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Experiences from pregnancy and childbirth related to female genital mutilation among Eritrean immigrant women in Sweden

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Abstract
Objective: to explore Eritrean immigrant women's experiences of female genital mutilation (FGM) during pregnancy, childbirth and the postpartum period.
Design: qualitative study using an ethnographic approach. Data were collected via tape-recorded interviews.
Setting: interviews in the Eritrean women's homes located in and around Uppsala, Sweden.
Participants: 15 voluntary Eritrean immigrant women.
Data collection and analysis: Semi-structured interview and open-ended questions were used. The interviews were tape-recorded, transcribed verbatim and then analysed.
Findings: six themes of experiences of FGM among Eritrean women during pregnancy and childbirth were identified. They are (1) fear and anxiety; (2) extreme pain and long-term complications; (3) health-care professionals' knowledge of circumcision and health-care system; (4) support from family, relatives and friends; (5) de-infibulation; and (6) decision against female circumcision of daughters.
Key conclusion and implications for practice: the Eritrean women had experiences of FGM and had suffered from its complications during pregnancy, childbirth and the postpartum period. Midwives and obstetricians should have competence in managing women with FGM, and they need increased understanding of cultural epistemology in order to be able to provide quality care to these women. At antenatal centres, circumcised women should be advised to de-infibulate before pregnancy. Special courses about anatomical differences should be offered to these women and their husbands. It is also important to inform them about Swedish law, which prohibits all forms of FGM.

Keywords Female genital mutilation; Eritrean immigrant women; Experiences; Pregnancy; Childbirth; Postpartum period; Sweden

Introduction

Female genital mutilation (FGM) and female circumcision are two terms that refer to the practice of removing parts of the woman's genitalia (Toubia, 1995). The former term is used by the World Health Organization (WHO), whereas the latter is commonly used by the population where this custom is practised (Cook et al., 2002). FGM exists primarily in Africa and in certain communities in the Middle East and Asia. It is practised in 28 countries in Africa and at a rate of at least 50% in more than 60% of these countries.

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The highest incidence of FGM has been reported in Somalia (98%), Djibouti (98%), Eritrea (90%), Sierra Leone (90%), Sudan (85%), Egypt (80%) and Gambia (80%) (Hosken, 1993; Toubia, 1995). It is estimated that between 100 and 400 million girls and women have experienced FGM, and that at least 2 million girls undergo some form of such mutilation every year (WHO, 1997, 1998). Roughly 100,000 immigrants in the Nordic countries originate from countries in Africa where FGM is still practised (Essén and Wilken-Jensen, 2003), and approximately 27,000 women from such countries presently live in Sweden (Andersson, 2001; Johnsdotter and Essén, 2005). As a consequence, FGM is a phenomenon that directly affects the Swedish health-care system.

Types of Female genital mutilation

Partial or total removal of the clitoris along with the clitoral prepuce is referred to as clitoridectomy, and the WHO classifies this as Type 1 circumcision (WHO, 1997, 1998). Excision, or Type 2 circumcision, includes partial or total removal of the clitoris and part or all of the labia minora. Infibulation, or Type 3 circumcision, means total removal of the clitoris and labia minora, partial or total removal of the labia majora, and stitching of the cut edges to cover the urethra and vaginal opening, leaving only a small opening for the passage of urine and menstrual blood. Type 4 circumcision includes other forms of genital cutting, such as pricking or piercing of the clitoris, labia, or both, and cutting of the vaginal wall or cervix. The unaltered female genitalia, as well as female genitalia subjected to Types 1, 2 and 3 circumcisions, are shown in Fig. 1.

The practice of FGM and the type of operation are often specific to particular ethnic groups, and thus the prevalence varies widely within and between countries. For example, Type 3 FGM is found mainly in Somalia (and in Somali groups in surrounding countries), Djibouti, Eritrea, Sudan

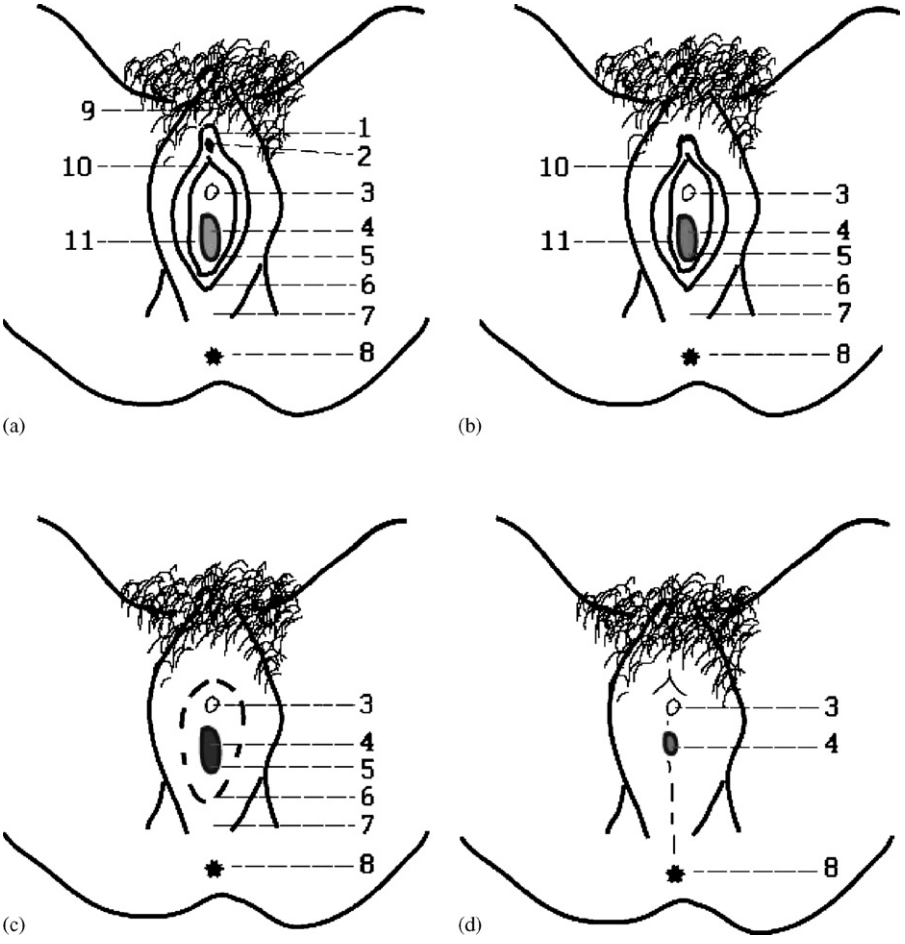

Fig. 1 (a) Unaltered female genitalia: (1) clitoral hood (foreskin); (2) clitoris; (3) urethra; (4) vaginal opening; (5) hymen; (6) Bartholin's glands; (7) perineum; (8) anus; (9) Mons veneris; (10) labia majora; (11) labia minora; (b) Type 1 circumcision; (c) Type 2 circumcision; (d) Type 3 circumcision. (Illustrations reproduced from http://www.nocirc.org with permission from NOCIRC).

(excluding southern Sudan) and in Boran ethnic groups in Ethiopia. It has also been reported in Mali and northern Nigeria (Toubia, 1999). The age at which FGM is performed varies from society to society depending on ethnic group and geographic location (Rahman and Toubia, 2000). FGM is most often carried out between the ages of 4 and 10 years, although in some communities it may be carried out in babies and it may also be carried out in adolescence or even at the time of marriage (Toubia, 1999; WHO, 1997, 1998; Nour, 2004; Holmgren et al., 2005).

Cultural issues

FGM has been documented in individuals from many religions, including Christianity, Islam and Judaism (Lane and Rubinstein, 1996; Leonard, 2000; Nour, 2004; Momoh, 2004; Walker and Parmar, 1993). Kopelman (1994) has summarised four reasons proposed to explain the custom of FGM: (1) to preserve group identity; (2) to help maintain cleanliness and health; (3) to preserve virginity and family honour and to prevent immorality; and (4) to further marriage goals, including enhancement of sexual pleasure for men. A woman who protects her virginity becomes highly admired (Toubia, 1999; Abusharaf, 2001; Toubia and Sharief, 2003). Women who advocate circumcision for their daughters feel that they are protecting their own as well as their daughters' virginity, and their family's reputation. Women who perform circumcision or FGM also gain respect and reverence in their community (Shweder, 2000). A woman is perceived to be strong, powerful and highly respected by her husband if she can resist her husband's sexual advances (Abusharaf, 2001). This ability is believed to increase a woman's fertility and the sexual pleasure of her husband (WHO, 1997, 1998).

Immigration and Eritrean women in Sweden

As a result of migration from Africa, the practice of FGM is seen also in Europe, North America and Australia. Eritrean citizens have emmigrated to Sweden because of war (Svanberg and Runblom, 1989). By the end of 2004, almost 8000 people of Eritean origin were living in Sweden (Statistical Central Bureau (SCB), 2006). Almost 5000 had emigrated, whereas slightly more than 3000 were born in Sweden. As many immigrants from Eritrea were registered as Ethiopians, the real figures are higher but difficult to estimate. The Association of Eritreans in Sweden estimated the total number in 2001 to be around 10,000, which at that time made Sweden the second largest home for Eritreans after Italy (Hamde, 2004).

As children, Eritrean girls normally have undergone FGM of Types 1, 2 or 3. Later in their lives, many of them develop medical problems, which occur especially during pregnancy and delivery (Odede and Asghedom, 2001). Haemorrhage and infections are complications that may occur immediately, whereas long-term complications include recurrent urinary tract infections and problems with menstruation, sexual intercourse, pregnancy and childbirth (Toubia, 1995; Toubia and Sharief, 2003; Momoh, 2004). Pregnancy, childbirth and the postpartum period are particularly important because of the increased risk of mortality and morbidity owing to FGM complications (Rushwan, 2000).

Sweden, like other Western countries, has to deal with FGM within its borders. Eritrean women come in contact with the Swedish health-care system for reasons such as pregnancy and childbirth, which can create dilemmas for health-care providers. Care of these women can be complex in many ways, and obstetric and gynaecological care in particular can put special demands on midwives and others.

It is highly useful for midwives and other health-care providers who come in contact with women with FGM to increase their knowledge and understanding of these women and their problems during pregnancy and childbirth. In this way, they increase their ability to provide holistic care and support to these women. Little is known about practices and problems related to pregnancy and childbirth among Eritrean immigrant women with FGM in Sweden. Therefore, this study was undertaken with the purpose of exploring the experiences from pregnancy and childbirth related to FGM among these women.

Method

Study design

For this study, the ethnographic method was chosen because of its ability to generate knowledge about phenomena that are highly embedded within the cultural context (Spradley, 1979; Hammersley and Atkinson, 1995; Patton, 2002). As FGM is a culturally embedded phenomenon, holistic understanding of its effects on Eritrean women's lives during pregnancy and childbirth requires studies in its naturalistic context. Ethnographic interviews permit informants to speak from their own point of

view and in their own language on their own perceptions and experiences (Spradley, 1979; Hammersley and Atkinson, 1995).

Participants

Eritrean women were selected by use of purposive sampling with the snowball technique. Thus, the selection was done with the aid of referrals from earlier participants (Patton, 2002). The women all lived in and around Uppsala, a university town with about 180,000 inhabitants, and they formed a group of 15 informants. The criteria for selection of the Eritrean women were as follows: (1) they had grown up in Eritrea and experienced FGM; (2) they had emigrated from Eritrea and lived in Sweden for more than 2 years; (3) their ages ranged from 30 to 50 years; (4) they had delivered at least one child; and (5) they were willing to participate in the study.

Interview

Background information, such as age, education, occupation, type of circumcision, number of children and number of years in Sweden, was gathered before the interview questions were asked. Five semi-structured and open-ended interview questions were developed for this study. They were used in order to allow the informants to describe and explain (Box 1). A pilot study with three Eritrean women was carried out in order to assess whether the informants would understand the interview questions the same way, whether they would understand the instructions, whether the format of the questions was suitable, and whether the questions were relevant. The investigators also made a test analysis of the transcriptions of the interviews.

Procedure

All informants were contacted by telephone and asked if they were willing to participate. They were given written and oral presentations of the study, its aim and ethical considerations, and they were assured of anonymity and confidentiality. They were told that each informant would be coded, that the code numbers would be used as identification in the analysis, and that the tape recordings would be destroyed at the end of the project. Written consent was obtained from those who agreed to participate in the study.

The informants were interviewed in-depth twice, and the length of the interviews varied depending on the informants' responses. The investigators, who were immigrants themselves, used methods of prolonged engagement with the informants during the interviews to increase trust relationship. Each interview lasted between 2 and 3 hours. The interviews took place in the informants' homes or in a separate room. In order to ensure consistency of the interview techniques and skills, the second investigator was informed and trained by the first investigator. Seven of the informants were interviewed in English by the first investigator. Eight of them preferred to be interviewed in their native language. Therefore, they were interviewed by the second investigator who was able to speak their language. The second investigator also translated the interviews into English. There was no problem with the communication between the investigators and the informants. During each interview, the informant was regularly checked for her answers in order to strengthen the credibility of the findings. The interviews continued until the information obtained became redundant. At the end of the interviews, the investigators felt that they had spent sufficient time to learn about the informants' experiences in depth. The interviews were tape-recorded, transcribed verbatim and coded to

Box 1 Principle interview questions.

Number	Question
1	What did you experience after marriage being a circumcised woman?
2	What did you experience during pregnancy, childbirth and postpartum period being a circumcised woman? The first time and later times?
3	How did you manage your life during pregnancy, childbirth and postpartum period?
4	Have you been re-sutured after childbirth? Why?
5	How is your quality of life being a circumcised woman?

ensure confidentiality. After the 15th interview, no new information emerged, and it was felt that data saturation was achieved. In the second round of interviews, each informant was given a copy of the transcription from her first interview and was asked about additions, which could clarify issues and deepen the discussion, and deletions. The reactions of the informants were also observed during the interviews to reaffirm what the investigators had heard, seen or experienced.

Data analysis

The interview data were analysed for recurrent patterns from which themes were drawn (Spradley, 1979; Hammersley and Atkinson, 1995). The data analysis began by reading the transcripts in their entirety over and over again to attain a general understanding of the content, to provide a sense of the whole and to gain ideas for further analyses. Similarities and differences between and within groups were also noted and interpreted. The investigators carried out thematic analysis first separately and then together in order to enhance the validity and reliability of the findings. This analysis process enhanced the trustworthiness of the data, as the investigators analysed the results independently and concurrently (Guba and Lincoln, 1989). At the end of the analysis, six themes of the findings were reviewed and validated by an experienced and independent researcher. The transcripts from the interviews were then read again to find out if the themes fitted the material.

Findings

The 15 women in the study were born in Eritrea and their ages ranged between 31 and 45 years. Their education varied from elementary school to university, but most of them had finished high school. Five of them worked as assistant nurses, three as care-givers, six as cleaners and one as a statistics data analyser. All women had Type 3 FGM. Twelve of them had arranged marriages, whereas three did not. They had three to five children. Twelve had experience of childbirth in Eritrea or Sudan and also in Sweden, whereas three had such experience only in Sweden. Thirteen women were Muslims and two were Christians. They had lived in Sweden between 10 and 22 years.

Six themes of experiences of pregnancy and childbirth related to FGM emerged, namely: (1) fear and anxiety; (2) extreme pain and long-term complications; (3) health-care professionals' knowledge of circumcision and health-care system; (4) support from family, relatives and friends; (5) de-infibulation and (6) decision against female circumcision for daughters.

Fear and anxiety

All the women in this study felt fear and anxiety during pregnancy and childbirth. They had heard people talk about women who died together with their babies when giving birth because of bleeding and infection. They had not been informed by their parents as to what would happen to them during delivery. Nobody had explained to them what they should do or how they should prepare themselves during pregnancy and childbirth. Therefore, they were worried and anxious about their delivery. Some mentioned that they were afraid of a caesarean section and therefore they tried not to eat too much. They were anxious about what might occur to them and their babies during delivery because of circumcision. For example, they were afraid of severe tearing of the vagina during childbirth and incontinence of urine and faeces that could make their husbands and communities reject them.

> When I was pregnant the first time I had no idea about the problems during childbirth. In my country, women do not speak about delivery and its hardships. I faced the complication. In my second pregnancy I started to think about my delivery…Would it become difficult or not? … What would happen to me if the baby came out too quickly? That's why I felt fear. (Woman 5)

> My first child was not delivered in Sweden. I told the midwife that I was circumcised and sutured. The midwife had to cut and open the stitches during my delivery. I was worried and feared how she was going to manage it. (Woman 9)

Extreme pain and long-term complications

Most of the women described that they faced extreme pain and suffering from complications due to circumcision. Some women described that it was very painful when they had sexual intercourse the first time. Most of the women described that during pregnancy they suffered from the pelvic examinations made when they visited the clinic once a month in Eritrea or in Sudan. Nobody could talk openly about her pain because it would be shameful to do so. They explained that they faced extreme pain due to the tightness of the small vaginal opening when the pelvic examinations were carried

out. They also felt extreme pain during and after delivery. Furthermore, some women mentioned that they were more sensitive and felt more pain when a male doctor made the pelvic examination.

> It was very difficult for my husband to penetrate. It took many days before he could do it. Before my marriage, I had no idea that it would be hard and painful. After the first contact with my husband I knew that I was sutured and that it had to be opened. (Woman 3)

> A bad thing during the antenatal care each month is when the doctor or midwife inserts his or her hand for (pelvic) examination. It is as painful as the first intercourse because of the tightness. You suffer and you can't say anything because no one talks openly about pain related to sex. Shortly, it is shameful. (Woman 10)

Most of the women had bad experiences with the postpartum period in their home country. They had complications, such as infected wounds, bleeding and urinary incontinence after the stitches had been cut during delivery. They mentioned that they felt excessive pain that was caused by the inelastic scar tissue from the original stitches. The healing of the wound took a long time. Some of them also described that they developed a postpartum infection because of incorrect cutting and the resulting wound infection. They indicated that they had to return to the hospital for medical treatment because of the infected wound. Two of them experienced severe tears, which caused haemorrhaging. In addition, one woman who had postpartum complications from incorrect cutting had to undergo plastic surgery.

> The delivery of my second child was too quick and the child was pushed very hard. It was opened too wide, so I got a big wound that caused bleeding. As a result of the wide opening, I suffered a lot until the wound healed and left a scar after it. (Woman 5)

> To let the child come out, the midwife cut off the stitches to open because I was circumcised. It was wrongly cut, and later on the wound became infected. I had high fever, so I had to return to the hospital and lie there for 1 week while they treated me with antibiotics. (Woman 8)

Health-care professionals' knowledge of circumcision and health-care system

All the women in this study had both positive and negative experiences of the health-care system and the health-care professionals' knowledge of circumcision. The positive experiences were related to the midwives or doctors they met who had good knowledge of circumcision and circumcised women. Meeting midwives or doctors with knowledge made them feel confident. They were delighted and felt happy to meet such health-care professionals who were able to inform and help them in their critical situation. For example, some met a midwife who was acquainted with problems facing circumcised women as she had worked in Africa. As for negative experiences, some of the women mentioned that they had felt uncertain when they had met midwives or doctors without knowledge of female circumcision. They stated that they had felt worry, fear and anxiety because of the lack of ability of such midwives or doctors to deal with circumcised women:

> My first meeting with a midwife was very good because I was lucky to meet a midwife who knew about circumcision from her previous work in Africa. Thanks to God, she had experience so it went well. (Woman 1)

> I was lucky when I met a midwife in Sweden who knew about circumcised women. This was a great help to make me feel secure because it was my first time to be pregnant and to live far from my parents and family. (Woman 6)

> The first midwife I met in Sudan had no knowledge of circumcised women. She was astonished and asked me a lot of questions about circumcision. This made me fear and feel uncertain. However, she wrote in the journal that I was circumcised and would contact a doctor who knew about circumcision. (Woman 8)

All women had good impressions of the health-care system in Sweden from receiving care during pregnancy, childbirth and the postpartum period. They mentioned that Sweden is now multicultural and houses a large number of people from countries where circumcision is practised. They had bad experiences with pregnancy and childbirth from their own country. The pregnancy care in Sudan was quite different from that in Sweden. In Sweden, welcoming reception and careful examination by midwives made them feel secure even though they lived far away from their families. They expressed that their meetings in hospitals and maternal wards in Sweden had made them feel safe and happy. They thought that the preparation for care of circumcised women was good in Sweden. However, some of them said they hoped that, in the future, midwives in Sweden should be taught more about circumcision and support for circumcised women:

> When I compared with my past experience I found that here in Sweden the care is more developed, and the midwives inform you about how to take care of yourself during delivery. (Woman 3)
>
> Here in Sweden it was quite different from Sudan. When I went for antenatal care I met a midwife who asked me if I was circumcised. She had good knowledge because she had taken care of many Somali women. She told me that she would send my journal to the hospital, and she advised me to attend the lessons for pregnant women at the centre… Also she told me to come back for an ultrasound test during the 18th week in order to check the fetus. (Woman 12)

Support from family, relatives and friends

All the women in this study mentioned the support they had received during childbirth and the postpartum period in Eritrea, Sudan or Sweden. In their own country, they were surrounded by family, mother, relatives and friends who gave support that would reduce their fear and pain. They received such help both in the hospital and at home. Family members or friends took responsibility for the care of the mother and her baby for 40 days. Also, old women played an important role by giving advice to the young mothers and sharing their experiences with them. They stated that, in Sweden, they felt loneliness as they lived far away from their relatives. They did not get the kind of support they had received in Eritrea. The absence of support from family and relatives was distressful to them. However, some mentioned that their husband and friends gave support to them during delivery and the postpartum period also in Sweden. In addition, they received help and support from midwives:

> In my country, women lie on the bed for 40 days and their movements are limited. They get full support from all members of their families, relatives and even neighbours. One can say that this is the only time they get full rest and good food. (Women 7)
>
> During two childbirths, I had my family, my mother and all relatives around me. This was a great support for me and minimised my fear and pain. I also felt secure. In my country you get all support and help from family members and even from neighbours. During my third pregnancy in Sweden I was thinking too much about childbirth because I was far from my family. (Woman 10)

De-infibulation and re-infibulation

Most of the women in this study had gone through re-infibulation after childbirth once or twice in their home country or in Sudan. They described that, in their own country, they were sutured after delivery. According to their tradition and culture, no one neglected to have this done. They did not want to be different from other women in their surrounding. When they were to give birth in Sweden, they were informed by midwives about the Swedish law, which prohibits re-infibulation. This gave them the chance to de-infibulate and leave the area open after cutting the stitches for delivery. They expressed that it was meaningless to face the pain and suffering again. After de-infibulation, they found that delivery became easier and gave rise to fewer complications. However, one woman explained that she was not satisfied because she could not have the stitches removed when she was 7 months pregnant. The doctor had told her that that there was risk for infection and therefore it was better to wait until delivery:

> I was re-sutured twice. The second time was in Sweden. The midwife sewed without asking if I wanted or not. I was surprised, because I knew that it was illegal. After my third delivery, the midwife told me that the law prohibits re-infibulation, but the midwife stitched a little from each side as the opening was too wide. (Woman 1)
>
> I was re-sewed after my first and second childbirth as no one left open and this was normal. But after my third childbirth in Sweden I decided to leave open because I knew that I had the right to do that. In my country all women are circumcised. Therefore, no one feels different and they never think about what would happen. (Woman 7)
>
> I and my husband asked the midwife to open the stitches for me because we found them meaningless and harmful. After opening, my three deliveries became easier and less painful, and there were no complications. (Woman 12)

Decision against female genital mutilation for daughters

All women described that they had been circumcised as children, and therefore they did not know the difference between being circumcised or not. In their society it was taboo to talk about sex. Some of them stated that women are victims of old

customs and traditions. Circumcision was devised by the society for control of female sexual desire and response. The society sees a woman as a machine for reproduction. Three of the women said that love, understanding and harmony made them enjoy sexual intercourse. They also described that they discussed sex openly with their husbands. Some said that consciousness, knowledge and solidarity of all mothers are needed in order to stop the abusive and inhuman tradition of circumcision. They were against the practice of female circumcision, because they had learnt from their own pain and suffering. Those who had daughters mentioned that they wanted to liberate their daughters from the experiences they had had. They did not want their daughters to be circumcised and they did not want the same things to happen to their daughters as had happened to themselves:

> I did not circumcise my daughter. I think circumcision is for happiness of men but for control and suppression of women. It is a reactionary tradition and culture we have got from our forefathers. When I visited my country, my family asked me if I wanted to circumcise my daughter. When I said no, they told me that she will run after boys according to their belief. I did my best to explain to them … Their belief is wrong. (Woman 3)

> We are a result of tradition. I had my first sexual intercourse after my marriage, and by that time I was 27 years old. For us, old tradition and culture, and suppression by the society, are behind our dead feelings. I don't want my daughter to pass through all the pain and suffering that I had. I have no right to cut any part from her body. I was against circumcision of my daughter. (Woman 5)

> When I went to the parent and child centre (antenatal care centre), I discovered that I was different from Swedish women because of my circumcision, which had made a lot of changes in my genital area. I also knew that circumcision was harmful and had bad consequences for childbirth. I discussed with my husband, and then we decided not to circumcise our daughters. (Woman 10)

Discussion

The aim of this study was to explore the experiences from pregnancy and childbirth related to FGM among Eritrean immigrant women. The findings show that they had different experiences. The fear and anxiety felt by the Eritrean women in this study was mainly related to the risk of dying during or after delivery because of bleeding or infections. Some were also afraid of a caesarean section. This result is in accord with several studies of Somalian women. Essén et al. (2000) reported that Somalian women felt fear and decreased their intake of food in order to limit the size of the fetus and avoid a caesarean section. Also, Vangen et al. (2004) found that Somalian women feared lack of experience and suboptimal treatment at delivery, and they expressed a strong fear of caesarean section. The Eritrean women of this study also felt fear if they met a midwife or a doctor who did not have enough knowledge of how to manage circumcised women during delivery. For many women, circumcised or not, labour can be a time of fear and anxiety, and the fear can be worse when they feel uncertain about the competence of the staff caring for them (Widmark et al., 2002). Several studies confirm the lack of practical knowledge, as perceived by the immigrant women, about FGM among Swedish midwives (Ahlberg et al., 2004; Holmgren et al., 2005; Berggren et al., 2006).

The Eritrean women in this study experienced extreme pain when they had their first sexual intercourse and during pelvic examination for pregnancy control. This was because of the tightness caused by Type 3 FGM. Rushwan (2000) described that sexual intercourse may not be easy for women with such FGM. Intercourse could be hindered by the tight fibrotic skin closing the vaginal introitus or by stenosis as a result of scarring. For those who had delivered in Eritrea or Sudan, the monthly pelvic examination 'by inserting hands' had been a source of frustration and pain. They could not talk about the pain related to sex or pelvic examination due to their customs and traditions. It was considered shameful. In general, it is taboo to talk about sex, especially for women. Lightfoot-Klein and Shaw (1991) found that women felt a great deal of pain during pelvic examination because Type 3 FGM normally results in a tight introitus, and therefore may increase the sensitivity to pain in the genital area. Such FGM makes vaginal examination in labour very difficult and painful, which results in inability to effectively monitor the progress of labour (Toubia, 1995; Thierfelder et al., 2005). Some women in this study mentioned that, if the doctor is a man, the problem becomes worse. This is explained by their cultural background, which does not accept the examination of a woman by a man. The result is supported

by Lightfoot-Klein and Shaw (1991), who pointed out that genital examination by male doctors or exposure of the patient in the presence of male practitioners may be considered sexual abuse by persons from some cultures with traditional views on female health care.

Most of the Eritrean women in this study had suffered from postpartum complications. The degree of complication differed from one to another. Some of them had had to stay in hospital because of infected wounds resulting from incorrect cuts or unclean instruments and environment. This is in accord with Anuforo et al. (2004), who also reported other complications, such as third-degree tears, incontinence of urine and stool, haemorrhaging, vaginal atresia and maternal or fetal death. Rushwan (2000) and Momoh (2004) described that infibulated women cannot give birth unassisted. The scar tissue covering the vaginal introitus does not allow the passage of the baby without de-fibulation. Invariably, such births are followed by vaginal tears involving the anal canal.

Several of the Eritrean women in this study had positive experiences from meeting midwives and doctors with knowledge about circumcision and circumcised women. They felt sure that they were not going to face problems during childbirth and postpartum. Those who had met midwives or doctors without knowledge about circumcision had felt worried about what would happen to them. They were mainly afraid of incorrect cutting that could cause damage to them or to their child. A Somali woman in the study of Widmark et al. (2002) commented:

> During delivery we have to ask the midwives to cut, sometimes the midwife calls a doctor to find out whether she should cut or not. During this argument the baby pops out causing too much tearing and bleeding. It is very frustrating to be confronted with a situation where the professionals appear as though they do not have control and are unsure of what is to be done. (Widmark et al., 2002)

According to the results of this study, it is important for midwives and health-care providers to have appropriate training for handling FGM in Swedish maternity care.

All the women in the current study expressed the difference between motherhood in Eritrea and in Sweden. In Eritrea, the family network is the main source of support and help for the women during pregnancy, childbirth and the postpartum period. In Sweden, they were far from their families and depended on their husbands and friends for support. Some mentioned that they were supported by midwives during childbirth and the postpartum period. Calder et al. (1993) pointed out that the preferred sources of help for circumcised women like friends, mother or grandmother might not be present in the new country. Other culturally defined networks for support of the women might also be absent. Therefore, the support of circumcised women during pregnancy, childbirth and the postpartum period by midwives with good knowledge has great importance.

Twelve of the 15 Eritrean women in this study, who had given birth in Eritrea or Sudan, had been re-infibulated once or twice in their lives. Although they did not want this, they had not been able to resist the social demands. Culture and traditions, as well as husbands, did not allow them to refuse re-infibulation. Such re-infibulation after childbirth is a common procedure where infibulation is widely practised (Rushwan, 2000). After childbirth in Sweden, all Eritrean women of this study had had a de-infibulation followed by a suture of the vulva aimed at restoring it so that it would not be left too widely open.

In this study, some mentioned that they had had a chance to leave the area open after childbirth in Sweden. Swedish law (SFS, 1982: 316; Jalamo, 2000) prohibits all forms of FGM, even if the woman herself would agree. Pospartum re-infibulation is seen as infibulation and is therefore illegal. Yet, some women were re-infibulated, even without their consent. This might occur if a midwife does not know the laws about circumcision. In Swedish media, there have been discussions about re-infibulation and, as a result, some written information has been circulated in obstetric departments. Unfortunately, the information was focused on what was not permitted rather than on how to take care of circumcised women (Widmark et al., 2002). Vangen et al. (2004), who studied Somali women in Norway, found that midwives generally did not know that re-infibulation was illegal, and one stated that re-infibulation was needed in order to avoid excessive bleeding. This resembles the situation of some Eritrean women in this study. One woman asked to be de-infibulated after 7 months of pregnancy because of her bad experience during her first childbirth and postpartum, but the doctor refused. Toubia (1999) reported that infibulated women should be advised to have a de-infibulation long before delivery in order to avoid obstructed labour and the added risk and discomfort of a perineal cut during labour.

According to the findings of this study, it is important that the education of Swedish health-care

professionals provides understanding of FGM and knowledge of Swedish law. In Swedish midwifery education, FGM is taught in courses related to cultural and global aspects of health and ill-health related to women's life, and to reproductive and perinatal care. In the study by Widmark et al. (2002), midwives with more recent education mentioned that they had received some education about FGM but still lacked knowledge upon which to firmly base their practice. Also, as the number of immigrant women subjected to FGM increases in Sweden, more emphasis should be given to FGM in basic midwifery education. Several researchers (Holmgren et al., 2005; Berggren et al., 2006) also described a need to handle female genital circumcision appropriately in Swedish maternity care by addressing it in the curriculum of midwifery and medical schools.

Thirteen (86.7%) of the 15 Eritrean women in this study mentioned that they were against FGM and that they did not want their daughters to have the experience of pain and suffering from FGM as they had faced themselves. They felt that they had no right to cut and remove parts of the bodies of their daughters. Chalmers et al. (2000) found that about one-third (34%) of 432 Somali women agreed with Canadian law, which prohibits the practice of FGM. Momoh et al. (2001) reported that less than 10% of African women in the UK refused to continue the tradition of FGM. This tradition has been characterised as a practice that violates the right of babies and children to good health and well-being, a part of universal basic human rights (James, 1994).

The findings of this study indicate a major change in the traditional views of the practice of circumcision of girls. Several factors may explain why such a relatively high percentage of the women in this study were against the tradition of FGM and did not want their daughters to undergo FGM. First, from reading or information provided by midwives, they knew about the differences between the genital areas of circumcised and uncircumcised women. Second, they had experienced harmful consequences of FGM related to sexual life and childbirth. Third, they knew that all forms of FGM are illegal in Sweden.

Women should be strongly supported in having non-traditional views of FGM, and they should be encouraged in their endeavours to move away from this harmful and life-threatening traditional practice. Counselling against re-infibulation and against the circumcision of daughters could take place within obstetric and gynaecological services.

The data of this study were obtained by means of purposive sampling with snowball technique of 15 voluntary Eritrean women interested in participating. Data were collected through ethnographic interviews. There is a risk of bias as the available participants might not be representative of the whole population. However, the snowball technique was found to be the most feasible way to recruit participants willing to talk about this sensitive matter. Therefore, the findings of this study reflect the participants' experiences of the informants of the current study and cannot be extrapolated to Eritrean women in general. The informants had the option to be interviewed in their own languages, which gave them the opportunity to express themselves naturally and easily. They could also choose to be interviewed in their homes. This made them feel secure, and they were happy with not losing time. Data gathering through direct contact between the investigators and the Eritrean women was a great aid in allowing them to talk freely about a highly sensitive subject that is considered taboo because of customs and traditions. Further studies will focus on the experiences of different health professionals of circumcised women during pregnancy, childbirth and the postpartum period. The views of these health professionals of FGM in curricula will also be studied. The studies will be carried out by use of qualitative method.

Conclusion

The findings of this study showed that the Eritrean women had experiences of FGM, and that they had suffered from its complications during pregnancy, childbirth and the postpartum period during which special care had to be considered in order to reduce the mortality and morbidity from FGM complications. Midwives and obstetricians should be competent in the management of women with FGM, and they need increased understanding of cultural epistemology in order to be able to provide quality care to these women. The topic of FGM should be integrated into the curricula for different health professionals in order to give them a better understanding of the problems of circumcised women and how to support them. In this context, the topic of FGM should include counselling and health promotion. At antenatal centres, circumcised women should be advised to de-infibulate before or during pregnancy to avoid obstructed delivery and perineal tears. These women and their husbands should be offered special courses at the antenatal wards about the

anatomical difference between the circumcised and non-circumcised women. It is also important to inform these women and their husbands, as well as parents of girls, about Swedish law that prohibits all forms of FGM.

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