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Article

In Their Own Words: The Health and Sexuality of Immigrant Women with Infibulation Living in Switzerland

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Abstract: Female genital mutilation (FGM) is a significant public health problem. It is estimated that around 14,700 women affected by FGM live in Switzerland, primarily among women with a history of migration. Our qualitative research investigated the sexual health of immigrant women living with FGM in Switzerland, describing their own perception of health, reproductive life and sexuality. We conducted semi-structured, in-depth interviews with a group of eight immigrant women of sub-Saharan origin living in Switzerland with Type III FGM (infibulation). Seven of the women were from Somalia and one was from the Ivory Coast. All of the Somali women were mothers and married (two separated), and the Ivorian woman was a single mother. The women in our study reported a low level of sexual satisfaction and reproductive health. They affirmed their desire to improve, or at least change, their condition. Although they rarely talk with their husbands about sexual subject matter, they would like to include them more and improve dialogue. Specific socio-sexual management is recommended when caring for immigrant women living with FGM in order to respond to their specific health care needs. Multidisciplinary approaches may be able to offer more comprehensive health care, including facilitated communication to improve dialogue between women and health care professionals, and eventually between women and their husbands in discussing sexual subject matter.

Keywords: migration; female genital mutilation; sexual health; reproductive health; communication

1. Introduction

Female genital mutilation (FGM) is a global public health concern and perceived as a form of violence against women and girls. The World Health Organization (WHO) defined FGM as procedures that "intentionally alter or cause injury to the female genital organs for non-medical reasons" [1]. FGM can involve cutting of the clitoris, labia minora and majora, and infibulation (narrowing of the vaginal orifice). Researchers have identified several short, middle and long-term health consequences of FGM for women and girls, such as pelvic infection, excessive bleeding, difficulty urinating, pain [2,3]. Female genital mutilation is a traditional practice embedded in the education of the child [4] and in the intergenerational transmission of a gender model [5], which is based on a strict separation between sexes' roles in the society [4]. Furthermore, FGM is also considered as an ethnic marker aim at preserving the ethnic identity of the group [6].

It is estimated that up to 125 million women and girls worldwide have undergone some type of FGM [7]. According to UNICEF, the countries in which the prevalence of FGMs among women and girls exceeds 80% are Somalia, Guinea, Djibouti, Egypt, Eritrea, Mali, Sierra Leone and Sudan [8]. In Switzerland, FGM affects approximately 14,700 women according to data from the Federal Service

of Public Health [9]. Women with FGM living in Switzerland are primarily from Eritrea, Somalia and Ethiopia. Most of these women belong to vulnerable populations, due to their recent arrival in Switzerland and additional forms of insecurity (e.g., unemployment and financial instability, lack of health insurance, and lack of residential permit).

In response to growing concern about FGM in many European countries, new guidelines were established in 2000 to provide a common treatment protocol with specific medical recommendations [10]. Surgical procedures to restore normal physiology have been developed and are practiced in France [11], Belgium, The Netherlands and Sweden. In Switzerland and elsewhere, however, reconstructive surgery is not the primary treatment. Due to a lack of robust evidence on the efficacy of the reconstructive surgery [12,13], the management of women with FGM has focused on addressing obstetrical complications and the psychological impact of FGM. Sexuality is rarely taken into account [14]. In some countries, multidisciplinary approaches are being initiated, with healthcare teams including physicians, nurses, psychologists and sexologists [15,16]. In France, this approach is mostly connected to the reconstructive dimension (surgical and psychosexual) [17]. Along with other countries, Switzerland has developed a clinical protocol to aid women with FGM [18] which seeks to integrate psychosexual therapy, rather than pursuing reconstructive surgery.

In the last three years, Switzerland has implemented research and other actions to address the impact of FGM among women within the country. These efforts include national public health reports to map existing services within Switzerland and studies approaching the issue from the perspective of health care professionals [19], to inform management needs [20] or make recommendations for health care [21]. In this article, we present data concerning the sexual and reproductive lives from the point of view of women with FGM and use a qualitative approach. Health and sexual dimensions are here understood as sociological objects and not interpreted exclusively by medical categories. This approach allows us to propose a larger and interdisciplinary reflection. The aim of this study is to provide clinicians and policymakers with useful information to improve follow up and health care services that assist women living in Switzerland with this type of FGM.

2. Methods

2.1. Participants

This qualitative research was conducted between July and December 2011 at a university hospital in Switzerland. We recruited women of sub-Saharan origin living in Switzerland, between 18 and 45 years old, with or without children, who had undergone a specific type of FGM (infibulation) visiting the Department of Gynaecology and Obstetrics. We approached a total of 20 women, and 10 agreed to participate in the study. Women were approached by midwives or gynaecologists, and word of mouth was used to recruit. All of the participants were at the hospital for a postnatal follow-up consultation. Two women withdrew consent just prior to participation due to time constraints, mentioning a "hold-up" and a "lack of time". Half of the group of recruited women refused to participate for three reasons: the topic was considered to be too sensitive after delivery (two women); the baby was too little to move with (three women) or they did not wish to undergone the interview with the baby (five women). Some of them expressed the wish to postpone the interview later.

2.2. Data Collection

We conducted semi-directed in-depth interviews using a structured questionnaire (including both open-ended and directed questions) [22]. The investigator filled out the questionnaire based on the participants' response and asked open-ended questions to promote the disclosure of the subjective narrative [23]. Questions were the same for each respondent and asked in the same order. Given the linguistic and cultural barriers between the researchers and the participants, as well as the sensitive nature of the subject matter, we worked in partnership with specially trained health care interpreters. These interpreters were all women (to avoid problems with gender bias during translation) and

were also intercultural mediators previously trained on issues relating to FGM [24,25]. The hospital was chosen as the place to conduct the interviews in order to ensure privacy and confidentiality. All interviews were recorded and completely transcribed by the researcher (MV).

The research protocol (n° 314/2011) was approved by the Cantonal Ethics Committee for Research on Humans. Particular precautions were taken at the ethical level. All sensitive data (such as name, address, places, etc.) remained confidential and were anonymous. The women were offered the possibility to talk with a sexual therapist or the gynaecologist if needed after the interview and if they had questions. The psychological unit was alerted in case it would be requested or needed by the women.

2.3. Measures

Using the updated WHO classification of the medical consequences of FGM [1], we asked the women to estimate, based on the somatic consequences described by the research team during interview, their own health status and ultimately their experienced diseases. This article presents the somatic consequences of FGM as reported by the women themselves, based on a subjective self-evaluation, rather than a specific medical diagnosis. This approach is based on the French survey "Excision and Handicap", which is particularly innovative because it uses the model of handicap and disability elaborated by the WHO [26].

Based on the categorization system proposed by the WHO [1], we separated the health consequences of FGM into three categories: (1) short-term medical consequences (e.g., pain, bleeding, urinary retention, infection and shock bound to the event) [27,28]; (2) long-term medical consequences (e.g., pelvic infections, infertility, menstrual difficulties and obstetric problems) [29,30]; (3) and sexual [31,32], mental and social consequences (e.g., change of sexual sensitivity, anxiety and depression) [33–35]. Furthermore, given the stress that the affected region of the body, involved in infibulation, is put under, we considered childbirth a potentially painful experience [36]. Further, some note that the use of technical procedures, such as episiotomy or deinfibulation [37,38] could reactivate traumatic memories of FGM for some women [33]. Therefore, we asked the women to describe both their sexual experiences (first sexual intercourse and follow up) and childbirth experience(s). We also provided the participants a list of possible immediate consequences after FGM, such as excessive bleeding, difficulty urinating, inflation of the sex, pelvic infection, pain (during <48 h; between 48 am and 1 week; >1 week) and potential mid-term or long-term consequences, such as dysmenorrhoea, locking of the vaginal opening, the hindrance of normal blood flow, vaginal infection, keloids, urinary infection, pains between periods, cysts, fistulae, urinary incontinence and/or faecal incontinence.

2.4. Terminology

Given the variability and diversity within these traditional practices, defining terms and using precise language is essential. In some official documents, especially within the legal and medical domains in Europe and North American, the term "female genital mutilation/cutting (FGM/c)" [7] or "female sexual mutilation" is used for these practices [9]. However, the terms used may vary based on the ethnic membership or geographical areas in which they are performed or studied [6]. Our study primarily focuses on women from East Africa, who have undergone so-called Type III FGM, commonly called "infibulation" or, in the local Somali language, "*sunna gudnin*" [39]. According to the WHO, Type III FGM (or "infibulation") consists of: "narrowing of the vaginal orifice with creation of a covering seal by cutting and positioning the labia minora and/or the labia majora, with or without excision of the clitoris" [1]. This type of FGM is primarily practiced throughout the Horn of Africa, particularly in Somalia, one of the most represented countries of origin among immigrants from sub-Saharan regions living in Switzerland [40]. In order to reflect the data and to respect the complexity of the phenomenon, in this study we use "infibulation" terms that the women in this study used during interviews.

2.5. Data Analysis

All interviews were recorded and completely transcribed by the researcher (MV). Inherently qualitative analyses were performed, including detailed descriptions, direct quotations and observations from the interviews [41]. Emotions expressed by women during interviews have also been registered and taken into account [42]. In particular, the collected data allowed for content analysis, based on thematic categories, produced by manual coding [43].

3. Results

3.1. Women's Background and Demographic Profile

Eight women participated in the study. All of the participants were migrants who had emigrated from sub-Saharan countries. Seven came from Somalia and one woman was from the Ivory Coast. Five of the Somali women came from an urban area (Mogadishu), while the other two came from rural areas and small villages. All of the Somali women requested linguistic interpreters, except the Ivory Coast woman who spoke French fluently. As an alternative she asked to the Obstetrician to stay during the interview. At the time of the interviews, the women were between 26 and 39-year-old. Five women had received no formal education, while two of them had received primary school education and only one attended secondary school education. They were mostly professionally inactive, principally due to the resident permit type (or the lack thereof). All of the women in our study were mothers. Women had between one and four children. Most of them were currently living with their partners, while two had separated from their husbands, and one was single. Women's profiles are recap below in Table 1 (names have been changed):

Table 1. Recap of interviewed women.

Name	Age	Country of Origin	Marital Status	N° Children	Profession/Job	Education	Age at Excision/ Infibulation
Gabrielle	24	Somalia	Married	3	Unemployed	Unschooled	8
Jeanne	38	Somalia	Divorced	3	Unemployed/interpreter	Secondary	8
Cindy	29	Somalia	Married	3	Unemployed	Primary	7
Fiona	32	Somalia	Couple	2	Food service	Primary	10
Anita	30	Somalia	Married	3	Health care assistant/ Unemployed	Further education	6
Samya	27	Ivory Coast	Single	1	Unemployed	Unschooled	10
Nadia	23	Somalia	Married	1	Unemployed	Unschooled	8
Zoé	28	Somalia	Married	2	Unemployed	Unschooled	4

3.2. The Circumstances of the Traditional Ritual

All women of our study underwent infibulation (FGM/c Type 3, according to the WHO classification). Five of them underwent the procedure between ages 4 and 9-year-old, whereas two women have been infibulated later at age 10 and 15-year-old, respectively. Almost all of the women recalled this moment as highly painful. One exception was Anita, a 30-year-old Somali woman, who underwent infibulation in a private clinical under general anaesthesia.

The context in which the infibulation was practiced varied: for some women it took place in their own home, while others were in the home of the practitioner. Generally, the women recounted that the ritual involved a small group of girls or that they were alone. In the following two examples, the women offer accounts of their differing experiences, revealing the impact of context on the recounting of the experience of FGM.

The first case is Samya, a 27-year-old woman from the Ivory Coast, for whom the FGM was performed in the area outside her rural village with 25 other girls in a celebration involving the whole village. While Samya talked about "excision" during the interview, the Obstetrician who followed Samya during her pregnancy (and who was present at the interview), specified that Samya had

undergone an "infibulation" on her medical report. In fact, all external parts of her genitalia had been excised, resulting in significant scarring and adherence of the labia minora, producing the effect of the vagina closing that is typical of a Type III FGM. Samya reported that she felt "traumatized" by her "excision" and that the "pain marked her mind for forever".

The second case is Anita, the eldest daughter of an Islamic community leader. Her story is unique among the group of women. Her family was part of the upper social class of Mogadishu, and she attended school and achieved a high level of education. Later she moved to Dubai with her family, where she worked as a nurse in a hospital. Her infibulation was performed under general anaesthesia in a private clinic by medical staff, and she received anti-anxiety treatment throughout her recovery. Anita's perception of FGM was impacted by the circumstances of her infibulation, both the surgical operation as well as the clinical follow-up. She described having undergone a "light" version of infibulation, while the other women, who were cut by female traditional practitioners, communicated a greater level of pain, as Jeanne and Fiona recall:

> The worst was the pain…because when you need to go pee or when you have your period, that was screaming, we all waited standing… (Jeanne, Somali, 38-year-old, interpreter).

> The worst was the days after when it starts to…when scars start to heal. Then we start to feel the real pain (Fiona, Somali, 32-year-old, food service employee).

Nearly all of the women recalled a two-week "convalescence" period, during which girls laid down on the ground or in bed, spending most of the time with their legs tied together. Activities including urination, moving and walking were described as particularly painful. For Fanny, the convalescence period and immobility lasted longer:

> I stayed sixty days in the house, without getting out, without seeing people. I needed one month to be good and standing up (Fiona, Somali, 32-year-old, food service employee).

After a period of immobility, the girls were allowed to stand and walk around, as Cindy, a 29-year-old Somali woman, reported:

> After one week and a half or two, we began to walk, but we always had our legs tied: we made small steps (Cindy, Somali, 29-year-old, unemployed).

Jeanne, a 38-year-old Somali woman, also has a unique profile. She received secondary education and had travelled a lot before coming to Switzerland. Jeanne works as a linguistic interpreter. She stated that, in Somalia, mothers do not talk about sex with their children. The topic is considered "bothering" (*being ashamed*): "if girls speak about sexuality they get a bad reputation in the community, they are considered as ill-mannered and all their family is stigmatized for that." Jeanne said that the topic of the infibulation is rarely discussed, and that the practice remains unquestioned. All of the women reported that no clear reason for the FGM was given, and that no explanations were offered before or after the infibulation.

3.3. Reproductive Life: Timing, Experienced Diseases and Values

The women in this study had common trajectories regarding the initiation of sexual activity. Most had their first sexual intercourse between 21 and 25-year-old, relatively late when compared to averages in European countries. For example, the average age of first sexual intercourse is 17-year-old in France and 16-year-old in Switzerland. The first sexual encounter took place with their husband or future husband on their wedding night for the women in our study. For the interviewed women, becoming sexually active coincides with the reproductive period: they initiate sexual intercourse in order to become pregnant. Use of contraception was delayed until after delivering at least one child, and most of the time waiting until the birth of the expected or desired number of children (at around 30-year-old). At the time of the interview only three women were using contraception.

The women reported numerous symptoms after infibulation. We showed the participants a list of immediate somatic consequences following infibulation and asked if they had experienced any of the following problems: excessive bleeding, difficulty urinating, inflammation, pelvic infection, pain (with specification of duration: less than 48 h; from 48 h to 1 week; more than a week). Each item was translated in the Somali language and the interpreter explained each symptom to ensure full comprehension of the health problem. All of the women—except Anita (who underwent the procedure in a hospital setting)—reported a sharp pain. Difficulty urinating was a frequent consequence, cited by six women.

In the same manner as somatic consequences, we listed a number of potential problems relating to reproductive and sexual health for the interviewed women. The listed symptoms were dysmenorrhoea, locking of the vaginal opening, disruption of normal blood flow during menstruation, vaginal infections, keloids, urinary infections, pain between periods, cysts, fistulae, urinary incontinence, and faecal incontinence. Almost all of the women reported multiple and coexisting symptoms. The most common problems cited by the women were dysmenorrhoea (five women), vaginal locking preventing blood flow during menstruation (four women), keloids (four women) and vaginal infections (four women). In response to our questioning, the women stated the belief that their health had been negatively affected by the infibulation. Other problems appeared less frequently; in particular, urinary infections (three women) and pain with menstruation (two women). Only one woman reported having been affected by cysts, while none reported fistulae, urinary or faecal incontinence.

The major health problem for almost all of the women was childbirth. Women reported significant fear in anticipation of delivery, having heard dramatic stories of women dying during childbirth. All women in our study required medical assistance during delivery: five women required a defibulation (the reopening of the vaginal orifice) and another three women had a caesarean. During the interviews, the women described childbirth as a very emotional experience, embedded with fear and a strong sensation that the whole body was "ripping and tearing", as Fiona described:

> This is super rough for excised women. . . I mean the moment of the delivery. Because it is a part of your body, which was always natural, and that has been stitched, closed and so then it makes a double pain when you give birth (Fiona, Somali, 32-year-old, food service employee).

3.4. Sexual Life: Intimate Relationships, Context and Experiences

When prompted, the women in our study answered all of the questions about their sexuality. Again, the women received a list of possible problems during sexual activities from which they could select multiple options and provide further explanations to deepen their responses. Most of the time, they described the moments preceding intercourse as "a source of stress, anxiety and pain". The problems listed were pain with penetration, pain during sexual intercourse, pain after sexual intercourse, absence of desire, difficulty achieving orgasm, vaginal dryness, and vulvar burning. Most women reported pain during and after sexual intercourse (five women), as well as difficulty achieving orgasm and the presence of vaginal dryness (five women). Four women reported feeling pain during penetration, while only two described vulvar burning during and after intercourse.

Next, we encouraged the women to think about the potential link between health problems and their infibulation. The women did not, however, establish a direct link between these two experiences initially. With further exploration of this possible connection, some of the women allowed that "it could be very possible" that a causal link exists, as they experience significant pain and sensitivity in their genital area. Relating to this point Nadia, a 23-year-old Somali woman from a nomadic ethnic group that resides in a remote interior region far from Mogadishu, recounted the painful experience. Her infibulation was a very frightening experience. She was cut by a female traditional practitioner with rudimentary tools and the operation was repeated four times before the practitioner stated that it was "well done". She underwent the procedure for the first time at the age of 5; an excruciating

experience she said she "will never forget". The procedure was repeated several times and led to permanent injuries:

> It was very difficult because it doesn't work the first time and they had to do it four times. On several occasions…it was four times. In each region, there's people who are more strict than others…in Mogadishu it's easier, but in the country it's very hard. They want to be sure that they have well done and so then they did several times to make sure. There are very bad memories for me…four times. I cried, they bound me; they tied my feet, my hands. I was restless (Nadia, 23-year-old, Somali, unemployed).

Samya described her experience differently, focusing more on the different types of relationships she has experienced. For her, any pain felt during intercourse was related to the aggressiveness of her partners and to the specific context. Only after migrating and meeting a more sensitive partner (from sub-Saharan region too), with whom she ultimately had a child, did she start to question her past intimate relationships and the link between pleasure and FGM:

> In my region, men are very different. Over there if you feel pain or not, that's not their problem. If I feel bad or sick, I keep that for me…I can't say to my boyfriend "It hurts me"…The purpose *is* to hurt actually. Men purpose over there is exactly to hurt you. So you have not said "yes it hurts"…that's not his problem if it hurts you or not. When I was there, I felt big pain. The man with whom I had my son here was not violent; he was not brutal compared to my first boyfriend in the country. I saw the difference (Samya, 27-year-old, Ivory Coast, unemployed).

When we inquired about self-inspection, women said that they found it difficult to look at their own genitals. Women said that they felt "blocked" and some underlined "a lack of initiative" during sexual intercourse. Some women mentioned a feeling of "distance" toward their bodies "as there's nothing to explore". Using Samya's words:

> For years, I've never seen how it was…what they did to it. When I was pregnant, they told me to look once to see how I am. It was here (in Switzerland) that I've seen myself first. And I realized that I have nothing. There's nothing over there. I've cried and then I said to myself that crying will not give me back what they've taken. I have nothing. It is like if you have been shaved off. Everything has gone (Samya, 27-year-old, Ivory Coast, unemployed).

When asked generally about their opinions on sex, women asserted that they "do not want sex" and that it is the husband "who comes and takes". For some, this approach reflects "something normal", as Anita explained: "a good woman does not run after the men" and added as an explanation: "a woman asking for sex is seen as very bad". Some women emphasized the moral dimensions underlying the infibulation over the physiological symptoms, and the women rarely explained the absence of sexual desire as a consequence of their infibulation. Some women in our study said that expressing sexual desire to a man is considered "vulgar" and "not appropriate to a well-educated woman". However, others established a link between infibulation and a limited sexual desire.

> It is evident, infibulation plays a role on pleasure, but it also depends on persons and on which kind of infibulation she has undergone. In Somalia there are different types of infibulation. For example, girls who have undergone a type sunna like these last years, that's the majority…and they look by their own for men! They have a lot of desire. But the infibulation that I have undergone, there's no desire, we don't look for nothing. If the man comes, we feel that desire but anything else (Cindy, 29-year-old, Somali, unemployed).

4. Discussion

4.1. Findings and Interpretation

Seven of the eight women in our study were from Somali, and one woman was from the Ivory Coast. In addition to country of origin, age, social class and geographic region also help to interpret the medical narratives of these women. In our study, migration represents a transition at which point memories of infibulation and cultural background are reviewed. As previously described in the literature [44–46], our study confirms that social class and social context have a major impact on how women understand and recall their FGM experiences. This is particularly true for women infibulated in a rural setting using rudimentary tools (such as in Samya's case) or belonging to the lower social class living in a rural region (Nadia's case) when compared to women from an upper social class, living in the capital or urban region and infibulated under anaesthesia in a private clinic (Anita's case).

The second group of results presents women's subjective perception of their reproductive and sexual health. When we showed the women a list of potential problems that could result from infibulation, they indicated several health problems that they experienced and perceived during their lives. Through their participation in this study, the women adopted the medical language introduced in order to describe the symptoms and other problems they were experiencing. Upon recognizing these medical problems, they were better able to identify the impact of infibulations on their everyday lives (painful menstruation and cysts), in their sexual lives (dryness and lack of desire) and relating to childbirth (requiring medical interventions).

4.2. Strengths and Weaknesses of the Study

Our findings clearly demonstrate the profound impact of FGM on women living in Switzerland. In addition to working toward prevention in younger generations, these results highlight the importance of addressing the current reproductive and sexual health needs of women similar to those in our study. Although the women did not initially make the connection between infibulation and their health and sexuality, when prompted and given examples, the women related the two.

From a methodological standpoint, this study illustrates the feasibility of conducting research that addresses this very sensitive theme: the phenomenon deserves to be studied on a larger sample. We also underline the ethical choices in our data production: our approach centred on engaging the women themselves [47] in the process of recalling, contextualizing and framing their experiences and the health consequences. Unexpected findings concern the exclusiveness of the women's narratives: for some of them the interview represented the first time that they have spoken about their infibulation in a specific way. An annexed major finding is that the women become aware about symptoms or sexual difficulties suggested during interview, which were until then ignored. Particularly, the link between the infibulation and some of the somatic consequences listed, was often not recognized by the women of our study. It therefore requires support (such as multidisciplinary counselling) in the rediscovery of the body and sexuality. This seems to be a major public health issue.

The principal and most evident weakness of our study is the small sample on which the whole study is based on. We are aware that, due to the sample's size, any generalization cannot be drawn. However, the participation of the women and the qualitative approach that we defend, allows a deeper comprehension about the inner knowledge of FGM coming from women's perspectives.

4.3. Differences in Results and Conclusions

The third set of results explores the sexual lives and experiences of the women in our study. These findings offer novel insights into the views of sexuality, and represent the most significant contribution of this study. Specifically, the women in our study—originally from Somalia and the Ivory Coast and having undergone infibulation—separated sexual desire from sexual pleasure. While they interpreted the absence of desire as a "normal condition" of female sexuality [48,49], they also report experiencing several negative consequences of the infibulation, including lack of vaginal lubrication

during sex, pain with penetration and vaginal itching. For the women in this study, sexual desire was a question of morality and education, and its presence (or lack thereof) reflected on a woman herself and impacted her family's reputation. Sexual desire and sexual pleasure are two distinct entities which emerge from the women's narratives. While most of them link desire to a normative dimension, shaped by socialization, education and moral values suppressing its expression, pleasure is seen as a welcome, sensitive experience which is not rejected or repressed, confirming previous research [13]. In fact, most of the women clearly expressed their discomfort, dissatisfaction, distress, regret or even pain during sexual encounters, consistent with past research [50]. The women discussed and expressed notions of sexual desire within the codes that exist in all cultures and societies and considered these codes to be "normal" [51,52]. However, the women were also aware of and concerned by their many symptoms and wished to improve their intimate relationships, as in Samya and Jeanne's cases. Sexual pleasure is often inaccessible, and the women in this study described this as problematic. For example, the first sexual encounter was frequently described as an experience marked by pain and fear. Through the interviews, we also found that the quality of their marital relationship was very important for the women, including communicating and sharing their feelings with their partner to improve wellbeing.

4.4. Relevance of the Findings: Implications for Clinicians and Policymakers

Through participation in the interviews, the women in this study had the opportunity, sometimes for the first time, to address the topic of infibulation. The content of the interviews suggests that symptoms and sexual difficulties that the women reported had not been previously recognized. The importance of speaking about their own experiences emerged during the interviews, in particular when we encouraged the women to speak about themes of intimacy and relationships. We present not only the problems reported by the women, but also their experiences and perceptions of links between infibulation and physical consequences, which the women did not initially recognize. Based on our findings, clinicians should inquire about physical symptoms among women who have undergone FGM, and explore—along with the women—their sexual function and satisfaction, and other specific needs that are identified. Furthermore, specialized health care services and intercultural communication practices, such as the use of trained interpreters, is highly needed.

4.5. Unanswered Questions and Future Research

Although our study provides new insights into the sexual and reproductive health of women who have undergone FGM, future research should seek to explore these themes in more depth with a larger sample. Several points emerged in our study that were not fully explored, such as inter-partner violence, and require further investigation. Furthermore, the ethical dimensions of these types of interviews should also be explored to determine the long-term effects on women's mental health. Finally, future research should explore the physical and emotional dimensions of intimacy and gender roles [53] in this population of women.

5. Conclusions

In conclusion, we found that infibulation is part of a process of socialization in the countries of origin of the women in our study. This practice is founded on a strict division of gender roles and an unequal access to education, and (sexual) rights and wellbeing. Female sexuality is primarily understood in relation to reproduction; sexual desire is seen as a potential danger to the stability of marital devotion. Relationships, especially marital ones, follow strict gender roles.

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