of her Uncle she was taken to a doctor who never examined her, and she never told him about her condition (Dirie et al 2011:141-143) Instead he prescribed her some birth control pills (Dirie et al 2011:141).

When she discussed with her aunt if she should not go to a specialist, she was not met with agreement, due to circumcision being something you do not discuss with men, certainly not white men (Dirie et al 2011:144).

She went to a specialist in secret and told him that she was circumcised, and he knew what it meant, because he had had other women from Africa come in with the same problems (Dirie et al 2011:145:148). There were some difficulties with language during this visit and the doctor found a Somali man working at the hospital who could translate (Dirie et al 2011:145). The doctor wanted the translator to explain that she had been stitched together too much and needed surgery to be opened, and the man translated it as "Well, if you really want it, they can open you up. But do you know this is against your culture? Does your family know you're doing this?" (Dirie et al 2011:145-146).

After finally going through with the surgery she was so relieved she could urinate without trouble and she felt a new kind of freedom (Dirie et al 2011:148). The story that Waris Dirie paints of her life shows how difficult it can be to live with female genital mutilation, and the challenges for both her and the health care personnel she met.

## 2 BACKGROUND

There are different reasons for women being cut and they will be explored in this thesis, one example is Figure 1.

*“Circumcision (Female Genital Mutilation) is a noble act to do to women. There’s nothing wrong with doing it. Some religious scholars have issued fatwas that it’s not allowed because many that perform the circumcision cut too much and they cause damage to the woman” – Sheikh Mohamad Alarefe. Popular Saudi cleric, Imam of the Mosque of the King Fahd (The Clarion Project 2013).*



*Figure 1. A girl going through female genital mutilation. Taken from “The Clarion Project” 2013.*

### 2.1 Female Genital Mutilation

World Health Organization (WHO 2014) defines Female genital mutilation (FGM) as a procedure where injury is caused to females genitals where

there are no medical reasons for it. There are no health benefits whatsoever to achieve from undergoing the procedure, on the contrary, women or girls who have undergone FGM have troubles with infections, urinating, problems with childbirth and might become infertile (WHO 2014).

According to WHO female genital mutilation is concentrated in 29 countries and among them 125 million women and girls have been cut (2014). Figure 2 and Figure 3 shows the differences between a circumcised and uncircumcised woman.

## **2.2 The Four types of Female Genital Mutilation**

UNICEF (2014) and the World Health Organization (2014) list's four types of Genital Mutilation that have been done to women.

1. First one is called "clitoridectomy", which means that the clitoris and/or the prepuce is partially or completely removed (UNICEF 2014; WHO 2014)
2. Type Two is when the clitoris and the labia minora are completely or only partially removed (UNICEF 2014; WHO 2014).
3. Type Three is when the vaginal opening is narrowed so there is only a small opening. This is done by stitching together the Labia Minora and/or Labia Majora, which in turn creates a type of seal. This type of procedure is called "infibulation". These women must be opened for intercourse and child birth (UNICEF 2014; WHO 2014).
4. Type Four is any type of harm done to the genitals, for example cutting, piercing or scraping etc. (UNICEF 2014; WHO 2014).

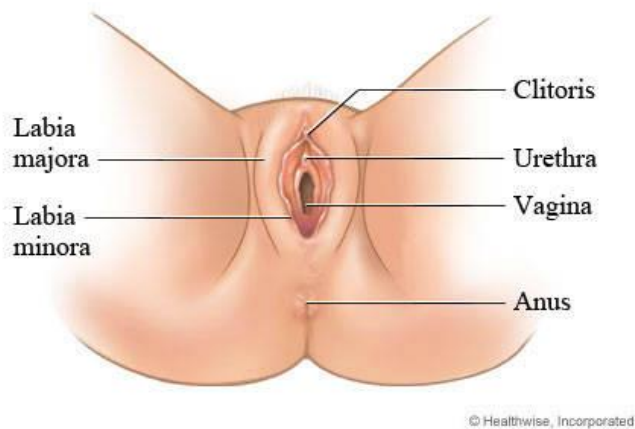


Figure 2. An uncircumcised female anatomy (Medical Encyclopedia 2010-2014).

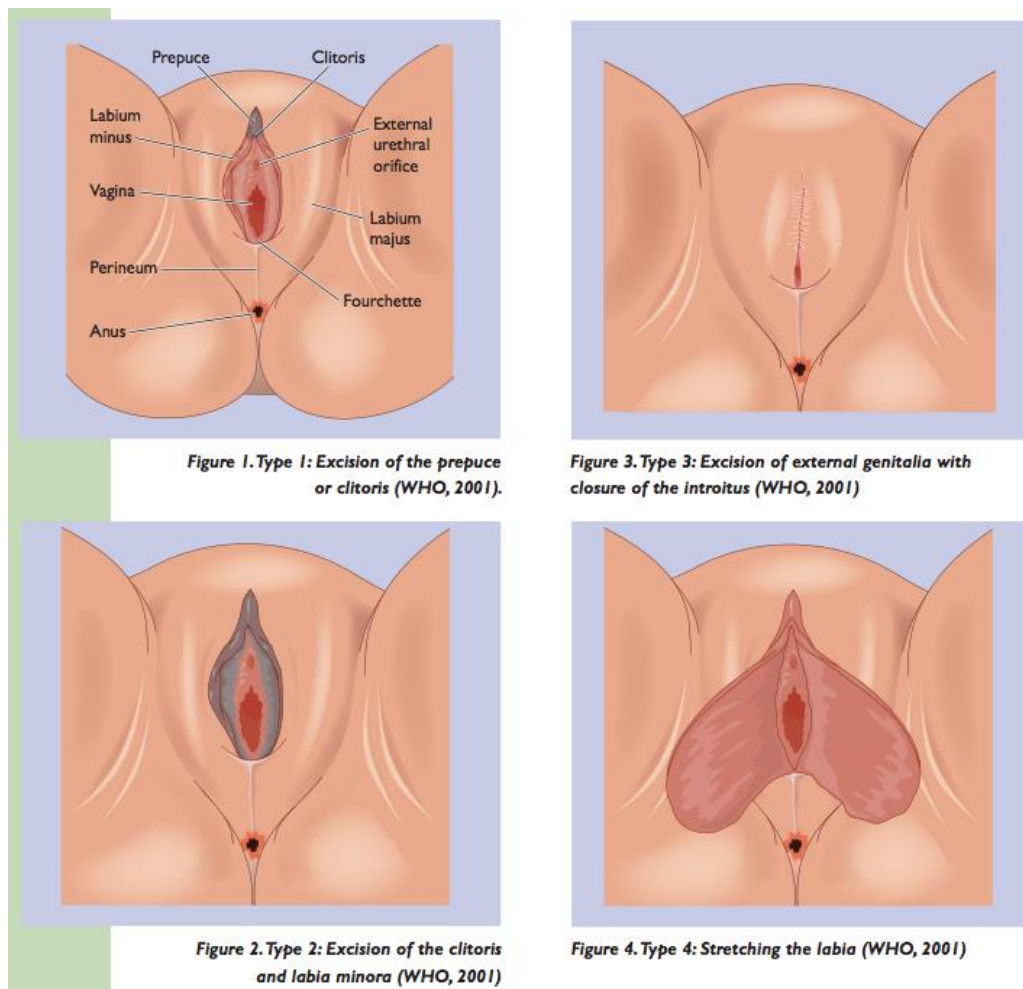


Figure 3. The four types of Female genital mutilation (Desert Flower Centre 2014).

## 2.3 Female Genital Mutilation around the world

Safe Hands for Mothers made a documentary called “The Cutting tradition”, which was commissioned by the International Federation of Gynecology and Obstetrics in 2010 (“The cutting truth” 2010). They interviewed some women in a Somali village about FGM. The women expressed concern if a woman was not circumcised, citing that “*they could not trust her*” and “*it would be embarrassing if my daughter was not cut*” and “*there is no harm in it*” smiling to the person interviewing (“The cutting truth” 2010). One women explained that since their ancestors managed to give birth to children without any problems, they should continue the custom (“The cutting truth 2010”). The documentary shows how the procedure is done, it’s very brutal and honest. Women who tie and hold on to the young girl while she is being circumcised by an old woman with dirty instruments and poor eyesight (“The Cutting truth 2010”).

In Egypt they campaigned against FGM, and even have a 24h hotline for children who need help regarding FGM, the hotline offers social advisors, doctors and psychologists depending on the child’s need (“The Cutting Truth” 2010).

Despite this, one African country has done a huge leap in its fight against Female Genital Mutilation. The digital media company “A Plus” reports on their website that the practice has been banned in the country of Nigeria (Richards 2015). They passed a law that came into effect on May5th 2015 (Richards 2015). The Guardian also reports on the subject, stating that some states in Nigeria already had the ban in effect but it is now banned in the whole country (Topping 2015). They estimate that up to date around a quarter of the Nigerian women have been cut (Topping 2015). It is thought to be an important precedent in Africa, but the battle is far from over to stop the practice altogether (Richards 2015).

CNN reports that in Egypt, where most of the female genital mutilation are taken place today, a doctor has been sentenced for performing genital mutilation on a girl (Thompson 2015). This is the first one since their ban in 2008 (Thompson 2015). Unfortunately due to the practice being a good income for doctors in Egypt this leads to too many willing to take the risk (Thompson 2015). It is a shame that in 7 years only one doctor has been prosecuted even though many medical personnel are performing the procedure.

In 2012, the UK had a case where a doctor was prosecuted for performing FGM on a patient after she had delivered a baby (Laville 2015). The situation was that the woman had undergone FGM type 3, had not been opened up prior to delivery, had to be opened with two cuts to the vaginal opening in order to perform a safe delivery (Laville 2015). After the delivery the doctor was then forced to stitch her up again to stop the bleeding and ensuring her safety (Laville 2015). The doctor was not charged, and was released based on the fact that his actions saved the woman and the baby's life (Laville 2015). This shows another side of how difficult it can be to follow hospital guidelines when things don't always go according to the plan in the delivery room. The article further explains that the case was complex but it was also the right thing to bring forth to the court (Laville 2015).

## **2.4 View on Genital Mutilation in Norway**

The Norwegian foreign ministry have made an action plan to combat female genital mutilation, where they state that the method should not only be regarded as a procedure that is only done physically, but also the importance it has in the community as a cultural custom (2003:5). Norwegian directorate of Health have released an information sheet for health care personnel where they state that more needs to be researched on the subject, due to this being a problematic topic for a sensitive group of people (2011:6).

If there is suspicion of a child/teenager who have undergone female genital mutilation, the health care personnel suspecting it is not bound to professional secrecy, but should report it to the police or Child Welfare Services (NKVTS – Jeg er bekymret att KLL har skjedd). The police in turn contacts the Child welfare and vice versa takes the child to a hospital for a medical examination (NKVTS – Jeg er bekymret att KLL har skjedd). Triggie (2013:9) writes in his article that in the UK in 2013 they needed a system just like this, where the police and child welfare system was involved in all of the cases.

### **3 RESEARCH REVIEW**

A critical literature review has an objective, to give knowledge about the current information about the area of interest, showcasing the researcher's critical skills by synthesizing the information and showing flaws and strengths of the information (Jesson & Lacey 2006:140). And finally lets the researcher show his/her analytical skills and present how the information fits into the big picture (Jesson et al 2006:140). A researcher needs to show that their research is based on earlier research by referencing in their work, as it would be unethical to use others information as their own (Jesson et al 2006:145).

I will be using a systematic research review which means that

*“A systematic review is a comprehensive (and if possible complete) review of published articles selected to address a specific question that uses a systematic method of identifying relevant studies in order to minimize biases and error.”* (Jesson et al 2006:145).

This involves three key factors. First, a systematic review is more meticulous than a regular research review, as it attempts to cover all material about the subject (Jesson et al 2006:145). Secondly there should be clear criteria's as to why the

particular data has been chosen (Jesson et al 2006:146). Thirdly, the researcher needs to make clear what type of criteria he/she has for including or excluding information (Jesson et al 2006:146).

I have used online platforms Google, EBSCO and PubMed for my background search with search words: Female Genital Mutilation, Nurse, challenges, Health care and Health. Using search words "Female genital mutilation", restricting to Full Text and peer reviewed text's I got a hit of 1208 results on EBSCO. Using Female genital mutilation, nurse and challenges gave me 590 of Full Text on EBSCO. Using Female genital mutilation and health care gave me 1214 results of full text on EBSCO. Using Female genital mutilation and health gave me 1873 hits in full text on EBSCO. My results compromised from the years 2004 and upwards. I have restricted my search to English articles and Norwegian and English websites with information that were no older than 10 years (from 2014), but books and laws I had no restrictions. I choose the information based on what I felt was relevant to my subject, what is Female genital mutilation, why it is done, what does a person working in the health sector need to know about the subject, what are the challenges and what does the Norwegian law state about it. After the data was ready and analysed I did another research review based on my results.

### **3.1 Reasons for the practice**

Lindstrand, Bergström, Rosling, Rubenson, Stenson & Tylleskär (2006:246) write in their book "Global Health- an introductory textbook" that it is unknown when and where female genital mutilation first took place, but can be dated as far back as 2000BC. Skaine writes in her book that archaeologists have found mummies who were well-preserved and had undergone female genital mutilation (2005:16). Historian Pietro Bembo believed that the practice started in



Egypt and from there spread to the Arab traders and from there further spread to Sudan in Africa (Skaine 2005:16).

Based on the systematic review there were four main themes that emerged: Reasons for the practice, Instruments and practitioners, Complications from FGM and Challenges for Health Care Personnel regarding FGM.

### **3.1.1 Hygiene and aesthetic reasons**

People believe that if they cut a girls genitals it will make her more beautiful (WHO 2001:38). This is because they believe the outer genitalia are ugly, and they will continue to grow unless they are removed (WHO 2001:38; Bishop 2004:478). It is believed that if these parts are removed the girl or women will be clean and hygienic (WHO 2001:38; Jaeger, Catflisch & Hohlfeld 2009:31). "). In Egypt, where it is against the law to perform FGM the documentary "The Cutting Tradition" shows a discussion with the women who commit the procedure. When they are asked if people still do it even though it is illegal they say "Some girls want to be clean and others they want to be like the foreigners", they them self prefer girls to be clean ("The Cutting truth" 2010).

Gele, Kumar, Hjelde & Sundby (2012) write in their study that some of the participants in Norway expressed fear for their daughters future because they were not circumcised, they feared that it would show through their pants and that the clitoris will continue to grow.

There exists a double standard in the western countries when it comes to genital surgery. Essén and Johnsdotter wrote an article about “Female genital mutilation in the West: traditional circumcision versus genital cosmetic surgery” (2004:611). They raise a discussion about who can decide what is right and wrong when it comes to altering the female genital. For example, is it right to undergo surgery to have a woman’s hymen re-instated like women are able to pay for in the West. In 2004 there was, and maybe still is, a growing trend to alter the female genital, to have a so called “designer-vagina”, how does this trend fit into the legislation of the laws on FGM? (Essen et al 2004:612).

### **3.1.2 Socio-cultural reasons**

In some parts of the world it is believed that the clitoris will hinder the girl into becoming a woman or even a person with the right to interact with other women or her ancestors (WHO 2001:37).

Some believe that the women’s genitalia has powers, powers like blinding anyone attending to her during child birth, powers to kill her infant, make him mad and deformed and also the power to kill her husband (WHO 2001:37).

It is also believed that in order to preserve the girls virginity she needs to be circumcised (WHO 2001:38). This will ensure that the family honour stays intact and secure the future of the family line (WHO 2001:38). Families are often pressured to perform the procedure with threats of being rejected if they don’t from the community (WHO 2001:38). Places where FGM is common are usually societies where women have little to no rights, where they cannot inherit and are only able to achieve security by marrying (WHO 2001:38). Only women who have been cut are suitable to be married (WHO 2001:38).

Others believe that it is a rite of passage that every girl needs to go through in order to become a woman (WHO 2001:38). Sadly, the women who perform the

procedure in the community are influential and paid for their services which makes them one of the speakers for the tradition (WHO 2001:38).

A study done in Norway 2012 shows that participants in the study did not feel the pressure to perform FGM on their daughters the same way as if they would have lived in their home country (Gele et al 2012). They also expressed that they believed many do not like the practice in their home country but cannot stop it due to social pressure (Gele et al 2012). One man in the study reported that he believed in the practice because he thought it could protect women against rapists, but when he finally married himself he saw first-hand how painful it must be for a woman to open to have sex and deliver a child (Gele et al 2012).

Jaeger et al (2009) write in their article that for a long time FGM was a requisite to be able to marry, but it has slowly been changing in the African countries where FGM is prevalent as well as immigrated men are less likely to demand it from their future bride (2009:31). On the other hand some men say nothing because they believe that the women want it (WHO 2014). Men were also under the impression that they were not “strong” enough if they could not have sex with their wife, and it is regarded as shameful for the man (Bell 2008:44). Data by UNICEF also shows that a large number of the men and women have no idea what the other sex’s thoughts are about the subject (WHO 2014). Gele et al (2012) write in their study that some male participants expressed that they did not wish to marry women who had been circumcised, instead they wished to be with women who had their genitals intact because it effects the marriage and the husband as well.

Curbing the females sexuality is only false security and her hygiene is most certainly not been improved, on the contrary, now she must handle re-occurring infections (Jaeger et al 2009:31). On the other hand, male circumcision has proven that it can be beneficial for the child as they get older, but it is still considered as a violation of Human Rights in the UN unless there is a clear medical indication for it (Lindstand et al 2006:248).

In Burkina Faso, a woman decided against circumcising her granddaughters because she was forced to listen to her circumcised granddaughter struggle after she got married ("The Cutting Truth" 2010). She had undergone FGM type 3, and was forced to be opened by a knife for intercourse, they kept trying for a whole week while the girl screamed in agony until the girl's grandmother intervened and put an end to it ("The Cutting Truth" 2010).

In Norway, some Somali immigrants faced pressure from their families when they visited to have their daughters cut (Gele et al 2012). One reported that

*"The last time I travelled to Somalia, I met my grandmother, who is very old. She asked me if my daughter was circumcised. I told my grandmother that my daughter was circumcised. I didn't tell her the truth because I didn't want to say that she was not circumcised. She felt happy that my daughter was circumcised. If I didn't lie, she might have stolen my daughter when I went out and circumcised her. She is an old person who is strict about her old culture. The young generations have learned about the problem that FC causes, and that is why we don't want to circumcise our daughters. (43-year-old female)" (Gele et al 2012).*

### **3.1.3 Religious and spiritual reasons**

If a woman is not cut it is believed she is not spiritually pure (WHO 2001:38). In Islamic and Christian cultures some people believe the Koran and Bible tells them to cut their girls but there is no mention of Female genital mutilation in the Koran (Dirie et al 2002:74) or the Bible (WHO 2001:38; Skaine 2005:29; Jaeger et al 2009:31;"The Cutting Truth" 2010).

In an interview with an Imam in Ethiopia, he states that the practice is older than Islam, and it was already a tradition when Allah came ("The Cutting Truth" 2010).

He further explains that Allah helped the circumcisers to do it the correct way ("The cutting truth" 2010). By only cutting a little piece of the clitoris, and not touching the lips, which is called the "Sunnah" way ("The Cutting Truth" 2010). The documentary also shows the Chairman for the religious committee in Egypt discuss that there are no indications for this practice in the Quran, but there are in the Hadith ("The Cutting Truth" 2010). This makes people disagree on the practice, and allows Imams to interpret things as they see fit ("The Cutting Truth" 2010). During a meeting with different Imams, many opinions are expressed, some want the women to be cut a little bit, others think it's necessary if the Hadith says so, others think it's not necessary while some think that as long as it's done safely and in an appropriate environment it is good ("The Cutting Truth" 2010). The men had also tried discussing circumcision with women, but none of the women had voiced the problems and symptoms the men were told about, so they felt that they did not know who to believe ("The Cutting Truth" 2010). Another Imam could not accept that the procedure would be harmful, because that would mean that all of their ancestors were criminals ("The Cutting Truth" 2010).

A woman working for a local NGO in Africa said that she has little power, if the religious leaders do not support her ("The Cutting Truth" 2010). The people will always listen to the religious leaders no matter how much information she gives about the harms of the practice ("The Cutting Truth" 2010).

#### **3.1.4 Psycho-sexual reasons**

If a girl is not cut it is believed that her sex drive will be out of control and result into her having sex before marriage which would disgrace her and her family (WHO 2001:38). They think that the clitoris will grow if untreated and create uncontrollable desire (WHO 2001:38; Bishop 2004:612). When a girl has been cut and the vaginal opening has been narrowed by infibulation, they think the male pleasure will be better and make him more faithful and not divorce her (WHO

2001:38). It is also believed in some communities that if a woman has troubles getting pregnant it can be solved with FGM (WHO 2001:38; Jaeger et al 2009:31).

### **3.2 Instruments and practitioners**

Surveys on the subject tell that the practitioners performing female genital mutilation are more commonly women, often older, who are traditional practitioners in the village (UNICEF 2014; WHO 2001:31). These women are usually called upon during child labour (UNICEF 2014; WHO 2001:31) but some have an only duty of performing female genital mutilation in the village (WHO 2001:31). Sometimes the families take the child to be circumcised by health care personnel (UNICEF 2014). It is believed these families do this to prevent complications later in life (UNICEF 2014).

The most common place for the procedure to take place is the child's home, the second most common was in a clinic or hospital setting (UNICEF 2014). When the procedure is done in the child's home there are women who must hold the child down during the procedure, most commonly relatives to the child (WHO 2001:31). The procedure can take between 15-20 minutes depending on how much the girl struggles, how experienced the one performing the procedure is and extent of the procedure (WHO 2001:31). The instruments used for the procedure were commonly a razor or a type of blade (UNICEF 2014;WHO 2001:31) and some used sharp rocks or cauterization, which means you use burning as a method (WHO 2001:31) In some areas of Gambia finger nails have been used to remove the clitoris from babies (WHO 2001:31). Some of these instruments are not cleaned or sterilized before the next use (WHO 2001:31). When they are done they use anything from cow dung, alcohol,

lemon juice, herb mixtures etc. to put on the wounds, all thought sometimes the girls legs might be bound together until her wound has healed (WHO 2001:31).

In some parts of Congo and Tanzania, they perform female genital mutilation by stretching out the labia's until they are an acceptable length (WHO 2001:31).

Some families reported using anaesthesia (UNICEF 2014). It is believed though that in poorer countries where there are less availability to clinics and hospitals the number of girls being cut without anaesthesia is much higher (UNICEF 2014). The procedure can be done from during all ages but the most common time is between the ages four and twelve (Skaine 2005:14).

The hospital personnel defends their action by saying that it is better for the girl to be treated at the hospital since it reduces risk's such as infections and the patient feels no pain (WHO 2001:37; Skaine 2005:33). They also feel that if they deny the families of the procedure the girls and women will have to undergo the procedure in unsafe environments with unsanitary tools (WHO 2001:37; Skaine 2005:33). Despite this there are still great health risks involved for the girl who is being cut (Westcott 2015:52). Westcott (2015:53) writes in her article that unfortunately there is also financial gain for medical professionals in rural areas to perform FGM.

There are some minority groups in Norway that support the practice but are afraid of getting in trouble with the Norwegian law so refrain from practicing (Gele et al 2012).

### 3.3 Complications from FGM

Short-term physical complications include: pains, bleeding, infection, shock, inability to heal and complications with the perineum, rectum, urethra and vagina (WHO 2001:44; Skaine 2005:23; NKVTS – your body is perfect by nature p.10).

Long-term physical complications include: infertility, inability to heal, problems urinating, infections in the pelvic, abscess, problems during menstruation, sexual problems like painful intercourse, fistulas in the genital area, problems when delivering a baby and re-occurring urinary tract infection (WHO 2001:44-45; Skaine 2005:23; NKVTS – your body is perfect by nature page 11). 41% of participants in a study done in United Kingdom in 2013 reported that they had undergone FGM and had both mental and physical health problems (Ahmed, Creighton, Elliott & Liao 2013:293).

Undergoing FGM can scar these women for life, suppressing their emotions and sometimes suffering in silence even though they experience pain during menstruation or intercourse (WHO 2001:44; Skaine 2005:23). They might also feel anxiety, bitterness, depression and have trust issues towards family and friends (WHO 2001:44-45). Some can develop symptoms like insomnia, eating disorders, eating too much, panic attacks and different phobias (WHO 2001:45). But if these women do not undergo the procedure they experience social stigma resulting in being shut out of the community and not being allowed to marry (WHO 2001:45).

### 3.4 Challenges for Health Care Personnel

Culture in this thesis as well as Madeleine Leiningers *“Transcultural Nursing”* theory is defined as: “the behaviors and beliefs characteristic of a particular social, ethnic, or age group” and “the sum total of ways of living built up by a group



of human beings and transmitted from one generation to another” (Leininger et al 2002:47; dictionary.com). Caring of humans with transcultural care is important for the well-being of the individual and society as well as respecting the cultures beliefs and values (Leininger 2002:62). This is a challenge for people working with women who have undergone FGM in Norway. FGM is a cultural tradition done to girls and women, but is extremely harmful. This creates a conflict for the health care workers who want to be respectful and culturally aware, but also follow the guidelines and laws that are in place in Norway.

In 2004 they did a study in the UK, where they found that the nurse curricula need to include more studies and practical experience’s about how nurses can properly care for patients from other cultures (Leishman 2004:33). Best solution is to create a culturally sensitive approach to dealing with female genital mutilation in Norway at workplaces where these women and children might need or seek help, which can be seen examples of procedures in the research review. However, there can always be made efforts to make improvements. Especially when it comes to educating professionals who may come in contact with women and children who have undergone female genital mutilation.

Turner writes in her article that some women who have undergone FGM reported having been met with horror when they have undergone examination or been questioned (Turner 2007:371). It is a challenge to discuss FGM, informing the patient without letting her feel negative emotions from the nurse, such as being rejected (Turner 2007:371).

An article in The Nursing Standard said that one of the problems in the UK are related to health care personnel not knowing their legal obligations when it comes to patients with FGM (Dean 2014:21). This led to many cases being unreported, due to the fear of breaking any patient confidentiality as well as damaging the patients trust in the health care worker (Dean 2014:21). Health care workers also

struggle with breaching the subject of FGM with them, since they feel it is a personal issue (Dean 2014:21). They should be encouraged to ask and if everyone at hospitals and other clinics ask then it will become normalcy (Dean 2014:21). The article also states that some people fear that if they report the cases with FGM then it will become more secretive and “underground” business than usual (Dean 2014:22). It is however important and recommended to become more open about the issue and tackle it head on (Dean 2014:22). Other nurses in the article felt that the child was cut with their best interest in mind and felt bad and were hesitant in reporting it to the authorities (Dean 2014:22).

A study was done in Belgium that shows that Flemish gynaecologists had not all received training to help women with FGM, and they also reported having little or no knowledge about the hospital guidelines, as well as the legal aspects (Leye, Ysebaert, Deblonde, Claeys, Vermeulen, Jacquemyn and Temmerman 2008:182). FGM has been illegal in Belgium since 2001 (Leye et al 2008:183). Only 35% of the gynaecologist who participated in their study would try to take pre-emptive measures to discuss with the patient about not having her daughters cut, the reasons given why the rest did not have this discussion was communication problems (Leye et al 2008:188).

It is best if the health care worker can gain the patients trust since this will be beneficial in order to help the patient deal with the physical and psychological problems (Richens 2014:524). In these situations it is important the Health care worker's attitude is not judgemental, condescending but instead positive (Richens 2014:524).

Flamand (2015:48) writes in her article that the countries in the EU are struggling with identifying FGM on their asylum seekers. This is troublesome since the asylum seekers themselves do not always know that FMG is illegal or wish to speak about it due to its sensitive nature (Flamand 2015:48). When an asylum seeker enters an EU member state most of them have a legal requirement of performing a medical check on the person seeking asylum (Flamand 2015:48). This means

that there is added pressure on the person performing the medical inspection to talk about FGM and also being educated enough on the subject (Flamand 2015:48). Language is another challenge, since the asylum seekers need to be informed about the laws regarding FGM in the country they have entered (Flamand 2015:48). This might help reduce the next family member from subjected to FGM (Flamand 2015:48). There are also evidence of countries in the EU re-infibulating women after birth (Stitching the vagina shut again), probably due to lack of guidelines or procedures in the matter (END FGM 2009).

In Egypt, where FGM is prevalent, medical staff are not receiving any education about FGM (Westcott 2015:53). Efforts are being made by the Egyptian Ministry of Health to educate health care personnel that every part of the vagina is important and serves a purpose, and by harming it they are violating their professional ethics and the victims human rights (Westcott 2015:53).

A study in Netherland regarding psychological symptoms after FGM showed that most women felt life-long effect of the procedure (Knipscheer, Van Den Muijsenbergh, Van Der Kwaak and Vloeberghs 2012:677). This was enhanced after their move to the Netherlands, and realising that the procedure is wrong (Knipscheer et al 2012:677). This also puts more pressure on health care personnel to not only recognize the physical symptoms but also the psychological symptoms that might occur.

An article by Christos & Malone (2013:182) stated that one of the important health care worker to prevent FGM is the school nurse. If the school nurse made a routine of asking families about FGM they might reduce the risk of the younger children in the family of going through FGM (Christos et al 2013:182). This adds pressure to school nurses to recognize and talk about a sensitive matter.

### **3.5 Institutes in Oslo**

In the beginning of the year 2000, institutes were formed to help women with female genital mutilation.

#### **3.5.1 Policlinic for women on Ullevål University Hospital**

In 2004, Eritrea born Midwife Sara Kahsay and Norwegian Doctor Sverre Sand opened up a gynaecology policlinic for women with FGM at Ullevål university hospital in Oslo, Norway (Dietrichson 2013). This way the women could receive help without their husbands, and receive important information about FGM, sexuality and complications (Dietrichson 2013).

The women can book an appointment there or any other gynaecology ward in Norway without any referral from their own doctor (NKVTS - Kvinneklinikken). Normally you need a referral from your doctor in Norway if you need to go to the hospital.

#### **3.5.2 NAKMI**

The Norwegian centre for Minority Health Research was established in 2003 (NAKMI 2015). They research, develop as well as supports health care professionals, policy makers, students, researcher and health policy managers (NAKMI 2015). The centre houses 19 employees with different educational background and experience (NAKMI 2015). Sara Kahsay now works for NAKMI, where she works as a consultant and educator of female genital mutilation (NAKMI – an-satte).

### 3.5.3 NKVTS – Norwegian centre for Violence and Traumatic stress

They opened their doors back in 2003, and their main mission is to spread knowledge about violence and traumatic stress as well as help improve competencies in the field (NKVTS - About).

They have developed a website on the subject Female Genital Mutilation: <http://www.nkvts.no/sites/Veiviser-KL/Pages/default.aspx>. Where both health care personnel and others can find all the information they need about the subject, in Norway. They also provide very informative brochures, such as *“Your body is perfect by nature”*, *“Is it a good idea to have your daughters cut”*, *“Have you been cut”* and *“Are you a boy and have questions about female genital mutilation”* (NKVTS - Brosjyrer). These are especially helpful for health care workers who can go to the website and download or order a brochure and use it when they are informing a patient on the subject.

## 3.6 Guidelines for personnel

### 3.6.1 Kindergartens

The Norwegian centre for violence and traumatic stress state on their website that there are signs workers can look out for (NKVTS - faresignaler). Such as psychological changes, like behaviour (NKVTS - Faresignaler). If the girl is more timid, shy, lack of concentration, sad and introvert (NKVTS- Faresignaler). Physiological changes can include, stomach aches, toilet visits takes longer or a child starts wetting themselves again after learning to use the toilet (NKVTS- Faresignaler).

If the worker has a suspicion about the child he/she should express their concern with their supervisor (NKVTS - Barnehave). They can also ask the child, *“You seem to be sad and upset, please tell me about it?”* or *“It seems to be more difficult for you to urinate, has something happened, tell me about it”* (NKVTS - Barnehave).

If discussing with the child and no observations are conclusive, the worker can express the kindergartens concern in the matter to the child’s guardian (NKVTS – Barnehave). Because the personnel at the kindergarten has limited experience and education in the matter it is important that the workers together with the guardian discuss and evaluate to contact a health clinic or take the child to her own doctor for an examination of health needs (NKVTS – Barnehave). If FGM is confirmed, the staff needs to evaluate if the child’s needs are properly cared for, if not then the staff are obliged to report to the Child Welfare Service (NKVTS-Barnehave). If there are suspicions that the child has undergone FGM after they moved to Norway the staff can report it to the police but it would be better that they should address their suspicion to the Child Welfare service who can then evaluate the whole picture and decide if reporting to the police will be in the child’s best interest (NKVTS – Barnehave). These measures are also applicable to staff working at schools (NKVTS – Skole).

### **3.6.2 Health Clinics**

If a person working at a health clinic have a suspicion of FGM then they should discuss it with their superior (NKVTA- Helsetjenesten). If the person working there observe any of the symptoms that can raise the question of FGM then they should ask the client if they have problems with their urination and menstruation (NKVTS – Helsetjenesten).

If FGM is discovered, then the staff needs to ascertain if the girls needs have been taken care of, if not, then they need to report it to the Child Welfare services

(NKVTS – Helsetjenesten). If the girl denies FGM, but her symptoms are still there (problems with urination, menstruation etc.) the staff needs to consider how to further an investigation (NKVTS – Helsetjenesten). If the girl is under 16, the decisions regarding the investigations must be done together with the child's guardian (NKVTS – helsetjenesten). If the Guardian refuses to cooperate the staff needs to evaluate if the issue needs to be reported to the Child Welfare services (NKVTS – Helsetjenesten).

According to Norwegian Law *“Professionals and persons employed in child care centers, the child welfare service, the health and social welfare service, schools, day care facilities for schoolchildren, and religious communities who willfully fail to seek to avert, by formal complaint or in another manner, female genital mutilation, cf. section 1, shall be liable to fines or imprisonment for a term not exceeding one year. The same applies to elders or religious leaders of a religious community. The duty to avert such an act shall apply regardless of any duty of confidentiality. Failure to do so is not punishable if the female genital mutilation is not completed or does not constitute a punishable attempt.”*(Kjønnslemlestelsesloven 1995, par.2).

#### **4 AIM AND RESEARCH QUESTION**

This is an important issue since female genital mutilation is not a common practice in Norway, or the other Nordic countries, but due to immigration it is seen more and more in Health Care environment. These women and children are/will be the heart of the family, if they cannot function properly mentally and physically the whole family suffers. Not to mention the women's wellbeing. Women's rights are important, they are the main care takers (in African cultures), they give birth to new humans, and they should be respected and cherished. My main focus will be on the situation in Norway and therefore I will only conduct my interviews in Norway.

The aim of this study is to shed some light on the challenges that can arise in the health care environment for employees taking care of patients who have undergone Female Genital Mutilation. I also aim to find a solution to the challenges, so that the care of these patients can be optimized.

1. What are the challenges health care personnel experience encountering patients with Female Genital Mutilation?
2. How can those challenges be met?

## 5 ETHICAL ISSUES

### 5.1 The study

*“In medical research involving human subjects capable of giving informed consent, each potential subject must be adequately informed of the aims, methods, sources of funding, any possible conflicts of interest, institutional affiliations of the researcher, the anticipated benefits and potential risks of the study and the discomfort it may entail, post-study provisions and any other relevant aspects of the study. The potential subject must be informed of the right to refuse to participate in the study or to withdraw consent to participate at any time without reprisal. Special attention should be given to the specific information needs of individual potential subjects as well as to the methods used to deliver the information.” World Medical Association- Declaration of Helsinki 2014, Nr.26.*

The participation in my thesis was optional. All the participants were given a consent sheet with my contact details and my supervisors e-mail address (See appendix 1). I explained to all the participants that they only need to contact me if they wish to alter something they said or want to withdraw completely from the study.



*“Some groups and individuals are particularly vulnerable and may have an increased likelihood of being wronged or of incurring additional harm.” World Medical Association – Declaration of Helsinki 2014, nr. 19.*

No women who had undergone the procedure were interviewed so there was no vulnerable group to take into account. All the participants were informed that what they said would be written anonymously in the thesis and I have tried to write so that results cannot be traced back to them.

*“Every precaution must be taken to protect the privacy of research subjects and the confidentiality of their personal information.” World Medical Association –Declaration of Helsinki 2014, nr. 24.*

All the data was gathered with a recorder on my cell phone which is protected by a code. The consent sheets that the participants have signed and the notes I took are being hidden.

During the interview I did not express any of my own ideas, rather asked more in debt what the participants meant if something was left uncertain. I did in some cases ask about things I’ve read in articles regarding struggles of health care personnel. If there were interesting points pointed out by previous participants, I did in some cases ask what the current participant’s opinion was on the matter to get a more diverse angle of the matter.

There were no risk’s involved for the participants, myself, or the women and men the participants used as examples since no real names or other identifying traits were given.

For my research permission I contacted The Norwegian National Research Ethics Committees (<https://www.etikkom.no/en/>) and asked them how to go about when doing a Thesis in Norway. I gave them details about my thesis and what would be needed to complete it. The reply was that I did not need to apply for permission from them to conduct my research in Oslo Norway (see appendix 2),

but I would need to apply for permission from the University Hospital Ullevål Department of Information safety and privacy (see appendix 3). From there I got accepted to conduct my interviews at the hospital as long as I used their consent sheet (see appendix 1), where I stated my purpose and contact details and they could sign the sheet. They also demanded that the consent sheet be written in Norwegian as there would be no confusion or misunderstandings. In addition they asked me to register my case at The Norwegian Data Protection Authority (<https://www.datatilsynet.no/English/>). There I registered that I was conducting my Thesis in Oslo and what kind of data I would be gathering. Later I received an email that they had registered my case. I forwarded this to the University Hospital Ullevål department of Information Safety and Privacy.

I used the consent sheet with all of my interviewees but only demanding signature if I interviewed them at their work, with the exception of two people. One had a private clinic and did not deem it necessary to sign it, and the other was off duty at the moment of the interview and outside the person's regular hospital of work.

## **5.2 Ethics regarding FGM**

The subject I have chosen is complex. Madeleine Leininger said in her nursing theory that every individual should receive care appropriate to their culture (Leininger & McFarland 2002:62). That is not always possible in Norway, especially when it comes to concerns around FGM that is an illegal practice in Norway. In order to give the best care to women who have undergone FGM, there needs to be a mix of both culturally sensitive care as Leininger describes but also a sensitive approach when talking about things that can make life better for a woman or girl who have immigrated to Norway that is not part of her culture. She should be offered tools to integrate into the Norwegian society, but not having to lose who she is and her values.

Since the subject is so sensitive it is important not to discuss the subject in a way that puts blame on the woman or her family. Health care personnel need to understand, and as far as the results show, health care personnel do understand that it is a result of an old practice and with the help of the right information and care, they have stopped FGM in being performed in the next generation of Norwegians.

## **6 METHOD**

### **6.1 Data collection**

To get the data needed qualitative research method and Interview was used as a data collecting tool. The interview were focused and semi structured. Barbara DiCoccio-Bloom and Benjamin F. Crabtree (2006) write in their article that a semi structured interview is when an interviewer uses a few questions that they prepare beforehand but they can ask new questions along the way during the discussion depending on the information provided. Robert K. Merton, Marjorie, Fiske and Patricia L. Kendall (1990:3) write in their book that a focused interview is about asking questions from an individual who have had a specific experience that you wish to know more about. These will be helpful since it allows digging deeper in questions and help to see the bigger picture if one is not constricted to certain questions.

The Questions that were used were:

- Could you tell me about your first meeting with a patient with FGM?
- What do you wish you knew then that you know now?
- What, in your opinion are the challenges with patients with FGM at your work?

- How would you like to be able to handle those challenges?
- Is there something the hospital can do to help you meet the mentioned challenges?

Due to privacy issues the participants were not asked their age, years active and other personal questions since Norway has a small community when it comes to experts working with FGM.

## 6.2 Informants

A total of 5 informants were interviewed. Informants have been selected based on where they work, and their past experiences with these type of patients. Most of them are experts in the field of either gynaecology, working as midwives or with female genital mutilation. Two of the participants were men (40%) and three (60%) were women.

The participants were interviewed on and outside of work, depending on availability. The interviews took 10-40min depending on availability and were conducted in private rooms (offices and break rooms), except one participant who wished to meet at a local café. One interview was 10 min and one interview was 40min. The mean interview time was 25,8min. The interviews had small interruptions (telephone) but otherwise went along uninterrupted. Information was received regarding research questions but also additional information. If there were new information in interviews they added to the next participant's interview. Some participants also shared information without being asked a question.

The results were later transcribed and written down amounting to eight pages. Only information that was relevant to the study were summarized and written down all though the participants gave more information. The results were partly

saturated. Some things were consistent answers, while others topics the participants had different opinions about. It would have added more strength to the study if there were a possibility to interview more people and had the time to go back for a second interview with the participants. In addition if more non-experts would have participated it would have given a broader view of the situation in Norway. The participants have been informed about the quotes from them that were used in this thesis, and they have had the opportunity to correct it in case of any misunderstandings.

### 6.3 Data analysis

Qualitative content analysis was used to analyse the data received through interviews. It can be used either as deductive or inductive approach (Eto & Kyngäs 2008:109). The researcher needs to determine which one to use based on what they want to achieve from the study (Eto et al. 2008:109).

*“Deductive content analysis is often used in cases where the researcher wishes to retest existing data in a new context”* (Eto et al. 2008:111). Deductive approach was used for content analysis because there are existing information about challenges for health care personnel regarding FGM but not enough about the situation in Norway. Deductive content analysis means it went from general knowledge to more specific knowledge (Eto et al. 2008:109). This was done through literature review and interviews.

The recordings were listened to and the answers relevant for the thesis were written on the computer using Microsoft Office Word. After this the answers were read through multiple times to try to find similarities, difference and if there were some errors, like forgetting to ask a question (Kumar 2014:296). The answers (themes) relevant to the thesis were put in a matrix (see Table 1). A categorized matrix was used, there you put in only the things that fits the matrix (Eto et al

2008:112). Meaning the data was searched for themes that were relevant for the research questions. Leaving out information that was not relevant for the thesis.

**Table 1.** Categorized Matrix

Research Questions	Interview Questions		Results: Themes
1. What are the challenges health care personnel experience encountering patients with Female Genital Mutilation?	Could you tell me about your first meeting with a patient with FGM? (1A)	1A	Lack of Hospital guidelines (before the law) <ul style="list-style-type: none"> <li>- Women were stitched up a little in their genitalia to prevent conflict in the women's home</li> </ul>
		1A	Lack of mutual language (before the law) <ul style="list-style-type: none"> <li>- spoken language</li> <li>- mutual understanding of the situation</li> </ul>
		1A	Medical examination of patient for delivery (before the law) <ul style="list-style-type: none"> <li>- Shame</li> <li>- Permission</li> </ul>
		1A	Lack of experience <ul style="list-style-type: none"> <li>- complicating deliveries</li> <li>- no knowledge about how to help these women</li> </ul>

		A1	<p>Lack of knowledge</p> <ul style="list-style-type: none"> <li>- the lack of knowledge of the woman</li> <li>- the lack of knowledge of the husband</li> </ul>
		A1	<p>Cultural challenges (before the law)</p> <ul style="list-style-type: none"> <li>- not wanting men in the delivery room</li> <li>- mother-in-law translating during delivery</li> </ul>
		A1	<p>Taboo about Female Genital Mutilation</p> <ul style="list-style-type: none"> <li>- Not speaking about it among themselves</li> <li>- Not knowing their own female anatomy</li> <li>- Unknowingly stigmatizing the patient/woman</li> </ul>
	What do you wish you knew then that you know now? (1B)	1B	<p>Challenges in education</p> <ul style="list-style-type: none"> <li>- Images of FGM</li> <li>- Information and practical exercises</li> </ul>
	What, in your opinion are the challenges with patients with FGM at your work? (1C)	1C	<p>Arriving on time or at all</p> <ul style="list-style-type: none"> <li>- Fear</li> <li>- Patients change their mind</li> </ul>
		1C	Translational problems

			<ul style="list-style-type: none"> <li>- Some things are “lost in translation”</li> <li>- Translation through the phone</li> </ul>
		1C	<p>Helplessness</p> <ul style="list-style-type: none"> <li>- Women who are too damaged to be fully functional</li> <li>- Emotional distress for personnel to see children being victim to FGM</li> </ul>
		1C	Not only helping physically but also psychologically
2 How can those challenges be met?	How would you like to be able to handle those challenges? (2A)	2A	<p>Women integrated into Norwegian society</p> <ul style="list-style-type: none"> <li>- Learn the language</li> </ul>
		2A	<p>Respecting appointments</p> <ul style="list-style-type: none"> <li>- Arriving on time</li> <li>- Arriving at all</li> </ul>
		2A	<p>Sensitivity</p> <ul style="list-style-type: none"> <li>- Avoiding stigmatization</li> </ul>
	Is there something the hospital can do to help you meet the mentioned challenges? (2B)	2B	<p>Psychological help</p> <ul style="list-style-type: none"> <li>- Information about exercise</li> <li>- Information about diet</li> <li>- Offering psychological help</li> </ul>



## 7 RESULTS

The results are compromised from the 90s up to date. This is due because part of the interview questions where to explore the participants first meetings with patients with FGM and how they experience work with the patients with FGM today. The main results in the study were language, sensitivity and culture. There is also a psychological need that needs to be met when treating patients who have undergone FGM. Which needs both language, sensitivity and culture awareness.

### 7.1 What are the challenges health care personnel experience encountering patients with Female Genital Mutilation?

#### 7.1.1 Lack of Hospital guidelines

One of the participants in the interview told me stories about how things were as a midwife before the law came to affect in 1995 that stated that *"Anyone who intentionally performs an operation on a woman's genitalia that damages the genitalia or permanently changes it, will be punished for genital mutilation."* (Kjønnslemlestelsesloven 1995, par.1).

*I wish there were clearer guidelines regarding stitching up after delivery before the law came into effect. Some people did this way and others did the other way. We had no mutual guide to follow. Midwife, female.*

After the baby was born, some women demanded they be stitched up exactly like they were from the beginning, while others who were too afraid of their family asked to be stitched up a little. The ethical issue the personnel faced were the

problem that there was no law against it, and the women who asked for it were going to get in trouble at home if they did not get stitched up again.

*Some women who had lived here for years asked us to only close them up a little bit. Some feared their husbands and families and said that we had to stitch them back together exactly like they were before delivery. Midwife, female.*

The midwife I interviewed explained that they stitched up the women a little but leaving enough room for her to be able to urinate and have their period comfortably. She explained that they acted by their heart and conscience at the time.

*We stitched them after our heart. We never closed them but stitched them as aesthetically possible but not closed completely and we pretended that this was the best we could do for the patient. Midwife, female.*

### **7.1.2 Lack of mutual language**

There was no service for interpreters at the hospital in the 90s, so most commonly the mother-in-law accompanied the woman who was giving birth. These women were usually newly-wed in a foreign country. Problems arose when the personnel could not communicate directly with the patient.

*These women often came to the delivery room in the last minute, and the poor women could not speak Norwegian, they did not know what was happening and we were unable to convey our knowledge to them. Midwife, female.*

The mother-in-law was responsible for the translation and the personnel felt like the mother-in-law was cold and authoritative towards her daughter-in-law. This left the mid-wives questioning if they were actually giving her the best possible care regarding things like pain killers.

*We don't know a 100% what the mother-in-law translated and did not. And what also made it so bad was that the culture is so different from Norwegian, they are more physical and verbal when they express themselves. But when the mother-in-law was present she would reprimand the poor girl to be quiet. I felt so bad for this poor women who was in a foreign country, put in a bed without knowing what was going too happened to her. Meanwhile the mother-in-law did not allow most of the pain medication due to her own experience delivering with little to no medication. And you can't really throw out the mother-in-law from the room, but the situation was very frustrating and unsatisfactory. Midwife, female.*

### **7.1.3 Medical examination of the patient before delivery**

In the 90s the struggles for this group of health care personnel included things like language, inspecting the patient for birth and the after care. The other issue was patients with a Type 3 genital mutilation were difficult to examine in regard to how open she is for birth, as vaginal inspection of the baby was impossible. They had to assert to rectal inspection, which is not as accurate.

*We had little time for preparations for delivery. In the old days we inspected women rectally to ascertain how far along they are in the delivery process. But you could not do this with foreign women without being able to explain what you are doing. So we waited and hoped to see some hair sticking out eventually from their tiny vaginal opening. Sometimes we were forced to perform C-sections because we could not ascertain how the baby was positioned. Midwife, female.*

When asked about when the best time is to open up a girl/woman who have undergone female genital mutilation the answer was

*It is recommended that the women are already opened before arrival for delivery. The best is to open before puberty and menstruation. Gynaecologist, male.*

Another participant stated when asking about the delivery room before and after the law came into effect in 1995.

*There has been a gradual shifting towards more and more women are already opened (vaginally) before delivery, in the beginning we received them when they were ready to deliver but now it's much more that they come in and are opened before pregnancy or before delivery. That is the biggest difference. Gynaecologist, male.*

#### **7.1.4 Lack of experience**

Working with patients who had undergone female genital mutilation awoke feelings in health care personnel in the 90s.

*We felt sorry for them and felt that it was completely shit. We had too little knowledge about it, and we were unsure if what we did for them was the best. Midwife, female.*

Another example was one of the participants worked at a hospital back in the 90s, encountered his first patient with female genital mutilation.

*It was back in 1990. I was working at a hospital and a woman came that was one out of seven sisters. She was circumcised. She was going to get married and wanted to be opened. I had never seen it before, only heard about it. So I read about it and saw what one is supposed to do and then I did that. It came out pretty well. She was a grade 3. Then I met her six months later and she yelled "Doctor ..., I have had my first orgasm!" So she was very happy and I became interested in it (female genital mutilation) and have worked with it for 26 years now. Gynaecologist, male.*

When the father of the woman in question saw what had been done to his daughter he refused the procedure for her six other siblings.

When asked about legal rights in cases where one of the patients express a worry that their younger sister will be cut.

*I have never experienced this. The confidentiality would be wavered. But it is a bit unclear who to report to. The law is also unclear if we should report to the police or*

*Child Welfare services. Since it is punishable by law to not report it, but there are no guidelines in the law. Obstetrician, female.*

I was told that the number of girls being cut, after they have moved to Norway, are very small. This is based on the visitors to the polyclinic in Oslo for women with FGM

Efforts have been made in Norway to make FGM less stigmatized but according to participants, health care workers can still struggle to speak about it without making the patient feel stigmatized.

#### **7.1.5 Lack of knowledge**

One gynaecologist told me a story about when he had a private practice in the 90`s.

*Suddenly I had a man in the waiting room. He was North African. He told me that he has just gotten married and when he is trying to be together with his wife, he is unable to. He came to me to ask for something strong to give him more power so that he can have intercourse with his wife. He was young and healthy with no erectile dysfunction. I asked him to come back the next week with his wife so that I could examine her. Then it turned out that this woman was circumcised and she only had a match stick sized opening. No wonder the husband could not lie with her. I have had other patients with FGM but this is the one I remember best. Gynaecologist, male.*

One of the participants explained some issues at work nowadays where the husband of a woman with female genital mutilation will ask after she has delivered the baby that they close her up again.

*Some men ask, more often when women are in delivery, I have experienced the women are not entirely up for it but the man will ask about it. But we are very clear that it is not allowed. It's nice to be able to rely on the law. Obstetrician, female.*

They have not experienced any troubles after this.

Women who come to them are usually not very knowledgeable into their own genital anatomy, most of them are grade 3, and they think it's beautiful.

*Women who come here have usually poor knowledge about their own anatomy. They are used to it being smooth, many of them are grade 3. And they think it is beautiful. But we try to have them look at themselves in the mirror before and after they are opened. But many think it is ugly afterwards. Many are afraid that we are going to open up too much and they think that there will only be a big gaping hole left after they are opened, so we explain to them what structures are behind. These things are challenging to explain when there are language problems. We really try to push them into looking at themselves in the mirror after and explain that this is normal and this is how a woman looks like before being cut. Obstetrician, female.*

Not many women discuss sexuality but even though the clitoris has been removed, the women still has their nerve endings left and can if they want achieve an orgasm.

*The clitoris is only peripheral, most of it is in the deep. They will have an enhanced feeling there so we try to explain to the women about it. But the women don't talk so much about it (sexuality). We explain to them if it is there or not (the clitoris). Obstetrician, female.*

#### **7.1.6 Cultural challenges**

In the delivery room there were situations that made the personnel uncomfortable that were due to cultural differences.

*Suddenly during delivery the mother-in-law could throw herself on the floor and start praying and we did not know if it was because she thought her daughter-in-law would die or if it was a regular time for prayers. Midwife, female.*

I was given an example of a cultural challenge in the 90s where there was a Muslim couple who came to the hospital, the woman was giving birth and it was night time. The maternity ward was full and the husband demanded that there be no men in the room. Of course this was difficult to oblige to due to lack of personnel at that time.

*Some people accept that there are no others available. They explain to the husband that "today I am on call and we will not call someone from home to get a female doctor in the room. Worst case scenario your wife dies, or your child dies, or both might die. You have to choose." Midwife, female.*

Two husbands had rejected and gone home. One of which had a baby that died and the other the midwife does not know the fate of the baby. No legal repercussions were taken that the midwife is aware about towards these men.

Another male participant have had positive feedback from women regarding male gynaecologists.

*Some women don't like it but some women thinks it is nice that I am a man due to bad memories with circumcisers that are women. I have experienced both. Maybe more that the men don't want their wives examined by women. But I feel like there have been little problems. But some prefer women, and that's normal everywhere. Gynaecologist, male.*

After the gynaecology policlinic opened for women with female genital mutilation in 2004, they have not received any girls that have been cut on vacation or similar. Most of the women have been cut prior to moving to Norway. This they feel is a great achievement. But it is still best to open the girl before she hits puberty.

*We have very few that have been circumcised after moving to Norway. I have no statistics on this. The children would be taken to the children's ward in that case, but I am also sometimes consulted in the matter and I have not been contacted for such cases. Obstetrician, female.*

An unexpected story revealed that some women who had undergone genital mutilation and been successfully opened in Norway, came back multiple times after with their husbands. Each time the women complained that she wanted to be opened more. When the gynaecologist finally had some time alone with the women:

*When I finally got her alone in the room it turned out she had been married off to her husband and she could not stand his face. So she wanted me to tell her husband that it looked bad and I could not help her so she could get rid of him. Gynaecology, male.*

After agreeing to do this, another women came to see the gynaecologist.

*Another woman came all the way from Bodö (North of Norway), and I saw that she was already opened. She said that she had been opened in Sweden already, but since she had heard that I am so nice she was wondering if I could make sure she could receive asylum in Norway. Gynaecology, male.*

All of the participants mentioned Karita Bekkemellen, children-and family minister who wanted to implement a law that all young girls be checked for genital mutilation (I could not verify this online). Back in 2000 Karita Bekkemellen saw a documentary about female genital mutilation, and became upset and demanded something be done (Aftonbladet 2000). All of the people I interviewed in this study took this as an example of poor judgement and none of them agreed with her.

One said

*I was sceptical against examining all the children. There is no point. From the age of five, are you going to be examined every year? It is hopeless. Girls who undergo Female Genital Mutilation change in personality, they are less active, take more time in the bathroom, so you can see the effect of being circumcised. Gynaecologist, male.*



Another one stated

*Luckily this never came to effect. But it is important to catch people that circumcise their children after coming to Norway but also working against the practice female genital mutilation as tradition. Gynaecology, male.*

Another participant told that while discussing the problems in Norway concerning FGM, a Somali woman said that Norwegians are too humanitarian, and that the punishments are not harsh enough. The people should be threatened to be exported back to their homeland if they cut their daughter/s. This would make them fearful and not attempt the procedure.

*Per definition, you are refugees from Somalia, basically you have received a refugee stamp arriving to Norway. Then we can't send them out of the country. She then said "You are so dumb, if they are told they will be deported nobody will dare to do circumcise." They have another though process. We are more humanitarian in Norway. Gynaecologist, male.*

#### **7.1.7 Taboo about Female Genital Mutilation**

One of the participant's works as an Obstetrician at the gynaecology ward, met a women who was having troubles with urination and pain.

*One of the early cases I remember, was a women with a lot of problems with slow urination and slow menstruation, what struck me most was that she had not discussed this with anyone. This was something you did not speak about. But I feel nowadays this might have changed and people are talking a bit more about it. Obstetrician, female.*

Another participant also stated

*I feel like women don't speak of this. Only insinuating and hinting. And men don't speak about it from father to son. Gynaecology, male.*

One participant on the other hand said when asked about what the most common challenges at hospitals were

*It was difficult with the taboo around it (female genital mutilation), but after we worked a few years the taboo situation is gone now. Now they speak openly about it with them it concerns. And the women are open and don't have problems speaking about it. Midwife, female.*

The most common group who come to the gynaecology policlinic at Ullevål University hospital are the women in their 20`s who are ready to start a family or are getting married. Teenagers are welcome to the polyclinic but children are taken care of at the children`s ward. When asked about situations where underage girls need help but the parents does not approve:

*It is not often that underage come to us for help without the consent of their parents, but those who do are child welfare cases. Those who are younger sometimes come with the school nurse, and gets support from there. But I haven't experienced many families who do not support their daughters. We have had some girls of age who have wished that their families not be informed. Obstetrician, female.*

The women who come there are often accompanied by friends, sometimes relatives, seldom parents. Some people wish that their parents are not notified and some have parents who know about them going there.

*What we have experienced know is that the oldest sisters are the only ones being circumcised. This is because the parents know that it is not ok. Obstetrician, female.*

When discussing gender roles when it comes to female genital mutilation with one participant she stated

*In reality men are a part of the problem. Because what happens is...listen to me carefully about my reason for this, this is a society problem. And men demand that girls are virgins when they get married and the women, now I speak of the women who live*

*in African countries where female genital mutilation is a practice, women are pressured to look after their daughters. Men don't say it but they pressure them for the daughters to be perfect. If she is not she can be delivered back after marriage. Like a thing. Midwife, female.*

#### **7.1.8 Better education in schools**

Most participants in the interview were not prepared in their first meeting with patients with female genital mutilation.

*I don't understand why there were no pictures or videos in nursing school. I would have liked to see more than just some cartoon images in black and white. But this might have changed since I went to school in the 90s. When you see it in real life you don't really understand what it is you are seeing. I wish my Midwife supervisor would have prepared me better for it during my internship. Midwife, female.*

When discussing education with another participant I was told

*I studied on (), and there were no circumcised women there so I had never met a woman who had had this procedure done. I did not learn about it (in school). Obstetrician, female.*

#### **7.1.9 Translational challenges**

They have a well working translation centre at their disposal at the gynaecology policlinic in Oslo now. Sometimes the translator cannot be there in person and he/she will translate through the phone, which they feel takes more time and is impractical.

*Language is problematic. We have become better to get a translator beforehand. And I think that a translator is the best to have in the room and not a telephone translator. Many (patients) have lived here many years and speak Norwegian well and that makes things easier. Obstetrician, female.*

Another participant stated

*An Iranian women who had lived in Sweden for 15 years, moved to Iran, came to Norway to try out life here. I examined her with the translator. It was problematic since you don't get an intuitive feeling if she understand you or not? When I was done she said in perfect Swedish that "This went so well!", when I asked her why we struggled with a translator for 30min if she knew Swedish she replied "We all do it". They can do it if they for example don't like the person they are going to for examination, and bring a translator to distance themselves from the person. That is another example how translation services are being misused. A couple I met who were from Somalia, spoke fluent Norwegian after living her for 2 years. They said "We understood that to be able to succeed in Norway you must learn the language". Gynaecology, male.*

#### **7.1.10 Helplessness**

One of the participants expressed a frustration when the woman is too damaged, and the clinic is unable the help her in being able to have normal urination and bowel movement.

When one participant was asked if he has met many women who have been "too damaged"

*Yes, many. You can reconstruct most things but the most damaged part is the psychological part. For example a 9 year old who fell twice and opened up the wound. All the procedures to close her up again was done without anaesthesia. Gynaecologist, male.*

Another one stated

*The most challenging with these women are that some of them are so damaged that it is difficult to replicate normal genitalia so that they can have normal urination, bowel release, normal intercourse and reproduction without pain and symptoms. We can try to reconstruct as close as possible. Gynaecologist, male.*

In addition one health care worker described her work as tough when meeting with children who had undergone the procedure.

*When I see small children being exposed to this (female genital mutilation) in the work environment, it was really tough. I received support from Ullevål (university hospital in Oslo), they offered guidance. It was really tough, it took me very hard. Consultant/Midwife, female.*

## **7.2 How can those challenges be met?**

### **7.2.1 Women integrated into Norwegian society**

One of the participants were asked by the Imam in Oslo to come speak to him and a group of men. Speaking to the congregation the participant was very clear on how damaging the procedure was, for example if the girl is sown too much and the blood during menstruation has nowhere to go, it flows back to the fallopian tubes and causes infections which in turn can cause infertility. So the main result that was very much pointed out was that FGM can cause infertile women. The subject of language was also strongly brought up, that the women should learn Norwegian so they can get the best health care and improve their quality of life. The participant felt like the men listened and took it to heart but was told before leaving that the husbands decide if the wives will learn Norwegian or not.

*They listened to me very interestingly when I told them that they risk of having women who are infertile by waiting (to be opened) due to it being too tight so that blood flows*

*back to the fallopian tubes, and if you then get an infection you risk of having tight fallopian tubes. They thought that was scary. So I explained to them that it is important to open up early. I also added that so that they themselves understand how important this is and receive good care, it is important for them to learn Norwegian. Then the chief Imam rose and said "You can say whatever you want about health, but we decide whether or not they learn a language or not". Gynaecology, male.*

One of the participants felt that instead of offering unlimited translation service the patients should only receive one year of the service and then be forced to learn Norwegian. This would according to the participant save money for the government, an estimate 3, 5 billion NOK. And also give these women, and men a better life in Norway. People who learn the language succeed better in the country.

*NAKMI made a big research if not having a translator affected the care you received. I called them and asked them to reformulate the question because I knew this study would go out to all health care personnel. Can't you ask how often you feel like you don't understand the language have been an obstacle of receiving optimal care? They refused. I knew the answer would be insufficient translators. So they started offering unlimited translation services. I wish they would instead offer free translation service the first year, and after that you would only receive translation if you had a special reason. Today in Norway we use 3, 5 Billion NOK on translation services. Think if we had used half of that on language learning. Gynaecology, male.*

Some felt that Norway is getting better and better, but some felt that there can be done more in the delivery room without specifying anything particular. There needs to be put in place better systems so that the immigrants, both women and men learn the Norwegian language so that they are thoroughly integrated into the society.

### **7.2.2 Patients arriving on time or at all**

There are some challenges with time and language at the gynaecology polyclinic (Ullevål university hospital).

*We have challenges with them (patients) not meeting up at the appointed time. Often I think they are afraid. Which makes it impractical for us to plan the day. Obstetrician, female.*

And sometimes they are not on time, which causes problems further down the line of the day since the days are usually well planned and packed with appointments.

### **7.2.3 Psychological help**

Another gynaecologist stated that he feels that the biggest problems with these women are not only physical but also psychological. They might have had several procedures done to their genitalia without anaesthesia.

More efforts into basic things like exercise and diet for immigrant women, who can have unhealthy habits when arriving to Norway. Some due to psychological symptoms from the procedure or what they have been through in their home country.

*We are behind in guiding them regarding physical activity and diet. I've said it all these years that language is important! Gynaecology, male.*

### **7.2.4 Sensitivity**

Participants shared their advice about bringing up the subject FGM. First the health care worker can explain that this is routine to talk about since the patient's nationality is from a country where they practice FGM and ask if they mind talking

about it. The Health care worker can ask what thoughts the woman have regarding FGM and her children/future children. Many young women in Norway can feel stigmatized because their parents are from countries that practice FGM even though they are born in Norway. The next generation does not practice FGM on their children and knows the dangers.

One participant said

*Don't stigmatize them because they have parents who are from Eritrea for example. The girls complain that the midwife or nurse tells them not to subject their child to it (FGM), it is her job to talk about it but in a polite way. These girls are born in Norway and have an education, know the language and have jobs. Consultant/midwife, female.*

One participant said that

*If you are not uncomfortable then the patient won't be uncomfortable. Most women have poor knowledge about their anatomy so you need to ask them questions. Like "Does it hurt when you have sex?", "Does sex make you sad?". Gynaecologist, male.*

And one should remember that they might not have good anatomy knowledge when it comes to the female genital, so one should ask simple questions.

When discussing the patient's daughters or future daughters, one should make sure to inform the harm and legal repercussions.

*When we bring it up we say that it is because we need to be pre-emptive, give them a brochure and then explain that it (FGM) is unnecessary, harmful and illegal. Those three things we need to talk about. That's what we were struggling with, but after they were informed thought the education we planned so now it's not difficult to talk about it. Consultant/Midwife, female.*



## 8 DISCUSSION AND CRITICAL REVIEW

My first research question wanted to answer what the challenges are for health care personnel. After conducting my study the results were interesting to see how far Norway has come from what it were before the law came into effect in 1995. All thought the aim of the study was not to find out how it was in the 90s, it was part of the results. Before the law the hospitals were scary for both the women who had undergone FGM, and the health care personnel. They may not have had a mutual language and it would have been difficult to convey any knowledge back and forth. Clash of culture also made problems arise, problems the hospitals were not always prepared for. Information is still important about the female anatomy. Today, there are clear guidelines that health care personnel can follow and much of the information collected is available for people online regarding the subject. In addition there are institutes and non-governmental organisations the women can seek help at if they wish. Such as Norwegian Red Cross. Health Care personnel still need to be mindful of not unintentionally stigmatizing their patient based on her or her parent's background. This has been discussed in previous studies, challenges in discussing FGM with patients in a way that they do not feel stigmatized (Turner 2007:371; Dean 2014:21; Richens 2014:524).

The participants I quoted about school education all graduated before or in the early 90's. I e-mailed the Oslo and Akershus University College of applied sciences asking if they have any lectures about Female Genital Mutilation and I received a reply: *"Female mutilation is not a topic in nursing education at Oslo and Akershus University College, campus Pilestredet. The subject can be theme treated in that students can choose this topic as the theme for a major or minor task. Furthermore, they can meet the topic in practice and during the exchange, but we have no education in the subject."* I spoke to a Nurse Graduate from 2014 who stated *"we did not learn anything about female genital mutilation in nursing school, it was not until later when I was on a seminar after graduation in Trondheim that I heard about it through a lecture"*. Unfortunately I have no updated

information about education in medical school or the midwife education in Norway. This enhances the need shown in a previous study that suggest that the curricula in nursing school in the UK need to include more studies about how to properly care for a patient with a different background (Leishman 2004:33).

Research question number two was about how we can meet those challenges. There is a need to expand the information given, not only about the female anatomy but also diet, exercise and the psychological aspect of going through FGM. In regard of respecting times there are not much that can be done from the hospitals side. Women who have immigrated to Norway also need to be integrated into the society but should there be done more to accommodate them, or should there be a stricter measures to get them to learn Norwegian that would in the long run be more beneficial? Or could it backfire and lead to these women being more isolated than before.

Much of the results about challenges are discussed about the situation in the 90s, when Norway was going through some changes in their attitude and work with FGM, laws came into effect and guidelines were outlined. It helps to show how far Norway has come on the subject.

This study is meant to be beneficial for anyone interested in the subject of Female Genital Mutilation, how Norway has taken measures to prevent it and how health care personnel in Oslo perceive working with this group of patients. The sample for this thesis was quite small. I was lucky to get a hold of many experts in the field, but also unlucky in not being able to speak to more people who do not work with FGM on a daily basis. Many people did not wish to be interviewed on the subject because they felt like they did not have enough information. Which I tried explaining was the point of my thesis, to find out what are the challenges and how they can be met. If there were more participants, and especially more participants that were not experts, the thesis would have had more depth.

I did not have a possibility to go back and interview the participants again, which would have made the results better. Since I only had six leading questions, each of the participants added something new to the results and it would have been interesting to go back and ask the previous participants of their opinion on the matter or how they perceived it.

Since the thesis is only concentrated in Norway the results are on a smaller scale than if it was done in Egypt or Somalia where FGM is more common.

The environment where the interview is taking place can have an effect on the results of the interview, for example an interview conducted in the participants home might make the participant more comfortable and generate more information than in a clinical environment (Holloway & Wheeler 2013:93). But it can also have the opposite effect if the interview is constantly being interrupted by playing children or the spouse (Holloway et al 2013:93).

The interview's in this study were conducted in the work environment, except one that was done in a local cafe'. The interviews in the work environment were done in private rooms, which did not affect the outcome of answers of the participants. The interview in the cafe', as far as the interviewer feels was not affected by the environment. The participant spoke freely and gave more information outside the asked interview questions.

Manderson, Bennett and Andajani-Sutjahjo (2006) write in their article:

*"Speech, comportment, and values inherent to gender and other social, structural, and contextual factors, such as age, socioeconomic positioning, and ethnicity, all influence the direction, flow, and content of interviews, informing how we might interpret the information collected in the process." (Manderson et al 2006).*

Three of the participants were born in Norway and two of the participants were born outside of Norway. I am not native to Norway but I feel like all the information

that was exchanged was understood mutually and not affected by background, gender, age or any other factor.

## **9 CONCLUSION**

In conclusion it seems like the problems facing a health care worker in Norway today is more cultural than medical for those who work with FGM. Things like language and custom. This does not include women and children born in Norway. It is not customary in Norway for a doctor to lie about a medical condition of the patient so she can get out of a marriage. In Norway you are supposed to arrive on time to an appointment. A lot of resources are put into translation service, which is not very effective when the translator is connected through a phone to the appointment, when some feel that there should also be put efforts into teaching them the Norwegian language. Overall Norway has tackled the problem head on and implemented new organizations to help curb the practice in Norway and offering help as easy as possible for women who have undergone FGM. There were no major problems that arose from the interviews regarding health care personnel experiences encountering women with FGM. Based on the people who did not dare agree to an interview due to lack of knowledge I conclude that there are still midwives out there who do not know enough about the practice but everyone has someone to turn to at their workplace who is knowledgeable in the practice.

After finishing my literature review I feel like the issue is still very complex, in Norway and the rest of Europe. Laws and regulations are being formed but it is not all black and white when you implement them. The only absolute is that female genital mutilation is a horrible practice that should be stopped once and for all. That and other beauty procedures in the female's genitals that are not necessary (for example "designer-vaginas" in the West). The main themes when it comes to challenges for health care workers are: Culture (for example being

asked to lie to the patient's husband about being damaged to get out of a marriage), language and sensitivity (how to bring up the subject without the patient feeling stigmatized).

## REFERENCES

1. Aftenbladet. (2000). *Lemlesting av jenter*. Found 22.7.2015. Available at: <http://www.aftenbladet.no/energi/kommentar/Lemlesting-av-jenter-2668395.html>
2. Ahmed, F., Creighton, S.M., Elliott, C. & Liao, L.-M. (2013). Adult recall of childhood female genital cutting and perceptions of its effects: A pilot study for service improvement and research feasibility. *Journal of Obstetrics & Gynaecology*, Vol. 33 Issue 3, p292-295.
3. Bell, T. (2008). Female Genital Mutilation. *Nursing Standard*, Vol 23, number 5, p. 43-47.
4. Bishop, J. (2004). Modern Liberalism, Female Circumcision, and the Rationality of Traditions. *Journal of Medicine & Philosophy*, Vol. 29, Issue 4, p473-497.
5. Christos, C. & Malone, M. (2013). Delivering compassionate care in school nursing: a case of female genital mutilation. *British Journal of School Nursing*, Issue 8, p. 181-4.
6. Dean, E. (2014). Hidden Toll of FMG. *Nursing Standard*. 5/7/2014, Vol. 28, Issue 36, p20-22.
7. Desert Flower Centre. (2014). *About Female Genital Mutilation*. Found 23.7.2015. Available at: <http://swisswomensclinic.com/swissdesert-flower/english/fgm.php>
8. DiCoccio-Bloom, B., Crabtree, F.B. (2006). The Qualitative research interview. *Medical Education*, 40; pages 314-321.
9. Dictionary.com. (2015). *Culture*. Found 22.7.2015. Available at: <http://dictionary.reference.com/browse/culture?s=t>
10. Dietrichen, F. (2013). *Jeg har møtt kvinner som er totalskadet nedentil*. Found: 22.7.2015. Available at: <https://sykepleien.no/2013/01/jeg-har-mott-kvinner-som-er-totalskadet-nedentil>
11. Dirie, W. & Miller, C. (2011). *Desert Flower*. New York: Harper Collins Publishing.

12. Dirie, W. & D'Haem, W. (2002). *Desert Dawn*. London: Virago Press.
13. Essen, B. & Johnsdotter. (2004). Female genital mutilation in the West: traditional circumcision versus genital cosmetic surgery. *Acta Obstetricia et Gynecologica Scandinavica*, Vol. 83, Issue 7, p611-613.
14. Eto, S. & Kyngäs, H. (2008). The qualitative content analysis process. *Journal of Advanced Nursing*, Vol. 62, Issue 1, p107-115.
15. Flamand, C. (2015). FMG: Challenges for asylum applicants and officials. *Forced Migration Review*, Issue 49, p79-81.
16. Gele, A.A., Kumar, B., Hjelde, K.H. & Sundby, J. (2012). Attitudes toward female circumcision among Somali immigrants in Oslo: a qualitative study. *International Journal of Women's Health*, Vol 4, p.7-17.
17. Jaeger, F., Caflisch, M. & Hohlfeld, P. (2009). "Female genital mutilation and its prevention: a challenge for pediatricians" *European Journal of Pediatrics*. Page 31
18. Jesson, J. & Lacey, F. (2006). How to do (or not to do) a critical literature review. *Pharmacy Education*, Vol. 6, Issue 2, p139-148.
19. Jonassen, W., & Saur, R. (2011). "Arbeid med Kjonnslemlestelse i Norge – en kartlegging. Found 16.7.2015. Available at: <http://www.nkvts.no/Arbeid-med-Kjonnslemlestelse-i-Norge.pdf#search=lemlestelse>
20. Knipsheer, J., Van Den Muijsenbergh, M., Van Der Kwaak, A. & Vloeberghs, E. (2012). Coping and chronic psychosocial consequences of Female Genital Mutilation in the Netherlands. *Ethnicity & Health*. Dec2012, Vol. 17 Issue 6, p677-695.
21. Kumar, R. (2014). *Research methodology – a step-by – step guide, fourth edition*. London: Sage
22. Laville, S. (2015). *Doctor found not guilty of FGM on patient at London hospital*. Found 28.7.2015. Available at: <http://www.theguardian.com/society/2015/feb/04/doctor-not-guilty-fgm-dhanuson-dharmasena>
23. Leishman, J. (2004). Perspectives of cultural competence in health care. *Nursing Standard*, Vol. 19 Issue 11, p33-38. 6p.
24. Leye, E., Ysebaert, I., Deblonde, J., Claeys, P., Vermeulen, G., Jacquemyn, Y. and Temmerman, M. (2008). Female genital mutilation:

- Knowledge, attitudes and practices of Flemish gynaecologists. *European Journal of Contraception & Reproductive Health Care*, Vol. 13 ,Issue 2, p182-190.
25. Lindstrand. A, Bergström. S, Rosling. H, Rubensen. B, Stenson. B and Tylleskär. T. (2006). *Global Health – An introductory Textbook*. Lund: Studentlitteratur.
26. Leininger, M. & McFarland, M., R. (2002). *Transcultural Nursing – concepts, theories, research & practice, third edition*. New York: The McGraw-Hill Companies, Inc.
27. Manderson, L., Bennett, E. & Andajani-Sutjahjo, S. (2006). The social dynamics of the interview: age, class, and gender. *Qualitative Health Research*, Vol. 16, Issue 10, p. 1317-34.
28. Medical Encyclopaedia. (2010-2014). *Vagina*. Found 14.7.2015. Available at: <http://medicalterms.info/anatomy/Vagina/>
29. Merton, K.R., Fiske, M. and Kendall L.M. (1990). *The focused interview – A manual of problems and procedures*. Second Edition. New York: The Free Press.
30. NKVTS – Nasjonalt kunnskapssenter om vold og traumatisk stress. *Brosjører*. Found 22.7.2015. Available at: <http://www.nkvts.no/sites/Veiviser-KL/komplikasjon-kl/Pages/Brosjyrer.aspx>
31. NKVTS - Nasjonalt kunnskapssenter om vold og traumatisk stress. *Norge*. Available 16.03.2015 at: <http://www.nkvts.no/sites/Veiviser-KL/Oversikt-sideinnhold/omfang-land/Pages/Norge.aspx>
32. NKVTS - Nasjonalt kunnskapssenter om vold og traumatisk stress. "Jeg er bekymret for at KLL skal skje". Available 24.6.2015 at: <http://www.nkvts.no/sites/Veiviser-KL/forebyggge-kl/Pages/default2.aspx>
33. NKVTS – Nasjonalt kunnskapssenter om vold og traumatisk stress. *About*. Found 22.7.2015. Available at: <http://www.nkvts.no/en/Pages/index.aspx>
34. NKVTS – Nasjonalt kunnskapssenter om vold og traumatisk stress. *Your body is perfect by nature*. Found 22.7.2015. Available at:



[http://www.nkvts.no/tema/Documents/KLL\\_BrosjyreKroppenDinErPerfekt\\_engelsk.pdf](http://www.nkvts.no/tema/Documents/KLL_BrosjyreKroppenDinErPerfekt_engelsk.pdf)

35. NKVTS – Nasjonalt kunnskapssenter om vold og traumatisk stress.  
*Faresignaler*. Found 23.7.2015. Available at:  
<http://www.nkvts.no/sites/Veiviser-KL/dialog-kl/Pages/Faresignaler.aspx>
36. NKVTS – Nasjonalt kunnskapssenter om vold og traumatisk stress.  
*Barnehage*. Found 23.7.2015. Available at:  
<http://www.nkvts.no/sites/Veiviser-KL/dialog-kl/for-ansatte/Pages/Barnehage.aspx>
37. NKVTS – Nasjonalt kunnskapssenter om vold og traumatisk stress.  
*Skole*. Found 23.7.2015. Available at: <http://www.nkvts.no/sites/Veiviser-KL/dialog-kl/for-ansatte/Pages/Skole.aspx>
38. NKVTS – Nasjonalt kunnskapssenter om vold og traumatisk stress.  
*Helsetjenesten*. Found 23.7.2015. Available at:  
<http://www.nkvts.no/sites/Veiviser-KL/dialog-kl/for-ansatte/Pages/Helsetjeneste.aspx>
39. NKVTS – Nasjonalt kunnskapssenter om vold og traumatisk stress.  
*Kvinneklinikk*. Found 17.8.2015. Available at:  
<http://www.nkvts.no/sites/Veiviser-KL/kl-paavist/hjelpeinstanser/Pages/Kvinneklinikk.aspx>
40. Norwegian Centre for Minority Health Research (NAKMI). (2015). About NAKMI. Available 24.6.2015 at: <http://www.nakmino.no/Detals.asp?cname=Om+NAKMI&cid=50>
41. Norwegian centre for minority Health Research (NAKMI). (2015). Staff. Available 17.8.2015 at: <http://www.nakmino.no/employees.asp?cname=Staff&cid=42>
42. Norwegian directorate for health - Forebygging av kjønnslemlestelse: Tilbud om samtale og frivillig underlivsundersøkelse. Jan 2011. Available 20.4.2015 at <https://helsedirektoratet.no/retningslinjer/forebygging-av-kjonnslemlestelse-tilbud-om-samtale-og-frivillig-underlivsundersokelse>
43. Norwegian law. (1995:1). Lov om forbud mot kjønnslemlestelse/Law prohibiting female genital mutilation. Available 16.3.2015 at:

<https://lovdata.no/dokument/NL/lov/1995-12-15-74?q=1995-12-15-74#%C2%A71>

44. Norwegian Law (1995:2). Lov om forbud mot kjønnslemlestelse/Law prohibiting female genital mutilation. Available 23.7.2015 at: <https://lovdata.no/dokument/NL/lov/1995-12-15-74>
45. Norwegian Ministry of foreign affairs. (2003). The Norwegian Government's International Action Plan for Combating Female Genital Mutilation. ISBN 82-7177-729-7. Available 16.3.2015 at: [https://www.regjeringen.no/globalassets/upload/kilde/ud/pla/2003/0002/ddd/pdfv/197557-ud\\_kjonnsllestelse\\_eng.pdf](https://www.regjeringen.no/globalassets/upload/kilde/ud/pla/2003/0002/ddd/pdfv/197557-ud_kjonnsllestelse_eng.pdf)
46. Richards, K. (2015). History Has Been Made. Female Genital Mutilation Banned In Nigeria. Found 28.7.2015. Available at: <http://nigeria.aplus.com/a/nigeria-bans-genital-mutilation>
47. Richen, Y. (2014). Nursing and midwifery at the crossroads—new challenges, new successes. *British Journal of Midwifery*, Vol 22, Issue 7, p 523-4.
48. Safe Hands for Mothers. (2010). "The Cutting truth"(video clip). Found 28.7.2015. Available at: <http://www.safehands.org/media/films/>
49. Skaine, R. (2005). Female Genital Mutilation. North Carolina: McFarland & Company, Inc., Publishers.
50. The Clarion Project. (2013). *Quotable quotes*. Found 21.2.2015. Available at: <http://www.clarionproject.org/content/mohamad-alarefe-circumcision-fgm-noble-act-do-women>
51. Thompson, N. (2015). Female genital mutilation: Why Egyptian girls fear the summer. Found 28.7.2015. Available at: <http://edition.cnn.com/2015/06/25/middleeast/egypt-female-genital-mutilation/index.html>
52. Turner, D. (2007). Female genital cutting: implications for nurses. *Nursing for Women's Health*, Vol 11, Issue 4, p.366-72.
53. Triggie, N. (2013). Care system must do more to protect girls from mutilation. *Nursing Children & Young People*, Vol 25 Issue 10, p. 9.

54. Topping, A. (2015). *Nigeria's female genital mutilation ban is important precedent, say campaigners*. Found 28.7.2015. Available at: <http://www.theguardian.com/society/2015/may/29/outlawing-fgm-nigeria-hugely-important-precedent-say-campaigners>
55. United Nations Children's Fund (UNICEF). (2014). *Female Genital Mutilation/Cutting*. Found 21.2.2015. Available at: [http://www.unicef.org/media/files/FGCM\\_Lo\\_res.pdf](http://www.unicef.org/media/files/FGCM_Lo_res.pdf)
56. Westcott, L. (2015). *How to End Female Genital Mutilation in Egypt*. Found 28.7.2015: <http://www.newsweek.com/2015/03/27/how-end-female-genital-mutilation-egypt-314264.html>
57. World Health Organization (WHO). (February 2014). *Female Genital Mutilation – fact sheet*. Found 21.2.2015. Available at: <http://www.who.int/mediacentre/factsheets/fs241/en/>
58. World Health Organization (WHO). (2001). *Female Genital Mutilation – A Teachers Guide*. Found 14.7.2015. Available at: [http://www.who.int/gender/other\\_health/teachersguide.pdf](http://www.who.int/gender/other_health/teachersguide.pdf)
59. World Health Organization (WHO). (2014). Slow progress in ending female genital mutilation. *Bulletin of the World Health Organization*, Volume 92, Number 1, p.6-7.
60. World Medical Association, Declaration of Helsinki. (2014). *WMA Declaration of Helsinki - Ethical Principles for Medical Research Involving Human Subjects*. Found 1.10.2015. Available at: [http://www.wma.net/en/30publications/10policies/b3/index.html.pdf?print-media-type&footer-right=\[page\]/toPage](http://www.wma.net/en/30publications/10policies/b3/index.html.pdf?print-media-type&footer-right=[page]/toPage)

## **APPENDIX 1.**

# Health Care Personnell challenges encountering patients with Female Genital Mutilation

## **LETTER OF CONSENT - TO MY INFORMANTS**

### **Presentation**

I am a Masters degree student in a join degree program with Arcada University of Applied Sciences in Helsinki Finland, Diak Diaconia univerisity of applied sciences in Helsinki,Finland and Baraton Eastern university in Kenya. My name is Raili Nilsson and I study long distance while living in Oslo, Norway.

### **Purpose**

The purpose of this study is to shed some light on the challenges that can arise in the health care environment for employees taking care of patients who have undergone Female Genital Mutilation. The other purpose is to try to find a solution to the challenges, so that the care of the these patients can be optimized.

I feel this is an important issue since female genital mutilation is not a common practice in Norway, or the other Nordic countries, but due to immigration it is seen more and more in the Health Care environment. My study will concentrate solely on the situation in Norway.

### **Implementation**

My data collection will consist of interviews. So I will ask you a series of questions and use a recorder on my mobile phone (that is protected by 2 pin locks) or if you wish a pen and pad. The time for the interview should not take more than 15-20min, depending on how much you would like to share and discuss with me.

### **Confidentiality**

The greatest possible confidentiality is pursued during the investigation by no unauthorized person has access to the material . The material is stored so that it is only accessible to us me who is the investigator . In reporting the results in the form of a final thesis at Arcada

University of Applied Sciences ,informants will be made anonymous so that it is not possible to link the results to individuals.

There are no risk's involved. The participants can be anonymous if they wish and I will keep all the confidential information safe.

Your participation in this study is completely voluntary . You may at any time terminate your participation , without giving reasons .

**Further information**

For further information about the study you can contact me, conducting the study.

I can be reached at :

Supervisor:

**Would you be willing to take part in my Study?**

\_\_\_\_\_

DATE \_\_\_\_\_

## APPENDIX 2

### The Norwegian National Research Ethics Committees

Hei igjen,

Du trenger ingen forhåndsgodkjenning fra oss. Vår oppgave er primært i drive veiledning og komme med råd. Det beste er nok å se på våre «Forskningsetiske retningslinjer for samfunnsvitenskap, humaniora, juss og teologi», som finnes på nettet (spesielt Del B om personvern). <https://www.etikkom.no/forskningsetiske-retningslinjer/Samfunnsvitenskap-jus-og-humaniora/>

Du har selv ansvaret for at prosjektet er forskningsetisk forsvarlig. Gitt at du skal jobbe med personopplysninger, og kanskje sensitive opplysninger, bør du avklare spørsmål om konsesjon. I Norge behandles dette av NSD og Datatilsynet, men ansvaret ligger på det landet hvor du formelt sett er student. Det betyr at disse spørsmålene må være avklart av egen (finsk?) instans.

Vennlig hilsen, Sekretariatsleder

Den nasjonale forskningsetiske komité for samfunnsvitenskap og humaniora (NESH) /

Nasjonalt utvalg for vurdering av forskning på menneskelige levninger (Skjelettutvalget)

<http://www.etikkom.no>

## **APPENDIX 3**

### **University Hospital Ullevål Department of Information safety and privacy**

Hei,

viser til innsendt meldeskjema og dokumentasjon for studentoppgaven din.

Ser av din beskrivelse at hoveddelen av oppgaven din går ut intervju ansatte ved sykehuset og deres erfaringer med behandling av pasienter som har vært utsatt for kjønnslemlestelse.

Dette kan gjennomføres forutsatt at du:

1) Melder behandlingen av personopplysninger til datatilsynet.

Det gjøres på <http://melding.datatilsynet.no/melding/>

Grunnen til at det må gjøres på denne måten er at du tilhører en utdanningsinstitusjon som ikke har base i Norge. Kvitteringen fra denne meldingen sender du tilbake til meg.

2) Du må få en tillatelse fra den avdelingen du planlegger å intervju (Kvinneklubben).

3) Det du planlegger krever samtykke fra intervjuobjektene som jeg ser du har utformet her.

Samtykke må skrives på norsk, og jeg anbefaler sterkt at du benytter malen som ligger vedlagt for å huske på alle de sentrale punktene. Grunnen til at det må være på norsk, er at skal være fullt ut forståelig for de ansatte.

Mvh, Personvernrådgiver

Seksjon for informasjonssikkerhet og personvern | Stab pasientsikkerhet og kvalitet

**Oslo universitetssykehus HF**

[www.oslo-universitetssykehus.no/personvern](http://www.oslo-universitetssykehus.no/personvern)

