Female Genital Mutilation: Finnish Midwives' experiences

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Laurea University of Applied Sciences **Abstract**
Global Health and Crisis Management
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The aim of this study was to enhance the competencies, knowledge and understanding of midwives on how to respond to the needs of women affected by female genital mutilation. The primary objective was to identify the special needs of genitally mutilated women in labour and delivery unit. The secondary objective was to develop recommendations for midwives to assist in assessing, planning, and implementing care of genitally mutilated women during labour and the delivery process.

Female genital mutilation (FGM) has serious health consequences, including adverse obstetric outcomes for women when giving birth. Women who have undergone FGM from high-prevalence countries and have migrated to Finland require to be handled and treated with relevant expertise to ensure specialized and quality maternity care. Midwives, as the forefront health care providers of women during childbirth in the delivery unit, are critical to the provision of this high-quality care.

The present study analysed the experiences of midwives taking care of FGM women in labour and delivery units of Finnish hospitals. This study used a qualitative approach in seeking answers to the research questions by exploring the views and perspectives of midwives taking care of such women.

The informants were recruited from the Federation of Finnish Midwives. Semi-structured open-ended questions through phone interviews were used for data collection. Seven midwives participated in the study. Thematic analysis was applied, and the themes were derived through inductive approach.

From the result of the analysis, four themes emerged. These included: a) management of pain due to de-infibulation, b) all-inclusive support during labour and delivery for FGM women, c) culturally sensitive care and challenges in communication, and d) midwives' lack of knowledge, experience and feeling unprepared to handle women who have undergone FGM. The findings of the present study indicate that FGM is largely a cultural practice, and many of the women who have undergone FGM and reported to the Finnish women`s hospital labour and delivery unit were coming from different cultural backgrounds across the globe. The Finnish midwives highlighted the need for diversity management training for midwives in order to provide culturally competent care in the labour ward and delivery unit. In addition, there was a knowledge gap hence the need for the hospital management team to organize continuous education programs addressing how to take care of FGM women during labour and the delivery process.

In conclusion, FGM continues to be a serious global health crisis that needs to be addressed accordingly to enhance the provision of quality maternal health care, especially during the labour and delivery process. The present study has used the World Health Organisation's guidelines to recommend continuous special training and supportive supervision for midwives to improve their expertise, skills and confidence hence providing holistic care in labour and delivery units to women who have undergone FGM.

Keywords: Female genital mutilation, semi-structured interview, guidelines, labour and delivery, recommendations, midwives.

Contents

1 Introduction

Female Genital Mutilation (FGM) is a global crisis. According to World Health Organization (2020), more than 200 million girls and women alive today have encountered FGM in 30 countries from Africa, Middle East and Asia and a total of 3 million women are at risk of being done for FGM every year. FGM is mostly carried out on young girls between infancy and age 15. According to World Health Organization (2020) FGM is not health beneficial, and it has adverse negative effects in both girls and women in several ways. Women who experience FGM are highly likely to experience complications during childbirth with a high risk of infant mortality rate. Other complications include excessive hemorrhage during labor and during delivery, long hospital stay after childbirth and shock.

According to Koukkula and Klemetti (2019), FGM and its related issues are experienced in Finnish women`s hospital, there are 10,000 girls and women who have undergone FGM. They further stated that, an estimation of 650 to 3,080 girls and women are at risk of undergoing FGM procedure in Finland. FGM breaches or infringes many international human rights treaties and according to the Penal code of Finland, it is termed as an assault.

Maligaye (2013) states that women and girls who have been genitally mutilated experiences several complications during labor and childbirth. Women who have been infibulated experiences the highest risk during the process of labor and delivery. Infibulated women cannot give birth without midwives` assistance during labor and childbirth process. The scar tissue surrounding the vaginal orifice does not allow the passage of the baby unless deinfibulation is carried out. Maligaye (2013) further says that prolonged second stage of labor can also be experienced in infibulated women due to the scars covering the vulva and the perineum. Severe hemorrhage from the vaginal and perineal tears could be fatal and needs immediate management.

Jadesola (2017) emphasizes that FGM is not universally incorporated in midwifery books or observed in many areas of clinical practices. As a result, this forms a barrier for both midwives and students during practice. Adequate training is recommended for the midwives, to identify signs and dangerous complications that might arise during childbirth in infibulated women. (Aziem 2012.) According to Jadesola (2017), cultural sensitivity entails the consciousness of issues in existing cultures similarities or differences, thus the understanding and provision of better care without bias. Implementation of culture sensitive issue should be accorded with respect in reference to the woman's beliefs and practices. The women who have been done for FGM believe in the positive attributes like religious related,

hygienic, “marriageability” and well desired for sexual pleasure (Terry & Harris 2013). This study aims to enhance the competencies, knowledge and understanding of the Midwives on how to respond to the needs of women affected by female genital mutilation.

2 Female genital mutilation

FGM comprises of all procedures that deliberately change or instigate pain or injury to the female genital organs for non-medical reasons (World Health Organization 2020). FGM is divided into four types see figure 1.

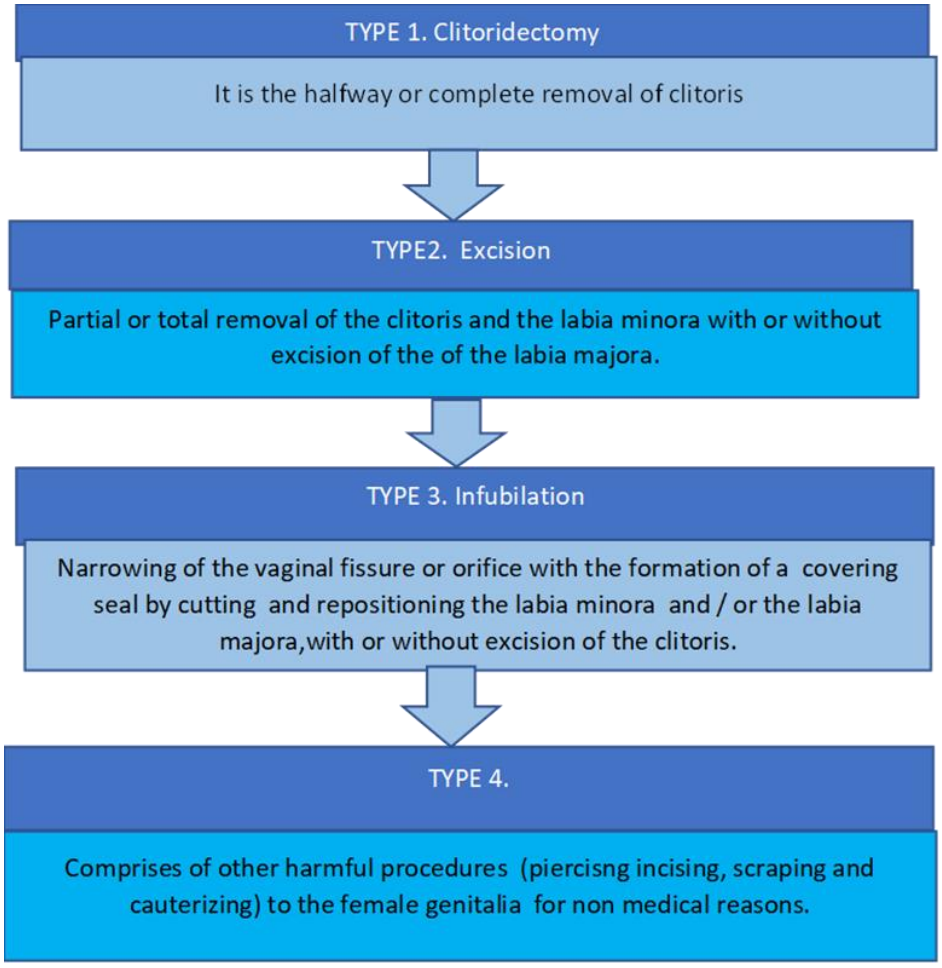

Figure 1: Types of FGM (World Health Organization 2020)

2.1 Reasons for practicing FGM

The practice of FGM is a mixture of religious, cultural, and social factors within the

Society (Krása 2010). From the social factors' perspective, there is social pressure to fit in the society for social acceptance. Society is motivated to continue practicing FGM to young girls in preparation for adulthood and marriage. In some African cultures, they consider the pain the young girls experience during the cutting process to be less as compared to the embarrassment that follows when their young girls remain unmarried since the FGM process makes the woman marriageable. (World Health Organization 202O.) Some cultures also believe that FGM makes the girls look beautiful, clean and prevents unacceptable sexual behaviors like premarital sex and infidelity in marriage since there is a belief that FGM lowers the women`s libido hence helping girls not engage in illicit sexual acts (Krása 2010).

According to World Health Organization (2020), in communities or societies where FGM is practiced, it is respected as part of the peoples` culture; hence they continue to do it in honor of their cultural tradition. Some communities also do it because their neighbors are doing it, so they copy the neighboring communities. Many religious leaders usually have different opinions about the practice, some support it, and some do not. However, no religious book or writing supports FGM. (World Health Organization 2020.) The woman’s body is also essential for passing on traditions and giving birth to the next generation (Koukkula & Klemetti 2019).

FGM is a cultural initiation ceremony celebrated on passage to womanhood and marriage. The women were subjected and educated on how to treat their husbands. In some communities, it was believed that circumcised women had a high chance of getting pregnant compared to their uncircumcised counterparts. (Mwendwa, Mutea, Kaimuri, Aoife & Thilo 2020.)

2.2 Consequences Of FGM

According to World Health Organization (2020), FGM has no health benefits. It harms women in many ways. It entails removing and destroying healthy and normal female genital tissue, hence damaging the natural functions of girls and women's bodies. There are several long-term and short-term risks related to FGM.

2.2.1 Physical consequences

World Health Organization (2020), states that FGM entails harm to women's physical health throughout their life. The most common physical related complications include hemorrhage, pain, urine retention, genital tissue swelling. Riesel and Creighton (2015) state that women are at a major risk of infections which ranges from septicemia, gangrene and tetanus. They further added that FGM can also lead to death. Additional direct complications comprise of impairment to other adjacent organs and incomplete healing.

2.2.2 Consequences on mental health, social life and sexuality

According to World Health Organization (2020), psychological trauma usually results from FGM women, especially when physical complications are ignored. FGM psychological complications include anxieties, depression, neurosis, and psychoses (Rushwan 2013). Abdalla and Galea (2019) carried out a systematic review study and reported that some women experience affective disorders post FGM, which comprises somatization, anxiety, and phobia. They further emphasized that FGM is a highly traumatic experience which can mark a long-lasting psychological effect. Behrendt and Moritz (2005) carried out structured clinical interviews with forty-seven women from Senegal to assess their mental health state. Twenty-three of these women had undergone FGM during childhood. They reported a high prevalence rate of post-traumatic stress disorder (30.4%) and other psychiatric syndromes, including memory problems (47.9%) in FGM women. The prevalence rate of mental health complications in FGM women was statistically higher as compared to the comparison group.

The short term and long-term consequences of FGM have adverse effects on a girls or women social life (Rushwan 2013). He further states the problems include ill-health, incontinency, which hinders the girl's participation in social activities. Married women experience difficult penetration, suspicion of barrenness which often leads to divorce.

According to Berg, Underland, Odgaard-Jensen, Fretheim and Vist (2012) a systematic review study of the sexual consequences of FGM elaborate the assumption that FGM women are highly likely to experience increased pain and low sexual libido. Any type of FGM of critical genital tissues results into scar formation and hinder its flexibility and sensitivity hence causing pain during sexual intercourse.

2.2.3 Consequences on pregnancy and labour

According to Riesel and Creighton (2015), women who have been infibulated usually have closed vaginal orifice, making it difficult or impossible to perform vaginal examination during the assessment of the labour progress. FGM women experience obstetric complications during labour and childbirth, prolonging the postpartum period. Due to the inelasticity of scar tissue in the perineum region, FGM mothers are prone to a high risk of complications, including prolonged labour, perineal trauma, caesarean section, perinatal death and neonatal resuscitation. Riesel and Creighton (2015), further emphasize that the second stage of labour may be delayed due to more invasive forms of FGM.

2.3 Managing FGM women in the labour and delivery process

According to Cousins (2016), infibulation or stage three FGM renders the vaginal introitus or opening tight; hence it is difficult to access the degree of cervical dilatation. Gupta and Lathe (2018) states that de-infibulation is usually carried out to open the passage. De-

infibulation refers to the opening of the vaginal orifice. It is a surgical procedure, and it requires local anaesthesia.

According to Esu, Udo, Okusanya, Agamse and Meremikwu (2017), an observational study was done on antepartum and intrapartum de-infibulation, the results indicated no differences in delivery time. A need for further observational studies was recommended. Gupta and Latthe (2018), stated that if the foetal head is held up on the scar, the second stage of labour may be complicated, leading to foetal asphyxia and uncontrolled perineal tears. This is dangerous for both mother and the baby. Cousins (2016), further states that the incision should not be extended above the urethra during the de-infibulation process to avoid haemorrhage.

Gupta and Latthe (2018), state that re-infibulation must be resisted, and any potential future health problem of such a procedure should be explained. The family and the husband should be educated and discouraged to re-suture the opening after delivery. Gupta and Latthe (2018), further state that the husband and the mother should be counselled for psychological support before and after de-infibulation. Further sessions of therapy should also continue after delivery.

3 Purpose, objectives and research questions

The main purpose of the study is to enhance the competencies, knowledge and understanding of Midwives on how to respond to the needs of women affected by female genital mutilation.

The objective of the study includes:

i. To identify the special labour and delivery related needs of genitally mutilated women.
ii. To develop recommendations for midwives to assist in assessing, planning, and implementing care of genitally mutilated women during the labour and delivery process.

The study is aimed to answer the following research questions:

i. What are the needs of genitally mutilated women during labour and delivery?
ii. How can genitally mutilated women be managed during labour and delivery?

4 Methods

The methods section portrays actions to be taken to explore a research problem and the justification for the application of distinct procedures or approaches used to identify, select, process, and analyze information applied to understanding the problem, thereby enabling the reader to critically evaluate a study's overall validity and reliability. (Williams 2007.) The research methods of data collection used across studies are classified as qualitative or quantitative. The approach used in a specific method for data collection determines the classification of a study to a large extent. (Silverman 2013.)

4.1 Qualitative approach

This study used qualitative approach in searching of answers to the research questions by exploring the experiences of midwives taking care of FGM women in labour and delivery. According to Bhattacharjee (2012), qualitative research deals with non-numerical that seeks to interpret the meaning from collected data and assists in understanding social life via the study of a certain population. Gupta and Awasthy (2015), further state that qualitative research is a form of social science where focus is on understanding people's world. Qualitative research approach was used in this study to obtain the subjectivity of human experience in terms of language, discussion during interviews and interaction (Wilkinson 2007).

The information and the data collected were analysed. They were entirely non-quantitative in nature and consisted of transcripts obtained from phone interviews regarding the experiences of midwives taking care of FGM women in labour and delivery unit. Qualitative study has the capacity to provide an aggregate description of how people experience a certain subject; hence this study was carried out using the qualitative approach, and the focus was on midwives' experiences in taking care of FGM women in labour and delivery unit.

4.2 Study setting

The informants were recruited from the Federation of Finnish Midwives. The Federation was founded in 1919. It is one of Finland's oldest professional non-profit organisations and has a long tradition of uniting midwives. There are more than 4300 members. On completion of midwifery degree qualifies one to become a member. (Suomen Kätilöliitto Ry 2020.)

The commission of the Finnish midwifery association is to develop the profession of midwives, maternity care, and gynecological nursing by increasing the professional skills and knowledge of midwives and supporting the cohesion of the profession, thus strengthening the midwifery professional identity. In accordance with its rules, the association of midwives conducts publishing and information activities, maintain contacts with domestic and foreign organizations,

participates in the international activities of midwives and make presentations related to midwifery and its field. (Suomen Kätilöliitto Ry 2020.)

4.3 Data collection

Semi-structured interview using open-ended questions was selected as the data collection method in this study because it allowed the midwives to explore their thoughts, feelings, experiences, and beliefs. Due to the covid 19 pandemic the writers could not meet the informants in person henceforth, they opted for phone interviews. According to Harrell and Bradley (2009), semi-structured interviews are often used when the researcher wants to delve deeply into a topic and to understand thoroughly the answers provided.

A pilot interview was conducted using three midwives from Global Health Course to test the reliability of the data collection instruments (Sullivan-Bolyai & Bova 2018). After carrying out the pilot interview, the researchers noted that some questions were unnecessary, and they omitted them. In this study, a non-probability sampling method was used. The non-probability sampling method entails recruiting informants in a non-random fashion for a research study. Thus, the individuals in the accessible population do not have the same opportunity to be recruited. Informants who participate in the study share characteristics that may be systematically different from the characteristics of informants who don't participate in the study. (El-Masri 2010.) In this study, only midwives who had taken care of the FGM women in the labor and delivery unit were selected and considered as the study sample.

The midwives for the study were rounded up via snowballing. In the snowballing technique, the researcher makes use of social contacts, and, after the initial intentional contact, the rest follow as recommended informants. (Kankkunen & Vehviläinen-Julkunen 2009, 85; Lo-Biondo-Wood & Haber 2018, 220.)

The thesis plan was accepted in the institution, and further approval to carry out the study was received from the leader of the Federation of Finnish midwives. The leader stated that we do not need a written permission to carry out our study that her word is as good as enough. Our contact person was the leader of the Federation of Finnish midwives and a THL worker who introduced our topic and research objectives to the Federation of Finnish midwives closed Facebook group. The THL worker sent to us via e-mail the contacts of three midwives who were interested in participating in the study. The three midwives later referred to us, other four midwives. The participation of the midwives in this study was voluntary. Before they took part in answering the phone interviews, each of the midwives was sent a consent letter via email to read and understand. The consent letters were both in English (Appendix 1) and Finnish (Appendix 2). The informants were also issued a participant`s

information sheet (Appendix 3). We had open-ended questions (Appendix 4), which were read to the midwives via phone interview. Data collection took place on different days in August. During the data collection process, seven midwives participated in the study.

Open-ended questions were written according to the need of the main research questions see (Appendix 4) and used as assisting list of questions for the semi-structured interview. There were ten questions in total. The interviews lasted between 15- 45minutes. Open-ended questions were used during one-on-one phone interviews with the midwives, which were recorded electronically on the writer's mobile phone and transcribed verbatim. Semi-structured open-ended questions helped the respondents to think carefully and to reveal what was on their mind, and it promoted dialogue and interpersonal engagement (Brendel 2015). The interviews were conducted in both English and Finnish language. One interview was carried out in Finnish language.

According to Fusch and Ness (2015), data saturation is applied in research to justify that no new information is expected to be added that will influence the findings of a study. The authors read and analyzed the nature of the data before deciding on the data saturation. The authors found that some midwives answered semi- structured open-ended phone interviews using long sentences and narratives about their personal experiences in handling FGM women in the labour and delivery unit, whereas some midwives answered using brief narratives. However, both answers outlined the midwives experience in taking care of FGM women in labour. In this study, data saturation was reached when the authors found the same type of responses from the midwives in different sets of questions, and it was firmly established that no new information on the midwives´ experiences in relation to special needs of FGM women in labour could be captured.

4.4 Data analysis

Data analysis being the complex phase in qualitative research, receives partially thoughtful discussion in the literature. For data analysis to be transparently communicated, it's done in a systematic and logical manner. (Nowell, Norris, White & Moules. 2017.) In this study, data analysis was accomplished following a precise method as outlined by Nowel et al. (2017), in table 1.

Nowell et al. (2017), state that thematic analysis is applicable and adversely used in various epistemologies and research questions. It is beneficial as it identifies, analyses, organises, describes, and reports themes across the data (Braun & Clarke 2006, 79). According to Saks and Allsop (2013), thematic analysis encompasses the establishment of recurring themes within the data, seeking the themes typologies, and looking at the discrepancies in relationships between and within the themes.

Lakh, Shamri-Zeevi and Kalmanowitz (2021), further state that thematic analysis is used in analysing interview transcripts whereby, the researcher meticulously examines the data to repeatedly classify common themes – topics, ideas, and patterns of meaning. In addition, there are various approaches to conducting thematic analysis. However, the most common form follows a six-step process: familiarisation, generating initial coding, generating themes, reviewing themes, defining and naming themes, and writing up. See Table 1. (Nowell et al. 2017; Gupta, Shaheen & Reddy 2019, 206.)

Steps thematic qualitative data analysis	**Description**
1. Familiarization	In-depth understanding of the data, noting items of potential interest.
2. Generating initial Codes	Coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code. Coding means highlighting sections of our text – usually phrases or sentences – and coming up with shorthand labels or "codes" to describe their content.
3. Generating themes	The codes were assembled into a potential theme, all related data were gathered to form main themes.
4. Reviewing themes	Themes were examined in relation to the coded extracts, thereafter, producing a thematic outline of the analysis.
5. Defining and naming of themes	Progressive analysis of the themes, for better clarification and analysis thus achieving a concise and understandable title for each theme for the authors.
6. Writing up the report	Generating consistent analysis from the chosen extracts which are a logical, coherent, concise, non-repetitive and interesting account of the story the data reports within and across themes.

Table 1: Example of phases of thematic analysis Nowell et al. (2017); Gupta, Shaheen & Reddy (2019)

Inductive analysis was applied in this study, the data collected determined the themes. According to (Braun & Clarke 2006, 84), inductive approach enables research findings to appear from the frequent, dominant, or significant themes inherent in raw data, without the restraints imposed by structured methodologies. According to Thomas (2006), inductive approach is a method of analysing qualitative data in which the analysis is highly likely to be guided by specific evaluations and objectives. In this study, during the data analysis process, the midwives' experiences in taking care of FGM women in labour and delivery unit guided the authors to achieve the study objectives.

Thomas (2006) further defines inductive analysis as a means that primarily use a comprehensive reading of raw data from informants to derive concepts and themes through interpretations made from the raw data by the authors. During the data analysis process, the authors began to focus on the topic of the study: Experiences of midwives taking care of FGM women in the labour and delivery unit. The identified codes enabled themes to emerge from the data. Below are the phases adopted in the data analysis process. See Figure 2.

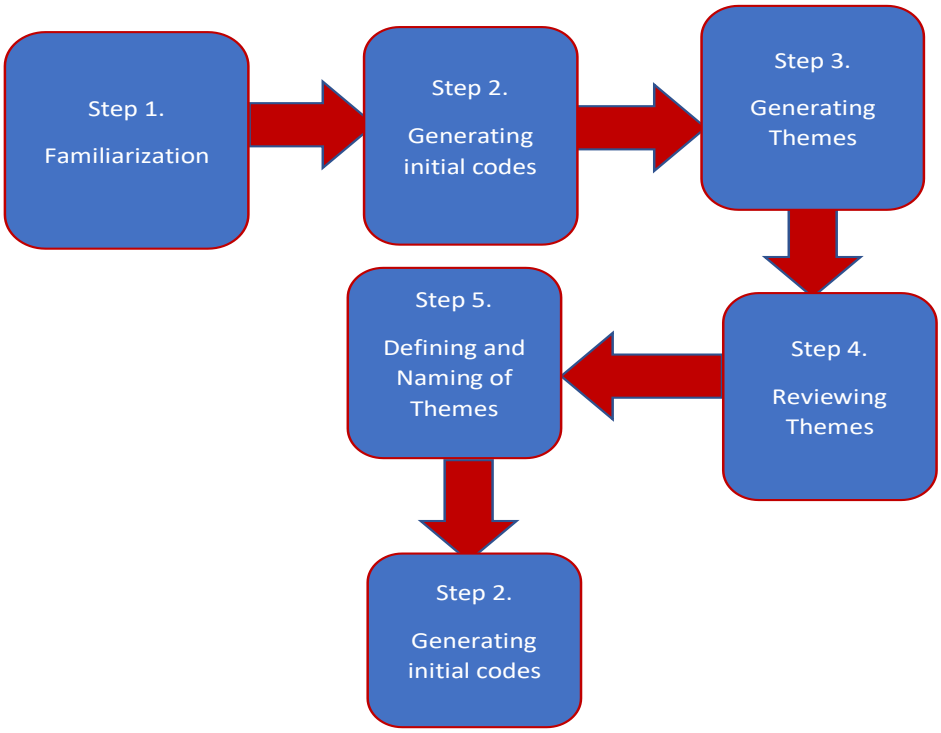

Figure 2: Steps of thematic analysis Gupta, Shaheen & Reddy (2019); Braun & Clarke (2006)

4.4.1 Data analysis step 1: Familiarization

After the collection of data from the midwives, one of the authors translated one interview that was carried out in the Finnish language to the English language. The interviews were carried out in both English and Finnish language. Six of the midwives were interviewed in English and one was interviewed in Finnish. In this stage, the authors immersed themselves into data by repeatedly listening to the interview recordings and transcribing the words into texts typed out into word document on the computer. A second listening was conducted to check if the transcripts were accurate prior to the labelling of this data or starting to search for codes

or any patterns. After reading throughout the data, the writers made short notes and commented on the data. The writers selected significant points on data and examined through to get familiar with it, as seen in table 2.

Midwife 4	I mean when these women come, that have undergone female genital mutilation. I see a traumatised woman and I see them just before or just when they are in labor. So, it feels like in a very short time, you kind of need to take up this very big topic with them
Midwife 5	This is a traumatizing experience; the women are sad and helpless. Personally, I think this act of FGM must stop by all means. De-infibulation process is very painful.
Midwife 7	These women are suffering. I realized FGM need more care and attention. For example, they need proper pain management during delivery

Table 2: Illustration of Familiarizing with Data.

4.4.2 Data analysis step 2: Generating initial Codes

After familiarising with the data, the authors organised data in a meaningful and systematic way. The frequency in the occurrence of interesting data was recognised whereby the small segments of data were highlighted and coded with regards to the writer's research questions which were: 1) What are the needs of genitally mutilated women during labour and delivery? 2). How can genitally mutilated women be managed during labour and delivery? This stage assisted the authors in further understanding the data. Open, inductive coding was used. The authors, therefore, developed and modified the codes as they worked through the coding process of the text. The authors read and interpreted the raw textual data to derive initial codes after the completion of data familiarisation in the interpretation based on data. After transcript coding was performed, the emergent initial coding's were highlighted using different colours that illustrated different ideas or meanings see Table 3. The authors examined the data coding in each section of the text so that the coding was relevant in addressing the research question. The authors discussed and modified the data before proceeding to the subsequent transcript. In the coding process, 20 initial codes that arise from the data were identified. The different colours used to distinguish the data, while bold were assigned to initial codes. The coding process was done manually using a computer; the data was then organised into meaningful groups and based on the midwife's experiences on the special needs Of FGM women in labour and delivery unit, as shown in Table 3.

Data Extract	**Initial codes**
The midwives need to have good communication skills and speak calmly to the mothers without judging them because the mothers are usually scared and feeling embarrassed. (M 5) (Good communication skills)	**Good communication skills**
I also think that diversity classes should be introduced to midwives so that they understand how to handle people from different cultures. (M6) (Diversity management training for midwives in order to provide culturally competent care)	Diversity management training for midwives in order to provide culturally competent care
They say that they don't say anything, many people act like they don't understand the question, of course there are many women they don't speak English and not speak Finnish at all. (M2) (Difficulty in communication).	**Difficulty in communication.**
We are, of course, trying to meet all the mothers calmly. Calmly because that goes well also depends on language skills, whether we have a common language or whether some genitally mutilated mother has just arrived. (M3)	**Good communication skills**
If we don't have a common language, we can use the tulka telephone for example to find some language we could understand. Tulkka nowadays the tulka telephone is very good". But then the lady doesn't need to be presence there because before it was problematic for labouring mothers earlier when we have what is this "tulkki pre" what is this in English. (M1) (Difficulty in communication).	**Difficulty in communication.**
The challenges are many, remember that this is a cultural practice, and we are from different cultures, we think differently, so as a midwife I have to stop stereotyping and manage the woman. (M7). (Diversity management training for midwives in order to provide culturally competent care)	Diversity management training for midwives in order to provide culturally competent care

Table 3: Generating initial codes

4.4.3 Data analysis step 3: Generating themes

In this step, the authors focused on categorising and selecting potentially relevant extracted data into sub-themes. The process brought together the elements and portions of the midwives' experiences of FGM women in the labour ward. In this section, initial codes were looked at, and most of them distinctly fitted together into sub-themes. The authors generated themes inductively from the raw data. Initial codes that appeared as subthemes are assorted in Table 4.

Data Extract	Sub- themes
The midwives need to have good communication skills and speak calmly to the mothers without judging them because the mothers are usually scared and feeling embarrassed. (M 5) We are, of course, trying to meet all the mothers calmly. Calmly because that goes well also depends on language skills, whether we have a common language or whether some genitally mutilated mother has just arrived. (M3)	Need for Good communication skills for midwives taking care of FGM women in labour and delivery
I also think that diversity classes should be introduced to midwives so that they understand how to handle people from different cultures. (M6) The challenges are many, remember that this is a cultural practice, and we are from different cultures, we think differently, so as a midwife I have to stop stereotyping and manage the woman (M 7).	Need for Diversity Management Training for midwives taking care of FGM women in labour ward in order to provide culturally competent care.
They say that they don't say anything, many people act like they don't understand the question, of course there are many women they don't speak English and not speak Finnish at all. (M2) If we don't have a common language, we can use the tulka telephone for example to find some language we could understand. Tulkka nowadays the tulka telephone is very good". But then the lady doesn't need to be presence there because before it was problematic for labouring mothers earlier when we have what is this "Tulkki pre" what is this in English. (M1)	Difficulty in communication between midwives and FGM women who neither speak Finnish nor English language in labor ward and delivery unit.

Table 4: Generation of sub-themes

4.4.4 Data analysis step 4: Reviewing themes

In this step, the authors looked at the coded data placed within each theme to ensure proper fit. They reviewed relevant codes and data extracts under each theme to ensure that each theme had adequate supporting data and was coherent. The authors discussed and agreed unanimously that data within each theme should have adequate commonality and coherence whereas data between themes should be distinct enough to merit separation. At this step the authors resorted data extract and themes were modified to better reflect and capture coded data. To ensure that data within the themes were coherent, meaningful and the themes were representing midwives' voices, the authors had to return to the raw data several times. To achieve this task, the authors re-read the entire dataset to re-examine the themes and to re-code for additional data that falls under the theme that has been created.

4.4.5 Data analysis step 5: Defining and naming of themes

In this stage, the authors apprehended the detailed analysis of the themes to understand the midwives' experiences in special needs of FGM women in labour and delivery unit. To ensure rich data content(themes), the authors kept on consulting each other. The authors re-read the whole data, and coding was scrutinised several times, and eventually, four themes emerged which includes management of pain due to de-infibulation, all-inclusive support during labour and delivery for FGM women, culturally sensitive care and challenges in communication and mmidwives' lack of knowledge, experience and feeling unprepared to handle FGM women.

4.4.6 Data analysis step 6: Writing up report

This stage involved the production of a clear and coherent description that makes reference to the data outlined in the thematic matrix. The write up was accompanied by explanations and clarifications. During the write-up, the authors ensured a clear presentation of data outlined thematic matrix to reflect the order of the hierarchical relationship between the theme and the sub-themes. The results from the data were distinctly produced so that the claim in the data shows credibility and trustworthiness in the data set, using both the midwives' narratives which were represented as data extracts. The authors used short quotes to ensure a clear understanding of meanings and also to display the predominance of the themes. The authors used the shorter as well as longer quotes within the narratives to give readers the ideas on original texts where all quotations were tagged with midwives' numbers. Themes and subthemes extracted from the original quotes were presented in the result sections, which will assist the readers to understand the experiences of midwives handling FGM women during labour and delivery.

5 Results of the study

The study results from the experiences of Finnish midwives taking care of FGM women in labour and delivery unit revealed four themes and eleven sub-themes that emerged from the 69 data extracts. The midwives who participated in the study had a previous experience of taking care of FGM women in labour and delivery unit. The midwives considered themselves as the major frontline health care professionals in taking care of FGM women in labor and delivery unit. They further highlighted the need for experience of care and demanded for a continuous training program and the provision of current guidelines used in taking care of FGM women in labor and delivery unit. The midwives expressed various challenges they face while taking care of FGM women in labor and delivery unit. The challenges included: difficulty in

communication, intercultural differences and the knowledge gap. The major experiences of midwives who participated in the study are shown in Figure 2.

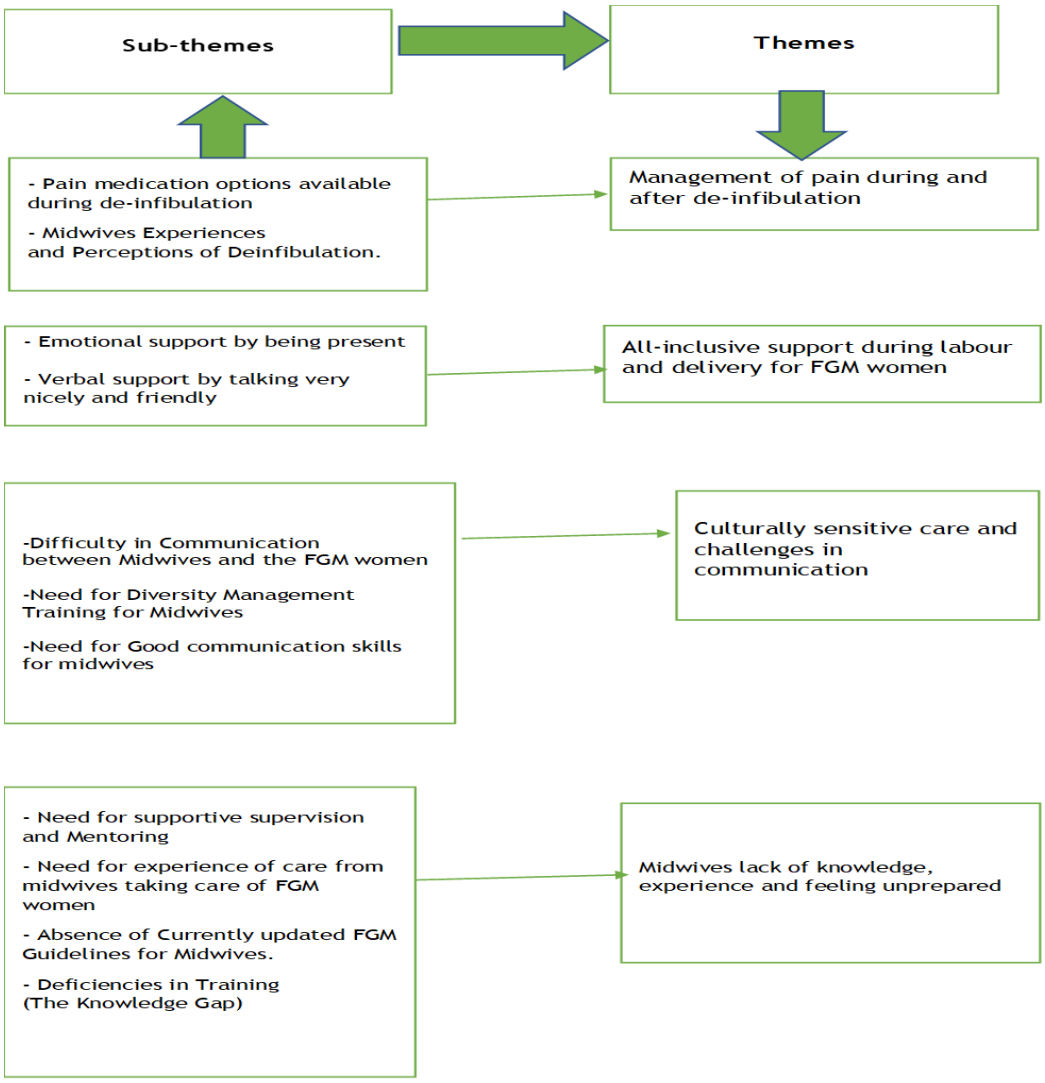

Figure 3: Results of the study.

5.1 All-inclusive support during labour and delivery for FGM women

The midwives considered themselves as the major frontline healthcare professionals who provide emotional support by being physically present and provide verbal support by talking to the FGM women during labor and delivery (all-inclusive support). The respondents mentioned that the team usually provide emotional support to the women and the necessary information they need about FGM. The midwives stated that the opportunity of talking to the FGM women and staying close during labor and delivery process should not be missed as a strategy to eliminate the practice in the future and to discourage Re-infibulation. The participants mentioned

that they usually talk to the FGM women during the whole process of labour. The sub-themes under all-inclusive support for FGM women during labor are mentioned below.

5.1.1 Emotional support by being present

The midwives revealed that throughout the labour process they are always present in the labor and in delivery rooms observing the FGM women hence they are not left alone. Some of the midwives highlighted that FGM is a traumatizing experience, and the women are always appearing sad and helpless.

> Then of course presence that we don't left him alone. (M1)
>
> This is a traumatizing experience; the women are sad and helpless. Personally, I think this act of FGM must stop by all means. (M5).
>
> I think the answer is quite close from answers from the first question but ln my opinion it's very important to be able to support the women during the whole labour process. (M 2)

5.1.2 Verbal support by talking very nicely and friendly

The midwives taking care of FGM women responded that communication throughout labour and during the delivery process needs to be ongoing and responsive to the women's needs. The midwives mentioned that they usually establish rapport with the woman and ask her about her wishes and expectations for labor and delivery process. During the interview the midwives mentioned that they personally talk to the women in a calm and friendly manner all the time to establish rapport with the women. Some phrases included.

> I personally talk to them and hear their side of the story. (M7)
>
> The women are always sad and depressed; the midwives need to talk to them very nicely and be very friendly. (M5).
>
> Well, I usually think about pain management, talking to the woman all the time. (M6)

5.2 Culturally sensitive care and challenges in communication

The midwives expressed that intercultural communication refers to the communication between people from two different cultures. From the data collected it is visible that the midwives responded that communication between midwives and FGM women from different cultures was difficult as most of the women did not understand the question hence could not answer back. One of the midwives responded that most of the women neither spoke English nor Finnish. Another midwife also mentioned that language barrier hindered communication process. However, some midwives further stated that certain tools were available to enhance the communication process. Several midwives also mentioned during the interview that it was

important to introduce diversity classes to improve the midwives understanding of the FGM women and their culture. Sub-themes mentioned under intercultural communication and diversity are as mentioned below.

5.2.1 Difficulty in communication between midwives and the FGM women

The midwives revealed that it was difficult to communicate in the labour ward, as FGM women could only speak their native language in the labour ward. One of the midwives mentioned that the FGM woman did not answer the question at all and was continuously crying. Several midwives mentioned that whenever they couldn't understand what the FGM women were speaking they had to look for a translator in order to assist in the translation process.

Other respondents also mentioned that they have been using "Tulkka telephone" to assist them in translating words from different languages to Finnish language which is the official language used in all women hospitals. Several midwives mentioned that tulka has been very useful.

> Personally, I experienced one woman who had language barrier, she could not speak neither Finnish nor English hence it was difficult, at that situation the midwives should look for a translator (M6).
>
> When we have this translator in the room so, I felt that these mothers were not happy about to have some foreign people, strangers. So now tulka telephone is very easy. (M1)
>
> We couldn't understand what she was speaking, so we had to look for a translator in order to understand what she was saying. (M5)
>
> They say that they don't say anything, many people act like they don't understand the question, of course there are many women they don't speak English and not speak Finnish at all. (M2)
>
> Example, to find some language we could understand. Tulkka nowadays the tulka telephone is very good". But then the lady doesn't need to be presence there because before it was problematic for labouring mothers earlier when we have what is this "tulkki pre" what is this in English. (M1)

5.2.2 Need for diversity management training for midwives

Most of the respondents mentioned that the FGM women were coming from different cultures across the globe. One of the midwives suggested during the interview that women's hospital management team should introduce diversity management trainings so that the midwives are well equipped with cultural knowledge about different cultures hence they could understand how to handle people from different cultures and respect the culture itself. From the data collected, one of the respondents stated that one of the challenges that the midwives faced with FGM women was that FGM is a cultural practice and many midwives in Finland may fail

to understand why some cultures are still practicing FGM act. One of the respondents further mentioned that midwives should think differently, stop stereotyping and just manage the FGM woman with dignity.

> I also think that diversity classes should be introduced to midwives so that they understand how to handle people from different cultures. (M6)

> The challenges are many, remember that this is a cultural practice, and we are from different cultures, we think differently, so as a midwife I have to stop stereotyping and manage the woman. (M 7)

> In different cultures and also in a way like of course this process can never be supported but in a way, we have to respect the culture itself. (M 2)

5.2.3 Need for good communication skills for midwives

Many respondents mentioned that the FGM women appeared traumatized, sad, scared and embarrassed, these women need someone talking to them calmly to create some safe space. One of the respondents stated that the midwives need to have good communication skills and speak calmly, peacefully, and composedly. She further added that the midwives should speak calmly with the FGM woman without judging them. Several midwives admitted that effective communication skill is paramount in the provision of culturally competent care for FGM women in labor and delivery unit.

> The midwives need to have good communication skills and speak calmly to the mothers without judging them because the mothers are usually scared and feeling embarrassed. (M 5)

> We are, of course, trying to meet all the mothers calmly. Calmly because that goes well also depends on language skills, whether we have a common language or whether some genitally mutilated mother has just arrived. (M3)

5.3 Midwives lack of knowledge, experience and feeling unprepared

The midwives working in labor ward and delivery unit from various womens' hospital expressed that there is no official guideline used in taking care of FGM women. The respondents further stated that they often learn from senior midwives who are more experienced. The midwives mentioned the need of further training in understanding the care of FGM women in labor and delivery unit. Nearly all midwives who participated in the study articulated that the junior midwives usually have limited knowledge base on how to take care of FGM women.

5.3.1 Need for supportive supervision and Mentoring

This study highlighted the need for supportive supervision and mentoring of inexperienced midwives by peers who had worked with FGM women in labour and delivery unit. Majority of the midwives who participated in the study stated that they learnt taking care of FGM women

from each other. The senior midwives who are more experienced demonstrated to the junior midwives how to take care of FGM women in labour.

> First of all, in ours ward its basically the senior midwives teaching other midwives especially when FGM women come to labor ward (M 6)

> But then after that the knowledge began to go from one to another, others who were more experienced they advised new and now there is, quite true guidance, (M3)

> Mostly if there is a midwife who has a good experience then they show it how to handle FGM women (M7)

> So, we all need some support with it, and I think that there is always someone who has always more experience about it and of course it helps but a new midwife doesn't really have the experience to do it herself. (M2)

5.3.2 Need for experience of care from midwives taking care of FGM women

Many midwives who participated in the study stated that FGM women in labour needs super skilled midwives who are well equipped with knowledge and can make decisions in case any obstetric complications such as emergency caesarean section and excessive bleeding arises.

One of the participants with over 30 years of experience stated that she uses observational skills to evaluate the progress in labour and delivery of FGM women in-case vaginal examination was difficult and traumatizing.

> Whether there are predictable difficulties with all the things we do, we think about/ reconsider if this is going well, if this is going normally, does anyone anticipate any inconvenience. Because inconvenience is overcome if you spot it on time in this childbirth case. (M3)

> Basically, FGM women are special, and their management is also special, it takes a well experienced nurse to take care of FGM mothers. One time from my experience, the delivery process was very complicated until an emergency cesarean section was carried out. (M 5)

> I learnt a lot about just watching the woman and see how she reacts, what she says and how she breathes, and I do questions I ask the way you feel the contractions what kind of feelings, do you have some sensations in your hips or something like that or I rather use questions and my eyes to follow to labour. (M1)

> A midwife needs to be skilled, sympathetic and empathetic at the same time. (M7)

5.3.3 Absence of Currently updated FGM Guidelines for Midwives.

Several midwives highlighted that the women`s hospital they are working at do not have official updated guidelines on how to handle FGM women. However, one midwife mentioned that there is one handbook in the ward that has information on how to do de-infibulation in-case the vaginal opening is closed. One of the respondents also stated that they do receive updated guidelines from THL.

> There is a handbook that has topics on labour in X-hospital, we use the FGM section where there are illustrations on how to the opening if the woman is still closed. (M 4)

> Second is lack of guidelines that the midwives might use in case the FGM mothers come in. (M5)

> From THL we have good at this guideline are always up to date and we have contact meetings with THL, from which to obtain the latest information and individually in this work one must be in every field self-active, and this applies to the same thing. (M3)

5.3.4 Deficiencies in training (The Knowledge Gap)

Majority of the midwives expressed that they had not received or undergone training in the management of FGM women in their unit. One midwife stated that she had been working in the unit for three years but had not received any training. Most of the midwives who participated in this study stated their interest in receiving training addressing FGM.

The midwives highlighted that lack of experience, usually leads to lack of confidence when handling FGM women in labour and delivery. They further mentioned that the junior midwives were clueless and depended on the senior midwives whenever there were FGM cases.

The midwives further stated that taking care of FGM women in labour and delivery is continuous learning process and they would wish to get trained on the currently updated interventions on how to take care of FGM women.

> This is a lifelong learning process we never know everything and there is always something new even after years and years of experience there is something new so it's through learning from others, through experience, through guidelines (M 2)

> The first challenge is lack of experience to handle an FGM mother .... Midwives need training about FGM in order to handle the case with confidence. (M5)

> Recently it happened young midwife she was educated about half year ago, and then she came to work for summertime. Then she asked someone to help that she needs to cut this woman open. So, I said OK I go there because some

> younger said I don't know how do it. So, I understood that she don't know.... She needed to have someone who have done it before. When I went into room, I saw that there was nothing to be done. (M1)
>
> I have not had training but has there has not been training. In Hospital X there was once an info on FGM but not training at all, I have there for 3,5years. (M4)

5.4 Management of pain during and after de-infibulation

The midwives highlighted that infibulated FGM women report to the Women's' hospital labour and delivery room with a narrow vaginal opening which makes it impossible to perform the vaginal examination to assess the progress of labour. They further mentioned that de-infibulation is usually needed in such cases to allow for proper management of labour. Many midwives mentioned that the de-infibulation procedure was performed under local anaesthesia. According to one of the midwives, a de-infibulation procedure was recommended during the first stage of labour or during the delivery process.

One midwife stated that where the vaginal examination is difficult or painful depending on the type of FGM type, the midwife should use one finger to do a vaginal examination. In some cases, other methods of measuring the progress of labour may be used.

5.4.1 Pain medication options available during de-infibulation

Many midwives highlighted that de-infibulation procedure is usually carried out under local anaesthesia. One midwife mentioned that she normally uses adequate local anaesthesia so that the FGM woman doesn't feel any pain.

> These women are suffering. I realized FGM need more care and attention. For example, they need proper pain management during delivery. (M 7)
>
> I explain that I use local anesthesia and I have to cut like open her" And of course, that I would use some painkillers like paracetamol.... I can use a lot of pain local anaesthesia so that she doesn't need to feel any pain when am suturing her. (M1)
>
> These women are sad and you can see pain and trauma in them, pain henceforth must always be managed. (M4)

5.4.2 Midwives experiences and perceptions of deinfibulation

Generally, the midwives reported positive and easier births after de-infibulation. One of the midwives reported that many midwives at the facility where she works preferred to carry out de-infibulation during intrapartum when the FGM woman is having a contraction rather than

antenatal period due to reluctance to let the FGM woman undergo two invasive procedures. For the FGM women who anticipated the need for an episiotomy, the midwife delayed the de-infibulation procedure until labour to ensure that any surgical procedures were done simultaneously.

> In our ward, there is a rule that deinfibulation is only carried out during a contraction and sometimes given with episiotomy at the same time. Many midwives from our ward usually assess if the woman will need episiotomy, so that the two procedures are carried out at the same time, remember this is a very painful procedure but the good news is that giving birth was easier after deinfibulation. (M5)

> De-infibulation is normally carried out during the birth process, and I remember one time I had to do an episiotomy too so the baby could come out. The delivery of FGM woman is always chaotic, at least from my personal experience, I experienced a high level of pain and fear from the FGM woman, they do show so much pain due to de-infibulation (M6)

> The first challenge is lack of experience to handle an FGM mother.... Midwives need training about FGM in order to handle the case with confidence. (M5)

> I have not had training but has there has not been training. In hospital X there was once an info on FGM but not training at all, I have there for 3,5years. (M4)

6 Discussion

The main aim of this study was to enhance the competencies, knowledge and understanding of the Midwives on how to respond to the needs of women affected by female genital mutilation in labour and delivery. The primary objective of this study was to identify the special labour and delivery related needs of genitally mutilated women. The secondary objective of this study was to develop recommendations for midwives to assist in assessing, planning, and implementing care of genitally mutilated women during labour and delivery process. In addition, the Research questions were what are the needs of genitally mutilated women during labour and delivery? How can genitally mutilated women be managed during labour and delivery? From the results of the study, four major themes emerged as follows: all-inclusive support during labour and delivery for FGM women, culturally sensitive care and challenges in communication, midwives lack of knowledge, experience and feeling unprepared to handle FGM women, management of pain due to de-infibulation. The discussion first starts with the authors own results then seek support from published research.

6.1 All- inclusive supportive care

In this study, the midwives considered themselves as the first healthcare professionals with whom the FGM women have contact and can build a trusting relationship with. They further

stated that throughout labour and the delivery process, they stand by the FGM women talking to them in a friendly manner and not leaving them on their own in the delivery room. One of the midwives mentioned that the FGM women usually appear sad and helpless hence they need emotional support. Several midwives mentioned that they usually sensitize the women by explaining to them the dangers of FGM and advising them that they should not allow for re-infibulation after the delivery process. According to Banks, Meirik, Farley and Akande et al. (2006), midwives can serve as advocates for the abandonment of female genital mutilation by providing information on the devastating consequences of the practice and the benefits of abandoning the practice. In addition, the midwives can help prevent the practice of FGM by sensitizing women on the consequences of female genital mutilation and re-infibulation, including health risks and human rights violations. The authors further state that when a midwife is vocal about her position, she will speak calmy with respect and create a safe environment where the FGM women will feel valued and be able to express themselves.

6.2 Cultural sensitivity care and communication challenges

From this study, the midwives mentioned that FGM women were coming from different cultures across the globe, and they further said that FGM is a cultural practice and midwives in Finland may fail to understand why some cultures are still practicing FGM act. The participants highlighted that the midwives need to take care of FGM women with respect and without biasness. According to Parekh and Trinh (2019, 7), cultural sensitivity care entails a critical shift or paradigm in perspectives employed by healthcare professionals. The authors further elaborate that culturally competent healthcare professionals focus on understanding culture as it refers to their clients and patients. Culturally sensitive healthcare however entails understanding and incorporating the effects of the patient's cultural background of healthcare providers on interaction with, and interpretation of the clients or patients. The results of this qualitative study get support from the results of the previous studies as mentioned above.

Many respondents in this study highlighted that the midwives` taking care of FGM women in labor and delivery unit use appropriate language and phrases, refrain from being judgmental, avoid stereotyping and work to develop rapport with the FGM woman in labor and delivery unit. Dawson, Turkmani, Varol, Nanayakkara, Sullivan and Homer (2015), conducted a study on the experiences and knowledge of reproductive health and contraception for Sudanese and Eritrean mothers and daughters which illustrated poor cultural competency as a major barrier to quality health care, seeking attitudes and the attainment of contraception and sexual and reproductive health knowledge. Culturally safe midwifery practice encompasses awareness of cultural difference and the legitimization of this difference in planning midwifery care, as well as the provision of a space for a woman to express her cultural needs. Dawson et al.

(2015), further state that cultural safety could be improved through in-service training for midwives and the provision of appropriately culturally competent midwives who can take care of FGM women safely in labor and delivery unit. According to Tucker, Marsiske, Rice, Jones and Herman (2011), culturally sensitive health care has been highlighted as care that reflect the ability to be appropriately responsive to the attitude, feelings and distinctive racial, national religious, linguistic and cultural heritage. Tharpe (2006) states that in a culturally sensitive health care, health care providers offer services in a manner that is relevant to patients needs and expectations. Tucker et al. (2011) conducted a research on patient-centered culturally sensitive health care and it was not only visible that cultural sensitivity in healthcare helped patients to perceive positive influences in adherence to treatment and health outcomes but it was also noted that low adherence to recommended treatment behaviors among ethnically and racially diverse patients is to some degree due to limited levels of culture-related knowledge, skills, experience, and awareness demonstrated by their health care providers.

In this study it is visible that the midwives responded that communication between FGM women in labour and midwives from different cultures was difficult as most of the women did not understand the questions hence could not answer back. The respondents also mentioned language barrier problem between the midwives and FGM women in labour and delivery unit as FGM women could not speak neither English nor Finnish. Capell (2007), highlighted that in a country such as Canada whereby immigrants constitute to almost 20 percent of the total population, the ways in which people from different cultures seek and receive information are essential to effective health care. For the information to be successfully transferred to patients, methods or means of providing and receiving information needs to be evaluated.

The issue that the midwives strongly emphasized in this study was that the women`s hospital management team should introduce diversity management trainings to midwives working with FGM women in labor and delivery unit so that they are well equipped with cultural knowledge from different cultures and hence they could understand how to handle people from different cultures and respect culture itself. According to Patrick and Kumar (2012), diversity management is a course intended to create and maintain a positive safe work environment whereby the similarities and differences of an individual is valued so that all can reach their potential goals and maximize their contributions to an organization's strategic objectives and overall big picture.

In this study the midwives revealed that the FGM women usually appear traumatized, scared sad and embarrassed. One of the respondents stated that the midwives need to have good communication skills when taking care of FGM women in labour and delivery unit. The participants further added that effective communication skill is paramount in the provision of culturally competent care of FGM women in labour and delivery unit. According to Alimoradi,

Taghizadeh, Rezaypour and Mehran (2013), communication is a fundamental basis of effective midwifery practice. The quality of communication between the midwife and the FGM women in labour and delivery unit is the key determinant of maternal Satisfaction. The authors further said that communication skills have effect on various aspects like patient satisfaction, interviews, effectiveness of counselling and impact of surgical procedures. Alimoradi et al. (2013) further linked medical errors to communication failure, they conducted research on Evaluation of midwives' communication skills, and the study found out forty-seven-point five percent of the midwives had poor communication skills and only seventeen-point five percent of participants were good communicators.

6.3 Lack of knowledge, experience and feeling unprepared

The participants in this study advocated for a continuous professional education and training for midwives and a working environment supported by updated guidelines on how to take care of FGM women in labour and delivery unit. In this study it is evident that the respondents stated that FGM women in labour needs super skilled midwives who are well equipped with knowledge and can make decisions in case any obstetric complications such as emergency caesarean section and excessive bleeding arises. Bäck, Hildingsson, Sjöqvist and Karlström (2017) carried out research on Developing competence and confidence in midwifery-focus groups with Swedish midwives and they emphasized that the midwifery profession requires knowledge, competence, confidence, and skills. They further highlighted that a competent and a confident midwife can make the difference between life and death. According to Morris (1999), midwives in the United States have very little knowledge base about FGM. Managing FGM complications, cultural attitudes and sensitivities towards this practice should become part of the curricula for students who are specializing in midwifery. Research, seminars and workshops for midwives are essential for addressing how to handle FGM women in labor and delivery room.

In this study nearly all midwives who participated in the study articulated that the junior midwives usually have limited knowledge base on how to take care of FGM women. The participants highlighted the need for supportive supervision and mentoring of inexperienced midwives by senior midwives who had worked with FGM women in labour and delivery unit. Dawson et al. (2015) conducted research on Midwives' experiences of caring for women with female genital mutilation: Insights and ways forward for practice in Australia and they argued that most midwives taking care of FGM women in labour gain knowledge and skills about taking care of FGM women while they are on the job. They further said that gaining experience from senior midwives through mentoring and training is very essential. According to Smith and Stein (2017), midwives need adequate knowledge and skill to provide quality care to FGM women in labour and delivery unit. Equally important is midwives´ capability to handle

discussions and issues about FGM and convey information to women in a special way that is easily understood so that the women can make informed decisions especially on de-infibulation.

The WHO guidelines located one systematic review and one quasi experimental study evaluating the effects of providing information to healthcare providers, but the evidence is of low quality and insufficient to make clear recommendations. However, the guidelines include several best practice statements relating to information interventions, which should encourage countries to continue to invest in pre- and in-service training and capacity strengthening programs as a means of improving the quality of care provided to women and girls living with FGM. (WHO 2020.)

In this study several midwives highlighted that the women`s hospital they are working at do not have official updated guidelines and lack of formal training on how to handle FGM women. Smith and Stein (2017) conducted a study on Health information interventions for Female genital Mutilation and they stated that despite the desire to better relate to women living with FGM, the midwives appear to lack the training and skills to do so. Smith and Stein (2017) further stated in their study that Swedish midwives expressed themselves that there is a gap in their education and since they have such a huge influx on immigration from FGM practicing countries, it's very essential for midwifery to learn about it since the more knowledge and information you possess the better it is both for the midwives and FGM women in labour and delivery unit. In the same study the nurse-midwives in the US, Norway and Sweden all reported never received formal training on management of FGM women in labour but rather learnt from the job from their senior experienced midwives.

6.4 De-infibulation and its pain management

The midwives in this study highlighted that infibulated FGM women presented themselves in the Women's' hospital labour and delivery room with a narrow vaginal opening which makes it hardly possible to perform the vaginal examination in order to assess the progress of labour. The respondents further stated that de-infibulation is usually needed in such situations to facilitate the delivery process. Several midwives in this present study highlighted that the de-infibulation procedure was performed under local an-aesthesia. According to one of the midwives, de-infibulation procedure was recommended during the first stage of labour or during the delivery process. According to Simpson, Robinson, Creighton and Hodes (2012), de-infibulation is a minor surgical procedure to separate the fused labia in infibulated women under local anaesthesia during the first stage of labor. De-infibulation enables the midwife to carry out vaginal examination and it reduces perineal trauma and lacerations during delivery.

According to Dawson et al. (2015), before de-infibulation is carried out, the benefits of the procedure are usually explained to the mother in a very clear and understandable manner. They further mentioned that de-infibulation is preferably performed under local anaesthesia during first stage of labour.

The participants in this study stated that they opted to carry out the de-infibulation procedure in the labor room during contraction and preferably together with episiotomy concurrently to prevent excessive invasive procedures and pain. According to Ball (2013), many midwives prefer to carry out de-infibulation procedure during the first stage of labour to experience only one lot of pain and trauma. The author further stated that local anaesthesia is always offered as pain relief is very essential.

One midwife stated that when the vaginal examination is difficult or painful depending on the type of FGM, the midwife should use one finger to do a vaginal examination. In some cases, other methods such as observation may be used to measure the progress of labour. Lundberg and Gerezgiher (2008) state that the increase to sensitivity to pain in the genitalia was as a result of tight vaginal opening, which makes vaginal examination difficult, hence the midwives are restricted to use only observations and other skills to monitor the progress of labour.

6.5 Ethical considerations

The ethical principles put forth in the WMA Declaration of Helsinki (2018) were followed in the research process of this thesis. Relevant precautions were taken to establish the privacy and anonymity of the informants. According to ARENE (2018), the handling of personal data and data protection requires the researchers to be highly knowledgeable in areas of managing personal information, data collection, recording of interviews, storage of data and destruction of information. The researchers should ensure that the informant being studied has given consent and finally the researchers should be knowledgeable in handling of pseudonymisation and anonymation of materials, research outcomes and publication.

In this study, the ethical principles, and General Data protection regulations (GDPR) were adhered to. The participants were not considered to be a vulnerable population and, therefore, a research permit from an ethical committee was not sought out. (World Medical Association 2018.) Informed consent forms (Appendix 1) and (Appendix 2) were sent via email to the voluntary midwife's participants to be filled prior to the collection of data through phone interview. Data collection was treated with confidentiality. During the data collection process, the authors protected the identity of the participants by using numbers instead of their names throughout the research process to preserve anonymity and safeguard confidentiality. After the publication of the thesis, the hard copies of the data will be destroyed in a confidential shredding machine in Laurea Tikkurila Library in December 2021.

Both authors were devoted to the research community in refereeing, reviewing, and evaluating the data. Keeping track of the resources, paraphrasing, giving the credit to the original authors in an in-text citation and organizing proper reference lists were maintained to avoid plagiarism. (The European Code of Conduct of Research Integrity 2017.)

The authors collected data manually through phone interviews hence, the access to the data were preserved within the reach of two authors and the supervisor of the study only. The data was stored through a secured password protection which could only be accessed by the authors. Separate working copies and backup copies were created in two different computers to avoid the data loss from unfortunate accidents or partial deletions of the file, or the damages caused by viruses. The final study report will be published in the Theseus Open Repository, a platform for thesis and publications of the Universities of Applied Sciences on the internet. Media release will be done as a part of the maturity test. The data will be stored until the final thesis is published and six months after the publication.

6.6 Quality of the study

In qualitative research, the outcome of the study can be evaluated by reliability and validity. According to Bhattacharjee (2012), reliability is also known as consistency whereby research methods have been undertaken and it is dependent on the researcher maintaining logical decision whereas the validity is the trustworthiness of qualitative research. In this study the authors made sure that the participants were clearly explained to the aim of the research study, how data will be collected and what the authors will do with the data.

Reliability and validity are two critical components in the determination of the applicability of research to similar circumstances and diverse population groups. It is associated with the ability of other researchers to come up with similar results using identical research methods and conditions. (Rolfe 2004.) The present study can be said to be reliable based on the adoption of suitable research tools as well as an objective approach to understand the experiences of midwives taking care of FGM women in labour and delivery taking of FGM women in labour and the delivery process.

Throughout this study process, the authors attempted to be as thorough and structured as possible to maintain the trustworthiness of the qualitative research. The procedures for fulfilling the trustworthiness criteria as proposed by Nowell et al. (2017) credibility was addressed by prolonged engagement in the data and persistent observation of the data to find the legitimate experiences from the nurse participants. The "fit" between informant´s opinions and the authors interpretation of the data was referred to as credibility (Nowell et al. 2017). Hence, to demonstrate the trustworthiness of the study's findings, the findings aimed to depict the real lived experiences of the midwives as obtained from the data in a best possible way.

According to Nowell et al. (2017), transferability refers to the generalizability of inquiry. It is a responsibility of a researcher to facilitate the transferability judgement to the potential stakeholders through the thick descriptions of the data. The different phases of thematic analysis first started with familiarization of the data then initial coding. To produce the reliable sub-themes and themes from the coding, a systematic analysis of the data was done. The data were coded inductively as the themes were derived from the data to produce the thick description and interpretations of the data driven themes.

Dependability was aimed to achieve by adopting a rational methodology for analysing the data. The method is traceable, logical, and well- documented. Writer's interpretations and assumptions were drawn from the evidence, and it necessitated the writers demonstrating how conclusions and explanations were reached throughout the entire study to ensure the confirmability. Reflexivity also demonstrated the trustworthiness as it is the practice of critically reflecting on one's own beliefs, interests, and preconceptions, as well as the writer's relationship with the participants and how that relationship influences the participants' responses to the questions.

6.7 Limitations of the study

The limitation in this study depicts to the ability to generalise the findings of the study. In qualitative method, the distillation of the experiences produces a greater understanding and meaning of the phenomenon that is generally measurable and observable. It does not enable or allow direct transference of the details of the study to same situations, as the results are more of researcher dependent as informant dependent. (Tobin & Begley 2004.)

The recruitment of the midwives was a slow process, due to the Covid 19 pandemic. The midwives who were referred to us via snowballing to participate in the study, were initially encouraging and enthusiastic about the research topic, only to decline to take part, citing that the interviews will be time consuming. Ten midwives were initially recruited for the study however three of them declined before the interview process.

7 Recommendations

The present study has constructed recommendation for Finnish women`s hospitals. The purpose of these recommendation is to design a continuous special training and supportive supervision for midwives in Finnish women`s hospitals to improve their expertise, skills and confidence hence providing holistic care in labour and delivery units to women who have undergone FGM.

These recommendations have been developed using standard operating procedures in accordance with the process described in the WHO handbook for guideline development (WHO 2014) and this process involved the identification of critical research questions in this present study which includes, a.) What are the needs of genitally mutilated women during labor and delivery? and b.) How can genitally mutilated women be managed during labour and delivery? In addition, the result of the study in accordance with the World Health Organisation's guidelines and other peer reviewed articles have been used to formulate the list of recommendations as highlighted below:

Management of pain due to de-infibulation: In this study the participants expressed that de-infibulation is recommended for preventing and treating obstetric complications in women living with type three FGM. They further stated that the novice midwives conducting de-infibulation must be adequately trained on how to carry out this surgical procedure. Therefore, WHO (2014) recommends adequate midwives training is a crucial and urgently needed step in the implementation of this recommendation. FGM women undergoing de-infibulation should be offered local anaesthesia to manage the excessive pain. In addition, Moxey and Jones (2016) emphasize that midwives should always provide an informed consent to the FGM women and their spouses explaining to them the information on the de-infibulation procedure.

All-inclusive support during labour and delivery for FGM women: It is evident in this study that FGM women usually appear sad, traumatized and helpless in the labor and delivery unit. Some of the midwives mentioned that they do offer emotional support by talking to them and staying with them throughout the labour process. This present study recommends midwives to provide a possibility of spouses to be present in the delivery rooms when de-infibulation procedure is being carried out during the birthing process. (WHO 2014.) The study also recommends the introduction of a multi-professional approach in the care plan for FGM women. For instance, a psychotherapist can be incorporated in the FGM care team in labour and delivery. The psychotherapist will be offering counseling services in areas of emotional trauma, Post traumatic stress disorder among other psychological support for both the FGM women and their spouses. (Simpson, Robinson, Creighton & Hodes 2012.)

Culturally sensitive care and challenges in communication: The study recommends a development of a language resource including interpreters and resources: e.g., books, videos and pamphlets. Midwives taking care of FGM women need a systematic communication both verbal and written to support the FGM women during labor and the delivery process. (Capell 2007.) The study also recommends diversity management courses for midwives working with FGM women in the labor and delivery units (Patrick & Kumar 2012). Considering that most of the FGM women are of diverse cultural, social, and religious background, it is of grave importance to understand them from their own perspective without bias or

stereotyping (Dawson et al. 2015; Dixon, Agha, Ali et al. 2018). Exposing the midwives to cultural and diversity courses will result in improved culturally competent care for the FGM women.

Midwives' lack of knowledge, experience and feeling unprepared to handle women who have undergone FGM: this study highlighted the knowledge gap with regards to taking care and management of FGM women in labour and delivery unit. A study in Canada revealed that Somali women perceived a lack of knowledge and ability by health care professionals to care appropriately for women with FGM during birth. (Leye, Powell, Nienhuis, Claeys & Temmerman 2006.) These recommendations are formulated for the Finnish midwives to take care of FGM women in labor and delivery unit:

- Development of nationally accessible resource that would facilitate the dissemination of knowledge to midwives taking care of FGM women in labor and delivery unit (Diaz, Steen, Brown, Fleet & Williams 2021).

- Introduction of on-going regular national programs of education specifically for midwives managing FGM women in labour and delivery unit (WHO 2014).

- The use of a designated liaison midwife to coordinate regional programs and to provide professional support and guidance to the midwives taking care of FGM women in labour (WHO 2014).

- The development of a mentorship program for both experienced midwives and the novice midwives who are caring for women with FGM. This mentorship program is aimed for the midwives to educate and support each another through reflection and by working in groups. (WHO 2014.)

Finally, this study highly recommends filling in the knowledge gap that exist among midwives caring for FGM women in labour and delivery units. Smith and Stein (2017) elaborated that in one sense the inadequate knowledge is the heart of the problem and should be a priority in addressing the issues faced by both midwives as well as genitally mutilated women. According to Bäck, Hildingsson, Sjöqvist and Karlström (2017), it is believed that with appropriate knowledge, most of the causative issues would simply not occur, or at the very least, their effect be greatly reduced. Tharpe (2006) states that with relevant knowledge many of the cultural misgivings would not occur, a higher level of understanding would prevail, and expectations would be more clearly understood. According to WHO (2020), with proper knowledge, some of the trauma of de-infibulation would be reduced and an understanding of the physiological benefits of the de-infibulated state would assist with its acceptance by the individual and the culture. With good knowledge base, correct procedures and options would be undertaken that are compliant with the law (WHO 2014).

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Tables

Figures

Appendices

Appendix 1: Participant Consent Form.

Title of the study: Master's Thesis: Female Genital Mutilation: Midwives experience in Finnish Midwives Experience

- Location of the study: Finland.

Researchers: [redacted] and [redacted]

Supervisor: [redacted]

I …… have been invited to participate in the above research study.

The purpose of the research is to improve the knowledge and understanding of the Midwives to respond to the needs of women affected by female genital mutilation. I have read and understood the written participant information sheet. The information sheet has provided me sufficient information about above study, the purpose and execution of the study, about my rights as well as about the benefits and risks involved in it. I have had the opportunity to ask questions about the study and have had these answered satisfactorily.

I have had sufficient information of the collection, processing, and transfer/disclosure of my personal data during the study and the Privacy Notice has been available.

I have not been pressurized or persuaded into participation. I have had enough time to consider my participation in the study.

I understand that my participation is entirely voluntary and that I am free to withdraw my consent at any time, without giving any reason. I am aware that if I withdraw from the study or withdraw my consent, any data collected from me before my withdrawal can be included as part of the research data.

By signing this form, I confirm that I voluntarily consent to participate in this study.

If the legal basis of processing personal data within this study is a consent granted by the data subject, by signing I grant the consent for process my personal data.

I have right to withdraw the consent regarding processing of personal data as described in the Privacy Notice.

Date _____

Signature of Participant The original consent signed by the participant and a copy of the participant information sheet will be kept in the records of the researcher. Participant information sheet, privacy notice and a copy of the signed consent will be given to the participant.

Appendix 2: Osallistujan suostumus lomake

Tutkimuksen Nimi. Master Thesis: Female Genital Mutilation: Finnish Midwives` experience.

Tutkimuksen toteuttaja: [redacted]

Ohjaaja: [redacted]

Minua ..... on pyydetty osallistumaan yllämainittuun tutkimukseen, jonka tarkoituksena on lisätä kätilöiden tietoa ja ymmärrystä silvottujen naisten tarpeista synnytyksessä.

Olen saanut tiedotteen tutkimuksesta ja ymmärtänyt sen. Tiedotteesta olen saanut riittävän selvityksen tutkimuksesta, sen tarkoituksesta ja toteutuksesta, oikeuksistani sekä tutkimuksen mahdollisesti liittyvistä hyödyistä ja riskeistä. Minulla on ollut mahdollisuus esittää kysymyksiä ja olen saanut riittävän vastauksen kaikkiin tutkimusta koskeviin kysymyksiini.

Olen saanut tiedot tutkimukseen mahdollisesti liittyvästä henkilötietojen keräämisestä, käsittelystä ja luovuttamisesta ja minun on ollut mahdollista tutustua tutkimuksen tietosuojaselosteeseen.

Osallistun tutkimukseen vapaaehtoisesti. Minua ei ole painostettu eikä houkuteltu osallistumaan tutkimukseen.

Minulla on ollut riittävästi aikaa harkita osallistumistani tutkimukseen.

Ymmärrän, että osallistumiseni on vapaaehtoista ja että voin peruuttaa tämän suostumukseni koska tahansa syytä ilmoittamatta. Olen tietoinen siitä, että mikäli keskeytän tutkimuksen tai peruutan suostumuksen, minusta keskeyttämiseen ja suostumuksen peruuttamiseen mennessä kerättyjä tietoja ja näytteitä voidaan käyttää osana tutkimusaineistoa.

Allekirjoituksellani vahvistan osallistumiseni tähän tutkimukseen.

Jos tutkimukseen liittyvien henkilötietojen käsittelyperusteena on suostumus, vahvistan allekirjoituksellani suostumukseni myös henkilötietojeni käsittelyyn. Minulla on oikeus peruuttaa suostumukseni tietosuojaselosteessa kuvatulla tavalla.

_____, ____ . ____. _____

Allekirjoitus: _____

Nimenselvennys: _____

Alkuperäinen allekirjoitettu tutkittavan suostumus sekä kopio tutkimustiedotteesta liitteineen jäävät tutkijan arkistoon. Tutkimustiedote liitteineen ja kopio allekirjoitetusta suostumuksesta annetaan tutkittavalle.

Appendix 3: Participant information sheet

This Participant Information Sheet Template includes essential information that you are obliged to provide to research participants. This template is a guide to help researchers design study information sheets. You can alter the text as relevant for your study, but headings should remain (if not mentioned otherwise). ‘

Study title: Female Genital Mutilation: [redacted]

Invitation to participate in a research study

We'd like to invite You to take part in our research study, where we will discuss the how we will explore the experience working in labour ward an delivery unit of midwives who have taken care of genitally mutilated women in labour ward and delivery units. Then co-create recommendations to be used by health care professionals for planning, implementing and assessment during labor and delivery of the genitally mutilated women.

An interview criterion focused on only midwives who have taken of women who undergone female genital mutilation during labor and child delivery. The midwives were enlightened about the topic prior to the interview. 7 midwives are selected size for the study.

This information sheet describes the study and Your role in it. Before you decide, it is important that You understand why the research is being done and what it would involve for You. Please take time to read this information and discuss it with others if You wish. If there is anything that is not clear, or if You would like more information, please ask us. After that we will ask You to sign a consent form to participate in the study.

Voluntary nature of participation

The participation in this study is voluntary. You can withdraw from the study at any time without giving any reason and without there being any negative consequences. If You withdraw from the study or withdraw Your consent, any data collected from You before the withdrawal can be included as part of the research data.

Purpose of the study

The main purpose of the study is to improve the knowledge and understanding of the needs of women affected by female genital mutilation. We will explore the experiences of midwives who have taken care of FGM women in labor and during process. Evidence-based peer reviewed literature will also be incorporated. The results of this study may be used to co-create

recommendations used by midwives in assessing, planning and implementation in the care of genitally mutilated women in labor and delivery unit.

Who is organising and funding the research?

- No funding is needed

What will the participation involve?

10 Midwives from either Lahti? Jorvi delivery unit? Or Kätilölitto. The midwives who have taken care of FGM women in labor ward and delivery unit.

The informants will be involved for 6 months

The study will last for 8 months

The interview will take 30 minutes

The research will be qualitative method

Possible benefits of taking part

Midwives Knowledge improvement

Possible disadvantages and risks of taking part

Not applicable

Financial information

Participants will not be given money for participation

Insurance policies

Not applicable.

Informing about the research results

One copy of the results will be handed to the head nurse.

The informants will not be identified in any form of publication

Termination of the study

Not applicable

Further information

We will ask as need arises

Contact details of the researchers

Researcher / Student

Name: [redacted]

Tel. number: [redacted]

Email: [redacted]

Person in charge of the study / Supervisor

Name: [redacted] Laurea University of Applied Sciences.

Name of the Organization / Faculty Laurea University of Applied Sciences

Tel. number: [redacted]

Email: [redacted]

Appendix to the Participant Information Sheet: A Privacy Notice for Scientific Research

Data controller of the study

In our study personal information collected will be kept safe. We use IDA storage service provided by the ministry of education and culture and Laurea University of Applied Sciences. We will contact ministry of education and culture on how to acquire IDA storage services.

Address: Laurea University of Applied Sciences

Ratatie 22, 01300

Responsibilities of joint controllers

No joint controllers

Contact person for matters related to the processing of personal data

[redacted]

Types of personal data that will be collected

Voice data

Personal data will be collected also from other sources

Not applicable

Personal data protection principles

Participant Information Sheet Describe the information systems, software, applications etc., which are used for collecting and processing personal data.

Describe the how the information systems has been protected. For example:

User ID

Password

User Registration

Access control

For what purpose will personal data be processed?

The purpose of the study is to improve knowledge of midwives in assessing, planning and implementation of care of FGM women in labor and delivery units

Legal basis of processing personal data

The participation in this study is voluntary. You can withdraw from the study at any time without giving any reason and without there being any negative consequences. If You withdraw from the study or withdraw Your consent, any data collected from You before the withdrawal can be included as part of the research data.

Nature and duration of the research (how long will the personal data be processed):

One-time research

Duration of the research: = time frame needed for collecting and analyzing the data and for the publication of the study (plus three years for possible reclamations about the research results and time needed to respond to them).

What happens to the personal data after the research has ended?

Please describe here the measures at the end of the study, will the personal data be destroyed or archived and for how long. For example:

How the personal data will be processed after the research has ended:

Any research materials containing personal data will be destroyed ☐ Any research materials containing personal data will be archived ☐ without identifiers ☐ with identifiers

Where the materials will be archived and for how long:

Data transfer outside of research registry:

Possible transfer of personal data outside the EU or the EEA:

Please describe if data will be transferred to a third country. For example:

Personal data will not be transferred to other parties.

Your data will not be / will be transferred outside of the EU or the EEA.

Your rights as a data subject

Because your personal data will be used in this study, You will be registered to study registry. Your rights as a data subject are the following

You can exercise your rights by contacting the data controller of the study.

If your processing basis is consent granted by the data subject, please list the following rights:

- Right to obtain information on the processing of personal data
- Right of access
- Right to rectification
- Right to erasure (right to be forgotten)
- Right to withdraw the consent regarding processing of personal data
- Right to restriction of processing
- Notification obligation regarding rectification or erasure of personal data or restriction of processing
- Right to data portability

• The data subject can allow automated decision-making (including profiling) with his or her specific consent

• Right to notify the Data Protection Ombudsman if you suspect that an organization or individual is processing personal data in violation of data protection regulations.

If the purposes for which a controller processes personal data do not or do no longer require the identification of a data subject by the controller, the controller shall not be obliged to maintain, acquire or process additional information in order to identify the data subject for the sole purpose of complying with this Regulation. If the controller cannot identify the data subject the rights of access, rectification, erasure, notification obligation and data portability shall not apply except if the data subject provides additional information enabling his or her identification. Participant Information Sheet

You can exercise your rights by contacting the data controller of the study.

Personal data collected in this study will not be used for automated decision-making

Not Applicable

Pseudonymisation and anonymisation

All information collected from you will be handled confidentially and according to the legislation. Individual participants will be given a code, and the data will be stored in a coded form in the research files. Results will be analysed and presented in a coded, aggregate form. Individuals cannot be identified without a code key. A code key, which can be used to identify individual research participants and their responses, will be stored in research data storage service (IDA) and the data will not be given to people outside the research group. The final research results will be reported in aggregate form, and it will be impossible to identify individual participants. Data will be destroyed use of a drive wiping software programme that cannot be recovered. Data is collected for use in Finland, data will not be used internationally.

Appendix 4: Questionnaire (English and Finnish)

Questionnaire to find out the special needs of genitally mutilated women in labour and delivery unit

Theme 1

Midwives' experiences of taking care of FGM women in labor and delivery units.

Kätilöiden kokemuksia silvottujen synnytyksistä.

- How would you describe your encounter with FGM women in labour and delivery unit? Kuinka kuvailisit silvottujen synnyttäjien kohtaamista?_____
_____
_____
_____
_____
_____

- How are you prepared to handle FGM women in labor and delivery? Miten olet valmistautunut hoitamaan silvottujen synnyttäjien synnytyksiä?_____
_____
_____
_____
_____
_____
_

- How would you describe the challenges faced when taking care of FGM women in labor and delivery? Minkälaisia haasteita kohtaat silvottujen synnytyksissä?_____
_____
_____
_____
_____
_____
_____

- What kind of issues did you find to be relevant, when taking care of FGM women in labor and delivery? Mitkä tekijät ovat mielestäsi merkityksellisiä silvottujen synnyttäjien synnytyksissä
_____
_____
_____
_____
_____

_____
_____

- Is there any sexual counselling or sexual therapy available for FGM women? Onko silvotuille synnytyille tarjolla seksuaalineuvontaa tai seksuaaliterapiaa?_____
_____
_____
_____
_____
_____
_____

Theme 2

Special labour and delivery need for FGM women. Erityistarpeet silvottujen synnyttäjien synnytyksissä

- What are the tools or strategies or guidelines to be used when taking care of FGM women in labor and in delivery? If yes, how are they used? Mitä toimintamalleja tai ohjeita on käytössä silvottujen synnyttäjien synnytyksiin? Millaisia ja miten niitä käytetään?_____
_____
_____
_____
_____
_____
- Does FGM mothers undergo support therapy before and after deinfibulation? If yes, how is it carried out in your facility? Saavatko silvotut synnyttäjät tukea ennen ja jälkeen synnytyksen?_____
_____
_____
_____
_____
_____
- What are the competencies (Knowledge, intercultural communication skills, attitudes) do you think is essential for midwives when taking care of FGM women? Millainen kätilön osaaminen (tiedot, taidot, kulttuurien väliset viestintätaidot, asenteet) on tärkeää silvottujen synnyttäjien synnytyksissä?_____
_____
_____
_____
_____
_____

- How and when is deinfibulation carried out in FGM women who are in labor? Miten ja missä synnytyksen vaiheessa suoritetaan deinfubilaatio?_____
  _____
  _____
  _____
  _____
  _____

- Is there any training on the matter of FGM for midwives in labor ward? Onko synnytysosaston kätilöille tarjolle koulutusta silvottujen synnyttäjien synnytyksistä?

  _____
  ___